RADIOLOGY / NUCLEAR MEDICINE

TECHNICAL MANUAL

Version 5.0
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Department of Veterans Affairs
VISTA System Design and Development
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1.0 **Introduction**

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

The package interfaces with the Record Tracking package for the purpose of tracking Radiology/Nuclear Medicine records and creating pull lists for those records needed for scheduled clinic appointments. It interfaces with and through the Health Level Seven package for the exchange of exam and report information. It interfaces with the Health Summary package to allow users to see patient histories and test results which may influence the nature of the examination. It interfaces with the Order Entry/Results Reporting package to allow requesting of exams and viewing of reports. It interfaces with the Adverse Reaction Tracking (ART) package for the exchange of data concerning a patient's allergies. It interfaces with Patient Care Encounter (PCE) for crediting outpatient imaging procedures. It also interfaces with the AMIE package to display exam results.
2.0 Implementation and Maintenance

2.1 Implementation of a Virgin Installation

1. Enter at least one division into the Rad/Nuc Med Division file #79 to activate the system. The division can be further defined by the ADPAC.

2. Give the ADPAC access to at least one Imaging Location (field #74) in the New Person file (#200). Without this, no one will be able to sign onto the system. Once the ADPAC has access, s/he must give each package user (technologist, interpreting resident physician, interpreting staff physician, or clerk) location access so they can sign on. The ADPAC can give users access with the Classification Enter/Edit [RA PNLCLASS] option. Without an assigned imaging location, a user simply cannot access the package.

3. Along with the ADPAC, determine the devices needed for each Imaging Location that will be defined. Use the option Device Specifications for Imaging Locations [RA DEVICE] in the IRM Menu [RA SITEMANAGER] to assign them.

4. You will need to associate an existing or new mail group with each of the exported bulletins (see page 21) so users can receive these Radiology/Nuclear Medicine messages. The bulletins are generated when an important action has taken place, such as the deletion of a report. Consult with the package ADPAC to determine how many mail groups to create, what mail group(s) to associate with each bulletin and who should be the mail group coordinator. It is strongly recommended that a mail group with the ADPAC and possibly an IRM support person as recipients be established and associated with the RAD/NUC MED CREDIT FAILURE bulletin. This is the only way users can be notified of credit failure due to lack of data or wrong data in Radiology/Nuclear Medicine.

5. Verifying reports¹

VISTA reports: Give the RA VERIFY key to staff who will be verifying reports and make sure they have an electronic signature.

COTS Voice Recognition Systems: In addition to the above, assign verifying privileges to staff who will be verifying reports on a COTS Voice Recognition system. Also, assign an ID to each physician that matches his/her IEN in the New Person file #200.

¹ Patch RA*5*12
6. The IRM Menu [RA SITEMANAGER] and the standalone option Imaging Type Mismatch Report [RA EXAM/STATUS ITYPE] covered in this chapter, will help with the continued maintenance of the software. Further implementation and maintenance can be done by the ADPAC and is described in full in the Radiology/Nuclear Medicine ADPAC Guide.

2.2 Implementation of an Installation over V. 4.5

1. Verifying reports

VISTA reports: Give the RA VERIFY key to staff who will be verifying reports and make sure they have an electronic signature.

COTS Voice Recognition Systems: In addition to the above, assign verifying privileges to staff who will be verifying reports on a COTS Voice Recognition system. Also, assign an ID to each physician that matches his/her IEN in the New Person file #200.

2. The burden of Implementation falls mainly on the ADPAC and is fully discussed in the ADPAC manual with a checklist of steps to use in the implementation process.

2.3 Informational Messages

There are two main messages that users may receive that concern IRM particularly during implementation after a virgin installation:

1. Radiology/Nuclear Medicine Division definition error. Call your site manager.

When a user calls about this message, it means there is insufficient information in the imaging location that was selected by the user. Make sure the ADPAC has assigned that location to a division in the Division Parameter Set-up option Rad/Nuc Med Division file (#79), field #50.

2. No default "ABC" printer has been assigned. Contact IRM.

This message appears when the ADPAC is editing an imaging location in the Location Parameter Set-up option and as yet a printer has not been assigned for that activity (jacket labels, flash cards, or exam labels). Use the option Device Specifications for Imaging Locations [RA DEVICE] to assign them.

1 Patch RA*5*12
2.4 Maintenance

Information throughout this manual is meant to help IRM in the maintenance of the software. The discussion that follows here covers the options available to assist IRM in that maintenance.

2.4.1 Imaging Type Mismatch Report

This option is not assigned to any menu. It generates a report listing each case where the imaging type of the visit does not match the imaging type of the current exam status. These cases should be edited to Complete as soon as possible to correct the exam status. This mismatch condition may have happened around the time a previous version was installed, but new mismatches should not occur.

The report requires 132 column output and displays the patient name, SSN, exam date/time, case number, imaging type of the visit, exam status and imaging type of the exam status for each discrepancy. Radiology/Nuclear Medicine personnel can use the case edit options to move these exams to a Complete status which automatically resolves the mismatch.

2.4.2 IRM Menu

2.4.2.1 Device Specifications for Imaging Locations

This function allows you to assign device names for printers to which the software will direct various outputs. Each imaging location can be assigned its own set of printers.

When a user signs on the system and tries to access the module, the first action by the module will be to determine which division and location the user is associated with. During the entire session the system automatically uses the parameters that the coordinator has specified for that division and location. For example, the user need never be asked how many flash cards to print or what flash card format if the parameters contain that information.

Once parameters are entered for default printers (flash card, jacket label, radiopharmaceutical dose ticket, report, request and request cancellation) and the printer names have been assigned to the location, output will automatically be routed to these devices.
If a default printer is not entered, the user will be prompted to select a printer at the
time they initially access the Radiology/Nuclear Medicine package. If a default
printer is not selected at the time of initial access to the package, the user will be
prompted for a printer each time they elect to print a flash card, jacket label, request,
or report.

Note: When an exam is requested via the Request an Exam option, the prompt,
"Submit Request To:" is screened. Therefore, if a Request Printer is malfunctioning,
it will have to be changed for that location until the printer is fixed. This is an option
that you may wish to assign to the package ADPAC.

One of the new fields, Dosage Ticket Printer, only appears if the Imaging Location
you select is an Imaging Type of Nuclear Medicine or Cardiology Studies.

The option requests the Imaging Location name and then default printer names for:

Flash Cards
Jacket Labels
Requests
Reports
Dosage Tickets
Cancelled Requests

2.4.2.2 Distribution Queue Purge
[RA RPTDISTPURGE]

The Distribution Queue Purge option allows you to purge the distribution files. This
can be done to eliminate old reports that have already been printed or reprinted.

The information purged includes the Activity Log in the Reports Distribution Queue
file (#74.3) and the reports in the Report Distribution file (#74.4).

You are prompted for a purge date and a device. Any reports printed prior to that
specified date are purged from the distribution files.

A mail message will be sent to you with the results of the purge which includes the
date/time the purge begins and ends.

---
Subj: Distribution Queue Purge   [#12256]  09 Feb 97 11:34   4 Lines
From: Radiology Package in 'IN' basket.      Page 1  **NEW**

Purge distribution files of reports printed before JAN 1,1997

Distribution files purge process begun at FEB 9,1997  11:34
Distribution files purge process completed at FEB 9,1997  11:34
---
Note: Occasionally, a facility has kept the Distribution Queues active, but reports have not been printed for a long time causing a high volume of unprinted reports to sit in the queue. This purge option is not designed to purge unprinted reports. To delete unprinted, historical reports that you do not want to print from the queues, use the Rebuild Distribution Queues [RA RPTDISTREBUILD] option. Rebuilding also supports populating the queues with reports verified on or after a date you choose.

2.4.2.3 Failsoft Parameters
[RA FAILSOFT]

The Failsoft Parameters option allows you to specify the Operating Conditions parameter. This feature will be obsolete in the future. It previously ignored imaging location devices if in emergency mode, but it no longer completely supports that.

2.4.2.4 Imaging Type Activity Log
[RA IMGLOG]

The Imaging Type Activity Log option enables you to acquire a hardcopy log of certain activities.

The log includes the following information by Imaging Type: the date on which the activity occurred, the type of activity, the user who initiated the activity, the number of exams affected (if any) and the number of reports affected (if any).

The types of activities listed are:

Changes in imaging type parameters
Scheduled data purges
Completion of data purges
Modification of on-line data criteria (changes made through the Purge Data Function option)

2.4.2.5 Purge Data Function
[RA PURGE]

1The Purge Data Function option enables you to purge specific data from the system without affecting the integrity of the patient records. The data purge deletes the report text, clinical history, and activity log entries from the Rad/Nuc Med Report file #74. However, if the report was amended, nothing is deleted. On the Rad/Nuc Med patient file #70, the activity log, clinical history, and exam status times are deleted. The entire request entry in the Rad/Nuc Med Orders file #75.1 is deleted.

1 Patch RA*5*26 Additional text description
You must enter cut off dates (or accept the default) for the following types of data which may be purged using this option:

1. Activity logs (ACTIVITY LOG CUT-OFF)
   - Purges the ACTIVITY LOG subfile from File #74
   and
   - Purges the ACTIVITY LOG subfile from File #70

2. Reports (REPORT CUT-OFF)
   - Purges the REPORT TEXT (not the impressions) subfile from File #74

3. Clinical histories (CLINICAL HISTORY CUT-OFF)
   - Purges the CLINICAL HISTORY subfile from File #74
   And
   - Purges the CLINICAL HISTORY FOR EXAM subfile from File #70

4. Status tracking times (TRACKING TIME CUT-OFF)
   - Purges the EXAM STATUS TIMES subfile from File #70

5. Order data (ORDER DATA CUT-OFF)
   - Purges the record (entire procedure request) from File #75.1

At each prompt concerning one of the above data types, you will be setting the imaging type parameter for the number of days to keep the various activity logs online. The number of days for each should be determined by the coordinator and the IRM site manager.

The number of days must be a whole number between 90 and 9999 for Activity Logs, Report, Clinical History, Tracking Time. The default number of days for the Order Data Cut-Off is 90 and, if changed, must be a whole number between 30 and 9999. The orders which will be purged include those whose last activity date is greater than the number of default days and whose order status is Discontinued, Hold, Complete or Pending. Order purges can also be initiated by OE/RR. The report impressions will remain on-line even after purging.

This operation should be run during off-hours. A system backup should be completed prior to execution of the purge routine.
**1Output**

The output will include the date/time the purge starts and finishes, and all purge statistics compiled for records processed, reports processed and requests processed. Entries are made to the imaging type activity log showing any changes to on-line criteria, purge routine scheduling and a record of completion.

The following describes how to interpret the summary counts in the output.

<table>
<thead>
<tr>
<th>Purge Counts</th>
<th>Count even if only 1 of 3 is within cut-off days</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of exam record processed</td>
<td>ACTIVITY LOG CUT OFF and/or CLINICAL HISTORY CUT OFF and/or TRACK TIME CUT OFF</td>
</tr>
<tr>
<td>No. of reports processed</td>
<td>ACTIVITY LOG CUT OFF and/or CLINICAL HISTORY CUT OFF and/or TRACK TIME CUT OFF</td>
</tr>
<tr>
<td></td>
<td>Count only if order was purged within cut-off day AND other criteria</td>
</tr>
<tr>
<td>No. of requests processed</td>
<td>ORDER DATA CUT-OFF</td>
</tr>
</tbody>
</table>

By purging information that is unnecessary for the maintenance of the system and associated patient records, you will extend your disk space and possibly speed up processing time.

**Note:** Be sure you do a system backup before you choose to purge data.

The following is an example:

```
Do you want to edit the Imaging Type purge parameters? Yes// <RET>
Select IMAGING TYPE: ULTRASOUND

Please indicate how many days each type of data should remain on-line:

ACTIVITY LOG CUT-OFF: 90
REPORT CUT-OFF: 90
CLINICAL HISTORY CUT-OFF: 90
TRACKING TIME CUT-OFF: 90
ORDER DATA CUT-OFF: 90// <RET>
Select IMAGING TYPE: <RET>
Do you wish to schedule the data purge? No// ?

Enter 'YES' to schedule the data purge, or 'NO' not to.
```

---

1 Patch RA*5*26 Additional text description.
Do you wish to schedule the data purge? No// Y

IMAGING TYPES
------------
1) ANGIO/NEURO/INTERVENTIONAL
2) CARDIOLOGY STUDIES (NUC MED)
3) CT SCAN
4) GENERAL RADIOLOGY
5) MAGNETIC RESONANCE IMAGING
6) MAMMOGRAPHY
7) NUCLEAR MEDICINE
8) ULTRASOUND
9) VASCULAR LAB

Select Imaging Type(s) to Purge: (1-8): 7
Do you wish to re-purge records that have been purged in the past? No// <RET>

DO YOU WANT YOUR OUTPUT QUEUED? NO// YES

Requested Start Time: NOW// <RET>
  Request Queued. Task #: 10157

Purge data routine started at MAR 1,1997 01:05.
Purging exams/reports.
Purging orders/requests.
Data purge completed at MAR 1,1997 01:18.
The following purge statistics were compiled:

  No. of exam records processed : 863
  No. of reports processed      : 620
  No. of requests processed     : 796

2.4.2.6 Rebuild Distribution Queues
[RA RPTDISTREBUILD]
The Rebuild Distribution Queue option allows you to rebuild distribution files with reports verified on or after a selected date.

Rebuilding the distribution queues allows the user to reprint reports that have been printed through the Distribution Queue Menu and then purged through the Distribution Queue Purge option. This might be necessary if the original reports were misplaced, if a printer has jammed, etc.

This option can also be used if a facility which has not been using Distribution Queues wants to clean out the queues completely and rebuild with only the reports
verified after a chosen date. In this way, the queues can be cleared without printing any reports.

Depending on the category of the report and the requirements of the distribution queue, there will be an entry made in the Report Distribution file (#74.4) for each report and the corresponding queue. In other words, if a report has a category of Outpatient and both the Clinic Reports Queue and the File Room Queue include outpatient reports, two entries will be made in the Report Distribution file (#74.4).

The output from this option will show the number of reports used to rebuild the distribution files.

This report should be queued to a printer.

### 2.4.2.7 Resource Device Specifications for Division

[RA RESOURCE DEVICE]

If your facility wishes to control the rate at which tasked exam status updates are released to be processed, use this option to enter resource device specifications. This is advised if the facility is experiencing drastic system slowdowns due to periodic heavy use of the online report verification and batch verification of reports options, which can queue a large number of tasks at once. However, if you choose to enter a Resource Device in this field, you should be careful to completely follow all directions in Kernel documentation after a system crash to bring this Resource Device back up. Failure to follow those directions could result in Rad/Nuc Med tasks being severely delayed and data corruption.

When you select the option, you are asked to enter a Division and the Device.

### 2.4.2.8 Template Compilation

[RA COMPILE TEMPLATES]

This option recompiles Radiology/Nuclear Medicine input and print templates which are currently compiled. It is advised that all Radiology/Nuclear Medicine users be off the system while the templates are being recompiled. The user may select compiled templates from any or all of the Radiology/Nuclear Medicine package files that have compiled templates. Also, the user will select the maximum size of the compiled routines.

Here is an example:

<table>
<thead>
<tr>
<th>Template Compilation</th>
</tr>
</thead>
<tbody>
<tr>
<td>This option will compile all Radiology/Nuclear Medicine input and print templates (within the defined file number range) which</td>
</tr>
</tbody>
</table>
are currently compiled on your system. Since these templates are critical to the operation of the software, it is strongly advised that all Radiology/Nuclear Medicine users be off the system. It is also strongly advised that the compilation of templates be done when system activity is at a minimum.

Is it ok to continue? No// **YES**

Maximum routine size on this computer in bytes. (2400-5000) : 5000//<RET>

Select Rad/Nuc Med Input Template: ??

Select a INPUT TEMPLATE NAME from the displayed list.
To deselect a NAME type a minus sign (-) in front of it, e.g. -NAME.
To get all NAMES type ALL.
Use an asterisk (*) to do a wildcard selection, e.g., enter NAME* to select all entries that begin with the text 'NAME'.

Choose from:
- RA ORDER EXAM File #: 75.1
- RA QUICK EXAM ORDER File #: 75.1
- RA REGISTER File #: 70
- RA REPORT EDIT File #: 74
- RA VERIFY REPORT ONLY File #: 74

Select Rad/Nuc Med Input Template: **ALL**

Another one (Select/De-Select): -RA REPORT EDIT File #: 74

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

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

You have already selected:
- RA ORDER EXAM File #: 75.1
- RA QUICK EXAM ORDER File #: 75.1
- RA REGISTER File #: 70
- RA VERIFY REPORT ONLY File #: 74

Choose from:
- RA REPORT EDIT File #: 74

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

Select Rad/Nuc Med Print Template: **ALL**

Another one (Select/De-Select): ??
Select a PRINT TEMPLATE NAME from the displayed list.  
To deselect a NAME type a minus sign (-)  
in front of it, e.g., -NAME.  
To get all NAMES type ALL.  
Use an asterisk (*) to do a wildcard selection, e.g.,  
enter NAME* to select all entries that begin  
with the text 'NAME'.  Wildcard selection is  
case sensitive.

You have already selected:  
RA REPORT PRINT STATUS   File #: 74

Choose from:

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

Are you sure you wish to compile the selected templates? No// YES

Input template to be compiled: RA ORDER EXAM  
For file #75.1: RAD/NUC MED ORDERS  
Routines filed under the following namespace: 'RACTOE'.

Compiling RA ORDER EXAM Input Template of File 75.1...  
'RACTOE' ROUTINE FILED.....  
'RACTOE1' ROUTINE FILED.....  
'RACTOE4' ROUTINE FILED.....  
'RACTOE5' ROUTINE FILED.....  
'RACTOE6' ROUTINE FILED........  
'RACTOE8' ROUTINE FILED..  
'RACTOE2' ROUTINE FILED..  
'RACTOE3' ROUTINE FILED...  
'RACTOE7' ROUTINE FILED.  
Done!

Input template to be compiled: RA QUICK EXAM ORDER  
For file #75.1: RAD/NUC MED ORDERS  
Routines filed under the following namespace: 'RACTQE'.

Compiling RA QUICK EXAM ORDER Input Template of File 75.1....  
'RACTQE' ROUTINE FILED......  
'RACTQE1' ROUTINE FILED......  
'RACTQE3' ROUTINE FILED.......  
'RACTQE4' ROUTINE FILED...  
'RACTQE6' ROUTINE FILED..  
'RACTQE2' ROUTINE FILED...  
'RACTQE5' ROUTINE FILED.  
Done!

Input template to be compiled: RA REGISTER  
For file #70: RAD/NUC MED PATIENT  
Routines filed under the following namespace: 'RACTRG'.

Compiling RA REGISTER Input Template of File 70..  
'RACTRG' ROUTINE FILED......  
'RACTRG1' ROUTINE FILED....  
'RACTRG2' ROUTINE FILED....  
'RACTRG3' ROUTINE FILED.......
2.4.2.9  

Report File x-ref Clean-up Utility

[RA XREF CLEANUP]

Use this option to clean-up left-over "ASTF" and "ARES" cross references from the Radiology Report file.

---

1 Patch RA*5*26
### Globals

<table>
<thead>
<tr>
<th>Global</th>
<th>Description</th>
</tr>
</thead>
</table>
| RA      | This global contains all of the general table type files used by the Radiology/Nuclear Medicine package. These files are pointed to by other files and contain various types of parameters that may be set up at each site to customize the package to meet that site's needs. The files contained in this global are:  
- Contract/Sharing Agreements (#34)  
- Route of Administration (#71.6)  
- Site of Administration (#71.7)  
- Radiopharmaceutical Source (#71.8)  
- Radiopharmaceutical Lot (#71.9)  
- Examination Status (#72)  
- Standard Reports (#74.1)  
- Rad/Nuc Med Reason (#75.2)  
- Complication Types (#78.1)  
- LBL/HDR/FTR Formats (#78.2)  
- Diagnostic Codes (#78.3)  
- Film Sizes (#78.4)  
- Camera/Equip/Rm (#78.6)  
- Label Print Fields (#78.7)  
- Rad/Nuc Med Division (#79)  
- Imaging Locations (#79.1)  
- Imaging Type (#79.2)  
  The global should be journaled and translated if the operating system supports these functions. Journaled: Mandatory |
| RADPT   | This global contains data for the Rad/Nuc Med Patient file (#70).  
  The global should be journaled and translated if the operating system supports these functions. Journaled: Mandatory |
| RADPTN  | This global contains patient exam data specific to radiopharmaceuticals for the Nuc Med Exam Data file (#70.2).  
  The global should be journaled and translated if the operating system supports these functions. Journaled: Mandatory |
| RAMIS   | This global contains all the files related to Rad/Nuc Med AMIS reporting. The files contained in this global are:  
- Rad/Nuc Med Procedures (#71)  
- Major Rad/Nuc Med AMIS Codes (#71.1)  
- Procedure Modifiers (#71.2)  
- Rad/Nuc Med Common Procedure (#71.3)  
- Rad/Nuc Med Procedure Message (#71.4)  
- Imaging Stop Codes (#71.5)  
  The global should be journaled and translated if the operating system supports these functions. Journaled: Mandatory |
| RABTCH  | This global contains data for:  
- Report Batches (#74.2)  
- Report Distribution Queue (#74.3)  
- Report Distribution (#74.4)  
  The global should be journaled and translated if the operating system supports these functions. Journaled: Mandatory |
2.5 Key Variables

<table>
<thead>
<tr>
<th>Key Variable</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RACCESS</strong></td>
<td>This local array identifies the user’s division, imaging type and imaging location access. This variable, along with RAIMGTY, RAMLC, RAMDV, and RAMDIV are package-wide variables set by the system. They are all normally computed during the login process. They are also set by the individual options of the package if they do not already exist. The routine series RAPSET* sets these variables. For any initial menu for the Radiology/Nuclear Medicine package created at the local site level, these variables must be killed. Do this by making D KILL^RAPSET1 the exit action for the menu. The array elements that identify the user’s division access look like the following: RACCESS(DUZ,&quot;DIV&quot;,File #79 IEN,File #79.1 IEN)=File #4 IEN^Division name The array elements that identify the user’s imaging type access look like the following: RACCESS(DUZ,&quot;IMG&quot;,File #79.2 IEN,File #79.1 IEN) =null^Imaging Type name The array elements that identify the user’s location access look like the following: RACCESS(DUZ,&quot;LOC&quot;,File #79.1 IEN)=File #44 IEN^Hospital Location name</td>
</tr>
<tr>
<td><strong>RABED</strong></td>
<td>Bedsection name. First piece of the zeroth-node for an entry in File #42.4 [Specialty - ^DIC(42.4)].</td>
</tr>
<tr>
<td><strong>RABTCH</strong></td>
<td>Internal entry number to File #74.2 [Report Batches - ^RABTCH()] that is used during various batch processing functions.</td>
</tr>
<tr>
<td><strong>RACLNC</strong></td>
<td>Default clinic name used in the initial exam entry process. First piece of the zeroth-node of an entry in File #44 [Hospital Location - ^SC()].</td>
</tr>
<tr>
<td><strong>RACN</strong></td>
<td>Case Number for an exam; ^RADPT(RADFN,&quot;DT&quot;,RADTI,&quot;P&quot;,RACNI,0)=RACN^...</td>
</tr>
<tr>
<td><strong>RACNI</strong></td>
<td>Internal entry number for an exam; ^RADPT(RADFN,&quot;DT&quot;,RADTI,&quot;P&quot;,RACNI,0)</td>
</tr>
<tr>
<td><strong>RACRT</strong></td>
<td>This variable is used by the various workload report routines and it contains either a 'y' for 'yes' or an 'n' for 'no' to indicate to the routine whether the exam being processed should be used in the compilation of the report. The value of RACRT is obtained from the Examination Status file (#72) entry for which the exam being processed points to. In the Examination Status file there is a field for each workload report. The variable name RACRT comes from 'CRiTeria'.</td>
</tr>
<tr>
<td><strong>RACS</strong></td>
<td>RACS=&quot;Y&quot; if the crediting has already been given to PCE (Patient Care Encounter) for the exam currently being processed.</td>
</tr>
<tr>
<td>Key Variable</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>RACT</td>
<td>Internal set value for the various activity logs throughout the system; for example, in the exam activity log 'E' means 'Exam Entry'.</td>
</tr>
<tr>
<td>RADATE</td>
<td>Date of registered exam expanded to a user readable format. (i.e., Jun 17, 1984)</td>
</tr>
<tr>
<td>RADFN</td>
<td>Internal entry number to Files #2 and #70 [Patient - ^DPT( ]; [Rad/Nuc Med Patient - ^RADPT( ]</td>
</tr>
<tr>
<td>RADIV</td>
<td>Used in the various workload reports, such as RAWKL*, RAPRC*, RALWKL*, RAMIS*, RAFLM*, to indicate the division currently being processed.</td>
</tr>
<tr>
<td>RADOB</td>
<td>Patient's date of birth. Third piece of the zeroth node of an entry in File #2 [Patient - ^DPT( ].</td>
</tr>
<tr>
<td>RADTE</td>
<td>Exam registration date/time; ^RADPT(RADFN,&quot;DT&quot;,RADTI,0)=RADTE^....</td>
</tr>
<tr>
<td>RADTI</td>
<td>Internal entry number of exam registration date/time; also the inverse exam registration date/time; ^RADPT(RADFN,&quot;DT&quot;,RADTI,0)</td>
</tr>
<tr>
<td>RADUZ</td>
<td>Most of the time this is the same as DUZ variable. However, the Radiology/Nuclear Medicine package has the 'feature' to require the user to input their access code during certain processes. RADUZ is equal to that access code's DUZ number.</td>
</tr>
<tr>
<td>RAEXFM</td>
<td>Internal entry number to File #78.2 [LBL/HDR/FTR Formats - ^RA(78.2, ] that is used for the 'exam' label.</td>
</tr>
<tr>
<td>RAEXLBS</td>
<td>Number of exam labels to be produced by RAFLH* routines.</td>
</tr>
<tr>
<td>RAF5</td>
<td>RAF5=IEN of the ward for the patient if the exam being processed was done while the patient was an Inpatient. RAF5's value is taken from the Ward field of the exam subfile of the Rad/Nuc Med Patient file.</td>
</tr>
<tr>
<td>RAFIN</td>
<td>This variable is a flag that is set inside the RA REGISTER input template. If defined after the template is exited, then the system knows that the registration process went to normal completion. If it is not defined, then the system will automatically delete that current exam because not all questions were answered during the registration process.</td>
</tr>
<tr>
<td>RAFLH</td>
<td>This variable can take on two different meanings depending on the routine that is being executed. When you first log on to the package, the routine RAPSET is executed. This routine computes various parameters for the current logon session. One of the parameters set is the printer where all the flash cards requested by the user are printed. The variable RAFLH is used to store this printer information temporarily until it is set in the third piece of the variable RAMLC. (See RAMLC description for more information.) The variable RAFLH, throughout the rest of the system, is used to specify which LBL/HDR/FTR Formats file (#78.2) entry to use when printing a flash card.</td>
</tr>
<tr>
<td>RAFMT</td>
<td>Internal entry number to File #78.2 [LBL/HDR/FTR Formats - ^RA(78.2, ] used to produce one of the following: 1) flash card (RAFLH) 2) exam label (RAEXFM) 3) film jacket label (RAJAC) 4) report header (RAHDFM) 5) report footer (RAFTFM) Before each of the above is produced, their respective routine sets RAFMT to their associated format entry and then PRT^RAFLH is called.</td>
</tr>
<tr>
<td>RAFTFM</td>
<td>Internal entry number to File #78.2 [LBL/HDR/FTR Formats - ^RA(78.2, ] that is used for the report footer.</td>
</tr>
<tr>
<td>Key Variable</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>RAHEAD</td>
<td>This is the header used when executing the utility routine RAPTLU. This routine displays the current exams on file for a patient. Depending on what the user is currently doing, the header is different.</td>
</tr>
<tr>
<td>RAIMGTY</td>
<td>This variable, along with RACCESS, RAMLC, RAMDV, and RAMDIV are package-wide variables set by the system. They are all normally computed during the login process. They are also set by the individual options of the package if they do not already exist. The routine series RAPSET* sets these variables. For any initial menu for the package created at the local site level, these variables must be killed. Do this by making D KILL^RAPSET1 the exit action for the menu. This variable tracks the Imaging Type for each user based on the location determined at sign-on.</td>
</tr>
<tr>
<td>RAJAC</td>
<td>Default jacket label printer information. (Used only in RAPSET*, the parameter setting routine executed upon logging into the program.)</td>
</tr>
<tr>
<td>RAKEY</td>
<td>During various processes in the Radiology/Nuclear Medicine system, the user must have a certain key. By setting RAKEY equal to this key and then calling USER^RAUTL the system uses one common set of code to check and verify if the user is qualified to do the current process and asks for an access code if required.</td>
</tr>
<tr>
<td>RAMDIV</td>
<td>This variable, along with RACCESS, RAMLC, RAMDV, and RAIMGTY are package-wide variables set by the system. They are all normally computed during the login process. They are also set by the individual options of the package if they do not already exist. The routine series RAPSET* sets these variables. For any initial menu for the package created at the local site level, these variables must be killed. Do this by making D KILL^RAPSET1 the exit action for the menu. The variable RAMDIV is the internal entry number to File #79 [Rad/Nuc Med Division - ^RA(79, ] . This is the division that the current location is associated with. NOTE: An imaging location can only be associated with one division.</td>
</tr>
<tr>
<td>Key Variable</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>RAMDV</td>
<td>This variable, along with RACCESS, RAMLC, RAMDIV, and RAIMGY are package-wide variables set by the system. They are all normally computed during the login process. They are also set by the individual options of the package if they do not already exist. The routine series RAPSET* sets these variables. For any initial menu for the package created at the local site level, these variables must be killed. Do this by making D KILL^RAPSET1 the exit action for the menu. The variable RAMDV has 26 pieces. Each piece contains parameter information pertaining to the current 'division' the user is signed on under. All values are '1' for 'yes' or '0' for 'no'. The following is a description of each piece:</td>
</tr>
<tr>
<td>1</td>
<td>[not used]</td>
</tr>
<tr>
<td>2</td>
<td>should a flash card be printed for each exam.</td>
</tr>
<tr>
<td>3</td>
<td>[no longer used]</td>
</tr>
<tr>
<td>4</td>
<td>[no longer used]</td>
</tr>
<tr>
<td>5</td>
<td>[no longer used]</td>
</tr>
<tr>
<td>6</td>
<td>various activity logs are kept during the processing of exams and their reports. This piece indicates whether the user should be asked for their access code during each process or should the system automatically use the user code associated with the initial logon. If 'yes' then system assumes the logon user code (DUZ).</td>
</tr>
<tr>
<td>7</td>
<td>should entry of a 'Detailed' or 'Series' procedure be required during initial exam registration. If '0' then user can enter a 'Broad' code. However, before the exam can be placed in a 'Complete' status the procedure must be changed to a 'Detailed' or 'Series' procedure.</td>
</tr>
<tr>
<td>8</td>
<td>should a jacket label be printed automatically during each visit.</td>
</tr>
<tr>
<td>9</td>
<td>should 'camera/equipment/room' be asked during exam editing.</td>
</tr>
<tr>
<td>10</td>
<td>should the system automatically collect the time when the exam status changes. If piece 10 is set to '1', collect status change time data, then should the user be asked the time of the status change or should the system automatically use the current date and time. (If you are batch filing the changes then this parameter would be '1' so that the user can put in the actual change time.)</td>
</tr>
<tr>
<td>11</td>
<td>should the transcriptionist be given the opportunity to select a standard report during initial report entry.</td>
</tr>
<tr>
<td>12</td>
<td>should the transcriptionist be given the opportunity to place reports in a batch during report entry.</td>
</tr>
<tr>
<td>13</td>
<td>should the transcriptionist be given the opportunity to copy the contents of one report into another.</td>
</tr>
<tr>
<td>14</td>
<td>[not used]</td>
</tr>
<tr>
<td>15</td>
<td>require that an impression be given on a report before the report can be verified and the exam to be considered 'complete'.</td>
</tr>
<tr>
<td>16</td>
<td>should the transcriptionist be prompted for the date the exam was requested.</td>
</tr>
<tr>
<td>Key Variable</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>RADDV (cont.)</td>
<td>18 allow interpreting residents to verify other interpreting physicians’ reports while using the On-line Verifying of Reports option. 19 collect the date and the time of request status changes. 20 [not used] 21 indicate that the user should be asked when requesting an exam, which Imaging Location the request should be forwarded to. 22 if a user without the RA MGR key can enter a report on a cancelled case. 23 [not used] 24 the number of hours in the future (0-168) that a user may register a patient for an exam. 25 should the report status appear on unverified reports. 26 should an e-mail of the radiology/nuclear medicine report findings be automatically sent to the requesting physician.</td>
</tr>
</tbody>
</table>

**Note:** These parameters are permanently stored in the .1 node of the appropriate entry in File #79 [Rad/Nuc Med Division - ^RA(79,)]. The Division Parameter Set-up option under the System Definition Menu is used to set this node. The Location Parameter Set-up option under the System Definition Menu is used to set this node.

<table>
<thead>
<tr>
<th>Key Variable</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAMUL</td>
<td>Internal entry number to File #71.2 [Procedure Modifiers - ^RAMIS(71.2, ]</td>
</tr>
<tr>
<td>RANME</td>
<td>Patient's name. First piece of the zeroth-node of File #2 [Patient - ^DPT( ]</td>
</tr>
<tr>
<td>RANUM</td>
<td>Number of flash cards, exam labels or jacket labels to produce when there is a call to PRT^RAFLH. RANUM is always one for report header and footer production.</td>
</tr>
<tr>
<td>RAPHY</td>
<td>Default provider name used in the initial exam entry process. First piece of the zeroth-node of an entry in File #200 [New Person - ^VA(200, ]</td>
</tr>
<tr>
<td>RAPRC</td>
<td>Exam Procedure name. First piece of the zeroth-node of an entry in File #71 [Rad/Nuc Med Procedures - ^RAMIS(71, ]</td>
</tr>
<tr>
<td>RAPRI</td>
<td>Internal entry number to File #71 [Rad/Nuc Med Procedures - ^RAMIS(71, ]</td>
</tr>
<tr>
<td>RAQUICK</td>
<td>This variable is used inside the ‘Edit Exam’ template to properly log an entry into the exam's activity log. The variable is set before going into the template. If set to ‘1’ then the template knows that the editing is occurring through the case number edit routine and if set to ‘0’ then it means the editing is occurring from the edit by patient routine.</td>
</tr>
<tr>
<td>RARPT</td>
<td>Internal entry number to File #74 [Rad/Nuc Med Reports - ^RARPT( ]</td>
</tr>
<tr>
<td>RASER</td>
<td>Service name. First piece of the zeroth-node of an entry in File #49 [Service/Section - ^DIC(49, ]</td>
</tr>
<tr>
<td>RASSN</td>
<td>Patient's SSN. Ninth piece of the zeroth-node of an entry in File #2 (Patient - ^DPT( ]</td>
</tr>
</tbody>
</table>
### Key Variable

<table>
<thead>
<tr>
<th>Key Variable</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAST</td>
<td>This variable can have three meanings depending on where it is used. In routine RADEM1, the patient demographic display routine, it is equal to the first piece of the zeroth node of an entry in File #72 [Examination Status - ^RA(72, ]. In routine RARTR, the report print routine, it is equal to the set code for the report status. Otherwise, this variable is normally equal to the internal entry number of an entry in File #72 [Examination Status - ^RA(72, ].</td>
</tr>
<tr>
<td>RASTI</td>
<td>Internal entry number to File #72 [Examination Status - ^RA(72, ].</td>
</tr>
<tr>
<td>RAWARD</td>
<td>Ward Name. First piece of the zeroth-node of an entry in File #42 [Ward Location - ^DIC(42, ].</td>
</tr>
</tbody>
</table>

### 2.6 Function

**RACAT**

Uses the RAUTL1 routine to compute the location (inpatient, outpatient, contract/sharing agreement, research) and convert time of day to external format. It computes the exam status and updates the status log and OE/RR. It sends alert/notification to OE/RR after the patient is examined.

### 2.7 Bulletins

We recommend that when setting up mail groups for each of the following bulletins, you name the mail group something similar to the bulletin.

<table>
<thead>
<tr>
<th>Bulletin Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAD/NUC MED CREDIT FAILURE</td>
<td>This bulletin will notify users in the selected mailgroup(s) that a crediting failure occurred.</td>
</tr>
<tr>
<td>RAD/NUC MED EXAM DELETED</td>
<td>This bulletin is used to notify the radiology supervisor that a radiology exam has been deleted and the computer user who did the deletion.</td>
</tr>
<tr>
<td>RAD/NUC MED REPORT DELETION</td>
<td>This bulletin is used to notify a mail group that a radiology report has been deleted.</td>
</tr>
<tr>
<td>RAD/NUC MED REPORT UNVERIFIED</td>
<td>This bulletin is used to notify the radiology supervisor, ADPAC and other selected recipients that a 'verified' radiology report was 'unverified' and the computer user who did the 'unverifying'.</td>
</tr>
<tr>
<td>RAD/NUC MED REQUEST CANCELLED</td>
<td>This bulletin is used to notify the recipient mail group (usually 'RA REQUEST CANCELLED') that a radiology request has cancelled.</td>
</tr>
<tr>
<td>RAD/NUC MED REQUEST HELD</td>
<td>This bulletin is used to notify the 'RA REQUEST HELD' mail group that a radiology request has been held.</td>
</tr>
</tbody>
</table>
3.0 Security

3.1 Keys

3.1.1 RA ALLOC
Ownership of the RA ALLOC key overrides the location access security given to personnel through Classification Enter/Edit. Owners of the RA ALLOC key have expanded access to Imaging Locations, Imaging Types, and Divisions. In the case of most workload reports, this means they can select from a list of all Divisions and Imaging Types to include on the report. In the case of various edit and ordering functions, it means they can select from all locations within the Imaging Type to which they are currently signed on through the "Select sign-on location prompt.

3.1.2 RA MGR
The RA MGR key gives the user access to supervisor-type functions. Those functions are the following:

- editing completed exams
- adding an exam to a visit that is older than yesterday
- showing the user all non-completed exams, not just those associated with the user's current Division, during execution of the "status tracking" function.
- updating the exam status of an exam to complete
- deleting exams
- deleting reports
- unverifying reports
- entering a report on a cancelled exam if site parameters don't allow it
- deleting printed batches by date

3.1.3 RA VERIFY
The RA VERIFY key allows users to verify reports.
3.2 Sign-on Security

Upon entering a Radiology/Nuclear Medicine menu, the user is prompted to select a "sign-on Imaging Location". The set of locations the user is privileged to access is controlled by the ADPAC or IRM through the Classification Enter/Edit option. Most options are screened by a combination of Imaging Type, Division and Location. Others are screened by ownership. For a thorough discussion of how users are allowed into the Radiology/Nuclear Medicine package options, see the Screening Methods section of the Radiology/Nuclear Medicine ADPAC Guide.

3.3 Electronic Signature

3.3.1 VISTA Options

When an Interpreting Staff physician or Interpreting Resident physician wants to verify a report via VISTA’s On-line Verifying of Reports or Resident On-Line Pre-Verification option, he must hold the RA VERIFY key and enter an electronic signature code before he can verify the report. This electronic signature code is encrypted.

3.3.2 COTS HL7 Interfaces

When an Interpreting Staff physician or Interpreting Resident physician verifies a report on a COTS Voice Recognition system (e.g., MedSpeak, TalkStation, or PowerScribe) interfaced to VISTA, the electronic signature processing is not the same as with the VISTA options.

The system administrator for the COTS system assigns verifying privileges, similar to the RA VERIFY key, to each physician. An ID that matches the IEN of the physician in the New Person file #200 is also assigned to the physician. When the physician logs on to the COTS application, an ID and secure password are entered to identify the physician. When a report has been signed and released on the COTS system, it is transmitted over the TCP/IP interface and is received by the Radiology HL7 "bridge" routine RAHLTCPB. Based on the HL7 status of the report, the processing logic will determine if the report has been verified on the COTS system. This routine will get the verifying physician from the OBR segment in the report message. If this physician holds the RA VERIFY key, and the physician has a valid electronic signature defined in File #200, the report is filed in the Rad/Nuc Med Report file as VERIFIED with the electronic signature printed block name attached. This process does not currently use any encryption technology, and the processing routine assumes that the verifying physician ID in the OBR segment of the HL7 message belongs to the physician that signed the report on the COTS system.

1 Patch RA*5*12
Even though the VISTA routine RAHLTCPB uses certain data items to validate the report sent from the COTS system before it assigns a signature to the report, it can not prevent a renegade software application from sending bogus HL7 messages to the Radiology/Nuclear Medicine system. While the sending of bogus HL7 messages is not a likely occurrence, it must be recognized as a real and potential breach that could have an impact on Rad/Nuc Med Reports. Technical Services is considering the use of Public Key Encryption schemes. When an encryption scheme such as this is implemented as a standard, the Radiology developers will issue a patch for COTS interfaces that use the Public Key Encryption schemes for electronic signatures.

**Note:** The Electronic Signature for COTS HL7 interfaces can be enabled or disabled for each division.

For information on setting up the COTS HL7 interface electronic signature feature, please refer to the Technical Manual's HL7 Interface section and the appendix section IRM and ADPAC Set-up Procedures:

- Appendix D for Medspeak
- Appendix E for TalkStation
- Appendix F for PowerScribe

### 3.4 VA FileMan File Protection

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>DD</th>
<th>RD</th>
<th>WR</th>
<th>DEL</th>
<th>LAYGO</th>
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<tbody>
<tr>
<td>34</td>
<td>Contract/Sharing Agreements</td>
<td>@</td>
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<tr>
<td>70</td>
<td>Rad/Nuc Med Patient</td>
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<td></td>
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<tr>
<td>70.2</td>
<td>Nuc Med Exam Data</td>
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<td></td>
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<tr>
<td>71</td>
<td>Rad/Nuc Med Procedures</td>
<td>@</td>
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<tr>
<td>71.1</td>
<td>Major Rad/Nuc Med AMIS Codes</td>
<td>@</td>
<td></td>
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<td>71.2</td>
<td>Procedure Modifiers</td>
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<tr>
<td>71.3</td>
<td>Rad/Nuc Med Common Procedure</td>
<td>@</td>
<td></td>
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<tr>
<td>71.4</td>
<td>Rad/Nuc Med Procedure Message</td>
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<tr>
<td>71.5</td>
<td>Imaging Stop Codes</td>
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<td>71.6</td>
<td>Route of Administration</td>
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<td></td>
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<td>71.7</td>
<td>Site of Administration</td>
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<td>71.8</td>
<td>Radiopharmaceutical Source</td>
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<td>71.9</td>
<td>Radiopharmaceutical Lot</td>
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<td>Examination Status</td>
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<td>Rad/Nuc Med Reports</td>
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<td>Standard Reports</td>
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<td>Report Batches</td>
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<td>74.3</td>
<td>Report Distribution Queue</td>
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<td></td>
</tr>
<tr>
<td>74.4</td>
<td>Report Distribution</td>
<td>@</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75.1</td>
<td>Rad/Nuc Med Orders</td>
<td>@</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75.2</td>
<td>Rad/Nuc Med Reason</td>
<td>@</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Legal Requirements

The Radiology/Nuclear Medicine package uses the Current Procedural Terminology (CPT) coding system which is an American Medical Association (AMA) copyrighted product. Its use is governed by the terms of the agreement between the Department of Veterans Affairs and the AMA.

---

1 Patch RA*5*12
4.0  Routine List

Use the option First Line Routine Print within Routine Tools under Programmer Options to obtain a list of routines and a brief description of each.

First Line Routine Print

PRINTS FIRST LINES

routine(s) ? > RA*
searching directory ...
routine(s) ? > -RACT*
routine(s) ? >

(A)lpha, (D)ate ,(P)atched, OR (S)ize ORDER: A// <ret>
Include line 2? NO// <ret>
DEVICE: HOME// <ret> HOME  RIGHT MARGIN: 80// <ret>
# 5.0 File List

## 5.1 Files

<table>
<thead>
<tr>
<th>File Number</th>
<th>File Name</th>
<th>Global File Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>Contract/Sharing Agreements</td>
<td>^DIC(34  This file contains the Contract and Sharing agreements used in Radiology. No data comes with this file.</td>
</tr>
<tr>
<td>70</td>
<td>Rad/Nuc Med Patient</td>
<td>^RADPT(  This file contains imaging information for patients. It is the focal point of the package. No data comes with the file.</td>
</tr>
<tr>
<td>70.2</td>
<td>Nuc Med Exam Data</td>
<td>^RADPTN(  This file contains information specific to nuclear medicine studies in which radiopharmaceuticals are used. No data comes with this file.</td>
</tr>
<tr>
<td>71</td>
<td>Rad/Nuc Med Procedures</td>
<td>^RAMIS(71  This file contains all the procedures that may be associated with an imaging exam. If the procedure has an inactivation date less than the current date then it is not a valid choice and will not appear as a selection to the user. Entries should be deactivated rather than deleted. Data comes with the file. It is ADDed ONLY IF NEW to the site’s existing entries.</td>
</tr>
<tr>
<td>71.1</td>
<td>Major Rad/Nuc Med AMIS Codes</td>
<td>^RAMIS(71.1  This file contains the valid AMIS codes, descriptions and weighted work units as assigned by VACO. The data in this file is used in the compilation of various workload reports. Data comes with the file. It is ADDed ONLY IF NEW to the site’s existing entries.</td>
</tr>
<tr>
<td>71.2</td>
<td>Procedure Modifiers</td>
<td>^RAMIS(71.2  This file contains the modifiers that can be associated with an imaging exam. These modifiers are used to further describe the procedure associated with the exam. Data comes with the file. It is ADDed ONLY IF NEW to the site’s existing entries. Only modifiers with an internal entry number of less than 6 are exported with this version.</td>
</tr>
<tr>
<td>71.3</td>
<td>Rad/Nuc Med Common Procedure</td>
<td>^RAMIS(71.3  This file contains the procedures used in the display of the common procedures when requesting a procedure. Forty active procedures are allowed per imaging type. No data comes with the file. }</td>
</tr>
<tr>
<td>File Number</td>
<td>File Name</td>
<td>Global File Description</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>71.4</td>
<td>Rad/Nuc Med Procedure Message</td>
<td>^RAMIS(71.4 This file contains messages concerning special requirements when ordering a procedure. One or more of these messages can be tied to a procedure in the Rad/Nuc Med Procedures file (#71) so that they are displayed to a requestor at the time an order is placed. No data comes with the file.</td>
</tr>
<tr>
<td>71.5</td>
<td>Imaging Stop Codes</td>
<td>^RAMIS(71.5 This file contains valid imaging stop codes. It is not pointed to by any other file. The Rad/Nuc Med ADPAC should make sure this file is updated. Obsolete or unused entries should be deleted. This file should contain all stop codes that can be assigned to imaging locations at the facility. No data comes with the file.</td>
</tr>
<tr>
<td>71.6</td>
<td>Route of Administration</td>
<td>^RAMIS(71.6 This file contains possible routes of radiopharmaceutical administration used in imaging exams. Data comes with this file. Routes may be added/edited.</td>
</tr>
<tr>
<td>71.7</td>
<td>Site of Administration</td>
<td>^RAMIS(71.7 This file contains frequently-used sites of radiopharmaceutical administration for imaging exams. Data comes with this file. Sites may be added/edited.</td>
</tr>
<tr>
<td>71.8</td>
<td>Radiopharmaceutical Source</td>
<td>^RAMIS(71.8 This file contains the names of vendors, pharmacies, and other sources of radiopharmaceuticals. No data comes with this file.</td>
</tr>
<tr>
<td>71.9</td>
<td>Radiopharmaceutical Lot</td>
<td>^RAMIS(71.9 This file is used to record names of radiopharmaceutical lots, batches, vials, syringes, or kits at the discretion of the facility. No data comes with this file.</td>
</tr>
<tr>
<td>72</td>
<td>Examination Status</td>
<td>^RA(72 This file contains the statuses an imaging exam may be in, as it is processed. Each status has a set of parameters that drives exam processing and management report logic. Data comes with the file. It is MERGE’d with existing entries. Statuses can be edited.</td>
</tr>
<tr>
<td>73.1</td>
<td>Rad Modality Defined Terms</td>
<td>VistA Imaging software will build a modality work list using this file and the Rad/Nuc Med Procedure file (#71) entries. The work list identifies the scheduled radiology cases to be performed on the individual modality (equipment). Entries in this file are as defined in the DICOM Standards PS 3.3 - 1998 under section General Series Attribute Descriptions (C.7.3.1.1). Data comes with this file. Do not change/add/delete any records in this file.</td>
</tr>
<tr>
<td>74</td>
<td>Rad/Nuc Med Reports</td>
<td>^RARPT( This file contains the reports for registered exams. No data comes with this file.</td>
</tr>
</tbody>
</table>

---

1 Patch RA*5*3
<table>
<thead>
<tr>
<th>File Number</th>
<th>File Name</th>
<th>Global File Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>74.1</td>
<td>Standard Reports</td>
<td>^RA(74.1) This file contains the standard report text the interpreting physician can choose from when dictating a report. No data comes with this file.</td>
</tr>
<tr>
<td>74.2</td>
<td>Report Batches</td>
<td>^RABTCH(74.2) This file provides the mechanism to group draft reports into logical categories to help in the efficient processing of these reports. No data comes with this file.</td>
</tr>
<tr>
<td>74.3</td>
<td>Report Distribution Queue</td>
<td>^RABTCH(74.3) This file contains the names of the distribution queues and the category of reports for each queue. Data comes with this file. It is ADDed ONLY IF NEW to the site's existing entries.</td>
</tr>
<tr>
<td>74.4</td>
<td>Report Distribution</td>
<td>^RABTCH(74.4) This file points to the Rad/Nuc Med Reports file (#74). It contains the only verified reports associated with the various active distribution queues. No data comes with this file.</td>
</tr>
<tr>
<td>75.1</td>
<td>Rad/Nuc Med Orders</td>
<td>^RAO(75.1) This file contains all information pertaining to an imaging order entered for a patient. No data comes with this file.</td>
</tr>
<tr>
<td>75.2</td>
<td>Rad/Nuc Med Reason</td>
<td>^RA(75.2) This file contains the reasons a user may select from when placing an order in the Hold or Cancelled status. Data comes with this file. It is ADDed ONLY IF NEW to the site's existing entries.</td>
</tr>
<tr>
<td>78.1</td>
<td>Complication Types</td>
<td>^RA(78.1) This file contains the types of complications that may occur while a procedure is being performed. Data comes with this file. It is ADDed ONLY IF NEW to the site's existing entries.</td>
</tr>
<tr>
<td>78.2</td>
<td>Lbl/Hdr/Ftr Formats</td>
<td>^RA(78.2) This file contains the print formats for flash cards, exam labels, jacket labels, report headers and report footers. No data comes with this file.</td>
</tr>
<tr>
<td>78.3</td>
<td>Diagnostic Codes</td>
<td>^RA(78.3) This file contains the diagnostic codes that can be associated with an exam. The diagnostic code represents a quick overall summary of what the interpreting physician wrote in the report concerning the exam. The diagnostic code is not the impression. The impression is stored in the Impression field (#300) of the Rad/Nuc Med Reports file (#74). Data comes with this file. It is ADDed ONLY IF NEW to the site's existing entries.</td>
</tr>
<tr>
<td>File Number</td>
<td>File Name</td>
<td>Global File Description</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>78.4</td>
<td>Film Sizes</td>
<td>This file contains the allowable film sizes that the technologist can choose from when entering the film data for an exam. No data comes with this file.</td>
</tr>
<tr>
<td>78.6</td>
<td>Camera/Equip/Rm</td>
<td>This file contains all the rooms that may be used to perform imaging examinations. The Imaging Locations file (#79.1) uses this file to indicate which rooms are allowable choices when the technologist attaches a camera/equipment/room to an exam that is performed. No data comes with this file.</td>
</tr>
<tr>
<td>78.7</td>
<td>Label Print Fields</td>
<td>This file contains the names of the data fields that can be printed on a flash card, exam label, jacket label, report header and report footer. The formats indicating which fields to print are stored in the Lbl/Hdr/Ftr Formats file (#78.2). Data comes with this file. It OVERWRITE's existing entries in the site's data.</td>
</tr>
<tr>
<td>79</td>
<td>Rad/Nuc Med Division</td>
<td>The package is designed to handle multiple divisions within a medical center. This file contains, for each division entry, parameters that the package uses during various stages of exam and report processing. No data comes with this file.</td>
</tr>
<tr>
<td>79.1</td>
<td>Imaging Locations</td>
<td>Within an imaging division there may be a number of physical locations where an imaging procedure can be performed. This file contains for each imaging location entry, parameters that the module uses during various stages of exam and report processing and inquiring. No data comes with this file.</td>
</tr>
<tr>
<td>79.2</td>
<td>Imaging Type</td>
<td>This file contains for each imaging type entry parameters that the package uses during various stages of exam and report processing. Data comes with the file. It is MERGE'd with existing entries.</td>
</tr>
<tr>
<td>79.3</td>
<td>HL7 Message Exceptions(^1)</td>
<td>This file contains details of HL7 messages from Sending Applications that have been rejected by Rad/Nuc Med. No data comes with this file.</td>
</tr>
</tbody>
</table>

\(^1\) Patch RA*5*12
5.2 Templates

5.2.1 Input Templates

<table>
<thead>
<tr>
<th>File</th>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>RA CANCEL</td>
<td>This template is used to cancel exams.</td>
</tr>
<tr>
<td>70</td>
<td>RA DIAGNOSTIC BY CASE</td>
<td>This template is used by the Diagnostic Code Entry by Case No. option.</td>
</tr>
<tr>
<td>70</td>
<td>RA EXAM EDIT</td>
<td>This template is used to edit exams.</td>
</tr>
<tr>
<td>70</td>
<td>RA LAST PAST VISIT</td>
<td>This template is used when adding the last visit prior to implementing the VISTA Radiology/Nuclear Medicine package.</td>
</tr>
<tr>
<td>70</td>
<td>RA NO PURGE SPECIFICATION</td>
<td>This template is used to set the no purge flag for an exam in the Indicate No Purging of an Exam/report option.</td>
</tr>
<tr>
<td>70</td>
<td>RA OUTSIDE ADD</td>
<td>This template is used to enter outside films for tracking purposes.</td>
</tr>
<tr>
<td>70</td>
<td>RA OUTSIDE EDIT</td>
<td>This template is used to edit information on outside film tracking.</td>
</tr>
<tr>
<td>70</td>
<td>RA OUTSIDE SUPEROK</td>
<td>This template is used to flag an outside film as needing a supervisor's concurrence in order to be released.</td>
</tr>
<tr>
<td>70</td>
<td>RA OVERRIDE</td>
<td>This template is used to override the status of an exam and set it to Complete.</td>
</tr>
<tr>
<td>70</td>
<td>RA REGISTER</td>
<td>This template is used to register patients for exams. It is compiled into the RACTRG* routines.</td>
</tr>
<tr>
<td>70</td>
<td>RA STATUS CHANGE</td>
<td>This template is used for the Status Tracking of Exams option.</td>
</tr>
<tr>
<td>71</td>
<td>RA PROCEDURE EDIT</td>
<td>This template is used to enter and edit procedures.</td>
</tr>
<tr>
<td>71.3</td>
<td>RA COMMON PROCEDURE EDIT</td>
<td>This template is used to set up and change the common procedure display used when requesting an exam.</td>
</tr>
<tr>
<td>72</td>
<td>RA STATUS ENTRY</td>
<td>This template is used to enter and edit a status for an exam.</td>
</tr>
<tr>
<td>74</td>
<td>RA PRE-VERIFY REPORT EDIT</td>
<td>This template is used by interpreting resident physicians to edit and pre-verify their reports.</td>
</tr>
<tr>
<td>74</td>
<td>RA PRE-VERIFY REPORT ONLY</td>
<td>This template is used by interpreting resident physicians to pre-verify their reports only.</td>
</tr>
<tr>
<td>74</td>
<td>RA REPORT EDIT</td>
<td>This template is used to enter and edit reports in File #74. It is compiled into the RACTWR* routines.</td>
</tr>
<tr>
<td>74</td>
<td>RA VERIFY REPORT ONLY</td>
<td>This template is used to verify reports in File #74. It is compiled into the RACTVR* routines.</td>
</tr>
<tr>
<td>74.1</td>
<td>RA STANDARD REPORT ENTRY</td>
<td>This template is used to enter standard reports into File #74.</td>
</tr>
<tr>
<td>74.3</td>
<td>RA DISTRIBUTION EDIT</td>
<td>This template is used in the Reports Distribution Edit option.</td>
</tr>
<tr>
<td>74.3</td>
<td>RA DISTRIBUTION LOG</td>
<td>This template is used to enter data in the activity log of File #74.</td>
</tr>
<tr>
<td>File</td>
<td>Name</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>75.1</td>
<td>RA OERR EDIT</td>
<td>This template is to edit requests by OE/RR V. 2.5 users. It is compiled into the RACTOE* routines.</td>
</tr>
<tr>
<td>75.1</td>
<td>RA ORDER EXAM</td>
<td>This template is used to request an exam.</td>
</tr>
<tr>
<td>75.1</td>
<td>RA QUICK EXAM ORDER</td>
<td>This template is used by OE/RR V. 2.5 users for ordering an exam. It is compiled into the RACTQE* routines.</td>
</tr>
<tr>
<td>78.2</td>
<td>RA FLASH CARD EDIT</td>
<td>This template is used to enter and edit flash cards, jacket labels, exam labels, report headers and report footers.</td>
</tr>
<tr>
<td>79</td>
<td>RA DIVISION PARAMETERS</td>
<td>This template is used to enter division parameters for the package.</td>
</tr>
<tr>
<td>79.1</td>
<td>RA LOCATION PARAMETERS</td>
<td>This template is used to enter the location parameters for the package.</td>
</tr>
<tr>
<td>79.1</td>
<td>RA SITE MANAGER</td>
<td>This template is used by the IRM Service to define input and printing devices for the package.</td>
</tr>
<tr>
<td>79.2</td>
<td>RA IMAGE PARAMETERS</td>
<td>This template is used to enter parameters for an imaging type.</td>
</tr>
<tr>
<td>79.2</td>
<td>RA ON-LINE CRITERIA</td>
<td>This template is used to enter data associated with the storing of on-line data for an imaging location.</td>
</tr>
<tr>
<td>200</td>
<td>RA PERSONNEL</td>
<td>This template is used to enter Radiology/ Nuclear Medicine personnel into the package.</td>
</tr>
</tbody>
</table>

### 5.2.2 Sort Templates

<table>
<thead>
<tr>
<th>File</th>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>RA DAILY LOG</td>
<td>This template is used to sort exams by exam date and hospital division.</td>
</tr>
<tr>
<td>70</td>
<td>RA OUTSIDE LIST</td>
<td>This template is used to sort the outside film registry.</td>
</tr>
<tr>
<td>71</td>
<td>RA ALPHA LIST OF ACTIVES</td>
<td>This template is used to determine which procedures are active and put them in alphabetical order.</td>
</tr>
<tr>
<td>71</td>
<td>RA PROCEDURES BY AMIS</td>
<td>This template is used to sort procedures by major AMIS code.</td>
</tr>
<tr>
<td>71</td>
<td>RA PROCEDURES BY AMIS CODES</td>
<td>This template sorts procedures by AMIS code and then by CPT code.</td>
</tr>
<tr>
<td>71</td>
<td>RA SERIES ONLY</td>
<td>This template is used to sort procedures by &quot;Series&quot; type only.</td>
</tr>
<tr>
<td>74.4</td>
<td>RA ALL UNPRINTED</td>
<td>This template is used to sort the Unprinted Reports List for the report distribution queue.</td>
</tr>
<tr>
<td>74.4</td>
<td>RA CLINIC BY PRINT DATE</td>
<td>This template sorts the distribution queue by clinic location. Also, it sorts reports by print status.</td>
</tr>
<tr>
<td>74.4</td>
<td>RA WARD BY PRINT DATE</td>
<td>This template sorts reports in the ward distribution queue by print date.</td>
</tr>
<tr>
<td>78.2</td>
<td>RA FLASH PRINT</td>
<td>This template sorts print formats by name for printing label set-ups.</td>
</tr>
<tr>
<td>79.1</td>
<td>RA EXAM ROOM LIST</td>
<td>This template sorts examination rooms by Radiology/Nuclear Medicine location.</td>
</tr>
<tr>
<td>79.1</td>
<td>RA IMAGE LOC LIST</td>
<td>This template is used to sort location parameters by imaging location.</td>
</tr>
</tbody>
</table>
### 200 RA PERSONNEL LIST
This template sorts Radiology/Nuclear Medicine personnel by classification (e.g., technologist).

### 5.2.3 Print Templates

<table>
<thead>
<tr>
<th>File</th>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>RA DAILY LOG</td>
<td>This template is used to print a daily log of registered examinations.</td>
</tr>
<tr>
<td>70</td>
<td>RA OUTSIDE LIST</td>
<td>This template is used to generate the Delinquent Outside Film Report for outpatients.</td>
</tr>
<tr>
<td>71</td>
<td>RA ALPHA LIST OF ACTIVES</td>
<td>This template produces an alphabetic listing of all active Radiology/Nuclear Medicine procedures.</td>
</tr>
<tr>
<td>71</td>
<td>RA PROCEDURE BY AMIS</td>
<td>This template is used to generate the Short Active Procedure List.</td>
</tr>
<tr>
<td>71</td>
<td>RA PROCEDURE LIST</td>
<td>This template is used to generate the Long Procedure List.</td>
</tr>
<tr>
<td>71</td>
<td>RA PROCEDURE SHORT LIST</td>
<td>This template is used to generate the Inactive Short Procedure List.</td>
</tr>
<tr>
<td>74.1</td>
<td>RA STANDARD REPORTS LIST</td>
<td>This template is used in the Standard Reports Print option.</td>
</tr>
<tr>
<td>74.3</td>
<td>RA DISTRIBUTION</td>
<td>This template is used in the Report Distribution List.</td>
</tr>
<tr>
<td>74.4</td>
<td>RA ALL UNPRINTED REPORTS</td>
<td>This template is used to generate a list of reports in the distribution queue that have not been printed.</td>
</tr>
<tr>
<td>74.4</td>
<td>RA PRINTED REPORTS</td>
<td>This template is used in the List Reports in a Batch option.</td>
</tr>
<tr>
<td>74.4</td>
<td>RA UNPRINTED REPORTS</td>
<td>This template is used to generate reports in the distribution queue that have not yet been printed.</td>
</tr>
<tr>
<td>78.2</td>
<td>RA FLASH PRINT</td>
<td>This template is used to generate the Flash Card/Label List.</td>
</tr>
<tr>
<td>78.3</td>
<td>RA DIAGNOSTIC CODE PRINT</td>
<td>This template is used to print the Diagnostic Code List.</td>
</tr>
<tr>
<td>78.4</td>
<td>RA FILM SIZE</td>
<td>This template is used to provide information about types of film (e.g., inactivation date).</td>
</tr>
<tr>
<td>79</td>
<td>RA IMAGE DIV LIST</td>
<td>This template is used to generate a list of divisions.</td>
</tr>
<tr>
<td>79.1</td>
<td>RA EXAM ROOM LIST</td>
<td>This template is used to generate an exam room list.</td>
</tr>
<tr>
<td>79.1</td>
<td>IMAGE LOC LIST</td>
<td>This template is used to generate a list of imaging locations.</td>
</tr>
<tr>
<td>79.2</td>
<td>RA ACTIVITY LOG</td>
<td>This template is used to print the activity log from File #79.2.</td>
</tr>
<tr>
<td>200</td>
<td>RA PERSONNEL LIST</td>
<td>This template is used to generate a list of personnel who have a Radiology/Nuclear Medicine classification and their inactivation date, if applicable.</td>
</tr>
<tr>
<td>200</td>
<td>RA RESIDENT RADIOLOGIST</td>
<td>This template is used to generate a list of personnel who have a Radiology/Nuclear Medicine classification, their inactivation date and whether a staff review is required.</td>
</tr>
</tbody>
</table>
### List Templates

<table>
<thead>
<tr>
<th>File</th>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>79.3</td>
<td>RA HL7 EXCEPTIONS</td>
<td>This template is used to display and print HL7 messages which have been rejected by VISTA Radiology/Nuclear Medicine.</td>
</tr>
</tbody>
</table>

1 Patch RA*5*12
6.0 Exported Options

6.1 Exported Menus

IRM Menu [RA SITEMANAGER]

- Device Specifications for Imaging Locations [RA DEVICE]
- Distribution Queue Purge [RA RPTDISTPURGE]
- Failsoft Parameters [RA FAILSOFT]
- Imaging Type Activity Log [RA IMGLOG]
- Purge Data Function [RA PURGE]
- Rebuild Distribution Queues [RA RPTDISTREBUILD]
- Resource Device Specifications for Division [RA RESOURCE DEVICE]
- Template Compilation [RA COMPIL TEMPLATES]

6.1.1 Rad/Nuc Med Total System Menu [RA OVERALL]

Exam Entry/Edit Menu [RA EXAMEDIT]
- Add Exams to Last Visit [RA ADDEXAM]
- Cancel an Exam [RA CANCEL]
- Case No. Exam Edit [RA EDITCN]
- Diagnostic Code and Interpreter Edit by Case No. [RA DIAGCN]
- Edit Exam by Patient [RA EDITPT]
- Enter Last Past Visit Before DHCP [RA PAST]
- Exam Status Display [RA STATLOOK]
- Indicate No Purging of an Exam/report [RA NOPURGE]
- Register Patient for Exams [RA REG]
- Status Tracking of Exams [RA STATRACK]
- Switch Locations [RA LOC SWITCH]
- View Exam by Case No. [RA VIEWCN]

Films Reporting Menu [RA RPT]

Batch Reports Menu [RA BTCH]
- Add/Remove Report From Batch [RA BTCHREMOVE]
- Create a Batch [RA BTCHNEW]
- Delete Printed Batches [RA BTCHDEL]
- List Reports in a Batch [RA BTCHLIST]
- Print a Batch of Reports [RA BTCHPRINT]
- Verify Batch [RA BTCHVERIFY] **LOCKED: RA VERIFY**

Display a Rad/Nuc Med Report [RA RPTDISP]

Distribution Queue Menu [RA RPTDIST]
- Activity Logs [RA RPTDISTACTIVITY]
- Clinic Distribution List [RA RPTDISTLISTCLINIC]
- Individual Ward [RA RPTDISTSINGLEWARD]
- Print By Routing Queue [RA RPTDISTQUE]
- Report's Print Status [RA RPTDISTPRINTSTATUS]
- Single Clinic [RA RPTDISTSINGLECLINIC]
- Unprinted Reports List [RA RPTDISTLISTUNPRINTED]
Ward Distribution List [RA RPTDISTLISTWARD]
Draft Report (Reprint) [RA REPRINT]
On-line Verifying of Reports [RA RPTONLINEVERIFY] **LOCKED: RA VERIFY**
Report Entry/Edit [RA RPTENTRY]
Resident On-Line Pre-Verification [RA RESIDENT PRE-VERIFY]
Select Report to Print by Patient [RA RPTPAT]
Switch Locations [RA LOC SWITCH]
Verify Report Only [RA RPTVERIFY] **LOCKED: RA VERIFY**
Management Reports Menu [RA MGTRPTS]
  Daily Management Reports [RA DAILYRPTS]
    Abnormal Exam Report [RA ABNORMAL]
    Complication Report [RA COMPLICATION]
    Daily Log Report [RA LOG]
    Delinquent Outside Film Report for Outpatients [RA OUTSIDERPT]
    Delinquent Status Report [RA DELINQUENT]
    Examination Statistics [RA DAISTATS]
    Incomplete Exam Report [RA INCOMPLETE]
    Log of Scheduled Requests by Procedure [RA ORDERLOG]
    Radiopharmaceutical Usage Report [RA RADIOPHARM USAGE]
    Unverified Reports [RA DAIUVR]
  Functional Area Workload Reports [RA LWKL]
    Clinic Report [RA LWKLCLINIC]
    PTF Bedsection Report [RA LWKLBEDSEC]
    Service Report [RA LWKLSERVICE]
    Sharing Agreement/Contract Report [RA LWKLSHARING]
    Ward Report [RA LWKLWARD]
  Personnel Workload Reports [RA WKL]
    Physician Report [RA WKLPHY]
    Radiopharmaceutical Administration Report [RA RADIOPHARM ADMIN]
    Resident Report [RA WKLRES]
    Staff Report [RA WKLSTAFF]
    Technologist Report [RA WKLTECH]
    Transcription Report [RA TRANSRIP REPORT]
  Special Reports [RA SPECRPTS]
    AMIS Code Dump by Patient [RA AMISDUMP]
    AMIS Report [RA AMIS]
    Camera/Equip/Rm Report [RA WKLROOM]
    Cost Distribution Report [RA CDR REPORT]
    Detailed Procedure Report [RA WKLPROCEDURE]
    Film Usage Report [RA FILMUSE]
    Procedure/CPT Statistics Report [RA CPTSTATS]
    Status Time Report [RA STATRPT]
    Wasted Film Report [RA WASTED FILM RPT]
Outside Films Registry Menu [RA OUTSIDE]
  Add Films to Registry [RA OUTADD]
  Delinquent Outside Film Report for Outpatients [RA OUTSIDERPT]
  Edit Registry [RA OUTEDIT]
  Flag Film to Need 'OK' Before Return [RA OUTFLAG]
  Outside Films Profile [RA OUTPROF]
Patient Profile Menu [RA PROFILES]
  Detailed Request Display [RA ORDERDISPLAY]
  Display Patient Demographics [RA PROFDemos]
  Exam Profile (selected sort) [RA PROFSORT]
  Outside Films Profile [RA OUTPROF]
  Profile of Rad/Nuc Med Exams [RA PROFQUICK]
Radiology/Nuclear Medicine Order Entry Menu [RA ORDER]
  Cancel a Request [RA ORDERCANCEL]
  Detailed Request Display [RA ORDERDISPLAY]
  Hold a Request [RA ORDERHOLD]
  Log of Scheduled Requests by Procedure [RA ORDERLOG]
  Pending/Hold Rad/Nuc Med Request Log [RA ORDERPENDING]
  Print Rad/Nuc Med Requests by Date [RA ORDERPRINTS]
  Print Selected Requests by Patient [RA ORDERPRINTPAT]
Rad/Nuc Med Procedure Information Look-Up [RA DISPLAY IMAGPROCINFO]
Request an Exam [RA ORDEREXAM]
Schedule a Request [RA ORDERSCHEDULE]
Ward/Clinic Scheduled Request Log [RAORDERLOGLOC]

Supervisor Menu [RA SUPERVISOR]
Access Uncorrected Reports [RA UNCORRECTED REPORTS]
Delete a Report [RA DELETERPT] **LOCKED: RA MGR**
Delete Printed Batches By Date [RA BTCHDELDATE]** LOCKED: RA MGR**
Exam Deletion [RA DELETEXAM]**LOCKED: RA MGR**
Inquire to File Entries [DINQUIRE]
List Exams with Inactive/Invalid Statuses [RA INVALID EXAM STATUSES]

Maintenance Files Print Menu [RA MAINTENANCE]
Complication Type List [RA COMPRINT]
Diagnostic Code List [RA DIAGP]
Examination Status List [RA EXAMSTATUSP]
Film Sizes List [RA FILMP]
Label/Header/Footer Format List [RA FLASHFORMP]
Major AMIS Code List [RA MAJORAMISP]
Modifier List [RA MODIFIERP]
Nuclear Medicine List Menu [RA NM PRINT MENU]
Lot (Radiopharmaceutical) Number List [RA NM PRINT LOT]
Route of Administration List [RA NM PRINT ROUTE]
Site of Administration List [RA NM PRINT SITE]
Vendor/Source (Radiopharmaceutical) List [RA NM PRINT SOURCE]

Procedure File Listings [RA PROCLISTS]
Active Procedure List (Long) [RA PROCLONG]
Active Procedure List (Short) [RA PROCSHORT]
Alpha Listing of Active Procedures [RA ALPHALIST]
Barcoded Procedure List [RA BARPROCPRINT]
Inactive Procedure List (Long) [RA INACPRCLONG]
Invalid CPT/Stop Code List [RA INVALID CPT/STOP]
List of Inactive Procedures (Short) [RA INACPRCSHORT]
Parent Procedure List [RA PROCPARENT]
Procedure Message List [RA PROCMSGPRINT]
Series of Procedures List [RA PROC SERIES]

Report Distribution Lists [RA DISTP]
Sharing Agreement/Contract List [RA SHARINGP]
Standard Reports Print [RA STANDPRINT]
Mass Override Exam Status [RA EXAM STATUS MASS OVERRIDE]**LOCKED: RA MGR**
Override a Single Exam Status to 'complete' [RA OVERRIDE]**LOCKED: RA MGR**

Print File Entries [DIPRINT]
Rad/Nuc Med Personnel Menu [RA PNL]
Classification Enter/Edit [RA PNLCCLASS]
Clerical List [RA PNLCLERK]
Interpreting Resident List [RA PNLRRES]
Interpreting Staff List [RA PNLSTAFF]
Technologist List [RA PNLTECH]

Search File Entries [DISEARCH]
Switch Locations [RA LOC SWITCH]

System Definition Menu [RA SYSED]
Camera/Equip/Rm Entry/Edit [RA SYSEXROOM]
Division Parameter Set-up [RA SYSDIV]
List of Cameras/Equip/Rms [RA SYSEXLIST]
Location Parameter List [RA SYSLOCLIST]
Location Parameter Set-up [RA SYSLOC]
Print Division Parameter List [RA SYSDIVLIST]
Unverify a Report for Amendment [RA UNVERIFY]**LOCKED: RA MGR**
Update Exam Status [RA UPDATEEXAM]

Utility Files Maintenance Menu [RA MAINTENANCE]
Complication Type Entry/Edit [RA COMEDIT]
6.1.2   Rad/Nuc Med Clerk Menu [RA CLERKMENU]

Add Exams to Last Visit [RA ADDEXAM]
Cancel an Exam [RA CANCEL]
Case No. Exam Edit [RA EDITCN]
Display a Rad/Nuc Med Report [RA RPTDISP]
Display Patient Demographics [RA PROFDEMS]
Duplicate Flash Card [RA FLASH]
Exam Status Display [RA STATLOOK]
Profile of Rad/Nuc Med Exams [RA PROFQUICK]
Radiology/Nuclear Med Order Entry Menu [RA ORDER]
Cancel a Request [RA ORDERCANCEL]
Detailed Request Display [RA ORDERDISPLAY]
Hold a Request [RA ORDERHOLD]
Log of Scheduled Requests by Procedure [RA ORDERLOG]
Pending/Hold Rad/Nuc Med Request Log [RA ORDERPENDING]
6.1.3 Rad/Nuc Med Ward Clerk Menu [RA WARD]

- Cancel a Request [RA ORDERCANCEL]
- Detailed Request Display [RA ORDERDISPLAY]
- Display a Rad/Nuc Med Report [RA RPTDISP]
- Display Patient Demographics [RA PROFDEMOS]
- Outside Films Registry Menu [RA OUTSIDE]
  - Add Films to Registry [RA OUTADD]
  - Delinquent Outside Film Report for Outpatients [RA OUTSIDERPT]
  - Edit Registry [RA OUTEDIT]
  - Flag Film To Need 'OK' Before Return [RA OUTFLAG]
  - Outside Films Profile [RA OUTPROF]
- Profile of Rad/Nuc Med Exams [RA PROFQUICK]
- Select Report to Print by Patient [RA RPTPAT]
- User Utility Menu [RA USERUTL]
  - Duplicate Dosage Ticket [RA DOSAGE TICKET]
  - Duplicate Flash Card [RA FLASH]
  - Jacket Labels [RA LABELS]
  - Print Worksheets [RA WORKSHEETS]
  - Switch Locations [RA LOC SWITCH]
  - Test Label Printer [RA LABELTEST]
- View Exam by Case No. [RA VIEWCN]
- Ward/Clinic Scheduled Request Log [RA ORDERLOGLOC]

6.1.4 Rad/Nuc Med File Room Clerk Menu [RA FILERM]

- Detailed Request Display [RA ORDERDISPLAY]
- Display a Rad/Nuc Med Report [RA RPTDISP]
- Display Patient Demographics [RA PROFDEMOS]
- Outside Films Registry Menu [RA OUTSIDE]
  - Add Films to Registry [RA OUTADD]
  - Delinquent Outside Film Report for Outpatients [RA OUTSIDERPT]
  - Edit Registry [RA OUTEDIT]
  - Flag Film To Need 'OK' Before Return [RA OUTFLAG]
  - Outside Films Profile [RA OUTPROF]
- Profile of Rad/Nuc Med Exams [RA PROFQUICK]
- Select Report to Print by Patient [RA RPTPAT]
- User Utility Menu [RA USERUTL]
  - Duplicate Dosage Ticket [RA DOSAGE TICKET]
  - Duplicate Flash Card [RA FLASH]
  - Jacket Labels [RA LABELS]
  - Print Worksheets [RA WORKSHEETS]
  - Switch Locations [RA LOC SWITCH]
  - Test Label Printer [RA LABELTEST]
- View Exam by Case No. [RA VIEWCN]
- Ward/Clinic Scheduled Request Log [RA ORDERLOGLOC]

6.1.5 Interpreting Physician Menu [RA RADIOLOGIST]

- Detailed Request Display [RA ORDERDISPLAY]
- Display a Rad/Nuc Med Report [RA RPTDISP]
- Draft Report (Reprint) [RA REPRINT]
- Indicate No Purging of an Exam/report [RA NOFURGE]
- On-line Verifying of Reports [RA RPTONLINEVERIFY] **LOCKED: RA VERIFY**
- Print Selected Requests by Patient [RA ORDERPRINTPAT]
- Profile of Rad/Nuc Med Exams [RA PROFQUICK]
- Resident On-Line Pre-Verification [RA RESIDENT PRE-VERIFY]
- Select Report to Print by Patient [RA RPTPAT]
6.1.6 Reports Menu [RA REPORTS]

- Abnormal Exam Report [RA ABNORMAL]
- Complication Report [RA COMPLICATION]
- Daily Log Report [RA LOG]
- Delinquent Outside Film Report for Outpatients [RA OUTSIDERPT]
- Delinquent Status Report [RA DELINQUENT]
- Duplicate Flash Card [RA FLASH]
- Film Usage Report [RA FILMUSE]
- Functional Area Workload Reports [RA LWKL]
  - Clinic Report [RA LWKLCLINIC]
  - PTF Bedsection Report [RA LWKLBEDSEC]
  - Service Report [RA LWKLSERVICE]
  - Sharing Agreement/Contract Report [RA LWKLSHARING]
  - Ward Report [RA LWKLWARD]
- Jacket Labels [RA LABELS]
- Log of Scheduled Requests by Procedure [RA ORDERLOG]
- Personnel Workload Reports [RA WKL]
  - Physician Report [RA WKLPHY]
  - Radiopharmaceutical Administration Report [RA RADIOPHARM ADMIN]
  - Resident Report [RA WKLRES]
  - Staff Report [RA WKLSTAFF]
  - Technologist Report [RA WKLTECH]
  - Transcription Report [RA TRANSCRIP REPORT]
- Print Worksheets [RA WORKSHEETS]
- Status Time Report [RA STATRPT]
- Test Label Printer [RA LABELTEST]

6.1.7 Rad/Nuc Med Secretary Menu [RA SECRETARY]

- Display a Rad/Nuc Med Report [RA RPTDISP]
- Draft Report (Reprint) [RA REPRINT]
- Rad/Nuc Med Personnel Menu [RA PNL]
  - Classification Enter/Edit [RA PNCLCLASS]
  - Clerical List [RA PNCLERK]
  - Interpreting Resident List [RA PNLRRES]
  - Interpreting Staff List [RA PNLSTAFF]
  - Technologist List [RA PNLTECH]
- Radiology/Nuclear Med Order Entry Menu [RA ORDER]
  - Cancel a Request [RA ORDERCANCEL]
  - Detailed Request Display [RA ORDERDISPLAY]
  - Hold a Request [RA ORDERHOLD]
  - Log of Scheduled Requests by Procedure [RA ORDERLOG]
  - Pending/Hold Rad/Nuc Med Request Log [RA ORDERPENDING]
  - Print Rad/Nuc Med Requests by Date [RA ORDERPRINTS]
  - Print Selected Requests by Patient [RA ORDERPRINTPAT]
  - Rad/Nuc Med Procedure Information Look-Up [RA DISPLAY IMAGPROCINFO]
  - Request an Exam [RA ORDEREXAM]
  - Schedule a Request [RA ORDERSCHEDULE]
  - Ward/Clinic Scheduled Request Log [RA ORDERLOGLOC]
- Report Entry/Edit [RA RPTENTRY]
- Select Report to Print by Patient [RA RTPAT]
- Switch Locations [RA LOC SWITCH]
6.1.8 Rad/Nuc Med Technologist Menu [RA TECHMENU]

- Add Exams to Last Visit [RA ADDEXAM]
- Cancel an Exam [RA CANCEL]
- Case No. Exam Edit [RA EDITCN]
- Display a Rad/Nuc Med Report [RA RPTDISP]
- Duplicate Flash Card [RA FLASH]
- Indicate No Purging of an Exam/report [RA NOPURGE]
- Log of Scheduled Requests by Procedure [RA ORDERLOG]
- Patient Profile Menu [RA PROFILES]
  - Detailed Request Display [RA ORDERDISPLAY]
  - Display Patient Demographics [RA PROFDEMO]
  - Exam Profile (selected sort) [RA PROFSORT]
  - Outside Films Profile [RA OUTPROF]
  - Profile of Rad/Nuc Med Exams [RA PROFQUICK]
- Print Selected Requests by Patient [RA ORDERPRINTPAT]
- Register Patient for Exams [RA REG]
- Status Tracking of Exams [RA STATRACK]
- Switch Locations [RA LOC SWITCH]
- View Exam by Case No. [RA VIEWCN]

6.1.9 Rad/Nuc Med Transcriptionist Menu [RA TRANSCRIPTIONIST]

- Batch Reports Menu [RA BTCH]
  - Add/Remove Report From Batch [RA BTCHREMOVE]
  - Create a Batch [RA BTCHNEW]
  - Delete Printed Batches [RA BTCHDEL]
  - List Reports in a Batch [RA BTCHLIST]
  - Print a Batch of Reports [RA BTCHPRINT]
  - Verify Batch [RA BTCHVERIFY] **LOCKED: RA VERIFY**
- Diagnostic Code and Interpreter Edit by Case No. [RA DIAGCN]
- Display a Rad/Nuc Med Report [RA RPTDISP]
- Draft Report (Reprint) [RA REPRINT]
- Report Entry/Edit [RA RPTENTRY]
- Select Report to Print by Patient [RA RPTPAT]
- Standard Reports Entry/Edit [RA STANDRPTS]

6.2 Single Options

The following options do not appear on any menu:

- Rad/Nuc Med [RA OERR EXAM]
- Imaging Type Mismatch Report [RA EXAM/STATUS ITYPE MISMATCH]
- Autopurge of Distribution Queues [RA RPTDISAUTOPURGE]
6.3 Menu/Option Assignment
The RA SITEMANAGER menu may be assigned to the IRM staff member who supports this package. Descriptions of the RA SITEMANAGER options are in the Implementation and Maintenance section of this manual.

The RA OVERALL menu is the most extensive menu and may be assigned to the ADPAC.

All other menu and option assignments should be decided upon by the ADPAC. Descriptions of non-RA SITEMANAGER options may be found in the ADPAC Guide or User Manual.

6.4 Protocols
The following protocols are exported with this version:

<table>
<thead>
<tr>
<th>RA CANCEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>RA EVSEND OR</td>
</tr>
<tr>
<td>RA EXAMINED</td>
</tr>
<tr>
<td>RA OERR DEFAULT PROTOCOL</td>
</tr>
<tr>
<td>RA OERR EXAM</td>
</tr>
<tr>
<td>RA OERR PROFILE</td>
</tr>
<tr>
<td>RA ORDERABLE ITEM UPDATE</td>
</tr>
<tr>
<td>RA RECEIVE</td>
</tr>
<tr>
<td>RA REG</td>
</tr>
<tr>
<td>RA RPT</td>
</tr>
<tr>
<td>RA SEND ORM</td>
</tr>
<tr>
<td>RA SEND ORU</td>
</tr>
<tr>
<td>^RA HL7 EXCEPTIONS DELETE</td>
</tr>
<tr>
<td>RA HL7 EXCEPTIONS MENU</td>
</tr>
<tr>
<td>RA HL7 EXCEPTIONS NEXT</td>
</tr>
<tr>
<td>RA HL7 EXCEPTIONS PREVIOUS</td>
</tr>
<tr>
<td>RA HL7 EXCEPTIONS PRINT</td>
</tr>
<tr>
<td>RA HL7 EXCEPTIONS RESEND</td>
</tr>
</tbody>
</table>

6.5 FileMan Options
Three FileMan namespaced options are exported with this software to allow users to inquire, print or search Radiology/Nuclear Medicine package files. They are:

<table>
<thead>
<tr>
<th>DIIINQUIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIPRINT</td>
</tr>
<tr>
<td>DISEARCH</td>
</tr>
</tbody>
</table>

^Patch RA*5*12
7.0 Archiving and Purging

This version of the Radiology/Nuclear Medicine package does not provide for the archiving of its data.

8.0 **Callable Routines**

For the latest information on active supported references, use the Custodial Package menu under the DBA's Integration Agreement menu on FORUM.

Select DBA Option: integration Agreements Menu

0 Instructions for Entering IA's
1 Get New Integration #'s
2 Add/Edit
3 Inquire
4 Roll-up into Mail Message
5 File Agreements Menu ...
6 Routine Agreements Menu ...
7 Subscriber Package Menu ...
8 Custodial Package Menu ...
9 Print Other
10 Print Pending
11 Print Active
12 Print All
13 Supported References Menu ...
14 Private References Menu ...
15 Controlled Subscription References Menu ...
16 Agreement Lookup by Variable

Select Integration Agreements Menu Option: 8 Custodial Package Menu

1 ACTIVE by Custodial Package
2 Print ALL by Custodial Package
3 Supported References Print All

Select Custodial Package Menu Option: 1 ACTIVE by Custodial Package
Select PACKAGE NAME: **RADIOLOGY/NUCLEAR MEDICINE**  RA
DEVICE: (Enter a device)
9.0 External Relations

The Radiology/Nuclear Medicine package relies on the following external packages to run effectively:

<table>
<thead>
<tr>
<th>Package</th>
<th>Minimum Version Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kernel</td>
<td>8.0</td>
</tr>
<tr>
<td>VA FileMan</td>
<td>21.0</td>
</tr>
<tr>
<td>MailMan</td>
<td>7.1</td>
</tr>
<tr>
<td>PIMS</td>
<td>5.3</td>
</tr>
<tr>
<td>Health Level Seven</td>
<td>1.6</td>
</tr>
<tr>
<td>Adverse Reaction Tracking (ART)</td>
<td>4.0</td>
</tr>
<tr>
<td>OE/RR</td>
<td>2.5</td>
</tr>
<tr>
<td>PCE</td>
<td>1.0</td>
</tr>
<tr>
<td>Visit Tracking</td>
<td>2.0</td>
</tr>
</tbody>
</table>

The following external files are expected to be present, with data:

- CPT (#81)
- CPT Categories (#81.1)
- Hospital Location (#44)
- Medical Center Division (#40.8)
- New Person (#200)
- Patient (#2)
- Ward Location (#42)

Also, the Electronic Signature fields in the New Person file (#200) are used by this package to verify reports.

9.1 DBIAs

For the latest information on active supported references, use the Subscriber Package Menu under the DBA's Integration Agreement Menu on FORUM.
7 Subscriber Package Menu ...
8 Custodial Package Menu ...
9 Print Other
10 Print Pending
11 Print Active
12 Print All
13 Supported References Menu ...
14 Private References Menu ...
15 Controlled Subscription References Menu ...
16 Agreement Lookup by Variable

Select Integration Agreements Menu Option: 7 Subscriber Package Menu

1 Print ACTIVE by Subscribing Package
2 Print ALL by Subscribing Package

Select Subscriber Package Menu Option: Print ACTIVE by Subscribing Package
START WITH SUBSCRIBING PACKAGE: FIRST// RADIOLOGY/NUCLEAR MEDICINE
GO TO SUBSCRIBING PACKAGE: LAST// RADIOLOGY/NUCLEAR MEDICINE
DEVICE: (Enter a device)
10.0 Internal Relations

All options in the Radiology/Nuclear Medicine V. 4.5 package can function independently. Most options require the use of the following package-wide variables: RACCESS, RAMDV, RAMLC, RAMDIV and RAIMGTY. Descriptions of these variables can be found under Package-wide Variables and under Key Variables of the Implementation and Maintenance section of this manual. If they do not already exist, these variables are set at the time the option is invoked. They are only killed by the exit action of the user's main Radiology/Nuclear Medicine menu (e.g., Rad/Nuc Med Transcriptionist Menu). If other options are invoked independently, these variables should be killed by adding 'D KILL^RAPSET1' to the exit action of the option.
11.0 Package-wide Variables

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RACCESS</td>
<td>This array identifies the user's division, imaging location and imaging type access.</td>
</tr>
<tr>
<td>RAIMGTY</td>
<td>This is the name of imaging type (File #79.2 entry) of the user based on the imaging location selected.</td>
</tr>
<tr>
<td>RAMDIV</td>
<td>The internal entry number of the division (File #79) the user has signed-on to.</td>
</tr>
<tr>
<td>RAMDV</td>
<td>The division parameters for a File #79 entry. The parameters that make up this variable are identified in the Key Variables portion, page 16, of this manual.</td>
</tr>
<tr>
<td>RAMLC</td>
<td>The imaging location parameters for a File #79.1 entry. The parameters that make up this variable are identified in the Key Variables portion of this manual.</td>
</tr>
</tbody>
</table>

These variables are created or changed when the user selects a sign-on imaging location usually during the log-in process or in the Switch Locations option. The variables are also set by the individual options if they do not already exist. The routine series RAPSET* sets these variables.

Example of when the package-wide variables are created or changed:

```
Please select a sign-on Imaging Location: X-RAY// <RET> (GENERAL RADIOLOGY)

Welcome, you are signed on with the following parameters:

Printer Defaults

Version : 4.5  ----------------
Division : HINES  Flash Card : RAD/NM FLASH CARDS
Location : X-RAY  1 card/exam
Img. Type: GENERAL RADIOLOGY  Jacket Label: RAD/NM JACKET LBLS
User     : METER,MILLIE  1 labels/visit
Report      : RAD/NM REPORT PTR

These variables are killed when the user exits the package menu they logged in under. The variables are killed by calling KILL^RAPSET1.
12.0 How to Generate On-line Documentation

This section describes various methods by which users may generate Radiology/Nuclear Medicine technical documentation.

12.1 Build File Print

The Build File Print option, found under the KIDS Utilities menu, lists the complete definition of the package, including all files, components, install questions, and the environment, pre-install, and post-install routines.

12.2 Question Marks

Entering question marks at the "Select ... Option:" prompt provide users with valuable technical information. For example, a single question mark (?) lists all options which can be accessed from the current option. Entering two question marks (??) lists all options accessible from the current one, showing the formal name and lock (if applicable) for each. Three question marks (???) displays a brief description for each option in a menu while an option name preceded by a question mark (?OPTION) shows extended help, if available, for the option.

12.3 XINDEX

This utility analyzes routines to determine if they adhere to VISTA Programming Standards. The XINDEX output may include the following components: Compiled list of Errors and Warnings, Routine Listing, Local Variables, Global Variables, Naked Global References, Label References and External References.

To run XINDEX for the Radiology/Nuclear Medicine package, specify the following namespace at the "routine(s) ?>" prompt: RA*.

RACT* routines are compiled template routines, which you may not wish to examine (i.e., -RACT*).

Note: If you run an XINDEX or %INDEX, you may run into several errors caused by references to routines not in the UCI if the imaging package and/or OE/RR V. 3.0 (CPRS) are not yet installed or released. These errors are benign and do not affect the operation of the Radiology/Nuclear Medicine package. Routines involved are:

MAGRIC MAGSET3 ORMFN ORXP ORERR
There will also be a false warning for RAUTL8. This occurs because XINDEX and \%INDEX can't recognize that a second line label is still part of an extrinsic function and is not called separately from the extrinsic function.

12.4 Inquire to File Entries

This option provides the following information about a specified option: option name, menu text, option description, type of option. All fields that have a value will be displayed (e.g., Entry Action).

To secure information about the Radiology/Nuclear Medicine options, the user must specify the name of the options desired (File #19). The options exported with this package begin with the letters RA.

12.5 Print Options File

Use this option to generate ad hoc reports about options from the Option file (#19). The user may choose one, many or all Radiology/Nuclear Medicine options. The options exported with this package begin with the letters RA.

12.6 List File Attributes

This option allows the user to generate documentation pertaining to files and file structure. The Radiology/Nuclear Medicine file numbers are 34 and 70-79.2. See the File List section, page 29, of this manual for a specific listing.

Select the Standard format to get the following data dictionary information for a specified file: file name and description, identifiers, cross-references, files pointed to by the file specified, files which point to the file specified, input templates, print templates and sort templates. In addition, the following applicable data is supplied for each field in the file: field name, number, title, global location, description, help prompt, cross-references, input transform, and date last edited.

Select the Global Map format to generate an output which lists all cross-references for the file selected, global location of each field in the file, input templates, print templates and sort templates.

For a more exhaustive option listing and further information about other utilities which supply on-line technical information, please consult the VISTA Kernel Systems Manual.
13.0 Glossary

AMIS code
For imaging, one of 27 codes used to categorize procedures, determine which procedures use contrast media, calculate workload crediting and weighted work units. AMIS codes are determined by VA Central Office and should not be changed at the medical centers.

AMIS weight multiplier
A number associated with a procedure-AMIS code pair that is multiplied by the AMIS code weighted work units. If the multiplier is greater than 1, a single exam receives multiple exam credits.

Active
An order status that occurs when a request to perform a procedure on a patient has been registered as an exam, but before it has reached a status of Complete.

Activity log
A log of dates and times data was entered and/or changed. The Radiology/Nuclear Medicine system is capable of maintaining activity logs for reports, exam status changes, imaging type parameter changes, purge dates, outside film registry activity, and order status changes.

Alert
Alerts consist of information displayed to specific users triggered by an event. For example, alerts pertaining to Rad/Nuc Med include the Stat Imaging Request alert, an Imaging Results Amended alert, and an Abnormal Imaging Results alert. The purpose of an alert is to make a user aware that something has happened that may need attention. Refer to Kernel and OE/RR documentation.

Attending physician
The Radiology/Nuclear Medicine software obtains this data from the MAS package, which is responsible for its entry and validity. Refer to the VISTA MAS package documentation for more information and a description of the meaning of this term as it applies to VISTA.

Batch
In the Radiology/Nuclear Medicine system, a batch is a set of results reports. Transcriptionists may create batches to keep similar reports together and cause them to print together. One possible purpose might be to print all reports dictated by the same physician together.

Bedsection
See PTF Bedsection.

Bilateral
A special type of modifier that can be associated with an exam, a procedure, or an AMIS code. When an exam is bilateral due to one of the aforementioned associations, workload credit and exam counts are doubled for that exam on most workload and AMIS reports.

Broad procedure
A non-specific procedure that is useful for ordering when the ordering party is not familiar enough with imaging procedures to be able to specify the exact procedure that is to be performed. Before an exam status can progress to Complete, the imaging service must determine a more specific procedure and change the exam procedure to reflect the actual Detailed or Series procedure done. Depending on site parameters, broad procedures may or may not be used at a given facility. Also see Detailed and Series procedure.
Bulletin

A special type of mail message that is computer-generated and sent to a designated user or members of a mail group. Bulletins are usually created to inform someone of an event triggered by another user's data entry, or exam and request updates that require some action on the part of the bulletin recipient.

CPT code

See Current Procedural Terminology

Camera/Equipment/Room

The specific room or piece of equipment used for a patient's imaging exam. Each is associated with one or more imaging locations. The Radiology/Nuclear Medicine system supports, but does not require users to record the camera/equipment/room used for each exam.

Cancelled

A status that can be associated with an exam. Also see Discontinued.

Case number

A computer-generated number assigned to the record generated when one patient is registered for one procedure at a given date/time. Note that when multiple procedures are registered for a patient at the same date/time, each procedure will be given a different case number. Case numbers will be recycled and reused by a new patient/procedure/date instance when the exam attains a Complete status.

Category of exam

For the purposes of this system, category of exam must be Outpatient, Inpatient, Contract, Sharing, Employee, or Research. Several workload and statistical reports print exam counts by category. Others use the category to determine whether exams should be included on the report.

Clinic

Hospital locations where outpatients are cared for. In VISYA, clinics are represented by entries in the Hospital Location file (#44). Radiology/Nuclear Medicine Imaging Locations, represented by entries in the Imaging Location file (#79.1), are a subset of the Hospital Location file.

Clinical history

Data entered in the Radiology/Nuclear Medicine system during exam ordering and exam edit. Usually entered by the requesting party to inform the imaging service why the exam needs to be done and what they hope to find out by doing the exam.

Clinical history message

Text that, if entered in system parameter setup, will always display when the user is prompted for clinical history. Generally used to instruct the user on what they should enter for clinical history.

Common procedure

A frequently ordered procedure that will appear on the order screen. Up to 40 per imaging type are allowed by the system. Other active Rad/Nuc Med procedures are selectable for ordering, but only the ones designated as common procedures and given a display sequence number will be displayed prior to selection.

Complete

A status that can be attained by an order or an exam.

Complication

A problem that occurs during or resulting from an exam, commonly a contrast medium reaction.

Contract

A possible category of exam when imaging services are contracted out.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contrast medium</td>
<td>A radio-opaque injectable or ingestible substance that appears on radiographic images and is helpful in image interpretation. It is used in many imaging procedures.</td>
</tr>
<tr>
<td>Contrast reaction message</td>
<td>A warning message that will display when a patient who has had a previous contrast medium reaction is registered for a procedure that uses contrast media. The message text is entered during Rad/Nuc Med division parameter setup.</td>
</tr>
<tr>
<td>Credit stop code</td>
<td>See Stop Code. Also see MAS package documentation.</td>
</tr>
<tr>
<td>Current Procedural Terminology (CPT)</td>
<td>A set of codes published annually by the American Medical Association which include Radiology/Nuclear Medicine procedures. Each active detailed or series procedure must be assigned a valid, active CPT code to facilitate proper workload crediting. In VISTA, CPT’s are represented by entries in the CPT file #81.</td>
</tr>
<tr>
<td>Descendent</td>
<td>A type of Rad/Nuc Med procedure. One of several associated with a 'Parent' type of procedure. The descendent procedures are actually registered and performed. Also see Parent.</td>
</tr>
<tr>
<td>Desired date (of an order)</td>
<td>The date the ordering party would like for the exam to be performed. Not an appointment date. The imaging service is at liberty to change the date depending on their availability.</td>
</tr>
<tr>
<td>Detailed procedure</td>
<td>A procedure that represents the exact exam performed, and is associated with a CPT code and an AMIS code.</td>
</tr>
<tr>
<td>Diagnostic code</td>
<td>Represented, for the purposes of this system, by entries in the Diagnostic Codes file (#78.3). Diagnostic codes describe the outcome of an exam, such as normal, abnormal. A case may be given one or more (or no) diagnostic code(s).</td>
</tr>
<tr>
<td>Discontinued</td>
<td>An order status that occurs when a user cancels an order.</td>
</tr>
<tr>
<td>Distribution queue</td>
<td>A mechanism within the Radiology/Nuclear Medicine system that facilitates printing results reports at various hospital locations, such as the patient's current ward or clinic, the file room, and medical records.</td>
</tr>
<tr>
<td>Division, Rad/Nuc Med</td>
<td>A subset of the VISTA Institution file (#4). Multi-divisional sites are usually sites responsible for imaging at more than one facility.</td>
</tr>
<tr>
<td>Draft</td>
<td>A report status that is assigned to all Rad/Nuc Med results reports as soon as they are initially entered into the system, but before they are changed to a status of Verified or (if allowed) Released/Not Verified.</td>
</tr>
<tr>
<td>DSS ID</td>
<td>Formerly Stop Code associated with each procedure, now DSS ID associated with each Imaging Location.</td>
</tr>
<tr>
<td>Electronic signature code</td>
<td>A security code that the user must enter to identify him/herself to the system. This is required before the user is allowed to electronically verify Rad/Nuc Med reports. This is not the same as the Access/Verify codes.</td>
</tr>
<tr>
<td>Exam label</td>
<td>One of 3 types of labels that can be printed at the time exam registration is done for a patient. Also see jacket label, flash card.</td>
</tr>
<tr>
<td>Exam set</td>
<td>An exam set contains a Parent procedure and its Detailed or Series descendent procedures. Requesting a Parent will automatically cause each descendent to be presented for registration as separate cases under a single visit date and time.</td>
</tr>
</tbody>
</table>
Exam status: The state of an exam that describes its level of progress. Valid exam statuses are represented in this system by entries in the Examination Status file (#72). Examples are ordered, cancelled, complete, waiting for exam, called for exam, and transcribed. The valid set of exam statuses can, to a degree, be tailored by the site. There are many parameters controlling required data fields, status tracking and report contents that are determined when the parameters of this file are set up. There are separate and different set of statuses for requests and reports.

Exam status parameter setup: See Exam status.

Exam status time: The date/time when an exam's status changes, triggered by exam data entry that can be done through over a dozen different options.

Film size: Represented by entries in the Film Sizes file (#78.4) in this system. Used to facilitate film use/waste tracking.

Flash card: One of 3 labels that can be generated at the time an exam is registered for a patient. The flash card was named because it can be photographed along with an x-ray, and its image will appear on the finished x-ray. Helpful in marking x-ray images with the patient's name, SSN, etc. to insure that x-rays are not mixed up.

Footer: The last lines of the results report, the format of which can be specified using the Label/Header/Footer Formatter.

Format: The specification for print locations of fields on a printed page. In this system, print formats can be specified using the Label/Header/Footer Formatter.

Header: The top lines of the results report, the format of which can be specified using the Label/Header/Footer Formatter.

Health Summary: Refers to a report or VISTA software package that produces a report showing historical patient data. Can be configured to meet various requirements. Refer to the Health Summary documentation for more information.

Hold: An order status occurring when a user puts an order on hold, indicating that a study should not yet be done or scheduled, but that it will likely be needed in the future.

Hospital location: Represented in VISTA by entries in the Hospital Location file (#44). Rad/Nuc Med locations are a subset of the Hospital Location file.

Imaging location: One of a subset of Hospital Locations (See Hospital location) that is represented in the Imaging Location file #79.1, and is a location where imaging exams are performed.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
</table>
| Imaging type | For the Rad/Nuc Med software, the set of valid imaging types is:  
- ANGIO/NEURO/INTERVENTIONAL  
- GENERAL RADIOLOGY  
- MAMMOGRAPHY  
- NUCLEAR MEDICINE  
- ULTRASOUND  
- VASCULAR LAB  
- CARDIOLOGY STUDIES (NUC MED)  
- CT SCAN  
- MAGNETIC RESONANCE IMAGING  
These are the imaging types that are supported by this version of the software. Each imaging location and procedure may be associated with only one imaging type. |
| Impression | A short description or summary of a patient's exam results report. Usually mandatory data to complete an exam. The impression is not purged from older reports even though the lengthier report text is. |
| Inactivate | The process of making a record in a file inactive, usually by entering an inactive date on that record or deleting a field that is necessary to keep it active. When a record is inactive, it becomes essentially "invisible" to users. Procedures, common procedures, modifiers, and exam statuses can be inactivated. |
| Inactivation date | A date entered on a record to make it inactive. See Inactivate. |
| Information Resources Management | The service within VA hospitals that supports the installation, maintenance, troubleshooting, and sometimes local modification of VISTA software packages and the hardware that they run on. |
| Interpreting physician | The resident or staff physician who interprets exam images. (also Interpreting Resident, Interpreting Staff) |
| IRM | See Information Resources Management. |
| Jacket label | One of the 3 types of labels that can be generated at the time an exam is registered for a patient. Usually affixed to the x-ray film jacket. (See also exam label, flash card.) |
| Key | See security key. |
| Label print fields | Fields that are selectable for printing on a label, report header, or report footer on formats that are designed using the Label/Header/Footer Formatter. |
| Label/Header/Footer Formatter | The name given to the option/mechanism that allows users to define formats for labels and for headers and footers on results reports. Users can specify which fields to print at various columns and lines on the label or report header/footer. |
| Mode of transport | The patient's method of moving within the hospital, (ambulatory, wheelchair, portable, stretcher) designated at the an exam is ordered. |
| Modifier | Additional information about the characteristics of an exam or procedure (such as bilateral, operating room, portable, left, right). Also see bilateral, operating room, portable. |
No purge indicator
A flag that can be set on the exam record to force the purge process to bypass the record. Guarantees that the record will not be purged when a historic data purge is scheduled by IRM. Also see Purge.

Non-credit stop code
Certain stop codes, usually for health screening, that do not count toward workload credit. If a non-credit stop code is assigned to a procedure, another credit stop code must also be assigned. Also see Stop code.

OE/RR
See Order Entry/Results Reporting.

On-line verification
The option within the Radiology/Nuclear Medicine package that allows physicians to review, modify, and electronically sign patient result reports.

Operating room
A special type of procedure modifier, that, when assigned to an exam will cause the exam to be included in workload/AMIS reports under both the AMIS code of the procedure and under the AMIS code designated for Operating Room.

Order
The paper or electronic request for an imaging exam to be performed.

Order Entry
The process of requesting that one or more exams be performed for a patient. Order entry for Radiology/Nuclear Medicine procedures can be accomplished through a Rad/Nuc Med software option or through a separate VISTA package, Order Entry/Results Reporting (OE/RR).

Order Entry/Results Reporting
A VISTA package that performs that functions of ordering for many clinical packages, including Radiology/Nuclear Medicine.

Outside films registry
A mechanism in this system that allows users to track films done outside of the medical center. This can also be accomplished through the VISTA Records Tracking package. Refer to Records Tracking documentation for more information.

Parent procedure
A type of Rad/Nuc Med procedure that is used for ordering purposes. It must be associated with Descendent procedures that are of procedure type Detailed and/or Series. At the time of registration the descendent procedures are actually registered. Setting up a parent procedure provides a convenient way to order multiple related procedures on one order. Parent/descendent procedure relationships must be set up ahead of time during system definition and file tailoring by the ADPAC.

Pending
An order status that every Rad/Nuc Med order is placed in as soon as it is ordered through this system’s ordering option. This system also receives orders from the VISTA OE/RR system and places them in a pending status.

Portable
A special type of procedure modifier, that, when assigned to an exam will cause the exam to be included in workload/AMIS reports under both the AMIS code of the procedure and under the AMIS code designated for Portable.

Pre-verification
The process whereby a resident reviews a report and affixes his/her electronic signature to indicate that the report is ready for staff (attending) review, facilitated through an option in this system for Resident Pre-verification.
<table>
<thead>
<tr>
<th>Term</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Primary Interpreting Staff/ Resident</td>
<td>The attending or resident primarily responsible for the interpretation of the case. (See also Secondary Interpreting Staff/Resident.)</td>
</tr>
<tr>
<td>Primary physician</td>
<td>The Radiology/Nuclear Medicine software obtains this data from the MAS package, which is responsible for its entry and validity. Refer to the VISTA MAS package documentation for more information and a description of the meaning of this term as it applies to VISTA.</td>
</tr>
<tr>
<td>Principal clinic</td>
<td>For the purposes of the Radiology/Nuclear Medicine system, this term is usually synonymous with 'referring clinic'. However, for the purposes of crediting, it is defined as the DSS (clinic/stop) code that is associated with the imaging location where the exam was performed.</td>
</tr>
<tr>
<td>Printset</td>
<td>A printset contains a Parent procedure and its Detailed or Series descendent procedures. If the parent is defined to be a printset, the collection and printing of all common report related data between the descendents is seen as one entity.</td>
</tr>
<tr>
<td>Problem draft</td>
<td>A report status that occurs when a physician identifies a results report as having unresolved problems, and designates the status to be Problem Draft. Depending on site parameters, a report may be designated as a Problem Draft due to lack of an impression. Also see Problem statement.</td>
</tr>
<tr>
<td>Problem statement</td>
<td>When a results report is in the Problem Draft status, the physician or transcriptionist is required to enter a brief statement of the problem. This problem statement appears on report displays and printouts.</td>
</tr>
<tr>
<td>Procedure</td>
<td>For the purposes of this system, a medical procedure done with imaging technology for diagnostic purposes.</td>
</tr>
<tr>
<td>Procedure message</td>
<td>Represented in this system by entries in the Rad/Nuc Med Procedure Message file (#71.4). If one or more procedure messages are associated with a procedure, the text of the messages will be displayed when the procedures is ordered, registered, and printed on the request form. Useful in alerting ordering clinicians and imaging personnel of special precautions, procedures, or requirements of a given procedure.</td>
</tr>
<tr>
<td>Procedure type</td>
<td>A characteristic of a Rad/Nuc Med procedure that affects exam processing and workload crediting. See Detailed, Series, Broad, and Parent.</td>
</tr>
<tr>
<td>PTF Bedsection</td>
<td>See MAS documentation.</td>
</tr>
<tr>
<td>Purge</td>
<td>The process that is scheduled at some interval by IRM to purge historic computer data. In this system, purges are done on results report text, orders, activity logs, and clinical history.</td>
</tr>
<tr>
<td>Registration (of an exam)</td>
<td>The process of creating a computer record for one or more patient/procedure/visit date-time instances. Usually done when the patient arrives at the imaging service for an exam.</td>
</tr>
<tr>
<td>Released/not verified</td>
<td>A results report status that may or may not be implemented at a given medical center. Reports in this status may be viewed or printed by hospital staff outside of the imaging service.</td>
</tr>
<tr>
<td>Report batch</td>
<td>See Batch.</td>
</tr>
</tbody>
</table>
Report status The state of a report that describes its progress level. Valid report statuses in this system are Draft, Problem draft, Released/not verified (if the site allows this status), and Verified. The status of a report may affect the status of an exam. Also see Exam status. Exams and requests each have a separate and different set of statuses.

Request Synonymous with order. See Order.

Request status The state of a request (order) that describes its progress level. Valid request statuses in this system are Unreleased (only if created through OE/RR), Pending, Hold, Scheduled, Active, Discontinued, and Complete. Reports and exams each have a separate and different set of statuses.

Request urgency Data entered at the time an exam is ordered to describe the priority/criticality of completing the exam quickly (i.e. Stat, Urgent, Routine).

Requesting location Usually the location where the patient was last seen or treated (an inpatient's ward, or an outpatient's clinic). All requesting locations are represented by an entry in the VistA Hospital Location file (#44). The requesting location may be, but is usually not an imaging location.

Requesting physician The physician who requested the exam.

Research source A research project or institution that refers a patient for a Radiology/Nuclear Medicine exam.

Scheduled An order status that occurs when imaging personnel enter a date when the exam is expected to be performed.

Secondary Interpreting Staff/Resident This generally refers to an attending/resident who assisted or sat in on review of the case, but is not primarily responsible for it. It may also be used to indicate a second reviewer of the case, for quality control or peer review purposes.

Security key Represented by an entry in the VistA Security Key file. Radiology/Nuclear Medicine keys include RA MGR, RA ALLOC, and RA VERIFY. Various options and functions within options require that the user "own" a security key.

Staff Imaging Attending.

Staff review (of reports) The requirement where an attending imaging physician is required to review the reports written by a resident imaging physician.

Standard report Represented in this system by entries in the Standard Reports file (#74.1). Standard reports can be created by the ADPAC during system definition and set-up. If the division setup specifies that they are allowed, transcriptionists will be offered a selection of standard report text and impressions to minimize data entry effort.

Status tracking The mechanism within this system that facilitates exam tracking from initial states to the complete state. ADPACs must specify during exam status parameter setup which statuses will be used, which data fields will be required to progress to each status, which data fields will be prompted, and exams of which statuses will be included on various management reports.
Stop code

Member of a coding system designed by VA Central Office to aid in determining workload and reimbursement of the medical centers. Stop codes are controlled by VA Central Office MAS. The set of valid stop codes is revised October 1 of each year. At this time the VISTA MAS package developers issue a maintenance patch to the VISTA software updating the file containing stop codes. Imaging stop codes are represented by entries in the Valid Imaging Stop Code file #71.5. Imaging stop codes are a subset of the VISTA Clinic Stop file #40.7. See MAS documentation for more information. (Also see DSS ID.)

Synonym

In the Radiology/Nuclear Medicine package, synonyms are alternate terms that can be associated with procedures for the purposes of convenient look-up/retrieval. A given procedure may have more than one synonym, and a given synonym may be used for more than one procedure.

Technologist

Radiology/Nuclear Medicine personnel who usually are responsible for performing imaging exams and entering exam data into the system.

Time-out

The amount of time allowed before a user is automatically logged out of the system if no keystrokes are entered. This is a security feature, to help prevent unauthorized users from accessing your VISTA account in case you forget to log off the system or leave your terminal unattended.

Transcribed

An exam status that may occur when a results report is initially entered into the system for an exam. If this status is not activated at the site, it will not occur.

Unreleased

An order status that occurs when an exam order is created, but no authorization to carry out the order has been given. This is possible only if the order is created through the OE/RR software.

Verification

For the purposes of this system, the process of causing a results report to progress to the status of Verified. This happens when a physician affixes his/her electronic signature to the report, or when a transcriptionist, with the proper authorization, enters the name of a physician who has reviewed and approved a report. This is analogous to a physician signing a paper report.

Verified

A results report status that occurs at the time of verification. A report is verified when the interpreting physician electronically signs the report or gives his/her authorization that the report is complete and correct. Also see Verification.

VISTA

Veterans Health Information Systems and Technology Architecture. Formerly known as DHCP.

Waiting for exam

An exam status that occurs as soon as the exam is first registered. The system automatically places all exams in this status upon registration.

Ward

The hospital location where an inpatient resides. In VISTA, wards are a subset of the Hospital Location file (#44).
Weighted work unit  The number that results from multiplying the weight of a procedure's AMIS code with the procedure's AMIS weight multiplier for that AMIS code. If a procedure has more than one AMIS code, the multiplication is done for each and the results are summed.

Workload credit  A general term that can refer to either the stop code or CPT type of workload credit that is used in the VA to calculate reimbursement to medical centers for work done, or the AMIS crediting used by the AMIS workload system.