RADIOLOGY / NUCLEAR MEDICINE

USER MANUAL

Version 5.0

April 2000

Department of Veterans Affairs
VISTA Technical Services

Revision History

Date	Page	Change
October 2001	V-9 and V-29	Case Edit Field | Procedures – Added: Requesting physician is alerted when the ordered exam is changed.
February 2002	VII-34	Daily Management Reports | Unverified Reports – If a Primary Resident is entered, then the report is counted toward the resident. If the Primary Interpreting Staff is entered, then the report is counted towards that Interpreting Staff member. If both Primary Resident and Primary Interpreting Staff are entered, then the report counts toward both. If neither is entered, the report is counted towards UNKNOWN.

Table of Contents

I. Introduction

The Veterans Health Information Systems and Technology Architecture (V*IST*A) Radiology / Nuclear Medicine package is a comprehensive software package, designed to assist with the functions related to processing patients for imaging examinations. The Radiology / Nuclear Medicine package automates the entire range of diagnostic functions performed in imaging departments, including request entries by clinical staff, registration of patients for exams, processing of exams, recording of reports/results, verification of reports 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 Radiology / Nuclear Medicine package automates many tedious tasks previously performed manually, providing faster, more efficient and accurate data entry and more timely results reporting.

The package is interfaced with Record Tracking software for the purpose of tracking radiology and nuclear medicine records and creating pull lists for those records needed for scheduled clinic appointments. The V*IST*A Radiology / Nuclear Medicine package is fully integrated with VA FileMan and provides certain patient demographic information supplied by the Medical Administration Service (MAS) package. It also interacts with other V*IST*A packages to allow personnel to see patient medication histories, contrast media reactions, and laboratory test results which may influence the nature of an examination. Request entry has been incorporated in two ways: functionality within this package and an interface with the OERR/CPRS package, allowing on-line requesting of exams and viewing of reports. Information regarding each examination is stored by the system and may be compiled to produce a variety of reports necessary in carrying out daily business and for use by management in analyzing the workload. Information required to generate AMIS reports and resource allocation reports is also collected.

The V*IST*A Radiology / Nuclear Medicine package supports the HL7 protocol. This allows the exchange of information concerning exam registration, cancellation, completion, and results (specifically reports and impressions) between the V*IST*A system and clients within or outside of V*IST*A.

Other related documents will also be of value in using this package. The Radiology / Nuclear Medicine ADPAC Guide, Technical Manual, Release Notes and Installation Guide provide IRM, the package coordinator, and other technical personnel with information necessary for installation and maintenance of the package.

Functional Description

The Radiology/Nuclear Medicine package is designed to assist with the functions related to processing patients for imaging examinations. The types of imaging exams supported are General Radiology, Nuclear Medicine, CT Scan, Magnetic Resonance Imaging, Angio/Neuro/Interventional, Ultrasound, Vascular Lab, Cardiology Studies, and Mammography.

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

Another important addition with this version is the ability to enter and edit information specific to radiopharmaceuticals for Nuclear Medicine. A new menu, Nuclear Medicine Setup Menu, under the Utility Files Maintenance Menu, allows the site to define parameters for radiopharmaceuticals concerning lot number, route and site of administration, and source/vendor. The addition of radiopharmaceutical fields has a major affect on case and status edits for Nuclear Medicine and Cardiology Studies Imaging Types. For more information, refer to the chapter on Case Edits and Status Tracking in the ADPAC Guide.

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

On-line verification "STAT" category

Ability to select and print multiple reports in "Select Report to Print by Patient"

The Radiology/Nuclear Medicine package:

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

- Allows for the on-line pre-verification by residents of transcribed reports
- Allows for the on-line verification of transcribed reports
- Provides for the registration and return of outside films
- Provides the ability to view patient demographic and examination data
- Interfaces with the OERR and CPRS packages to support request entry and processing
- Provides the ability to print jacket labels, worksheets and flash cards
- Integrates with VA FileMan and captures certain patient demographic information supplied by the Medical Administration Service (MAS) package
- Interfaces with the Record Tracking package for the purpose of tracking records and creating pull lists for those records needed for scheduled clinic appointments
- Interfaces with the Patient Care Encounter (PCE) package for the purpose of crediting outpatient imaging workload
- Interfaces with the Adverse Reaction Tracking package for the purpose of capturing and displaying contrast media allergies and reactions
- Allows the exchange of information concerning results (specifically reports and impressions) between the V*IST*A system and non-V*IST*A applications through the HL7 interface
- Provides mechanisms whereby personnel working in a given imaging department can enter, view, and report data separately from other imaging departments within the hospital
- Interfaces with the Health Summary package to print and display relevant medical history
- Interfaces with the Imaging/Multi-Media package to store Image IDs on reports, display 'i' in front of procedures for which Image IDs have been collected, provide HL7-formatted data upon exam registration, cancellation, and completion and report verification.

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

II. Orientation

How to Work with the System

Is this Chapter for You?

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

Other Resources

If you are not familiar with V*IST*A software applications, we recommend that you read *The DHCP Users Guide to Computing*. This orientation guide is a comprehensive handbook benefiting first time users of any V*IST*A application. The purpose of the introductory material is to help you become familiar with basic computer terms and the components of a computer. To request a copy, contact your local Information Resource Management (IRM) staff. You may also obtain information through the VA Intranet. The Clinicians' Guide to DHCP can be found at http://deptva.invweb.net/dhcp/ and all software manuals are available at 152.127.195/softserv/clin_broad/index.html.

How Does V*IST*A Work?

Veterans Health Information Systems and Technology Architecture (V*IST*A) software packages use the computer in an interactive fashion. An interactive system involves a conversation with the computer. The computer asks you to supply information and immediately processes it. You will be interacting with the software by responding to prompts (the questions) in the program. Your responses are recognized by the computer when you complete the interaction by pressing the Return or Enter key.

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

How to Sign-on

The procedure for establishing a link to the computer involves access and verify codes. These codes are assigned by IRM staff. Contact your supervisor if you need these codes. For security reasons, the access code and verify code are not displayed on the terminal screen when you type them in. Please do not write your code down or reveal it to others. The sign-on banner shows the date and time when you last signed on. The banner also shows whether or not the account had any unsuccessful attempts at logon. Periodically, you will be required to change your verify code. Rad/Nuc Med staff and residents will also see a displayed message telling them how many reports are awaiting review, if any.

Press the Return key on the keyboard. A blinking cursor will appear on the terminal. You will then see:

`ACCESS CODE:`	Enter your assigned access code
`VERIFY CODE:`	Enter your assigned verify code

How to Exit an Option

In most cases, when you begin an option you will continue through it to a normal ending. At times however, you might want to exit the option to do something else. To stop what you are doing, enter a caret ^, which can also be referred to as an up-arrow or circumflex (Shift-6 on most keyboards). You can use the caret at almost any prompt to terminate the line of questioning and return to the previous level in the routine. Continue entering the caret to completely exit the system.

How to Enter Data

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

If a prompt has no "default response" (see next page for more details), and you want to bypass the question, press the Return or Enter key and the computer will go on to the next question. You will be allowed to bypass a question only if the information is not required to continue with the option. If the prompt has a default response, entering Return or Enter is the same as entering the default response.

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

How to Obtain Help

If you need assistance while interacting with the software, enter a question mark or two to receive on-line help.

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

?? Using two question marks will provide a more detailed help message. For example, two question marks entered at any radiopharmaceutical prompt will display all radiopharmaceutical selections, but may cause a long wait since it is searching through a large file.

Responding to Prompts

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

`DATE OF BIRTH:` This type of prompt is waiting for you to enter a value, like March 3, 1960. Do not forget to complete your interaction by pressing the Return or Enter key.

Select Prompt

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

```
Select PATIENT NAME:
```

Yes/No Prompt

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

```
ARE YOU SURE?
```

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

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

Default Prompt

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

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

One-Many-All Selector Prompts

Within the Radiology/Nuclear Medicine package you will often be given the opportunity to select one or more items from a list. Typical examples of items selected are imaging locations, imaging types, and divisions. Various workload reports allow supervisors to select multiple staff or resident names, transcriptionist names, wards, clinics, etc. The Abnormal Exam Report now allows for a selection of diagnostic codes. Transcriptionists can choose one or more divisions and imaging types for report entry. Exam status tracking allows selection of only the desired imaging locations. Sometimes, the prompt appears with a default of All. If you take the All default you will be selecting all possible items that you have access to, given your set of computer privileges as set up by IRM and the Radiology/Nuclear Medicine ADPAC(s). If you choose an item, but then decide you do not want it included, you can enter a minus sign - followed by the item name to de-select it. (e.g., -MAMMOGRAPHY to delete mammography from your list of selections). Sometimes, it will save time if you use the wildcard method of selecting. For example, if you are selecting from a list of hospital locations, and you want all the locations that start with the characters 2N, you can enter 2N*. The wildcard feature is case sensitive; this means that you have to enter your wildcard characters in uppercase if the items are in uppercase, and lowercase if the items are in lowercase. In the sample below, RR* is a wildcard response used to select all imaging locations starting with the letters RR (e.g., RR A&D and RR Rapid).

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

     Select a IMAGING LOCATIONS LOCATION from the displayed list.
     To deselect a LOCATION type a minus sign (-)
```

```
     in front of it, e.g.,  -LOCATION.
     Use an asterisk (*) to do a wildcard selection, e.g.,
     enter LOCATION* to select all entries that begin
     with the text 'LOCATION'.  Wildcard selection is
     case sensitive.


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


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

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

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

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

Another one (Select/De-Select): ?

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

You have already selected:
   OPC RADIOLOGY                (GENERAL RADIOLOGY-523BZ)
   RR A&D                       (GENERAL RADIOLOGY-523)
   RR BATCH                     (GENERAL RADIOLOGY-523)
   RR CT                        (CT SCAN-523)
   RR ICU                       (GENERAL RADIOLOGY-523)
   RR OPC                       (GENERAL RADIOLOGY-523)
   RR RAPID                     (GENERAL RADIOLOGY-523)
   RR SPECIAL                   (GENERAL RADIOLOGY-523)
   RR ULTRA                     (GENERAL RADIOLOGY-523)
   VAMC BOSTON                  (GENERAL RADIOLOGY-523BZ)

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

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

Printsets

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

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

Note: The lowercase i indicates that the site has the Rad/Nuc Med - Imaging/Multimedia package interface running and that images were collected for those exams.

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

Invalid Response

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

LAYGO

Veterans Health Information Systems and Technology Architecture (V*IST*A) software checks your answers against an internally stored table of valid answers. If your answer is not stored in this table but the Learn-As-You-GO (LAYGO) mode is allowed, the computer adds your response as one of those valid answers. If LAYGO mode is allowed, then an example dialogue goes something like this:

`ARE YOU ADDING A NEW CLINIC?` If you respond with a Y (or YES, yes or y), the software adds the new clinic in its validation table and accepts the answer. If anything other than Yes is entered, the original answer will be invalidated and the question will be repeated.

How to Enter Dates and Times

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

```
Examples of Valid Dates:
       JAN 20 1957 or 20 JAN 57 or 1/20/57 or 012057
       T   (for TODAY),  T+1 (for TOMORROW),  T+2,  T+7,  etc.
       T-1 (for YESTERDAY),  T-3W (for 3 WEEKS AGO), etc.
     If the year is omitted, the computer uses the CURRENT YEAR.
     If only the time is entered, the current date is assumed.
     Follow the date with a time, such as JAN 20@10, T@10AM, 10:30, etc.
     You may enter a time, such as NOON, MIDNIGHT or NOW.
```

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

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

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

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

```
T@330
```

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

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

Making Corrections

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

`DATE OF BIRTH: May 21, 1946//@` In this example, the date on file has been erased and now there is no answer to the "DATE OF BIRTH" prompt; it is null.

The system will ask you to confirm that you really intend to delete the information. Note: You may not be able to delete a response if the information is required:

`ARE YOU SURE?` This question is a safety feature, giving you a chance to change your mind now, without re-editing later.

Spacebar Recall Feature

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

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

Select WARD: <space><return> 5EAST

Printing Reports

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

Right Margin

Sometimes you will be asked to specify the right margin of the report. You will not be asked this in all cases as the information might be preset for the device you specify and a default answer provided. Nevertheless, your choices are simple. Generally, 80 is used for standard size paper or for displaying on the terminal screen; 132 is used for wider paper.

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

Display the Report on the Terminal Screen

Display is the word used to indicate data printed to a terminal screen rather than on paper. At the DEVICE prompt, if you want to view a report on your screen, press the Return key. Normally, if you do not specify a device name, the information will print on your screen. After the screen fills with the first page of the report, you will be prompted to press the Return key to continue with the next screen of data. The process is repeated at the bottom of every screen. You can exit the option at any time by entering an up-arrow ^.

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

Queue Report to a Printer

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

`DEVICE:`	Enter the letter Q to queue the print job.
`QUEUE TO PRINT ON:`	Enter the device name or number.

`Requested Start Time: NOW//` Press the Return key or enter a time here using the date and time formats discussed above (e.g., NOW+1 for one hour from now).

How to Stop Printing (Long Documents)

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

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


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

Select User's Toolbox Option: TaskMan User


Select TASK: ??


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

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

Select TASK: 37388 START^RADLQ1
```

```
                Taskman User Option

                     Display status.
                     Stop task.
                     Edit task.
                     Print task.
                     List own tasks.
                     Select another task.

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

Task unscheduled and stopped.
```

III. Use of the Software

Package Management

This package utilizes electronic signature codes for those functions which require sign-off approval; i.e., physician sign-off on dictated reports. The electronic signature code is a code of 6-20 characters which, upon being entered into the system, identifies you specifically to the system. It is similar to your access and verify codes and the same security measures should be observed in protecting it. It should never be given to anyone. The Chief, IRM Service, as well as your supervisor, should be notified immediately should you suspect that someone else is using your code.

Electronic signature codes are assigned through the Edit Electronic Signature Code option of Kernel. IRM Service will assign this option to appropriate users requiring an electronic signature code. Each user has only one electronic signature code that can be used across all applications that require an electronic signature.

The package makes use of Current Procedural Terminology (CPT) codes which is an AMA copyrighted product. Its use is governed by the terms of the agreement between the Department of Veterans Affairs and the American Medical Association.

Sign-On Message

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

```
Good morning Sasha
     You last signed on Mar 7,1997 at 09:12
*** You have 1 imaging report to pre-verify. ***
```

This message is for residents only.

```
*** You have 12 imaging reports to verify. ***
```

This message is for staff only.

Package Maintenance

The ADP Applications Coordinator (ADPAC) should be assigned the Rad/Nuc Med Total System Menu, the RA ALLOC key, and RA MGR key. There are many options within the submenus of the **Supervisor Menu** [RA SUPERVISOR] that help maintain the system. Among these are system and file set-up options which are discussed in depth in the ADPAC Guide. The rest of the options under the Supervisor Menu may be used by ADPACs and supervisors to take care of day-to-day maintenance issues, and are discussed in this manual.

The **IRM Menu** [RA SITEMANAGER] should be assigned to the appropriate personnel by IRM Service and will not appear on the Total System Menu. Refer to the Technical Manual for a detailed explanation of these options.

Switch Locations

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

When the package is first set up, the ADPAC assigns imaging locations to users through the Personnel Classification Menu (see ADPAC Guide). This determines which imaging locations users are allowed to select when they first sign on to the Radiology/Nuclear Medicine package.

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

Prompt/**User Response**

Discussion

```
Switch Locations

Please select a sign-on Imaging Location: NUC// ??

Choose from:
   ULTRASOUND A                 (ULTRASOUND-499)
   MAGNETIC RESONANCE IMAGING   (MAGNETIC RESONANCE IMAGING-499)
   FLUORO                       (GENERAL RADIOLOGY-499)
   WESTSIDE XRAY                (GENERAL RADIOLOGY-639)
   CAT SCAN                     (CT SCAN-499)
   US                           (ULTRASOUND-578)
   MAMMOGRAPHY                  (MAMMOGRAPHY-499)
   PET SCANNER                  (ANGIO/NEURO/INTERVENTIONAL-499)
   X-RAY                        (GENERAL RADIOLOGY-499)
   NUC MED LOC                  (NUCLEAR MEDICINE-639)
   MAMMO ROOM 112B              (MAMMOGRAPHY-499)

Please select a sign-on Imaging Location: NUC// X-RAY
(GENERAL RADIOLOGY-499)
```

Question marks entered at this prompt cause a display of imaging locations in the left column and the imaging type of each location in parentheses in the right column.

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

                                  Printer Defaults
 Version  : 5.0                   ----------------
 Division : HINES CIO FIELD OFFI  Flash Card  : P-DOT MATRIX BACK
 Location : X-RAY                               1 card/exam
 Img. Type: GENERAL RADIOLOGY     Jacket Label: P-DOT MATRIX BACK
 User     : BEAMERS,TENA                        1 labels/visit
                                  Report      : P-DOT MATRIX BACK

--------------------------------------------------------------------------
```

IV. Rad/Nuc Med Total System Menu

The Rad/Nuc Med Total System menu is broken down into each of its sub-menus, and sometimes menus within the sub-menu, with a discussion of each option and examples of user/program interaction. This portion should be thought of and used as a reference guide to the options within the software.

Exam Entry/Edit Menu …
Films Reporting Menu …
Management Reports Menu …
Outside Films Registry Menu …
Patient Profile Menu …
Radiology/Nuclear Med Order Entry Menu …
Supervisor Menu …
Switch Locations
Update Patient Record
User Utility Menu …

Changes and Variations

Due to variations in site parameter setup at each facility and changes from software patches after release, the sample sessions in this manual will probably not match sessions at your site. They are only provided for additional information and as quick visual samples.

V. Exam Entry/Edit Menu

This menu provides the user with all the functions that relate to entering and editing the exams.

Add Exams to Last Visit
Cancel an Exam
Case No. Exam Edit
Diagnostic Code and Interpreter Edit by Case No.
Edit Exam by Patient
Enter Last Past Visit Before V*IST*A
Exam Status Display
Indicate No Purging of an Exam/Report
Register Patient for Exams
Status Tracking of Exams
Switch Locations
View Exam by Case No.

Exam Entry/Edit Menu

Add Exams to Last Visit

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

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

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

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

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

Depending on how the parameters are set at your site, you may be asked to enter your Access Code after you have entered the information for the new examination.

Prompt/**User Response** Discussion

```
Add Exams to Last Visit

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


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

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

  YES(V)                                PTSD(V)

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

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

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

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

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

```
              **** Requested Exams for ZMOUSE,MINNIE ****        9  Requests
    St  Urgency  Procedure                    Desired Requester    Req'g Loc
    --  -------  ---------------------------  ------- ----------  ----------
 1  h   ROUTINE  SHOULDER 1 VIEW              02/19   SCHOT,MARY   CONTINUING
 2  h   ROUTINE  ABDOMEN 1 VIEW               12/12   SCHOT,MARY   RADIOLOGY-U
 3  h   ROUTINE  CT THORACIC SPINE W/O CONT    12/12   GALES,M. EL  LOWELL OP1
```

```
 4  s   ROUTINE  CHEST 2 VIEWS PA&LAT           10/27   GLASHIN,KEN  IM ALEX
 5  h   ROUTINE  WRIST 2 VIEWS                  10/10   SCHOT,MARY   RADIOLOGY-U
 6  h   ROUTINE  MAMMOGRAM BILAT                10/03   SIML,GARY    RADIOLOGY-B
 7  h   ROUTINE  BONE IMAGING, TOMOGRAPHIC (SP  07/18   GALES,M. EL  RADIOLOGY-M
 8  h   ROUTINE  CT ABDOMEN W&W/O CONT          06/13   SCHOT,MARY   RADIOLOGY-U
 9  h   ROUTINE  HIP 1 VIEW                     04/22   JOHNSON,JIM  C PRIMARY T

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

     Procedure: SHOULDER 1 VIEW

   ...will now register ZMOUSE,MINNIE with the next case number...

    Case Number: 264
    ----------------
    PROCEDURE: SHOULDER 1 VIEW//  <RET>                    (RAD  Detailed) CPT:73020
   [12]Select PROCEDURE MODIFIERS: <RET>

    CATEGORY OF EXAM: OUTPATIENT// <RET>  OUTPATIENT
    PRINCIPAL CLINIC: CONTINUING CARE-RN 7000//  <RET>         7000

   [3] TECHNOLOGIST COMMENT: <RET>

     ...all needed flash cards and exam labels queued to print on BAR88 PRT.
  Task #: 6567354


     ...all film jacket labels queued to print on D129.
  Task #: 6567355
```

Enter comments for the reading radiologist about the patient and/or case.

[1] Patch RA*5*10 April 2000
[2] Patch RA*5*19 May 2000 Prompt for CPT Modifiers removed.
[3] Patch RA*5*18 November 2000 Added field for comments by the technologist.

Exam Entry/Edit Menu

Cancel an Exam

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

Once the examination is cancelled, the user will be prompted to answer with a YES or NO to cancel the request associated with this exam. If YES, the request will also be cancelled and the request status updated to DISCONTINUED as long as there are no other registered exams based on this order. (This might happen if the ordered procedure was designated by the ADPAC as a parent procedure.) If NO, the request status will be updated to HOLD as long as no other registered exams are based on the order, and may be selected for re-registration at a future date. When all descendents of a parent procedure are cancelled, the user will be prompted to answer Yes or No to cancel the associated request.

If an exam with radiopharmaceuticals is cancelled, the system will ask if you want to delete the radiopharmaceutical data from the case to prevent its being counted in the Radiopharmaceutical Usage Reports. If the radiopharmaceutical was not drawn or administered, it is appropriate to delete.

If a request is cancelled, the RAD/NUC MED REQUEST CANCELLED mail bulletin will be sent to members of a mail group usually named RA REQUEST CANCELLED. If it is placed on HOLD, a similar bulletin RAD/NUC MED REQUEST HELD is sent.

Prompt/**User Response**

```
Cancel an Exam

Enter Case Number: 681
```

Discussion

You can also enter the patient's name or last initial + last 4 digits of SSN, or any other common V*IST*A method of patient look-up.

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

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

This question may not appear on your system depending on system parameters. It is useful if data entry is done at a later date/time than the actual processing of exams.

```
    [1] TECHNOLOGIST COMMENT: Patient cancelled due to ...
```

Enter or edit any comment about the patient or case. If editing the previous comment, both comments are saved for tracking purposes, however, only the latest comment is displayed when viewing or editing the record.

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

Choose from:
   1               ANESTHESIA CONSULT NEEDED              Synonym: ANES
   6               CONFLICT OF EXAMINATIONS               Synonym: CON
   7               DUPLICATE REQUESTS                     Synonym: DUP
   8               INADEQUATE CLINICAL HISTORY            Synonym: INAD
   11              OTHER CANCEL REASON                    Synonym: OTH
   13              PATIENT CONSENT DENIED                 Synonym: PCD
   14              PATIENT EXPIRED                        Synonym: EXP
   17              REQUESTING PHYSICIAN CANCELLED         Synonym: REQ
   19              WRONG EXAM REQUESTED                   Synonym: WRN
   20              EXAM CANCELLED                         Synonym: CAN
   21              EXAM DELETED                           Synonym: DEL
   22              CALLED-WARD DID NOT SEND               Synonym:
   25              PATIENT REFUSED THE PROCEDURE          Synonym:
   26              EQUIPMENT FAILURE                      Synonym: EQF

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

You will likely have a different set of cancellation reasons on your system.

```
Do you want to cancel the request associated with this exam? No// ?

Required, enter 'YES' if the request should be cancelled or 'NO' to put
it on hold.

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

Sample mail bulletin sent to members of the RA REQUEST CANCELLED or other mail group set up by IRM to receive the RAD/NUC MED REQUEST CANCELLED bulletin:

[1] Patch RA*5*18 November 2000 Added field for comments by the technologist.

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

The request for exam with the following identification was cancelled:
          1) Patient              : MILLER,FRANK
          2) Patient SSN          : 837-73-9747
          3) Procedure            : ARTHROGRAM KNEE S&I
          4) Date Desired         : APR 10, 1997
          5) Requesting Physician : CEBEL,GREGORY J
          6) Requesting Location  : X-RAY
          7) Reason               : EXAM DELETED
          8) User                 : ORBY,SKIP


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

Exam Entry/Edit Menu

Case No. Exam Edit

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

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

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

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

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

Once an exam attains a status of COMPLETE, only holders of the RA MGR security key are allowed to edit the exam, and the long case number must be entered to retrieve the case.

Imaging departments must make sure that cases are routinely processed to a COMPLETE status. Otherwise, the case numbers will increment until the maximum number is reached (99,999) and the system will not allow registration of any more cases.

It should be noted that the ADPAC can use the Procedure Enter/Edit option to set up default film sizes and amounts for procedures. If this is done, these sizes and amounts used are automatically entered into the film size and number used fields. That means that the tech editing the case will have to make a point of manually deleting and re-editing these fields if the film size and number used for a specific case are not the same as the standard film size and number used, as entered in the procedure parameters by the ADPAC. See the ADPAC Guide for more information about procedure set-up using Procedure Enter/Edit. The ADPAC Guide also contains a chart showing

every possible data field that can appear in the Case Edits and Status Tracking options and includes which conditions cause the fields to be prompted.

CASE EDIT FIELDS

Procedure: You will only be able to select active procedures from the Rad/Nuc Med Procedures file (#71) of the imaging type you are in. If contrast media is used with the procedure and the patient had a previous reaction to the media, you will be asked to "OK" the use of it. You may enter any of the following to select your procedure:

Name of procedure
CPT Code
Site specific synonym for the procedure

[1]If the procedure, procedure modifier, and/or requesting physician for a case are changed, then an alert will be sent to the requesting physician, if the exam's order is not a parent-type procedure. If patch OR*3.0*112 is not installed, this alert cannot be turned off. However, if patch OR*3.0*112 is installed, the users may enable or disable this alert, "Imaging Exam Changed", via the CPRS Notifications Mgmt Menu

If the procedure is changed for a case using radiopharmaceuticals, a message will appear telling you to review the radiopharmaceutical data previously entered. This field appears during Case Edits and also during Status Tracking if the "Ask" parameter is set to YES.

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

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

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

Inpatient if the patient is on a ward,
the category on the order if there is no ward,
the Usual Category if no order category exists.

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

Ward: This only appears during Registration if the patient is an inpatient at the time of the exam, and only appears during Case Edits if it is already populated. It is the patient's location at the time the exam was performed. It is automatically entered by the system during registration. If the appropriate Report Distribution Queue is active, the report for this

[1] Patch RA*5*28 October 2001 – Requesting physisian is alerted when the ordered exam is changed

exam will automatically be placed in the queue for this clinic, or in the current ward if the patient is admitted before the report is verified.

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

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

Principal Clinic: This field only appears during Registration if the Category of Exam is Outpatient or Employee and only appears during Case Edits, if it is already populated. It is the principal clinic that referred the patient to Radiology/Nuclear Medicine for the exam and is automatically entered by the system during Registration. If the appropriate Report Distribution Queue is active, the report for this exam will automatically be placed in the queue for this clinic, or in the current ward if the patient is admitted before the report is verified.

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

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

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

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

Procedures in some AMIS categories may use contrast media, but do not always use contrast media. In this case, the user will have the opportunity to answer the "Contrast Media Used?" question. The AMIS categories where use of contrast media is a possibility are:

4 Cardiac Series
15 Digital Subtraction Angiography
21 Computed Tomography
22 Interventional Radiography

The system assumes that procedures in all other AMIS categories do not use contrast media, so no prompt appears.

The use of Barium is assumed for all procedures whose AMIS category is 9 - Gastrointestinal. In this case, the Barium Used? question will automatically be set to Yes.

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

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

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

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

Film Size: This field points to the Film Sizes file (#78.4) and indicates the size of the film used during the Rad/Nuc Med exam. Users may also enter film sizes that have been wasted during the exam. This data is automatically entered during registration if it has been associated with the procedure registered. It is asked in Case Edits and it is asked in Status Tracking if the Examination Status "Ask" parameter is set to YES.

The following sample list of selectable film sizes shows a set of seven entries followed by the same seven entries repeated with a "W-" preceding the names. The "W-" is a convention used to indicate wasted film. Wasted film sizes as well as used film sizes may be entered at the same Film Size prompt. If a "W-" precedes the name, the system will count those as wasted films on the Wasted Film Report.

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

Amount: This field contains the amount of film (a number between 0 and 999) used or wasted during the Rad/Nuc Med exam. The amount represents either the number of that film size or the number of cine feet of that film size. On the Film Usage Report, these two amounts are distinguished from each other. This data is automatically entered during registration if it has been associated with the procedure registered. It is asked in Case Edits and it is asked in Status Tracking if the Examination Status "Ask" parameter is set to YES.

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

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

CPT Modifiers: This is a multiple that points to the CPT Modifier file #81.3. Only modifiers associated with the CPT code for the procedure are selectable.

[1] Patch RA*5*10 April 2000

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

Med Administered: If any medications were administered to the patient during this exam, they may be recorded here. If medications are associated with a procedure during system set-up, the system will enter them automatically when the procedure is registered. This field also appears in both Case Edits and Status Tracking if the Procedure parameter for this data contains a YES. However, if the Status Tracking "Ask" parameter contains a NO then it is not asked in Status Tracking. Medications are not a factor in status updating.

Med Dose: This is a free text field. Enter the dose and unit of measure for the medication administered. This field appears in both Case Edits and Status Tracking if the Procedure parameter for this data contains a YES. However, if the Examination Status "Ask" parameter contains a NO, it is not asked in Status Tracking.

Date/Time Med Administered: This is the date and time the dosage was administered. It only appears in Case Edits if the field is already populated and appears in Status Tracking only if both the parameter for the procedure and the "Ask" parameter for the status are set to YES.

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

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

It only appears in Case Edits if the field is already populated and appears in Status Tracking only if both the parameter for the procedure and the "Ask" parameter for the status are set to YES.

Radiopharmaceuticals: If this is a nuclear medicine procedure and radiopharmaceutical(s) have been associated with the procedure, they will be automatically entered by the system when the case is registered. Radiopharmaceuticals may be deleted or added during case editing if the prompt is **not** suppressed by the procedure parameter. This is also true for Status Tracking if the "Ask" parameter is set to YES. Certain Radiopharmaceutical data entry is mandatory for printing dosage tickets to meet NRC standards. The fields needed for NRC standards are indicated below.

[1]Technologist Comment: This comment field can be used as a means to provide details about the patient or case for the reading radiologist. A comment can be added or the previous comment edited. A history of all changes to this field are kept for tracking purposes.

[1] Patch RA*5*18 November 2000 Added field for comments by the technologist.

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

Prescribed Dose by MD Override: This is the dosage (in mCi) of the radiopharmaceutical as prescribed by an MD. It must be a value between .0001 and 99999.9999. This field is printed on dosage tickets to meet NRC standards. Both Case Edits and Status Tracking prompt for this field if the procedure parameter prompt for Radiopharm RX is YES.

Prescribing Physician: The physician who prescribed the Radiopharmaceutical can be entered here, but is not required to proceed to the next status. It only appears in Case Edits if the procedure parameter Prompt for Radiopharm Rx is set to YES. It only appears in Status Tracking if the procedure parameter Prompt for Radiopharm Rx is set to YES, and if it is not already entered.

Activity Drawn: This is the radiopharmaceutical activity drawn to be administered to the patient. Enter an activity drawn between .0001 and 99999.9999. The unit of measure is mCi. The radiopharmaceutical's high, low, usual dose will be displayed above the prompt and user response is checked to see if it falls within the high/low range if the ADPAC has entered a range for the radiopharmaceutical for the procedure used. It is asked in Case Edits only if already populated and in Status Tracking only if the Examination Status "Ask" parameter is set to YES. This field is necessary to meet NRC requirements for dosage tickets.

Date/Time Drawn: This is the date/time the radiopharmaceutical was drawn. The date/time drawn may precede the exam date/time by as much as seven days. It is asked in Case Edits only if already populated and in Status Tracking only if the Examination Status "Ask" parameter is set to YES.

Person Who Measured Dose: The clinician who measured the amount of radiopharmaceutical drawn can be entered here. This person must have a Rad/Nuc Med Personnel Classification other than Clerk. The person who measured the dose is necessary to meet NRC requirements for dosage tickets. It is asked in Case Edits only if already populated and in Status Tracking only if the Examination Status "Ask" parameter is set to YES.

Dose Administered: This is the radiopharmaceutical dosage actually administered to the patient. Enter a dosage between .0001 and 99999.9999 that is the same or less than dosage drawn (if entered). Unit of Measure is mCi. The high, low, usual dosage for this radiopharmaceutical when used on this procedure will be displayed above the prompt. User response will be checked to verify that it falls within the range, if a range has been entered by the ADPAC. If not, a warning message will be displayed. It is asked in Case Edits and it is asked in Status Tracking if the Examination Status "Ask" parameter is set to YES. Dose administered is also printed on dosage tickets.

Date/Time Dose Administered: This is the date/time this radiopharmaceutical was administered. The date/time drawn is presented as the default response, if entered. It is asked in Case

Edits and it is asked in Status Tracking if the Examination Status "Ask" parameter is set to YES.

Person Who Administered Dose: This is the individual who administered the dose. This individual must have a Rad/Nuc Med Classification other than Clerk. It is asked in Case Edits and it is asked in Status Tracking if the Examination Status "Ask" parameter is set to YES.

Witness to Dose Administration: This is the person who witnessed the administration of the radiopharmaceutical. This field cannot be required to progress to the next status. It is only asked in Case Edits and Status Tracking if the procedure parameter Prompt for Radiopharm Rx is set to YES. Once it is entered, future Status Tracking edits will not ask it again, but it can be reedited through case edit options.

Route of Administration: This is the route of administration for the radiopharmaceutical. It is asked in Case Edits only if already populated and in Status Tracking only if the Examination Status "Ask" parameter is set to YES.

Site of Administration: This is the site of administration for this radiopharmaceutical. It only appears if a route is entered. It is asked in Case Edits only if already populated. It is asked in Status Tracking only if the "Ask" parameter is set to YES and there are predefined sites for the route.

Site of Admin Text: Enter an answer of 3-45 characters in length. It is asked in Case Edits only if already populated and in Status Tracking only if the Examination Status "Ask" parameter is set to YES, and the Route of Administration for the case is configured to prompt for a free text site of administration.

Lot No.: This is the lot number for the radiopharmaceutical. The Lot number can be the number of the batch, vial, syringe or kit. Lot number is necessary for printing dosage tickets to meet NRC requirements. The Lot for the number must be active and its Expiration date must be the same or later than the Date/Time Dose Administered or the date/time of the exam if there is no entry for the date/time the dose was administered, and its radiopharmaceutical must match the exam's radiopharmaceutical. Entering a new Lot number (LAYGO) into the Lot Number file is allowed. It is asked in Case Edits only if already populated and in Status Tracking only if the Examination Status "Ask" parameter is set to YES.

Volume: This is the volume of the radiopharmaceutical administered. The units of measure will either be "c" for caplets or "m" for milliliters. The number must be in the range of: 1-99999.99. It is asked in Case Edits only if already populated and in Status Tracking only if the "Ask" parameter is set to YES.

Possible radiopharmaceutical forms are:

Liquid (all injections)

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

Form is asked in Case Edits only if already populated and in Status Tracking only if the Examination Status "Ask" parameter is set to YES.

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

Exam Entry/Edit Menu

Diagnostic Code and Interpreter Edit by Case No.

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

Owners of the RA MGR key may also edit exams in the COMPLETE status as long as the associated report has not yet been verified.

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

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

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

If all required data is not available, a bulletin (RAD/NUC MED CREDIT FAILURE) will be generated and sent to members of an associated mail group (set up by IRM). The bulletin tells the recipient which case and procedure caused the crediting failure, and can provide useful information for determining the cause of credit failure.

DIAGNOSTIC CODE FIELDS

Primary Interpreting Staff: This is the staff member who interpreted the images. It is asked when doing diagnostic code edits and status tracking if the procedure is not one of a printset. (If it is one of a printset, this field should be entered during report editing.) Only staff with access to at least one imaging location with the same imaging type as the exam will be selectable. Depending on the requirements set up in the Examination Status file (#72), it may be necessary for this field to be filled in before the exam status can be considered complete.

Secondary Interpreting Staff: This multiple field can be used to enter other staff who participated in the image interpretation. It is asked when doing diagnostic code edits and status tracking if the procedure is not one of a printset. (If it is one of a printset, this data can be entered during report editing.) Only staff with access to at least one imaging location with the same imaging type as the exam will be selectable.

Primary Interpreting Resident: This is the primary interpreting resident who read the images of this exam. If interpreting staff is required to review this resident's results, then the Primary Interpreting Staff field must also be filled in. Only residents with access to at least one imaging location with the same imaging type as the exam will be selectable. It is asked when doing diagnostic code edits and status tracking if the procedure is not one of a printset. (If it is one of a printset, this field should be entered during report editing.) Depending on the requirements set up in the Examination Status file (#72), it may be necessary for this field to be filled in before the exam status can be considered complete.

Secondary Interpreting Resident: This multiple field can be used to enter the other resident(s) in addition to the primary interpreting resident who interpreted the images of this exam. Only residents with access to at least one imaging location with the same imaging type as the exam will be selectable. It is asked when doing diagnostic code edits and status tracking if the procedure is not one of a printset. (If it is one of a printset, this field can be entered during report editing.)

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

Secondary Diagnostic Code: If the primary diagnostic code is entered, the system will also prompt for secondary diagnostic codes. This multiple field is used to indicate additional diagnostic codes associated with this exam. It is asked when doing diagnostic code edits and status tracking if the procedure is not one of a printset. (If it is one of a printset, this field can be entered during report editing.)

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

[1]Technologist Comment: This comment field can be used as a means to provide details about the patient or case for the reading radiologist. A comment can be added or the previous comment edited. A history of all changes to this field are kept for tracking purposes.

Prompt/**User Response** Discussion

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

Enter Case Number: 250

Choice   Case No.       Procedure                 Name                  Pt ID
------   --------       ---------                 ----------------      ------
 1       092396-250     TOE(S) 2 OR MORE VIEWS    ZZMOUSE,MICKEY        3432
    PRIMARY DIAGNOSTIC CODE: NORMAL
    Select SECONDARY DIAGNOSTIC CODE: <RET>
    PRIMARY INTERPRETING RESIDENT: ?
     Enter the name of the Primary Resident who interpreted the images for this
     exam.
     Personnel must be classified as Interpreting Resident.
    PRIMARY INTERPRETING RESIDENT: ABNER,JENNIFER          JA      114
    Select SECONDARY INTERPRET'G RESIDENT: <RET>
    PRIMARY INTERPRETING STAFF: ?
     Enter the name of the primary staff who interpreted these images.
     Personnel must be classified as Interpreting Staff Physician.
    PRIMARY INTERPRETING STAFF: ARTISIAN,MIKE          art      525B/114
    Select SECONDARY INTERPRETING STAFF: BROWN,ARTHUR M          aB      114
    Select SECONDARY INTERPRETING STAFF: <RET>

   [2] TECHNOLOGIST COMMENT:

     ...exam status remains 'EXAMINED'.
```

Enter or edit any comment about the patient or case. If editing the previous comment, both comments are saved for tracking purposes, however, only the latest comment is displayed when viewing or editing the record.

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

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

The system tries to credit procedures when the case status goes to Complete. Failure to credit triggers a bulletin if your IRM has a receiving mail group set up. Failure to credit can be because

[1] Patch RA*5*18 November 2000 Added field for comments by the technologist.
[2] Patch RA*5*18 November 2000 Added field for comments by the technologist.

of missing or invalid rad/nuc med data, factors preventing PCE from crediting, or problems preventing Scheduling software from storing or transmitting credit data.

Exam Entry/Edit Menu

Edit Exam by Patient

This function can be used to edit active exams for a patient. It is identical to the Case No. Exam Edit function except that examinations are selected by patient name rather than case number. Please see the Case No. Exam Edit section, page V-8, of this manual for information about fields edited.

Exam Entry/Edit Menu

Enter Last Past Visit Before V*IST*A

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

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

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

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

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

Prompt/**User Response** Discussion

```
Enter Last Past Visit Before VISTA


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

  Are you adding 'GREETER,PETER E' as
    a new RAD/NUC MED PATIENT (the 304TH)? Y  (Yes)
Last Exam Date before VISTA: TODAY  (MAR 28, 1995)  (MAR
28, 1995@00:01)
```

Exam Entry/Edit Menu

Exam Status Display

This function allows the user to view the status of exams for selected imaging locations within the user's current sign-on imaging type. Only exam statuses configured into the system by the ADPAC will appear in the display. For example, exams with a status of WAITING FOR EXAM may appear on the screen, but exams with a status of TRANSCRIBED may not, depending on the exam status parameters set up by the ADPAC. Refer to the ADPAC Guide if more information is needed on examination status parameters.

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

```
Exam Status Display

     Current Division: BOSTON, MA
     Current Imaging Type: NUCLEAR MEDICINE

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

   Searching for incomplete statuses.  Be patient, this may take a while


 Exam Status Tracking Module           Division: BOSTON, MA
 Date    : 08/18/97  1:53 PM           Status  : WAITING FOR EXAM
 Locations: NUCLEAR MEDICINE

 Case #   Date      Patient               Procedure                     Equip/Rm
 ------   ----      -------               ---------                     --------

 859      08/13/97  AXELRODDY,WILLIAM B   BONE DENSITY STUDY, DUAL
 143       8:15 AM  PHEY,RAYMOND I.       BONE IMAGING, WHOLE BODY
 180       9:27 AM  CARSON,ROBERT O.      BONE DENSITY STUDY, DUAL
 181       9:30 AM  LAREDOS,DOROTHY A     BONE DENSITY STUDY, DUAL
 216      10:40 AM  SLOAN,THOMAS R.       BONE IMAGING, WHOLE BODY

Enter Status, (N)ext status, '^' to Stop: NEXT// <RET>


 Exam Status Tracking Module           Division: BOSTON, MA
 Date    : 08/18/97  1:54 PM           Status  : EXAMINED
 Locations: NUCLEAR MEDICINE

 Case #   Date      Patient               Procedure                     Equip/Rm
 ------   ----      -------               ---------                     --------

 613      09/25/95  KENETH,THOMAS A       ABSCESS LOCALIZATION, WHO
 3012     09/28/95  JORDAN,WILLIAM        BONE IMAGING, WHOLE BODY      N3
 568      07/01/97  STEGALON,GEORGE M     BONE DENSITY STUDY, DUAL      N3
 853      07/16/97  BENNET,ROBERT         PULMONARY PERFUSION, PART     N3
 854      07/16/97  BENNET,ROBERT         PROVISION OF DIAGNOSTIC R     N3
 855      07/16/97  BENNET,ROBERT         PROVISION OF DIAGNOSTIC R     N3
 858      07/16/97  BENNET,ROBERT         VENTILATION SCAN              N3
 978      07/23/97  CRAIGINS,BRIDGET      BONE DENSITY STUDY, DUAL      N1
```

```
 1138     07/23/97  MORNISON,EVELYN       BONE DENSITY STUDY, DUAL      N1
 1137     07/23/97  LOANE,RITA A.         BONE DENSITY STUDY, DUAL      N1
 1435     08/08/97  SNODERS,WILLIAM B     MYOCARDIAL PERFUSION (SPE     N2
 1347     08/14/97  GIBBONS,THOMAS E.     PROVISION OF DIAGNOSTIC R     N2
 131      08/15/97  LOWELL,JOSEPH L.      ACUTE GI BLOOD LOSS IMAGI     N3
 132      08/15/97  LOWELL,JOSEPH L.      PROVISION OF DIAGNOSTIC R     N3

Enter Status, (N)ext status, '^' to Stop: NEXT// N
Last status - Do you want to start over? YES// N
```

Exam Entry/Edit Menu

Indicate No Purging of an Exam/Report

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

You are first prompted to enter a case number. You may also enter a patient's name at this prompt. If a patient's name is entered, all active cases for that patient will be displayed and you will be prompted to choose one. Only active cases (i.e., registered cases that are not yet in a COMPLETE status) may be selected. However, if you hold the RA MGR security key, you may select exams with a status of COMPLETE by entering the patient's name rather than the case number at the Enter Case Number: prompt.

Next, you will be asked whether you wish to flag the selected case with a NO PURGE indicator. A NO PURGE entry will retain all the data on the computer. An OK TO PURGE entry will allow some of the exam data to be deleted when IRM runs the next purge. The data that is deleted includes the activity log, status tracking times, clinical history, and report text.

Prompt/**User Response** | Discussion

```
Indicate No Purging of an Exam/report

Enter Case Number: MILLER,FRANK
          06-12-25     837739747   NO   NSC VETERAN
```

Note: Only active case numbers may be entered here. If, for example, case no. 100 for a certain patient is COMPLETE (i.e., currently inactive) and you enter 100 at this prompt, the system may find a more recent, active case no. 100 which has been assigned to a different patient and case than you intended.

If you have the RA MGR key,and enter the patient's name at this prompt, then the system will allow you to select a completed case as shown in this example.

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

```
Patient's Name: MILLER,FRANK  837-73-9747             Run Date: MAR 28,1995

   Case No.  Procedure                   Exam Date  Status of Exam   Imaging Loc
   --------  -------------               ---------  ---------------- ---------
1     286    ABDOMEN 1 VIEW              01/28/95   EXAMINED         X-RAY
2     67     FOREARM 2 VIEWS             11/04/94   CANCELLED        X-RAY
3     280    ARTHROGRAM KNEE S&I         11/04/94   CANCELLED        X-RAY
4     34     FOREARM 2 VIEWS             11/04/94   CANCELLED        X-RAY
5     300    ABDOMEN 1 VIEW              10/21/94   COMPLETE         X-RAY
6     301    CHEST STEREO PA             10/21/94   COMPLETE         X-RAY
7     302    BONE AGE                    10/21/94   COMPLETE         X-RAY
Type '^' to STOP, or
CHOOSE FROM 1-7: 5
    PREVENT PURGE: ??
     If this field is set to 'NO PURGE' then the data for this exam will not be
     purged or archived, nor will the report associated with this exam be
     purged or archived.
     Choose from:
       n        NO PURGE
       o        OK TO PURGE
PREVENT PURGE: N  NO PURGE
Select REASON FOR NOT PURGING: ??

     This field indicates why the examination should not be purged.
Choose from:
       A Agent Orange Exposure
       C Cancer/Tumor Registry
       E Employee
       M Mammography
       P Persian Gulf War
       R Radiation Exposure
       T Teaching
    Select REASON FOR NOT PURGING: T   (Teaching)
    Select REASON FOR NOT PURGING: <RET>
     ...exam status remains 'EXAMINED'.
```

Exam Entry/Edit Menu

Register Patient for Exams

This function allows the user to register a patient for one or more procedures. You may register a patient by selecting an existing request or by initiating a new request. Only requests in the HOLD, PENDING, or SCHEDULED statuses are valid choices. If a request is not available, the user will be prompted to request an exam and the ordering process will be the same as described under the Request an Exam option.

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

1. Enter Pn at the prompt where P indicates that you want to trigger the parent-printset registration feature and "n" is the request number. The request must NOT be a parent. Only one request may be chosen. You will then see a prompt for a parent procedure.
2. Enter a parent procedure of the same imaging type as the requested procedure. The parent must be predefined as a printset. (The list of requests displayed to choose from will have "+" in front of printset parent procedures.
3. Then, proceed to register the predefined descendant(s) OR, discard "^" its descendant(s) and register any descendants that you choose when it asks for more procedures to add. After the replacement printset is registered, all outstanding potentially duplicate orders to any just registered will be displayed as a reminder that these may have to be cancelled.

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

When an exam is registered using an existing request, there will be information carried over from the request record to the exam record. You will be given the opportunity to edit the default information, which includes procedure, procedure modifiers, category of exam, and principal clinic of outpatient. Procedure modifiers available for selection are screened by imaging type, so if a modifier that you need is not available for selection, the ADPAC should refer to the ADPAC Manual, the Procedure Modifier Entry option. Registering a request changes the request status to ACTIVE.
[1]Note: If the procedure and/or the procedure modifier for the case are changed, an alert will be sent to the requesting physician, if the exam's order is not a parent-type procedure. If patch

[1] Patch RA*5*28 October 2001 – Requesting physician is alerted when the ordered exam is changed.

OR*3.0*112 is not installed, this alert cannot be turned off. However, if patch OR*3.0*112 is installed, the users may enable or disable this alert, "Imaging Exam Changed",via the CPRS Notifications Mgmt Menu.

If the patient is an inpatient, the standard default mode of transport will be WHEEL CHAIR. The standard default mode of transport for outpatients will be AMBULATORY. However, if PORTABLE is entered as a modifier, the standard default mode of transport will be PORTABLE regardless of the patient category.

When an exam is registered, a case number is assigned. The case number is a sequential number that is calculated by the system. When a case is processed to the COMPLETE status, its case number becomes available for re-use. Normally, a case number can only be assigned to one active case at a time. However, consider the following scenario: A case is completed, then the case number is re-used and assigned to a second case during registration. The completed case is then Unverified causing the case to be "re-opened" and active once more. This means that the same case number is now associated with two active cases. Although this does not happen often, users should be aware that it can happen. If this happens, you will have to use the exam dates and patient names to discern between the cases.

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

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

The advantages of using pre-defined parent procedures are:

a) Instead of requiring the ordering clinician to order multiple procedures for a study, a single parent procedure can be ordered.

b) The registration process is less prone to error and less time-consuming since the procedures are a pre-defined set and appear automatically.

c) Predefined descendant procedures can be registered or discarded, allowing registration of procedures you select.

d) If the parent is set up as a printset, one report covers all set members.

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

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

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

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

[1]Comments can be entered about the patient or case at the Technologist Comment prompt. Existing text can also be edited. A history of all changes to this field for a case is kept for tracking purposes. If there is more than one comment for the case from different sessions, the most recent text is displayed as a default value for the prompt.

The following sample shows the registration of two requests; one is a single procedure and one is a parent procedure.

The sample below illustrates several advanced features (a – d):

```
Register Patient for Exams
```

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

[1] Patch RA*5*18 November 2000 Added field for comments by the technologist.

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

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

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

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

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

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


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

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

  YES(V)                                PTSD(V)

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


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

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

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

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

     Parent procedure: CHEST CT
```

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

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

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


Please select a sign-on Imaging Location: CTG          523       (CT SCAN-523)

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

                                  Printer Defaults
 Version  : 5.0T9                 ----------------
 Division : BOSTON, MA            Flash Card  : P-CTSCAN  RADIOLOGY, CT SCAN E
 Location : CTG                                 1 card/exam
 Img. Type: CT SCAN               Jacket Label: D129  (D2-150) RADIOLOGY FILE
 User     : HELLER,CINDY A                      1 labels/visit
                                  Report      : D73  D2-149
------------------------------------------------------------------------------
```

c) Registration of parent-descendent exams is shown.

```
     Descendent procedure: CT THORAX W/O CONT

   ...will now register ZZMOUSE,MINNIE with the next case number...  (AUG 18, 19
97@14:06)

    Case Number: 306
    ----------------
    PROCEDURE: CT THORAX W/O CONT//  <RET>                (CT   Detailed) CPT:71250
  [1]Select PROCEDURE MODIFIERS: RIGHT// <RET>

    CATEGORY OF EXAM: OUTPATIENT// <RET>  OUTPATIENT
    PRINCIPAL CLINIC: C MHC MEDICATION GR 7428// <RET>        7428
FLOURNOY,DAVID
   [2]TECHNOLOGIST COMMENT: These are the commentsf or case #306.


Register next descendent exam (CT ABDOMEN W/O CONT)
```

[1] Patch RA*5*10 April 2000 and Patch RA*5*19 Removed CPT Modifiers prompt.
[2] Patch RA*5*18 November 2000 Added field for comments by the technologist.

```
for ZZMOUSE,MINNIE? Yes// <RET>  YES

     Descendent procedure: CT ABDOMEN W/O CONT

   ...will now register ZZMOUSE,MINNIE with the next case number...

    Case Number: 307
    ----------------
    PROCEDURE: CT ABDOMEN W/O CONT//  <RET>                  (CT   Detailed)
CPT:74150
   [1]Select PROCEDURE MODIFIERS: RIGHT// <RET>


    CATEGORY OF EXAM: OUTPATIENT// <RET>    OUTPATIENT
    PRINCIPAL CLINIC: C MHC MEDICATION GR 7428// <RET>       7428      FLOURNOY
DAVID
    [2]TECHNOLOGIST COMMENT: These are the comments for case #307.

Register another descendent exam for ZZMOUSE,MINNIE (Y/N)? YES

   ...will now register ZZMOUSE,MINNIE with the next case number...

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


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




Choose from:
   CONSULTATION OF OUTSIDE CT FILMS WITH REPORT       (CT   Detailed) CPT:76140
   CT ABDOMEN W/CONT                                  (CT   Detailed) CPT:74160
   CT ABDOMEN W/O CONT                                (CT   Detailed) CPT:74150
   CT CERVICAL SPINE W/CONT                           (CT   Detailed) CPT:72126
   CT CERVICAL SPINE W/O CONT                         (CT   Detailed) CPT:72125
   CT GUIDANCE FOR CYST ASPIRATION S&I                (CT   Detailed) CPT:76365
   CT GUIDANCE FOR NEEDLE BIOPSY S&I                  (CT   Detailed) CPT:76360
   CT HEAD W/IV CONT                                  (CT   Detailed) CPT:70460
   CT HEAD W/O CONT                                   (CT   Detailed) CPT:70450
   CT LOWER EXTREMITY W&W/O CONT                      (CT   Detailed) CPT:73702
   CT LOWER EXTREMITY W/CONT                          (CT   Detailed) CPT:73701
   CT LOWER EXTREMITY W/O CONT                        (CT   Detailed) CPT:73700
   CT LUMBAR SPINE W/CONT                             (CT   Detailed) CPT:72132
   CT LUMBAR SPINE W/O CONT                           (CT   Detailed) CPT:72131
   CT MAXILLOFACIAL W/CONT                            (CT   Detailed) CPT:70487
   CT MAXILLOFACIAL W/O CONT                          (CT   Detailed) CPT:70486
   CT NECK SOFT TISSUE W/CONT                         (CT   Detailed) CPT:70491
```

[1] Patch RA*5*10 April 2000 and Patch RA*5*19 Removed CPT Modifiers prompt.
[2] Patch RA*5*18 November 2000 Added field for comments by the technologist.

```
   CT NECK SOFT TISSUE W/O CONT                          (CT   Detailed) CPT:70490
   CT ORBIT SELLA P FOS OR TEMP BONE W/CONT              (CT   Detailed) CPT:70481
   CT ORBIT SELLA P FOS OR TEMP BONE W/O CONT            (CT   Detailed) CPT:70480
   CT PELVIS W/CONT                                      (CT   Detailed) CPT:72193
              ^
    PROCEDURE: CT HEAD W/IV CONT                         (CT   Detailed) CPT:70460
   [1]Select PROCEDURE MODIFIERS: <RET>

    CATEGORY OF EXAM: OUTPATIENT// <RET>  OUTPATIENT
    PRINCIPAL CLINIC: C MHC MEDICATION GR 7428// <RET>      7428      FLOURNOY,
DAVID
   [2]TECHNOLOGIST COMMENT: These are the comments for case #308.

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

[1] Patch RA*5*10 April 2000 and Patch RA*5*19 May 2000 CPT Modifier prompt removed.
[2] Patch RA*5*18 November 2000 Added field for comments by the technologist.

```
    ...all needed flash cards and exam labels queued to print on P-CTSCAN.
  Task #: 6571875

    ...all film jacket labels queued to print on D129.
  Task #: 6571876

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


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

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

  YES(V)                                PTSD(V)

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


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

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

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

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

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

Current procedure for this order is ABDOMEN 1 VIEW

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

Select Printset Parent Procedure : ??

Choose from:
   BARIUM SWALLOW                                        (RAD  Parent  )
   MYELOMA SURVEY                                        (RAD  Parent  )
   PHARYNX                                               (RAD  Parent  )
   UGI                                                   (RAD  Parent  )
   UGI SBFT                                              (RAD  Parent  )

Select Printset Parent Procedure : BARIUM SWALLOW       (RAD  Parent  )

     Parent procedure: BARIUM SWALLOW

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

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


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

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

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

     Descendent procedure: ESOPHAGUS RAPID SEQUENCE FILMS

   ...will now register ZZMOUSE,MINNIE with the next case number...  (AUG 18, 19
97@14:07)

    Case Number: 310
    ----------------
    PROCEDURE: ESOPHAGUS RAPID SEQUENCE FILMS// <RET>       (RAD  Detailed)
CPT:74230
```

```
    [1]Select PROCEDURE MODIFIERS: <RET>

    CATEGORY OF EXAM: OUTPATIENT// <RET>  OUTPATIENT
    PRINCIPAL CLINIC: RADIOLOGY-UGI 4710// <RET>          4710
   [2]TECHNOLOGIST COMMENT: These are the comments.


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

     Descendent procedure: ESOPHAGUS PHARYNX/CERVICAL

   ...will now register ZZMOUSE,MINNIE with the next case number...

    Case Number: 311
    ----------------
    PROCEDURE: ESOPHAGUS PHARYNX/CERVICAL// <RET>          (RAD  Detailed) CPT:74210
    Select MODIFIERS: <RET>
    CATEGORY OF EXAM: OUTPATIENT// <RET>  OUTPATIENT
    PRINCIPAL CLINIC: RADIOLOGY-UGI 4710// <RET>          4710
   [3]TECHNOLOGIST COMMENT: These are the comments.

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


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


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

[1] Patch RA*5*10 April 2000 and Patch RA*5*19 May 2000 CPT Modifier prompt removed.
[2] Patch RA*5*18 November 2000 Added field for comments by the technologist.
[3] Patch RA*5*18 November 2000 Added field for comments by the technologist.

Exam Entry/Edit Menu

Status Tracking of Exams

This function is used mainly by the technologist to update the status of an exam. Entering exam data such as technologist, films used, diagnostic code, camera/equipment/room, etc., causes the system to automatically attempt to move the status of the exam forward. The system compares the data entered to the data required to progress to the next status. The data required is pre-defined by the ADPAC by answering questions asked in the Examination Status Entry/Edit option. Certain division and imaging type parameters also affect the set of questions asked during this option. If further instructions are needed concerning exam status parameter set-up, refer to the ADPAC Guide.

This option differs from the Case No. Exam Edit and Edit Exam by Patient options in that prompts are predetermined by the parameters in the Examination Status file for each status change in this option. (In the case edit options, a set of basic prompts always appears, and any field already entered also appears.) The type of data asked for during each status change in this option is specified by the site. See the ADPAC Guide for more information about Examination Status parameter set-up.

The set of statuses that appear for edit during this option are also site specific. A site may not want to bring up exams with a particular exam status for edit if the data needed to update the exam status is not usually entered through this option. For example, going from the EXAMINED status to the TRANSCRIBED status usually requires data supplied by an interpreting physician and entered by a transcriptionist. By limiting the statuses that appear in this option, the efficiency of processing and tracking exams is increased. After all active statuses set up to appear on Status Tracking are cycled through, the system will start to display inactive statuses set up to appear on Status Tracking if any are so configured.

You may select one or more imaging locations to work on at once, but all the imaging locations must fall within your sign-on division and imaging type. If you have access to only one location within that imaging type, the system will default to that location instead of asking you to select imaging locations. Exams with a given status will be displayed in chronological order by exam date. Included in the display heading are the current date/time, division, imaging location(s), and the status currently under review. Each line represents an exam and includes the case number, exam date, patient name, procedure, and camera/equipment/room. You may select one and edit it, view the next screen within the current status, or move on to display exams with the next status.

When an exam moves to the Complete status, the system will automatically attempt to pass the credit information associated with that exam to the PCE package for use in determining reimbursement to the hospital.

It should be noted that the ADPAC can use the Procedure Enter/Edit option to set up default film sizes and amounts for procedures, default medications and doses, and default radiopharmaceutical

and associated data (seen only when editing Nuclear Medicine and Cardiology Studies imaging types). If this is done, the data is automatically entered into their respective fields at registration. That means that the tech editing the case will have to make a point of manually deleting and re-editing these fields if the data for a specific case is not the same as the data that is entered in the procedure parameters by the ADPAC. Although radiopharmaceuticals are automatically entered, their dosages and related data are not. Radiopharmaceutical dosage and other default data set up on procedures by the ADPAC will appear as default responses during Case Edits and Status Tracking. See the ADPAC Guide for more information about procedure setup using Procedure Enter/Edit.

Status Tracking will inform the user if the case just edited meets the criteria for a higher status. If so, it should be reedited immediately. Status Tracking cannot "leap frog" over the status displayed as the next one because additional prompts may need to be asked through an additional edit.

If the default next status is invalid (i.e., no order number on the status), the Status Tracking edit will detect this and search for the next valid status to use instead. If the user selects a default next status, only valid statuses with an order number can be chosen. (See ADPAC Guide for more information.)

Imaging departments must make sure that cases are routinely processed to a COMPLETE status. Otherwise, the case numbers will increment until the maximum number (99,999) is reached and the system will not allow registration of any more cases.

Please refer to the Case No. Exam Edit option in this manual, page V-8, for an explanation of fields editable in Status Tracking.

Only imaging locations with your current sign-on imaging type are selectable. To do Exam Status Tracking for locations of a different imaging type such as Nuclear Medicine, you must use the Switch Locations option or sign back on under an imaging location whose imaging type is Nuclear Medicine.

If there is a long delay at this point, there are two possible reasons:

a) A large number (for example, more than two or three days of accumulated case workload) of incomplete cases exists and should be cleaned up, or
b) One or more inactive statuses are configured to appear on Status Tracking.

Exam Entry/Edit Menu

Switch Locations

This option appears on several menus as a convenience to users. Please refer to the option description earlier in this section where it first appears under Use of the Software on page III-2.

Exam Entry/Edit Menu

View Exam by Case No.

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

The activity log shows the date/time any action took place on the examination and/or report, what that action was and the computer user responsible for that action. The status tracking log shows the various examination statuses, the date/time it acquired that status, elapsed time between statuses and cumulative time the case has been active. The exam report text shows the patient's name, exam date, procedure, case no., requesting physician, resident and staff interpreting physicians, exam modifiers, clinical history, report text, status and impression.

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

```
View Exam by Case No.

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

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

Patient's Name: VETERAN,JOE           000-99-8888      Run Date: AUG 18,2000

   Case No.  Procedure                  Exam Date  Status of Exam   Imaging Loc
   --------  -------------              ---------  ---------------- -----------
1    +578    THALLIUM SCAN (SPECT)      07/24/00   COMPLETE         NUCLEAR MED
2    .580    PROVISION OF RADIONUCLID   07/24/00   COMPLETE         NUCLEAR MED
3    .582    COMPUTER MANIPULATION <    07/24/00   COMPLETE         NUCLEAR MED
4    .583    INTRODUCTION OF NEEDLE O   07/24/00   COMPLETE         NUCLEAR MED
5     319    FOOT-3 VIEWS (ROUTINE)     04/13/00   COMPLETE         XRAY
6     321    SPINE CERVICAL MIN 4 VIEWS 04/13/00   COMPLETE         XRAY
7     252    CHEST 2 VIEWS PA&LAT (ROUT 11/06/99   COMPLETE         XRAY
8     258    CT HEAD W&WO CONT          11/01/99   COMPLETE         XRAY
9     164    CHEST 2 VIEWS PA&LAT       04/17/99   COMPLETE         XRAY
Type '^' to STOP, or
CHOOSE FROM 1-9: 1

================================================================================
  Name        : VETERAN,JOE             000-99-8888
  Division    : WHITE RIVER JUNCTION    Category     : OUTPATIENT
  Location    : NUCLEAR MEDICINE        Ward         :
  Exam Date   : JUL 24,2000  08:11      Service      :
  Case No.    : 578                     Bedsection   :
                                        Clinic       : 10 EKG-MISC
--------------------------------------------------------------------------------
[1] Registered    : THALLIUM SCAN (SPECT) (NM   Detailed) CPT:nnnnn
  Requested     : THALLIUM SCAN
  Requesting Phy: WELBY,MARCUS          Exam Status  : COMPLETE
```

[1] Patch RA*5*10 April 2000

```
  Int'g Resident:                       Report Status: VERIFIED
  Pre-Verified  : NO                    Cam/Equip/Rm :
  Int'g Staff   : LEMOY,LEONARD         Diagnosis    :
  Technologist  : HINESLEY,RICK         Complication :
                                        Films        : NUC  (NucMed Kodak EC-1) - 1
---------------------------------Modifiers--------------------------------
  Proc Modifiers: None

  CPT Modifiers  :None
-----------------------------Radiopharmaceuticals-----------------------------
Rpharm: TL-201 THALLOUS CHLORIDE       Activity Drawn: 3.35 mCi
Drawn: JUL 24, 2000@08:06              Measured By: HINESLEY,RICK
Dose Adm'd: 3.35 mCi                   Date Adm'd: JUL 24, 2000@08:06
Adm'd By: HINESLEY,RICK                Route: INTRAVENOUS
Site: RIGHT ANTECUBITAL FOSSA          Lot #: T20372
Volume: 1.83 ml                        Form: Liquid

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


                          *** Imaging Personnel ***
--------------------------------------------------------------------------------
Primary Int'g Resident:
Primary Int'g Staff   : LEMOY,LEONARD
Pre-Verifier:
Verifier    : LEMOY,LEONARD  081100@09:31

Secondary Interpreting Resident        Secondary Interpreting Staff
-------------------------------        ----------------------------
None                                   None

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

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

                       *** Exam Activity Log ***
  Date/Time              Action                              Computer User
  ---------              ------                              -------------
[1] JUL 24,2000  08:11     EXAM ENTRY                          HINESLEY,RICK
   This is a tech note on the patient/case.
  JUL 25,2000  09:51     EXAM STATUS TRACKING                HINESLEY,RICK
   This is another tech note on the patient and or case.  If the note is longer than
   2 lines then the entire note can be seen in this option along with all other tech
   notes written on the case.

                      *** Report Activity Log ***
  Date/Time              Action                              Computer User
  ---------              ------                              -------------
  AUG  8,2000  21:30     INITIAL REPORT TRANSCRIPTION        TYPESWELL,AUDREY
  AUG 11,2000  09:31     VERIFIED                            NIMOY,LEONARD
================================================================================

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


                           *** Status Tracking Log ***
                                                  Elapsed Time  Cumulative Time
  Status                 Date/Time                (DD:HH:MM)      (DD:HH:MM)
  ------                 ---------               ------------  ---------------
  REGISTERED FOR EXAM    JUL 24,2000  08:11       01:01:40        01:01:40
```

[1] Patch RA*5*18 November 2000 New field for comments by the technologist added to report.

```
  EXAMINED               JUL 25,2000  09:51      14:11:41        15:13:21
  TRANSCRIBED            AUG  8,2000  21:32      02:12:00        17:25:21
  COMPLETE               AUG 11,2000  09:32
================================================================================

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


VETERAN,JOE (000-99-8888)               Case No.        : 072400-578 @08:11
THALLIUM SCAN (SPECT)                   Transcriptionist: TYPESWELL,AUDREY
Req. Phys : WELBY,MARCUS                Pre-verified    : NO
Staff Phys: LEMOY,LEONARD (P)
Residents :
================================================================================
THALLIUM SCAN (SPECT)
     Exam modifiers : None
     Radiopharmaceutical: TL-201 THALLOUS CHLORIDE, 3.35 mCi
      Adm'd on JUL 24, 2000@08:06 by HINESLEY,RICK
      Route INTRAVENOUS Site RIGHT ANTECUBITAL FOSSA
PROVISION OF RADIONUCLIDE;DIAGNOSTIC
     Exam modifiers : None
COMPUTER MANIPULATION < 30 MIN.
     Exam modifiers : None
INTRODUCTION OF NEEDLE OR INTRACATHETER,VEIN
     Exam modifiers : None

   Clinical History:
  EXERTIONAL ANGINA (NEW SINCE BEGINNING OF 6/00) WITH MULTIPLE RISK FACTORS

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

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

   Primary Diagnostic Code:
```

VI. Films Reporting Menu

This menu provides the user with all the functions related to reports of imaging examinations.

Batch Reports Menu …
Display a Rad/Nuc Med Report
Distribution Queue Menu …
Draft Report (Reprint)
On-line Verifying of Reports
Report Entry/Edit
Resident On-Line Pre-Verification
Select Report to Print by Patient
Switch Locations
Verify Report Only

Films Reporting Menu

Batch Reports Menu

This menu contains options that support maintenance of batches of results reports. Functions include the following:

Add/Remove Report From Batch
Create a Batch
Delete Printed Batches
List Reports in a Batch
Print a Batch of Reports
Verify a Batch

Films Reporting Menu

Batch Reports Menu

Add/Remove Report from Batch

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

Once a batch is deleted you are no longer able to access that batch.

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

Prompt/**User Response** Discussion

```
Add/Remove Report From Batch
```

Example 1 - Adding a report to a batch:

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

Example 2 - Removing a report from a batch:

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

Films Reporting Menu

Batch Reports Menu

Create a Batch

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

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

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

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

Prompt/**User Response**	Discussion
`Create a Batch`	
`Select Batch:` **`4/3/95 GALES REPORTS`** `  Are you adding '4/3/95 GALES REPORTS' as a new REPORT BATCHES?` **`Y`** `(Yes)`	The system requires that new batch names be entered in uppercase. Existing batch names may be retrieved in either case.

Films Reporting Menu

Batch Reports Menu

Delete Printed Batches

This option allows the user to delete batches after they are no longer needed. The batch must have been created by the current user and need not have actually been printed. That is, the user cannot delete a batch created by another user. The Delete Printed Batches by Date option under the Supervisor menu allows supervisors to delete printed batches belonging to any user.

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

Once a batch is deleted you are no longer able to access that batch. You would not be able to use the Add/Remove Report from Batch option to add more reports to the batch. You would have to create a new batch through the Report Entry/Edit or Create a Batch options with the same name and then add reports to it.

After you select a batch for deletion, the system will display the date/time the batch was created, the name of the user who created the batch and the date the batch was last printed (if any). Only batches which have been printed at least once are shown as choices. Refer to the Supervisor Menu for another option that allows supervisors to delete printed batches regardless of who they belong to.

Prompt/**User Response** Discussion

```
Delete Printed Batches


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



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

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


You have already selected:
```

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

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


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


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


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

Do you wish to delete all the above Report Batches? YES

     Beginning the interactive deletion process.
     <Deleting>.
     Deletion process has successfully completed.
```

Films Reporting Menu

Batch Reports Menu

List Reports in a Batch

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

If a user's name was entered, all the allowable batches for that user are displayed for selection. The following information is displayed for the specified batch: batch name, date created, date last printed and the name of the user who created the batch. The following information is then listed for each report in the batch: case number, exam date, patient and interpreting physician. An asterisk(*) is placed next to the report if the report has been previously printed.

Prompt/**User Response** Discussion

```
List Reports in a Batch

Select Batch:    HOWARD,MOE REPORTS        03-06-95
TAYLOR,SARA

DEVICE: HOME//  <RET> RIGHT MARGIN: 80// <RET>
```

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

* indicates the report has been printed from batch
================================================================================

 Case No.      Exam Date      Patient                       Interpreting Phys.
 --------      ---------      -------                       ------------------
  * 137        MAR  6,1995    HOWARD,MOE                    GALE,E.
  * 138        MAR  6,1995    HOWARD,MOE                    GALE,E.
```

Films Reporting Menu

Batch Reports Menu

Print a Batch of Reports

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

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

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

Prompt/**User Response** Discussion

```
Print a Batch of Reports


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


Batch: DOE 3/24/95   Date Created: MAR 24,1995  15:10  BAKER,JOE
Are you sure? No// Y
QUEUE TO PRINT ON
DEVICE: LINE  COMP. ROOM    RIGHT MARGIN: 132// <RET>

Requested Start Time: NOW//  <RET> (APR 03,
1995@09:56:42)
     Request Queued.  Task #: 11620
```

If you are prompted for a device, the results reports will print on the printer chosen.

Films Reporting Menu

Batch Reports Menu

Verify Batch

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

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

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

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

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

Prompt/**User Response** Discussion

```
Verify Batch

Select Batch: HOWARD,MOE REPORTS          03-06-95
TAYLOR,SARA


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

Is this the batch you want to verify? No// Y

[1]Enter your Current Signature Code: (Enter your electronic signature code here)
SIGNATURE VERIFIED
-------------------------------------------------------------------------------
Report for case no. 137 for HOWARD,MOE

     Select one of the following:

          V         VERIFIED
          R         RELEASED/NOT VERIFIED
          PD        PROBLEM DRAFT
          D         DRAFT

REPORT STATUS: D// VERIFIED
VERIFYING PHYSICIAN: GALES,M.         MEG
PRIMARY DIAGNOSTIC CODE: NORMAL// <RET>
  Select SECONDARY DIAGNOSTIC CODE: <RET>
-------------------------------------------------------------------------------
Report for case no. 138 for HOWARD,MOE

     Select one of the following:

          V         VERIFIED
          R         RELEASED/NOT VERIFIED
          PD        PROBLEM DRAFT
          D         DRAFT

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

Can this batch now be deleted? No// Y
   ...deletion complete.
     Status updates queued!
```

Note that the RELEASED/NOT VERIFIED status will not appear as a selection unless division parameters allow it. Refer to the ADPAC Guide for more information.

[1] Patch RA*5*8 October 1999

Films Reporting Menu

Display a Rad/Nuc Med Report

This option allows the user to display a VERIFIED or RELEASED/NOT VERIFIED imaging results report at the terminal. (Not all hospitals use the RELEASED/NOT VERIFIED status; see the ADPAC Guide for more information.) Draft reports cannot be displayed since this option may be available to users outside of Rad/Nuc Med. The report format output when using this option is specially tailored for screen display by omitting footer information and blank lines.

You will be prompted to select a Rad/Nuc Med patient. If the patient selected has more than one examination on file, a list will display with the following information for each report: case no., procedure, exam date, status of the report and imaging location of the exam. You will be prompted to choose one of the displayed cases. More than one can be selected, delimited by commas, or a range can be selected by entering the first and last separated by a hyphen. After reviewing a report, you will be given the opportunity to view the case again or continue to review other reports if more than one was selected initially.

[1]The report display includes procedure and CPT modifiers (includes all procedures in a set), pharmaceuticals when used and radiopharmaceuticals when used, clinical history, report text, impression text, report status, and the names of all the primary and secondary interpreting staff and residents. The report headers are determined by the ADPAC when imaging location parameters are set up. If the ADPAC has answered Yes to the Imaging Locations parameter Print DX Codes in Report?, all primary and secondary diagnostic codes will also print in the report. (See the ADPAC Guide for more information about imaging location set-up and flash card formats.) If the selected case is part of a printset, the report will include the procedures and modifiers for all cases in the set. The displayed report does not include the headers and footers that would be printed on a hard copy.

Reports are filed through the Report Entry/Edit option of the Films Reporting Menu.

[1] Patch RA*5*10 April 2000

Films Reporting Menu

Distribution Queue Menu

This menu contains the options which allow the user to print reports sorted for distribution to the wards, clinics and file rooms.

Other options on the menu include printing the activity logs for the various distribution queues and displaying a report's print status.

Activity Logs
Clinic Distribution List
Individual Ward
Print By Routing Queue
Report's Print Status
Single Clinic
Unprinted Reports List
Ward Distribution List

Films Reporting Menu

Distribution Queue Menu

Activity Logs

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

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

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

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

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

Prompt/**User Response** Discussion

```
Activity Logs

Select Routing Queue: WARD REPORTS// ??

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

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

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

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

Films Reporting Menu

Distribution Queue Menu

Clinic Distribution List

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

You will be prompted to enter one or more clinic names. You will also be able to choose whether to list the previously printed reports or unprinted reports for the selected clinic(s). If you choose to list printed reports, you are then prompted to enter a date range for the listing.

The list prints alphabetically by patient name. If run for unprinted reports the output generated will include: date/time the report is run, date/case number, patient name and patient ID, date/time the report was verified and the clinic that requested the procedure. If the listing is generated for previously printed reports the information provided will include: date/time the report is run, date/case number, patient name and ID, date report was printed, user who printed the report and the clinic that requested the procedure.

Only outpatients will be listed on this report. If the patient was an outpatient when the exam was requested but an inpatient when the report was initially printed, the report would appear on the Ward Distribution List.

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

Prompt/**User Response** | Discussion

```
Clinic Distribution List

Select Clinic: ALL

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

Printed/Unprinted Report Selection
----------------------------------

  Choose one of the following:
          PRINTED
          UNPRINTED

  Report Selection: UNPRINTED// printed       PRINTED
```

One, many, all clinics may be selected.

```
**** Date Range Selection ****

   Beginning DATE : 4/1/95  (APR 01, 1995)

   Ending    DATE : t  (APR 05, 1995)
```

When PRINTED is selected, all reports that were initially printed within this date range will appear on this list.

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

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

```
Printed Reports by Clinic                    APR  5,1995  10:51    PAGE 1

Day/Case    Patient           BID     Date Printed    Printed By    Ward/Clinic
-------------------------------------------------------------------------------

021194-92   ABCEK,ANN         8476    04/05/95@10:33  TRACKER,FRANK  EMERGENCY
101293-13   ABLKCBFV,ALAN K.  1556    04/05/95@10:33  CEBEL,GREG     EMERGENCY
011194-33   BOGQ,WILLIAM J.   1026    04/05/95@10:33  TRACKER,FRANK  EMERGENCY
011094-30   BOGQ,WILLIAM J.   1026    04/05/95@10:33  TRACKER,FRANK  GENERAL MEDICI
010794-36   BOGQ,WILLIAM J.   1026    04/05/95@10:33  TRACKER,FRANK  GENERAL MEDICI
010594-35   BOGQ,WILLIAM J.   1026    04/05/95@10:33  TRACKER,FRANK  GENERAL MEDICI
030994-4    CORLEONE,VITO     3953    04/05/95@10:33  CEBEL,GREG     GENERAL MEDICI
040395-309  DENT,VERNON       0623    04/05/95@10:33  CEBEL,GREG     EAR NOSE & THR
062394-64   FINE,LARRY        8243    04/05/95@10:33  JONES,THOM     EAR NOSE & THR
062394-63   FINE,LARRY        8243    04/05/95@10:33  JONES,THOM     MAGNETIC RESON
062394-58   FINE,LARRY        8243    04/05/95@10:33  JONES,THOM     MAGNETIC RESON
062394-57   FINE,LARRY        8243    04/05/95@10:33  JONES,THOM     MAGNETIC RESON
040194-74   HELLER,RALPH      8277    04/05/95@10:33  TAYLOR,SAR     MAGNETIC RESON
110193-25   HELLER,RALPH      8277    04/05/95@10:33  TAYLOR,SAR     MAGNETIC RESON
031894-284  HELLER,RALPH      8277    04/05/95@10:33  TAYLOR,SAR     ULTRASOUND
040494-81   HELLER,RALPH      8277    04/05/95@10:33  TAYLOR,SAR     ULTRASOUND
032294-15   HELLER,RALPH      8277    04/05/95@10:33  TAYLOR,SAR     ULTRASOUND
040494-20   HELLER,RALPH      8277    04/05/95@10:33  TAYLOR,SAR     ULTRASOUND
```

Note: The column with the heading BID (Brief ID) contains the last four digits of the patient's social security number or other ID.

Films Reporting Menu

Distribution Queue Menu

Individual Ward

This option prints either:

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

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

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

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

[1]The report printout will include procedure and CPT modifiers, clinical history, report text, impression text, report status, and the names of all the primary and secondary interpreting staff and residents, with a notation beside the report verifier's name. The report headers and footers are determined by the ADPAC when the imaging location parameters are set up. If the ADPAC has answered Yes to the Imaging Locations parameter Print DX Codes in Report?, all primary and secondary diagnostic codes will also print in the report. (See the ADPAC Guide for more information about imaging location set-up and flash card formats.) The total number of reports printed will also be provided.

This output must be queued to a printer.

Prompt/**User Response** Discussion

```
Individual Ward

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

[1] Patch RA*5*10 April 2000

```
Select Imaging Type: All// <RET>

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

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

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

  Select Sequence: Patient// <RET>

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

  Enter Response: UNPRINTED// REPRINT

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

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

```
Select Ward: 1S

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

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

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

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

The results reports will print on the printer entered at the "Device:" prompt.

Films Reporting Menu

Distribution Queue Menu

Print By Routing Queue

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

The user is prompted for the routing queue, division, one or more imaging types, sort sequence (Terminal Digits, SSN, Patient), whether or not to sort by patient location before your chosen sort sequence, and choice of unprinted or reprint reports. If you choose to print reprints, you are then prompted to enter a date range for the listing. The reports are then printed (preceded and followed by a queue banner).

[1]The report printout will include procedure and CPT modifiers, clinical history, report text, impression text, report status, and the names of all the primary and secondary interpreting staff and residents, with a notation beside the report verifier's name. The report headers and footers are determined by the ADPAC when the imaging location parameters are set up. If the ADPAC has answered Yes to the Imaging Locations parameter Print DX Codes in Report?, all primary and secondary diagnostic codes will also print in the report. (See the ADPAC Guide for more information about imaging location set-up and flash card, label, header and footer formats.) The total number of reports printed is shown at the end of the entire set of reports.

This output must be queued to a printer.

Prompt/**User Response** | Discussion

```
Print by Routing Queue

Select Routing Queue: WARD REPORTS// <RET>

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

Select Imaging Type: All// <RET>

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

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

[1] Patch RA*5*10 April 2000

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

  Select Sequence: Patient// <RET>
```

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

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

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

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

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

  Enter Response: UNPRINTED// REPRINT

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

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

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

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

The results reports will print on the printer entered at the Device prompt.

Films Reporting Menu

Distribution Queue Menu

Report's Print Status

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

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

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

Prompt/**User Response** Discussion

```
Report's Print Status

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

```
---------------------------------------------------------------------------

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

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

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

NOTE: Reports can be periodically purged from the Distribution Queue by IRM after they are printed, so older printed reports may not be displayed.

Films Reporting Menu

Distribution Queue Menu

Single Clinic

This option prints either:

- All verified reports, not previously printed from the distribution queue, of imaging studies of a specified imaging type for all patients in specified clinic(s), or
- Reprints of verified reports, previous printed from the distribution queue, of imaging studies of a specified imaging type, done between two specified dates, for all patients in specified clinic(s).

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

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

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

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

This output must be queued to a printer.

[1] Patch RA*5*10 April 2000

Prompt/**User Response** Discussion

```
Single Clinic

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


Select Imaging Type: ALL // <RET>

Another one (Select/De-Select):

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

  Select Sequence: Patient// <RET>

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

  Enter Response: UNPRINTED// <RET>
```

```
Select Clinic: ER   EMERGENCY ROOM

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

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

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

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

Films Reporting Menu

Distribution Queue Menu

Unprinted Reports List

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

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

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

Prompt/**User Response** Discussion

```
Unprinted Reports List

DEVICE: <RET>  SET HOST
```

```
Unprinted Reports List                          APR 10,1995  09:12    PAGE 1
Day/Case
            Patient           BID
                                        Date Verified   Ward/Clinic Routing Queue
-------------------------------------------------------------------------------

032795-23   ABINDPKP,CHESTER          03/27/95        BILLINGS B  CLINIC REPORT
032795-23   ABINDPKP,CHESTER          03/27/95        BILLINGS B  MEDICAL RECOR
033094-62   ABOAACQC,EUGENE           06/10/94        NUCLEAR ME  CLINIC REPORT
033094-62   ABOAACQC,EUGENE           06/10/94        NUCLEAR ME  MEDICAL RECOR
111593-26   HELLER,RALPH              04/26/94        1N          WARD REPORTS
111593-26   HELLER,RALPH              04/26/94        1N          FILE ROOM
111593-26   HELLER,RALPH              04/26/94        1N          MEDICAL RECOR
082694-31   HOWARD,MOE                08/26/94        BILLINGS B  CLINIC REPORT
082694-31   HOWARD,MOE                08/26/94        BILLINGS B  MEDICAL RECOR
090494-25   MARX,HARPO                09/04/94        DENTAL      CLINIC REPORT
090494-25   MARX,HARPO                09/04/94        DENTAL      MEDICAL RECOR
071594-58   SAUNDERS,CHIP             07/26/94        NUCLEAR ME  CLINIC REPORT
071594-58   SAUNDERS,CHIP             07/26/94        NUCLEAR ME  MEDICAL RECOR
012794-54   ABCEK,ANN                 06/10/94        EMERGENCY   CLINIC REPORT
012794-54   ABCEK,ANN                 06/10/94        EMERGENCY   MEDICAL RECOR
051394-8    ABCEK,ANN                 06/10/94                    MEDICAL RECOR
051394-8    ABCEK,ANN                 06/10/94                    OTHER THAN WA
021194-92   ABCEK,ANN                 04/26/94        EMERGENCY   MEDICAL RECOR
```

Films Reporting Menu

Distribution Queue Menu

Ward Distribution List

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

You will be prompted to enter one or more ward names. You will also be able to choose whether to list previously printed reports or unprinted reports for the selected ward(s). If you choose to list printed reports, you are then prompted to enter a date range for the listing.

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

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

Prompt/**User Response**	Discussion
`Ward Distribution List`	
`Select Ward: **ALL**`	One, many, all may be selected.

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

```
**** Date Range Selection ****

   Beginning DATE : 3/1/95  (MAR 01, 1995)

   Ending    DATE : 3/31/95  (MAR 31, 1995)
```

When PRINTED is selected, all reports that were initially printed within this date range will appear on this list.

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

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

```
Printed Reports by Ward                          APR 10,1995  09:24    PAGE 1
Day/Case
            Patient           BID     Date Printed    Printed By    Ward/Clinic
-------------------------------------------------------------------------------

012695-95   ADENAUER,KONRAD   7512    03/07/95@12:56  MILLET,BOB    1N
012695-94   ADENAUER,KONRAD   7512    03/07/95@12:56  MILLET,BOB    1N
012695-92   ADENAUER,KONRAD   7512    03/07/95@12:56  MILLET,BOB    1N
011394-46   ADOGA,LARAY       4944    03/07/95@12:56  SHARF,MILLIE  1N
013095-1    BALCK,HERMAN      7575    03/07/95@12:56  SMIT,BERNIE   1N
012595-82   BALCK,HERMAN      7575    03/07/95@12:56  SMIT,BERNIE   1N
012595-83   BALCK,HERMAN      7575    03/07/95@12:56  SMIT,BERNIE   1N
012595-87   BALCK,HERMAN      7575    03/07/95@12:56  SMIT,BERNIE   1N
012595-72   BALCK,HERMAN      7575    03/07/95@12:56  SMIT,BERNIE   1N
041194-166  CAAPT,SHELBY      5441    03/07/95@12:56  SHARF,MILLIE  1S
041194-167  DAEVZS,JAMES H    1941    03/07/95@12:56  SHARF,MILLIE  1S
020295-47   HELLER,RALPH      8277    03/07/95@12:56  RUIZ,RUDY     215E
021395-4    HELLER,RALPH      8277    03/07/95@12:56  RUIZ,RUDY     215E
011895-131  HELLER,RALPH      8277    03/07/95@12:56  RUIZ,RUDY     215E
101994-224  HELLER,RALPH      8277    03/07/95@12:56  RUIZ,RUDY     215E
020894-90   HELLER,RALPH      8277    03/07/95@12:56  RUIZ,RUDY     215E
022894-71   HELLER,RALPH      8277    03/07/95@12:56  RUIZ,RUDY     215E
020394-72   HELLER,RALPH      8277    03/07/95@12:56  RUIZ,RUDY     215E
```

Films Reporting Menu

Draft Report (Reprint)

This option should only be given to those users in the department who need to reprint a DRAFT report. Since access to unverified results reports is usually not advisable, caution should be exercised in determining to whom this option is assigned. For example, the transcriptionist should have access to this option, but ward clerks should not. Instead, the ward clerks could be given access to the Select Report to Print by Patient option which prints only verified or released/not verified reports.

Reports selected to be printed through this option will always have a status of DRAFT or PROBLEM DRAFT.

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

Prompt/**User Response** Discussion

```
Draft Report (Reprint)


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


                    **** Patient's Exams ****
Patient's Name: WHITE,JULES  231-68-0695              Run Date: MAR 14,1997

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

Films Reporting Menu

On-line Verifying of Reports

This option allows the interpreting physician to verify reports on-line. To use this option an Electronic Signature Code is required. The user must also be assigned the RA VERIFY security key. If the user does not own the RA VERIFY key, this option will not appear under the Films Reporting Menu.

The classification of a user as Staff or Resident is done by the ADPAC through the Personnel Classification menu of this package. A results report is associated with an interpreting resident or staff member when the physician's name is entered as the Primary or Secondary Interpreting Staff, or Primary or Secondary Interpreting Resident under several options in the Exam Entry/Edit menu or the Report Entry/Edit option. Several site-configurable parameters play a part in determining the behavior of this option. See the ADPAC Guide for a complete description of Personnel Classification and Division parameter set-up.

The system first prompts for an electronic signature code to check that the user is valid. Electronic signature codes are assigned through the Kernel option, Electronic Signature code Edit [XUSESIG]. Users requiring an electronic signature code should be given this option.

An interpreting staff physician may verify reports associated with his/her name. Additionally, if the staff member's personnel parameter ALLOW VERIFYING OF OTHERS is set to YES, the staff member will see an additional prompt, Select Interpreting Physician, where s/he can enter the name of another physician and will be able to verify reports associated with that other physician. If the division parameter ALLOW VERIFYING BY RESIDENTS is set to YES and the personnel parameter ALLOW VERIFYING OF OTHERS is set to YES, the resident may also verify reports associated with other interpreting physicians. If the division parameter ALLOW VERIFYING BY RESIDENTS is set to NO, residents will not be allowed to use this option at all. Similarly, if Allow Verifying by Residents is set to YES, and ALLOW VERIFYING OF OTHERS is set to NO, residents will not be allowed to verify other physicians' reports. (See the Troubleshooting section of the ADPAC manual for a more complete discussion of the effects of various combinations of the set-up parameters.)

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

1) reports pre-verified by an interpreting resident (which always have a status of DRAFT or RELEASED/NOT VERIFIED,
2) reports that are not pre-verified which have a status of RELEASED/NOT VERIFIED,
3) reports with a status of DRAFT,
4) reports with a status of PROBLEM DRAFT,
5) all reports,
6) the user enters a list of selections, or
7) reports for STAT exams.

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

After each report is displayed, you are given the choices: print, edit, go back to the top of the report, status and print, continue on to change the report status and enter diagnostic code(s), edit the status then print the report, or stop processing.
After every re-edit of the report, you will get these same choices. If you edit or print the report, it will return back to the continue prompt. If you select "continue" or "status and print", you will then be asked if the status of the report should change. You may select one of the following statuses:

VERIFIED - The report has been verified by a RA VERIFY keyholder who is usually the interpreting physician. It can be displayed by appropriate users outside the Imaging department (e.g., ward clerks, nurses, and physicians).

RELEASED/NOT VERIFIED - The report can be displayed outside the Imaging department even though it has not been verified by the radiologist. A case is tied to an imaging location, which in turn, is associated with a division. Entry of this status is only allowed if the ALLOW RELEASED/NOT VERIFIED parameter of the [1]Imaging Locations file is set to YES. You may use the Display Report or Select Report to Print options to view or print reports with this status if this status is allowed at your facility.

DRAFT - The report can only be displayed in the Imaging Department.

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

The system will not allow you to verify a report without the Impression Text being complete - it will put it in PROBLEM DRAFT.

If you have chosen Status and Print, you will be given a Device prompt after editing the status. You may then print a report in any status, or convert the report to an e-mail message using P-MESSAGE, or FAX if your site has these available as legitimate devices.

Next, you will see prompts for primary and secondary diagnostic codes. The prompt for secondary diagnostic code will only appear if a primary diagnostic code has been entered. If the

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

diagnostic code you select has been designated by the ADPAC to generate an abnormal alert message, the requesting physician will be notified. For additional details on diagnostic code set-up, please refer to the ADPAC Guide. If you select a case that is part of a printset, the report applies to all cases in the printset. Printsets are displayed on most exam display screens with a + in front of the first case and a . in front of the remaining cases in the set. Exam display screens that sort exams by a field other than exam date/time cannot display + and . characters because the members of a printset do not appear in contiguous lines. An example would be Exam Profile (selected sort) when sorted by procedure.

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

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

Report entry can be done through vendor-supplied voice recognition units via an HL7 (Health Level 7) interface provided partially by this package and partially by the vendor. Set-up of this interface must be done by IRM, who should refer to the Technical Manual for more information.

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

[1] Patch RA*5*18 November 2000 New field for comments by the technologist added to report.

Films Reporting Menu

Report Entry/Edit

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

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

If the user has access to multiple imaging locations of different imaging types, s/he will be asked to select division(s) and imaging type(s). The system will allow report entry only for cases whose division and imaging types are among those selected. Transcriptionists may be given the RA ALLOC key so that they can access all reports regardless of imaging type or division.

This option will detect if the user has an electronic signature and is a staff or resident with the RA VERIFY key. If so, a prompt for electronic signature will appear and any verified reports will have the electronic signature affixed.

Batching of Reports

If the Division parameters have been set by the ADPAC to allow batching of reports, the user will be given the option of placing the reports in a batch. At this time, you will be prompted to select a batch.

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

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

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

Copying Other Reports

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

Advanced Tip: When entering the report to copy, you may enter a day-case number or a patient. The patient can be specified by SSN, name, last initial and last four digits of SSN, or any other standard V*IST*A method of patient look-up. Although you can choose an active case to copy, you cannot specify just its case number as you ordinarily do with active cases. Rather, you must specify its date-case number in MMDDYY-case# format (e.g., 012095-240). If you specify a 4-digit case number, the computer will assume you are referring to the last 4 digits of the patient's SSN. If you enter "022595", the computer will search for all cases registered for Feb. 25, 1995. If you enter "022" the computer will search for all cases done on Feb 20 - Feb 29 of any year. (This is applicable whenever you have to specify a date-case number, such as in the Unverified Reports option.)

Interpreting Physician(s)

Next you will be prompted to enter the name of the Primary Interpreting Resident. This is optional, since there is not necessarily a resident reading for every case, and some sites may not have residents at all. If you select a Primary Interpreting Resident, you will also be asked to enter a Secondary Interpreting Resident (also optional). You may enter more than one Secondary Interpreting Resident if you wish. However, there can be only one Primary Interpreting Resident. When asked to select a resident, you may enter the name of anyone classified as a "resident" via the Classification Enter/Edit option of this package (see ADPAC Guide).

The next prompt is for the Primary Interpreting Staff (attending). As with residents, after entering a Primary Interpreting Staff, you have the option of entering the name(s) of one or more Secondary Interpreting Staff. In order for someone to be a valid entry for one of these prompts, they must be classified as “staff” via the Classification Enter/Edit option of this package (See ADPAC Guide).

Standard Reports

The next feature, which may or may not be available to you (depending on your Division parameter set-up), is the ability to use a "standard report." A standard report is a pre-defined generic report (or part of a report) which may be copied into your current report. This eliminates the need to type the same text repeatedly into many different reports. One example of a standard report is a complete "normal" dictation (report text and impression) for a simple study, such as a chest x-ray. Another use for a standard report is to insert the standard preliminary paragraph(s) for a more complex study (such as a CT or Nuclear scan) which describes how the procedure was done or how the images were obtained. Once the text of a standard report is copied into the active report you are working on, the text may be edited to any extent that you wish on a per-case basis. This means that the text of the standard report does not have to be identical to the final text you want, in order for it to be useful. You can use a standard report which is similar to the text you want, then make the needed modifications. Unlike copying an existing report which replaces the current report text entirely, more than one standard report may be appended to your active report. This is generally useful if the standard report text is merely a single paragraph. This allows you to "pick and choose" among many individual paragraphs without having huge numbers of standard reports for every possible variation of a multi-paragraph report. (For more information about creating and modifying standard reports, see the ADPAC Guide, Standard Reports Entry/Edit section.)

After selecting a standard report to copy into your current report, you will be asked for verification that you actually want to copy the text of this standard report into your current report. Here again, if you have any pre-existing text in your report, copying a standard report will **replace** whatever text you previously had in your report. You will then be asked if you want to add an additional standard report. This is the one exception to the rule that previously-existing text will be erased. However, the second (and subsequent) standard reports must be added during a single instance of using the Report Entry/Edit option. If you enter one standard report, exit this option, then go back into this option and enter a second standard report, the first standard report

(and any other text you may have entered) will be erased and replaced by the text of the new standard report.

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

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

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

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

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

Report entry can be done through vendor-supplied voice recognition units via an HL7 (Health Level 7) interface provided partially by this package and partially by the vendor. Set-up of this interface must be done by IRM, who should refer to the Technical Manual for more information.

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

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

[1] Patch RA*5*18 November 2000 New field for comments by the technologist added to report.

Films Reporting Menu

Resident On-Line Pre-Verification

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

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

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

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

RELEASED/NOT VERIFIED - The report can be displayed outside the Imaging department even though it has not been verified by the radiologist. A report/case is tied to an imaging location, which in turn, is associated with a division. Entry of this status is only allowed if the ALLOW RELEASED/NOT VERIFIED parameter of this [1]Imaging Locations file is set to YES. You may use the Display a Rad/Nuc Med Report or Select Report to Print options to view reports with this status.

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

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

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

If the interpreting resident answers YES to the question, WANT TO PRE-VERIFY THIS REPORT?, then the resident's encrypted electronic signature, electronic signature code, and the date and time will be affixed on the report. Electronic signature codes are assigned through the Kernel option, Electronic Signature code Edit [XUSESIG]. Users requiring an electronic signature code should be given this option.

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

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

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

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

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

[1] Patch RA*5*18 November 2000 New field for comments by the technologist added to report.

Films Reporting Menu

Select Report to Print by Patient

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

The report produced by this option is formatted for a printer as opposed to the output from the Display a Report option which is formatted for the screen.

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

[1]The report printout will include parents and their descendents when defined as a printset, procedure and CPT modifiers, clinical history, report text, impression text, report status, and the names of all the primary and secondary interpreting staff and residents, with a notation beside the report verifier's name. The report headers and footers are determined by the ADPAC when the imaging location parameters are set up. If the ADPAC has answered Yes to the Imaging Locations parameter Print DX Codes in Report?, all primary and secondary diagnostic codes will also print in the report. (See the ADPAC Guide for more information about imaging location set-up and flash card, label, header and footer formats.)

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

A notation will appear to the right of the verifying physician's name to indicate that s/he verified the report. If the report was verified by a physician whose name was not entered as a Primary or Secondary Staff or Resident, the verifier's name will appear at the end of the report under the caption Verified By.

The title of each physician appears to the right of the name. The title is taken from the Signature Block Title field of the New Person file (#200). To change your title on this report, use the Electronic Signature code Edit [XUSESIG]. Whatever you enter as your SIGNATURE BLOCK TITLE will print on this report.

[2]If the verifier verifies a report and the electronic signature is not entered, then the report would display "(verifier, no e-sig)" below the verifier's name. This happens when the "Verify Report Only" option or vendor software (e.g., Medspeak, Talkstation) is used verify a report. If a transcriptionist or someone other than the verifier changed the report status to

[1] Patch RA*5*10 April 2000
[2] Patch RA*5*8 October 1999

Verified, the wording will be "Verified by transcriptionist for Dr. xxx." If an electronic signature is affixed to the report (i.e., it was verified through On-Line Verification), the wording will be "(Verifier)".

This report should be directed or queued to a printer.

Prompt/**User Response** Discussion

```
Select Report to Print by Patient

Select Patient: WHITE,JULES          03-23-20     231680695   NO   NSC VETERAN
                        **** Patient's Exams ****

Patient's Name: WHITE,JULES  231-68-0695              Run Date: MAR 17,1997

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

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

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

Films Reporting Menu

Switch Locations

This option appears on several menus as a convenience to users. Please refer to the option description earlier in this section where it first appears under Use of the Software on page III-2.

Films Reporting Menu

Verify Report Only

This function allows the user to verify a report without having to edit all of the report fields required by the Report Entry/Edit option. This function is often used when a report has been edited, but the report status has not been updated to reflect the VERIFIED status. If interpreting physicians at the hospital do not use the On-line Verify option to verify reports, this option can be used by the transcriptionist to verify reports that have been reviewed and manually signed by staff and/or residents.

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

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

The current report status is displayed, and you are prompted to change the status. If you change the status to VERIFIED, you will be asked to enter the name of the Verifying Physician. Any physician classified as "staff" or "resident" through the Classification Enter/Edit option (ADPAC Manual) with verification privileges can be selected.

Next you will see prompts for primary and secondary diagnostic codes. The prompt for secondary diagnostic code will only appear if you have entered a primary diagnostic code. You may only choose one primary diagnostic code, but you may choose multiple secondary diagnostic codes or none at all. If the diagnostic code you select has been designated by the ADPAC to generate an abnormal alert message, the requesting physician will be notified. For additional details on diagnostic code set-up, please refer to the ADPAC Guide.

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

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

Report entry can be done through vendor-supplied voice recognition units via an HL7 (Health Level 7) interface provided partially by this package and partially by the vendor. Set-up of this interface must be done by IRM, who should refer to the Technical Manual for more information.

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

The system will not allow you to verify a report without the Impression Text being complete - it will put it in PROBLEM DRAFT.

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

Prompt/**User Response** Discussion

```
Verify Report Only

Select Rad/Nuc Med Division: All// <RET>

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


Select Imaging Type: All// <RET>

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


Enter Case Number: HELLER,RALPH          05-15-84
321448277     NO     SHARING AGREEMENT
```

If the case number is not known, the patient's name, SSN, or other standard V*IST*A patient identifier can be entered at this prompt and a list of cases will be displayed.

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

Patient's Name: HELLER,RALPH  321-44-8277              Run Date: MAR 19,1997

   Case No.  Procedure                  Exam Date  Status of Report Imaging Loc
   --------  -------------              ---------  ---------------- -----------
1     624    CHEST 2 VIEWS PA&LAT       06/29/00   DRAFT            X-RAY
2     608    SPINE CERVICAL MIN 2 VIEWS 02/24/00   VERIFIED         X-RAY
3     612    CHEST 2 VIEWS PA&LAT       02/13/00   VERIFIED         WESTSIDE XR
4     613    ABDOMEN 2 VIEWS            02/13/00   VERIFIED         WESTSIDE XR
5     614    ANGIO CAROTID CEREBRAL BIL 02/13/00   None             WESTSIDE XR
6    +402    ANKLE 2 VIEWS              01/28/00   None             X-RAY
7    .420    FOOT 2 VIEWS               01/28/00   None             X-RAY
8    .423    TOE(S) 2 OR MORE VIEWS     01/28/00   None             X-RAY
9     392    THYROID SCAN               01/15/00   None             NUC MED LOC
10    343    ULTRASONIC GUID FOR RX FIE 01/15/00   None             US
11   +415    BONE IMAGING, MULTIPLE ARE 01/06/00   DRAFT            NUC MED LOC
12   .416    BONE IMAGING, WHOLE BODY   01/06/00   DRAFT            NUC MED LOC
13   .417    PROVISION OF DIAGNOSTIC RA 01/06/00   DRAFT            NUC MED LOC
14   +1      ANKLE 2 VIEWS              01/05/00   VERIFIED         X-RAY
Type '^' to STOP, or
```

[1] Patch RA*5*18 November 2000 New field for comments by the technologist added to report.

```
CHOOSE FROM 1-14: 1

[1]--------------------------------------------------------------------------------
 Name     : HELLER,RALPH                Pt ID       : 321-44-8277
 Case No. : 624  Exm. St: EXAMINED                   : CHEST 2 VIEWS PA&LAT
 Tech.Comment: No comments.
 Exam Date: JUN 29,2000  07:31         Technologist: PERSON,TECH
                                       Req Phys    : SHAM,SHAVKAT
--------------------------------------------------------------------------------
     Select one of the following:

          V         VERIFIED
          R         RELEASED/NOT VERIFIED
          PD        PROBLEM DRAFT
          D         DRAFT

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

     Status update queued!
```

[1] Patch RA*5*18 November 2000 New field for comments by the technologist added to display.

VII. Management Reports Menu

Daily Management Reports ...
Functional Area Workload Reports ...
Personnel Workload Reports ...
Special Reports ...

Management Reports Menu

Daily Management Reports

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

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

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

Any bolding in reports is used only to demonstrate sort selection. The bolding will not appear on an actual report.

Management Reports Menu

Daily Management Reports

Abnormal Exam Report

This option, usually used by Radiology/Nuclear Medicine supervisors, ADPACS, or other management personnel, allows the user to print a listing entitled "Abnormal Diagnostic Report" showing reported examinations which have a diagnostic code indicating special action should be taken. Only those exams for which a Primary or Secondary Diagnostic Code has been entered whose "Print on Abnormal Report" field is set to YES in the Diagnostic Codes file will be included on this report.

This report is compiled from the primary and secondary diagnostic code examination data entered through the Diagnostic Code and Interpreter Edit by Case No. and Status Tracking of Exams options under the Exam Entry/Editt Menu, or Report Entry/Edit option under the Films Reporting Menu. If the person generating the report has access to more than one Radiology/Nuclear Medicine division, a prompt will be displayed asking for a selection of one or more divisions. If the person generating the report has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type. A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. One, many, or all diagnostic codes may be selected.

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

A date range must also be selected. The date range refers to the exam date/time entered at the time of exam registration and only exams within the selected date range will be included. [1]For a procedure to appear in the report, the beginning date must be before the exam date/time, and the ending date must be after the reported date. It is therefore suggested that a broad range be used to catch those exams with a significant delay.

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

[1] Patch RA*5*15 NOIS: MUS-0399-72971 Description change for selecting the date range.

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

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

Prompt/**User Response** Discussion

```
Abnormal Exam Report

          ABNORMAL EXAM REPORT


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

Select Diagnostic Codes: All// <RET>
Another one (Select/De-Select): <RET>
Print only those exams not yet printed? Yes// NO
```

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

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

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

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

Patient Name                                Ward/Clinic     Requesting Physician
                    Procedure                                 Exam Date
================================================================================
                      Division: WHITE RIVER JUNCTION, VT.
                  Imaging Type: GENERAL RADIOLOGY
               Diagnostic Code: ABNORMALITY, ATTN. NEEDED
               ----------------

*BLYNCHROY,JAMES ARNOLD -9990         (P) 1-WT            ZELLA,HELEN H.
  Case #: 210       CHEST 2 VIEWS PA&LAT (ROUTINE)          MAY 13,1997@10:21

*COLDWELL,FREDERICK J. -8888          (P) SDP 2-NORTH     LEMOY,LEONARD
  Case #: 390       CHEST 2 VIEWS PA&LAT (ROUTINE)          MAY 13,1997@08:05

*TIBMAN,HENRY WALLACE -4442           (P) ER              METTZINGER,JOANNE E.
  Case #: 888       KNEE 2 VIEWS (ROUTINE)                  MAY 10,1997@11:58

*WYLER, JOHN DARWIN -2220             (P) 1-WT            JOSEPH, MARVIN L.
  Case #: 2         CHEST 2 VIEWS PA&LAT (ROUTINE)          MAY 11,1997@10:33

               Diagnostic Code: ABNORMALITY, PHYSICIAN NOTIFIED
               ----------------

*POLTER,MARK ANTHONY -2222            (P) 1-WT            SMITH,DENNIS
  Case #: 345       ANGIO RENAL UNILAT SELECT:S&I           MAY 13,1997@12:00

*SALIZAR,JOHN -3333                   (P) ER              DAVIS,TRUDY
  Case #: 898       CHEST 2 VIEWS PA&LAT (ROUTINE)          MAY 14,1997@14:46

               Diagnostic Code: POSSIBLE MALIGNANCY, FOLLOW-UP NEEDED
               ----------------

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

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

Patient Name                                Ward/Clinic     Requesting Physician
                    Procedure                                 Exam Date
================================================================================
                      Division: WHITE RIVER JUNCTION, VT.
                  Imaging Type: NUCLEAR MEDICINE

                                ***********************
                                *  No Abnormal Exams  *
                                ***********************
```

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

Management Reports Menu

Daily Management Reports

Complication Report

This option allows the user (usually a supervisor, ADPAC, or other management personnel) to generate a listing of patient examinations in which complications occurred. To be included on this report, an exam must have data in either the Complication field or the Complication Text field of the Rad/Nuc Med Patient file.

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

Sort order of the report is: Division, Imaging Type, Patient name, Exam date, Case number. Negative reporting is included for each selected imaging type within division. If "No Complication" is entered at the "Complication" question during exam edit, it will not appear in this report.

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

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

The following example sorts by a single Division and Imaging Type. Your selections may be different according to your needs.

Prompt/**User Response** Discussion

```
Complication Report



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

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

Select Imaging Type: All// ?

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

 Answer with IMAGING TYPE TYPE OF IMAGING, or
ABBREVIATION
Choose from:
   ANGIO/NEURO/INTERVENTIONAL
   CT SCAN
   GENERAL RADIOLOGY
   MAGNETIC RESONANCE IMAGING
   NUCLEAR MEDICINE
   ULTRASOUND


Select Imaging Type: All// GENERAL RADIOLOGY

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

**** Date Range Selection ****

   Beginning DATE : 1/1/95  (JAN 1, 1995)

   Ending    DATE : T  (FEB 27, 1995)

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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

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

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

Note: The abbreviation “C.M.” above stands for “Contrast Media”.

Management Reports Menu

Daily Management Reports

Daily Log Report

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

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

Sort order of the report is: Division, Imaging Type, Patient name, Exam date, Case number.

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

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

For each exam, the following items will print: patient name, patient ID, ward/clinic, procedure, exam status, case number, exam time, and a “yes/no” notation telling whether the report was entered yet.

The following example sorts by all Divisions and Imaging Types. Your selections may be different according to your needs.

```
Daily Log Report



Select Imaging Location: All// ?

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

 Answer with IMAGING LOCATIONS, or TYPE OF IMAGING
Choose from:
   XRAY                         (GENERAL RADIOLOGY-405)
   NUCLEAR MEDICINE             (NUCLEAR MEDICINE-405)
   TECH. WORK AREA (XRAY)       (GENERAL RADIOLOGY-405)
   CT SCAN                      (CT SCAN-405)


Select Imaging Location: All// XRAY                (GENERAL RADIOLOGY-405)

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


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

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

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

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

```
                  Daily Log Report For: Aug 17, 1997          Page: 1
Division         : WHITE RIVER JUNCTION, VT.                  Date: Aug 18, 1997
Imaging Location : XRAY (GENERAL RADIOLOGY)
Name                     Pt ID        Ward/Clinic           Procedure
        Exam Status              Case #     Time               Reported
--------------------------------------------------------------------------------
BAYER,JOSEPH             111-22-3333  1-NO                   CHEST SINGLE VIEW
        TRANSCRIBED              9        11:28 AM           Yes
CRYER,DARLENE            999-88-7777  1-NO S                 ANGIO VISCERAL SELE
        EXAMINED                 18       8:53 AM            No
FREY,DARBY               000-55-7777  1-NO S                 TRANSCATH INFUSION
        EXAMINED                 2        9:00 AM            No
        Imaging Location Total 'XRAY': 3
        Imaging Type Total 'GENERAL RADIOLOGY': 3
        Division Total 'WHITE RIVER JUNCTION, VT.': 3
```

Management Reports Menu

Daily Management Reports

Delinquent Outside Film Report for Outpatients

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

NOTE: It is suggested that the Record Tracking software be used instead of the Outside Films Registry functionality within this package. Eventually, the Outside Films Registry functionality will be eliminated from this package.

Outside films are those belonging to private physicians, hospitals, institutions, etc., on loan to the VA. This function assists the file room with the return of outside films to their owners.

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

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

This report can take quite awhile to search through the file, so it is recommended that it be queued rather than tying up a terminal for a long time.

Prompt/**User Response**	Discussion
`Delinquent Outside Film Report for Outpatients`	
`All Films with 'Needed Back' Dates Less Than: **T** (FEB 27, 1995)`	
`DEVICE: (Printer Name or "Q")`	Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
IMAGING SERVICE DELINQUENT OUTSIDE FILM REPORT FOR OUTPATIENTS
                                              FEB 27,1995  09:05    PAGE 1
PATIENT                                    PT ID            NEEDED BACK
--------------------------------------------------------------------------------

ZRIOT,CONE                                 195-86-0001      FEB  8,1994
'OK' NEEDED:
SOURCE     :  MEMORIAL HOSPITAL
REMARKS    :  Several wrist views
--------------------------------------------------------------------------------
ZRIOT,CONE                                 195-86-0001      FEB 13,1994
'OK' NEEDED:
SOURCE     :  GOOD SAMARITAN HOSPITAL
REMARKS    :  ANKLE
--------------------------------------------------------------------------------
SHAW,RAYMOND E                             945-85-4480      FEB 14,1994
'OK' NEEDED:
SOURCE     :  HARRIS HOSPITAL
REMARKS    :  Chest X-Ray
--------------------------------------------------------------------------------
```

Management Reports Menu

Daily Management Reports

Delinquent Status Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a listing of examination reports with a status considered delinquent. The only statuses considered to be delinquent are those designated by the ADPAC through the "Exam Status Entry/Edit" option when answering the "Delinquent Status Report?" question.

This report is compiled from the examination data entered through the Exam Entry/Edit Menu. If the person generating the report has access to more than one radiology/nuclear medicine division a prompt will be displayed asking for a selection of one or more divisions. If the person generating the report has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type. A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. An exam date range must also be selected. After selecting whether to include Inpatient, Outpatient, or Both there is a selection to sort by Patient or Exam Date. A screen display prior to device selection shows all exam statuses to be included for each imaging type selected.

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

[1]For each delinquent exam, the following will print: patient name, patient ID, exam date, case number, procedure, exam status, ward/clinic, yes/no to indicate if report text was entered, and the report status. Report status may be: "Verified", "Released" (Released/Not Verified), "Prb Drft" (Problem Draft), "Draft", and "No Rpt" (No report). "No Rpt" means that the report text has not been entered, but a report stub record has been created by the Imaging package for this exam. Imaging type and division totals are also printed.

So that all imaging types will be accounted for, a page will print for each even if the total is zero.

```
Delinquent Status Report

Select Rad/Nuc Med Division: All// ?

     Select a RAD/NUC MED DIVISION DIVISION from the displayed list.
     To deselect a DIVISION type a minus sign (-)
```

[1] Patch RA*5*15 Report status added to the report, "Verified" deleted from report.

```
     in front of it, e.g.,  -DIVISION.
     Use an asterisk (*) to do a wildcard selection, e.g.,
     enter DIVISION* to select all entries that begin
     with the text 'DIVISION'.  Wildcard selection is
     case sensitive.

 Answer with RAD/NUC MED DIVISION
Choose from:
   BOSTON, MA
   LOWELL OPC, MA
   BOSTON OC, MA


Select Rad/Nuc Med Division: All// BOSTON, MA      MA              523

Another one (Select/De-Select): LOWELL OPC, MA        MA  VAMC     523BY

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



Select Imaging Type: All// ?

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

 Answer with IMAGING TYPE TYPE OF IMAGING, or ABBREVIATION
Choose from:
   ANGIO/NEURO/INTERVENTIONAL
   CT SCAN
   GENERAL RADIOLOGY
   MAGNETIC RESONANCE IMAGING
   MAMMOGRAPHY
   NUCLEAR MEDICINE
   ULTRASOUND


Select Imaging Type: All// MAGNETIC RESONANCE IMAGING

Another one (Select/De-Select): MAMMOGRAPHY

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

                          Delinquent Status Report

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

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

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

**** Date Range Selection ****

   Beginning DATE : T  (AUG 18, 1997)

   Ending    DATE : T  (AUG 18, 1997)

     Select one of the following:

          I         INPATIENT
          O         OUTPATIENT
          B         BOTH

Report to include: BOTH

     Now that you have selected BOTH do you want to sort by
     Patient or Date ?

     Select one of the following:

          P         PATIENT
          D         DATE

Enter response: PATIENT


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

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

 Imaging Type Total 'MAGNETIC RESONANCE IMAGING': 4
```

[1] Patch RA*5*15 Added "Rpt Stat" as heading to report. Deleted "Verified" as heading.

```
                          Delinquent Status Report
Division: BOSTON, MA                                          Page: 2
Imaging Type: MAMMOGRAPHY                                     Date: Aug 18, 1997
================================================================================
Patient Name          Case #    Pt ID        Date      Ward/Clinic      [1]Rpt Stat   |
 Procedure             Exam Status  Rpt Text  Interp. Phys.    Tech
================================================================================
TURANO,MARJORIE       199       333-99-3333  08/18/97  C SURG GYN THOR  Verified   |
 MAMMOGRAM UNILAT      EXAMINED     Yes       Unknown          WALTERS,BETH
--------------------------------------------------------------------------------

 Imaging Type Total 'MAMMOGRAPHY': 1

 Division Total 'BOSTON, MA': 5
```

```
                          Delinquent Status Report
Division: LOWELL OPC, MA                                      Page: 3
Imaging Type: MAMMOGRAPHY                                     Date: Aug 18, 1997
================================================================================
Patient Name          Case #    Pt ID        Date      Ward/Clinic      Rpt Stat
 Procedure             Exam Status  Rpt Text  Interp. Phys.    Tech
================================================================================

 Division Total 'LOWELL OPC, MA': 0
```

```
                          Delinquent Status Report
Division:                                                     Page: 4
Imaging Type:                                                 Date: Aug 18, 1997
================================================================================
Patient Name          Case #    Pt ID        Date      Ward/Clinic      Rpt Stat
 Procedure             Exam Status  Rpt Text  Interp. Phys.    Tech
================================================================================

Division: BOSTON, MA
   Imaging Type(s): MAGNETIC RESONANCE IMAGING   MAMMOGRAPHY

Division: LOWELL OPC, MA
   Imaging Type(s):

 Total Over All Divisions: 5
```

[1] Patch RA*5*15 Added "Rpt Stat" as heading to report. Deleted "Verified" as heading.

Management Reports Menu

Daily Management Reports

Examination Statistics

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

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

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

The report contains each registered exam date followed by the number of visits, the number of exams, the number of completed exams, and the number of examinations in each corresponding exam category. Patient categories are determined by the contents of the Category of Exam field on the exam record in the Rad/Nuc Med Patient file #70. This field is automatically set to Inpatient or Outpatient by the system, but can be edited to change it to another category when placing orders as long as the category selected does not conflict with MAS data about the patient's inpatient or outpatient status. (A related data item is the Usual Category which the system looks at when determining the category of a given exam; Usual Category is editable through the Update Patient Record option, but editing this will not change the category of a single given case after the system has automatically determined it during registration.) If this field is blank (a sign of data corruption) the exam would not be included on this report. Exam category headings are abbreviations of the following:

CONTRACT
EMPLOYEE
INPATIENT
OUTPATIENT
RESEARCH
SHARING

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

Sort order of the report is: division, imaging type, imaging location, date.

Totals are printed, depending on detail level chosen, by location, imaging type, division, and grand total.

The following example sorts by a single Division and Imaging Type. Your selections may be different according to your needs.

Prompt/**User Response** Discussion

```
Examination Statistics


     Select one of the following:

          L         Location
          I         Imaging Type
          D         Division
          T         Totals Only

Enter Report Detail Needed: Location// <RET>

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

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


Select Imaging Type: All// GENERAL RADIOLOGY

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

**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 19, 1994)

   Ending    DATE : T  (FEB 27, 1995)
```

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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
                    >>>>> EXAMINATION STATISTICS <<<<<                Page: 1

Division: HINES CIO FIELD OFFFICE       Location: FLUORO
Run Date: Feb 27, 1995                  Imaging Type: GENERAL RADIOLOGY
                   For Period: Nov 19, 1994 to Feb 27, 1995.

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

```
                    >>>>> EXAMINATION STATISTICS <<<<<                Page: 2

Division: HINES CIO FIELD OFFICE        Location: MAMMOGRAPHY
Run Date: Feb 27, 1995                  Imaging Type: GENERAL RADIOLOGY
                   For Period: Nov 19, 1994 to Feb 27, 1995.

                            COMPLETE --------------EXAM CATEGORY--------------
DATE         VISITS  EXAMS    EXAMS    CON    EMP    INP    OUT    RES    SHA
-------------------------------------------------------------------------------
Jan 25, 1995      1      2        2      0      0      0      2      0      0
Jan 26, 1995      3      4        4      0      0      4      0      0      0
             ------ ------   ------ ------ ------ ------ ------ ------ ------
TOTAL             4      6        6      0      0      4      2      0      0
```

>>>>> EXAMINATION STATISTICS <<<<< Page: 3

Division: HINES CIO FIELD OFFICE Location: X-RAY
Run Date: Feb 27, 1995 Imaging Type: GENERAL RADIOLOGY
For Period: Nov 19, 1994 to Feb 27, 1995.

DATE	VISITS	EXAMS	COMPLETE EXAMS	EXAM CATEGORY CON	EMP	INP	OUT	RES	SHA
Nov 21, 1994	1	1	0	0	0	0	1	0	0
Nov 25, 1994	1	1	0	0	0	0	1	0	0
Nov 28, 1994	4	4	1	0	0	0	4	0	0
Nov 29, 1994	2	2	2	0	0	0	2	0	0
Dec 02, 1994	1	1	0	0	0	0	1	0	0
Dec 06, 1994	1	1	0	0	0	0	1	0	0
Dec 08, 1994	2	6	2	0	0	0	6	0	0
Dec 09, 1994	2	2	0	0	0	0	2	0	0
Dec 14, 1994	1	1	1	0	0	0	1	0	0
Dec 15, 1994	1	1	1	0	0	0	0	1	0
Dec 30, 1994	1	1	0	0	0	0	1	0	0
Dec 31, 1994	1	1	1	0	0	0	1	0	0
Jan 02, 1995	1	1	0	0	0	0	1	0	0
Jan 03, 1995	2	2	1	0	0	0	2	0	0
Jan 04, 1995	2	3	1	0	0	0	3	0	0
Jan 05, 1995	2	2	0	0	0	0	2	0	0
Jan 06, 1995	2	2	0	0	0	0	2	0	0
Jan 11, 1995	1	1	0	0	0	0	1	0	0
Jan 12, 1995	5	5	1	0	0	1	4	0	0
Jan 13, 1995	1	1	0	0	0	0	1	0	0
Jan 17, 1995	8	21	0	0	0	0	21	0	0
Jan 18, 1995	15	36	0	0	0	4	32	0	0
Jan 19, 1995	13	43	0	0	0	1	42	0	0
Jan 20, 1995	5	22	6	0	0	4	18	0	0
Jan 23, 1995	2	2	2	0	0	0	2	0	0
Jan 24, 1995	5	8	3	0	0	5	3	0	0
Jan 25, 1995	3	7	7	0	0	5	2	0	0
Jan 26, 1995	5	10	5	0	0	3	7	0	0
Jan 27, 1995	2	4	2	0	0	0	4	0	0
Jan 30, 1995	4	6	5	0	0	1	5	0	0
Jan 31, 1995	2	3	2	0	0	3	0	0	0
Feb 02, 1995	4	4	2	0	0	2	2	0	0
Feb 08, 1995	2	2	0	0	0	1	1	0	0
Feb 13, 1995	1	2	1	0	0	2	0	0	0
Feb 14, 1995	2	3	0	0	0	2	1	0	0
Feb 16, 1995	9	18	5	0	0	0	18	0	0
Feb 17, 1995	3	13	0	0	0	0	13	0	0
Feb 21, 1995	3	3	0	0	0	3	0	0	0
Feb 22, 1995	19	34	4	1	0	6	27	0	0
TOTAL	141	280	55	1	0	43	235	1	0

Imaging Type: GENERAL RADIOLOGY

TOTAL	146	288	61	1	0	49	237	1	0

Division: HINES CIO FIELD OFFICE

TOTAL	146	288	61	1	0	49	237	1	0

```
                    >>>>> EXAMINATION STATISTICS <<<<<                Page: 4

Division:                                  Location:
Run Date: Feb 27, 1995                     Imaging Type:
                    For Period: Nov 19, 1994 to Feb 27, 1995.

                            COMPLETE --------------EXAM CATEGORY--------------
DATE         VISITS  EXAMS    EXAMS    CON    EMP    INP    OUT    RES    SHA
-------------------------------------------------------------------------------

Division: HINES CIO FIELD OFFICE
   Imaging Type(s): GENERAL RADIOLOGY

TOTAL           146    288       61      1      0     49    237      1      0
```

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

Management Reports Menu

Daily Management Reports

Incomplete Exam Report

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

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

Prompt/**User Response** Discussion

```
Incomplete Exam Report


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

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


Select Imaging Type: All// GENERAL RADIOLOGY

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

            Incomplete Exam Report

**** Date Range Selection ****

   Beginning DATE : T-100   (JAN 12, 1997)

   Ending    DATE : T  (APR 22, 1997)

     Select one of the following:

          I         INPATIENT
          O         OUTPATIENT
          B         BOTH

Report to include: BOTH
```

```
     Now that you have selected BOTH do you
     want to sort by Patient or Date ?

     Select one of the following:

          P         PATIENT
          D         DATE

Enter response: PATIENT

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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

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

```
                          Incomplete Exam Report
Division: HINES CIO FIELD OFFICE                                  Page: 4
Imaging Type: GENERAL RADIOLOGY                                   Date: Apr 22, 1997
================================================================================
Patient Name          Case #    Pt ID        Date      Ward/Clinic      Verified
 Procedure             Exam Status  Rpt Text  Interp. Phys.    Tech
================================================================================

*** OUTPATIENT ***             *** OUTPATIENT ***             *** OUTPATIENT ***
AMES,FISHER           88        119-87-4863  04/17/97  X-RAY STOP       No
 ARTHROGRAM ELBOW S&I  WAITING FOR  No        Unknown          Unknown
--------------------------------------------------------------------------------
AMES,FISHER           107       119-87-4863  04/17/97  X-RAY STOP       No
 CT HEAD W/IV CONT     WAITING FOR  No        Unknown          Unknown
--------------------------------------------------------------------------------
AMES,FISHER           121       119-87-4863  04/17/97  X-RAY STOP       No
 STEREOTACTIC LOCALIZ  WAITING FOR  No        Unknown          Unknown
--------------------------------------------------------------------------------
AMES,FISHER           130       119-87-4863  04/17/97  X-RAY STOP       No
 CHEST 4 VIEWS         WAITING FOR  No        Unknown          Unknown
--------------------------------------------------------------------------------
Enter RETURN to continue or '^' to exit:
```

```
                          Incomplete Exam Report
Division: HINES CIO FIELD OFFICE                                  Page: 22
Imaging Type: GENERAL RADIOLOGY                                   Date: Apr 22, 1997
================================================================================
Patient Name          Case #    Pt ID        Date      Ward/Clinic      Verified
 Procedure             Exam Status  Rpt Text  Interp. Phys.    Tech
================================================================================
YATSEN,SUN            451       147-56-5571  03/03/97  EMERGENCY ROOM   No
 ABDOMEN 1 VIEW        WAITING FOR  No        Unknown          Unknown
--------------------------------------------------------------------------------
YATSEN,SUN            633       147-56-5571  03/20/97  GENERAL MEDICIN  No
 ACROMIOCLAVICULAR J   WAITING FOR  Yes       MOE,SELMA        Unknown
--------------------------------------------------------------------------------

 Imaging Type Total 'GENERAL RADIOLOGY': 106

 Division Total 'HINES CIO FIELD OFFICE': 106
```

Management Reports Menu

Daily Management Reports

Log of Scheduled Requests by Procedure

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

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

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

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

Only orders that have a Scheduled Date (field #23 of the Rad/Nuc Med Orders file #75.1) entered that falls within the date range selected will be included. Orders with an Imaging Location (field 20 of file 75.1) selected, and orders with no imaging location will be included. [1]Requests with no data in the Imaging Location field will print under UNKNOWN regardless of which locations are selected, but only if their imaging type matches one of the selected location's imaging types. UNKNOWN imaging locations that belong to other imaging types will not be printed. (The Imaging Location field contains the location entered by a requesting clinician when they see the SUBMIT REQUEST TO prompt during order placement, and the SUBMIT REQUEST TO: question is only asked if the Rad/Nuc Med Division file #79 parameter in field #.121 Ask Imaging Location is set to YES.)

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

[1] Patch RA*5*15 May 2000 NOIS: BHS-1199-12241

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

Prompt/**User Response** Discussion

```
Log of Scheduled Requests by Procedure



Starting Scheduled Date: 1/1/95  (JAN 1, 1995)

Ending Scheduled Date: T  (FEB 27, 1995)

    [1]Enter * to select all imaging locations that
    you are allowed here (enter ?? to view them.)
Select Imaging Location(s): ??

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

Choose from:
   X-RAY                        (GENERAL RADIOLOGY)
   FLUORO                       (GENERAL RADIOLOGY)
   WESTSIDE XRAY                (GENERAL RADIOLOGY)
   MAMMOGRAPHY                  (GENERAL RADIOLOGY)

Select Imaging Location(s): X-RAY             (GENERAL
RADIOLOGY)

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

Scheduled requests to be included on this report are:

Starting Schedule date: Nov 19, 1994
Ending Schedule date:   Feb 27, 1995 11:59 pm
Locations:  X-RAY

SELECTION CRITERIA OK? YES// <RET>

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

You may enter "*" to include all imaging locations to which you have access.

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

[1] Patch RA*5*15 May 2000 Added two lines of text help on selecting all imaging locations.

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

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

```
Scheduled Request Log by Imaging Location, Procedure                  Page: 2
     Includes requests scheduled from NOV 19,1994 to FEB 27,1995  23:59
Run Date: FEB 27,1995  09:14   Imaging Location: X-RAY

Patient       Procedure             Pt ID   Pt Loc      Sched. Date    Urgency
------------------------------------------------------------------------------
==============================================================================
EQUATOL,BRIA  BONE AGE              5463    X-RAY       1/2/94@09:23   ROUTINE

==============================================================================
HABEN,JOSEPH  BONE AGE              3053    X-RAY       1/7/94@16:30   ROUTINE

==============================================================================
VALANCE,LIBE  BRAIN IMAGING COMPLET 7641    DISCHARGED  1/10/95@16:00  ROUTINE
                           Requesting Loc: 1S
==============================================================================
FORD,HARRISO  X-RAY PARENT PROCEDUR 9938    1S          2/8/95@14:23   ROUTINE

==============================================================================
FORD,HARRISO  CHEST STEREO PA       9938    1S          2/21/95@07:23  ROUTINE
```

Management Reports Menu

Daily Management Reports

Radiopharmaceutical Usage Report

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

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

Sort order if radiopharmaceutical is selected as primary sort:
Division, imaging type, radiopharmaceutical, exam date/time, patient, case number
Sort order if exam date/time is selected as primary sort:
Division, imaging type, exam date/time, radiopharmaceutical, patient, case number

Detailed reports or summaries only can be printed. The report is designed for a 132 column page. If an administered dosage falls outside of the high/low dose range, an asterisk (*) prints next to it. If a radiopharmaceutical is currently inactive but has DX200, DX201, or DX202, it will be included on the report if used during the exam date range. Since a case may have more than one radiopharmaceutical, total number of unique cases may be less than total number of radiopharmaceuticals reported.

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

Select Rad/Nuc Med Division: All// ?

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

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


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

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



Select Imaging Type: All// ?

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

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


Select Imaging Type: All// NUCLEAR MEDICINE

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

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

**** Date Range Selection ****

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

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

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

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


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

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

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

Long-Case@Time  Patient Name       SSN      Radiopharm     Act.Drawn  Dose Adm'd    Low       High   Procedure       Who Adm'd
-------------------------------------------------------------------------------------------------------------------------------
080697-706@1211 RUTHERFORD,ERNE 741-61-3328 THALLIUM 201      3.3000    3.3000     3.0000    3.6300  THALLIUM SCAN
080697-709@1233 GAUSS,KARL F    168-93-0889 THALLIUM 201      3.3000    3.3000     3.0000    3.6300  THALLIUM SCAN
061897-558@1406 HEIER,RALPH     321-44-8277 THALLIUM 201      3.3000    3.3000     3.0000    3.6300  THALLIUM SCAN
080797-718@0807 HEIER,RALPH     321-44-8277 THALLIUM 201      3.3000    3.3000     3.0000    3.6300  THALLIUM SCAN
080797-721@0902 HEIER,RALPH     321-44-8277 SESTAMIBI TC-99   8.0000    8.0000     8.0000   10.0000  MYOCARDIAL PERF HINESLEY,RICK
072597-703@1245 KIROV,SERGI     961-23-7958 Tc99m MEDRONATE  19.6000   19.6000    18.0000   22.0000  BONE IMAGING    CEBEL,GREG
070997-700@0907 OSTER,HANS      259-21-9318 SULFUR COLLOID    4.0000    4.0000     3.0000    6.0000  LIVER SCAN      CEBEL,GREG
070997-701@0932 CRIPPS,RICHARD  573-89-6827 SULFUR COLLOID    4.5000    4.5000     3.0000    6.0000  LIVER SCAN      CEBEL,GREG
080797-719@0807 HEIER,RALPH     321-44-8277 Tc-99m MACROAGG   3.0000    3.0000     3.0000    6.0000  LUNG PERFUSION  HINESLEY,RICK
```

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

NUCLEAR MEDICINE's Total number of unique cases: 9

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

Management Reports Menu

Daily Management Reports

Unverified Reports

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

If the person generating the report has access to more than one radiology/nuclear medicine division a prompt will be displayed asking for a selection of one or more divisions. If the person generating the report has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type. A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type.

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

Sort order of the report is: division, imaging type, staff/ resident/ unknown, physician's name, and date report entered.

The Primary Interpreting Resident and Primary Interpreting Staff fields in the Rad/Nuc Med Patient file #70 determine who is responsible for the report. [1]If a Primary Resident is entered, then the report is counted toward the resident. If the Primary Interpreting Staff is entered, then the report is counted towards that Interpreting Staff member. If both Primary Resident and Primary Interpreting Staff are entered, then the report counts toward both. If neither is entered, the report is counted towards UNKNOWN.

If there are no unverified reports for a given division and imaging type combination, then the message "No Unverified Reports" appears.

The "Exam Date, Itemized List" format and the "Staff, Itemized List" format each provide one line per report. Only exams with a report are included. The "Exam Date, Itemized List" sorts by division, exam date/time, patient and case. It is useful for case turn-around and completion since the oldest cases appear first. The "Staff, Itemized List" sorts by staff, exam date/time, patient and case. If a report exists but no staff is entered, it will appear as Staff Unknown. Separate pages print for each staff member, so it can be handed out to the staff for their review and follow-up.

[1] Patch RA*5*29 February 2002 Unverified Reports options enhanced.

The detailed format includes report aging breakout, report age totals by category (resident and staff) and by individual physician. This format includes very detailed information, such as transcription date, patient ID, report status, pre-verification date, exam date/time, order's desired date, procedure, other staff and residents, and a division summary. The division summary is suppressed to prevent redundancy if only one imaging type prints for a division.

The following "brief format" example sorts by a single Division and Imaging Type. Your selections may be different according to your needs.

Prompt/**User Response** Discussion

The first sample shows an itemized list by exam date. If a 132-column device is used, it would be formatted differently and easier to read:

```
Unverified Reports

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

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


Select Imaging Type: All// <RET>

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


     Select one of the following:

          b         Brief
          d         Detailed
          e         Exam Date, Itemized List
          s         Staff, Itemized List

Enter response: b// Exam Date, Itemized List

This report requires a 132 column output device.

(The date range refers to DATE EXAM REGISTERED)

**** Date Range Selection ****

   Beginning DATE : T-60  (JUN 20, 1997)

   Ending    DATE : T  (AUG 19, 1997)


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

```
                    UNVERIFIED IMAGING REPORTS BY DIVISION
Division: HINES CIO FIELD OFFICE
             Aug 19, 1997   Page: 1

       Exam     Report
Patient              Patient ID       Exam Date Case   Procedure
       Status   Entered   Pri. Int'g Staff
-------------------------------------------------------------------------------
BARNIQ,FRANK W       463-27-7311      7/22/97   702    CARDIOLOGY TEST
       WAITING  8/8/97    BEAMERS,TENA
FOCKE,HEINRICH       331-59-2115      8/7/97    722    ABDOMEN 1 VIEW
       WAITING  8/7/97    Unknown
```

Sample 2 shows the brief format of the report:

```
Unverified Reports

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

Another one (Select/De-Select): CHICAGO (WESTSIDE)        IL  VAMC  639

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


Select Imaging Type: All// RAD    GENERAL RADIOLOGY

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


     Select one of the following:

          b         Brief
          d         Detailed
          e         Exam Date, Itemized List
          s         Staff, Itemized List

Enter response: b// Brief

(The date range refers to DATE REPORT ENTERED)

**** Date Range Selection ****

   Beginning DATE : T-100  (MAY 11, 1997)

   Ending    DATE : T  (AUG 19, 1997)

Default cut-off limits (in hours) for aging of reports are :

                                  24   48   96

Do you want to enter different cut-off limits? N// YES
Enter the first cutoff hours:  (0-87660): 12
Enter the second cutoff hours:  (12-87660): 48
Enter the third cutoff hours:  (48-87660): 96


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

```
                    >>>>> Unverified Reports (brief) <<<<<            Page: 1
Division: CHICAGO (WESTSIDE)               Report Date Range: May 11, 1997
Imaging Type: GENERAL RADIOLOGY                               Aug 19, 1997@23:59
Run Date: AUG 19,1997  10:19               Total Unverified Reports: 0


                          **************************
                          *  No Unverified Reports  *
                          **************************
```

```
                    >>>>> Unverified Reports (brief) <<<<<             Page: 2
Division: HINES CIO FIELD OFFICE            Report Date Range: May 11, 1997
Imaging Type: GENERAL RADIOLOGY                                Aug 19, 1997@23:59
Run Date: AUG 19,1997  10:19                Total Unverified Reports: 12

Hours (age of report)        24        48        96        > 96
                             --        --        --        ----
* STAFF: 4 *
  2 BEAMERS,TENA              0         0         0           2
  1 EICHMANN,SASHA            0         0         0           1
  1 WILLIAMS,CATHY            0         0         0           1

Hours (age of report)        24        48        96        > 96
                             --        --        --        ----
* RESIDENT: 8 *
  2 FLASHCARD,VERYLONGNA      0         0         0           2
  1 KEPPEL,BART               0         0         0           1
  2 MOTT,CAROL                0         0         0           2
  3 TRACKER,FRED              0         0         0           3


* UNKNOWN: 0 *
```

Sample 3 shows a few pages from the Detailed format:

```
Unverified Reports

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

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


Select Imaging Type: All// <RET>

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


     Select one of the following:

          b         Brief
          d         Detailed
          e         Exam Date, Itemized List
          s         Staff, Itemized List

Enter response: b// Detailed

(The date range refers to DATE REPORT ENTERED)

**** Date Range Selection ****
```

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

   Ending    DATE : T  (AUG 19, 1997)

Default cut-off limits (in hours) for aging of reports are :

                                    24   48   96

Do you want to enter different cut-off limits? N// <RET>O

DEVICE: HOME// (Enter a device that prints 132 columns)
```

```
                                  >>>>> Unverified Reports (detailed) <<<<<                                  Page: 1
Division: HINES CIO FIELD OFFICE                                                  Report Date Range: May 21, 1997
Imaging Type: ANGIO/NEURO/INTERVENTIONAL                                                          Aug 19, 1997@23:59
Run Date: AUG 19,1997  11:38                                                      Total Unverified Reports: 0


                                          **************************
                                          *  No Unverified Reports  *
                                          **************************
```

```
                                  >>>>> Unverified Reports (detailed) <<<<<                                  Page: 2
Division: HINES CIO FIELD OFFICE                                                  Report Date Range: May 21, 1997
Imaging Type: CARDIOLOGY STUDIES (NUC MED)                                                        Aug 19, 1997@23:59
Run Date: AUG 19,1997  11:38                                                      Total Unverified Reports: 1

* STAFF: 1 *
=============================================================================================================================
Hours (age of report)        24        48        96        > 96
                             --        --        --        ----
  1 BEAMERS,TENA              0         0         0          1
Transcrip: 080897@15:56    ID: B463-27-7311    DRAFT      Pre-ver:
Exam Date: 072297-702@15:28    Order Date Desired: 072297         Proc: CARDIOLOGY TEST
Other Att/Res:



* RESIDENT: 0 *


* UNKNOWN: 0 *
```

```
                                    >>>>> Unverified Reports (detailed) <<<<<                                    Page: 4
Division: HINES CIO FIELD OFFICE                                                        Report Date Range: May 21, 1997
Imaging Type: GENERAL RADIOLOGY                                                                    Aug 19, 1997@23:59
Run Date: AUG 19,1997  11:38                                                           Total Unverified Reports: 12

* STAFF: 4 *
================================================================================================================================
Hours (age of report)        24        48        96        > 96
                             --        --        --        ----
  2 BEAMERS,TENA              0         0         0          2
Transcrip: 070797@14:36    ID: V463-27-7311    DRAFT      Pre-ver:
Exam Date: 060597-686@08:06    Order Date Desired: 060597         Proc: CHEST APICAL LORDOTIC
Other Att/Res:

Transcrip: 080897@15:54    ID: V412-18-7492    DRAFT      Pre-ver:
Exam Date: 060997-268@09:29    Order Date Desired: 060997         Proc: ABDOMEN 1 VIEW
Other Att/Res:

================================================================================================================================
Hours (age of report)        24        48        96        > 96
                             --        --        --        ----
  1 ELDENBERGER,MARCY         0         0         0          1
```

```
                                    >>>>> Unverified Reports (detailed) <<<<<                                    Page: 11
Division: HINES CIO FIELD OFFICE                                                        Report Date Range: May 21, 1997
Imaging Type: NUCLEAR MEDICINE                                                                     Aug 19, 1997@23:59
Run Date: AUG 19,1997  11:38                                                           Total Unverified Reports: 1

* STAFF: 0 *


* RESIDENT: 1 *
================================================================================================================================
Hours (age of report)        24        48        96        > 96
                             --        --        --        ----
  1 MYER,JOAN                 0         0         0          1
Transcrip: 080197@12:36    ID: H321-44-8277    DRAFT      Pre-ver:
Exam Date: 061897-558@14:06    Order Date Desired: 061897         Proc: LUNG AEROSOL SCAN, MULTIPLE PROJECTIONS
Other Att/Res: HELLER,CINDY; GALES,M.; SOMNAMBULA,DOCTOR



* UNKNOWN: 0 *
```

```
                                    >>>>> Unverified Reports (detailed) <<<<<                                    Page: 12
Division: HINES CIO FIELD OFFICE                                                        Report Date Range: May 21, 1997
Imaging Type: ULTRASOUND                                                                           Aug 19, 1997@23:59
Run Date: AUG 19,1997  11:38                                                           Total Unverified Reports: 1

* STAFF: 1 *
================================================================================================================================
Hours (age of report)        24        48        96        > 96
                             --        --        --        ----
  1 CEBEL,GREGORY J           0         0         0          1
Transcrip: 070897          ID: E314-93-2168    DRAFT      Pre-ver:
Exam Date: 042594-360@16:01    Order Date Desired:                Proc: ULTRASONIC GUID FOR RX FIELD PLACEMENT
Other Att/Res:



* RESIDENT: 0 *


* UNKNOWN: 0 *
```

```
                                    >>>>> Unverified Reports (detailed) <<<<<                                    Page: 13
Division: HINES CIO FIELD OFFICE                                                  Report Date Range: May 21, 1997
                                                                                                     Aug 19, 1997@23:59
Imaging Type(s): ANGIO/NEURO/INTERVENTIONAL   CARDIOLOGY STUDIES (NUC MED)   CT SCAN   GENERAL RADIOLOGY
                 MAGNETIC RESONANCE IMAGING   MAMMOGRAPHY   NUCLEAR MEDICINE   ULTRASOUND

Run Date: AUG 19,1997  11:38


                         Division Summary
                         ----------------
Hours (age of report)       24        48        96        > 96
                            --        --        --        ----

Total Unverified Reports:    0         0         0          15


Division Total: 15
```

Management Reports Menu

Functional Area Workload Reports

This menu provides the user (usually a supervisor, ADPAC or other managerial personnel) with a list of options available to generate workload reports for Clinics, PTF Bedsections, Radiology/Nuclear Medicine Service, Sharing Agreement/Contracts and Wards.

Clinic Report
PTF Bedsection Report
Service Report
Sharing Agreement/Contract Report
Ward Report

All of the reports listed above have similar prompts, formats, and data retrieval and reporting logic. Sample prompts and formats are shown on the page with the individual report. The selection criteria prompts, data retrieval and reporting logic, and report format for all the workload reports are described in detail in the section of this manual entitled **General Information about Workload Reports**, which can be found at the end of the Management Reports Menu section.

NOTE: The reports in this section use AMIS counting methods. The AMIS system is scheduled to be obsolete as of December 1998.

Management Reports Menu

Functional Area Workload Reports

Clinic Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a listing entitled Clinic Workload Report.

This is one of a series of workload reports that have similar selection criteria, report output, data retrieval and reporting logic. See the section entitled **General Information about Workload Reports** at the end of the Management Reports Menu chapter for a full report.

The following example selects a complete report and sorts by All for Division, Imaging Type, and Clinic. Your selections may be different according to your needs.

Prompt/**User Response** Discussion

```
Clinic Report


   Clinic Workload Report:
   -----------------------

Do you wish only the summary report? No// <RET>

Select Rad/Nuc Med Division: All// <RET>

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

Select Imaging Type: All// <RET>

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


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

**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 19, 1994)

   Ending    DATE : T  (FEB 27, 1995)


            The entries printed for this report will be based only
             on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit: <RET>

          ANGIO/NEURO/INTERVENTIONAL
          ----------------------------
               WAITING FOR EXAM
               EXAMINED
```

```
          COMPLETE


     CT SCAN
     -------
          WAITING FOR EXAM
          EXAMINED
          COMPLETE


     GENERAL RADIOLOGY
     -----------------
          WAITING FOR EXAM
          EXAMINED
          TRANSCRIBED
          COMPLETE

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

     MAMMOGRAPHY
     -----------
          WAITING FOR EXAM
          COMPLETE

     NUCLEAR MEDICINE
     ----------------
          WAITING FOR EXAM
          EXAMINED
          TRANSCRIBED
          COMPLETE

     ULTRASOUND
     ----------
          WAITING FOR EXAM
          EXAMINED
          COMPLETE
```

Statuses included depend on the parameters entered by the ADPAC (see ADPAC Guide).

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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

The following example report starts with the first Division (Hines CIO field Office) and Imaging Type (General Radiology) and prints a different page for each clinic with the clinic totals (see report pages 1-5).

Then it summarizes the Imaging Type with totals for each clinic in the Imaging Type and totals for the Imaging Type (see report page 6).

Then this example jumps to report page 16 which contains totals for each clinic for all Imaging Types in the Division and totals for the Division. Some text is bolded in the sample to point out the organization of the report; it will not be bolded on the actual reports printed at your facility.

```
     >>> Clinic Workload Report <<<                                  Page: 1

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                    For period: Nov 20, 1994 to
    Run Date: FEB 28,1995  14:05                                  Feb 28, 1995

                                 -------Examinations------
                                                          % of          % of
Procedure                       Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          Clinic: DENTAL
STEREOTACTIC LOCALIZATION HE      0     2     0     0      2  100.0    10  100.0

Clinic Total                      0     2     0     0      2           10
-------------------------------------------------------------------------------
```

```
     >>> Clinic Workload Report <<<                                  Page: 2

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                    For period: Nov 20, 1994 to
    Run Date: FEB 28,1995  14:05                                  Feb 28, 1995

                                 -------Examinations------
                                                          % of          % of
Procedure                       Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          Clinic: EAR NOSE & THROAT
CT HEAD W/IV CONT                 0     2     0     0      2  100.0    16  100.0

Clinic Total                      0     2     0     0      2           16
-------------------------------------------------------------------------------
```

>>> Clinic Workload Report <<< Page: 3

Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY For period: Nov 20, 1994 to
Run Date: FEB 28,1995 14:05 Feb 28, 1995

Procedure	Inpt	Opt	Res	Other	Total	% of Exams	WWU	% of WWU
Clinic: EMERGENCY ROOM								
BONE SURV COMP (INCL APPENDI	0	1	0	0	1	8.3	25	25.0
ABDOMEN MIN 3 VIEWS+CHEST	0	1	0	0	1	8.3	5	5.0
ABDOMEN 1 VIEW	0	3	0	0	3	25.0	6	6.0
ABDOMEN 2 VIEWS	0	1	0	0	1	8.3	2	2.0
SPINE CERVICAL MIN 4 VIEWS	0	1	0	0	1	8.3	3	3.0
SCAPULA	0	1	0	0	1	8.3	2	2.0
TOE(S) 2 OR MORE VIEWS	0	1	0	0	1	8.3	2	2.0
ANGIO CERVICOCEREBRAL CATH S	0	1	0	0	1	8.3	15	15.0
ANGIO CORONARY BYPASS MULT S	0	2	0	0	2	16.7	40	40.0
Clinic Total	0	12	0	0	12		100	

>>> Clinic Workload Report <<< Page: 4

Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY For period: Nov 20, 1994 to
Run Date: FEB 28,1995 14:05 Feb 28, 1995

Procedure	Inpt	Opt	Res	Other	Total	% of Exams	WWU	% of WWU
Clinic: GENERAL MEDICINE								
SKULL 4 OR MORE VIEWS	0	3	0	0	3	33.3	9	36.0
CHEST SINGLE VIEW	0	1	0	0	1	11.1	1	4.0
CHEST STEREO PA	0	2	0	0	2	22.2	2	8.0
ABDOMEN 1 VIEW	0	1	0	0	1	11.1	2	8.0
SPINE LUMBOSACRAL MIN 2 VIEW	0	1	0	0	1	11.1	3	12.0
CT HEAD W/IV CONT	0	1	0	0	1	11.1	8	32.0
Clinic Total	0	9	0	0	9		25	

>>> Clinic Workload Report <<< Page: 5

Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY For period: Nov 20, 1994 to
Run Date: FEB 28,1995 14:05 Feb 28, 1995

Procedure	Inpt	Opt	Res	Other	Total	% of Exams	WWU	% of WWU
		-------Examinations------						
Clinic: X-RAY STOP								
NECK SOFT TISSUE	0	22	0	0	22	13.6	66	8.6
SKULL 4 OR MORE VIEWS	0	15	0	0	15	9.3	45	5.9
CHEST APICAL LORDOTIC	0	1	0	0	1	0.6	1	0.1
CHEST STEREO PA	0	1	0	0	1	0.6	1	0.1
CHEST 2 VIEWS PA&LAT	0	1	0	0	1	0.6	2	0.3
CHEST 4 VIEWS	0	8	0	0	8	4.9	16	2.1
ABDOMEN 1 VIEW	0	2	0	0	2	1.2	4	0.5
SPINE CERVICAL MIN 2 VIEWS	0	2	0	0	2	1.2	6	0.8
SPINE LUMBOSACRAL MIN 2 VIEW	0	1	0	0	1	0.6	3	0.4
ACROMIOCLAVICULAR J BILAT	0	4	0	0	4	2.5	8	1.0
ANKLE 2 VIEWS	0	9	0	0	9	5.6	18	2.4
FOOT 2 VIEWS	0	8	0	0	8	4.9	16	2.1
FOREARM 2 VIEWS	0	10	0	0	10	6.2	20	2.6
TOE(S) 2 OR MORE VIEWS	0	17	0	0	17	10.5	34	4.4
GASTROINTESTINAL	0	1	0	0	1	0.6	6	0.8
CHOLANGIOGRAM ORAL CONT	0	1	0	0	1	0.6	5	0.7
CHOLANGIOGRAM IV	0	5	0	0	5	3.1	50	6.5
ANGIO CAROTID CEREBRAL BILAT	0	2	0	0	2	1.2	30	3.9
ANGIO CAROTID CEREBRAL SELEC	0	6	0	0	6	3.7	90	11.8
ANGIO CORONARY BILAT INJ S&I	0	4	0	0	4	2.5	80	10.5
CT CERVICAL SPINE W/CONT	0	1	0	0	1	0.6	8	1.0
CT HEAD W/IV CONT	0	16	0	0	16	9.9	128	16.7
CT MAXILLOFACIAL W&W/O CONT	0	1	0	0	1	0.6	8	1.0
ARTHROGRAM ANKLE S&I	0	3	0	0	3	1.9	15	2.0
ARTHROGRAM KNEE S&I	0	1	0	0	1	0.6	5	0.7
NON-INVAS.,LOW EXT. VEIN W/O	0	6	0	0	6	3.7	30	3.9
STEREOTACTIC LOCALIZATION HE	0	14	0	0	14	8.6	70	9.2
Clinic Total	0	162	0	0	162		765	

```
     >>> Clinic Workload Report <<<                                  Page: 6

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                    For period: Nov 20, 1994 to
    Run Date: FEB 28,1995  14:05                                 Feb 28, 1995

                               -------Examinations------
                                                          % of          % of
Clinic                        Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
         (Imaging Type Summary)
DENTAL                           0     2     0     0      2    1.1    10    1.1
EAR NOSE & THROAT                0     2     0     0      2    1.1    16    1.7
EMERGENCY ROOM                   0    12     0     0     12    6.3   100   10.8
GENERAL MEDICINE                 0     9     0     0      9    4.8    25    2.7
X-RAY STOP                       0   162     0     0    162   85.7   765   83.0
-------------------------------------------------------------------------------

Imaging Type Total               0   187     0     0    187          916

   # of Clinics selected: ALL
```

```
     >>> Clinic Workload Report <<<                                  Page: 16

    Division: HINES CIO FIELD OFFICE               For period: Nov 20, 1994 to
    Run Date: FEB 28,1995  14:05                                 Feb 28, 1995

                               -------Examinations------
                                                          % of          % of
Clinic                        Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
         (Division Summary)
DENTAL                           0     2     0     0      2    1.0    10    1.0
EAR NOSE & THROAT                0     3     0     0      3    1.5    23    2.4
EMERGENCY ROOM                   0    12     0     0     12    6.1   100   10.4
GENERAL MEDICINE                 0     9     0     0      9    4.6    25    2.6
NUCLEAR MEDICINE                 0     2     0     0      2    1.0     2    0.2
RAD 101                          0     2     0     0      2    1.0     6    0.6
ULTRASOUND                       0     5     0     0      5    2.5    35    3.6
X-RAY STOP                       0   162     0     0    162   82.2   765   79.2
-------------------------------------------------------------------------------

Division Total                   0   197     0     0    197          966

  Imaging Type(s): CT SCAN   GENERAL RADIOLOGY   MAGNETIC RESONANCE IMAGING
                   ANGIO/NEURO/INTERVENTIONAL   NUCLEAR MEDICINE
                   ULTRASOUND

   # of Clinics selected: ALL
```

Management Reports Menu

Functional Area Workload Reports

PTF Bedsection Report

This option generates a listing of PTF bedsection workloads. The bedsections used to sort the report are those stored in the Bedsection field of the exam record if the patient is an inpatient at the time the exam is registered.

The bedsection is determined by the system based on data in MAS files. At the time a patient is registered for an imaging exam, the Bedsection field of the Examinations subfile of the Rad/Nuc Med Patient file is calculated as follows:

1) If the patient is an inpatient, Rad/Nuc Med programs call a standard MAS data retrieval program to find out the patient's treating specialty as of the date/time of the exam.

2) The program finds this treating specialty in the Treating Specialty file and retrieves its Specialty (field 2 of file 45.7).

3) The specialty is looked up in the Specialty file #42.4. The Name field of this file is entered automatically in the Bedsection field #19 of the Rad/Nuc Med Patient's exam record.

This is one of a series of workload reports that has similar selection criteria, report output, data retrieval and reporting logic. See the section entitled **General Information about Workload Reports** at the end of the Management Reports Menu chapter for a full description of this report.

The following example selects a full report and sorts by a single Division and all Imaging Types and PTF Bedsections. Your selections may be different according to your needs.

Prompt/**User Response** Discussion

```
PTF Bedsection Report


   PTF Bedsection Workload Report:
   -------------------------------

Do you wish only the summary report? No// <RET>

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

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

```
Select Imaging Type: All// <RET.

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

Do you wish to include all PTF Bedsections? Yes//
<RET>

**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 19, 1994)

   Ending    DATE : T  (FEB 27, 1995)


            The entries printed for this report will be based only
             on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit: <RET>

          ANGIO/NEURO/INTERVENTIONAL
          ------------------------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

          CT SCAN
          -------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

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

          MAMMOGRAPHY
          -----------
               WAITING FOR EXAM
               COMPLETE

          NUCLEAR MEDICINE
          ----------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

          ULTRASOUND
          ----------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE
```

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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
     >>> PTF Bedsection Workload Report <<<                          Page: 1

    Division: HINES CIO FIELD OFICE
Imaging Type: GENERAL RADIOLOGY                    For period: Nov 21, 1994 to
    Run Date: MAR  1,1995  08:45                               Mar 01, 1995

                               -------Examinations------
                                                          % of          % of
Procedure                     Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          PTF Bedsection: GENERAL(ACUTE MEDICINE)
NECK SOFT TISSUE                4     0     0     0      4    9.8    12    5.5
SKULL 4 OR MORE VIEWS           7     0     0     0      7   17.1    21    9.7
CHEST STEREO PA                 3     0     0     0      3    7.3     3    1.4
CHEST 4 VIEWS                   2     0     0     0      2    4.9     4    1.8
ABDOMEN 1 VIEW                  1     0     0     0      1    2.4     2    0.9
SPINE LUMBOSACRAL MIN 2 VIEW    2     0     0     0      2    4.9     6    2.8
UPPER GI + SMALL BOWEL          2     0     0     0      2    4.9    12    5.5
ANGIO CAROTID CEREBRAL SELEC    1     0     0     0      1    2.4    15    6.9
ANGIOGRAM,CATH - CEREBRAL       2     0     0     0      2    4.9    30   13.8
CT HEAD W/IV CONT               9     0     0     0      9   22.0    72   33.2
ARTHROGRAM ANKLE S&I            1     0     0     0      1    2.4     5    2.3
ARTHROGRAM TM JOINT CONT S&I    1     0     0     0      1    2.4     5    2.3
STEREOTACTIC LOCALIZATION HE    6     0     0     0      6   14.6    30   13.8

PTF Bedsection Total           41     0     0     0     41          217
-------------------------------------------------------------------------------
```

```
     >>> PTF Bedsection Workload Report <<<                          Page: 2

    Division: HINES CIO FIELD OFICE
Imaging Type: GENERAL RADIOLOGY                    For period: Nov 21, 1994 to
    Run Date: MAR  1,1995  08:45                               Mar 01, 1995

                               -------Examinations------
                                                        % of          % of
Procedure                     Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          PTF Bedsection: REHABILITATION MEDICINE
CHEST 4 VIEWS                   1     0     0     0      1  100.0     2  100.0

PTF Bedsection Total            1     0     0     0      1            2
-------------------------------------------------------------------------------
```

```
     >>> PTF Bedsection Workload Report <<<                          Page: 3

    Division: HINES CIO FIELD OFICE
Imaging Type: GENERAL RADIOLOGY                    For period: Nov 21, 1994 to
    Run Date: MAR  1,1995  08:45                               Mar 01, 1995

                               -------Examinations------
                                                        % of          % of
PTF Bedsection                Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          (Imaging Type Summary)
GENERAL(ACUTE MEDICINE)         41     0     0     0     41   97.6   217   99.1
REHABILITATION MEDICINE          1     0     0     0      1    2.4     2    0.9
-------------------------------------------------------------------------------

Imaging Type Total              42     0     0     0     42          219

   # of PTF Bedsections selected: ALL
```

```
     >>> PTF Bedsection Workload Report <<<                          Page: 4

    Division: HINES CIO FIELD OFICE
Imaging Type: MAGNETIC RESONANCE IMAGING           For period: Nov 21, 1994 to
    Run Date: MAR  1,1995  08:45                               Mar 01, 1995

                               -------Examinations------
                                                        % of          % of
PTF Bedsection                Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          (Imaging Type Summary)
-------------------------------------------------------------------------------

Imaging Type Total              0     0     0     0      0            0

   # of PTF Bedsections selected: ALL
```

```
     >>> PTF Bedsection Workload Report <<<                          Page: 9

    Division: HINES CIO FIELD OFICE          For period: Nov 21, 1994 to
    Run Date: MAR  1,1995  08:45                                Mar 01, 1995

                                -------Examinations------
                                                                % of          % of
PTF Bedsection                 Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          (Division Summary)
GENERAL(ACUTE MEDICINE)          41     0     0     0     41   97.6   217   99.1
REHABILITATION MEDICINE           1     0     0     0      1    2.4     2    0.9
-------------------------------------------------------------------------------
Division Total                   42     0     0     0     42          219

  Imaging Type(s): ANGIO/NEURO/INTERVENTIONAL   CT SCAN   GENERAL RADIOLOGY
                    MAGNETIC RESONANCE IMAGING   NUCLEAR MEDICINE
                   ULTRASOUND

   # of PTF Bedsections selected: ALL
```

Management Reports Menu

Functional Area Workload Reports

Service Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a listing of Radiology/Nuclear Medicine Service workloads. The Service is stored in the Service field of the exam record, and is determined by the system at the time an exam is registered based on data in MAS files about the patient's hospital location.

This is one of a series of workload reports that has similar selection criteria, report output, data retrieval and reporting logic. See the section entitled **General Information about Workload Reports** at the end of the Management Reports Menu chapter for a full description of this report.

The following example selects a full report and sorts by a single Division, two Imaging Types and all Services. Your selections may be different according to your needs.

Prompt/**User Response** Discussion

```
Service Report


   Service Workload Report:
   ------------------------

Do you wish only the summary report? No// <RET>

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

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

Select Imaging Type: All// GENERAL RADIOLOGY

Another one (Select/De-Select): CT SCAN

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

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

**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 19, 1994)

   Ending    DATE : T  (FEB 27, 1995)
```

If you answer no you will be asked to choose one or more individual services.

```
             The entries printed for this report will be based only
              on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit: <RET>

          CT SCAN
          -------
               WAITING FOR EXAM
               EXAMINED
               TRANSCRIBED
               COMPLETE

          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE


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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
     >>> Service Workload Report <<<                                Page: 1

    Division: HINES CIO FIELD OFICE
Imaging Type: CT SCAN                          For period: Nov 21, 1994 to
    Run Date: MAR  1,1995  09:06                           Mar 01, 1995

                               -------Examinations------
                                                        % of          % of
Service                       Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          (Imaging Type Summary)
-------------------------------------------------------------------------------

Imaging Type Total               0     0     0     0      0            0

   # of Services selected: ALL
```

When there is no data for a sort selection, in this case Service and Imaging Type, the total page appears as shown above.

```
     >>> Service Workload Report <<<                                Page: 2

    Division: HINES CIO FIELD OFICE
Imaging Type: GENERAL RADIOLOGY                For period: Nov 21, 1994 to
    Run Date: MAR  1,1995  09:06                           Mar 01, 1995

                               -------Examinations------
                                                        % of          % of
Procedure                     Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          Service: MEDICAL
NECK SOFT TISSUE                4     0     0     0      4    9.8    12    5.5
SKULL 4 OR MORE VIEWS           7     0     0     0      7   17.1    21    9.7
CHEST STEREO PA                 3     0     0     0      3    7.3     3    1.4
CHEST 4 VIEWS                   2     0     0     0      2    4.9     4    1.8
ABDOMEN 1 VIEW                  1     0     0     0      1    2.4     2    0.9
SPINE LUMBOSACRAL MIN 2 VIEW    2     0     0     0      2    4.9     6    2.8
UPPER GI + SMALL BOWEL          2     0     0     0      2    4.9    12    5.5
ANGIO CAROTID CEREBRAL SELEC    1     0     0     0      1    2.4    15    6.9
ANGIOGRAM,CATH - CEREBRAL       2     0     0     0      2    4.9    30   13.8
CT HEAD W/IV CONT               9     0     0     0      9   22.0    72   33.2
ARTHROGRAM ANKLE S&I            1     0     0     0      1    2.4     5    2.3
ARTHROGRAM TM JOINT CONT S&I    1     0     0     0      1    2.4     5    2.3
STEREOTACTIC LOCALIZATION HE    6     0     0     0      6   14.6    30   13.8

Service Total                  41     0     0     0     41          217
-------------------------------------------------------------------------------
```

```
     >>> Service Workload Report <<<                                Page: 3

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                    For period: Nov 21, 1994 to
    Run Date: MAR  1,1995  09:06                                  Mar 01, 1995

                                -------Examinations------
                                                          % of          % of
Procedure                      Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
         Service: AMBULATORY CARE
CHEST 4 VIEWS                    1     0     0     0      1  100.0     2  100.0

Service Total                    1     0     0     0      1            2
-------------------------------------------------------------------------------
```

```
     >>> Service Workload Report <<<                                Page: 4

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                    For period: Nov 21, 1994 to
    Run Date: MAR  1,1995  09:06                                  Mar 01, 1995

                                -------Examinations------
                                                          % of          % of
Service                        Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
         (Imaging Type Summary)
MEDICAL                         41     0     0     0     41   97.6   217   99.1
AMBULATORY CARE                  1     0     0     0      1    2.4     2    0.9
-------------------------------------------------------------------------------

Imaging Type Total              42     0     0     0     42          219

   # of Services selected: ALL
```

```
     >>> Service Workload Report <<<                                Page: 5

    Division: HINES CIO FIELD OFFICE               For period: Nov 21, 1994 to
    Run Date: MAR  1,1995  09:06                                  Mar 01, 1995

                                -------Examinations------
                                                          % of          % of
Service                        Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
         (Division Summary)
MEDICAL                         41     0     0     0     41   97.6   217   99.1
AMBULATORY CARE                  1     0     0     0      1    2.4     2    0.9
-------------------------------------------------------------------------------

Division Total                  42     0     0     0     42          219

  Imaging Type(s): CT SCAN   GENERAL RADIOLOGY

   # of Services selected: ALL
```

Management Reports Menu

Functional Area Workload Reports

Sharing Agreement/Contract Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personel) to generate a listing entitled Sharing/Contract Workload Report. In order to be included in this report, an exam's Category of Exam field must be set to Contract or Sharing, and the Contract/Sharing Source field must contain a valid contract or sharing source. This data can be entered at the time the exam is requested, or after the exam is registered.

This is one of a series of workload reports that have similar selection criteria, report output, data retrieval and reporting logic. See the section entitled **General Information about Workload Reports** at the end of the Management Reports Menu chapter for a full description of this report.

The following is an example of a complete report sorting by one Division, one Imaging Type, and one Sharing Agreement/Contract. Your selections may be different according to your needs.

Prompt/**User Response** Discussion

```
Sharing Agreement/Contract Report


   Sharing/Contract Workload Report:
   ---------------------------------

Do you wish only the summary report? No// <RET>

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

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

Select Imaging Type: All// GENERAL RADIOLOGY

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


Do you wish to include all Sharing/Contracts? Yes// NO

Select Sharing/Contract: ?

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

 Answer with CONTRACT/SHARING AGREEMENTS AGREEMENT NAME
Choose from:
   CONTRACTOR LFL
   MEMORIAL HOSPITAL
```

```
   UNIVERSITY HOSPITAL
   MEDICARE

Select Sharing/Contract: MEMORIAL HOSPITAL

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

**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 20, 1994)

   Ending    DATE : T  (FEB 28, 1995)


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

          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
     >>> Sharing/Contract Workload Report <<<                        Page: 1

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                    For period: Nov 20, 1994 to
    Run Date: FEB 28,1995  13:58                                  Feb 28, 1995

                               -------Examinations------
                                                          % of          % of
Procedure                     Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          Sharing/Contract: MEMORIAL HOSPITAL
SPINE SI JOINTS 1 OR 2 VIEWS      0     0     0     1      1  100.0     3  100.0

Sharing/Contract Total            0     0     0     1      1            3
-------------------------------------------------------------------------------
```

```
     >>> Sharing/Contract Workload Report <<<                        Page: 2

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                    For period: Nov 20, 1994 to
    Run Date: FEB 28,1995  13:58                                  Feb 28, 1995

                               -------Examinations------
                                                          % of          % of
Sharing/Contract              Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          (Imaging Type Summary)
MEMORIAL HOSPITAL                 0     0     0     1      1  100.0     3  100.0
-------------------------------------------------------------------------------

Imaging Type Total                0     0     0     1      1            3

   # of Sharing/Contracts selected: 1
```

```
     >>> Sharing/Contract Workload Report <<<                        Page: 3

    Division: HINES CIO FIELD OFFICE               For period: Nov 20, 1994 to
    Run Date: FEB 28,1995  13:58                                  Feb 28, 1995

                               -------Examinations------
                                                          % of          % of
Sharing/Contract              Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          (Division Summary)
MEMORIAL HOSPITAL                 0     0     0     1      1  100.0     3  100.0
-------------------------------------------------------------------------------

Division Total                    0     0     0     1      1            3

  Imaging Type(s): GENERAL RADIOLOGY

   # of Sharing/Contracts selected: 1
```

Management Reports Menu

Functional Area Workload Reports

Ward Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a listing of ward workloads. The wards are stored in the Ward field of the exam record. This field is determined by the system for inpatients at the time an exam is ordered. Data in MAS files is used to determine the ward location of the patient. The requesting ward and patient's ward location are considered to be the same by the system. For the purposes of this workload report, the requesting ward is used rather than the ward at the time the study was done or the report was entered.

This is one of a series of workload reports that have similar selection criteria, report output, data retrieval and reporting logic. See the section entitled **General Information about Workload Reports** at the end of the Management Reports Menu chapter for a full description of this report.

The following is an example of a summary report sorting by one Division, all Imaging Types, and all wards. Your selections may be different according to your needs.

Prompt/**User Response** Discussion

```
Ward Report


   Ward Workload Report:
   ---------------------

Do you wish only the summary report? No// YES

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

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

Select Imaging Type: All// <RET>

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

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

**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 20, 1994)

   Ending    DATE : T  (FEB 28, 1995)


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

```
Enter RETURN to continue or '^' to exit:

          ANGIO/NEURO/INTERVENTIONAL
          ----------------------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE



          CT SCAN
          -------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

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

          MAMMOGRAPHY
          -----------
               WAITING FOR EXAM
               COMPLETE

          NUCLEAR MEDICINE
          ----------------
               WAITING FOR EXAM
               EXAMINED
               TRANSCRIBED
               COMPLETE

          ULTRASOUND
          ----------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
     >>> Ward Workload Report <<<                                    Page: 1

    Division: HINES CIO FIELD OFFICE
Imaging Type: CT SCAN                              For period: Nov 20, 1994 to
    Run Date: FEB 28,1995  14:00                               Feb 28, 1995

                                -------Examinations------
                                                          % of          % of
Ward                           Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          (Imaging Type Summary)
-------------------------------------------------------------------------------

Imaging Type Total:               0     0     0     0      0            0

   # of Wards selected: ALL
```

```
     >>> Ward Workload Report <<<                                    Page: 2

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                    For period: Nov 20, 1994 to
    Run Date: FEB 28,1995  14:00                               Feb 28, 1995

                                -------Examinations------
                                                          % of          % of
Ward                           Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          (Imaging Type Summary)
1N                              33     0     0     0     33   78.6   177   80.8
1S                               9     0     0     0      9   21.4    42   19.2
-------------------------------------------------------------------------------

Imaging Type Total:             42     0     0     0     42          219

   # of Wards selected: ALL
```

```
     >>> Ward Workload Report <<<                                  Page: 7

    Division: HINES CIO FIELD OFFICE              For period: Nov 20, 1994 to
    Run Date: FEB 28,1995  14:00                              Feb 28, 1995

                                -------Examinations------
                                                          % of          % of
Ward                           Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
          (Division Summary)
1N                               33     0     0     0     33   78.6   177   80.8
1S                                9     0     0     0      9   21.4    42   19.2
-------------------------------------------------------------------------------

Division Total                   42     0     0     0     42          219

  Imaging Type(s): ANGIO/NEURO/INTERVENTIONAL   CT SCAN   GENERAL RADIOLOGY
                     MAGNETIC RESONANCE IMAGING   NUCLEAR MEDICINE
                   ULTRASOUND

   # of Wards selected: ALL
```

Management Reports Menu

Personnel Workload Reports

Physician Report
Radiopharmaceutical Administration Report
Resident Report
Staff Report
Technologist Report
Transcription Report

The Physician Report shows which exams were ordered by which physicians. The Resident and Staff reports show exams interpreted by resident and staff interpreting physicians. The Technologist Report shows workload by technologist. There may be more than one technologist, resident, or staff per exam, so the total amount of exams does not correspond to the sum of the separate totals.

All of these reports have similar prompts, formats, and data retrieval and reporting logic. Sample prompts and formats are shown on the page with the individual report. The data retrieval and reporting logic for all the workload reports is described in the section of this manual entitled **General Information about Workload Reports**, which can be found at the end of the Management Reports Menu section.

Management Reports Menu

Personnel Workload Reports

Physician Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a listing of examinations and work associated with exams requested by referring physicians. The report is entitled Requesting M.D. Workload Report. The physicians for this report are stored in the Requesting Physician field of the exam.

This is one of a series of workload reports that have similar selection criteria, report output, data retrieval and reporting logic. See the section entitled **General Information about Workload Reports** at the end of the Management Reports Menu chapter for a full description of this report.

Prompt/**User Response** Discussion

```
Physician Report


Requesting M.D. Workload Report:
--------------------------------

Do you wish only the summary report? NO// <RET>

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

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

Select Imaging Type: All// GENERAL RADIOLOGY

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


Do you wish to include all Requesting M.D.s? Yes// NO

Select Requesting M.D.: WELBY,MARCUS

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

**** Date Range Selection ****

   Beginning DATE : T-100  (JAN 01, 1997)

   Ending    DATE : T  (APR 11, 1997)


             The entries printed for this report will be based only
              on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit: <RET>
```

This sample shows only a single requesting physician being selected.

```
          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               TRANSCRIBED
               COMPLETE

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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
          >>> Requesting M.D. Workload Report <<<                    Page: 1

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                    For period: JAN  1,1997 to
    Run Date: APR 11,1997  15:01                                   APR 11,1997

                                          Examinations    Percent
  Procedure (CPT)                        In    Out  Total   Exams
-------------------------------------------------------------------------------
          Requesting M.D.: WELBY,MARCUS
COLON BARIUM ENEMA          (74270)       0      2      2  100.0
-------------------------------------------------------------------------------

  Requesting M.D. Total                  0      2      2
Enter RETURN to continue or '^' to exit:
```

```
          >>> Requesting M.D. Workload Report <<<                    Page: 2

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                    For period: JAN  1,1997 to
    Run Date: APR 11,1997  15:01                                   APR 11,1997

                                          Examinations    Percent
  Requesting M.D.                        In    Out  Total   Exams
-------------------------------------------------------------------------------
          (Imaging Type Summary)
WELBY,MARCUS                             0      2      2  100.0
-------------------------------------------------------------------------------

  Imaging Type Total                     0      2      2

   # of Requesting M.D.s selected: 1
```

Management Reports Menu

Personnel Workload Reports

Radiopharmaceutical Administration Report

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

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

Sort order if Radiopharmaceutical is selected as primary sort:
Division, imaging type, radiopharmaceutical, exam date/time, patient, case number
Sort order if exam date/time is selected as primary sort:
Division, imaging type, exam date/time, radiopharmaceutical, patient, case number

Detailed reports or summaries only can be printed. The report is designed for a 132-column page. If an administered dosage falls outside of the high/low dose range, an asterisk (*) prints next to it. If a radiopharmaceutical is currently inactive, but has DX200, DX201, or DX202, it will be included in the report if used during the exam date range. Since a case may have more than one radiopharmaceutical, the total number of unique cases may be less than the total number of radiopharmaceuticals reported.

```
Radiopharmaceutical Administration Report

Do you wish only the summary report? No// <RET>  NO

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

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


Select Imaging Type: All// ?

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

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


Select Imaging Type: All// <RET>

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

Do you wish to include all who administered dose ? Yes// <RET>  YES

**** Date Range Selection ****

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

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

Sort Exam Date/Time before Who Admin Dose ? : NO// <RET>

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


DEVICE: HOME// (Enter a device that prints 132 columns)
```

```
                              >>> Radiopharmaceutical Administration Report <<<    Run Date: AUG 19,1997  11:18   Page: 1

Division: HINES CIO FIELD OFFICE        Imaging Type: CARDIOLOGY STUDIES (NUC MED)  For period: May 21, 1997 to Aug 18, 1997@24:00

Long-Case@Time  Patient Name       SSN      Radiopharm     Act.Drawn Dose Adm'd    Low       High   Procedure       Who Adm'd
-------------------------------------------------------------------------------------------------------------------------------
072297-702@1528 BARNIQ,FRANK W  463-27-7311 PERCHLORACAP 25    7.0000    5.0000    0.0000    0.0000 CARDIOLOGY TEST MYER,JOAN
```

```
                              >>> Radiopharmaceutical Administration Report <<<    Run Date: AUG 19,1997  11:18   Page: 2

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

Long-Case@Time  Patient Name       SSN      Radiopharm     Act.Drawn Dose Adm'd   Low       High   Procedure         Who Adm'd
-------------------------------------------------------------------------------------------------------------------------------
080697-709@1233 GAUSS,KARL F   168-93-0889 SESTAMIBI TC-99 600.0000  600.0000  250.0000  500.0000 THYROID IMAGING    ALLEN,STEVE *
070997-700@0907 OSTER,HANS     259-21-9318 SULFUR COLLOID    0.0000   10.0000   10.0000   15.0000 RADIONUCLIDE TH    CEBEL,GREG
070997-701@0932 CRIPPS,RICHARD 573-89-6827 SULFUR COLLOID   12.0000   12.0000   10.0000   15.0000 RADIONUCLIDE TH    CEBEL,GREG
072597-703@1245 KIROV,SERGI    961-23-7958 SODIUM PERTECHN  12.0000   12.0000    0.0000   15.0000 THYROID IMAGING    CEBEL,GREG
080797-718@0807 HEIER,RALPH    321-44-8277 Tc-99m DTPA       0.6000    0.6000    0.5000    1.5000 LUNG AEROSOL SC    HINESLEY,RICK
080797-719@0807 HEIER,RALPH    321-44-8277 Tc-99m MACROAGG   3.0000    3.0000    3.0000    6.0000 LUNG PERFUSION     HINESLEY,RICK
080797-721@0902 HEIER,RALPH    321-44-8277 SESTAMIBI TC-99   8.0000    8.0000    8.0000   10.0000 MYOCARDIAL PERF    HINESLEY,RICK
```

```
                              >>> Radiopharmaceutical Administration Report <<<    Run Date: AUG 19,1997  11:18   Page: 3
                                            (Imaging Summary)
Division: HINES CIO FIELD OFFICE        Imaging Type: CARDIOLOGY STUDIES (NUC MED)  For period: May 21, 1997 to Aug 18, 1997@24:00
Who Admin Dose                      Total Drawn    Total Adm'd   No. cases      (%)        No. outside range
-------------------------------------------------------------------------------------------------------------------------------
MYER,JOAN                              7.0000         5.0000          1       100.00

CARDIOLOGY STUDIES (NUC MED)'s Total number of unique cases: 1

Notes: A case may have more than 1 radiopharm, so total no. unique cases may be less than total no. radiopharms listed.
     * denotes administered dosage outside of normal range.
```

```
                              >>> Radiopharmaceutical Administration Report <<<    Run Date: AUG 19,1997  11:18   Page: 4
                                            (Imaging Summary)
Division: HINES CIO FIELD OFFICE             Imaging Type: NUCLEAR MEDICINE         For period: May 21, 1997 to Aug 18, 1997@24:00
Who Admin Dose                      Total Drawn    Total Adm'd   No. cases      (%)        No. outside range
-------------------------------------------------------------------------------------------------------------------------------
ALLEN,STEVE                          600.0000       600.0000          1       14.29             1
CEBEL,GREGORY J                       24.0000        34.0000          3       42.86
HINESLEY,RICK                         11.6000        11.6000          3       42.86

NUCLEAR MEDICINE's Total number of unique cases: 7

Notes: A case may have more than 1 radiopharm, so total no. unique cases may be less than total no. radiopharms listed.
     * denotes administered dosage outside of normal range.
```

```
                              >>> Radiopharmaceutical Administration Report <<<     Run Date: AUG 19,1997  11:18   Page: 5
                                            (Division Summary)
Division: HINES CIO FIELD OFFICE                                                   For period: May 21, 1997 to Aug 18, 1997@24:00
Who Admin Dose                      Total Drawn    Total Adm'd   No. cases      (%)        No. outside range
-------------------------------------------------------------------------------------------------------------------------------
ALLEN,STEVE                          600.0000       600.0000          1       12.50             1
CEBEL,GREGORY J                       24.0000        34.0000          3       37.50
HINESLEY,RICK                         11.6000        11.6000          3       37.50
MYER,JOAN                              7.0000         5.0000          1       12.50

HINES CIO FIELD OFFICE's Total number of unique cases: 8

Notes: A case may have more than 1 radiopharm, so total no. unique cases may be less than total no. radiopharms listed.
     * denotes administered dosage outside of normal range.
```

Management Reports Menu

Personnel Workload Reports

Resident Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a report of exams and work associated with interpreting resident physicians. The residents for this report are stored in the Primary Interpreting Resident field and Secondary Interpreting Resident multiple field of the exam record. The user can choose to include only the Primary Interpreting Resident. If Primary and Secondary Residents are included, more than one resident can be associated with a single exam, so totals do not correspond to the sum of the separate totals.

This is one of a series of workload reports that have similar selection criteria, report output, data retrieval and reporting logic. See the section entitled **General Information about Workload Reports** at the end of the Management Reports Menu chapter for a full description of this report.

Prompt/**User Response** Discussion

```
Interpreting Resident Workload Report:
----------------------------------

Do you wish only the summary report? NO// <RET>

Count Resident when entered as 'secondary' resident interpreter? Yes// ?

Answer 'Yes' if both Primary and Secondary Resident personnel will be included
in this report.  Answer 'No' if only Primary Resident personnel will be
included in this report.  Input a '^' to exit without a report.

Count Resident when entered as 'secondary' resident interpreter? Yes// <RET>  YES

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

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


Select Imaging Type: All// RAD    GENERAL RADIOLOGY

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

Do you wish to include all Interpreting Residents? Yes//     In this example, all
<RET>  YES                                                   residents will be
                                                             included.

**** Date Range Selection ****

   Beginning DATE : T-100  (MAY 11, 1997)

   Ending    DATE : T  (AUG 19, 1997)

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

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


          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

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

```
          >>> Interpreting Resident Workload Report <<<              Page: 1

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: MAY 11,1997 to
    Run Date: AUG 19,1997  11:55                                  AUG 19,1997

                                          Examinations    Percent
  Procedure (CPT)                        In    Out  Total   Exams
-------------------------------------------------------------------------------
          Interpreting Resident: FLAHERTY,DONALD
ABDOMEN 1 VIEW               (74000)       1      0      1   25.0
SPINE SI JOINTS 1 OR 2 VIEW  (72200)       0      1      1   25.0
ANKLE 2 VIEWS                (73600)       0      1      1   25.0
ANGIO CAROTID CEREBRAL SELE  (75660)       0      1      1   25.0
-------------------------------------------------------------------------------

  Interpreting Resident Total              1      3      4
```

```
          >>> Interpreting Resident Workload Report <<<              Page: 7

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: MAY 11,1997 to
    Run Date: AUG 19,1997  11:55                                    AUG 19,1997

                                                 Examinations    Percent
  Procedure (CPT)                              In    Out  Total   Exams
-------------------------------------------------------------------------------
          Interpreting Resident: UNKNOWN
SKULL 4 OR MORE VIEWS          (70260)        0      2      2    2.1
ABDOMEN MIN 3 VIEWS+CHEST      (74022)        0      1      1    1.1
CHEST APICAL LORDOTIC          (71021)        0      4      4    4.2
CHEST STEREO PA                (71015)        2      2      4    4.2
CHEST 4 VIEWS                  (71030)        0      5      5    5.3
CHEST INCLUDE FLUORO           (71034)        0      3      3    3.2
ABDOMEN 1 VIEW                 (74000)        1     13     14   14.7
ABDOMEN 2 VIEWS                (74010)        0      5      5    5.3
SPINE CERVICAL MIN 2 VIEWS     (72040)        0      1      1    1.1
SPINE SI JOINTS 1 OR 2 VIEW    (72200)        0      1      1    1.1
ACROMIOCLAVICULAR J BILAT      (73050)        0      2      2    2.1
```

```
          >>> Interpreting Resident Workload Report <<<              Page: 8

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: MAY 11,1997 to
    Run Date: AUG 19,1997  11:55                                    AUG 19,1997

                                                 Examinations    Percent
  Procedure (CPT)                              In    Out  Total   Exams
-------------------------------------------------------------------------------
          Interpreting Resident: UNKNOWN
ANKLE 2 VIEWS                  (73600)        0      2      2    2.1
ANKLE 3 OR MORE VIEWS          (73610)        0      3      3    3.2
CLAVICLE                       (73000)        0      1      1    1.1
FOOT 2 VIEWS                   (73620)        0      3      3    3.2
FOREARM 2 VIEWS                (73090)        0      2      2    2.1
HAND 3 OR MORE VIEWS           (73130)        0      1      1    1.1
TOE(S) 2 OR MORE VIEWS         (73660)        0      1      1    1.1
UPPER GI AIR CONT W/SMALL B    (74249)        2      0      2    2.1
CHOLANGIOGRAM IV               (74310)        0      1      1    1.1
CHOLANGIOGRAM PERC S&I         (74320)        0      4      4    4.2
ANGIO CAROTID CEREBRAL BILA    (75671)        0      2      2    2.1
```

```
      >>> Interpreting Resident Workload Report <<<              Page: 11

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: MAY 11,1997 to
    Run Date: AUG 19,1997  11:55                                AUG 19,1997

                                              Examinations    Percent
  Interpreting Resident                     In    Out  Total   Exams
-------------------------------------------------------------------------------
          (Imaging Type Summary)
FLAHERTY,DONALD                              1      3      4    2.9
KEPPEL,BART                                  0      5      5    3.6
MYER,JOAN                                    0      3      3    2.2
SOMNAMBULA,DOCTOR                            1      5      6    4.4
SPOCK,DOCTOR                                 0      7      7    5.1
TRACKER,FRED                                 4     13     17   12.4
UNKNOWN                                     11     84     95   69.3
-------------------------------------------------------------------------------

  Imaging Type Total                        17    120    137


  NOTE: Since a procedure can be performed by more than one Interpreting
        Resident, the total number of exams by division and imaging type
        is likely to be higher than the other workload reports.
        Both Primary and Secondary Interpreting Resident are included in
        this report.

   # of Residents selected: ALL
```

Management Reports Menu

Personnel Workload Reports

Staff Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a report of examinations and work associated with interpreting staff physicians. The report is entitled Interpreting Staff Workload Report. The staff for this report are stored in the Primary Interpreting Staff field and the Secondary Interpreting Staff multiple field of the exam record. The user can choose to include the Primary Interpreting Staff only. If Primary and Secondary Staff are included, more than one interpreting staff can be associated with a single exam, so totals do not correspond to the sum of the separate totals.

This is one of a series of workload reports that have similar selection criteria, report output, data retrieval and reporting logic. See the section entitled **General Information about Workload Reports** at the end of the Management Reports Menu chapter for a full description of this report.

Prompt/**User Response** Discussion

```
Staff Report

[1]Do you want to count CPT Modifiers separately? No//?

Enter YES to put different combinations of CPT modifiers onto separate lines.

Do you want to count CPT Modifiers separately? No//<RET>

Interpreting Staff Workload Report:
----------------------------------

Do you wish only the summary report? NO// <RET>

Count Staff when entered as 'secondary' staff interpreter? Yes// ?

Answer 'Yes' if both Primary and Secondary Staff personnel will be included
in this report.  Answer 'No' if only Primary Staff personnel will be
included in this report.  Input a '^' to exit without a report.

Count Staff when entered as 'secondary' staff interpreter? Yes// NO

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

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


Select Imaging Type: All// NUCLEAR MEDICINE

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

Do you wish to include all Primary Interpreting Staff? Yes// <RET>  YES
```

[1] Patch RA*5*26 Allows printing of different combinations of CPT modifiers on separate lines.

```
**** Date Range Selection ****

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

   Ending    DATE : T  (AUG 19, 1997)

             The entries printed for this report will be based only
              on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit: <RET>


          NUCLEAR MEDICINE
          ----------------
               WAITING FOR EXAM
               EXAMINED
               TRANSCRIBED
               COMPLETE


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

```
          >>> Interpreting Staff Workload Report <<<                 Page: 1

    Division: HINES CIO FIELD OFFICE
Imaging Type: NUCLEAR MEDICINE                       For period: MAY 21,1997 to
    Run Date: AUG 19,1997  12:02                                   AUG 19,1997

                                          Examinations    Percent
  Procedure (CPT)                        In    Out  Total   Exams
-------------------------------------------------------------------------------
          Interpreting Staff: HELLER,CINDY
LUNG AEROSOL SCAN, MULTIPLE  (78587)      0      1      1   33.3
LUNG PERFUSION, PARTICULATE  (78580)      0      1      1   33.3
PROVISION OF DIAGNOSTIC RAD  (78990)      0      1      1   33.3
-------------------------------------------------------------------------------

  Interpreting Staff Total                0      3      3
```

```
          >>> Interpreting Staff Workload Report <<<                 Page: 2

    Division: HINES CIO FIELD OFFICE
Imaging Type: NUCLEAR MEDICINE                       For period: MAY 21,1997 to
    Run Date: AUG 19,1997  12:02                                   AUG 19,1997

                                          Examinations    Percent
  Procedure (CPT)                        In    Out  Total   Exams
-------------------------------------------------------------------------------
          Interpreting Staff: UNKNOWN
BONE IMAGING, MULTIPLE AREA  (78305)      0      1      1   14.3
LUNG AEROSOL SCAN, MULTIPLE  (78587)      0      1      1   14.3
LUNG PERFUSION, PARTICULATE  (78580)      0      1      1   14.3
MYOCARDIAL PERFUSION (SPECT  (78465)      0      1      1   14.3
PROVISION OF DIAGNOSTIC RAD  (78990)      0      1      1   14.3
THYROID IMAGING WITH UPTAKE  (78007)      0      2      2   28.6
-------------------------------------------------------------------------------

  Interpreting Staff Total                0      7      7
```

```
          >>> Interpreting Staff Workload Report <<<                Page: 3

    Division: HINES CIO FIELD OFFICE
Imaging Type: NUCLEAR MEDICINE                      For period: MAY 21,1997 to
    Run Date: AUG 19,1997  12:02                                AUG 19,1997

                                                 Examinations    Percent
  Interpreting Staff                           In    Out  Total   Exams
-------------------------------------------------------------------------------
          (Imaging Type Summary)
HELLER,CINDY                                    0      3      3   30.0
UNKNOWN                                         0      7      7   70.0
-------------------------------------------------------------------------------

  Imaging Type Total                            0     10     10

  NOTE: Only Primary Interpreting Staff are included in this report.

   # of Primary Staff selected: ALL
```

Management Reports Menu

Personnel Workload Reports

Technologist Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a report of workload for technologists. The technologists for this report are stored in the Technologist multiple field of the exam record. Since more than one technologist can be associated with a single exam, totals do not correspond to the sum of the separate totals.

This is one of a series of workload reports that has similar selection criteria, report output, data retrieval and reporting logic. See the section entitled **General Information about Workload Reports** at the end of the Management Reports Menu chapter for a full description of this report.

Prompt/**User Response** Discussion

```
Technologist Report


Technologist Workload Report:
-----------------------------

Do you wish only the summary report? NO// <RET>

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

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

Select Imaging Type: All// GENERAL RADIOLOGY

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

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

**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 21, 1994)

   Ending    DATE : T  (MAR 01, 1995)

             The entries printed for this report will be based only
              on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit: <RET>

          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE
```

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

Enter the name of a printer or 'Q' to queue.

```
          >>> Technologist Workload Report <<<                    Page: 1

    Division: HINES INFORMATION SYSTEMS CTR
Imaging Type: GENERAL RADIOLOGY                    For period: NOV 21,1994 to
    Run Date: MAR  1,1995  10:07                                MAR  1,1995

                                          Examinations    Percent     Percent
  Procedure (CPT)                       In    Out  Total   Exams  WWU   WWU
-------------------------------------------------------------------------------
          Technologist: ALLEN,STEVE
NECK SOFT TISSUE(70360)                  0      2      2   13.3      6    9.1
SKULL 4 OR MORE VIEWS(70260)             0      1      1    6.7      3    4.5
CHEST STEREO PA(71015)                   0      2      2   13.3      2    3.0
ABDOMEN 1 VIEW(74000)                    1      1      2   13.3      4    6.1
FOREARM 2 VIEWS(73090)                   0      1      1    6.7      2    3.0
CHOLANGIOGRAM IV(74310)                  0      1      1    6.7     10   15.2
CT HEAD W/IV CONT(70460)                 1      1      2   13.3     16   24.2
CT MAXILLOFACIAL W&W/O CONT(70488)       0      1      1    6.7      8   12.1
STEREOTACTIC LOCALIZATION HEAD(70022)    2      1      3   20.0     15   22.7
-------------------------------------------------------------------------------
  Technologist Total                     4     11     15             66
```

>>> Technologist Workload Report <<< Page: 11

Division: HINES INFORMATION SYSTEMS CTR
Imaging Type: GENERAL RADIOLOGY For period: NOV 21,1994 to
Run Date: MAR 1,1995 10:07 MAR 1,1995

Technologist	Examinations In	Out	Total	Percent Exams	Percent WWU	WWU
(Imaging Type Summary)						
ALLEN,STEVE	4	11	15	17.9	66	15.6
BITNER,GAYLE	13	14	27	32.1	148	35.1
BRUCE,NANCY	2	1	3	3.6	9	2.1
CAPON,GERRY	1	7	8	9.5	22	5.2
DRUMMOND,DAN	2	1	3	3.6	11	2.6
GAULT,MICHAEL	0	3	3	3.6	21	5.0
HIMMEL,RICK	0	2	2	2.4	4	0.9
MINER,JOE	0	1	1	1.2	3	0.7
ROBERTS,RICHARD.	3	1	4	4.8	26	6.2
SMITH,BARRY	9	9	18	21.4	112	26.5
Imaging Type Total	34	50	84		422	

NOTE: **Since a procedure can be performed by more than one technologist, the total number of exams and weighted work units by division and imaging type is likely to be higher than the other workload reports.**

# of Technologists selected: ALL

Management Reports Menu

Personnel Workload Reports

Transcription Report

This option allows you to print a report entitled Imaging Transcription Report showing the number of lines and reports transcribed for each transcriptionist for a specified date range. Only one transcriptionist may be associated with an exam. The number of lines counted is always the current number of lines in the report. So, if lines have been added, changed, or deleted, only the final number of lines at the time the report is run will be counted. The report does not reflect changes made by subsequent transcriptionists. All workloads will be credited to the initial transcriptionist for each report. The total character count is divided by 75 to produce the line count.

This one of a series of workload reports that have similar selection criteria, report output, data retrieval and reporting logic. See the section entitled **General Information about Workload Reports** at the end of the Management Reports Menu chapter for a full description of this report.

Prompt/**User Response** Discussion

```
Transcription Report

          >>> IMAGING TRANSCRIPTIONIST WORKLOAD REPORT <<<


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

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

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

**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 21, 1994)

   Ending    DATE : T  (MAR 01, 1995)

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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
                    >>> IMAGING TRANSCRIPTION REPORT <<<            PAGE: 1
                      Division: HINES CIO FIELD OFFICE
                    Date Range: NOV 21,1994 - MAR  1,1995
# of Transcriptionists selected: ALL

RADIOLOGY/NUCLEAR MEDICINE PERSONNEL        NUMBER OF LINES  NUMBER OF REPORTS
================================================================================

CENTER,MARY                                              76               38
ELDER,JOHN                                               2                1
HEMP,SANDY                                               25               9
KASTLE,STEPHEN                                           2                1
MARKER,MANDY                                             56               14
TYLER,FRANK                                              39               14
```

Management Reports Menu

Special Reports

AMIS Code Dump by Patient
AMIS Report
Camera/Equip/Rm Report
Cost Distribution Report
Detailed Procedure Report
Film Usage Report
Procedure/CPT Statistics Report
Status Time Report
Wasted Film Report

NOTE: Several reports in this section are for AMIS reporting. The AMIS system is scheduled to become obsolete as of December 1998.

Management Reports Menu

Special Reports

AMIS Code Dump by Patient

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a listing of patients who have had an examination associated with a specified AMIS code within a designated time frame.

The listing is printed chronologically by examination date. The following information is shown in the report: patient name, patient ID, procedure, exam date and time, and ward/clinic that ordered that exam. At the bottom of the report is the total number of examinations for the specified AMIS category and a breakdown of the total into inpatient and outpatient examinations. The report also indicates which procedures have been counted as multiple or zero exams.

You will be asked to select one AMIS category. Next you will be asked if you want to include all procedures within the selected AMIS category. If you want to select a subset of procedures, answer NO and you will be prompted for one or more of the procedures which are associated with the specified AMIS code to be included in the report. Two question marks (??) entered at any of these prompts will produce on-line help and lists of valid responses.

Although the report will print on either an 80-column or 132-column device, it is easier to read if printed on a 132-column device.

Exams must meet certain criteria to be included in the report:

The exam date/time must fall within the date range selected. The current status of the exam must be specified in the Examination Status parameters as a status to include in this report. (This is determined during system set-up when the ADPAC answers the AMIS Report question during Examination Status Entry/Edit.) The division on the exam record must be one of divisions you selected, or your default division if you did not see a division selection prompt.

Procedures included must be among those you selected with one exception: If AMIS category 25 (Operating Room) or 26 (Portable) was selected, then all exams that meet the other criteria, regardless of the AMIS code of the procedure done, will be further checked for exam modifier types of “portable” or “operating room.” Therefore, if an ankle x-ray with AMIS code 8 is done, and a modifier of the “operating room” type was entered for the exam, then that exam will show up in this report when AMIS category 25 is selected AND when AMIS category 8 is selected.

Exam counts

In the ankle x-ray example above, if the exam has no other multipliers or bilateral modifiers, it will count as 1 exam. If an exam's procedure has an AMIS weight multiplier of 3 for the selected

AMIS category in the Rad/Nuc Med Procedure file, it would be counted as 3 exams. If a procedure's AMIS weight multiplier is 1 or blank, but the procedure's Bilateral field is set to YES for the selected AMIS category, it would count as 2. If a bilateral type of modifier was entered during exam ordering or editing, it also would count as 2 exams. If both conditions are true, the count will still be 2.

It is possible for an exam to get a count of zero if the AMIS weight multiplier on the procedure for the selected AMIS code is set to zero. Only procedures designated by VACO as having an AMIS weight of zero should be set to zero.

The Category of Exam on the exam record is used to determine whether the exam count is added to inpatient totals or outpatient totals. If the Category of Exam is "Inpatient," it will be added to the inpatient totals. If the Category of Exam is anything else (outpatient, research, employee, contract, sharing), it will be added to the outpatient totals.

Totals are separated by division, and a grand total will also print.

Prompt/**User Response** Discussion

```
AMIS Code Dump by Patient


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

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

**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 21, 1994)

   Ending    DATE : T  (MAR 01, 1995)



Select MAJOR RAD/NUC MED AMIS CODES DESCRIPTION: ??

Choose from:
   1               SKULL,INC.SINUS,MASTOID,JAW,ETC
   2               CHEST-SINGLE VIEW
   3               CHEST MULTIPLE VIEW
   4               CARDIAC SERIES
   5               ABDOMEN-KUB
   6               OBSTRUCTIVE SERIES
   7               SKELETAL-SPINE & SACROILIAC
   8               SKELETAL-BONE & JOINTS
   9               GASTROINTESTINAL
   10              GENITOURINARY
   11              CHOLECYSTOGRAM,ORAL
   12              CHOLANGIOGRAM
   13              LAMINOGRAM
   14              BRONCHOGRAM
   15              DIGITAL SUBTRACTION ANGIOGRAPHY
```

```
   16              ANGIOGRAM,CATH- CEREBRAL
   17              ANGIOGRAM,CATH- VISCERAL
   18              ANGIOGRAM,CATH- PERIPHERAL
   19              VENOGRAM
   20              MYELOGRAM
   21              COMPUTED TOMOGRAPHY
   '^' TO STOP: <RET>
   22              INTERVENTIONAL RADIOGRAPHY
   23              ULTRASOUND,ECHOENCEPHALOGRAM
   24              OTHER
   25              EXAMS IN OPER.SUITE AT SURGERY
   26              PORTABLE (BEDSIDE) EXAMINATIONS
   27              NUCLEAR MEDICINE

Select MAJOR RAD/NUC MED AMIS CODES DESCRIPTION: ABDOMEN-KUB

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

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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
>>>>> AMIS Code Dump by Patient <<<<<                                    Page: 1
Patient List for AMIS Category 5 - ABDOMEN-KUB
                                                  For Period: NOV 21,1994 to
Run Date: MAR  1,1995  10:58                                   MAR  1,1995
Division: HINES CIO FIELD OFFICE
# of Procedures Selected: All

Patient Name        Pt ID          Procedure           Exam Date          Ward/Clinic
------------        -----          ---------           -----------        -----------
MARX,CHICO          819-19-7536     ABDOMEN 2 VIEWS     NOV 28,1994  13:46  EMERGENCY ROOM
TRAMG,HENRY         793-13-3012     ABDOMEN 1 VIEW      DEC  2,1994  15:05  EMERGENCY ROOM
SLADE,FRANK H       512-99-2785     ABDOMEN 1 VIEW      DEC  8,1994  10:22  X-RAY STOP
JORDAN,MICHAEL      232-32-3230     ABDOMEN 1 VIEW      JAN 12,1995  09:40  X-RAY STOP
LUSH,ROBERT         123-98-7123    +ABDOMEN 1 VIEW      JAN 23,1995  15:23  EMERGENCY ROOM
HELLER,RALPH        321-44-8277     ABDOMEN 1 VIEW      FEB 13,1995  12:41  1N
DUMOND,PAUL         194-56-3594     ABDOMEN 1 VIEW      FEB 22,1995  15:34  GENERAL MEDICINE

Total=8  Inpatient=1  Outpatient=7

+ counts as multiple exams
- counts as zero exams
```

Management Reports Menu

Special Reports

AMIS Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a report entitled Overall Workload Report, based on examinations performed within a specified date range. The report contains the AMIS category number and name, and counts are listed for inpatient, outpatient, total and % of total examination statistics, weighted work unit statistics and film usage.

A separate page prints for each division, with AMIS codes listed in numerical order. An all-division page will print if more than one division is included.

If you have access to more than one Radiology/Nuclear Medicine division, you will be prompted for one or more to include in the report. If you have access to only one division, the system will automatically select that division for you and you will not see a prompt. You will be prompted for a date range, and only data from examination dates within the range you specify will be included.

Exams must meet certain criteria to be included in the report:

The exam date/time must fall within the date range selected. The current status of the exam must be specified in the Examination Status parameters as a status to include in this report. (This is determined during system set-up when the ADPAC answers the AMIS Report question during Examination Status Entry/Edit.) The division on the exam record must be one of divisions you selected, or your default division if you did not see a division selection prompt.

The procedure on the exam record must have an AMIS code. If the procedure's CPT code is the same as that of another procedure on the same visit (i.e., same exam date/time), the exam is bypassed. If more than one procedure done during a visit does not have a CPT code, only the first procedure without a CPT will be counted and the rest without a CPT will be bypassed.

The exam counts are determined as follows:

If the Ward on the exam record contains a valid ward, the exam is counted as an inpatient exam. Otherwise, it is assumed to be outpatient. One count per exam is added to the division visits and totals visits.

The number of each film size used (including wasted film) is added to the appropriate total for division, inpatient or outpatient, film or cine total, and grand total. If the film is cine, the Cine Runs total is incremented by 1.

The “Patient Visits” total includes one count for each exam date/time. So, if multiple cases are registered under one date/time, the count will be one for that visit. “Average Exams Per Visit” shows average cases registered per each exam date/time.

For each exam, the inpatient and outpatient examination totals for the appropriate AMIS code(s) are incremented by the number in the AMIS Weight Multiplier field in the Procedure file (the weight multiplier in most cases is 1). For each exam, the inpatient and outpatient weighted work units are incremented by the product of the AMIS Weight Multiplier and the number in the Weight field of the Major Rad/Nuc Med AMIS Codes file. If the AMIS Weight Multiplier is 1, it will be doubled before these calculations are done if the exam is considered bilateral.

There are many cases where characteristics of the exam or procedure affect the exam counts. The program may turn on “flags” signaling that an exam is BILATERAL, PORTABLE or done in an OPERATING ROOM. The appropriate flag is turned on if any of the exam modifiers are of the bilateral, portable, or operating room modifier type. A flag will also be turned on if AMIS code 25 (Operating Room) or AMIS code 26 (Portable) has been assigned to the procedure, or if there is a YES in the Bilateral field of the procedure for the selected AMIS code. If the OPERATING ROOM flag is set, counts are added to AMIS Code 25 as well as to the AMIS code of the procedure. If the PORTABLE flag is set, counts are added to AMIS code 26 as well as to the AMIS code of the procedure. The counts added will be identical to those added to the procedure's AMIS code, described in the above paragraph.

A MYELOGRAM flag will be set if the procedure's AMIS code is 20. A COMPUTED TOMOGRAPHY-HEAD flag is set if the AMIS code is 21 and CT Head or Body field of the procedure is set to “head.” A COMPUTED TOMOGRAPHY-BODY flag is set if the AMIS code is 21 and the CT Head or Body field of the procedure is set to “body”. If a procedure has both AMIS codes 20 and 21 or more than one of each code, counts will only be applied once. However, if a computed tomography head and a computed tomography body are on the same procedure, counts will be added for each.

A SERIES flag is turned on if the procedure has been assigned more than one AMIS code. If the SERIES flag is on, counts are added to the Series of AMIS Codes total as well as to each AMIS code total. The counts added will be identical to those added to the procedure's AMIS code, described above.

The operating room, portable, and series totals appear at the end of the report.

Prompt/**User Response** Discussion

```
AMIS Report

NOTE: This output should be queued to a printer that supports 132 columns.

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

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

```
**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 21, 1994)

   Ending    DATE : T  (MAR 01, 1995)

             The entries printed for this report will be based only
              on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit: <RET>


ANGIO/NEURO/INTERVENTIONAL
          --------------------------
               EXAMINED
               COMPLETE

          CARDIOLOGY STUDIES (NUC MED)
          ----------------------------
               EXAMINED
               COMPLETE

          CT SCAN
          -------
               EXAMINED
               TRANSCRIBED
               COMPLETE

          GENERAL RADIOLOGY
          -----------------
               EXAMINED
               TRANSCRIBED
               COMPLETE

          MAGNETIC RESONANCE IMAGING
          --------------------------
               EXAMINED
               COMPLETE

          MAMMOGRAPHY
          -----------
               COMPLETE

          NUCLEAR MEDICINE
          ----------------
               CALLED FOR EXAM
               EXAMINED
               TRANSCRIBED
               COMPLETE

          ULTRASOUND
          ----------
               EXAMINED
               TRANSCRIBED
               COMPLETE

          VASCULAR LAB
          ------------
               CALLED FOR EXAM
               EXAMINED
```

```
                ALL DONE

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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

>>> Overall Workload Report <<< Page: 1

Division: HINES CIO FIELD OFFICE For period: NOV 21,1994 to
Run Date: MAR 1,1995 10:59 MAR 1,1995

	Amis Category	Weight	Examinations IN	OUT	TOTAL	%	Weighted Work Units IN	OUT	TOTAL	%
1	SKULL,INC.SINUS,MASTOID,JAW,ETC	3	11	33	44	18.3	33	99	132	11.5
2	CHEST-SINGLE VIEW	1	3	7	10	4.1	3	7	10	0.9
3	CHEST MULTIPLE VIEW	2	3	9	12	5.0	6	18	24	2.1
4	CARDIAC SERIES	3	0	0	0	0.0	0	0	0	0.0
5	ABDOMEN-KUB	2	1	7	8	3.3	2	14	16	1.4
6	OBSTRUCTIVE SERIES	3	0	1	1	0.4	0	3	3	0.3
7	SKELETAL-SPINE & SACROILIAC	3	2	10	12	5.0	6	30	36	3.1
8	SKELETAL-BONE & JOINTS	2	0	55	55	22.8	0	110	110	9.6
9	GASTROINTESTINAL	6	2	1	3	1.2	12	6	18	1.6
10	GENITOURINARY	6	0	0	0	0.0	0	0	0	0.0
11	CHOLECYSTOGRAM,ORAL	5	0	1	1	0.4	0	5	5	0.4
12	CHOLANGIOGRAM	10	0	5	5	2.1	0	50	50	4.4
13	LAMINOGRAM	5	0	0	0	0.0	0	0	0	0.0
14	BRONCHOGRAM	5	0	0	0	0.0	0	0	0	0.0
15	DIGITAL SUBTRACTION ANGIOGRAPHY	15	0	0	0	0.0	0	0	0	0.0
16	ANGIOGRAM,CATH- CEREBRAL	15	3	8	11	4.6	45	120	165	14.4
17	ANGIOGRAM,CATH- VISCERAL	20	0	6	6	2.5	0	120	120	10.5
18	ANGIOGRAM,CATH- PERIPHERAL	10	0	0	0	0.0	0	0	0	0.0
19	VENOGRAM	15	0	0	0	0.0	0	0	0	0.0
20	MYELOGRAM	10	0	0	0	0.0	0	0	0	0.0
21	COMPUTED TOMOGRAPHY	8	9	21	30	12.4	72	168	240	20.9
22	INTERVENTIONAL RADIOGRAPHY	20	0	0	0	0.0	0	0	0	0.0
23	ULTRASOUND,ECHOENCEPHALOGRAM	7	0	6	6	2.5	0	42	42	3.7
24	OTHER	5	8	27	35	14.5	40	135	175	15.2
27	NUCLEAR MEDICINE	1	0	2	2	0.8	0	2	2	0.2
99	UNKNOWN		0	0	0	0.0	0	0	0	0.0
	TOTALS		42	199	241		219	929	1148	
	AVERAGE WEIGHT PER EXAM						5.2	4.7	4.8	
25	EXAMS IN OPER.SUITE AT SURGERY	9	10	19	7.9		77	96	173	15.1
26	PORTABLE (BEDSIDE) EXAMINATIONS	2	5	7	2.9		11	79	90	7.8
	SERIES OF AMIS CODES	0	2	2	0.8		0	30	30	2.6

Statistic Item	Other Statistics IN	OUT	TOTAL
*CINE RUNS	0	0	0
*NO. OF CINE FEET USED	0	0	0
*NO. OF FILMS USED	168	308	476
PATIENT VISITS	27	103	130
AVERAGE EXAMS PER VISIT	1.6	1.9	1.9
AVERAGE WORK UNITS PER VISIT	8.1	9.0	8.8

* These data are not to be used for AMIS. Use your inventory data.

Management Reports Menu

Special Reports

Camera/Equip/Rm Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a workload report for cameras/equipment/rooms. The report contains the following information: procedure, number of examinations performed, percent of total exams performed, associated weighted work units, and percent of total weighted work units. The cameras, equipment and rooms in the report are stored in the Primary Camera/Equip/Rm field of the exam record.

This is one of a series of workload reports that have similar selection criteria, report output, data retrieval and reporting logic. See the section entitled **General Information about Workload Reports** at the end of the Management Reports Menu chapter for a full description of this report.

Prompt/**User Response** Discussion

```
Camera/Equip/Rm Report

 Camera/Equip/Room Workload Report:
----------------------------------

Do you wish only the summary report? NO// <RET>

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

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


Select Imaging Type: All// GENERAL RADIOLOGY

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


Do you wish to include all Camera/Equip/Rooms? Yes//
<RET>

**** Date Range Selection ****

   Beginning DATE : T-100  (APR 20, 1997)

   Ending    DATE : T  (JUL 29, 1997)


             The entries printed for this report will be based only
              on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit: <RET>

          GENERAL RADIOLOGY
```

```
          -----------------
               WAITING FOR EXAM
               EXAMINED
               TRANSCRIBED
               COMPLETE

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

Enter the name of a printer or "Q" to queue.

```
>>> Camera/Equip/Room Workload Report <<<                  Page: 1

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                    For period: APR 20,1997 to
    Run Date: JUL 29,1997  15:10                               JUL 29,1997

                                          Examinations    Percent     Percent
  Procedure (CPT)                       In    Out  Total   Exams  WWU   WWU
-------------------------------------------------------------------------------
         Camera/Equip/Room: CAMERA 1 - Triple Head SPECT S
ARTHROGRAM SHOULDER S&I      (73040)       0      1      1  100.0      5  100.0
-------------------------------------------------------------------------------

  Camera/Equip/Room Total                   0      1      1             5
Enter RETURN to continue or '^' to exit: <RET>
```

```
>>> Camera/Equip/Room Workload Report <<<                  Page: 4

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                    For period: APR 20,1997 to
    Run Date: JUL 29,1997  15:10                               JUL 29,1997

                                          Examinations    Percent     Percent
  Procedure (CPT)                       In    Out  Total   Exams  WWU   WWU
-------------------------------------------------------------------------------
         Camera/Equip/Room: PORTABLE - PORTABLE
CHEST 4 VIEWS                (71030)       0      2      2    5.1      4    2.3
ABDOMEN 1 VIEW               (74000)       0      9      9   23.1      9    5.1
ABDOMEN 2 VIEWS              (74010)       0      1      1    2.6      1    0.6
SPINE CERVICAL MIN 2 VIEWS   (72040)       0      1      1    2.6      3    1.7
ANKLE 2 VIEWS                (73600)       0      3      3    7.7      6    3.4
ANKLE 3 OR MORE VIEWS        (73610)       0      2      2    5.1      4    2.3
CLAVICLE                     (73000)       0      1      1    2.6      2    1.1
FOOT 2 VIEWS                 (73620)       0      4      4   10.3      8    4.6
FOREARM 2 VIEWS              (73090)       0      2      2    5.1      4    2.3
TOE(S) 2 OR MORE VIEWS       (73660)       0      2      2    5.1      4    2.3
CHOLANGIOGRAM IV             (74310)       0      1      1    2.6     10    5.7
Enter RETURN to continue or '^' to exit: <RET>
```

>>> Camera/Equip/Room Workload Report <<< Page: 9

Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY For period: APR 20,1997 to
Run Date: JUL 29,1997 15:10 JUL 29,1997

Camera/Equip/Room	Examinations In	Out	Total	Percent Exams	Percent WWU	WWU
(Imaging Type Summary)						
CAMERA 1 - Triple Head SPECT S	0	1	1	0.9	5	1.0
FRANK'S PLACE - YOU CHECK IN,	0	4	4	3.8	4	0.8
OUTP1 X-RAY - X-RAYS ONLY IN T	0	1	1	0.9	2	0.4
PORTABLE - PORTABLE	0	39	39	36.8	175	36.1
UNKNOWN	12	49	61	57.5	299	61.6
Imaging Type Total	12	94	106		485	

# of Camera/Equip/Rooms selected: ALL

Management Reports Menu

Special Reports

Cost Distribution Report

This option produces a report of exam workload by cost distribution center to assist the department in preparing their Cost Distribution Report (CDR).

This report is compiled from the examination data entered through the Exam Entry/Edit Menu. If the person generating the report has access to more than one radiology/nuclear medicine division, a prompt will be displayed asking for a selection of one or more divisions. If the person generating the report has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type. A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. A date range must also be selected.

If the exam date of a case is within the date range selected, the case may be included on the report as long as the exam was not cancelled, the division and category of exam data on the exam are not missing or invalid, and the cost center can be determined using the steps described below.

There are four category headings on the report: Inpatient, Outpatient and Research each have their own heading. Contract, Sharing and Employee are reported under "Other."

Inpatient Method of Determining Cost Center

If the category of exam is Inpatient, Research, Contract, or Sharing, the Ward field of the Rad/Nuc Med Patient file is used to find a Specialty (in the Ward Location file) for that ward. The name of that specialty is used as the cost center for the exam and its CDR account number (in the Specialty file) is used as the cost center number.

Outpatient Method of Determining Cost Center

If the category of exam is Outpatient or Employee, the Principal Clinic field of the Rad/Nuc Med Patient file is used to find the Stop Code for that location in the Hospital Location file. The Stop Code Name is used on the report as the Cost Center name. The stop code's Cost Distribution Center (in Clinic Stop file) appears on the report as the cost distribution center number.

If a cost center has not been determined at this point, the Requesting Location field of the Rad/Nuc Med Patient file is used to try to determine the cost center. The program determines if the requesting location is an Inpatient or Outpatient location by looking at its Type in the Hospital Location file (W for ward, C for clinic). If neither, the record is bypassed. If the requesting location is a ward, the Inpatient method is used to find the cost center. If the requesting location is a clinic, the Outpatient method is used.

If the cost center still has not been determined (i.e., all the above pathways failed due to one or more fields in the database not entered or invalid), the exam is bypassed.

Although the cost center names have already been calculated at this point, the program unconditionally resets the names of four cost centers:

Cost Center 1110 changes to "GENERAL MEDICINE"
Cost Center 1111 changes to "NEUROLOGY"
Cost Center 1210 changes to "GENERAL SURGERY"
Cost Center 1310 changes to "ACUTE AND LONG TERM PSYCHIATRY"

All other cost centers retain the name acquired during the previous steps.

If any AMIS code for the procedure has a YES in the Bilateral field of the AMIS subfile of the Procedure file #71, a MULTIPLIER flag is turned on.

One count is added to the appropriate exam category and cost center totals. If the MULTIPLIER flag is on, one additional count is added to the totals.

A summary prints at the end of each Imaging Type. A division summary prints if more than one imaging type for the division is included on the report. If only one imaging type is included for a division, no division summary is printed because the imaging type summary already includes all of the division summary totals.

Prompt/**User Response** Discussion

```
Cost Distribution Report

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

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

Select Imaging Type: All// GENERAL RADIOLOGY

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


**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 21, 1994)

   Ending    DATE : T  (MAR 01, 1995)


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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
                    >>>>> COST DISTRIBUTION REPORT <<<<<              Page: 1

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For Period: 11/21/94 to
    Run Date: MAR 01, 1995@11:00:33                             03/01/95

                                                                        % of
Procedure                                  Inpt   Opt   Res   Oth  Total  Exams
-------------------------------------------------------------------------------
          Cost Distribution Center: 1110.00  GENERAL MEDICINE

BONE AGE                                      3     0     0     0      3   27.3
CHEST 4 VIEWS                                 2     0     0     0      2   18.2
CT HEAD W/IV CONT                             2     0     0     0      2   18.2
SKULL 4 OR MORE VIEWS                         1     0     0     0      1    9.1
SPINE LUMBOSACRAL MIN 2 VIEWS                 2     0     0     0      2   18.2
STEREOTACTIC LOCALIZATION HEAD                1     0     0     0      1    9.1

                               Total         11     0     0     0     11  100.0
                             Percent      100.0   0.0   0.0   0.0
```

```
                    >>>>> COST DISTRIBUTION REPORT <<<<<              Page: 11

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For Period: 11/21/94 to
    Run Date: MAR 01, 1995@11:00:33                             03/01/95

                                                                        % of
Cost Distribution Center                   Inpt   Opt   Res   Oth  Total  Exams
-------------------------------------------------------------------------------
          (Imaging Type Summary)
  1110.00  GENERAL MEDICINE                   11     0     0     0     11    3.9
  1117.00  MEDICAL ICU/CCU                    38     0     0     0     38   13.5
  2110.00  GENERAL INTERNAL MEDICINE           0    23     0     0     23    8.2
  2210.00  ENT                                0     6     0     0      6    2.1
  2612.00  X-RAY                              0   204     0     0    204   72.3

                               Total         49   233     0     0    282  100.0
                             Percent       17.4  82.6   0.0   0.0
```

Management Reports Menu

Special Reports

Detailed Procedure Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a report entitled Detailed Procedure Workload Report. The report consists of the following information for each AMIS category: procedure, number of inpatient and outpatient examinations, total number of examinations, percent of exams, weighted work units, and percent of weighted work units.

This report is compiled from the examination data entered through the Exam Entry/Edit Menu. If the person generating the report has access to more than one radiology/nuclear medicine division, a prompt will be displayed asking for a selection of one or more divisions. If the person generating the report has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type. A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. A date range must also be selected.

Since the output can be lengthy, you may wish to run this report during off hours.

If the exam date of a case is within the date range selected, the case will be included on the report as long as the procedure has been assigned an AMIS code, and the exam's division and imaging type are among those selected. The current status of the exam must be specified in the Examination Status parameters as a status to include on this report. (This is determined during system set-up when the ADPAC answers the Detailed Procedure Report question during Examination Status Entry/Edit.)

Examination counts:

If the Ward field of the exam record contains a valid ward, the exam is counted under the Inpatient heading. In all other cases it is counted under the Outpatient heading.

For each exam, the inpatient and outpatient examination totals for the appropriate AMIS code(s) are incremented by the number in the AMIS Weight Multiplier field in the Procedure file (the weight multiplier in most cases is 1). For each exam, weighted work units are the product of the AMIS Weight Multiplier and the number in the Weight field of the Major Rad/Nuc Med AMIS Codes file. If the AMIS Weight Multiplier is 1, it will be doubled before these calculations are done if the exam is considered bilateral.

There are many cases where characteristics of the exam or procedure affect the exam counts. The program may turn on flags signaling that an exam is BILATERAL, PORTABLE or done in an OPERATING ROOM. The appropriate flag is turned on if any of the exam modifiers are of the

bilateral, portable, or operating room modifier type. A flag will also be turned on if AMIS code 25 (Operating Room) or AMIS code 26 (Portable) has been assigned to the procedure, or if there is a YES in the Bilateral field of the procedure for the selected AMIS code. If the OPERATING ROOM flag is set, counts are added to AMIS Code 25 as well as to the AMIS code of the procedure. If the PORTABLE flag is set, counts are added to AMIS code 26 as well as to the AMIS code of the procedure. The counts added will be identical to those added to the procedure's AMIS code, described in the above paragraph.

A SERIES flag is turned on if the procedure has been assigned more than one AMIS code. If the SERIES flag is on, counts are added to the Series of AMIS Codes total as well as to each AMIS code total. The counts added will be identical to those added to the procedure's AMIS code, described above.

The operating room, portable, and series totals appear at the end of the report in the division summary.

Prompt/**User Response** Discussion

```
Detailed Procedure Report


Select Rad/Nuc Med Division: All// HINES INFORMATION
SYSTEMS CTR      ILLINOIS  ISC  499

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

Select one IMAGING TYPE: GENERAL RADIOLOGY
```

This prompt differs from the Imaging Type selection prompt in other options. Note that only **one** Imaging Type can be selected.

```
**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 21, 1994)

   Ending    DATE : T  (MAR 01, 1995)

             The entries printed for this report will be based only
              on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit:

          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

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

Enter the name of a printer, or "Q" to see prompts for a device and a time to print.

```
         >>>>> Detailed Procedure Workload Report <<<<<                    Page:
1

     Division: HINES INFORMATION SYSTEMS CTR
 Imaging Type: GENERAL RADIOLOGY                  For period: NOV 21,1994 to
     Run Date: MAR  1,1995  11:01                             MAR  1,1995

                                      Examinations    Percent       Percent
  Procedure                         In    Out  Total   Exams   WWU    WWU
-------------------------------------------------------------------------------
     Amis: 1   SKULL,INC.SINUS,MASTOID,JAW,ETC
  BONE SURV COMP (INCL APPENDIC      0      1      1    1.9      3    1.9
  NECK SOFT TISSUE                   4     24     28   51.9     84   51.9
  SKULL 4 OR MORE VIEWS              7     18     25   46.3     75   46.3

  AMIS CATEGORY TOTALS              11     43     54           162
```

>>>>> Detailed Procedure Workload Report <<<<< Page: 18

Division: HINES INFORMATION SYSTEMS CTR
Imaging Type: GENERAL RADIOLOGY For period: NOV 21,1994 to MAR 1,1995
Run Date: MAR 1,1995 11:01

Amis Category	Examinations In	Out	Total	Percent Exams	WWU	Percent WWU
(Division Summary)						
1-SKULL,INC.SINUS,MASTOID,JAW,ET	11	43	54	22.2	162	14.6
2-CHEST-SINGLE VIEW	3	7	10	4.1	10	0.9
3-CHEST MULTIPLE VIEW	3	9	12	4.9	24	2.2
5-ABDOMEN-KUB	1	7	8	3.3	16	1.4
6-OBSTRUCTIVE SERIES	0	1	1	0.4	3	0.3
7-SKELETAL-SPINE & SACROILIAC	2	10	12	4.9	36	3.2
8-SKELETAL-BONE & JOINTS	0	55	55	22.6	110	9.9
9-GASTROINTESTINAL	2	1	3	1.2	12	1.1
11-CHOLECYSTOGRAM,ORAL	0	1	1	0.4	5	0.5
12-CHOLANGIOGRAM	0	5	5	2.1	50	4.5
16-ANGIOGRAM,CATH- CEREBRAL	2	9	11	4.5	150	13.5
17-ANGIOGRAM,CATH- VISCERAL	0	6	6	2.5	120	10.8
21-COMPUTED TOMOGRAPHY	9	21	30	12.3	240	21.7
24-OTHER	8	27	35	14.4	170	15.3
DIVISION TOTALS	41	1922	233		1083	
25-EXAMS IN OPER.SUITE AT SURGERY	14	13	27	11.1	173	15.6
26-PORTABLE (BEDSIDE) EXAMINATION	3	15	18	7.4	96	8.7
-SERIES OF AMIS CODES	0	2	2		30	2.7

Management Reports Menu

Special Reports

Film Usage Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a record of film usage according to film size. The report shows procedure, number of films used, number of exams, average number of films used per exam and percentage of films used for a given procedure. This listing may be generated as a detailed or summary report. The film sizes in the report are stored in the Film Size and Amount subfields of the exam record.

The person generating the report will be asked if s/he wants to print a summary only. A summary report groups all examinations together by film size for each imaging type and division. A detailed report gives information for each individual procedure performed within the film size.

This report is compiled from the film size data entered through the Exam Entry/Edit Menu. If the person generating the report has access to more than one radiology/nuclear medicine division a prompt will be displayed asking for a selection of one or more divisions. If the person generating the report has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type. A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. A beginning and ending exam date range must be selected. If only one or a few film sizes are desired on the report, the "Do you wish to include all films?" prompt may be answered NO to get a Select film: prompt.

Before the report prints, a list of exam statuses to be included in the report will be displayed. The exam statuses may be different for each imaging type selected. This is determined during system set-up when the ADPAC answers the Film Usage Report question during Examination Status Entry/Edit. See the ADPAC Guide for more information on exam status parameter set-up.

Since the output can be lengthy, you may wish to run this report during off hours.

If the exam date of a case is within the date range selected, the case will be included in the report as long as the exam's division and imaging type are among those selected. The current status of the exam must be specified in the Examination Status parameters as a status to include in this report. If, during exam edit/entry, a film size was entered for an exam but no amount was entered, nothing will be added to the totals.

The exam counts are doubled if the exam is considered bilateral. An exam is bilateral if any exam modifiers are of the bilateral modifier type, or if the Bilateral field of the procedure's AMIS subrecord is set to Yes. If the AMIS Weight Multiplier field of the procedure's AMIS subrecord is set to a number greater than 1, this number will be used, and the bilateral modifiers will have no effect. An exam with more than one AMIS code will only be counted as one exam regardless of whether it is bilateral.

Film counts are not affected by multipliers or bilateral modifiers. Film counts are determined by the numbers entered during exam editing. Wasted film types are bypassed. If the film is a cine type, its statistics are included under the Cine film size page which reports number of cine feet. Cine is included in a line on the summary page, but not in the totals. Only AMIS codes 1-24, and 27 are used in summing totals for each procedure.

The report in sort order of the report is: division number, imaging type, film size, AMIS category, and procedure.

There is a notation at the end of the summary page that serves as a reminder of the number of film sizes selected to include on the report.

Prompt/**User Response** Discussion

```
Film Usage Report


Film Usage Report
-----------------

Do you wish only the summary report? NO// <RET>

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

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

Select Imaging Type: All// GENERAL RADIOLOGY

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


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

**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 21, 1994)

   Ending    DATE : T  (MAR 01, 1995)

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

          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               TRANSCRIBED
               COMPLETE
```

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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
        >>>>> Film Usage Report <<<<<                              Page: 1

    Division: HINES CIO FIELD OFICE
Imaging Type: GENERAL RADIOLOGY                    For period: NOV 21,1994 to
    Run Date: MAR  1,1995  11:02                                  MAR  1,1995

                                        Number    Number    Films     Percentage
                                          of        of        per      Films
  Procedure(CPT)                        Films     Exams     Exam      Used
-------------------------------------------------------------------------------
          Film Size: 10X12
SKULL 4 OR MORE VIEWS(70260)              10         2       5.0       6.7
CHEST STEREO PA(71015)                    24         5       4.8      16.0
CHEST 4 VIEWS(71030)                       8         2       4.0       5.3
ABDOMEN 1 VIEW(74000)                     10         3       3.3       6.7
SPINE LUMBOSACRAL MIN 2 VIEWS(72100)       2         1       2.0       1.3
ANKLE 2 VIEWS(73600)                      18         9       2.0      12.0
FOREARM 2 VIEWS(73090)                     2         1       2.0       1.3
UPPER GI + SMALL BOWEL(74245)             10         2       5.0       6.7

 Film Usage Total                         84        25       3.4
```

>>>>> Film Usage Report <<<<< Page: 19

Division: HINES CIO FIELD OFICE
Imaging Type: GENERAL RADIOLOGY For period: NOV 21,1994 to
Run Date: MAR 1,1995 11:02 MAR 1,1995

Film Size	Number of Films*	Number of Exams	Films per Exam	Percentage Films Used
(Imaging Type Summary)				
10X10	1	1	1.0	0.3
10X12	150	33	4.5	40.3
11X14	11	5	2.2	3.0
14X14	13	3	4.3	3.5
14X17	88	23	3.8	23.7
14X38	29	2	14.5	7.8
4X6	2	2	1.0	0.5
6X4	7	1	7.0	1.9
6X8	6	2	3.0	1.6
8X8	9	2	4.5	2.4
9X9	7	2	3.5	1.9
DENTAL	22	9	2.4	5.9
FLUORO ONLY	8	1	8.0	2.2
PANOREX	6	2	3.0	1.6
POLAROID	10	1	10.0	2.7
SUBTRACTION FILM	3	1	3.0	0.8
Imaging Type Total	372	90	4.1	

* Cine data not included in imaging type totals.
Percentages calculated on film data only.

# of Films selected: ALL

Management Reports Menu

Special Reports

Procedure/CPT Statistics Report

This report will generate statistics on the number of each procedure performed for a specified date range. The numbers are not affected by modifiers or AMIS weights. This report includes cost figures based on procedure costs entered by the Rad/Nuc Med ADPAC.

If the person generating the report has access to more than one radiology/nuclear medicine division a prompt will be displayed asking for a selection of one or more divisions. If the person generating the report has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type. A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. One, many, or all procedures may be selected for inclusion on the report. A beginning and ending exam date range must be selected. Selection criteria include a choice of Inpatient, Outpatient or Both. If Both is selected, separate pages will still print for Inpatient and Outpatient, with Inpatient pages printing first.

To be included in the report, an exam must have an exam date that falls within the selected date range, the exam's Division field must contain one of the divisions selected, and the exam's Imaging Type field must contain one of the imaging types selected. If the Ward field of the exam record contains a valid ward in the Ward Location file, the exam is assumed to be an Inpatient exam. If there is no CPT assigned to the procedure, the exam is bypassed. If the exam passes all these criteria, a count of one (1) is added to the procedure total. Cancelled exams may or may not be included depending on the user’s selection criteria.

The sort order of this report is: division number, imaging type, CPT code.

The report has no division summary page. There is a page (or section) for each Imaging type within division for each patient category (inpatient or outpatient).

Prompt/**User Response** Discussion

```
Procedure/CPT Statistics Report

[1]Do you want to count CPT Modifiers separately? NO//
<RET>

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

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

Select Imaging Type: All// GENERAL RADIOLOGY

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


Do you wish to include cancelled cases? Yes//  <RET>
YES

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

**** Date Range Selection ****

   Beginning DATE : T-100  (APR 22, 1997)

   Ending    DATE : T  (JUL 31, 1997)

     Select one of the following:

          I         INPATIENT
          O         OUTPATIENT
          B         BOTH

Report to include: BOTH// <RET>

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

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

[1] Patch RA*5*26 Allows printing of different combinations of CPT modifiers on separate lines.

>>>>> PROCEDURE/CPT STATISTICS REPORT (INPATIENT) <<<<< Page: 1

Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY For period: 04/22/97 to
Run Date: JUL 31,1997 15:12 07/31/97
# of Procedures selected: All Cancelled Exams: included

CPT	PROCEDURE	# DONE	(%)	$UNIT	$TOTAL	(%)
71015	CHEST STEREO PA	2	20	10.00	20.00	6
71022	CHEST OBLIQUE PROJECTIONS	1	10	20.00	20.00	6
74000	ABDOMEN 1 VIEW	3	30	10.00	30.00	9
74249	UPPER GI AIR CONT W/SMALL BOWEL	1	10	40.00	40.00	12
75660	ANGIO CAROTID CEREBRAL SELECT EXT UNIL	2	20	90.00	180.00	52
76091	MAMMOGRAM BILAT	1	10	50.00	50.00	15
	Total for this imaging type -->	10			340.00	

Management Reports Menu

Special Reports

Status Time Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a Status Tracking Statistics Report. [1]The report may be filtered by Division, Requesting Location, Imaging Type, and Procedure. For each status change, the report lists the original status, the updated status, minimum time to make the status change, maximum time to make the status change, and the average time to make the status change for an associated procedure. This report would be used to track the progress of examinations from status to status, to determine where delays in processing occur and to see that exams are moved through the system in a timely fashion.

A beginning and ending exam date range must be selected. This report should be queued to a device.

The times in this output are rounded off; that is, seconds are dropped and only whole minutes are used.

Prompt/**User Response**	Discussion
`Status Time Report`	
`Select Rad/Nuc Med Division: All// **HI**NES CIO FIELD OFFICE IL CIOFO 499`	
`Another one (Select/De-Select): **<RET>**`	
`Select all requesting locations? Y/N: **N**`	[2] Enter YES to obtain a report for all requesting locations. Enter NO to select one or more requesting location(s). In this example, the report is for a single location (X-Ray Clinic).
`Select requesting location: **X-RAY CLINIC**`	
`Another one (Select/De-Select): **<RET>**`	
`Select IMAGING TYPE: **GEN**ERAL RADIOLOGY`	You may only select one Imaging Type.

[1] Patch RA*5*20 May 2000 Enhancements to Status Time Report.
[2] Patch RA*5*20 May 2000 Enhancements to Status Time Report.

```
[1]Select all procedures? Y/N: Y

**** Date Range Selection ****

   Beginning DATE : 4/1/2000  (APR 01, 2000)

   Ending    DATE : 4/30/2000  (APR 30, 2000)
[2]Do you wish to print detailed reports? No// <ret>

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

Enter YES to obtain a report for all procedures. Enter NO to select one.

Enter the date range for the report.

Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

[3]The **Procedure Detail by Requesting Location** report reflects statistics sorted by **requesting location**, **status changes,** and **procedures.** If the user chooses only one specific procedure, the report includes only that procedure. If the user chooses only one specific requesting location, the report includes only data for that location.

```
                  ** Status Tracking Statistics Report **           Page:  11
                     Procedure Detail by Requesting Location
                (Only requesting locations with data are included)

  Run Date: 05/03/00                        For Period: 04/01/00 - 04/30/00
  Division: HINES CIO FIELD OFFICE          Imaging Type: GENERAL RADIOLOGY
  Requesting Location: X-RAY CLINIC

          From: WAITING FOR EXAM
          To  : COMPLETE
                                  Minimum     Maximum     Average
                                    Time        Time        Time     Number of
    Procedure (CPT)             (DD:HH:MM)  (DD:HH:MM)  (DD:HH:MM)  Procedures
    ---------------
                                ----------  ----------  ----------  ----------

KNEE 3 VIEWS(73562)              00:00:02    00:00:02    00:00:02          1
ANKLE 2 VIEWS(73600)             00:01:10    00:01:10    00:01:10          1
FOOT 2 VIEWS(73620)              00:00:58    15:01:38    07:13:18          2
                                ----------  ----------  ----------  ----------
    Overall:                     00:00:02    15:01:38    03:18:57          4
```

[1] Patch RA*5*20 May 2000 Enhancements to Status Time Report.
[2] Patch RA*5*24
[3] Patch RA*5*20 May 2000 Enhancements to Status Time Report.

The **Division Summary Requesting Location Details** report reflects summary statistics sorted by **requesting location** and **status changes. Total number of completed exams** that match the criteria specified by the user is displayed at the end of the report.

```
                  ** Status Tracking Statistics Report **            Page:  26
                     Division Summary Requesting Location Details
                  (Only requesting locations with data are included)

  Run Date: 05/03/00                       For Period: 04/01/00 - 04/30/00
  Division: HINES CIO FIELD OFFICE         Imaging Type: GENERAL RADIOLOGY
  Requesting Location: X-RAY CLINIC
                                  Minimum     Maximum     Average
                                   Time        Time        Time      Number of
                                (DD:HH:MM)  (DD:HH:MM)  (DD:HH:MM)  Procedures
                                ----------  ----------  ----------  ----------

    From: WAITING FOR EXAM
    To  : COMPLETE               00:00:02    15:01:38    03:18:57          4

    From: WAITING FOR EXAM
    To  : EXAMINED               01:00:05    01:00:05    01:00:05          1
. . . skipped

    From: CALLED FOR EXAM
    To  : EXAMINED               00:00:16    00:00:16    00:00:16          1

                                ----------  ----------  ----------  ----------
    From: WAITING FOR EXAM
    To  : COMPLETE               00:00:00    15:01:38    02:19:27

    Total number of exams moved to a status of COMPLETE
    for period  04/01/00 - 04/30/00:                                        8
```

The **Division Summary Procedure Detail** report reflects statistics sorted by **status changes** and **procedures.** If the user chooses only one specific procedure, the report includes only that procedure and the caption reflects the name of the procedure in the **Procedure** field. If the user chooses only one requesting location, the report includes only data for that location and the caption reflects the name of the location in the **Requesting Location** field.

```
                  ** Status Tracking Statistics Report **            Page:  31
                       Division Summary Procedure Detail

  Run Date: 05/03/00                       For Period: 04/01/00 - 04/30/00
  Division: HINES CIO FIELD OFFICE         Imaging Type: GENERAL RADIOLOGY
  Requesting Location:ALL                  Procedure:ALL

          From: WAITING FOR EXAM
          To  : EXAMINED

                                  Minimum     Maximum     Average
                                   Time        Time        Time      Number of
    Procedure (CPT)             (DD:HH:MM)  (DD:HH:MM)  (DD:HH:MM)  Procedures
    ---------------             ----------  ----------  ----------  ----------

KNEE 2 VIEWS(73560)              01:00:05    01:00:05    01:00:05          1
ABDOMEN FOR FETAL AGE 1 V(74720)00:00:03    00:00:03    00:00:03          1
                                ----------  ----------  ----------  ----------
    Overall:                     00:00:03    01:00:05    00:12:04          2
```

The **Division Summary Overall** report reflects summary statistics sorted by **status changes.** **Total number of completed exams** that match the criteria specified by the user is displayed at the end of the report.

```
                  ** Status Tracking Statistics Report **            Page:  38
                           Division Summary Overall

  Run Date: 05/03/00                        For Period: 04/01/00 - 04/30/00
  Division: HINES CIO FIELD OFFICE          Imaging Type: GENERAL RADIOLOGY
  Requesting Location:ALL                   Procedure:ALL

                                  Minimum      Maximum      Average
                                    Time         Time         Time      Number of
                                (DD:HH:MM)   (DD:HH:MM)   (DD:HH:MM)  Procedures
                                ----------   ----------   ----------  ----------

    From: WAITING FOR EXAM
    To  : COMPLETE                00:00:02     15:01:38     05:11:26          10

    From: WAITING FOR EXAM
    To  : EXAMINED                00:00:03     01:00:05     00:12:04           2

. . . skipped

    From: COMPLETE
    To  : TRANSCRIBED             05:19:44     05:19:44     05:19:44           1

    From: CALLED FOR EXAM
    To  : EXAMINED                00:00:16     00:00:16     00:00:16           1

                                ----------   ----------   ----------  ----------
    From: WAITING FOR EXAM
    To  : COMPLETE                00:00:02     15:01:38     05:06:35

    Total number of exams moved to a status of COMPLETE
    for period  04/01/00 - 04/30/00:                                          17
```

Note: As shown in the example above, exam statuses can move backwards. This happens if data is deleted, or if a report is unverified.

Management Reports Menu

Special Reports

Wasted Film Report

This option allows the user to generate a record of wasted film according to size, imaging type and division. This report calculates the number of all films used, the number of films wasted, and the percentage wasted.

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

Before the report prints, a list of exam statuses to be included on the report will be displayed. The exam statuses may be different for each imaging type selected. This is determined during system set-up when the ADPAC answers the Film Usage Report question during Examination Status Entry/Edit. See the ADPAC Guide for more information on exam status parameter set-up.

Since the output can be lengthy, you may wish to run this report during off hours.

If the exam date of a case is within the date range selected, the case may be included on the report as long as the exam's division and imaging type are among those selected. The current status of the exam must be specified in the Examination Status parameters as a status to include on this report. If, during exam edit/entry, a wasted film size was entered for an exam but no amount was entered, nothing will be added to the totals.

Each film size entered on the exam record is checked. If the film size has been deleted from the Film Size file the exam is bypassed. If the film size is a wasted type, the number used is added to the total for that wasted film size. The used films are also tracked so that a percentage wasted can be calculated. The units of wasted film are separate and not included in the units of used film. The calculation for percentage wasted is: number wasted/(number used + number wasted) x 100.

In order for this report to be valid, each film size must have a wasted film entry set up in the Film Sizes file that points to the analogous unwasted film size. Refer to the ADPAC Guide for more information about setting up Film Sizes correctly so that this report is valid.

Prompt/**User Response** Discussion

```
Wasted Film Report

                          Radiology/Nuclear Med
                       *** Wasted Film Report ***
                       --------------------------

Do you wish to generate a summary report only? No// <RET>


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

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


Select Imaging Type: All// GENERAL RADIOLOGY

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


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

          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               TRANSCRIBED
               COMPLETE

Enter the start date for the search: Mar 01, 1995// T-100  (NOV 21, 1994)

Enter the ending date for the search: NOV 21,1994// T  (MAR 01, 1995)

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

```
                        >>>>> Wasted Film Report <<<<<             Page: 1

     Division: HINES CIO FIELD OFICE              For Period: NOV 22,1994 to
     Imaging Type: GENERAL RADIOLOGY                          MAR 2,1995.
     Run Date: Mar 02, 1995@13:32:31

                                  Units     Units          Percentage
                                  Of Used   Of Wasted      Of Wasted
Film Size                         Films     Films          Film
-------------------------------------------------------------------------------
W-10X12                           150       9                5.7

     Subtotals:                   150       9                5.7
-------------------------------------------------------------------------------

     * Cine data not included in totals.
```

General Information About Workload Reports

For most workload reports that are sortable/selectable for one-many-all division(s) and imaging type(s), the division totals page will only print if there is more than one imaging type in the division. If there is only one imaging type in the division, the imaging type total page should be used for the division total.

The following reports calculate workload counts (i.e., exam counts, patient visit counts, and weighted work units) in a similar way:

Functional Area Workload Reports...
- Clinic Report
- PTF Bedsection Report
- Service Report
- Sharing Agreement/Contract Report
- Ward Report

Personnel Workload Reports...
- Physician Report
- Resident Report
- Staff Report
- Technologist Report
- Transcription Report

Special Reports...
- Camera/Equip/Rm Report

Selection Criteria

Before the report is printed, you will be asked to specify the following selection criteria:

1) You may choose to print the summary report only. The summary consists of a page for each imaging type selected within each division selected, and a division summary.
2) If you have access to more than one division (determined by the ADPAC who uses Personnel Classification to enter the imaging locations to which you have access) you will see a prompt to select Rad/Nuc Med Divisions. The default is All, which prints all divisions to which you have access. If you do not see this prompt, it means that you only have access to one division, and the report will default to that division. After selecting a division, you will be prompted for another division at the Another one (Select/De-Select) prompt. At this prompt you may also de-select a previously chosen division by entering its name preceded by a minus sign (i.e., -Western Division).
3) If you have access to more than one imaging type (determined by the ADPAC who uses Personnel Classification to enter the imaging locations to which you have access) you will see a prompt to select Imaging Type. The default is All, which prints all imaging types to which you have access. If you do not see this prompt, it means that you only have access to one imaging type, and the report will default to that imaging type. After selecting an imaging type, you will be prompted for another imaging type at the Another one (Select/De-Select) prompt. At this prompt you may also de-select a previously chosen imaging type by entering its name preceded by a minus sign (i.e., -Ultrasound).

4) The next prompt will ask if you wish to include all of the residents, wards, transcriptionists, etc. For example, if you are running the clinic report and want to include only one or a few selected clinics, you can answer no to this prompt and you will be asked which individual clinic(s) to include.
5) Beginning and ending date range prompts appear next. The date range applies to the exam date. The reports will retrieve data for exams having a date within the range you select.

After the selection prompts are answered, a list of exam statuses will be displayed to let you know which statuses are included in the report. The statuses included are pre-determined by the ADPAC who answers a question for each report for each status within each imaging type to specify whether exams of that status should be included in the report. Refer to the ADPAC Guide, Examination Status Entry/Edit section for more information on exam status parameter set-up.

Data retrieval criteria:

An exam will be included in the report if it meets the following criteria:

1) The exam date must fall within the date range selected.
2) The status of the exam at the time the report is run must be marked to be included in the report. This is done during system set-up by the ADPAC when the Examination Status questions are answered. There is a question for each report above except the Transcription report which is not affected by exam status. For more information about status set-up, refer to the ADPAC Manual.
3) The exam's division must be one of the divisions selected or the default division of the person generating the report if no division selection prompt appeared.
4) The imaging type of the exam status must be one of the imaging types selected or the default imaging type of the person generating the report if no imaging type selection prompt appeared.
5) The procedure on the exam record must be valid. The only way this requirement would not be met is if there is a data corruption problem, or broken pointer, which theoretically should not happen. If it does, it means someone completely deleted a procedure from the Rad/Nuc Med Procedure file.
6) There must be an AMIS code associated with the procedure (AMIS codes are usually entered by the ADPAC using the Procedure Enter/Edit option; refer to the ADPAC Guide for more information about the Procedure Enter/Edit option).
7) If the exam's category is Sharing/Contract and the Sharing/Contract source of the exam is invalid, the exam will not be included. This would not happen unless an entry in the Contract/Sharing Agreements file (#34) has been inadvertently deleted.

Reporting Logic:

The program uses the Category of Exam field of the exam record to determine whether to count the exam under Inpatient, Outpatient, Research, or Other. The Personnel reports only print Inpatient and Outpatient. If there is a valid ward in the Ward field of the exam, it will be counted

under Inpatient. All other cases will be counted under Outpatient regardless of the contents of the Category of Exam field.

The functional area reports print Inpatient, Outpatient, Research, and All Other, based on whether the Category of Exam field contains Inpatient, Outpatient, Research or some other value. The report headings are abbreviated to In, Out, Res, and Other.

The Functional Area reports, the Camera/Equip/Rm Report, and the Technologist Workload Report show weighted work units (WWU). WWUs do not apply to the other Personnel reports. The AMIS Weight Multiplier Field of the Rad/Nuc Med Procedures file contains a number (0-99) to indicate to the various workload report programs how many times to multiply the weighted work units associated with the AMIS code. The Weight for each AMIS code is stored in the Weight field of the Major Rad/Nuc Med AMIS Code file.

Most multipliers will be 1. However, there are some that are greater than 1. For example, a procedure called Upper GI and Small Bowel might have AMIS code 9-Gastrointestinal which has a Weight of 6, and an AMIS Weight Multiplier of 2. Therefore, on the workload reports, the site will get credit for 12 WWUs each time it is performed. If there are multiple AMIS codes for the procedure, each AMIS Weight Multiplier is multiplied by the AMIS Weight, then the results are summed.

Depicted below is a sample of the exam/procedure/AMIS file relationship. Using this sample, the WWUs for the exam would be 12, and the exam would count as 2 exams.

Rad/Nuc Med Exam data stored in Rad/Nuc Med Patient file (#70)	Procedure stored in Rad/Nuc Med Procedure file (#71)	AMIS Categories stored in the Major Rad/Nuc Med AMIS Code Code file (#71.1)
Patient: Joe Veteran	Procedure:	Code: 9
Procedure: ---------->Upper GI		Weight: 6
Modifiers: (none)	AMIS code data:	Description:
	AMIS Code: ---------->Gastrointestinal	
	AMIS Weight Multiplier: 2	
	Bilateral: (n/a)	
	CT Head or Body: (n/a)	

In the above example, the calculation for WWUs would be: 6 x 2 = 12 because
Weight x AMIS Weight Multiplier = WWU

The bilateral modifier has special meaning and can cause increased counts. If the AMIS Weight Multiplier is one (1), "bilateral" affects the WWUs by multiplying the AMIS Weight Multiplier by 2 if and only if the AMIS weight multiplier is 1. The result is multiplied by the AMIS code's Weight. In the sample above, if the procedure had been bilateral WWUs would NOT have been affected because the AMIS Weight Multiplier is greater than 1. The exam counts are printed under the In, Out, Res and Other headings on the report. WWUs are printed under the WWU heading.

If more than one AMIS code exists for the procedure, the appropriate exam category count is incremented by one. If only one AMIS code exists for the procedure, the count is incremented by the AMIS Weight Multiplier.

Cases with more than one technologist, resident, or staff will be incremented accordingly, with a message warning that the total number of exams and weighted work units will be higher in these personnel reports than in the other workload reports.

Report Output:

The report is sorted first by division number, then alphabetically by imaging type, then alphabetically by topic (clinic, ward, resident, etc.). If there are exams that fit the selection criteria, but the topic sort field is missing, they will be printed under Unknown on the report for that topic. For example, if no residents were entered on the exam, but the exam fits the selection criteria, it will be included under Unknown on the Resident Workload Report.

The report headings show the date range selected, run date, division, imaging type, report title and page numbers.

If the full report was selected, one page prints for each topic within imaging type. However, for example, if there were no exams for any clinics within a selected imaging type, only an imaging type summary sheet would print showing totals of zero. A division summary prints for each division selected. The detailed pages print one line for every procedure. The imaging type and division summaries print one line for each topic. Division summaries print a list of imaging types at the bottom of the page. Division summaries also state at the bottom of the page the number of topics selected, to remind you that you may have selected only certain residents, staff, clinics, wards, etc., or that you selected all. If only one imaging type within a division was selected, only the imaging type summary will print for that division (this is because the division summary would be identical to the imaging type summary in this case, so you can use the imaging type summary as the division summary).

If the summary only was selected, a page prints for each imaging type selected within each division selected, as well as a division summary. Summary pages for all workload reports show the selected divisions and imaging types in the body of the report rather than in the headings. (This was done because in some cases the list of divisions and imaging types can be lengthy and would not fit into the limited space of a page heading.)

The Transcriptionist Report is an exception. It prints one line per transcriptionist, one page per division, showing a total number of lines and reports transcribed. The notation showing whether you selected only certain transcriptionists or all transcriptionists appears in the report heading.

VIII. Outside Films Registry Menu

This function provides the user with many functions that relate to the registration and return of films from other hospitals and institutions to/from the department.

Add Films to Registry
Delinquent Outside Film Report for Outpatients
Edit Registry
Flag Film To Need 'OK' Before Return
Outside Films Profile

NOTE: The functionality within this sub-menu is also provided by the Record Tracking package. Sites should migrate away from this sub-menu if they are still using it, and use the Record Tracking package instead. At some future date, this sub-menu will no longer be available within the Radiology/Nuclear Medicine package.

Outside Films Registry Menu

Add Films to Registry

This function allows the user to add new films to the existing outside films registry. This registry tracks films received from outside sources (e.g., private or other VA hospitals).

If the patient selected is not in the Rad/Nuc Med Patient file, s/he can be added through this option.

A single patient may have more than one outside film registered at the same time. Through this option, you can add a new entry to those already in the registry. The Edit Registry option should be used to make changes in existing entries.

The registry includes registration date, date to be returned to the source, the source of the films and remarks.

Prompt/**User Response** Discussion

```
Add Films to Registry

Select Patient: POTTS,BERTRAM              10-27-45     894416023   NO   NSC VETERAN
         ...OK? Yes// <RET>  (Yes)

   Patient is currently an inpatient.
Select OUTSIDE FILMS REGISTER DATE: JUN 15,1994// TODAY   MAR 31, 1995
   Are you adding 'MAR 31, 1995' as a new OUTSIDE FILMS REGISTER DATE (the 3RD for
this RAD/NUC MED PATIENT)? Y  (Yes)
   OUTSIDE FILMS REGISTER DATE REMARKS: CHEST - 2 VIEWS
  NEEDED BACK DATE: APRIL 30, 1995  (APR 30, 1995)
  SOURCE OF FILMS: COUNTY HOSPITAL
  REMARKS: CHEST - 2 VIEWS// <RET>
```

Outside Films Registry Menu

Delinquent Outside Film Report for Outpatients

This function allows the user to obtain a report of all the patients who have outside films registered that have a Needed Back date less than the date the user specifies. The outside films' needed back dates must have first been entered through the Add Films to Registry or the Edit Registry options.

This function assists the file room with the return of outside films to other hospitals and institutions.

Outside films for inpatients are not shown on this report because it is assumed that the department would not want to send back films for patients still receiving care at the facility. The report is in chronological order and includes patient name, SSN, needed back date, whether a supervisor's OK is needed before these films can be returned to the source, the source from which the films were borrowed, and remarks.

Prompt/**User Response**	Discussion
`Delinquent Outside Film Report for Outpatients`	
`All Films with 'Needed Back' Dates Less Than: **T** (FEB 27, 1995)`	
`DEVICE: (Printer Name or "Q")`	Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
IMAGING SERVICE DELINQUENT OUTSIDE FILM REPORT FOR OUTPATIENTS
                                              FEB 27,1995  09:05    PAGE 1
PATIENT                                    PT ID            NEEDED BACK
--------------------------------------------------------------------------------

ZRIOT,CONE                                 195-86-0001      FEB  8,1994
'OK' NEEDED:
SOURCE     :  MEMORIAL HOSPITAL
REMARKS    :  Several wrist views
--------------------------------------------------------------------------------
ZRIOT,CONE                                 195-86-0001      FEB 13,1994
'OK' NEEDED:
SOURCE     :  GOOD SAMARITAN HOSPITAL
REMARKS    :  ANKLE
--------------------------------------------------------------------------------
SHAW,RAYMOND E                             945-85-4480      FEB 14,1994
'OK' NEEDED:
SOURCE     :  HARRIS HOSPITAL
REMARKS    :  Chest X-Ray
--------------------------------------------------------------------------------
```

Outside Films Registry Menu

Edit Registry

This function allows the user to edit information pertaining to a specific outside film that has been registered.

Only patients currently entered in the Rad/Nuc Med patient file can be selected.

A single patient may have more than one outside film registered at once. This option can be used to edit an existing entry. New outside film register dates should be added through the Add Films to Registry option.

The registry includes registration date, date to be returned to the source, the source of the films and a remarks field. You may edit any or all of these fields through this option.

This option is used to enter a date on which the films were actually returned to the source. If the entry has been flagged through the Flag Film To Need OK Before Return option, supervisory approval is needed before the films can be returned.

Prompt/**User Response** Discussion

```
Edit Registry

Select Patient: EDISON,THOMAS           10-06-20
787140368     NO     NSC VETERAN
Select OUTSIDE FILMS REGISTER DATE: MAR 3, 1997   MAR 03,
1997
  Are you adding 'MAR 03, 1997' as
    a new OUTSIDE FILMS REGISTER DATE (the 1ST for this
RAD/NUC MED PATIENT)? No
// Y (Yes)
   OUTSIDE FILMS REGISTER DATE REMARKS: Need to review.
  RETURNED DATE: MAR 8  (MAR 08, 1997)
  NEEDED BACK DATE: MAR 8  (MAR 08, 1997)
  SOURCE OF FILMS: COUNTY HOSPITAL
  REMARKS: Need to review.// <RET>
```

Outside Films Registry Menu

Flag Film to Need "OK" Before Return

This option is used to flag entries in the films registry for supervisory approval before being returned to the outside source. An example would be films that need to be retained for treatment and reference.

Only patients currently entered in the Rad/Nuc Med Patient file can be selected. A patient may have more than one outside film registered at once and one or more of these can be flagged.

If an entry is flagged as needing an OK before return, then users in the Edit Registry option will be asked if the supervisor has authorized the return of the borrowed films. A film that has already been returned cannot be flagged.

The Add Films to Registry option should be used instead of this option to add new outside film dates to insure completeness of data.

Prompt/**User Response** Discussion

```
Flag Film to Need 'OK' Before Return

Select Patient: POTTS,BERTRAM           10-27-45     894416023   NO   NSC VETERAN
Select OUTSIDE FILMS REGISTER DATE: MAR 31,1995// <RET>
  ASK FOR 'OK' BEFORE RETURNING?: Y  YES
```

Outside Films Registry Menu

Outside Films Profile

This function allows users to see if films from other hospitals or institutions have been registered for this patient. Both returned and unreturned films are listed in the profile. If they have been returned, then the Date Returned is given.

You will be prompted for a patient's name and the device on which to print the profile.

The profile will include registration dates, returned dates, the source, remarks, and an indication showing whether supervisory approval is needed before returning the films.

Prompt/**User Response** Discussion

```
Outside Films Profile

Select Patient: POTTS,BERTRAM          10-27-45     894416023   NO   NSC VETERAN
DEVICE: HOME//  <RET>  SET HOST
```

```
               *****  Outside Films Profile  *****
--------------------------------------------------------------------------------
Registered: 09/21/94          Returned : still on file      'OK' Needed: No
Source    : COUNTY HOSPITAL
Remarks   : CHEST - 2 VIEWS
--------------------------------------------------------------------------------
Registered: 06/15/94          Returned : still on file      'OK' Needed: No
Source    : COUNTY HOSPITAL
Remarks   : BROKEN HIP, LEFT
--------------------------------------------------------------------------------
Registered: 03/31/95          Returned : still on file      'OK' Needed: Yes
Source    : COUNTY HOSPITAL
Remarks   : CHEST - 2 VIEWS
--------------------------------------------------------------------------------
```

IX. Patient Profile Menu

This menu provides the user with various functions that allow the user to view exam and report information about a specific patient.

Detailed Request Display
Display Patient Demographics
Exam Profile (selected sort)
Outside Films Profile
Profile of Rad/Nuc Med Exams

Patient Profile Menu

Detailed Request Display

This option allows the user to see detailed information on a requested examination for a particular patient.

After selecting a patient, a selection must be made from a list of available requests, showing request status, urgency, procedure, desired date, requester, and requesting location. Possible statuses for requests are: UNRELEASED, PENDING, SCHEDULED, ACTIVE (i.e., registered and in process), HOLD, COMPLETE, and DISCONTINUED. Possible request urgencies are Stat, Urgent, and Routine.

The following information about the selected request is displayed when available: the procedure requested, procedure(s) registered if different from request, request status, requester, patient location and room-bed if available, who entered the request, desired date, transportation mode, isolation precautions, and imaging location to which the request was submitted (if available). If the request was cancelled (i.e., the current status of the request is DISCONTINUED) or placed on HOLD, the reason if available, will be displayed. It should be noted that requests cancelled through OE/RR will not have a reason for cancellation because OE/RR does not require users to enter a reason. If the requested exam has been registered, the exam status will also be displayed, and case numbers will appear beside the registered procedure names and their CPT codes.

If information has been recorded in the status tracking log for the request, the user will also have the option to view the log. The tracking log display includes date/time of change, the new status, the computer user who made the change, and the reason (where applicable). The system will only keep this tracking log if the Track Request Status Changes question is answered Yes when the ADPAC does division parameter set-up. (See ADPAC Guide for additional information.)

Prompt/**User Response** Discussion

The sample shown is a request for a parent procedure, displayed after the descendents are registered.

```
Detailed Request Display

Select PATIENT NAME:    ZMOUSE,MINNIE             NO     NSC VETERAN       06-0
5-96   000004444
                              PRIM. CARE: CARLISLE,JIM J MD   TEL 2222; 2221
                              ALT. PRIM. CARE: CROSSMAN,KEN E. MD   TEL 2223



Select Rad/Nuc Med Location: All// <RET>

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

```
Imaging Location(s) included:   1ST FLOOR RECEPTION   2ND FLOOR RECEPTION
                                A&D RADIOLOGY   ADMINISTRATOR   CTG


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

**** Requested Exams for ZMOUSE,MINNIE ****     127  Requests
    St  Urgency  Procedure                      Desired Requester    Req'g Loc
    --  -------  -----------------------------  ------- -----------  -----------
1   dc  ROUTINE  CHEST 2 VIEWS PA&LAT           06/24   SIDLEY,MART  10CN
2   dc  ROUTINE  CHEST 2 VIEWS PA&LAT           06/17   WALRACE,KEN  10CN
3   dc  ROUTINE  CHEST 2 VIEWS PA&LAT           06/13   SIDLEY,MART  11D/MICU
4   dc  ROUTINE +CHEST CT                       05/22   GALES,M. EL  WOMEN VETER
5   dc  ROUTINE  ECHOGRAM ABDOMEN COMPLETE      04/20   GALES,M. EL  CAUSEWAY-IV
6       ROUTINE +GALLIUM TUMOR                  04/19   GALES,M. EL  C ADULT DAY
7   dc  ROUTINE  ORBIT MIN 4 VIEWS              03/31   KALE,JOHN    8CR
8   dc  ROUTINE  CHEST SINGLE VIEW              03/19   WELBY,MARCU  RADIOLOGY-I
9   dc  ROUTINE  CHEST SINGLE VIEW              03/18   WELBY,MARCU  S SURGERY 1

Select Request(s) 1-9 to Display or '^' to Exit:  Continue// 6


               **** Detailed Display ****

Name: ZMOUSE,MINNIE    (000-00-4444)        Date of Birth: JUN  5,1896
------------------------------------------------------------------------
Requested:          GALLIUM TUMOR                          (NM Parent )
Registered:    3350 TUMOR LOCALIZATION (GALLIUM SCAN), (  (NM Detailed 78803)
               3351 PROVISION OF DIAGNOSTIC RADIONUCLIDE  (NM Detailed 78990)
               3352 COMPUTER MANIPULATION > 30 MIN.       (NM Detailed 78891)


Current Status:       ACTIVE
Requestor:            MANEY,M. DR
 Tel/Page/Dig Page: 5181 / 465-9710 / 465 9710
Patient Location:     C ADULT DAY NEURO 52
Entered:              Apr 19, 1997 12:15 pm  by MANEY,M. DR

Desired Date:         Apr 19, 1997
Transport:            AMBULATORY
Clinical History:     Internal bleeding, pain

Request Submitted to: UNKNOWN

Do you wish to display request status tracking log? NO// YES

                  [1] *** Request Status Tracking Log ***
Date/Time         Status       User         Reason
---------------- ------------ -----------  ----------------------------------
04/19/97 12:15 PM PENDING      MANEY,M. EL
04/19/97 12:17 PM ACTIVE       SMITH,TIM
```

[1] Patch RA*5*15 NOIS: FRE-1099-60873 "Request" added to line.

Patient Profile Menu

Display Patient Demographics

This function allows the user to see demographics and limited clinical data for a selected patient. Some of the data will be displayed even if the patient has no registered examinations filed. Any or all of the following information may be listed:

Sometimes one, two or three asterisks will appear at the left of the case number. The explanations are as follows:

* Barium Used field on case is set to "yes"
** Cholecystogram AMIS code 11 is assigned to the procedure
*** Contrast Media Used field on case is set to "yes"

If the V*IST*A imaging software interface is used at your site, a lowercase i may appear to the left of the procedure to indicate that images were collected and image IDs have been stored on a report stub record in the Rad/Nuc Med Report file.

- name
- address
- patient ID
- date of birth
- age
- veteran (yes or no)
- eligibility
- exam category (inpatient, outpatient, contract, sharing, employee, research)
- sex
- narrative (special remark)
- currently an inpatient
- ward
- service
- bedsection
- contrast medium reaction
- other allergies
- PENDING orders for imaging exams
- case #, procedure, exam date, and status of up to the last 5 imaging exams
- message stating an exam has been performed using contrast material within the last {#} days
- any number of special messages; i.e., patient died, or the record accessed is a sensitive record

Prompt/**User Response** Discussion

Display Patient Demographics

Select PATIENT NAME: **DERRY,FRED** 03-15-21 914159230 NO NSC VETERAN

```
***********    Patient Demographics   ***********

  Name         : DERRY,FRED             Address:  948 DIXON
  Pt ID        : 914-15-9230                      BOONETOWNE, IL  66666
  Date of Birth: MAR 15,1921
  Age          : 74
  Veteran      : Yes                       Currently is an inpatient.
  Eligibility  : NSC                           Ward       : 1N
  Exam Category: OUTPATIENT                    Service    : MEDICINE
  Sex          : MALE                          Bedsection : GENERAL (ACUTE MEDICINE)
  Phone Number : 222-0755

  Contrast Medium Reaction: No
  Other Allergies:
       'V' denotes verified allergy   'N' denotes non-verified allergy


Case #    Last 5 Procedures/New Orders Exam Date   Status of Exam  Imaging Loc.
------    ---------------------------- ---------   --------------  ------------
133       ABDOMEN 1 VIEW               MAR 18,1995 WAITING FOR     ULTRASOUND
139       ECHOGRAM ABDOMEN COMPLETE    MAR 18,1995 WAITING FOR     ULTRASOUND
140     i CHEST 1 VIEW                 MAR 18,1995 EXAMINED        X-RAY

Press <RETURN> key to continue.
```

Patient Profile Menu

Exam Profile (selected sort)

This function allows the user to list a patient's exam profile. It initially displays a list of exams that can be sorted by procedure or exam date, and asks for a single exam selection. Once a single exam is selected and displayed, you will have the opportunity to select various other displays, including exam activity log, status change log, and results report.

The initial list of exams shows case no., procedure, exam date, exam status, and imaging location of the exam. The single exam display shows most exam data entered into the system. The activity log shows which menu options were used to take action on the exam, and the status tracking log shows when status changes occurred, how much time elapsed between status changes, and total elapsed time from when the exam was registered to the last status change. The report text is the actual procedure report.

Prompt/**User Response** Discussion

```
Exam Profile (selected sort)

Select Patient:    ABCEK,ANN          01-05-32    422458476
NO   EMPLOYEE

Sort by one of the following:
          P ==> Procedure
          D ==> Date of Exam
                              Procedure// <RET>

Do you wish to look for a specific procedure? Yes// <RET>

Select Procedure: ACUTE GI BLOOD LOSS IMAGING     (NM  Detailed) CPT:782

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

```
Profile for ABCEK,ANN  422-45-8476              Run Date: JUL 30,2000

                    ***** Registered Exams Profile *****
   Case No.  Procedure                    Exam Date  Status of Exam   Imaging Loc
   --------  -------------                ---------  ------------     -----------
1     31     ACUTE GI BLOOD LOSS IMAGIN  05/19/00   CALLED FOR EXAM  NUC
CHOOSE FROM 1-1: 1



================================================================================
  Name        : ABCEK,ANN    422-45-8476
  Division    : HINES CIO FIELD OFFI    Category     : INPATIENT
  Location    : NUC                     Ward         : 1S
  Exam Date   : MAY 19,2000  11:43      Service      : MEDICAL
  Case No.    : 31                      Bedsection   : GENERAL(ACUTE MEDICINE)
                                        Clinic       :
--------------------------------------------------------------------------------
[1]  Procedure     : ACUTE GI BLOOD LOSS IMAGING (NM  Detailed) CPT:782
  Requesting Phy: WILLIAM,CATHY         Exam Status  : CALLED FOR EXAM
  Int'g Resident: CHANG,JERY            Report Status: VERIFIED
  Pre-Verified  : NO                    Cam/Equip/Rm : NUC2
  Int'g Staff   : KAST,STEVEN           Diagnosis    : MINOR ABNORMALITY
  Technologist  : HINESLEY,RICK         Complication : NO COMPLICATION
                                        Films        : 11X14 - 1
---------------------------------Modifiers--------------------------------
  Proc Modifiers: None

  CPT Modifiers  :None
---------------------------------Medications------------------------------------
Med: LIDOCAINE 0.5% W/EPI INJ MDV

Med: ASPIRIN 325MG TAB                Dose Adm'd: 1 TAB


---------------------------------Medications------------------------------------
Adm'd By: WILLIAM,CATHY               Date Adm'd: MAY 19, 2000@11:46

-----------------------------Radiopharmaceuticals-------------------------------
Rpharm: SULFUR COLLOID TC-99M         Dose (MD Override): 1 mCi
Prescriber: WILLIAM,CATHY             Activity Drawn: 1 mCi
Drawn: MAY 19, 2000@11:47             Measured By: WILLIAM,CATHY
Dose Adm'd: 1 mCi                     Date Adm'd: MAY 19, 2000@11:47
Adm'd By: WILLIAM,CATHY               Witness: BEAMERS,TENA
Lot #: 789

Rpharm: PERCHLORACAP 250MG CAPS       Activity Drawn: 250 mCi
Drawn: MAY 19, 2000@11:48             Measured By: WILLIAM,CATHY
Dose Adm'd: 250 mCi
================================================================================
Do you wish to display all personnel involved? No// <RET>  NO
```

[1] Patch RA*5*10 April 2000

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

                      *** Exam Activity Log ***
  Date/Time             Action                              Computer User
  ---------             ------                              -------------
[1] MAY 19,2000  11:45     EXAM ENTRY                         WILLIAM,CATHY
  MAY 19,2000  11:45     EXAM STATUS TRACKING                WILLIAM,CATHY
   This is a tech note on the patient/case.
  MAY 19,2000  14:10     EDIT BY CASE NO.                    WILLIAM,CATHY
   This is another tech note on the patient and or case.  If the note is longer than
   2 lines then the entire note can be seen in this option along with all other tech
   notes written on the case.

                     *** Report Activity Log ***
  Date/Time             Action                              Computer User
  ---------             ------                              -------------
  JUN 16,2000  14:12     INITIAL REPORT TRANSCRIPTION        WILLIAM,CATHY
  JUN 16,2000  14:14     VERIFIED                            WILLIAM,CATHY
================================================================================

[2]Do you wish to display exam status tracking log? No// Y



                          *** Exam Status Tracking Log ***
                                                 Elapsed Time  Cumulative Time
  Status                Date/Time                (DD:HH:MM)      (DD:HH:MM)
  ------                ---------               ------------  ---------------
  WAITING FOR EXAM      MAY 19,2000  11:45        00:00:00        00:00:00
  CALLED FOR EXAM       MAY 19,2000  11:45
================================================================================

Do you wish to display exam report text? No// N
```

[1] Patch RA*5*18 November 2000 New field for comments by the technologist added to report.
[2] Patch RA*5*15 NOIS: FRE-1099-60873 "Exam" added to both lines.

Patient Profile Menu

Outside Films Profile

This function allows the user to see if films from other hospitals or institutions have been registered for this patient. Both returned and unreturned films are listed in the profile. If they have been returned, then the Date Returned is given.

This option prompts for a patient's name and a device.

The output includes the date the outside films were registered and returned, the source of the films (i.e., another hospital), remarks, and an indication specifying whether a supervisor's authorization is needed before returning the films.

This option appears on the Outside Films Registry menu. Please refer to the example earlier in this section.

Patient Profile Menu

Profile of Rad/Nuc Med Exams

This function allows the user to see a quick list of the patient's registered exams. The exams are presented in reverse chronological order. A specific exam can be selected from the list. When an exam is selected, a very detailed display of the exam is presented.

You will be prompted to select a patient. If the patient has radiology records (films) on file within the Record Tracking system, information relevant to these records will be displayed.

If the patient has more than one registered radiology exam, a list will be displayed showing the case no., procedure, exam date, exam status, and imaging location of the exam. You may then select one exam for detailed display. The remaining output is the same as in the Exam Profile (selected sort) option.

If the Record Tracking system is not used at your site, you will see a message as shown in the sample below, No 'RADIOLOGY/NUCLEAR MEDICINE' records on file. If Record Tracking is used at your facility, you will see information about the location of the patient's folders.

Prompt/**User Response** Discussion

```
Profile of Rad/Nuc Med Exams

Select Patient: ABCEK,ANN          01-05-32     422458476     NO     EMPLOYEE
```

```
          **** RADIOLOGY/NUCLEAR MEDICINE Profile ****
================================================================================
Name      : ABCEK,ANN  (422-45-8476)                  Page: 1
Birth Date: JAN 05, 1932  Ward: 1S             Run Date: JUL 30, 2000@10:00
================================================================================

   No 'RADIOLOGY/NUCLEAR MEDICINE' records on file.

============================ Exam Procedure Profile ============================

   Case No.  Procedure                   Exam Date  Status of Exam   Imaging Loc
   --------  -------------               ---------  ---------------- -----------
1     94     BONE IMAGING, WHOLE BODY    05/19/00   WAITING FOR EXAM NUC
2     31     ACUTE GI BLOOD LOSS IMAGIN  05/19/00   CALLED FOR EXAM  NUC
3     103    UPPER GI AIR CONT W/SMALL   05/13/00   WAITING FOR EXAM X-RAY
4     203    CHEST OBLIQUE PROJECTIONS   05/13/00   CANCELLED        X-RAY
5     280    THYROID UPTAKE, MULTIPLE D  04/23/00   CALLED FOR EXAM  NUC
6    +430    ANKLE 2 VIEWS               01/28/00   CANCELLED        X-RAY
7    .431    FOOT 2 VIEWS                01/28/00   CANCELLED        X-RAY
8    .432    TOE(S) 2 OR MORE VIEWS      01/28/00   CANCELLED        X-RAY
Type '^' to STOP, or
CHOOSE FROM 1-8: 2
```

```
================================================================================
  Name        : ABCEK,ANN    422-45-8476
  Division    : HINES CIO FIELD OFFI    Category     : INPATIENT
  Location    : NUC                     Ward         : 1S
  Exam Date   : MAY 19,2000  11:43      Service      : MEDICAL
  Case No.    : 31                      Bedsection   : GENERAL(ACUTE MEDICINE)
                                        Clinic       :
--------------------------------------------------------------------------------
 [1] Procedure     : ACUTE GI BLOOD LOSS IMAGING (NM   Detailed) CPT:nnnnn
   Requesting Phy: WILLIAM,CATHY         Exam Status  : CALLED FOR EXAM
   Int'g Resident: CHANG,JERY            Report Status: VERIFIED
   Pre-Verified  : NO                    Cam/Equip/Rm : NUC2
   Int'g Staff   : KAST,STEVEN           Diagnosis    : MINOR ABNORMALITY
   Technologist  : HINESLEY,RICK         Complication : NO COMPLICATION
                                         Films        : 11X14 - 1
 ---------------------------------Modifiers--------------------------------
   Proc Modifiers: None

   CPT Modifiers  :None
---------------------------------Medications-------------------------------
Med: LIDOCAINE 0.5% W/EPI INJ MDV

Med: ASPIRIN 325MG TAB                Dose Adm'd: 1 TAB


---------------------------------Medications-------------------------------
Adm'd By: WILLIAM,CATHY               Date Adm'd: MAY 19, 2000@11:46

------------------------------Radiopharmaceuticals-----------------------------
Rpharm: SULFUR COLLOID TC-99M         Dose (MD Override): 1 mCi
Prescriber: WILLIAM,CATHY             Activity Drawn: 1 mCi
Drawn: MAY 19, 2000@11:47             Measured By: WILLIAM,CATHY
Dose Adm'd: 1 mCi                     Date Adm'd: MAY 19, 2000@11:47
Adm'd By: WILLIAM,CATHY               Witness: BEAMERS,TENA
Lot #: 789

Rpharm: PERCHLORACAP 250MG CAPS       Activity Drawn: 250 mCi
Drawn: MAY 19, 2000@11:48             Measured By: WILLIAM,CATHY
Dose Adm'd: 250 mCi
================================================================================
Do you wish to display all personnel involved? No//  <RET>  NO

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

[1] Patch RA*5*10 April 2000

```
                    *** Exam Activity Log ***
  Date/Time             Action                            Computer User
  ---------             ------                            -------------
[1] MAY 19,2000  11:45     EXAM ENTRY                       WILLIAM,CATHY
  MAY 19,2000  11:45     EXAM STATUS TRACKING              WILLIAM,CATHY
   This is a tech note on the patient/case.
  MAY 19,2000  14:10     EDIT BY CASE NO.                  WILLIAM,CATHY
   This is another tech note on the patient and or case.  If the note is longer than
   2 lines then the entire note can be seen in this option along with all other tech
   notes written on the case.

                    *** Report Activity Log ***
  Date/Time             Action                            Computer User
  ---------             ------                            -------------
  JUN 16,2000  14:12     INITIAL REPORT TRANSCRIPTION      WILLIAM,CATHY
  JUN 16,2000  14:14     VERIFIED                          WILLIAM,CATHY
================================================================================

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



                          *** Status Tracking Log ***
                                                 Elapsed Time  Cumulative Time
  Status                Date/Time                 (DD:HH:MM)      (DD:HH:MM)
  ------                ---------                ------------  ---------------
  WAITING FOR EXAM      MAY 19,2000  11:45        00:00:00        00:00:00
  CALLED FOR EXAM       MAY 19,2000  11:45
================================================================================

Do you wish to display exam report text? No// N
```

[1] Patch RA*5*18 November 2000 New field for comments by the technologist added to report.

X. Radiology/Nuclear Med Order Entry Menu

This menu provides the user with functions to request an exam, cancel an exam, hold a requested exam, schedule a request, access a detailed report of the requested exam, print a log report of SCHEDULED requests by procedure, and to print a list of PENDING requests by date.

Cancel a Request
Detailed Request Display
Hold a Request
Log of Scheduled Requests by Procedure
Pending/Hold Rad/Nuc Med Request Log
Print Rad/Nuc Med Requests by Date
Print Selected Requests by Patient
Rad/Nuc Med Procedure Information Look-Up
Request an Exam
Schedule a Request
Ward/Clinic Scheduled Request Log

Radiology/Nuclear Med Order Entry Menu

Cancel a Request

This option allows users within Radiology/Nuclear Medicine to cancel a request. When an exam is cancelled, a reason must be entered for the cancellation.

When a request is cancelled, it is placed in the DISCONTINUED status. Only requests that have not been acted upon by Radiology/Nuclear Medicine may be cancelled. These include requests in the PENDING or HOLD status.

You will be prompted to select a patient. In the event that another person is editing orders for the patient you select, you may see a message asking that you try again later. If no one else is working on orders for that patient, a list of requests for the patient will be displayed, including the request status, urgency, procedure, request date, requester, and patient location. Printouts of cancelled requests include the name of the person who cancelled the request.

Once you select a request to cancel, you will be asked the reason for cancellation. If a reason is not entered, the request is not cancelled.

When you cancel a request, the the RAD/NUC MED REQUEST CANCELLED MailMan bulletin is sent to members of the RA REQUEST CANCELLED mail group, or other mail group set up by your IRM to receive this bulletin.

Prompt/**User Response** Discussion

```
Cancel a Request

Select PATIENT NAME: ABCEK,ANN           01-05-32     422458476     NO     EMPLOYEE



               **** Requested Exams for ABCEK,ANN ****            8  Requests
    St  Urgency  Procedure                     Desired Requester    Req'g Loc
    --  -------  ----------------------------  ------- -----------  -----------
 1  p   ROUTINE  ABDOMEN 1 VIEW                09/05   HELLER,CINDY  1S
 2  p   ROUTINE  ANGIO CAROTID CEREBRAL SELECT  09/04   HELLER,CINDY  1S
 3  p   ROUTINE  ANGIO CAROTID CEREBRAL UNILAT  09/04   HELLER,CINDY  1S
 4  p   ROUTINE  BRAIN IMAGING, PLANAR ONLY     06/28   HELLER,CINDY  EMERGENCY R
 5  p   ROUTINE  GALLIUM SCAN FOR INFECTIOUS/I  06/27   HELLER,CINDY  OPERATING R
 6  p   ROUTINE  RADIONUCLIDE THERAPY, THYROID  06/27   HELLER,CINDY  OPERATING R
 7  s   ROUTINE  SPINE LUMBOSACRAL MIN 2 VIEWS  11/16   HELLER,CINDY  ORTHOPEDIC
 8  s   ROUTINE  CT LOWER EXTREMITY W&W/O CONT  11/16   HELLER,CINDY  ORTHOPEDIC

Select Request(s) 1-8 to Cancel or '^' to Exit:  Exit// 2

Select CANCEL REASON: ??

Choose from:
   1              ANESTHESIA CONSULT NEEDED              Synonym: ANES
   6              CONFLICT OF EXAMINATIONS               Synonym: CON
```

```
   7               DUPLICATE REQUESTS                      Synonym: DUP
   8               INADEQUATE CLINICAL HISTORY             Synonym: INAD
   11              OTHER CANCEL REASON                     Synonym: OTH
   13              PATIENT CONSENT DENIED                  Synonym: PCD
   14              PATIENT EXPIRED                         Synonym: EXP
   17              REQUESTING PHYSICIAN CANCELLED          Synonym: REQ
   19              WRONG EXAM REQUESTED                    Synonym: WRN
   20              EXAM CANCELLED                          Synonym: CAN
   21              EXAM DELETED                            Synonym: DEL
   22              CALLED-WARD DID NOT SEND                Synonym:
   25              PATIENT REFUSED THE PROCEDURE           Synonym:
   26              EQUIPMENT FAILURE                       Synonym: EQF

Select CANCEL REASON: 8  INADEQUATE CLINICAL HISTORY       Synonym: INAD
   ...will now 'CANCEL' selected request(s)...
          ...ANGIO CAROTID CEREBRAL SELECT EXT UNILAT S&I cancelled...

   Task 39174: cancellation queued to print on device P-DOT MATRIX BACK
```

Radiology/Nuclear Med Order Entry Menu

Detailed Request Display

This option is identical to the Detailed Request Display option under the Patient Profile Menu. Please refer to that section of the manual for a description and sample.

Radiology/Nuclear Med Order Entry Menu

Hold a Request

This option allows users within Radiology/Nuclear Medicine to place a requested exam in the HOLD status. The user will be asked to select a reason from the Rad/Nuc Med Reason file (#75.2). Only requests with a status of pending or scheduled may be placed on HOLD.

You will be prompted to select a patient. In the event that another person is editing orders for the patient you select, you may see a message asking that you try again later. If no one else is working on orders for that patient, a list of requests for the patient will be displayed, including the request status, urgency, procedure, request date, requester, and patient location.

Once a request has been selected, you will be asked for a reason for putting the request on HOLD. If a reason is not entered, the request will not be placed on HOLD.

When the request status is changed to HOLD, the RAD/NUC MED REQUEST HELD mail bulletin will be automatically sent to all members of the RA REQUEST HELD mail group, or other mail group set up by your IRM to receive this bulletin.

Prompt/**User Response** Discussion

```
Hold a Request

Select PATIENT NAME: DENT,VERNON           07-06-46     412760624   YES  SC VETERAN


              **** Requested Exams for DENT,VERNON ****          3  Requests
    St  Urgency  Procedure                       Desired Requester    Req'g Loc
    --  -------  ---------------------------  ------- -----------  -----------
 1  s   ROUTINE  ARTHROGRAM SHOULDER S&I        04/03   DAVIDSON,MA  EMERGENCY R
 2  s   ROUTINE  ARTHROGRAM WRIST S&I           04/03   DAVIDSON,MA  EMERGENCY R
 3  p   ROUTINE  ANOTHER PARENT PROCEDURE       01/20   DAVIDSON,MA  X-RAY STOP

Select Request(s) 1-3 to Hold or '^' to Exit:  Exit// 1

Select HOLD REASON: ??
```

```
Choose from:
   1              ANESTHESIA CONSULT NEEDED              Synonym: ANES
   2              AWAITING C.A.T. EXAM RESULTS           Synonym: CAT
   3              AWAITING NUC. MED. RESULTS             Synonym: NUC
   4              AWAITING ULTRASOUND RESULTS            Synonym: US
   5              CARDIOLOGY CONSULT NEEDED              Synonym: CARD
   9              MEDICAL CONSULT NEEDED                 Synonym: MED
   10             NEUROLOGY CONSULT NEEDED               Synonym: NEUR
   12             OTHER HOLD REASON                      Synonym: OHR
   15             PATIENT TOO ILL FOR STUDY              Synonym: ILL
   16             REPEAT PATIENT PREP                    Synonym: REP
   18             SURGERY CONSULT NEEDED                 Synonym: SUR
   20             EXAM CANCELLED                         Synonym: CAN
   21             EXAM DELETED                           Synonym: DEL
   26             EQUIPMENT FAILURE                      Synonym: EQF
   27             PATIENT ATE                            Synonym: ATE

Select HOLD REASON: 18  SURGERY CONSULT NEEDED            Synonym: SUR
   ...will now 'HOLD' selected request(s)...
          ...ARTHROGRAM SHOULDER S&I held...

Select PATIENT NAME: <RET>
```

Radiology/Nuclear Med Order Entry Menu

Log of Scheduled Requests by Procedure

This option allows the user to generate a list of SCHEDULED requests sorted by procedure.

This is the same report that appears on the Daily Management Reports submenu of the Management Reports menu. Please refer to the description for that option for complete information about this report.

Radiology/Nuclear Med Order Entry Menu

Pending/Hold Rad/Nuc Med Request Log

This option will print a listing entitled Log of Pending Requests or Log of Hold Requests depending on selections made by the person generating the report. It is used to determine which requests have not yet been acted upon. The output will give desired date, patient name and last 4 digits of patient ID number, procedure, patient location, date ordered and the requesting location if different from the patient's current location.

Selection criteria includes a choice of printing the HOLD or the PENDING requests, a selection of one or more of the imaging locations accessible by the person generating the report, and a date range selection (which is applied to the Desired Date).

The report is sorted chronologically by Desired Date/time. Output for each imaging location starts on a new page.

Requests will not appear in the report if no Desired Date (field #21 of the Rad/Nuc Med Order file #75.1) has been entered, if the Request Entered Date/Time (field #16 of file #75.1) is blank, if the procedure is missing or invalid due to data corruption, or if the desired date of the request is not within the selected date range. [1]If there is no imaging location on the request, it will print under the UNKNOWN imaging location heading, but only if its imaging type matches one of the selected location's imaging types. UNKNOWN imaging locations that belong to other imaging types will not be printed. This will identify orders that have not been submitted to an imaging location because the division parameter, Ask Imaging Location (in field #.121 of the Rad/Nuc Med Division file #79), is set to NO.

Prompt/**User Response** Discussion

```
Pending/Hold Rad/Nuc Med Request Log

This option will generate a list of requests for a selected date
range with the status of 'PENDING' or 'HOLD'


     Select one of the following:

          H         HOLD
          P         PENDING

Select REQUEST STATUS: P// <RET> ENDING


Select Imaging Location(s): X-RAY             (GENERAL RADIOLOGY)


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

[1] Patch RA*5*15 May 2000 NOIS: BHS-1199-12241

```
**** Date Range Selection ****

   Beginning DATE : 4/1/95  (APR 01, 1995)

   Ending    DATE : T  (APR 03, 1995)

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

```
                          LOG OF PENDING REQUESTS
             Includes requests scheduled from 4/1/95 to 4/3/95
IMAGING LOCATION: X-RAY                              Run Date: APR  3,1995  13:13

PATIENT NAME                   PROCEDURE             PT LOC          DATE ORDERED
================================================================================


                 Desired Date (Time optional): APR 01, 1995
                 ------------------------------------------

JORDAN,MICHAEL -3230      ABDOMEN 1 VIEW            EMERGENCY ROOM MAR 31, 1995

                 Desired Date (Time optional): APR 03, 1995
                 ------------------------------------------

FIFE,BARNEY -7203         BONE AGE                  MAMMOGRAPHY    APR 03, 1995
FIFE,BARNEY -7203         ARTHROGRAM WRIST S&I      MAMMOGRAPHY    APR 03, 1995
RTEZ,CALVIN -2877         BONE AGE                  DISCHARGED     APR 03, 1995
                            Requesting Location: 1N

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


                          LOG OF PENDING REQUESTS
             Includes requests scheduled from 4/1/95 to 4/3/95
IMAGING LOCATION: X-RAY                              Run Date: APR  3,1995  13:13

PATIENT NAME                   PROCEDURE             PT LOC          DATE ORDERED
================================================================================

DENT,VERNON -0624         ARTHROGRAM SHOULDER S&I   EMERGENCY ROOM APR 03, 1995
DENT,VERNON -0624         ARTHROGRAM WRIST S&I      EMERGENCY ROOM APR 03, 1995
```

Radiology/Nuclear Med Order Entry Menu

Print Rad/Nuc Med Requests by Date

This option allows the user to print requests of a selected status for a specific range of date/times. The requests are printed by urgency, beginning with STAT and ending with ROUTINE.

If your division parameter ASK IMAGING LOCATION is set to Yes, you will first be asked to select an imaging location. You may select one location or ALL locations.

You will be asked to choose one of the request statuses. When shown on various display screens, each status may be indicated by a lowercase abbreviation that is shown below in parentheses.

DISCONTINUED (dc) - same as cancelled. Action on the request has been terminated.

COMPLETE (c) - exam has been performed and the exam status is COMPLETE (or whichever status has an order number of 9 for the appropriate imaging type of the exam).

HOLD (h) - a request is put on HOLD when the procedure cannot be performed as scheduled, but will probably be performed at another time.

PENDING (p) - the request has been entered but no action (such as scheduling or registering an exam) has been taken by the imaging department.

REQUEST ACTIVE ( ) - the exam has been registered and is currently being processed by the imaging department.

SCHEDULED (s) - the imaging department has accepted the request and scheduled the procedure using the Schedule a Request option. Note: Scheduling a patient through the MAS package does NOT change the request status to scheduled.

ALL CURRENT ORDERS - all requests with a status of HOLD, PENDING, ACTIVE, OR SCHEDULED.

Next, you will be asked to specify whether the program should look at the date the request was entered into the system or the desired date of the request when it chooses requests to include in the output.

The date range selection that you will make next will be used to retrieve requests to print. Depending on how you answered the last prompt, the date range will be applied to either the date the request was entered, or the desired date on the request.

You will also be asked whether you want to print a Health Summary along with the requests. Health Summaries will only print if the procedure requested has a Health Summary format assigned for printout. (See the ADPAC Guide for more information on Procedure set-up.)

The request form may include some or all of the following data: patient name and ID, date of birth, age, urgency, transportation mode, patient location, phone extension of requesting location, and room-bed (for current inpatients), procedure, procedure message, modifiers, current request status, exam status if the exam was registered, requester, primary and attending physician at time of order and current [1]("Attend Phy At Order:" will only be displayed if different from "Attend Phy Current:"), date/time ordered, desired date, clinical history, pregnancy information, isolation, pre-op, approving physician, bar-coded SSN, and portable notation.

There is also a worksheet section on the form for date performed, case number, technologist initials, interpreting physician initials, number/size of films used and comments. [2]If entered for the case, the Case Number(s), Technician(s), Film(s) used, and Technician Comments will be printed following the Interpreting Physician Initials and Comments.

The output should be queued to a printer.

Prompt/**User Response** Discussion

```
Print Rad/Nuc Med Requests by Date

Select IMAGING LOCATION: X-RAY            (GENERAL RADIOLOGY)

Request Status Selection
------------------------
  Choose one of the following:
          Discontinued
          Complete
          Hold
          Pending
          Request Active
          Scheduled
          All Current Orders

  Select Status: Pending// <RET>


Date Criteria Selection
-----------------------

     Select one of the following:

          E         ENTRY DATE OF REQUEST
          D         DESIRED DATE FOR EXAM

Date criteria to use for choosing requests to print: E// <RET> NTRY DATE OF REQUEST

**** Date Range Selection ****

Beginning DATE : 2/1/97  (FEB 01, 1997)

   Ending    DATE : T  (APR 08, 1997)
```

[1] Patch RA*5*26 Additional text description.
[2] Patch RA*5*18 November 2000 Additional fields printed on form.

```
Print HEALTH SUMMARY for each patient? NO

DEVICE: HOME// (Enter printer name)

 >> Rad/Nuc Med Consultation for X-RAY <<                APR  8,1997  16:07
================================================================================
Name         : POPITZ,JOHN                    Urgency    : ROUTINE
Pt ID Num    : 914-73-4594                    Transport  : AMBULATORY
Date of Birth: DEC  2,1934                    Patient Loc: RAD 101
Age          : 62                             Phone Ext  :
================================================================================

Requested:            FOREARM 2 VIEWS (RAD Detailed) CPT: 73090
[1]Procedure Modifiers:  LEFT
Request Status:       PENDING (p)

Requester:            CEBE,GREGORY B
 Tel/Page/Dig Page: (708) 786-5904 / (708) 786-5904 / (708) 786-5904
Attend Phy Current:   UNKNOWN
Prim Phy Current:     UNKNOWN
Date/Time Ordered:    FEB 12,1997  10:48  by CEBE,GREGORY B
Date Desired:         FEB 12,1997
Clinical History:
                                    |      |

 >> Rad/Nuc Med Consultation for X-RAY <<                APR  8,1997  16:07
================================================================================
Name         : POPITZ,JOHN                    Urgency    : ROUTINE
Pt ID Num    : 914-73-4594                    Transport  : AMBULATORY
Date of Birth: DEC  2,1934                    Patient Loc: RAD 101
Age          : 62                             Phone Ext  :
================================================================================
    Clinical History:
       Rule out fractures.
--------------------------------------------------------------------------------
Date Performed: _____________________________   [2]Case No.: _____________________
Technologist Initials: _____________________
                                                Number/Size Films: _______________
Interpreting Phys. Initials: _____________                         _______________
                                                                   _______________

Comments:
```

Note: If the request printer and its setup support barcode printing, the patient's barcoded SSN will also print on this form on the right above clinical history.

[1] Patch RA*5*10 April 2000

[2] Patch RA*5*18 November 2000 "See above" appears following "Case No.:" when a case number(s) is shown previous to this point.

Radiology/Nuclear Med Order Entry Menu

Print Selected Requests by Patient

This option allows the user to print or reprint a request for a selected patient.

After entering the patient's name, all of the requested exams for that patient will be displayed and you will be prompted to select one or more. You may print requests in any status, including DISCONTINUED.

The request form may include some or all of the following data: patient name and ID, date of birth, age, urgency, transportation mode, patient location, phone extension of requesting location, and room-bed (for current inpatients), procedure, procedure message, modifiers, current request status, exam status if the exam was registered, requester, primary and attending physician at time of order and current [1]("Attend Phy At Order:" will only be displayed if different from "Attend Phy Current:"), date/time ordered, desired date, clinical history, pregnancy information, isolation, pre-op, approving physician, bar-coded SSN, and portable notation.

There is also a worksheet section on the form for date performed, case number, technologist initials, interpreting physician initials, number/size of films used and comments. [2]If entered for the case, the Case Number(s), Technician(s), Film(s) used, and Technician Comments will be printed following the Interpreting Physician Initials and Comments.

If the Rad/Nuc Med Procedure parameters for the procedure ordered specify a Health Summary format to be used when requests print, a Health Summary for the patient will also print. (See ADPAC Guide for information on Procedure set-up.)

The output should be queued to a printer.

Prompt/**User Response**

```
Print Selected Requests by Patient

Select PATIENT NAME: DELIEAS,DARWIN   12-24-30  111111111     YES   SC VETERAN
                                PRIM. CARE: WANDERLY,SUSAN S   TEL 1555

                 **** Requested Exams for DELIEAS,DARWIN ****       9 Requests
   St  Urgency  Procedure                      Desired Requester    Req'g Loc
   --  -------  -----------------------------  ------- -----------  -----------
1  p   ROUTINE  CHEST 2 VIEWS PA&LAT           10/27   THORNWILDER  S SURGERY 1
2  p   ROUTINE  CHEST 2 VIEWS PA&LAT           10/09   THORNWILDER  S SURGERY 1
3  c   ROUTINE +ABDOMINAL CT                   09/09   THORNWILDER  4B/OBS
4  c   ROUTINE +AORTIC RUNOFF                  09/08   JANSEN,SARA  S VASCULAR
...
9  c   ROUTINE  CHEST SINGLE VIEW              04/08   SMITHSON,AN  11B/CCU

Select Request(s) 1-11 to Print or '^' to Exit:  Exit// 4
```

[1] Patch RA*5*26 Additional text explanation.
[2] Patch RA*5*18 November 2000 Additional fields printed on form.

Do you wish to generate a Health Summary Report? No// **<RET>** NO
DEVICE: HOME// **<RET>**

```
 >> Rad/Nuc Med Consultation for S VASCULAR <<     OCT 16,1997  16:45  Page 1
===============================================================================
Name         : DELIEAS,DARWIN                  Urgency    : ROUTINE
Pt ID Num    : 111-11-1111                    Transport  : AMBULATORY
Date of Birth: DEC 24,1930                    Patient Loc: S VASCULAR LAB 4TH F
Age          : 66                             Phone Ext  : 3333/3334
===============================================================================

Requested:          AORTIC RUNOFF                          (ANI Parent )
Registered:     267 ANGIO EXTREMITY BILAT S&I              (ANI Detailed 75716)
                268 INTRODUCTION OF CATHETER, AORTA        (ANI Detailed 36200)
                269 AORTO ABD TRANS L W/SERIAL FILMS S&I   (ANI Detailed 75625)
Procedure Message:
   -ALL REQUISITIONS MUST CONTAIN CLINICAL HISTORIES THAT COMPLY WITH ACR
    STANDARDS: INDICATIONS FOR THIS ANGIOGRAM
   -Diagnosis and evaluation of atherosclerotic vascular disease,
   -including aneurysms, emboli, occlusive disease, and thrombosis.
   -Diagnosis and evaluation of other primary vascular abnormalities,
   -including vascular malformations, vasculitis, entrapment syndrome,
   -thoracic outlet syndrome, etc.
   -Diagnosis and evaluation of vascular trauma
   -Diagnosis and evaluation of tumors
   -Preoperative planning for reconstructive surgery
   -Evaluation of surgical bypass grafts and dialysis grafts and fistulas
Request Status:       COMPLETE (c)

Requester:            JANSEN,SARATHAN K
 Tel/Page/Dig Page:  /  / 532-6022
Attend Phy Current:   UNKNOWN
Prim Phy Current:     UNKNOWN
Date/Time Ordered:    Aug 27, 1997 12:29 pm  by JANSEN,SARATHAN K
Date Desired:         Sep 08, 1997

Clinical History:
    pt with severe lifestyle limiting claudication on right, please help
    evaluation and possible angioplasty

>> Rad/Nuc Med Consultation for S VASCULAR <<    OCT 16,1997  16:45  Page 2
===============================================================================
Name         : DELIEAS,DARWIN                  Urgency    : ROUTINE
Pt ID Num    : 111-11-1111                    Transport  : AMBULATORY
Date of Birth: DEC 24,1930                    Patient Loc: S VASCULAR LAB 4TH F
Age          : 66                             Phone Ext  : 3333/3334
===============================================================================
-------------------------------------------------------------------------------
Date Performed: _____________________          Case No.: ______[1]see above____
Technologist Initials: _____________
                                                 Number/Size Films:_____________
Interpreting Phys. Initials: _______                                _____________
                                                                    _____________
Comments:
[2]Case No: 267 Tech: KNIGHT,XXXXXXXXXX  Film: 1-MEDIUM;
 These are the comments from the technologist.
Case No.: ...

VA Form 519a-ADP
```

[1] Patch RA*5*18 November 2000 "See above" appears when a case number is shown previous to this point.
[2] Patch RA*5*18 November 2000 Added Case No., Tech, Film, and Tech Comments data to end of form.

Radiology/Nuclear Med Order Entry Menu

Rad/Nuc Med Procedure Information Look-Up

This option allows the user to view procedure information as requested. The display includes procedure, procedure type, imaging type, CPT and all procedure messages and educational description. You will be prompted to select an imaging type, and asked whether or not you want to include inactive procedures. When prompted to select a Rad/Nuc Med procedure, you may select one procedure or ALL. Inactive Procedures will not be included.

Prompt/**User Response** Discussion

```
Rad/Nuc Med Procedure Information Look-Up

Select an Imaging Type: RAD  GENERAL RADIOLOGY     RAD

Select a Rad/Nuc Med Procedure: CHOLANGIOGRAM OPERATIVE    (RAD  Detailed)
CP T:74300

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

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

```
                Radiology/Nuclear Medicine Procedure Information

Run Date/Time: Aug 19, 1997 1:37 pm                                  Page: 1
------------------------------------------------------------------------------
CHOLANGIOGRAM OPERATIVE           (RAD  Detailed) CPT:74300
Guidelines for Work-up of Emergency Interventional Procedures
Requested On Call

Emergency Transhepatic Cholangiogram and/or Biliary Drainage

 1.  What is the clinical history?  Mental status?
 2.  Has the patient had an ultrasound or CT to look for obstruction?
 3.  Is the patient febrile?  What is the WBC?  Is the patient on
      antibiotics - if so, what, for how long?
 4.  Is that patient allergic to any medications or contrast?
 5.  Has the patient had prior surgery pertinent to the area of
      interest?  Is there ascites?
 6.  What are the pertinent labs, including CBC, PT, PTT, platelets,
      BUN, creatinine, bilirubin, SGOT, SGPT, alk phos, EKG (read
      by MD)?
 7.  If there is a coagulopathy, is the hematology team seeing the
      patient?
 8.  If the patient is on the medical wards, have the surgeons been
      consulted? Did the surgical resident discuss the case with the
      staff surgeon on call?  Did the staff surgeon agree that the
      procedure should be performed?
 9.  Permit for percutaneous biliary cholangiogram and drainage
      signed.
10.  Pre-angiography orders: IV in arm, NPO.
11.  Patient must be on IV antibiotics, preferably 24 hours prior to
      the procedure.
```

Radiology/Nuclear Med Order Entry Menu

Request an Exam

This option allows the user to request one or more procedures for a patient. Once the request has been entered, it is assigned a status of "pending."

You will be asked to select a patient. In the event that another person is editing orders for the patient you select, you may see a message asking that you try again later.

After a patient is selected, you will be prompted for patient location and person requesting order. If the patient is an inpatient, you will see a default showing the ward the patient is currently on according to data in the MAS package. The default requesting person will be yourself.

A display will show the last five registered procedures (including cancelled exams but not including cancelled requests) and all imaging requests not yet registered or cancelled (i.e., PENDING, SCHEDULED, UNRELEASED), and the date they were ordered.

To help speed up the ordering process, the ADPAC can create up to 40 Common Procedures for each imaging type. (See the ADPAC Guide for information about setting up Common Procedures.) If common procedures have been set up by the ADPAC, they will display on the selection screen.

Next you will be prompted for a procedure. Only active procedures, that is, procedures without an inactivation date, or whose inactivation date is before the current date, may be selected. If the division parameter Detailed Procedure Required? is set to Yes, procedures of the Broad type will not be selectable either. Detailed, Series, and Parent procedures are always selectable independent of this parameter setting. (See ADPAC Guide for more information about division parameter set-up and Procedure Enter/Edit.) The user may choose one of the common procedures displayed or any other valid procedure even though it does not appear on the common list.

[1]You will also be prompted for modifiers and a clinical history. A procedure can be further defined by using the Procedure Modifiers field. Several modifiers may be entered for one procedure. The clinical history should state why the exam is being requested (i.e., conditions to rule out, conditions to confirm, past history relevant to this exam, and any additional helpful information, such as pertinent lab values or dates of pertinent trauma, surgery, or procedures). The AMIS special procedure modifiers (portable, bilateral, and operating room) are not selectable for "Series" type procedures as they would make the AMIS reports inaccurate.

At the procedure prompt, multiple procedure choices can be made by entering a comma between selections. Selections can be made by common procedure number, CPT code, procedure name, or synonym. (See ADPAC Guide for more information about Procedure Enter/Edit for assigning CPTs and synonyms.)

[1] Patch RA*5*8 October 1999

Depending on how the ADPAC has set up procedure messages, a message may be displayed giving special instructions that must be followed by the requester when this procedure is ordered. (See ADPAC Guide for additional information regarding Procedure Message set-up.)

[1]You will be asked to enter procedure modifiers, desired date, and clinical history in all circumstances. Default information is automatically entered in some fields (patient category, urgency, mode of transport, isolation and pre-op). If your facility is running CPRS (OE/RR 3.0 or higher), your ADPAC may set up a feature where Specified Imaging Service Personnel will receive an alert when a STAT or URGENT request is entered. If the specified patient is an inpatient, the standard default mode of transport will be wheel chair. The standard default mode of transport for outpatients will be ambulatory. However, if portable is entered as a modifier, the standard default mode of transport will be portable regardless of the patient category. You will be given the opportunity to edit the default information. If multiple procedures are chosen, the data you enter for the first procedure is automatically entered for the following procedures. If anything needs to be changed, you will have to edit it.

If you are entering a request for a female patient (who may be pregnant), you will also see a "Pregnant:" prompt. You may answer No, Yes, or Unknown. Your answer will appear in the pregnancy status notation of the printed request form.

If your division parameter Ask Imaging Location? is set to Yes you will see a SUBMIT REQUEST TO: prompt at which you should select an imaging location where the request form will be printed. Only imaging locations whose imaging type matches the imaging type of the procedure selected can be chosen. If IRM has defined a printer for request printout through the IRM menu of this package, a request form will print on that printer. (See Technical Manual for information about setting up printers for imaging locations.)

Prompt/**User Response** Discussion

```
Request an Exam

Select PATIENT NAME: DENT,VERNON          07-06-46     412760624     YES     SC
 VETERAN

Patient Location: GENERAL MEDICINE
Person Requesting Order: KEPPEL,BART


Case #    Last 5 Procedures/New Orders Exam Date   Status of Exam  Imaging Loc.
------    ---------------------------- ---------   --------------  ------------
335       CHOLANGIOGRAM IV             APR 12,1995 CANCELLED       X-RAY
          ARTHROGRAM WRIST S&I         APR  3,1995 COMPLETE        X-RAY
          ANKLE 2 VIEWS                APR  3,1995 COMPLETE        X-RAY
          CT HEAD W/IV CONT            JAN 19,1995 COMPLETE        X-RAY
          SKULL 4 OR MORE VIEWS        JAN 19,1995 COMPLETE        X-RAY
          ARTHROGRAM SHOULDER S&I                  Ord 4/9/97      X-RAY
          ARTHROGRAM WRIST S&I                     Ord 4/9/97      X-RAY
```

[1] Patch RA*5*10 April 2000

```
          ARTHROGRAM SHOULDER S&I                  Ord 4/9/97      X-RAY

Press <RETURN> key to continue. <RET>

Select one of the following imaging types:
   GENERAL RADIOLOGY
   NUCLEAR MEDICINE
   ULTRASOUND
   CT SCAN
   ANGIO/NEURO/INTERVENTIONAL
   CARDIOLOGY STUDIES (NUC MED)

Select IMAGING TYPE: NUCLEAR MEDICINE



        COMMON RADIOLOGY/NUCLEAR MEDICINE PROCEDURES (NUCLEAR MEDICINE)
        ---------------------------------------------------------------
 1) ACUTE GI BLOOD LOSS IMAGING             7) GALLIUM SCAN FOR INFECTIOUS/INFL
 2) BRAIN IMAGING, PLANAR ONLY              8) BONE SCAN PARENT
 3) RADIONUCLIDE THERAPY, THYROID SU        9) THYROID SCAN
 4) KIDNEY FUNCTION STUDY (RENOGRAM)        10) MUGA SCAN PARENT (3 CHILDREN)
 5) STEVE'S TEST PROCEDURE                  11) V/Q SCAN PARENT (3 CHILDREN)
 6) BONE SCAN                               12) BONE MARROW IMAGING
Select Procedure (1-12): or enter '?' for help: 1


Processing procedure: ACUTE GI BLOOD LOSS IMAGING



NOTE: The following special requirements apply to this procedure: ACUTE GI BLOOD
 LOSS IMAGING

CALL DR. SMITH BEFORE ORDERING THIS PROCEDURE

This test is designed to LOCATE the site of KNOWN GI bleeding, NOT to
determine whether there IS GI bleeding.


[1]Select PROCEDURE MODIFIERS: ASAP
Select PROCEDURE MODIFIERS: <RET>
DATE DESIRED (Not guaranteed): TODAY//  <RET>  (APR 09, 1997)

   Enter clin hist relevant to procedure, problems to rule out/confirm.

Enter RETURN to continue or '^' to exit:
CLINICAL HISTORY FOR EXAM

==[ WRAP ]==[ INSERT ]==========< Clin Hist/Reason >=========[ <PF1>H=Help ]====
Enter patient's clinical history here.



<======T=======T=======T=======T=======T=======T=======T=======T=======T=>=====T


--------------------------------------------------------------------------------
          Patient: DENT,VERNON
        Procedure: ACUTE GI BLOOD LOSS IMAGING
        Modifiers: ASAP
         Category: OUTPATIENT                  Mode of Transport: AMBULATORY
     Desired Date: Apr 09, 1997              Isolation Procedures: NO
```

[1] Patch RA*5*10 April 2000

```
  Request Urgency: ROUTINE                    Scheduled for Pre-op: NO
 Request Location: GENERAL MEDICINE

Clinical History:

Enter patient's clinical history here.

--------------------------------------------------------------------------------
Do you want to change any of the above? NO// <RET>

SUBMIT REQUEST TO: ??
     This field points to the 'IMAGING LOCATIONS' file
(#79.1) to indicate the name of the imaging location
within the hospital division where the rad/nuc med exam is
to be performed.

Choose from:
   NUC                          (NUCLEAR MEDICINE-499)
   NUC MED LOC                  (NUCLEAR MEDICINE-639)
```

Only imaging locations pre-defined (by the ADPAC) to have the same imaging type as the procedure requested will be selectable. If there is only one imaging location with an imaging type that matches the procedure, the system will automatically submit the request to that location.

```
SUBMIT REQUEST TO: NUC MED LOC               (NUCLEAR MEDICINE-639)

     ...request has been submitted to P-DOT MATRIX BACK.
  Task #: 39212
```

Radiology/Nuclear Med Order Entry Menu

Schedule a Request

This option allows the user to schedule requested examinations for a specific date/time. An order must already have been requested through the Request an Exam option. Only requests with a status of HOLD or PENDING are eligible for scheduling.

You will be asked to select a patient. In the event that another person is editing orders for the patient you select, you may see a message asking that you try again later. If no one else is working on orders for that patient, a list of requests for the patient will be displayed, including the request status, urgency, procedure, desired date, requester, and patient location.

A selection prompt will ask which request should be scheduled, then you will be asked to enter the date and time you wish to schedule the procedure.

NOTE: Scheduling in the Radiology/Nuclear Medicine package is accomplished through this option. Scheduling in the MAS package is a completely separate function. Neither interacts with the other. MAS scheduling is used at many hospitals in addition to Radiology/Nuclear Medicine scheduling because it is helpful in arranging transportation, charts, etc.

Prompt/**User Response** Discussion

```
Schedule a Request

Select PATIENT NAME: DENT,VERNON           07-06-46     412760624     SC VETERAN

                **** Requested Exams for DENT,VERNON ****          3  Requests
    St  Urgency  Procedure                        Desired Requester    Req'g Loc
    --  -------  -----------------------------  ------- -----------  -----------
 1  p   ROUTINE  ARTHROGRAM SHOULDER S&I        04/03   DAVIDSON,MA  EMERGENCY R
 2  p   ROUTINE  ARTHROGRAM WRIST S&I           04/03   DAVIDSON,MA  EMERGENCY R
 3  p   ROUTINE  ANOTHER PARENT PROCEDURE       01/20   DAVIDSON,MA  X-RAY STOP

Select Request(s) 1-3 to Schedule or '^' to Exit:  Exit// 1,2

Schedule Request Date/Time: ??
     Examples of Valid Dates:
       JAN 20 1957 or 20 JAN 57 or 1/20/57 or 012057
       T   (for TODAY),  T+1 (for TOMORROW),  T+2,  T+7,  etc.
       T-1 (for YESTERDAY),  T-3W (for 3 WEEKS AGO), etc.
     If the year is omitted, the computer assumes a date in the FUTURE.
     If only the time is entered, the current date is assumed.
     Follow the date with a time, such as JAN 20@10, T@10AM, 10:30, etc.
     You may enter a time, such as NOON, MIDNIGHT or NOW.
Schedule Request Date/Time: T@2:30PM  (APR 03, 1995@14:30)

Select PATIENT NAME: <RET>
```

Radiology/Nuclear Med Order Entry Menu

Ward/Clinic Scheduled Request Log

This option allows the user to generate a list of SCHEDULED requests for patients on a selected ward or clinic. The list includes the following information: patient name, patient ID, scheduled date, procedure and imaging location if the request was submitted to a specific imaging location. If the Ask Imaging Location parameter (field #.121 of the Rad/Nuc Med Division file #79) is set to YES the imaging location will be asked when the order is created. If the parameter field is set to NO, the imaging location will not be captured and therefore will not appear on this report.

Selection criteria include a prompt asking for a ward or clinic, and a starting and ending date range. Radiology/Nuclear Medicine orders with a Scheduled Date (field #23 of the Rad/Nuc Med Order file #75.1) that falls within the date range selected will be included.

Only Rad/Nuc Med requests which have been ordered, then scheduled through the Schedule a Request option are included on this report. Scheduled appointments entered through MAS only do not appear on this report.

At the time the order is placed, the requesting location is assumed to be the patient's location. If the current patient location (based on MAS data) changed since the time the order was placed the scheduled exam will print on the report for both the old and the new location with a notation on each showing the other location. If the requesting location was an inpatient location, but the patient is no longer an inpatient, the notation simply says DISCHARGED.

The report prints in chronological order by scheduled date/time.

Prompt/**User Response** Discussion

```
Ward/Clinic Scheduled Request Log

Select Ward/Clinic: ER  EMERGENCY ROOM

Starting Imaging Exam Scheduled Date: T  (APR 03, 1995)

Ending Imaging Exam Scheduled Date: T  (APR 03, 1995)

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

```
                      >>> RADIOLOGY/NUCLEAR MEDICINE <<<

Scheduled Request Log for EMERGENCY ROOM                              Page: 1
     Schedule dates from APR  3,1995 to APR  3,1995  23:59
Run Date: APR  3,1995  13:20

Patient             Pt ID   Sched. Date    Procedure              Imaging Loc
------------------- -----   -------------  ---------------------  -------------
DENT,VERNON         0624    4/3/95@14:30   ARTHROGRAM WRIST S&I   X-RAY


Press RETURN to continue...
```

XI. Supervisor Menu

This menu provides many functions which should only be used by the package coordinator. The functions involve very sensitive aspects of the system; incorrect usage can cause problems.

Access Uncorrected Reports
Delete a Report
Delete Printed Batches by Date
Exam Deletion
Inquire to File Entries
List Exams with Inactive/Invalid Statuses
Maintenance Files Print Menu …
Mass Override Exam Status
Override a Single Exam Status to 'complete'
Print File Entries
Rad/Nuc Med Personnel Menu …
Search File Entries
Switch Locations
System Definition Menu …
Unverify a Report for Amendment
Update Exam Status
Utility Files Maintenance Menu …

The sub-menus listed below are usually used only by the system ADPAC, and are not explained within this manual. Please refer to the ADPAC Guide for a complete explanation of these items:

Maintenance Files Print Menu
Rad/Nuc Med Personnel Menu
System Definition Menu
Utility Files Maintenance Menu

Please refer to the V*IST*A FileMan User Guide for a complete explanation of Inquire to File Entries, Print File Entries, and Search File Entries.

Supervisor Menu

Access Uncorrected Reports

This option allows the user to view uncorrected reports on a selected patient. These are the report contents saved prior to amendment. The report shows case no., procedure, exam date, status of exam, date/time report was retained, social security no., age of patient, physicians, patient location, imaging location, and service. There may be more than one uncorrected report for a single exam.

```
Access Uncorrected Reports

Select Patient: ANVIOLI,DAVID J.               NO     NSC VETERAN       07-03-30
  555-55-5555

                  **** Patient's Exams ****

Patient's Name: ANVIOLI,DAVID J.  555-55-5555           Run Date: AUG 19,1997

   Case No.  Procedure                  Exam Date  Status of Exam   Imaging Loc
   --------  -------------              ---------  ---------------- -----------
1    +234  i CT THORAX W/O CONT         08/05/97   COMPLETE         CTG
Type '^' to STOP, or
CHOOSE FROM 1-1: 1

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

```
*** Uncorrected Reports for: ANVIOLI,DAVID J. ***
Run Date: Aug 19, 1997                                                Page: 1
------------------------------------------------------------------------------
   Date/Time Uncorrected Report retained: Aug 06, 1997 12:27:15 pm

ANVIOLI,DAVID J.  555-55-5555    67 yr. old male      Case: 080597-234@13:42
Req Phys: MOE,SUSAN                        Pat Loc: 9CM/080697@12:27
Att Phys: SANDER,DENIS                        Img Loc: CTG
Pri Phys: MOE,SUSAN                        Service: MEDICINE


Report Unverified by: ANDERSON,MICHAEL E, M.D.

CT THORAX W/O CONT
     Exam Modifiers : None

    Clinical History:
      67 yo male w/ newly dx'd sq cell lung ca...? chest wall spread
      and mets.
```

```
                *** Uncorrected Reports for: ANVIOLI,DAVID J. ***
Run Date: Aug 19, 1997                                                Page: 2
-------------------------------------------------------------------------------
                                            *** Uncorrected Version   ***
                                            *** Refer to final report ***

    Report:

    Impression:
       CT SCAN OF THE CHEST, ABDOMEN AND PELVIS: 08/05/97

      FINDINGS:  There is a 5 X 3cm cavitary superior segment right
      lower lobe lesion invading the posterior pleura and adjacent rib,
      compatible with advanced neoplasm. There is adenopathy in the
      paratracheal, pretracheal, precarinal, subcarinal spaces.  There
      is right hilar adenopathy.

Primary Interpreting Staff:
  MICHAEL E. ANDERSON, MD, STAFF RADIOLOGIST
Primary Interpreting Resident:
```

```
                *** Uncorrected Reports for: ANVIOLI,DAVID J. ***
Run Date: Aug 19, 1997                                                Page: 4
-------------------------------------------------------------------------------
  MAYER,LOUIS, M.D., Radiology Resident
VERIFIED BY:
  MICHAEL E. ANDERSON, MD, STAFF RADIOLOGIST

/CG

********************** P R O B L E M   S T A T E M E N T **********************
None entered.
```

Supervisor Menu

Delete a Report

This function allows holders of the RA MGR security key to delete a report. This option should only be used by authorized personnel. Deleting a report should only be done to correct problems that cannot be corrected in any other way. This option should be used rarely and with extreme caution. An example where this option might be necessary is when a transcriptionist enters a report on a wrong patient, discovers it and asks the supervisor to delete it before it is verified.

You will be prompted for a day-case number of the report you wish to delete. You may also enter a patient name at this prompt to see all eligible reports for that patient.

If a report for a printset is deleted, all exams in the set will reflect the changed exam status, and the fact that there is no report for any of them.

When this function is executed, a bulletin is sent to the members of the RADIOLOGY REPORT DELETION mail or other group set up by IRM to receive the RAD/NUC MED REPORT DELETION bulletin.

Prompt/**User Response** Discussion

```
Delete a Report

Select Report Day-Case#: PARISH,HOMER           08-27-41     222948704     NO
  NSC VETERAN
     1     031895-143     PARISH,HOMER   ABDOMEN 1 VIEW
     2     010897-427     PARISH,HOMER   +BONE IMAGING, WHOLE BODY
CHOOSE 1-2: 2  010897-427

Do you wish to delete this report? NO// Y
          ...report deletion complete.


   ...will now designate exam status as 'EXAMINED'... for case no. 427
          ...exam status backed down.
Credit deleted for this Visit.
```

Supervisor Menu

Delete Printed Batches By Date

This option allows the user to delete batches. The option purges all records up to a user defined date. This purges records by date printed, not by the users who created the batch. This option can only be accessed by those users who hold the RA MGR key.

All batches prior to the date you select will be purged from the Report Batches file #74.2. After you select a date, the system will inform you how many batches will be deleted and ask if you want to task the job, to be completed at a later time.

If you answer Y to include unprinted batches, batches without a Date Printed will also be displayed.

Prompt/**User Response** Discussion

```
Delete Printed Batches by Date

     All batches up to the date you enter will be purged
     from the Report Batches file #74.2.

Purge report batches printed before: APR 10,1995//4/1/95  (APR 01, 1995)

Want to include unprinted batches created before APR 1,1995? No// <RET>  NO


The following Report Batches have been selected to be purged:

   Batch: MARK                          Date Created: JUN 13, 1994@12:48
   User: MELNIK,MARK                    Date Printed: MAR 22, 1995@08:54

   Batch: TEST BATCH                    Date Created: SEP 28, 1994@10:37
   User: HELLER,CINDY                   Date Printed: SEP 28, 1994

   Batch: MARCH 6 REPORTS               Date Created: MAR 06, 1995@11:59
   User: TRACKER,FRANK                  Date Printed: MAR 06, 1995@12:03

   Batch: GREG'S TEST                   Date Created: MAR 09, 1995
   User: CEBEL,GREGORY J                Date Printed: MAR 09, 1995@10:00


     'APR 1,1995', are you sure?

Enter Yes or No: YES

     There are 4 batches selected to be deleted.
     Do you wish to task this job off to be completed
     at a later time?

Enter Yes or No: YES
Requested Start Time: NOW// <RET> (APR 10, 1995@09:34:57)
```

Supervisor Menu

Exam Deletion

This function allows holders of the RA MGR security key to delete exams from the system. This function should only be used by authorized personnel to correct problems that cannot be corrected in any other way. Deletion of an exam means permanent, non-retrievable deletion of exam data. This differs from the Cancel an Exam option where the exam data remains accessible to the user. Use of the Cancel an Exam option should be considered before using the Exam Deletion option. This option would be useful if a clerk registers an exam for the wrong patient, the exam is not performed and s/he asks the supervisor to delete it before any more action is taken.

When this function is executed, the RAD/NUC MED EXAM DELETED mail bulletin is sent to members of the RADIOLOGY EXAM DELETED mail group , or other mail group set up by IRM, to notify them of the exam deletion.

Deletion of an exam is prohibited if the exam has an associated report. The report must be deleted first before the exam can be deleted.

Once the examination is DELETED, the user will be prompted to answer with a YES or NO to cancel the request associated with this exam. If YES, the request will also be cancelled and the request status updated to CANCELLED. If NO, the request status will be updated to HOLD and may be selected for registration at a future date. If the request applies to a parent procedure, for which other descendent procedures are registered, you will not be allowed to HOLD or cancel (i.e., DISCONTINUE) the request.

Prompt/**User Response** Discussion

Exam Deletion

An exam with a status of Complete cannot be deleted:

```
Enter Case Number: DILG,LEOPOLD
           01-22-20     688328575     YES     SC VETERAN

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

Patient's Name: DILG,LEOPOLD  688-32-8575              Run Date: AUG 19,1997

   Case No.  Procedure                   Exam Date  Status of Exam   Imaging Loc
   --------  ------------                ---------  ---------------- -----------
1     583    BONE AGE                    08/31/95   WAITING FOR EXAM X-RAY
2     558    CHEST STEREO PA             08/31/95   COMPLETE         X-RAY
3     559    ANGIO CAROTID CEREBRAL UNI  08/31/95   WAITING FOR EXAM X-RAY
4     582    ANGIO CAROTID CEREBRAL SEL  08/31/95   WAITING FOR EXAM X-RAY
5     552    CHEST STEREO PA             08/31/95   WAITING FOR EXAM X-RAY
6     553    ANGIO CAROTID CEREBRAL UNI  08/31/95   WAITING FOR EXAM X-RAY
```

```
7     376    RADIONUCLIDE THERAPY, THYR  04/27/95   COMPLETE         NUC MED LOC
8     153    ECHOGRAM ABDOMEN COMPLETE   03/21/95   WAITING FOR EXAM ULTRASOUND
9     196  i BONE AGE                    12/08/94   COMPLETE         X-RAY
10    217    CHOLANGIOGRAM IV            12/08/94   CANCELLED        X-RAY
11    218    SPINE CERVICAL MIN 2 VIEWS  12/08/94   COMPLETE         X-RAY
12    1      ARTHROGRAM KNEE CP          06/08/94   COMPLETE         X-RAY
13    22     CHEST STEREO PA             06/08/94   COMPLETE         X-RAY
14    78     ULTRASONIC GUID FOR RX FIE  04/04/94   COMPLETE         ULTRASOUND
Type '^' to STOP, or
CHOOSE FROM 1-14: 2

   A report has been filed for this case. Therefore deletion is not allowed!
```

Example of an exam deletion:

```
Enter Case Number: DILG,LEOPOLD
           01-22-20     688328575     YES     SC VETERAN

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

Patient's Name: DILG,LEOPOLD  688-32-8575              Run Date: AUG 19,1997

   Case No.  Procedure                   Exam Date  Status of Exam   Imaging Loc
   --------  -------------               ---------  ---------------- -----------
1     583    BONE AGE                    08/31/95   WAITING FOR EXAM X-RAY
2     558    CHEST STEREO PA             08/31/95   COMPLETE         X-RAY
3     559    ANGIO CAROTID CEREBRAL UNI  08/31/95   WAITING FOR EXAM X-RAY
4     582    ANGIO CAROTID CEREBRAL SEL  08/31/95   WAITING FOR EXAM X-RAY
5     552    CHEST STEREO PA             08/31/95   WAITING FOR EXAM X-RAY
6     553    ANGIO CAROTID CEREBRAL UNI  08/31/95   WAITING FOR EXAM X-RAY
7     376    RADIONUCLIDE THERAPY, THYR  04/27/95   COMPLETE         NUC MED LOC
8     153    ECHOGRAM ABDOMEN COMPLETE   03/21/95   WAITING FOR EXAM ULTRASOUND
9     196  i BONE AGE                    12/08/94   COMPLETE         X-RAY
10    217    CHOLANGIOGRAM IV            12/08/94   CANCELLED        X-RAY
11    218    SPINE CERVICAL MIN 2 VIEWS  12/08/94   COMPLETE         X-RAY
12    1      ARTHROGRAM KNEE CP          06/08/94   COMPLETE         X-RAY
13    22     CHEST STEREO PA             06/08/94   COMPLETE         X-RAY
14    78     ULTRASONIC GUID FOR RX FIE  04/04/94   COMPLETE         ULTRASOUND
Type '^' to STOP, or
CHOOSE FROM 1-14: 6


Do you wish to delete this exam? NO// Y

Do you want to cancel the request associated with this exam? No// N  (No)

HOLD DESCRIPTION:
  No existing text
  Edit? NO// YES


==[ WRAP ]==[ INSERT ]==========< HOLD DESCRIPTION >=========[ <PF1>H=Help ]====
Patient called and postponed.



<======T=======T=======T=======T=======T=======T=======T=======T=======T=>=====T

          ...request status updated to hold.
      ...exam status backed down to 'CANCELLED'
          ...deletion of exam complete.
```

Supervisor Menu

Inquire to File Entries

This option is used to display all the data for one or a small number of specified entries in a file. This is useful for a quick look at an entry. Use the Print File Entries option for larger numbers of entries.

This option is the same as using the VA FileMan Inquire to File Entries option, so it is necessary that the user be assigned all appropriate file access codes by his/her IRM. You will be prompted for a file name and then, one by one, the entries in the file you wish to view.

Since new versions of the FileMan software affect the behavior of this option, no example is shown here. For examples and assistance in using this option, you may refer to the FileMan User Manual.

Supervisor Menu

List Exams with Inactive/Invalid Statuses

This option will list all exams which are linked to an exam status which is invalid. An exam status is inactive/invalid if the value in the Order field is null. This could happen if the ADPAC deactivates the status while some exams are still in that status.

The report generated shows the exam status, imaging type, and for each exam with the invalid status, the patient name and SSN, exam date, case number, and procedure. Case edits or Status Tracking can be used to update to valid statuses.

Prompt/**User Response** Discussion

```
List Exams with Inactive/Invalid Statuses

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

```
                                                                Page 1
                                                                Date: APR 11,1997

                     Exams with Inactive/Invalid Statuses
================================================================================

Exam Status: EXAMINED                          Imaging Type: ULTRASOUND
***********                                    ************

Patient: ABLKCBFV,ALAN K.                      SSN: 119-11-1556
Exam Date: JUN 21,1994@15:31                   Case #: 48
Reported: Yes                                  Report Status: DRAFT
Procedure: ULTRASOUND ABDOMEN

Patient: CORLEONE,VITO                         SSN: 625-34-3953
Exam Date: MAR 9,1994@13:44                    Case #: 7
Reported: Yes                                  Report Status: VERIFIED
Procedure: ECHOGRAM ABDOMEN COMPLETE

Patient: JORDAN,MICHAEL                        SSN: 232-32-3230
Exam Date: JAN 12,1995@10:14                   Case #: 29
Reported: Yes                                  Report Status: VERIFIED
Procedure: ECHOGRAM ABDOMEN COMPLETE

Enter RETURN to continue or '^' to exit:
```

Supervisor Menu

Mass Override Exam Status

This option can be used by holders of the RA MGR security key to override one or more statuses of exams to COMPLETE. It can be used to clean up old exams that were never completed and are still assigned a case number. This will allow case numbers to be re-cycled and re-used. However, it is preferable to use exam status tracking or case editing options to move an exam to a COMPLETE status if work was performed. The Mass Override Exam Status option will not attempt to do any automatic stop code or procedure crediting, so if the procedures being overridden to complete represent actual work done, data for reimbursement will have to be entered manually into the PCE package.

Exams with a status of COMPLETE or CANCELLED will not be updated through this option. Only exams whose imaging type is the same as the supervisor's sign-on imaging type will be updated.

The user is asked to select the statuses to override and is then asked for a cutoff date. The cutoff date must be at least 60 days prior to the current date. A printed report is generated of all the exams whose status is overridden to COMPLETE. The report should be queued to a printer. Due to the volume of records which may be affected by this option, it is recommended that this option be run during off hours.

Data displayed on the report will include cutoff date, date report is run, patient name, exam date, case number and the status before the override. The report is sorted by status.

Prompt/**User Response** Discussion

```
Mass Override Exam Status

Your sign-on imaging type is GENERAL RADIOLOGY, so only
exams of imaging type GENERAL RADIOLOGY will be changed
to complete.

Are you sure you want to proceed? YES
Select EXAMINATION STATUS: EXAMINED          GENERAL
RADIOLOGY
         ...OK? Yes// <RET>  (Yes)
Select EXAMINATION STATUS: <RET>

Enter a cutoff date that is at least sixty days prior to
today.
Enter a date: T-60  FEB 10, 1997
QUEUE TO PRINT ON
DEVICE: HOME// Select a printer <RET>
```

```
Requested Start Time: NOW// <RET> (FEB 10, 1997@04:42:13)
     Output Queued.  Task #: 39392


                                Cutoff Date for this Report is : FEB 10, 1997
                                        Date Report was Run: Apr 11, 1997

Patient Name        Exam Date                 Case #       Status Before Override

LIME,HARRY          MAY 20, 1996@10:17        212          EXAMINED
SHAW,RAYMOND E.     JUL 16, 1996@08:59        261          EXAMINED
STILICHO,FLAVIUS    MAY 22, 1996@14:50        232          EXAMINED
```

Supervisor Menu

Override a Single Exam’s Status to 'complete'

This function allows owners of the RA MGR security key to override the status of any exam to COMPLETE. The only exceptions to this function are exams which are already COMPLETE or those which have been CANCELLED. This option can be used to update an old exam that was never completed and is still assigned a case number. This will allow case numbers to be re-cycled and re-used. However, it is preferable to use exam status tracking or case editing options to move an exam to a COMPLETE status if work was performed. The Override a Single Exam Status to 'complete' option will not attempt to do any automatic stop code or procedure crediting, so if the procedures being overridden to complete represent actual work done, data for reimbursement will have to be entered manually into the PCE package.

You will be prompted for the case number of the exam whose status you wish to override. The case number, patient name and ID, procedure, exam date, technologist and physician will be displayed for the selected case.

If you do not know the case number, you may enter the patient name to see a list of exams on file and be prompted for a selection.

You will be prompted for the status change date and time, with the current date/time showing as the default.

Prompt/**User Response** Discussion

```
Override a Single Exam Status to 'complete'

Enter Case Number: DILG,LEOPOLD          01-22-20     688328575   YES  SC VETERAN


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

Patient's Name: DILG,LEOPOLD  688-32-8575             Run Date: APR 10,1995

   Case No.  Procedure                   Exam Date  Status of Exam   Imaging Loc
   --------  -------------               ---------  ---------------- -----------
1     151    ABDOMEN 1 VIEW              03/21/95   WAITING FOR EXAM X-RAY
2     196    BONE AGE                    12/08/94   COMPLETE         X-RAY
3     217    CHOLANGIOGRAM IV            12/08/94   WAITING FOR EXAM X-RAY
4     218    SPINE CERVICAL MIN 2 VIEWS  12/08/94   WAITING FOR EXAM X-RAY
5     1      ARTHROGRAM KNEE CP          06/08/94   COMPLETE         X-RAY
6     22     CHEST STEREO PA             06/08/94   COMPLETE         X-RAY
Type '^' to STOP, or
CHOOSE FROM 1-6: 1
------------------------------------------------------------------------------
 Name     : DILG,LEOPOLD               Pt ID       : 688-32-8575
 Case No. : 151                        Procedure   : ABDOMEN 1 VIEW
 Exam Date: MAR 21,1995  11:00         Technologist:
                                       Req Phys    : WELBY,MARCUS
------------------------------------------------------------------------------
```

```
Are you sure? No// Y
   ...will now attempt override...
      STATUS CHANGE DATE/TIME: APR 10,1995@09:40//
      ...exam status is now 'COMPLETE'.

   ...will now designate request status as 'COMPLETE'...
         ...request status successfully updated.
```

Supervisor Menu

Print File Entries

This option is used to print a report from a file, where a number of entries will be listed in a columnar format. Each column can be individually controlled for format, tabulation, justification, etc. The Print File Entries option is often used to generate ad hoc reports.

This option is the same as using the VA FileMan Print File Entries option, so it is necessary that the user be assigned all appropriate file access codes by his/her IRM. This FileMan utility is extremely powerful and can interpret a large set of instructions about entry retrieval and print formatting.

Since new versions of the FileMan software affect the behavior of this option, no example is shown here. For examples and assistance in using this option, you may refer to the FileMan User Manual.

Supervisor Menu

Search File Entries

This option is used to search file fields for specific data. It allows the user to specify the search logic for multiple fields and obtain a more specific set of entries than the Inquire to File Entries or Print File Entries options.

This option is the same as using the VA FileMan Search File Entries option, so it is necessary that the user be assigned all appropriate file access codes by his/her IRM. This FileMan utility is extremely powerful, but can be an intensive computer resource drain, so it should be used with care, preferably in off hours if the file being searched contains a large number of entries.

Since new versions of the FileMan software affect the behavior of this option, no example is shown here. For examples and assistance in using this option, you may refer to the FileMan User Manual.

Supervisor Menu

Switch Locations

This option appears on several menus as a convenience to users. Please refer to the option description earlier in this section where it first appears under Use of the Software, on page III-2.

Supervisor Menu

Unverify a Report for Amendment

This option can be used by holders of the RA MGR security key to change the status of a report to other than VERIFIED. Since a verified report cannot be edited, the report status must be changed before any corrections can be made. If this option is being used frequently, it usually means that procedures for reviewing reports before verifying them are inadequate. This option should be used rarely, if at all.

You will be prompted for a report date/case number. Only reports with a status of VERIFIED can be selected. If you enter a patient name, you will be prompted to select from a list of eligible reports.

After selecting a report, the valid status choices are DRAFT, PROBLEM DRAFT, VERIFIED, or, if your ADPAC has the division parameters set to allow it, RELEASED/NOT VERIFIED.

The RAD/NUC MED REPORT UNVERIFIED MailMan bulletin will be sent to members of the RADIOLOGY REPORT UNVERIFIED mail group or other mail group set up by IRM each time a report is unverified through this option. The entire contents of the report prior to unverification are copied for permanent retention and are accessible through the Supervisor Menu, Access Uncorrected Reports option.

NOTE: If Report Status is changed to PD, you will be prompted for a Problem Statement.

Prompt/**User Response** Discussion

```
Unverify a Report for Amendment

Select RAD/NUC MED REPORTS DAY-CASE#: EQUATOL,BRIAN
12-01-50     613345463   NO   NSC VETERAN


     1     013194-10        EQUATOL,BRIAN   ANGIO CAROTID CEREBRAL UNILAT S&I
     2     013194-47        EQUATOL,BRIAN   ARTHROGRAM KNEE CP
CHOOSE 1-2: 1  013194-10

     Select one of the following:

          V         VERIFIED
          R         RELEASED/NOT VERIFIED
          PD        PROBLEM DRAFT
          D         DRAFT

REPORT STATUS: V// D <RET> RAFT
   ...will now designate exam status as 'WAITING FOR EXAM'...
          ...exam status successfully updated.
```

```
Subj: Imaging Report Unverified (613-34-5463)  [#12475] 10 Apr 95 09:43
  10 Lines
From: POSTMASTER (Sender: HELLER,CINDY)  in 'IN' basket.      Page 1
-------------------------------------------------------------------------------

The following verified radiology report has been unverified:
               1) Patient              : EQUATOL,BRIAN
               2) SSN                  : 613-34-5463
               3) Case Number          : 013194-10
               4) Exam Date            : JAN 31, 1994@11:09
               5) Desired Date         : JAN 28, 1994
               6) New Status           : DRAFT
               7) Requesting Physician : JOHNSON,SUSAN
               8) Procedure            : ANGIO CAROTID CEREBRAL UNILAT S&I
               9) Imaging Loc          : X-RAY


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

Supervisor Menu

Update Exam Status

This option is used to update the status of an examination. In most cases an examination's status will be automatically updated when the required information for the next status has been entered. Occasionally, an exam will not have the correct status. This may occur if the status requirements have been changed by the ADPAC; you may then need to execute this function. (See ADPAC Manual for information about Examination Status parameter set-up.)

This option evaluates the current data entered for an examination against the exam status requirements that are currently in effect. If necessary, the specified examination will have its status changed. If the selected examination still does not meet the requirements of the next status, no change will be made. A message will be displayed on screen to inform you if a change does occur.

You will be prompted for a case number. If you enter a patient's name, you can choose from a list of cases for that patient.

When an exam moves from one status to the next, the system will automatically attempt to pass the stop codes and procedures associated with the exam to the Scheduling package. This information is used to determine workload reimbursement.

Prompt/**User Response** Discussion

```
Update Exam Status

Enter Case Number: 608

Choice   Case No.       Procedure                 Name                  Pt ID
------   --------      ---------                 -----------------     ------
 1       032097-608     BONE AGE                  GALOIS,EVARISTE       0154
 2       022497-608     SPINE CERVICAL MIN 2 VIEW HEUER,RALPH           8277
CHOOSE FROM 1-2: 2

 Case No.: 608  Procedure: SPINE CERVICAL MIN 2 VIEWS     Name: HEUER,RALPH
   ...will now designate exam status as 'COMPLETE'... for case no. 608
          ...exam status successfully updated.
```

XII. Switch Locations

This option appears on several menus as a convenience to users. Please refer to the option description earlier in this section where it first appears under Use of the Software on page III-2.

XIII. Update Patient Record

This function allows the user to update certain fields of information in an existing Rad/Nuc Med patient record. Only patients in the Rad/Nuc Med Patient file may be selected.

This option is used if, after initial registration, data in these categories has changed and needs to be revised. Normally, these fields are edited only once.

You will be given the opportunity to enter/edit the usual category of the patient, the narrative for the patient, and whether s/he is allergic to contrast media.

If the selected patient is an inpatient, the patient category on exam records will override to "inpatient" regardless of what is entered for usual category through this option.

The narrative entered here will be displayed when the Display Patient Demographics, Request an Exam, and Register Patient for Exams options are used.

The contrast allergy question invokes an interface to the Adverse Reaction Tracking package if you answer Yes, or if you change an existing Yes answer to No. The contrast media allergy data is stored in the Adverse Reaction Tracking package, not in the Radiology/Nuclear Medicine package.

Prompt/**User Response** Discussion

```
Update Patient Record

Select Patient: SLADE,FRANK H           06-21-19     512992785   NO   NSC VETERAN
         ...OK? Yes// <RET>  (Yes)


USUAL CATEGORY: ??
     This field contains a default value used during the exam registration
     process to indicate the category of exam for this Radiology/Nuclear
     Medicine patient. Available categories are: 'O' for OUTPATIENT, 'C' for
     CONTRACT, 'S' for SHARING, 'R' for RESEARCH, and 'E' for EMPLOYEE.
     Choose from:
       O        OUTPATIENT
       C        CONTRACT
       S        SHARING
       R        RESEARCH
       E        EMPLOYEE
USUAL CATEGORY: O  OUTPATIENT
NARRATIVE: ??
     This field may contain a brief note (up to 250 characters) about
     this Radiology/Nuclear Medicine patient. It may describe the personality
     or any unusual characteristic to identify this Radiology/Nuclear Medicine
     patient.
NARRATIVE: Aggressive, independent, stubborn
CONTRAST MEDIUM ALLERGY: NO// ??
     The value in this field is used to indicate if this Radiology
     /Nuclear Medicine patient has had an allergic reaction to the contrast
```

```
     medium during a Radiology/Nuclear Medicine procedure.  It may contain a
     'Y' for YES, or 'N' for NO.  If YES, then a warning message is
     displayed to the receptionist whenever this patient is
     registered for a procedure that may involve contrast material.
     CHOOSE FROM:
      Y        YES
      N        NO

CONTRAST MEDIUM ALLERGY: NO// <RET>
```

XIV. User Utility Menu

This menu contains utility options the user may be required to use during a data entry session.

Duplicate Dosage Ticket
Duplicate Flash Card
Jacket Labels
Print Worksheets
Switch Locations
Test Label Printer

User Utility Menu

Duplicate Dosage Ticket

This function allows the user to print additional dosage tickets for exams where radiopharmaceuticals have been entered.

You will be prompted for a case number. If you enter a patient's name at this prompt, all exam cases for that patient will be displayed for selection. You may also enter two question marks (??) and get a list of all active cases. Only cases having an Imaging Type of Nuclear Medicine or Cardiology Studies will be displayed.

Prompt/**User Response**

```
Duplicate Dosage Ticket

Enter Case Number: POE,
EDGAR A           08-23-18     138181787     NO     NSC VETERAN

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

Patient's Name: POE,EDGAR ALLEN  138-18-1787      Run Date: OCT 28,1997

   Case No.  Procedure                   Exam Date  Status of Exam   Imaging Loc
   --------  -------------               ---------  ---------------- -----------
1    +24     BONE SCAN, WHOLE BODY       09/08/97   COMPLETE         NUCLEAR MED
2    .25     BONE SCAN, MULTIPLE AREAS   09/08/97   COMPLETE         NUCLEAR MED
3    .26     ..PROVISION OF RADIONUCLID  09/08/97   COMPLETE         NUCLEAR MED
4    .27     ..INTRODUCTION OF NEEDLE O  09/08/97   COMPLETE         NUCLEAR MED
5     263    BONE SCAN (ROUTINE), WB W/  06/18/96   COMPLETE         NUCLEAR MED
6     436    BONE SCAN (ROUTINE), WB W/  03/15/94   COMPLETE         NUCLEAR MED
Type '^' to STOP, or
CHOOSE FROM 1-6: 1

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

```
          Radiopharmaceutical Dose Computation and Measurement Record
                          Printed: Oct 28, 1997 2:22 pm

Case                     : 24@Sep 08, 1997 8:43 am

Patient                  : POE,EDGAR ALLEN
Patient ID               : 138-18-1787
Study                    : BONE SCAN, WHOLE BODY

Radiopharmaceutical      : Tc99m MEDRONATE
Form                     : Liquid
Lot No.                  : 6138P
Kit No.                  :
Lot Expiration Date      : APR 01, 1999

Date/Time of Measurement: SEP 08, 1997@08:31
Dose Prescribed          : Low: 18 mCi   High: 22 mCi
Activity Drawn           : 21.2 mCi
Dose Administered        : 21.2 mCi
Time of Administration   : SEP 08, 1997@08:31

Signature of Person Measuring Dose: _____________________________________________
```

User Utility Menu

Duplicate Flash Card

This function allows the user to print additional flash cards or exam labels for an exam registered previously. (Usually, flash cards and exam labels are set up by the ADPAC to print at the time an exam is registered.) The user can print up to 20 additional flash cards or exam labels at one time. This may be necessary due to a printer malfunction occurring during the original printing of the labels.

You will be prompted for a case number. If you enter a patient's name at this prompt, all exam cases for the patient will be displayed for selection.

Since the format of the flash card and exam label is determined by the imaging location to which you are signed on (see ADPAC manual for information on Imaging Location Parameter Set-up), if the system detects the exam that was taken was registered in a location other than your sign-on location, it will give you an opportunity to switch to the more appropriate location. However, if you choose not to switch, the labels will still print, but the format for your sign-on location will be used.

You will be asked how many flash cards and exam labels you wish to print (0-20).
If a flash card printer has not been defined by IRM through the Device Specifications for Imaging Locations option, you will be prompted for a device. This should be queued to a printer.

Prompt/**User Response** Discussion

```
Duplicate Flash Card

Enter Case Number: LIME,HARRY
           08-17-08     714262873   NO   NSC VETERAN

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

Patient's Name: LIME,HARRY  714-26-2873
Run Date: MAR 31,1995


   Case No.  Procedure                 Exam Date  Status of Exam   Imaging Loc
   --------  -------------             ---------  ---------------- -----------
1     45     CHEST 4 VIEWS             01/24/95   COMPLETE         X-RAY
2     83     SKULL 4 OR MORE VIEWS     01/17/95   CANCELLED        X-RAY
3     84     NECK SOFT TISSUE          01/17/95   EXAMINED         X-RAY
4     85     STEREOTACTIC LOCALIZATION 01/17/95   WAITING FOR EXAM X-RAY
5     86     NECK SOFT TISSUE          01/17/95   WAITING FOR EXAM X-RAY
6     30     SPINE CERVICAL MIN 4 VIEWS 11/04/94  CANCELLED        X-RAY
7     19     SPINE CERVICAL MIN 2 VIEWS 11/04/94  CANCELLED        X-RAY
8     65     BONE AGE                  10/12/94   EXAMINED         X-RAY
9     54     ANGIO CORONARY BILAT INJ S 10/12/94  CANCELLED        X-RAY
10    48     CHEST STEREO PA           10/12/94   CANCELLED        X-RAY
11    26     ABDOMEN 1 VIEW            10/12/94   COMPLETE         X-RAY
CHOOSE FROM 1-11: 1
```

```
How many flash cards? 1// <RET>
How many exam labels? 1// <RET>

QUEUE TO PRINT ON
DEVICE: P-DOT MATRIX BACK// <RET>  BY DON BERRY'S DESK


Duplicates queued to print on P-DOT MATRIX BACK.  Task #: 11575
```

User Utility Menu

Jacket Labels

This option is used to print film jacket labels for a Rad/Nuc Med patient. This would be necessary for patients with multiple volumes of films.

You will be prompted for a Rad/Nuc Med patient. Only patients registered in the Rad/Nuc Med Patient file can be selected. You will be asked how many jacket labels you wish to print (0-20).

If a jacket label printer has not been defined by IRM through the Device Specifications for Imaging Locations option, you will be prompted for a device. This should be queued to a printer.

Prompt/**User Response** Discussion

```
Jacket Labels
Select Patient: ASQUITH,JOHN L          08-03-41     692161668   NO   NSC VETERAN
How many jacket labels? 1// <RET>
Duplicates queued to print on P-DOT 10 LINESAPAGE.  Task #: 39436
```

User Utility Menu

Print Worksheets

This function allows the user to print any number of worksheets needed.

These worksheets are designed to be used by an imaging department that does not have enough terminals to capture exam status in a real-time mode.

These worksheets should accompany the exam requisition as it proceeds through the department. As the exam status changes, the appropriate entries on the worksheet should be made.

The data captured on the sheets should then be entered in a batch mode later in the day, when terminals are available.

The worksheets should be printed on a 132-column device.

Prompt/**User Response** | Discussion

```
Print Worksheets

     ***  RADIOLOGY/NUCLEAR MEDICINE WORKSHEETS  ***



Enter the number of worksheets needed: 1

NOTE: This output should be sent to a printer that
supports 132 columns.

DEVICE: HOME// LINE  COMP. ROOM    RIGHT MARGIN: 132//
<RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

Requested Start Time: NOW//  <RET>  (MAR 31,
1995@15:43:59)
     Request Queued.  Task #: 11574
```

The worksheet cannot be displayed on a terminal. It must be sent to a printer.

RADIOLOGY/NUCLEAR MEDICINE WORKSHEET

VAMC HINES CIO FIELD OFFICE

DATE _____ AGE _____ TIME: _____

SSN _____ TCH _____ LAST EXAM: _____

NAME _____ WARD OR OTHER: _____

AMIS	DESCRIPTION	TECH	DIAG.	M.D.

DATA ENTRY CLERK:

User Utility Menu

Switch Locations

This option appears on several menus as a convenience to users. Please refer to the option description earlier in this section where it first appears under Use of the Software on page III-2.

User Utility Menu

Test Label Printer

This function allows the user to test a label printer by printing out a label in the default format. This option would be used to check the alignment of a device before printing actual labels.

Prompt/**User Response** Discussion

```
Test Label Printer

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

```
Patient Name:JONES,JOHN           SSN:382-38-3342                      AGE:35
RAD LOC:SECOND FLOOR C-WING            DATE OF EXAM:DEC 13,1984  14:30
PROCEDURE:1A - SKULL                   REPORT STATUS:RELEASED/NOT VERIFIED
LAST VISIT:Oct 12,1984  13:30          DX CODE:NORMAL
THIS IS A FLASH CARD FORMAT
Attend Phy At Order:DOE,JOE            Prim Phy At Order:DOE,JOE
Request Entered: Jan 21, 1994  10:30   CASE: 543
Patient Location: EENT CLINIC 51D/060894@13:35
```

XV. Glossary

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 for more information about alerts.
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.
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 V*IST*A MAS package documentation for more information and a description of the meaning of this term as it applies to V*IST*A.
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.
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 V*IST*A, 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.
Contrast medium	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.

Contrast reaction message	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.
CPT	See Current Procedural Terminology.
Credit stop code	See Stop Code. Also see MAS package documentation.
Current Procedural Terminology (CPT)	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 V*IST*A, CPT's are represented by entries in the CPT file #81.
Descendent	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.
Desired date (of an order)	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.
Detailed procedure	A procedure that represents the exact exam performed, and is associated with a CPT code and an AMIS code.
Diagnostic code	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).
Discontinued	An order status that occurs when a user cancels an order.
Distribution queue	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.

Division, Rad/Nuc Med	A subset of the V*IST*A Institution file (#4). Multi-divisional sites are usually sites responsible for imaging at more than one facility.
Draft	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.
DSS ID	Formerly Stop Code associated with each procedure, now DSS ID associated with each Imaging Location.
Electronic signature code	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.
Exam label	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.
Exam set	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.
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.

FileMan	V*IST*A's Database Management System (DBMS). The central component of the Kernel that defines the way standard V*IST*A files are structured and manipulated.
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.
Lbl/Hdr/Ftr 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.
Footer	The last lines of the results report, the format of which can be specified using the Lbl/Hdr/Ftr formatter.
Format	The specification for print locations of fields on a printed page. In this system, print formats can be specified using the Lbl/Hdr/Ftr formatter.
Header	The top lines of the results report, the format of which can be specified using the Lbl/Hdr/Ftr formatter.
Health Summary	Refers to a report or V*IST*A 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 users 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 V*IST*A 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.
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 V*IST*A software packages and the hardware that they run on.
Interpreting physician (also Interpreting Resident, Interpreting Staff)	The resident or staff physician who interprets exam images.

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 Lbl/Hdr/Ftr formatter.
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 V*IST*A package, Order Entry/Results Reporting (OE/RR).
Order Entry/Results Reporting	A V*IST*A 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 V*IST*A 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 V*IST*A 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.
Primary Interpreting Staff/ Resident	The attending or resident primarily responsible for the interpretation of the case. (See also Secondary Interpreting Staff/Resident.)
Primary physician	The Radiology/Nuclear Medicine software obtains this data from the MAS package, which is responsible for its entry and validity. Refer to the V*IST*A MAS package documentation for more information and a description of the meaning of this term as it applies to V*IST*A.
Principal clinic	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.
Printset	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.
Problem draft	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.
Problem statement	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.
Procedure	For the purposes of this system, a medical procedure done with imaging technology for diagnostic purposes.

Procedure message	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.
Procedure type	A characteristic of a Rad/Nuc Med procedure that affects exam processing and workload crediting. See Detailed, Series, Broad, and Parent.
PTF Bedsection	See MAS documentation.
Purge	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.
Registration (of an exam)	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.
Released/not verified	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.
Report batch	See Batch.
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 V*IST*A 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 V*IST*A Security Key file. Radiology/Nuclear Medicine keys include RA MGR, RA ALLOC, and RA VERIFY. Various options and functionalities 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. Imaging stop codes are represented by entries in the Valid Imaging Stop Code file #71.5. Imaging stop codes are a subset of the V*IST*A Clinic Stop file #40.7. See MAS documentation for more information.
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 V*IST*A 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.
V*IST*A	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 V*IST*A, 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 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.

XVI. Index