



RADIOLOGY/NUCLEAR MEDICINE USER MANUAL

Version 5.0

June 2019

Department of Veterans Affairs
Health Systems Design and Development
Provider Systems

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Revisions

Revision History

Date	Page	Change
April 2000		Revision History added.
October 2001	4-25, 4-41	RA*5*28: Case Edit Field Procedures – Added: Requesting physician is alerted when the ordered exam is changed.
February 2002	6-128	RA*5*29: Daily Management Reports Unverified Reports – Added: 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.
April 2002	4-22	RA*5*27: Description text field added – if user elects not to cancel, the exam has associated request.
	4-56, 5-63, 5-92, 5-97	Additional clinical history added to report.
July 2002	5-80, 5-92, 5-100	RA*5*25: Reference to Technical Manual changed to the Radiology/Nuclear Medicine V. 5.0 HL7 Manual.
September 2002	6-121	RA*5*31: Change in text descriptions
	6-124	RA*5*31: Added selection of Procedure Name or Date/Time of report.
	6-146	RA*5*31: Change of location for the Procedure and the Pt ID columns for the Log of Scheduled Requests by Procedures.
	8-226	RA*5*31: If a procedure was registered via the Add Exams to Last Visit [RA ADDEXAM] option, then a note will be displayed, showing the date of the last visit that was selected.
	9-247	RA*5*31: If this procedure was registered via the Add Exams to Last Visit [RA ADDEXAM] option, then a note will be displayed, showing the date of the last visit that was selected.
	9-250	RA*5*31: If this procedure was registered via the Add Exams to Last Visit [RA ADDEXAM] option, then a note will be displayed, showing the date of the last visit that was selected.
December 2002	4-56	RA*5*35: Deleted four instances of “Exam modifiers: None”.
	4-56	RA*5*35: Added new paragraph – The display of cases for a printset will be condensed as much as possible...
	5-64, 5-64	RA*5*35: Changes in displays

Date	Page	Change
	13-287	RA*5*35: New option added – Set preference for Long Display of Procedures [RA SET PREFERENCE LONG DISPLAY].
	13-287	RA*5*35: Added description and example for the Set preference for Long Display of Procedures option.
May 2003	4-22	RA*5*34: RA Manager Key prompt text added.
	6-105	RA*5*34: Text explaining print of several cases sharing one printset.
	6-122	RA*5*34: Text explaining if the SUBMIT REQUEST TO question was not asked.
	9-263	RA*5*34: Removed ‘...and therefore will not appear on this report’ sentence replacing with ‘...if there are more than one imaging locations for the same imaging types to choose from. However,....’
June 2003	6-103	RA*5*37: Added Performance Indicator Section to Management Reports Menu options.
	6-147	RA*5*37: Added Performance Indicator Section to Management Reports Menu.
	6-166	RA*5*37: Added 2 ‘Hrs’ columns to Detail Performance Indicator Report placed after D/T Transcribed and D/T Verified; added ‘Hrs to Transcription’ and ‘Hrs to Verification’ Sort report by categories.
September 2003	6-165	RA*5*42: Replaced PERFORM INDICATOR MAIL ADDRESS with PERF INDC SMTP E-MAIL ADDRESS
September 2003	4-18	RA*5*38: Added new paragraph – Use of data screens to ensure CPT Code and CPT Modifiers of the procedure are active for the exam date
	4-25	RA*5*38: Added – “...and the procedure’s CPT Code must be active for the exam date...”
	4-29	RA*5*38: Added – “...and are active for that exam date date...”
	4-41	RA*5*38: Text change to add information for screening of CPT Codes and CPT Modifiers
	4-49	RA*5*38: Text added. Use of data screens to ensure CPT Code and CPT Modifiers of the procedure are active for the exam date
January 2004	6-160	RA*5*44: New prompt. “Primary Interpreting Staff Physician (Optional):” New text added “The verification date...”
	6-162	RA*5*44: New text added “* A printset, i.e.,...”
	6-162	RA*5*44: New paragraph added. “Verification date is always the first item...”

Revisions

Date	Page	Change
	6-163	RA*5*44: " New prompt. "Primary Interpreting Staff Physician (Optional):."
	6-164	RA*5*44: Text added. "* A printset, i.e.,...", and a new column "Procedure Name".
	6-166	RA*5*44: New option. Run Previous Month's Summary Report option with example.
May 2005	4-26	RA*5*45 'Case No. Exam Edit' option Contrast Media Used/Contrast Media prompts explained
	4-27	RA*5*45 'Case No. Exam Edit' option 'Barium Used?' field removed from the data dictionary
	4-51	RA*5*45 Referenced the appearance of the 'CONTRAST MEDIA' and 'CONTRAST MEDIA USED' fields when the 'Status Tracking of Exams' option is exercised.
	4-53	RA*5*45: 'View Exam by Case No.' option has been changed to show the option displaying an exam associated with contrast media.
	5-81, 5-92, 5-97	RA*5*45: 'Display of associated contrast media.
	8-226	RA*5*45: 'Detailed Request Display' displays contrast media if appropriate.
	8-228	RA*5*45: 'Display Patient Demographics' displays contrast media if appropriate.
	8-229	RA*5*45: Exam Profile describes to the user that contrast media displays, if appropriate. Exam Profile describes to the user that contrast media displays, if appropriate. New Exam Profile example.
	8-232	RA*5*45: Rad/Nuc Med Exams displays contrast media, if appropriate
	9-247	RA*5*45: If a patient wasn't pregnant at the time of the order, the "Patient not pregnant at time of order" will display instead of not displaying a pregnancy status.
	9-250	RA*5*45: Pregnancy Status updated; 'Rad/Nuc Med Requests by Patient' describes to the user that contrast media is displayed if appropriate. Rad/Nuc Med Requests by Patient displays contrast media, if appropriate If a patient wasn't pregnant at the time of the order, "Patient not pregnant at time of order" displays instead of not displaying a pregnancy status.
	9-251	RA*5*45: Added new Prompt/User Response information; New screen capture, showing contrast media.

Date	Page	Change
	9-252	RA*5*45: 'Rad/Nuc Med Procedure Information Look-Up' describes to the user that contrast media is displayed if appropriate.
	9-258	RA*5*45: A warning displays in 'Request an Exam' if patient has a CM allergic reaction & the ordered procedure has CM associations.
	10-266	RA*5*45: 'Access Uncorrected Reports' displays contrast media if appropriate.
September 2005	4-17	RA*5*41: New paragraph added.
	4-45	RA*5*41: New paragraph added.
	5-90	RA*5*41: Interpreting Imaging Location section added.
	5-95	RA*5*41: <ul style="list-style-type: none"> • Text added - and Interpreting Imaging Location. • Text added – The default value and informational messages for the Interpreting Imaging Location prompt are explained in Report Entry/Edit section.
	9-252	RA*5*41: New text display – Ordering Diagnosis and Clinical Indicators.
	9-252	RA*5*41: New text display – Ordering Diagnosis.
	9-253	RA*5*41: <ul style="list-style-type: none"> • New instructions added. • Deleted reference to ORES key, added new prompt description.
	9-255	RA*5*41: New prompt description.
	9-256	RA*5*41: New prompt to copy a previous order's ICD codes and SC/EC values.
	9-257	RA*5*41: <ul style="list-style-type: none"> • New prompts added. • New display example.
October 2005	6-199	RA*5*63: <ul style="list-style-type: none"> • Added explanation of new field OQP PERFORMANCE MGMT? • Added new prompt OQP PERFORMANCE MGMT? and new display.
	6-167	RA*5*63: New example shows new prompts and help messages.
April 2006	All pages	Altered all sensitive data to comply with SOP 192-352. Replaced Roman numeral chapter/page numbers with Arabic numbers to conform to current HSD&D documentation standards. Updated package names throughout the manual: replaced MAS with PIMS, OE/RR with CPRS. Updated Title Page, TOC, Revision History, and Index entries.

Revisions

Date	Page	Change
	6-147	RA*5*67: Changed menu name from Performance Indicator to Timeliness Reports and added two submenus; new Outpatient Procedure Wait Time report option, and re-named Verification Timeliness report option (formerly the Performance Indicator report).
	6-151	RA*5*67: Added new Outpatient Procedure Wait Time report option; examples of Summary and Detail reports.
	6-164	RA*5*67: <ul style="list-style-type: none"> • Changed report name to Summary Verification Timeliness Report; added text to sample “*Cancelled or ‘No Credit’ cases...” • Changed report name to Detail Verification Timeliness Report; added text to sample “*Cancelled or ‘No Credit’ case...”
	6-199, 6-166	RA*5*67: Renamed Performance Indicator Report to Verification Timeliness Report; updated examples to match.
July 2006		Updated Title Page, TOC, Revision History, and Index.
	1-2	Updated the list of features to reflect current functionality.
	1-1, 6-103, 6- 6-186, 6-189, 6-197	RA*5*64: <ul style="list-style-type: none"> • Updated or removed references to AMIS throughout this manual: AMIS is no longer used for calculating workload credit. • Added notes to redirect users to wRVU and CPT workload reporting options.
	6-170	RA*5*64: <ul style="list-style-type: none"> • Added a Note regarding the wRVU/CPT and AMIS reports. • Added five new wRVU/CPT-based Physician report types to the list of Personnel Workload Reports. Added report descriptions. • Separated the AMIS-based reports from the wRVU/CPT-based reports, and updated the report descriptions.
	6-207	RA*5*64: Added Physician CPT Report by Img Type description and example
	6-208	RA*5*64: Added Physician Scaled wRVU Report by Img Type description and example.
	6-210	RA*5*64: Added Physician Scaled wRVU Report by CPT description and example.
	6-172	RA*5*64: Added Physician wRVU Report by CPT description and example.
	6-214	RA*5*64: Added Physician wRVU Report by I-Type description and example

Date	Page	Change
	6-231	RA*5*64: Added two Procedure wRVU report types to list of Special Reports.
	6-251	RA*5*64: Added Procedure Scaled wRVU/CPT Report description and example.
	6-203	RA*5*64: Added Procedure wRVU/CPT Report description and example.
	6-214	RA*5*64: Changed section name to distinguish AMIS report options from wRVU/CPT options. Added Note to redirect users to the wRVU and CPT Procedure reports section. Updated entire section to reflect current functionality.
	14-360, 14-364, 14-365, 14-368	RA*5*64: Added entries for HL7, RVU, Scaling Factor, and wRVU.
February 2007		Updated Title Page, TOC, Revision History, and Index.
	6-151	RA*5*79: Added new background information about this report and its updated functionality.
	6-152	RA*5*79: Updated the Summary Report description and examples: replaced “Imaging Type” selection prompt with “Procedure Type” prompt; added help text; removed Imaging Type(s) from report header; removed “Average number of days wait” calculation, and updated the report footnotes.
	6-155	RA*5*79: Added Summary Report by CPT Code/Procedure Name description and example.
	6-157	RA*5*79: Updated the Detail Report description and example, added Procedure Type to Sort By list, and added printset note.
	14-	RA*5*79: Updated entry for Procedure Type.
June 2007		Note: Patches RA*5*75, RA*5*77, and RA*5*82 were released in March and June 2007. Updates for all three patches are included in this user manual release.
		Updated Title Page, TOC, Revision History, and Index.
	4-24	RA*5*75: Added Reason for Study to the sample mail bulletin.
	5-63, 5-97, 5-98	RA*5*75: Added Reason for Study to the report display list and sample report.
	6-209, 6-210	RA*5*77: Added new report example to include default Scaled wRVU values.
	8-226, 8-227	RA*5*75: Added Reason for Study to the selection criteria and sample report.
	9-244	RA*5*75: Removed Desired Date statement from the request list.

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Date	Page	Change
	9-247, 9-248	RA*5*75: Added age at request and Reason for Study to the sample report.
	9-250, 9-251, 9-251, 9-254, 9-257, 9-257, 9-259, 9-260	RA*5*75: Edited paragraphs to include reason for study and update the clinical history description; Removed “Reason” from Clinical History report title in two examples; added Reason for Study prompt to several examples.
	10-265	RA*5*82: Added Radiology HL7 Menu option to Supervisor Menu.
June 2007	6-154, 6-156	RA*5*83: Updated the Summary Report examples to show the new “Avg Days” column and footnote for the Outpatient Procedure Wait Time Report.
July 2008	5-57	RA*5*56: Added a new option, Outside Report Entry/Edit, to the Films Reporting menu.
	5-82	RA*5*56: Added information about the Outside Report Entry/Edit option.
	10-265	RA*5*56: Added a new option, Restore a Deleted Report, to the Supervisor menu.
	10-267	RA*5*56: Modified the information about the Delete a Report option.
	10-273	RA*5*56: Added information about the Restore a Deleted Report option.
	14-295	RA*5*56: Added a definition for the ‘Deleted’ status.
	14-296	RA*5*56: Added a definition for the ‘Electronically Filed’ status.
	14-302	RA*5*56: Added Electronically Filed and Deleted to the report status definition.
March 2009		Updated Title Page, TOC, Revision History, and Index.
	9-255	RA*5*70: Changed “Environmental Contaminants” to “Southwest Asia Conditions”; added “PROJ 112/SHAD”.
	9-258	RA*5*70: <ul style="list-style-type: none"> • Prompt changed - “Environmental Contaminants” to “Southwest Asia Conditions”, added - “PROJ 112/SHAD” • Changed EI to SWAC; added SHAD Related? No.
May 2009	5-84	RA*5*95: Removed the paragraph about “No Credit” imaging location and the reference about displaying a warning message.
	5-84	RA*5*95: Removed the “No Credit” warning message.
	5-85	RA*5*95: Modified the “Visit credited” statement.

Date	Page	Change
September 2009	4-33	RA*5*97: Added two paragraphs regarding a case as part of a printset, diagnostic codes, and the Report Enter/Edit and the Outside Reporting Entry/Edit options.
	5-83	RA*5*97: Added BI-RADS information to the Outside Report Enter/Edit option.
	6-104	RA*5*97: <ul style="list-style-type: none"> • Moved two sentences from a paragraph into individual sentences. • Added a paragraph about “VA radiologist”, “Electronically Filed”, or “All”.
	6-106	RA*5*97: Added “VA radiologist”, “Electronically Filed”, or “All” information to the Outside Reporting Enter/Edit option example.
	14-241	RA*5*97: Added definition for Breast Imaging Reporting and Data System (BI-RADS™).
February 2010	4-18, 4-19, 4-27, 4-43, 4-45, 4-46, 4-47, 4-48, 4-51, 4-52	RA*5*99: Inserted the field ‘PREGNANT AT TIME OF ORDER ENTRY.’ Also added two pregnancy screen fields: ‘PREGNANCY SCREEN’ and ‘PREGNANCY SCREEN COMMENT.’
	4-21	RA*5*99: Inserted the field ‘PREGNANT AT TIME OF ORDER ENTRY.’ Replaced the ‘Pregnant’ field with ‘Pregnant at time of order entry.’
	4-21	RA*5*99 : Replaced the ‘Pregnant’ field with ‘Pregnant at time of order entry.’ Inserted the field ‘PREGNANT AT TIME OF ORDER ENTRY.’ Also added two pregnancy screen fields: ‘PREGNANCY SCREEN’ and ‘PREGNANCY SCREEN COMMENT.’
	4-35	RA*5*99: Changed the pregnant field from ‘PREGNANT’ to ‘PREGNANT AT TIME OF ORDER ENTRY.’ Added two pregnancy screen prompts: ‘PREGNANCY SCREEN’ and ‘PREGNANCY SCREEN COMMENT.’
	4-53, 4-54	RA*5*99: Inserted the field ‘Pregnant at time of order entry.’
	5-63, 5-77, 5-81, 5-84, 5-86, 5-87, 5-95, 5-98, 5-101, 5-102	RA*5*99: Inserted two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’

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Date	Page	Change
	5-64, 5-81 5-96	RA*5*99: Replaced the 'Staff Phys' field title with 'Staff Imaging Phys' field title. Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'
	5-92	RA*5*99: Added a note about: 'Pregnancy Screen' and 'Pregnancy Screen Comment.' Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'
	6-122, 6-125	RA*5*99: Replaced the 'Interpreting Stf.' field title with 'Staff Imaging Phys' field title. Inserted the field 'Pregnant at time of order entry.' Also added two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'
	6-147	RA*5*99: Added 'Radiology Timeliness Performance Reports' as a new menu option. Changed the reporting period for the automated Outlook email from monthly to quarterly. Changed subject of automated Outlook email from "Radiology Summary Verification Timeliness" to "Radiology Timeliness Performance Reports."
	6-148	RA*5*99: Inserted the "Summary Radiology Outpatient Procedure Wait Time Report" in the automated Outlook email. Inserted two performance summary values in the automated Outlook email. Explanation of the "<=14 Days" reporting interval column .
	6-148	RA*5*99: <ul style="list-style-type: none"> • Inserted two performance summary values in the automated Outlook email. • Inserted the "<=14 Days" reporting interval column .
	6-150	RA*5*99: <ul style="list-style-type: none"> • Inserted the "Summary Radiology Outpatient Procedure Wait Time Report" in the automated Outlook email. • Inserted the "<=14 Days" reporting interval column .
	6-148	RA*5*99: <ul style="list-style-type: none"> • Inserted the "<=14 Days" reporting interval column . • Explanation of the "<=14 Days" reporting interval column .

Date	Page	Change
	6-154	RA*5*99: Inserted the "<=14 Days" reporting interval column .
	6- 154, 6-157	RA*5*99: <ul style="list-style-type: none"> • Inserted the "<=14 Days" reporting interval column . • Explanation of the "<=14 Days" reporting interval column .
	6-158, 6- Error! Bookmark not defined.	RA*5*99: The date range is 92 days maximum for the Detail Report.
	6-160	RA*5*99: Moved two menu options to the 'Radiology Timeliness Performance Reports' menu option: 'Enter/Edit OUTLOOK mail group' and 'Run Previous Quarter's Summary Report.'
	6-165	RA*5*99: Moved the 'Enter/Edit OUTLOOK mail group' option from the 'Verification Timeliness' option.
	6-201	RA*5*99: Changed option: 'Run Previous Month's Summary Report' to 'Run Previous Quarter's Summary Report.' Moved the 'Run Previous Quarter's Summary Report' option from the 'Verification Timeliness' option. Changed the reporting period from monthly to quarterly. Updated the report distribution to on or before the 15th of the month following the preceding calendar quarter-end. Inserted the "Summary Radiology Outpatient Procedure Wait Time Report" in the automated Outlook email.
	6-167	Patch RA*5*99: Inserted two performance summary values in the automated Outlook email. Changed the reporting period from monthly to quarterly. For this option, deleted all references to OQP. Changed 'Radiology Verification Timeliness Report'request name to 'Radiology Timeliness Performance Reports.'
	6-168	RA*5*99: <ul style="list-style-type: none"> • Insterted two performance summary values in the automated Outlook email. • Inserted the "<=14 Days" reporting interval column for extra calculations.
	6-169	RA*5*99: <ul style="list-style-type: none"> • Inserted the "Summary Radiology Outpatient Procedure Wait Time Report" in the automated Outlook email. • Inserted the "<=14 Days" reporting interval column .

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Date	Page	Change																				
	6-169	RA*5*99: <ul style="list-style-type: none"> • Inserted the "<=14 Days" reporting interval column . • Explanation of the "<=14 Days" reporting interval column . 																				
	8-226, 8-227	RA*5*99: Replaced the 'Pregnancy Status' field with the 'Pregnant at time of order entry' field. Inserted the two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'																				
	8-230, 8-232, 8-232	RA*5*99: Inserted the field 'Pregnant at time of order entry.'																				
	9-250, 9-251	RA*5*99: Replaced the 'Pregnancy Status' field with the 'Pregnant at time of order entry' field. Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'																				
	9-255	RA*5*99: Replaced the 'PREGNANT' prompt to 'PREGNANT AT TIME OF ORDER ENTRY.'																				
	9-257, 9-258, 9-259	RA*5*99 : Inserted the 'PREGNANT AT TIME OF ORDER ENTRY' prompt.																				
	9-257	RA*5*99: Replaced the 'Pregnant' field with 'Pregnant at time of order entry.'																				
	9-260	RA*5*99: Replaced the 'Pregnant' field with 'Pregnant at time of order entry.' Inserted the 'PREGNANT AT TIME OF ORDER ENTRY' prompt.																				
September 2011	6-104 10-265 4-16 5-57 4-22 4-24 5-67 6-110 10-267 6-112 4-32	RA*5*47:The options affected by turning on the new Site Specific Accession Number (SSAN): <table border="0" style="margin-left: 20px;"> <thead> <tr> <th data-bbox="716 1423 821 1459" style="text-align: left;">Option</th> <th data-bbox="1078 1459 1333 1495"></th> </tr> </thead> <tbody> <tr> <td data-bbox="716 1459 1057 1495">Abnormal Exam Report</td> <td data-bbox="1078 1459 1333 1495">[RA ABNORMAL]</td> </tr> <tr> <td data-bbox="716 1495 1057 1568">Access Uncorrected Reports</td> <td data-bbox="1078 1495 1390 1568">[RA UNCORRECTED REPORTS]</td> </tr> <tr> <td data-bbox="716 1568 1057 1604">Add Exams to Last Visit</td> <td data-bbox="1078 1568 1308 1604">[RA ADDEXAM]</td> </tr> <tr> <td data-bbox="716 1640 1057 1713">Add/Remove Report From Batch</td> <td data-bbox="1078 1640 1377 1713">[RA BTCHREMOVE]</td> </tr> <tr> <td data-bbox="716 1713 1057 1749">Cancel an Exam</td> <td data-bbox="1078 1713 1279 1749">[RA CANCEL]</td> </tr> <tr> <td data-bbox="716 1749 1057 1785">Case No. Exam Edit</td> <td data-bbox="1078 1749 1268 1785">[RA EDITCN]</td> </tr> <tr> <td data-bbox="716 1785 1057 1820">Clinic Distribution List</td> <td data-bbox="1078 1785 1451 1820">[RA RPTDISTLISTCLINIC]</td> </tr> <tr> <td data-bbox="716 1820 1057 1856">Daily Log Report</td> <td data-bbox="1078 1820 1219 1856">[RA LOG]</td> </tr> <tr> <td data-bbox="716 1856 1057 1892">Delete a Report</td> <td data-bbox="1078 1856 1338 1892">[RA DELETERPT]</td> </tr> </tbody> </table>	Option		Abnormal Exam Report	[RA ABNORMAL]	Access Uncorrected Reports	[RA UNCORRECTED REPORTS]	Add Exams to Last Visit	[RA ADDEXAM]	Add/Remove Report From Batch	[RA BTCHREMOVE]	Cancel an Exam	[RA CANCEL]	Case No. Exam Edit	[RA EDITCN]	Clinic Distribution List	[RA RPTDISTLISTCLINIC]	Daily Log Report	[RA LOG]	Delete a Report	[RA DELETERPT]
Option																						
Abnormal Exam Report	[RA ABNORMAL]																					
Access Uncorrected Reports	[RA UNCORRECTED REPORTS]																					
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Delete a Report	[RA DELETERPT]																					

Date	Page	Change
	8-228	Delinquent Status [RA DELINQUENT]
	5-63	Report
	76	Diagnostic Code and [RA DIAGCN]
	13-282	Interpreter Edit by
	13-283	Case No.
	4-36	Display Patient [RA PROFDEMOS]
	10-269	Demographics
	8-229	Display a Rad/Nuc [RA RPTDISP]
	4-37	Med Report
	6-119	Draft Report (Reprint) [RA REPRINT]
	4-38	Duplicate Dosage [RA DOSAGE TICKET]
		Ticket
	13-284	Duplicate Flash Card [RA FLASH]
	5-60	Edit Exam by Patient [RA EDITPT]
	5-78	Exam Deletion [RA DELETEXAM]
	5-82	Exam Profile (selected [RA PROFSORT]
	10-272	sort)
		Exam Status Display [RA STATLOOK]
	TM	Incomplete Exam [RA INCOMPLETE]
	9-246	Report
		Indicate No Purging of [RA NOPURGE]
	9-249	an Exam/report
	5-60	Jacket Labels [RA LABELS]
	8-231	List Reports in a Batch [RA BTCHLIST]
	6-176	On-line Verifying of [RA RPTONLINEVERIFY]
		Reports
	6-125	Outside Report [RA OUTSIDE RPTENTRY]
		Entry/Edit
		Override a Single [RA OVERRIDE]
	4-40	Exam's Status to
	5-88	'complete'
	5-71	Print Division [RA SYSDIVLIST]
	9-253	Parameter List
	10-273	Print Rad/Nuc Med [RA ORDERPRINTS]
	5-97	Requests by Date
	4-49	Print Selected [RA ORDERPRINTPAT]
	6-151	Requests by Patient
		Print a Batch of [RA BTCHPRINT]
	6-192	Reports
		Profile of Rad/Nuc Med [RA PROFQUICK]
	5-84	Exams
	6-127	Radiopharmaceutical [RA NM RADIOPHARM
	10-340	Administration Report ADMIN]
	10-342	Radiopharmaceutical [RA NM RADIOPHARM
	5-61	Usage Report USAGE]

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Date	Page	Change
	5-99 4-52 5-74	Register Patient for Exams [RA REG] Report Entry/Edit [RA RPTENTRY] Report's Print Status [RA RPTDISTPRINTSTATUS] Request an Exam [RA ORDEREXAM] Restore a Deleted Report [RA RESTORE REPORT] Select Report to Print by Patient [RA RPTPAT] Status Tracking of Exams [RA STATRACK] Summary/Detail report (for Outpt Proc Wait Times) [RA TIMELINESS REPORT] Summary/Detail report (for Verification Timeliness) [RA PERFORMIN RPTS] Unprinted Reports List [RA RPTDISTLISTUNPRINTED] Unverified Reports [RA DAIUVR] Unverify a Report for Amendment [RA UNVERIFY] Update Exam Status [RA UPDATEEXAM] Verify Batch [RA BTCHVERIFY] Verify Report Only [RA RPTVERIFY] View Exam by Case No. [RA VIEWCN] Ward Distribution List [RA RPTDISTLISTWARD]
		<p>Examples of the existing and new Case No. (SSAN) from the Case No. Exam Edit menu option</p> <pre> EXAMPLE (EXISTING DISPLAY, DIVISION PARAMETER = NO or NULL): Select Exam Entry/Edit Menu Option: Case No. Exam Edit Enter Case Number: 3039 Choice Case No. Procedure Name Pt ID ----- - 1 032009-3039 ANGIO CAROTID CEREBRAL UN POLHAUS,TOM 9865 (RAD Detailed) CPT:75665 EXAMPLE (NEW DISPLAY, DIVISION PARAMETER = YES): ===== Select Exam Entry/Edit Menu Option: Case No. Exam Edit Enter Case Number: 141-032009-3039 <-- user may still select by case # (3039) Choice Case No. Procedure Name Pt ID ----- - 141-032009-3039 ANGIO CAROTID CEREBRAL UN POLHAUS,TOM 9865 (RAD Detailed) CPT:75665 </pre>

Date	Page	Change
	14-302	RA*5*47: Added Site Specific Accession Number (SSAN) to the Glossary.
November 2013	See TOC	<p>RA*5*113 and RA*5*116</p> <p>Added in Section 9 'Special Reports' [RA SPECRPTS] update to include the new menu item 'Radiation Dose Summary Report' [RA RAD DOSE SUMMARY]</p> <p>Added in Section 11 'Patient Profile Menu' [RA PROFILES] update to include the new menu item 'Exam Profile with Radiation Dosage Data' [RA PROFRAD DOSE]</p> <p>Added in Section 16 with special notes and details on Patch RA*5*116 and Patch RA*5*113</p>
April 2016	<p><u>364-365</u></p> <p><u>418-419</u></p>	<p>RA*5*123</p> <p>Added Patient Weight and Weight Date to Order Entry example.</p> <p>In conjunction with RA*5*123 changes, corrected Order Entry example to include Sex, Room-Board, reflecting current view.</p> <p>Updated all references to ftp files to reflect sourcing Secure ftp.</p>
December 2016	<p>322-385</p> <p>301-360</p> <p>Error! Bookmark not defined.</p>	<p>RA*5*133</p> <p>Added in Section 12 'Radiology/Nuclear Med Order Entry Menu' [RA ORDER] updated to include the new menu item 'Update a Hold Reason' [RA ORDERREASON UPDATE]</p> <p>Added in Section 12 updates to the Pending/Hold Rad/Nuc Med Request Log</p> <p>Index updated</p>
June 2017	<p>400,409, 458</p> <p>65-66</p>	<p>RA*5*137</p> <p>Removed RA EXAMSTATUS MASS OVERRIDE documentation as this option has been retired.</p> <p>Pregnancy Screen and Pregnancy Screen Comments are prompts instead of display-only on 'Status Tracking of Exams' [RA STATRACK] menu.</p>
March 2018	<p><u>18, 20, 44, 47, 247, 248, 249, 251, 251</u></p>	<p>RA*5*132</p> <p>Added Height and Weight information to Radiology Exam Patient Demographics examples for the Register Patient for Exams, Add Exams to Last Visit, and Print Selected Requests by Patient options. Added Height information to the Print Rad/Nuc Med Requests by Date option.</p>
March 2019	<u>281 - 289</u>	RA*5*148

Revisions

Date	Page	Change
		New Radiology menu item 'Refer Selected Requests to COMMUNITY CARE Provider [RA ORDERREF]' added to Radiology/Nuclear Med Order Entry Menu [RA ORDER].
March 2019	200, 202-205, 221, 240-241, 358, 363-364, 368, 370	RA*5.0*153: Remove all references to scaled workload and procedure reports.
June 2019	23, 243-244	RA*5.0*158 Update screenshots for standardized Cancel Reasons.

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1. Introduction

The Veterans Health Information Systems and Technology Architecture (VistA) 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 VistA 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 VistA Radiology/Nuclear Medicine package is fully integrated with VA FileMan and provides certain patient demographic information supplied by the Patient Information Management System (PIMS), formerly the Medical Administration Service (MAS) package.

It also interacts with other VistA 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 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 a variety of workload reports and resource allocation reports is also collected.¹

The VistA 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 VistA system and clients within or outside of VistA.

¹ Patch RA*5*64 July 2006: Replaced "AMIS" reference with "workload."

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 IT SERVICE, 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 version 5.0 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 of “STAT” category requests
- Ability to select and print multiple reports

The Radiology/Nuclear Medicine package²:

- Allows users to enter and edit examinations, and view patient demographic and examination data.
- Allows users to establish site-specific division, imaging location, and examination status parameters.
- Allows users to complete on-line verification of transcribed reports. Residents may also pre-verify transcribed reports on-line.

2

Order Entry

- Allows users to generate a variety of management statistics, including daily reports, functional and personnel workload reports, timeliness reports, and other special reports.
- Allows the grouping of results reports into distribution/routing queues which electronically distribute reports to hospital locations.
- Allows users to track registration and return of outside films.
- Allows users to print jacket labels, worksheets and flash cards.
- Allows users to initialize and maintain device specifications, timeout parameters and other IT SERVICE functions.
- Integrates with VA FileMan and captures certain patient demographic information supplied by the PIMS package.
- Interfaces with Computerized Patient Record System (CPRS) for entry of radiology/nuclear medicine requests, and display of results to clinical staff.
- 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.
- Interfaces with the Health Summary package to print and display relevant medical history.
- Interfaces with the Imaging 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, completion, and report verification.
- Allows the exchange of information concerning results (specifically reports and impressions) between the VistA system and non-VistA applications through the HL7 interface
- Will collect information on how much radiation a patient was exposed to in the course of a study (Studies for which dose parameters are to be captured are limited to: Computed Tomography and Fluoroscopy.)
- Will accept Secondary Diagnostic Codes and file exam specific secondary Dx Codes into the RAD/NUC MED PATIENT database.

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

2. Orientation

Is this Chapter for You?

If you are just learning to use Veterans Health Information Systems and Technology Architecture (VistA) software, this chapter will introduce you to a small but important part of the VistA 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 VistA 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 VistA user, this chapter can serve as a reminder.

How Does VistA Work?

VistA 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.

Signing on

The procedure for establishing a link to the computer involves access and verify codes. These codes are assigned by IT SERVICE 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

Exiting 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.

Entering 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 I are not interchangeable. Also, the number 0 and the letter O are not interchangeable.

Obtaining 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 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: Enter a value, like March 3, 1960, then press 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 //. Either you 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 IT SERVICE 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*.

Order Entry

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 an 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 an 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 question marks, and repeats the question on a new line.

LAYGO

VistA 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

Order Entry

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.

Entering 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.

Order Entry

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 a caret ^.

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

Queue Report to a Printer

Queuing a time-consuming print job or other task uses computer time more efficiently and frees your terminal immediately so you can continue to work rather than making you wait until the information prints before you can use your terminal.

If you want to queue your output to run in the background, type the letter Q at the DEVICE prompt. Next, you will be prompted to 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).

Stop Printing a Long Document

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.
-----
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
```

3. Using 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 Area Manager, IT³ Operations and Services⁴, 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. IT SERVICE

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
  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*.

³ IT – Information Technology

⁴ Formally known as Chief, IRM Service

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 IT 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.

Order Entry

Prompt/User Response

Discussion

<p>Switch Locations Please select a sign-on Imaging Location: NUC// ??</p> <p>Choose from:</p> <table><tr><td>ULTRASOUND A</td><td>(ULTRASOUND-499)</td></tr><tr><td>MAGNETIC RESONANCE IMAGING</td><td>(MAGNETIC RESONANCE IMAGING-499)</td></tr><tr><td>FLUORO</td><td>(GENERAL RADIOLOGY-499)</td></tr><tr><td>WESTSIDE XRAY</td><td>(GENERAL RADIOLOGY-639)</td></tr><tr><td>CAT SCAN</td><td>(CT SCAN-499)</td></tr><tr><td>US</td><td>(ULTRASOUND-578)</td></tr><tr><td>MAMMOGRAPHY</td><td>(MAMMOGRAPHY-499)</td></tr><tr><td>PET SCANNER</td><td>(ANGIO/NEURO/INTERVENTIONAL-499)</td></tr><tr><td>X-RAY</td><td>(GENERAL RADIOLOGY-499)</td></tr><tr><td>NUC MED LOC</td><td>(NUCLEAR MEDICINE-639)</td></tr><tr><td>MAMMO ROOM 112B</td><td>(MAMMOGRAPHY-499)</td></tr></table> <p>Please select a sign-on Imaging Location: NUC// X-RAY (GENERAL RADIOLOGY-499)</p>	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)	<p>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.</p>
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)																						
<p>Welcome, you are signed on with the following parameters:</p> <table><tr><td>Version : 5.0</td><td>Printer Defaults</td></tr><tr><td>Division : HINES CIO FIELD OFFI</td><td>-----</td></tr><tr><td>Location : X-RAY</td><td>Flash Card : P-DOT MATRIX BACK</td></tr><tr><td>Img. Type: GENERAL RADIOLOGY</td><td>1 card/exam</td></tr><tr><td>User : RAUSER, ONE</td><td>Jacket Label: P-DOT MATRIX BACK</td></tr><tr><td></td><td>1 labels/visit</td></tr><tr><td></td><td>Report : P-DOT MATRIX BACK</td></tr></table>		Version : 5.0	Printer Defaults	Division : HINES CIO FIELD OFFI	-----	Location : X-RAY	Flash Card : P-DOT MATRIX BACK	Img. Type: GENERAL RADIOLOGY	1 card/exam	User : RAUSER, ONE	Jacket Label: P-DOT MATRIX BACK		1 labels/visit		Report : P-DOT MATRIX BACK								
Version : 5.0	Printer Defaults																						
Division : HINES CIO FIELD OFFI	-----																						
Location : X-RAY	Flash Card : P-DOT MATRIX BACK																						
Img. Type: GENERAL RADIOLOGY	1 card/exam																						
User : RAUSER, ONE	Jacket Label: P-DOT MATRIX BACK																						
	1 labels/visit																						
	Report : P-DOT MATRIX BACK																						

4. 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 ...

Note: 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.

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 VistA
- 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 ⁵

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 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.

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 create a new request and have the PROVIDER key, and the "CIDC Insurance and Switch" function returns a non-zero value, you will be prompted for Primary Ordering ICD-9; you may also be prompted for SC/EI values if the patient is service connected. The default values for these prompts will come from the original request of the visit being added to. For examples of the new prompts, please refer to the section, "Request an Exam."⁶

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.

⁵ Patch RA*5*47 September 2011: Add Exams to Last Visit option is affected by the new Site Specific Accession Number (SSAN).

⁶ Patch RA*5*41 September 2005: New paragraph added.

This option will use the same data screens as those used in the Register Patient for Exams option to check the procedure's assigned CPT Code's active status and also to check the default CPT Modifier's active status. The default CPT Modifier is obtained from the Procedure, if assigned; otherwise from the Imaging Location, if assigned.⁷

The 'PREGNANT AT TIME OF ORDER ENTRY' field is a display-only field and when adding an exam to an existing order, the value is mapped over from the existing order that was selected. When adding an exam and adding an order, the 'PREGNANT AT TIME OF ORDER ENTRY' field value will be mapped over from the pregnancy status value from the most recent order in 'ACTIVE' status. This field captures whether or not a female patient between the ages of 12 and 55 is pregnant at the time the order is placed.

The 'PREGNANCY SCREEN' field is display-only, and is populated with the value from the last exam. It captures whether or not a female patient between the ages of 12 and 55 is pregnant at the time of the last exam. The 'PREGNANCY SCREEN COMMENT' field is also display-only, and is also populated with the value from the last exam. It captures any comments the technologist enters at the time of the exam. ⁸

Below are two examples of adding an exam to the last visit: 1) add an exam to an existing order, and 2) add an exam and add an order.

Example 1: Add an exam to an existing order

Add Exams to Last Visit				
Select Patient:	RADPATIENT,ONE	NO	NSC VETERAN	06-05-96 000004444
		PRIM. CARE:	RADPROVIDER,ONE	TEL 4418; 5021
		ALT. PRIM. CARE:	RADPROVIDER,TWO	TEL 4418
	*****	Patient Demographics	*****	
Name	:	RADPATIENT,ONE		
Pt ID	:	000-00-0001		
Date of Birth:		JUN 5,1966 (101)		
Veteran	:	Yes	Eligibility :	NSC
Sex	:	FEMALE		
Height	:	69" on JUL 16, 2004	08:50	
Weight	:	124.9 lbs on JUL 6, 2007	08:59	
Narrative	:	This is real		
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	

⁷ Patch RA*5*38 September 2003: Added new paragraph – Use of data screens to ensure CPT Code and CPT Modifiers of the procedure are active for the exam date.

⁸ Patch RA*5*99 February 2010: Inserted the field 'PREGNANT AT TIME OF ORDER ENTRY.' Also added two pregnancy screen fields: 'PREGNANCY SCREEN' and 'PREGNANCY SCREEN COMMENT.'

Order Entry

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 automatically gives you the opportunity to enter a request.
---	--

```

**** Requested Exams for RADPATIENT,ONE ****          9 Requests
St  Urgency  Procedure                               Desired Requester  Req'g Loc
--  -
1  h  ROUTINE  SHOULDER 1 VIEW                          02/          RADPROVID,FI CONTINUING
2  h  ROUTINE  ABDOMEN 1 VIEW                          12/12       RADPROVID,FI RADIOLOGY-U
3  h  ROUTINE  CT THORACIC SPINE W/O CONT            12/12       RADPROVID,ON L LOWELL OPI
4  s  ROUTINE  CHEST 2 VIEWS PA&LAT              10/27       RADPROVID,SI IM ALEX
5  h  ROUTINE  WRIST 2 VIEWS                    10/10       RADPROVID,FI RADIOLOGY-U
6  h  ROUTINE  MAMMOGRAM BILAT                10/03       RADPROVID,SE RADIOLOGYB
7  h  ROUTINE  BONE IMAGING, TOMOGRAPHIC (SP 07/18  RADPROVID,ON RADIOLOGY-M
8  h  ROUTINE  CT ABDOMEN W&W/O CONT          06/13       RADPROVID,FI RADIOLOGY-U
9  h  ROUTINE  HIP 1 VIEW                      04/22       RADPROVID,EI C PRIMARY T

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

Procedure: SHOULDER 1 VIEW

...will now register RADPATIENT,ONE with the next case number...

Case Number: 264
-----
PROCEDURE: SHOULDER 1 VIEW// <RET>          (RAD Detailed) CPT:000000
Select PROCEDURE MODIFIERS: <RET>9 10

CATEGORY OF EXAM: OUTPATIENT// <RET> OUTPATIENT
PRINCIPAL CLINIC: CONTINUING CARE-RN 7000// <RET>          7000000

TECHNOLOGIST COMMENT: <RET>11          Enter comments for the reading radiologist
                                         about the patient and/or case.

PREGNANT AT TIME OF ORDER ENTRY: YES
PREGNANCY SCREEN: Patient answered yes.
PREGNANCY SCREEN COMMENT: The patient is alert and oriented and is 9 weeks pregnant. Patient
has shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to
procedure          12

...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

```

9 Patch RA*5*10 April 2000

10 Patch RA*5*19 May 2000: Prompt for CPT Modifiers removed.

11 Patch RA*5*18 November 2000: Added field for comments by the technologist.

12 Patch RA*5*99 February 2010: Inserted the field 'PREGNANT AT TIME OF ORDER ENTRY.' Also added two pregnancy screen fields: 'PREGNANCY SCREEN' and 'PREGNANCY SCREEN COMMENT.'

Example 2: Add an exam and add an order

```

Add Exams to Last Visit
Select Patient: RADPATIENT, TWO          1-6-53   XXXXXXXXXP **Pseudo SSN**   NO   NON-VETERAN
(OTHER)

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

Name          : RADPATIENT, TWO
Pt ID         : XXX-XX-XXXXP
Date of Birth: JAN  6,1953 (56)
Veteran       : No                      Eligibility : SHARING AGREEMENT
Sex           : FEMALE
Height        : 62" on AUG 24, 2014   10:24
Weight        : 104.4 lbs on AUG 24, 2014  10:24
Other Allergies:
'V' denotes verified allergy  'N' denotes non-verified allergy

Case #   Last 5 Procedures/New Orders Exam Date   Status of Exam   Imaging Loc.
-----
20       ANGIO PELVIC SELECT OR SUPRA MAY 18,2009   WAITING FOR     ANGIO
          CAROTID DOPPLER (BILATERAL) MAY 18,2009   COMPLETE        ULTRASOUND
16       ANGIO PULMONARY BILAT SEL  MAY 18,2009   WAITING FOR     ANGIO
          CHEST SINGLE VIEW                               Ord 5/18/09     RADIOLOGY
          ANGIO VISCERAL SELECT OR SUP                   Ord 5/18/09     ANGIO

Last Visit Date/Time: MAY 18,2009  11:55

Case No. Procedure                               Status
-----
20       ANGIO PELVIC SELECT OR SUPRASE WAITING FOR EXAM

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

***** Requested Exams for RADPATIENT, TWO *****      2 Requests

St  Urgency Procedure / (Img. Loc.)   Desired   Requester   Req'g Loc
--  -----
1  p  ROUTINE CHEST SINGLE VIEW           05/18/2009 ADAMS,VICTO DAYTON (TRA (RADIOLOGY)
2  p  ROUTINE ANGIO VISCERAL SELECT OR   05/18/2009 ADAMS,VICTO DAYTON (TRA (ANGIO)

Select Request(s) 1-2 or '^' to Exit: Exit//

Do you want to Request an Exam for RADPATIENT, TWO? No// yes

...requesting an exam for RADPATIENT, TWO...
Select one of the following imaging types:
GENERAL RADIOLOGY
NUCLEAR MEDICINE
ULTRASOUND
CT SCAN
ANGIO/NEURO/INTERVENTIONAL

Select IMAGING TYPE: angIO/NEURO/INTERVENTIONAL
COMMON RADIOLOGY/NUCLEAR MEDICINE PROCEDURES (ANGIO/NEURO/INTERVENTIONAL)
-----
1) ANGIO AORTOFEMORAL CATH W/SERIAL          6) ANGIO PULMONARY BILAT SELECT S&I
2) ANGIO BRACHIAL RETROGRADE S&I            7) ANGIO RENAL BILAT SELECT S&I
3) ANGIO CAROTID CEREBRAL BILAT S&I        8) ANGIO RENAL UNILAT SELECT S&I
4) ANGIO EXTREMITY UNILAT S&I              9) ANGIO VISCERAL SELECT OR SUPRASE
5) ANGIO PELVIC SELECT OR SUPRASELE

Select Procedure (1-9) or enter '?' for help: 7

Processing procedure: ANGIO RENAL BILAT SELECT S&I
    
```

Order Entry

```
Select PROCEDURE MODIFIERS: ?
  Answer with PROCEDURE MODIFIERS NAME
  Choose from:
  BILATERAL EXAM

Select PROCEDURE MODIFIERS:
DATE DESIRED (Not guaranteed): t+1 (MAY 19, 2009)
PREGNANT AT TIME OF ORDER ENTRY: YES13

  REASON FOR STUDY: Suspected Renal failure

  A clinical history is required. "Routine" is unacceptable.

Enter RETURN to continue or '^' to exit:
CLINICAL HISTORY FOR EXAM
==[ WRAP ]==[ INSERT ]=====< Clinical History >===== [ <PF1>H=Help ]=====

I am adding additional text here while I am adding an exam via "Add Exams to Last Visit"

The patient has aortic stinosis

<=====T=====T=====T      T=====T=====T=====T=====T>=====
-----
          Patient : RADPATIENT,ONE      Pregnant at time of order entry: Yes 14
          Procedure : ANGIO RENAL BILAT SEL
          Proc. Modifiers :
            Category : OUTPATIENT          Mode of Transport : AMBULATORY
            Desired Date : May 19, 2009    Isolation Procedures : NO
            Request Urgency : ROUTINE      Scheduled for Pre-op: NO
            Request Location : DAYTON (TRAVEL) N/C  Nature of order: SVC CORRECTION
            Reason for Study : Suspected Renal failure

Clinical History:
I am adding additional text here while I am adding an exam via "Add Exams to Last Visit"
-----
Do you want to change any of the above? NO// y YES

PROCEDURE: ANGIO RENAL BILAT SELECT S&I//          (ANI Detailed) CPT:75724
Select PROCEDURE MODIFIERS:
REASON FOR STUDY: Suspected Renal failure Replace

  A clinical history is required. "Routine" is unacceptable.

CLINICAL HISTORY FOR EXAM:
I am adding additional text here while I am adding an exam via "Add Exams
to Last Visit"
  Edit? NO//
CATEGORY OF EXAM: OUTPATIENT// r RESEARCH
RESEARCH SOURCE: The research source is Dr Smith
IS PATIENT SCHEDULED FOR PRE-OP? No// (No)
  PREGNANT AT TIME OF ORDER ENTRY: YES15
DATE DESIRED (Not guaranteed): May 19, 2009// (MAY 19, 2009)
MODE OF TRANSPORT: AMBULATORY// w WHEEL CHAIR
IS PATIENT ON ISOLATION PROCEDURES?: NO// NO
REQUEST URGENCY: ROUTINE// u URGENT
NATURE OF (NEW) ORDER ACTIVITY: SERVICE CORRECTION
  // SERVICE CORRECTION
  ...request submitted to: ANGIO
  Procedure: ANGIO RENAL BILAT SELECT S&I
  ...will now register RADPATIENT, ONE with the next case number...
  Case Number: 21
-----
PROCEDURE: ANGIO RENAL BILAT SELECT S&I//          (ANI Detailed) CPT:75724
Select PROCEDURE MODIFIERS:
CATEGORY OF EXAM: RESEARCH// RESEARCH
RESEARCH SOURCE: The research source is Dr Smith
```

13 Patch RA*5*99 February 2010: Inserted the field 'PREGNANT AT TIME OF ORDER ENTRY.'

14 Patch RA*5*99 February 2010: Replaced the 'Pregnant' field with 'Pregnant at time of order entry.'

15 Patch RA*5*99 February 2010: Replaced the 'Pregnant' field with 'Pregnant at time of order entry.'

```

Replace
PRINCIPAL CLINIC: DAYTON (TRAVEL) N/C//
TECHNOLOGIST COMMENT: I think the patient is pregnant!
PREGNANT AT TIME OF ORDER ENTRY: YES
PREGNANCY SCREEN: Patient answered yes.
REGNANCY SCREEN COMMENT: The patient is alert and oriented and is 9 weeks pregnant. Patient
has shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to
procedure.16

```

Cancel an Exam ¹⁷

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.

If the exam is associated with an image, a warning message regarding associated images and another prompt will be displayed. The user must have the RA MGR key in order to cancel an exam with associated images¹⁸.

Prompt/User Response

```

RADPATIENT,TWO's Case No. 020730-1519
This exam has associated images.
-----
Do you really want to cancel this exam with images? NO// YES
** You do not have the RA MGR key to cancel an exam with images. **
Press RETURN to continue.

```

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.

A Hold Description text may then be entered.¹⁹ When all descendents of a parent procedure are cancelled, the user will be prompted to answer Yes or No to cancel the associated request.

16 Patch RA*5*99 February 2010: Inserted the field 'PREGNANT AT TIME OF ORDER ENTRY.' Also added two pregnancy screen fields: 'PREGNANCY SCREEN' and 'PREGNANCY SCREEN COMMENT.'

17 Patch RA*5*47 September 2011: Cancel an Exam option is affected by the new Site Specific Accession Number (SSAN).

18 Patch RA*5*34 May 2003: RA Mgr Key prompt text added.

19 Patch RA*5*27 April 2002: Description text field added if user elects not to cancel the exam's associated request.

Order Entry

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

Discussion

<p>Cancel an Exam</p> <p>Enter Case Number: 681</p>	<p>You can also enter the patient's name or last initial + last 4 digits of SSN, or any other common VistA method of patient look-up.</p>																																							
<table border="1"> <thead> <tr> <th>Choice</th> <th>Case No.</th> <th>Procedure</th> <th>Name</th> <th>Pt ID</th> </tr> <tr> <th>-----</th> <th>-----</th> <th>-----</th> <th>-----</th> <th>-----</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>681</td> <td>ARTHROGRAM KNEE S&I</td> <td>RADPATIENT,TEN</td> <td>0610</td> </tr> </tbody> </table>	Choice	Case No.	Procedure	Name	Pt ID	-----	-----	-----	-----	-----	1	681	ARTHROGRAM KNEE S&I	RADPATIENT,TEN	0610																									
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<p>Do you wish to cancel this exam? NO// Y ...exam status backed down to 'CANCELLED' STATUS CHANGE DATE/TIME: APR 11,2007@14:41// <RET></p>	<p>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.</p>																																							
<p>TECHNOLOGIST COMMENT: Patient cancelled due to ... 20</p>	<p>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.</p>																																							
<p>REASON FOR CANCELLATION: ?? This is the reason this exam was cancelled.</p>																																								
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<p>Do you want to cancel the request associated with this exam? No// ?</p> <p>Required, enter 'YES' if the request should be cancelled or 'NO' to put it on hold.</p>																																								

20 Patch RA*5*18 November 2000: Added field for comments by the technologist.

```
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 IT Service to receive the RAD/NUC MED REQUEST CANCELLED bulletin:

```
Subj: Imaging Request Cancelled (000-00-0610) [#12481] 11 Apr 07 14:41
9 Lines
```

```
From: POSTMASTER (Sender: RADUSER,EIGHT) in 'IN' basket. Page 1
```

```
-----
The request for exam with the following identification was cancelled:
```

```
1) Patient           : RADPATIENT,TEN
2) Patient SSN      : 000-00-0610
3) Procedure        : ARTHROGRAM KNEE S&I
4) Reason for Study21 : Patient has complained of constant knee pain.
5) Date Desired     : APR 10, 2007
6) Requesting Physician : RADPROVIDER,SIX
7) Requesting Location : X-RAY
8) Reason           : EXAM DELETED
9) User             : RADUSER,EIGHT
```

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

Case No. Exam Edit 22

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

21 Patch RA*5*75 June 2007: Added Reason for Study to the sample mail bulletin; updated date values.

22 Patch RA*5*47 September 2011: Case No. Exam Edit option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

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. And the procedure's CPT Code must be active for the exam date.²³ 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

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 procedure²⁴ 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.

²³ Patch RA*5*38 September 2003: The procedure's CPT Code must be active for the exam date.

²⁴ Patch RA*5*28 October 2001: Requesting physician is alerted when the ordered exam is changed.

This field appears during Case Edits and also during Status Tracking if the "Ask" parameter is set to YES.

Contrast Media Used: If the Rad/Nuc Med procedure does not involve the use of a contrast, the field is automatically filled in with NO by the system but the user is prompted with this question. 25

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 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

25 Patch RA*5*45 May 2005: Added Contrast Media field.

Order Entry

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.

Requesting Physician: The person who requested the exam. The entry may not be a physician;²⁶ a nurse might request the exam. This data is automatically entered during registration and can be edited while in Case Edits.

Pregnant at time of order entry: This field is display-only and is the value that the clinician entered when the order was placed.

Pregnancy Screen: This prompt displays when the patient is female between the ages of 12 and 55. The responses are Yes, No, and Unknown.

Pregnancy Screen Comment: This prompt displays only when the response to the 'Pregnancy Screen' prompt is 'Yes' or 'Unknown.'²⁷

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

²⁶ Patch RA*5*45 May 2005: Removed Barium Used field

²⁷ Patch RA*5*99 February 2010: Inserted the field 'PREGNANT AT TIME OF ORDER ENTRY.' Also added two pregnancy screen prompts: 'PREGNANCY SCREEN' and 'PREGNANCY SCREEN COMMENT.'

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

Order Entry

“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.

Procedure Modifiers²⁸: 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: A multiple that points to the CPT Modifier file #81.3. Only CPT modifiers associated with the CPT code for the procedure and are active for that exam date are selectable.²⁹

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: 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.

²⁸ Patch RA*5*10 April 2000

²⁹ Patch RA*5*38 September 2003: Added to sentence "...CPT..." "... and are active for that exam date...."

Person Who Administered Med: 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.

Technologist Comment³⁰: This comment field can be used 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.

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: 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

³⁰ Patch RA*5*18 November 2000: Added field for comments by the technologist.

Order Entry

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: 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: 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 radio-pharmaceutical 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 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: 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 in Status Tracking if the Examination Status "Ask" parameter is set to YES.

Person Who Administered Dose: 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 in Status Tracking if the Examination Status "Ask" parameter is set to YES.

Witness to Dose Administration: 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: 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: 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 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.: 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 radio-pharmaceutical 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 if the Examination Status "Ask" parameter is YES.

Volume: 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.

Diagnostic Code and Interpreter Edit by Case No. 31

31 Patch RA*5*47 September 2011: Diagnostic Code and Interpreter Edit by Case No. option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

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..

This option cannot be used if the case is part of a printset, if the case has no report or if the case has a verified or electronically filed report. (The stub report created by the Imaging application to associate an image to a Radiology case but has no report status and report text is considered “no report”.)

For a case that is part of a printset, the interpreter(s) and diagnostic code(s) for an in-house report can be entered in the ‘Report Entry/Edit’ option and will apply to all cases in the printset. Or the diagnostic code(s) for an outside report can be entered in the ‘Outside Report Entry/Edit’ option and will apply to all cases in the printset. 32
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 IT Service). 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

32 Patch RA*5*97 September 2009: Added two paragraphs regarding a case as part of a printset, diagnostic codes, and the Report Enter/Edit and the Outside Reporting Entry/Edit options.

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: 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

Order Entry

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.

Technologist Comment³³: 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 RADPATIENT,ONE 0071
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: RADPROVIDER, THREE	JA 114
Select SECONDARY INTERPRETING 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: RADPROVIDER, FOUR	art 525B/114
Select SECONDARY INTERPRETING STAFF: RADPROVIDER, FIVE	aB 114
Select SECONDARY INTERPRETING STAFF: <RET>	
TECHNOLOGIST COMMENT:34 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.	
PREGNANT AT TIME OF ORDER ENTRY: YES	
REGNANCY SCREEN: Patient answered yes.	
PREGNANCY SCREEN COMMENT: The patient is alert and oriented and is 9 weeks pregnant. Patient has shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to procedure. ³⁵	
COMPLICATION: NO COMPLICATION// <RET>	
PRIMARY CAMERA/EQUIP/RM: <RET>	
Select FILM SIZE: LASER 14X17// <RET>	
FILM SIZE: LASER 14X17// <RET>	
AMOUNT(#films or cine ft): 1// <RET>	
Select FILM SIZE:	
...exam status remains 'EXAMINED'.	

33 Patch RA*5*18 November 2000: Added field for comments by the technologist.

34 Patch RA*5*18 November 2000: Added field for comments by the technologist.

35 Patch RA*5*99 February 2010: Changed the pregnant field from 'PREGNANT' to 'PREGNANT AT TIME OF ORDER ENTRY.' Added two pregnancy screen prompts: 'PREGNANCY SCREEN' and 'PREGNANCY SCREEN COMMENT.'

Note: Staff and residents must have access to at least one imaging location with the same imaging type as the exam, to be selectable when entering 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 IT Service has a receiving mail group set up. Failure to credit can be because of missing or invalid rad/nuc med data, factors preventing PCE from crediting, or problems preventing Scheduling software from storing or transmitting credit data.

Edit Exam by Patient ³⁶

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-1, of this manual for information about fields edited.

Enter Last Past Visit Before VistA

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, the patient must first be entered in File #2 through PIMS.

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.

36 Patch RA*5*47 September 2011: Edit Exam by Patient option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

Prompt/User Response

Discussion

```
Enter Last Past Visit Before VISTA

Select Patient:  RADPATIENT,TWO      04-18-14      000000072
NSC VETERAN

Are you adding 'RADPATIENT,TWO'      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 Status Display 37

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  RADPATIENT,THREE  BONE DENSITY STUDY, DUAL
143      8:15 AM  RADPATIENT,FOUR.  BONE IMAGING, WHOLE BODY
180      9:27 AM  RADPATIENT,FIVE   BONE DENSITY STUDY, DUAL
181      9:30 AM  RADPATIENT,SIX    BONE DENSITY STUDY, DUAL
216      10:40 AM RADPATIENT,SEVEN  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
```

37 Patch RA*5*47 September 2011: Exam Status Display option is affected by the new Site Specific Accession Number (SSAN).

Case #	Date	Patient	Procedure	Equip/Rm	
-----	----	-----	-----	-----	-----
				613	09/25/95
RADPATIENT,EIGHT		ABSCESS LOCALIZATION, WHO			
3012	09/28/95	RADPATIENT,TWO	BONE IMAGING, WHOLE BODY	N3	
568	07/01/97	RADPATIENT,NINE	BONE DENSITY STUDY, DUAL	N3	
853	07/16/97	RADPATIENT,ONE	PULMONARY PERFUSION, PART	N3	
854	07/16/97	RADPATIENT,ONE	PROVISION OF DIAGNOSTIC R	N3	
855	07/16/97	RADPATIENT,ONE	PROVISION OF DIAGNOSTIC R	N3	
858	07/16/97	RADPATIENT,ONE	VENTILATION SCAN	N3	
978	07/23/97	RADPATIENT,TWO	BONE DENSITY STUDY, DUAL	N1	
1138	07/23/97	RADPATIENT,THREE	BONE DENSITY STUDY, DUAL	N1	
1137	07/23/97	RADPATIENT,FOUR.	BONE DENSITY STUDY, DUAL	N1	
1435	08/08/97	RADPATIENT,FIVE	MYOCARDIAL PERFUSION (SPE	N2	
1347	08/14/97	RADPATIENT,SIX.	PROVISION OF DIAGNOSTIC R	N2	
131	08/15/97	RADPATIENT,SEVEN.	ACUTE GI BLOOD LOSS IMAGI	N3	
132	08/15/97	RADPATIENT,SEVEN.	PROVISION OF DIAGNOSTIC R	N3	

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

Indicate No Purging of an Exam/Report 38

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 IT Service. (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 IT Service runs the next purge. The data that is deleted includes the activity log, status tracking times, clinical history, and report text.

38 Patch RA*5*47 September 2011: Indicate No Purging of an Exam/Report option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

Indicate No Purging of an Exam/report

Prompt/User Response Discussion

Enter Case Number: RADPATIENT,TEN 000-00-00610 NO NSC VETERAN	06-12-25	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: RADPATIENT,TEN 000-00-0610          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 39

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 (PIMS) Patient file #2 and the Rad/Nuc Med Patient file #70.

If a patient is already entered in the main Patient file, you may enter him/her in the Rad/Nuc Med Patient file through this option at the Select Patient prompt. If the patient does not exist yet in File #2, then PIMS 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 PIMS.)

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

39 Patch RA*5*47 September 2011: Register Patient for Exams option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

edit the default information, which includes procedure, procedure modifiers, category of exam, and principal clinic of outpatient.

The procedure will be screened to ensure that its assigned CPT Code is active for the exam date. If the procedure was registered with a future exam date, then when that future date arrives, the procedure's assigned CPT Code will be checked again.⁴⁰ If the procedure or the imaging location has default CPT Modifiers, these CPT Modifiers will be screened to ensure that they are active for the exam date, before they are stuffed into the exam record.

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 Guide*, the Procedure Modifier Entry option. Registering a request changes the request status to ACTIVE.

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 procedure⁴¹. 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 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.

⁴⁰ Patch RA*5*38 September 2003: Text change to add information for screening of CPT Codes and CPT Modifiers.

⁴¹ Patch RA*5*28 October 2001: Requesting physician is alerted when the ordered exam is changed.

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:

1. Instead of requiring the ordering clinician to order multiple procedures for a study, a single parent procedure can be ordered.
2. The registration process is less prone to error and less time-consuming since the procedures are a pre-defined set and appear automatically.
3. Predefined descendant procedures can be registered or discarded, allowing registration of procedures you select.
4. 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.

Order Entry

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.

Comments can be entered about the patient or case at the Technologist Comment prompt. Existing text can also be edited⁴². 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 'PREGNANT AT TIME OF ORDER ENTRY' field is a display-only field. It captures whether or not a female patient between the ages of 12 and 55 is pregnant at the time the order is placed. The 'PREGNANCY SCREEN' prompt is editable. The responses are Yes, No, or Unknown. It captures whether or not a female patient between the ages of 12 and 55 is pregnant at the time of the exam.

The 'PREGNANCY SCREEN COMMENT' prompt is also editable when the response to the 'Pregnancy Screen' prompt is 'Yes' or 'Unknown.' It captures comments the technologist enters at the time of the exam.⁴³

Registration Example

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

The samples below (a – d) illustrate several advanced features:

```
Register Patient for Exams
```

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

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

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

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

⁴² Patch RA*5*18 November 2000: Added field for comments by the technologist.

⁴³ Patch RA*5*99 February 2010: Inserted the field 'PREGNANT AT TIME OF ORDER ENTRY.' Also added two pregnancy screen prompts: 'PREGNANCY SCREEN' and 'PREGNANCY SCREEN COMMENT.'

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 : RADUSER,NINE          2 labels/visit
Report : D73 D2-149
```

```
Select Patient: RADPATIENT,ONE          NO          NSC VETERAN          06-05-96
000000014
PRIM. CARE: RADPROVIDER, NINE          TEL 4418; 5021
ALT. PRIM. CARE: RADPROVIDER,TWO          TEL 4418
***** Patient Demographics *****
```

```
Name : RADPATIENT,ONE
Pt ID : 000-00-0001
Date of Birth: JUN 5,1996 (101)
Veteran : Yes          Eligibility : NSC
Sex : FEMALE
Height : 69" on JUL 16, 2004 08:50
Weight : 124.9 lbs on JUL 6, 2007 08:59
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		Or 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 RADPATIENT,ONE **** 9 Requests

St	Urgency	Procedure	Desired	Requester	Req'g Loc
1	h	STAT +CHEST CT	04/18	RADPROVID,ON	C MHC MEDIC
2	h	ROUTINE ABDOMEN 1 VIEW	12/12	RADPROVID,FI	RADIOLOGY-U
3	h	ROUTINE CT THORACIC SPINE W/O CONT	12/12	RADPROVID,ON	LOWELL DIET
4	s	ROUTINE CHEST 2 VIEWS PA&LAT	10/27	RADPROVID,TE	IM ALEX
5	h	ROUTINE WRIST 2 VIEWS	10/10	RADPROVID,FI	RADIOLOGY-U
6	h	ROUTINE MAMMOGRAM BILAT	10/03	RADPROVID,TE	RADIOLOGY-B
7	h	ROUTINE BONE IMAGING, TOMOGRAPHIC (SP	07/18	RADPROVID,ON	RADIOLOGY-M
8	h	ROUTINE CT ABDOMEN W&W/O CONT	06/13	RADPROVID,FI	RADIOLOGY-U
9	h	ROUTINE HIP 1 VIEW	04/22	RADPROVID,EI	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

Order Entry

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:

Version : 5.0T9
Division : BOSTON, MA
Location : CTG
Img. Type: CT SCAN
User : RADPROVIDER,SEVEN

Printer Defaults
-----
Flash Card : P-CTSCAN RADIOLOGY, CT SCAN E
            1 card/exam
Jacket Label: D129 (D2-150) RADIOLOGY FILE
            1 labels/visit
Report : D73 D2-149
-----
```

This sign-on and switched-to location will be used as the default value for the 'Interpreting Imaging Location in the 'Report Entry/Edit' and 'Resident On-Line Pre-Verification' options, except if its credit method is "Technical Component only" or if its Imaging Type doesn't match the exam's Imaging Type 44.

Registration of parent-descendent exams is shown.

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

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

Case Number: 306
-----
PROCEDURE: CT THORAX W/O CONT// <RET>          (CT Detailed) CPT:71250
Select PROCEDURE MODIFIERS: RIGHT// <RET>45

CATEGORY OF EXAM: OUTPATIENT// <RET> OUTPATIENT
PRINCIPAL CLINIC: C MHC MEDICATION GR 7428// <RET>          7428          RADCLINIC,ONE

TECHNOLOGIST COMMENT:46 These are the comments for case #306.
PREGNANT AT TIME OF ORDER ENTRY: YES 47
PREGNANCY SCREEN: Patient answered yes.
PREGNANCY SCREEN COMMENT: The patient is alert and oriented and is 9 weeks pregnant. Patient
has shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to
procedure.

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

Descendent procedure: CT ABDOMEN W/O CONT

...will now register RADPATIENT,ONE with the next case number...
```

44 Patch RA*5*41 September 2005: New paragraph added.

45 Patch RA*5*10 April 2000 and Patch RA*5*19: Removed CPT Modifiers prompt.

46 Patch RA*5*18 November 2000: Added field for comments by the technologist.

47 Patch RA*5*99 February 2010: Inserted the field 'PREGNANT AT TIME OF ORDER ENTRY.' Also added two pregnancy screen prompts: 'PREGNANCY SCREEN' and 'PREGNANCY SCREEN COMMENT.'

Case Number: 307

```

-----
PROCEDURE: CT ABDOMEN W/O CONT// <RET>          (CT Detailed) CPT:74150
Select PROCEDURE MODIFIERS: RIGHT// <RET> 48
CATEGORY OF EXAM: OUTPATIENT// <RET>    OUTPATIENT
PRINCIPAL CLINIC: C MHC MEDICATION GR 7428// <RET>    7428    RADCLINIC,ONE
TECHNOLOGIST COMMENT: These are the comments for case #307.49
PREGNANT AT TIME OF ORDER ENTRY: YES50
PREGNANCY SCREEN: Patient answered yes.
PREGNANCY SCREEN COMMENT: The patient is alert and oriented and is 9 weeks pregnant. Patient
has shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to
procedure.

```

Register another descendent exam for RADPATIENT,ONE (Y/N)? YES

...will now register RADPATIENT,ONE with the next case number...

Case Number: 308

PROCEDURE: ??

This field points to the 'RAD/NUC MED PROCEDURES' file (#71) to indicate the Imaging procedure associated with this case number.

ALLOWABLE WAYS TO ENTER THE IMAGING PROCEDURE FOR THIS CASE NUMBER:

```

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

```

Choose from:

```

CONSULTATION OF OUTSIDE CT FILMS WITH REPORT    (CT Detailed) CPT:76140
CT ABDOMEN W/CONT                               (CT Detailed) CPT:74160
CT ABDOMEN W/O CONT                             (CT Detailed) CPT:74150
CT CERVICAL SPINE W/CONT                        (CT Detailed) CPT:72126
CT CERVICAL SPINE W/O CONT                     (CT Detailed) CPT:72125
CT GUIDANCE FOR CYST ASPIRATION S&I           (CT Detailed) CPT:76365
CT GUIDANCE FOR NEEDLE BIOPSY S&I             (CT Detailed) CPT:76360
CT HEAD W/IV CONT                              (CT Detailed) CPT:70460
CT HEAD W/O CONT                              (CT Detailed) CPT:70450
CT LOWER EXTREMITY W&W/O CONT                  (CT Detailed) CPT:73702
CT LOWER EXTREMITY W/CONT                      (CT Detailed) CPT:73701
CT LOWER EXTREMITY W/O CONT                   (CT Detailed) CPT:73700
CT LUMBAR SPINE W/CONT                         (CT Detailed) CPT:72132
CT LUMBAR SPINE W/O CONT                       (CT Detailed) CPT:72131
CT MAXILLOFACIAL W/CONT                       (CT Detailed) CPT:70487
CT MAXILLOFACIAL W/O CONT                     (CT Detailed) CPT:70486
CT NECK SOFT TISSUE W/CONT                     (CT Detailed) CPT:70491
CT NECK SOFT TISSUE W/O CONT                  (CT Detailed) CPT:70490
CT ORBIT SELLA P FOS OR TEMP BONE W/CONT      (CT Detailed) CPT:70481
CT ORBIT SELLA P FOS OR TEMP BONE W/O CONT    (CT Detailed) CPT:70480
CT PELVIS W/CONT                              (CT Detailed) CPT:72193

```

```

^
PROCEDURE: CT HEAD W/IV CONT                    (CT Detailed) CPT:70460
Select PROCEDURE MODIFIERS: <RET>51

```

```

CATEGORY OF EXAM: OUTPATIENT// <RET>    OUTPATIENT
PRINCIPAL CLINIC: C MHC MEDICATION GR 7428// <RET>    7428    RADCLINIC,ONE

```

48 Patch RA*5*10 April 2000 and Patch RA*5*19: Removed CPT Modifiers prompt.

49 Patch RA*5*18 November 2000: Added field for comments by the technologist.

50 Patch RA*5*99 February 2010: Inserted the field 'PREGNANT AT TIME OF ORDER ENTRY.' Also added two pregnancy screen prompts: 'PREGNANCY SCREEN' and 'PREGNANCY SCREEN COMMENT.'

51 Patch RA*5*10 April 2000 and Patch RA*5*19 May 2000: CPT Modifier prompt removed.

Order Entry

TECHNOLOGIST COMMENT:52 **These are the comments for case #308.**
 PREGNANT AT TIME OF ORDER ENTRY: YES 53
 PREGNANCY SCREEN: Patient answered yes.
 PREGNANCY SCREEN COMMENT: The patient is alert and oriented and is 9 weeks pregnant. Patient has shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to procedure.

Register another descendent exam for RADPATIENT,ONE (Y/N)? **NO**

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

Select Patient: **RADPATIENT,ONE** NO NSC VETERAN 06-05-96 00000001
 PRIM. CARE: RADPROVIDER,ONE TEL 4418; 5021
 ALT. PRIM. CARE: RADPROVIDER,TWO TEL 4418

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

Name : RADPATIENT,ONE
 Pt ID : 000-00-0001
 Date of Birth: JUN 5,1996 (101)
 Veteran : Yes Eligibility : NSC
 Sex : FEMALE
 Height : 69" on JUL 16, 2004 08:50
 Weight : 124.9 lbs on JUL 6, 2007 08:59
 Narrative : This is real
 Other Allergies:
 'V' denotes verified allergy 'N' denotes non-verified allergy

YES (V) PTSD (V)

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

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

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

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

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

**** Requested Exams for RADPATIENT,ONE **** 8 Requests

St	Urgency	Procedure	Desired	Requester	Req'g Loc
1	h	ROUTINE ABDOMEN 1 VIEW	12/12	RADPROVI,FI	RADIOLOGY-U
2	h	ROUTINE CT THORACIC SPINE W/O CONT	12/12	RADPROVI,ON	LOWELL DIET
3	s	ROUTINE CHEST 2 VIEWS PA&LAT	10/27	RADPROVI,TE	IM ALEX

52 Patch RA*5*18 November 2000: Added field for comments by the technologist.
 53 Patch RA*5*99 February 2010: Inserted the field 'PREGNANT AT TIME OF ORDER ENTRY.' Also added two pregnancy screen prompts: 'PREGNANCY SCREEN' and 'PREGNANCY SCREEN COMMENT.'

```

4 h ROUTINE WRIST 2 VIEWS 10/10 RADPROVI,FI RADIOLOGY-U
5 h ROUTINE MAMMOGRAM BILAT 10/03 RADPROVI,TE RADIOLOGY-B
6 h ROUTINE BONE IMAGING, TOMOGRAPHIC (SP 07/18 RADPROVI,ON RADIOLOGY-M
7 h ROUTINE CT ABDOMEN W&W/O CONT 06/13 RADPROVI,FI RADIOLOGY-U

```

(Use Pn to replace request 'n' with a Printset procedure.)

Select Request(s) 1-7 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 : RADPROVIDER,SEVE 2 labels/visit
Report : D73 D2-149
Descendent procedure: ESOPHAGUS RAPID SEQUENCE FILMS

```

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

Case Number: 310

PROCEDURE: ESOPHAGUS RAPID SEQUENCE FILMS// <RET> (RAD Detailed) CPT:74230
Select PROCEDURE MODIFIERS:54 <RET>

CATEGORY OF EXAM: OUTPATIENT// <RET> OUTPATIENT
PRINCIPAL CLINIC: RADIOLOGY-UGI 4710// <RET> 4710

TECHNOLOGIST COMMENT:55 These are the comments. PREGNANT AT TIME OF ORDER ENTRY:56 YES
PREGNANCY SCREEN: Patient answered yes.
PREGNANCY SCREEN COMMENT: The patient is alert and oriented and is 9 weeks pregnant. Patient
has shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to
procedure.

Register next descendent exam (ESOPHAGUS PHARYNX/CERVICAL)
for RADPATIENT,ONE? Yes// YES

Descendent procedure: ESOPHAGUS PHARYNX/CERVICAL

...will now register RADPATIENT,ONE with the next case number...

54 Patch RA*5*10 April 2000 and Patch RA*5*19 May 2000: CPT Modifier prompt removed.
55 Patch RA*5*18 November 2000: Added field for comments by the technologist.
56 Patch RA*5*99 February 2010: Inserted the field 'PREGNANT AT TIME OF ORDER ENTRY.' Also
added two pregnancy screen prompts: 'PREGNANCY SCREEN' and 'PREGNANCY SCREEN
COMMENT.'

Order Entry

```
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
TECHNOLOGIST COMMENT:57 These are the comments.
PREGNANT AT TIME OF ORDER ENTRY:58  YES
PREGNANCY SCREEN: Patient answered yes.
PREGNANCY SCREEN COMMENT: The patient is alert and oriented and is 9 weeks pregnant. Patient
has shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to
procedure.

Register another descendent exam for RADPATIENT,ONE (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
```

Status Tracking of Exams 59

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 uses the same data screen from the Case No. Exam Edit and Edit Exam by Patient options to ensure that the CPT Code and CPT Modifiers of the procedure are active for that exam date.⁶⁰

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.

57 Patch RA*5*18 November 2000: Added field for comments by the technologist.

58 Patch RA*5*99 February 2010: Inserted the field 'PREGNANT AT TIME OF ORDER ENTRY.' Also added two pregnancy screen prompts: 'PREGNANCY SCREEN' and 'PREGNANCY SCREEN COMMENT.'

59 Patch RA*5*47 September 2011: Status Tracking of Exams option is affected by the new Site Specific Accession Number (SSAN).

60 Patch RA*5*38 September 2003: Use of screens to ensure CPT Code and CPT Modifiers of the procedure are active for the exam date.

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 in 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 edited case 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.

Order Entry

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-1, for an explanation of fields editable in Status Tracking specifically regarding the appearance of the 'CONTRAST MEDIA USED' and 'CONTRAST MEDIA' fields.⁶¹

The 'PREGNANT AT TIME OF ORDER ENTRY' field is display-only. It captures whether or not a female patient between the ages of 12 and 55 is pregnant at the time the order is placed.

The 'PREGNANCY SCREEN' field is displayed for female patients between the ages of 12 and 55. The responses are Yes, No, or Unknown.

The 'PREGNANCY SCREEN COMMENT' field displays only when the response to the 'PREGNANCY SCREEN' prompt is 'Yes' or 'Unknown.' It captures comments the technologist enters at the time of the exam.⁶²

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:

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

Prompt/User Response	Discussion
Status Tracking of Exams	
Current Division: DAYTON Current Imaging Type: GENERAL RADIOLOGY	
Select the Location(s) you wish to track: All//	
Another one (Select/De-Select):	
Exam Status Tracking Module Date : 02/20/09 10:44 AM	Division: DAYTON Status : WAITING FOR EXAM

61 Patch RA*5*45 May 2005: Referenced the Contrast Media and Contrast Media Used fields.

62 Patch RA*5*99 February 2010: Inserted the field 'PREGNANT AT TIME OF ORDER ENTRY.' Also added two pregnancy screen fields: 'PREGNANCY SCREEN' and 'PREGNANCY SCREEN COMMENT.'

```

Locations: INPATIENT RADIOLOGY      OUTPATIENT RADIOLOGY      RADIOLOGY
          TRANSCRIPTION (RADIOLOGY)

Case #   Date       Patient                Procedure                Equip/Rm
-----   -
340     04/18/08 GALLOP,ELI L          CHEST 2 VIEWS PA&LAT
2       02/12/09 ADAMS,LYNN M          ABDOMEN 1 VIEW

Enter Case #, Status, (N)ext status, '^' to Stop: NEXT// 2

Case # being tracked: 2

Name: ADAMS,LYNN M           Case #   : 2
Division : DAYTON              Location: RADIOLOGY
Procedure: ABDOMEN 1 VIEW      (RAD Detailed) CPT:74000
PREGNANT AT TIME OF ORDER ENTRY: YES 63
PREGNANCY SCREEN: Patient answered yes.
PREGNANCY SCREEN COMMENT: The patient is alert and oriented and is 9 weeks pregnant. Patient
has shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to
procedure.

***** Old Status: WAITING FOR EXAM
***** New Status: CALLED FOR EXAM
Do you wish to continue? YES// Y
  PROCEDURE: ABDOMEN 1 VIEW//
  CONTRAST MEDIA USED: YES//
  Select CONTRAST MEDIA: Ionic Iodinated//
  Select TECHNOLOGIST: SMITH, JOHN
TECHNOLOGIST COMMENT: This is a technologist comment!

...exam status not changed??
...Status unchanged for case #: 2

```

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 14.

View Exam by Case No. 64

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.

Additionally, the pregnancy status of a female patient between the ages of 12 and 55 at the time the order was placed is displayed by the 'Pregnant at time of order entry' field.⁶⁵

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

63 Patch RA*5*99 February 2010: Inserted the field 'PREGNANT AT TIME OF ORDER ENTRY.' Also added two pregnancy screen fields: 'PREGNANCY SCREEN' and 'PREGNANCY SCREEN COMMENT.'

64 Patch RA*5*47 September 2011: View Exam by Case No. option is affected by the new Site Specific Accession Number (SSAN).

65 Patch RA*5*99 February 2010: Inserted the field 'Pregnant at time of order entry.'

Order Entry

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 two examples show cases that have contrast media associations and are part of a printset.66

This sample shows a case that has contrast media associations.

```
Prompt/User Response
Select Exam Entry/Edit Menu Option: View Exam by Case No.

Enter Case Number:    020705-1808

=====
Name       : RADPATIENT,SIX    00-00-9812
Division   : SUPPORT ISC           Category   : OUTPATIENT
Location   : X-RAY CLINIC COUNT   Ward       :
Exam Date  : FEB  7,2005  14:50   Service    :
Case No.   : 1808                 Bedsection :
                                      Clinic      : CO-B'S CLINIC 2
=====

Registered : ABDOMEN 2 VIEWS              (RAD Detailed) CPT:74010
Requesting Phy: RADPROVIDER,ONE   Exam Status : WAITING FOR EXAM
Int'g Resident:                   Report Status: NO REPORT
Pre-Verified : NO                  Cam/Equip/Rm :
Int'g Staff  :                    Diagnosis    :
Technologist :                    Complication : NO COMPLICATION
Comment:                               Films       :
    Pregnant at time of order entry: YES67
-----Modifiers-----
Proc Modifiers: PORTABLE EXAM

CPT Modifiers : GC RESIDENT/TEACHING PHYS SERV
               GJ 'OPT OUT' PHYS/PRACT EMERG OR URGENT SERVICE

Contrast Media: Barium, Cholecystographic, Ionic Iodinated,
               Non-ionic Iodinated, Gadolinium, Gastrografin,
               unspecified contrast media
=====
Do you wish to display all personnel involved? No// y YES

                *** Imaging Personnel ***
-----
Primary Int'g Resident:
Primary Int'g Staff   :
Pre-Verifier:
Verifier             :

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

Technologist(s)                    Transcriptionist
-----
None                                 No Report

                Contrast Media Edit History
```

66 Patch RA*5*45 May 2005: 'View Exam by Case No' has been changed.

67 Patch RA*5*99 February 2010: Inserted the field 'Pregnant at time of order entry.'

```

Date/Time Changed          User
Contrast Media
-----
Feb 25, 2005 1:31 pm      RADPROVIDER,ONE
Barium, Cholecystographic, Ionic Iodinated, Non-ionic Iodinated,
Gadolinium, Gastrografin, unspecified contrast media

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

*** Exam Activity Log ***
Date/Time          Action          Computer User
Technologist comment
-----
FEB 25,2005 13:21  EXAM ENTRY          RADPROVIDER,ONE
add exam to last visit option being exercised when CM is involved...
FEB 25,2005 13:31  EDIT BY CASE NO.    RADPROVIDER,ONE

```

This 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.

Prompt/User Response

```

View Exam by Case No.

Enter Case Number: RADPATIENT,SEVEN
RILL          11-12-47      000000088      YES      SC VETERAN      WR/

          **** Case Lookup by Patient ***00
Patient's Name: RADPATIENT,SEVEN      000-99-0088      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

Type '^' to STOP, or
CHOOSE FROM 1-7: 1
Name       : RADPATIENT,SEVEN      000-00-0088
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

-----
Registered : THALLIUM SCAN (SPECT) (NM Detailed) CPT:nnnnn68
Requested  : THALLIUM SCAN
Requesting Phy: RADPROVIDER,TWO      Exam Status : COMPLETE
Int'g Resident:                      Report Status: VERIFIED
Pre-Verified : NO                    Cam/Equip/Rm :
Int'g Staff  : RADPROVIDER,TEN       Diagnosis   :
Technologist : RADPROVIDER,FIVE      Complication :
Comment     :                          Films       : NUC (NucMed Kodak EC-1) - 1

Pregnant at time of order entry: YES69

-----Modifiers-----
Proc Modifiers: None
CPT Modifiers :None

```

68 Patch RA*5*10 April 2000

69 Patch RA*5*99 February 2010: Inserted the field 'Pregnant at time of order entry.'

Order Entry

```

-----Radiopharmaceuticals-----
Rpharm: TL-201 THALLOUS CHLORIDE      Activity Drawn: 3.35 mCi
Drawn: JUL 24, 2000@08:06             Measured By: RADPROVIDER,FIVE
Dose Adm'd: 3.35 mCi                  Date Adm'd: JUL 24, 2000@08:06
Adm'd By: RADPROVIDER,FIVE            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   : RADPROVIDER,TEN
Pre-Verifier:
Verifier              : RADPROVIDER,TEN 081100@09:31

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

Technologist(s)                      Transcriptionist
-----
RADPROVIDER,FIVE                     RADUSER,TEN

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

*** Exam Activity Log ***
Date/Time      Action                      Computer User
-----
JUL 24,2000  08:11  EXAM ENTRY                      RADPROVIDER,FIVE
This is a tech note on the patient/case.70
JUL 25,2000  09:51  EXAM STATUS TRACKING           RADPROVIDER,FIVE
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    RADUSER,TEN
AUG 11,2000  09:31  VERIFIED                        RADPROVIDER,TWO
=====
Do you wish to display status tracking log? No// Y
*** Status Tracking Log ***
Status          Date/Time      Elapsed Time  Cumulative Time
-----
REGISTERED FOR EXAM  JUL 24,2000  08:11      01:01:40      01:01:40
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

```

EXAMPLE

```

RADPATIENT,EIGHT (000-00-0088)      Case No.       : 072400-578 @08:11
THALLIUM SCAN (SPECT)                Transcriptionist: RADUSER,TEN
Req. Phys : RADPROVIDER,TWO           Pre-verified   : NO
Staff Phys: RADPROVIDER,TWO (P)
Residents :
=====
THALLIUM SCAN (SPECT)

Radiopharmaceutical: TL-201 THALLOUS CHLORIDE, 3.35 mCi

```

70 Patch RA*5*18 November 2000: New field for comments by the technologist added to report.

Adm'd on JUL 24, 2000@08:06 by RADPROVIDER,FIVE
Route INTRAVENOUS Site RIGHT ANTECUBITAL FOSSA
PROVISION OF RADIONUCLIDE;DIAGNOSTIC
COMPUTER MANIPULATION < 30 MIN.
INTRODUCTION OF NEEDLE OR INTRACATHETER,VEIN71

Clinical History:

EXERTIONAL ANGINA (NEW SINCE BEGINNING OF 6/00) WITH MULTIPLE RISK FACTORS 72

Additional Clinical History:

PATIENT FELT PAIN IN THE LEFT ARM.

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:

The display of cases for a printset will be condensed as much as possible. Please see detailed explanation under the "Display a Rad/Nuc Med Report" section.73

71 Patch RA*5*35 December 2002: Deleted four instances of "Exam modifiers : None"

72 Patch RA*5*27 April 2002: Added Additional Clinical History to the report.

73 Patch RA*5*35 December 2002: Display of cases for a printset will be condensed as much as possible.

5. 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
- Outside Report Entry/Edit⁷⁴
- Report Entry/Edit
- Resident On-Line Pre-Verification
- Select Report to Print by Patient
- Switch Locations
- Verify Report Only

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
- Batch Reports Menu

Add/Remove Report from Batch ⁷⁵

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.

⁷⁴ Patch RA*5*56 July 2008: Added a new option, Outside Report Entry/Edit, to the Films Reporting menu.

⁷⁵ Patch RA*5*47 September 2011: Add/Remove Report from Batch option is affected by the new Site Specific Accession Number (SSAN).

Prompt/User Response

Discussion

Add/Remove Report From Batch	
------------------------------	--

Example 1 - Adding a report to a batch:

Select Batch: RADPROVIDER, THREE 3/7/97	03-07-97	RADPROVIDER, EIGHT
Select REPORT: 010397-411	RADPROVIDER, FOUR	
Select REPORT: <RET>		

Example 2 - Removing a report from a batch:

Select Batch: RADPROVIDER, THREE 3/7/97	03-07-97	RADPROVIDER, EIGHT
Select REPORT: 010397-411// @		
SURE YOU WANT TO DELETE THE ENTIRE REPORT? Y (Yes)		
Select REPORT: <RET>		

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 RADPROVIDER, ONE REPORTS Are you adding '4/3/95 RADPROVIDER, ONE 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.

```
*****
1] 2/22/95 RADPROVIDER,EIGHT <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.
```

List Reports in a Batch 76

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

<pre>List Reports in a Batch Select Batch: RADPROVIDER,FIVE REPORTS 03-06-95 RADPROVIDER,SEVEN DEVICE: HOME// <RET> RIGHT MARGIN: 80// <RET></pre>	
<pre>Batch: RADPROVIDER,FIVE 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 RADPROVIDER,FIVE RADPROVIDER,ONE * 138 MAR 6,1995 RADPROVIDER,FIVE RADPROVIDER,ONE</pre>	

Print a Batch of Reports 77

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

76 Patch RA*5*47 September 2011: List Reports in a Batch option is affected by the new Site Specific Accession Number (SSAN).

77 Patch RA*5*47 September 2011: Print a Batch of Reports option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

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: RADPATIENT,TWO 3/24/95 03-24-95 RADPROVIDER,SIX	
Batch: RADPATIENT,TWO 3/24/95 Date Created: MAR 24,1995 15:10 RADPROVIDER,SIX 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.

Verify Batch 78

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

78 Patch RA*5*47 September 2011: Verify Batch option is affected by the new Site Specific Accession Number (SSAN).

attending and requesting physicians and any teams associated with the patient through CPRS will be notified.

Please be aware that receiving alerts depends on a variety of factors, including whether or not the appropriate clinicians' names are being entered into the PIMS system as primary and attending physicians in CPRS as members of a team, whether the personal preference flags for the various alerts are turned on in CPRS 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

<pre>Verify Batch Select Batch: RADPROVIDER,FIVE REPORTS 03-06-95 RADPROVIDER,SEVEN</pre>	
<pre>Batch: RADPATIENT,TWO REPORTS Date Created: MAR 6,1995 12:57 RADPROVIDER,SEVEN Last Printed: MAR 6,1995 13:05 Is this the batch you want to verify? No// Y Enter your Current Signature Code: (Enter your electronic signature code here) SIGNATURE VERIFIED79 ----- Report for case no. 137 for RADPATIENT,TWO Select one of the following: Note: Released/Not Verified status will not display as a selection, unless the division parameters allow it. Refer to the ADPAC Guide for more information. V VERIFIED R RELEASED/NOT VERIFIED PD PROBLEM DRAFT D DRAFT REPORT STATUS: D// VERIFIED VERIFYING PHYSICIAN: RADPROVIDER,ONE MEG PRIMARY DIAGNOSTIC CODE: NORMAL// <RET> Select SECONDARY DIAGNOSTIC CODE: <RET> ----- Report for case no. 138 for RADPATIENT,TWO Select one of the following: V VERIFIED R RELEASED/NOT VERIFIED PD PROBLEM DRAFT D DRAFT REPORT STATUS: D// VERIFIED VERIFYING PHYSICIAN: RADPROVIDER,ONE.// <RET> PRIMARY DIAGNOSTIC CODE: NORMAL// <RET> Select SECONDARY DIAGNOSTIC CODE: <RET> ----- Can this batch now be deleted? No// Y ...deletion complete. Status updates queued!</pre>	

Display a Rad/Nuc Med Report ⁸⁰

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.

The report display includes procedure and CPT modifiers (includes all procedures in a set)⁸¹, reason for study ⁸², pharmaceuticals and radiopharmaceuticals when used, clinical history and additional clinical history ⁸³, report text, impression text, report status, the names of all the primary and secondary interpreting staff and residents, and two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'⁸⁴ 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. The display of cases for a printset will be condensed as much as possible. CPT modifiers and Procedure modifiers with the value of "None" will not be displayed.

⁸⁰ Patch RA*5*47 September 2011: Display a Rad/Nuc Med Report option is affected by the new Site Specific Accession Number (SSAN).

⁸¹ Patch RA*5*10 April 2000

⁸² Patch RA*5*75 June 2007: Added Reason for Study to report display list.

⁸³ Patch RA*5*27 April 2002: Additional clinical history added to report.

⁸⁴ Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

Duplicate procedure names with matching CPT modifiers and Procedure modifiers will be displayed only once, preceded by a number to indicate the number of occurrence of that procedure and its modifiers.⁸⁵

For example,

The long (traditional) display:

MYOCARDIAL PERFUSION STUDY

SESTAMIBI (PER DOSE)

SESTAMIBI (PER DOSE)

The condensed (new default) display:⁸⁶

MYOCARDIAL PERFUSION STUDY

2x SESTAMIBI (PER DOSE)

Users may change the default display (condensed vs. long) by using the "Set preference for Long Display of Procedures" option, which is under the "User Utility Menu" option.

Prompt/User Response

Discussion

```

Display a Rad/Nuc Med Report 87

Select Patient: RADPATIENT,SIX      0-0-45      666456754      4AS-1
Enrollment Priority: GROUP 2      Category: IN PROCESS      End Date:
                **** Patient's Exams ****

Patient's Name: RADPATIENT,SIX 666-45-6754      Run Date: MAR 26,2007

  Case No.  Procedure                Exam Date  Status of Report  Imaging Loc
  -----  -
1    2240    HIP 1 VIEW                        03/26/07  VERIFIED          OUTPATIENT
2    2114    CT ABDOMEN W&W/O CONT 06/28/06  None              CT SCAN
3    2113    CT ABDOMEN W/O CONT  06/28/06  None              CT SCAN
4    2112    CT ABDOMEN W&W/O CONT 06/28/06  None              CT SCAN
CHOOSE FROM 1-4: 1
RADPATIENT,SIX (666-45-6754)      Case No.       : 032607-2240 @14:46
HIP 1 VIEW                          Transcriptionist: TRANSCRIP,ONE
Req. Phys : PROVIDER,THREE          Pre-verified   : NO
Staff Imaging Phys : RADPROVIDER,TWO 88

Residents :
  Pregnancy Screen: Patient answered yes.89
Pregnancy Screen Comment: The patient is alert and oriented and is 9 weeks pregnant. Patient
has shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to
procedure.
=====
HIP 1 VIEW                          (RAD Detailed) CPT:73500
Proc Modifiers : LEFT
Reason for Study: Patient presents with hip pain after fall at home
Pharmaceutical: DIGOXIN 0.25MG TAB, 2.5MG
Clinical History:
  Severe left hip pain after trip-and-fall at home. Rule out fracture.
Additional Clinical History:
  No hx of hip fracture/pain.
Report:                               Status: VERIFIED
  
```

85 Patch RA*5*35 February 2010: Changes on displays.

86 Patch RA*5*35 December 2002: Continued changes in displays.

87 Patch RA*5*82 June 2007: Added new sample prompts and report output.

88 Patch RA*5*99 February 2010: Replaced the 'Staff Phys' field with 'Staff Imaging Phys' field.

89 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

Order Entry

No gross abnormalities; some arthritic degeneration noted.

Impression:

Appears normal; possible hairline fracture

Primary Diagnostic Code:

NORMAL

6. 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

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

Order Entry

```
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  RADPROVIDER,SIX      12
JAN 29,1996  12:09  PRINT    RADPROVIDER,SIX      8
AUG 31,1995  10:38  PRINT    RADPROVIDER,SIX     46
```

Clinic Distribution List 90

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.

90 Patch RA*5*47 September 2011: Clinic Distribution List option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

- 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 and listing new reports.

If you choose to list reprints of reports, you are then prompted to enter a date range for the listing.

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.⁹¹

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
```

```
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:  
-----
```

91 Patch RA*5*10 April 2000

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.

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).

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.⁹² 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.

⁹² Patch RA*5*10 April 2000

Order Entry

Prompt/User Response

Discussion

<pre>Print by Routing Queue Select Routing Queue: WARD REPORTS// <RET> Division Selection: ----- Requesting Division: HINES CIO FIELD OFFICE// <RET> IL CIOFO 499</pre>	
<pre>Select Imaging Type: All// <RET> Another one (Select/De-Select): <RET></pre>	<p>You may choose one, several, or all imaging types.</p>
<pre>Sort Sequence Selection: ----- Choose one of the following: Terminal Digits SSN Patient Select Sequence: Patient// <RET></pre>	<p>Note: The terminal digit sort uses the last two digits of the patient's SSN.</p>
<pre>First Sort Selection: ----- Sort by patient location before Patient? Yes// <RET></pre>	<p>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.</p>
<pre>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)</pre>	
<pre>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</pre>	<p>The results reports will print on the printer entered at the Device prompt.</p>

Report's Print Status 93

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.

93 Patch RA*5*47 September 2011: Report's Print Status option is affected by the new Site Specific Accession Number (SSAN).

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:	RADPATIENT,ONE	11-15-19	000000091 SC VETERAN
1	071594-64	RADPATIENT,ONE	RADIONUCLIDE THERAPY, HYPERTHYROIDISM
2	091494-198	RADPATIENT,ONE	BONE AGE
3	080494-165	RADPATIENT,ONE	RIBS UNILAT+CHEST 3 OR MORE VIEWS
CHOOSE 1-3: 3 080494-165			
Report :	080494-165	Patient :	RADPATIENT,ONE 000-00-0091
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	RADUSER,ONE	1S
FILE ROOM			1S
MEDICAL RECORDS			1S

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

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 through 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.

Order Entry

The reports are then printed (preceded and followed by the queue banner).⁹⁴ 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.

Prompt/User Response

Discussion

<pre>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></pre>	
<pre>Select Clinic: ER EMERGENCY ROOM Another one (Select/De-Select):</pre>	<p>The clinic selection prompts allow you to choose more than one clinic, or de-select clinics. Enter "?" for online help.</p>
<pre>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</pre>	

Unprinted Reports List 95

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  RADPATIENT, TWO    03/27/95      BILLINGS B  CLINIC REPORT
032795-23  RADPATIENT, TWO    03/27/95      BILLINGS B  MEDICAL RECOR
033094-62  RADPATIENT, THREE  06/10/94      NUCLEAR ME  CLINIC REPORT
033094-62  RADPATIENT, THREE  06/10/94      NUCLEAR ME  MEDICAL RECOR
111593-26  RADPATIENT, FOUR   04/26/94      1N          WARD REPORTS
111593-26  RADPATIENT, FOUR   04/26/94      1N          FILE ROOM
111593-26  RADPATIENT, FOUR   04/26/94      1N          MEDICAL RECOR
082694-31  RADPATIENT, FOUR   08/26/94      BILLINGS B  CLINIC REPORT
082694-31  RADPATIENT, FOUR   08/26/94      BILLINGS B  MEDICAL RECOR
090494-25  RADPATIENT, FIVE   09/04/94      DENTAL      CLINIC REPORT
090494-25  RADPATIENT, FIVE   09/04/94      DENTAL      MEDICAL RECOR
071594-58  RADPATIENT, SIX    07/26/94      NUCLEAR ME  CLINIC REPORT
071594-58  RADPATIENT, SIX    07/26/94      NUCLEAR ME  MEDICAL RECOR
012794-54  RADPATIENT, TWO    06/10/94      EMERGENCY   CLINIC REPORT
012794-54  RADPATIENT, TWO    06/10/94      EMERGENCY   MEDICAL RECOR
051394-8   RADPATIENT, TWO    06/10/94      MEDICAL RECOR
051394-8   RADPATIENT, TWO    06/10/94      OTHER THAN WA
021194-92  RADPATIENT, TWO    04/26/94      EMERGENCY   MEDICAL RECOR

```

Ward Distribution List 96

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.

95 Patch RA*5*47 September 2011: Unprinted Reports List option is affected by the new Site Specific Accession Number (SSAN).

96 Patch RA*5*47 September 2011: Ward Distribution List option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

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    RADPATIENT,SEVEN    0097    03/07/95@12:56    RADUSER,TWO    1N
012695-94    RADPATIENT,SEVEN    0097    03/07/95@12:56    RADUSER,TWO    1N
012695-92    RADPATIENT,SEVEN    0097    03/07/95@12:56    RADUSER,TWO    1N
011394-46    RADPATIENT,EIGHT    0098    03/07/95@12:56    RADUSER,THREE  1N
013095-1     RADPATIENT,NINE     0910    03/07/95@12:56    RADUSER,FOUR   1N
012595-82    RADPATIENT,NINE     0910    03/07/95@12:56    RADUSER,FOUR   1N
012595-83    RADPATIENT,NINE     0910    03/07/95@12:56    RADUSER,FOUR   1N
012595-87    RADPATIENT,NINE     0910    03/07/95@12:56    RADUSER,FOUR   1N
012595-72    RADPATIENT,NINE     0910    03/07/95@12:56    RADUSER,FOUR   1N
041194-166   RADPATIENT,TEN      5091    03/07/95@12:56    RADUSER,THREE  1S
041194-167   RADPATIENT,ONE      1001    03/07/95@12:56    RADUSER,THREE  1S
020295-47    RADPATIENT,FOUR     0004    03/07/95@12:56    RADUSER,FIVE    215E
021395-4     RADPATIENT,FOUR     0004    03/07/95@12:56    RADUSER,FIVE    215E
011895-131   RADPATIENT,FOUR     0004    03/07/95@12:56    RADUSER,FIVE    215E
101994-224   RADPATIENT,FOUR     0004    03/07/95@12:56    RADUSER,FIVE    215E
020894-90    RADPATIENT,FOUR     0004    03/07/95@12:56    RADUSER,FIVE    215E
022894-71    RADPATIENT,FOUR     0004    03/07/95@12:56    RADUSER,FIVE    215E
020394-72    RADPATIENT,FOUR     0004    03/07/95@12:56    RADUSER,FIVE    215E

```

Draft Report (Reprint) 97

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.

97 Patch RA*5*47 September 2011: Draft Report (Reprint) option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

Prompt/User Response

Discussion

```
Select Films Reporting Menu Option: Draft Report (Reprint)
Select Patient: RADPATIENT,THREE 1-20-50 666030495

**** Patient's Exams ****

Patient's Name: RADPATIENT,THREE 666-03-0495 Run Date: SEP 1,2009

Case No. Procedure Exam Dt Rpt St Imaging Loc
-----
1 141-062509-3087 ABDOMEN 2 VIEWS 06/25/09 NANCY
2 141-100208-2960 ZZSS SHAVKAT TEST PROCEDUR 10/02/08 DRAFT RADIOLOGY LA
3 141-092508-2952 SKULL LESS THAN 4 VIEWS 09/25/08 RADIOLOGY LA
4 141-092508-2948 ANGIO CAROTID CEREBRAL UNI 09/25/08 VERIFIED RADIOLOGY LA
5 2941 CHEST 4 VIEWS 09/23/08 RADIOLOGY LA
6 2951 CHEST 4 VIEWS 09/18/08 OUTPATIENT R
7 141-091608-2946 CLAVICLE 09/16/08 DRAFT RADIOLOGY LA
8 141-091608-2945 ANKLE 2 VIEWS 09/16/08 RADIOLOGY LA
9 141-091608-2943 ABDOMEN 2 VIEWS 09/16/08 RADIOLOGY LA
10 141-091608-2942 KNEE 3 VIEWS 09/16/08 RADIOLOGY LA
11 141-020408-2540 KNEE 3 VIEWS 02/04/08 RADIOLOGY LA
12 141-123107-2463 ANGIO CAROTID CEREBRAL UNI 12/31/07 X-RAY CLINIC
13 141-092607-2408 HIP 2 OR MORE VIEWS 09/26/07 VERIFIED RADIOLOGY LA
14 141-092607-2461 SKULL LESS THAN 4 VIEWS 09/26/07 RADIOLOGY LA
Type a '^' to STOP, or
CHOOSE FROM 1-14: 2

Select a device: HOME// TELNET Right Margin: 80//
CASE #:000-000000-2960HEADER Patient: RADPATIENT,THREE Verif. Dt:
Procedure:ZZSS SHAVKAT TEST PROCEDURE Tech:RADTECHNICIAN,EIGHT
Patient Location: 5NM/09-01-2009@23:56

PREGNANCY SCREEN: Patient answered yes.98
PREGNANCY SCREEN COMMENT: The patient is alert and oriented and is 9 weeks pregnant.
Patient has shattered pelvis and needs immediate surgery. Patient has been counseled and agreed
to procedure.
(Case 141-100208-2960 EXAMINE) ZZSS SHAVKAT TEST PROCEDURE (RAD Detailed)
CPT:000000
Proc Modifiers : RIGHT
Reason for Study: Generate alert for DX code 4 resulted in VR?

Clinical History:
Create a report in VR and send to VistA with a DX code of 4 and
check that it generates an alert.

Report:
Impression:

Enter RETURN to continue or '^' to exit:

Primary Diagnostic Code:

Primary Interpreting Staff:
RADCLINICIAN,TWO
Primary Interpreting Resident:
RADPROVIDER,FIVE
VERIFIED BY:

/RVD

Enter RETURN to continue or '^' to exit:
*****
*DRAFT*
*****
```

98 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

```

FOOTER ver.sign
Verifier:
Date of Exam:OCT  2,2008  08:40
Name: RADPATIENT,THREE
EXM/PRC MDFIER:RIGHT
Report Status:DRAFT
VAF 10-9034 VICE SF 519B RADIOLOGY/NUCLEAR MEDICINE REPORT

```

On-line Verifying of Reports 99

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 Guide* for a more complete discussion of the effects of various combinations of the set-up parameters.)

99 Patch RA*5*47 September 2011: On-line Verifying of Reports option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

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 Imaging Locations file100 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.

100 Patch RA*5*10 April 2000: Corrected file, from Rad/Nuc Med Division to Imaging Locations.

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 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 IT Service, who should refer to the *Radiology/Nuclear Medicine 5.0 HL7 Manual* 101 for more information.

101 Patch RA*5*25 July 2002: Reference to Technical Manual changed to the Radiology/Nuclear Medicine 5.0 HL7 Manual.

Order Entry

Note: If there is a technologist comment, it is shown in the body of the report. 102 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?".

Note: If there are contrast media associations with the exam, they are shown in the body of the report.103

Note: If a female patient is between the ages of 12 and 55, two pregnancy screen fields are shown on the body of the report. Both fields are populated at the time of the exam: 1) Pregnancy Screen - the responses are Yes, No, and Unknown; 2) Pregnancy Screen Comment - this field displays only when the response to the 'Pregnancy Screen' field is 'Yes' or 'Unknown.' It captures comments the technologist enters at the time of the exam.104

Prompt/User Response

Discussion

```
On-line Verifying of Reports

Enter your Current Signature Code: 0000 SIGNATURE VERIFIED

Select Interpreting Physician: RADCLINICIAN,ONE// <RET> VA 192
RADIOLOGIST
There is only one report (RELEASED/NOT VERIFIED, PRE-VERIFIED) to choose from.
Do you wish to review this one report? YES// <RET>
  Select one of the following:
    P PAGE AT A TIME
    E ENTIRE REPORT
How would you like to view the reports?: P// E ENTIRE REPORT

RADPATIENT,SEVEN (XXXXXXXXXX) Case No. : 030309-7 @13:16
ESOPHAGUS Transcriptionist : RADTRANSCRIPTIONIST,ONE
Req. Phys : RADCLINICIAN,FIVE Pre-verified : RADCLINICIAN,SEVEN

Staff Imaging Phys: RADCLINICIAN,SIX (P)105
Residents : RADCLINICIAN,SEVEN (P)
Pregnancy Screen: Patient answered yes.106
Pregnancy Screen Comment: The patient is alert and oriented and is 9 weeks pregnant.
Patient has shattered pelvis and needs immediate surgery. Patient has been counseled
and agreed to procedure.
=====
ESOPHAGUS (RAD Detailed) CPT:00000
Reason for Study: PATIENT IS COMPLAINING THAT SHE NEEDS A
LARENJECTAOMY
Clinical History:
  PATIENT WOULD LIKE A LARYNJECTOMY.

Report: Status: RELEASED/NOT VERIFIED
PORTABLE CHEST: 1-1-00: 06:10 hours:
```

102 Patch RA*5*18 November 2000: New field for comments by the technologist added to report.

103 Patch RA*5*45 May 2005: Display of associated contrast media.

104 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

105 Patch RA*5*99 February 2010: Replaced the 'Staff Phys' field with 'Staff Imaging Phys' field.

106 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

Reexamination of the chest by single frontal projection with a portable unit showed no significant interval change as compared to the previous study a day ago.

Impression:

No significant change compared to previous study of 1-31-99.

Primary Diagnostic Code:
CRITICAL ABNORMALITY

=====

Type '?' for action list, 'Enter' to continue// ?

Select one of the following:

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

REPORT STATUS: R// <RET> ELEASED/NOT VERIFIED
PRIMARY DIAGNOSTIC CODE: CRITICAL ABNORMALITY// <RET>

Select SECONDARY DIAGNOSTIC CODE: <RET>
Return to Resident (delete pre-verification)? N NO

Press RETURN to Continue: ^

Outside Report Entry/Edit 107 108

This option allows you to enter a canned report to record the receipt of a report that was interpreted outside your facility without the need to verify the report in order for the exam status of the case to reach 'COMPLETE.' This option prompts for 'Standard' Report to Copy, Reported Date, Report Text, Impression Text, and Diagnostic Codes.

It automatically assigns an Electronically Filed (EF) report status to the report, if a canned report was selected, and/or report text and/or impression text was entered via this option. Except for the Diagnostic Code, this option ignores all other site-required items for the exam status of 'COMPLETE,' including verifying physician and verified date.

If diagnostic and BI-RADS codes are not required for the exam status of 'COMPLETE,' this option automatically sets the exam status to 'COMPLETE'; otherwise, it automatically sets the exam status to 'COMPLETE' when a diagnostic code or a required BI-RADS code is entered later via this option.

The requirement for diagnostic code is set via the 'Examination Status Entry/Edit' [RA EXAMSTATUS] option.

The requirement for BI-RADS code is determined by having all the following conditions met:

1. The CPT code of the procedure is a record in the RADIOLOGY CPT BY PROCEDURE TYPE file (#73.2). This file is updated annually by a Radiology patch with data from the Program Office.

107 Patch RA*5*56 July 2008: Added information about the Outside Report Entry/Edit option.

108 Patch RA*5*47 September 2011: Outside Report Entry/Edit option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

2. Field #3, PROCEDURE SUBCATEGORY of this record is IMAGING.
3. Field #4, RVU PROCEDURE TYPE of this record is MAMMOGRAPHY.
4. Field #8, BIRADS PROCEDURE of this record is YES.

When a required BI-RADS code is missing, a warning message is displayed 109

This option also allows you to enter diagnostic codes even after the case has reached the 'COMPLETE' exam status. Each time this option is used to change or add new diagnostic codes, the added or changed codes are rechecked to see if alerts should be generated. Alerts are not generated again for existing, unchanged diagnostic codes that previously triggered the generation of alerts.

The generation of alerts is based upon the value of "GENERATE ABNORMAL ALERT?" in the DIAGNOSTIC CODES file (#78.3), which is updated via the 'Diagnostic Code Enter/Edit' [RA DIAGEDIT] option. If an alert is generated, its notification appears as follows on the VistA roll-n-scroll screen:

```
RADPATIENT,ONE (R4558): Abnormal Imaging Results: CHEST 2 VIEWS PA&LAT
Enter "VA to jump to VIEW ALERTS option
```

109 Patch RA*5*97 September 2009: Added BI-RADS information to the Outside Report Enter/Edit option.

Example 1

```

Enter a new outside report for a case that is registered from a credit location.110

Select Films Reporting Menu Option: OUTSIDE Report Entry/Edit

+-----+
| This option is for entering canned text for |
| outside work: interpreted report done outside, |
| and images made outside this facility. |
+-----+

Select Rad/Nuc Med Division: All//
Another one (Select/De-Select):

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

Enter Case Number: RADPATIENT,ONE
RADPATIENT,ONE      6-1-27      000000000

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

Patient's Name: RADPATIENT,ONE  000-00-0000      Run Date: MAR  5,2008

Case No.  Procedure              Exam Date  Status of Report Imaging Loc
-----
1    2794  CHEST 2 VIEWS PA&LAT          03/05/08          RADIOLOGY L
2    2612  SPINE ENTIRE AP&LAT          02/13/08  ELECTRONICALLY F RADIOLOGY L
3    2610  ELBOW 2 VIEWS                02/13/08  DRAFT          X-RAY CLINI
4    2608  HAND 1 OR 2 VIEWS            02/13/08  ELECTRONICALLY F X-RAY CLINI
5    +2552  ABDOMEN 1 VIEW               01/31/08  DRAFT          X-RAY CLINI
6    .2553  ABDOMEN 2 VIEWS              01/31/08  DRAFT          X-RAY CLINI
7    .2554  ABDOMEN 3 OR MORE VIEWS      01/31/08  DRAFT          X-RAY CLINI
8    2551  MANDIBLE LESS THAN 4 VIEWS    01/31/08  DRAFT          X-RAY CLINI
9    2498  CLAVICLE                     12/19/07  (Exam Dc'd)    RADIOLOGY L
10   2152  FOOT 2 VIEWS                 09/08/06  VERIFIED       X-RAY CLINI
11   2153  CLAVICLE                     09/08/06  ELECTRONICALLY F X-RAY CLINI
12   2122  HIP 1 VIEW                   07/07/06          RADIOLOGY L

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

-----
Name      : RADPATIENT,ONE      Pt ID      : 000-00-0000
Case No.  : 2794  Exm. St: WAITING FOR Procedure   : CHEST 2 VIEWS PA&LAT
Tech.Comment: This is the tech comment entered during registration.
Exam Date: MAR  5,2008  10:29      Technologist:
Req Phys   : RADPROVIDER,ONE
Pregnancy Screen: Patient answered yes.111
Pregnancy Screen Comment: The patient is alert and oriented and is 9 weeks pregnant.
Patient has shattered pelvis and needs immediate surgery. Patient has been counseled
and agreed to procedure.

-----112

Do you want to continue? NO// YES
...report not entered for this exam...
...will now initialize report entry...

-----
Select 'Standard' Report to Copy:
REPORTED DATE: T (MAR 05, 2008)

```

110 Patch RA*5*95 May 2009: Removed the paragraph about 'No Credit' imaging location and the reference about displaying a warning message.

111 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

112 Patch RA*5*95 May 2009: Removed the "No Credit" warning message.

Order Entry

```
CLINICAL HISTORY:
This is the clinical history entered during Request an Exam.

+++++
Required: REPORT TEXT and/or IMPRESSION TEXT
+++++
REPORT TEXT:
No existing text
Edit? NO//

IMPRESSION TEXT:
No existing text
Edit? NO//

+++++
Required: REPORT TEXT and/or IMPRESSION TEXT
+++++

==[ WRAP ]==[ INSERT ]===== < REPORT TEXT >===== [ <PF1>H=Help ]====

REPORT TEXT: If nothing is entered for REPORT TEXT and IMPRESSION
No existing text TEXT, the option loops back to ask for both, until data is
Edit? NO// YES entered for at least one of them.

This is the report text.

T=====T=====T=====T=====T=====T=====T=====T=====T>=====
IMPRESSION TEXT:
No existing text
Edit? NO//
PRIMARY DIAGNOSTIC CODE: NORMAL
Select SECONDARY DIAGNOSTIC CODE: 9 NO DISCRETE MASS
Select SECONDARY DIAGNOSTIC CODE:
Report status is stored as "Electronically Filed".
...will now designate exam status as 'COMPLETE'... for case no. 2794
...exam status successfully updated.
...will now designate request status as 'COMPLETE'...
Visit credited.
...request status successfully updated.
Do you wish to print this report? No//
```

Results

Both exam status and request status are updated to 'COMPLETE.'

If you enter an outside report for an exam that was registered from a "No Credit" imaging location, the "Visit credited" does not appear.113

There is no alert for "Imaging Results," as would be automatically generated for Verified Reports.

There is no Abnormal alert because the diagnostic codes here do not require alerts.

The 'Outside Report Entry/Edit' option does not recognize the case number once the case reaches 'COMPLETE,' because the case is no longer active. You must enter the **patient name or Last initial and Last 4 SSN** at the Enter Case Number prompt to display a list of patient cases from which to select. This general feature is also seen from the 'View Exam by Case No.' option.

113 Patch RA*5*95 May 2009: Modified the "Visit credited" statement.

Example 1 continued

```

Select Films Reporting Menu Option:  Outside Report Entry/Edit
+-----+
|
| This option is for entering canned text for
| outside work:  interpreted report done outside,
| and images made outside this facility.
|
|

Select Rad/Nuc Med Division: All//
Another one (Select/De-Select):
Select Imaging Type: All//
Another one (Select/De-Select):
Enter Case Number: 2794           The completed case is no longer active.
No matches found!                So, the case cannot be found by case number.

```

Example 2

Use the same option on an existing outside report, but do not change any data.
Select Films Reporting Menu Option: OUTSIDE Report Entry/Edit

```

CHOOSE FROM 1-12: 1
-----
Name      : RADPATIENT,ONE          Pt ID      : 000-00-0000
Case No.  : 2794  Exm. St: COMPLETE  Procedure   : CHEST 2 VIEWS PA&LAT
Tech.Comment: This is the tech comment entered during registration.
Exam Date: MAR  5,2008 10:29       Technologist:
Req Phys   : RADPROVIDER,ONE
Pregnancy Screen: Patient answered yes.114
Pregnancy Screen Comment: The patient is alert and oriented and is 9 weeks pregnant.
Patient has shattered pelvis and needs immediate surgery. Patient has been counseled
and agreed to procedure.
-----
Select 'Standard' Report to Copy:
REPORTED DATE: MAR 5,2008//
CLINICAL HISTORY:
This is the clinical history entered during Request an Exam.

+++++
Required: REPORT TEXT and/or IMPRESSION TEXT
+++++
REPORT TEXT:
This is the report text.
Edit? NO//
IMPRESSION TEXT:
No existing text
Edit? NO//
PRIMARY DIAGNOSTIC CODE: NORMAL//
Select SECONDARY DIAGNOSTIC CODE: NO DISCRETE MASS
//
SECONDARY DIAGNOSTIC CODE: NO DISCRETE MASS//
Select SECONDARY DIAGNOSTIC CODE:
Report status is stored as "Electronically Filed".
Do you wish to print this report? No//

```

Results

114 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

Order Entry

There is no update of exam and request statuses, because this exam already reached the exam status of 'COMPLETE.'

There is no alert because none of the diagnostic codes were changed.

Example 3

Change some diagnostic codes for a previously entered outside report.

Select Films Reporting Menu Option: **Outside Report Entry/Edit**

```
CHOOSE FROM 1-12: 1
-----
Name       : RADPATIENT,ONE          Pt ID       : 000-00-0000
Case No.   : 2794  Exm. St: COMPLETE  Procedure   : CHEST 2 VIEWS PA&LAT
Tech.Comment: This is the tech comment entered during registration.
Exam Date:  MAR  5,2008 10:29        Technologist:
Req Phys   : RADPROVIDER,ONE
Pregnancy Screen: Patient answered yes.115
Pregnancy Screen Comment: The patient is alert and oriented and is 9 weeks pregnant.
Patient has shattered pelvis and needs immediate surgery. Patient has been counseled
and agreed to procedure.
-----
Select 'Standard' Report to Copy:
REPORTED DATE: MAR 5,2008//
CLINICAL HISTORY:
This is the clinical history entered during Request an Exam.
+++++
Required: REPORT TEXT and/or IMPRESSION TEXT
+++++
REPORT TEXT:
This is the report text.

Edit? NO//
IMPRESSION TEXT:
No existing text
Edit? NO//
PRIMARY DIAGNOSTIC CODE: NORMAL// 4 ABNORMALITY, ATTN. NEEDED
Select SECONDARY DIAGNOSTIC CODE: NO DISCRETE MASS
// @
SURE YOU WANT TO DELETE THE ENTIRE SECONDARY DIAGNOSTIC CODE? Y (Yes)
Select SECONDARY DIAGNOSTIC CODE:
Report status is stored as "Electronically Filed".

Do you wish to print this report? No//

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

RADPATIENT,ONE (R4558): Abnormal Imaging Results: CHEST 2 VIEWS PA&LAT
Enter "VA to jump to VIEW ALERTS option
```

115 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

Result

An Abnormal alert is generated because the primary diagnostic code was changed to one that requires the generation of an alert notification.

Report Entry/Edit 116

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 by the Transcriptionist Report option.

The behavior and appearance of this option varies greatly between sites, so the sample provided may be different from your site. The following sections describe the prompts and data required to enter a report.

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 you have access to multiple imaging locations or different imaging types, you 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 Reports

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

You may choose an existing batch or create a new one by typing in a 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.

116 Patch RA*5*47 September 2011: Report Entry/Edit option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

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.

Entering a Case Number

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 VistA 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.)

Specify 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*).

Specify Interpreting Imaging Location¹¹⁷

After the Interpreting Physician prompts are displayed, the INTERPRETING IMAGING LOCATION prompt will be displayed. This prompt may be displayed with a default value, which will be calculated from the current sign-on or switched-to location, if possible. If no default value can be determined, then a warning message will be displayed. The four possible displays after the INTERPRETING IMAGING LOCATION prompt are:

1. If a default value can be determined, the display shows the user's sign-on Radiology location.
2. If the sign-on or switched-to location is "Technical Component only", the display would be:

Your signed-on or switched-to location is AAAAA which has a Credit Method of 'Technical Component Only'. This Credit Method does not allow for Interpretation work.

3. If the sign-on location's Imaging Type doesn't match the exam's Imaging Type, the display would be:

Your signed-on or switched-to location is AAAAA, which has an Imaging Type of MMMMM. But the exam has an Imaging Type of GGGGG.

4. If (2) and (3), then the following reminder is also displayed:

You may optionally switch your current location to a location that allows either Regular or Interpretation credit. This will facilitate subsequent report entries, if you have more than one report to enter.

Since this field will be added to the report instead of the exam, the user would only have to enter its value once for the report, instead of x times for a printset with x exams.

If the home site uses a remote site to do the interpretation, and the remote site isn't already defined in file #79.1, then the ADPAC will have to use the **Location Parameter**

¹¹⁷ Patch RA*5*41 September 2005: Added section for Interpreting Imaging Location.

Order Entry

Set-up option to create a new imaging location for the remote site. Then he must use the **Division Parameter Set-up** option to link the new Imaging Location to a Division.

Using a Standard Report

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.

Entering Case-Specific Data

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 apply to every case in the set. They will only need to be entered once, although they can later be edited any number of times.

- Additional Clinical History¹¹⁸
- 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 IT Service, who should refer to the *Radiology/Nuclear Medicine 5.0 HL7 Manual* 119 for more information.

Note: If there is a technologist comment,¹²⁰ 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?".

Note: If there are contrast media associations with the exam, they are shown in the body of the report.¹²¹

Note: If a female patient is between the ages of 12 and 55, two pregnancy screen fields are shown on the body of the report. Both fields are populated at the time of the exam: 1) Pregnancy Screen - the responses are Yes, No, and Unknown; 2) Pregnancy Screen Comment - this field displays only when the response to the 'Pregnancy Screen' field is 'Yes' or 'Unknown.' It captures comments the technologist enters at the time of the exam.¹²²

118 Patch RA*5*27 April 2002: Additional data added to report.

119 Patch RA*5*25 July 2002: Reference to Technical Manual changed to the Radiology/Nuclear Medicine V. 5.0 HL7 Manual.

120 Patch RA*5*18 November 2000: New field for comments by the technologist added to report.

121 Patch RA*5*45 May 2005: Display of associated contrast media.

122 Patch RA*5*99 February 2010: Added a note about: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

Order Entry

Example:

```
Report Entry/Edit
Note: To enter receipt of OUTSIDE INTERPRETED REPORTS, please use the 'Outside Report/Entry Edit'
option.
Select Imaging Type: All// <RET>

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

Enter your Current Signature Code: 0000 SIGNATURE VERIFIED

Do you want to batch print reports? Yes// <RET>

Select Batch: MN031009
Are you adding 'MN042009' as a new REPORT BATCHES? No// Y (Yes)

Enter Case Number: 000000-0
-----
Name       : RADPATIENT,SIXTEEN          Pt ID      : XXXXXXXXX
Case No.   : 5       Exm. St: WAITING FOR Procedure   : CHEST SINGLE VIEW
Tech.Comment: COMMENT THIS!
Exam Date: MAR 3,2009 13:11              Technologist:
Req Phys   : RADCLINICIAN,FORTY
Pregnancy Screen: Patient answered yes.123
Pregnancy Screen Comment: The patient is alert and oriented and is 9 weeks pregnant.
Patient has shattered pelvis and needs immediate surgery. Patient has been counseled
and agreed to procedure.
-----
...report not entered for this exam...
...will now initialize report entry...
Select Report to Copy: 010100-1373      RADPATIENT,SIXTY      CHEST 2 VIEWS PA&LAT
-----
PRIMARY INTERPRETING STAFF: RADCLINICIAN,FORTY      TI      111      RADIOLOGIST
Select SECONDARY INTERPRETING STAFF: <RET>

INTERPRETING IMAGING LOCATION: RADIOLOGY// <RET>      (GENERAL RADIOLOGY-552)
-----
REPORTED DATE: T (MAR 10, 2009)
-----
CLINICAL HISTORY:
PATIENT IS WHEEZING AND SHOWS ACUTE PULMINARY DISTRESS.

ADDITIONAL CLINICAL HISTORY:
No existing text
Edit? NO// Y YES
==[ WRAP ]==[ INSERT ]=====< ADDITIONAL CLINICAL HISTORY >====[ <PF1>H=Help
This is additional clinical history text.

REPORT TEXT:. . .
. . .

There are no infiltrates. Pleura is clear.

Cardiothoracic ratio is normal.

Moderate aortic ectasia is seen. Osseous structures remain notable for
variable ventral osteophytic spurs seen at most thoracic levels with some
associated disc height deterioration especially in the mid and upper
thoracic spine.

Edit? NO// <RET>
-----
IMPRESSION TEXT:
```

123 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

```
No new findings to suggest either active pneumonitis or acute
cardiovascular decompensation. There is evidence of bi-thoracic healed
granulomatous disease.
```

```
Edit? NO// <RET>
```

```
-----
Select one of the following:
```

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

```
REPORT STATUS: D// V VERIFIED
```

```
PRIMARY DIAGNOSTIC CODE: 3 MAJOR ABNORMALITY, NO ATTN. NEEDED
```

```
Select SECONDARY DIAGNOSTIC CODE: <RET>
```

```
Status update queued!
```

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 Imaging Locations file124 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.

124 Patch RA*5*10 April 2000: Corrected file, from Rad/Nuc Med Division to Imaging Locations.

Order Entry

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 IT Service 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.

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, Secondary Interpreting Staff and Interpreting Imaging Location.¹²⁵

The default value and informational messages for the Interpreting Imaging Location prompt are explained in the Report Entry/Edit section.¹²⁶

Note: If there is a technologist comment¹²⁷, 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?"

Note: If a female patient is between the ages of 12 and 55, two pregnancy screen fields are shown on the body of the report. Both fields are populated at the time of the exam: 1) Pregnancy Screen - the responses are Yes, No, and Unknown; 2) Pregnancy Screen Comment - this field displays only when the response to the 'Pregnancy Screen' field is 'Yes' or 'Unknown.' It captures comments the technologist enters at the time of the exam.¹²⁸

125 Patch RA*5*41 September 2005: Text added - ...and Interpreting Imaging Location.

126 Patch RA*5*41 September 2005: The default value and informational message for the Interpreting Image Location prompt are explained in the ReportEntry/Edit section.

127The default value and informational messages for the Interpreting Imaging Location prompt are explained in the Report Entry/Edit section.

128 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

Example:

```

Select Films Reporting Menu Option: Resident On-Line Pre-Verification
Enter your Current Signature Code: 0000 SIGNATURE VERIFIED

Do you wish to review this one report? Yes// <RET> yes

Select one of the following:

P          PAGE AT A TIME
E          ENTIRE REPORT

How would you like to view the reports?: P// E ENTIRE REPORT

RADPATIENT,SIXTEEN (XXXXXXXXXX)                Case No.           : 030309-7 @13:16
ESOPHAGUS                                       Transcriptionist: RADTRANSCRIPTIONIST,FIVE
Req. Phys : RADCLINICIAN,TEN                   Pre-verified      : NO

Staff Imaging Phys: RADCLINICIAN,SEVEN (P)129
Residents : RADCLINICIAN,FIVE (P)
Pregnancy Screen: Patient answered yes.130
Pregnancy Screen Comment: The patient is alert and oriented and is 9 weeks pregnant. Patient has
shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to procedure.
=====
ESOPHAGUS                                       (RAD Detailed) CPT:00000
Reason for Study: PATIENT IS COMPLAINING THAT SHE NEEDS ALARENJECTOMY

Clinical History:
PATIENT WOULD LIKE A LARYNJECTOMY.

Report:                                           Status: RELEASED/NOT VERIFIED
PORTABLE CHEST: 1-1-00: 06:10 hours:

Reexamination of the chest by single frontal projection with a portable unit showed no
significant interval change
Impression:
No significant change compared to previous study of 1-31-99.

Primary Diagnostic Code:
CRITICAL ABNORMALITY
=====
Enter Response: Continue// <RET>

Select one of the following:

R          RELEASED/NOT VERIFIED
PD         PROBLEM DRAFT
D          DRAFT

RESIDENT PRE-VERIFICATION REPORT STATUS: R// <RET> RELEASED/NOT VERIFIED
WANT TO PRE-VERIFY THIS REPORT? Y YES

Report is now marked as pre-verified.

PRIMARY DIAGNOSTIC CODE: CRITICAL ABNORMALITY// <RET>
Select SECONDARY DIAGNOSTIC CODE: <RET>
PRIMARY INTERPRETING STAFF: RADCLINICIAN,SEVEN // <RET>
Select SECONDARY INTERPRETING STAFF: <RET>

INTERPRETING IMAGING LOCATION: RADIOLOGY// <RET>

```

129 Patch RA*5*99 February 2010: Replaced the 'Staff Phys' field with 'Staff Imaging Phys' field.
130 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and
'Pregnancy Screen Comment.'

Select Report to Print by Patient 131

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 reports may be selected.

The report printout will include parent procedures and their descendants when defined as a printset, procedure and CPT modifiers¹³², reason for study¹³³, clinical history and ¹³⁴, contrast media associations ¹³⁵ (if applicable), 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.

131 Patch RA*5*47 September 2011: Select Report to Print by Patient option is affected by the new Site Specific Accession Number (SSAN).

132 Patch RA*5*10 April 2000

133 Patch RA*5*75 June 2007: Added Reason for Study to report display list.

134 Patch RA*5*27 April 2002: Additional clinical history added to report.

135 Patch RA*5*45 May 2005: Display of associated contrast media

If the verifier verifies a report and the electronic signature is not entered, then the report displays "(verifier, no e-sig)" below the verifier's name.¹³⁶ If this happens when the "Verify Report Only" option or commercial dictation software (e.g., PowerScribe, TalkStation) is used to verify a report. If a transcriptionist or someone other than the verifier changed the report status to Verified, the wording will be "Verified by transcriptionist for Dr. xxx." If an electronic signature is affixed to the report (i.e., it was verified through On-Line Verification), the wording will be "(Verifier)".

This report should be sent or queued to a printer.

Prompt/User Response

Discussion

```
Select Report to Print by Patient137
Select Patient:  RADPATIENT,THREE      01-01-65      666456754      4AS-1
Enrollment Priority:  GROUP 2      Category:  IN PROCESS      End Date:
          **** Patient's Exams ****
Patient's Name:  RADPATIENT,THREE      666-45-6754      Run Date:  MAR 26,2007
Case No.  Procedure          Exam Date  Status of Report  Imaging Loc--
-----
1      2240  HIP 1 VIEW          03/26/07  VERIFIED          OUTPATIENT
2      2114  CT ABDOMEN W&W/O CONT  06/28/06  None              CT SCAN
3      2113  CT ABDOMEN W/O CONT  06/28/06  None              CT SCAN
4      2112  CT ABDOMEN W&W/O CONT  06/28/06  None              CT SCAN
```

CHOOSE FROM 1-4: 1

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

```
DEVICE: HOME// <RET> SET HOST
PREGNANCY SCREEN:  Patient answered yes.138
PREGNANCY SCREEN COMMENT:  The patient is alert and oriented and is 9 weeks pregnant.
Patient has shattered pelvis and needs immediate surgery. Patient has been counseled
and agreed to procedure.

(Case 2240 COMPLETE) HIP 1 VIEW          (RAD Detailed) CPT:73500
Proc Modifiers :  LEFT
Reason for Study:  Patient presents with hip pain after fall at home

Clinical History:
Severe left hip pain after trip-and-fall at home. Rule out fracture.

Report:
No gross abnormalities; some arthritic degeneration noted.

Impression:
Appears normal; possible hairline fracture
Primary Diagnostic Code:
NORMAL
Primary Interpreting Staff:
THREE RADPROVIDER, Staff Physician (Verifier)

/TRP
```

136 Patch RA*5*8 October 1999

137 Patch RA*5*75 June 2007: Updated sample prompts and report to show Reason for Study field and formatting.

138 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

Switch Locations

This option appears on several menus as a convenience to users. Please refer to the option description where it first appears under Use of the Software on page 14.

Verify Report Only ¹³⁹

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 (see the *ADPAC Guide*) 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.

¹³⁹ Patch RA*5*47 September 2011: Verify Report Only option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

CHOOSE FROM 1-14: 5

-----142
Name : RADPATIENT,FOUR Pt ID : 000-00-0004
Case No. : 624 Exm. St: EXAMINED : CHEST 2 VIEWS PA&LAT
Tech.Comment: No comments.
Exam Date: JUN 15,2009 07:31 Technologist: RADPROVIDER,SIX
Req Phys : RADPROVIDER,SEVEN

Select one of the following:

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

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

Status update queued!

Subj: Rad/Nuc Med Report (032400-916) [#186359] 06/16/09@10:26 57 lines
From: POSTMASTER In 'IN' basket. Page 1

RAPATIENT,FOUR 000-00-0004 DOB-may 15, 1984 F Case: 000000-006@13:0

Req Phys: RACLINICIAN,ELEVEN Pat Loc: HOSP(Req'g Loc)
Att Phys: RACLINICIAN,THIRTY Img Loc: RADIOLOGY LAB
Pri Phys: RACLINICIAN,ELEVEN Service: Unknown

Pregnancy Screen: Patient is unable to answer or is unsure143
Pregnancy Screen Comment: Pt not sure if pregnant

(Case 000 COMPLET) ANGIO CAROTID CEREBRAL UNILAT S&I(RAD Detailed) CPT:00000
Proc Modifiers : BILATERAL EXAM, PORTABLE EXAM, OPERATING ROOM EXAM, LEFT,
RIGHT
CPT Modifiers : 00 UNUSUAL PROCEDURAL SERVICES
00 UNRELATED PROC OR SERVICE BY SAME PHYS DURING POSTOP PERIOD
00 STAGED OR RELATED PROC BY SAME PHYS DURING POSTOP PERIOD
00 RETURN TO OP ROOM FOR RELATED PROC DURING POSTOP PERIOD

Enter RETURN to continue or '^' to exit:

Subj: Rad/Nuc Med Report (032400-916) [#186359] Page 2

D
LT LEFT SIDE
TC TECHNICAL COMPONENT

Clinical History:
clinical

history

entered

Report: Status: VERIFIED

Impression:

Primary Diagnostic Code: A POSSIBLE MALIGNANCY, FOLLOW-UP NEEDED
Secondary Diagnostic Codes:
MINOR ABNORMALITY

142 Patch RA*5*18 November 2000: New field for comments by the technologist added to display.
143 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and
'Pregnancy Screen Comment.'

Primary Interpreting Staff:

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

Processing alert: RADPATIENT,TEN (C7890): Abnl Imaging Reslt, Needs Attn: ZZSS SHAVKAT TEST P

Radiology Display Jun 16, 2009@09:15:18 Page: 1 of 4
 RADPATIENT,FOUR 000-00-0004 5/15/84(25)

ZZSS SHAVKAT TEST PROCEDURE

Proc Ord: HIP 1 VIEW

Exm Date: JUN 26, 2009@11:24

Req Phys: RACLINICIAN,F

Pat Loc: 1ASTEMPORARYLONGNAME (Req'g Lo

Img Loc: RADIOLOGY LAB

Service: Unknown

Pregnancy Screen: Patient answered Yes144

Pregnancy Screen Comment: pt is pregnant now

(Case 141-062609-3091 COMPLET) ZZSS SHAVKAT TEST PROCEDURE (RAD Detailed)

Contrast Media : Ionic Iodinated

+ Enter ? for more help.

+ Next Screen	UP	Up a Line	ADPL Auto Display(On/Off)
- Previous Screen	DN	Down a Line	PS Print Screen
FS First Screen	GO	Go to Page	PT Print Data
LS Last Screen	SL	Search List	Q Close

Select Action: Next Screen// ^

144 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

7. Management Reports Menu

This menu provides the user with functions for management reporting.

- Daily Management Reports ...
- Functional Area Workload Reports ...
- Timeliness Reports...145
- Personnel Workload Reports ...
- Special Reports ...

Note: Several reports under the Functional Area Workload Reports, Personnel Workload Reports, and Special Reports menus use AMIS counting methods. AMIS has been discontinued as an official VACO reporting metric, though these reports are still available for sites that find them useful. Workload credit is now calculated by Work Relative Value Units (wRVU) and CPT codes: please see the Personnel Reports and Special Reports sections for more information.146

General information about AMIS-based Workload Reports is available at the end of this chapter.

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

145 Patch RA*5*37 June 2003: Added Performance Indicator Reports to Management Reports Menu options. Renamed menu to Timeliness Reports for Patch RA*5*67 April 2006.

146 Patch RA*5*64 July 2006: Added information about AMIS and wRVU/CPT reporting options.

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.

Abnormal Exam Report 147

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/Edit 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 148
“VA radiologist”, “Electronically Filed”, or “All” may be selected. Cases that do not yet have associated interpreted reports would be included in all three selections¹⁴⁹.

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.

147 Patch RA*5*47 September 2011: Abnormal Exam Report option is affected by the new Site Specific Accession Number (SSAN).

148 Patch RA*5*97 September 2009: Moved two sentences from a paragraph into individual sentences.

149 Patch RA*5*97 September 2009: Added a paragraph about “VA radiologist”, “Electronically Filed”, or “All”.

Order Entry

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. 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.150 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. If several cases share one report (printset), then they will be printed together under the same patient end exam date/time.151

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>
Select one of the following:
  V      VA RADIOLOGIST
  E      ELECTRONICALLY FILED
  A      ALL

Enter type of reporting: ALL// ??

  Select one of the following:

  V      VA Radiologist      to include in-house reports only,
  E      Electronically Filed to include Electronically Filed reports only,
```

150 Patch RA*5*15 June 2000: NOIS: MUS-0399-72971 Description change for selecting the date range.
151 Patch RA*5*34 May 2003: Text added regarding several cases sharing one printset.

A ALL to include All reports.

Select one of the following:

V VA RADIOLOGIST
 E ELECTRONICALLY FILED
 A ALL

Enter type of reporting: ALL// <RET> 152

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
*RADPATIENT,FIVE -0005 (P) 1-WT      RADPROVIDER,NINE.
Case #: 210      CHEST 2 VIEWS PA&LAT (ROUTINE)      MAY 13,1997@10:21
*RADPATIENT,SIX -0006 (P) SDP 2-NORTH  RADPROVIDER,TEN
Case #: 390      CHEST 2 VIEWS PA&LAT (ROUTINE)      MAY 13,1997@08:05
*RADPATIENT,SEVE -0007 (P) ER          RADPROVIDER,ONE
Case #: 888      KNEE 2 VIEWS (ROUTINE)              MAY 10,1997@11:58
*RADPATIENT,EIGH -0008 (P) 1-WT      RADPROVIDER,TWO
Case #: 2        CHEST 2 VIEWS PA&LAT (ROUTINE)      MAY 11,1997@10:33

          Diagnostic Code: ABNORMALITY, PHYSICIAN NOTIFIED
          -----
*RADPATIENT,NINE -0009 (P) 1-WT      RADPROVIDER,THREE
Case #: 345      ANGIO RENAL UNILAT SELECT:S&I      MAY 13,1997@12:00
*RADPATIENT,TEN -0010 (P) ER          RADPROVIDER,FOUR
Case #: 898      CHEST 2 VIEWS PA&LAT (ROUTINE)      MAY 14,1997@14:46

          Diagnostic Code: POSSIBLE MALIGNANCY, FOLLOW-UP NEEDED
          -----
*RADPATIENT,ONE -0010 (P) ER          RADPROVIDER,FIVE
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
    
```

152 Patch RA*5*97 September 2009: Added "VA radiologist", "Electronically Filed", or "All" information to the Outside Reporting Enter/Edit option example.

Order Entry

Procedure	Exam Date
=====	
Division: WHITE RIVER JUNCTION, VT.	
Imaging Type: NUCLEAR MEDICINE	

* No Abnormal Exams *	

Note: 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.

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, staff imaging physician,¹⁵³ pregnant at time of order entry, pregnancy screen, pregnancy screen comments,¹⁵⁴ 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.

¹⁵³ Patch RA*5*99 February 2010: Replaced the ‘Interpreting Stf.’ field with ‘Staff Imaging Phys’ field.
¹⁵⁴ Patch RA*5*99 February 2010: Inserted the field ‘Pregnant at time of order entry.’ Also added two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’

Order Entry

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
-----
RADPATIENT,THREE   2/13/95          ABDOMEN 1 VIEW
000-00-1003        12:41 PM        CONTRAST REACTION
  Physician: RADPROVIDER1,SIX
  Interpreting Res. : RADPROVIDER,SEVEN
  Staff Imaging Phys.155 : RADPROVIDER,EIGHT
  Tech: [Note: only displays if populated.]
Pregnant at time of order entry: YES156
Pregnancy Screen: Patient answered yes.
Pregnancy Screen Comment: The patient is alert and oriented and is 9 weeks pregnant. Patient has
shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to procedure.
  
```

155 Patch RA*5*99 February 2010: Replaced the 'Interpreting Stf.' field with 'Staff Imaging Phys' field.
 156 Patch RA*5*99 February 2010: Inserted the field 'Pregnant at time of order entry.' Also added two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

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 OFFICE
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”.

Daily Log Report 157

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

157 Patch RA*5*47 September 2011: Daily Log Report option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

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: 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.

Name		Pt ID	Ward/Clinic	Procedure
Exam Status	Case #	Time	Reported	

RADPATIENT, TWO	000-00-0012	1-NO		CHEST SINGLE VIEW
TRANSCRIBED	9	11:28 AM		Yes
RADPATIENT, THREE	000-00-0013	1-NO S		ANGIO VISCERAL SELE
EXAMINED	18	8:53 AM		No
RADPATIENT, FOUR	000-00-0014	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				

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 a while 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.
<pre> IMAGING SERVICE DELINQUENT OUTSIDE FILM REPORT FOR OUTPATIENTS FEB 27,1995 09:05 PAGE 1 PATIENT PT ID NEEDED BACK ----- RADPATIENT,FIVE 000-00-0015 FEB 8,1994 'OK' NEEDED: SOURCE : MEMORIAL VAZ HOSPITAL REMARKS : Several wrist views ----- RADPATIENT,FIVE 000-00-0015 FEB 13,1994 'OK' NEEDED: SOURCE : VAMC HOSPITAL REMARKS : ANKLE ----- RADPATIENT,SIX 000-00-0016 FEB 14,1994 'OK' NEEDED: SOURCE : VA GENERAL HOSPITAL REMARKS : Chest X-Ray </pre>	

Delinquent Status Report 158

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

158 Patch RA*5*47 September 2011: Delinquent Status Report option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

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*.)

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.¹⁵⁹

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 (-)
      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
```

¹⁵⁹ Patch RA*5*15 July 2000: Report status added to the report, "Verified" deleted from report.

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 ?


```

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

```

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 PIMS data about the patient's inpatient or outpatient status. (A related data item is the Usual Category which the system looks at when determining the category of a given exam; Usual Category is editable through the Update Patient

Order Entry

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

```
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>
```

Discussion

```

**** Date Range Selection ****

Beginning DATE : T-100 (NOV 19, 1994)

Ending DATE : T (FEB 27, 1995)
    
```

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 OFFICE					Location: FLUORO					
Run Date: Feb 27, 1995					Imaging Type: GENERAL RADIOLOGY					
For Period: Nov 19, 1994 to Feb 27, 1995.										
DATE	VISITS	EXAMS	COMPLETE 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.										
DATE	VISITS	EXAMS	COMPLETE 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	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	
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 14, 1994	1	1	1	0	0	0	1	0	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 04, 1995	2	3	1	0	0	0	3	0	0	
Jan 05, 1995	2	2	0	0	0	0	2	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 18, 1995	15	36	0	0	0	4	32	0	0	
Jan 20, 1995	5	22	6	0	0	4	18	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 30, 1995	4	6	5	0	0	1	5	0	0	
Jan 31, 1995	2	3	2	0	0	3	0	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 16, 1995	9	18	5	0	0	0	18	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	

Order Entry

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.									
DATE	VISITS	EXAMS	COMPLETE EXAMS	CON	EMP	INP	OUT	RES	SHA
-----EXAM CATEGORY-----									

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.

Incomplete Exam Report 162

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>
```

162 Patch RA*5*47 September 2011: Incomplete Exam Report option is affected by the new Site Specific Accession Number (SSAN).

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 Procedure	Case # Exam Status	Pt ID Rpt Text	Date Interp.	Ward/Clinic Phys.	Verified Tech
RADPATIENT,TWO ANKLE 2 VIEWS	427 WAITING FOR	000-00-0022 No	01/28/97 Unknown	1S	No Unknown
RADPATIENT,TWO FOOT 2 VIEWS	428 WAITING FOR	000-00-0022 No	01/28/97 Unknown	1S	No Unknown
RADPATIENT,TWO TOE(S) 2 OR MORE VIE	429 WAITING FOR	000-00-0022 No	01/28/97 Unknown	1S	No Unknown
RADPATIENT,TWO ANKLE 2 VIEWS	430 WAITING FOR	000-00-0022 No	01/28/97 Unknown	1S	No Unknown
RADPATIENT,TWO FOOT 2 VIEWS	431 WAITING FOR	000-00-0022 No	01/28/97 Unknown	1S	No Unknown

Enter RETURN to continue or '^' to exit: **<Ret>**

Incomplete Exam Report

Division: HINES CIO FIELD OFFICE Page: 4
 Imaging Type: GENERAL RADIOLOGY Date: Apr 22, 1997

Patient Name Procedure	Case # Exam Status	Pt ID Rpt Text	Date Interp.	Ward/Clinic Phys.	Verified Tech
RADPATIENT,THREE ARTHROGRAM ELBOW S&I	88 WAITING FOR	000-00-0023 No	04/17/97 Unknown	X-RAY STOP	No Unknown
RADPATIENT,THREE CT HEAD W/IV CONT	107 WAITING FOR	000-00-0023 No	04/17/97 Unknown	X-RAY STOP	No Unknown

Order Entry

```
-----  
RADPATIENT,THREE      121      000-00-0023  04/17/97  X-RAY STOP      No  
STEREOTACTIC LOCALIZ  WAITING FOR No      Unknown      Unknown  
-----  
RADPATIENT,THREE      130      000-00-0023  04/17/97  X-RAY STOP      No  
CHEST 4 VIEWS        WAITING FOR No      Unknown      Unknown  
-----  
Enter RETURN to continue or '^' to exit: <Ret>  
  
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  
-----  
RADPATIENT,FOUR      451      000-00-0024  03/03/97  EMERGENCY ROOM  No  
ABDOMEN 1 VIEW      WAITING FOR No      Unknown      Unknown  
-----  
RADPATIENT,FOUR      633      000-00-0024  03/20/97  GENERAL MEDICIN No  
ACROMIOCLAVICULAR J  WAITING FOR Yes      RADPROVIDER,FOUR      Unknown  
-----  
  
Imaging Type Total 'GENERAL RADIOLOGY': 106  
  
Division Total 'HINES CIO FIELD OFFICE': 106
```

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" or "Scheduled Request Log by Imaging Location, Date/Time," depending upon whether procedure or date/time was selected to sort by.¹⁶³ 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 PIMS 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.¹⁶⁴ 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.

¹⁶³ Patch RA*5*31 September 2002: Added changes to the documentation

¹⁶⁴ Patch RA*5*31 September 2002: Added changes to the documentation

In addition to these prompts, a new prompt will appear asking for which of two fields to sort by, procedure (default sort by) or date/time.

A display of user-selected choices is shown and the opportunity to change selections is given.

The default sort order of the report is: imaging location, procedure name, scheduled day and time, and AMIS category of procedure. The sort by date order is: imaging location, scheduled day and time, procedure name, and AMIS category of procedure. Each imaging location will begin on a separate page.¹⁶⁵

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. 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 locations is imaging types.¹⁶⁶ 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 the SUBMIT REQUEST TO: question was not asked the system may stuff in an imaging location for that order, if there's only one imaging location available with the same imaging type as the order's imaging type.¹⁶⁷)

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.

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

165 Patch RA*5*31 September 2002: Added changes to the documentation

166 Patch RA*5*15 May 2000: NOIS: BHS-1199-12241

167 Patch RA*5*34 May 2003:Text regarding not asking the SUBMIT REQUEST TO question.

Order Entry

Prompt/User Response

Discussion

Log of Scheduled Requests by Procedure	<input type="checkbox"/>
Starting Scheduled Date: 1/1/95 (JAN 1, 1995)	
Ending Scheduled Date: T (FEB 27, 1995)	

```
Enter * to select all imaging locations that168
you are allowed here (enter ?? to view them.)
Select Imaging Location(s): ??

Select an 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>
```

You may enter "*" to include all imaging locations to which you have access.

168 Patch RA*5*15 May 2000: Added two lines of text help on selecting all imaging locations.

Order Entry

<p>Select one of the following:169</p> <table style="margin-left: 40px;"> <tr> <td style="padding-right: 20px;">P</td> <td>Procedure Name</td> </tr> <tr> <td>D</td> <td>Date/Time</td> </tr> </table> <p>Sort by (P)rocedure Name or (D)ate/Time: P // P Procedure Name</p> <p>Scheduled requests to be included on this report are:</p> <p>Starting Schedule date: Nov 19, 1994 Ending Schedule date: Feb 27, 1995 11:59 pm Locations: X-RAY</p> <p>Sorted by : Procedure Name</p> <p>SELECTION CRITERIA OK? YES// <RET></p>	P	Procedure Name	D	Date/Time	<p>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.</p>
P	Procedure Name				
D	Date/Time				
<p>DEVICE: HOME// (Printer Name or "Q")</p>					

Scheduled Request Log by Imaging Location, Procedure						Page: 1
170						
Includes requests scheduled from JAN 1,1995 to FEB 27,1995 23:59						
Run Date: FEB 27,1995 09:14 Imaging Location: UNKNOWN						
Patient	Pt ID	Procedure	Pt Loc	Sched. Date	Urgency	

=====						
RADPATIENT,	0025	CHEST STEREO PA	X-RAY	2/21/95@07:24	ROUTINE	
Scheduled Request Log by Imaging Location, Procedure						Page: 2 171
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	Pt ID	Procedure	Pt Loc	Sched. Date	Urgency	

-						
=====						
RADPATIENT,	0026	BONE AGE	X-RAY	1/2/94@09:23	ROUTINE	
RADPATIENT,	0027	BONE AGE	X-RAY	1/7/94@16:30	ROUTINE	
RADPATIENT,	0028	BRAIN IMAGING COMPLET	DISCHARGED	1/10/95@16:00	ROUTINE	
Requesting Loc: 1S						
=====						
-						

169 Patch RA*5*31 September 2002: Added new prompt for sorting by Procedure Name or Date/Time.
 170 Patch RA*5*31 September 2002: Change of location for the Procedure and the Pt ID columns.
 171 Patch RA*5*31 September 2002: Change of location for the Procedure and the Pt ID columns.

Order Entry

RADPATIENT,	0029	X-RAY PARENT PROCEDUR	1S	2/8/95@14:23	ROUTINE
=====					
=					
RADPATIENT,	0029	CHEST STEREO PA	1S	2/21/95@07:23	ROUTINE

Radiopharmaceutical Usage Report 172

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.
```

172 Patch RA*5*47 September 2011: Radiopharmaceutical Usage Report option is affected by the new Site Specific Accession Number (SSAN).

```
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:
  RADIOLOGY 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)
```

Order Entry

Long-Case@Time Procedure	Patient Name Who Adm'd	SSN	Radiopharm	Act.Drawn	Dose Adm'd	Low	High
080697-706@1211 THALLIUM SCAN	RADPATIENT,TEN RADPROVIDER,SIX	000-00-0210	THALLIUM 201	3.3000	3.3000	3.0000	3.6300
080697-709@1233 THALLIUM SCAN	RADPATIENT,ONE RADPROVIDER,SIX	000-00-0031	THALLIUM 201	3.3000	3.3000	3.0000	3.6300
061897-558@1406 THALLIUM SCAN	RADPATIENT,TWO RADPROVIDER,FIVE	000-00-0032	THALLIUM 201	3.3000	3.3000	3.0000	3.6300
080797-718@0807 THALLIUM SCAN	RADPATIENT,TWO RADPROVIDER,SIX	000-00-0032	THALLIUM 201	3.3000	3.3000	3.0000	3.6300
080797-721@0902 MYOCARDIAL PERF	RADPATIENT,TWO RADPROVIDER,FIVE	000-00-0032	SESTAMIBI TC-	8.0000	8.0000	8.0000	10.0000
072597-703@1245 BONE IMAGING	RADPATIENT,THR RADPROVIDER,SIX	000-00-0033	Tc99m MEDRONA	19.6000	19.6000	18.0000	22.0000
070997-700@0907 LIVER SCAN	RADPATIENT,FOU RADPROVIDER,SIX	000-00-0034	SULFUR COLLOID	4.0000	4.0000	3.0000	6.0000
070997-701@0932 LIVER SCAN	RADPATIENT,FIV RADPROVIDER,SIX	000-00-0035	SULFUR COLLOID	4.5000	4.5000	3.0000	6.0000
080797-719@0807 LUNG PERFUSION	RADPATIENT,TWO RADPROVIDER,FIVE	000-00-0032	Tc-99m MACROAG	3.0000	3.0000	3.0000	6.0000

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 radiopharmaceutical, so the total number of unique cases may be less than total number of radiopharmaceuticals listed.

Unverified Reports 173

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.

173 Patch RA*5*47 September 2011: Unverified Reports option is affected by the new Site Specific Accession Number (SSAN).

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. If a Primary Resident is entered, then the report is counted toward the resident.¹⁷⁴ 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.

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.

Sample 1 shows an itemized list by exam date. If a 132-column device is used, it will be formatted differently and easier to read:

¹⁷⁴ Patch RA*5*29 February 2002: Unverified Reports options enhanced.

Order Entry

Prompt/User Response

Discussion

```
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
-----
RADPATIENT,SIX      000-00-0036      7/22/97  702  CARDIOLOGY TEST
WAITING 8/8/97      RADUSER,ONE
RADPATIENT,SEVEN    000-00-0037      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 RADUSER,ONE          0      0      0      2
1 RADUSER,TWO          0      0      0      1
1 RADUSER,THREE        0      0      0      1
    
```

Hours (age of report)	24	48	96	> 96
	--	--	--	----

```

* RESIDENT: 8 *
2 RADPROVIDER,SEVEN    0      0      0      2
1 RADPROVIDER,EIGHT    0      0      0      1
2 RADPROVIDER,NINE     0      0      0      2
3 RADPROVIDER,TEN      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

Order Entry

(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: RADIOLOGY 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 RADUSER,ONE 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: RADIOLOGY 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 RADUSER,ONE 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 RADUSER,FOUR 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 RADPROVIDER,ONE      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: RADPROVIDER,SEVEN; RADPROVIDER,ONE.; RADPROVIDER,TWO
* 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 RADPROVIDER,SIX      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  RADIOLOGY 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
    
```

8. 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

Note: The reports in this section use AMIS counting methods. AMIS has been discontinued as an official reporting metric, though these reports are still available for sites that find them useful. Workload credit is now calculated by Work Relative Value Units (wRVU) and CPT codes: see the Personnel Reports and Special Reports sections for wRVU/CPT reporting options.¹⁷⁵

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 AMIS-Based 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 AMIS-Based Workload Reports**, starting on page 214, for a full description of this report's options.

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.

¹⁷⁵ Patch RA*5*64 July 2006: Updated the AMIS note to redirect users to the wRVU and CPT report options.

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:

ANGIO/NEURO/INTERVENTIONAL

WAITING FOR EXAM
EXAMINED
COMPLETE

CT SCAN

WAITING FOR EXAM
EXAMINED
COMPLETE

Statuses included depend on the parameters entered by the ADPAC (see ADPAC Guide).

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

Order Entry

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.

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-----											
Procedure	Inpt	Opt	% of		% of						
			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-----											
Procedure	Inpt	Opt	% of		% of						
			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	
-----Examinations-----											
Procedure	Inpt	Opt	% of		% of						
			Res	Other	Total	Exams	WWU	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

-----Examinations-----

Procedure	Inpt	% of		Total	Exams	WWU	WWU	
		Opt	Res Other					
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

-----Examinations-----

Procedure	Inpt	Opt	% of		Total	Exams	WWU	WWU
			Res	Other				
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-----

Clinic	Inpt	% of		Total	Exams	WWU	WWU
		Opt	Res Other				

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
    
```


Order Entry

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 OFFICE
Imaging Type: GENERAL RADIOLOGY For period: Nov 21, 1994 to
 Run Date: MAR 1,1995 08:45 Mar 01, 1995

-----Examinations-----

Procedure	Inpt	Opt	% of		Total	% of Exams	WWU	WWU	
			Res	Other					
PTF Bedsection: GENERAL (ACUTE MEDICINE)									
NECK SOFT TISSUE	4	0	0	0	0	4	9.8	12	5.5
SKULL 4 OR MORE VIEWS	7	0	0	0	0	7	17.1	21	9.7
CHEST STEREO PA	3	0	0	0	0	3	7.3	3	1.4
CHEST 4 VIEWS	2	0	0	0	0	2	4.9	4	1.8
ABDOMEN 1 VIEW	1	0	0	0	0	1	2.4	2	0.9
SPINE LUMBOSACRAL MIN 2 VIEW	2	0	0	0	0	2	4.9	6	2.8
UPPER GI + SMALL BOWEL	2	0	0	0	0	2	4.9	12	5.5
ANGIO CAROTID CEREBRAL SELEC	1	0	0	0	0	1	2.4	15	6.9
ANGIOGRAM, CATH - CEREBRAL	2	0	0	0	0	2	4.9	30	13.8
CT HEAD W/IV CONT	9	0	0	0	0	9	22.0	72	33.2
ARTHROGRAM ANKLE S&I	1	0	0	0	0	1	2.4	5	2.3
ARTHROGRAM TM JOINT CONT S&I	1	0	0	0	0	1	2.4	5	2.3
STEREOTACTIC LOCALIZATION HE	6	0	0	0	0	6	14.6	30	13.8
PTF Bedsection Total	41	0	0	0	0	41		217	

>>> PTF Bedsection Workload Report <<< Page: 2

Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY For period: Nov 21, 1994 to
 Run Date: MAR 1,1995 08:45 Mar 01, 1995

-----Examinations-----

Procedure	Inpt	Opt	% of		Total	% of Exams	WWU	WWU	
			Res	Other					
PTF Bedsection: REHABILITATION MEDICINE									
CHEST 4 VIEWS	1	0	0	0	0	1	100.0	2	100.0
PTF Bedsection Total	1	0	0	0	0	1		2	

>>> PTF Bedsection Workload Report <<< Page: 3

Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY For period: Nov 21, 1994 to
 Run Date: MAR 1,1995 08:45 Mar 01, 1995

-----Examinations-----

PTF Bedsection	Inpt	Opt	% of		Total	% of Exams	WWU	WWU	
			Res	Other					
(Imaging Type Summary)									
GENERAL (ACUTE MEDICINE)	41	0	0	0	0	41	97.6	217	99.1
REHABILITATION MEDICINE	1	0	0	0	0	1	2.4	2	0.9
Imaging Type Total	42	0	0	0	0	42		219	

of PTF Bedsections selected: ALL

```

>>> PTF Bedsection Workload Report <<<                               Page: 4

  Division: HINES CIO FIELD OFFICE
Imaging Type: MAGNETIC RESONANCE IMAGING      For period: Nov 21, 1994 to
  Run Date: MAR 1,1995 08:45                    Mar 01, 1995
          -----Examinations-----
PTF Bedsection      Inpt  Opt  Res Other  Total  % of  % of
                                     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 OFFICE      For period: Nov 21, 1994 to
  Run Date: MAR 1,1995 08:45                    Mar 01, 1995
          -----Examinations-----
PTF Bedsection      Inpt  Opt  Res Other  Total  % of  % of
                                     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

```

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 PIMS 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 AMIS-Based Workload Reports** for a full description of this report's options.

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.

Order Entry

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>	If you answer no, you will be asked to choose one or more individual services.
**** 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:	
<pre> CT SCAN ----- WAITING FOR EXAM EXAMINED TRANSCRIBED COMPLETE GENERAL RADIOLOGY ----- WAITING FOR EXAM EXAMINED COMPLETE </pre>	
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.
<pre> >>> Service Workload Report <<< <div style="float: right;">Page: 1</div> Division: HINES CIO FIELD OFFICE Imaging Type: CT SCAN <div style="float: right;">For period: Nov 21, 1994 to</div> Run Date: MAR 1,1995 09:06 <div style="float: right;">Mar 01, 1995</div> -----Examinations----- % of % of Service Inpt Opt Res Other Total Exams WWU WWU ----- <div style="text-align: center;">(Imaging Type Summary)</div> ----- Imaging Type Total 0 0 0 0 0 0 # of Services selected: ALL </pre>	

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 OFFICE									
Imaging Type: GENERAL RADIOLOGY						For period: Nov 21, 1994 to			
Run Date: MAR 1,1995 09:06						Mar 01, 1995			
-----Examinations-----									
Procedure	Inpt	Opt	Res	Other	Total	% of Exams	WWU	% of 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-----									
Procedure	Inpt	Opt	Res	Other	Total	% of Exams	WWU	% of 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-----									
Service	Inpt	Opt	Res	Other	Total	% of Exams	WWU	% of 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									
Imaging Type: GENERAL RADIOLOGY						For period: Nov 21, 1994 to			
Run Date: MAR 1,1995 09:06						Mar 01, 1995			
-----Examinations-----									
Service	Inpt	Opt	Res	Other	Total	% of Exams	WWU	% of WWU	

(Division Summary)									

Order Entry

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								

Sharing Agreement/Contract Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) 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 AMIS-Based Workload Reports**, starting on page 214, for a full description of this report's options.

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: ? <RET> 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**
 Run Date: FEB 28,1995 13:58

For period: Nov 20, 1994 to
 Feb 28, 1995

Procedure	-----Examinations-----				Total	% of Exams	WWU	WWU
	Inpt	Opt	Res	Other				
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**
 Run Date: FEB 28,1995 13:58

For period: Nov 20, 1994 to
 Feb 28, 1995

Sharing/Contract	-----Examinations-----				Total	% of Exams	WWU	WWU
	Inpt	Opt	Res	Other				
(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**

Run Date: FEB 28,1995 13:58

For period: Nov 20, 1994 to
 Feb 28, 1995

Sharing/Contract	-----Examinations-----				Total	% of Exams	WWU	WWU
	Inpt	Opt	Res	Other				

Order Entry

(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									

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 PIMS 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 AMIS-Based Workload Reports**, starting on page 214, for a full description of this report's options.

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

Ward	-----Examinations-----				Total	% of Exams	WWU	WWU
	Inpt	Opt	Res	Other				

(Imaging Type Summary)

Imaging Type Total: 0 0 0 0 0 0

of Wards selected: ALL

>>> Ward Workload Report <<<

Page: 2

Order Entry

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

Ward	-----Examinations-----					Total	% of Exams	WWU	WWU
	Inpt	Opt	Res	Other	% of				
(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

Ward	-----Examinations-----					Total	% of Exams	WWU	WWU
	Inpt	Opt	Res	Other	% of				
(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

Timeliness Reports 176 177

This menu provides the user (usually a supervisor, ADPAC or other managerial personnel) with three types of reports related to wait times and timeliness.

- Outpatient Procedure Wait Time
- Verification Timelines
- Radiology Timeliness Performance Reports 178

The can be Outpatient Procedure Wait Time and Verification Timeliness reports can be ran in Summary or Detail format, and the Verification report also allows the user to create or edit Outlook mail groups for automated delivery of the report. Sample prompts and formats are shown for each individual report in the detailed sections that follow.

176 Patch RA*5*37 June 2003: Added Performance Indicator option.

177Patch RA*5*67 April 2006: Changed menu name from Performance Indicator to Timeliness Reports, added two submenus: a new Outpatient Procedure Wait Time report option, and a re-named Verification Timeliness report option (formerly the Performance Indicator report). Also added new description of Timeliness Reports.

178Patch RA*5*99 February 2010: Added 'Radiology Timeliness Performance Reports' as a new menu option.

Automated Quarterly¹⁷⁹

Outlook Email

The Radiology Timeliness Performance Report¹⁸⁰ is the automated Outlook email that is generated on or before the fifteenth of the month following the quarter-end. The quarters are calendar quarters (i.e., Jan, Feb, Mar = 1st quarter).

Month that Outlook email is generated	Report data range (Quarter)
On or before January 15 th	October, November, December
On or before April 15 th	January, February, March
On or before July 15 th	April, May, June
On or before October 15 th	July, September, September

This automated Outlook email contains the following:

- Summary Verification Timeliness Report
- Summary Radiology Outpatient Procedure Wait Time Report ¹⁸¹
- Two performance value calculations: 1) a single calculated value, the verification timeliness performance value, and 2) a table using data from the report ¹⁸²

A “<=14 Days” column contains data that is also in the “<=30 Days” column. The reason that performance is calculated for both <=14 days and <=30 days is so that facilities can track their performance to a 14 day performance standard rather than a 30 day standard if they choose to do so. ¹⁸³

¹⁷⁹Patch RA*5*99 February 2010: Changed the reporting period for the automated Outlook email from monthly to quarterly.

¹⁸⁰Patch RA*5*99 February 2010: Changed subject of automated Outlook email from “Radiology Summary Verification Timeliness” to “Radiology Timeliness Performance Reports.”

¹⁸¹ Patch RA*5*99 February 2010: Inserted the “Summary Radiology Outpatient Procedure Wait Time Report” in the automated Outlook email.

¹⁸² Patch RA*5*99 February 2010: Inserted two performance summary values in the automated Outlook email.

¹⁸³ Patch RA*5*99 February 2010: Explanation of the “<=14 Days” reporting interval column .

through the 48th hour.)

- * PENDING means there's no data for DATE REPORT ENTERED or VERIFIED DATE. So, if the expected report is missing one of these fields, or is missing data for fields .01 through 17 from file #74, RAD/NUC MED REPORTS, or is a Stub Report that was entered by the Imaging package when images were captured before a report was entered, then the expected report would be counted in the PENDING column.
- * A printset, i.e., a set of multiple exams that share the same report, will be expected to have 1 report.
- * Cancelled and "No Credit" cases are excluded from this report.

Summary Radiology Outpatient Procedure Wait Time Report186 Page: 1

Facility: HINES DEVELOPMENT Station: 499 VISN: 12
 Division(s): HINESTEST, SUPPORT ISC
 Exam Date Range: 1/1/09-3/31/09
 PROCEDURE TYPES: All, except RADIATION THERAPY
 Run Date/Time: 6/26/09 10:47 am

Total number of procedures registered during specified exam date range: 27

DAYS WAIT -- PERCENTAGES

PROCEDURE TYPE	<=14 Days	187	<=30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days
CARDIAC STRESS TEST	0.0		0.0	0.0	0.0	0.0	0.0
COMPUTED TOMOGRAPHY	100.0		0.0	0.0	0.0	0.0	0.0
GENERAL RADIOLOGY	100.0		0.0	0.0	0.0	0.0	0.0
INTERVENTIONAL PROCEDURE	100.0		0.0	0.0	0.0	0.0	0.0
MAGNETIC RESONANCE IMAGING	0.0		0.0	0.0	0.0	0.0	0.0
MAMMOGRAPHY	100.0		0.0	0.0	0.0	0.0	0.0
NUCLEAR MEDICINE	0.0		0.0	0.0	0.0	0.0	0.0
OTHER	100.0		0.0	0.0	0.0	0.0	0.0
ULTRASOUND	0.0		0.0	0.0	0.0	0.0	0.0

DAYS WAIT -- COUNTS

PROCEDURE TYPE	<=14 Days	188	<=30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days	ROW TOTAL	Avg. Days
CARDIAC STRESS TEST	0		0	0	0	0	0	0	-
COMPUTED TOMOGRAPHY	1		0	0	0	0	0	1	0
GENERAL RADIOLOGY	20		0	0	0	0	0	20	-
INTERVENTIONAL PROCEDURE	3		0	0	0	0	0	3	0
MAGNETIC RESONANCE IMAGING	0		0	0	0	0	0	0	-
MAMMOGRAPHY	2		0	0	0	0	0	2	0
NUCLEAR MEDICINE	0		0	0	0	0	0	0	-
OTHER	1		0	0	0	0	0	1	0
ULTRASOUND	0		0	0	0	0	0	0	-

The "<=14 Days" column contains data that is also in the "<=30 Days" column. The reason that performance is calculated for both <=14 days and <=30 days is so that facilities can track their performance to a 14 day performance standard rather than a 30 day standard if they choose to do so. 189

Number of procedures cancelled and re-ordered on the same day = 0

(There are 2 cases with negative days wait included in the first column.)

1. Cancelled, "No Credit", inpatient cases, and not the highest modality of a printset are excluded from this report. (See 3. below.)

2. Columns represent # of days wait from the Registered date (the date/time entered at the "Imaging Exam Date/Time:" prompt) backwards to the Date Desired for the ordered procedure. The

186 Patch RA*5*99 February 2010: Inserted the "Summary Radiology Outpatient Procedure Wait Time Report" in the automated Outlook email.

187 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column .

188 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column .

189 Patch RA*5*99 February 2010: Explanation of the "<=14 Days" reporting interval column .

Order Entry

calculation is based on the number of different days and not rounded off by hours. The "31-60" column represents those orders that were registered 31 days or more but less than 61 days after the Date Desired.

3. If the user did not select a specific CPT Code or Procedure Name, then the cases from a printset (group of cases that share the same report) will have only the case with the highest modality printed. The modalities have this hierarchical order, where (1) is the highest: 1) Interventional, (2) MRI, (3) CT, (4) Cardiac Stress test, (5) Nuc Med, (6) US, (7) Mammo, (8) General Rad (9) Other

4. "Procedure Types" are assigned by a national CPT code look-up table and may differ from locally defined "Imaging Types." Therefore the number of procedures in each category may not be the same as other radiology management reports.

5. "Avg. Days" is the average days wait. It is calculated from the sum of the days wait for that Procedure Type, divided by the count of cases included in this report for that Procedure Type. Negative days wait is counted as 0. A "-" means an average cannot be calculated.

Outpatient Procedure Wait Time 190

Summary/Detail report191

This report measures the waiting time for outpatient radiology procedures by computing the time in days between the date that the patient was registered in the VistA Radiology Software (the date/time entered at the "Imaging Exam Date/Time:" prompt), back to the Date Desired for the ordered procedure ("Request Date:" prompt).192

The Office of Patient Care Services uses data from this report for physician productivity monitoring; to ensure report consistency throughout the VA, this report searches by CPT code rather than by imaging type. CPT codes are grouped into ten Procedure Types:

- Cardiac Stress Test
- Computed Tomography
- General Radiology
- Interventional Procedure
- Magnetic Resonance Imaging
- Mammography
- Nuclear Medicine
- Other
- Ultrasound
- Unknown (cases that either have no procedure type assigned, or are missing data)

The procedure types are stored in the Radiology CPT By Procedure Type File #73.2, which was initially exported as part of Patch RA*5*79. File #73.2 cannot be edited locally.

190 Patch RA*5*67 April 2006: New Outpatient Procedure Wait Time report option and examples.

191 Patch RA*5*47 September 2011: Summary/Detail report (for Outpt Proc Wait Times) option is affected by the new Site Specific Accession Number (SSAN).

192 Patch RA*5*79 February 2007: Added new background information about this report and its updated functionality.

The Summary/Detail Report option prompts for:

- Report Type: Summary, Detail, or Both.
- Starting and Ending dates
- Division
- Procedure Type -or- CPT Code/Procedure Name

The following sections describe the Summary and Detail report options.

- Timeliness Reports
- Outpatient Procedure Wait Time
- Summary Report Overview

The Summary report includes two data tables, one showing the percentage of procedures completed for each procedure type, and one showing the same information expressed in number of procedures. Both tables are organized by Procedure Type: these procedure types have been assigned by the Office of Patient Care Services, and are used to group cases with similar CPT codes together.

Procedure Types may differ from locally-defined Imaging Types; therefore, the number of procedures in each category may not be the same as shown in other radiology management reports that are based on Imaging Types.

Six of these procedure types are used by the VHA Support Service Center (VSSC) for physician performance monitoring: Cardiac Stress Test, Computed Tomography, Magnetic Resonance Imaging, Mammography, Nuclear Medicine, and Ultrasound. Radiation Therapy has been excluded from performance monitoring, and from this report, because some sites do not use the Radiology package to register these cases and this causes inconsistent report results.

The Outpatient Procedure Wait Time summary report can be run at any time. No automatic background job runs this report.

The Date Range is 92 days maximum for the summary report.

Summary Report by Procedure Type - After the Rad/Nuc Med Division prompt, the next prompt asks for either "Procedure Type" or "CPT Code /Procedure Name". If the user selects "Procedure Type," all Procedure Types will be displayed alphabetically on the summary report, as shown in this example.¹⁹³

¹⁹³ Patch RA*5*79 February 2007: Updated the Summary Report description and examples: replaced "Imaging Type" selection prompt with "Procedure Type" prompt; added help text; removed Imaging Type(s) from report header; removed "Average number of days wait" calculation, and updated the report footnotes.

Order Entry

Prompt/User Response

Discussion

```
Radiology Outpatient Procedure Wait Time Report

Enter Report Type
  Select one of the following:

      S      Summary
      D      Detail
      B      Both

Select Report Type: S// Summary

  The starting and ending dates are based upon what was entered at
  the "Imaging Exam Date/Time" prompt during Registration.

Enter starting date: 1/1/05 (JAN 01, 2005)
Enter ending date: (1/1/2005 - 4/2/2005): 1/31/05 (JAN 31, 2005)
Select Rad/Nuc Med Division: All// <RET>

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

Enter next item to select.
  Select one of the following:
      C      CPT Code/Procedure Name
      P      Procedure Type
What do you want to choose next: P// ??

  "CPT Code/Procedure Name" will include only the user selected CPT
  Codes and Procedure names in this date range, except for cases that
  are cancelled, have no credit, or are inpatient.

  "Procedure Type" will include all cases in this date range, except
  for the 3 exclusions above and also except if the case is part of a
  printset and it is not the highest ranked modality in the printset.

What do you want to choose next: P// Procedure Type

  All PROCEDURE TYPES will be included, except RADIATION THERAPY.

DEVICE: HOME// <RET> TELNET   Right Margin: 80//
```

The output includes two tables, both organized by Procedure Type. The top table displays the percentage of procedures completed for each procedure type, in groups of 30 days; the bottom table shows the same information expressed in number of procedures. The percentages will be reported to the Office of Patient Care Management for physician performance monitoring.

Note: When two or more cases are grouped as one study under one report (as part of a printset), only one will be included in this report, using the case that has the highest-ranked Procedure Type according to the hierarchy below. (All cases from an examset will be included, because each case has its own exam report.)

1. Interventional Procedure
2. Magnetic Resonance
3. Computed Tomography
4. Cardiac Stress Test
5. Nuclear Medicine

- 6. Ultrasound
- 7. Mammography
- 8. General Radiology
- 9. Other

The number of procedures cancelled and re-ordered on the same day is shown below the tables. "Negative days wait" represents exams that were performed earlier than the Desired Date, and those exams are included in the first column.

Summary Radiology Outpatient Procedure Wait Time Report							Page: 1 194		
Facility: HINES ISC		Station: 499		VISN:					
Division(s): HINESTEST, SUPPORT ISC									
Exam Date Range: 1/1/05-1/31/05									
PROCEDURE TYPES: All, except RADIATION THERAPY									
Run Date/Time: 5/29/07 11:15 am									
Total number of procedures registered during specified exam date range: 22									
DAYS WAIT -- PERCENTAGES									
PROCEDURE TYPE	<=14 Days	195 Days	<=30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days		
CARDIAC STRESS TEST	0.0		0.0	0.0	0.0	0.0	0.0		
COMPUTED TOMOGRAPHY	0.0		0.0	0.0	0.0	0.0	0.0		
GENERAL RADIOLOGY	90.9		100.0	0.0	0.0	0.0	0.0		
INTERVENTIONAL PROCEDURE	100.0		100.0	0.0	0.0	0.0	0.0		
MAGNETIC RESONANCE IMAGI	0.0		0.0	0.0	0.0	0.0	0.0		
MAMMOGRAPHY	100.0		100.0	0.0	0.0	0.0	0.0		
NUCLEAR MEDICINE	0.0		0.0	0.0	0.0	0.0	0.0		
OTHER	0.0		0.0	0.0	0.0	0.0	0.0		
ULTRASOUND	100.0		100.0	0.0	0.0	0.0	0.0		
"unknown"	0.0		0.0	0.0	0.0	0.0	100.0		
DAYS WAIT -- COUNTS									
PROCEDURE TYPE	<=14 Days	196 Days	<=30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days	ROW TOTAL	Avg. Days
CARDIAC STRESS	0	0	0	0	0	0	0	0	-
COMPUTED TOMOGR	0	0	0	0	0	0	0	0	-
GENERAL RADIOLO	10	11	0	0	0	0	11	11	3
INTERVENTIONAL	5	5	0	0	0	0	5	5	0
MAGNETIC RESONA	0	0	0	0	0	0	0	0	-
MAMMOGRAPHY	10	10	0	0	0	0	10	10	0
NUCLEAR MEDICIN	0	0	0	0	0	0	0	0	-
OTHER	0	0	0	0	0	0	0	0	-
ULTRASOUND	4	4	0	0	0	0	4	4	0
"unknown"	0	0	0	0	0	1	1	1	853
The "<=14 Days" column contains data that is also in the "<=30 Days" column.									
The reason that performance is calculated for both <=14 days and <=30 days is so that facilities can track their performance to a 14 day performance standard rather than a 30 day standard if they choose to do so. 197									

194 Patch RA*5*83 June 2007: Updated Summary Report example, showing new "Avg Days" column in the "Days Wait – Counts" table, and minor footnote corrections.

195 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column .

196 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column .

197 Patch RA*5*99 February 2010: Explanation of the "<=14 Days" reporting interval column .

Order Entry

Number of procedures cancelled and re-ordered on the same day = 0.

(There is 1 case with negative days wait included in the first column.)

1. Cancelled, "No Credit", inpatient cases, and not the highest modality of a printset are excluded from this report. (See 3. below.)
2. Columns represent # of days wait from the Registered date (the date/time entered at the "Imaging Exam Date/Time:" prompt) backwards to the Date Desired for the ordered procedure. The calculation is based on the number of different days and not rounded off by hours. The "31-60" column represents those orders that were registered 31 days or more but less than 61 days after the Date Desired.
3. If the user did not select a specific CPT Code or Procedure Name, then the cases from a printset (group of cases that share the same report) will have only the case with the highest modality printed. The modalities have this hierarchical order, where (1) is the highest:
(1) Interventional, (2) MRI, (3) CT, (4) Cardiac Stress test,
(5) Nuc Med, (6) US, (7) Mammo, (8) General (9) Other
4. "Procedure Types" are assigned by a national CPT code look-up table and may differ from locally defined "Imaging Types." Therefore the number of procedures in each category may not be the same as other radiology management reports.
5. "Avg. Days" is the average days wait. It is calculated from the sum of the days wait for that Procedure Type, divided by the count of cases included in this report for that Procedure Type. Negative days wait is counted as 0.
A "-" means an average cannot be calculated.
6. Procedure Type of "unknown" refers to either cases that have no matching procedure type in the spreadsheet of CPT Codes provided by the Office of Patient Care Services, or cases that are missing data for the procedure.

Summary Report by CPT Code/Procedure Name 198

After the Rad/Nuc Med Division prompt, the next prompt asks for either "Procedure Type" or "CPT Code/Procedure Name". If the user selects "CPT Code/Procedure Name" they will then select one or more procedures to be displayed on the report, either by entering a procedure name or CPT Code. The same prompt will reappear until the user presses the "Return" key without entering any more procedures.

198 Patch RA*5*79 February 2007: Added Summary Report by CPT Code/Procedure Name description and example.

Prompt/User Response

Discussion

```

Radiology Outpatient Procedure Wait Time Report

Enter Report Type

    Select one of the following:
        S      Summary
        D      Detail
        B      Both

Select Report Type: S// Summary

    The starting and ending dates are based upon what was entered at
    the "Imaging Exam Date/Time" prompt during Registration.

Enter starting date: 010105 (JAN 01, 2005)
Enter ending date: (1/1/2005 - 4/2/2005): 013105 (JAN 31, 2005)
Select Rad/Nuc Med Division: All// <Ret>
Another one (Select/De-Select): <Ret>
Enter next item to select.
    Select one of the following:
        C      CPT Code/Procedure Name
        P      Procedure Type

What do you want to choose next: P// C CPT Code/Procedure Name
Select Procedure/CPT Code: 76090 MAMMOGRAM, ONE BREAST
Another one (Select/De-Select): 76091 MAMMOGRAM, BOTH BREASTS
Another one (Select/De-Select): 76092 MAMMOGRAM, SCREENING
Another one (Select/De-Select): <Ret>
DEVICE: HOME// TELNET Right Margin: 80//

```

Similar to the Summary Report by Imaging Type, this report includes two tables, showing the percentage of procedures completed for each procedure type in the top table, and the number of procedures in the second table. These tables display only the procedure types that have data for the selected procedure/CPT code, as shown in the example report below.

The number of procedures cancelled and re-ordered on the same day is shown below the tables. "Negative days wait" represents exams that were performed earlier than the Desired Date, and those exams are included in the first column.

```

Summary Radiology Outpatient Procedure Wait Time Report199          Page: 1

Facility: HINES ISC              Station: 499          VISN:
Division(s): HINESTEST, JESSE BROWN VAMC, SUPPORT ISC
Exam Date Range: 1/1/05-1/31/05
CPT CODES and PROCEDURES:
    76091 MAMMOGRAM BILAT
    76092 MAMMOGRAM SCREENING
    76090 MAMMOGRAM UNILAT
Run Date/Time: 12/2/09 8:26 am

Total number of procedures registered during specified exam date range: 7

                                DAYS WAIT -- PERCENTAGES

```

199 Patch RA*5*83 June 2007: Updated Summary Report example, showing new "Avg Days" column in the "Days Wait – Counts" table, and minor footnote corrections.

Order Entry

PROCEDURE TYPE	<=14 Days	<=30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days
MAMMOGRAPHY	100.0	100.0	0.0	0.0	0.0	0.0

DAYS WAIT -- COUNTS								
PROCEDURE TYPE	<=14 Days	<=30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days	ROW TOTAL	Avg. Days
MAMMOGRAPHY	7	7	0	0	0	0	7	0

The "<=14 Days" column contains data that is also in the "<=30 Days" column. The reason that performance is calculated for both <=14 days and <=30 days is so that facilities can track their performance to a 14 day performance standard rather than a 30 day standard if they choose to do so. 201

Number of procedures cancelled and re-ordered on the same day = 0
Press RETURN to continue, "^" to exit:

1. Cancelled, "No Credit", inpatient cases, and not the highest modality of a printset are excluded from this report. (See 3. below.)
2. Columns represent # of days wait from the Registered date (the date/time entered at the "Imaging Exam Date/Time:" prompt) backwards to the Date Desired for the ordered procedure. The calculation is based on the number of different days and not rounded off by hours. The "31-60" column represents those orders that were registered 31 days or more but less than 61 days after the Date Desired.
3. If the user did not select a specific CPT Code or Procedure Name, then the cases from a printset (group of cases that share the same report) will have only the case with the highest modality printed. The modalities have this hierarchical order, where (1) is the highest: (1) Interventional, (2) MRI, (3) CT, (4) Cardiac Stress test, (5) Nuc Med, (6) US, (7) Mammo, (8) General Rad (9) Other
4. "Procedure Types" are assigned by a national CPT code look-up table and may differ from locally defined "Imaging Types." Therefore the number of procedures in each category may not be the same as other radiology management reports.
5. "Avg. Days" is the average days wait. It is calculated from the sum of the days wait for that Procedure Type, divided by the count of cases included in this report for that Procedure Type. Negative days wait is counted as 0. A "-" means an average cannot be calculated.

Detail Report

The Outpatient Procedure Wait Time Detail Report shows detailed information for exams registered in the selected date range, organized by patient.²⁰² This report can be run as needed.

If the Report Type is "Detail" or "Both" then the user will be asked which column heading should be used to sort the list: Case Number, CPT Code, Date Desired, Days Wait, Date of Order, Date of Registration, Imaging Type, Patient Name, Procedure Type, or Procedure Name. The default sort is Days Wait.

200 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column .

201 Patch RA*5*99 February 2010: Explanation of the "<=14 Days" reporting interval column .

202 Patch RA*5*79 February 2007: Updated the Detail Report description and example, added Procedure Type to Sort By list, and added printset note.

The Date Range is 92 days maximum for the Detail Report.203

The number of lines printed in the Detail Report can be reduced by entering a minimum number of wait days. The default choice is 0, which also includes negative wait days.

Prompt/User Response

Discussion

```

Radiology Outpatient Procedure Wait Time Report
Enter Report Type
  Select one of the following:

      S      Summary
      D      Detail
      B      Both

Select Report Type: S// Detail

  The starting and ending dates are based upon what was entered at
  the "Imaging Exam Date/Time" prompt during Registration.

Enter starting date: 1/1/05 (JAN 01, 2005)
Enter ending date: (1/1/2005 - 2/1/2005): 1/31/05 (JAN 31, 2005)

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

Enter next item to select.
  Select one of the following:
      C      CPT Code/Procedure Name
      P      Procedure Type

What do you want to choose next: P// rocedure Type

  All PROCEDURE TYPES will be included, except RADIATION THERAPY.

Sort report by
  Select one of the following:

      CN      Case Number
      CPT     CPT Code
      DD      Date Desired
      D       Days Wait
      DO      Date of Order
      DR      Date of Registration
      I       Imaging Type
      PN      Patient Name
      PT      PROCEDURE TYPE
      PROC    Procedure Name

Sorted by: D// <RET>

Print wait days greater than or equal to: (0-120): 0// <RET>
*** The detail report requires a 132 column output device ***
DEVICE: HOME// ;132;99 TELNET

```

The output will list the cases for the selected exam date range. The listing may show fewer cases than the total number of cases registered during that date range, if the user selected a "minimum Wait Days" greater than 0.

Note: When two or more cases are grouped as one study under one report (as part of a printset), only one will be included in this report, using the case

203 Patch RA*5*99 February 2010: The date range is 92 days maximum for the Detail Report.

Order Entry

that has the highest-ranked Procedure Type according to the hierarchy below. (All cases from an examset will be included, because each case has its own exam report.)

1. Interventional Procedure
2. Magnetic Resonance
3. Computed Tomography
4. Cardiac Stress Test
5. Nuclear Medicine
6. Ultrasound
7. Mammography
8. General Radiology
9. Other

Detail Radiology Outpatient Procedure Wait Time Report										
Page: 1										
Facility: HINES ISC Station: 499 VISN:										
Division(s): HINESTEST, SUPPORT ISC										
Exam Date Range: 1/1/05-1/31/05										
PROCEDURE TYPES: All, except RADIATION THERAPY										
Run Date/Time: 12/12/06 1:14 pm										
Sorted by: Days Wait Print only cases with minimum Days Wait of: 0										
Total number of procedures registered during specified exam date range: 22										
Patient Name	Case #	Date Ordered	Date Desired	Date Register	Days Exam Wait	Exam Status	CPT Code	Name of Procedure	Img Type	PROC. TYPE
PATIENT, THREE	012505-1768	1/26/05	1/26/05	1/25/05	-1	WAITING FOR	74010	ABDOMEN 2 VIEWS	GEN	GENER
PATIENT, TWO	010705-25	1/7/05	1/7/05	1/7/05	0	WAITING FOR	76091	MAMMOGRAM BILAT	MAM	MAMMO
PATIENT, SIX	011205-842	1/12/05	1/12/05	1/12/05	0	CALLED FOR	76091	MAMMOGRAM BILAT	MAM	MAMMO
PATIENT, ONE	011205-1611	1/12/05	1/12/05	1/12/05	0	WAITING FOR	75665	ANGIO CAROTID CEREBRAL UNILAT S&I	GEN	INTER
PATIENT, ONE	011205-1741	1/12/05	1/12/05	1/12/05	0	WAITING FOR	75650	ANGIO CERVICOCEREBRAL CATH S&I	GEN	INTER
PATIENT, TWEL	011405-1748	1/14/05	1/14/05	1/14/05	0	CALLED FOR	76092	MAMMOGRAM SCREENING	MAM	MAMMO
PATIENT, SEVE	011905-1578	1/19/05	1/19/05	1/19/05	0	CALLED FOR	76090	MAMMOGRAM UNILAT	MAM	MAMMO
PATIENT, SEVE	011905-1745	1/19/05	1/19/05	1/19/05	0	WAITING FOR	76645	BREAST ULTRASOUND	ULT	ULTRA
PATIENT, FOUR	012005-1746	1/20/05	1/20/05	1/20/05	0	WAITING FOR	76645	BREAST ULTRASOUND	ULT	ULTRA
PATIENT, FOUR	012005-1749	1/20/05	1/20/05	1/20/05	0	WAITING FOR	76856	PELVIC ULTRASOUND	ULT	ULTRA
PATIENT, FOUR	012005-1750	1/20/05	1/20/05	1/20/05	0	WAITING FOR	76830	VAGINAL ULTRASOUND	ULT	ULTRA
PATIENT, ONE	012005-1751	1/20/05	1/20/05	1/20/05	0	CALLED FOR	76091	MAMMOGRAM BILAT	MAM	MAMMO
PATIENT, FIVE	012005-1752	1/20/05	1/20/05	1/20/05	0	CALLED FOR	76090	MAMMOGRAM UNILAT	MAM	MAMMO
PATIENT, THREE	012005-1753	1/20/05	1/20/05	1/20/05	0	CALLED FOR	76092	MAMMOGRAM SCREENING	MAM	MAMMO
PATIENT, FOUR	p012605-1763	1/26/05	1/26/05	1/26/05	0	WAITING FOR	74000	ABDOMEN 1 VIEW	GEN	GENER
PATIENT, FOUR	012605-1766	1/26/05	1/26/05	1/26/05	0	WAITING FOR	71030	CHEST 4 VIEWS	GEN	GENER
PATIENT, SIX	012605-1767	1/26/05	1/26/05	1/26/05	0	WAITING FOR	71020	CHEST 2 VIEWS PA&LAT	GEN	GENER
PATIENT, SIX	012605-1769	1/26/05	1/26/05	1/26/05	0	WAITING FOR	75665	ANGIO CAROTID CEREBRAL UNILAT S&I	GEN	INTER
PATIENT, SIX	012605-1770	1/26/05	1/26/05	1/26/05	0	WAITING FOR	75650	ANGIO CERVICOCEREBRAL CATH S&I	GEN	INTER
PATIENT, TWO	012605-1771	1/26/05	1/26/05	1/26/05	0	WAITING FOR	75680	ANGIO CAROTID CERVICAL BILAT S&I	GEN	INTER
PATIENT, THREE	012705-1778	1/27/05	1/27/05	1/27/05	0	WAITING FOR	71030	CHEST 4 VIEWS	GEN	GENER
PATIENT, FOUR	011205-1747	9/12/02	9/12/02	1/12/05	853	WAITING FOR	93619	ELECTROPHYSIOLOGIC EVALUATION, RIGHT ATRIAL P VAS	unkno	

(There is 1 case with negative days wait included in the listing.)

1. Cancelled, "No Credit", inpatient cases, and not the highest modality of a printset are excluded from this report. (See 3. below.)
2. The "Days Wait" represent # of days from the Registered date (the date/time entered at the "Imaging Exam Date/Time:" prompt) backwards to the Date Desired for the ordered procedure. The calculation is based on the number of different days and not rounded off by hours.
3. If the user did not select a specific CPT Code or Procedure Name, then the cases from a printset (group of cases that share the same report) will have only the case with the highest ranked modality printed. Modalities are ranked in this order, (1) being the highest:
(1) Interventional, (2) MRI, (3) CT, (4) Cardiac Stress test, (5) Nuc Med, (6) US, (7) Mammo, (8) General Rad (9) Other
However, all the cases from an examset (group of cases that have separate reports) will all be listed.
4. "Procedure Types" are assigned by a national CPT code look-up table and may differ from locally defined "Imaging Types." Therefore the number of procedures in each category may not be the same as other radiology management reports.
5. Procedure Type of "unknown" refers to either cases that have no matching procedure type in the spreadsheet of CPT Codes provided by the Office of Patient Care Services, or cases that are missing data for the procedure.
6. CPT Code is not available for parent and broad procedures in the header section. CPT Code of the parent order's highest ranked modality case will be printed in the line by line section. (See 3. above.)
7. Date/Time Registered is the "Imaging Exam Date/Time" entered by the user during Registration.
8. "*" under the "Date Register" column denotes the request was cancelled and re-ordered on the same day that it was cancelled.
9. "p" under the "Case #" column, before the case number, denotes printset case with the highest ranked Procedure Type.

Timeliness Reports ²⁰⁴ - Verification Timeliness ²⁰⁵

Summary/Detail report ²⁰⁶

The Summary/Detail Report option will prompt for:

- Report Type: Choices include Summary, Detail, or Both.
- Primary Interpreting Staff Physician (Optional)²⁰⁷
- Starting and Ending Dates
- Division
- Imaging Type

Summary Report

The Summary Verification Timeliness Report should be run on the 15th of the month for the previous month's registered exams. If the Report Type is "Summary" or "Both," then the user will be asked if the summary output should also be sent to the local mail group "G.RAD PERFORMANCE INDICATOR" and to any OUTLOOK mail group(s) defined with the 'Enter/Edit OUTLOOK mail group' option.

*Paragraph changed for Patch RA*5*99 December 2009 ²⁰⁸*

The Date Range is 92 days maximum for the Summary Report. The 'End Date' for the Summary Report must be at least 10 days prior to the current date. **Note:** An 'End Date' 10 days prior to the current date must be entered for the Detail Report in order to obtain data which is identical to the Summary Report.

The verification date is always the first time that the report was verified. If a report was un-verified and later verified again, the date that the report was first verified would be used, not the date that it was verified the second time.²⁰⁹

²⁰⁴ Patch RA*5*37 June 2003: Added Performance Indicator; Renamed to Timeliness Reports, April 2006 RA*5*67.

²⁰⁵ Patch RA*5*99 February 2010: Moved two menu options to the 'Radiology Timeliness Performance Reports' menu option: 'Enter/Edit OUTLOOK mail group' and 'Run Previous Quarter's Summary Report.'

²⁰⁶ Patch RA*5*47 September 2011: Summary/Detail report (for Verification Timeliness) option is affected by the new Site Specific Accession Number (SSAN).

²⁰⁷ Patch RA*5*44 January 2004: New prompt added: "Primary Interpreting Staff Physician (Optional)."

²⁰⁸ Patch RA*5*63 October 2005: Explanation of new question if a full month of data was requested.

²⁰⁹ Patch RA*5*44 January 2004: New text added: "The verification date..."

Order Entry

Prompt/User Response

Discussion

```
Radiology Verification Timeliness Report

Enter Report Type

    Select one of the following:
        S      Summary
        D      Detail
        B      Both

Select Report Type: S// <RET> Summary

    The begin date for Summary and Both must be at least 10 days before today.

Enter starting date: 01/01/2009 (JAN 01, 2009)
    The ending date for Summary and Both must be at least 10 days before today.
Enter ending date: (1/1/2009 - 4/2/2009): 04/01/2009 (APR 01, 2009)
Select Primary Interpreting Staff Physician (Optional):
Select Rad/Nuc Med Division: All// <RET>
Another one (Select/De-Select): <RET>

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

    *** Imaging type 'Vascular Lab' will not be included in this report ***

Send summary report to local mail group "G.RAD PERFORMANCE INDICATOR"? Yes// <RET> YES
Send summary report to OUTLOOK mail group(s)? Yes// <RET> YES210

DEVICE: HOME// <RET> TELNET    Right Margin: 80// <RET>
```

The report is shown below.

```
Summary Verification Timeliness Report                                Page: 1 211

Facility: SUPPORT ISC                Station:                VISN:
Division: HINESTEST, SUPPORT ISC
Exam Date Range: 3/1/05 - 3/31/05
Imaging Type(s): RADIOLOGY STUDIES (NUC MED), CT SCAN, GENERAL RADIOLOGY,
                  MAGNETIC RESONANCE IMAGING, MAMMOGRAPHY, NUCLEAR MEDICINE,
                  ULTRASOUND
Run Date/Time: 9/16/05 9:17 am

Total number of reports expected for procedures performed during specified
date range: 10

Hrs   >0   >24   >48   >72   >96   >120  >144  >168  >192  >216  >240  PENDING
From  -24   -48   -72   -96   -120  -144  -168  -192  -216  -240  Hrs
Ex Dt Hrs   Hrs   Hrs   Hrs   Hrs   Hrs   Hrs   Hrs   Hrs   Hrs

#Tr   3     0     0     0     0     0     0     0     0     0     1     6
%Tr   30.0  0.0   0.0   0.0   0.0   0.0   0.0   0.0   0.0   0.0   10.0  60.0

#Vr   2     0     0     0     0     0     0     0     0     0     1     7
%Vr   20.0  0.0   0.0   0.0   0.0   0.0   0.0   0.0   0.0   0.0   10.0  70.0

Press RETURN to continue.

Summary Verification Timeliness Report                                Page: 2
```

210Patch RA*5*63 October 2005: New lines added to the report.

211 Patch RA*5*67 April 2006: Report name changed to Summary Verification Timeliness Report.

- * Columns represent # of hours elapsed from exam date/time through date/time report entered or date/time report was verified.
e.g. ">0-24 Hrs" column represents those exams that had a report transcribed and/or verified within 0-24 hours from the exam date/time.
- * Columns following the initial elapsed time column ">0-24 Hrs" begin at .0001 after the starting hour (e.g. ">24-48 Hrs" = starts at 24.001 through the 48th hour.)
- * PENDING means there's no data for DATE REPORT ENTERED or VERIFIED DATE. So, if the expected report is missing one of these fields, or is missing data for fields .01 through 17 from file #74, RAD/NUC MED REPORTS, or is a Stub Report that was entered by the Imaging package when images were captured before a report was entered, then the expected report would be counted in the PENDING column.
- *A printset, i.e., a set of multiple exams that share the same report, will be expected to have 1 report.²¹²
- *Cancelled and "No Credit" cases are excluded from this report.²¹³

Verification Timeliness Detail Report

The Verification Timeliness Detail Report can be run as needed.²¹⁴

If the Report Type is "Detail" or "Both", then the user will be asked which item should be used to sort the listing: Case Number, Category of Exam, Imaging Type, Patient Name, Radiologist (Primary Interpreting Staff), Hrs to Transcription, or Hrs to Verification.

The default sort is Case Number. If data is sorted by 'Hours to Verification', hours will be displayed for 'Date/Time Verified', all other sorts will be displayed for 'Date / Time Transcribed'.

The Date Range is 92 days maximum for the Detail Rreport.

Note: Due to restrictions set on the Summary Report, an 'End Date' which is 10 days prior to the current date must be entered for the Detail Report in order to obtain data identical to the Summary Report.

The number of lines printed in the Detail Report can be reduced by entering a minimum number of hours elapsed. The default for this option is 72.

The verification date is always the first time that the report was verified.²¹⁵ If a report was un-verified and later verified again, the date that the report was first verified would be used, not the date that it was verified the second time.

Prompt/User Response

Discussion

212 Patch RA*5*44 January 2004: New text added "* A printset, i.e.,...

213 Patch RA*5*67 April 2006: New text added "*Cancelled and "No Credit" cases are excluded..."

214 Patch RA*5*37 June 2003: Detail Report text and example reflect addition of Hour columns after the "Date/Time Transcribed" and "Date/Time Verified" columns and addition of Hrs to Verification and Hrs to Transcription sorts.

215 Patch RA*5*44 January 2004: New paragraph added. "Verification date is always the first time..."

Order Entry

```
Radiology Verification Timeliness Report
Enter Report Type

    Select one of the following:

        S      Summary
        D      Detail
        B      Both

Select Report Type: S// Detail

Enter starting date: 03/24/00 (MAR 24, 2000)
Enter ending date:  : (3/24/2000 - 4/24/2000): 03/29/00 (MAR 29, 2000)

Select Primary Interpreting Staff Physician (Optional): <RET>216
Select Rad/Nuc Med Division: All// <RET>

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

Select Imaging Type: All// <RET>

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

    *** Imaging type 'Vascular Lab' will not be included in this report ***

Sort report by

    Select one of the following:

        C      Case Number
        E      Category of Exam
        I      Imaging Type
        P      Patient Name
        R      Radiologist
        T      Hrs to Transcrip.
        V      Hrs to Verif.

Select Sorted by: C// V Hrs to Verif.
Print PENDING and Verif. hours greater than or equal to: (0-240): 72// 0

    *****
    *** The detail report requires a 132 column output device ***
    *****

DEVICE: HOME// ;132;99 TELNET
```

The report is shown on the next page.

216 Patch RA*5*44 January 2004: New prompt added. "Select Primary Interpreting Staff Physician (Optional)."

Detail Verification Timeliness Report 217										Page: 1	
Facility: SUPPORT ISC			Station:			VISN:					
Division: HINESTEST, SUPPORT ISC											
Exam Date Range: 3/24/00 - 03/29/00											
Imaging Type(s): RADIOLOGY STUDIES (NUC MED), CT SCAN, GENERAL RADIOLOGY, MAGNETIC RESONANCE IMAGING, MAMMOGRAPHY,											
NUCLEAR MEDICINE, ULTRASOUND											
Run Date/Time: 10/24/04 4:04 pm											
Sorted by: Hrs to Verification					Min. hours elapsed to Verification: 0						
Total number of reports expected for procedures performed during specified date range: 22											
Date/Time	Date/Time	Date/Time	Cat	Rpt	Img	Procedure	218				
Patient Name	Case #	Registered	Transcribed	Hrs	Verified	Hrs	Radiologist				
Exm	Sts	Typ	Name								
RADP	E		032400-913	3/24/00@11:37	O	GEN	ABDOMEN 2 V				
RADP	E		032400-915	3/24/00@11:58	RADP	ROVIDER,THREE	O GEN ANKLE 2 VIE				
RADP	E		032800-822	3/28/00@09:51	3/28/00@10:54	1	RADP	ROVIDER,THREE	I	R	
GEN			ANKLE 2 VIE								
RADP	E		032800-850	3/28/00@09:58			RADP	ROVIDER,THREE	O	GEN	
FOOT			2 VIEW								
RADP	E		032800-876	3/28/00@16:14	O	GEN	SKULL 4 OR				
RADP	E		032800-880	3/28/00@16:14	O	GEN	ANKLE 3 OR				
RADP	E		032900-895	3/29/00@07:30	O	ULT	ECHOGRAM AB				
RADP	E		032900-903	3/29/00@07:33	O	NUC	BONE IMAGIN				
RADP	E		032900-907	3/29/00@07:42	O	NUC	BONE IMAGIN				
RADP	O		032900-908	3/29/00@07:45	O	NUC	LIVER AND S				
RADP	E		032900-914	3/29/00@07:48	O	ULT	ECHOENCEPHA				
RADP	E		032900-917	3/29/00@07:52	O	NUC	LIVER AND S				
RADP	E		032900-919	3/29/00@07:57	O	NUC	LIVER IMAGI				
RADP	E		032800-852	3/28/00@10:39	3/28/00@10:41	<1	3/28/00@10:41	<1			
RADP	ROVIDER,THREE	O V GEN	KNEE 3 VIEW								
RADP	E		032800-872	3/28/00@15:03	3/28/00@15:13	<1	3/28/00@15:13	<1			
RADP	ROVIDER,THREE	O V GEN	KNEE 3 VIEW								
RADP	E		032800-802	3/28/00@09:20	3/28/00@11:21	2	3/28/00@11:21	2			
RADP	ROVIDER,THREE	O V GEN	KNEE 4 OR M								
RADP	E		032400-912	3/24/00@09:20	3/24/00@09:32	<1	3/30/00@08:07	143			
RADP	ROVIDER,THREE	O V GEN	ANGIO BRACH								
RADP	E		032900-920	3/29/00@08:24	4/4/00@10:22	146	4/4/00@10:22	146			
RADP	ROVIDER,FOUR	O V GEN	KNEE 3 VIEW								
RADP	E		032800-870	3/28/00@15:00	4/12/00@09:43	355	4/12/00@09:43	355			
RADP	ROVIDER,THREE	O V GEN	ABDOMEN 3 O								
RADP	E		032900-918	3/29/00@07:55	4/12/00@11:47	340	7/17/00@13:47	>999			
RADP	ROVIDER,FOUR	O V NUC	LIVER FUNCT								
RADP	E		032400-910	3/24/00@08:04	5/12/00@08:46	>999	5/17/01@15:53	>999			
RADP	ROVIDER,FIVE	O V GEN	CHEST 4 VIE								
RADP	E		032400-916	3/24/00@13:01	3/7/02@11:52	>999	RADP	ROVIDER,FOUR	O V GEN		
ANGIO			CAROT								

Note: Category of Exam: 'I' for Inpatient; 'O' for Outpatient; 'C' for Contract; 'S' for Sharing; 'E' for Employee; 'R' for Research

Report Status: 'V' for Verified; 'R' for Released/Not Verified; 'PD' for Problem Draft; 'D' for Draft

* A printset, i.e., a set of multiple exams that share the same report, will be expected to have 1 report.

*Cancelled and "No Credit" cases are excluded from this report.219

217 Patch RA*5*67 April 2006: Report name changed to Detail Verification Timeliness Report.
 218 Patch RA*5*44 January 2004: New "Procedure Name" column added. Text added "* A printset, i.e.,..."
 219 Patch RA*5*67 April 2006: Text added. "Cancelled and "No Credit" cases are excluded..."

Radiology Timeliness Performance Reports 220 221

Enter/Edit OUTLOOK mail group 222

This option allows the user to enter one or more Outlook mail groups that are to receive the output of the Radiology Timeliness Performance Report. Most VISNs will have a Radiology Performance Monitoring mail group. If no Outlook mail group is entered, the user will not be asked if the Summary report should be sent to Outlook.

The Outlook mail group is entered at the PERF INDC SMTP E-MAIL ADDRESS prompt. The next prompt, OQP PERFORMANCE MGMT?, is used to designate whether the mail group belongs to the Office of Quality and Performance. Only the "VHARADIOLOGYREPORTS@HQ.MED.VA.GOV" mail group should be given a Yes. Entering nothing at this prompt would be the same as entering an "N." 223

The following example shows how to enter a new Outlook mail group for the first time, and then how to delete an entry.

Prompt/User Response

Discussion

```
(entering an OUTLOOK mail group for the first time)
You may add another mail group.
To edit or replace a mail group, you must delete the old one first.

Select PERF INDC SMTP E-MAIL ADDRESS:224 YourVISNmailgroup@med.va.gov
Are you adding 'YourVISNmailgroup@med.va.gov' as
a new PERF INDC SMTP E-MAIL ADDRESS (the 1ST for this RAD/NUC MED DIVISION)? No// Y (Yes)
OQP PERFORMANCE MGMT?: N NO 225

Select PERF INDC SMTP E-MAIL ADDRESS:

(deleting a previously entered OUTLOOK mail group)

OUTLOOK mail groups previously entered:

YourVISNmailgroup@med.va.gov                OQP Perf. Mgmt?
                                             -----
                                             N

You may add another mail group.
To edit or replace a mail group, you must delete the old one first.

Select PERF INDC SMTP E-MAIL ADDRESS: YourVISNmailgroup@med.va.gov
// @
```

220 Patch RA*5*37 June 2003: Added Performance Indicator; Renamed to Timeliness Reports, April 2006 RA*5*67

221 Patch RA*5*67 April 2006: Renamed Performance Indicator Report to Verification Timeliness Report.

222 Patch RA*5*99 February 2010: Moved the 'Enter/Edit OUTLOOK mail group' option from the 'Verification Timeliness' option.

223 Patch RA*5*63 October 2005: Added explanation of new field OQP PERFORMANCE MGMT?

224 Patch RA*5*42 September 2003: Replaced MAIL ADDRESS with PERF INDC SMTP E-MAIL ADDRESS

225 Patch RA*5*63 October 2005: Added new prompt OQP PERFORMANCE MGMT? and new display.

SURE YOU WANT TO DELETE THE ENTIRE 'YourVISNmailgroup@med.va.gov' PERF INDC SMTP E-MAIL ADDRESS?? **Y** (Yes)
Timeliness Reports**226**

Run Previous Quarter's ^{227 228} Summary Report ^{229 230}

This option generates a summary report for the entire previous quarter.²³¹ It will first display all Outlook mail groups defined for Radiology Performance Monitoring. If there are no Outlook mail groups defined, then the processing would stop. Otherwise, it will prompt for the date to start a background job to generate a summary report for the entire previous quarter.

The requested start time must be at least 10 days into the current quarter. The option will assume all Rad/Nuc Med Divisions, all Imaging Types (except Vascular Lab), and all Primary Interpreting Staff Physicians.

After the installation of patch RA*5*99, there should be an automatically scheduled task that runs on the 15th of each month. For the following months, the previous quarter's Summary Report will be generated: January, April, July, and October. For all other months, no report will be generated.

The quarters are calendar quarters (i.e., Jan, Feb, Mar = 1st quarter).²³² See *Technical Manual* section entitled "Schedule Perf. Indic. Summary for Fifteenth of Month Following the Quarter End."

MONTH THAT SCHEDULED TASK IS RUN	REPORT DATA RANGE	QUARTER
On or before January 15 th	October, November, December	4
On or before April 15 th	January, February, March	1
On or before July 15 th	April, May, June	2
On or before October 15 th	July, September, September	3

For this option, the following will be included on the Outlook email report:

- The "Summary Radiology Outpatient Procedure Wait Time Report" ²³³

²²⁶ Patch RA*5*37 June 2003: Added Performance Indicator; Renamed to Timeliness Reports, April 2006 RA*5*67.

²²⁷ Patch RA*5*67 April 2006: Renamed Performance Indicator Report to Verification Timeliness Report
²²⁸ Patch RA*5*99 February 2010: Changed option: 'Run Previous Month's Summary Report' to 'Run Previous Quarter's Summary Report.'

²²⁹ Patch RA*5*44 January 2004: Added new option, Run Previous Month's Summary Report, with example.

²³⁰ Patch RA*5*99 February 2010: Moved the 'Run Previous Quarter's Summary Report' option from the 'Verification Timeliness' option.

²³¹ Patch RA*5*99 February 2010: Changed the reporting period from monthly to quarterly.

²³² Patch RA*5*99 February 2010: Updated the report distribution to on or before the 15th of the month following the preceding calendar quarter-end.

²³³ Patch RA*5*99 February 2010: Inserted the "Summary Radiology Outpatient Procedure Wait Time Report" in the automated Outlook email.

Order Entry

- The “Summary Verification Timeliness Report”
- The two performance value calculations: “Report verification timeliness performance value” and “Wait Time Performance Values.” 234

Prompt/User Response

Discussion

```
Run Previous Quarter's235 Summary Report236

The Summary Report of Last Quarter's data will be sent to the
Outlook mail group(s) in File 79's PERF INDC SMTP E-MAIL ADDRESS

  VHARADIOLOGYREPORTS@HQ.MED.VA.GOV
  RAPROVIDER.ONE@VA.GOV
  RAPROVIDER.SEVEN@va.gov

Note: Patch RA*5*99 removed all references to "OQP Performance Management" 237

Enter date to start this Task

(time will be the same hh:mm as now.): (9/9/2009 - 10/10/2009): 09/10 (SEP 10, 2009)

Request queued: Radiology Timeliness Performance Reports238
to start on: Sep 10, 2009@12:01:22
Task#:13072
```

The report is shown below.

Gates, Water

From: GATES.WATER@WASHINGTON.MED.VA.GOV
[mailto: GATES.WATER@WASHINGTON.MED.VA.GOV](mailto:GATES.WATER@WASHINGTON.MED.VA.GOV)
Sent: Monday, September 14, 2009 12:56 PM
To: VHA Radiology Reports; VISN5RadiologyReports@MED.VA.GOV
Subject: Radiology Timeliness Performance Reports

234 Patch RA*5*99 February 2010: Inserted two performance summary values in the automated Outlook email.

235Patch RA*5*99 February 2010: Changed the reporting period from monthly to quarterly.

236 Patch RA*5*99 February 2010: For this option, deleted all references to OQP.

237Patch RA*5*63 October 2005: New example shows new prompts and help messages. **Note:** Patch 99 removed all references to “OQP Performance Management,” therefore, removing Patch 63’s new prompts and help messages.

238 Patch RA*5*99 February 2010: Changed ‘Radiology Verification Timeliness Report’ request name to ‘Radiology Timeliness Performance Reports.’

```

Facility: SUPPORT ISC          Station: 688          VISN: VISN 5
Division: HINESTEST, SUPPORT ISC
Exam Date Range: 1/1/09-3/31/09
Run Date/Time: 6/26/09 10:47 am

PERFORMANCE VALUE SUMMARY239
-----
15.4% - Report verification timeliness performance value

Wait Time performance values:

%          %
<=14 240  <=30          PROCEDURE
Days  Days          TYPE
-----
  0.0  0.0          CARDIAC STRESS TEST
100.0  0.0          COMPUTED TOMOGRAPHY
100.0  0.0          GENERAL RADIOLOGY
100.0 100.0          INTERVENTIONAL PROCEDURE
  0.0  0.0          MAGNETIC RESONANCE IMAGING
100.0  0.0          MAMMOGRAPHY
  0.0  0.0          NUCLEAR MEDICINE
100.0  0.0          OTHER
  0.0  0.0          ULTRASOUND
  0.0  0.0          "unknown"

                Summary Verification Timeliness Report          Page: 1

Facility: SUPPORT ISC          Station: 499          VISN: 12
Division: HINESTEST, SUPPORT ISC
Exam Date Range: 1/1/09-3/31/09
Run Date/Time: 6/26/09 10:47 am

Total number of reports expected for procedures performed during specified
date range: 117

Hrs   >0   >24   >48   >72   >96   >120  >144  >168  >192  >216  >240  PENDING
From  -24   -48   -72   -96   -120  -144  -168  -192  -216  -240  Hrs
Ex Dt Hrs   Hrs   Hrs   Hrs   Hrs   Hrs   Hrs   Hrs   Hrs   Hrs   Hrs

#Tr   20    3    0    0    2    1    1    0    1    0    2    87
%Tr  17.1   2.6   0.0   0.0   1.7   0.9   0.9   0.0   0.9   0.0   1.7   74.4

#Vr   17    1    1    0    0    1    0    0    0    0    1    96
%Vr  14.5   0.9   0.9   0.0   0.0   0.9   0.0   0.0   0.0   0.0   0.9   82.1

* Columns represent # of hours elapsed from exam date/time through
date/time report entered or date/time report was verified.
e.g. ">0-24 Hrs" column represents those exams that had a report
transcribed and/or verified within 0-24 hours from the exam date/time.

* Columns following the initial elapsed time column (0-24 Hrs) begin
at .0001 after the starting hour (e.g. ">24-48 Hrs" = starts at 24.001
through the 48th hour.)

* PENDING means there's no data for DATE REPORT ENTERED or VERIFIED DATE.
So, if the expected report is missing one of these fields, or is missing
data for fields .01 through 17 from file #74, RAD/NUC MED REPORTS, or
is a Stub Report that was entered by the Imaging package when images
were captured before a report was entered, then the expected report
would be counted in the PENDING column.

```

239Patch RA*5*99 February 2010: Insterted two performance summary values in the automated Outlook email.

240 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column for extra calculations.

Order Entry

* A printset, i.e., a set of multiple exams that share the same report, will be expected to have 1 report.

* Cancelled and "No Credit" cases are excluded from this report.

Summary Radiology Outpatient Procedure Wait Time Report241 Page: 1

Facility: HINES DEVELOPMENT Station: 499 VISN: 12
 Division(s): HINESTEST, SUPPORT ISC
 Exam Date Range: 1/1/09-3/31/09
 PROCEDURE TYPES: All, except RADIATION THERAPY
 Run Date/Time: 6/26/09 10:47 am

Total number of procedures registered during specified exam date range: 27

DAYS WAIT -- PERCENTAGES

PROCEDURE TYPE	<=14 Days	242	<=30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days
CARDIAC STRESS TEST	0.0		0.0	0.0	0.0	0.0	0.0
COMPUTED TOMOGRAPHY	100.0		0.0	0.0	0.0	0.0	0.0
GENERAL RADIOLOGY	100.0		0.0	0.0	0.0	0.0	0.0
INTERVENTIONAL PROCEDURE	100.0		0.0	0.0	0.0	0.0	0.0
MAGNETIC RESONANCE IMAGING	0.0		0.0	0.0	0.0	0.0	0.0
MAMMOGRAPHY	100.0		0.0	0.0	0.0	0.0	0.0
NUCLEAR MEDICINE	0.0		0.0	0.0	0.0	0.0	0.0
OTHER	100.0		0.0	0.0	0.0	0.0	0.0
ULTRASOUND	0.0		0.0	0.0	0.0	0.0	0.0

DAYS WAIT -- COUNTS

PROCEDURE TYPE	<=14 Days	243	<=30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days	TOTAL	ROW	Avg. Days
CARDIAC STRESS TEST	0		0	0	0	0	0	-		
COMPUTED TOMOGRAPHY	1		0	0	0	0	0	0		
GENERAL RADIOLOGY	20		0	0	0	0	0	20		-
INTERVENTIONAL PROCEDURE	3		0	0	0	0	0	3		0
MAGNETIC RESONANCE IMAGING	0		0	0	0	0	0	0		-
MAMMOGRAPHY	2		0	0	0	0	0	2		0
NUCLEAR MEDICINE	0		0	0	0	0	0	0		-
OTHER	1		0	0	0	0	0	1		0
ULTRASOUND	0		0	0	0	0	0	0		-

The "<=14 Days" column contains data that is also in the "<=30 Days" column. The reason that performance is calculated for both <=14 days and <=30 days is so that facilities can track their performance to a 14 day performance standard rather than a 30 day standard if they choose to do so.244

Number of procedures cancelled and re-ordered on the same day = 0

(There are 2 cases with negative days wait included in the first column.)

1. Cancelled, "No Credit", inpatient cases, and not the highest modality of a printset are excluded from this report. (See 3. below.)

2. Columns represent # of days wait from the Registered date (the date/time entered at the "Imaging Exam Date/Time:" prompt) backwards to the Date Desired for the ordered procedure. The calculation is based on the number of different days and not rounded off by hours. The "31-60" column represents those orders that were registered 31 days or more but less than 61 days after the Date Desired.

241 Patch RA*5*99 February 2010: Inserted the "Summary Radiology Outpatient Procedure Wait Time Report" in the automated Outlook email.

242 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column .

243 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column

244 Patch RA*5*99 February 2010: Explanation of the "<=14 Days" reporting interval column .

3. If the user did not select a specific CPT Code or Procedure Name, then the cases from a printset (group of cases that share the same report) will have only the case with the highest modality printed. The modalities have this hierarchical order, where (1) is the highest: 1) Interventional, (2) MRI, (3) CT, (4) Cardiac Stress test, (5) Nuc Med, (6) US, (7) Mammo, (8) General Rad (9) Other

4. "Procedure Types" are assigned by a national CPT code look-up table and may differ from locally defined "Imaging Types." Therefore the number of procedures in each category may not be the same as other radiology management reports.

5. "Avg. Days" is the average days wait. It is calculated from the sum of the days wait for that Procedure Type, divided by the count of cases included in this report for that Procedure Type. Negative days wait is counted as 0. A "-" means an average cannot be calculated.

Personnel Workload Reports

Note: Two types of Personnel Workload Reports are available from this menu: wRVU/CPT-based reports, and AMIS-based reports. Workload credit is now calculated through Work Relative Value Units (wRVU) and CPT codes: AMIS has been discontinued as an official VACO reporting metric, though these reports are still available for sites that find them useful. 245

- Physician CPT Report by Imaging Type
- Physician wRVU Report by CPT
- Physician wRVU Report by Imaging Type
- Physician Report
- Radiopharmaceutical Administration Report
- Resident Report
- Staff Report
- Technologist Report
- Transcription Report

The first five Physician Reports are wRVU/CPT-based reports. They show which exams were ordered by which physicians, and can be classified by CPT code or by wRVU.

These five Physician Reports can be sorted by Imaging Type or by CPT code. In each of these reports, workload is assigned on the date the report is verified.

The remaining six reports are based on the now-obsolete AMIS workload credit calculation. Physician, Resident, and Staff reports show exams interpreted by various types of physicians. 246 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.

245Patch RA*5*64 July 2006: Added a **Note** regarding the wRVU/CPT and AMIS reports. Added five new wRVU/CPT-based Physician report types to the list of Personnel Workload Reports. Added report descriptions.

246 Patch RA*5*64 July 2006: Separated the AMIS-based reports from the wRVU/CPT-based reports, and updated the report descriptions.

Order Entry

All of the AMIS-based 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 these workload reports is described in the **General Information about AMIS-Based Workload Reports** section at the end of the Management Reports Menu chapter.

Physician CPT Report by Imaging Type 247

This report will generate the number of procedures within an imaging type that are performed by a specific physician within a user-defined time frame. In this report, workload is assigned on the date the report is verified, not on the date the report is registered or dictated.

The user is asked to select a physician or number of physicians. The user is then asked to select the time frame to tabulate totals for non-cancelled exams with verified reports. The user may select a date range of up to one year. Once the physicians and date range have been selected, the user is asked to select a device to display the results of the report.

The total number of procedures per physician, per imaging type by physician, for all imaging locations, and for all physicians are displayed on the report. The report data is sorted by physician name.

Prompt/User Response

Discussion

Physician CPT Report by Imaging Type	
Select Physician: All// RADPROVIDER* Another one (Select/De-Select): <RET>	
Calculate physician workload over a date range; enter a start date of: Jan 12, 2006// ? Workload is assigned on the date the report is verified, not the date the report is dictated. This is the date from which our search will begin. The starting date must not precede: Jan 01, 1911 and must not come after: Jun 19, 2006. Dates associated with a time will not be accepted. Calculate physician workload over a date range; enter a start date of: Jan 12, 2006// 011205 (JAN 12, 2005) Enter an end date of: Jan 12, 2006// <Ret> (JAN 12, 2006)	
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 report is shown on the next page. IMAGING PHYSICIAN WORKLOAD SUMMARY BY NUMBER OF CPT CODES	

247 Patch RA*5*64 July 2006: Added Physician CPT Report by Imaging Type description and example.

Run Date: Jan 12, 2006 Page: 1
 Facility: HINES DEVELOPMENT Date Range: JAN 12,2005 - JAN 12,2006

Physician	RAD	MRI	CT	US	NUC	VAS	ANI	CARD	MAM	Total
RADPROVIDER,ONE	1023	361	955	0	0	0	0	0	0	2339
RADPROVIDER,TWO	180	0	390	0	701	0	0	0	0	1271
PHYSICIAN TOTAL	1203	361	1345	0	701	0	0	0	0	3610

Physician wRVU Report by CPT 248

This report will generate the total number of procedures, wRVU per procedure, and the total wRVU for all procedures performed by a specific physician within a user-defined time frame. In this report, workload is assigned on the date the report is verified, not on the date the report is registered or dictated.

The user is asked to select a physician or number of physicians. The user is then asked to select the time frame to tabulate totals for non-cancelled exams with verified reports. The user may select a date range of up to one year.

Once the physicians and date range have been selected, the user is asked to select a device to display the results of the report.

The total number of wRVU per physician, per procedure by physician, and the total number of specific procedures per physician are displayed on the report. The report data is sorted by physician name.

248 Patch RA*5*64 July 2006: Added Physician wRVU Report by CPT description and example.

Order Entry

Prompt/User Response

Discussion

Physician wRVU Report by CPT	
Select Physician: All// RADPROVIDER* Another one (Select/De-Select): <RET>	
Calculate physician workload over a date range; enter a start date of: Jan 12, 2006// 010105 (JAN 01, 2005)	
Enter an end date of: Jan 01, 2006// <Ret> (JAN 01, 2006)	

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 PHYSICIAN UN-SCALED wRVU SUMMARY BY CPT					
Run Date: Jan 12, 2006		Page: 1			
Facility: HINES DEVELOPMENT		Date Range: JAN 1,2005 - JAN 1,2006			
Staff Physician	CPT Code	Procedure	Total # wRVU	Total of exams	wRVU
RADPROVIDER, SIX					
	76091	MAMMOGRAM BILAT	0.87	11	9.57
	76092	MAMMOGRAM SCREENING	0.70	7	4.90
	73600	ANKLE 2 VIEWS	0.16	3	0.48
	73620	FOOT 2 VIEWS	0.16	1	0.16
				-----	-----
	22	15.11			
RADPROVIDER, SEVEN					
	71020	CHEST 2 VIEWS PA&LAT	0.22	2	0.44
	71030	CHEST 4 VIEWS	0.31	4	1.24
	74000	ABDOMEN 1 VIEW	0.18	2	0.36
	74010	ABDOMEN 2 VIEWS	0.23	5	1.15
				-----	-----
	13	3.19			

Physician wRVU Report by Imaging Type 249

This report will generate the total wRVU within each imaging type that are performed by a specific physician within a user defined time frame. In this report, workload is assigned on the date the report is verified, not on the date the report is registered or dictated. Please note that this report is best suited for display on a 132 column device.

The user is asked to select a physician or number of physicians. The user is then asked to select the time frame to tabulate totals for non-cancelled exams with verified reports. The user may select a date range of up to one year. Once the physicians and date range have been selected, the user is asked to select a device to display the results of the report.

The total number of wRVU per physician, per imaging type by physician, for all imaging locations, and for all physicians are displayed on the report.

249 Patch RA*5*64 July 2006: Added Physician wRVU Report by Imaging Type description and example.

The report data is sorted by physician name.

Prompt/User Response

Discussion

Physician wRVU Report by Imaging Type	
Select Physician: All// RADPROVIDER* Another one (Select/De-Select): <RET>	
Calculate physician workload over a date range; enter a start date of: Feb 24, 2006// 010105 (JAN 01, 2005) Enter an end date of: Jan 01, 2006// 060105 (JUN 01, 2005)	
DEVICE: HOME// (Printer Name or "Q")	Enter name of a printer. If you enter "Q" instead of a printer name, you will see prompts for a device and a time to print.

IMAGING PHYSICIAN WORKLOAD SUMMARY BY PROFESSIONAL COMPONENT CMS RVU										
Run Date: Feb 24, 2006					Page: 1					
Facility: HINES DEVELOPMENT				Date Range: JAN 1,2005 - JUN 1,2005						
(un-scaled wRVU)										
Physician	RAD	MRI	CT	US	NUC	VAS	ANI	CARD	MAM	Total
RADPROVIDER,ONE	324	321	355	0	0	0	0	0	0	1000
RADPROVIDER,TWO	23	0	420	0	631	0	0	0	0	1074
PHYSICIAN TOTAL	347	321	775	0	631	0	0	0	0	2074

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 AMIS-Based 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>

Order Entry

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.: **RADPROVIDER,TWO**
 Another one (Select/De-Select): <RET>

This sample shows only a single requesting physician being selected.

**** 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:

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

Procedure (CPT)	Examinations			Percent Exams
	In	Out	Total	

Requesting M.D.: RADPROVIDER,TWO				
COLON BARIUM ENEMA (74270)	0	2	2	100.0

Requesting M.D. Total	0	2	2	

>>> 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

Requesting M.D.	Examinations			Percent Exams
	In	Out	Total	

(Imaging Type Summary)				
RADPROVIDER,TWO	0	2	2	100.0

Imaging Type Total	0	2	2	

of Requesting M.D.s selected: 1

Radiopharmaceutical Administration Report 250

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.

Prompt/User Response

Discussion

```
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// ? <RET>
```

```
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
```

250 Patch RA*5*47 September 2011: Radiopharmaceutical Administration Report option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

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 Procedure	Patient Name Who Adm'd	SSN	Radiopharm	Act.Drawn	Dose Adm'd	Low	High
072297-702@1528 CARDIOLOGY TEST	RADPATIENT,SIX RADPROVIDER,ONE	000-00-0036	PERCHLORACAP 25	7.0000	5.0000	0.0000	0.0000

>>> 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 Procedure	Patient Name Who Adm'd	SSN	Radiopharm	Act.Drawn	Dose Adm'd	Low	High
080697-709@1233 THYROID IMAGING	RADPATIENT,ONE RADPROVIDER,THRE	000-00-0039	SESTAMIBI TC-99	600.0000	600.0000	250.0000	500.0000
070997-700@0907 RADIONUCLIDE TH	RADPATIENT,FOU RADPROVIDER,SIX	000-00-0034	SULFUR COLLOID	0.0000	10.0000	10.0000	15.0000
070997-701@0932 RADIONUCLIDE TH	RADPATIENT,FIV RADPROVIDER,SIX	000-00-0035	SULFUR COLLOID	12.0000	12.0000	10.0000	15.0000
072597-703@1245 THYROID IMAGING	RADPATIENT,THR RADPROVIDER,SIX	000-00-0033	SODIUM PERTECHN	12.0000	12.0000	0.0000	15.0000
080797-718@0807 LUNG AEROSOL SC	RADPATIENT,TWO RADPROVIDER,FIVE	000-00-0032	Tc-99m DTPA	0.6000	0.6000	0.5000	1.5000
080797-719@0807 LUNG PERFUSION	RADPATIENT,TWO RADPROVIDER,FIVE	000-00-0032	Tc-99m MACROAGG	3.0000	3.0000	3.0000	6.0000
080797-721@0902 MYOCARDIAL PERF	RADPATIENT,TWO RADPROVIDER,FIVE	000-00-0032	SESTAMIBI TC-99	8.0000	8.0000	8.0000	10.0000

>>> 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 outside range	Total Drawn	Total Adm'd	No. cases	(%)	No.

RADPROVIDER,ONE	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 outside range	Total Drawn	Total Adm'd	No. cases	(%)	No.

RADPROVIDER,THREE	600.0000	600.0000	1	14.29	1
RADPROVIDER,SIX	24.0000	34.0000	3	42.86	
RADPROVIDER,FIVE	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 (%)	No. outside range	Total Drawn	Total Adm'd	No. cases	

RADPROVIDER,THREE	600.0000	600.0000	1	12.50	1
RADPROVIDER,SIX	24.0000	34.0000	3	37.50	
RADPROVIDER,FIVE	11.6000	11.6000	3	37.50	
RADPROVIDER,ONE	7.0000	5.0000	1	12.50	
HINES CIO FIELD OFFICE's Total number of unique cases: 8					
Note: 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.					

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 AMIS-Based Workload Reports**, for a full description of this report's options.

Order Entry

Prompt/User Response

Discussion

```

Interpreting Resident Workload Report:
-----
Do you wish only the summary report? NO// <RET>

Count Resident when entered as 'secondary' resident interpreter? Yes// ?

Answer 'Yes' if both Primary and Secondary Resident personnel will be included
in this report. Answer 'No' if only Primary Resident personnel will be
included in this report. Input a '^' to exit without a report.
Count Resident when entered as 'secondary' resident interpreter? Yes// <RET> YES
Select Rad/Nuc Med Division: All// HINES CIO FIELD OFFICE IL CIOFO 499
Another one (Select/De-Select): <RET>
Select Imaging Type: All// RAD GENERAL RADIOLOGY
Another one (Select/De-Select): <RET>

Do you wish to include all Interpreting Residents? Yes//
<RET> YES
    
```

In this example, all residents will be included.

```

**** Date Range Selection ****

Beginning DATE : T-100 (MAY 11, 1997)

Ending DATE : T (AUG 19, 1997)

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

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

GENERAL RADIOLOGY
-----
WAITING FOR EXAM
EXAMINED
COMPLETE

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

>>> 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

Procedure (CPT) Examinations Percent
In Out Total Exams
-----
Interpreting Resident: RADPROVIDER,SIX
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

Procedure (CPT) Examinations Percent
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		
Procedure (CPT)		Examinations		Percent	
		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		
Interpreting Resident		Examinations		Percent	
		In	Out	Total	Exams

(Imaging Type Summary)					
RADPROVIDER,SEVEN		1	3	4	2.9
RADPROVIDER,EIGHT		0	5	5	3.6
RADPROVIDER,ONE		0	3	3	2.2
RADPROVIDER,TWO		1	5	6	4.4
RADPROVIDER,EIGHT		0	7	7	5.1
RADPROVIDER,EIGHT		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					

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 staffs 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.

Order Entry

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 AMIS-Based Workload Reports**, starting on page 214, for a full description of this report's options.

Prompt/User Response

Discussion

```
Staff Report
Do you want to count CPT Modifiers separately? No//? 251

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// ? <RET>

Answer 'Yes' if both Primary and Secondary Staff personnel will be included
in this report. Answer 'No' if only Primary Staff personnel will be
included in this report. Input a '^' to exit without a report.

Count Staff when entered as 'secondary' staff interpreter? Yes// NO

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

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

Select Imaging Type: All// NUCLEAR MEDICINE

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

Do you wish to include all Primary Interpreting Staff? Yes// <RET> YES

**** Date Range Selection ****

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

Ending DATE : T (AUG 19, 1997)

The entries printed for this report will be based only
on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit: <RET>

      NUCLEAR MEDICINE
      -----
      WAITING FOR EXAM
      EXAMINED
      TRANSCRIBED
      COMPLETE

DEVICE: HOME// (Enter a device at this prompt)
>>> Interpreting Staff Workload Report <<<
      Division: HINES CIO FIELD OFFICE
```

Page: 1

251 Patch RA*5*26 July 2001: Allows printing of different combinations of CPT modifiers on separate lines.

Imaging Type: NUCLEAR MEDICINE		For period: MAY 21,1997 to			
Run Date: AUG 19,1997 12:02		AUG 19,1997			
Procedure (CPT)	Examinations			Percent Exams	
	In	Out	Total		

Interpreting Staff: RADPROVIDER, SEVEN					
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			
Procedure (CPT)	Examinations			Percent Exams	
	In	Out	Total		

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			
Interpreting Staff	Examinations			Percent Exams	
	In	Out	Total		

(Imaging Type Summary)					
RADPROVIDER, SEVEN	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					

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**

Order Entry

about **AMIS-Based Workload Reports**, starting on page 214, for a full description of this report's options.

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

Procedure (CPT)                Examinations   Percent   Percent
                                In    Out  Total   Exams  WWU   WWU
-----
Technologist: RADPROVIDER,ONE
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

Run Date: MAR 1,1995 10:07

For period: NOV 21,1994 to

MAR 1,1995

Technologist	Examinations			Percent		Percent
	In	Out	Total	Exams	WWU	WWU
(Imaging Type Summary)						
RADPROVIDER, SIX	4	11	15	17.9	66	15.6
RADPROVIDER, NINE	13	14	27	32.1	148	35.1
RADPROVIDER, ONE	1	7	8	9.5	22	5.2
RADPROVIDER, TWO	2	1	3	3.6	11	2.6
RADPROVIDER, THREE	0	3	3	3.6	21	5.0
RADPROVIDER, FOUR	0	2	2	2.4	4	0.9
RADPROVIDER, FIVE	0	1	1	1.2	3	0.7
RADPROVIDER, SIX	3	1	4	4.8	26	6.2
RADPROVIDER, SEVEN	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

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 AMIS-Based Workload Reports**, starting on page 214, for a full description of this report's options.

Prompt/User Response

Discussion

Transcription Report

>>> IMAGING TRANSCRIPTIONIST WORKLOAD REPORT <<<

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

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

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

Order Entry

**** 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 REPORTS	NUMBER OF LINES	NUMBER OF
=====		
RADPROVIDER, EIGHT	76	38
RADPROVIDER, NINE	2	1
RADPROVIDER, TEN	25	9
RADPROVIDER, ONE	2	1
RADPROVIDER, TWO	56	14
RADPROVIDER, THREE	39	14

9. Special Reports

- AMIS Code Dump by Patient
- AMIS Report
- Camera/Equip/Rm Report
- Cost Distribution Report
- Detailed Procedure Report
- Film Usage Report
- Procedure wRVU/CPT Report
- Procedure/CPT Statistics Report
- Radiation Dose Summary Report
- Status Time Report
- Wasted Film Report

Note: Several reports in this section use AMIS calculation methods. AMIS has been discontinued as an official reporting metric, though these reports are still available for sites that find them useful. Workload credit is now determined by Work Relative Value Units (wRVU) and CPT codes: please see the Procedure Report sections for more information. 252

AMIS Code Dump by Patient

Note: AMIS is no longer used to calculate VA workload credits and productivity; please use the Procedure Reports, later in this section, to run reports based on wRVU and CPT codes. The AMIS Code Dump report is still available but should not be used to calculate workload. 253

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 are 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

252 Patch RA*5*64 July 2006: Updated the AMIS note to redirect users to the wRVU and CPT report options.

253 Patch RA*5*64 July 2006: Added **Note** to redirect users to the wRVU and CPT Procedure reports section.

Order Entry

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 <<<<< Patient List for AMIS Category 5 - ABDOMEN-KUB	
Page: 1	

Order Entry

Run Date: MAR 1,1995 10:58	MAR 1,1995	For Period: NOV 21,1994 to		
Division: HINES CIO FIELD OFFICE				
# of Procedures Selected: All				
Patient Name	Pt ID	Procedure	Exam Date	Ward/Clinic
-----	-----	-----	-----	-----
RADPATIENT,FOUR	000-00-0044	ABDOMEN 2 VIEWS	NOV 28,1994 13:46	EMERGENCY ROOM
RADPATIENT,FIVE	000-00-0045	ABDOMEN 1 VIEW	DEC 2,1994 15:05	EMERGENCY ROOM
RADPATIENT,SIX	000-00-0046	ABDOMEN 1 VIEW	DEC 8,1994 10:22	X-RAY STOP
RADPATIENT,SEVEN	000-00-0047	ABDOMEN 1 VIEW	JAN 12,1995 09:40	X-RAY STOP
RADPATIENT,EIGHT	000-00-0048	+ABDOMEN 1 VIEW	JAN 23,1995 15:23	EMERGENCY ROOM
RADPATIENT,FOUR	000-00-0004	ABDOMEN 1 VIEW	FEB 13,1995 12:41	1N
RADPATIENT,NINE	000-00-0049	ABDOMEN 1 VIEW	FEB 22,1995 15:34	GENERAL MEDICINE
Total=8 Inpatient=1 Outpatient=7				
+ counts as multiple exams				
- counts as zero exams				

AMIS Report

Note: AMIS is no longer used to calculate VA workload credits and productivity; please use the Procedure Reports, later in this section, to run reports based on wRVU and CPT codes. This AMIS Report is still available but should not be used to calculate workload. 254

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

254 Patch RA*5*64 July 2006: Added **Note** to redirect users to the wRVU and CPT Procedure reports section.

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.

Order Entry

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:
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	Examinations		Weighted Work Units				IN	OUT	TOTAL
	Weight	IN	OUT	TOTAL	%				
1 SKULL, INC. SINUS, MASTOID, JAW, ETC	3	11	33	44	18.3	33	99	132	
2 CHEST-SINGLE VIEW	1	3	7	10	4.1	3	7	10	
3 CHEST MULTIPLE VIEW	2	3	9	12	5.0	6	18	24	
4 CARDIAC SERIES	3	0	0	0	0.0	0	0	0	
5 ABDOMEN-KUB	2	1	7	8	3.3	2	14	16	
6 OBSTRUCTIVE SERIES	3	0	1	1	0.4	0	3	3	
7 SKELETAL-SPINE & SACROILIAC	3	2	10	12	5.0	6	30	36	
8 SKELETAL-BONE & JOINTS	2	0	55	55	22.8	0	110	110	
9 GASTROINTESTINAL	6	2	1	3	1.2	12	6	18	
10 GENITOURINARY	6	0	0	0	0.0	0	0	0	
11 CHOLECYSTOGRAM, ORAL	5	0	1	1	0.4	0	5	5	
12 CHOLANGIOGRAM	10	0	5	5	2.1	0	50	50	
13 LAMINOGRAM	5	0	0	0	0.0	0	0	0	
14 BRONCHOGRAM	5	0	0	0	0.0	0	0	0	
15 DIGITAL SUBTRACTION ANGIOGRAPHY	15	0	0	0	0.0	0	0	0	
16 ANGIOGRAM, CATH- CEREBRAL	15	3	8	11	4.6	45	120	165	
17 ANGIOGRAM, CATH- VISCERAL	20	0	6	6	2.5	0	120	120	
18 ANGIOGRAM, CATH- PERIPHERAL	10	0	0	0	0.0	0	0	0	
19 VENOGRAM	15	0	0	0	0.0	0	0	0	

Order Entry

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									

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 AMIS-Based Workload Reports**, starting on page 214, for a full description of this report's options.

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: 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 JUL 29,1997
 Run Date: JUL 29,1997 15:10

Procedure (CPT)	Examinations			Percent	
	In	Out	Total	Exams	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

>>> Camera/Equip/Room Workload Report <<< Page: 4

Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY For period: APR 20,1997 to JUL 29,1997
 Run Date: JUL 29,1997 15:10

Procedure (CPT)	Examinations			Percent	
	In	Out	Total	Exams	WWU
Camera/Equip/Room: PORTABLE - PORTABLE					
CHEST 4 VIEWS (71030)	0	2	2	5.1	4 2.3
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
CHOLANGIOGRAM IV (74310)	0	1	1	2.6	10 5.7

Order Entry

>>> Camera/Equip/Room Workload Report <<<

Page: 9

Division: HINES CIO FIELD OFFICE

Imaging Type: GENERAL RADIOLOGY

Run Date: JUL 29,1997 15:10

For period: APR 20,1997 to
JUL 29,1997

Camera/Equip/Room	Examinations			Percent		
	In	Out	Total	Exams	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

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.

Special Reports - Cost Distribution Report

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>	

Order Entry

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			

Detailed Procedure Report

Note: AMIS is no longer used to calculate VA workload credits and productivity; please use the Procedure Reports, later in this section, to run reports based on wRVU and CPT codes. The Detailed Procedure Report is still available but should not be used to calculate workload. 255

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a report entitled Detailed Procedure Workload Report.

255 Patch RA*5*64 July 2006: Added **Note** to redirect users to the wRVU and CPT Procedure reports section.

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.

Order Entry

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.																																															
<p>**** Date Range Selection ****</p> <p>Beginning DATE : T-100 (NOV 21, 1994)</p> <p>Ending DATE : T (MAR 01, 1995)</p>																																																
<p>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:</p> <p>GENERAL RADIOLOGY ----- WAITING FOR EXAM EXAMINED COMPLETE</p>																																																
DEVICE: (Printer Name or "Q")	Enter the name of a printer, or "Q" to see prompts for a device and a time to print.																																															
<p>>>>> Detailed Procedure Workload Report <<<<< Page: 1</p> <p>Division: HINES INFORMATION SYSTEMS CTR</p> <p>Imaging Type: GENERAL RADIOLOGY For period: NOV 21,1994 to Run Date: MAR 1,1995 11:01 MAR 1,1995</p> <table border="1"> <thead> <tr> <th rowspan="2">Procedure</th> <th colspan="3">Examinations</th> <th colspan="2">Percent</th> </tr> <tr> <th>In</th> <th>Out</th> <th>Total</th> <th>Exams</th> <th>WWU</th> </tr> </thead> <tbody> <tr> <td colspan="6">-----</td> </tr> <tr> <td>Amis: 1 SKULL, INC.SINUS,MASTOID,JAW,ETC</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>BONE SURV COMP (INCL APPENDIC</td> <td>0</td> <td>1</td> <td>1</td> <td>1.9</td> <td>3 1.9</td> </tr> <tr> <td>NECK SOFT TISSUE</td> <td>4</td> <td>24</td> <td>28</td> <td>51.9</td> <td>84 51.9</td> </tr> <tr> <td>SKULL 4 OR MORE VIEWS</td> <td>7</td> <td>18</td> <td>25</td> <td>46.3</td> <td>75 46.3</td> </tr> <tr> <td>AMIS CATEGORY TOTALS</td> <td>11</td> <td>43</td> <td>54</td> <td></td> <td>162</td> </tr> </tbody> </table> <p>>>>> Detailed Procedure Workload Report <<<<< Page: 18</p>		Procedure	Examinations			Percent		In	Out	Total	Exams	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
Procedure	Examinations			Percent																																												
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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			
Amis Category	Examinations		Percent		Percent	
	In	Out	Total	Exams	WWU	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

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.

Order Entry

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

The whole panel must come off. Rear door sill must be removed, 2 screws for rear panel there, seat belt bolt must be removed. Also, rear hatch trim must be removed, 2 more screws for rear panel, and the knob in the middle of the panel must be unscrewed. I removed the panel and put dynamat, wow what a difference! Also, sound proofed where the spare tire goes, much better!

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 OFFICE
 Imaging Type: GENERAL RADIOLOGY
 Run Date: MAR 1,1995 11:02

For period: NOV 21,1994 to
 MAR 1,1995

Procedure (CPT)	Number of Films	Number of Exams	Films per Exam	Percentage Films 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
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 OFFICE
 Imaging Type: GENERAL RADIOLOGY
 Run Date: MAR 1,1995 11:02

For period: NOV 21,1994 to
 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
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

Order Entry

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

Procedure wRVU/CPT Report 256

This report generates Work Relative Value Unit (wRVU) statistics for detailed and series procedure(s) selected by the user. The wRVU accompanies a CPT code to provide a weighted value to measure the provider's time, complexity, and expertise required to perform a medical service.

Please note that this report returns a list of procedures and the wRVU associated with those procedures: it does not contain any physician information. Use the Physician wRVU/CPT reports, starting on page 171, to view physician workload statistics.

The user is asked to select a procedure or number of procedures, then to select a device to display the results of the report. The name of the procedure, procedure type, imaging type, CPT Code, and wRVU values are displayed on the report.

The report data is sorted by procedure name.

Prompt/User Response

Discussion

Procedure wRVU/CPT Report																																				
Select Procedures: All// CARDIAC CATH* Another one (Select/De-Select): <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.																																			
PROCEDURE CPT CODE AND WORK RELATIVE VALUE UNITS (wRVU) Run Date: Feb 22, 2006 Page: 1																																				
<table border="1"> <thead> <tr> <th>Procedure</th> <th>Proc Type</th> <th>Img Type</th> <th>CPT Code</th> <th>wRVU</th> </tr> </thead> <tbody> <tr><td>CARDIAC CATH LEFT SIDE CP</td><td>Detailed</td><td>RAD</td><td>75524</td><td>0.00</td></tr> <tr><td>CARDIAC CATH LEFT SIDE S&I</td><td>Detailed</td><td>RAD</td><td>75523</td><td>0.00</td></tr> <tr><td>CARDIAC CATH RIGHT SIDE CP</td><td>Detailed</td><td>RAD</td><td>75520</td><td>0.00</td></tr> <tr><td>CARDIAC CATH RIGHT SIDE S&I</td><td>Detailed</td><td>RAD</td><td>75519</td><td>0.00</td></tr> <tr><td>CARDIAC CATH SELECT BOTH SIDES CP</td><td>Detailed</td><td>RAD</td><td>75528</td><td>0.00</td></tr> <tr><td>CARDIAC CATH SELECT BOTH SIDES S&I</td><td>Detailed</td><td>RAD</td><td>75527</td><td>0.00</td></tr> </tbody> </table>	Procedure	Proc Type	Img Type	CPT Code	wRVU	CARDIAC CATH LEFT SIDE CP	Detailed	RAD	75524	0.00	CARDIAC CATH LEFT SIDE S&I	Detailed	RAD	75523	0.00	CARDIAC CATH RIGHT SIDE CP	Detailed	RAD	75520	0.00	CARDIAC CATH RIGHT SIDE S&I	Detailed	RAD	75519	0.00	CARDIAC CATH SELECT BOTH SIDES CP	Detailed	RAD	75528	0.00	CARDIAC CATH SELECT BOTH SIDES S&I	Detailed	RAD	75527	0.00	
Procedure	Proc Type	Img Type	CPT Code	wRVU																																
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CARDIAC CATH SELECT BOTH SIDES S&I	Detailed	RAD	75527	0.00																																

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 procedure modifiers or AMIS

256 Patch RA*5*64 July 2006: Added Procedure wRVU/CPT Report description and example.

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 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	
Do you want to count CPT Modifiers separately? NO// <RET> 257	
Select Rad/Nuc Med Division: All// HINES CIO FIELD OFFICE IL CIOFO 499	
Another one (Select/De-Select): <RET>	

257 Patch RA*5*26 July 2001: Allows printing of different combinations of CPT modifiers on separate lines.

Order Entry

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.																																																																
>>>> PROCEDURE/CPT STATISTICS REPORT (INPATIENT) <<<<< Page: 1																																																																	
Division: HINES CIO FIELD OFFICE Imaging Type: GENERAL RADIOLOGY Run Date: JUL 31,1997 15:12 # of Procedures selected: All																																																																	
For period: 04/22/97 to 07/31/97 Cancelled Exams: included																																																																	
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">CPT</th> <th style="text-align: left;">PROCEDURE</th> <th style="text-align: right;">#</th> <th style="text-align: right;">DONE</th> <th style="text-align: right;">(%)</th> <th style="text-align: right;">\$UNIT</th> <th style="text-align: right;">\$TOTAL</th> <th style="text-align: right;">(%)</th> </tr> </thead> <tbody> <tr> <td>71015</td> <td>CHEST STEREO PA</td> <td style="text-align: right;">2</td> <td></td> <td style="text-align: right;">20</td> <td style="text-align: right;">10.00</td> <td style="text-align: right;">20.00</td> <td style="text-align: right;">6</td> </tr> <tr> <td>71022</td> <td>CHEST OBLIQUE PROJECTIONS</td> <td style="text-align: right;">1</td> <td></td> <td style="text-align: right;">10</td> <td style="text-align: right;">20.00</td> <td style="text-align: right;">20.00</td> <td style="text-align: right;">6</td> </tr> <tr> <td>74000</td> <td>ABDOMEN 1 VIEW</td> <td style="text-align: right;">3</td> <td></td> <td style="text-align: right;">30</td> <td style="text-align: right;">10.00</td> <td style="text-align: right;">30.00</td> <td style="text-align: right;">9</td> </tr> <tr> <td>74249</td> <td>UPPER GI AIR CONT W/SMALL BOWEL</td> <td style="text-align: right;">1</td> <td></td> <td style="text-align: right;">10</td> <td style="text-align: right;">40.00</td> <td style="text-align: right;">40.00</td> <td style="text-align: right;">12</td> </tr> <tr> <td>75660</td> <td>ANGIO CAROTID CEREBRAL SELECT EXT UNIL</td> <td style="text-align: right;">2</td> <td></td> <td style="text-align: right;">20</td> <td style="text-align: right;">90.00</td> <td style="text-align: right;">180.00</td> <td style="text-align: right;">52</td> </tr> <tr> <td>76091</td> <td>MAMMOGRAM BILAT</td> <td style="text-align: right;">1</td> <td></td> <td style="text-align: right;">10</td> <td style="text-align: right;">50.00</td> <td style="text-align: right;">50.00</td> <td style="text-align: right;">15</td> </tr> <tr> <td colspan="2" style="text-align: right;">Total for this imaging type --></td> <td style="text-align: right;">10</td> <td></td> <td></td> <td></td> <td style="text-align: right;">340.00</td> <td></td> </tr> </tbody> </table>		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	
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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																																																											

Radiation Dose Summary Report

The Radiation Dose Summary Report menu option shall provide three report formats to choose from before selecting the filter criteria and running the report. Before selecting the exam date range and filter criteria, the user shall be able to choose from one of three new report formats:

- CT Totals(Only) – a summary CT dose report
- CT by Series – a detailed CT dose report.
- Fluoro – a summary Fluoroscopy dose report

The Radiation Dose Summary Report menu option provides filter criteria to choose from before running the report. After selecting the type of report and date range, the user shall be prompted to select one of the following filter criteria that will determine which exams with dose data are displayed:

- Filter by a single radiologist or all radiologists
- Note:** The radiologist is the Primary Interpreting Staff
- Filter by a single CPT Code, many CPT codes, or all CPT codes
 - Filter by a single, many patients, or all patients

No Radiology-specific keys shall be required to access this menu. Intended users should be assigned the Rad/Nuc Med Total System Menu if they do not already have it.

The intended users of this option include Radiology Safety Officers, Nurse Practitioners, Radiologists, Radiology, Technologists, and Medical Physicists.

Example: Display a CT Detailed report by patient name.

```

Select Special Reports <TEST ACCOUNT> Option: Radiation Dose Summary Report

  Select one of the following:

      F      Fluoroscopy
      D      CT Detailed
      S      CT Summary
Enter a report format:
Enter the format of the report: 'F' for a Fluoroscopy summary report
'D' for a detailed Cat Scan (CT) report or 'S' for a CT summary report.

Enter '^' to exit.

  Select one of the following:

      F      Fluoroscopy
      D      CT Detailed
      S      CT Summary
Enter a report format:
This is a required response. Enter '^' to exit

  Select one of the following:

      F      Fluoroscopy
      D      CT Detailed
      S      CT Summary
Enter a report format: CT DE CT Detailed

**** Date Range Selection ****

  Beginning DATE : 6/1/2011 (JUN 01, 2011)

  Ending   DATE : 8/31/2011 (AUG 31, 2011)
  Select one of the following:
      C      CPT Code
      P      Patient
      R      Radiologist
Enter a filter parameter: Patient
Select Rad/Nuc Med Patient: All// RADIOLOGY,IMA RADIOLOGY,IMA      12-25-56      6663
89467      LASTEMPORARYLONGNAME
  Enrollment Priority: GROUP 1      Category: IN PROCESS      End Date:

Another one (Select/De-Select):
DEVICE: HOME// ;132;999 Local SSH Device

Facility          : HINES DEVELOPMENT
Page: 1
Station           : 14100
Report Date Range : 06/01/11 - 08/31/11
Report Run Date/Time: 8/12/13 2:11 pm
=====

```

Order Entry

CT by Series Radiation Dose Summary Report by Patient

Patient gist	Dose Series	Highest		DLP CPT mGy-cm	Procedure Name	Radiolo
		CTDIvol SSN mGy	Date			
RADIOLOGY, IMA		9467	08/23/11	73500	HIP 1 VIEW	RADIOLO
GY, OUTSIDE SERVI	1		23.45	528.63		
RADIOLOGY, IMA		9467	08/23/11	73500	HIP 1 VIEW	RADIOLO
GY, OUTSIDE SERVI	2		345.89	123.76		
RADIOLOGY, IMA		9467	08/23/11	73500	HIP 1 VIEW	RADIOLO
GY, OUTSIDE SERVI	3		12345.09	23.01		
RADIOLOGY, IMA		9467	08/23/11	73500	HIP 1 VIEW	RADIOLO
GY, OUTSIDE SERVI	4		23456.09	12.78		
RADIOLOGY, IMA		9467	08/23/11	73500	HIP 1 VIEW	RADIOLO
GY, OUTSIDE SERVI	Total		36170.52	688.18		
RADIOLOGY, IMA		9467	08/23/11	73620	FOOT 2 VIEWS	RADIOL
OGY, STAFFER	1		45665.07	46464.45		
RADIOLOGY, IMA		9467	08/23/11	73620	FOOT 2 VIEWS	RADIOL
OGY, STAFFER	2		12345.01	345.33		
RADIOLOGY, IMA		9467	08/23/11	73620	FOOT 2 VIEWS	RADIOL
OGY, STAFFER	Total		58010.08	46809.78		

1. The purpose of this report is to facilitate tracking of procedure doses to identify opportunities for improvement. It is not intended to provide a complete record of patient dose. Doses resulting from plain films and radiopharmaceuticals are not supported.
2. Only procedures for which dose data has been received are listed. Data may be missing if the modality does not support DICOM structured dose reporting, if the dose report was not sent to Vista Imaging, if the radiology report was not verified, or if the procedure was performed before patches MAG*3*137 and RA*5*113 were installed.
3. Only the five highest dose CT series are listed. The total dose refers to the sum of all series and so may be larger than the sum of the five displayed doses.
4. If separate exposure instances during a CT examination were of different body parts, the total CTDIvol stated here may exceed the actual CTDIvol for any body part. More detailed dose information is available on the modality (until it is deleted) or in the DICOM Radiation Dose Structured Report (RDSR) file stored in Vista Imaging. Viewing the RDSR file is not yet supported.

Example: Display a CT Summary report by CPT Code.

Select Special Reports <TEST ACCOUNT> Option: Radiation Dose Summary Report

Select one of the following:

- F Fluoroscopy
- D CT Detailed
- S CT Summary

Enter a report format: S CT Summary

**** Date Range Selection ****

Beginning DATE : 8/1/2011 (AUG 01, 2011)
Ending DATE : 8/31/2011 (AUG 31, 2011)

Select one of the following:

- C CPT Code
- P Patient
- R Radiologist

Enter a filter parameter: CPT Code

Select Rad/Nuc Med Procedures: All// 73500 X-RAY EXAM OF HIP

HIP 1 VI

EW

(RAD Detailed) CPT:73500

Another one (Select/De-Select):

DEVICE: HOME// ;132;999 Local SSH Device

Facility : HINES DEVELOPMENT Page: 1
 Station : 14100
 Report Date Range : 08/01/11 - 08/31/11
 Report Run Date/Time: 8/12/13 2:19 pm

=====
 CT Totals (ONLY) Radiation Dose Summary Report by CPT Code
 Sum of Sum of

Patient	all CDTI	all DLP	Procedure Name	Radiologist
vol mGy mGy-cm	SSN Date	CPT		
RADIOLOGY, IMA	9467 08/23/11	73500	HIP 1 VIEW	
RADIOLOGY, OUTSIDE SERVICE	36170.52	688.18		

1. The purpose of this report is to facilitate tracking of procedure doses to identify opportunities for improvement. It is not intended to provide a complete record of patient dose. Doses resulting from plain films and radiopharmaceuticals are not supported.
2. Only procedures for which dose data has been received are listed. Data may be missing if the modality does not support DICOM structured dose reporting, if the dose report was not sent to VistA Imaging, if the radiology report was not verified, or if the procedure was performed before patches MAG*3*137 and RA*5*113 were installed.
4. If separate exposure instances during a CT examination were of different body parts, the total CTDIvol stated here may exceed the actual CTDIvol for any body part. More detailed dose information is available on the modality (until it is deleted) or in the DICOM Radiation Dose Structured Report (RDSR) file stored in VistA Imaging. Viewing the RDSR file is not yet supported.

Example: Display a Fluoroscopy report by Primary Interpreting Staff.

Select Special Reports <TEST ACCOUNT> Option: Radiation Dose Summary Report

Select one of the following:

- F Fluoroscopy
- D CT Detailed
- S CT Summary

Enter a report format: Fluoroscopy

**** Date Range Selection ****

Beginning DATE : 1/1/1999 (JAN 01, 1999)
 Ending DATE : 12/31/1999 (DEC 31, 1999)

Select one of the following:

- C CPT Code
- P Patient
- R Radiologist

Enter a filter parameter: Radiologist

Select Radiologist: All// PROVIDER, IMA D CRT

Another one (Select/De-Select):

DEVICE: HOME// ;132;399 Local SSH Device

DEVICE: HOME// ;132;3999 Local SSH Device

Order Entry

Facility : HINES DEVELOPMENT Page: 1
Station : 14100
Report Date Range : 01/01/99 - 12/31/99
Report Run Date/Time: 8/12/13 2:08 pm

=====

Fluoro Radiation Dose Summary Report by Radiologist

Patient	Air Kerma	Air Product	Time	Procedure Name	Radio
logist	SSN	Date	CPT		
	mGy	mGy-cm	min		
RADIOLOGY, PATIENT		2343	07/27/99	ULTRASOUND OF LIVER	PROVIDER, IMA D
667.07 3456.33	2.8				
RADIOLOGY, PATIENT		2343	07/30/99	AORTIC ULTRASOUND	PROVI
DER, IMA D	337.11	2345.87	2.6		
RADIOLOGY, PATIENT		2343	12/22/99	ANGIO CAROTID CEREBRAL UN	PROVI
DER, IMA D	234.56	12345.44	2.2		

1. The purpose of this report is to facilitate tracking of procedure doses to identify opportunities for improvement. It is not intended to provide a complete record of patient dose. Doses resulting from plain films and radiopharmaceuticals are not supported.
2. Only procedures for which dose data has been received are listed. Data may be missing if the modality does not support DICOM structured dose reporting, if the dose report was not sent to VistA Imaging, if the radiology report was not verified, or if the procedure was performed before patches MAG*3*137 and RA*5*113 were installed.
5. Air Kerma Area Product is also called the Dose Area Product. If fluoroscopy was performed using more than one projection, the total air kerma stated here may exceed the air kerma to any single projection.
1. The purpose of this report is to facilitate tracking of procedure doses to identify opportunities for improvement. It is not intended to provide a complete record of patient dose. Doses resulting from plain films and radiopharmaceuticals are not supported.
2. Only procedures for which dose data has been received are listed. Data may be missing if the modality does not support DICOM structured dose reporting, if the dose report was not sent to VistA Imaging, if the radiology report was not verified, or if the procedure was performed before patches MAG*3*137 and RA*5*113 were installed.
5. Air Kerma Area Product is also called the Dose Area Product. If fluoroscopy was performed using more than one projection, the total air kerma stated here may exceed the air kerma to any single projection.

Status Time Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a Status Tracking Statistics Report. 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. 258

258 Patch RA*5*20 May 2000: Enhancements to Status Time Report.

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// HINES CIO FIELD OFFICE IL CIOFO 499 Another one (Select/De-Select): <RET>	
Select all requesting locations? Y/N: N Select requesting location: X-RAY CLINIC Another one (Select/De-Select): <RET>	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). 259
Select IMAGING TYPE: GENERAL RADIOLOGY	You may only select one Imaging Type.
Select all procedures? Y/N: Y 260	Enter YES to obtain a report for all procedures. Enter NO to select one.
**** Date Range Selection **** Beginning DATE : 4/1/2000 (APR 01, 2000) Ending DATE : 4/30/2000 (APR 30, 2000) Do you wish to print detailed reports? No// <ret> 261	Enter the date range for the report.
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.
<p>The Procedure Detail by Requesting Location report reflects statistics sorted by requesting location, status changes, and procedures. 262 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.</p> <p style="text-align: center;">** Status Tracking Statistics Report ** Page: 11 Procedure Detail by Requesting Location (Only requesting locations with data are included)</p> <p>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</p>	

- 259 Patch RA*5*20 May 2000: Enhancements to Status Time Report.
- 260 Patch RA*5*20 May 2000: Enhancements to Status Time Report.
- 261 Patch RA*5*24 September 2000: New prompt added
- 262 Patch RA*5*20 May 2000: Enhancements to Status Time Report.

Order Entry

Procedure (CPT)	Minimum Time (DD:HH:MM)	Maximum Time (DD:HH:MM)	Average Time (DD:HH:MM)	Number of 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

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.

From: WAITING FOR EXAM To : COMPLETE		Minimum Time (DD:HH:MM)	Maximum Time (DD:HH:MM)	Average Time (DD:HH:MM)	Number of Procedures
From: WAITING FOR EXAM To : COMPLETE		00:00:02	15:01:38	03:18:57	4
From: WAITING FOR EXAM To : EXAMINED . . . skipped		01:00:05	01:00:05	01:00:05	1
From: CALLED FOR EXAM To : EXAMINED		00:00:16	00:00:16	00:00:16	1
From: WAITING FOR EXAM To : COMPLETE		00:00:00	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.

From: WAITING FOR EXAM To : COMPLETE		Minimum Time (DD:HH:MM)	Maximum Time (DD:HH:MM)	Average Time (DD:HH:MM)	Number of Procedures
From: WAITING FOR EXAM To : COMPLETE		00:00:02	15:01:38	03:18:57	4
From: WAITING FOR EXAM To : EXAMINED . . . skipped		01:00:05	01:00:05	01:00:05	1
From: CALLED FOR EXAM To : EXAMINED		00:00:16	00:00:16	00:00:16	1
From: WAITING FOR EXAM To : COMPLETE		00:00:00	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

Division: HINES CIO FIELD OFFICE	Imaging Type: GENERAL RADIOLOGY			
Requesting Location: ALL	Procedure: ALL			
From: WAITING FOR EXAM				
To : EXAMINED				
	Minimum Time (DD:HH:MM)	Maximum Time (DD:HH:MM)	Average Time (DD:HH:MM)	Number of Procedures
Procedure (CPT)	-----	-----	-----	-----
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 Time (DD:HH:MM)	Maximum Time (DD:HH:MM)	Average Time (DD:HH:MM)	Number of 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.

Wasted Film Report

Order Entry

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: $\text{number wasted} / (\text{number used} + \text{number wasted}) \times 100$.

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 OFFICE                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
                Films      Films      Film
Film Size -----
W-10X12                150      9        5.7

                Subtotals:                150      9        5.7
                -----
                * Cine data not included in totals.
    
```

General Information About AMIS-Based Workload Reports 263

Note: AMIS is no longer used to calculate VA workload credits and productivity; instead, please see the new wRVU/CPT-based reports, shown under the Personnel Workload Reports and Special Reports sections in this chapter. The AMIS-based reports are still available but should not be used to calculate workload.

263 Patch RA*5*64 July 2006: Changed section name to distinguish AMIS report options from wRVU/CPT options. Added **Note** to redirect users to the wRVU and CPT Procedure reports section. Updated entire section to reflect current functionality.

Order Entry

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...	PERSONNEL WORKLOAD REPORTS...
Clinic Report PTF Bedsection Report Service Report Sharing Agreement/Contract Report Ward Report	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 Guide*.
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.

Order Entry

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 file (#71.1)
Patient: RADPATIENT,SIX Procedure: -----> Modifiers: (none)	Procedure: Upper GI AMIS code data: AMIS Code: -----> AMIS Wt Multiplier: 2 Bilateral: (n/a) CT Head or Body: (n/a)	Code: 9 Weight: 6 Description: Gastrointestinal

In the above example, the calculation for WWUs would be: $6 \times 2 = 12$ 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.

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.

Special Reports - General Information About AMIS-Based 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.)

Order Entry

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.

10. 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.

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: RADPATIENT,TEN      10-27-45      000006023      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>

```

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

Order Entry

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

RADPATIENT, FIVE	000-00-0015	FEB 8, 1994
'OK' NEEDED:		
SOURCE : VA MEMORIAL HOSPITAL		
REMARKS : Several wrist views		

RADPATIENT, FIVE	000-00-0015	FEB 13, 1994
'OK' NEEDED:		
SOURCE : VA HOSPITAL		
REMARKS : ANKLE		

RADPATIENT, SIX	000-00-0016	FEB 14, 1994
'OK' NEEDED:		
SOURCE : VAMC HOSPITAL		
REMARKS : Chest X-Ray		

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

<pre> Edit Registry Select Patient: RADPATIENT,TWO 10-06-20 000-00-0042 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> </pre>	
--	--

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
<pre> Flag Film to Need 'OK' Before Return Select Patient: RADPATIENT,TEN 10-27-45 000-00-0410 NO NSC VETERAN Select OUTSIDE FILMS REGISTER DATE: MAR 31,1995// <RET> ASK FOR 'OK' BEFORE RETURNING?: Y YES </pre>	

Order Entry

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: RADPATIENT, TEN 10-27-45 000006023 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	

11. 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.

- Exam Profile with Radiation Dosage Data
- Detailed Request Display
- Display Patient Demographics
- Exam Profile (selected sort)
- Outside Films Profile
- Profile of Rad/Nuc Med Exams

Exam Profile with Radiation Dosage Data

The user will be able to run the Radiation Dose History Report for a single user-specified patient.

If the Radiation Dose History Report cannot be created for the selected patient, a message will be displayed in VistA to indicate that there are no radiology exams with dosage data on file for the selected patient. Completed studies associated with the following imaging types will be used to populate the Radiation Dose History Report for the selected patient:

- CT Scan
- General Radiology

If the patient has one or more radiation dose events a list will be displayed showing the accession no., exam date/time, procedure, CPT and primary interpreting staff information for that exam. You may then select one or more exams for display. A disclaimer will display for each study chosen by the user. The disclaimer outlines the business rules involved in capturing the radiation dosage data associated with this exam.

No Radiology-specific keys are required to access this menu. Intended users should be assigned the Patient Profile Menu if they don't already have it. The intended users of this option include Radiation Safety Officers, Radiologists, and Radiology Technologists.

The following is an example of the new Radiation Dose History Report:

Prompt/User Response

Discussion

Patient Profile With Radiation Dose Data		Page: 1	
Date: Jun 11, 2013@15:42			
Name	: RADPATIENT, IMA 0000	Category	: INPATIENT
Division	: SUPPORT ISC	Ward	: 1ASTEMPORARYLONGNAME
Location	: X-RAY CLINIC COUNT	Service	: MEDICINE
Exam Date	: AUG 23, 2011@11:15	Bedsection	: MEDICAL OBSERVATION
Case No.	: 141-082311-3436	Clinic	:

Order Entry

```
-----
Registered : HIP 1 VIEW (RAD Detailed) CPT:73500
Requesting Phy: RADIOLOGY,REQUEST Exam Status : COMPLETE
Int'g Resident: RADIOLOGY,RESIDENT Report Status: VERIFIED
Pre-Verified : No Cam/Equip/Rm : X-RAY2
Int'g Staff : RADIOLOGY,OUTSIDE Diagnosis : NORMAL
Technologist : RADIOLOGY,TECH Complication : NO COMPLICATION
-----
-----Modifiers-----
Modifiers : PORTABLE EXAM
          LEFT
CPT Modifiers : 23 UNUSUAL ANESTHESIA
-----
-----Medications-----
Med: DIGOXIN 0.25MG TAB Dose Adm'd: 2.5MG
Adm'd by: Date Adm'd:
-----
-----Rad Dose-----
Air Kerma (mGy) Air Kerma Area Product (Gy-cm2) Fluoro Time (min)
-----
23456.45 345.555 3.0
-----
-----Rad Dose-----
Irradiation Event CTDIvol DLP Target Region
(5 highest DLP) (mGy) (mGy-cm)
-----
1 23.45 528.63 Neck and chest
2 345.89 123.76 Neck, chest, abdomen and
3 12345.09 23.01 Neck, chest and abdomen
4 23456.09 12.78 Rib
Total Exam CTDIvol: 36170.52 mGy from all irradiation events.
Total Exam DLP: 688.18 mGy-cm from all irradiation events.
Total # irradiation events: 4

Patient Profile With Radiation Dose Data
Date: Jun 11, 2013@15:42 Page: 2
=====
Name: RADPATIENT,IMA 0000 Exam Date: AUG 23, 2011@11:15
Procedure: HIP 1 VIEW Case Number: 141-082311-3436
-----
-----Rad Dose-----
The purpose of this report is to facilitate tracking of procedure doses to identify opportunities
for improvement. It is not intended to provide a
complete record of patient dose. Doses resulting from plain films and radiopharmaceuticals are
not supported.

Only procedures for which dose data has been received are listed. Data may
be missing if the modality does not support DICOM structured dose reporting, if the dose report
was not sent to Vista Imaging, if the radiology report was not verified, or if the procedure was
performed before patches MAG*3*137 and RA*5*113 were installed.

Only the five highest dose CT series are listed. The total dose refers to the sum of all series
and so may be larger than the sum of the five displayed doses.

If separate exposure instances during a CT examination were of different body parts, the total
CTDIvol stated here may exceed the actual CTDIvol for any body part. More detailed dose
information is available on the modality (until it is deleted) or in the DICOM Radiation Dose
Structured Report (RDSR) file stored in Vista Imaging. Viewing the RDSR file is not yet
supported.

Air Kerma Area Product is also called the Dose Area Product. If fluoroscopy was performed using
more than one projection, the total air kerma stated here may exceed the air kerma to any single
projection.
-----
```

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, reason for study 264, 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, contrast media associations²⁶⁵, request status, requester, patient location and room-bed if available, who entered the request, desired date, transportation mode, isolation precautions, pregnancy information, 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 CPRS will not have a reason for cancellation because CPRS does not require users to enter a reason.

Since a substantial amount of time may pass from the time the order is placed to the time the order is registered, the 'Pregnant at time of order entry:' 266 field will display the pregnancy status at the time the order was placed, with the appropriate answer (Yes, No, Unknown).

Additionally, the 'Pregnancy Screen' field displays when the patient is female between the ages of 12 and 55. The responses are Yes, No, and Unknown. The 'Pregnancy Screen Comment' field displays only when the response to the 'Pregnancy Screen' prompt is 'Yes' or 'Unknown.' 267

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 it was registered via the 'Add Exams to Last Visit' [RA ADDEXAM] option, then a note will be displayed, showing the date of the last visit that was selected.²⁶⁸ For example:

**** Note:** Request Associated with Visit on Apr 30, 2001 12:00pm **

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

264 Patch RA*5*75 June 2007: Added Reason for Study to selection criteria.

265 Patch RA*5*45 May 2005: Detailed Request Display displays contrast media, if appropriate

266 Patch RA*5*99 February 2010: Replaced the 'Pregnancy Status' field with the 'Pregnant at time of order entry' field.

267 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

268 Patch RA*5*31 September 2002: If a procedure was registered via the 'Add Exams to Last Visit' [RA ADDEXAM] option, then a note will be displayed, showing the date of the last visit that was selected.

Order Entry

(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
This sample is a request for a parent procedure, displayed after descendents are registered. Detailed Request Display	
Select PATIENT NAME: RADPATIENT,ONE NO NSC VETERAN 06-0 5-66 000000001	PRIM. CARE: RADPROVIDER,NINE TEL 2222; 2221 ALT. PRIM. CARE: RADPROVIDER,TEN 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 RADPATIENT,ONE****	127 Requests
St Urgency Procedure Desired Requester Req'g Loc	
1 dc ROUTINE CHEST 2 VIEWS PA&LAT 06/24 RADPROVIDER,ONE 10CN	
2 dc ROUTINE CHEST 2 VIEWS PA&LAT 06/17 RADPROVIDER,TWO 10CN	
3 dc ROUTINE CHEST 2 VIEWS PA&LAT 06/13 RADPROVIDER,ONE 11D/MICU	
4 dc ROUTINE +CHEST CT 05/22 RADPROVIDER,ONE WOMEN VETER	
5 dc ROUTINE ECHOGRAM ABDOMEN COMPLETE 04/20 RADPROVIDER,ONE CAUSEWAY-IV	
6 ROUTINE +GALLIUM TUMOR 04/19 RADPROVIDER,ONE C ADULT DAY	
7 dc ROUTINE ORBIT MIN 4 VIEWS 03/31 RADPROVIDER,FOUR 8CR	
8 dc ROUTINE CHEST SINGLE VIEW 03/19 RADPROVIDER,TWO RADIOLOGY-I	
9 dc ROUTINE CHEST SINGLE VIEW 03/18 RADPROVIDER,TWO S SURGERY 1	
Select Request(s) 1-9 to Display or '^' to Exit: Continue// 6	
**** Detailed Display ****	
Name: RADPATIENT,ONE (000-00-0001) Date of Birth: JUN 5,1966	
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: RADPROVIDER,FOUR	
Tel/Page/Dig Page: 4444 / 444-4445 / 444-4446	
Patient Location: C ADULT DAY NEURO 52	
Entered: Apr 19, 1997 12:15 pm by MANEY,M. DR	
Pregnant at the time of order entry: YES269	
PREGNANCY SCREEN: Patient answered yes.270	
PREGNANCY SCREEN COMMENT: The patient is alert and oriented and is 9 weeks pregnant. Patient has shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to procedure.	
Desired Date: Apr 19, 1997	
Transport: AMBULATORY	
Reason for Study: 271 Patient indicated discomfort.	
Clinical History: Internal bleeding, pain	
Request Submitted to: UNKNOWN	
Do you wish to display request status tracking log? NO// YES	

269 Patch RA*5*99 February 2010: Replaced the 'Pregnancy Status' field with the 'Pregnant at time of order entry' field.

270 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

271 Patch RA*5*75 June 2007: Added a line for Reason for Study to the sample report.

*** Request Status Tracking Log *** 272			
Date/Time	Status	User	Reason
04/19/97 12:15 PM	PENDING	RADUSER, SIX	
04/19/97 12:17 PM	ACTIVE	RADUSER, SEVEN	

Display Patient Demographics 273

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 contrast medium used within seven days of the exam 274**
	Cholecystographic contrast medium used within seven days of the exam
***	Contrast Media Used within three days of the exam

If the VistA 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

272 Patch RA*5*15 June 2001: NOIS: FRE-1099-60873 "Request" added to line.

273 Patch RA*5*47 September 2011: Display Patient Demographics option is affected by the new Site Specific Accession Number (SSAN).

274 Patch RA*5*45 May 2005: Display Patient Demographics displays contrast media, if appropriate

Order Entry

- 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: RADPATIENT,ONE      03-15-21      000000051      NO      NSC VETERAN
***** Patient Demographics *****

Name      : RADPATIENT,ONE      Address: 948 Anystreet
Pt ID     : 000-00-0051      ANYTOWNE, 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 : 222-2222
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
```

Exam Profile (selected sort) 275

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, contrast media edit history 276, status change log, and results report.

The initial list of exams shows case no., procedure, contrast media associations 277, 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.

275 Patch RA*5*47 September 2011: Exam Profile (selected sort) option is affected by the new Site Specific Accession Number (SSAN).

276 Patch RA*5*45 May 2005: Exam Profile describes to the user that contrast media displays, if appropriate.

277 Patch RA*5*45 May 2005: Exam Profile describes to the user that contrast media displays, if appropriate.

The report text is the actual procedure report.

Prompt/User Response

Discussion

```
Exam Profile (selected sort) 278

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> YES

Select Procedure:      ABDOMEN 2 VIEWS                (RAD Detailed) CPT:74010

DEVICE: HOME// <RET> TELNET      Right Margin: 80// <RET>

Profile for RADPATIENT,SIX 000-00-9812                Run Date: MAR 1,2005

          ***** Registered Exams Profile *****
Case No.  Procedure                Exam Date  Status of Exam  Imaging Loc
-----
1      1808  ABDOMEN 2 VIEWS                02/07/05  WAITING FOR EXAM X-RAY CLINI
CHOOSE FROM 1-1: 1
=====
Name       : RADPATIENT,SIX 000-00-9812
Division   : SUPPORT ISC           Category    : OUTPATIENT
Location   : X-RAY CLINIC COUNT   Ward       :
Exam Date  : FEB 7,2005 14:50     Service    :
Case No.   : 1808                 Bedsection :
                               Clinic       : CO-B'S CLINIC 2
-----
Registered : ABDOMEN 2 VIEWS                (RAD Detailed) CPT:74010
Requesting Phy: RADPROVIDER,ONE   Exam Status : WAITING FOR EXAM
Int'g Resident: RADPROVIDER,TWO   Report Status: DRAFT
Pre-Verified : NO                 Cam/Equip/Rm :
Int'g Staff : RADPROVIDER,ONE     Diagnosis   : NORMAL
Technologist :                    Complication : NO COMPLICATION
Pregnant at time of order entry: YES 279  Films      :
-----
-----Modifiers-----
Proc Modifiers: PORTABLE EXAM

CPT Modifiers : GC RESIDENT/TEACHING PHYS SERV
                GJ 'OPT OUT' PHYS/PRACT EMERG OR URGENT SERVICE

Contrast Media: Barium, Cholecystographic, Ionic Iodinated,
                Non-ionic Iodinated, Gadolinium, Gastrografin,
                unspecified contrast media
=====
Do you wish to display all personnel involved? No// YES

          *** Imaging Personnel ***
-----
Primary Int'g Resident: RADPROVIDER,TWO
Primary Int'g Staff : RADPROVIDER,ONE  Pre-Verifier:
Verifier           :

Secondary Interpreting Resident      Secondary Interpreting Staff
-----
None                                 None
-----
Technologist(s)                      Transcriptionist
-----
None                                 RADPROVIDER,ONE
-----
```

278 Patch RA*5*45 May 2005: New Exam Profile example.

279 Patch RA*5*99 February 2010: Inserted the field 'Pregnant at time of order entry.'

Order Entry

Date/Time Changed	Contrast Media	Contrast Media Edit History	User
Feb 25, 2005 1:31 pm	Barium, Cholecystographic, Ionic Iodinated, Non-ionic Iodinated, Gadolinium, Gastrografin, unspecified contrast media		RADPROVIDER,ONE
Do you wish to display activity log? No// Y			
*** Exam Activity Log ***			
Date/Time	Technologist comment	Action	Computer User
FEB 25,2005 13:21		EXAM ENTRY	RADPROVIDER,ONE
		add exam to last visit option being exercised when CM is involved...	
FEB 25,2005 13:31		EDIT BY CASE NO.	RADPROVIDER,ONE
*** Report Activity Log ***			
Date/Time		Action	Computer User
MAR 1,2005 09:52		INITIAL REPORT TRANSCRIPTION	RADPROVIDER,ONE
MAR 1,2005 10:29		VERIFIED	RADPROVIDER,ONE
MAR 1,2005 12:41		REPORT UNVERIFIED	RADPROVIDER,ONE

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.

Profile of Rad/Nuc Med Exams 280

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.

280 Patch RA*5*47 September 2011: Profile Rad/Nuc Med Exams option is affected by the new Site Specific Accession Number (SSAN).

If the patient has more than one registered radiology exam, a list will be displayed showing the case no., procedure, contrast media associations 281, 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.

If the patient was female, between the ages of 12 and 55, and was pregnant at the time of an exam, the field 'Pregnant at time of order entry:' will display. The responses are Yes, No, and Unknown.282

Prompt/User Response	Discussion
Profile of Rad/Nuc Med Exams	
Select Patient: RADPATIENT,TWO 01-05-32 000000022 NO EMPLOYEE	
**** RADIOLOGY/NUCLEAR MEDICINE Profile ****	
=====	
Name : RADPATIENT,TWO (000-00-0022) 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 : RADPATIENT,TWO 000-00-0022	
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 :	
Procedure : ACUTE GI BLOOD LOSS IMAGING (NM Detailed) CPT:nnnnn283	
Requesting Phy: RADPROVIDER,FOUR Exam Status : CALLED FOR EXAM	
Int'g Resident: RADPROVIDER,FIVE Report Status: VERIFIED	
Pre-Verified : NO Cam/Equip/Rm : NUC2	
Int'g Staff : RADPROVIDER,Six Diagnosis : MINOR ABNORMALITY	
Technologist : RADPROVIDER,FIVE Complication : NO COMPLICATION	
Pregnant at time of order entry: NO 284 Films : 11X14 - 1	

281 Patch RA*5*45 May 2005: Rad/Nuc Med Exams displays contrast media, if appropriate

282 Patch RA*5*99 February 2010: Inserted the field 'Pregnant at time of order entry.'

283 Patch RA*5*10 April 2000

284 Patch RA*5*99 February 2010: Inserted the field 'Pregnant at time of order entry.'

Order Entry

```

-----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: RADPROVIDER5          Date Adm'd: MAY 19, 2000@11:46
-----Radiopharmaceuticals-----
Rpharm: SULFUR COLLOID TC-99M   Dose (MD Override): 1 mCi
Prescriber: RADPROVIDER5        Activity Drawn: 1 mCi
Drawn: MAY 19, 2000@11:47      Measured By: RADPROVIDER,FOUR
Dose Adm'd: 1 mCi              Date Adm'd: MAY 19, 2000@11:47
Adm'd By: RADPROVIDER5,FIVE     Witness: RADUSER,ONE
Lot #: 789

Rpharm: PERCHLORACAP 250MG CAPS Activity Drawn: 250 mCi
Drawn: MAY 19, 2000@11:48      Measured By: RADPROVIDER,FOUR
Dose Adm'd: 250 mCi

=====
Do you wish to display all personnel involved? No// <RET> NO
Do you wish to display activity log? No// Y

```

Exam Activity Log

```

*** Exam Activity Log ***
Date/Time      Action                      Computer User
-----
MAY 19,2000  11:45    EXAM ENTRY                  RADPROVIDER5,FI  This is a
technologist's comment on an exam. 285
MAY 19,2000  11:45    EXAM STATUS TRACKING       RADPROVIDER5,FI
This is a tech note on the patient/case.
MAY 19,2000  14:10    EDIT BY CASE NO.          RADPROVIDER5,FI
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 RADPROVIDER5,FI
JUN 16,2000  14:14    VERIFIED                   RADPROVIDER5,FI
Do you wish to display status tracking log? No// Y

*** Status Tracking Log ***
Status          Date/Time      Elapsed Time   Cumulative 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

```

285 Patch RA*5*18 November 2000: New field for comments by the technologist added to report.

12. 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.

- Refer Selected Requests to COMMUNITY CARE Provider
- 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

Refer Selected Requests to COMMUNITY CARE Provider

This option allows a Radiology Technician, within VistA, to choose those CPRS orders created and signed by the Radiology Ordering Provider to be sent to a COMMUNITY CARE Provider. The Technician selects the patient name and the pending request(s) and answers associated questions. Then the Consult Order # is created.

Note: If the sex of the patient is male and the imaging type is mammography, Mammography Diagnostic will automatically be the default selection within VistA. If the sex of the patient is female and the imaging type selected is mammography, you will be prompted to answer the following additional question: Select one of the following 1. Mammography Diagnostic 2. Mammography Screening

In RA*5.0*148, two main modifications were made:

- The functionality of the menu option Refer Selected Requests to COMMUNITY CARE Provider was changed to the following:

Justification for Community Care	
Select one of the following:	
1	VA facility does not provide the required service
2	Veteran cannot safely travel to VA facility due to medical reason
3	Veteran cannot travel to VA facility due to geographical inaccessibility
4	VA facility cannot timely provide the required service
5	Unusual or excessive travel burden
Enter response:	

Then, if #5 is chosen, a sub-menu appears:

Order Entry

Unusual or excessive travel burden

Select one of the following:

- 1 Geographical challenges
- 2 Environmental factors
- 3 Medical condition
- 4 Nature or simplicity of services

Select Reason for Unusual or excessive travel burden:

- In all options, when the consult is created a comment is added which contains tags for the CDW software import.

The screens below show each option 1 through 4, then the new option #5 processing:

Justification for Community Care

VA facility does not provide the required service

```
SELECT FROM IMAGING ORDERS
PATIENT NAME          SSN          PROCEDURE
DATE DESIRED          DATE ORDERED          ORDERING PROVIDER
IMAGING LOCATION      REQUEST STATUS
=====
1. ORPATIENT,THIRTY   *****3923          CT ABDOMEN W/CONT
   NOV 05, 2018       NOV 05, 2018          CPRSPROVIDER,ONE
   CT SCAN DIV 442 OOS ID 150          PENDING
2. ORPATIENT,THIRTY   *****3923          MAMMOGRAPHY BILATERAL
   NOV 05, 2018       NOV 05, 2018          CPRSPROVIDER,ONE
   MAMMOGRAPHY          PENDING
3. ORPATIENT,THIRTY   *****3923          MRA HEAD
   NOV 05, 2018       NOV 05, 2018          CPRSPROVIDER,ONE
   MRI DIV 442 OOS ID 151          PENDING
4. ORPATIENT,THIRTY   *****3923          GASTRIC EMPTYING STUDY
   NOV 05, 2018       NOV 05, 2018          CPRSPROVIDER,ONE
   NUC MED DIV 442 OOS ID 109          PENDING
5. ORPATIENT,THIRTY   *****3923          DEXA
   NOV 05, 2018       NOV 05, 2018          CPRSPROVIDER,ONE
   RADIOLOGY DIV 442 OOS ID 105          PENDING
Select NUMBER of ORDER to be REFERRED to COMMUNITY CARE: (1-5): 1
You selected number 1

Justification for Community Care

Select one of the following:

1 VA facility does not provide the required service
2 Veteran cannot safely travel to VA facility due to medical reason
3 Veteran cannot travel to VA facility due to geographical inaccessibility
4 VA facility cannot timely provide the required service
5 Unusual or excessive travel burden

Enter response: 1 VA facility does not provide the required service

Consult with UCID: 442_884075 has been created
```

This is the end of the consult detail showing the comment with the CDW tags:

COMMENT:
 #COI#
 COI-Veteran OPT-IN for Community Care
 Service Not Available: VA facility does not provide the required service

Veteran cannot safely travel to VA facility due to medical reason

```

SELECT FROM IMAGING ORDERS
PATIENT NAME          SSN          PROCEDURE
DATE DESIRED    DATE ORDERED    ORDERING PROVIDER
IMAGING LOCATION          REQUEST STATUS
=====
1. ORPATIENT,THIRTY          *****3923    MAMMOGRAPHY BILATERAL
   NOV 05, 2018    NOV 05, 2018    CPRSPROVIDER,ONE
   MAMMOGRAPHY          PENDING
2. ORPATIENT,THIRTY          *****3923    MRA HEAD
   NOV 05, 2018    NOV 05, 2018    CPRSPROVIDER,ONE
   MRI DIV 442 OOS ID 151    PENDING
3. ORPATIENT,THIRTY          *****3923    GASTRIC EMPTYING STUDY
   NOV 05, 2018    NOV 05, 2018    CPRSPROVIDER,ONE
   NUC MED DIV 442 OOS ID 109    PENDING
4. ORPATIENT,THIRTY          *****3923    DEXA
   NOV 05, 2018    NOV 05, 2018    CPRSPROVIDER,ONE
   RADIOLOGY DIV 442 OOS ID 105    PENDING
Select NUMBER of ORDER to be REFERRED to COMMUNITY CARE: (1-4): 1
You selected number 1

Please select the type of Mammography order from the following options:

Select one of the following:
1      Diagnostic Mammography
2      Screen Mammography

Enter response: 1 Diagnostic Mammography

Justification for Community Care

Select one of the following:
1      VA facility does not provide the required service
2      Veteran cannot safely travel to VA facility due to medical reason
3      Veteran cannot travel to VA facility due to geographical inaccessibility
4      VA facility cannot timely provide the required service
5      Unusual or excessive travel burden

Enter response: 2 Veteran cannot safely travel to VA facility due to medical reason
Medical Reason: BROKEN LEG

Consult with UCID: 442_884076 has been created
    
```

This is the end of the consult detail showing the comment with the CDW tags:

```

ADDED COMMENT          11/21/18 12:23    CPRSDEVELOPER,ONE    CPRSDEVELOPER,ONE
#COI#
COI-Veteran OPT-IN for Community Care
Veteran cannot safely travel to VA facility due to medical reason
BROKEN LEG
    
```

Veteran cannot travel to VA facility due to geographical inaccessibility

Order Entry

```

SELECT FROM IMAGING ORDERS
PATIENT NAME          SSN          PROCEDURE
DATE DESIRED    DATE ORDERED    ORDERING PROVIDER
IMAGING LOCATION          REQUEST STATUS
=====
1. ORPATIENT,THIRTY          *****3923    MRA HEAD
   NOV 05, 2018    NOV 05, 2018    CPRSPROVIDER,ONE
   MRI DIV 442 OOS ID 151          PENDING
2. ORPATIENT,THIRTY          *****3923    GASTRIC EMPTYING STUDY
   NOV 05, 2018    NOV 05, 2018    CPRSPROVIDER,ONE
   NUC MED DIV 442 OOS ID 109          PENDING
3. ORPATIENT,THIRTY          *****3923    DEXA
   NOV 05, 2018    NOV 05, 2018    CPRSPROVIDER,ONE
   RADIOLOGY DIV 442 OOS ID 105          PENDING
Select NUMBER of ORDER to be REFERRED to COMMUNITY CARE:  (1-3): 1
You selected number 1

Justification for Community Care

  Select one of the following:

    1      VA facility does not provide the required service
    2      Veteran cannot safely travel to VA facility due to medical reason
    3      Veteran cannot travel to VA facility due to geographical inaccessibility
    4      VA facility cannot timely provide the required service
    5      Unusual or excessive travel burden

Enter response: 3  Veteran cannot travel to VA facility due to geographical inaccessibility

Consult with UCID: 442_884077 has been created

```

This is the end of the consult detail showing the comment with the CDW tags:

```

ADDED COMMENT          11/21/18 12:57    CPRSDEVELOPER,ONE    CPRSDEVELOPER,ONE
#COI#
COI-Veteran OPT-IN for Community Care
UXB-Unusual or excessive travel burden
GEO-Geographical challenges:
There's a mountain between me and the VA

```

VA facility cannot timely provide the required service

```

SELECT FROM IMAGING ORDERS
PATIENT NAME          SSN          PROCEDURE
DATE DESIRED    DATE ORDERED    ORDERING PROVIDER
IMAGING LOCATION          REQUEST STATUS
=====
1. ORPATIENT,THIRTY          *****3923    GASTRIC EMPTYING STUDY
   NOV 05, 2018    NOV 05, 2018    CPRSPROVIDER,ONE
   NUC MED DIV 442 OOS ID 109          PENDING
2. ORPATIENT,THIRTY          *****3923    DEXA
   NOV 05, 2018    NOV 05, 2018    CPRSPROVIDER,ONE
   RADIOLOGY DIV 442 OOS ID 105          PENDING
Select NUMBER of ORDER to be REFERRED to COMMUNITY CARE:  (1-2): 1
You selected number 1

Justification for Community Care

  Select one of the following:

    1      VA facility does not provide the required service
    2      Veteran cannot safely travel to VA facility due to medical reason
    3      Veteran cannot travel to VA facility due to geographical inaccessibility

```

```

4          VA facility cannot timely provide the required service
5          Unusual or excessive travel burden

Enter response: 4  VA facility cannot timely provide the required service

Consult with UCID: 442_884078 has been created
    
```

This is the end of the consult detail showing the comment with the CDW tags:

```

ADDED COMMENT          11/21/18 12:52          CPRSDEVELOPER,ONE    CPRSDEVELOPER,ONE
#COI#
COI-Veteran OPT-IN for Community Care
Wait Time: VA appointment is greater than Wait Time Standard (WTS) from CID
    
```

Unusual or excessive travel burden

Geographical Challenges

```

                                SELECT FROM IMAGING ORDERS
PATIENT NAME                      SSN          PROCEDURE
DATE DESIRED    DATE ORDERED          ORDERING PROVIDER
IMAGING LOCATION                      REQUEST STATUS
=====
1. ORPATIENT,THIRTY                *****3923    DEXA
   NOV 05, 2018    NOV 05, 2018          CPRSPROVIDER,ONE
   RADIOLOGY DIV 442 OOS ID 105          PENDING
Select NUMBER of ORDER to be REFERRED to COMMUNITY CARE: (1-1): 1
You selected number 1

Justification for Community Care

  Select one of the following:

    1          VA facility does not provide the required service
    2          Veteran cannot safely travel to VA facility due to medical reason
    3          Veteran cannot travel to VA facility due to geographical inaccessibility
    4          VA facility cannot timely provide the required service
    5          Unusual or excessive travel burden

Enter response: 5  Unusual or excessive travel burden

Unusual or excessive travel burden

  Select one of the following:

    1          Geographical Challenges
    2          Environmental Factors
    3          Medical condition
    4          Nature or simplicity of services

Select Reason for Unusual or excessive travel burden: 1  Geographical Challenges
Explain: Mountains have 3 feet of snow

Consult with UCID: 442_884079 has been created
    
```

Order Entry

This is the end of the consult detail showing the comment with the CDW tags:

```
ADDED COMMENT          11/21/18 12:57      CPRSDEVELOPER,ONE    CPRSDEVELOPER,ONE
#COI#
COI-Veteran OPT-IN for Community Care
UXB-Unusual or excessive travel burden
GEO-Geographical challenges:
Mountains have 3 feet of snow
```

Unusual or excessive travel burden Environmental Factors

```
SELECT FROM IMAGING ORDERS
PATIENT NAME          SSN          PROCEDURE
DATE DESIRED         DATE ORDERED         ORDERING PROVIDER
IMAGING LOCATION          REQUEST STATUS
=====
1. ORPATIENT,THIRTY          *****3923    CT ABDOMEN & PELVIS WITH
   NOV 05, 2018    NOV 05, 2018          CPRSPROVIDER,ONE
   CT SCAN DIV 442 OOS ID 150          PENDING
2. ORPATIENT,THIRTY          *****3923    KNEE 3 VIEWS
   NOV 05, 2018    NOV 05, 2018          CPRSPROVIDER,ONE
   RADIOLOGY DIV 442 OOS ID 105        PENDING
Select NUMBER of ORDER to be REFERRED to COMMUNITY CARE: (1-2): 1
You selected number 1

Justification for Community Care

Select one of the following:

1          VA facility does not provide the required service
2          Veteran cannot safely travel to VA facility due to medical reason
3          Veteran cannot travel to VA facility due to geographical inaccessibility
4          VA facility cannot timely provide the required service
5          Unusual or excessive travel burden

Enter response: 5 Unusual or excessive travel burden

Unusual or excessive travel burden

Select one of the following:

1          Geographical Challenges
2          Environmental Factors
3          Medical condition
4          Nature or simplicity of services

Select Reason for Unusual or excessive travel burden: 2 Environmental Factors
Explain: Roads blocked due to truck overturning

Consult with UCID: 442_884080 has been created
```

This is the end of the consult detail showing the comment with the CDW tags:

```
ADDED COMMENT          11/21/18 13:02      CPRSDEVELOPER,ONE    CPRSDEVELOPER,ONE
#COI#
COI-Veteran OPT-IN for Community Care
UXB-Unusual or excessive travel burden
ENV-Environmental factors:
Roads blocked due to truck overturning
```

Unusual or excessive travel burden Medical condition

```

SELECT FROM IMAGING ORDERS
PATIENT NAME          SSN          PROCEDURE
DATE DESIRED    DATE ORDERED          ORDERING PROVIDER
IMAGING LOCATION          REQUEST STATUS
=====
1. ORPATIENT,THIRTY          *****3923    KNEE 3 VIEWS
   NOV 05, 2018    NOV 05, 2018          CPRSPROVIDER,ONE
   RADIOLOGY DIV 442 OOS ID 105          PENDING
Select NUMBER of ORDER to be REFERRED to COMMUNITY CARE: (1-1): 1
You selected number 1

Justification for Community Care

Select one of the following:

1          VA facility does not provide the required service
2          Veteran cannot safely travel to VA facility due to medical reason
3          Veteran cannot travel to VA facility due to geographical inaccessibility
4          VA facility cannot timely provide the required service
5          Unusual or excessive travel burden

Enter response: 5 Unusual or excessive travel burden

Unusual or excessive travel burden

Select one of the following:

1          Geographical Challenges
2          Environmental Factors
3          Medical condition
4          Nature or simplicity of services

Select Reason for Unusual or excessive travel burden: 3 - Medical condition

Explain: Patient is unable to travel on vehicle for more than two minutes

Consult with UCID: 442_884081 has been created
    
```

This is the end of the consult detail showing the comment with the CDW tags:

```

ADDED COMMENT          11/21/18 13:26          CPRSDEVELOPER,ONE    CPRSDEVELOPER,ONE
#COI#
COI-Veteran OPT-IN for Community Care
UXB-Unusual or excessive travel burden
MED-Medical condition:
  Explain: Patient is unable to travel on vehicle for more than two minutes
    
```

Unusual or excessive travel burden Nature or simplicity of services

```

Justification for Community Care

Select one of the following:

1          VA facility does not provide the required service
2          Veteran cannot safely travel to VA facility due to medical reason
3          Veteran cannot travel to VA facility due to geographical inaccessibility
4          VA facility cannot timely provide the required service
    
```

Order Entry

```
5 Unusual or excessive travel burden
Enter response: 5 Unusual or excessive travel burden
Unusual or excessive travel burden

Select one of the following:

1 Geographical challenges
2 Environmental factors
3 Medical condition
4 Nature or simplicity of services

Select Reason for Unusual or excessive travel burden: 4 Nature or simplicity of services

Explain: Test Nature or Simplicity
Consult with UCID: 442_884136 has been created
```

NOTE: *In this case the explanation is a mandatory field. It is the only mandatory explanation field in the testing.*

This is the end of the consult detail showing the comment with the CDW tags:

```
ADDED COMMENT 11/21/18 13:34 CPRSDEVELOPER,ONE CPRSDEVELOPER,ONE
#COI#
COI-Veteran OPT-IN for Community Care
UXB-Unusual or excessive travel burden
Nature or simplicity of services:
Test Nature or Simplicity
```

Explanation Text Field is Greater than 74 Characters in Length

On any of the options above where an explanation is entered, the field can be three (3) to 240 characters in length. If the length of the text is greater than 74 characters, for it to be readable in CPRS, the text will be broken down into two (2) or more lines. Here is an example of the output:

```
Justification for Community Care:
Veteran cannot safely travel to VA facility due to medical reason
The patient fell downstairs and broke his leg. He is currently using
crutches to get around, but he is unable to get into a vehicle. Etc,
etc, etc, etc, etc, etc, etc.
```

This is the end of the consult detail showing the comment with the CDW tags:

```
Comment and CDW tag:
#COI#
COI-Veteran OPT-IN for Community Care
Veteran cannot safely travel to VA facility due to medical reason
The patient fell downstairs and broke his leg. He is currently using
crutches to get around, but he is unable to get into a vehicle. Etc, etc,
etc, etc, etc, etc, etc, etc.
```

The text will be broken on a word, never in the middle of a word.

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 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 IT SERVICE to receive this bulletin.

Prompt/User Response

Discussion

```

Cancel a Request

Select PATIENT NAME:  RADPATIENT,TWO          01-05-32      000000022      NO      EMPLOYEE

          **** Requested Exams for RADPATIENT,TWO****          8 Requests
St  Urgency  Procedure                               Desired Requester  Req'g Loc
-----
1  p  ROUTINE  ABDOMEN 1 VIEW                          09/05  RADPROVIDER,SEVEN  1S
2  p  ROUTINE  ANGIO CAROTID CEREBRAL SELECT          09/04  RADPROVIDER,SEVEN  1S
3  p  ROUTINE  ANGIO CAROTID CEREBRAL UNILAT          09/04  RADPROVIDER,SEVEN  1S
4  p  ROUTINE  BRAIN IMAGING, PLANAR ONLY            06/28  RADPROVIDER,SEVEN  EMERGENCY R
5  p  ROUTINE  GALLIUM SCAN FOR INFECTIOUS/I          06/27  RADPROVIDER,SEVEN  OPERATING R
6  p  ROUTINE  RADIONUCLIDE THERAPY, THYROID          06/27  RADPROVIDER,SEVEN  OPERATING R
7  s  ROUTINE  SPINE LUMBOSACRAL MIN 2 VIEWS      11/16  RADPROVIDER,SEVEN  ORTHOPEDIC
8  s  ROUTINE  CT LOWER EXTREMITY W&W/O CONT      11/16  RADPROVIDER,SEVEN  ORTHOPEDIC

Select Request(s) 1-8 to Cancel or '^' to Exit:  Exit// 2
Select CANCEL REASON: ??
Choose from:
 20          EXAM CANCELLED                  Synonym: EXAM CANCELLED
 57          CC-IMAGING CONSULT DC/ADMIN CLOSURE POLICY  Synonym: CC ADMIN CLOSE
 58          CC-IMAGING CONSULT DC PT CX'D             Synonym: CC CANCEL
 59          CC-IMAGING CONSULT DC PT NO SHOW          Synonym: CC NO SHOW
 60          CC-IMAGING CONSULT DC UNABLE TO CONTACT   Synonym: CC NO RESPONSE
 61          OBSOLETE ORDER                          Synonym: OBSOLETE
 62          UNABLE TO CONTACT THE PATIENT              Synonym: NO RESPONSE
 63          FUTURE DD/CID GREATER THAN 390 DAYS       Synonym: FUTURE > 390
 64          PATIENT NO SHOWED                          Synonym: NO SHOW
 65          DUPLICATE ORDER                          Synonym: DUPLICATE

```


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
...will now 'HOLD' selected request(s)...
...ARTHROGRAM SHOULDER S&I held...
Select PATIENT NAME: <RET>

```

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.

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, patient name and last 4 digits of patient ID number, procedure, desired date, and date ordered. Additional output for Held requests includes the last activity date and current hold reason. Pending requests will also display the ordering provider and ordering location. This report requires a 132 column output device.

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 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. 286 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. 287 UNKNOWN imaging locations that belong to other imaging types will not be printed.

286 Patch RA*5*75 June 2007: Removed the statement "if no Desired Date (field #21 of the Rad/Nuc Med Order file #75.1) has been entered" from the request list.

287 Patch RA*5*15 May 2000: NOIS: BHS-1199-12241

Order Entry

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'

Beginning DATE : **1/1/16** (JAN 01, 2016)

Ending DATE : **T** (DEC 15, 2016)

This report requires a 132 column output device.

DEVICE: HOME// Local SSH Device Right Margin: 80// **132**

LOG OF PENDING REQUESTS
Includes requests scheduled from 1/1/16 to 12/15/16
IMAGING LOCATION: X-RAY CLINIC COUNT Run Date: DEC 15,2016 12:20

PATIENT NAME	SSN	PROCEDURE	DATE DESIRED	DATE ORDERED	ORDERING PROVIDER	PT LOC
TEST,PATIENT THREE	1113	HIP 2 OR MORE VIEWS	FEB 10, 2017	FEB 08, 2017	PROVIDER,ONE	
TRANSITIONAL PHARMACY BENEFI						
TEST,PATIENT THREE	1113	FEMUR 2 VIEWS	FEB 10, 2017	FEB 08, 2017	PROVIDER,ONE	
TRANSITIONAL PHARMACY BENEFI						
TEST,PATIENT FOUR	1114	HUMERUS 2 OR MORE VIEWS	FEB 13, 2017	FEB 08, 2017	PROVIDER,ONE	
TRANSITIONAL PHARMACY BENEFI						

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

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// **H** HOLD
Select Imaging Location(s): **X-RAY CLINIC COUNT**
Another one (Select/De-Select):

**** Date Range Selection ****

Beginning DATE : **1/1/16** (JAN 01, 2016)

Ending DATE : **T** (DEC 15, 2016)

This report requires a 132 column output device.

DEVICE: HOME// Local SSH Device Right Margin: 80// **132**
LOG OF HOLD REQUESTS
Includes requests scheduled from 1/1/16 to 12/15/16
IMAGING LOCATION: X-RAY CLINIC COUNT Run Date: DEC 15,2016 12:21

PATIENT NAME	SSN	PROCEDURE	DATE DESIRED	DATE ORDERED	HOLD DATE	HOLD REASON
RADPATIENT,TWO	0122	HIP 1 VIEW	FEB 08, 2016	FEB 08, 2016	FEB 08, 2016	MEDICAL
CONSULT NEEDED						
RADPATIENT,FIVE	1234	HIP 1 VIEW	NOV 03, 2016	NOV 03, 2016	NOV 03, 2016	OTHER
HOLD REASON						

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

Print Rad/Nuc Med Requests by Date 288

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 PIMS 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.

288 Patch RA*5*47 September 2011: Print Rad/Nuc Med Requests by Date option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

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), height and weight (including date when recorded), pregnancy status at time of order entry, pregnancy screen and pregnancy screen comment at the time of the exam 289, procedure, procedure message, contrast media associations, modifiers, current request status, exam status if the exam was registered, requester, primary and attending physician at time of order and current ("Attend Phy At Order:" will only be displayed if different from "Attend Phy Current:") 290, date/time ordered, date desired, reason for study 291, clinical history, pregnancy information, isolation, pre-op, approving physician, bar-coded SSN, and portable notation.

Since a substantial amount of time may pass from the time the order is placed to the time the order is registered, a pregnancy status of "Patient not pregnant at time of order" will display if the patient wasn't pregnant at the time of the order. 292

If this procedure was registered via the 'Add Exams to Last Visit' [RA ADDEXAM] option, then a note will be displayed, showing the date of the last visit that was selected. 293 For example:

**** Note:** Request Associated with Visit on Apr 30, 2001 12:00pm **

There is also a worksheet section on the form for date performed, case number, technologist initials, interpreting physician initials, number/size of films used and comments. If 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. 294

The output should be queued to a printer.

Prompt/User Response

Discussion

Print Rad/Nuc Med Requests by Date

289 Patch RA*5*99 February 2010: Replaced the 'Pregnancy Status' field with the 'Pregnant at time of order entry' field. Also added two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

290 Patch RA*5*26 July 2001: Additional text description.

291 Patch RA*5*75 June 2007: Added "reason for study" to the list.

292 Patch RA*5*45 May 2005: If a patient wasn't pregnant at the time of the order, the "Patient not pregnant at time of order" will display instead of not displaying a pregnancy status.

293 Patch RA*5*31 September 2002: If this procedure was registered via the 'Add Exams to Last Visit' [RA ADDEXAM] option, then a note will be displayed, showing the date of the last visit that was selected.

294 Patch RA*5*18 November 2000: Additional fields printed on form.

Select IMAGING LOCATION: **X-RAY** (GENERAL RADIOLOGY)

Request Status Selection

 Choose one of the following:
 Discontinued
 Complete
 Hold
 Pending
 Request Active
 Scheduled
 All Current Orders

Select Status: Pending// <RET>

Date Criteria Selection

 Select one of the following:
 E ENTRY DATE OF REQUEST
 D DESIRED DATE FOR EXAM

Date criteria to use for choosing requests to print: E// <RET> NTRY DATE OF REQUEST

**** Date Range Selection ****

Beginning DATE : **2/1/97** (FEB 01, 1997)
 Ending DATE : **T** (APR 08, 1997)
 Print HEALTH SUMMARY for each patient? **NO**

DEVICE: HOME// (Enter printer name)

>> Rad/Nuc Med Consultation for X-RAY << APR 8,1997 16:07

```

=====
Name          : RADPATIENT,FIVE                  Urgency      : ROUTINE
Pt ID Num     : 000-00-0055                      Transport    : AMBULATORY
Date of Birth  : DEC 2,1934                      Patient Loc  : RAD 101
Age at req    : 62 295                           Phone Ext   :
Sex           : MALE                             Room-Bed     : 724-D 296
Height (in.)  : 66                               Height Date  : JUN 15, 2015@10:00
Weight (lbs)  : 165                              Weight Date  : JUN 15, 2015@10:00 297
=====
  
```

Pregnant at time of order entry: NO298
 Pregnancy Screen: Patient answered yes299
 Pregnancy Screen Comment: This is the pregnancy screen comments.
 Requested: FOREARM 2 VIEWS (RAD Detailed) CPT: 73090
 Procedure Modifiers: LEFT300
 Request Status: PENDING (p)

Requester: RADPROVIDER, SIX
 Tel/Page/Dig Page: (777) 777-7777 / 777-7778 / 777-7779
 Attend Phy Current: UNKNOWN

295 Patch RA*5*75 June 2007: Added "at req(uest)" to patient age display.
 296 Added Sex, Room-Bed to Order Entry example to reflect current view.
 297 Patch RA*5*123 September 2015: Added Weight and Weight Date.
 298 Patch RA*5*99 February 2010: Replaced the 'Pregnancy Status' field with the 'Pregnant at time of order entry' field.
 299 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'
 300 Patch RA*5*10 April 2000

Order Entry

Prim Phy Current: UNKNOWN
Date/Time Ordered: FEB 12,1997 10:48 by RADP,SIX
Date Desired: FEB 12,1997
Reason for Study: 301 Patient has severe arm pain.

Clinical History:

>> Rad/Nuc Med Consultation for X-RAY << APR 8,1997 16:07

```
=====
Name           : RADPATIENT,FIVE           Urgency      : ROUTINE
Pt ID Num      : 000-00-0055              Transport   : AMBULATORY
Date of Birth  : DEC 2,1934               Patient Loc  : RAD 101
Age           : 62                        Phone Ext   :
Sex           : MALE                      Room-Bed    : 724-D 302
Weight (lbs)  : 165                       Weight Date: JUN 15, 2015@10:00
303
=====
```

=
Clinical History:
Rule out fractures.

-
Date Performed: _____ Case No.: _____
304

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.

Print Selected Requests by Patient 305

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), height and weight (including

301 Patch RA*5*75 June 2007: Added Reason for Study line to report output example.

302 Added Sex, Room-Bed to Order Entry Example to reflect current view.

303 Patch RA*5*123 September 2015: Added Weight and Weight Date.

304 Patch RA*5*18 November 2000: "See above" appears following "Case No.:" when a case number(s) is shown previous to this point.

305 Patch RA*5*47 September 2011: Print Selected Requests by Patient option is affected by the new Site Specific Accession Number (SSAN).

date when recorded), procedure, procedure message, contrast media associations³⁰⁶, modifiers, current request status, exam status if the exam was registered, requester, primary and attending physician at time of order and current ("Attend Phy At Order:" will only be displayed if different from "Attend Phy Current:")³⁰⁷, date/time ordered, desired date, reason for study³⁰⁸, clinical history, pregnancy information, isolation, pre-op, approving physician, bar-coded SSN, and portable notation.

Since a substantial amount of time may pass from the time the order is placed to the time the order is registered, if the patient wasn't pregnant at the time of the order³⁰⁹, instead of not displaying a pregnancy status, 'Pregnant at time of order entry:'³¹⁰ will display, with the response.

Additionally, at the time of the exam, if the patient is female and between the ages of 12 and 55, 'Pregnancy Screen' will display. Responses are Yes, No, and Unknown. If the response is Yes or Unknown, 'Pregnancy Screen Comment' will display. ³¹¹

If this procedure was registered via the 'Add Exams to Last Visit' [RA ADDEXAM] option, then a note will be displayed, showing the date of the last visit that was selected.³¹² For example:

**** Note:** Request Associated with Visit on Apr 30, 2001 12:00pm **

There is also a worksheet section on the form for date performed, case number, technologist initials, interpreting physician initials, number/size of films used and comments. If 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.³¹³

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

306 Patch RA*5*45 May 2005: Rad/Nuc Med Requests by Patient displays contrast media, if appropriate

307 Patch RA*5*26 July 2001: Additional text explanation.

308 Patch RA*5*75 June 2007: Added "reason for study" to the list of data.

309 Patch RA*5*45 May 2005: If a patient wasn't pregnant at the time of the order, "Patient not pregnant at time of order" displays instead of not displaying a pregnancy status.

310 Patch RA*5*99 February 2010: Replaced the 'Pregnancy Status' field with 'Pregnant at time of order entry.'

311 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

312 Patch RA*5*31 November 2002: If this procedure was registered via the 'Add Exams to Last Visit' [RA ADDEXAM] option, then a note will be displayed, showing the date of the last visit that was selected.

313 Patch RA*5*18 January 2001: Additional fields printed on form.

Order Entry

```

Select PATIENT NAME:   RADPATIENT,SIX   12-12-33   000009812   NO   ALLIED VETERAN314

Enrollment Priority:  GROUP 5   Category:  IN PROCESS   End Date:

**** Requested Exams for RADPATIENT,SIX ****           14 Requests
Height      : 69" on JUL 16, 2004 08:50
Weight      : 150.1 lbs on JUL 16, 2004 08:59
St  Urgency Procedure / (Img. Loc.)   Desired   Requester   Req'g Loc
-----
1    ROUTINE FOREARM 2 VIEWS           02/25/2005  RADPROVIDER, CO-B'S CLIN
      (X-RAY CLINIC COUNT)
2    ROUTINE CHEST 4 VIEWS             02/07/2005  RADPROVIDER, CO-B'S CLIN
      (X-RAY CLINIC COUNT)
3    ROUTINE +PRINTSET PROCEDURE       01/26/2005  RADPROVIDER, DISPOSITION
      (X-RAY CLINIC COUNT)
4    ROUTINE ABDOMEN 3 OR MORE VIEWS   10/21/2004  RADPROVIDER, DISPOSITION
      (RADIOLOGY LAB)
5    ROUTINE HIP 1 VIEW                 10/08/2004  RADPROVIDER, DISPOSITION
      (X-RAY CLINIC COUNT)
6    ROUTINE HIP 1 VIEW                 06/30/2004  RADPROVIDER, MULTIDIVISI
      (X-RAY CLINIC COUNT)

Select Request(s) 1-6 to Print or '^' to Exit:  Continue// 1

Do you wish to generate a Health Summary Report? No//  NO
...
DEVICE: HOME// <RET>
>>Rad/Nuc Med Consultation for X-RAY CLINIC COUN<< MAR 1,2005 13:38 Page 1 315
=====
Name       : RADPATIENT,SIX           Urgency   : ROUTINE *PORTABLE*
Pt ID Num  : 000-00-9812              Transport : PORTABLE
Date of Birth: DEC 12,1933            Patient Loc: CO-B'S CLINIC 2
Height (in.) : 69                    Height Date: JUL 16, 2004@08:50:02
Weight (lbs) : 150.1                 Weight Date: JUL 16, 2004@08:59:32
Age at req  : 316 71                 Phone Ext  : 444-444-4444
Sex        : MALE
Pregnant at the time of order entry: Yes317
PREGNANCY SCREEN: Patient answered yes.318
PREGNANCY SCREEN COMMENT: The patient is alert and oriented and is 9 weeks pregnant. Patient
has shattered pelvis and needs immediate surgery. Patient has been counseled and agreed to
procedure

** Note Request Associated with Visit on Feb 07, 2005 2:50 pm **

Requested:      FOREARM 2 VIEWS (RAD Detailed) CPT: 73090
Registered:     FOREARM 2 VIEWS (RAD Detailed) CPT: 73090
Procedure Modifiers: PORTABLE EXAM
Request Status: ACTIVE
Exam Status:    WAITING FOR EXAM
Requester:      RADPROVIDER,ONE
Tel/Page/Dig Page: 444-4444 / /
Attend Phy Current: UNKNOWN
Prim Phy Current: UNKNOWN
Date/Time Ordered: Feb 25, 2005 1:21 pm by RADPROVIDER,ONE
Date Desired:    Feb 25, 2005
Reason for Study: 319 Patient reports severe arm pain
  
```

- 314 Patch RA*5*45 May 2005: Added new Prompt/User response.
- 315 Patch RA*5*45 May 2005: New sample report output, showing contrast media notifications.
- 316 Patch RA*5*75 June 2007: Added "at req(uest)" to patient age display.
- 317 Patch RA*5*99 February 2010: Replaced the 'Pregnancy Status' field with 'Pregnant at time of order entry.'
- 318 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'
- 319 Patch RA*5*75 June 2007: Added Reason for Study line to sample report output, updated sample data.

```

Ordering Diagnoses 320      |
715.13 LOC PRIM OSTEOART-FORARM |
      Clinical Indicator (s): SC |
715.23 LOC 2ND OSTEOART-FOREARM |
Clinical History:
      Prior history of SC arm and wrist pain...
-----
Date Performed: _____ Case No.: _____ see above ____
Technologist Initials: _____ Number/Size Films: _____
Interpreting Phys. Initials: _____
Comments:
Case No: 1808 Tech: _____ Film: _____
      Patient very uncomfortable when flexing wrist. _____

```

Rad/Nuc Med Procedure Information Look-Up

This option allows the user to view procedure information as requested. The display includes procedure, procedure type, contrast media associations 321, 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:   GENERAL RADIOLOGY   RAD

Select a Rad/Nuc Med Procedure: ABDOMEN 2 VIEWS   (RAD Detailed)
CPT:74010

Another one (Select/De-Select):

Select a Device: HOME//   (Enter a device at this prompt)
      Radiology/Nuclear Medicine Procedure Information
Run Date/Time: Mar 01, 2005 1:52 pm   Page: 1
-----
---
ABDOMEN 2 VIEWS   (RAD Detailed) CPT:74010
Contrast Media: Barium, Cholecystographic, Ionic Iodinated, Non-ionic
Iodinated, Gadolinium, Gastrografin, unspecified contrast media
Educational Desc: This is the ***first line*** of Educational Description
text
This is the second line of Educational Description text
This is the third line of Educational Description text
This is the fourth line of Educational Description text
This is the fifth line of Educational Description text
This is the sixth line of Educational Description text
For parent procedures with a descendant using contrast media, the display
appears as follows:

      Radiology/Nuclear Medicine Procedure Information

```

320 Patch RA*5*41 September 2005: Added Ordering diagnoses and Clinical Indicators to sample report output.

321 Patch RA*5*45 May 2005: Contrast media associations will display, if appropriate

Order Entry

Run Date/Time: Mar 02, 2005 7:14 am

Page: 1

```
-----  
ZZPROV'S PRINTSET PARENT          (RAD Parent ) CPT:See Descendents  
  ANGIO BRACHIAL RETROGRADE S&I    (RAD Detailed) CPT:75658  
  ANGIO VERTEBRAL S&I             (RAD Detailed) CPT:75685  
  ABDOMEN 2 VIEWS                 (RAD Detailed) CPT:74010  
  Contrast Media: Barium, Cholecystographic, Ionic Iodinated, Non-ionic  
  Iodinated, Gadolinium, Gastrografin, unspecified contrast media  
Educational Desc: this is educational text for Provider's Printset Parent  
In this example, procedure specific contrast media association are printed  
immediately below the procedure name.
```

Request an Exam 322

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. The "Person Requesting Order" is screened so that only those people who have the PROVIDER key and are not terminated from the NEW PERSON file (#200) can be selected.³²³

If the user of this option has both conditions met, then the user's name would be displayed as the default value to this "Person Requesting Order" prompt. If the patient is an inpatient, you will see a default showing the ward the patient is currently on according to data in the PIMS 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, if you have the PROVIDER key and the "CIDC Insurance and Switch" function returns a non-zero value, you will be asked if you want to "copy a previous order's ICD codes and SC/EI values." ³²⁴ (The "SC/EI" will not be in the prompt string if the patient is not service connected according to the Enrollment package.) If you answer 'Y', then

322 Patch RA*5*47 September 2011: Request an Exam option is affected by the new Site Specific Accession Number (SSAN).

323 Patch RA*5*41 September 2005: New instructions added.

324 Patch RA*5*41 September 2005: Deleted reference to ORES key, added new prompt description.

a list of this patient's non-discontinued orders would be displayed, and you would be prompted to select one of them.

Selection of a previous order would cause that previous order's ICD (and SC/EI data if applicable) to appear as default values in the ICD (and SC/EI) prompts later in this option.

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.

You will be prompted for procedure modifiers 325, date desired, reason for study 326, and clinical history. A procedure can be further defined by using the Procedure Modifiers field. Several modifiers may be entered for one procedure. The Reason for Study field is required for all exam requests is a short (64 characters or less) patient history summarizing the condition of the patient and background information as to why the study has been initiated.

The clinical history field is optional, and can contain past history relevant to this exam, conditions to rule out, conditions to confirm, or 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.)

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.) 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.

325 Patch RA*5*8 October 1999

326 Patch RA*5*75 June 2007: Edited section to include reason for study and update clinical history description.

Order Entry

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 have the PROVIDER key and the "CIDC Insurance and Switch" function returns a non-zero value, you will be prompted to enter a Primary Ordering ICD-9 Diagnosis. 327 If you had selected a previous order to copy this information, that previous order's Primary Ordering ICD-9 would be displayed as a default value to this prompt.

You may change the default value, or press the return key to accept the default value. If the patient has Service Connected status (from the Enrollment package), then you will be asked if the treatment was related to a Service Connected condition.

And if the patient has Environmental Indicator (according to the Enrollment package), then you will be asked the following: Combat Veteran, Agent Orange, Ionizing Radiation, Southwest Asia Conditions. 328 PROJ 112/SHAD, Military Sexual Trauma, and Head Neck Cancer. After the Primary Order ICD-9 and SC/EI prompts, you will be prompted to enter a Secondary Ordering ICD-9 Diagnosis and any related SC/EI conditions.

The answers to these prompts are optional, and if you had selected a previous order to copy this information, that previous order's Secondary Ordering ICD-9 would be displayed as a default value for this prompt. If you enter data (or accept the default) for a Secondary Ordering ICD-9 prompt, you will be prompted to enter another secondary, until you press the 'Enter' key without a default value, to indicate that there are no more secondary data to enter.

If you are entering a request for a female patient (who may be pregnant), you will also see a 'Pregnant at time of order entry' prompt.329 You may answer No, Yes, or Unknown. Your answer will appear in the pregnancy status notation of the printed request form.

327 Patch RA*5*41 September 2005: New prompt description.

328 Patch RA*5*70 March 2009: Changed the "Environmental Contaminants" to "Southwest Asia Conditions", added "PROJ 112/SHAD"

329 Patch RA*5*99 February 2010: Replaced the 'PREGNANT' prompt to 'PREGNANT AT TIME OF ORDER ENTRY.'

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 IT SERVICE 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: RADPATIENT,TWO 07-06-46 000-00-0053 YES SC VETERAN

Patient Location: GENERAL MEDICINE
Person Requesting Order: RADPROVIDER,EIGHT

Case #      Last 5 Procedures/New Orders Exam Date   Status of Exam   Imaging Loc.
-----
335         CHOLANGIOGRAM IV                APR 12,1995     CANCELLED        X-RAY
           ARTHROGRAM WRIST S&I           APR  3,1995     COMPLETE         X-RAY
           ANKLE 2 VIEWS                   APR  3,1995     COMPLETE         X-RAY
           CT HEAD W/IV CONT              JAN 19,1995     COMPLETE         X-RAY
           SKULL 4 OR MORE VIEWS         JAN 19,1995     COMPLETE         X-RAY
           ARTHROGRAM SHOULDER S&I        Ord 4/9/97      X-RAY
           ARTHROGRAM WRIST S&I          Ord 4/9/97      X-RAY
           ARTHROGRAM SHOULDER S&I        Ord 4/9/97      X-RAY

Copy a previous order's ICD codes and SC/EI values? NO//YES 330
#          Last Procedures/New Orders   Order Date      Imaging Loc.
-----
1          CHANGE OF PERC DRAIN CATH CP    5/2/96         X-RAY
2          NECK SOFT TISSUE                5/2/96         RADIOLOGY MAIN
3          ABDOMEN 2 VIEWS                 5/19/03        RADIOLOGY MAIN

Select Order # to copy: 3

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. RADPROVIDER,ONE BEFORE ORDERING THIS PROCEDURE

```

330 Patch RA*5*41 September 2005: New prompt to Copy a previous order's ICD codes and SC/EI values.

Order Entry

```
This test is designed to LOCATE the site of KNOWN GI bleeding, NOT to
determine whether there IS GI bleeding.
Select PROCEDURE MODIFIERS: ASAP 331
Select PROCEDURE MODIFIERS: <RET>
DATE DESIRED (Not guaranteed): T <RET> 332 (APR 09, 2007)
PREGNANT AT TIME OF ORDER ENTRY: YES 333
REASON FOR STUDY: Patient reports severe abdominal pain, blood in stool 334
  Clin Hx must be appropriate for a procedure

CLINICAL HISTORY FOR EXAM
==[ WRAP ]==[ INSERT ]====< Clinical History 335 >=====[ <PF1>H=Help ]====
Blood in stool; hx of ulcers.

<=====T=====T=====T=====
Primary Ordering ICD-9 Diagnosis: 336 BLOOD IN STOOL 578.1
  SC Related? NO
Ordering ICD-9 Diagnosis: 578.1// <RET>
  ...OK? Yes// <RET>
Was treatment for a SC Condition? // YES
  Was treatment related to Combat Vet (Combat Related)? Yes// YES
  Was treatment related to Agent Orange Exposure? NO// <RET>
  Was treatment related to Ionizing Radiation Exposure? // NO
Was treatment related to Southwest Asia Conditions? // NO 337
  Was treatment related to PROJ 112/SHAD? // NO
  Was treatment related to Military Sexual Trauma? // NO
  Was treatment related to Head and/or Neck Cancer? // NO
Secondary Ordering ICD-9 Diagnosis: LOW BLOOD PRESS READING 796.3
  SC Related? NO
Secondary Ordering ICD-9 Diagnosis: 796.3// <RET>
  ...OK? Yes// (Yes)
  Was treatment for a SC Condition? // YES
  Was treatment related to Combat Vet (Combat Related)? Yes// YES
  Was treatment related to Agent Orange Exposure? NO// <RET>
  Was treatment related to Ionizing Radiation Exposure? // NO
  Was treatment related to Southwest Asia Conditions? // NO 338
Was treatment related to PROJ 112/SHAD? // NO

Secondary Ordering ICD-9 Diagnosis:
-----
Patient: RADPATIENT,SEVEN Pregnant at time of order entry: YES339
  Procedure: ACUTE GI BLOOD LOSS IMAGING
  Modifiers: ASAP
  Category: OUTPATIENT Mode of Transport: AMBULATORY
  Desired Date: Apr 09, 1997 Isolation Procedures: NO
  Request Urgency: ROUTINE Scheduled for Pre-op: NO
  Request Location: GENERAL MEDICINE
Reason For Study:340
Patient reports severe abdominal pain, blood in stool

Primary Ordering ICD-9 Diagnosis:341 BLOOD IN STOOL 578.1
SC Related? YES CV Related? YES
```

331 Patch RA*5*10 April 2000

332 Patch RA*5*75 June 2007: Removed "Today" default from Desired Date field – user must now enter a date.

333 Patch RA*5*99 February 2010: Inserted the 'PREGNANT AT TIME OF ORDER ENTRY' prompt.

334 Patch RA*5*75 June 2007: Added Reason for Study prompt and sample text.

335 Patch RA*5*75 June 2007: Removed "Reason" from Clinical History report title, added sample text.

336 Patch RA*5*41 September 2005: New prompts added.

337 Patch RA*5*70 March 2009: Prompt changed - "Environmental Contaminants" to "Southwest Asia Conditions", added - "PROJ 112/SHAD".

338 Patch RA*5*70 March 2009: Prompt changed - "Environmental Contaminants" to "Southwest Asia Conditions", added - "PROJ 112/SHAD"

339 Patch RA*5*99 February 2010: Replaced the 'Pregnant' field with 'Pregnant at time of order entry.'

340 Patch RA*5*75 June 2007: Added Reason for Study to the display.

341 Patch RA*5*41 September 2005: New display example.

```

AO Related? NO                IR Related? NO
SWAC Related? NO342          SHAD Related? NO
MST Related? NO              HNC Related? NO

Secondary Ordering ICD-9 Diagnosis: LOW BLOOD PRESS READING 796.3
SC Related? YES              CV Related? YES
AO Related? NO                IR Related? NO
SWAC Related? NO              SHAD Related? NO
MST Related? NO              HNC Related? NO

Clinical History:
Blood in stool; hx of ulcers.
-----
Do you want to change any of the above? NO// YES
PROCEDURE: ACUTE GI BLOOD LOSS IMAGING // (RAD Detailed) CPT:70220
Select PROCEDURE MODIFIERS: ASAP//
REASON FOR STUDY: Patient reports severe abdominal pain, blood in stool
Replace
CLINICAL HISTORY FOR EXAM:
Blood in stool; hx of ulcers.
Edit? NO//
CATEGORY OF EXAM: OUTPATIENT// OUTPATIENT
IS PATIENT SCHEDULED FOR PRE-OP? No// (No)
PREGNANT AT TIME OF ORDER ENTRY: YES// 343
DATE DESIRED (Not guaranteed): APR 09, 2007//
MODE OF TRANSPORT: AMBULATORY// AMBULATORY
IS PATIENT ON ISOLATION PROCEDURES?: NO// NO
REQUEST URGENCY: ROUTINE// ROUTINE
NATURE OF (NEW) ORDER ACTIVITY: SERVICE CORRECTION
// SERVICE CORRECTION
..request has been submitted to P-DOT MATRIX BACK.
Task #: 39212
NOTE: Only imaging locations pre-defined (by the ADPAC) to have the same imaging type as the
procedure requested will be selectable. If only one imaging location has 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

```

When a procedure with contrast media associations is ordered for a patient with a history of contrast media allergic reactions (derived from VistA Adverse Reaction Tracking) the following warning is displayed to the individual ordering the procedure. 344

Prompt/User Response

Discussion

```

Request an Exam

Select PATIENT NAME: RADPATIENT,FOUR      4-14-73      000000444      NO
EMPLOYEE

Patient Location: DISPOSITION-SUPPORT ISC(PCE)      RADPROVIDER,FIVE
Person Requesting Order: RADPROVIDER,ONE//

Case #      Last 5 Procedures/New Orders Exam Date      Status of Exam      Imaging
Loc.
-----
--

```

342 Patch RA*5*70 March 2009: Changed EI to SWAC, Added SHAD Related? No
343 Patch RA*5*99 February 2010: Inserted the 'PREGNANT AT TIME OF ORDER ENTRY' prompt.
344 Patch RA*5*45 May 2005: A warning displays for a patient with a history of contrast media allergic reactions when a procedure with contrast media associations is ordered.

Order Entry

```
1769      ANGIO CAROTID CEREBRAL UNILA JAN 26,2005 WAITING FOR      RADIOLOGY
LA
1770      ANGIO CERVICOCEREBRAL CATH S JAN 26,2005 WAITING FOR      RADIOLOGY
LA
1771      ANGIO CAROTID CERVICAL BILAT JAN 26,2005 WAITING FOR      RADIOLOGY
LA
1732      MAMMOGRAM UNILAT          DEC  1,2004 WAITING FOR MAMMOGRAPHY
1734      ECHOGRAM BREAST B-SCAN &/OR NOV 26,2004 WAITING FOR RADIOLOGY
LA
```

Select one of the following imaging types:

```
GENERAL RADIOLOGY
NUCLEAR MEDICINE
ULTRASOUND
MAGNETIC RESONANCE IMAGING
CT SCAN
CARDIOLOGY STUDIES (NUC MED)
VASCULAR LAB
MAMMOGRAPHY
```

Select IMAGING TYPE: **RAD** GENERAL RADIOLOGY

COMMON RADIOLOGY/NUCLEAR MEDICINE PROCEDURES (GENERAL RADIOLOGY)

```
-----
1) CHEST 4 VIEWS                9) FOOT 2 VIEWS
2) ABDOMEN 2 VIEWS              10) SKULL 4 OR MORE VIEWS
3) ANKLE 2 VIEWS                11) ANKLE 3 OR MORE VIEWS
4) CHEST 2 VIEWS PA&LAT         12) CLAVICLE
5) HIP 1 VIEW                   13) ABDOMEN 3 OR MORE VIEWS
6) SKELETAL-BONE AND JOINTS     14) KNEE 3 VIEWS
7) ANGIO CAROTID CEREBRAL UNILAT S&  15) ZZPRINTSET PROCEDURE
8) SKULL LESS THAN 4 VIEWS
```

Select Procedure (1-15) or enter '?' for help: 2

Processing procedure: **ABDOMEN 2 VIEWS**

The following requests are already on file for this procedure:

```
A request dated OCT 28,2004 is already on HOLD for this procedure.
Is it ok to continue? No// Y
```

```
***** Patient reaction to contrast media *****
```

```
ABDOMEN 2 VIEWS uses contrast media: Barium, Cholecystographic,
Ionic Iodinated, Non-ionic Iodinated, Gadolinium, Gastrografen,
unspecified contrast media
```

```
*****
```

Select PROCEDURE MODIFIERS: **PORTABLE EXAM**

Select PROCEDURE MODIFIERS: **<RET>**

DATE DESIRED (Not guaranteed):345 **T <RET>** (APR 10, 2007)

PREGNANT AT TIME OF ORDER ENTRY: YES346

REASON FOR STUDY:347 **Patient reports severe abdominal pain**

345 Patch RA*5*75 June 2007: Removed "Today" default from Desired Date field – user must now enter a date.

346 Patch RA*5*99 February 2010: Inserted the 'PREGNANT AT TIME OF ORDER ENTRY' prompt.

347 Patch RA*5*75 June 2007: Added Reason for Study prompt to the sample order and summary.

Clin Hx must be appropriate for a procedure

CLINICAL HISTORY FOR EXAM

```
==[ WRAP ]==[ INSERT ]=====< Clinical History 348 >===== [ <PF1>H=Help ]==
```

This is a test of the contrast media display logic. CM is displayed if the procedure being ordered is associated with contrasts AND if patient has had a previous contrast media allergic reaction (according to the VISTA Allergy Reaction Tracking (ART) package).

```
<=====T====T=====T=====T=====T=====T=====T=====T=====T>=====
```

```
-----
      Patient: RADPATIENT,FOUR   Pregnant at time of order entry:  YES349
      Procedure: ABDOMEN 2 VIEWS
      Proc. Modifiers: PORTABLE EXAM
      Category: OUTPATIENT                Mode of Transport: PORTABLE
      Desired Date: Apr 10, 2007          Isolation Procedures: NO
      Request Urgency: ROUTINE            Scheduled for Pre-op: NO
      Request Location: DISPOSITION-SUPPORT ISC(PCE)Nature of order:  SVC
CORRECTION
```

Reason For Study: Patient reports severe abdominal pain

Clinical History:

This is a test of the contrast media display logic. CM is displayed if the procedure being ordered is associated with contrasts AND if patient has had a previous contrast media allergic reaction (according to the VISTA Allergy Reaction Tracking (ART) package).

```
-----
Do you want to change any of the above? NO// y YES
```

```
PROCEDURE: ABDOMEN 2 VIEWS//                (RAD Detailed)
CPT:74010
```

The following requests are already on file for this procedure:

A request dated OCT 28,2004 is already on HOLD for this procedure.

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

Select PROCEDURE MODIFIERS: PORTABLE EXAM//

Clin Hx must be appropriate for a procedure

CLINICAL HISTORY FOR EXAM:

This is a test of the contrast media display logic. CM is displayed if the procedure being ordered is associated with contrasts AND if patient has had a previous contrast media allergic reaction (according to the VISTA Allergy Reaction Tracking (ART) package).

Edit? NO//

CATEGORY OF EXAM: OUTPATIENT// OUTPATIENT

IS PATIENT SCHEDULED FOR PRE-OP? No// (No)

PREGNANT AT TIME OF ORDER ENTRY: NO350

DATE DESIRED (Not guaranteed): Apr 10, 2007// (APR 10, 2007)

REASON FOR STUDY: Patient reports severe abdominal pain351

348 Patch RA*5*75 June 2007: Removed "Reason" from Clinical History report title.

349 Patch RA*5*99 February 2010: Replaced the 'Pregnant' field with 'Pregnant at time of order entry.'

350 Patch RA*5*99 February 2010: Inserted the 'PREGNANT AT TIME OF ORDER ENTRY' prompt.

351 Patch RA*5*75 June 2007: Added Reason for Study prompt to the display.

Order Entry

```
MODE OF TRANSPORT: PORTABLE//    PORTABLE
IS PATIENT ON ISOLATION PROCEDURES?: NO//    NO
REQUEST URGENCY: ROUTINE//    ROUTINE
NATURE OF (NEW) ORDER ACTIVITY: SERVICE CORRECTION// SERVICE CORRECTION
```

```
SUBMIT REQUEST TO:    X-RAY CLINIC COUNT    (GENERAL RADIOLOGY-)
```

```
...request has been submitted to RADIOLOGY.
Task #: 765308
```

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 PIMS package is a completely separate function. Neither interacts with the other. PIMS scheduling is used at many hospitals in addition to Radiology/Nuclear Medicine scheduling because it is helpful in arranging transportation, charts, etc.

Prompt/User Response

Discussion

```
Schedule a Request

Select PATIENT NAME: RADPATIENT, SEVEN          07-06-46          000000624          SC VETERAN

          **** Requested Exams for RADPATIENT,SEVEN****          3 Requests
St  Urgency  Procedure                               Desired Requester  Req'g Loc
--  -
1  p  ROUTINE  ARTHROGRAM SHOULDER S&I                04/03  RADPROVIDER, EMERGENCY R
2  p  ROUTINE  ARTHROGRAM WRIST S&I                  04/03  RADPROVIDER, EMERGENCY R
3  p  ROUTINE  ANOTHER PARENT PROCEDURE          01/20  RADPROVIDER, 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>**

Update a Hold Request

This option allows users within Radiology/Nuclear Medicine to update the reason on 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 HOLD will be presented for selection.

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 keeping the request on HOLD. If a reason is not entered, the request will not be updated.

Prompt/User Response

Discussion

```

**** Requested Exams for RADPATIENT,FIVE ****      1 Requests
  St  Urgency  Procedure/(Img. Loc.)  Desired  Requester  Req'g Loc
  --  -
  1  h  ROUTINE  ABDOMEN 3 OR MORE VIEWS  07/26/2016  CEBELINSKI,  381TEST
          (OUTPATIENT RADIOLOGY)

Select Request(s) 1-1 to Update hold reason or '^' to Exit:  Exit// 1

Select HOLD REASON: ?? <RET>

Choose from:
  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
  11     OTHER CANCEL REASON                  Synonym: OTH
  12     OTHER HOLD REASON                    Synonym: OHR
  13     PATIENT CONSENT DENIED               Synonym: PCD
  15     PATIENT TOO ILL FOR STUDY            Synonym: ILL
  16     REPEAT PATIENT PREP                  Synonym: REP
  18     SURGERY CONSULT NEEDED               Synonym: SUR
  44     KERRY'S TEST II                      Synonym: KR
  45     CALLED VETERAN FOR APPT              Synonym: CALL
  46     MYHEALTHYVET CONTACT                 Synonym: MHV
  47     LETTER SENT TO CALL VA                Synonym: LETTER
  48     RESCHED CALL BY VETERAN              Synonym: RESCHED
  49     MRI SAFETY REVIEW                     Synonym: MRISAFETY
  50     RADIOLOGIST REVIEW                   Synonym: RADREV
  51     COMMUNITY CARE APPT                  Synonym: COMCARE
  52     WAITING ON OUTSIDE IMAGES             Synonym: OUTIMAGE
  53     FUTURE APPOINTMENT                   Synonym: FUTUREAPT
  54     NON RADIOLOGY CONSULT                Synonym: NONRADCON

Select HOLD REASON: LETTER SENT TO CALL VA      Synonym: LETTER

...will now update the hold reason for the selected request(s)...
...ABDOMEN 3 OR MORE VIEWS updated...

Select PATIENT NAME: <RET>

```

Order Entry

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, if there is more than one imaging location for the same imaging type to choose from. 352 However, if there is only one imaging location for the same imaging type as the order, that imaging location will be captured.

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 PIMS 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 PIMS data) changed since the time the order was placed the scheduled exam will print on the report for both the old and the new location 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
```

352 Patch RA*5*34 May 2003: Deleted ‘...and therefore will not appear on this report’ and replaced with ‘..if there is more than one imaging location...’ text.

RADPATIENT, SEVEN	0058	4/3/95@14:30	ARTHROGRAM WRIST S&I	X-RAY
-------------------	------	--------------	----------------------	-------

13. 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.

- Radiology HL7 Menu³⁵³
- 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 ...
- Override a Single Exam Status to 'complete'
- Print File Entries
- Rad/Nuc Med Personnel Menu ...
- Restore a Deleted Report ³⁵⁴
- Search File Entries
- Switch Locations
- System Definition Menu ...
- Unverify a Report for Amendment
- Update Exam Status
- Utility Files Maintenance Menu ...

Refer to the VistA FileMan User Guide for a complete explanation of Inquire to File Entries, Print File Entries, and Search File Entries.

The sub-menus listed below are usually used only by the system ADPAC, and are not explained within this manual. Please refer to the Radiology/Nuclear Medicine 5.0 ADPAC Guide for a complete explanation of these items:

- Radiology HL7 Menu
- Maintenance Files Print Menu
- Rad/Nuc Med Personnel Menu
- System Definition Menu
- Utility Files Maintenance Menu

Access Uncorrected Reports ³⁵⁵

³⁵³ Patch RA*5*82 June 2007: Added Radiology HL7 Menu option to Supervisor Menu list. This option was created with Patch RA*5*25 and updated with patch 82; included here simply as a cross-reference to the *ADPAC Guide*.

³⁵⁴ Patch RA*5*56 July 2008: Added a new option, Restore a Deleted Report, to the Supervisor menu.

³⁵⁵ Patch RA*5*47 September 2011: Access Uncorrected Reports option is affected by the new Site Specific Accession Number (SSAN).

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, contrast media associations 356 (if applicable), 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.

Prompt/User Response

```

Access Uncorrected Reports
Select Patient:  RADPATIENT,EIGHT      NO      NSC VETERAN      07-03-30  000-00-5555
                **** Patient's Exams ****
Patient's Name:  RADPATIENT,EIGHT 000-00-5555      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:  RADPATIENT,EIGHT ***
Run Date:  Aug 19, 1997                                     Page:  1
-----
Date/Time Uncorrected Report retained:  Aug 06, 1997 12:27:15 pm
RADPATIENT,EIGHT 000-00-5555 67 yr. old male      Case: 080597-234@13:42
Req Phys:  RADPROVIDER,TEN      Pat Loc: 9CM/080697@12:27
Att Phys:  RADPROVIDER,ONE      Img Loc: CTG
Pri Phys:  RADPROVIDER,TEN      +      Service: MEDICINE
Report Unverified by:  RADPROVIDER,TWO
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:  RADPATIENT,EIGHT ***
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.
Interpreting Staff:
RADPROVIDER,TWO, STAFF RADIOLOGIST
Primary Interpreting Resident:

*** Uncorrected Reports for:  RADPATIENT,EIGHT ***
Run Date:  Aug 19, 1997                                     Page:  4
-----
RADPROVIDER,THREE., Radiology Resident
VERIFIED BY:
RADPROVIDER,TWO, , STAFF RADIOLOGIST
/CG

***** P R O B L E M   S T A T E M E N T *****

```

356 Patch RA*5*45 May 2005: Supervisor Menu/ Access Uncorrected Reports display contrast media, if applicable.

Delete a Report 357

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.

Prior to Patch RA*5*56, a deleted report is erased from the database. Patch RA*5*56 keeps the deleted report in the RAD/NUC MED REPORTS file (#74), but removes its association to an exam, so that it is no longer accessible via the Radiology application. The only way to view a deleted report is via VA Fileman. 358

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 group or other group set up by IT SERVICE to receive the RAD/NUC MED REPORT DELETION bulletin. Delete a report shared by three cases (printset). The deletion session outwardly appears the same as before patch RA*5*56:

357 Patch RA*5*47 September 2011: Delete a Report option is affected by the new Site Specific Accession Number (SSAN).

358 Patch RA*5*56 July 2008: Modified the information about the Delete a Report option.

Prompt/User Response

Discussion

```

Select Supervisor Menu Option: DELETE A REPORT

Select Report Day-Case#: RADPATIENT,ONE  RADPATIENT,ONE          6-1-27
000000000
1  RADPATIENT,ONE  090806-2152  RADPATIENT,ONE  FOOT 2 VIEWS
2  RADPATIENT,ONE  090806-2153  RADPATIENT,ONE  CLAVICLE
3  RADPATIENT,ONE  013108-2551  RADPATIENT,ONE  MANDIBLE LESS THAN 4 VIEWS
4  RADPATIENT,ONE  013108-2553  RADPATIENT,ONE  +ABDOMEN 2 VIEWS
5  RADPATIENT,ONE  021308-2610  RADPATIENT,ONE  ELBOW 2 VIEWS
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 4  013108-2553  RADPATIENT,ONE  +ABDOMEN 2 VIEWS

Do you wish to delete this report? NO// Y
    ...report deletion complete.
    ...exam status remains 'WAITING FOR EXAM'.
    ...exam status remains 'WAITING FOR EXAM'.
    ...exam status remains 'WAITING FOR EXAM'.

```

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: TEST 1                      Date Created: JUN 13, 1994@12:48
User: RADPROVIDER,FIVE              Date Printed: MAR 22, 1995@08:54

Batch: TEST BATCH                  Date Created: SEP 28, 1994@10:37
User: RADPROVIDER,SEVEN            Date Printed: SEP 28, 1994

Batch: MARCH 6 REPORTS             Date Created: MAR 06, 1995@11:59
User: RADPROVIDER,TEN              Date Printed: MAR 06, 1995@12:03

Batch: TEST                         Date Created: MAR 09, 1995
User: RADPROVIDER,SIX              Date Printed: MAR 09, 1995@10:00

```

Order Entry

```
'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)
```

Exam Deletion 359

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 IT SERVICE, 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.

Exam Deletion

Prompt/**User Response**

Discussion

Note: An exam with a status of Complete cannot be deleted:

359 Patch RA*5*47 September 2011: Exam Deletion option is affected by the new Site Specific Accession Number (SSAN).

```

Enter Case Number: RADPATIENT,Ten
                   01-22-20      000-00-0510      YES      SC VETERAN

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

Patient's Name: RADPATIENT,Ten  000-00-0510      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: RADPATIENT,Ten
                   01-22-20      000000510      YES      SC VETERAN

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

Patient's Name: RADPATIENT,Ten  000-00-0510      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=====TT=====T=====T=====T=====T=====T=====T=====T=====
  ...request status updated to hold.
  ...exam status backed down to 'CANCELLED'

```

Order Entry

...deletion of exam complete.

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 FileMann Inquire to File Entries option, so it is necessary that the user be assigned all appropriate file access codes by his/her IT SERVICE. 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, refer to the FileMan User Manual.

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: RADPATIENT,ONE         SSN: 000-00-0061
Exam Date: JUN 21,1994@15:31    Case #: 48
Reported: Yes                  Report Status: DRAFT
Procedure: ULTRASOUND ABDOMEN

Patient: RADPATIENT,TWO         SSN: 000-00-0062
Exam Date: MAR 9,1994@13:44     Case #: 7
Reported: Yes                  Report Status: VERIFIED
Procedure: ECHOGRAM ABDOMEN COMPLETE

Patient: RADPATIENT,SEVEN       SSN: 000-00-0047
Exam Date: JAN 12,1995@10:14    Case #: 29
Reported: Yes                  Report Status: VERIFIED
Procedure: ECHOGRAM ABDOMEN COMPLETE
```

Override a Single Exam's Status to 'complete' 360

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:  RADPATIENT, TEN          01-22-20      000000510   YES   SC
VETERAN

                **** Case Lookup by Patient ****
Patient's Name: RADPATIENT, TEN 000-00-0510          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      RADPATIENT, TEND          Pt ID      : 000-00-0510

```

360 Patch RA*5*47 September 2011: Override a Single Exam's Status to 'complete' option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

```
Case No. : 151                      Procedure : ABDOMEN 1 VIEW
Exam Date: MAR 21,1995  11:00       Technologist:
                                      Req Phys   : RADPROVIDER,TWO
```

```
-----
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.
```

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 IT SERVICE. 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, refer to the FileMan User Manual.

Restore A Deleted Report 361 362

This option allows you to relink a previously deleted report to its associated case, only if another report was not linked to the case in the interim (time between deletion and restoration). The restored report is re-assigned the report status it had prior to being deleted; however, the status of the exam is not updated.

If a case had a report entered and deleted, then had a second report entered and deleted for it, the case would have two deleted reports in the database. This option allows you to choose any previously deleted report for a case, not just the most recently deleted report for that case. The other deleted report that was not selected for restoration remains as a deleted report in the database.

To view a list of deleted reports to select from this option, enter "???" at the "Select Deleted Report to restore:" prompt. After you select a deleted report, the first prompt displayed is:

```
Do you want to restore this deleted report? NO//
```

361 Patch RA*5*56 July 2008: Added information about the Restore a Deleted Report option.

362 Patch RA*5*47 September 2011: Restore a Deleted Report option is affected by the new Site Specific Accession Number (SSAN).

Before allowing you to restore a report, this option checks whether the case associated with this report has another report linked to it and whether the case has data for diagnostic codes, staff, and resident. If any such data are found, the option does not continue, but displays a warning message. For example:

```
Case #123 is already associated with a report!
Restoration was not done.
```

This message indicates that either another previously deleted report was restored to its associated case or a new report was entered for the case during the time between report deletion and attempted restoration.

```
Case #461 already has SECONDARY DIAGNOSTIC CODE
Restoration was not done.
```

This message indicates that the case associated with this report already has secondary diagnostic code data, which may or may not be associated with this report. The supervisor must determine if the correct deleted report was selected for restoration; and if so, must remove the secondary diagnostic code from the case before the deleted report can be restored. The 'Diagnostic Code and Interpreter Edit by Case No.' [RA DIAGCN] option can be used to remove the diagnostic code data.

If no problems are found, then the patient name and some case data are displayed. If the patient name and case data match the case for the deleted report you want to restore, then enter "YES" to the second prompt:

```
Are you sure you want to link this report back to the case? NO//
```

After a report is restored to its associated case, you can view statuses for previously deleted and restored activities from the Report Activity Log section of the 'View Exam by Case No.' option.

Example of restoring a report to one case

Restore a deleted report back to its case. This option relinks the report back to its associated case and repopulates the diagnostic code(s), staff, and resident data to the case.

```
Select Supervisor Menu Option: RESTORE a Deleted Report

+-----+
|          This option is for restoring a deleted report.          |
+-----+

Select Deleted Report to restore: ??
Choose from:
013108-2551      RADPATIENT,ONE      MANDIBLE LESS THAN 4 VIEWS
021308-2608      RADPATIENT,ONE      HAND 1 OR 2 VIEWS
070706-2122      RADPATIENT,ONE      HIP 1 VIEW
```


Order Entry

```
072304-1608      RADPATIENT,TWO      MANDIBLE LESS THAN 4 VIEWS
072304-1609      RADPATIENT,TWO      FOOT 3 OR MORE VIEWS
090806-2153      RADPATIENT,ONE      CLAVICLE
```

```
Select Deleted Report to restore: 013108-2551      RADPATIENT,ONE      MANDIBLE
LESS THAN 4 VIEWS
```

```
Do you want to restore this deleted report? NO// YES
```

```
-----
Name       : RADPATIENT,ONE      Pt ID      : 000-00-0000
Case No.   : 2551  Exm. St: WAITING FOR Procedure   : MANDIBLE LESS THAN 4 VIEW
Tech.Comment: This is the tech comment during registration
Exam Date: JAN 31,2008  10:23      Technologist:
                                           Req Phys   : RADPROVIDER,ONE
-----
```

```
Are you sure you want to link this report back to the case? NO// YES
```

```
... Restored 013108-2551's report status to: DRAFT.
... Linked restored report to case no. 2551
... Restored case 2551's PRIMARY DIAGNOSTIC CODE to: NORMAL
... Restored case 2551's SECONDARY DIAGNOSTIC CODE to: UNDICTATED FILMS NOT
RETURNED, 3 DAYS
... Restored case 2551's SECONDARY DIAGNOSTIC CODE to: NO DISCRETE MASS
... Restored case 2551's PRIMARY INTERPRETING STAFF to: RADPRIMARYSTAFF,ONE
... Restored case 2551's SECONDARY INTERPRETING STAFF to: RADSECONDARYSTAFF,ONE
... Restored case 2551's PRIMARY INTERPRETING RESIDENT to: RADPRIMARYRESIDENT,ONE
```

```
** You need to edit the case to update the exam status. **
Press RETURN to exit.
```

Example of restoring a report to several cases that previously shared this report

Restore the deleted report back to its cases (printset). The option relinks the report back to its associated cases and repopulates the diagnostic code(s), staff, and resident data to each of the cases.

```
Select Supervisor Menu Option: RESTORE a Deleted Report
```

```
+-----+
|                                     |
|      This option is for restoring a deleted report.      |
|                                     |
+-----+
```

```
Select Deleted Report to restore: ??
```

```
Choose from:
```

```
013108-2553      RADPATIENT,ONE      -2552,-2554      +ABDOMEN 2 VIEWS
021308-2608      RADPATIENT,ONE      HAND 1 OR 2 VIEWS
070706-2122      RADPATIENT,ONE      HIP 1 VIEW
072304-1608      RADPATIENT,TWO      MANDIBLE LESS THAN 4 VIEWS
072304-1609      RADPATIENT,TWO      FOOT 3 OR MORE VIEWS
090806-2153      RADPATIENT,ONE      CLAVICLE
```

```
Select Deleted Report to restore: 013108-2553      RADPATIENT,ONE      -2552,-
2554
```

```
+ABDOMEN 2 VIEWS
```

```
Do you want to restore this deleted report? NO// YES
```

```
-----
Name       : RADPATIENT,ONE      Pt ID      : 000-00-0000
Case No.   : 2553  Exm. St: WAITING FOR Procedure   : ABDOMEN 2 VIEWS
-----
```

```

Tech.Comment: unable enter def CPT mod GC, 50 (case 2552, Cmod KB)
Case No. : 2552  Exm. St: WAITING FOR  Procedure   : ABDOMEN 1 VIEW
Tech.Comment: tech comment during registration
Case No. : 2554  Exm. St: WAITING FOR  Procedure   : ABDOMEN 3 OR MORE
VIEWS
Exam Date: JAN 31,2008  10:24                Technologist:
                                           Req Phys    : RADPROVIDER,ONE

```

```

-----
Are you sure you want to link this report back to the cases? NO// YES
... Restored 013108-2553's report status to: DRAFT.
... Linked restored report to case no. 2552
... Linked restored report to case no. 2553
... Linked restored report to case no. 2554
... Restored case 2552's PRIMARY DIAGNOSTIC CODE to: MINOR ABNORMALITY
... Restored case 2552's SECONDARY DIAGNOSTIC CODE to: NO DISCRETE MASS
... Restored case 2552's SECONDARY DIAGNOSTIC CODE to: UNDICTATED FILMS
NOT RETURNED, 3 DAYS
... Restored case 2553's PRIMARY DIAGNOSTIC CODE to: MINOR ABNORMALITY
... Restored case 2553's SECONDARY DIAGNOSTIC CODE to: NO DISCRETE MASS
... Restored case 2553's SECONDARY DIAGNOSTIC CODE to: UNDICTATED FILMS
NOT RETURNED, 3 DAYS
... Restored case 2554's PRIMARY DIAGNOSTIC CODE to: MINOR ABNORMALITY
... Restored case 2554's SECONDARY DIAGNOSTIC CODE to: NO DISCRETE MASS
... Restored case 2554's SECONDARY DIAGNOSTIC CODE to: UNDICTATED FILMS
NOT RETURNED, 3 DAYS
... Restored case 2552's PRIMARY INTERPRETING STAFF to:
RADPRIMARYSTAFF,ONE
... Restored case 2552's SECONDARY INTERPRETING STAFF to:
RADSECONDARYSTAFF,ONE
... Restored case 2552's SECONDARY INTERPRETING STAFF to:
RADSECONDARYSTAFF,TWO
... Restored case 2553's PRIMARY INTERPRETING STAFF to:
RADPRIMARYSTAFF,ONE
... Restored case 2553's SECONDARY INTERPRETING STAFF to:
RADSECONDARYSTAFF,ONE
... Restored case 2553's SECONDARY INTERPRETING STAFF to:
RADSECONDARYSTAFF,TWO
... Restored case 2554's PRIMARY INTERPRETING STAFF to:
RADPRIMARYSTAFF,ONE
... Restored case 2554's SECONDARY INTERPRETING STAFF to:
RADSECONDARYSTAFF,ONE
... Restored case 2554's SECONDARY INTERPRETING STAFF to:
RADSECONDARYSTAFF,TWO
... Restored case 2552's PRIMARY INTERPRETING RESIDENT to:
RADPRIMARYRESIDENT,ONE
... Restored case 2553's PRIMARY INTERPRETING RESIDENT to:
RADPRIMARYRESIDENT,ONE
... Restored case 2554's PRIMARY INTERPRETING RESIDENT to:
RADPRIMARYRESIDENT,ONE

** You need to edit the cases to update the exam status. **
Press RETURN to exit.

```

Search File Entries

Order Entry

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 IT SERVICE. 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, refer to the *FileMan User Manual*.

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.

Unverify a Report for Amendment 363

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 IT SERVICE 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

363 Patch RA*5*47 September 2011: Unverify a Report for Amendment option is affected by the new Site Specific Accession Number (SSAN).

Unverify a Report for Amendment

Select RAD/NUC MED REPORTS DAY-CASE#: **RADPATIENT, FOUR**
 12-01-50 000000064 NO NSC VETERAN

1 013194-10 RADPATIENT, FOUR ANGIO CAROTID CEREBRAL UNILAT S&I
 2 013194-47 RADPATIENT, FOUR 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 (000-00-5463) [#12475] 10 Apr 95 09:43
 10 Lines

From: POSTMASTER (Sender: RADPROVIDER, SEVEN) in 'IN' basket. Page 1

 The following verified radiology report has been unverified:

1) Patient	: RADPATIENT, ONE
2) SSN	: 000-00-5463
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	: RADPROVIDER, SEVEN
8) Procedure	: ANGIO CAROTID CEREBRAL UNILAT S&I
9) Imaging Loc	: X-RAY

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

Update Exam Status 364

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 Guide* 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.

364 Patch RA*5*47 September 2011: Update Exam Status option is affected by the new Site Specific Accession Number (SSAN).

Order Entry

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          RADPATIENT,FOUR    0154
2        022497-608      SPINE CERVICAL MIN 2 VIEW RADPATIENT,FIVE    8277
CHOOSE FROM 1-2: 2
Case No.: 608 Procedure: SPINE CERVICAL MIN 2 VIEWS Name: RADPATIENT,FIVE
...will now designate exam status as 'COMPLETE'... for case no. 608
...exam status successfully updated.
```

14. 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 14.

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: RADPATIENT, SIX	06-21-19 000-00-0066 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: <input checked="" type="radio"/> OUTPATIENT	
NARRATIVE: ??	
This field may contain a brief note (up to 250 characters) about	

Order Entry

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>

15. 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
- Set preference for Long Display of Procedures
- 365
- Switch Locations
- Test Label Printer

Duplicate Dosage Ticket 366

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: RADPATIENT,SEVEN 08-23-18 000-00-0067 NO NSC VETERAN
                    **** Case Lookup by Patient ****
Patient's Name: RADPATIENT,SEVEN 000-00-0067 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 : RADPATIENT,SEVEN
Patient ID : 000-00-0067
Study : BONE SCAN, WHOLE BODY

Radiopharmaceutical : Tc99m MEDRONATE

```

365 Patch RA*5*35 December 2002: Added new option.

366 Patch RA*5*47 September 2011: Duplicate Dosage Ticket option is affected by the new Site Specific Accession Number (SSAN).

User Utility Menu

```
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: _____
```

Duplicate Flash Card 367

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 Guide* 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 IT SERVICE through the Device Specifications for Imaging Locations option, you will be prompted for a device. This should be queued to a printer.

367 Patch RA*5*47 September 2011: Duplicate Flash Card option is affected by the new Site Specific Accession Number (SSAN).

Prompt/User Response

Discussion

```

Duplicate Flash Card

Enter Case Number: RADPATIENT,FIVE
                   08-17-08      000000025   NO   NSC VETERAN

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

Patient's Name: RADPATIENT,FIVE 000-00-0025
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 RADUSER,SIX'S DESK
Duplicates queued to print on P-DOT MATRIX BACK. Task #: 11575

```

Jacket Labels 368

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 IT SERVICE through the Device Specifications for Imaging Locations option, you will be prompted for a device. This should be queued to a printer.

368 Patch RA*5*47 September 2011: Jacket Labels option is affected by the new Site Specific Accession Number (SSAN).

User Utility Menu

Prompt/User Response

Discussion

Jacket Labels

```
Select Patient: RADPATIENT,EIGHT          08-03-41  000-00-0068  NO  NSC
VETERAN
How many jacket labels? 1// <RET>
Duplicates queued to print on P-DOT 10 LINESAPAGE.  Task #: 39436
```

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

Set preference for Long Display of Procedures 369

This option allows the user to set his preference for the display of procedures and modifiers to the long (traditional) format, instead of the condensed (new default) format.

Prompt/User Response

```
SET preference for Long Display of Procedures
Do you want to set your preference for Long Display of Procedures
in all Radiology reports ? No// YES
Your preference for Long Display of Procedures has been set.
```

This option can also be used to switch from the long format to the condensed format.

Prompt/User Response

```
SET preference for Long Display of Procedures
Your preference for Long Display of Procedures has already been set.
Do you want to delete your preference ? No// YES
Your preference for Long Display of Procedures has been removed.
```

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.

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: RADPATIENT,NINE          SSN: 000-00-0069
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: RADPROVIDER,FOUR  Prim Phy At Order: RADPATIENT,TWO
Request Entered: Jan 21, 1994  10:30   CASE: 543
```

369 Patch RA*5*35 December 2002: Added new option, description, and example.

Patient Location: EENT CLINIC 51D/060894@13:35

16. Special Notes on Patch RA*5*116 and Patch RA*5*113

Patch RA*5*116

The VistA Imaging Importer III (for the Radiology Information System Support (RIS)), is a DICOM Image Gateway application for transferring DICOM objects from PAC studies performed outside of the VA, into VistA Imaging databases.

DICOM objects may be electronically transferred or transferred directly from portable media (such as CDs, DVDs, Flash Drives).

Portable media must conform to:

- DICOM Standards
- IHE Portable Data for Imaging PDI profiles

CDs and DVDs saved in proprietary formats usually cannot be transferred by (and used) by VistA Imaging nor can saved Report files (a planned future release).

The VistA Imaging Importer III can correct patient and/or study identification information mismatches previously processed by older utility software.

Further enhancements to the Radiology Information System (RIS) include database save features for Secondary Diagnostic Codes and file exam specific secondary Dx Codes (RAD/NUC MED PATIENT database).

Exported Components (ex-routines)

Component Type

RAMAG EXAM COMPLETE

Remote Procedure Call (RPC)

Patch RA*5*113

The Patient Specific Radiation Dose Aggregation patch collects patient radiation information and how many Rankin's study patients were exposed to. Radiation dose information studies are limited to Computed Tomography and Fluoroscopy.

Patient Radiation dose data is available in two report options; Exam Profile with Radiation Dosage Data and a Radiation Dose Summary Report. The intended API users include:

- Radiation Safety Officers
- Radiologists
- Radiology Technologists.

The Exam Profile with Radiation Dosage Data is a menu item under the Patient Profile Menu. No Radiology-specific keys are required to access this menu but users must be **assigned the Patient Profile Menu**.

The Radiation Dose Summary Report is found in the Special Reports menu and it also does not require a specific key but, users must have access to the correct Menu.

The Radiation Dose Summary Report lists completed exams performed within a user-selected date range but only for patients whom such dose data has been collected.

After selecting the type of report and date range, the user is then asked to select one of the following filter criteria that will determine which exams (with dose data) are to be displayed on screen.

Users must select the type of report format.

- CT Totals (Only) - a summary CT dose report

- CT by Series - a detailed CT dose report.
- Fluoro - a summary Fluoroscopy dose report

Users must select the filter criteria for which exams (with dose data) is displayed:

- Filter by a single or all radiologists Note: The radiologist is the Primary Interpreting Staff
- Filter by a single, many, or all CPT codes
- Filter by a single, many, or all patients

If a requested Radiation Dose Summary Report cannot be created for the selected filter criteria, an VistA error message is displayed. When an exam is deleted using the 'Exam Deletion' RA DELETExAM option, all radiation dosage information associated with that study will be deleted from the RADIATION ABSORBED DOSE file

If the study is downgraded from a 'Complete' status or is moved from the 'Complete' archive, the API is called and all existing data is updated accordingly. Any new radiation dose data will be added to the current radiation dose record for that study. A history of that patient's exposure will be made permanently as part of the VistA Imaging package profile. Information of how a patient's radiation dosage history is viewed after a study is deleted may be found in VistA Imaging documentation.

Exported in this patch are new options:

OPTIONS	DESCRIPTION
Exam Profile with Radiation Dosage Data - RA PROFRAD DOSE	RA PROFRAD DOSE is a menu item under the 'Patient Profile Menu' RA PROFILES menu. RA PROFRAD DOSE behaves the same as current patient profile options but now reports may be printed. This option is best when used with a eighty (80) column display device.
Radiation Dose Summary Report - RA RAD DOSE SUMMARY	RA RAD DOSE SUMMARY is a menu item under the 'Special Reports' RA SPECRPTS menu. RA RAD DOSE SUMMARY will allow the user to select the type of report and the filters applied to the report. This option is best when used with a one hundred thirty-two (132) column display device.

Note: More documentation on these reports can be found within the associated VistA Radiology/Nuclear Medicine User Manual.

Updated VistA documentation describing new functionality (such as enhancements introduced by these two patches) are continually available.

When using **Attachmate Reflection**:

Enter: DOWNLOAD.VISTA.MED.VA.GOV

Special Notes

Select **FTP CLIENT** in Reflection,
NEW, enter the FTP site (example: *fo-albany.med.va.gov*), **NEXT**
Check **User** , click **ADVANCED** button
Log on as: **USER**,
User Name: **anonymous**; leave Password blank
click **SECURITY** button.
Security Properties box:
Choose **SECURE SHELL** Tab
Check box '**Use Reflection Secure Shell**' and say **OK** to pop up box, then
click **OK**.
Click **APPLY**, then **OK**
Click **Next**
User name: **anonymous**, Click **NEXT**
What name would you like to use for this FTP Site: **<create a name here for your new session>**
Click **FINISH**
Press **OK** through other prompts.
To save session, **Click File/Save**.

When using the **COMMAND** prompt:

The preferred method is to use Secure FTP from

anonymous@download.vista.med.va.gov (no password). This site transmits the files from the first available Secure FTP server.

Click Start,
In search box, type: **cmd** <RETURN>
In command window go to any site:
(example: *sftp anonymous@download.vista.med.va.gov*).
The first time you use it, it will prompt you to type in:
'no', 'once' or 'always', (Open notepad and type in the word
always, then copy/paste it into the command window at the
prompt. Press return at the password prompt without typing in
a password. You should be in the anonymous directory.

17. 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 CPRS 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 PIMS package, which is responsible for its entry and validity. Refer to the PIMS package documentation for more information and a description of the meaning of this term as it applies to VistA.
Batch	In the Radiology/Nuclear Medicine system, a batch is a set of results reports. Transcriptionists may create batches to keep similar reports together and cause them to print together. One possible purpose might be to print all reports dictated by the same physician together.
Bedsection	See PTF Bedsection.
Bilateral	A special type of modifier that can be associated with an exam, a procedure, or an AMIS code. When an exam is bilateral due to one of the aforementioned associations, workload credit and exam counts are doubled for that exam on most workload and AMIS reports.

Glossary

BI-RADS™ 370	Breast Imaging Reporting and Data System: A system created by the American College of Radiology (ACR) to standardize assessment and categorization of breast imaging results and 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.

370 Patch RA*5*97 September 2009: Added definition for Breast Imaging Reporting and Data System (BI-RADS™).

Clinic	Hospital locations where outpatients are cared for. In VistA, 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. 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.
CMS	Centers for Medicare and Medicaid Services, a division of the US Department of Health and Human Services. Formerly known as HCFA.
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.
CPRS	Computerized Patient Record System. A VistA system that replaced the Order Entry/Results Reporting package.
CPT	See Current Procedural Terminology.
Credit stop code	See Stop Code. Also see PIMS documentation.

Glossary

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 VistA, CPTs are represented by entries in the CPT file #81.
Deleted (X) 371	A report status that refers to a report deleted from a case but remains in the database. The deleted report status is seen on the Report Activity Log after the deleted report is restored. A deleted report is not viewable from any Radiology options.
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 an 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 VistA 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 (Decision Support System) 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 verify Rad/Nuc Med reports electronically. This is not the same as the Access/Verify codes.

371 Patch RA*5*56 July 2008: Added a definition for the 'Deleted' status.

Electronically Filed (EF) 372	A report status that refers to a report interpreted outside the Rad/Nuc Med Department. The content is not the actual interpreted report, but canned or manually entered text referring to the outside interpreted report.
Exam label	One of three 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. Many parameters control the 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 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	VistA's Database Management System (DBMS). The central component of the Kernel that defines the way standard VistA 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.
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.

372 Patch RA*5*56 July 2008: Added a definition for the 'Electronically Filed' status.

Glossary

HCPCS	Healthcare Common Procedure Coding System, formerly the HCFA Common Procedures Coding System. HCPCS uses standardized codes to describe the specific items and services used in health care services.
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 VistA software package that produces a report showing historical patient data. Can be configured to meet various requirements. Refer to the Health Summary documentation for more information.
HL7 / Health Level 7 373	American National Standards Institute (ANSI) standard for electronic data exchange in healthcare environments.
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 VistA by entries in the Hospital Location file (#44). Rad/Nuc Med locations are a subset of the Hospital Location file.
ICD-9	International Classification of Diseases Ninth Revision. A coding system designed by the WHO (World Health Organization). ICD-9 provides standardized diagnosis and procedure codes, used for statistical, research and reimbursement purposes.
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: <ul style="list-style-type: none"> • ANGIO/NEURO/INTERVENTIONAL • GENERAL RADIOLOGY • MAMMOGRAPHY • NUCLEAR MEDICINE • ULTRASOUND • VASCULAR LAB • CARDIOLOGY STUDIES (NUC MED) • CT SCAN • MAGNETIC RESONANCE IMAGING <p>These imaging types are supported by version 5.0 of the software. Each imaging location and procedure may be associated with only one imaging type.</p>

373 Patch RA*5*64 July 2006: Added glossary entry for HL7.

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, 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 (IT SERVICE)	The service within VA hospitals that supports the installation, maintenance, troubleshooting, and sometimes local modification of Vista software packages and the hardware that they run on.
Interpreting physician (Interpreting Resident, Interpreting Staff)	The resident or staff physician who interprets exam images.
IT SERVICE	See Information Resources Management.
Jacket label	One of the three 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.
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.
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.
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.

Glossary

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 IT SERVICE. 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.
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 CPRS.
Order Entry/Results Reporting	A VistA package that performs that functions of ordering for many clinical packages, including Radiology/Nuclear Medicine. This package has been replaced by CPRS.
Outside films registry	A mechanism in this system that allows users to track films done outside of the medical center. This can also be accomplished through the VistA Record Tracking package. Refer to Record 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.
Patient Care Encounter (PCE)	A VistA program that provides clinical reminders which appear on Health Summaries. PCE helps sites collect, manage and display patient encounters and other clinically significant data.

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 CPRS and places them in a pending status.
PIMS	Patient Information Management System. A VistA system that replaced the MAS package.
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 PIMS, which is responsible for its entry and validity. Refer to PIMS documentation for more information and a description of the meaning of this term as it applies to VistA.
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.

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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 procedure 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 374	A characteristic of a Rad/Nuc Med procedure that affects exam processing and workload crediting. See Detailed, Series, Broad, and Parent. Also used in Outpatient Procedure Wait Time reports to standardize the reporting of performance monitors throughout VA. Procedure Type categories have been assigned by the Office of Patient Care Services.
PTF Bedsection	Patient Tracking File Bedsection. See PIMS documentation.
Purge	The process that is scheduled at some interval by IT SERVICE 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.
Relative Value Unit (RVU) 375	This is a "unit of work" assigned to a CPT code. RVUs are based on the cost of providing a particular service to a patient, and are broken down into three components: the Work RVU is the provider time, the Practice Expense RVU is what that time is costing in overhead, and the Malpractice RVU is the liability cost (likelihood of complications). Each RVU is a weight based on complexity, and is used as a multiplier to calculate Medicare and other fee schedules.
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.

374 Patch RA*5*79 February 2007: Updated definition of Procedure Type.

375 Patch RA*5*64 July 2006: Added glossary entry for RVU.

Report status 376	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), Verified, Electronically Filed, and Deleted. 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	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 CPRS), Pending, Hold, Scheduled, Active, Discontinued, and Complete. Reports and exams each have a separate and different set of statuses.
Request urgency	Data entered at the time an exam is ordered to describe the priority/criticality of completing the exam quickly (i.e. Stat, Urgent, Routine).
Requesting location	Usually the location where the patient was last seen or treated (an inpatient's ward, or an outpatient's clinic). All requesting locations are represented by an entry in the VistA Hospital Location file (#44). The requesting location may be, but is usually not an imaging location.
Requesting physician	The physician who requested the exam.
Research source	A research project or institution that refers a patient for a Radiology/Nuclear Medicine exam.
Scheduled	An order status that occurs when imaging personnel enter a date when the exam is expected to be performed.
Secondary Interpreting Staff/Resident	This generally refers to an attending/resident that assisted or sat in on review of the case, but is not primarily responsible for it. It may also be used to indicate a second reviewer of the case, for quality control or peer review purposes.
Security key	Represented by an entry in the VistA Security Key file. Radiology/Nuclear Medicine keys include RA MGR, RA ALLOC, and RA VERIFY. Various options and functionalities within options require that the user "own" a security key.
Site Specific Accession Number (SSAN) 377	This is a case number with the 3-digit Site ID and the Date appended at the beginning of it in the format of 'SSS-MMDDYY-CASE#'. An example is 141-052709-23457, where 141 is the site ID, 052709 is the date and 23457 is the case number. (see also, Case Number above)

376 Patch RA*5*56 July 2008: Added Electronically Filed and Deleted to the report status definition.

377 Patch RA*5*47 September 2011: Added Site Specific Accession Number (SSAN) to the Glossary.

Glossary

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. Imaging stop codes are represented by entries in the Valid Imaging Stop Code file #71.5. Imaging stop codes are a subset of the VistA Clinic Stop file #40.7. See PIMS 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 VistA account in case you forget to log off the system or leave your terminal unattended.
Transcribed	An exam status that may occur when a results report is initially entered into the system for an exam. If this status is not activated at the site, it will not occur.
Unreleased	An order status that occurs when an exam order is created, but no authorization to carry out the order has been given. This is possible only if the order is created through the CPRS software.

Verification	The process of causing a results report to progress to the status of Verified. This happens when a physician affixes an 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. Analogous to a physician signing a paper report. Verification Timeliness reports are available to show the amount of time elapsed between registration of an exam and its transcription and/or verification. 378
Verified	A results report status that occurs at the time of verification. A report is verified when the interpreting physician electronically signs the report or gives his/her authorization that the report is complete and correct. Also see Verification.
VistA	Veterans Health Information Systems and Technology Architecture. Formerly known as DHCP.
Waiting for exam	An exam status that occurs when the exam is registered. The system automatically places all exams in this status upon registration.
Ward	The hospital location where an inpatient resides. In VistA, wards are a subset of the Hospital Location file (#44).
Weighted work unit	The number that results from multiplying the weight of a procedure's AMIS code with its 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 refers to the CPT type of workload credit that is used in the VA to calculate reimbursement to medical centers for work done.
wRVU (Work Relative Value Unit) 379	The work RVU correlates time, intensity, and difficulty of service. A service with a wRVU of "2" is considered to involve twice as much physician work as a service with a wRVU of "1". These units of work are assigned to CPT codes to take account of the relative amount of effort taken to perform a procedure based on the cost of supplies, the risk or difficulty and the time spent. For instance, brain surgery has more RVUs than a wart removal.

378 Patch RA*5*67 April 2006: Added Verification Timeliness report description information to Verification entry.

379 Patch RA*5*64 July 2006: Added glossary entry for wRVU.

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