Table of Contents

User Stories For Radiology Module

Table of Content

Authors / Contributors

1. Judy Gichoya
2. Olakunle Oladiran
3. Jayanth Kumar Medam.
4. Ankit Rastogi
5. Saptarshi Purkayastha

Kindly click on the sections for detailed stories

Logging into the System

Users have different privileges based on their position. While some users are expected to have more privileges than others, some would also be restricted from performing certain actions.

Summary: The actions that a user is allowed to perform will be based on the type of privileges granted with consideration for the designated task. Also, the level of the user in the hierarchy is considered before grating privileges.

Who cannot approve a “preliminary” reports: Trainees,Technologists , Referring Physicians, PACS Administrators

Steps

1. A user is required to punch in userId and pass-code, which would have been given by an administrator.
2. The userid can be designed to have prefixes match the category of user e.g TCH0123, RS012, RT012,
3. at the point of logging in, the systems is designed to recognize the category of user and grant privileges based on their category.If the user is:

- **Resident:** The user is granted reporting privileges such as claiming a study, editing a study, updating a study. **If the Resident is a Staff**: The user is granted all privileges including:
- Claiming a study in all status, provided it has not been currently claimed by a staff.
- Drafting a study
- Approving a report except the ones being currently conducted by another staff
- Adding addendum to any report other than a report currently worked on by another staff
- Discarding any report other than report currently worked on by another staff

If the Resident is a Trainee: The user is granted privileges including:

- Claiming a study in a 'completed' status
- Drafting a claimed study for later reporting activities
- Updating a report from a 'draft' status to a 'preliminary' status
- Adding addendum to a report that has only being claimed by the current user
- Communicate with other user over the communication channel, including file exchange etc.

- **Technologist:** The user is granted privileges such as uploading studies for the reporting activities of residents.

Notes:

- Verify that A staff gets a pop-up when they try to override privileges of other Staff. e.g "You are not authorize to override another Staff's privileges"
- Verify that a trainee gets prevented from overriding privileges of other users.

Introduction

The following documentation is the user stories prepared for the developer(s) to understand the perspective of prospective users as regards the radiology reporting framework.

Purpose:
To develop a guideline to support radiology reporting module in LibreHealth.

Intended Audience:
Application Developer(s)

Project Scope:
The scope of this document describes what will be provided for during the development of the radiology module to support radiology reporting for LibreHealth.

Items Covered
Radiology Reporting

Definitions:
The following are the definition of the key concepts used in the user stories developed below.

:**Report** - This is is the documentation developed by the user after thorough examination of the current study and comparison with other studies conducted on the patient.

Dictation - This is the process of documentation using alternative method to keyboard by using 3rd-party speech recognition software integrated with the Radiology Information System.

Draft - This is the stage at which a report or a study(images) assume when it has been claimed by a particular user. This would prevent other users from reclaiming it.

Addendum- This is additional reporting activity conducted on a report that has assumed a ‘Finalized’ status

Preliminary - This is is the stage at which a report assumes when awaiting approval from a user who is higher in ranks.

Finalized- This is the final stage of reporting. At this stage the report is visible to the ordering physician

Radiologist-A personnel trained to offer reporting support to the clinician

Staff- A full-fledge radiologist who is authorized to approve report to the ‘finalized’ stage

Trainee - A radiologist in training who conducts radiology reporting under the supervision of a staff

Instance-(To be added)

Study-This is a the folder containing the images sent by the Technologist.

Series- (To be added)

Use Cases

Components of the Radiology Information System

Template Generator The template generator serves as a repository for templates that can be reused by the user for reporting on different types of study. The sections will contain the following:

- **Indications:** The main reason for the study
- **Date**: This would be retrieved from the system when the particular template is chosen
- **Comparison**: This would contain the previous study that the user wishes to compare the current study with
- **Technique:** This shows the method used by the Technologist and the it would be retrieved from the study when the template is chosen
- **Findings:** Would be recorded by the user throw dictation of typing
- **Impression:** Would contain the speculations made by the user

Dictation Software:

This is the separate voice-recognition software that would be integrated with the reporting software for easy documentation. The use would speak to a compatible mouthpiece device to record reports. Apart from documentation, it would be designed to have additional functionalities such as command recognition and execution e.g. erase, remove three words forward, skip to 6 words backwards etc.

Reporting Software

This is an editor to be used by the user to perform reporting activities. Templates will be hosted on the Reporting Software and it will be resumed on claiming a new study or updating a previously claimed study.

- **User’s Report**

- The user’s report would be viewed on the reporting software and it will contain a breakdown of studies that are grouped under different categories based on the status of the study. The user’s report will update after every action is completed by the user.
- The following categories may be used to group the studies that have been claimed by the user:
- **Approval Queue**: This would contain the list of studies waiting to be approved by the user(Trainee) before the staff conducts final approval
- **Approved Today**: The list of the studies that have been approved by the trainee on a daily basis
- **Touched today**: This is the list of studies that have not been claimed but has been examined by the user.
- **Draft:** This is the list of the studies that have been claimed by the user but the user has neither chosen any template nor started any reporting on it. This would also have the status of Draft in the main central user interface.

User Interface

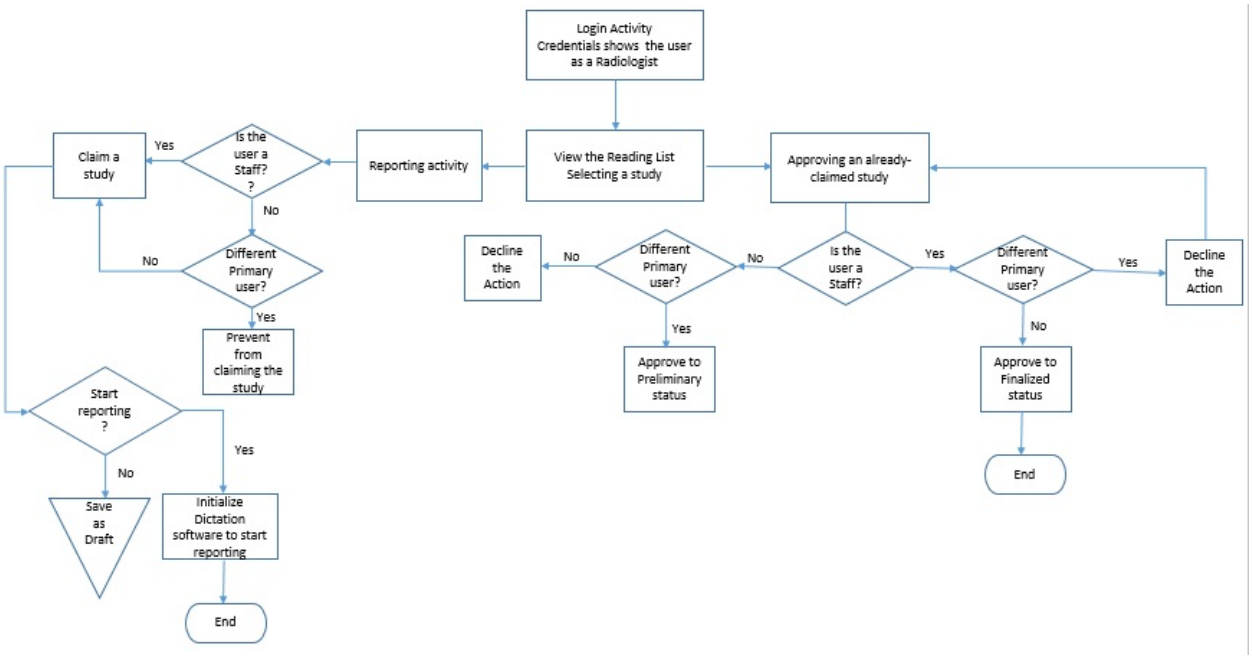
This is the interface where major activity on the status of the study would be displayed. It would be enabled to retrieve the list of the ordered study and also have capability of sorting of studies based on different criteria e.g. priority, date, type of study etc.

- **Reading List: This is the list of studies sent by the Technologist**

Image Viewer

This is an image viewing software used for the purpose of examining the batches of images in the study. It would be enabled with magnifying functionality.

Relationship Definition



Preconditions

- The Interface would have been enabled to retrieve patient information from the EMR system
- The dictation software would have been integrated with the reporting editor to enable the user to dictate observations.
- The template generator would have been design to retrieve metadata information from the DICOM images in the report.
- The image viewer would have been integrated to the user interface for image transfer
- The reporting software would have been enabled to communicate directly with the reading list of the ordered tests and the dictation software
- The RIS would have been designed to grant privileges based on roles of the user through recognition of login credentials (See login Procedure page)

Task 1-Creating New Report

Users should be able to create a new radiology report.

Summary : This task assists the users to create a report for a radiology study. The final report can be available for patient and referring doctor to support diagnosis of the patient's illness . Various ways can be used to create a report - using voice dictation, templates and free-text typing.

Users : Must be radiologists (trainees and staff).

Who cannot create reports: Technologists , Referring doctors, PACS administrators

Steps:

1. Login into the system (See login Procedure page)
2. The user can view a reading list which include studies that are yet to be claimed or reported upon(Status="Completed")
3. Claim a study to start reporting:
4. If the study is currently being reported on by someone else - Notify the user that was reporting on it that it has been claimed by someone else.(This task is reserved for a Staff)
5. If the study is already reported on and finalized - Inform user(must be a staff) and ask if they would like to add an addendum
6. If the study has not being claimed , confirm that the user would like to go ahead and make a report on this study
7. If the study is in Draft or Preliminary status - then open the reporting interface to display the existing report
8. This action opens the text editor that supports reporting to be done (It is similar to one ‘Composing a New Email’) when claiming a report

Notes

- Verify that the reporting editor allows a user to create a report on the study:
- Verify that the reporting editor has functionality that allows a user to view the list of templates available that can be used to generate the report
- Verify that the editor supports voice dictation when available
- Verify that the editor provides a blank page that a user can type or pre-populate using template
- Verify that it supports multimedia integration of key images from the study e.g if a user selects a specific instance from the study viewer , he/she should be able to drag it to the editor to be incorporated into the report.
- Verify that only a staff has the right to claim any study that has been claimed before.
- Verify that a staff may not claim a study from another staff without confirmation from the

primary user(staff)
- Verify that previous user(Staff) has to confirm relinquishing reporting authority to another user before user can resume reporting activity on an already-claimed study.

Once a user is happy with the report, then the user needs to exit the editor using the following options

- Can approve/Finalize a report(See Task 2)
- Can provide a preliminary report (See Task 3)
- Can Draft a report (See Task 4)
- Can Discard a report(See Task-5)

Task 2- Approving Workflow for the Staff

Users would be able to approve a study after completion of reporting activity.

Summary: The task of final approval is solely the responsibility of the user who is a staff(Users would be differentiated at the point of loging in). A staff goes through the list of the reports to perform different task on them, one of which is to change studies with “Preliminary” status to “Finalized” status after thorough examination of the reporting done by either a trainee or the user him or herself. The finalized report becomes visible to both the patient and the ordering physician(Nurse Practitioner included).

Users : Must be radiologists (Staff only).

Who cannot approve a “preliminary” reports: Trainees,Technologists , Referring Physicians, PACS Administrators. Anyone who is not a radiologist with a staff status.

Steps:

1. Loging into the system (See login Procedure page)
2. The user views a reading list with studies having different status
3. The user right-clicks on a study to change the status (See Task 1 for additional task for a staff)
4. Provide the user approving the study with details on who conducted reporting on the study
5. For a finalized report- ask the user if they would like to create an addendum
6. If the user decides to create addendum, open the reporting interface for the user to view an editable report (See Task 1-Step 4)
7. if the user decides not to create addendum, open the reporting interface with broad report that is not editable.(for viewing purpose)
8. Once a user has added addendum, the user can exit the reporting interface.

Notes:

- Verify that the study can attain all status including 'Finalized' as specified by the user.
- Verify that a dialogue box ask if the user would like to finalize the report
- Verify that a user without a staff status would be prevented from finalizing a report
- Verify that the report becomes visible to the ordering physician and the patient on the event that the user finalizes the report.

Task 3 - Approval Workflow for “Preliminary” Status A trainee can approve a report by changing the status from "Draft" or “Dictated” to “Preliminary”.

Summary: A user can only approve a study which has been previously claimed by the user himsef/herself, and the highest level of approval granted to a trainee is the "Preliminary".Also, a user can claim a study in Draft or Dictated status reported on by another user provided that the primary user is not a staff. However, the Drafted report would be discarded for the current user to start reporting afresh.

Users : Must be radiologists (Trainees and Staff).

Who cannot approve “Dictated” reports: Technologists , Referring Physicians, PACS Administrators

Steps

1. Login into the system (See login Procedure page)
2. The user views a reading list with studies with different status
3. The user right-click on a study to change the status of the report:
4. If the user's login credentials is different from the credentials of the user who previously claimed the study, ask if the current user would like to reclaim the study.
5. If yes:(See Task 1)
6. If No: (Notify the user to open another study)
7. If the login credentials tallies with the current user’s login, ask the user if they would like to update the document:
8. For a Dictated report- ask the user if they would like to create an addendum(See Task 1-Step 4).
9. For a Draft report- ask the user if they would like to continue dictating the report(See Task 1-Step 4)

Notes:

- Verify that a dialogue box ask if the user would like to approve for “Preliminary” status if the previous status is “Dictated”
- Verify that a dialogue box would ask if the user would like Save or approve to preliminary stage if the previous state is “Draft”

Task 4- Workflow for a Draft

Users should be able to claim a study and save as draft to continue reporting activity on it.

Summary : A user is allowed to claim more than one complete study for reporting. While working on a study, a user could save other studies that has been claimed as draft. A study in draft mode prevent other users to claim it.

Users : Must be radiologists (trainees and staff).

Who cannot create a draft: Technologists , Referring doctors, PACS administrators

Steps

1. Login into the system (See login Procedure page)
2. The user views a reading list with studies that are yet to be dictated
3. The user claims a study to start reporting (See task 1)
4. After claiming the study the user closes the editor(empty) and options of saving as draft or discard is given to the user

Notes

- Verify that a user can sort the lists with different criteria
- Verify that a dialogue box pops up to as “Would you like to save? Click yes to save as Draft, No to discard”.
- Verify that the drafted study moves under the Draft folder in the user’s Reporting
- Verify that the complete study goes back to the “unclaimed list” after the user discard

Task 5- Workflow to Discard Report

Users should be able to discard an already-claimed study regardless of its status. e.g "Preliminary", "Draft" or even "Finalized".

Summary : A user is allowed to discard a report if it seems unfit for diagnostic support. A staff should be able to discard any report regardless of who primarily claimed the study that is not a staff, while a trainee should only be able to discard a report that was initially claimed by the particular trainee.

Users : Must be radiologists (trainees and staff).

Who cannot create a draft: Technologists , Referring doctors, PACS administrators

Steps

1. Login into the system (See login Procedure page)
2. View a reading list of all the studies
3. Right-click to view the study. For preliminary or finalized, a report will be available for view in document format. For draft, a blank report will be available.
4. A user may decide to discard the report by also right-clicking to choose “Discard the Report” from the dropdown.
5. If the user is:
6. a Staff: The report can be discarded if the report was developed by any of the Trainees. The Trainee will be notified that their report has been discarded. A staff may not discard a report developed by another staff.
7. A Trainee: The report can be discarded if the report was developed by the user. If developed by another user(Trainee or Staff), a dialogue box pops up to tell the user they are not authorized to perform the action.

Notes"

- Verify that the trainee gets a notification that their report has been discarded.
- Verify that a confirmation dialogue box pops up to request the user to confirm discarding activity.
- Verify that the study status changes back to “completed” After discarding it.

Task 6-Collaboration Workflow for Communication between users

Residents should have a way of communicating between themselves through a communication platform that has file-attachment capability.

Summary: A user may require a second opinion in regards to a report done after a study examination. The user should be able to attached the report through a chatting platform that would be available to residents all the time. The recipient should be able to click on the file attached and view the report as long as it comes from the primary user who had previously claimed and reported on the complete study. The system would be designed to support drag-through capabilities. This may be handled by a third-party chatting application integrated into the system.

Users: Must be radiologists (Trainees and Staff). Who cannot share “Draft or Preliminary” Reports: Technologists, Referring Physicians, PACS Administrators Steps

1. During the process of reporting, the user starts the 3rd-party chatting application which would have been integrated with the reporting software.
2. If the user would like to communicate with anyone on the network, the user can search in the user tab at the top of the chatting application.
3. The user finds the name of the user (A fellow resident) and start conversation with them.
4. If the user has a study opened, as soon as the user starts the chatting application and picks who they would like to converse with, a dialogue box should prompt the user if they would like to add the currents study to the chat page.
5. If Yes: The study folder gets added with the link-enabled metadata information such as the patient information, Ordering Physician information, Technologist Information.
6. If no: The study does not get added to the chat.
7. If the user has reasons to communicate an issue with anyone on the network such as the Ordering Physician or the Technologist who ordered and carried out the procedure, they could send a message to them through the application.

Notes

• Verify that the user can search the name of any user in the organization

• Verify that the user can add notes to study sent to another user.

• Verify that the user can communicate with the Ordering Physician, patient, Technologist whose contact links are in the metadata of the study

• Verify that the application keeps track of the timing and the recipient of any message sent through the application (It could be used for any legal or audit purpose)

Task 7- Workflow for Template Generation

Rather than resuming reporting activity on a blank page, users should be able to generate a template that would be prepopulate the editor with the sections to be reported upon. e.g. Indications, Date, Comparison etc.

Also, a user should be to save a template for future use. There cases that are have high number of occurences and the user shoulf be able to save a complete report which could be easily edited for future use.

Users: Must be radiologists (trainees and staff). Who cannot use a Template: Technologists, Referring doctors, PACS administrators.

Steps

1. See Task -1-Create New Report
2. The user clicks the dropdown in front of Template to choose the procedure eg CT, MRI, UV
3. The user chooses the appropriate template for the type of report.
4. A dialogue box pops up prompting the user to choose yes to use the template for the study type(“CT”)
5. If the user clicks yes to proceed and the editor gets populated with predefined summary which can be edited by the user.
6. If the user clicks no; the process goes back to step-2 above
7. In the process fo saving the report. a Dialogue box should prompt the user to save as a template for future use.

Notes

• Verify that the user has the option of saving template for future use.

• Verify that user can edit the template based on how the user wants it.

• Verify that the use can save a complete study as template for future use

• Verify that a user can grand public privileges to the template developed.

The following describes the concern of the Technologist when interacting with the System:

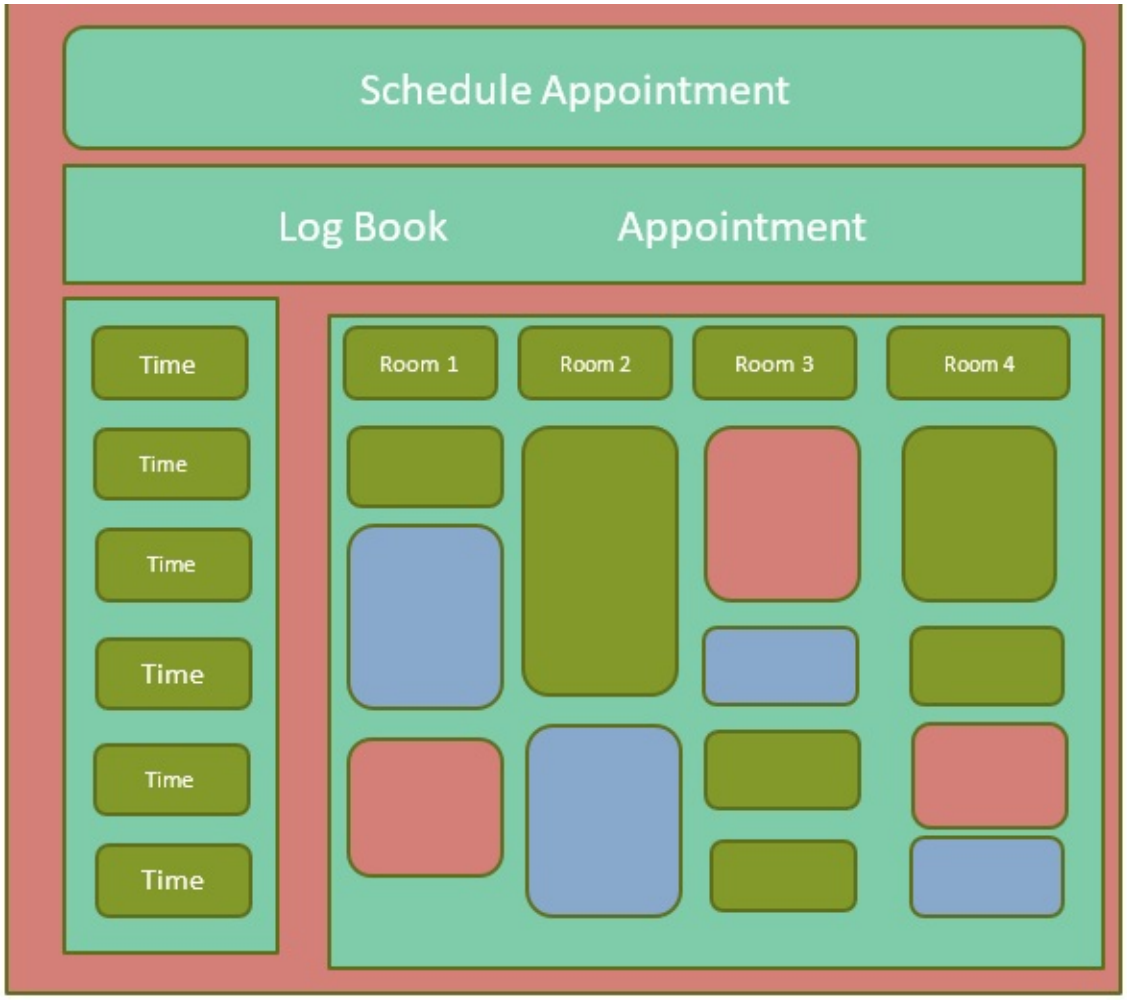
List of actions expected from a Technologist:

Navigation Through the Workspace
Preconditions: Privileges would have been created based on rank of the Technologists. A Team Lead gets to have access to more Apps on the dashboard as shown below. Roles of a Lead Technologist include granting privileges and access to other data tracking activities to Junior Technologists.

The Technologist should have a movable Icon board for easy navigation to the sections of applications such as:

- **Woklist**: A Table which containing all the color-coded worklists from all the affiliated hospitals. This makes it easy for the Technologist to prioritize appointment scheduling. The user gets routed to a list containing all the scheduled procedures under the specific hospital chosen.
-
- **Department Order entry:** a page where the technologist can input patient information based on the ordered procedure from other department.
- **Appointment Scheduling**: A calendar designed to accommodate dragging of a specified timeline to schedule or reschedule an appointment.
- **Analytics:** A broadsheet to track the number of procedures with other information such as the administering technologist and the origin of the order.
- **Analytics Administration:**
- **Order Review**: A table where the Lead Technologist can review daily order placed and daily procedure completed. The Technologist also has the privilege to remove orders also.
- **User status:**
- Lead Technologist
- Technologist

```
**  Appointment Scheduling Layout**
```


Schedule Appointment
Log Book
Appointment
Time
Time
Time
Time
Time
Time
Room 1
Room 2
Room 3
Room 4

Task 1- Create patient appointment schedule

A user looks through the worklist and goes to the appointment scheduling page to research a spot for the patient. This is action is completed based on priority.

Summary: A user should be able to go through the worklist containing all the orders placed from affiliated departments and hospitals. The user looks through the list to schedule based on priority.

Users: Must be Technologist (Lead or Junior).

Who cannot create an appointment: Technologists, Referring doctors, PACS administrators. Anyone who is not a Technologist.

Steps

1. The user is logged in already.
2. View a worklist of all the affiliated hospitals
3. Click to view the list.
4. Sort by date or priority to view more urgently required patients
5. Click the patient of interest to view the patient information and procedure required.
6. Click the Appointment Schedule icon on the movable icon board to view the calendar.
7. Click an unlocked timeline (Deeper colored) of preference to schedule the appointment. This is also an available room at a particular time.

The user is directed to a page where the patient can be searched through name or Hospital Number.

1. Using the search criteria of preference, locate the patient in the worklist and click “Schedule patient” button to add patient additional information. User is routed to the Order Entry page. Additional information about the imaging technique and other important information would be added by the user in “Notes” section on the Order Entry page. These pieces of information may include patient’s allergy and medication information, patient contact number, emergency phone number and person of contact, insurance id number and the CPT code.
2. Click “Confirm Appointment” button to add the patient to the timeframe on the calendar. The patient information gets added to the timeframe in the calendar and it can be viewed by all authorized users, Technologists,administrative staff, Referring Physicians, Nurse practitioners and Radiologist. At that instance, the patients is notified through email text message. And further confirmation is conducted by the Admin staff.

Notes"

- Verify that the Appointment scheduling is integrated to the worklist

- Verify that the user can drag a patient from the worklist to the calendar and the

Task 1- Update Scheduled appointment

In some cases, patients miss their appointment, or call ahead to cancel their appointment. It is the duty of the Technologist to reschedule them and also substitute the patient's prescheduled spot with another patient based on priority. This task is reserve for the lead technologist.

A patient can either call in to cancel or cancel through a link of confirmation sent to them in an email. When they call in, the Admin Staff changes their status to canceled and input the available time as specified by the user.

Summary: A user (Lead Technologist) should be able to go through the worklist and sort the list based on status. To reschedule, the user sort for Canceled appointments and goes to the calendar to reschedule for the next available spot.

Users: Must be Lead Technologist.

Who cannot create an appointment: Technologists, Referring doctors, PACS administrators. Anyone who is not a Technologist.

Steps

The user is logged in already.

1. Click on the patient's prescheduled appointment on the calendar. The user is rerouted to an order entry page with added sections for the user to change the time, room and the day of the rescheduled appointment.
2. Set the day and the available time frame for the next appointment (See-Task-1 for additional steps)
3. Click "Confirm Rescheduled Appointment" button to add the patient to the timeframe on the calendar. The patient information gets added to the timeframe in the calendar and it can be viewed by all authorized users, Technologists, Referring Physicians, Nurse practitioners and Radiologist. Another confirmation is sent to the patient.

Notes"

- Verify that only the Lead Technologist can reschedule appointment
- Verify only available time frame will appear in the order entry page when the user want to specify future timeframe for the rescheduled appointment

1. Introduction

The following gives a general overview of how a Nurse Practitioner interacts with system on a daily basis. The focus is how the User places order to the radiology department, an action which is usually taken based on discretion rather than instruction by the Resident Physician.

2. Purpose

The purpose of the User Stories is to understand how the user prefers to interact with the order placement methodology basing our report on what currently exist and other things that are currently not existing but could make the order placement easier.

3. Intended user

The Intended user is a Nurse practitioner and also a Radiologist PA, who would have gone through the training as a Technologist. These individuals place order to the Technologist to conduct a certain procedure on a particular Patient.

4. Use Case

Components of the System

Laboratory: The laboratory tab should contain a spreadsheet categorized to see test from different procedures the patient has gone through e.g Radiology, Biopsy, Ultrasound etc.

Order: This should contain a page where the user can place order to different section of the hospital.

Review: The section where the user can check the status of the ordered tests. The user should be able to review new orders results as well as old ones.

Task 1-Routine Check on Patient's status

Users should be able to conduct a general routine check on a patient to determine if there might a reason to for further test.

Summary : Patient status cane be viewed through the laboratory section of the interface. The user can lookout for vital signs and make decisions such as ordering for aditional test.

Users : Must be Nurse Practitioner, Referring Physician.

Steps

1. Login into the system (See login Procedure page)
2. Search for the patient through their name or ID
3. View the labortatory tab to check for vital signs
4. if there is a need to conduct further check, place an order (see task 2)

Outcome:

Task 2-Place an order

Users should can place an order to any of the sections of the healthcare ecosystem.

Summary : The user is allowed to place an order based on reports of the vital signs. The users can input information about the order in a form that has a dropdown containing different procedures e.g Radiology, Ultrasound

Users : Must be Nurse Practitioner, Referring Physician.

Steps

1. The user is already logged in
2. Click the order tab
3. Choose the appropriate procedure type: which could be radiology, Biopsy e.t.c
4. The user clicks the selects the procedure title (e.g. CT, US) from the drop down. If it doesn’t exist, the user types it in the box.
5. The user writes a note in the **Additional Information** box to make the order clearer to the receipient(s), in this case a Radiologist e.g. P.O. Contrast
6. Go to to the box for **Reason for Examination.** state the procedure in detail to as this is required to point the Technologist in the right direction and also to account for the accurate billing of the patient.
7. in the next box, set the priority to guide the technologist on how urgent the report is.
8. Send the order

Outcome:

Verify that the user gets notified to fill an empty box when they try to send an incomplete order

4.1 Laboratory

Under the Laboratory tab, the user sees a Vital Signs spreadsheet containing horizontally arranged tabs of different procedure sections of the Laboratory etc. Complete Blood Count(CBC).This is where the user derives the assertiveness to place any order based on the need of the patient.

Task 3 Order Result Review

User can view the list of ordered test under the review section.

Summary : The user clicks the tabs of different procedures to check the order result list. The result is expected to contained a finalized report from a Radiologist.

Steps

1. The user is already logged in
2. Click the Review tab
3. click the Radiology column to view the list of the reports
4. click the report to view the breakdown(see the Resident page for the format of the report

Outcome:

Verify that the user can sort the list of the report based on different criteria e.g Day, time).

Verify that the newer reports are at the top of the list.

Verify that the new report are in deep colors to differentiate from older ones.

Task 1-Routine Check on Patient's status Users should be able to conduct a general routine check on a patient to determine if there might a reason to for further test.

Summary : Patient status cane be viewed through the laboratory section of the interface. The user can lookout for vital signs and make decisions such as ordering for additional test.

Users : Must be Nurse Practitioner, Referring Physician.

Steps

1. Login into the system (See login Procedure page)
2. The user Search for the patient through their name or Hospital Number
3. The user views the laboratory tab to check for vital signs
4. if there is a need to conduct further check, place an order (see task 2)

Notes:

Task 2-Place an order

Users should be able to place an order to any of the sections of the hospital.

Summary : The user is allowed to place an order based on reports of the vital signs. The users can input information about the order in an order entry form with drop-down containing different procedures format e.g Radiology, Ultrasound

Users : Must be Nurse Practitioner, Referring Physician.

Steps

1. The user is already logged in
2. The user click the order tab
3. Chooses the appropriate procedure type: which could be radiology, Biopsy e.t.c
4. The user clicks the selects the procedure title (e.g. CT, US) from the drop down. If it doesn't exist, the user types it in the box.
5. The user writes a note in the Additional Information box to make the order clearer to the recipient(s), in this case a Radiologist e.g. P.O. Contrast
6. The user goes to the section for 'Reason for Examination'. State the procedure in detail to point the Technologist in the right direction and also to account for the accurate billing of the patient.
7. in the next box, set the priority to guide the Technologist on how urgent the report is.
8. Send the order

Note

- Verify that the user gets notified to fill an empty box when they try to send an incomplete order

Task 3 Order Result Review User can view the list of ordered test under the review section.

Summary : The user clicks the tabs of different procedures to check the order result list. The result is expected to contained a finalized report from a Radiologist.

Steps

1. The user is already logged in
2. The user clicks the Review tab
3. The user clicks the Radiology column to view the list of the reports
4. The user views the breakdown of the report(see the Resident page for the format of the report)

Note:

- Verify that the user can sort the list of the report based on different criteria e.g Day, time, PID).
- Verify that the newer reports are at the top of the list.
- Verify that the new report are in deep colors to differentiate from older ones.

under Construction