RADIOLOGY / NUCLEAR MEDICINE

USER MANUAL

Version 5.0

March 2019

Department of Veterans Affairs
Health Systems Design and Development
Provider Systems

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Revision History

Date	Page	Change
April 2000		Revision History added.
October 2001	4-27, 4-41	RA*5*28: Case Edit Field | Procedures – Added: Requesting physician is alerted when the ordered exam is changed.
February 2002	6-145	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	4-23	RA*5*27: Description text field added – if user elects not to cancel, the exam has associated request.
	4-60, 5-67, 5-98, 5-105	Additional clinical history added to report.
July 2002	5-87, 5-99, 5-107	RA*5*25: Reference to Technical Manual changed to the Radiology / Nuclear Medicine V. 5.0 HL7 Manual.
September 2002	6-137	RA*5*31: Change in text descriptions
	6-140	RA*5*31: Added selection of Procedure Name or Date / Time of report.
	6-141	RA*5*31: Change of location for the Procedure and the Pt ID columns for the Log of Scheduled Requests by Procedures.
	8-271	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.
	9-297	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.
	9-301	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	4-60	RA*5*35: Deleted four instances of “Exam modifiers: None”.
	4-60	RA*5*35: Added new paragraph – The display of cases for a printset will be condensed as much as possible…
	5-67, 5-68	RA*5*35: Changes in displays

Date	Page	Change
	13-341	RA*5*35: New option added – Set preference for Long Display of Procedures [RA SET PREFERENCE LONG DISPLAY].
	13-341	RA*5*35: Added description and example for the Set preference for Long Display of Procedures option.
May 2003	4-23	RA*5*34: RA Manager Key prompt text added.
	6-115	RA*5*34: Text explaining print of several cases sharing one printset.
	6-138	RA*5*34: Text explaining if the SUBMIT REQUEST TO question was not asked.
	9-316	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	6-112	RA*5*37: Added Performance Indicator Section to Management Reports Menu options.
	6-172	RA*5*37: Added Performance Indicator Section to Management Reports Menu.
	6-194	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	6-193	RA*5*42: Replaced PERFORM INDICATOR MAIL ADDRESS with PERF INDC SMTP E-MAIL ADDRESS
September 2003	4-16	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
	4-26	RA*5*38: Added – "…and the procedure's CPT Code must be active for the exam date…"
	4-30	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
	4-52	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	6-187	RA*5*44: New prompt. "Primary Interpreting Staff Physician (Optional):" New text added "The verification date…"
	6-189	RA*5*44: New text added "* A printset, i.e.,…"
	6-190	RA*5*44: New paragraph added. "Verification date is always the first item…

Revisions

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	6-190	RA*5*44: ” New prompt. “Primary Interpreting Staff Physician (Optional):.”
	6-191	RA*5*44: Text added. “* A printset, i.e.,...”, and a new column “Procedure Name”.
	6-195	RA*5*44: New option. Run Previous Month’s Summary Report option with example.
May 2005	4-27	RA*5*45 ‘Case No. Exam Edit’ option Contrast Media Used / Contrast Media prompts explained
	4-28	RA*5*45 ‘Case No. Exam Edit’ option ‘Barium Used?’ field removed from the data dictionary
	4-53	RA*5*45 Referenced the appearance of the ‘CONTRAST MEDIA’ and ‘CONTRAST MEDIA USED’ fields when the ‘Status Tracking of Exams’ option is exercised.
	4-55	RA*5*45: ‘View Exam by Case No.’ option has been changed to show the option displaying an exam associated with contrast media.
	5-87, 5-99, 5-105	RA*5*45: ‘Display of associated contrast media.
	8-271	RA*5*45: ‘Detailed Request Display’ displays contrast media if appropriate.
	8-274	RA*5*45: ‘Display Patient Demographics’ displays contrast media if appropriate.
	8-275	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.
	8-278	RA*5*45: Rad / Nuc Med Exams displays contrast media, if appropriate
	9-297	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.
	9-301	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.
	9-302	RA*5*45: Added new Prompt / User Response information; New screen capture, showing contrast media.

Date	Page	Change
	9-305	RA*5*45: 'Rad / Nuc Med Procedure Information Look-Up' describes to the user that contrast media is displayed if appropriate.
	9-311	RA*5*45: A warning displays in 'Request an Exam' if patient has a CM allergic reaction & the ordered procedure has CM associations.
	10-319	RA*5*45: 'Access Uncorrected Reports' displays contrast media if appropriate.
September 2005	4-16	RA*5*41: New paragraph added.
	4-46	RA*5*41: New paragraph added.
	5-97	RA*5*41: Interpreting Imaging Location section added.
	5-102	RA*5*41: • 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.
	9-304	RA*5*41: New text display – Ordering Diagnosis and Clinical Indicators.
	9-304	RA*5*41: New text display – Ordering Diagnosis.
	9-306	RA*5*41: • New instructions added. • Deleted reference to ORES key, added new prompt description.
	9-307	RA*5*41: New prompt description.
	9-309	RA*5*41: New prompt to copy a previous order's ICD codes and SC / EC values.
	9-310	RA*5*41: • New prompts added. • New display example.
October 2005	6-193	RA*5*63: • Added explanation of new field OQP PERFORMANCE MGMT? • Added new prompt OQP PERFORMANCE MGMT? and new display.
	6-196	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.

Date	Page	Change
	6-172	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).
	6-176	RA*5*67: Added new Outpatient Procedure Wait Time report option; examples of Summary and Detail reports.
	6-192	RA*5*67: • 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…"
	6-193, 6-195	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, 6-112, 6-**Error! Bookmark not defined.**, 6-224, 6-228, 6-237	RA*5*64: • 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.
	6-200	RA*5*64: • 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.
	6-201	RA*5*64: Added Physician CPT Report by Img Type description and example
	6-202	RA*5*64: Added Physician Scaled wRVU Report by Img Type description and example.
	6-204	RA*5*64: Added Physician Scaled wRVU Report by CPT description and example.
	6-205	RA*5*64: Added Physician wRVU Report by CPT description and example.

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	6-207	RA*5*64: Added Physician wRVU Report by I-Type description and example
	6-224	RA*5*64: Added two Procedure wRVU report types to list of Special Reports.
	6-243	RA*5*64: Added Procedure Scaled wRVU / CPT Report description and example.
	6-245	RA*5*64: Added Procedure wRVU / CPT Report description and example.
	6-258	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.
	14-351, 14-355, 14-356, 14-359	RA*5*64: Added entries for HL7, RVU, Scaling Factor, and wRVU.
February 2007		Updated Title Page, TOC, Revision History, and Index.
	6-176	RA*5*79: Added new background information about this report and its updated functionality.
	6-177	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.
	6-182	RA*5*79: Added Summary Report by CPT Code / Procedure Name description and example.
	6-184	RA*5*79: Updated the Detail Report description and example, added Procedure Type to Sort By list, and added printset note.
	14-**Error! Bookmark not defined.**	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.
	4-25	RA*5*75: Added Reason for Study to the sample mail bulletin.
	5-67, 5-105, 5-106	RA*5*75: Added Reason for Study to the report display list and sample report.

Date	Page	Change
	6-203, 6-204	RA*5*77: Added new report example to include default Scaled wRVU values.
	8-271, 8-273	RA*5*75: Added Reason for Study to the selection criteria and sample report.
	9-294	RA*5*75: Removed Desired Date statement from the request list.
	9-297, 9-298	RA*5*75: Added age at request and Reason for Study to the sample report.
	9-301, 9-302, 9-303, 9-307, 9-309, 9-310, 9-313, 9-314	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.
	10-318	RA*5*82: Added Radiology HL7 Menu option to Supervisor Menu.
June 2007	6-179, 6-183	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	5-61	RA*5*56: Added a new option, Outside Report Entry / Edit, to the Films Reporting menu.
	5-89	RA*5*56: Added information about the Outside Report Entry / Edit option.
	10-318	RA*5*56: Added a new option, Restore a Deleted Report, to the Supervisor menu.
	10-320	RA*5*56: Modified the information about the Delete a Report option.
	10-327	RA*5*56: Added information about the Restore a Deleted Report option.
	14-349	RA*5*56: Added a definition for the 'Deleted' status.
	14-350	RA*5*56: Added a definition for the 'Electronically Filed' status.
	14-356	RA*5*56: Added Electronically Filed and Deleted to the report status definition.
March 2009		Updated Title Page, TOC, Revision History, and Index.
	9-308	RA*5*70: Changed "Environmental Contaminants" to "Southwest Asia Conditions"; added "PROJ 112 / SHAD".
	9-311	RA*5*70: • Prompt changed - "Environmental Contaminants" to "Southwest Asia Conditions", added - "PROJ 112 / SHAD"

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		• Changed EI to SWAC; added SHAD Related? No.
May 2009	5-90	RA*5*95: Removed the paragraph about “No Credit” imaging location and the reference about displaying a warning message.
	5-91	RA*5*95: Removed the “No Credit” warning message.
	5-92	RA*5*95: Modified the “Visit credited” statement.
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.
	5-89	RA*5*97: Added BI-RADS information to the Outside Report Enter / Edit option.
	6-114	RA*5*97: • Moved two sentences from a paragraph into individual sentences. • Added a paragraph about “VA radiologist”, “Electronically Filed”, or “All”.
	6-115	RA*5*97: Added “VA radiologist”, “Electronically Filed”, or “All” information to the Outside Reporting Enter / Edit option example.
	14-291	RA*5*97: Added definition for Breast Imaging Reporting and Data System (BI-RADS™).
February 2010	4-17, 4-19, 4-28, 4-43, 4-46, 4-47, 4-48, 4-51, 4-53, 4-54	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.’
	4-22	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.’
	4-36	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.’
	4-56, 4-58	RA*5*99: Inserted the field ‘Pregnant at time of order entry.’

Revisions

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	5-67, 5-83, 5-87, 5-91, 5-93, 5-94, 5-102, 5-106, 5-110, 5-111	RA*5*99: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'
	5-68, 5-88 5-103	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.'
	5-99	RA*5*99: Added a note about: 'Pregnancy Screen' and 'Pregnancy Screen Comment.' Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'
	6-118, 6-120	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.'
	6-172	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."
	6-172	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 .
	6-172	RA*5*99: • Inserted two performance summary values in the automated Outlook email. • Inserted the "<=14 Days" reporting interval column .
	6-174	RA*5*99:

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		• Inserted the “Summary Radiology Outpatient Procedure Wait Time Report” in the automated Outlook email. • Inserted the "<=14 Days" reporting interval column .
	6-173	RA*5*99: • Inserted the "<=14 Days" reporting interval column . • Explanation of the "<=14 Days" reporting interval column .
	6-179	RA*5*99: Inserted the "<=14 Days" reporting interval column .
	6- 179, 6-183	RA*5*99: • Inserted the "<=14 Days" reporting interval column . • Explanation of the "<=14 Days" reporting interval column .
	6-184, 6-190	RA*5*99: The date range is 92 days maximum for the Detail Report.
	6-187	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.’
	6-193	RA*5*99: Moved the ‘Enter / Edit OUTLOOK mail group’ option from the ‘Verification Timeliness’ option.
	6-195	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.
	6-195	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’**r**equest name to ‘Radiology Timeliness Performance Reports.’
	6-196	RA*5*99: • Insterted two performance summary values in the automated Outlook email.

Revisions

Date	Page	Change
		• Inserted the "<=14 Days" reporting interval column for extra calculations.
	6-198	RA*5*99: • Inserted the “Summary Radiology Outpatient Procedure Wait Time Report” in the automated Outlook email. • Inserted the "<=14 Days" reporting interval column .
	6-198	RA*5*99: • Inserted the "<=14 Days" reporting interval column . • Explanation of the "<=14 Days" reporting interval column .
	8-271, 8-273	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.’
	8-276, 8-278, 8-279	RA*5*99: Inserted the field ‘Pregnant at time of order entry.’
	9-301, 9-302	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.’
	9-308	RA*5*99: Replaced the ‘PREGNANT’ prompt to ‘PREGNANT AT TIME OF ORDER ENTRY.’
	9-309, 9-311, 9-313	RA*5*99 : Inserted the ‘PREGNANT AT TIME OF ORDER ENTRY’ prompt.
	9-310	RA*5*99: Replaced the ‘Pregnant’ field with ‘Pregnant at time of order entry.’
	9-313	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	6-114 10-318 4-15 5-61	RA*5*47:The options affected by turning on the new Site Specific Accession Number (SSAN): **Option** Abnormal Exam Report [RA ABNORMAL] Access Uncorrected Reports [RA UNCORRECTED REPORTS]

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	4-23 4-25 5-71 6-120 10-320 6-125 4-33 8-274 5-67 82 13-336 13-337 4-36 10-322 8-275 4-37 6-134 4-39 13-338 5-64 5-84 5-89 10-325 TM 9-296 9-300 5-64 8-277 6-210 6-142 4-40 5-95 5-78 9-306 10-327 5-105 4-51	Add Exams to Last Visit Add / Remove Report From Batch Cancel an Exam Case No. Exam Edit Clinic Distribution List Daily Log Report Delete a Report Delinquent Status Report Diagnostic Code and Interpreter Edit by Case No. Display Patient Demographics Display a Rad / Nuc Med Report Draft Report (Reprint) Duplicate Dosage Ticket Duplicate Flash Card Edit Exam by Patient Exam Deletion Exam Profile (selected sort) Exam Status Display Incomplete Exam Report Indicate No Purging of an Exam / report Jacket Labels List Reports in a Batch On-line Verifying of Reports Outside Report Entry / Edit Override a Single Exam's Status to 'complete' Print Division Parameter List Print Rad / Nuc Med Requests by Date	[RA ADDEXAM] [RA BTCHREMOVE] [RA CANCEL] [RA EDITCN] [RA RPTDISTLISTCLINIC] [RA LOG] [RA DELETERPT] [RA DELINQUENT] [RA DIAGCN] [RA PROFDEMOS] [RA RPTDISP] [RA REPRINT] [RA DOSAGE TICKET] [RA FLASH] [RA EDITPT] [RA DELETEXAM] [RA PROFSORT] [RA STATLOOK] [RA INCOMPLETE] [RA NOPURGE] [RA LABELS] [RA BTCHLIST] [RA RPTONLINEVERIFY] [RA OUTSIDE RPTENTRY] [RA OVERRIDE] [RA SYSDIVLIST] [RA ORDERPRINTS]

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		Print Selected Requests by Patient [RA ORDERPRINTPAT]
		Print a Batch of Reports [RA BTCHPRINT]
		Profile of Rad / Nuc Med Exams [RA PROFQUICK]
		Radiopharmaceutical Administration Report [RA NM RADIOPHARM ADMIN]
		Radiopharmaceutical Usage Report [RA NM RADIOPHARM USAGE]
		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 UPDATEXAM]
		Verify Batch [RA BTCHVERIFY]
		Verify Report Only [RA RPTVERIFY]
		View Exam by Case No. [RA VIEWCN]
		Ward Distribution List [RA RPTDISTLISTWARD]
		Examples of the existing and new Case No. (SSAN) from the Case No. Exam Edit menu option
		`EXAMPLE (EXISTING DISPLAY, DIVISION PARAMETER = NO or NULL):`
		`Select Exam Entry / Edit Menu Option:  Case No. Exam Edit`
		
		`Enter Case Number: 3039`

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		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
	14-357	RA*5*47: Added Site Specific Accession Number (SSAN) to the Glossary.
November 2013	See TOC	RA*5*113 and RA*5*116 Added in Section 9 'Special Reports' [RA SPECRPTS] update to include the new menu item 'Radiation Dose Summary Report' [RA RAD DOSE SUMMARY] 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] Added in Section 16 with special notes and details on Patch RA*5*116 and Patch RA*5*113
April 2016	364-365 418-419	RA*5*123 Added Patient Weight and Weight Date to Order Entry example. In conjunction with RA*5*123 changes, corrected Order Entry example to include Sex, Room-Board, reflecting current view. Updated all references to ftp files to reflect sourcing Secure ftp.
December 2016	315-385 294-360	RA*5*133 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]

Revisions

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	Error! Bookmark not defined.	Added in Section 12 updates to the Pending/Hold Rad/Nuc Med Request Log Index updated
June 2017	400,409, 458 65-66	RA*5*137 Removed RA EXAMSTATUS MASS OVERRIDE documentation as this option has been retired. Pregnancy Screen and Pregnancy Screen Comments are prompts instead of display-only on 'Status Tracking of Exams' [RA STATRACK] menu.
March 2018	18, 20, 44, 49, 296, 298, 300, 302, 302	RA*5*132 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.
March 2019	281 - 289	RA*5*148 New Radiology menu item 'Refer Selected Requests to COMMUNITY CARE Provider [RA ORDERREF]' added to Radiology/Nuclear Med Order Entry Menu [RA ORDER].

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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.

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

Functional Description

The Radiology / Nuclear Medicine package is designed to assist with the functions related to processing patients for imaging examinations. The types of imaging exams

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

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 package[1]:

- 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.
- 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 IRM 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.

---

1 Sept 2013: Updated the list of features to reflect current functionality.

- 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 IRM staff. Contact your supervisor if you need these codes. For security reasons, the access code and verify code are not displayed on the terminal screen when you type them in. Please do not write your code down or reveal it to others.

The sign-on banner shows the date and time when you last signed on. The banner also shows whether or not the account had any unsuccessful attempts at logon.

Periodically, you will be required to change your verify code. Rad / Nuc Med staff and residents will also see a displayed message telling them how many reports are awaiting review, if any.

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

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

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 l 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 IRM and the Radiology / Nuclear Medicine ADPAC(s). If you choose an item, but then decide you do not want it included, you can enter a minus sign - followed by the item name to de-select it. (e.g., -MAMMOGRAPHY to delete mammography from your list of selections).
Sometimes, it will save time if you use the wildcard method of selecting. For example, if you are selecting from a list of hospital locations, and you want all the locations that start with the characters 2N, you can enter 2N*.
The wildcard feature is case sensitive; this means that you have to enter your wildcard characters in uppercase if the items are in uppercase, and lowercase if the items are in lowercase. In the sample below, RR* is a wildcard response used to select all imaging locations starting with the letters RR (e.g., RR A&D and RR Rapid).

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

     Select 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 questions 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 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.

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 Chief, IRM Service, as well as your supervisor, should be notified immediately should you suspect that someone else is using your code.

Electronic signature codes are assigned through the Edit Electronic Signature Code option of Kernel. IRM

Service will assign this option to appropriate users requiring an electronic signature code. Each user has only one electronic signature code that can be used across all applications that require an electronic signature.

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

Sign-On Message

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

```
Good morning
     You last signed on Mar 7,1997 at 09:12
*** You have 1 imaging report to pre-verify. ***                  This
message is for
    residents only.
*** You have 12 imaging reports to verify. ***                   This message
is for staff only.
```

Package Maintenance

The ADP Applications Coordinator (ADPAC) should be assigned the Rad / Nuc Med Total System Menu, the RA ALLOC key, and RA MGR key. There are many options within the submenus of the **Supervisor Menu** [RA SUPERVISOR] that help maintain the system. Among these are system and file set-up options which are discussed in depth in the *ADPAC Guide*.

The rest of the options under the Supervisor Menu may be used by ADPACs and supervisors to take care of day-to-day maintenance issues, and are discussed in this manual.

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

Switch Locations

This option is listed first to show the user how to select a new location without first logging out, then logging back into the package. This option appears on several menus. It is meant to be a timesaving convenience to users.
When the package is first set up, the ADPAC assigns imaging locations to users through the Personnel Classification Menu (see *ADPAC Guide*). This determines which imaging locations users are allowed to select when they first sign on to the Radiology / Nuclear Medicine package.
The imaging location selected determines the default division, imaging location, imaging type, label printers, and report printer during the user's interactive session. It will determine, in some cases, which data the user can access during the session because data is often "screened" by imaging type.
For instance, a user signed on to an imaging location of the “Nuclear Medicine” imaging type would not be able to edit exams of a “General Radiology” imaging type.

Prompt / User Response	Discussion
Switch Locations Please select a sign-on Imaging Location: NUC / / ?? Choose from: ULTRASOUND A (ULTRASOUND-499) MAGNETIC RESONANCE IMAGING (MAGNETIC RESONANCE IMAGING-499) FLUORO (GENERAL RADIOLOGY-499) WESTSIDE XRAY (GENERAL RADIOLOGY-639) CAT SCAN (CT SCAN-499) US (ULTRASOUND-578) MAMMOGRAPHY (MAMMOGRAPHY-499) PET SCANNER (ANGIO / NEURO / INTERVENTIONAL-499) X-RAY (GENERAL RADIOLOGY-499) NUC MED LOC (NUCLEAR MEDICINE-639) MAMMO ROOM 112B (MAMMOGRAPHY-499) Please select a sign-on Imaging Location: NUC / / X-RAY (GENERAL RADIOLOGY-499)	Question marks entered at this prompt cause a display of imaging locations in the left column and the imaging type of each location in parentheses in the right column.

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

                                    Printer Defaults
Version  : 5.0                      ----------------
Division : HINES CIO FIELD OFFI     Flash Card  : P-DOT MATRIX BACK
Location : X-RAY                                  1 card / exam
Img. Type: GENERAL RADIOLOGY        Jacket Label: P-DOT MATRIX BACK
User     : RAUSER, ONE                            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 [1]

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

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."[1]
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.
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.[2]

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

---

1 Patch RA*5*41 September 2005: New paragraph added.
2 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.

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. [1]

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.

1 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 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
          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 OP1
 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>1 2

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

    TECHNOLOGIST COMMENT: <RET>3                        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
4

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

1 Patch RA*5*10 April 2000
2 Patch RA*5*19 May 2000: Prompt for CPT Modifiers removed.
3 Patch RA*5*18 November 2000: Added field for comments by the technologist.
4 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.’

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

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
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:  YES1

  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 2
             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
```

1 Patch RA*5*99 February 2010: Inserted the field ‘PREGNANT AT TIME OF ORDER ENTRY.’
2 Patch RA*5*99 February 2010: Replaced the ‘Pregnant’ field with ‘Pregnant at time of order entry.’

```
 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:  YES1
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
           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
```

1 Patch RA*5*99 February 2010: Replaced the ‘Pregnant’ field with ‘Pregnant at time of order entry.’

```
procedure.1
```

Exam Entry / Edit Menu - Cancel an Exam 2

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 images3.
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.4 When all descendents of a parent procedure are cancelled, the user will be prompted to answer Yes or No to cancel the associated request.
If an exam with radiopharmaceuticals is cancelled, the system will ask if you want to delete the radiopharmaceutical data from the case to prevent its being counted in the Radiopharmaceutical Usage Reports. If the radiopharmaceutical was not drawn or administered, it is appropriate to delete.

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

---

1 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.'
2 Patch RA*5*47 September 2011: Cancel an Exam option is affected by the new Site Specific Accession Number (SSAN).
3 Patch RA*5*34 May 2003: RA Mgr Key prompt text added.
4 Patch RA*5*27 April 2002: Description text field added if user elects not to cancel the exam's associated request.

Prompt / User Response	Discussion
Cancel an Exam Enter Case Number: **681**	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.

```
Choice  Case No.    Procedure                        Name                 Pt
ID
------  --------    ---------                        -----------------    ----
--
  1       681       ARTHROGRAM KNEE S&I              RADPATIENT,TEN
0610
```

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>**	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.
TECHNOLOGIST COMMENT: Patient cancelled due to ... [1]	Enter or edit any comment about the patient or case. If editing the previous comment, both comments are saved for tracking purposes, however, only the latest comment is displayed when viewing or editing the record.
REASON FOR CANCELLATION: **??** This is the reason this exam was cancelled.	

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

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

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

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

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

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

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

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

```
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 Study1       : 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
```

Exam Entry / Edit Menu - Case No. Exam Edit 2

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

---

1 Patch RA*5*75 June 2007: Added Reason for Study to the sample mail bulletin; updated date values.
2 Patch RA*5*47 September 2011: Case No. Exam Edit option is affected by the new Site Specific Accession Number (SSAN).

- Primary Interpreting Staff or Primary Interpreting Resident
- Patient
- Exam Date / Time
- DSS ID
- Requesting Location

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

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

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

It should be noted that the ADPAC can use the Procedure Enter / Edit option to set up default film sizes and amounts for procedures. If this is done, these sizes and amounts used are automatically entered into the film size and number used fields.

That means that the tech editing the case will have to make a point of manually deleting and re-editing these fields if the film size and number used for a specific case are not the same as the standard film size and number used, as entered in the procedure parameters by the ADPAC. See the *ADPAC Guide* for more information about procedure set-up using Procedure Enter / Edit. The *ADPAC Guide* also contains a chart showing every possible data field that can appear in the Case Edits and Status Tracking options and includes which conditions cause the fields to be prompted.

Case Edit Fields

Procedure: You will only be able to select active procedures from the Rad / Nuc Med Procedures file (#71) of the imaging type you are in. And the procedure's CPT Code must be active for the exam date.[1] 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

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

order is not a parent-type procedure[1] If patch OR*3.0*112 is not installed, this alert cannot be turned off. However, if patch OR*3.0*112 is installed, the users may enable or disable this alert, "Imaging Exam Changed", via the CPRS Notifications Mgmt Menu.
If the procedure is changed for a case using radiopharmaceuticals, a message will appear telling you to review the radiopharmaceutical data previously entered. This field appears during Case Edits and also during Status Tracking if the "Ask" parameter is set to YES.

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. [2]

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

---

1 Patch RA*5*28 October 2001: Requesting physician is alerted when the ordered exam is changed.
2 Patch RA*5*45 May 2005: Added Contrast Media field.

Medicine for the exam and is automatically entered by the system during Registration. If the appropriate Report Distribution Queue is active, the report for this exam will automatically be placed in the queue for this clinic, or in the current ward if the patient is admitted before the report is verified.

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

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

Requesting Physician: The person who requested the exam. The entry may not be a physician;[1] 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.'
[2]

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

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

Primary Camera / Equip / Rm: This field points to the Camera / Equip / Rm file (#78.6) for the name of the primary camera / equipment / room where the imaging exam was performed. Usually there is only one camera / equipment / room per procedure. Depending on the requirements set up in the Examination Status file (#72), it may be necessary for this field to be filled in before the exam status can

---

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

2 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.'

be considered complete. This field appears during Case Edits if the division parameter contains a YES, and appears in Status Tracking if the Examination Status "Ask" parameter is set to YES.

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

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

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

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

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

Procedure Modifiers[1]: 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 [2].

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.

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

---

1 Patch RA*5*10 April 2000

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

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 Comment[1]: 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 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

---

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

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.

Exam Entry / Edit Menu - Diagnostic Code and Interpreter Edit by Case No. 1

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. 2

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

---

1 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).

2 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.

- DSS ID
- Requesting Location

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

Diagnostic Code Fields

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

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

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

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

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

(#72), it may be necessary for this field to be filled before the exam status can be considered complete.

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

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

Technologist Comment[1]: 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 INTERPRET'G RESIDENT: <RET>
    PRIMARY INTERPRETING STAFF: ?
     Enter the name of the primary staff who interpreted these images.
     Personnel must be classified as Interpreting Staff Physician.
    PRIMARY INTERPRETING STAFF: RADPROVIDER,FOUR          art      525B / 114
    Select SECONDARY INTERPRETING STAFF: RADPROVIDER,FIVE       aB      114
    Select SECONDARY INTERPRETING STAFF: <RET>
        TECHNOLOGIST COMMENT:2                  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.
```

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

```
 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.1

    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'.
```

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 IRM has a receiving mail group set up. Failure to credit can be because of missing or invalid rad / nuc med data, factors preventing PCE from crediting, or problems preventing Scheduling software from storing or transmitting credit data.

Exam Entry / Edit Menu - Edit Exam by Patient 2

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

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1 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.’

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

bulletin will be sent to the station security office notifying him / her that a sensitive record has been accessed.
If the patient's last visit date has already been logged, a message will be displayed. Otherwise, you will be prompted to enter the date of the patient's last visit.

Prompt / **User Response**	Discussion

```
Enter Last Past Visit Before VISTA


Select Patient: 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 1

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
```

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

```
 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

 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
```

Exam Entry / Edit Menu - Indicate No Purging of an Exam / Report [1]

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

You are first prompted to enter a case number. You may also enter a patient's name at this prompt. If a patient's name is entered, all active cases for that patient will be displayed, and you will be prompted to choose one. Only active cases (i.e., registered cases that are not yet in a COMPLETE status) may be selected.

However, if you hold the RA MGR security key, you may select exams with a status of COMPLETE by entering the patient's name rather than the case number at the Enter Case Number: prompt..

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

Prompt **/ User Response** Discussion

Indicate No Purging of an Exam / report

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

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

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

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

Patient's Name: RADPATIENT,TEN 000-00-0610             Run Date: MAR 28,1995

   Case No.  Procedure                   Exam Date  Status of Exam   Imaging
Loc
   --------  -------------               ---------  ---------------- --------
-
```

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

```
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 [1]

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

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

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 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.[1]

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 procedure[2]. 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.

---

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

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

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

Imaging departments must make sure that cases are routinely processed to a COMPLETE status. Otherwise, the case numbers will increment until the maximum number is reached, and the system will not allow registration of any more cases.
If the request that you select for registration is a "parent" procedure (i.e., a set of procedures called "descendents" associated with the parent procedure that has been predefined by the ADPAC), several procedures will automatically appear in sequence. You may choose to register or discard each one. After the entire set of descendents is processed, you will be asked if there are any more procedures to add to the exam set. If you later find that an additional procedure was done, you cannot re-enter the option to add it to the same exam set, but you may use this Registration option to add the procedure under a new exam date / time that is a few minutes later or earlier than the exam date / time under which the exam set was registered. Or, if no report data has been entered yet, you can use the Add Exam to Last Visit option to add the procedure to the existing exam set.
The advantages of using pre-defined parent procedures are:

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.
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 edited[1]. 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.[2]

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.
```

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

```
   If you wish to register this patient for an exam, locations must be
switched.

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


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

Welcome, you are signed on with the following parameters:

                            Printer Defaults
 Version  : 5.0T9                 ----------------
 Division : BOSTON, MA            Flash Card  : BAR88 PRT
RADIOLOGYRECEPTION2
 Location : FILE ROOM                            1 card / exam
 Img. Type: GENERAL RADIOLOGY   Jacket Label: D129  (D2-150) RADIOLOGY FILE
 User     : 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
```

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

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

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

Please select a sign-on Imaging Location: CTG        523       (CT SCAN-523)
-------------------------------------------------------------------------------
-
Welcome, you are signed on with the following parameters:

                                     Printer Defaults
 Version  : 5.0T9                    ----------------
 Division : BOSTON, MA               Flash Card  : P-CTSCAN  RADIOLOGY, CT SCAN
E
 Location : CTG                                    1 card / exam
 Img. Type: CT SCAN            Jacket Label: D129  (D2-150) RADIOLOGY FILE
 User     : RADPROVIDER,SEVEN                     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[1].

2. 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>2

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

    TECHNOLOGIST COMMENT:3  These are the comments for case #306.
    PREGNANT AT TIME OF ORDER ENTRY:  YES 4
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...

    Case Number: 307
    ----------------

 PROCEDURE: CT ABDOMEN W / O CONT /  /   <RET>                  (CT
Detailed) CPT:74150
   Select PROCEDURE MODIFIERS: RIGHT /  /  <RET> 5
    CATEGORY OF EXAM: OUTPATIENT /  /  <RET>    OUTPATIENT
    PRINCIPAL CLINIC: C MHC MEDICATION GR 7428 /  /  <RET>       7428
RADCLINIC,ONE
```

---

1 Patch RA*5*41 September 2005: New paragraph added.
2 Patch RA*5*10 April 2000 and Patch RA*5*19: Removed CPT Modifiers prompt.
3 Patch RA*5*18 November 2000: Added field for comments by the technologist.
4 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.’
5 Patch RA*5*10 April 2000 and Patch RA*5*19: Removed CPT Modifiers prompt.

```
    TECHNOLOGIST COMMENT: These are the comments for case #307.1
PREGNANT AT TIME OF ORDER ENTRY:  YES2
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
```

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

```
   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>1


    CATEGORY OF EXAM: OUTPATIENT /  /  <RET>  OUTPATIENT
    PRINCIPAL CLINIC: C MHC MEDICATION GR 7428 /  /  <RET>      7428
RADCLINIC,ONE
   TECHNOLOGIST COMMENT:2 These are the comments for case #308.
    PREGNANT AT TIME OF ORDER ENTRY:  YES 3
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
000000001
                              PRIM. CARE: RADPROVIDER,ONE   TEL 4418; 5021
                              ALT. PRIM. CARE: RADPROVIDER,TWO TEL 4418

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

  Name         : RADPATIENT,ONE
```

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

```
  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
 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:1 <RET>
```

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

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

    TECHNOLOGIST COMMENT:1 These are the comments.     PREGNANT AT TIME OF
ORDER ENTRY:2  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...
    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:3 These are the comments.
PREGNANT AT TIME OF ORDER ENTRY:4  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
```

Exam Entry / Edit Menu - Status Tracking of Exams 5

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

---

1 Patch RA*5*18 November 2000: Added field for comments by the technologist.
2 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.’
3 Patch RA*5*18 November 2000: Added field for comments by the technologist.
4 Patch RA*5*99 February 2010: Inserted the field ‘PREGNANT AT TIME OF ORDER ENTRY.’ Alsoadded two pregnancy screen prompts: ‘PREGNANCY SCREEN’ and ‘PREGNANCY SCREEN COMMENT.’
5 Patch RA*5*47 September 2011: Status Tracking of Exams option is affected by the new Site Specific Accession Number (SSAN).

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.[1]
This option differs from the Case No. Exam Edit and Edit Exam by Patient options in that prompts are predetermined by the parameters in the Examination Status file for each status change in this option. (In the case edit options, a set of basic prompts always appears, and any field already entered also appears.)
The type of data asked for during each status change in this option is specified by the site. See the *ADPAC Guide* for more information about Examination Status parameter set-up.
The set of statuses that appear for edit during this option are also site specific. A site may not want to bring up exams with a particular exam status for edit if the data needed to update the exam status is not usually entered through this option. For example, going from the EXAMINED status to the TRANSCRIBED status usually requires data supplied by an interpreting physician and entered by a transcriptionist.
By limiting the statuses that appear in this option, the efficiency of processing and tracking exams is increased. After all active statuses set up to appear on Status Tracking are cycled through, the system will start to display inactive statuses set up to appear on Status Tracking if any are so configured.
You may select one or more imaging locations to work on at once, but all the imaging locations must fall within your sign-on division and imaging type. If you have access to only one location within that imaging type, the system will default to that location instead of asking you to select imaging locations. Exams with a given status will be displayed in chronological order by exam date. Included in the display heading are the current date / time, division, imaging location(s), and the status currently under review.
Each line represents an exam and includes the case number, exam date, patient name, procedure, and camera / equipment / room. You may select one and edit it, view the next screen 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

---

1 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.

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.
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.1

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.2
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
```

1 Patch RA*5*45 May 2005: Referenced the Contrast Media and Contrast Media Used fields.
2 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.'

```
     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              Division: DAYTON
 Date    : 02 / 20 / 09  10:44 AM                 Status  : WAITING FOR EXAM
 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 1
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 13.

---

1 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.’

View Exam by Case No. 1

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.2

The activity log shows the date / time any action took place on the examination and / or report, what that action was and the computer user responsible for that action. The status tracking log shows the various examination statuses, the date / time it acquired that status, elapsed time between statuses and cumulative time the case has been active.
The exam report text shows the patient's name, exam date, procedure, case no., requesting physician, resident and staff interpreting physicians, exam modifiers, clinical history, report text, status and impression.
The following two examples show cases that have contrast media associations and are part of a printset.3

1 Patch RA*5*47 September 2011: View Exam by Case No. option is affected by the new Site Specific Accession Number (SSAN).
2 Patch RA*5*99 February 2010: Inserted the field 'Pregnant at time of order entry.'
3 Patch RA*5*45 May 2005: 'View Exam by Case No' has been changed.

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: YES1
 -------------------------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
Date / Time Changed                       User
  Contrast Media
-----------------------------------------------------------------------
```

1 Patch RA*5*99 February 2010: Inserted the field ‘Pregnant at time of order entry.’

```
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:nnnnn1
  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: YES2

 ---------------------------------Modifiers-----------------------------
  Proc Modifiers: None
  CPT Modifiers  :None
------------------------------Radiopharmaceuticals---------
Rpharm: TL-201 THALLOUS CHLORIDE       Activity Drawn: 3.35 mCi
Drawn: JUL 24, 2000@08:06              Measured By: RADPROVIDER,FIVE
Dose Adm'd: 3.35 mCi                   Date Adm'd: JUL 24, 2000@08:06
```

1 Patch RA*5*10 April 2000
2 Patch RA*5*99 February 2010: Inserted the field ‘Pregnant at time of order entry.’

```
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.1
  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 ***
                                                 Elapsed Time  Cumulative Time
  Status                 Date / Time                (DD:HH:MM)      (DD:HH:MM)
  ------                 ---------              ------------  ---------------
  REGISTERED FOR EXAM    JUL 24,2000  08:11       01:01:40        01:01:40
  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

---

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

```
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
      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,VEIN1

Clinical History:
 EXERTIONAL ANGINA (NEW SINCE BEGINNING OF 6 / 00) WITH MULTIPLE RISK FACTORS
2
   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.3
```

1 Patch RA*5*35 December 2002: Deleted four instances of "Exam modifiers : None"
2 Patch RA*5*27 April 2002: Added Additional Clinical History to the report.
3 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 / Edit[1]
- 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 [2]

This option allows the user to remove reports from or add reports to an active batch created by the user. You may not remove / add reports from / to a batch created by another user.
Once a batch is deleted you are no longer able to access that batch.
If you enter a report number NOT contained in the selected batch, that report will be added to the batch. Entry of an “at sign” @ will delete the specified report from a batch.

Prompt / **User Response**	Discussion
`Add / Remove Report From Batch`	

1 Patch RA*5*56 July 2008: Added a new option, Outside Report Entry / Edit, to the Films Reporting menu.
2 Patch RA*5*47 September 2011: Add / Remove Report from Batch option is affected by the new Site Specific Accession Number (SSAN).

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>
```

Batch Reports Menu - Create a Batch

This option is used to create a new batch of results reports. When you create a batch, you are designating a name by which a group of individual reports can be referenced. You would use this option if you wished to print several different reports to the same device. By placing all of the reports in a batch, you would only have to run the Print a Batch of Reports option once instead of printing each report separately.
You could also use this option to batch all the reports for a particular interpreting physician. Then, when the physician wished to verify his / her reports, he / she would only need to call up the batch name (usually his / her last name) instead of each report individually.
More than one transcriptionist may enter batches with the same name, but a user is only allowed to remove reports from and add reports to batches he / she created. The Add / Remove Report from Batch option is used to place reports in batches.
The Report Entry / Edit option has built-in functionality for creating and adding reports to batches.

Prompt / **User Response**	Discussion
Create a Batch Select Batch: 4 / 3 / 95 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.

Delete Printed Batches

This option allows the user to delete batches after they are no longer needed. The batch must have been created by the current user and need not have actually been printed. That is, the user cannot delete a batch created by another user. The Delete Printed Batches by Date option under the Supervisor menu allows supervisors to delete printed batches belonging to any user.
This option would be used to free up batch names so they could be reused. For instance, after a batch has been verified by the interpreting physician and printed, deleting the batch would enable the batch name (usually the interpreting physician's last name) to be used again.

Once a batch is deleted you are no longer able to access that batch. You would not be able to use the Add / Remove Report from Batch option to add more reports to the batch. You would have to create a new batch through the Report Entry / Edit or Create a Batch options with the same name and then add reports to it.
After you select a batch for deletion, the system will display the date / time the batch was created, the name of the user who created the batch and the date the batch was last printed (if any). Only batches which have been printed at least once are shown as choices. Refer to the Supervisor Menu for another option that allows supervisors to delete printed batches regardless of which they belong to.

Prompt / **User Response** Discussion

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

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

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

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

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

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


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


                                                                Page: 1
                      <<< Report Batches To Be Deleted >>>
***************************************************************************
1]   2 / 22 / 95 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 [1]

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

Prompt / **User Response** Discussion

```
List Reports in a Batch

Select Batch:    RADPROVIDER,FIVE REPORTS       03-06-95
RADPROVIDER,SEVEN

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

```
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
```

Print a Batch of Reports [2]

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

---

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

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>`	If you are prompted for a device, the results reports will print on the printer chosen.
`Requested Start Time: NOW / / <RET> (APR 03, 1995@09:56:42)` `Request Queued. Task #: 11620`	

Verify Batch 1

This option allows the user to verify every report in a batch without having to enter each case number. However, the user must indicate whether to verify each report one at a time.
This option would most likely be used to verify results reports after the printed reports generated through the Print a Batch of Reports option have been reviewed and signed off.
Only active batches may be selected. You may select a batch by batch name or user name. If a user name is entered at this prompt, all active batches created by that user will be displayed for selection.
Each report within the batch with a status other than VERIFIED will be individually displayed and the user will be able to change the report status. Once all the reports in a batch have been verified, the user has the option of deleting the batch.
If any diagnostic code for the selected exam is defined by the ADPAC as a code that should generate an abnormal alert (via the Diagnostic Code Enter / Edit option), the attending and requesting physicians and any teams associated with the patient through 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

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

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

```
Verify Batch

Select Batch: RADPROVIDER,FIVE  REPORTS          03-
06-95      RADPROVIDER,SEVEN

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 VERIFIED1
-----------------------------------------------------------------------
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!
```

1 Patch RA*5*8 October 1999

Display a Rad / Nuc Med Report 1

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)2, reason for study 3, pharmaceuticals and radiopharmaceuticals when used, clinical history and additional clinical history 4, 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.'5 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.
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.6

For example,

The long (traditional) display:

---

1 Patch RA*5*47 September 2011: Display a Rad / Nuc Med Report option is affected by the new Site Specific Accession Number (SSAN).
2 Patch RA*5*10 April 2000
3 Patch RA*5*75 June 2007: Added Reason for Study to report display list.
4 Patch RA*5*27 April 2002: Additional clinical history added to report.
5 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'
6 Patch RA*5*35 February 2010: Changes on displays.

MYOCARDIAL PERFUSION STUDY
SESTAMIBI (PER DOSE)
SESTAMIBI (PER DOSE)
The condensed (new default) display:[1]
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 2

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 3
Residents :
    Pregnancy Screen: Patient answered yes.4
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:
```

1 Patch RA*5*35 December 2002: Continued changes in displays.
2 Patch RA*5*82 June 2007: Added new sample prompts and report output.
3 Patch RA*5*99 February 2010: Replaced the ‘Staff Phys ‘field with ‘Staff Imaging Phys’ field.
4 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’

```
   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
   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

```
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      1N                   8
AUG 31,1995  10:38  PRINT     RADPROVIDER,SIX                           46
```

Distribution Queue Menu - Clinic Distribution List [1]

This option is used to produce a listing of **verified** reports by clinic for a specified date range. You may also generate this report to include data for all clinics. This option does not print the results reports themselves, it just prints a list of reports.
Reports are automatically entered into the distribution queues at the time they are verified.
You will be prompted to enter one or more clinic names. You will also be able to choose whether to list the previously printed reports or unprinted reports for the selected clinic(s). If you choose to list printed reports, you are then prompted to enter a date range for the listing.
The list prints alphabetically by patient name. If run for unprinted reports the output generated will include: date / time the report is run, date / case number, patient name and patient ID, date / time the report was verified and the clinic that requested the procedure.
If the listing is generated for previously printed reports the information provided will include: date / time the report is run, date / case number, patient name and ID, date report was printed, user who printed the report and the clinic that requested the procedure.
Only outpatients will be listed on this report. If the patient was an outpatient when the exam was requested but an inpatient when the report was initially printed, the report would appear on the Ward Distribution List.
The output from this option can be very long, so you may want to queue it to a printer instead of tying up your terminal for a long time.

Prompt / **User Response**	Discussion
`Clinic Distribution List`	
`Select Clinic:` **`ALL`**	One, many, all clinics may be selected.
`Another one (Select / De-Select):` **`<RET>`**	

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

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

  Choose one of the following:
          PRINTED
          UNPRINTED
  Report Selection: UNPRINTED /  /  printed       PRINTED
71
```

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

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

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

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

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

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

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

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

021194-92  RADPATIENT,TWO    0022 04 / 05 / 95@10:33  RADPROVIDER,TEN
EMERGENCY
101293-13  RADPATIENT,ONE    0062 04 / 05 / 95@10:33  RADPROVIDER,SIX
EMERGENCY
011194-33  RADPATIENT,NINE   1026 04 / 05 / 95@10:33  RADPROVIDER,TEN
EMERGENCY
011094-30  RADPATIENT,NINE   1089 04 / 05 / 95@10:33  RADPROVIDER,TEN
GENERAL MEDICI
010794-36  RADPATIENT,NINE   0089 04 / 05 / 95@10:33  RADPROVIDER,TEN
GENERAL MEDICI
010594-35  RADPATIENT,NINE   0089 04 / 05 / 95@10:33  RADPROVIDER,TEN
GENERAL MEDICI
030994-4   RADPATIENT,TWO    0062 04 / 05 / 95@10:33  RADPROVIDER,SIX
GENERAL MEDICI
040395-309 RADPATIENT,TWO    0052 04 / 05 / 95@10:33  RADPROVIDER,SIX     EAR
NOSE & THR
062394-64  RADPATIENT,TEN    0810 04 / 05 / 95@10:33  RADPROVIDER,EIGHT   EAR
NOSE & THR
062394-63  RADPATIENT,TEN    0810 04 / 05 / 95@10:33  RADPROVIDER,EIGHT
MAGNETIC RESON
062394-58  RADPATIENT,TEN    0810 04 / 05 / 95@10:33  RADPROVIDER,EIGHT
MAGNETIC RESON
062394-57  RADPATIENT,TEN    0810 04 / 05 / 95@10:33  RADPROVIDER,EIGHT
MAGNETIC RESON
040194-74  RADPATIENT,FOUR   0004 04 / 05 / 95@10:33  RADPROVIDER,SEVEN
MAGNETIC RESON
```

```
110193-25  RADPATIENT,FOUR   0004 04 / 05 / 95@10:33  RADPROVIDER,SEVEN
MAGNETIC RESON
031894-284 RADPATIENT,FOUR   0004 04 / 05 / 95@10:33  RADPROVIDER,SEVEN
ULTRASOUND
040494-81  RADPATIENT,FOUR   0004 04 / 05 / 95@10:33  RADPROVIDER,SEVEN
ULTRASOUND
032294-15  RADPATIENT,FOUR   0004 04 / 05 / 95@10:33  RADPROVIDER,SEVEN
ULTRASOUND
040494-20  RADPATIENT,FOUR   0004 04 / 05 / 95@10:33  RADPROVIDER,SEVEN
ULTRASOUND
```

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

Distribution Queue Menu - Individual Ward

This option prints either:

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

Reports are automatically entered in the distribution queues at the time they are verified.
You will be prompted to select one or more wards, division, and one or more imaging types. You are then asked to select a sorting sequence, either by terminal digits, SSN or patient name. You can also choose between listing reprints of previously printed reports 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.[1]
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:
----------------------------------
```

1 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.

Distribution Queue Menu - Print By Routing Queue

This option allows the user to print the reports for the respective distribution queues. For instance, if you want to print all results reports for all inpatients on the hospital wards, you would use this option.
The user is prompted for the routing queue, division, one or more imaging types, sort sequence (Terminal Digits, SSN, Patient), whether or not to sort by patient location before your chosen sort sequence, and choice of unprinted or reprint reports. If you choose to print reprints, you are then prompted to enter a date range for the listing. The reports are then printed (preceded and followed by a queue banner).
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.[1] 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

1 Patch RA*5*10 April 2000

the *ADPAC Guide* for more information about imaging location set-up and flash card, label, header and footer formats.)
The total number of reports printed is shown at the end of the entire set of reports.
This output must be queued to a printer.

Prompt / **User Response** Discussion

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

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

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

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

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

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

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

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

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

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

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

  Enter Response: UNPRINTED /  /  ??
  Enter one of the following:
     'UNPRINTED'         to print verified reports that have not been printed
     'REPRINT'           to reprint previously printed reports
     ^                   to stop.
  Enter Response: UNPRINTED /  /  REPRINT
Date Range Selection:
---------------------
  Beginning DATE / TIME of Initial Print : T@1201AM /  / 1 / 1 / 97@1201AM
(JAN 01, 1997@
00:01)

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

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

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

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

Distribution Queue Menu - Report's Print Status [1]

This option allows the user to inquire about the print status of a specific report. The print status can only be checked for verified reports. This option would be used to determine if and when a report had been printed.
You may select the report by date / case number or by patient's name. If you select by patient's name, a list of that patient's verified reports will be displayed for selection.
The inquiry lists the report's day / case #, patient name and ID number, procedure, date verified, routing queue, date printed, who it was printed by and the patient's ward / clinic.

Prompt / **User Response** Discussion

```
Report's Print Status

Select Report: 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 IRM after they are printed, so older printed reports may not be displayed.

Distribution Queue Menu - Single Clinic

This option prints either:

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

Only outpatient reports will be printed through this option. If the patient was an outpatient when the report was requested, but an inpatient when the report was printed, the report would have to be printed though the Individual Ward option.
The user is prompted for one or more clinic(s), division, imaging type, and sort sequence (terminal digits, SSN, patient name). You can also choose between

---

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

unprinted or reprint reports. If you choose to reprint reports, you are then prompted to enter a date range for the listing.
The reports are then printed (preceded and followed by the queue banner).1 The report printout will include procedure and CPT modifiers, clinical history, report text, impression text, report status, and the names of all the primary and secondary interpreting staff and residents, with a notation beside the report verifier's name.
The report 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

```
Single Clinic

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

Select Imaging Type: ALL  /  /  <RET>

Another one (Select / De-Select):

Sort Sequence Selection:
------------------------
  Choose one of the following:
          Terminal Digits
          SSN
          Patient
  Select Sequence: Patient /  /  <RET>
Print / Reprint Reports Selection:
----------------------------------
  Choose one of the following:
          UNPRINTED
          REPRINT
  Enter Response: UNPRINTED /  /  <RET>
```

```
Select Clinic: ER   EMERGENCY ROOM

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

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

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

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

1 Patch RA*5*10 April 2000

Distribution Queue Menu - Unprinted Reports List 1

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
```

Distribution Queue Menu - Ward Distribution List 2

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.

---

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

Distribution Queue Menu

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) 1

This option should only be given to those users in the department who need to reprint a DRAFT report. Since access to unverified results reports is usually not advisable, caution should be exercised in determining to whom this option is assigned.
For example, the transcriptionist should have access to this option, but ward clerks should not. Instead, the ward clerks could be given access to the Select Report to Print by Patient option which prints only verified or released / not verified reports.
Reports selected to be printed through this option will always have a status of DRAFT or PROBLEM DRAFT.
You will first be prompted to select a patient name. If the patient selected has more than one examination report on file, these reports will be listed and you will be prompted to choose one or more. The only other prompt in this option is for a device on which to print the output.

Prompt / **User Response** Discussion

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

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

```
                        **** 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.1
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?
```

1 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’

```
     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*
                                     *******
    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 [1]

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

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

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.)
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 file[1] is set to YES. You may use the Display Report or Select Report to Print options to view or print reports with this status if this status is allowed at your facility.
DRAFT - The report can only be displayed in the Imaging Department.
PROBLEM DRAFT - The report is only available for display in the Imaging department. A statement to the interpreting physician describing the reason for this status will be shown.
The system will not allow you to verify a report without the Impression Text being complete - it will put it in PROBLEM DRAFT.
If you have chosen Status and Print, you will be given a Device prompt after editing the status. You may then print a report in any status, or convert the report to an e-mail message using P-MESSAGE, or FAX if your site has these available as legitimate devices.
Next, you will see prompts for primary and secondary diagnostic codes. The prompt for secondary diagnostic code will only appear if a primary diagnostic code has been entered. If the 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.

---

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

Distribution Queue Menu

Set-up of this interface must be done by IRM, who should refer to the *Radiology / Nuclear Medicine 5.0 HL7 Manual* 1for more information.

> **Note:** If there is a technologist comment, it is shown in the body of the report. 2 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.3
>
> **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.4

---

1 Patch RA*5*25 July 2002: Reference to Technical Manual changed to the Radiology / Nuclear Medicine 5.0 HL7 Manual.
2 Patch RA*5*18 November 2000: New field for comments by the technologist added to report.
3 Patch RA*5*45 May 2005: Display of associated contrast media.
4 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

Prompt / **User Response** Discussion

```
On-line Verifying of Reports

Enter your Current Signature Code: OOOO   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 (XXXXXXXXX)                Case No.        : 030309-7 @13:16
ESOPHAGUS                                 Transcriptionist  :
RADTRANSCRIPTIONIST,ONE
Req. Phys : RADCLINICIAN,FIVE               Pre-verified   :
RADCLINICIAN,SEVEN

Staff Imaging Phys: RADCLINICIAN,SIX (P)1
Residents : RADCLINICIAN,SEVEN (P)
Pregnancy Screen: Patient answered yes.2
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:

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

1 Patch RA*5*99 February 2010: Replaced the ‘Staff Phys’ field with ‘Staff Imaging Phys’ field.
2 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’

```
  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 [1] [2]

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.
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 [3]

---

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

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

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

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
```

Example 1

```
Enter a new outside report for a case that is registered from a credit
location.[1]

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
```

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

```
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.1
 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.

---------------------------------------------------------------------------2
   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)
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:
```

1 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’
2 Patch RA*5*95 May 2009: Removed the “No Credit” warning message.

```
  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>======
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.[1]

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.

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,      |
```

1 Patch RA*5*95 May 2009: Modified the “Visit credited” statement.

```
   |  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.1
 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

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.

---

1 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’

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.1
 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
```

1 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’

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

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 [1]

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.

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.

---

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

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 Location[1]

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 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.

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

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 History[1]
- Report text
- Impression
- Diagnostic codes
- Primary and secondary residents and staff
- Verifier
- Reported date
- Status

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

A standard or copied report will also apply to all cases in the set. Since the diagnostic codes, residents, and staff apply to all cases, the system will no longer allow entry of this data through the Case Edits, Status Tracking, or Diagnostic Code and Interpreter Edit options. The reporting options must be used instead.
If Distribution Queues are used at the hospital, then verification of a report is the event that triggers the report's entry into the appropriate distribution queue(s).
Report entry can be done through vendor-supplied voice recognition units via an HL7 (Health Level 7) interface provided partially by this package and partially by the vendor. Set-up of this interface must be done by IRM, who should refer to the *Radiology / Nuclear Medicine 5.0 HL7 Manual* 1 for more information.

> **Note:** If there is a technologist comment,2 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.3
>
> **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.4

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
```

1 Patch RA*5*25 July 2002: Reference to Technical Manual changed to the Radiology / Nuclear Medicine V. 5.0 HL7 Manual.
2 Patch RA*5*18 November 2000: New field for comments by the technologist added to report.
3 Patch RA*5*45 May 2005: Display of associated contrast media.
4 Patch RA*5*99 February 2010: Added a note about: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

```
---------------------------------------------------------------------------
 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.1
 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:
```

1 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 file[1] is set to YES. You may use the Display a Rad / Nuc Med Report or Select Report to Print options to view reports with this status.
PROBLEM DRAFT - The report is only available for display in the Imaging department. A statement to the interpreting physician describing the Reason for this status will be shown. If left in this status, the system will not prompt for pre-verification.
DRAFT - The report can only be displayed in the Imaging department.
If you have chosen Status and Print you will be given a Device prompt after editing the status. You may then print a report in any status, or convert the report to an e-mail message using P-MESSAGE or FAX if your IRM supports these devices.
If the interpreting resident answers YES to the question, WANT TO PRE-VERIFY THIS REPORT?, then the resident's encrypted electronic signature, electronic signature code,

---

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

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.[1]
The default value and informational messages for the Interpreting Imaging Location prompt are explained in the Report Entry / Edit section.[2]

> **Note:** If there is a technologist comment[3], 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.[4]

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
```

---

1 Patch RA*5*41 September 2005: Text added - …and Interpreting Imaging Location.
2 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.
3The default value and informational messages for the Interpreting Imaging Location prompt are explained in the Report Entry / Edit section.
4 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'

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

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

Staff Imaging Phys: RADCLINICIAN,SEVEN (P)1
Residents : RADCLINICIAN,FIVE (P)
Pregnancy Screen: Patient answered yes.2
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>
```

1 Patch RA*5*99 February 2010: Replaced the ‘Staff Phys‘ field with ‘Staff Imaging Phys’ field.
2 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’

```
INTERPRETING IMAGING LOCATION: RADIOLOGY /  /  <RET>
```

Select Report to Print by Patient [1]

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 descendents when defined as a printset, procedure and CPT modifiers[2], reason for study[3], clinical history and [4], contrast media associations [5] (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.
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.[6] 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.

---

1 Patch RA*5*47 September 2011: Select Report to Print by Patient option is affected by the new Site Specific Accession Number (SSAN).
2 Patch RA*5*10 April 2000
3 Patch RA*5*75 June 2007: Added Reason for Study to report display list.
4 Patch RA*5*27 April 2002: Additional clinical history added to report.
5 Patch RA*5*45 May 2005: Display of associated contrast media
6 Patch RA*5*8 October 1999

Prompt / **User Response** Discussion

```
Select Report to Print by Patient1

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.2
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:
```

1 Patch RA*5*75 June 2007: Updated sample prompts and report to show Reason for Study field and formatting.
2 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’

```
THREE RADPROVIDER, Staff Physician (Verifier)

 / TRP
```

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 13.

Verify Report Only [1]

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. Set-up of this interface must be done by IRM, who should refer to the *Radiology / Nuclear Medicine 5.0 HL7 Manual* 2for more information.

---

1 Patch RA*5*47 September 2011: Verify Report Only option is affected by the new Site Specific Accession Number (SSAN).
2 Patch RA*5*25 July 2002: Reference to Technical Manual changed to Radiology / Nuclear Medicine 5.0 HL7 Manual.

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

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

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

Prompt / **User Response**	Discussion
Verify Report Only Select Rad / Nuc Med Division: All / / **<RET>** Another one (Select / De-Select): **<RET>** Select Imaging Type: All / / **<RET>** Another one (Select / De-Select): **<RET>**	
Enter Case Number: **RADPATIENT,FOUR** 05-15-84 000000004 NO SHARING AGREEMENT	If the case number is not known, the patient's name, SSN, or other standard VistA patient identifier can be entered at this prompt and a list of cases will be displayed.

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

Patient's Name: RADPATIENT,FOUR  000-00-0004              Run Date: JUN
15,2009

   Case No.  Procedure                    Exam Date  Status of Report Imaging
Loc
   --------  -------------                ---------  ---------------- --------
---
1     624    CHEST 2 VIEWS PA&LAT         06 / 29 / 00   DRAFT            X-
RAY
2     608    SPINE CERVICAL MIN 2 VIEWS   02 / 24 / 00   VERIFIED         X-
RAY
3     612    CHEST 2 VIEWS PA&LAT         02 / 13 / 00   VERIFIED
WESTSIDE XR
4     613    ABDOMEN 2 VIEWS              02 / 13 / 00   VERIFIED
WESTSIDE XR
5     614    ANGIO CAROTID CEREBRAL BIL   02 / 13 / 00   None
WESTSIDE XR
```

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

```
6    +402    ANKLE 2 VIEWS                01 / 28 / 00   None            X-
RAY
7    .420    FOOT 2 VIEWS                 01 / 28 / 00   None            X-
RAY
8    .423    TOE(S) 2 OR MORE VIEWS       01 / 28 / 00   None            X-
RAY
9     392    THYROID SCAN                 01 / 15 / 00   None            NUC
MED LOC
10    343    ULTRASONIC GUID FOR RX FIE   01 / 15 / 00   None            US
11   +415    BONE IMAGING, MULTIPLE ARE   01 / 06 / 00   DRAFT           NUC
MED LOC
12   .416    BONE IMAGING, WHOLE BODY     01 / 06 / 00   DRAFT           NUC
MED LOC
13   .417    PROVISION OF DIAGNOSTIC RA   01 / 06 / 00   DRAFT           NUC
MED LOC
14   +1      ANKLE 2 VIEWS                01 / 05 / 00   VERIFIED        X-
RAY
Type '^' to STOP, or
CHOOSE FROM 1-14: 5

----------------------------------------------------------------------1
 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
```

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

```
Pregnancy Screen: Patient is unable to answer or is unsure1
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
PERIO

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

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)
```

1 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’

```
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
Yes1
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 /  /  ^
```

1 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…[1]
- 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.[2]

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

---

1 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.

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

Management Reports Menu - Daily Management Reports

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

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

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

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

Management Reports Menu - Abnormal Exam Report 1

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 [2]
“VA radiologist”, “Electronically Filed”, or “All” may be selected. Cases that do not yet have associated interpreted reports would be included in all three selections[3].
The “Print only those exams not yet printed?” prompt allows the person generating the report to decide whether to include all abnormal exams or just those that have not appeared on any previous listing of this report. If the exam appeared on a previous listing of this report, the Diagnostic Print Date field of the Rad / Nuc Med Patient file exam record will contain the date printed.
A date range must also be selected. The date range refers to the exam date / time entered at the time of exam registration and only exams within the selected date range will be included. 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.[4] 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.,

---

1 Patch RA*5*47 September 2011: Abnormal Exam Report option is affected by the new Site Specific Accession Number (SSAN).
2 Patch RA*5*97 September 2009: Moved two sentences from a paragraph into individual sentences.
3 Patch RA*5*97 September 2009: Added a paragraph about “VA radiologist”, “Electronically Filed”, or “All”.
4 Patch RA*5*15 June 2000: NOIS: MUS-0399-72971 Description change for selecting the date range.

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.[1]
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,
       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>
2
```

1 Patch RA*5*34 May 2003: Text added regarding several cases sharing one printset.
2 Patch RA*5*97 September 2009: Added “VA radiologist”, “Electronically Filed”, or “All” information to the Outside Reporting Enter / Edit option example.

```
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
                    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.

Management Reports Menu - 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,[1] pregnant at time of order entry, pregnancy screen, pregnancy screen comments,[2] and reaction description (if available) will print.

---

1 Patch RA*5*99 February 2010: Replaced the 'Interpreting Stf.' field with 'Staff Imaging Phys' field.
2 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.'

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

Prompt / **User Response**	Discussion
Complication Report	
Select Rad / Nuc Med Division: All / / HINES CIO FIELD OFFICE IL CIOFO 499 Another one (Select / De-Select): **<RET>**	
Select Imaging Type: All / / **?** Select an IMAGING TYPE TYPE OF IMAGING from the displayed list. To deselect a TYPE OF IMAGING type a minus sign (-) in front of it, e.g., -TYPE OF IMAGING. Use an asterisk (*) to do a wildcard selection, e.g., enter TYPE OF IMAGING* to select all entries that begin with the text 'TYPE OF IMAGING'. Wildcard selection is case sensitive. Answer with IMAGING TYPE TYPE OF IMAGING, or ABBREVIATION Choose from: ANGIO / NEURO / INTERVENTIONAL CT SCAN GENERAL RADIOLOGY MAGNETIC RESONANCE IMAGING NUCLEAR MEDICINE ULTRASOUND Select Imaging Type: All / / **GEN**ERAL 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.1 : RADPROVIDER,EIGHT
     Tech: [Note: only displays if populated.]
Pregnant at time of order entry:  YES2
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.
Description: Patient experienced fast heartbeat, flushing.
===============================================================================
Complications: 1   Exams: 252   % Complications:   0.40
Contrast Media Complications: 1   C.M. Exams: 1   % C.M. Comp.: 100.00

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

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

Management Reports Menu - Daily Log Report 3

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.

---

1 Patch RA*5*99 February 2010: Replaced the ‘Interpreting Stf.’ field with ‘Staff Imaging Phys’ field.
2 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.’

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

An exam date must also be selected. The default response is T-1 or yesterday. Only exams whose Exam Date field contains a day that matches the selected day will be included.
Sort order of the report is: Division, Imaging Type, Patient name, Exam date, Case number.
If division or imaging type is missing from an exam record, the exam will appear under Unknown. (This should not happen under normal circumstances.)
Totals are printed for each selected imaging type and division. If more than one imaging type occurs within a division, a division total will print. If more than one division was included, a grand total for all divisions will print.
For each exam, the following items will print: patient name, patient ID, ward / clinic, procedure, exam status, case number, exam time, and a "yes / no" notation telling whether the report was entered yet.
The following example sorts by all Divisions and Imaging Types. Your selections may be different according to your needs.

```
Daily Log Report

Select Imaging Location: All /  /  ?

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

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


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

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


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

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

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

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

```
                   Daily Log Report For: Aug 17, 1997          Page: 1
Division         : WHITE RIVER JUNCTION, VT.                   Date: Aug 18,
1997
Imaging Location : XRAY (GENERAL RADIOLOGY)
Name                      Pt ID        Ward / Clinic           Procedure
        Exam Status             Case #     Time                Reported
--------------------------------------------------------------------------
---
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
```

Management Reports Menu - Delinquent Outside Film Report for Outpatients

This function allows the user to obtain a report of all the patients who have outside films registered that have a “Needed Back” date less than the date the user specifies. 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.`

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

Management Reports Menu - Delinquent Status Report [1]

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a listing of examination reports with a status considered delinquent. The only statuses considered to be delinquent are those designated by the ADPAC through the “Exam Status Entry / Edit” option when answering the “Delinquent Status Report?” question.
This report is compiled from the examination data entered through the Exam Entry / Edit Menu. If the person generating the report has access to more than one radiology / nuclear medicine division a prompt will be displayed asking for a selection of one or more divisions. If the person generating the report has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type.
A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. An exam date range must also be selected. After selecting whether to include Inpatient, Outpatient, or Both there is a selection to sort by Patient or Exam Date.
A screen display prior to device selection shows all exam statuses to be included for each imaging type selected.
Exams that fall within the specified date range and meet the other selection criteria will be included in the report. The program decides whether or not to include an exam based on imaging type by looking at the imaging type of the exam status.
Exams which have a CANCELLED status (any status in the Examination Status file with an Order of zero) and a COMPLETE status (any status in the Examination Status file with an Order of 9) will never be included in the report even if these statuses have a YES in the Delinquent Status Report? field on the Examination Status file 72. (For more information on setting the Examination Status parameters, see the *ADPAC Guide*.)
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.[2]
So that all imaging types will be accounted for, a page will print for each even if the total is zero.

```
Delinquent Status Report

Select Rad / Nuc Med Division: All /  /  ?

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

1 Patch RA*5*47 September 2011: Delinquent Status Report option is affected by the new Site Specific Accession Number (SSAN).
2 Patch RA*5*15 July 2000: Report status added to the report, "Verified" deleted from report.

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

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

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

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

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

Select Imaging Type: All /  /  ?

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

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

Select Imaging Type: All /  /  MAGNETIC RESONANCE IMAGING

Another one (Select / De-Select): MAMMOGRAPHY

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

                            Delinquent Status Report

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

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

          MAMMOGRAPHY
          -----------
               EXAMINED
```

```
               TRANSCRIBED

**** Date Range Selection ****

   Beginning DATE : T  (AUG 18, 1997)

   Ending    DATE : T  (AUG 18, 1997)

     Select one of the following:

          I         INPATIENT
          O         OUTPATIENT
          B         BOTH

Report to include: BOTH

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

     Select one of the following:

          P         PATIENT
          D         DATE

Enter response: PATIENT

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

```
                            Delinquent Status Report
Division: BOSTON, MA                                          Page: 1
Imaging Type: MAGNETIC RESONANCE IMAGING                      Date: Aug 18,
1997
Patient Name        Case #    Pt ID        Date      Ward / Clinic      Rpt
Stat1
 Procedure             Exam Status  Rpt Text  Interp. Phys.    Tech
==============================================================================
===
RADPATIENT,SEVEN    111       000-00-0017  08 / 18 / 97  13C     No Rpt
 MRI BRAIN + BRAIN ST  EXAMINED     RADPROVIDER,ONE         RADPROVIDER,NINE
------------------------------------------------------------------------------
---
RADPATIENT,EIGHT.   333       000-00-0018  08 / 18 / 97  6CN      Draft
 MULTIPLANAR MRI COMP  EXAMINED     Yes       Unknown       RADPROVIDER,TEN
------------------------------------------------------------------------------
---
*** OUTPATIENT ***             *** OUTPATIENT ***             *** OUTPATIENT
***
RADPATIENT,NINE  221 000-00-0019  08 / 18 / 97  C SURG ORTHO MO  Released
 MRI LOWER EXTREMITY   EXAMINED     RADPROVIDER,ONE         RADPROVIDER,NINE
------------------------------------------------------------------------------
---
```

1 Patch RA*5*15 June 2000: Added "Rpt Stat" as column heading to report. Deleted "Verified" as heading.

```
RADPATIENT,TEN      502       000-00-0110  08 / 18 / 97  RADIOLOGY-WEST   Prb
Drft
 MRI SPINAL CANAL CER  EXAMINED     Yes       Unknown       RADPROVIDER,NINE
-------------------------------------------------------------------

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

```
                            Delinquent Status Report
Division: BOSTON, MA                                          Page: 2
Imaging Type: MAMMOGRAPHY                                     Date: Aug 18,
1997
==============================================================================
===
Patient Name     Case #    Pt ID        Date      Ward / Clinic      Rpt
Stat1
 Procedure             Exam Status  Rpt Text  Interp. Phys.    Tech
==============================================================================
===
RADPATIENT,ONE    199    000-00-0021  08 / 18 / 97  C RADPROVIDER,TWO
Verified
 MAMMOGRAM UNILAT     EXAMINED   Yes       Unknown       RADPROVIDER,THREE
-----------------------------------------------------------------------
Imaging Type Total 'MAMMOGRAPHY': 1
Division Total 'BOSTON, MA': 5

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

 Division Total 'LOWELL OPC, MA': 0



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

Division: BOSTON, MA
```

1 Patch RA*5*15 June 2000: Added "Rpt Stat" as heading to report. Deleted "Verified" as heading.

```
   Imaging Type(s): MAGNETIC RESONANCE IMAGING   MAMMOGRAPHY

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

 Total Over All Divisions: 5
```

Management Reports Menu - 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 Record option, but editing this will not change the category of a single given case after the system has automatically determined it during registration.)
If this field is blank (a sign of data corruption) the exam would not be included on this report. Exam category headings are abbreviations of the following:

- CONTRACT
- EMPLOYEE
- INPATIENT
- OUTPATIENT
- RESEARCH
- SHARING

Since the program needs to know whether or not an exam is complete to accurately report numbers under the COMPLETE EXAMS column, if an exam's imaging type does not have a corresponding COMPLETE status entered in the Examination Status file #72 (a status with the Order field set to 9), the exam will not be counted.
See the ADPAC Guide for information that the ADPAC needs to set up the Examination Status file parameters.
Sort order of the report is: division, imaging type, imaging location, date.
Totals are printed, depending on detail level chosen, by location, imaging type, division, and grand total.
The following example sorts by a single Division and Imaging Type. Your selections may be different according to your needs.

Prompt / **User Response**	Discussion
Examination Statistics	
Select one of the following: L Location I Imaging Type D Division T Totals Only Enter Report Detail Needed: Location **/ / <RET>**	
Select Rad **/** Nuc Med Division: All **/ / H**INES CIO FIELD OFFICE IL CIOFO 499 Another one (Select **/** De-Select): **<RET>**	
Select Imaging Type: All **/ / GEN**ERAL RADIOLOGY Another one (Select **/** De-Select): **<RET>**	
**** Date Range Selection **** Beginning DATE : **T-100** (NOV 19, 1994) Ending DATE : **T** (FEB 27, 1995)	
DEVICE: HOME **/ / <RET>** (Printer Name or "Q")	Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
                    >>>>> EXAMINATION STATISTICS <<<<<                Page: 1

Division: HINES CIO FIELD OFFFICE       Location: FLUORO
Run Date: Feb 27, 1995                  Imaging Type: GENERAL RADIOLOGY
                   For Period: Nov 19, 1994 to Feb 27, 1995.

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

                    >>>>> EXAMINATION STATISTICS <<<<<                Page: 2

Division: HINES CIO FIELD OFFICE        Location: MAMMOGRAPHY
Run Date: Feb 27, 1995                  Imaging Type: GENERAL RADIOLOGY
                   For Period: Nov 19, 1994 to Feb 27, 1995.

                           COMPLETE --------------EXAM CATEGORY--------------
```

DATE	VISITS	EXAMS	EXAMS	CON	EMP	INP	OUT	RES	SHA
Jan 25, 1995	1	2	2	0	0	0	2	0	0
Jan 26, 1995	3	4	4	0	0	4	0	0	0
TOTAL	4	6	6	0	0	4	2	0	0

>>>>> EXAMINATION STATISTICS <<<<< Page: 3

Division: HINES CIO FIELD OFFICE Location: X-RAY
Run Date: Feb 27, 1995 Imaging Type: GENERAL RADIOLOGY
For Period: Nov 19, 1994 to Feb 27, 1995.

			COMPLETE	----------EXAM CATEGORY----------					
DATE	VISITS	EXAMS	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
TOTAL	141	280	55	1	0	43	235	1	0

Imaging Type: GENERAL RADIOLOGY

TOTAL	146	288	61	1	0	49	237	1	0

Division: HINES CIO FIELD OFFICE

TOTAL	146	288	61	1	0	49	237	1	0

>>>>> EXAMINATION STATISTICS <<<<< Page: 4

Division: Location:
Run Date: Feb 27, 1995 Imaging Type:
For Period: Nov 19, 1994 to Feb 27, 1995.

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

Division: HINES CIO FIELD OFFICE
   Imaging Type(s): GENERAL RADIOLOGY

TOTAL           146    288       61      1      0     49    237      1     0
```

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

Management Reports Menu - Incomplete Exam Report 1

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a list of all exams that have not been completed. This report is the same as the Delinquent Status Report, except for the way it determines whether to include an exam based on its status.
For this report, all exams except those with a COMPLETE or CANCELLED status are included. Refer to the Delinquent Status Report for an explanation of the report logic.
The following example sorts by a single division and Imaging Type.
Your selections may be different according to your needs.

Prompt / **User Response** | Discussion

```
Incomplete Exam Report
```

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

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

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

            Incomplete Exam Report
```

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

   Beginning DATE : T-100   (JAN 12, 1997)

   Ending    DATE : T  (APR 22, 1997)

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

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

     Select one of the following:

          P         PATIENT
          D         DATE

Enter response: PATIENT
```

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

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

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

```
                              Incomplete Exam Report
Division: HINES CIO FIELD OFFICE                                Page: 1
Imaging Type: GENERAL RADIOLOGY                                 Date: Apr 22,
1997
==============================================================================
===
Patient Name          Case #    Pt ID        Date      Ward / Clinic
Verified
 Procedure             Exam Status  Rpt Text  Interp. Phys.    Tech
==============================================================================
===
RADPATIENT,TWO        427       000-00-0022  01 / 28 / 97  1S
No
 ANKLE 2 VIEWS         WAITING FOR  No        Unknown          Unknown
------------------------------------------------------------------------------
---
RADPATIENT,TWO        428       000-00-0022  01 / 28 / 97  1S
No
 FOOT 2 VIEWS          WAITING FOR  No        Unknown          Unknown
------------------------------------------------------------------------------
---
RADPATIENT,TWO        429       000-00-0022  01 / 28 / 97  1S
No
 TOE(S) 2 OR MORE VIE  WAITING FOR  No        Unknown          Unknown
------------------------------------------------------------------------------
---
RADPATIENT,TWO        430       000-00-0022  01 / 28 / 97  1S
No
 ANKLE 2 VIEWS          WAITING FOR  No        Unknown         Unknown
------------------------------------------------------------------------------
---
RADPATIENT,TWO        431       000-00-0022  01 / 28 / 97  1S
No
 FOOT 2 VIEWS          WAITING FOR  No        Unknown          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          Case #    Pt ID        Date      Ward / Clinic
Verified
 Procedure             Exam Status  Rpt Text  Interp. Phys.    Tech
==============================================================================
===
```

```
*** OUTPATIENT ***             *** OUTPATIENT ***             *** OUTPATIENT
***
RADPATIENT,THREE       88       000-00-0023  04 / 17 / 97  X-RAY STOP
No
 ARTHROGRAM ELBOW S&I  WAITING FOR  No        Unknown          Unknown
-------------------------------------------------------------------------------
---
RADPATIENT,THREE      107       000-00-0023  04 / 17 / 97  X-RAY STOP
No
 CT HEAD W / IV CONT     WAITING FOR  No        Unknown          Unknown
-------------------------------------------------------------------------------
---
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.[1] 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.[2] 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.

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.[3]

---

1 Patch RA*5*31 September 2002: Added changes to the documentation
2 Patch RA*5*31 September 2002: Added changes to the documentation
3 Patch RA*5*31 September 2002: Added changes to the documentation

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.[1] 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.[2])
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.

---

1 Patch RA*5*15 May 2000: NOIS: BHS-1199-12241
2 Patch RA*5*34 May 2003:Text regarding not asking the SUBMIT REQUEST TO question.

Prompt / **User Response**	Discussion
Log of Scheduled Requests by Procedure	
Starting Scheduled Date: 1 / 1 / 95 (JAN 1, 1995) Ending Scheduled Date: T (FEB 27, 1995)	
Enter * to select all imaging locations that[1] 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.

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

```
Select one of the following:1

                  P               Procedure Name
                  D               Date / Time

Sort by (P)rocedure Name or (D)ate / Time: P  /
/  P Procedure Name

Scheduled requests to be included on this report
are:

Starting Schedule date: Nov 19, 1994
Ending Schedule date:   Feb 27, 1995 11:59 pm
Locations:  X-RAY

Sorted by :  Procedure Name

SELECTION CRITERIA OK? YES /  /  <RET>
```

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.

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

1 Patch RA*5*31 September 2002: Added new prompt for sorting by Procedure Name or Date / Time.

```
Scheduled Request Log by Imaging Location, Procedure                  Page: 1
1

Includes requests scheduled from JAN 1,1995 to FEB 27,1995  23:59
Run Date: FEB 27,1995  09:14   Imaging Location: UNKNOWN

Patient      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 2
     Includes requests scheduled from NOV 19,1994 to FEB 27,1995  23:59
Run Date: FEB 27,1995  09:14   Imaging Location: X-RAY

Patient       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
===============================================================================
=
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
```

1 Patch RA*5*31 September 2002: Change of location for the Procedure and the Pt ID columns.
2 Patch RA*5*31 September 2002: Change of location for the Procedure and the Pt ID columns.

Radiopharmaceutical Usage Report [1]

This option allows the user to generate a report showing radiopharmaceutical usage. It asks for a selection of one, many or all divisions, imaging types (only if both imaging types that use radiopharmaceuticals are activated), radiopharmaceuticals, and an exam date range. Selectable imaging types are based on those types that use radiopharmaceuticals, and the user's location access.
If individual radiopharmaceuticals are selected, a notation will appear on the report to explain that not all radiopharmaceuticals are included.
The default date range is the previous 24 hour day. Users can choose to sort date / time before radiopharmaceutical. The status of the exam is NOT a factor in determining whether a case is included on this report. If a measured and / or administered radiopharmaceutical dosage is entered, the case will be included.

- Sort order if radiopharmaceutical is selected as primary sort:
  Division, imaging type, radiopharmaceutical, exam date / time, patient, case number
- Sort order if exam date / time is selected as primary sort:
  Division, imaging type, exam date / time, radiopharmaceutical, patient, case number

Detailed reports or summaries only can be printed. The report is designed for a 132 column page. If an administered dosage falls outside of the high / low dose range, an asterisk (*) prints next to it.
If a radiopharmaceutical is currently inactive but has DX200, DX201, or DX202, it will be included on the report if used during the exam date range. Since a case may have more than one radiopharmaceutical, total number of unique cases may be less than total number of radiopharmaceuticals reported.

```
Radiopharmaceutical Usage Report
Do you wish only the summary report? No /  /    NO
Select Rad / Nuc Med Division: All /  /  ?
     Select a RAD / NUC MED DIVISION DIVISION from the displayed list.
     To deselect a DIVISION type a minus sign (-)
     in front of it, e.g.,  -DIVISION.
     Use an asterisk (*) to do a wildcard selection, e.g.,
     enter DIVISION* to select all entries that begin
     with the text 'DIVISION'.  Wildcard selection is
     case sensitive.

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

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

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

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

Select Imaging Type: All /  /  ?

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

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

Select Imaging Type: All /  /  NUCLEAR MEDICINE

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

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

**** Date Range Selection ****

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

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

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

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

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

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

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

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

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

NUCLEAR MEDICINE's Total number of unique cases: 9
```

Note: A case may have more than 1 radiopharmaceutical, so the total number of unique cases may be less than total number of radiopharmaceuticals listed.

Unverified Reports [1]

This option allows the user to generate a report showing results reports that are not verified. This report is divided into two sections. The first section shows the total number of unverified reports for each interpreting staff physician.
The second section shows the total number of unverified reports for each interpreting resident physician.
If the person generating the report has access to more than one radiology / nuclear medicine division, a prompt will be displayed asking for a selection of one or more divisions. If the person generating the report has access to only one division, the system will default to that division rather than prompting for a selection.
The same is true with imaging type. A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type.
The report includes all results report statuses except VERIFIED. If the division or imaging type field of the exam record is missing or corrupted, the record will be bypassed.
Sort order of the report is: division, imaging type, staff / resident / unknown, physician's name, and date report entered.
The Primary Interpreting Resident and Primary Interpreting Staff fields in the Rad / Nuc Med Patient file #70 determine who is responsible for the report. If a Primary Resident is entered, then the report is counted toward the resident.[2] 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.

---

1 Patch RA*5*47 September 2011: Unverified Reorts option is affected by the new Site Specific Accession Number (SSAN).
2 Patch RA*5*29 February 2002: Unverified Reports options enhanced.

Prompt / **User Response** Discussion

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:

```
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

(The date range refers to DATE REPORT ENTERED)

**** Date Range Selection ****

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

   Ending    DATE : T  (AUG 19, 1997)

Default cut-off limits (in hours) for aging of reports are :

                                   24   48   96

Do you want to enter different cut-off limits? N /  /  <RET>O


DEVICE: HOME /  /  (Enter a device that prints 132 columns)


             >>>>> Unverified Reports (detailed) <<<<<         Page: 1
Division: HINES CIO FIELD OFFICE    Report Date Range: May 21, 1997
Imaging Type: ANGIO / NEURO / INTERVENTIONAL      Aug 19, 1997@23:59
Run Date: AUG 19,1997  11:38         Total Unverified Reports: 0

                           ***************************
```

```
                          *  No Unverified Reports  *
                          **************************

            >>>>> Unverified Reports (detailed) <<<<<           Page: 2
Division: HINES CIO FIELD OFFICE           Report Date Range: May 21, 1997
Imaging Type: CARDIOLOGY STUDIES (NUC MED) Aug 19, 1997@23:59
Run Date: AUG 19,1997  11:38     Total Unverified Reports: 1

* STAFF: 1 *
====================================================
Hours (age of report)        24        48        96        > 96
                             --        --        --        ----
  1 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:
CARDIOLOGY TEST
Other Att / Res:

* RESIDENT: 0 *

* UNKNOWN: 0 *

          >>>>> Unverified Reports (detailed) <<<<<         Page: 4
Division: HINES CIO FIELD OFFICE       Report Date Range: May 21, 1997
Imaging Type: GENERAL RADIOLOGY        Aug 19, 1997@23:59
Run Date: AUG 19,1997  11:38           Total Unverified Reports: 12
* STAFF: 4 *
=========================================================
Hours (age of report)        24        48        96        > 96
                             --        --        --        ----
  2 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   CARDIOLOGY STUDIES (NUC
MED) CT SCAN   GENERAL RADIOLOGY
                 MAGNETIC RESONANCE IMAGING   MAMMOGRAPHY   NUCLEAR MEDICINE
ULTRASOUND

Run Date: AUG 19,1997  11:38

                          Division Summary
                          ----------------
Hours (age of report)        24        48        96        > 96
                             --        --        --        ----
Total Unverified Reports:     0         0         0          15
Division Total: 15
```

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.[1]

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 258, 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.

Prompt / **User Response**	Discussion
`Clinic Report`	

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

```
   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

          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               TRANSCRIBED
               COMPLETE

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

          MAMMOGRAPHY
          -----------
               WAITING FOR EXAM
               COMPLETE

          NUCLEAR MEDICINE
          ----------------
```

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

```
               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.

The following example report starts with the first Division (Hines CIO field Office) and Imaging Type (General Radiology) and prints a different page for each clinic with the clinic totals (see report pages 1-5).
Then it summarizes the Imaging Type with totals for each clinic in the Imaging Type and totals for the Imaging Type (see report page 6).
Then this example jumps to report page 16 which contains totals for each clinic for all Imaging Types in the Division and totals for the Division. Some text is bolded in the sample to point out the organization of the report; it will not be bolded on the actual reports printed at your facility.

```
     >>> Clinic Workload Report <<<                          Page: 1

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: Nov 20, 1994
to
    Run Date: FEB 28,1995  14:05                                Feb 28, 1995

                                 -------Examinations------
                                          % of          % of
Procedure                       Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-------------------------------------------------------------------------------
---
          Clinic: DENTAL
STEREOTACTIC LOCALIZATION HE      0     2     0     0      2  100.0    10
100.0
Clinic Total                      0     2     0     0      2           10
     >>> Clinic Workload Report <<<                                   Page: 2
Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: Nov 20, 1994
to
    Run Date: FEB 28,1995  14:05                                Feb 28, 1995

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

```
-------------------------------------------------------------
          Clinic: EAR NOSE & THROAT
CT HEAD W / IV CONT         0     2     0     0      2  100.0    16  100.0

Clinic Total              0     2     0     0      2           16
>>> Clinic Workload Report <<<                                  Page: 3

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: Nov 20, 1994
to
    Run Date: FEB 28,1995  14:05                                Feb 28, 1995

                                -------Examinations------
                                                          % of          %
of
Procedure                      Inpt   Opt   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------
                                      % of          % of
Procedure                      Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-------------------------------------------------------------------------------
---
          Clinic: GENERAL MEDICINE
SKULL 4 OR MORE VIEWS             0     3     0     0      3   33.3     9
36.0
CHEST SINGLE VIEW                 0     1     0     0      1   11.1     1
4.0
```

```
CHEST STEREO PA                    0     2     0     0      2   22.2     2
8.0
ABDOMEN 1 VIEW                     0     1     0     0      1   11.1     2
8.0
SPINE LUMBOSACRAL MIN 2 VIEW       0     1     0     0      1   11.1     3
12.0
CT HEAD W / IV CONT                  0     1     0     0      1   11.1     8
32.0
Clinic Total                       0     9     0     0      9           25
>>> Clinic Workload Report <<<                                   Page: 5
    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: Nov 20, 1994
to
    Run Date: FEB 28,1995  14:05                        Feb 28, 1995
                      -------Examinations------
                                                % of          % of
Procedure          Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------
          Clinic: X-RAY STOP
NECK SOFT TISSUE                   0    22     0     0     22   13.6    66
8.6
SKULL 4 OR MORE VIEWS              0    15     0     0     15    9.3    45
5.9
CHEST APICAL LORDOTIC              0     1     0     0      1    0.6     1
0.1
CHEST STEREO PA                    0     1     0     0      1    0.6     1
0.1
CHEST 2 VIEWS PA&LAT               0     1     0     0      1    0.6     2
0.3
CHEST 4 VIEWS                      0     8     0     0      8    4.9    16
2.1
ABDOMEN 1 VIEW                     0     2     0     0      2    1.2     4
0.5
SPINE CERVICAL MIN 2 VIEWS         0     2     0     0      2    1.2     6
0.8
SPINE LUMBOSACRAL MIN 2 VIEW       0     1     0     0      1    0.6     3
0.4
ACROMIOCLAVICULAR J BILAT          0     4     0     0      4    2.5     8
1.0
ANKLE 2 VIEWS                      0     9     0     0      9    5.6    18
2.4
FOOT 2 VIEWS                       0     8     0     0      8    4.9    16
2.1
FOREARM 2 VIEWS                    0    10     0     0     10    6.2    20
2.6
TOE(S) 2 OR MORE VIEWS             0    17     0     0     17   10.5    34
4.4
GASTROINTESTINAL                   0     1     0     0      1    0.6     6
0.8
CHOLANGIOGRAM ORAL CONT            0     1     0     0      1    0.6     5
0.7
CHOLANGIOGRAM IV                   0     5     0     0      5    3.1    50
6.5
ANGIO CAROTID CEREBRAL BILAT       0     2     0     0      2    1.2    30
3.9
ANGIO CAROTID CEREBRAL SELEC       0     6     0     0      6    3.7    90
11.8
```

```
ANGIO CORONARY BILAT INJ S&I      0     4     0     0      4    2.5    80
10.5
CT CERVICAL SPINE W / CONT          0     1     0     0      1    0.6     8
1.0
CT HEAD W / IV CONT                 0    16     0     0     16    9.9   128
16.7
CT MAXILLOFACIAL W&W / O CONT       0     1     0     0      1    0.6     8
1.0
ARTHROGRAM ANKLE S&I              0     3     0     0      3    1.9    15
2.0
ARTHROGRAM KNEE S&I               0     1     0     0      1    0.6     5
0.7
NON-INVAS.,LOW EXT. VEIN W / O      0     6     0     0      6    3.7    30
3.9
STEREOTACTIC LOCALIZATION HE      0    14     0     0     14    8.6    70
9.2

Clinic Total                      0   162     0     0    162          765
 >>> Clinic Workload Report <<<                                    Page: 6

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: Nov 20, 1994
to
    Run Date: FEB 28,1995  14:05                                Feb 28, 1995

                                 -------Examinations------
                                      % of          % of
Clinic                          Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-----------------------------------------------------------------
          (Imaging Type Summary)
DENTAL                            0     2     0     0      2    1.1    10
1.1
EAR NOSE & THROAT                 0     2     0     0      2    1.1    16
1.7
EMERGENCY ROOM                    0    12     0     0     12    6.3   100
10.8
GENERAL MEDICINE                  0     9     0     0      9    4.8    25
2.7
X-RAY STOP                        0   162     0     0    162   85.7   765
83.0
-----------------------------------------------------------------
Imaging Type Total                0   187     0     0    187          916
   # of Clinics selected: ALL
[Pages omitted to conserve space]
   >>> Clinic Workload Report <<<                                   Page: 16

    Division: HINES CIO FIELD OFFICE                For period: Nov 20, 1994
to
    Run Date: FEB 28,1995  14:05                                Feb 28, 1995

                           -------Examinations------
                                % of          % of
Clinic                          Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-----------------------------------------------------------------
          (Division Summary)
```

```
DENTAL                          0     2     0     0      2    1.0    10
1.0
EAR NOSE & THROAT               0     3     0     0      3    1.5    23
2.4
EMERGENCY ROOM                  0    12     0     0     12    6.1   100
10.4
GENERAL MEDICINE                0     9     0     0      9    4.6    25
2.6
NUCLEAR MEDICINE                0     2     0     0      2    1.0     2
0.2
RAD 101                         0     2     0     0      2    1.0     6
0.6
ULTRASOUND                      0     5     0     0      5    2.5    35
3.6
X-RAY STOP                      0   162     0     0    162   82.2   765
79.2
-----------------------------------------------------------------
Division Total                  0   197     0     0    197          966
Imaging Type(s): CT SCAN   GENERAL RADIOLOGY   MAGNETIC RESONANCE IMAGING
                   ANGIO / NEURO / INTERVENTIONAL   NUCLEAR MEDICINE
                   ULTRASOUND
# of Clinics selected: ALL
```

PTF Bedsection Report

This option generates a listing of PTF bedsection workloads. The bedsections used to sort the report are those stored in the Bedsection field of the exam record if the patient is an inpatient at the time the exam is registered.

The bedsection is determined by the system based on data in PIMS files. At the time a patient is registered for an imaging exam, the Bedsection field of the Examinations subfile of the Rad / Nuc Med Patient file is calculated as follows:

1. If the patient is an inpatient, Rad / Nuc Med programs call a standard data retrieval program to find out the patient's treating specialty as of the date / time of the exam.
2. The program finds this treating specialty in the Treating Specialty file and retrieves its Specialty (field 2 of file 45.7).
3. The specialty is looked up in the Specialty file #42.4. The Name field of this file is entered automatically in the Bedsection field #19 of the Rad / Nuc Med Patient's exam record.

This is one of a series of workload reports that has similar selection criteria, report output, data retrieval, and reporting logic. See the section entitled **General Information about AMIS-Based Workload Reports**, starting on page 258, for a full description of this report's options.

The following example selects a full report and sorts by a single Division and all Imaging Types and PTF Bedsections. Your selections may be different according to your needs.

Prompt / **User Response**	Discussion
PTF Bedsection Report	

```
   PTF Bedsection Workload Report:
   -------------------------------

Do you wish only the summary report? No /  /  <RET>

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

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

Select Imaging Type: All /  /  <RET>

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

Do you wish to include all PTF Bedsections? Yes /  /
<RET>

**** Date Range Selection ****

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

   Ending    DATE : T  (FEB 27, 1995)

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

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

          ANGIO / NEURO / INTERVENTIONAL
          ------------------------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

          CT SCAN
          -------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

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

          MAMMOGRAPHY
          -----------
               WAITING FOR EXAM
               COMPLETE
```

```
          NUCLEAR MEDICINE
          ----------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

          ULTRASOUND
          ----------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE
```

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

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

```
 >>> PTF Bedsection Workload Report <<<                              Page: 1
 Division: HINES CIO FIELD OFICE
Imaging Type: GENERAL RADIOLOGY                      For period: Nov 21, 1994
to
    Run Date: MAR  1,1995  08:45                                   Mar 01, 1995
                        -------Examinations------
                                          % of          % of
Procedure                    Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------------------
---
          PTF Bedsection: GENERAL(ACUTE MEDICINE)
NECK SOFT TISSUE                  4     0     0     0      4    9.8    12
5.5
SKULL 4 OR MORE VIEWS             7     0     0     0      7   17.1    21
9.7
CHEST STEREO PA                   3     0     0     0      3    7.3     3
1.4
CHEST 4 VIEWS                     2     0     0     0      2    4.9     4
1.8
ABDOMEN 1 VIEW                    1     0     0     0      1    2.4     2
0.9
SPINE LUMBOSACRAL MIN 2 VIEW      2     0     0     0      2    4.9     6
2.8
UPPER GI + SMALL BOWEL            2     0     0     0      2    4.9    12
5.5
ANGIO CAROTID CEREBRAL SELEC      1     0     0     0      1    2.4    15
6.9
ANGIOGRAM,CATH - CEREBRAL         2     0     0     0      2    4.9    30
13.8
CT HEAD W / IV CONT                 9     0     0     0      9   22.0    72
33.2
ARTHROGRAM ANKLE S&I              1     0     0     0      1    2.4     5
2.3
ARTHROGRAM TM JOINT CONT S&I      1     0     0     0      1    2.4     5
2.3
```

```
STEREOTACTIC LOCALIZATION HE      6     0     0     0      6   14.6    30
13.8

PTF Bedsection Total             41     0     0     0     41          217


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

    Division: HINES CIO FIELD OFICE
Imaging Type: GENERAL RADIOLOGY                      For period: Nov 21, 1994
to
    Run Date: MAR  1,1995  08:45                                Mar 01, 1995
                      -------Examinations------
                                        % of          % of
Procedure                       Inpt   Opt   Res Other  Total  Exams   WWU
WWU
--------------------------------------------------
          PTF Bedsection: REHABILITATION MEDICINE
CHEST 4 VIEWS                      1     0     0     0      1  100.0     2
100.0

PTF Bedsection Total               1     0     0     0      1            2
```

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

    Division: HINES CIO FIELD OFICE
Imaging Type: GENERAL RADIOLOGY                 For period: Nov 21, 1994 to
    Run Date: MAR  1,1995  08:45                            Mar 01, 1995
                                 -------Examinations------
                                                     % of          % of
PTF Bedsection              Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-------------------------------------------------------------------
          (Imaging Type Summary)
GENERAL(ACUTE MEDICINE)          41     0     0     0     41   97.6   217
99.1
REHABILITATION MEDICINE           1     0     0     0      1    2.4     2
0.9
-----------------------------------------------------------------
Imaging Type Total               42     0     0     0     42          219

   # of PTF Bedsections selected: ALL
  >>> PTF Bedsection Workload Report <<<                     Page: 4

    Division: HINES CIO FIELD OFICE
Imaging Type: MAGNETIC RESONANCE IMAGING            For period: Nov 21, 1994
to
    Run Date: MAR  1,1995  08:45                            Mar 01, 1995
                                 -------Examinations------
                                                     % of          % of
PTF Bedsection         Inpt   Opt   Res Other  Total  Exams   WWU   WWU
-----------------------------------------------------------------
          (Imaging Type Summary)
-----------------------------------------------------------------
Imaging Type Total               0     0     0     0      0            0

   # of PTF Bedsections selected: ALL
>>> PTF Bedsection Workload Report <<<                          Page: 9

    Division: HINES CIO FIELD OFICE          For period: Nov 21, 1994 to
    Run Date: MAR  1,1995  08:45                            Mar 01, 1995
                                 -------Examinations------
                                                     % of          % of
PTF Bedsection                 Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-----------------------------------------------------------------
          (Division Summary)
GENERAL(ACUTE MEDICINE)         41     0     0     0     41   97.6   217
99.1
REHABILITATION MEDICINE          1     0     0     0      1    2.4     2
0.9
-----------------------------------------------------------------
Division Total                  42     0     0     0     42          219
  Imaging Type(s): ANGIO / NEURO / INTERVENTIONAL   CT SCAN   GENERAL
RADIOLOGY
                   MAGNETIC RESONANCE IMAGING   NUCLEAR MEDICINE
                   ULTRASOUND
   # of PTF Bedsections selected: ALL
```

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.

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 / / **GEN**ERAL 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:

          CT SCAN
          -------
               WAITING FOR EXAM
               EXAMINED
               TRANSCRIBED
               COMPLETE

          GENERAL RADIOLOGY
```

```
          -----------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE
```

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

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

```
     >>> Service Workload Report <<<                                Page: 1

    Division: HINES CIO FIELD OFICE
Imaging Type: CT SCAN                              For period: Nov 21, 1994
to
    Run Date: MAR  1,1995  09:06                                Mar 01, 1995
                                 -------Examinations------
                                 % of          % of
Service                         Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-----------------------------------------------------------------------
          (Imaging Type Summary)
-----------------------------------------------------------------

Imaging Type Total                 0     0     0     0      0            0

   # of Services selected: ALL
```

When there is no data for a sort selection, in this case Service and Imaging Type, the total page appears as shown above.

```
     >>> Service Workload Report <<<                                Page: 2

    Division: HINES CIO FIELD OFICE
Imaging Type: GENERAL RADIOLOGY                    For period: Nov 21, 1994
to
    Run Date: MAR  1,1995  09:06                                Mar 01, 1995
                                 -------Examinations------
                                                            % of          %
of
Procedure                       Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-------------------------------------------------------------------------
---
          Service: MEDICAL
NECK SOFT TISSUE                   4     0     0     0      4    9.8    12
5.5
SKULL 4 OR MORE VIEWS              7     0     0     0      7   17.1    21
9.7
CHEST STEREO PA                    3     0     0     0      3    7.3     3
1.4
CHEST 4 VIEWS                      2     0     0     0      2    4.9     4
1.8
```

```
ABDOMEN 1 VIEW                    1     0     0     0      1    2.4     2
0.9
SPINE LUMBOSACRAL MIN 2 VIEW      2     0     0     0      2    4.9     6
2.8
UPPER GI + SMALL BOWEL            2     0     0     0      2    4.9    12
5.5
ANGIO CAROTID CEREBRAL SELEC      1     0     0     0      1    2.4    15
6.9
ANGIOGRAM,CATH - CEREBRAL         2     0     0     0      2    4.9    30
13.8
CT HEAD W / IV CONT                 9     0     0     0      9   22.0    72
33.2
ARTHROGRAM ANKLE S&I              1     0     0     0      1    2.4     5
2.3
ARTHROGRAM TM JOINT CONT S&I      1     0     0     0      1    2.4     5
2.3
STEREOTACTIC LOCALIZATION HE      6     0     0     0      6   14.6    30
13.8

Service Total                    41     0     0     0     41          217

     >>> Service Workload Report <<<                                Page: 3

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: Nov 21, 1994
to
    Run Date: MAR  1,1995  09:06                                Mar 01, 1995
                                 -------Examinations------
                                                                % of          %
of
Procedure                        Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-----------------------------------------------------------------
          Service: AMBULATORY CARE
CHEST 4 VIEWS                     1     0     0     0      1  100.0     2
100.0
Service Total                     1     0     0     0      1            2
     >>> Service Workload Report <<<                            Page: 4

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: Nov 21, 1994
to
    Run Date: MAR  1,1995  09:06                                Mar 01, 1995
                                 -------Examinations------
                                                                % of          %
of
Service                          Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-------------------------------------------------------------------------------
---
          (Imaging Type Summary)
MEDICAL                          41     0     0     0     41   97.6   217
99.1
AMBULATORY CARE                   1     0     0     0      1    2.4     2
0.9
-------------------------------------------------------------------------
Imaging Type Total               42     0     0     0     42          219
```

```
   # of Services selected: ALL

     >>> Service Workload Report <<<                                  Page: 5

    Division: HINES CIO FIELD OFFICE         For period: Nov 21, 1994 to
    Run Date: MAR  1,1995  09:06                   Mar 01, 1995

                     -------Examinations------
                                                % of          % of
Service                        Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-----------------------------------------------------------------------
          (Division Summary)
MEDICAL                          41     0     0     0     41   97.6   217
99.1
AMBULATORY CARE                   1     0     0     0      1    2.4     2
0.9
-------------------------------------------------------------------------------
---
Division Total                   42     0     0     0     42          219
  Imaging Type(s): CT SCAN   GENERAL RADIOLOGY

   # of Services selected: ALL
```

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 258, 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                     For period: Nov 20, 1994
to
    Run Date: FEB 28,1995  13:58                                Feb 28, 1995
                                 -------Examinations------
                                                 % of          % of
Procedure                       Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-------------------------------------------------------------------------------
---
          Sharing / Contract: MEMORIAL HOSPITAL
SPINE SI JOINTS 1 OR 2 VIEWS      0     0     0     1      1  100.0     3
100.0

Sharing / Contract Total            0     0     0     1      1            3
     >>> Sharing / Contract Workload Report <<<                        Page:
2

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: Nov 20, 1994
to
    Run Date: FEB 28,1995  13:58                                Feb 28, 1995
                                 -------Examinations------
                                            % of          % of
Sharing / Contract                Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-----------------------------------------------------------------
          (Imaging Type Summary)
MEMORIAL HOSPITAL                  0     0     0     1      1  100.0     3
100.0
-------------------------------------------------------------------------------
---
Imaging Type Total                 0     0     0     1      1            3

   # of Sharing / Contracts selected: 1
     >>> Sharing / Contract Workload Report <<<                      Page: 3

    Division: HINES CIO FIELD OFFICE                 For period: Nov 20, 1994
to
    Run Date: FEB 28,1995  13:58                                Feb 28, 1995

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

```
-------------------------------------------------------------------------------
---
          (Division Summary)
MEMORIAL HOSPITAL                 0     0     0     1      1  100.0     3
100.0
-------------------------------------------------------------------------------
---

Division Total                    0     0     0     1      1            3

  Imaging Type(s): GENERAL RADIOLOGY

   # of Sharing / Contracts selected: 1
```

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 258, 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 / / **Y**ES	
Select Rad / Nuc Med Division: All / / **HI**NES CIO FIELD OFFICE IL CIOFO 499 Another one (Select / De-Select): **<RET>**	
Select Imaging Type: All / / **<RET>** Another one (Select / De-Select): **<RET>**	

```
Do you wish to include all Wards? Yes /  /  <RET>

**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 20, 1994)

   Ending    DATE : T  (FEB 28, 1995)

             The entries printed for this report will be based only
              on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit:

          ANGIO / NEURO / INTERVENTIONAL
          ------------------------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

          CT SCAN
          -------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE

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

          MAMMOGRAPHY
          -----------
               WAITING FOR EXAM
               COMPLETE

          NUCLEAR MEDICINE
          ----------------
               WAITING FOR EXAM
               EXAMINED
               TRANSCRIBED
               COMPLETE

          ULTRASOUND
          ----------
               WAITING FOR EXAM
               EXAMINED
               COMPLETE
```

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

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

```
     >>> Ward Workload Report <<<                                    Page: 1

    Division: HINES CIO FIELD OFFICE
Imaging Type: CT SCAN                              For period: Nov 20, 1994
to
    Run Date: FEB 28,1995  14:00                                  Feb 28, 1995
                                 -------Examinations------
                                              % of          % of
Ward                            Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-------------------------------------------------------------------
          (Imaging Type Summary)
Imaging Type Total:                0     0     0     0      0            0

   # of Wards selected: ALL
```

```
     >>> Ward Workload Report <<<                                    Page: 2

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                    For period: Nov 20, 1994
to
    Run Date: FEB 28,1995  14:00                                  Feb 28, 1995

                                 -------Examinations------
                                                % of          % of
Ward                            Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-------------------------------------------------------------------------------
---
          (Imaging Type Summary)
1N                             33     0     0     0     33   78.6   177   80.8
1S                              9     0     0     0      9   21.4    42   19.2
-------------------------------------------------------------------------------
---

Imaging Type Total:            42     0     0     0     42          219

   # of Wards selected: ALL

    >>> Ward Workload Report <<<                                     Page: 7

    Division: HINES CIO FIELD OFFICE                   For period: Nov 20, 1994
to
    Run Date: FEB 28,1995  14:00                                  Feb 28, 1995

                                 -------Examinations------
```

```
                                                                  % of          %
of
Ward                            Inpt   Opt   Res Other  Total  Exams   WWU
WWU
-------------------------------------------------------------------------------
---
          (Division Summary)
1N                        33     0     0     0     33   78.6   177   80.8
1S                         9     0     0     0      9   21.4    42   19.2
-------------------------------------------------------------------------------
---

Division Total            42     0     0     0     42          219

  Imaging Type(s): ANGIO / NEURO / INTERVENTIONAL   CT SCAN   GENERAL
RADIOLOGY
       MAGNETIC RESONANCE IMAGING   NUCLEAR MEDICINE
                   ULTRASOUND

   # of Wards selected: ALL
```

Timeliness Reports 1 2

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 3

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.
Automated Quarterly4 Outlook Email

The Radiology Timeliness Performance Report5 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 15th	October, November, December
On or before April 15th	January, February, March
On or before July 15th	April, May, June
On or before October 15th	July, September, September

This automated Outlook email contains the following:

- Summary Verification Timeliness Report
- Summary Radiology Outpatient Procedure Wait Time Report 6
- Two performance value calculations: 1) a single calculated value, the verification timeliness performance value, and 2) a table using data from the report 7

---

1 Patch RA*5*37 June 2003: Added Performance Indicator option.
2Patch 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.
3Patch RA*5*99 February 2010: Added ‘Radiology Timeliness Performance Reports’ as a new menu option.
4Patch RA*5*99 February 2010: Changed the reporting period for the automated Outlook email from monthly to quarterly.
5Patch RA*5*99 February 2010: Changed subject of automated Outlook email from “Radiology Summary Verification Timeliness“ to “Radiology Timeliness Performance Reports.“
6 Patch RA*5*99 February 2010: Inserted the “Summary Radiology Outpatient Procedure Wait Time Report” in the automated Outlook email.
7 Patch RA*5*99 February 2010: Inserted two performance summary values in the automated Outlook email.

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. 1

The Outlook email report is shown on the next page.

Gates, Shelly	**Automated Outlook Email Report**
From:	GATES.SHELLYA@WASHINGTON.MED.VA.GOV
	mailto: GATES.SHELLY@WASHINGTON.MED.VA.GOV
Sent:	Thursday, January 15, 2009 8:19 AM
To:	VHA Radiology Reports; VISN5RadiologyReports@MED.VA.GOV
Subject:	**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 SUMMARY 2
-------------------------
15.4% - Report verification timeliness performance value
Wait Time performance values:
    %      %
 <=14 3  <=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   0.0      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
```

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

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

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

```
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    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.

    * 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 Report1          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
```

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

```
PROCEDURE                    <=14 1    <=30   31-60   61-90  91-120   >120
TYPE                          Days    Days    Days    Days    Days   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                     <=142   <=30  31-60  61-90  91-
120   >120   ROW    Avg.
TYPE                          Days   Days   Days   Days    Days   Days  TOTAL
   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. 3
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
```

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

```
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 1

Summary / Detail report2

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).3
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)

---

1 Patch RA*5*67 April 2006: New Outpatient Procedure Wait Time report option and examples.
2 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).
3 Patch RA*5*79 February 2007: Added new background information about this report and its updated functionality.

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.
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.

Timeliness Reports - Outpatient Procedure Wait Time

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.[1]
Prompt / **User Response**

```
Radiology Outpatient Procedure Wait Time Report

Enter Report Type
     Select one of the following:
```

1 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.

```
          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 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: 5 / 29 / 07 11:15 am

Total number of procedures registered during specified exam date range: 22

                            DAYS WAIT -- PERCENTAGES

PROCEDURE                <=14 2    <=30    31-60    61-90    91-120    >120
TYPE                       Days    Days     Days     Days      Days    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          <=14 3    <=30   31-60   61-90  91-120    >120     ROW
Avg.
TYPE               Days    Days    Days    Days    Days    Days   TOTAL
Days
--------------- ------- ------- ------- ------- ------- ------- ------- -----
--
CARDIAC STRESS        0       0       0       0       0       0       0
-
COMPUTED TOMOGR       0       0       0       0       0       0       0
-
GENERAL RADIOLO      10      11       0       0       0       0      11
3
INTERVENTIONAL        5       5       0       0       0       0       5
0
```

1 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.
2 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column .
3 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column .

```
MAGNETIC RESONA        0        0        0        0        0        0        0
-
MAMMOGRAPHY           10       10        0        0        0        0       10
0
NUCLEAR MEDICIN        0        0        0        0        0        0        0
-
OTHER                  0        0        0        0        0        0        0
-
ULTRASOUND             4        4        0        0        0        0        4
0
"unknown"              0        0        0        0        0        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. 1

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.
```

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

```
      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.
```

Timeliness Reports - Outpatient Procedure Wait Time

Summary Report by CPT Code / Procedure Name [1]

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.

Prompt / **User Response**

```
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.

---

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

```
Summary Radiology Outpatient Procedure Wait Time Report1              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

PROCEDURE               <=14 2    <=30    31-60    61-90    91-120    >120
TYPE                     Days    Days     Days     Days      Days    Days
---------------------   ------  ------   ------   ------    ------  ------
MAMMOGRAPHY              100.0   100.0      0.0      0.0       0.0     0.0

                          DAYS WAIT -- COUNTS

PROCEDURE          <=14 2    <=30   31-60   61-90  91-120    >120     ROW
Avg.
TYPE               Days    Days    Days    Days    Days    Days   TOTAL
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. 3

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"
```

1 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.
2 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column .
3 Patch RA*5*99 February 2010: Explanation of the "<=14 Days" reporting interval column .

```
       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.
```

Timeliness Reports - Outpatient Procedure Wait Time

Detail Report

The Outpatient Procedure Wait Time Detail Report shows detailed information for exams registered in the selected date range, organized by patient.[1] 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.
The Date Range is 92 days maximum for the Detail Report.[2]
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**

```
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
```

1 Patch RA*5*79 February 2007: Updated the Detail Report description and example, added Procedure Type to Sort By list, and added printset note.
2 Patch RA*5*99 February 2010: The date range is 92 days maximum for the Detail Report.

```
    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 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 example report is shown on the next page.

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 Wait	Exam Status	CPT Code	Name of Procedure	Img Type	PROC. TYPE
PATIENT,THRE	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,THRE	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,THRE	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 1 - Verification Timeliness2

Summary / Detail report3

The Summary / Detail Report option will prompt for:

- Report Type: Choices include Summary, Detail, or Both.
- Primary Interpreting Staff Physician (Optional)4
- 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 5*

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.6

Prompt / **User Response**

```
Radiology Verification Timeliness Report

Enter Report Type

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

Select Report Type: S /  /  <RET> Summary
```

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

2 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.'

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

4Patch RA*5*44 January 2004: New prompt added: "Primary Interpreting Staff Physician (Optional)."

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

6 Patch RA*5*44 January 2004: New text added: "The verification date…

```
    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>  YES1

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

The report is shown below.

```
                 Summary Verification Timeliness Report           Page: 1 2

Facility: SUPPORT ISC                    Station:          VISN:
Division: HINESTEST, SUPPORT ISC
Exam Date Range: 3 / 1 / 05 - 3 / 31 / 05
Imaging Type(s): CARDIOLOGY 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
```

1Patch RA*5*63 October 2005: New lines added to the report.
2 Patch RA*5*67 April 2006: Report name changed to Summary Verification Timeliness Report.

```
#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

     * 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.1

     *Cancelled and "No Credit" cases are excluded from this report.2
```

1 Patch RA*5*44 January 2004: New text added "* A printset, i.e.,…
2 Patch RA*5*67 April 2006: New text added “*Cancelled and “No Credit” cases are excluded…”

Timeliness Reports - Verification Timeliness Detail Report

The Verification Timeliness Detail Report can be run as needed.[1]
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 922 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.[3] 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**

```
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>4
Select Rad / Nuc Med Division: All /  /  <RET>

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

---

1 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.
2 Patch RA*5*99 February 2010: The date range is 92 days maximum for the Detail Report.
3 Patch RA*5*44 January 2004: New paragraph added. "Verification date is always the first time…"
4 Patch RA*5*44 January 2004: New prompt added. "Select Primary Interpreting Staff Physician (Optional)."

```
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.
```

```
           Detail Verification Timeliness Report 1                Page: 1

Facility: SUPPORT ISC                    Station:           VISN:
Division: HINESTEST, SUPPORT ISC
Exam Date Range: 3 / 24 / 00 - 03 / 29 / 00
Imaging Type(s): CARDIOLOGY 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
Procedure2
Patient Name      Case #        Registered      Transcribed    Hrs  Verified
Hrs Radiologist      Exm  Sts   Typ   Name
```

1 Patch RA*5*67 April 2006: Report name changed to Detail Verification Timeliness Report.
2 Patch RA*5*44 January 2004: New "Procedure Name" column added. Text added "* A printset, i.e.,..."

```
RADPATIENT,EIGHT  032400-913    3 / 24 / 00@11:37    O        GEN  ABDOMEN 2
V
RADPATIENT,EIGHT  032400-915    3 / 24 / 00@11:58  RADPROVIDER,THREE  O   GEN
ANKLE 2 VIE
RADPATIENT,NINE   032800-822    3 / 28 / 00@09:51   3 / 28 / 00@10:54    1
RADPROVIDER,THREE  I   R    GEN  ANKLE 2 VIE
RADPATIENT,NINE   032800-850    3 / 28 / 00@09:58
RADPROVIDER,THREE  O        GEN  FOOT 2 VIEW
RADPATIENT,TEN    032800-876    3 / 28 / 00@16:14    O        GEN  SKULL 4 OR
RADPATIENT,TEN    032800-880    3 / 28 / 00@16:14    O        GEN  ANKLE 3 OR
RADPATIENT,EIGHT  032900-895    3 / 29 / 00@07:30    O        ULT  ECHOGRAM
AB
RADPATIENT,EIGHT  032900-903    3 / 29 / 00@07:33    O        NUC  BONE
IMAGIN
RADPATIENT,EIGHT  032900-907    3 / 29 / 00@07:42    O        NUC  BONE
IMAGIN
RADPATIENT,ONE    032900-908    3 / 29 / 00@07:45    O        NUC  LIVER AND
S
RADPATIENT,EIGHT  032900-914    3 / 29 / 00@07:48    O        ULT
ECHOENCEPHA
RADPATIENT,EIGHT  032900-917    3 / 29 / 00@07:52    O        NUC  LIVER AND
S
RADPATIENT,EIGHT  032900-919    3 / 29 / 00@07:57    O        NUC  LIVER
IMAGI
RADPATIENT,EIGHT  032800-852    3 / 28 / 00@10:39   3 / 28 / 00@10:41   <1 3
/ 28 / 00@10:41   <1 RADPROVIDER,THREE  O   V    GEN  KNEE 3 VIEW
RADPATIENT,EIGHT  032800-872    3 / 28 / 00@15:03   3 / 28 / 00@15:13   <1 3
/ 28 / 00@15:13   <1 RADPROVIDER,THREE  O   V    GEN  KNEE 3 VIEW
RADPATIENT,EIGHT  032800-802    3 / 28 / 00@09:20   3 / 28 / 00@11:21    2 3
/ 28 / 00@11:21    2 RADPROVIDER,THREE  O   V    GEN  KNEE 4 OR M
RADPATIENT,TWO    032400-912    3 / 24 / 00@09:20   3 / 24 / 00@09:32   <1 3
/ 30 / 00@08:07  143 RADPROVIDER,THREE  O   V    GEN  ANGIO BRACH
RADPATIENT,THREE  032900-920    3 / 29 / 00@08:24    4 / 4 / 00@10:22  146 4
/ 4 / 00@10:22   146 RADPROVIDER,FOUR   O   V    GEN  KNEE 3 VIEW
RADPATIENT,EIGHT  032800-870    3 / 28 / 00@15:00   4 / 12 / 00@09:43  355 4
/ 12 / 00@09:43  355 RADPROVIDER,THREE  O   V    GEN  ABDOMEN 3 O
RADPATIENT,EIGHT  032900-918    3 / 29 / 00@07:55   4 / 12 / 00@11:47  340 7
/ 17 / 00@13:47 >999 RADPROVIDER,FOUR   O   V    NUC  LIVER FUNCT
RADPATIENT,EIGHT  032400-910    3 / 24 / 00@08:04   5 / 12 / 00@08:46 >999 5
/ 17 / 01@15:53 >999 RADPROVIDER,FIVE   O   V    GEN  CHEST 4 VIE
RADPATIENT,TEN    032400-916    3 / 24 / 00@13:01  3 / 7 / 02@11:52  >999
RADPROVIDER,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.1
```

1 Patch RA*5*67 April 2006: Text added. "*Cancelled and "No Credit" cases are excluded…"

Timeliness Reports[1] - Radiology Timeliness Performance Reports [2]

Enter / Edit OUTLOOK mail group[3]

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." [4]
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**

```
(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:5 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 6

 Select PERF INDC SMTP E-MAIL ADDRESS:

(deleting a previously entered OUTLOOK mail group)

     OUTLOOK mail groups previously entered:
                                                        OQP Perf. Mgmt?
                                                        --------------
        YourVISNmailgroup@med.va.gov                           N
```

1 Patch RA*5*37 June 2003: Added Performance Indicator; Renamed to Timeliness Reports, April 2006 RA*5*67
2 Patch RA*5*67 April 2006: Renamed Performance Indicator Report to Verification Timeliness Report.
3 Patch RA*5*99 February 2010: Moved the 'Enter / Edit OUTLOOK mail group' option from the 'Verification Timeliness' option.
4 Patch RA*5*63 October 2005: Added explanation of new field OQP PERFORMANCE MGMT?
5 Patch RA*5*42 September 2003: Replaced MAIL ADDRESS with PERF INDC SMTP E-MAIL ADDRESS
6 Patch RA*5*63 October 2005: Added new prompt OQP PERFORMANCE MGMT? and new display.

```
     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
          /  /  @
   SURE YOU WANT TO DELETE THE ENTIRE 'YourVISNmailgroup@med.va.gov' PERF
INDC SMTP E-MAIL ADDRESS?? Y  (Yes)
Timeliness Reports1
```

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

Radiology Timeliness Performance Reports[1] - Run Previous Quarter's[2] Summary Report [3] [4]

This option generates a summary report for the entire previous quarter.[5] 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).[6] 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 15th	October, November, December	4
On or before April 15th	January, February, March	1
On or before July 15th	April, May, June	2
On or before October 15th	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" [7]
- The "Summary Verification Timeliness Report"
- The two performance value calculations: "Report verification timeliness performance value" and "Wait Time Performance Values." [8]

---

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

2 Patch RA*5*99 February 2010: Changed option: 'Run Previous Month's Summary Report' to 'Run Previous Quarter's Summary Report.'

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

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

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

6 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.

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

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

Prompt / **User Response**

```
Run Previous Quarter's1 Summary Report2

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" 3

 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 Reports4
to start on: Sep 10, 2009@12:01:22
Task#:13072
```

The report is shown below.

Gates, Shelly	
From:	GATES.SHELLYA@WASHINGTON.MED.VA.GOV
	mailto: GATES.SHELLY@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**

```
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 SUMMARY5
----------------------

15.4% - Report verification timeliness performance value
```

1Patch RA*5*99 February 2010: Changed the reporting period from monthly to quarterly.
2 Patch RA*5*99 February 2010: For this option, deleted all references to OQP.
3Patch 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.
4 Patch RA*5*99 February 2010: Changed ‘Radiology Verification Timeliness Report’ request name to ‘Radiology Timeliness Performance Reports.’
5Patch RA*5*99 February 2010: Insterted two performance summary values in the automated Outlook email.

```
Wait Time performance values:

%      %
 <=14 1  <=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

#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.)
```

1 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column for extra calculations.

```
    * 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 Report1          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                    <=14 2    <=30   31-60   61-90  91-120   >120
TYPE                          Days    Days    Days    Days    Days   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                     <=14 3   <=30  31-60  61-90  91-
120   >120   ROW    Avg.
TYPE                          Days   Days   Days   Days    Days   Days  TOTAL
   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      0     20     -
INTERVENTIONAL
PROCEDURE         3      0       0      0      0       0      0      3     0
```

1 Patch RA*5*99 February 2010: Inserted the “Summary Radiology Outpatient Procedure Wait Time Report” in the automated Outlook email.
2 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column .
3 Patch RA*5*99 February 2010: Inserted the "<=14 Days" reporting interval column

```
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.1

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.

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.

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

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. [1]

- Physician CPT Report by Imaging Type
- Physician scaled wRVU Report by Imaging Type
- Physician scaled wRVU Report by CPT
- 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. Scaled and non-scaled versions of the two wRVU reports are available: the scaled versions use a multiplier on the wRVU to adjust for over-estimating the effort of reading CT and MRI and under-estimating the effort of reading General Radiology and Nuclear Medicine in comparison with plain films.

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. [2] The Technologist Report shows workload by technologist. There may be more than one technologist, resident, or staff per exam, so the total amount of exams does not correspond to the sum of the separate totals.

All of 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.

1Patch 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.

2 Patch RA*5*64 July 2006: Separated the AMIS-based reports from the wRVU / CPT-based reports, and updated the report descriptions.

Physician CPT Report by Imaging Type [1]

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 Run Date: Jan 12, 2006 Page: 1	

1 Patch RA*5*64 July 2006: Added Physician CPT Report by Imaging Type description and example.

```
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 Scaled wRVU Report by Imaging Type 1

This report will generate the total scaled 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 scaled wRVU per physician, per imaging type by physician, for all imaging locations, and for all physicians are displayed on the report. (**Note**: At the bottom of any report displaying scaled wRVU statistics, the scaling factors for all applicable imaging types will be displayed.)
Please be aware that the figures used as scaled wRVU values in the example below are not necessarily the actual scaled wRVU values for that procedure.
The report data is sorted by physician name.

Prompt / **User Response**	Discussion
Physician Scaled 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: Jan 12, 2006 **/ / 020105** (FEB 01, 2005) Enter an end date of: Jan 12, 2006 **/ / 011206** (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.

1 Patch RA*5*64 July 2006: Added Physician scaled wRVU Report by Imaging Type description and example.

The report is shown on the next page.

```
IMAGING PHYSICIAN WORKLOAD SUMMARY BY PROFESSIONAL COMPONENT CMS RVU 1
Run Date: May 01, 2007                                          Page: 1
Facility: HINES DEVELOPMENT            Date Range: JAN 1,2007 - MAR 31,2007
                                  (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
For calendar year 2007 the following scaling factors apply:
Imaging Type                       Abbreviation   wRVU scaling factor
-------------------------------------------------------------------------------
-NUCLEAR MEDICINE                   NM             1.57 (2007)
ULTRASOUND                         US             1.00 (default)
MAGNETIC RESONANCE IMAGING         MRI            0.70 (2007)
CT SCAN                            CT             0.70 (2007)
ANGIO / NEURO / INTERVENTIONAL        ANI            0.61 (2007)
CARDIOLOGY STUDIES (NUC MED)       CARD           1.00 (default)
VASCULAR LAB                       VAS            1.00 (default)
MAMMOGRAPHY                        MAM            1.00 (default)
```

1 Patch RA*5*77 June 2007: Added new sample report, showing default scaling factors at bottom of report.

Physician Scaled wRVU Report by CPT 1

This report will generate the total number of procedures, scaled wRVU per procedure, and the total scaled 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 scaled wRVU per physician, per procedure by physician, and the total number of specific procedures per physician are displayed on the report. (**Note**: At the bottom of any report displaying scaled wRVU statistics, the scaling factors for all applicable imaging types will be displayed.)
Please be aware that the figures used as scaled wRVU values in the example below are not necessarily the actual scaled wRVU values for that procedure.
The report data is sorted by physician name.

Prompt / **User Response** | Discussion

```
Physician Scaled 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: Jun 1, 2006 / /  010105  (JAN 01, 2005)

Enter an end date of: Jan 01, 2006 / /  060105  (JUN 01, 2005)

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 SCALED wRVU SUMMARY BY CPT 2
Run Date: May 1, 2007                                          Page: 1
Facility: HINES DEVELOPMENT              Date Range: MAR 1,2007 - MAY 1,2007

Staff Physician                                          Total #
Total
  CPT Code  Procedure                              SwRVU   of exams
SwRVU
RADPROVIDER,FOUR
```

1 Patch RA*5*64 July 2006: Added Physician Scaled wRVU Report by CPT description and example.
2 Patch RA*5*77 June 2007:Added new sample report, showing default scaling factors at bottom of report.

```
  74330     ENDOSCOPIC CATH BIL & PANC DUCTS S&     0.90         1
0.90
  75665     ANGIO CAROTID CEREBRAL UNILAT S&I       1.31         1
1.31
  76091     MAMMOGRAM BILAT                         0.87         9
7.83
  76092     MAMMOGRAM SCREENING                     0.70         5
3.50
  76362     TEST FOR KEN                            3.99         2
7.98
                                                          -------     ------
-
                                                               18
21.43
RADPROVIDER,THREE
  71020     CHEST 2 VIEWS PA&LAT                    0.22         1
0.22
  71030     CHEST 4 VIEWS                           0.31         3
0.93
  73600     ANKLE 2 VIEWS                           0.16         2
0.32
  73620     FOOT 2 VIEWS                            0.16         1
0.16
  74010     ABDOMEN 2 VIEWS                         0.23         2
0.46
                                                          -------     ------
-
                                                                9
2.09

For calendar year 2007 the following scaling factors apply:
Imaging Type                      Abbreviation   wRVU scaling factor
-------------------------------------------------------------------------------
---
GENERAL RADIOLOGY                 RAD            1.21 (2007)
NUCLEAR MEDICINE                  NM             1.57 (2007)
ULTRASOUND                        US             1.00 (default)
MAGNETIC RESONANCE IMAGING        MRI            0.70 (2007)
CT SCAN                           CT             0.70 (2007)
ANGIO / NEURO / INTERVENTIONAL        ANI            0.61 (2007)
CARDIOLOGY STUDIES (NUC MED)      CARD           1.00 (default)
VASCULAR LAB                      VAS            1.00 (default)
MAMMOGRAPHY                       MAM            1.00 (default)
```

Personnel Workload Reports - Physician wRVU Report by CPT [1]

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.

---

1 Patch RA*5*64 July 2006: Added Physician wRVU Report by CPT description and example.

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.

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                                   Total #     Total
  CPT Code  Procedure                               wRVU    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
```

Personnel Workload Reports - Physician wRVU Report by Imaging Type [1]

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.
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
```

1 Patch RA*5*64 July 2006: Added Physician wRVU Report by Imaging Type description and example.

Personnel Workload Reports - Physician Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a listing of examinations and work associated with exams requested by referring physicians. The report is entitled Requesting M.D. Workload Report. The physicians for this report are stored in the Requesting Physician field of the exam.
This is one of a series of workload reports that have similar selection criteria, report output, data retrieval and reporting logic. See the section entitled **General Information about 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 **/ / HI**NES CIO FIELD OFFICE IL CIOFO 499 Another one (Select **/** De-Select): **<RET>**	
Select Imaging Type: All **/ / GE**NERAL RADIOLOGY Another one (Select **/** De-Select): **<RET>**	
Do you wish to include all Requesting M.D.s? Yes **/ / N**O 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

                                              Examinations    Percent
  Procedure (CPT)                           In    Out  Total   Exams
-------------------------------------------------------------------------------
---
          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

                                              Examinations    Percent
  Requesting M.D.                           In    Out  Total   Exams
-------------------------------------------------------------------------------
---
          (Imaging Type Summary)
RADPROVIDER,TWO                             0      2      2  100.0
-------------------------------------------------------------------------------
---

  Imaging Type Total                        0      2      2

   # of Requesting M.D.s selected: 1
```

Personnel Workload Reports - Radiopharmaceutical Administration Report 1

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
     case sensitive.

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

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

```
   NUCLEAR MEDICINE

Select Imaging Type: All /  /  <RET>

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

Do you wish to include all who administered dose ? Yes /  /  <RET>  YES

**** Date Range Selection ****

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

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

Sort Exam Date / Time before Who Admin Dose ? : NO /  /  <RET>

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

DEVICE: HOME /  /  (Enter a device that prints 132 columns)


        >>> Radiopharmaceutical Administration Report <<<    Run Date: AUG
19,1997  11:18   Page: 1

Division: HINES CIO FIELD OFFICE        Imaging Type: CARDIOLOGY STUDIES (NUC
MED)  For period: May 21, 1997 to Aug 18, 1997@24:00

Long-Case@Time  Patient Name       SSN      Radiopharm     Act.Drawn Dose
Adm'd    Low       High   Procedure       Who Adm'd
-------------------------------------------------------------
072297-702@1528 RADPATIENT,SIX000-00-0036   PERCHLORACAP 25    7.0000
5.0000    0.0000  0.0000 CARDIOLOGY TEST RADPROVIDER,ONE



                                >>> Radiopharmaceutical Administration Report
<<<    Run Date: AUG 19,1997  11:18   Page: 2

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

Long-Case@Time  Patient Name       SSN      Radiopharm    Act.Drawn  Dose
Adm'd  Low      High   Procedure         Who Adm'd
-------------------------------------------------------------------
080697-709@1233 RADPATIENT,ONE000-00-0039  SESTAMIBI TC-99  600.0000 600.0000
250.0000 500.0000 THYROID IMAGING RADPROVIDER,THRE
070997-700@0907 RADPATIENT,FOU000-00-0034  SULFUR COLLOID     0.0000  10.0000
10.0000   15.0000 RADIONUCLIDE TH RADPROVIDER,SIX
070997-701@0932 RADPATIENT,FIV000-00-0035  SULFUR COLLOID    12.0000  12.0000
10.0000   15.0000 RADIONUCLIDE TH RADPROVIDER,SIX
072597-703@1245 RADPATIENT,THR000-00-0033  SODIUM PERTECHN   12.0000  12.0000
0.0000    15.0000 THYROID IMAGING RADPROVIDER,SIX
080797-718@0807 RADPATIENT,TWO000-00-0032  Tc-99m DTPA        0.6000   0.6000
0.5000     1.5000 LUNG AEROSOL SC RADPROVIDER,FIVE
```

```
080797-719@0807 RADPATIENT,TWO000-00-0032  Tc-99m MACROAGG    3.0000   3.0000
3.0000     6.0000 LUNG PERFUSION  RADPROVIDER,FIVE
080797-721@0902 RADPATIENT,TWO000-00-0032  SESTAMIBI TC-99    8.0000   8.0000
8.0000    10.0000 MYOCARDIAL PERF RADPROVIDER,FIVE

                              >>> Radiopharmaceutical Administration Report
<<<    Run Date: AUG 19,1997  11:18   Page: 3
                                                  (Imaging Summary)
Division: HINES CIO FIELD OFFICE        Imaging Type: CARDIOLOGY STUDIES (NUC
MED)  For period: May 21, 1997 to Aug 18, 1997@24:00
Who Admin Dose                     Total Drawn    Total Adm'd   No. cases
(%)        No. outside range
------------------------------------------------------------
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                     Total Drawn    Total Adm'd   No. cases
(%)        No. outside range
-----------------------------------------------
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                     Total Drawn    Total Adm'd   No. cases
    (%)        No. outside range
-------------------------------------------------------------------
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.
```

Personnel Workload Reports - Resident Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a report of exams and work associated with interpreting resident physicians. The residents for this report are stored in the Primary Interpreting Resident field and Secondary Interpreting Resident multiple field of the exam record.
The user can choose to include only the Primary Interpreting Resident. If Primary and Secondary Residents are included, more than one resident can be associated with a single exam, so totals do not correspond to the sum of the separate totals.
This is one of a series of workload reports that have similar selection criteria, report output, data retrieval, and reporting logic.
See the section entitled **General Information about AMIS-Based Workload Reports**, for a full description of this report's options.

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

                                              Examinations    Percent
  Procedure (CPT)                           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
                                            Examinations    Percent
  Procedure (CPT)                           In    Out  Total   Exams
-------------------------------------------------------------------
          Interpreting Resident: UNKNOWN
SKULL 4 OR MORE VIEWS         (70260)        0      2      2    2.1
ABDOMEN MIN 3 VIEWS+CHEST     (74022)        0      1      1    1.1
CHEST APICAL LORDOTIC         (71021)        0      4      4    4.2
CHEST STEREO PA               (71015)        2      2      4    4.2
CHEST 4 VIEWS                 (71030)        0      5      5    5.3
CHEST INCLUDE FLUORO          (71034)        0      3      3    3.2
ABDOMEN 1 VIEW                (74000)        1     13     14   14.7
ABDOMEN 2 VIEWS               (74010)        0      5      5    5.3
SPINE CERVICAL MIN 2 VIEWS    (72040)        0      1      1    1.1
SPINE SI JOINTS 1 OR 2 VIEW   (72200)        0      1      1    1.1
ACROMIOCLAVICULAR J BILAT     (73050)        0      2      2    2.1
          >>> Interpreting Resident Workload Report <<<            Page: 8
    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                      For period: MAY 11,1997
to
    Run Date: AUG 19,1997  11:55                                 AUG 19,1997
                                              Examinations    Percent
  Procedure (CPT)                           In    Out  Total   Exams
-------------------------------------------------------------------
          Interpreting Resident: UNKNOWN
ANKLE 2 VIEWS                 (73600)        0      2      2    2.1
ANKLE 3 OR MORE VIEWS         (73610)        0      3      3    3.2
CLAVICLE                      (73000)        0      1      1    1.1
FOOT 2 VIEWS                  (73620)        0      3      3    3.2
FOREARM 2 VIEWS               (73090)        0      2      2    2.1
HAND 3 OR MORE VIEWS          (73130)        0      1      1    1.1
TOE(S) 2 OR MORE VIEWS        (73660)        0      1      1    1.1
UPPER GI AIR CONT W / SMALL B  (74249)        2      0      2    2.1
```

```
CHOLANGIOGRAM IV              (74310)        0      1      1    1.1
CHOLANGIOGRAM PERC S&I        (74320)        0      4      4    4.2
ANGIO CAROTID CEREBRAL BILA   (75671)        0      2      2    2.1
    >>> Interpreting Resident Workload Report <<<                Page: 11

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: MAY 11,1997
to
    Run Date: AUG 19,1997  11:55                                AUG 19,1997
                                      Examinations    Percent
  Interpreting Resident               In    Out  Total   Exams
-------------------------------------------------------------------------------
---
           (Imaging Type Summary)
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
```

Personnel Workload Reports - Staff Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a report of examinations and work associated with interpreting staff physicians. The report is entitled Interpreting Staff Workload Report.
The 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.
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 258, for a full description of this report's options.

Prompt / **User Response** Discussion

```
Staff Report
Do you want to count CPT Modifiers separately? No /  / ? 1

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 ****
```

1 Patch RA*5*26 July 2001: Allows printing of different combinations of CPT modifiers on separate lines.

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

   Ending    DATE : T  (AUG 19, 1997)

             The entries printed for this report will be based only
              on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit: <RET>

          NUCLEAR MEDICINE
          ----------------
               WAITING FOR EXAM
               EXAMINED
               TRANSCRIBED
               COMPLETE

DEVICE: HOME /  /   (Enter a device at this prompt)
  >>> Interpreting Staff Workload Report <<<                  Page: 1
    Division: HINES CIO FIELD OFFICE
Imaging Type: NUCLEAR MEDICINE            For period: MAY 21,1997 to
    Run Date: AUG 19,1997  12:02          AUG 19,1997
                                          Examinations    Percent
  Procedure (CPT)                         In    Out  Total   Exams
-----------------------------------------------------------------------
          Interpreting Staff: 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

                                            Examinations    Percent
  Procedure (CPT)                          In    Out  Total   Exams
-----------------------------------------------------------------------
Interpreting Staff: UNKNOWN
BONE IMAGING, MULTIPLE AREA  (78305)        0      1      1   14.3
LUNG AEROSOL SCAN, MULTIPLE  (78587)        0      1      1   14.3
LUNG PERFUSION, PARTICULATE  (78580)        0      1      1   14.3
MYOCARDIAL PERFUSION (SPECT  (78465)        0      1      1   14.3
PROVISION OF DIAGNOSTIC RAD  (78990)        0      1      1   14.3
THYROID IMAGING WITH UPTAKE  (78007)        0      2      2   28.6
-----------------------------------------------------------------------
Interpreting Staff Total                  0      7      7
        >>> Interpreting Staff Workload Report <<<                  Page: 3

    Division: HINES CIO FIELD OFFICE
```

```
Imaging Type: NUCLEAR MEDICINE                        For period: MAY 21,1997
to
    Run Date: AUG 19,1997  12:02                                AUG 19,1997

                                                  Examinations    Percent
  Interpreting Staff                            In    Out  Total   Exams
-------------------------------------------------------------------------
          (Imaging Type Summary)
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
```

Personnel Workload Reports - Technologist Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a report of workload for technologists. The technologists for this report are stored in the Technologist multiple field of the exam record. Since more than one technologist can be associated with a single exam, totals do not correspond to the sum of the separate totals.
This is one of a series of workload reports that has similar selection criteria, report output, data retrieval, and reporting logic. See the section entitled **General Information about AMIS-Based Workload Reports**, starting on page 258, 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 **/ / HI**NES CIO FIELD OFFICE IL CIOFO 499 Another one (Select **/** De-Select): **<RET>**	
Select Imaging Type: All **/ / GEN**ERAL RADIOLOGY Another one (Select **/** De-Select): **<RET>**	
Do you wish to include all Technologists? Yes **/ / <RET>** **** Date Range Selection **** Beginning DATE : **T-100** (NOV 21, 1994) Ending DATE : **T** (MAR 01, 1995)	
The entries printed for this report will be based only on exams that are in one of the following statuses: Enter RETURN to continue or '^' to exit: **<RET>** GENERAL RADIOLOGY ---------- WAITING FOR EXAM EXAMINED COMPLETE	
DEVICE: (Printer Name or "Q")	Enter the name of a printer or 'Q' to queue.

```
          >>> Technologist Workload Report <<<                    Page: 1

    Division: HINES INFORMATION SYSTEMS CTR
Imaging Type: GENERAL RADIOLOGY                     For period: NOV 21,1994
to
    Run Date: MAR  1,1995  10:07                                MAR  1,1995

                                            Examinations    Percent
Percent
  Procedure (CPT)                           In    Out  Total   Exams  WWU
WWU
-------------------------------------------------------------------------------
---
          Technologist: 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                     For period: NOV 21,1994
to
    Run Date: MAR  1,1995  10:07                                MAR  1,1995

                                              Examinations    Percent
Percent
  Technologist                              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
```

Personnel Workload Reports - Transcription Report

This option allows you to print a report entitled Imaging Transcription Report showing the number of lines and reports transcribed for each transcriptionist for a specified date range. Only one transcriptionist may be associated with an exam. The number of lines counted is always the current number of lines in the report.
So, if lines have been added, changed, or deleted, only the final number of lines at the time the report is run will be counted. The report does not reflect changes made by subsequent transcriptionists. All workloads will be credited to the initial transcriptionist for each report. The total character count is divided by 75 to produce the line count.
This one of a series of workload reports that have similar selection criteria, report output, data retrieval and reporting logic. See the section entitled **General Information about AMIS-Based Workload Reports**, starting on page 258, 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 OFICE      IL
CIOFO  499

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

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

**** Date Range Selection ****

   Beginning DATE : T-100  (NOV 21, 1994)

   Ending    DATE : T  (MAR 01, 1995)
```

DEVICE: HOME / / (Printer Name or "Q")	Enter the name of a printer. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
                    >>> IMAGING TRANSCRIPTION REPORT <<<            PAGE: 1
                       Division: HINES CIO FIELD OFFICE
                     Date Range: NOV 21,1994 - MAR  1,1995
# of Transcriptionists selected: ALL

RADIOLOGY / NUCLEAR MEDICINE PERSONNEL        NUMBER OF LINES  NUMBER OF
REPORTS
=====================================================================

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 Scaled wRVU / CPT Report 1
- 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. 2

Special Reports - 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. 3

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

---

1 Patch RA*5*64 July 2006: Added two new Procedure wRVU report types to the list of Special Reports.

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

3 Patch RA*5*64 July 2006: Added **Note** to redirect users to the wRVU and CPT Procedure reports section.

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.

Special Reports - 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 / / **HI**NES CIO FIELD OFFICE IL CIOFO 499 Another one (Select / De-Select): **<RET>**	
**** Date Range Selection **** Beginning DATE : **T-100** (NOV 21, 1994) Ending DATE : **T** (MAR 01, 1995)	

```
Select MAJOR RAD / NUC MED AMIS CODES DESCRIPTION: ??

Choose from:
   1               SKULL,INC.SINUS,MASTOID,JAW,ETC
   2               CHEST-SINGLE VIEW
   3               CHEST MULTIPLE VIEW
   4               CARDIAC SERIES
   5               ABDOMEN-KUB
   6               OBSTRUCTIVE SERIES
   7               SKELETAL-SPINE & SACROILIAC
   8               SKELETAL-BONE & JOINTS
   9               GASTROINTESTINAL
   10              GENITOURINARY
   11              CHOLECYSTOGRAM,ORAL
   12              CHOLANGIOGRAM
   13              LAMINOGRAM
   14              BRONCHOGRAM
```

```
   15              DIGITAL SUBTRACTION ANGIOGRAPHY
   16              ANGIOGRAM,CATH- CEREBRAL
   17              ANGIOGRAM,CATH- VISCERAL
   18              ANGIOGRAM,CATH- PERIPHERAL
   19              VENOGRAM
   20              MYELOGRAM
   21              COMPUTED TOMOGRAPHY
   '^' TO STOP: <RET>
   22              INTERVENTIONAL RADIOGRAPHY
   23              ULTRASOUND,ECHOENCEPHALOGRAM
   24              OTHER
   25              EXAMS IN OPER.SUITE AT SURGERY
   26              PORTABLE (BEDSIDE) EXAMINATIONS
   27              NUCLEAR MEDICINE

Select MAJOR RAD / NUC MED AMIS CODES DESCRIPTION: ABDOMEN-KUB

Do you wish to include all Procedures? Yes /  /  <RET>
```

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

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

```
>>>>> AMIS Code Dump by Patient <<<<<                          Page: 1
Patient List for AMIS Category 5 - ABDOMEN-KUB
                                                                 For Period:
NOV 21,1994 to
Run Date: MAR  1,1995  10:58                       MAR  1,1995
Division: HINES CIO FIELD OFFICE
# of Procedures Selected: All

Patient Name        Pt ID           Procedure            Exam Date
Ward / Clinic
------------        -----           ---------            -----------
-----------
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
```

Special Reports - 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. 1

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a report entitled Overall Workload Report, based on examinations performed within a specified date range. The report contains the AMIS category number and name, and counts are listed for inpatient, outpatient, total, and % of total examination statistics, weighted work unit statistics and film usage.

A separate page prints for each division, with AMIS codes listed in numerical order. An all-division page will print if more than one division is included.
If you have access to more than one Radiology / Nuclear Medicine division, you will be prompted for one or more to include in the report. If you have access to only one division, the system will automatically select that division for you and you will not see a prompt. You will be prompted for a date range, and only data from examination dates within the range you specify will be included.
Exams must meet certain criteria to be included in the report:
The exam date / time must fall within the date range selected. The current status of the exam must be specified in the Examination Status parameters as a status to include in this report. (This is determined during system set-up when the ADPAC answers the AMIS Report question during Examination Status Entry / Edit.) The division on the exam record must be one of divisions you selected, or your default division if you did not see a division selection prompt.
The procedure on the exam record must have an AMIS code. If the procedure's CPT code is the same as that of another procedure on the same visit (i.e., same exam date / time), the exam is bypassed. If more than one procedure done during a visit does not have a CPT code, only the first procedure without a CPT will be counted and the rest without a CPT will be bypassed.
The exam counts are determined as follows:
If the Ward on the exam record contains a valid ward, the exam is counted as an inpatient exam. Otherwise, it is assumed to be outpatient. One count per exam is added to the division visits and totals visits.
The number of each film size used (including wasted film) is added to the appropriate total for division, inpatient or outpatient, film or cine total, and grand total. If the film is cine, the Cine Runs total is incremented by 1.
The “Patient Visits” total includes one count for each exam date / time. So, if multiple cases are registered under one date / time, the count will be one for that visit. “Average Exams Per Visit” shows average cases registered per each exam date / time.

---

1 Patch RA*5*64 July 2006: Added **Note** to redirect users to the wRVU and CPT Procedure reports section.

For each exam, the inpatient and outpatient examination totals for the appropriate AMIS code(s) are incremented by the number in the AMIS Weight Multiplier field in the Procedure file (the weight multiplier in most cases is 1).
For each exam, the inpatient and outpatient weighted work units are incremented by the product of the AMIS Weight Multiplier and the number in the Weight field of the Major Rad / Nuc Med AMIS Codes file. If the AMIS Weight Multiplier is 1, it will be doubled before these calculations are done if the exam is considered bilateral.
There are many cases where characteristics of the exam or procedure affect the exam counts. The program may turn on “flags” signaling that an exam is BILATERAL, PORTABLE or done in an OPERATING ROOM. The appropriate flag is turned on if any of the exam modifiers are of the bilateral, portable, or operating room modifier type. A flag will also be turned on if AMIS code 25 (Operating Room) or AMIS code 26 (Portable) has been assigned to the procedure, or if there is a YES in the Bilateral field of the procedure for the selected AMIS code.
If the OPERATING ROOM flag is set, counts are added to AMIS Code 25 as well as to the AMIS code of the procedure. If the PORTABLE flag is set, counts are added to AMIS code 26 as well as to the AMIS code of the procedure. The counts added will be identical to those added to the procedure's AMIS code, described in the above paragraph.
A MYELOGRAM flag will be set if the procedure's AMIS code is 20. A COMPUTED TOMOGRAPHY-HEAD flag is set if the AMIS code is 21 and CT Head or Body field of the procedure is set to “head.” A COMPUTED TOMOGRAPHY-BODY flag is set if the AMIS code is 21 and the CT Head or Body field of the procedure is set to “body”. If a procedure has both AMIS codes 20 and 21 or more than one of each code, counts will only be applied once. However, if a computed tomography head and a computed tomography body are on the same procedure, counts will be added for each.
A SERIES flag is turned on if the procedure has been assigned more than one AMIS code. If the SERIES flag is on, counts are added to the Series of AMIS Codes total as well as to each AMIS code total. The counts added will be identical to those added to the procedure's AMIS code, described above.
The operating room, portable, and series totals appear at the end of the report.

Prompt / **User Response**	Discussion
AMIS Report	

```
NOTE: This output should be queued to a printer that supports 132 columns.

Select Rad / Nuc Med Division: All /  /  HINES CIO FIELD OFFICE   IL  CIOFO
499
Another one (Select / De-Select): <RET>
**** Date Range Selection ****
   Beginning DATE : T-100  (NOV 21, 1994)
   Ending    DATE : T  (MAR 01, 1995)
             The entries printed for this report will be based only
              on exams that are in one of the following statuses:
    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
```

```
                                        Examinations   Weighted Work Units
     Amis Category                     Weight     IN    OUT  TOTAL     %
IN    OUT  TOTAL     %
-----------------------------------------------------------
 1   SKULL,INC.SINUS,MASTOID,JAW,ETC    3       11     33     44   18.3
33     99    132   11.5
 2   CHEST-SINGLE VIEW                  1        3      7     10    4.1
3      7     10    0.9
 3   CHEST MULTIPLE VIEW                2        3      9     12    5.0
6     18     24    2.1
 4   CARDIAC SERIES                     3        0      0      0    0.0
0      0      0    0.0
 5   ABDOMEN-KUB                        2        1      7      8    3.3
2     14     16    1.4
 6   OBSTRUCTIVE SERIES                 3        0      1      1    0.4
0      3      3    0.3
 7   SKELETAL-SPINE & SACROILIAC        3        2     10     12    5.0
6     30     36    3.1
 8   SKELETAL-BONE & JOINTS             2        0     55     55   22.8
0    110    110    9.6
 9   GASTROINTESTINAL                   6        2      1      3    1.2
12      6     18    1.6
 10  GENITOURINARY                      6        0      0      0    0.0
0      0      0    0.0
 11  CHOLECYSTOGRAM,ORAL                5        0      1      1    0.4
0      5      5    0.4
 12  CHOLANGIOGRAM                     10        0      5      5    2.1
0     50     50    4.4
 13  LAMINOGRAM                         5        0      0      0    0.0
0      0      0    0.0
 14  BRONCHOGRAM                        5        0      0      0    0.0
0      0      0    0.0
 15  DIGITAL SUBTRACTION ANGIOGRAPHY   15        0      0      0    0.0
0      0      0    0.0
 16  ANGIOGRAM,CATH- CEREBRAL          15        3      8     11    4.6
45    120    165   14.4
 17  ANGIOGRAM,CATH- VISCERAL          20        0      6      6    2.5
0    120    120   10.5
 18  ANGIOGRAM,CATH- PERIPHERAL        10        0      0      0    0.0
0      0      0    0.0
 19  VENOGRAM                          15        0      0      0    0.0
0      0      0    0.0
 20  MYELOGRAM                         10        0      0      0    0.0
0      0      0    0.0
 21  COMPUTED TOMOGRAPHY                8        9     21     30   12.4
72    168    240   20.9
 22  INTERVENTIONAL RADIOGRAPHY        20        0      0      0    0.0
0      0      0    0.0
 23  ULTRASOUND,ECHOENCEPHALOGRAM       7        0      6      6    2.5
0     42     42    3.7
 24  OTHER                              5        8     27     35   14.5
40    135    175   15.2
 27  NUCLEAR MEDICINE                   1        0      2      2    0.8
0      2      2    0.2
 99  UNKNOWN                                     0      0      0    0.0
0      0      0    0.0
```

```
     TOTALS                                    42    199    241
219    929   1148
     AVERAGE WEIGHT PER EXAM
5.2    4.7    4.8
-------------------------------------------------------
 25  EXAMS IN OPER.SUITE AT SURGERY              9     10     19    7.9
77     96    173   15.1
 26  PORTABLE (BEDSIDE) EXAMINATIONS             2      5      7    2.9
11     79     90    7.8
     SERIES OF AMIS CODES                        0      2      2    0.8
0     30     30    2.6
```

Special Reports - Camera / Equip / Rm Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a workload report for cameras / equipment / rooms.
The report contains the following information: procedure, number of examinations performed, percent of total exams performed, associated weighted work units, and percent of total weighted work units. The cameras, equipment, and rooms in the report are stored in the Primary Camera / Equip / Rm field of the exam record.
This is one of a series of workload reports that have similar selection criteria, report output, data retrieval, and reporting logic. See the section entitled **General Information about AMIS-Based Workload Reports**, starting on page 258, 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
    Run Date: JUL 29,1997  15:10                                JUL 29,1997
                                              Examinations    Percent
Percent
  Procedure (CPT)                           In    Out  Total   Exams  WWU
WWU
-------------------------------------------------------------------------------
---
          Camera / Equip / Room: CAMERA 1 - Triple Head SPECT S
ARTHROGRAM SHOULDER S&I      (73040)        0      1      1  100.0      5
100.0
-----------------------------------------------------------------------

Camera / Equip / Room Total                   0      1      1             5


>>> Camera / Equip / Room Workload Report <<<                    Page: 4

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: APR 20,1997
to
    Run Date: JUL 29,1997  15:10                                JUL 29,1997
                                              Examinations    Percent
Percent
  Procedure (CPT)                           In    Out  Total   Exams  WWU
WWU
-------------------------------------------------------------------------------
---
          Camera / Equip / Room: PORTABLE - PORTABLE
CHEST 4 VIEWS                (71030)        0      2      2    5.1      4
2.3
ABDOMEN 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


>>> Camera / Equip / Room Workload Report <<<                    Page: 9

    Division: HINES CIO FIELD OFFICE
Imaging Type: GENERAL RADIOLOGY                     For period: APR 20,1997
to
    Run Date: JUL 29,1997  15:10                                JUL 29,1997
                                              Examinations    Percent
Percent
  Camera / Equip / Room                         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
```

Special Reports - Cost Distribution Report

This option produces a report of exam workload by cost distribution center to assist the department in preparing their Cost Distribution Report (CDR).
This report is compiled from the examination data entered through the Exam Entry / Edit Menu. If the person generating the report has access to more than one radiology / nuclear medicine division, a prompt will be displayed asking for a selection of one or more divisions. If the person generating the report has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type.
A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. A date range must also be selected.
If the exam date of a case is within the date range selected, the case may be included on the report as long as the exam was not cancelled, the division and category of exam data on the exam are not missing or invalid, and the cost center can be determined using the steps described below.

There are four category headings on the report: Inpatient, Outpatient, and Research each have their own heading. Contract, Sharing and Employee are reported under "Other."

Inpatient Method of Determining Cost Center

If the category of exam is Inpatient, Research, Contract, or Sharing, the Ward field of the Rad / Nuc Med Patient file is used to find a Specialty (in the Ward Location file) for that ward. The name of that specialty is used as the cost center for the exam and its CDR account number (in the Specialty file) is used as the cost center number.
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>

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
```

Special Reports - 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. 1

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a report entitled Detailed Procedure Workload Report.
The report consists of the following information for each AMIS category: procedure, number of inpatient and outpatient examinations, total number of examinations, percent of exams, weighted work units, and percent of weighted work units.
This report is compiled from the examination data entered through the Exam Entry / Edit Menu. If the person generating the report has access to more than one radiology / nuclear medicine division, a prompt will be displayed asking for a selection of one or more divisions. If the person generating the report has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type.
A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. A date range must also be selected.
Since the output can be lengthy, you may wish to run this report during off hours.
If the exam date of a case is within the date range selected, the case will be included on the report as long as the procedure has been assigned an AMIS code, and the exam's division and imaging type are among those selected.
The current status of the exam must be specified in the Examination Status parameters as a status to include on this report. (This is determined during system set-up when the ADPAC answers the Detailed Procedure Report question during Examination Status Entry / Edit.)

Special Reports - 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

---

1 Patch RA*5*64 July 2006: Added **Note** to redirect users to the wRVU and CPT Procedure reports section.

Procedure file (the weight multiplier in most cases is 1). For each exam, weighted work units are the product of the AMIS Weight Multiplier and the number in the Weight field of the Major Rad / Nuc Med AMIS Codes file. If the AMIS Weight Multiplier is 1, it will be doubled before these calculations are done if the exam is considered bilateral.
There are many cases where characteristics of the exam or procedure affect the exam counts. The program may turn on flags signaling that an exam is BILATERAL, PORTABLE or done in an OPERATING ROOM. The appropriate flag is turned on if any of the exam modifiers are of the bilateral, portable, or operating room modifier type.
A flag will also be turned on if AMIS code 25 (Operating Room) or AMIS code 26 (Portable) has been assigned to the procedure, or if there is a YES in the Bilateral field of the procedure for the selected AMIS code. If the OPERATING ROOM flag is set, counts are added to AMIS Code 25 as well as to the AMIS code of the procedure. If the PORTABLE flag is set, counts are added to AMIS code 26 as well as to the AMIS code of the procedure.
The counts added will be identical to those added to the procedure's AMIS code, described in the above paragraph.
A SERIES flag is turned on if the procedure has been assigned more than one AMIS code. If the SERIES flag is on, counts are added to the Series of AMIS Codes total as well as to each AMIS code total. The counts added will be identical to those added to the procedure's AMIS code, described above.
The operating room, portable, and series totals appear at the end of the report in the division summary.

Prompt / **User Response**	Discussion
Detailed Procedure Report	
Select Rad / Nuc Med Division: All / / **HI**NES INFORMATION SYSTEMS CTR ILLINOIS ISC 499 Another one (Select / De-Select): **<RET>**	
Select one IMAGING TYPE: **GEN**ERAL RADIOLOGY	This prompt differs from the Imaging Type selection prompt in other options. **Note** that only one Imaging Type can be selected.
**** Date Range Selection **** Beginning DATE : **T-100** (NOV 21, 1994) Ending DATE : **T** (MAR 01, 1995)	

```
              The entries printed for this report will be based only
               on exams that are in one of the following statuses:
Enter RETURN to continue or '^' to exit:

          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
```

```
                COMPLETE
```

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

Enter the name of a printer, or "Q" to see prompts for a device and a time to print.

```
         >>>>> Detailed Procedure Workload Report <<<<<      Page: 1

     Division: HINES INFORMATION SYSTEMS CTR
 Imaging Type: GENERAL RADIOLOGY                    For period: NOV 21,1994
to
     Run Date: MAR  1,1995  11:01                              MAR  1,1995
                                      Examinations    Percent       Percent
  Procedure                           In    Out  Total   Exams   WWU    WWU
-------------------------------------------------------------------------------
--
     Amis: 1   SKULL,INC.SINUS,MASTOID,JAW,ETC
  BONE SURV COMP (INCL APPENDIC        0      1      1    1.9      3    1.9
  NECK SOFT TISSUE                     4     24     28   51.9     84   51.9
  SKULL 4 OR MORE VIEWS                7     18     25   46.3     75   46.3

  AMIS CATEGORY TOTALS                11     43     54           162

         >>>>> Detailed Procedure Workload Report <<<<<       Page: 18

     Division: HINES INFORMATION SYSTEMS CTR
 Imaging Type: GENERAL RADIOLOGY                    For period: NOV 21,1994
to
 Run Date: MAR  1,1995  11:01                              MAR  1,1995
                                    Examinations    Percent       Percent
  Amis Category                        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

Special Reports - Film Usage Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a record of film usage according to film size. The report shows procedure, number of films used, number of exams, average number of films used per exam and percentage of films used for a given procedure. This listing may be generated as a detailed or summary report. The film sizes in the report are stored in the Film Size and Amount subfields of the exam record.

The person generating the report will be asked if s / he wants to print a summary only. A summary report groups all examinations together by film size for each imaging type and division. A detailed report gives information for each individual procedure performed within the film size.

This report is compiled from the film size data entered through the Exam Entry / Edit Menu. If the person generating the report has access to more than one radiology / nuclear medicine division a prompt will be displayed asking for a selection of one or more divisions. If the person generating the report has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type.

A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. A beginning and ending exam date range must be selected. If only one or a few film sizes are desired on the report, the “Do you wish to include all films?” prompt may be answered NO to get a Select film: prompt.

Before the report prints, a list of exam statuses to be included in the report will be displayed. The exam statuses may be different for each imaging type selected. This is determined during system set-up when the ADPAC answers the Film Usage Report question during Examination Status Entry / Edit. See the *ADPAC Guide* for more information on exam status parameter set-up.

Since the output can be lengthy, you may wish to run this report during off hours.

If the exam date of a case is within the date range selected, the case will be included in the report as long as the exam's division and imaging type are among those selected. The current status of the exam must be specified in the Examination Status parameters as a status to include in this report. If, during exam edit / entry, a film size was entered for an exam but no amount was entered, nothing will be added to the totals.

The exam counts are doubled if the exam is considered bilateral. An exam is bilateral if any exam modifiers are of the bilateral modifier type, or if the Bilateral field of the procedure's AMIS subrecord is set to Yes.

If the AMIS Weight Multiplier field of the procedure's AMIS subrecord is set to a number greater than 1, this number will be used, and the bilateral modifiers will have no effect. An exam with more than one AMIS code will only be counted as one exam regardless of whether it is bilateral.

Film counts are not affected by multipliers or bilateral modifiers. Film counts are determined by the numbers entered during exam editing. Wasted film types are bypassed. If the film is a cine type, its statistics are included under the Cine film size page which reports number of cine feet. Cine is included in a line on the summary page, but not in the totals. Only AMIS codes 1-24, and 27 are used in summing totals for each procedure.

The report in sort order of the report is: division number, imaging type, film size, AMIS category, and procedure.
There is a notation at the end of the summary page that serves as a reminder of the number of film sizes selected to include on the report.

Prompt / **User Response** | Discussion

```
Film Usage Report
```

```
Film Usage Report
-----------------
Do you wish only the summary report? NO /  /  <RET>
```

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

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

```
Do you wish to include all Films? Yes /  /  <RET>

**** Date Range Selection ****
   Beginning DATE : T-100  (NOV 21, 1994)
   Ending    DATE : T  (MAR 01, 1995)
```

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

         GENERAL RADIOLOGY
         WAITING FOR EXAM
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 waht 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 OFICE
Imaging Type: GENERAL RADIOLOGY                    For period: NOV 21,1994
to
    Run Date: MAR  1,1995  11:02                                  MAR  1,1995

                                          Number    Number    Films
Percentage
                                            of        of        per      Films
```

```
  Procedure(CPT)                          Films     Exams      Exam      Used
-----------------------------------------------------------------
          Film Size: 10X12
SKULL 4 OR MORE VIEWS(70260)                10         2       5.0       6.7
CHEST STEREO PA(71015)                      24         5       4.8      16.0
CHEST 4 VIEWS(71030)                         8         2       4.0       5.3
ABDOMEN 1 VIEW(74000)                       10         3       3.3       6.7
SPINE LUMBOSACRAL MIN 2 VIEWS(72100)         2         1       2.0       1.3
ANKLE 2 VIEWS(73600)                        18         9       2.0      12.0
UPPER GI + SMALL BOWEL(74245)               10         2       5.0       6.7

 Film Usage Total                           84        25       3.4
        >>>>> Film Usage Report <<<<<                                  Page:
19

    Division: HINES CIO FIELD OFICE
Imaging Type: GENERAL RADIOLOGY                     For period: NOV 21,1994
to
    Run Date: MAR  1,1995  11:02                                MAR  1,1995

                                          Number    Number    Films
Percentage
                                            of        of        per      Films
  Film Size                               Films*    Exams      Exam      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
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 Scaled wRVU / CPT Report 1

This report generates scaled Work Relative Value Unit (wRVU) statistics for detailed and series procedure(s) selected by the user. The wRVU accompanies a CPT code to

1 Patch RA*5*64 July 2006: Added Procedure Scaled wRVU / CPT Report description and example.

provide a weighted value to measure the provider's time, complexity, and expertise required to perform a medical service.
SCARD (Society of Chairmen in Academic Radiology Departments) has determined that the wRVU, which was originally developed for billing, may over or under-estimate the actual time required to interpret a study and has proposed scaling factors to better calculate personal workload.
Please note that this report returns a list of procedures and the scaled wRVU associated with those procedures: it does not contain any physician information. Use the Physician wRVU / CPT reports, starting on page 201, 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 scaling factors applied to the VistA Radiology / Nuclear Medicine imaging types are displayed at the bottom of the report. (Please note that the scaling factors shown in this example are not necessarily the actual scaling factors in the system for 2006.)
The report data is sorted by procedure name.

Prompt / **User Response**	Discussion
`Procedure Scaled wRVU / CPT Report`	

`Select Procedures: All / / ABDOMEN*`
`Another one (Select / De-Select): <RET>`
 	
`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.

The sample report is as shown.

```
         PROCEDURE CPT CODE AND SCALED WORK RELATIVE VALUE UNITS (wRVU)
Run Date: Jun 19, 2006                                          Page: 1

Procedure                            Proc Type  Img Type  CPT Code    SwRVU
-----------------------------------------------------------------------------
ABDOMEN 1 VIEW                       Detailed   RAD       74000        0.22
ABDOMEN 2 VIEWS                      Detailed   RAD       74010        0.56
ABDOMEN 3 OR MORE VIEWS              Detailed   RAD       74020        0.33
ABDOMEN FOR FETAL AGE 1 VIEW         Detailed   RAD       74720        0.00
ABDOMEN FOR FETAL AGE MULT VIEWS     Detailed   RAD       74725        0.00
ABDOMEN MIN 3 VIEWS+CHEST            Series     RAD       74022        0.39

For calendar year 2006 the following scaling factors apply:
GENERAL RADIOLOGY                 RAD            1.21 (2006)
NUCLEAR MEDICINE                  NM             1.57 (2006)
MAGNETIC RESONANCE IMAGING        MRI            0.70 (2006)
CT SCAN                           CT             0.70 (2006)
ANGIO / NEURO / INTERVENTIONAL        ANI            0.61 (2006)
```

Procedure wRVU / CPT Report [1]

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 201, 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

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 / 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 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

1 Patch RA*5*64 July 2006: Added Procedure wRVU / CPT Report description and example.

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> 1`	

`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>`	

1 Patch RA*5*26 July 2001: Allows printing of different combinations of CPT modifiers on separate lines.

```
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                    For period: 04 / 22 / 97
to
    Run Date: JUL 31,1997  15:12                              07 / 31 / 97
    # of Procedures selected: All                  Cancelled Exams: included

CPT    PROCEDURE                              # DONE  (%)    $UNIT     $TOTAL
(%)
=========================================================================
71015  CHEST STEREO PA                          2   20    10.00      20.00
6
71022  CHEST OBLIQUE PROJECTIONS                1   10    20.00      20.00
6
74000  ABDOMEN 1 VIEW                           3   30    10.00      30.00
9
74249  UPPER GI AIR CONT W / SMALL BOWEL          1   10    40.00      40.00
12
75660  ANGIO CAROTID CEREBRAL SELECT EXT UNIL   2   20    90.00     180.00
52
76091  MAMMOGRAM BILAT                          1   10    50.00      50.00
15
            Total for this imaging type -->     10                    340.00
```

Special Reports - 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     1ASTEMPORARYLONGNAME
 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
====================================================
CT by Series Radiation Dose Summary Report by Patient

                  Highest

                  Dose     CTDIvol    DLP
Patient                  SSN   Date      CPT    Procedure Name
Radiolo
gist              Series   mGy        mGy-cm
----------------------------------------------------------------------
----------------------------
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

                              all CDTI   all DLP
Patient                      SSN   Date      CPT    Procedure Name
Radiologist                  vol mGy    mGy-cm
------------------------------
-----------------------------------------------------
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


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

                    Air         Air Kerma    Fluoro

                    Kerma       Air Product  Time
Patient                  SSN   Date      CPT    Procedure Name
Radio
logist              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  76770  AORTIC ULTRASOUND
PROVI
DER,IMA D            337.11     2345.87      2.6
RADIOLOGY,PATIENT            2343  12/22/99  75665  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.
```

Special Reports - Status Time Report

This option allows the user (usually a supervisor, ADPAC, or other managerial personnel) to generate a Status Tracking Statistics Report. 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. 1
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>`	

1 Patch RA*5*20 May 2000: Enhancements to Status Time Report.

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). 1

Select IMAGING TYPE: **GEN**ERAL RADIOLOGY	You may only select one Imaging Type.
Select all procedures? Y / N: **Y** 2	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>** 3	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.

The Procedure Detail by Requesting Location report reflects statistics sorted by requesting location, status changes, and procedures. 4 If the user chooses only one specific procedure, the report includes only that procedure. If the user chooses only one specific requesting location, the report includes only data for that location.

```
                    ** Status Tracking Statistics Report **            Page:
11
                    Procedure Detail by Requesting Location
              (Only requesting locations with data are included)

  Run Date: 05 / 03 / 00                      For Period: 04 / 01 / 00 - 04 /
30 / 00
  Division: HINES CIO FIELD OFFICE        Imaging Type: GENERAL RADIOLOGY
  Requesting Location: X-RAY CLINIC

          From: WAITING FOR EXAM
          To  : COMPLETE
                                  Minimum     Maximum     Average
```

1 Patch RA*5*20 May 2000: Enhancements to Status Time Report.
2 Patch RA*5*20 May 2000: Enhancements to Status Time Report.
3 Patch RA*5*24 September 2000: New prompt added
4 Patch RA*5*20 May 2000: Enhancements to Status Time Report.

```
                                  Time        Time        Time     Number of
    Procedure (CPT)             (DD:HH:MM)  (DD:HH:MM)  (DD:HH:MM)  Procedures
    ---------------             ----------  ----------  ----------  ----------

KNEE 3 VIEWS(73562)              00:00:02    00:00:02    00:00:02          1
ANKLE 2 VIEWS(73600)             00:01:10    00:01:10    00:01:10          1
FOOT 2 VIEWS(73620)              00:00:58    15:01:38    07:13:18          2
                                ----------  ----------  ----------  ----------
    Overall:                     00:00:02    15:01:38    03:18:57          4
```

The Division Summary Requesting Location Details report reflects summary statistics sorted by requesting location and status changes. Total number of completed exams that match the criteria specified by the user is displayed at the end of the report.

```
            ** Status Tracking Statistics Report **            Page:  26
                    Division Summary Requesting Location Details
                 (Only requesting locations with data are included)

  Run Date: 05 / 03 / 00                      For Period: 04 / 01 / 00 - 04 /
30 / 00
  Division: HINES CIO FIELD OFFICE        Imaging Type: GENERAL RADIOLOGY
  Requesting Location: X-RAY CLINIC
                                  Minimum     Maximum     Average
                                   Time        Time        Time     Number of
                                (DD:HH:MM)  (DD:HH:MM)  (DD:HH:MM)  Procedures
                                ----------  ----------  ----------  ----------
    From: WAITING FOR EXAM
    To  : COMPLETE               00:00:02    15:01:38    03:18:57          4

    From: WAITING FOR EXAM
    To  : EXAMINED               01:00:05    01:00:05    01:00:05          1
. . . skipped

    From: CALLED FOR EXAM
    To  : EXAMINED               00:00:16    00:00:16    00:00:16          1

                                ----------  ----------  ----------  ----------
    From: WAITING FOR EXAM
    To  : COMPLETE               00:00:00    15:01:38    02:19:27

    Total number of exams moved to a status of COMPLETE
    for period  04 / 01 / 00 - 04 / 30 / 00:
8
```

The Division Summary Procedure Detail report reflects statistics sorted by status changes and procedures.

If the user chooses only one specific procedure, the report includes only that procedure and the caption reflects the name of the procedure in the Procedure field.

If the user chooses only one requesting location, the report includes only data for that location and the caption reflects the name of the location in the Requesting Location field.

```
** Status Tracking Statistics Report **            Page:  31
                      Division Summary Procedure Detail
```

```
  Run Date: 05 / 03 / 00                      For Period: 04 / 01 / 00 - 04 /
30 / 00
  Division: HINES CIO FIELD OFFICE        Imaging Type: GENERAL RADIOLOGY
  Requesting Location:ALL                 Procedure:ALL

          From: WAITING FOR EXAM
          To  : EXAMINED
                                  Minimum     Maximum     Average
                                   Time        Time        Time      Number of
    Procedure (CPT)             (DD:HH:MM)  (DD:HH:MM)  (DD:HH:MM)  Procedures
    ---------------             ----------  ----------  ----------  ----------

KNEE 2 VIEWS(73560)              01:00:05    01:00:05    01:00:05          1
ABDOMEN FOR FETAL AGE 1 V(74720)00:00:03    00:00:03    00:00:03          1
                                ----------  ----------  ----------  ----------
    Overall:                     00:00:03    01:00:05    00:12:04          2
```

The Division Summary Overall report reflects summary statistics sorted by status changes. Total number of completed exams that match the criteria specified by the user is displayed at the end of the report.

```
 ** Status Tracking Statistics Report **            Page:  38
                            Division Summary Overall

  Run Date: 05 / 03 / 00                      For Period: 04 / 01 / 00 - 04 /
30 / 00
  Division: HINES CIO FIELD OFFICE        Imaging Type: GENERAL RADIOLOGY
  Requesting Location:ALL                 Procedure:ALL

                                  Minimum     Maximum     Average
                                   Time        Time        Time      Number of
                                (DD:HH:MM)  (DD:HH:MM)  (DD:HH:MM)  Procedures
                                ----------  ----------  ----------  ----------

    From: WAITING FOR EXAM
    To  : COMPLETE               00:00:02    15:01:38    05:11:26         10

    From: WAITING FOR EXAM
    To  : EXAMINED               00:00:03    01:00:05    00:12:04          2

. . . skipped

    From: COMPLETE
    To  : TRANSCRIBED            05:19:44    05:19:44    05:19:44          1

    From: CALLED FOR EXAM
    To  : EXAMINED               00:00:16    00:00:16    00:00:16          1

                                ----------  ----------  ----------  ----------
    From: WAITING FOR EXAM
    To  : COMPLETE               00:00:02    15:01:38    05:06:35

    Total number of exams moved to a status of COMPLETE
    for period  04 / 01 / 00 - 04 / 30 / 00:                              17
```

Note: As shown in the example above, exam statuses can move backwards. This happens if data is deleted, or if a report is unverified.

Special Reports - Wasted Film Report

This option allows the user to generate a record of wasted film according to size, imaging type and division. This report calculates the number of all films used, the number of films wasted, and the percentage wasted.
If the person generating the report has access to more than one radiology / nuclear medicine division, a prompt will be displayed asking for a selection of one or more divisions. If the person generating the report has access to only one division, the system will default to that division rather than prompting for a selection. The same is true with imaging type.
A prompt for selection of one or more imaging types will appear only if the person has access to more than one imaging type. A beginning and ending exam date range must also be selected.
Before the report prints, a list of exam statuses to be included on the report will be displayed. The exam statuses may be different for each imaging type selected. This is determined during system set-up when the ADPAC answers the Film Usage Report question during Examination Status Entry / Edit. See the *ADPAC Guide* for more information on exam status parameter set-up.
Since the output can be lengthy, you may wish to run this report during off hours.
If the exam date of a case is within the date range selected, the case may be included on the report as long as the exam's division and imaging type are among those selected.
The current status of the exam must be specified in the Examination Status parameters as a status to include on this report. If, during exam edit / entry, a wasted film size was entered for an exam but no amount was entered, nothing will be added to the totals.
Each film size entered on the exam record is checked. If the film size has been deleted from the Film Size file the exam is bypassed. If the film size is a wasted type, the number used is added to the total for that wasted film size.
The used films are also tracked so that a percentage wasted can be calculated. The units of wasted film are separate and not included in the units of used film. The calculation for percentage wasted is: number wasted / (number used + number wasted) x 100.
In order for this report to be valid, each film size must have a wasted film entry set up in the Film Sizes file that points to the analogous unwasted film size. Refer to the *ADPAC Guide* for more information about setting up Film Sizes correctly so that this report is valid.

Prompt / **User Response**	Discussion
Wasted Film Report	

```
                    Radiology / Nuclear Med
                 *** Wasted Film Report ***
                 --------------------------

Do you wish to generate a summary report only? No /  /  <RET>
```

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

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


Select Imaging Type: All /  /  GENERAL RADIOLOGY

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

             The entries printed for this report will be based only
              on exams that are in one of the following statuses:
          GENERAL RADIOLOGY
          -----------------
               WAITING FOR EXAM
               EXAMINED
               TRANSCRIBED
               COMPLETE
Enter the start date for the search: Mar 01, 1995 /  /  T-100  (NOV 21, 1994)
Enter the ending date for the search: NOV 21,1994 /  /  T  (MAR 01, 1995)
```

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

```
                         >>>>> Wasted Film Report <<<<<              Page: 1

     Division: HINES CIO FIELD OFICE              For Period: NOV 22,1994 to
     Imaging Type: GENERAL RADIOLOGY                          MAR 2,1995.
     Run Date: Mar 02, 1995@13:32:31

                                    Units     Units          Percentage
                                    Of Used   Of Wasted      Of Wasted
Film Size                           Films     Films          Film
-------------------------------------------------------------------------------
-
W-10X12                             150       9                5.7

     Subtotals:                     150       9                5.7
-------------------------------------------------------------------------------
-
     * Cine data not included in totals.
```

General Information About AMIS-Based Workload Reports [1]

> **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.

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

---

1 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.

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	

Special Reports - General Information About AMIS-Based Workload Reports

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 Classificationn 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.

Special Reports - General Information About AMIS-Based Workload Reports

Reporting Logic

The program uses the Category of Exam field of the exam record to determine whether to count the exam under Inpatient, Outpatient, Research, or Other. The Personnel reports only print Inpatient and Outpatient. If there is a valid ward in the Ward field of the exam, it will be counted under Inpatient. All other cases will be counted under Outpatient regardless of the contents of the Category of Exam field.
The functional area reports print Inpatient, Outpatient, Research, and All Other, based on whether the Category of Exam field contains Inpatient, Outpatient, Research, or some other value. The report headings are abbreviated to In, Out, Res, and Other.
The Functional Area reports, the Camera / Equip / Rm Report, and the Technologist Workload Report show weighted work units (WWU). WWUs do not apply to the other Personnel reports.

The AMIS Weight Multiplier Field of the Rad / Nuc Med Procedures file contains a number (0-99) to indicate to the various workload report programs how many times to multiply the weighted work units associated with the AMIS code. The Weight for each AMIS code is stored in the Weight field of the Major Rad / Nuc Med AMIS Code file. Most multipliers will be 1. However, there are some that are greater than 1. For example, a procedure called Upper GI and Small Bowel might have AMIS code 9-Gastrointestinal which has a Weight of 6, and an AMIS Weight Multiplier of 2. Therefore, on the workload reports, the site will get credit for 12 WWUs each time it is performed. If there are multiple AMIS codes for the procedure, each AMIS Weight Multiplier is multiplied by the AMIS Weight, then the results are summed.
Depicted below is a sample of the exam / procedure / AMIS file relationship. Using this sample, the WWUs for the exam would be 12, and the exam would count as 2 exams.

Rad / Nuc Med Exam data stored in Rad / Nuc Med Patient file (#70)	Procedure stored in Rad / Nuc Med Procedure file (#71)	AMIS Categories stored in the Major Rad / Nuc Med AMIS Code 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 x 2 = 12 because Weight x AMIS Weight Multiplier = WWU
The bilateral modifier has special meaning and can cause increased counts. If the AMIS Weight Multiplier is one (1), "bilateral" affects the WWUs by multiplying the AMIS Weight Multiplier by 2 if and only if the AMIS weight multiplier is 1. The result is multiplied by the AMIS code's Weight.
In the sample above, if the procedure had been bilateral WWUs would NOT have been affected because the AMIS Weight Multiplier is greater than 1. The exam counts are printed under the In, Out, Res and Other headings on the report.
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.)
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.

Outside Films Registry Menu - Add Films to Registry

This function allows the user to add new films to the existing outside films registry. This registry tracks films received from outside sources (e.g., private or other VA hospitals). If the patient selected is not in the Rad / Nuc Med Patient file, s / he can be added through this option.
A single patient may have more than one outside film registered at the same time. Through this option, you can add a new entry to those already in the registry. The Edit Registry option should be used to make changes in existing entries.
The registry includes registration date, date to be returned to the source, the source of the films and remarks.

Prompt / **User Response** Discussion

```
Add Films to Registry

Select Patient: 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>
```

Outside Films Registry Menu - Delinquent Outside Film Report for Outpatients

This function allows the user to obtain a report of all the patients who have outside films registered that have a Needed Back date less than the date the user specifies. The

outside films' needed back dates must have first been entered through the Add Films to Registry or the Edit Registry options.
This function assists the file room with the return of outside films to other hospitals and institutions.
Outside films for inpatients are not shown on this report because it is assumed that the department would not want to send back films for patients still receiving care at the facility. The report is in chronological order and includes patient name, SSN, needed back date, whether a supervisor's OK is needed before these films can be returned to the source, the source from which the films were borrowed, and remarks.

Prompt / **User Response** Discussion

```
Delinquent Outside Film Report for Outpatients

All Films with 'Needed Back' Dates Less Than: T  (FEB
27, 1995)

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

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

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

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
```

Outside Films Registry Menu - Edit Registry

This function allows the user to edit information pertaining to a specific outside film that has been registered.
Only patients currently entered in the Rad / Nuc Med patient file can be selected.
A single patient may have more than one outside film registered at once. This option can be used to edit an existing entry. New outside film register dates should be added through the Add Films to Registry option.
The registry includes registration date, date to be returned to the source, the source of the films and a remarks field. You may edit any or all of these fields through this option.
This option is used to enter a date on which the films were actually returned to the source. If the entry has been flagged through the Flag Film To Need OK Before Return option, supervisory approval is needed before the films can be returned.

Prompt / **User Response**	Discussion

```
Edit Registry


Select Patient: 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>
```

Outside Films Registry Menu - Flag Film to Need “OK” Before Return

This option is used to flag entries in the films registry for supervisory approval before being returned to the outside source. An example would be films that need to be retained for treatment and reference.
Only patients currently entered in the Rad / Nuc Med Patient file can be selected. A patient may have more than one outside film registered at once and one or more of these can be flagged.
If an entry is flagged as needing an OK before return, then users in the Edit Registry option will be asked if the supervisor has authorized the return of the borrowed films. A film that has already been returned cannot be flagged.
The Add Films to Registry option should be used instead of this option to add new outside film dates to insure completeness of data.

```
Prompt / User Response  Discussion
Flag Film to Need 'OK' Before Return


Select Patient: 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
```

Outside Films Registry Menu - Outside Films Profile

This function allows users to see if films from other hospitals or institutions have been registered for this patient. Both returned and unreturned films are listed in the profile. If they have been returned, then the Date Returned is given.
You will be prompted for a patient's name and the device on which to print the profile. The profile will include registration dates, returned dates, the source, remarks, and an indication showing whether supervisory approval is needed before returning the films.

Prompt **/ User Response** Discussion

```
Outside Films Profile



Select Patient: 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

Patient Profile Menu - 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**

```
                 Patient Profile With Radiation Dose Data
Date: Jun 11, 2013@15:42                                        Page: 1
=========================================================================
  Name        : RADPATIENT,IMA    0000
  Division    : SUPPORT ISC           Category   : INPATIENT
  Location    : X-RAY CLINIC COUNT    Ward       : 1ASTEMPORARYLONGNAME
  Exam Date   : AUG 23, 2011@11:15    Service    : MEDICINE
  Case No.    : 141-082311-3436       Bedsection : MEDICAL OBSERVATION
                                      Clinic     :
-------------------------------------------------------------------------
  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
(5 highest DLP)          (mGy)         (mGy-cm)       Target Region
-----------------       -------        --------       -------------
  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.
```

Patient Profile Menu - Detailed Request Display

This option allows the user to see detailed information on a requested examination for a particular patient.
After selecting a patient, a selection must be made from a list of available requests, showing request status, urgency, procedure, desired date, reason for study 1, 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 associations[2], 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:' 3 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.' 4
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.5 For example:

** **Note**: Request Associated with Visit on Apr 30, 2001 12:00pm **

---

1 Patch RA*5*75 June 2007: Added Reason for Study to selection criteria.
2 Patch RA*5*45 May 2005: Detailed Request Display displays contrast media, if appropriate
3 Patch RA*5*99 February 2010: Replaced the 'Pregnancy Status' field with the 'Pregnant at time of order entry' field.
4 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'
5 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.

If information has been recorded in the status tracking log for the request, the user will also have the option to view the log. The tracking log display includes date / time of change, the new status, the computer user who made the change, and the reason (where applicable). The system will only keep this tracking log if the Track Request Status Changes question is answered Yes when the ADPAC does division parameter set-up. (See *ADPAC Guide* for additional information.)

Prompt / **User Response** Discussion

```
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: YES1
PREGNANCY SCREEN:  Patient answered yes.2
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: 3       Patient indicated discomfort.
Clinical History:     Internal bleeding, pain
Request Submitted to: UNKNOWN


Do you wish to display request status tracking log? NO /  /  YES

                   *** Request Status Tracking Log *** 4
Date / Time         Status       User         Reason
---- ------------ -----------  ------------------------------------
04 / 19 / 97 12:15 PM PENDING      RADUSER,SIX
04 / 19 / 97 12:17 PM ACTIVE       RADUSER,SEVEN
```

1 Patch RA*5*99 February 2010: Replaced the ‘Pregnancy Status’ field with the ‘Pregnant at time of order entry’ field.
2 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’
3 Patch RA*5*75 June 2007: Added a line for Reason for Study to the sample report.
4 Patch RA*5*15 June 2001: NOIS: FRE-1099-60873 "Request" added to line.

Patient Profile Menu - Display Patient Demographics [1]

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 2**
      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
- 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`	

1 Patch RA*5*47 September 2011: Display Patient Demographics option is affected by the new Site Specific Accession Number (SSAN).
2 Patch RA*5*45 May 2005: Display Patient Demographics displays contrast media, if appropriate

```
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
```

Patient Profile Menu - Exam Profile (selected sort) [1]

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 [2], status change log, and results report.
The initial list of exams shows case no., procedure, contrast media associations [3], exam date, exam status, and imaging location of the exam. The single exam display shows most exam data entered into the system.
The activity log shows which menu options were used to take action on the exam, and the status tracking log shows when status changes occurred, how much time elapsed between status changes, and total elapsed time from when the exam was registered to the last status change.
The report text is the actual procedure report.

Prompt / **User Response** Discussion

```
Exam Profile (selected sort) 4
```

1 Patch RA*5*47 September 2011: Exam Profile (selected sort) option is affected by the new Site Specific Accession Number (SSAN).
2 Patch RA*5*45 May 2005: Exam Profile describes to the user that contrast media displays, if appropriate.
3 Patch RA*5*45 May 2005: Exam Profile describes to the user that contrast media displays, if appropriate.
4 Patch RA*5*45 May 2005: New Exam Profile example.

```
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 1    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 ***
---------------------------------------------------------------------
```

1 Patch RA*5*99 February 2010: Inserted the field ‘Pregnant at time of order entry.’

```
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

                          Contrast Media Edit History
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
                     *** 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
=================================================================
```

Patient Profile Menu - Outside Films Profile

This function allows the user to see if films from other hospitals or institutions have been registered for this patient. Both returned and unreturned films are listed in the profile. If they have been returned, then the Date Returned is given.
This option prompts for a patient's name and a device.
The output includes the date the outside films were registered and returned, the source of the films (i.e., another hospital), remarks, and an indication specifying whether a supervisor's authorization is needed before returning the films.
This option appears on the Outside Films Registry menu. Please refer to the example earlier in this section.

Patient Profile Menu - Profile of Rad / Nuc Med Exams [1]

1 Patch RA*5*47 September 2011: Profile Rad / Nuc Med Exams option is affected by the new Site Specific Accession Number (SSAN).

This function allows the user to see a quick list of the patient's registered exams. The exams are presented in reverse chronological order. A specific exam can be selected from the list. When an exam is selected, a very detailed display of the exam is presented.
You will be prompted to select a patient. If the patient has radiology records (films) on file within the Record Tracking system, information relevant to these records will be displayed.
If the patient has more than one registered radiology exam, a list will be displayed showing the case no., procedure, contrast media associations 1, 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.2

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
```

1 Patch RA*5*45 May 2005: Rad / Nuc Med Exams displays contrast media, if appropriate
2 Patch RA*5*99 February 2010: Inserted the field 'Pregnant at time of order entry.'

```
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:nnnnn1
   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 2      Films        : 11X14 - 1
 ---------------------------------Modifiers--------------------------------
   Proc Modifiers: None
   CPT Modifiers  :None
----------------------------------Medications---------------------------
Med: LIDOCAINE 0.5% W / EPI INJ MDV
Med: ASPIRIN 325MG TAB                 Dose Adm'd: 1 TAB

----------------------------------Medications----------------------
Adm'd By: 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
  ---------              ------                             -------------
```

1 Patch RA*5*10 April 2000
2 Patch RA*5*99 February 2010: Inserted the field ‘Pregnant at time of order entry.’

```
   MAY 19,2000  11:45     EXAM ENTRY                        RADPROVIDER5,FI
This is a technologist's comment on an exam. 1
   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 ***
                                                 Elapsed Time  Cumulative Time
  Status                 Date / Time                (DD:HH:MM)      (DD:HH:MM)
  ------                 ---------               ------------  ---------------
  WAITING FOR EXAM       MAY 19,2000  11:45        00:00:00        00:00:00
  CALLED FOR EXAM        MAY 19,2000  11:45
=================================================================
Do you wish to display exam report text? No /  /  N
```

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

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

Radiology / Nuclear Med Order Entry Menu – 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:

```
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 – option #1 - 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
```

Justification for Community Care – option #2 – 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
```

Justification for Community Care – option #3 – Veteran cannot travel to VA facility due to geographical inaccessibility

```
                            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
```

Justification for Community Care – option #4 – 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
```

Justification for Community Care – option #5 - Unusual or excessive travel burden, and sub-option #1 - 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
```

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
```

Justification for Community Care – option #5 - Unusual or excessive travel burden, and sub-option #2 – 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
```

Justification for Community Care – option #5 - Unusual or excessive travel burden, and sub-option #3 – 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
```

Justification for Community Care – option #5 - Unusual or excessive travel burden, and sub-option #4 - 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
          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, ETC.
```

```
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.

Radiology / Nuclear Med Order Entry Menu - Cancel a Request

This option allows users within Radiology / Nuclear Medicine to cancel a request. When an exam is cancelled, a reason must be entered for the cancellation.

When a request is cancelled, it is placed in the DISCONTINUED status. Only requests that have not been acted upon by Radiology / Nuclear Medicine may be cancelled. These include requests in the PENDING or HOLD status.
You will be prompted to select a patient. In the event that another person is editing orders for the patient you select, you may see a message asking that you try again later. If no one else is working on orders for that patient, a list of requests for the patient will be displayed, including the request status, urgency, procedure, request date, requester, and patient location.
Printouts of cancelled requests include the name of the person who cancelled the request.
Once you select a request to cancel, you will be asked the reason for cancellation. If a reason is not entered, the request is not cancelled.

When you cancel a request, the RAD / NUC MED REQUEST CANCELLED MailMan bulletin is sent to members of the RA REQUEST CANCELLED mail group, or other mail group set up by your IRM to receive this bulletin.

Prompt / **User Response** Discussion

```
Cancel a Request


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

Select CANCEL REASON: 8  INADEQUATE CLINICAL HISTORY        Synonym: INAD
   ...will now 'CANCEL' selected request(s)...
          ...ANGIO CAROTID CEREBRAL SELECT EXT UNILAT S&I cancelled...
   Task 39174: cancellation queued to print on device P-DOT MATRIX BACK
```

Radiology / Nuclear Med Order Entry Menu - Detailed Request Display

This option is identical to the Detailed Request Display option under the Patient Profile Menu. Please refer to that section of the manual for a description and sample.

Radiology / Nuclear Med Order Entry Menu - Hold a Request

This option allows users within Radiology / Nuclear Medicine to place a requested exam in the HOLD status. The user will be asked to select a reason from the Rad / Nuc Med Reason file (#75.2). Only requests with a status of pending or scheduled may be placed on HOLD.
You will be prompted to select a patient. In the event that another person is editing orders for the patient you select, you may see a message asking that you try again later. If no one else is working on orders for that patient, a list of requests for the patient will be displayed, including the request status, urgency, procedure, request date, requester, and patient location.
Once a request has been selected, you will be asked for a reason for putting the request on HOLD. If a reason is not entered, the request will not be placed on HOLD. When the request status is changed to HOLD, the RAD / NUC MED REQUEST HELD mail bulletin will be automatically sent to all members of the RA REQUEST HELD mail group, or other mail group set up by your IRM to receive this bulletin.

Prompt / **User Response** Discussion

```
Hold a Request


Select PATIENT NAME: RADPATIENT,TWO        07-06-46     000000624   YES  SC
VETERAN
               **** Requested Exams for RADPATIENT,TWO****     3  Requests
    St  Urgency  Procedure                    Desired Requester    Req'g Loc
    --  -------  -------------------------  ------- -----------  -----------
 1  s   ROUTINE  ARTHROGRAM SHOULDER S&I     04 / 03   RADPROVIDER,FOUR
EMERGENCY R
 2  s   ROUTINE  ARTHROGRAM WRIST S&I        04 / 03   RADPROVIDER,FOUR
EMERGENCY R
 3  p   ROUTINE  ANOTHER PARENT PROCEDURE    01 / 20   RADPROVIDER,FOUR   X-
RAY STOP

Select Request(s) 1-3 to Hold or '^' to Exit:  Exit /  /  1

Select HOLD REASON: ?? <RET>
Choose from:
   1              ANESTHESIA CONSULT NEEDED                Synonym: ANES
   2              AWAITING C.A.T. EXAM RESULTS             Synonym: CAT
   3              AWAITING NUC. MED. RESULTS               Synonym: NUC
   4              AWAITING ULTRASOUND RESULTS              Synonym: US
   5              CARDIOLOGY CONSULT NEEDED                Synonym: CARD
   9              MEDICAL CONSULT NEEDED                   Synonym: MED
   10             NEUROLOGY CONSULT NEEDED                 Synonym: NEUR
   12             OTHER HOLD REASON                        Synonym: OHR
   15             PATIENT TOO ILL FOR STUDY                Synonym: ILL
   16             REPEAT PATIENT PREP                      Synonym: REP
   18             SURGERY CONSULT NEEDED                   Synonym: SUR
   20             EXAM CANCELLED                           Synonym: CAN
   21             EXAM DELETED                             Synonym: DEL
```

```
   26              EQUIPMENT FAILURE                        Synonym: EQF
   27              PATIENT ATE                              Synonym: ATE
Select HOLD REASON: 18  SURGERY CONSULT NEEDED              Synonym: SUR
   ...will now 'HOLD' selected request(s)...
          ...ARTHROGRAM SHOULDER S&I held...
Select PATIENT NAME: <RET>
```

Radiology / Nuclear Med Order Entry Menu - Log of Scheduled Requests by Procedure

This option allows the user to generate a list of SCHEDULED requests sorted by procedure.
This is the same report that appears on the Daily Management Reports submenu of the Management Reports menu. Please refer to the description for that option for complete information about this report.

Radiology / Nuclear Med Order Entry Menu - Pending / Hold Rad / Nuc Med Request Log

This option will print a listing entitled Log of Pending Requests or Log of Hold Requests depending on selections made by the person generating the report. It is used to determine which requests have not yet been acted upon. The output will give, 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. 1 If there is no imaging location on the request, it will print under the UNKNOWN imaging location heading, but only if its imaging type matches one of the selected location's imaging types. 2 UNKNOWN imaging locations that belong to other imaging types will not be printed.
This will identify orders that have not been submitted to an imaging location because the division parameter, Ask Imaging Location (in field #.121 of the Rad / Nuc Med Division file #79), is set to NO.

Prompt / **User Response** Discussion

```
pending/Hold Rad/Nuc Med Request Log
```

1 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.
2 Patch RA*5*15 May 2000: NOIS: BHS-1199-12241

```
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>
```

Radiology / Nuclear Med Order Entry Menu - Print Rad / Nuc Med Requests by Date [1]

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.
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

---

1 Patch RA*5*47 September 2011: Print Rad / Nuc Med Requests by Date option is affected by the new Site Specific Accession Number (SSAN).

pregnancy screen comment at the time of the exam 1, 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:") 2, date / time ordered, date desired, reason for study 3, 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. 4

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. 5 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. 6
The output should be queued to a printer.

Prompt / **User Response** Discussion

```
Print Rad / Nuc Med Requests by Date


Select IMAGING LOCATION: X-RAY              (GENERAL RADIOLOGY)

Request Status Selection
------------------------
  Choose one of the following:
          Discontinued
          Complete
          Hold
```

1 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.'
2 Patch RA*5*26 July 2001: Additional text description.
3 Patch RA*5*75 June 2007: Added "reason for study" to the list.
4 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.
5 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.
6 Patch RA*5*18 November 2000: Additional fields printed on form.

```
          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 1                         Phone Ext  :
Sex          : MALE                         Room-Bed   : 724-D 2
Height (in.) : 66                           Height Date: JUN 15, 2015@10:00
Weight (lbs) : 165                          Weight Date: JUN 15, 2015@10:00
3
==============================================================================
Pregnant at time of order entry: NO4
Pregnancy Screen: Patient answered yes5
Pregnancy Screen Comment: This is the pregnancy screen comments.
Requested:            FOREARM 2 VIEWS (RAD Detailed) CPT: 73090
Procedure Modifiers:  LEFT6
Request Status:       PENDING (p)

Requester:            RADPROVIDER, SIX
Tel / Page / Dig Page: (777) 777-7777  /  777-7778  /  777-7779
Attend Phy Current:   UNKNOWN
```

1 Patch RA*5*75 June 2007: Added "at req(uest)" to patient age display.
2 Added Sex, Room-Bed to Order Entry example to reflect current view.
3 Patch RA*5*123 September 2015: Added Weight and Weight Date.
4 Patch RA*5*99 February 2010: Replaced the ‘Pregnancy Status’ field with the ‘Pregnant at time of order entry’ field.
5 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’
6 Patch RA*5*10 April 2000

```
Prim Phy Current:     UNKNOWN
Date / Time Ordered:    FEB 12,1997  10:48  by RADP,SIX
Date Desired:         FEB 12,1997
Reason for Study: 1    Patient has severe arm pain.

Clinical History:

 >> Rad / Nuc Med Consultation for X-RAY <<                APR  8,1997  16:07
==============================================================================
=
```

1 Patch RA*5*75 June 2007: Added Reason for Study line to report output example.

```
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 1
Weight (lbs) : 165                            Weight Date: JUN 15, 2015@10:00
2
==============================================================================
=
    Clinical History:
       Rule out fractures.
------------------------------------------------------------------------------
-
Date Performed: _________________________      Case No.: ______________________
3
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.
```

Radiology / Nuclear Med Order Entry Menu - Print Selected Requests by Patient 4

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 date when recorded), procedure, procedure message, contrast media associations5, 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:") 6, date / time ordered, desired

---

1 Added Sex, Room-Bed to Order Entry Example to reflect current view.
2 Patch RA*5*123 September 2015: Added Weight and Weight Date.
3 Patch RA*5*18 November 2000: "See above" appears following "Case No.:" when a case number(s) is shown previous to this point.
4 Patch RA*5*47 September 2011: Print Selected Requests by Patient option is affected by the new Site Specific Accession Number (SSAN).
5 Patch RA*5*45 May 2005: Rad / Nuc Med Requests by Patient displays contrast media, if appropriate
6 Patch RA*5*26 July 2001: Additional text explanation.

date, reason for study 1, 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 order 2, instead of not displaying a pregnancy status, 'Pregnant at time of order entry:' 3 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. 4

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. 5 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.6
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**

```
Select PATIENT NAME:    RADPATIENT,SIX   12-12-33  000009812     NO
ALLIED VETERAN7

 Enrollment Priority: GROUP 5    Category: IN PROCESS    End Date:

                **** Requested Exams for RADPATIENT,SIX ****          14
Requests
```

1 Patch RA*5*75 June 2007: Added "reason for study" to the list of data.
2 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.
3 Patch RA*5*99 February 2010: Replaced the 'Pregnancy Status' field with 'Pregnant at time of order entry.'
4 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: 'Pregnancy Screen' and 'Pregnancy Screen Comment.'
5 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.
6 Patch RA*5*18 January 2001: Additional fields printed on form.
7 Patch RA*5*45 May 2005: Added new Prompt / User response.

```
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
1
=====================================================================
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  :2 71                         Phone Ext  : 444-444-4444
Sex           : MALE
Pregnant at the time of order entry: Yes3
PREGNANCY SCREEN:  Patient answered yes.4
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
```

1 Patch RA*5*45 May 2005: New sample report output, showing contrast media notifications.
2 Patch RA*5*75 June 2007: Added "at req(uest)" to patient age display.
3 Patch RA*5*99 February 2010: Replaced the ‘Pregnancy Status’ field with ‘Pregnant at time of order entry.’
4 Patch RA*5*99 February 2010: Inserted two pregnancy screen fields: ‘Pregnancy Screen’ and ‘Pregnancy Screen Comment.’

```
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: 1    Patient reports severe arm pain
```

1 Patch RA*5*75 June 2007: Added Reason for Study line to sample report output, updated sample data.

```
Ordering Diagnoses  1   |
  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.         _____________
```

1 Patch RA*5*41 September 2005: Added Ordering diagnoses and Clinical Indicators to sample report output.

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 1, 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

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.
```

1 Patch RA*5*45 May 2005: Contrast media associations will display, if appropriate

Radiology / Nuclear Med Order Entry Menu - Request an Exam [1]

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.[2]
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." [3] (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 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.

---

1 Patch RA*5*47 September 2011: Request an Exam option is affected by the new Site Specific Accession Number (SSAN).
2 Patch RA*5*41 September 2005: New instructions added.
3 Patch RA*5*41 September 2005: Deleted reference to ORES key, added new prompt description.

You will be prompted for procedure modifiers 1, date desired, reason for study 2, 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.

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. 3 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

---

1 Patch RA*5*8 October 1999

2 Patch RA*5*75 June 2007: Edited section to include reason for study and update clinical history description.

3 Patch RA*5*41 September 2005: New prompt description.

Radiation, Southwest Asia Conditions. 1 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.2 You may answer No, Yes, or Unknown. Your answer will appear in the pregnancy status notation of the printed request form.

If your division parameter Ask Imaging Location? is set to Yes, you will see a SUBMIT REQUEST TO: prompt at which you should select an imaging location where the request form will be printed.
Only imaging locations whose imaging type matches the imaging type of the procedure selected can be chosen. If IRM has defined a printer for request printout through the IRM menu of this package, a request form will print on that printer. (See *Technical Manual* for information about setting up printers for imaging locations.)

Prompt / **User Response** Discussion

```
Request an Exam


Select PATIENT NAME: 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
```

1 Patch RA*5*70 March 2009: Changed the "Environmental Contaminants" to "Southwest Asia Conditions", added
"PROJ 112 / SHAD"
2 Patch RA*5*99 February 2010: Replaced the 'PREGNANT' prompt to 'PREGNANT AT TIME OF ORDER ENTRY.'

```
Copy a previous order's ICD codes and SC / EI values? NO /  / YES 1
#          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

This test is designed to LOCATE the site of KNOWN GI bleeding, NOT to
determine whether there IS GI bleeding.
Select PROCEDURE MODIFIERS: ASAP 2
Select PROCEDURE MODIFIERS: <RET>
DATE DESIRED (Not guaranteed): T  <RET> 3  (APR 09, 2007)
PREGNANT AT TIME OF ORDER ENTRY: YES 4
REASON FOR STUDY: Patient reports severe abdominal pain, blood in stool 5
   Clin Hx must be appropriate for a procedure

CLINICAL HISTORY FOR EXAM
```

1 Patch RA*5*41 September 2005: New prompt to Copy a previous order's ICD codes and SC / EI values.
2 Patch RA*5*10 April 2000
3 Patch RA*5*75 June 2007: Removed "Today" default from Desired Date field – user must now enter a date.
4 Patch RA*5*99 February 2010: Inserted the 'PREGNANT AT TIME OF ORDER ENTRY' prompt.
5 Patch RA*5*75 June 2007: Added Reason for Study prompt and sample text.

```
==[ WRAP ]==[ INSERT ]===< Clinical History 1 >======[ <PF1>H=Help ]====
Blood in stool; hx of ulcers.

<======T=======T=======T=====
Primary Ordering ICD-9 Diagnosis: 2 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 3
 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 4
Was treatment related to PROJ 112 / SHAD?  /  /  NO

Secondary Ordering ICD-9 Diagnosis:
----------------------------------------------------
Patient: RADPATIENT,SEVEN     Pregnant at time of order entry:  YES5
    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:6
Patient reports severe abdominal pain, blood in stool

Primary Ordering ICD-9 Diagnosis:7    BLOOD IN STOOL  578.1
SC Related? YES                    CV Related? YES
```

1 Patch RA*5*75 June 2007: Removed "Reason" from Clinical History report title, added sample text.
2 Patch RA*5*41 September 2005: New prompts added.
3 Patch RA*5*70 March 2009: Prompt changed - “Environmental Contaminants” to “Southwest Asia Conditions”,
added - “PROJ 112 / SHAD”.
4 Patch RA*5*70 March 2009: Prompt changed - “Environmental Contaminants” to “Southwest Asia Conditions”,
added - “PROJ 112 / SHAD”
5 Patch RA*5*99 February 2010: Replaced the ‘Pregnant’ field with ‘Pregnant at time of order entry.’
6 Patch RA*5*75 June 2007: Added Reason for Study to the display.
7 Patch RA*5*41 September 2005: New display example.

```
AO Related? NO                      IR Related? NO
SWAC Related? NO1                    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 /  /  2
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. 3

Prompt / **User Response** Discussion

```
Request an Exam

Select PATIENT NAME: RADPATIENT,FOUR     4-14-73    000000444       NO
EMPLOYEE
```

---

1 Patch RA*5*70 March 2009: Changed EI to SWAC, Added SHAD Related? No
2 Patch RA*5*99 February 2010: Inserted the 'PREGNANT AT TIME OF ORDER ENTRY' prompt.
3 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.

```
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.
------    ---------------------------- ---------   --------------  ----------
--
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, Gastrografin,
unspecified contrast media
************************************************************
Select PROCEDURE MODIFIERS: PORTABLE EXAM
Select PROCEDURE MODIFIERS: <RET>
```

```
    DATE DESIRED (Not guaranteed):1  T <RET>  (APR 10, 2007)
PREGNANT AT TIME OF ORDER ENTRY: YES2
REASON FOR STUDY:3 Patient reports severe abdominal pain

   Clin Hx must be appropriate for a procedure

CLINICAL HISTORY FOR EXAM

==[ WRAP ]==[ INSERT ]========< Clinical History 4 >=======[ <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:  YES5
        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
```

1 Patch RA*5*75 June 2007: Removed "Today" default from Desired Date field – user must now enter a date.
2 Patch RA*5*99 February 2010: Inserted the ‘PREGNANT AT TIME OF ORDER ENTRY’ prompt.
3 Patch RA*5*75 June 2007: Added Reason for Study prompt to the sample order and summary.
4 Patch RA*5*75 June 2007: Removed "Reason" from Clinical History report title.
5 Patch RA*5*99 February 2010: Replaced the ‘Pregnant’ field with ‘Pregnant at time of order entry.’

```
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: NO1
DATE DESIRED (Not guaranteed): Apr 10, 2007 /  /    (APR 10, 2007)
REASON FOR STUDY: Patient reports severe abdominal pain2

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
```

Radiology / Nuclear Med Order Entry Menu - Schedule a Request

This option allows the user to schedule requested examinations for a specific date / time. An order must already have been requested through the Request an Exam option. Only requests with a status of HOLD or PENDING are eligible for scheduling. You will be asked to select a patient. In the event that another person is editing orders for the patient you select, you may see a message asking that you try again later. If no one else is working on orders for that patient, a list of requests for the patient will be displayed, including the request status, urgency, procedure, desired date, requester, and patient location.
A selection prompt will ask which request should be scheduled, then you will be asked to enter the date and time you wish to schedule the procedure.

> **Note:** Scheduling in the Radiology / Nuclear Medicine package is accomplished through this option. Scheduling in the 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
```

1 Patch RA*5*99 February 2010: Inserted the 'PREGNANT AT TIME OF ORDER ENTRY' prompt.
2 Patch RA*5*75 June 2007: Added Reason for Study prompt to the display.

```
    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>
```

Radiology/Nuclear Med Order Entry Menu – 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>
```

Radiology / Nuclear Med Order Entry Menu - Ward / Clinic Scheduled Request Log

This option allows the user to generate a list of SCHEDULED requests for patients on a selected ward or clinic. The list includes the following information: patient name, patient ID, scheduled date, procedure and imaging location if the request was submitted to a specific imaging location. If the Ask Imaging Location parameter (field #.121 of the Rad / Nuc Med Division file #79) is set to YES the imaging location will be asked when the order is created.

If the parameter field is set to NO, the imaging location will not be captured, if there is more than one imaging location for the same imaging type to choose from. 1 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.

---

1 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.

Order Entry

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
------------------- -----   -------------  ------------  --------------
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 Menu 1
- 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 2
- 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

Supervisor Menu - Access Uncorrected Reports 3

---

1 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*.

2 Patch RA*5*56 July 2008: Added a new option, Restore a Deleted Report, to the Supervisor menu.

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

Supervisor Menu

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 1 (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:
```

1 Patch RA*5*45 May 2005: Supervisor Menu / Access Uncorrected Reports display contrast media, if applicable.

```
  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
**********************
None entered.
```

Supervisor Menu - Delete a Report 1

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. 2
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 IRM to receive the RAD / NUC MED REPORT DELETION bulletin.
Example
Delete a report shared by three cases (printset). The deletion session outwardly appears the same as before patch RA*5*56:

```
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
```

1 Patch RA*5*47 September 2011: Delete a Report option is affected by the new Site Specific Accession Number (SSAN).
2 Patch RA*5*56 July 2008: Modified the information about the Delete a Report option.

```
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'.
```

Supervisor Menu - Delete Printed Batches By Date

This option allows the user to delete batches. The option purges all records up to a user defined date. This purges records by date printed, not by the users who created the batch. This option can only be accessed by those users who hold the RA MGR key. All batches prior to the date you select will be purged from the Report Batches file #74.2. After you select a date, the system will inform you how many batches will be deleted and ask if you want to task the job, to be completed at a later time.
If you answer Y to include unprinted batches, batches without a Date Printed will also be displayed.

Prompt / **User Response** Discussion

```
Delete Printed Batches by Date


     All batches up to the date you enter will be purged
     from the Report Batches file #74.2.
Purge report batches printed before: APR 10,1995 /  / 4 / 1 / 95  (APR 01,
1995)
Want to include unprinted batches created before APR 1,1995? No /  /  <RET>
NO
The following Report Batches have been selected to be purged:
   Batch: 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

     'APR 1,1995', are you sure?

Enter Yes or No: YES

     There are 4 batches selected to be deleted.
     Do you wish to task this job off to be completed
     at a later time?

Enter Yes or No: YES
Requested Start Time: NOW /  /  <RET> (APR 10, 1995@09:34:57)
```

Supervisor Menu - Exam Deletion [1]

This function allows holders of the RA MGR security key to delete exams from the system. This function should only be used by authorized personnel to correct problems that cannot be corrected in any other way. Deletion of an exam means permanent, non-retrievable deletion of exam data.
This differs from the Cancel an Exam option where the exam data remains accessible to the user. Use of the Cancel an Exam option should be considered before using the Exam Deletion option. This option would be useful if a clerk registers an exam for the wrong patient, the exam is not performed and s / he asks the supervisor to delete it before any more action is taken.
When this function is executed, the RAD / NUC MED EXAM DELETED mail bulletin is sent to members of the RADIOLOGY EXAM DELETED mail group , or other mail group set up by IRM, to notify them of the exam deletion.
Deletion of an exam is prohibited if the exam has an associated report. The report must be deleted first before the exam can be deleted.
Once the examination is DELETED, the user will be prompted to answer with a YES or NO to cancel the request associated with this exam. If YES, the request will also be cancelled and the request status updated to CANCELLED.
If NO, the request status will be updated to HOLD and may be selected for registration at a future date. If the request applies to a parent procedure, for which other descendent procedures are registered, you will not be allowed to HOLD or cancel (i.e., DISCONTINUE) the request.

Supervisor Menu - Exam Deletion

Prompt / **User Response** Discussion

Note: An exam with a status of Complete cannot be deleted:

```
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
```

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

```
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=======T=======TT=======T=======T=======T=======T=>=====T
          ...request status updated to hold.
      ...exam status backed down to 'CANCELLED'
          ...deletion of exam complete.
```

Supervisor Menu - Inquire to File Entries

This option is used to display all the data for one or a small number of specified entries in a file. This is useful for a quick look at an entry. Use the Print File Entries option for larger numbers of entries.
This option is the same as using the VA FileMann Inquire to File Entries option, so it is necessary that the user be assigned all appropriate file access codes by his / her IRM. You will be prompted for a file name and then, one by one, the entries in the file you wish to view.
Since new versions of the FileMan software affect the behavior of this option, no example is shown here. For examples and assistance in using this option, refer to the FileMan User Manual.

Supervisor Menu - List Exams with Inactive / Invalid Statuses

This option will list all exams which are linked to an exam status which is invalid. An exam status is inactive / invalid if the value in the Order field is null. This could happen if the ADPAC deactivates the status while some exams are still in that status.
The report generated shows the exam status, imaging type, and for each exam with the invalid status, the patient name and SSN, exam date, case number, and procedure.
Case edits or Status Tracking can be used to update to valid statuses.

Prompt / **User Response** Discussion

```
List Exams with Inactive / Invalid Statuses

DEVICE: HOME /  /  <RET>  SET HOST

                                                        Page 1
```

```
                                                Date: APR 11,1997
                      Exams with Inactive / Invalid Statuses
=====================================================================
Exam Status: EXAMINED                          Imaging Type: ULTRASOUND
***********                                    ************
Patient: 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
```

Supervisor Menu - Override a Single Exam's Status to 'complete' 1

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 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).

```
   --------  -------------                ---------  ---------------- --------
---
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
 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.
```

Supervisor Menu - Print File Entries

This option is used to print a report from a file, where a number of entries will be listed in a columnar format. Each column can be individually controlled for format, tabulation, justification, etc. The Print File Entries option is often used to generate ad hoc reports. This option is the same as using the VA FileMan Print File Entries option, so it is necessary that the user be assigned all appropriate file access codes by his / her IRM. This FileMan utility is extremely powerful and can interpret a large set of instructions about entry retrieval and print formatting.
Since new versions of the FileMan software affect the behavior of this option, no example is shown here. For examples and assistance in using this option, refer to the FileMan User Manual.

Supervisor Menu - Restore A Deleted Report [1] [2]

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 /  /
```

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.

---

1 Patch RA*5*56 July 2008: Added information about the Restore a Deleted Report option.
2 Patch RA*5*47 September 2011: Restore a Deleted Report option is affected by the new Site Specific Accession Number (SSAN).

```
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
   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.
```

Supervisor Menu - Search File Entries

This option is used to search file fields for specific data. It allows the user to specify the search logic for multiple fields and obtain a more specific set of entries than the Inquire to File Entries or Print File Entries options.
This option is the same as using the VA FileMan Search File Entries option, so it is necessary that the user be assigned all appropriate file access codes by his / her IRM. This FileMan utility is extremely powerful, but can be an intensive computer resource drain, so it should be used with care, preferably in off hours if the file being searched contains a large number of entries.
Since new versions of the FileMan software affect the behavior of this option, no example is shown here. For examples and assistance in using this option, refer to the *FileMan User Manual.*

Supervisor Menu - Switch Locations

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

Supervisor Menu - Unverify a Report for Amendment [1]

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

---

1 Patch RA*5*47 September 2011: Unverify a Report for Amendment option is affected by the new Site Specific Accession Number (SSAN).

status must be changed before any corrections can be made. If this option is being used frequently, it usually means that procedures for reviewing reports before verifying them are inadequate. This option should be used rarely, if at all.
You will be prompted for a report date / case number. Only reports with a status of VERIFIED can be selected. If you enter a patient name, you will be prompted to select from a list of eligible reports.
After selecting a report, the valid status choices are DRAFT, PROBLEM DRAFT, VERIFIED, or, if your ADPAC has the division parameters set to allow it, RELEASED / NOT VERIFIED.
The RAD / NUC MED REPORT UNVERIFIED MailMan bulletin will be sent to members of the RADIOLOGY REPORT UNVERIFIED mail group or other mail group set up by IRM each time a report is unverified through this option. The entire contents of the report prior to unverification are copied for permanent retention and are accessible through the Supervisor Menu, Access Uncorrected Reports option.

Note: If Report Status is changed to PD, you will be prompted for a Problem Statement.

Prompt / **User Response** | Discussion

```
Unverify a Report for Amendment

Select RAD / NUC MED REPORTS DAY-CASE#:
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
```

Supervisor Menu - Update Exam Status 1

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.
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 13.
Update Patient Record

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

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: O  OUTPATIENT
NARRATIVE: ??
     This field may contain a brief note (up to 250 characters) about
     this Radiology / Nuclear Medicine patient. It may describe the
personality
     or any unusual characteristic to identify this Radiology / Nuclear
Medicine
     patient.
NARRATIVE: Aggressive, independent, stubborn
CONTRAST MEDIUM ALLERGY: NO /  /  ??
     The value in this field is used to indicate if this Radiology
      / Nuclear Medicine patient has had an allergic reaction to the contrast
     medium during a Radiology / Nuclear Medicine procedure.  It may contain
a
     'Y' for YES, or 'N' for NO.  If YES, then a warning message is
     displayed to the receptionist whenever this patient is
     registered for a procedure that may involve contrast material.
     CHOOSE FROM:
      Y        YES
      N        NO
CONTRAST MEDIUM ALLERGY: NO /  /  <RET>
```

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[1]
- Switch Locations
- Test Label Printer

User Utility Menu - Duplicate Dosage Ticket [2]

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
```

1 Patch RA*5*35 December 2002: Added new option.
2 Patch RA*5*47 September 2011: Duplicate Dosage Ticket option is affected by the new Site Specific Accession Number (SSAN).

```
                          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
Form                     : Liquid
Lot No.                  : 6138P
Kit No.                  :
Lot Expiration Date      : APR 01, 1999

Date / Time of Measurement: SEP 08, 1997@08:31
Dose Prescribed          : Low: 18 mCi   High: 22 mCi
Activity Drawn           : 21.2 mCi
Dose Administered        : 21.2 mCi
Time of Administration   : SEP 08, 1997@08:31

Signature of Person Measuring Dose: ____________________________________________
```

User Utility Menu - Duplicate Flash Card 1

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 IRM through the Device Specifications for Imaging Locations option, you will be prompted for a device. This should be queued to a printer.
Prompt **/ User Response** Discussion

1 Patch RA*5*47 September 2011: Duplicate Flash Card option is affected by the new Site Specific Accession Number (SSAN).

```
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
```

User Utility Menu - Jacket Labels [1]

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).

1 Patch RA*5*47 September 2011: Jacket Labels option is affected by the new Site Specific Accession Number (SSAN).

If a jacket label printer has not been defined by IRM through the Device Specifications for Imaging Locations option, you will be prompted for a device. This should be queued to a printer.

Prompt / **User Response** Discussion

```
Jacket Labels

Select Patient: 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
```

User Utility Menu - Print Worksheets

This function allows the user to print any number of worksheets needed.
These worksheets are designed to be used by an imaging department that does not have enough terminals to capture exam status in a real-time mode.
These worksheets should accompany the exam requisition as it proceeds through the department. As the exam status changes, the appropriate entries on the worksheet should be made.
The data captured on the sheets should then be entered in a batch mode later in the day, when terminals are available.
The worksheets should be printed on a 132-column device.

Prompt / **User Response**	Discussion

`Print Worksheets`
 	
`  ***  RADIOLOGY / NUCLEAR MEDICINE WORKSHEETS ***`	

	`The worksheet cannot be displayed on a terminal. It must be sent to a printer.`

`Enter the number of worksheets needed: 1`
 	
`NOTE: This output should be sent to a printer that supports 132 columns.`
 	
`DEVICE: HOME /  /  LINE  COMP. ROOM  RIGHT MARGIN: 132 /  /  <RET>`
`DO YOU WANT YOUR OUTPUT QUEUED? NO /  /  Y (YES)`
 	
`Requested Start Time: NOW /  /  <RET>  (MAR 31, 1995@15:43:59)`
`  Request Queued.  Task #: 11574`	

```
                    RADIOLOGY / NUCLEAR MEDICINE WORKSHEET
-------------------------------------------------------------------------------
|  |                                |                                         |
|  |  VAMC HINES CIO FIELD OFFICE   |                                         |
|  |  DATE  _____________ AGE ______ |     TIME:  ______________________       |
|  |  SSN   _____________ TCH ______ |     LAST EXAM:  _________________       |
|  |  NAME  _____________            |     WARD OR OTHER:  _____________       |
|  |--------------------------------|                                         |
|                                                                             |
|                                                                             |
|                                                                             |
|     AMIS        |     DESCRIPTION       |     TECH  |     DIAG.|      M.D.  |
|-----------------------------------------------------------------------------|
|                 |                       |           |          |            |
|                 |                       |           |          |            |
|-----------------------------------------------------------------------------|
|                 |                       |           |          |            |
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                                                DATA ENTRY CLERK:
```

User Utility Menu - Set preference for Long Display of Procedures [1]

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
```

1 Patch RA*5*35 December 2002: Added new option, description, and example.

```
Your preference for Long Display of Procedures has been removed.
```

User Utility Menu - Switch Locations

This option appears on several menus as a convenience to users. Please refer to the option description earlier in this section where it first appears under Use of the Software on page 13

User Utility Menu - Test Label Printer

This function allows the user to test a label printer by printing out a label in the default format. This option would be used to check the alignment of a device before printing actual labels.

Prompt / **User Response**	Discussion

```
Test Label Printer

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

Patient Name: 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
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 transfering 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 mismatchs 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 patchs) are continuely available.

Sites may elect to retrieve software directly from a specific server using Attachmate Reflection (Using Secure Shell) or the Command prompt.

When using **Attachmate Reflection:**

Albany	fo-albany.med.va.gov
Hines	fo-hines.med.va.gov
Salt Lake City	fo-slc.med.va.gov

```
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.
```

Special Notes

```
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. Or if you would like, sites may elect to retrieve software directly from a specific 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.
```

Albany	anonymous@ftp.fo-albany.med.va.gov
Hines	anonymous@ftp.fo-hines.med.va.gov
Salt Lake City	anonymous@ftp.fo-slc.med.va.gov

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.

BI-RADS™ [1]	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.

1 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.

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) 1	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.

1 Patch RA*5*56 July 2008: Added a definition for the ‘Deleted’ status.

Electronically Filed (EF) [1]	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.

1 Patch RA*5*56 July 2008: Added a definition for the 'Electronically Filed' status.

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 [1]	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: • ANGIO / NEURO / INTERVENTIONAL • GENERAL RADIOLOGY • MAMMOGRAPHY • NUCLEAR MEDICINE • ULTRASOUND • VASCULAR LAB • CARDIOLOGY STUDIES (NUC MED) • CT SCAN • MAGNETIC RESONANCE IMAGING 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.

1 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 (IRM)	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.
IRM	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.

No purge indicator	A flag that can be set on the exam record to force the purge process to bypass the record. Guarantees that the record will not be purged when a historic data purge is scheduled by IRM. Also see Purge.
Non-credit stop code	Certain stop codes, usually for health screening, that do not count toward workload credit. If a non-credit stop code is assigned to a procedure, another credit stop code must also be assigned. Also see Stop code.
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.

Procedure message	Represented in this system by entries in the Rad / Nuc Med Procedure Message file (#71.4). If one or more procedure messages are associated with a procedure, the text of the messages will be displayed when the procedures is ordered, registered, and printed on the request form. Useful in alerting ordering clinicians and imaging personnel of special precautions, procedures, or requirements of a given procedure.
Procedure Type [1]	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 IRM to purge historic computer data. In this system, purges are done on results report text, orders, activity logs, and clinical history.
Registration (of an exam)	The process of creating a computer record for one or more patient / procedure / visit date-time instances. Usually done when the patient arrives at the imaging service for an exam.
Relative Value Unit (RVU) [2]	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.

1 Patch RA*5*79 February 2007: Updated definition of Procedure Type.
2 Patch RA*5*64 July 2006: Added glossary entry for RVU.

Report status [1]	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.
Scaling Factor [2]	A multiplier that is used to adjust for the over-estimating the effort of reading CT and MRI and under-estimating the effort of reading General Radiology and Nuclear Medicine in comparison with plain films. The Radiology package uses SCARD (Society of Chairmen in Academic Radiology Departments) multipliers, or scaling factors, to more accurately compute personal productivity.
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.

1 Patch RA*5*56 July 2008: Added Electronically Filed and Deleted to the report status definition.
2 Patch RA*5*64 July 2006: Added glossary entry for Scaling Factor.

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) 1	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)
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.

1 Patch RA*5*47 September 2011: Added Site Specific Accession Number (SSAN) to the Glossary.

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. 1
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.

1 Patch RA*5*67 April 2006: Added Verification Timeliness report description.information to Verification entry.

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) 1	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.

1 Patch RA*5*64 July 2006: Added glossary entry for wRVU.

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