STAR 2000™

STAR LABORATORY REFERENCE GUIDE
Maintenance Worksheets Volume

Preface

Maintenance Worksheets Volume is one volume in the STAR Laboratory Reference Guide series. It provides detailed information concerning how to build your system using the maintenance processors.

The *General Information Volume* is prerequisite reading for all other volumes of the *STAR Laboratory Reference Guide*. Successful use of the *Maintenance Worksheets Volume* depends upon your knowledge of the concepts covered in the *General Information Volume*.

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Introduction

The Maintenance Worksheets are used to design your STAR Laboratory system prior to the system build. Following the 19 chapters of worksheet instructions and the appendix, blank worksheet forms are provided. Use these blank master forms to make the necessary copies to complete your STAR Laboratory system.

Chapter 1: Flags/Utilities

This chapter contains the worksheets that are used to collect system- and department-wide information.

Chapter 2: Tables

This chapter contains the worksheets that are used to define laboratory-specific information.

Chapter 3: Employee Files

This chapter contains the worksheets that are used to define information pertaining to laboratory employees.

Chapter 4: Menus

This chapter contains the worksheets used to define the laboratory main menu, section menus, bay menus, and result menus.

Chapter 5: Main Test Information

This chapter contains the worksheets that are used to define specific data elements of test files.

Chapter 6: Supporting Test Files

This chapter contains the worksheets that are used to define the files necessary for test processing and resulting.

Chapter 7: Equipment/Instruments

This chapter contains the worksheets and instructions for building your equipment and instrument files.

Chapter 8: Workload

This chapter contains the worksheets that are used to design how workload accumulates in the laboratory department.

Chapter 9: Quality Control

This chapter contains the worksheets that are used to define quality control information for the laboratory's equipment and samples.

Chapter 10: Spooler And Printer Matrix

This chapter contains the worksheets that are used to define spooler and printer information.

Chapter 11: Patient Reports

This chapter contains the worksheets that are used to define the parameters and files necessary for STAR Laboratory Patient Reports.

Chapter 12: Collection Walk Order

This chapter contains the worksheets that are used to define the order in which batch collection labels print by assigning nursing stations to groups. Within a nursing station, print order can be further specified by room and bed.

Chapter 13: Archiving Parameters

This chapter contains the worksheets that are used to design the archiving parameters for your STAR Laboratory system.

Chapter 14: Test Code Lookup Parameters

This chapter contains the worksheets that are used to define the Test Code Lookup Parameters for your STAR Laboratory system.

Chapter 15: Sales Commission

This chapter contains the worksheets that are used to define the Sales Commission information for your STAR Laboratory system.

Appendix A: Base Tables Listing

This appendix contains a list of the STAR Laboratory base tables and their contents.

Appendix B: Worksheet Forms

This appendix contains blank worksheet forms for STAR Laboratory. Please do not write on these forms; use these forms to copy enough worksheets to complete your system.

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Chapter 1 - Flags/Utilities

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SYSTEM OPTIONS

System Options are separately priced modules. Use these flags to indicate the modules your laboratory has purchased. Your McKesson installer will set these flags for you.

MULTIPLE DEPARTMENTS AND/OR MULTIPLE FACILITY
Check Yes if you purchased multifacility or multidepartment.

RELEASES
Check Yes if you are on a release contract.

ADVANCED MICROBIOLOGY
Check Yes if you purchased the Advanced Microbiology module.

ADVANCED BLOOD BANK INTERFACE
Check Yes if you purchased the Advanced Blood Bank System interface.

REFERENCE LAB INTERFACE
Check Yes if you purchased the Reference Lab interface.

ANATOMIC PATHOLOGY
Check Yes if you purchased the Anatomic Pathology module.

TEXT PROCESSING MODULE?
Check Yes if you purchased the Soft-Key Editor word-processing software.

REVIEW REPORTS (SPECIAL SEARCHES)
Check Yes if you purchased the Review Reports software.

REPORT WRITER
Check Yes if you purchased the Report Writer module.

CONTRACT BILLING
Check Yes if you purchased the Contract Billing module.

NETWORKED SYSTEM
Check Yes if you are networked to STAR Patient Care.

SQL
Check Yes if you purchased the K-based SQL systems.

INSTRUMENT LICENSES
Indicate how many instrument interface licenses you purchased.

MULTIPLE ABB TESTS PER ACCESSION
Allows multiple Blood Bank tests per Accession number.

GENERAL DEPARTMENT FLAGS

Complete a separate form for each department.

DEPARTMENT CODE/NAME
Enter the three-letter code for the department followed by the name of the department.

NOTE: The Lab LIVE and Advanced Micro Live fields in the Flags - General Department maintenance functions processor can only be changed by your McKesson representative. Those fields are not part of this worksheet. For more information, see your McKesson representative.

PRINTER MATRIX
Check Yes if Printer Matrix will be used in this department. Printer Matrix enables you to route specific report types to any system printer based on routing criteria. Report types include collection labels and primary reports. Each report type can be routed separately.

TABLE DISPLAY OF SECTIONS
Check Yes to display a table of sections at sign-on instead of the Main Menu. The Main Menu can only contain 16 options or less. Therefore if there are more than 16 sections created for the laboratory, check Yes (to set this flag to Yes if there are more than 16 sections).

NOTE: You cannot attach Functions to a table display. Functions can only be added to a menu. Therefore, to attach functions, such as Patient Inquiry, this field should be set to No.

ADVANCED BLOOD BANK INTERFACE
This flag cannot be set to Yes unless the System flag for Advanced Blood Bank Interface is also set to Yes. Set this field to activate the Advanced Blood Bank Interface for this department. The following prompt displays:

Select ABB interface Western Star(W) Hemocare(H) HL7(L) or None(N) [N]--

The options are LifeLine® (that is, Western Star) (W), Hemocare® (H), HL7® (L), or None (N).

REFERENCE LAB INTERFACE
Check Yes if you purchased the Reference Lab interface. This flag cannot be set to Yes unless the System flag for Reference Lab Interface is also set to Yes.

CANCEL UNCOLL MIDNIGHT
This field controls activation of the Pending Order Cancellation process which automatically cancels uncollected orders on inpatients at midnight of the day of discharge. Check Yes to activate Pending Order Cancellation. There is no default.

CHARGE SCHEME
Define the charge scheme for your laboratory by checking Order for Charge on Order, Accession for Charge on Accession, or Resulting for Charge on Result/Report. The default response is Charge on Order. If you are networked with STAR Patient Care, this flag should be defined in conjunction with the flags defined on STAR Patient Care.

NOTE: The flag on STAR Patient Care system must be set appropriately when implementing any of the Charge schemes.

If the Charge on Result/Report option is selected in this field, all tests must have Charge Components/Reports defined before this can be implemented.

MISCELLANEOUS CHARGES TO HIS
Indicate if miscellaneous charges and credits are to pass from STAR Laboratory to STAR Patient Care or to your HIS. Enter **Y** for Yes or **N** for No. There is no default response.

DEFAULT CHARGE LOCATION CODE
Access to this field is denied if the field, Misc Charges to HIS, is set to No. If the Misc Charges to HIS field is set to Yes, define the default charge location to use for miscellaneous charges passed to STAR Patient Care or your HIS when the charges are generated as a result of Anatomic Pathology and/or Advanced Microbiology test processing. This field is completed by entering the charge location code or selecting from a table display of charge location codes.

DUPLICATE/CONFLICT CHECKING
To activate Duplicate/Conflict Checking in STAR Laboratory's Order Entry processor, enter **Y** on the worksheet. In addition to setting this flag, you must define duplicates and conflicts for each test code.

DUP/CONF COLLECTION RETENTION DAYS
If you activate duplicate/conflict checking, enter the number of days that the duplicate/conflict check file is retained.

REPORT CLINICAL QUESTIONS
This field determines if any Clinical Order detail information prints on any Laboratory reports. The Clinical Questions Active field must be set to Yes for you to access this field. Entering **Y** sets this field to Yes and for patient reports, the system follows the specification's setup for the individual test/reports. All administrative reports - Incomplete, Worklists, Collections Summary, Daily Culture, and Archive Summary print all Clinical OrderDetail information, despite the ordered test flags. Entering **N** sets this field to No, which overrides any printing specifications for Clinical Order Questions setup through other options. No Clinical Order Detail information prints despite how it is defined in the SIM file for the test or for the Clinical Ordering Questions on any Laboratory report. The default for this field is *No*.

The system displays the following prompt:

Print clinical questions on patient reports? (Y/N) [N]

PANIC NOTIFICATION
This field determines if notification of panic processing is required prior to accepting results in result reporting. Entering **N** sets this field to *No* and the result may be accepted without answering the *Reported Results to* field in the Panic Notification screen. Entering **Y** sets this field to *Yes* and the panic notification field, *Reported Results to* must be answered before the results can be accepted. When this field is set to Yes and the *Reported Results to* field is not answered, the following prompt appears, forcing the user to result the field:

Panic values reported! Reject all test results? (Y/N) [N]--

FLAGS - CARDFILE

History Cardfile is an online file storage system for maintaining results of specific test codes. Cardfile results, such as anatomic pathology diagnoses, blood types and antibody screens, may be viewed, printed, and searched through Patient Inquiry even after the test has been archived.

As tests are resulted, selected results are automatically added to the cardfile. Previously resulted tests can also be added to the cardfile (backloaded). Cardfile flags control the backloading process.

Complete a separate form for each department.

SECURITY LEVEL (2-N-R)
Indicate the minimum security level required to enter and result accessions for backloading previous tests within the Cardfile. If clerical personnel will be entering previous cases, it is advisable to set a low security level to allow them access and then reset it to a higher level once backloading is complete.

QUEUE RETENTION DAYS (1-N-R)
STAR Laboratory retains the cardfile print queue for reprinting. Indicate the number of days (zero to seven) to retain the queue before automatic deletion via Midnight Processing. For more information on cardfile print queue functionality, refer to Chapter 15: History Cardfile in the *General Applications Volume II* of the *STAR Laboratory Reference Guide*.

STATUS RETENTION DAYS (2-N-R)
Indicate the number of days (one to 30) for the status of previously entered cases to remain Backload. Once this number is reached, Midnight Processing changes the status from Backload to Cardfile. The accession cannot be edited once Cardfile status is reached.

ENDING ACCESSION NUMBER (10-N-R)
Indicate the highest accession number that can be used for accessioning previous cardfile cases.

NOTE: The system starts accession numbers for backloading at 9000000000 and allows up to 9999999999. Most laboratories set this field to the highest allowed, 9999999999.

FLAGS - COLLECTION BATCH

Automatic collection batch creation depends on the following flags. Your laboratory uses these flags to set parameters to define how and when automatic collection batch generation occurs.

Complete one worksheet for each department in your laboratory.

CREATE BATCH - PARAMETERS

TIMEFRAME TO SEARCH FOR FUTURE ORDERS (3-N-O)
This field contains the time in minutes for batch creation to search the Unassigned Laboratory Orders file for future orders to add to the batch. For example, if you specify that all orders collected within 60 minutes of each other are to be placed in the same batch, the STAR Laboratory system automatically groups (batches) these orders without any further intervention.

CREATE/PRINT (1-A-O)
This field determines if collection labels print immediately at batch creation or if you must command them to print. Indicate if you want to create the batch only or if you want to create the batch and print immediately.

NOTE: The option you select here becomes the default for the Create/Print Option field in the Create/Print Batch processor.

SORT MODE (1-A-O)
Orders within the batch can be sorted by location, number of patients with orders per batch, or number of collectors. Indicate which mode you want to use to sort orders.

ASSIGNED BATCH PRINTER (35-C-O)
This field defines the default Collection label printer. Indicate if you want to print Collection labels on a printer other than the printer most commonly used for Collection labels.

OTHER BATCH - PARAMETERS

NEXT BATCH NUMBER (U-N-O)
A batch number is sequentially assigned at batch creation. The STAR Laboratory system increments this number with each batch. Enter a new batch number in this field if you want to reassign the batch number counter.

WARNING: Change this field with caution. All batches previously assigned with these new numbers are overwritten. It is best to use the Delete Batches processor first.

TIMEFRAME TO VIEW FUTURE ORDERS (U-N-O)
This field controls the number of future orders to display in the Unassigned Laboratory Orders file. The time you enter in minutes determines for how far into the future the system searches for unassigned/uncollected laboratory orders to display.

BATCH INCLUSION TIME (U-N-O)

This field contains the time in minutes the system uses when evaluating whether an order ordered for a collection time priority is placed into the collection pool or printed immediately. If the difference between the date and the time you enter the order and the requested collection date and time is greater than the parameter defined here, the order goes into the collection pool. If the difference is less than the batch inclusion time parameter, the label prints immediately. For example, if you order a test at 11:00 am with a Timed priority (priority is defined with label generation collection based time) to be collected at 16:00 and the batch inclusion time parameter is defined at 120 minutes, the order is placed in the collection pool. This is because the difference between the time the order is placed and the requested collection date and time is 300 minutes, which is greater than 120 minutes.

COLLAPSE TIME (U-N-O)

This is the time frame in minutes that orders with different requested collect times can be collapsed together when the batch is created. For example, if there are two different orders in the batch on a patient, one for a CBC at 6:00 AM and another for a glucose at 7:00 AM, when the batch is created, the STAR Laboratory system uses the time in this field to determine if the two orders can be collapsed into one order.

NOTE: The two orders have to belong to the same priority collapse group to be considered for collapsing into one order. For more information on priorities, refer to Chapter 2: Tables in the *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide*.

When the STAR Laboratory system detects duplicate orders within the batch, they are collapsed into one order and a credit/cancellation record is generated.

CONSOLIDATION SEARCH (3-N-C)

This field determines the time window used by the system to search for future orders during consolidation processing. Enter the time window as a number of minutes. This field is used when consolidation processing/labels are activated to search for orders that are scheduled to be collected within plus or minus X minutes of the requested collection date/time of the immediate print order. The maximum number of minutes allowed is 999 minutes, which equates to approximately two shifts.

FLAGS - DATE OF SERVICE

The Flags - Date of Service processor defines the parameters for order and charge date of service.

USE DATE OF SERVICE (1-A-R)
This field allows for date of service processing to be used by the system.

EFFECTIVE DATE (DATE-R)
If the Use Date of Service field displays *Yes*, this field accepts a future date using any of the McKesson approved date input options.

If a viable date is entered the field fills with the date in the format defined by your institution.

If the Use Date of Service field displays *No* then *N/A* displays in this field. The field then cannot be edited without a change to the Use Date of Service field.

EDIT BY (DISPLAY ONLY)
Once the screen is accepted, this field fills with the name of the individual who accepted the screen.

EDIT DATE/TIME (DISPLAY ONLY)
Once the screen is accepted, this field displays the date/time of the edits made to the screen.

FLAGS - GFR RACE CODE ID

The GFR Race Code ID processor is used to identify the code defined by the facility for African American race.

1. AFRICAN AMERICAN RACE CODE (1N)
Race codes are user defined and can vary for each system. The race code for African American must be indicated in this field for the system to use the appropriate constant in the GFR calculation.

When this field is accessed the following prompt is displayed:

Enter Race code for African American or '-' for table-

Enter the numeric code for African American as defined in the Race Code table located in STAR Patient Care or enter a hyphen (**-**) and the race table is displayed.

After the field is filled, the following prompt is displayed:

Accept this screen? (Y/N) [Y]--

If you enter **Y**, the response is filed for use in the GFR calculation. If you enter **N**, the following prompt is displayed for you to access the field and enter another response.

Enter field number or '/' starting field number-

2. EDIT BY (DISPLAY ONLY)
The name of the person who last edited the African American Race Code field is displayed in this field.

3. EDIT DATE (DISPLAY ONLY)
The date and time the last edit was made to this screen is displayed in this field.

FLAGS - LABELS

Collection

Complete a separate form for each department.

COLLECT LABEL PRINT (1-A-R)
There are two types of label stock. Single column stock arrange labels vertically down the paper. Three across stock come with labels arranged horizontally across the paper three in a row. Indicate whether collection labels should print in a Single column or Three Across by checking the appropriate answer.

NOTE: If you use bar-coded labels, you must select single column labels.

 # MASTER LABELS (1-N-R)
Indicate the number of master labels to print (from one to nine) per order. Master labels list each test within the order. (This only applies to dot matrix labels, not barcode labels.)

CUTOUT # TYPE (1-A-R)
Indicate which number to print in the lower right corner of collection labels by checking either Account #, Unit #, or Collection #. Cutout labels are often used for micro specimen containers.

USE PRINTER MATRIX (1-A-R)
Check Yes to use printer matrix for non-interfaced or networked orders (that is, orders placed directly on STAR Laboratory that need to print collection labels on a different printer than the default). Check No to use the same printer for both interfaced and non-interfaced collection labels.

COLLECTION LABELS AT ORDER/ACCESSION (1-A-R)
According to how order priorities are set up, tests may be ordered and accessioned within the same processor (screen). For priorities which allow simultaneous order and accession, indicate whether collection labels should print (in addition to the accession labels) by checking Yes or No.

COLLECTION LABELS # TYPE (1-A-R)
Indicate the number to print on the first line of collection labels by checking Account Number or Unit Number.

NURSE-COLLECT PRINT? (1-A-R)
Should nurse-collect orders print collection labels immediately (upon order entry) in the laboratory? NC prints on these labels indicating Nurse Collect. Respond by checking Yes or No.

Accession

ACCESSION LABEL TIME (1-A-R)
Indicate the time to print on accession labels by checking Accession Time, Collection Time, or Request Time.

NOTE: Request Time is the time indicated at order entry for the test to be collected.

MASTER ACCESSION LABELS (1-N-R)
Indicate the number of master accession labels to print (from zero to nine). Master accession labels list each test within the order. If you enter zero, printing of master labels is suppressed completely (including number pool generated master labels). If no bay labels are defined and master equals zero, no accession labels print for test. (This only applies to dot matrix labels, not barcode labels.)

ACCESSION ISOLATION LABEL (1-A-R)
Indicate whether to print isolation labels at accessioning. Isolation labels automatically print with collection labels sets if proper flags are set.

Label Flags - Other

PRINT SPECIMEN REJECTION LABELS (1-A-R)
Indicate whether to print Specimen Rejection labels by checking Yes or No. These are specimens exceeding the specimen age limit for the test or specimens for which you enter accession numbers followed by an X in the Result Reporting or Accessioning processors.

PRINT CALL STAT LABELS (1-A-R)
Indicate whether to print Call STAT Labels for STAT accessions by checking Yes or No.

CONSOLIDATION LABELS (1-A-R)
Indicate whether consolidation processing occurs and if consolidation labels print with immediate print collection labels by checking Yes or No.

PROMPT LABELS
The system prints ProCom labels for prompt response based on the setting of the Prompt Labels flag and the presence or absence of a prompt response.

Enter **O** to print Prompt labels when ordering. Enter **A** to print Prompt labels during accessioning. Enter **B** to print these labels at both ordering and accessioning. Enter **N** to not print labels. The default is Both.

Enter **O** to print Prompt labels when order comments exist. Enter **A** to print Prompt labels when accession comments exist. Enter **B** to print these labels when both ordering and accessioning comments exist. Enter **N** to not print labels. The default is Both.

Refer to Chapter 1: Flags/Utilities in *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide* for detailed tables that explain how the prompt/comment labels will print or will not print.

Label Flags - Interdepartment

INTERDEPARTMENT ACCESSION LABELS (1-A-R)
Indicate the time/place for accession labels to print when the test is an interdepartment test. To print labels upon accessioning in the department that collected the specimen, check Accessioning. To print labels at check-in, in the performing department, select Check-In.

TRANSFER LABELS AT ACCESSION (1-A-R)
Indicate whether to print interdepartment transfer labels at accessioning. These labels contain the same information as Master accession labels, plus the name of the performing department. The labels include special handling instructions. Transfer labels can be affixed to the container for shipment or used internally as an audit.

SENDOUT LABELS AT ACCESSION (1-A-R)
Indicate whether to print sendout labels at accessioning. These labels contain the same information as Master accession labels, plus the name of the sendout laboratory. The labels include special handling instructions. Sendout labels can be affixed to the container for shipment or used internally as an audit.

Laboratory Data Elements for User-Defined Labels

The following elements can be applied to user-defined dot-matrix labels. The information includes element name, description, length/truncate, and an example. Your McKesson representative will assist you in formatting these labels.

Element	Description Example	Length/Truncate
LLBAC	Accession Number (Elongated) 1234567	14/No
LLBAC1	Accession Number 1234567	7/No
LLBEN	Account Number A7313419	10/No
LLBAY	Bay Astra-8	30/No
LLBACT	Collection Date/Time 08/06/92 1200	13/No
LLBCON	Container Type 1-Red (No Preservatives)	25/No

Element	Description Example	Length/Truncate
LLLBDT	Current Date/Time 08/06/92 0212	13/No
LLBSTARS	Header ****** ********* ******	54/No
LLBHAC	Header "ACC" (Elongated) Acc	6/No
LLBHAD	Header "Add'l Draw Label" Add'l draw label only!	23/No
LLBHBAY	Header "BAY" Bay:	4/No
LLBHBD	Header "BD" Bd:	3/No
LLBHCL	Header "Cons label" (Elongated) *****Consolidation Label*****	54/No
LLBHSC	Header "Container" Container:	10/No
LLBHDR	Header "DR" Dr	3/No
LLBHLF	Header "LAB Specimen For" Laboratory Specimen For:	17/No
LLBHME	Header "Media" Media	6/No
LLBHPR	Header "Prompt" Prompt:	8/No
LLBHRN	Header "Req #" REQ #:	5/No
LLBHSEC	Header "Section" Section:	8/No
LLBHST	Header "Send To" Send to:	8/No
LLBHSF	Header "Sendout From" Sendout From:	12/No
LLBHSP	Header "SP" SP:	4/No

Element	Description Example	Length/Truncate
LLBHSR	Header "Spec Rejected" *Spec Rejected.Bad Spec*	54/No
LLBHSPT	Header "Spec Type" Spec Type:	10/No
LLBHSI	Header "Special Instruction" *Special Instruction Label Only!*	38/No
LLBHSOI	Header "Special Instructions" Special Instructions:	21/No
LLBHTS	Header "Test" Test:	5/No
LLBHTST	Header "Tests" Tests:	6/No
LLBHTM	Header "Time" Time:	5/No
LLBSPC	Header One Space	1/No
LLBNH	Histotech Number S92-3-A2	16/No
LLBPN	Histotech Process Cyto St @ 1 1/4	16/No
LLBIT	Isolation Banner Respiratory Isolation	54/No
LLBPS	Label Print Status Printed	13/No
LLBLN	Laboratory Name General Hospital Laboratory	30/No
LLBSEC	Laboratory Section CHM	3/No
LLBME	Media BAP	30/No
LLBMR	Medical Record Number A987654321	12/No
LLBMNC	Micro/NC Notice ~NC~	9/No
LLBNP	Number Pools HEM-12/CHEM-32	14/No

Element	Description Example	Length/Truncate
LLBNS	Nurse Station 4T	6/No
LLBPRI1	Order Priority STAT	16/No
LLBPRI	Order Priority (Elongated) STAT	16/No
LLBPR	Order Prompt List Patient's Medications	36/No
LLBPRR	Order Prompt Response Digoxin	36/No
LLBOC	Order/Accn Comment Draw in Left Arm	25/No
LLBOT	Ordered Test Lytes	8/No
LLBT1	Ordered Tests GLU/BUN/CBC W/DIFF/CHEM 24	44/No
LLBT3	Ordered Tests (17-20) CBC W/DIFF/CHEM 24/PLT	54/No
LLBT2	Ordered Tests (9-16) Hgb/HCT/PLT CT/WBL/ESR	54/No
LLBOD	Ordering Doctor Abbott, John K	25/No
LLBBD	Birthdate 08/06/55	8/No
LLBLOC	Patient Location 3N-301-O2	9/No
LLBLOC1	Patient Location 3N-102-02	9/No
LLBNM	Patient Name Elbert, John A	24/No
LLBSX	Patient Sex M	1/No
LLBCAC	Ref Lab Sender ARUPID	10/No

Element	Description Example	Length/Truncate
LLBSTR	Ref Lab Storage Requirements Room Temperature	20/No
LLBCTC	Ref Lab Test Code Z123-2W	10/No
LLBCDT	Requested Collection Date/Time 08/06/91 0212	13/No
LLBSA1	Sendout Address Line 1 123 East	35/No
LLBSA2	Sendout Address Line 2 Suite 100	35/No
LLBSA3	Sendout Address Line 3 Atlanta, GA 30341	35/No
LLBSOC	Sendout Comment Process ASAP	35/No
LLBSOL	Sendout LAB Smith Kline	30/No
LLBRN	Sendout Request # 3672345	7/No
LLBSOV	Sendout Volume Send 100 ml's	12/No

LLBSL2	Slide (Spec, # Pool or Pat #)
	A12345678=Pat
		12/No

LLBSL1	Slide (Test or Accn) 1234567=Acc	11/No
LLBSI	Special Instruction -Avoid Hemolysis	35/No
LLBSPM	Specimen Modifier -Left Arm	12/No
LLBSP	Specimen Type Blood	19/No
LLBSVOL	Specimen Volume Send 2 ml's	12/Yes
LLBDIA	Working Diagnosis Appendicitis	33/No

FLAGS - ORDER/ACCESSION

Ordering

Use this form to define how the Order Entry and Accession processors will function within STAR Laboratory, such as label generation and processing prompts. Complete a separate form for each department.

TESTS PER ACCESSION (1-N-R)
Enter a number from 1 to 20 indicating the maximum number of tests that can be on one accession.

NOTE: If STAR Laboratory is interfaced or networked to a Hospital Information System (HIS), this must be set to five or less.

If you define more than eight tests per accession, the Standard Order/Access label's field must be "User-defined."

MICRO SAMPLE ORDER (1-A-R)
Tests can be ordered as Routine, Stat, or ASAP and designated as Macro or Micro. Within the Micro order category (as with all other categories) labels are defined by the minimum collection volume required, container type, number of labels, aliquot volume, and special instructions. Tests designated as Micro can be ordered by entering the test code immediately followed by the letter M which causes the (collection) labels defined for this category to be generated. To allow tests to be ordered with a Micro sample size, check Yes. To prevent Micro test orders, check No.

NOTE: Test orders for the Micro category can only be entered on STAR Laboratory; that is, STAR Patient Care currently does not accommodate this function unless the HIS interface has been customized for this.

HIS AUTO CANCEL (1-A-R)
This department flag controls cancel/credit transactions between Patient Care and Laboratory systems. Respond by checking Yes or No. If the flag is set to Yes, one of the following processes occurs when an order cancellation is requested by the HIS:

1. If the order is still in the uncollected (Unaccessioned) pool, STAR Laboratory automatically cancels the order and passes a cancel/credit record to the HIS. In addition, the following message prints on the interface audit printer: *(Test code/test name, patient unit number, name, account number and test order/accession number) cancelled per STAR Patient Care request*.

2. If the order has been accessioned, a cancellation/credit record does **not** pass. However, the following message prints on the interface audit printer: *Request from STAR Patient Care to cancel (test code/test name, patient unit number, account number, name, and test accession number)*.

The cancellation must then be performed using STAR Laboratory's Order Cancellation processor. This is also the case if the flag is set to No.

Accessioning

ACCESSION COMMENT DISPLAY (1-A-R)
Check Yes to display comments entered during order entry within the accession screen. Check No to restrict display. If you check No, you can display order comments in the accession comment field by entering an equals sign (**=**), enter a free text comment, or select from the comment table.

ACCESSION COLLECTION REQUEST (1-A-R)
Check Yes to require a Collection Time field entry during accessioning. Check No to auto-fill the Collection Time field with the time entered at order entry. If No, the Accession Collection Display flag must be Yes.

ACCESSION COLLECTION DISPLAY (1-A-R)
Check Yes to auto-fill the Collection Time field with the time entered at order entry. The Accession Collection Request flag **must** be No. Check No to require entry of a collection time at accessioning.

ACCESSION COLLECTOR ID (1-A-R)
Check Yes to automatically capture and fill in the Collector field (on the accession screen) the ID of the person signed on at accessioning. Check No to require an entry in the Collector field for each accession.

MICRO SAMPLE ACCESSION (1-A-R)
Tests can be ordered as Routine, Stat, or ASAP and designated as Macro or Micro. Within the Micro order category (as with all other categories) labels are defined by the minimum collection volume required, container type, number of labels, aliquot volume, and special instructions. Tests ordered as Micro can be accessioned by entering the test code immediately followed by the letter M which causes the accession labels defined for this category to be generated. To allow tests to be accessioned with a MICRO sample size, check Yes. To prevent Micro test accessions, check No.

NOTE: Test orders for the Micro category can only be entered on STAR Laboratory when the HIS interface has been customized for this. STAR Patient Care currently does not accommodate this function

SPECIMEN EDIT (1-A-R)
Check Yes to allow editing of the specimen type during accessioning or Revise Order Information Processor. Check No to restrict editing of the specimen type.

VIEW CLINICAL QUESTIONS (1-A-R)

This field determines if the prompt to display Clinical Order Detail Information displays during accessioning. The Clinical Questions Active flag in the Flags - General Department processor must be set to Yes for you to access this field. Entering **Y** sets this field to Yes and allows you to be prompted to view Clinical Order Detail Information during accessioning. Entering **N** sets this field to No and results in Clinical Order Detail Information not displaying during accessioning. You are not prompted to view the information, regardless of whether or not there are Clinical Questions associated with this test. The default for this field is No.

 The system displays the following prompt:

> *View clinical questions at accessioning? (Y/N) [N] --*

Order/Accession Flags - Both

FREE-TEXT DOCTOR (1-A-R)

Check Yes to allow the Doctor field to be filled in by typing a name. Check No to restrict the Doctor field to either entering a doctor code or selecting from the doctor table.

STANDARD ORDER/ACCESSION LABELS

If you selected more than eight tests per accession, you must check User-defined labels. If you selected fewer than eight tests per accession, you can check User-defined or Standard.

If you check User-defined, you must design and use dot matrix labels. This field has no effect if you use bar code collection and accession labels.

DUPLICATE/CONFLICT SECURITY

Enter the minimum security level required to override a duplicate/conflict order during STAR Laboratory's Order Entry.

FLAGS - PATIENT INQUIRY/PRIMARY REPORTS

By Department

PATIENT INQUIRY ORDERS (1-A-R)
Unless otherwise indicated, only tests with at least a status of Accessioned can be viewed in Patient Inquiry. To also view tests with a status of Ordered in Patient Inquiry, check Yes. Checking No restricts viewing of Ordered tests to Order Inquiry.

REMOTE PRINTER MATRIX (1-A-R)
Printer Matrix enables you to control printing based on patient types/locations, test code, ordering priority, or a combination of these. For example, in a non-interfaced and/or non-networked environment, to print a copy of all Emergency Room (ER) Primary Reports, simply locate a printer in the ER, activate this flag, and through the Printer Matrix processor, select the ER location and print all ER Primary Reports on the ER printer. For further information, refer to Chapter 11: Spooler and Printer Matrix in the *Maintenances Worksheet Volume* of the *STAR Laboratory Reference Guide*. Check Yes to activate Printer Matrix; check No if you do not intend to use this feature.

By Facility

STAT/ASAP PARTIAL (1-A-R)
This flag controls printing of partially completed reports for tests ordered STAT or ASAP. Check Suppress to prevent printing of Primary Reports for partially completed tests. Check Print to allow printing of Primary Reports of partially completed tests ordered as STAT or ASAP; whenever results are accepted for a STAT or ASAP test, a primary report will automatically generate even though all required external results are not entered.

ABNORMALS FLAG (1-A-R)
Indicate which (if any) character for the system to use to flag abnormal results on Primary, Summary, and Cumulative Reports. Check Star to flag abnormals with an asterisk. Check Character to indicate abnormal results with the appropriate character (H-high, L-low, D-delta check, P-panic). Check Do Not Flag if you do not wish to indicate abnormal results.

RESULTS TO PATIENT CARE (1-A-R)
Indicate whether test results will go to STAR Patient Care and print a Primary Report. Check No Results if no results are to pass to STAR Patient Care. Check Stats/ASAPS/ Force Print Only if only tests ordered as Stats or ASAPS or those that are force printed will pass to Patient Care for printing.

PATIENT CARE RESULT WINDOW (2-N-R)
Indicate the number of hours between order collection and result reporting (result window). This controls whether results pass to the ordering location or to the current patient location based on the amount of elapsed time between the two events.

DISCHARGE OUTPATIENT PRIMARIES (SPECIAL PROCESSING)
List outpatient patient types that will print primary reports on tests which result after the discharge date.

By System

RANGE HEADER DEFAULT (TABLE-R)
Refer to the Range Headings worksheet in Appendix B: Worksheets in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide* to indicate the default range heading to display in Patient Inquiry or print on patient reports for tests which do not have a range heading specified.

INFORMATION WINDOWS
STAR Laboratory provides four information windows in Patient Inquiry:

- Abnormal Results
- Panic Values
- Patient Information
- Physician Information

To view available Information Windows:

- You must be using an IBM-compatible personal computer

- Your PC and host ID computer must be set up to enable the use of Information Windows

The next two flags control the timeframe to search for the abnormal and panic value results per patient type.

INPATIENT (3-N-O)
This field controls the number of days to search for information for the abnormal and panic values information windows. Typically, the days to search for inpatient data is less than the days for outpatient data. The greater the number of days entered, the longer the time to download the data to the information windows.

Enter the number of days between 1 and 999.

OUTPATIENT (3-N-O)
This field controls the number of days to search for information for the abnormal and panic values information windows. Typically, the days to search for inpatient data is less than the days for outpatient data. The greater the number of days entered, the longer the time to download the data to the information windows.

Enter the number of days between 1 and 999.

FLAGS - REPORT QUEUE

The Report Queue flag enables you to set the default for accepting a test in the review queue processor. Complete a separate form for each department.

DEFAULT FOR REVIEW QUEUE REPORTING ACCEPT QUESTION (1-A-R)
Indicate the default for the following prompt line found in the Review Queue processor:

> *Enter number to edit,accept(A),print(P),fill(F)[P]--*
> *=options,queue(Q),skip(S)*

by checking either Accept or Force Print. Accept files the results and prints a Primary Result Report only when all other criteria for report printing are met. Force Print always prints the Primary Result Report when test results are accepted a Review Queue.

FLAGS - SPECIMEN REJECTION

DEFAULT AUTOMATIC REORDER (1-A-R)
Check the option for default automatic reorder. Check either Automatic reordering of rejected tests, Ask Question to have the system prompt you for reordering, or No Reorder. The Specimen Rejection Maintenance Processor requires that you enter either **A**, **Q**, or **N** to correspond to the option you check.

EXCEPTION REORDER

FACILITY (U-C-O)
If your laboratory serves multiple facilities, you must specify exceptions for reordering by facility. Enter the facility name.

NOTE: This worksheet provides areas for two facilities. If your laboratory serves more than two facilities you must make additional copies of this worksheet.

EXCEPTION BY (1-A-O)
You have the option to define reorder exceptions by patient type. If your laboratory has the STAR Laboratory Contract Billing module, you also have the option to define reorder exceptions by vendor. Check either the Patient Type or Vendor option or leave them both blank if you are not defining reorder exceptions by either.

PATIENT TYPE/VENDOR (U-C-O)
If you are defining reorder exceptions by patient type or vendor enter the code or descriptions for the patient type/vendor in this field. The Specimen Rejection Maintenance Processor provides a table of these codes and descriptions for you to choose from.

REORDER OPTION (1-N-R)
Indicate the reorder exception option by entering a 1 for automatic reordering of rejected tests, 2 for system prompting for reordering rejected tests, or 3 for no reordering of rejected tests. If you are defining reorder exceptions by patient type or vendor indicate one of these options for each entry you made in the Patient Type/ Vendor column.

RETENTION PARAMETER (1-N-R)
Enter the number of months you want to retain specimen rejection report data up to a maximum of 9. The default is 3 months.

FLAGS - SYSTEM FLAGS

This worksheet enables you to set system-level flags.   Complete this worksheet once for the entire system.

DELTA CHECK (1-A-R)
This field is for McKesson use only. It cannot be edited.

MISCELLANEOUS CHARGING (1-A-R)
This field determines whether miscellaneous charging takes place on the system. The Miscellaneous Charging processor enables charges to be applied or credited to an account for procedures or other chargeable items associated with an ordered test but not included in the price of the test after accessioning is completed. Should the flag be set to allow input of charges or credits, once the accession and associated processes are completed, the user will be prompted to enter miscellaneous charges or credits. If the prompt is answered affirmatively, the Miscellaneous Charge Processor screen will display for the user in order to place the necessary charges or credits.

HISTORIZATION (1-A-R)
This field is for McKesson use only. It cannot be edited.

FORCE SECRET CODE AT BARCODE SIGN-ON (1-A-R)
This field determines whether manual security code entry will be required for employee bar code sign-on.

VALID RANGE (1-A-R)
This flag determines whether the system performs valid range checking.

VALID VALUE (1-A-R)
This flag determines whether the system performs valid value checking.

RESULT FLAGGING (1-A-R)
This field determines whether result flagging (Normals, Panics, Delta Checks, Valid Values, and Valid Ranges) will be performed against the resulting test or the ordered test. The system also checks that the specimen type assigned to the order matches the default specimen type before flagging occurs.

For example, a Creatinine Clearance test (specimen type Blood/Urine) is ordered and the serum Creatinine is resulted through the instrument test (specimen type Blood). If the flag is set to flag against the ordered test, the specimen type check that occurs is between the actual specimen type on the accession and the default specimen type of the Creatinine Clearance test. The specimen type matches and flagging occurs.

If the flag is set to flag against the resulting test, the specimen type check is between the default specimen type of the instrument test and the Creatinine Clearance test. In this example, the specimen types don't match and result flagging does not occur.

NOTE: Using the option for the ordered test can have an impact on system performance.

RECALL MANAGEMENT LIVE (1-YN-O)
This field determines whether Recall Management is activated. All tables can be built without this option.

NOTE: All tables can be built without the Recall Management flag set to *Yes*. Do not set the Recall Management Live flag until all other Recall Management parameters have been defined. Once the flag is set to *Yes* it cannot be edited.

FLAGS - WORD PROCESSING

This worksheet enables you to set the word processing line length parameter and header download option by section.

SOFTKEY EDITOR LINE LENGTH (2-N-R)
This is the number of columns the system allows in the softkey editor. If you are using another word processing package, the margins settings are compatible. If you are using the softkey editor, enter **72** (which is the default on the system). The maximum length is 80 characters.

NOTE: If you are using primary reports as the only method for reporting word processing results and you want to keep the format of the document so that it fits properly on the report, set this length to 62 or less. The width of a primary report is 62 columns.

SPACES FOR TAB (2-N-O)
To revise the number of spaces, select the Spaces for Tab field. The list of departments that you can access displays along with the spaces for tab setting in a scrolling screen along with the following prompt:

Enter the number of spaces that should replace each tab <3-10>--

Tab to the same line as the department you want to change.

Enter a number from 3 to 10 or press ENTER to accept the default value of five. If this field is left blank, the default value of five spaces is used for documents processed in the Windows-based word processing interface.

Scrolling Screen Field

This field allows you to define the number of spaces that should replace each tab character in the Windows-based word processing interface per department. The replacement occurs for the ASCII text version of each document that is created or maintained in the Windows-based word processing interface. Tab characters are not replaced in the RichText Format (RTF) version of the documents. The Spaces For Tab field displays select to edit.

For information on scrolling screen processing refer to Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide*.

SECTIONS FOR DEPARTMENTS (20-C-R)
Enter each section name for the laboratory department.

USE HEADER (1-A-R)
You have the option to download the header information for each section. Check Yes to download the header information or No if you want no header information downloaded for the section.

INCOMPLETE PRIORITY PRINT ORDER

Complete a separate worksheet for each department.

Enter the priorities you want to define as the print order of the tests on the Incomplete Work Report. When completing this worksheet remember to:

- Refer to the ordering priorities you have already defined in the priority table. For more information on what priorities are currently defined, refer to Tables and to Chapter 2: Tables in the *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide.*

- List the priorities in the *proper sequence.*

- Exclude any priorities you don't want to print.

FLAGS - PROFESSIONAL BILLING

Complete a separate worksheet for each department.

ACTIVATE PROFESSIONAL BILLING (1-A-R)
This field enables the professional billing option. You can build the Professional Billing flag in the test file but professional billing processing is not available until you set this flag to yes. Enter **Y** to activate professional billing. Enter **N** to deactivate professional billing.

PROF BILL REPORT RETENTION (1-N-R)
Enter the number of months you want the system to retain data for the Professional Billing Report. You can enter from **1** to **12** months.

SECTION/DEFAULT RENDERING MD/PROF MISC CHG (SPECIAL FORMAT-R)
Each column in the field is described below.

SECTION
For each section in the department, you can define the Default Rendering MD and Pro Misc Charge.

DEFAULT RENDERING MD
If only one physician is billing from a laboratory section, you can define that physician as the default for professional billing. If more than one physician routinely bills or if no professional billing is done in the section, then you do not have to define the default physician.   In this case, you can select a rendering physician from the Physician table when you enter the professional billing information for an accession.

NOTE: Any rendering physician you enter in this field must be included in the doctor file. STAR Laboratory does not use the Laboratory Employee file to define rendering physicians.

PRO MISC CHARGE
Enter the miscellaneous charge code to use for all professional fee billing for the section. You must define the miscellaneous charge item in the Miscellaneous Charge Add/Edit processor before you can add it here. You must set the professional fee indicator for this item within the SIM maintenance processor.

DATA RETENTION PARAMETERS

Complete a separate worksheet for each department.

MISC. CHARGE/CREDIT RETENTION (1-N-R)
Enter the number of days (from 2 to 7) to retain miscellaneous charges and credits on the system.

PU CANCELS/SPECIMEN REJECTION (1-A-R)
Indicate whether to include canceled orders and specimens rejected in Physician Utilization Report statistics by checking Yes or No.

ACTIVATE PHYSICIAN UTILIZATION (1-A-R)
To compile physician utilization statistics as each test is accessioned, check Yes. To prevent compiling of statistics, check No.

PU RETENTION (2-A-R)
Indicate the number of months (from 1 to 12) to retain the Physician Utilization Report data on the system.

COLLECTION BATCHES (2-N-R)
Indicate the number of days you want to retain collection batches on the system. Any collection batches older than the number of days you enter are deleted during midnight processing. Collection batches are deleted regardless of status.

VALID VALUE/RANGE RETENTION (2-N-R)
Use this field to set the number of months for the system to retain the data for the Valid Value and Valid Range Override reports. The number of months can be set from 1 to 12 months. Data stored for these reports that is older in months than the value of this field will be deleted at midnight processing.

REVISE ORDER RETENTION (3-N-O)
Upon entering the field the user is prompted to indicate how long data should reside on the system. The default is 365 days. Any number between 1 and 365 is permitted as a response and that number displays in the field. A default of 365 allows users to go back and review previous edits even though months may have passed. No more than 365 days is allowed for data retention. Midnight Processing cleans up the data as the retention time is exceeded.

Chapter 2 - Tables

CONTAINER TYPES

Results of clinical laboratory procedures are reliable only if the specimen is collected properly. To ensure proper collection, an appropriate collection container should be selected for each specimen. Containers are classified according to their anticoagulant, preservative content, or sterility features.

The STAR Laboratory system files must contain information about the types of containers the laboratory is using and the maximum volume of specimen to be collected in each. The system uses this information each time collection labels and send-out labels are generated.

STAR Laboratory comes with a base list of the most commonly used container types. Refer to Appendix A: Base Tables Listing in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide.* You may add, edit, or delete any of these containers. Use the blank worksheet provided for additions and/or corrections.

CODE (3-N-R)
Each container type is assigned a unique numeric code. This code can be 1 to 3 digits in length. The system will automatically assign this code if desired.

DESCRIPTION (30-AN-R)
This is a 30-character alphanumeric field for the descriptive name of the container type. Blood collection containers are usually named after the color of the stoppers, which indicate the type of anticoagulant contained in the tube.

SHORT NAME (8-AN-O)
This is the short name for the container type which will print on the labels. The short name must be eight or less characters.

MAXIMUM VOLUME (3-NP-O)
The maximum volume of specimen (in milliliters) contained in the tube or bottle must be indicated for each entry so that the system can calculate the total number of tubes necessary for a particular order. The calculation is based on the total milliliters of specimen required to perform each test ordered. If a maximum volume is not applicable (such as for stool containers), this portion of the worksheet should be left blank.

RANGE HEADINGS

You can define the way normal range headings are to appear on patient reports and in Patient Inquiry using the Range Headings processor located on the Table Data - General menu. The following predefined headings come with the system:

Code	Single Column	Double Column
1	Normal Range	Norm Range
2	Reference Range	Ref Range
3	Therapeutic Range	The Range

Up to nine headings can be defined for your system.

CODE (1-N-R)
Enter the code for this range header.

DESCRIPTION (20-AN-R)
Enter the description for this range header to be used in the case of single column Primary Result Reports.

SHORT DESC (11-AN-R)
Enter the description for this range heading to be used in the case of double column Primary Result Reports.

RESULT UNIT CODES

Result units must be established for each test methodology in the system. A base tables of Result Units is provided. (Refer to Appendix A: Base Tables Listing in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide.*) You may add, edit, or delete these as needed.

CODE (3-N-R)
This is a 3-digit numeric code for each result unit. The code can be automatically assigned by the system or you may designate your own. Do not duplicate numbers. Refer to the base table list for the next available number.

DESCRIPTION (20-AN-R)
This field is a 20-character alphanumeric field for the unit name.

CAP UNITS CODE (3-N-O)
This is a 3-digit numeric code that is used by CAP for identifying the result unit.

SPECIAL INSTRUCTIONS

Special instructions are an important quality control mechanism in specimen collection and test processing. STAR Laboratory prints special handling instructions on collection and send-out labels, based on descriptions given on the Special Instructions worksheets that follow.

To aid in the file build and to save the laboratory time, McKesson has provided a base table of special instructions. Refer to Appendix A: Base Tables Listing in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide*. You may add, edit, or delete from this table.

CODE (3-N-R)
This is a 1- to 3-digit numeric field. This code can be assigned by the system or defined by the user. Do not duplicate codes!

DESCRIPTION (40-AN-R)
This field cannot exceed 40 alphanumeric characters. Combine several short instructions to make one long one if possible. An individual label will print for every special instruction used for collection purposes so it is best to keep these as concise as possible.

SPECIMENS

The Specimens table must contain all specimens that can possibly be ordered for your test codes. This table is generic for all facilities, in other words, facility-specific specimen types are not allowed. Therefore, define all specimens necessary for all facilities connected to your STAR system.

The specimen type required for analysis is usually known for most tests. Within STAR Laboratory, the default specimen type is linked to the ordered test. Only when this default specimen type is used for analysis will the normal ranges defined in the Master Test files be included on result reports. If a different specimen type is selected or entered, the system will suppress printing of normal ranges.

Some tests (such as routine cultures) will not have a usual specimen type. For these, laboratory personnel indicate a type or source when the specimen arrives in the laboratory by selecting from the table of allowable specimen types. It is for this reason that all known specimens should be listed on the Specimen Types worksheets. Use the base table provided in Appendix A: *Base Tables Listing* as a starting point. You may add, edit or delete as needed.

CODE (3-N-R)
This is a 1- to 3-character numeric code that can be automatically assigned by the system or selected by the user. Do not use duplicate codes. Refer to the base list for the next available number.

DESCRIPTION (19-AN-R)
This is a 19-character alphanumeric field used to enter the descriptive name of the specimen.

ORDERING PRIORITIES

All tests ordered through STAR Laboratory are assigned a priority. Examples of priorities include Routine, Stat, ASAP, and Timed. The laboratory must specify which tests are eligible for which priority. It is unlikely, for example, that a VDRL would be ordered with the priority of Stat, but a test such as CK Isoenzyme could be ordered as Routine, Stat, or ASAP.

Label generation must be considered when creating a priority. For example, the laboratory must decide whether it wants labels for Stats to print immediately, whether future orders are to be printed in a batch, and whether it will be possible to combine like priorities.

NOTE: In an interfaced or networked environment, priorities **must** match the HIS.

The appropriate information must be provided on the Ordering Priorities worksheet. Following are detailed instructions for completing this worksheet.

CODE (2-N-R)
This is a 1 to 2 digit code for each ordering priority. Start at 1 andincrement by one for each priority.

DESCRIPTION (19-C-R)
Enter the description of the order priority code.

SHORT DESCRIPTION (7-AN-R)
Enter a short description of the order priority code, which is required by the system. This description appears on the requisitions and in Order Inquiry.

ADDITIONAL CHARGE (1-A-O)
Specify whether there is an additional charge if this priority is selected when ordering procedures. Enter **Y** for Yes indicating there is a SIM charge item identified in the McKesson Tables. The priority charge is set to either (A)ll or (I)nitial and an additional charge is created.

START DATE/TIME ENTRY (TABLE LOOKUP)
This optional field contains the requirements of the date and/or time entry at the time of order for this priority. Use the following coding scheme to select an entry option:

D (the start date field only)
T (the start time field only)
B (both the start date and time fields)
N (neither field)

If a date or time field is not accessible, then the system uses either the current system date and time or a calculated date and time utilizing the information entered in the Cutoff Time and Additional Days fields and is automatically entered. If data entry is allowed in these fields (they are not Display Only), the cut-off information is utilized to display warning messages to the users, but any valid dates and times within the specified days parameters of the SIM department is accepted.

For a Timed Collection, asking for either the date and time or the time only would be appropriate. On the other hand, if the priority STAT means draw and run the test now, the start date/time entry field should be set to N to allow the time to automatically be entered.

RECURRING (1-A-O)
Specify that an item with this priority can be ordered as recurring. Enter **Y** for Yes, to order an item with this priority as Recurring during the ordering process. Enter **N** for No and the system prevents you from ordering an item with this priority as Recurring.

CUTOFF TIME (15-C-O)
The time entered while ordering is compared to the system date and time, and can potentially change the requested date of the item ordered based upon the cutoff time.

ADDITIONAL DAYS (1-N-O)
Specify the number of days to add to the system date if the request date is not entered, or if the order is placed beyond the cutoff date and the default response was chosen to calculate the requested date.

ORDER CATEGORY/STATUS (3-C-R)
Every priority in the system needs to be classified into one of the three ordering categories used by the STAR Laboratory system. Categories are Routine, ASAP, and Stat. Categories not only determine how the collection of the order is handled but also how the work is processed and reports are printed. (The STAR Laboratory system allows STAT and ASAP categories to print reports immediately whether they have a status of partial or done. Routines only print when completed.)

For example, a specimen that needs to be drawn and run immediately would be categorized as a Stat, the priority name would probably be Stat, and the reports for this priority print immediately because it is categorized as a Stat.   A timed order might be classified as ASAP but the priority name would be Timed. An order to be drawn today could be classified as Routine but the priority name would be Today. The following are examples of the flexibility of priorities and categories:

Priority	Category	Collection Labels	Reports
Stat	Stat	Immediately	Immediately
Timed	ASAP	Based on time	Immediately
Routine	Routine	Tomorrow	When completed
Today	Routine	Batch/Today	When completed

LABEL REQUEST GENERATION (1-N-R)

Label Generation determines when collection labels will print for each priority. Some priorities (such as STAT and ASAP) imply that labels are to print as soon as the order is placed. Other priorities, such as Timed, base the time of label printing on the collection time and the current time of day. Some laboratories log the next day's collections into a pool that can be processed as a batch, such as the next morning's draws.

Label generation must be considered when assigning priority eligibility. For example, the laboratory must decide whether it wants labels for STAT orders to print immediately, whether future orders are to be printed in a batch, and whether it will be possible to combine like priorities.

The Label Generation column should be completed by entering:

    1 = If collection labels are to print immediately upon order entry.

    2 = If collection label printing depends on the collection time specified in the order and the current time.

    3 = If an order is to be logged into a collection pool for future printing.

If option 2 is chosen for any priority, the system must include a reference time to judge whether or not labels should print immediately. For example, if a time of 60 minutes is designated, any order for which a specimen is to be collected within the next 60 minutes will generate collection labels immediately. Collections to be made after the next 60 minutes, however, will be held for future printing.

Indicate the desired reference time in the blank following Time Decision Print Time at the bottom of the worksheet.

Radiology has a selection of:

    (1) Immediate
    (2) Decide
    (3) Pooled

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DEFAULT TIME (4-N-R)
This field indicates the time of the collection. Indicate the appropriate time in military format (HHMM).

COLLAPSE STATUS (1-N-O)
For orders that do not trigger immediate label printing, STAR Laboratory allows the laboratory to combine different orders (of like specimen types) that have been placed separately, including those with the same priority and those with different priorities. This is called the Collapse feature.

For example, if a CBC is ordered for collection with a priority of Routine, and later that day a Chemistry Profile with a Routine priority is also ordered, the orders can be collapsed so that only one set of collection labels will be produced containing both test requests. Likewise, if two tests with different priorities (Timed CBC and Routine Chem Profile) belong to the same collapse group, the system will collapse them into one collection order. By combining label printing, the Collapse Feature helps to avoid duplication of orders and blood draws.

NOTE: This field is also used to check duplicate orders and automatically cancel/credit the test.

For example, if two glucoses are ordered for the same time and are in the same batch, the collapse status within the priority must be set for the system to automatically cancel and credit one of these. The same is true of the same test code with different priorities. Only if they belong to the same collapse status will they combine and generate one draw label.

To activate this feature, select the priorities you wish to collapse together and enter one of the priority codes as the group code. For example, if you wish Routine (Priority code of 1), Timed (Priority code of 2) and Today's (Priority code of 3) to collapse if in a batch together, enter one of their priority codes in all three of their collapse status fields.

NOTE: Collapsing works only if the orders are in the same batch and the labels have not printed immediately!

At the bottom of the worksheet, a Collapse Time must also be indicated. This time represents the amount of time before label generation in which like priorities can be combined. If the collapse time is set to 60 minutes, for example, and a PTT were ordered at 1000 for collection at 1600, a T4 would have to be ordered at least 60 minutes before the PTT label generation if the orders are to be combined. Remember that the collapse time chosen will apply to **all** priorities for which the collapse feature has been activated.

ACCESSION AT ORDER (1-A-O)
Circle Yes if you want the system to allow accessioning at the time of ordering. Circle No if you do not want that ability.

When you circle Yes to this field, the system displays the following question at the time of ordering:

Accession now? (Y/N) [default]--

The default answer in the prompt will be Yes if the label generation for this priority is to print immediately, it will be No if label generation for the priority is to go into a batch.

SENDOUT/INTERDEPARTMENT LABORATORIES

Since most clinical laboratories are not equipped to perform all analytical procedures a physician might request, procedures are often done by reference (sendout) laboratories or in the case of the multidepartment environment, another interdepartmental laboratory. Such tests are typically called sendouts or interdepartmental.

The STAR Laboratory system supports the processing of send-outs and interdepartmentals by printing additional accession labels that indicate the name of the reference or processing laboratory, the volume of specimen required by that laboratory, the proper container type for the specimen, and any special handling instructions. Result reports also include the name and address of the reference laboratory that performed the test.

To support these functions, the system's files must contain the names and addresses of all reference laboratories. Use the following worksheet to supply information for each send-out and/or interdepartmental laboratory.

CODE (3-N-R)
A unique 1- to 3-digit numeric code should be indicated for each laboratory, beginning with the number 1 for the first one and incrementing by one for each additional laboratory.

LABORATORY NAME (30-AN-R)
This is a 30-character alphanumeric field for the name of the sendout/ interdepartmental laboratory. The name should be listed as it is to appear on patient reports.

REFERRAL TYPE (1-N-R)
This field is to indicate which type of laboratory is being defined, sendout or interdepartmental. A sendout laboratory is any reference laboratory that is not a laboratory belonging to a facility defined as part of the STAR Laboratory system.   An interdepartmental referral laboratory is any laboratory that is defined as a part of the STAR Laboratory system.

INTERDEPARTMENT (3-A-O)
This field needs to be filled in only if the Referral type is an interdepartment referral. At the time of building, a table of all defined laboratory departments will appear for selection. Indicate the laboratory department the specimen is to be sent to in this field.

ADDRESS LINE 1 (U-AN-O)
This is the first of three lines that can be used for the address or any other information needed (such as a Pathologist or Department name) to be included with the reference laboratory for printing on reports and the mailing labels.

ADDRESS LINE 2 (U-AN-O)
This is the second line for the address or any other information needed to be included with the reference laboratory for printing on reports and/or the mailing labels.

ADDRESS LINE 3 (U-AN-O)
This is the third line for the address or any other information needed to be included with
the reference laboratory for printing on reports and/or the mailing labels.

SENDOUT WORKLOAD (5-N-O)
This field is to allow the automatic accumulation of processing workload for a sendout/
interdepartmental test when using the Specimen Transfer processor. Enter either the
workload code or name of the procedure that will be used.

NUMBER POOLS

Complete one worksheet for each department.

A Number Pool further identifies accessioned specimens within a laboratory section so that they can be sorted, stored and easily retrieved for later use. A numbering pool number has two parts: the number pool code indicating the number pool name, and a number that identifies the accessioned specimen. While accession numbers can never be reused, numbering pool numbers can be recycled according to the laboratory's own criteria. Recycling frequencies may be specified by date and time, or by the absolute value of the Numbering Pool itself. If desired, a number other than 1 can be used to begin a new cycle.

Numbering pools appear on the top line of the accession labels, and for each pool indicated, one additional Master Accession Label is generated. A single Numbering Pool may be associated with more than one test within an accession.

The purpose of numbering pools is to aid in sorting and storing accessioned specimens for a laboratory section. For a chemistry and hematology section, for example, accessioned specimens may be stored in a central area for all bays, but would be easily retrieved with a CHEM or HEM numbering pool identification. When setting up specimens for aliquoting and bay distribution, racks with number pool sequence can be used for fast distribution and run set ups. Numbering Pools can also aid in longterm storage of specimens. In hematology, for example, the Slide Numbering Pool may be assigned to all peripheral smears and recycled once a year. Microbiology sections often employ a variety of Numbering Pools to locate cultures stored in several different incubators and special locations. They can also be a useful tool for cataloging surgical specimens in cytology or histology.

NUMBER POOL CODE (4-C-R)
A unique 1- to 4-alpha character code. This code should contain no punctuation and be kept as short as possible. This code concatenates with the number pool number and prints on labels, appears in Patient Inquiry and prints on various reports.

DESCRIPTION (19-C-R)
Each number pool name should be a unique, alphabetic name no more than 19 characters long and should include no digits or punctuation.

CURRENT VALUE (10-N-R)
The value of the last assigned number.

RESET IF POOL NUMBER IS GREATER THAN (10-N-O)
If the pool is to be recycled after a certain number is reached, a Recycling Value should be indicated. This represents one less than the maximum value to be reached before the numbering pool begins a new cycle.

RESET POOL NUMBER TO (10-N-O)
The value entered here should be the number at which the new numbering pool cycle will begin when it is reset.

FREQUENCY (SPECIAL FORMAT-O)
The last item Frequency, is normally not completed if a Reset Value was chosen. However, it must be completed if numbering pools are to be recycled on a timed basis. The choices for frequency are:

1. Hours
2. Days
3. Weeks
4. Months
5. Quarters
6. Semesters (1/2 years)
7. Years

You must be as specific as possible for frequencies. Examples of recycling frequency values that might be used are as follows:

Every eight hours
Once per day, at midnight
Once daily at 6:00 a.m.
Once monthly on the first day of the month, at midnight
Once yearly, on January 1 at midnight

NEXT RESET DATE (8-NP-O)
The system will automatically calculate this field; however, it can be edited if needed. If, for example during training, you did not want the number pool to recycle until live, you would set the live date as the next recycle date.

SLIDE POOLS

Slide pools provide a method of combining slide labels. A group number can be defined for tests with slide labels that might be accessioned together so that slide labels, each with their own text, do not print individually, but rather are combined and printed on one label. For example, if a CBC (which has one slide label defined with text of Diff) and a Platelet test (with a defined slide label text of Plt) are accessioned together, a defined slide pool group causes only one slide label to print. The label will contain the combined text Diff/Plt instead of two individual slide labels, one with Diff and one with Plt.

CODE (1-N-R)
This is a 1-digit numeric field for the group number you wish to define for the slide labels. The standard group numbers to use are as follows:

1	=	Any CBC test that includes a diff, platelet.
9 or null	=	Any default slide that does not really belong to any group. (The system currently defaults to null and groups all slide labels.)

A maximum of 7 slide pools can be defined.

DESCRIPTION (20-AN-R)
This is a free-text 20-character alphanumeric field describing the group.

PREDEFINED RESULTS

STAR Laboratory allows results to be coded and used by technologists during result entry for improved speed and consistency. For example, R can be used for Reactive, NR for Non-reactive, P for Positive, N for Negative, and Q to mean Quantity Not Sufficient.

NOTE: Each predefined result can have a code up to three characters. This permits a maximum of 63 to 65 actual entries (depending on the length of the code). Maintaining a large number of code entries may conflict with free text entry and impact system performance.

CODE (3-A-R)
A 1- to 3-alphacharacter code can be used for each pre-canned result. Be careful not to use a letter code that is the same as an actual result, such as Blood Group A. McKesson installation representatives can offer assistance in choosing non-conflicting codes.

DESCRIPTION (20-AN-R)
This is a translation of the code as it will appear during result entry and on all reports. The description can be in both upper and lower case and cannot exceed 20 characters.

MISCELLANEOUS CHARGE ITEMS

The Miscellaneous Billing processor allows billing data to be captured for procedures or other chargeable items associated with an ordered test but not included in the charge for that test. An example is an H & E Stain. Once the Miscellaneous Charge Items are defined, they can be assigned to a Histotech procedure for automatic charge capture at processing. Or, they can be manually charged to a patient's account using the Miscellaneous Charge/Credit processor. You can use a miscellaneous charge item with the professional fee indicator type set to Yes for entering information for professional fee billing that requires more than one CPT®-4 code billed.

Use the Miscellaneous Charge Items worksheet to define all chargeable items to be used with the Miscellaneous Billing processors.

The data fields required for defining Miscellaneous Charge items include: Charge (SIM) code, description of item, billing code, price, and professional fee indicator.

SECTION CODE (3-A-R)
Indicate the section code to be used when defining the Miscellaneous Charges on this worksheet. Use a separate worksheet for each section.

MISCELLANEOUS CHARGE RANGE (20-AN-R)
When the laboratory sections are defined, a SIM code (Test Code) range must be defined for the charges within that section. Thus, an area of the Service Item Master file is reserved for each section's charges, thus allowing easier access to the items for a given section of the laboratory. Indicate the range for this section's Misc. Charges. The range per section must accommodate the number of miscellaneous charge items required when the test code range is defined for the section. If the test code range(s) for a section is already assigned, the miscellaneous code range must be a subset of the range(s). If the codes for these items are scattered throughout a large range, the table display will require more system overhead.

NOTE: This range must be the same as that entered on the Section Parameters worksheet under Miscellaneous Charge Range.

CHARGE CODE (8-N-O)
Enter the SIM code for the Misc. Charge Item (must be within the predefined range for the section).

MISC CHARGE DESCRIPTION (21-AN-O)
Enter the description of the charge item up to 21 characters.

BILLING CODE (9-AN-R)
The billing code can be up to 9 alphanumeric characters. This code is needed by the Financial System. Select this code in conjunction with your financial system.

PRICE (7-N-O)
The price is the amount that will be billed each time the item is charged/credited. Enter the price in decimal format ($99999.99 maximum).

NOTE: The price per the item is optional. If you do not defined it here, you can enter it when you enter manual charge/credit. However, if you want to assign the item to a histotech process or an advanced microbiology menu option, enter a price here since STAR Laboratory captures charges automatically.

PROFESSIONAL FEE INDICATOR (1-A-0)
If you use this miscellaneous charge to enter multiple CPT-4 codes for professional billing, enter **Y**.

NON-LABORATORY COLLECTOR CODES

Accessioning a specimen in the STAR Laboratory system requires identification of the specimen procurer. In some cases, this will be someone from outside the laboratory (for example, a nurse or doctor). A code must exist for these non-lab collectors so that they may be identified in the system. Workload is captured for non-laboratory collectors.

The following are examples of non-laboratory collector codes/descriptions:

```
CODE DESCRIPTION
==== ===========
CLA   Clinic A
DIA   Dialysis
DR    Doctor
ER    Emergency Room
EMT   Emergency Technician
ICU   Intensive Care
NUR   Nurse Collect
```

CODE (4-AN-R)
Enter a code (up to 4 characters) for each type of non-laboratory collector.

DESCRIPTION (20-AN-R)
Enter a description (up to 20 characters) for each collector type.

SHIFTS

Use the Laboratory Shifts worksheet to indicate the normal starting time for each shift recognized by the laboratory. A name must be given for each shift also. These shifts are used for workload capture and turnaround time reports.

SHIFT CODE (1-N-R)
This is a 1-digit numeric field identifying the shift number.

DESCRIPTION (20-AN-R)
This field contains the name of the shift.

START TIME (U-NC-R)
This field contains the time of day at which the shift starts.

STANDARD RESULT TEXT

The Standard Result Text (SRT) worksheet is used to establish pre-formatted text useful as a base document for lengthy textual results. Standard Result Text documents are often created for particular pathologists, specimen types, disease states, or a combination of these. Once created, these documents can be assigned to one or more subgroups for Result Entry or used in Interpretive Reporting.

Within results entry, standard result text documents are available for any test result assigned with Word Processing as a *Special Processing* feature. The standard result text selected can be edited to reflect the specimen at hand.

CODE (12-AN-R)
Enter the code for the standard result text. This code should reflect the type or use of the standard result text. For example, if the SRT is specific for a pathologist, use his/her initials as the code.

NOTE: If more than one person is maintaining these files for the laboratory, you may want to prefix the code with a section indicator letter. For example, CCARD for Chemistry.

DESCRIPTION (25-C-R)
Enter the description of this standard result text. This description should reflect the type or use of the SRT.

NOTE: If more than one person is maintaining these files for the laboratory, you may want to prefix the description with the section responsible for maintaining this file. For example, CHEM-Cardiac Profile,Normal. This helps with the selection of the correct standard result text to edit in the processors and in result reporting when you have a component set up for wordprocessing with access to all standard result text documents.

TEXT (U-C-R)
Enter the exact text as it is to appear in a report. The text can be more than 220 characters in length, if necessary. Special characters can be used within the text to represent data element locations which will require editing during result entry. For example, use *xx* where numeric values will be entered for dimensions, weights, and so on. The laboratory staff can replace these data elements with specimen-specific data using the word-processing module. When formatting this text, refer to the line length you defined for your system. For information on line length refer to Chapter 1: Flags/Utilities in the *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide.*

STANDARD RESULT SUBGROUP

CODE (12-N-R)
Enter the subgroup code.

DESCRIPTION (25-C-R)
Enter the description of this subgroup.

GROUPED STANDARD RESULT TEXT
Use this worksheet to list Standard Result Text documents for this group.

CODE (12-AN-R)
Enter the standard result text name.

DESCRIPTION (25-C-R)
Enter the standard result text description.

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COMMENT TABLE

Various comments can be entered here for use during the order entry and/or accession process.

CODE (3-N-R)
Enter a numeric code for each Comment. A maximum of three characters is allowed.

DESCRIPTION (20-AN-R)
Enter the comment (up to 20 characters).

FINANCIAL CLASSES

Define the patient type exceptions for financial classes eligible for sales commission.

FINANCIAL CLASS CODE (1-A-R)
Enter the code for the financial class for this worksheet.

DESCRIPTION (33-C-R)
Enter the description for the financial class for this worksheet.

PATIENT TYPE EXCEPTION CODE (3-C-R)
In this column enter the code for each patient type exception you want to associate with this financial class.

DESCRIPTION (33-C-R)
In this column enter the description for each patient type exception you want to associate with this financial class.

RECALL CATEGORIES

RECALL CATEGORY CODE (3-AN-R)
This is a 3 character alphanumeric code for the recall category.

RECALL CATEGORY DESCRIPTION (36-AN-R)
Enter the description for the recall category. The description can contain up to 36 alphanumeric characters in length. Do **not** duplicate descriptions.

DELINQUENT QUEUE RETENTION (3-N-O)
This field determines the number of days to retain the recall accessions in the delinquent queue before the system automatically deletes them from the queue and moves the recall accessions to the Deletion Audit.

This field is not required. If you do not enter a value, the recall accessions remain in the delinquent queue until one of the following events occurs:

- A recall follow-up test is performed.

- The patient (recall accession) is manually deleted from the queue through the Delete Patient From Queue processor.

- A group of recall accessions are moved to the Recall Deletion Audit through the Delete Delinquent Queue processor.

During Midnight Processing the system removes patients from this queue based on the number of retention days defined and the date the patients were added to the queue. If this field is left blank, Midnight Processing does not maintain the removal of the Delinquent Queue.

DELETION AUDIT RETENTION (3-N-O)
This field determines the number of days to retain the audit used to review all patients deleted from the Recall Process.

When a patient is removed from the recall process the patient is listed in the Recall Deletion Audit. This audit provides a means to review all patients removed from the recall process. The Deletion Audit Retention field provides a way to automatically delete a group of patients from the Deletion Audit.

NOTE: The Delete Deletion Audit function provides a way to manually delete patients from the audit.

During Midnight Processing the system removes patients from this audit based on the retention days defined and the date the patients were added to the audit. If this field is left blank, Midnight Processing does not maintain the removal of the Deletion Audit and the patients remain on the audit until manually deleted.

REMINDER LETTER MODULE/TYPE (TABLE SELECTION - R)
This field defines the letter module and letter type for all letters pertaining to this category from the ALLSTAR Letter Utility. Currently, the only feature using this option is Lab - Recall Management. The only types defined are Recall Letters. Both of these selections are defined by McKesson.

RECALL TYPES

RECALL CATEGORY CODE (3-AN-R)
This is a 3 alphanumeric character code for the Recall Category.

RECALL TYPE CODE (8-AN-R)
This is an 8 alphanumeric character code for the Recall Type.

RECALL TYPE DESCRIPTION (30-AN-R)
Enter the description for the recall category. The description can contain up to 30 alphanumeric characters in length. Do **not** duplicate descriptions.

HOLD PERIOD (SPECIAL PROCESSING - R)
This field enables you to enter the Hold Period in days, months or years. This is the time period used to calculate a patient's Hold Date during result reporting. The patient's calculated Hold Date is the Hold Period added to the date and time the test is resulted to a done status. This Hold Period determines the time frame the patient is kept in the Hold Queue. This is the period of time defined before it is time for the patient to return for follow-up testing. A Hold Period defined for prompt allows the user to determine the Recall Period at time of result reporting. Once the Hold Date is reached, the patient is moved, via midnight processing, to the next defined step in the Recall Process.

The following examples show how to enter the different Hold Periods correctly.

For a Hold Period of 15 days, enter **15D**.
For a Hold Period of 3 months, enter **3M**.
For a Hold Period of 2 years, enter **2Y**.
For a prompt Hold Period, enter **P**.
For no Hold Period, enter **N**.

NOTE: If you enter none in the field you do not have access to any reminder queue times or to the fields that define patient or physician letter types. Selecting none automatically causes the accession to move to the hold queue until midnight processing runs. At that time, the recall accession moves to the Recall Deletion Audit.

RECALL FOLLOW-UP TESTS (SPECIAL PROCESSING - O)
This field indicates the Recall Follow-up Tests for this Recall Type. Recall Follow-up Tests are a list of test codes that, if subsequently ordered and resulted to a status of Done, removes a patient's current Recall (hold, reminders or delinquent) Queue entry (recall accession) and either makes a new enty for that patient based on the follow-up test or adds that patient to the Recall Deletion Audit.

EXCLUDE PATIENT TYPES (SPECIAL PROCESSING - O)
This field excludes patient types from the defined Recall Type processing. This gives you the ability to limit the display of certain Recall Types during result reporting according to the patient's type. Excluded patient types can be defined for any facility.

FIRST REMINDER (3-N-R)

This field indicates the number of days for the First Reminder period. This entry is added to the Hold Date to calculate the patient's first reminder date. If a value is entered in this field both patient and/or physician letters can be defined for the first reminder period. First reminder letters can be sent to the patient and/or physician while the recall accession is in the first Reminder Queue.

NOTE: If a patient had follow-up tests performed during this period, the recall accession will not be processed through any more reminder queues and is sent to the Recall Deletion Audit as the final step in the recall process.

If no follow-up tests are performed during this period and a second reminder period is defined, the patient is sent to the second reminder queue after reaching the first reminder date.

If no follow-up tests are performed during this period and no second reminder period is defined, the patient is sent to the Delinquent Queue after reaching the first reminder date.

If this field is left blank, no patient or physician reminder letters can be defined and if follow-up testing does not occur for the patient during the defined first reminder period, the patient is sent directly to the Delinquent Queue. (If the hold period is defined as **None**, the patient is sent directly to the Deletion Audit).

SECOND REMINDER (3-N-O)

This field indicates the number of days for the Second Reminder period. This entry is added to the first reminder date to calculate the patient's second reminder date. If a value is entered in this field both patient and/or physician letters can be defined for the second reminder queue. Second reminder letters can be sent to the patient and/or the physician while the patient is in the second reminder period. This field cannot be accessed unless First Reminder period is completed.

NOTE: If a patient had follow-up tests performed during this period, then the recall accession will not be processed through the third reminder queues (if defined) and is sent to the deletion audit as the final step in the recall process.

If no follow-up testing occurs during the second reminder period and no third reminder period is defined, the patient is sent to the delinquent queue.

If no follow-up testing occurs during the second reminder period and a third reminder period is defined, the patient is sent to the third reminder queue once it reaches the second reminder date.

THIRD REMINDER (3-N-O)

This field indicates the number of days for the Third Reminder period. This entry is added to the second reminder date to calculate the patient's third reminder date. If a value is entered in this field both patient and/or physician letters can be defined for the

third reminder queue. Third reminder letters can be sent to the patient and/or the physician while the patient is in the third reminder period. This field cannot be accessed unless Second Reminder period is completed.

NOTE: If a patient had follow-up tests performed during this period, then the recall accession is sent to the deletion audit once the third reminder date has been reached.

   If no follow-up testing occurs during the third reminder period, the recall accession is sent to the delinquent queue.

PATIENT FIRST LETTER (TABLE SELECTION - O)
This field indicates the name of the Letter, from the ALLSTAR Letter Utility, used for the First Reminder Letter, patient's copy, for this recall type. This field cannot be accessed unless the First Reminder field is completed. When the First Reminder period field is defined and the Patient First Letter field is left blank, no First Reminder letter for this recall type is printed for the patient.

A table of Letter versions for Recall Letter displays when you enter the field. All defined letter versions displays. Enter the letter version that is appropriate for a first reminder letter for the patient.

NOTE: Summary format reminder letters are not supported for the patient reminder letter.

PATIENT SECOND LETTER (TABLE SELECTION - O)
This field indicates the name of the Letter, from the ALLSTAR Letter Utility, used for the Second Reminder Letter, patient's copy, for this Recall Type. This field cannot be accessed unless the Second Reminder field is completed. When the Second Reminder period field is defined and the Patient Second Letter field is left blank, no Second Reminder letter for this recall type is printed for the patient. Processing for this field is the same as for Patient First Letter.

A table of Letter versions for Recall Letter displays when you enter the field. All defined letter versions displays. Enter the letter version that is appropriate for a second reminder letter for the patient.

NOTE: Summary format reminder letters are not supported for the patient reminder letter.

PATIENT THIRD LETTER (TABLE SELECTION - O)
This field displays the name of the Letter, from the ALLSTAR Letter Utility, used for the Third Reminder Letter, patient's copy, for this Recall Type. This field cannot be accessed unless the Third Reminder field is completed. When the Third Reminder period field is defined and the Patient Third Letter field is left blank, no Third Reminder letter for this recall type is printed for the patient. Processing for this field is the same as for Patient First Letter.

A table of Letter versions for Recall Letter displays when you enter the field. All defined letter versions displays. Enter the letter version that is appropriate for a third reminder letter for the patient.

NOTE: Summary format reminder letters are not supported for the patient reminder letter.

PHYSICIAN LETTERS FIRST, SECOND, THIRD DETAIL/SUMMARY (SCROLLING SCREEN/TABLE SELECTION)
This field indicates the name of the Letters, from the ALLSTAR Letter Utility, used for the First, Second and Third Detail and Summary letters for the Attending, Ordering, Primary Care, Referring, Admitting, and Consulting Physicians.

NOTE: When you need a Second or Third Reminder Detail Letter, enter the information for these fields using the same manner as for the First Reminder Detail Letter.

The system supports two letter type formats that can be printed for the physician. Both formats can be defined for a physician. The Detail Letter prints an individual letter to the physician for each patient that meets the criteria for the reminder queue. The Summary Letter generates one physician letter with a list of all patients that meet the criteria for the reminder queue.

• The First Letter fields cannot be accessed unless the First Reminder field is completed. When the First Reminder period field is defined and the Physician First Detail Letter or Summary Letter field is left blank, no First Reminder letters for this recall type are printed for the physician.

• Similarly, the Second Letter fields cannot be accessed unless the Second Reminder field is completed. When the Second Reminder period field is defined and the Physician Second Letter Detail or Summary Letter field is left blank, no Second Reminder letters for this recall type are printed for the physician.

• Also, the Third Letter fields cannot be accessed unless the Third Reminder field is completed. When the Third Reminder period field is defined and the Physician Third Detail Letter or Summary Letter field is left blank, no Third Reminder letters for this recall type are printed for the physician.

RECALL DELETION REASONS

CODE (8-AN-R)
This is an 8 alphanumeric character code for the Recall Deletion Reason.

DESCRIPTION (36-AN-R)
Enter the description for the recall deletion reason. The description can contain up to 36 alphanumeric characters in length. Do not duplicate descriptions.

RECALL COMPONENT/TEST LISTING

RECALL CATEGORIES (TABLE SELECTION - R)
This field indicates the description for the Recall Category selected.

HARDCOPY? (1-YN-R)
This field determines if a printed copy of this report is desired. If not, the report displays on the user's screen.

DEFAULT PRINTER (TABLE SELECTION - R)
This field designates the printer for the report. The default printer is defined in Maintenance for the General Report printer.

NOTE: This report when sent to the screen could take several minutes to complete the search for all test codes.

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Chapter 3 - Employee Files

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SECURITY LEVELS

STAR Laboratory supports up to 80 different security levels. Each level allows users to perform a different set of functions, based on the desires of laboratory management. The levels are assigned numerically from 1 to 80, usually in increments of five to ten units so that additional levels may be added as needed to accommodate new jobs or variations in job responsibilities. In a typical laboratory, the following security scheme might be employed:

SECURITY LEVEL	DESCRIPTION
0	Doctors (Patient Inquiry only)
5	Receptionist
10	Phlebotomist
20	Student
30	Medical Laboratory Technician
40	Medical Technologist
50	Section Supervisor
60	Pathologist
70	Laboratory Administrator
80	System Manager

McKesson will automatically assign the System Manager a level of 80 so that he or she can perform all functions available in the system.

SCREEN NAME (U-AN-R)
This is the name of the security level that will appear on the screen for selection of securities as you build the various files in the system. It is suggested that you not only list the name of the security level but also the level itself. If you do that, as you fill out the other worksheets necessary for a system build, you will only have to list the numeric value for the security rather than writing the whole name. For example, the security level 70 for Pathologist would have a screen name of Pathologist (70).

SECURITY NAME (U-AN-R)
This is the name for the security level. There is no limit to the length; however, generally this is a 20- to 30-character alpha field.

SECURITY LEVEL (2-N-R)
This is the actual numeric value of the security level defined in the Security Name field. This can be any number from 1 to 80.

ACCESS CODES

Access codes provide an additional security clearance for selected individuals and may be specified for functions to which the laboratory wants to restrict access (rather than allowing access by all individuals at one security level.)

Access codes are attached to a function and individual's records in the system files. Users who do not have the access code for a particular function will be unable to perform that function. For example, if Med Tech's security level is 40 and this same level is attached to the Quality Control function, all Med Tech's with the level of 40 can access Quality Control. To restrict access of the Quality Control function to only certain Med Techs, an access code called QC could be created and attached to both the employee and the function called Quality Control. Access codes are not visible to the user and they do not have to be entered before using a function.

An access code called Special Office Access is already defined within the system. Special Office Access allows users of lower security level to access a function normally reserved for a higher security level. (This functions in reverse of the previous description.) For example, if an office person with a security level of 5 needs to access the Administration section which might have a security level of 50, assign the Special Office Access to both the employee and the Administrative section. That employee can then access a function normally restricted due to the security level of that function.

Remember, access codes restrict users not assigned access codes from a function regardless of their security level. Special Office Access on the other hand allows users of lower security to access a function normally reserved for users with a higher security level.

It is important to note that if access codes are assigned to functions, they must also be assigned to the individuals who need to access that function.

ACCESS NAMES (20-C-O)
Fill in the fields with the names of the access codes you wish to create for your system. They should reflect the function or level for which they will be used. You can have a maximum of 36 access codes.

SECTIONS/SHIFTS

Authorized users must be identified by their sections or shifts in the system's employee files. Use the Employee Sections/Shifts worksheet to list these sections and shifts.

Since users of the system may include individuals from outside the laboratory, other areas/sections (such as house staff and nursing service) should be included on the worksheet.

SECTION/SHIFT NAME (33-C-R)
This is the name of the section or shift that can be assigned to employees. This field does have a limit of 33 characters but is generally 15 to 25 characters.

SECRET CODE DAYS (3-N-O)
This field allows you to designate by the section or shift level the number of days before the system will force the changing of the secret code. Fill the blank with the number of days the secret code will be valid.

The employee data management and security processors control access to the rest of the processors of STAR Laboratory. All users of the system will have a unique identification code which enables them to sign-on to the system. This sign-on code is coupled with an employee-chosen secret code or personal password, which assures that the sign-on code is not used by other individuals. This secret code should be changed periodically to assure an even greater degree of system security.

POSITIONS

Employees are identified in the system with specific job categories or positions. Each position is assigned a default security level (from the list of security levels previously defined), corresponding to the level of the majority of employees who hold that position. An alternate security level may be assigned to selected individuals within a position.

POSITION NAME (U-C-R)
This is the name of the position. This field is not limited but is generally less than 30 alpha characters.

DEFAULT SECURITY LEVEL (2-N-R)
This is the default security level that will be assigned to the employee when they are assigned the above position. This security level option is based on the security levels you have designed for your system.

ALLOW SPECIAL OFFICE PERSONNEL ACCESS? (1-A-R)
Refer to "ACCESS CODES" on page 3-4 for a description of Special Office Access. If you want to attach this access code to the position, circle Yes. If you do not want the access code to be part of the position, circle No.

OTHER PARAMETERS

Other parameters used within the STAR Laboratory employee processors are explained as follows:

TOP MANAGEMENT LEVEL (2-N-C)
Use this field to list the top level of security (usually the System Manager) to be used within the Employee Processor. For example, a user who is trying to edit or assign himself/herself higher security will cause the system to display the following message:

You are not authorized to do this function. Top Management must intervene!

Allow special office personnel access? - Check **Yes** if this security level is to have this access code attached to it. Otherwise check **No**.

Access code(s) - Use these lines to list access codes to assign to this security level. Select the access codes from the those previously defined for your laboratory.

ADD EMPLOYEE (2-N-R)
Enter the security level required to add an employee to STAR Laboratory.

Allow special office personnel access? - Check **Yes** if this security level should have this access code attached to it. Otherwise, check **No**.

Access code(s) - Use these lines to list access codes to assign to this security level. Select the access codes from the those previously defined for your laboratory.

EDIT ACCESS CODES (2-N-O)
Enter the security level necessary to edit access codes.

Allow special office personnel access? - Check **Yes** if this security level is to have this access code attached to it. Otherwise check **No**.

Access code(s) - Use these lines to list access codes to assign to this security level. Select the access codes from the those previously defined for your laboratory.

DEFAULT AREA CODE (3-N-O)
Enter the default area code to be used to auto-fill within the phone number field for the employee record.

DEFAULT CITY (15-C-O)
Enter the default city to be used to auto-fill the city field for the employee record.

DEFAULT STATE (2-A-O)
Enter the default state to be used to auto-fill the state field for the employee record.

PERSONNEL RECORD/EMPLOYEE DEMOGRAPHICS

An Employee Demographic Record worksheet should be completed on every laboratory and data processing employee, regardless of whether he or she will use the STAR Laboratory system. All personnel will thereby be included in the system's files so that management reports pertaining to the entire laboratory staff can be generated. Consult your McKesson installation representatives about employees in nursing and other areas who should also complete a worksheet. Some fields on the worksheets are REQUIRED.

All employees should be entered into the system before the training phase of installation.

Personnel Record

ID CODE (7-AN-R)
Each employee must have a unique ID code to sign-on to the system. The ID code can be a system-assigned number or one designated by the laboratory. Enter a single alpha character followed by numeric characters or all numeric characters up to seven characters in length. For the system to assign the number, enter **A**.

EMPLOYEE NAME (22-A-R)
Enter the employee name in LAST,FIRST M format. This is a required field with a 22 alpha character limit.

INITIALS (3-A-R)
Enter three employee initials in this field.

EMPLOYEE # (U-AN-R)
This is a required alphanumeric field for the employee's number. It has no limit; however, it is suggested it be no longer than eight or nine characters. It can be the employee's hospital number, laboratory number, and so on.

STAR ENVIRONMENT (17-C-O)
For information on this field refer to the *ALLSTAR SignOn User's Guide.*

DEFAULT STAR ENVIRONMENT (17-C-O)
For information on this field refer to the *ALLSTAR SignOn User's Guide.*

O.S. ID CODE (7-C-O)
For information on this field refer to the *ALLSTAR SignOn User's Guide.*

POSITION (2-N-R)
This is a required field for the position the employee holds in the laboratory. Select from the table you have designed for your system.

SECTION/SHIFT (U-C-R)
Each employee must be assigned to a section or shift. This is a required field. Select one from the table designed by your laboratory.

ADVANCED BLOOD BANKER (1-A-R)
Indicate in this field if the employee works on the Advanced Blood Bank system. Check Yes to have the system send employee data for this employee to the Advanced Blood Bank module. Check No if this employee does not work on Advanced Blood Bank.

INITIAL MENU (1-A-R)
This field is used to designate which screen will display when the employee signs on. Check either Department or Section.

If Department is selected, the employee will sign-on to the main menu (of the facility listed in the next field). If more than one facility exists, a table of facilities will display for selection.

If Section is selected, list the section name (from the Sections worksheet).

MAIN MENU RETURN (1-C-O)
This field is completed for those employees who use section menu for the initial menu sign-on. This field allows you to give an employee who signs on at the section menu access to the main menu access to the main menu (the employee would press ENTER at the section menu). Check **Y** if you want to allow access to the main menu. Check **N** if you do not want to allow access to the main menu. Employees who are not allowed access will be signed off the system when they press ENTER at the main menu.

SECURITY LEVEL (2-N-R)
Enter the security level for this employee.

ALLOW SPECIAL OFFICE PERSONNEL ACCESS? (1-A-R)
If the Special Office Access code should be assigned to this employee, check Yes. If the code should not be assigned, check No.

ACCESS CODES (U-AN-O)
List any access codes this employee will be using. Select from the previously-defined list for your laboratory.

DEPARTMENT ACCESS (3-A-R)
Use this required field to designate the laboratory department(s) this employee can access. At least one department must be listed.

PATIENT FACILITIES (2-A-R)
Use this field to designate which facilities an employee can access. Most will only have one facility while the System Manager will probably need all.

NAVIGATOR PATIENT INFORMATION ICON RESTRICTED (NPIIR)
Use this field to view a series of fields that restrict different data fields from displaying when the user clicks the Navigator Patient Information Icon.

Demographics

These optional fields can be used to enter additional information on employees. These fields are used within some of the Employee File Processors, such as the mailing label processor. The first three fields (Name, Employee Number, and ID Code) are display only and cannot be edited.

PROFESSIONAL DESIGNATION (U-AN-O)
Use this field to enter the employee's title/professional designations. These display along with the name when the employee signs-on (for example, BROWN,JANICE A MT(ASCP) - MT(ASCP) is the professional designation).

SOCIAL SECURITY NUMBER (11-C-O)
Enter the employee's social security number.

REGISTRY OR LICENSE NUMBER (U-C-O)
Enter the registry or license number of the employee.

HIRE DATE (8-N-O)
Enter the employee's hire date in MM/DD/YY format.

BIRTHDATE (8-N-O)
Enter the employee's birthdate in MM/DD/YY format.

STREET ADDRESS (U-AN-O)
Enter the employee's street address.

CITY (U-A-O)
Enter the employee's city or an equal (**=**) sign to use the default city designated on the Other Parameters screen.

STATE (2-A-O)
Enter the two alpha character abbreviation for the employee's state or an equal sign (**=**) to use the default designated on the Other Parameters screen.

ZIP (5-N-O)
Enter the employee's five-digit zip code.

HOME PHONE (10-N-O)
Enter the employee's phone number (10 digits). If the area code is the same as the default area code, enter the seven digit number. (The system automatically formats this field with hyphens and parentheses.)

ANNIVERSARY DATE (8-N-O)
Enter the employee's anniversary/review date in MM/DD/YY format.

PAY CODE/PAY SCALE/STEP (U-C-O)
Enter the pay code/scale/step of the employee.

PAY RATE (U-C-O)
Enter the pay rate of the employee.

Chapter 4 - Menus

STAR Laboratory Reference Guide - Maintenance Worksheets Volume
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LABORATORY MENU - MAIN

The Main Menu of STAR Laboratory functions as a doorway to the rest of the system. It is from this pathway that you progress to the various sections and functions of the system.

This worksheet is used to design the main menu. A maximum of 16 options can be assigned to it. Blank lines may be included within the menu. It is recommended that **all** sections be placed on the main menu and **only** one or two functions (such as Patient Inquiry and Order Inquiry). Be sure to include a section called Administration and one called Front Office.

Administration generally contains functions such as the Maintenance Processor, System Manager Processor, and Interface Control, that are not section-specific and do not need to be available to the whole laboratory. They are also functions that probably require a higher security than the section level functions.

Front Office is generally used for the batch reports such as Cumulative Trends, Summaries, Interim Summaries, and other functions that are generally performed by the laboratory's clerical staff These functions do not generally require a high security.

NOTE: If the "Table Display of Sections" field under Flags-General Department is set to Yes, all sections defined in Laboratory Menu - Section, display as a table. Functions do not display. There is no reason, therefore, to build a main menu as it does not display. If the flag is set to No, use the following worksheet to design the main menu.

OPTION # (2-N-R)
Indicate the position this function or section will occupy on the main menu by entering a number from 1 to 16.

S/F (1-A-R)
Enter **S** if this menu option is a section; enter **F** if it is a function. A section is a group of workstations or bays contained under one option such as Hematology. A function is a processor that is used for a specific job such as Patient Inquiry.

STAR Laboratory functions include:

1.   Change Your Secret Code
2.   Department Incomplete Work Report
3.   Menu type/Color/Function keys
4.   Order Inquiry
5.   Patient Inquiry
6.   Patient Care Interface
7.   Patient Care Patient Management
8.   Spooler Management
9.   SQL
10. SQL - DBA

NOTE: For more information on the SQL and SQL -DBA functions, refer to the *STAR Vista Reporting/SQL Reference Guide.*

MENU OPTION (U-C-R)
Indicate the exact wording as it is to appear on the menu. This is automatically filled in when the option is selected in the builder.

SCREEN TITLE (U-C-R)
Screen Title refers to the word or phrase that appears at the top of the next screen when that menu option is selected. Generally, the menu option and the screen title are the same. This is automatically filled in when the option is selected in the builder.

SECURITY (3-N-R)
Indicate the minimum security level required to access this option. Select from the security levels you have designed for your system.

ACCESS CODES (U-A-O)
Indicate the access code (if any) required to access this menu option. Select from those defined for your system.

LABORATORY MENU - MAIN II

This is an optional worksheet and can be used to position the main menu options. Sixteen lines are allowed (including blanks) for this menu. The system automatically places the option numbers at the 15th or 16th column depending on whether it is one or two characters. Text for the screen display options starts at the 24th column. If you are building your own system, you may not find it necessary to complete this worksheet; however, if you are having someone else build your system, you should complete the worksheet.

LABORATORY MENU - SECTION I

Since STAR Laboratory is internally organized by laboratory sections, most data entered into the system is associated with a specific area or section. In most clinical laboratories, sections are already defined before the computer system is installed. Each laboratory section is usually associated with a particular group of bays (work stations), a specific set of test procedures, a list of equipment items, and particular workload statistics.

The Laboratory Menu - Section worksheets are used to collect information concerning each section of the laboratory. This information determines how the system accumulates, sorts, processes and prints data.

Section Fields

Complete one worksheet for each section in your laboratory.

LAB SECTION CODE (3-A-R)
Enter a three-character alphabetic code which reflects the section name. Due to space limitations, this code may be printed on some reports in lieu of the section name. For example, CHM for Chemistry and MIC for Microbiology.

SECTION NAME (20-C-R)
Enter the section name up to 20 characters.

CHARTING CODE (1-A-O)
Enter a single alphabetic character which prints on all Primary Result Reports generated from this section. This code is used in report charting and/or sorting. Some hospitals "shingle" Primary Reports on colored charting paper. (The color usually reflects the color of manual requisitions.) Therefore, the charting code usually indicates either the color of charting paper for the report or the section from which the report was generated. For example, **Y** for yellow charting paper, **G** for green charting paper, **C** for Chemistry, or **H** for Hematology. If Primary Result Reports are not charted, this field can be left blank.

ACCUMULATE WORKLOAD (1-C-O)
Workload can be accumulated by Section, Section and Employee, or Neither. It is important to note that workload by Section/Employee requires considerable more disk space then workload by the Section. Therefore, it is suggested that "Workload by Section/Employee" only be used for short time intervals (a week or two) for statistical purposes and not be the usual mode of accumulation. If workload is not activated prior to live, select Neither. Otherwise, place a check before the appropriate accumulation.

MISC CHARGES AT ACCN (1-A-R)
Press the ENTER key or select **N** to prevent the user from entering any miscellaneous charges or credits after accessioning. Select **Y** to allow the user to be prompted to enter miscellaneous charges or credits after accessioning is completed.

MISC CHARGES WARNING MESSAGE (1-A-R)
Press the ENTER key or select **Y** to alert the user that some miscellaneous charges exist after specimen rejecting a patient specimen. Select **N** and the user will not receive the message. If Misc Charges at Accn field is set to *No* this field will be automatically set to *No*.

Section Ranges

One of the most important items on the worksheet is test code range assignment. Many of the system's management reports can be sorted by section and this range is used to determine the section. The system also uses the section range to determine which test code statistics to assign to which section. Every procedure performed by the laboratory is identified in STAR Laboratory by a unique test code. All procedures performed by a particular section are thus classified into a specific range of these test codes.

NOTE: For those test procedures that are shared by the various sections of the laboratory, the test code must be assigned to one of the section ranges. This does not prevent it from being assigned to any bay or section in the system.

Section ranges should be broad enough so that a unique number can be assigned for every procedure performed within that section and so that new tests can be added when necessary. Since test codes need not be assigned in numeric order, every second or fifth number may be assigned if desired. The lowest test code should be 1000. Examples of section test code ranges are:

Code	Section	Range 1
HEM	Hematology	1000-1999
CHM	Chemistry	2000-3999
OUT	Send-Outs	4000-5999
COG	Coagulation	6000-6499
MIC	Microbiology	7000-7999
BLB	Blood Bank	8000-8999
SER	Serology	9000-9499
URN	Urinalysis	9500-9999

Note that two of the sections, Chemistry and Send-Outs, have a much broader range than the others. That is because these two sections generally have the majority of tests with new procedures constantly being developed and added.

NOTE: If all test codes within a section range are used, a second range can be defined. For practical purposes, however, it is best to keep all test codes within one range.

LOW SECTION RANGE 1 (4-N-R)
Enter the lowest test code in the section range. For Hematology in the preceding example, this could be 1000.

HIGH SECTION RANGE 1 (4-N-R)
Enter the highest test code in the section range. For Hematology in the preceding example, this could be 1999.

It is possible to have "mini" ranges of test codes within the section range to reflect different bays. These do not, however, need to be broken out into separate section ranges.

LOW SECTION RANGE 2 (4-N-O)
This field is only used when it becomes necessary for a section to contain two separate ranges. This is usually not necessary. If the section does not contain two ranges, do not enter a number here. Enter the low test code for the second range.

HIGH SECTION RANGE 2 (4-N-R)
Enter the high test code for the second range.

ACTIVATE EQC (1-C-O)
Each section determines whether or not to activate quality control and who is allowed to defer, cancel and overwrite equipment quality control (EQC) values.

Check Yes to activate accumulation of EQC statistics. Check No if EQC is not to be activated until later.

EQC SECURITY (DCO) (U-C-O)
Enter the minimum security level allowed to defer/cancel/overwrite equipment quality control (EQC) values at result entry. This level is based on the security levels designed for your laboratory.

ACTIVATE SQC (1-C-O)
Each section determines whether or not to activate quality control and who is allowed to defer, cancel, and overwrite sample quality control (SQC) values. Check Yes to activate accumulation of SQC statistics. Check No if sample quality control is not to be activated until later.

SQC SECURITY (DCO) (U-C-O)
Enter the minimum security level allowed to defer/cancel/overwrite sample quality control (SQC) values at result entry. This level is based on the security levels designed for your laboratory.

PANIC REPORT SECURITY (U-R-O)
Enter the minimum security level required to release a report with a panic value. This level is based on the security levels designed for your laboratory.

FLAG AT RESULTING (1-A-R)
This field determines if STAR Laboratory flags results for Abnormal, High, or Low conditions during resulting. Check **Yes** to enable flagging at resulting. Check **No** to disable flagging at resulting.

WARNING: Entering Yes in this field to enable flagging at resulting may have an impact on system performance.

VALIDITY OVERRIDE (1-A-R)
This field determines overrides to valid range and valid values. Check Yes to enable overrides. Check No to disable overrides.

LOW ORDERING RANGE 1 (4-N-R)
The ordering range determines the ordering and accessioning capabilities of a section. STAR Laboratory allows two types of ordering and accessioning: departmental and centralized. Departmental accessioning restricts the tests which can be ordered and accessioned within a section to those falling within the section's "ordering" range. "Centralized" allows a section to order and accession **all** tests within the laboratory. It is these ordering ranges at the section level that determine how specimen processing is handled.

If the laboratory elects to have departmental accessioning at the section level, the ordering ranges should be the same as the section ranges (that is, Hematology, 1000-1999). If a section needs to order and accession for two different sections, ranges 1 and 2 should be filled in (that is, Hematology accessions Blood Bank's tests, 1000-1999, 8000-8999). If departmental ordering and accessioning is not used by the laboratory, then range 1 should reflect the range of all test codes in the system (that is, 1000-9999).

Commonly, laboratories choose a combination of the preceding; that is, Central Processing provides the capability of ordering and accessioning all tests while individual sections allow only the ordering and accessioning of their own tests.

Enter the lowest test code for range 1.

HIGH ORDERING RANGE 1 (4-N-R)
Enter the highest test code for range 1.

LOW ORDERING RANGE 2 (4-N-O)
Enter the lowest test code for range 2.

HIGH ORDERING RANGE 2 (4-N-O)
Enter the highest test code for range 2.

LOW MISC. CHARGE CODE (4-N-O)
Currently STAR Laboratory assumes that the charging of all orderable laboratory tests
will be handled at time of ordering, accessioning, or resulting; however, all procedures
or chargeable items provided by the laboratory are not always linked to an order. Or,
at the time of charging, the exact item to be charged cannot be determined. This is
true for nearly all services of the advanced modules such as Anatomic Pathology and
Advanced Microbiology, for example, additional plate media used during a culture's
identification. As you define your section, a subset range of test codes within the
section range can be defined for these billable items. It is possible for the entire section
range to be listed here; however, it will cause more system overhead if that is the case.

NOTE: The code must be within either section range 1 (defined in fields 5 and 6) or
            section range 2 (defined in fields 7 and 8).

HI MISC. CHARGE CODE (4-N-O)
Enter the highest test code to be used for miscellaneous charges.

NOTE: The code must be within either section range 1 (defined in fields 5 and 6) or
            section range 2 (defined in fields 7 and 8).

PI DISPLAY (1-C-R)
If Patient Inquiry is available in this section, indicate the test codes that can be viewed
in Patient Inquiry within this section. Check *Y* to allow only those test code ranges
defined in this section to display, or *N* to display all tests in Patient Inquiry when
accessed in this section.

TEST LOOKUP SEARCH (4-N-R)
To begin test code lookup search, enter the number of days prior to current date.
Some sections may limit the search to the last several months; others may need years
or days. Enter between 1 and 9999 days. A default of 180 is suggested.

Indicate the minimum security level required to accept and report a panic value, using
one of the table entry techniques described in Chapter 4 Information Entry Techniques
in the *General Information Volume* of the *STAR Laboratory Reference Guide*. After
you select a security level, the system files the information on the screen.

PARTIAL CORRECTION   (1-A-R)
This field indicates whether to activate partial to partial correction logic for the selected
section.

When you enter **Y**, the system displays *Yes* in the field. Partial to partial correction
logic processing occurs when an external result changes on a test with a status of
Partial and the test is viewable in Inquiry Processors or a Primary Report prints.

When you enter **N**, the system displays *No* in the field. Correction logic processing
occurs only when an external result changes on a test with a *Done* status.

Routine ordered tests in a review queue with a *Partial* status whose results are not viewable in Inquiry Processors are not flagged as corrected even if results are changed. STAT and ASAP *Partial* tests in a review queue are flagged as corrected, whether the results are viewable in Inquiry Processors or not, as long as a primary report prints.

BATCH RELEASE QUEUE (1-A-R)
Press ENTER or enter **N** to prohibit batch release processing from any review queue in the selected section. Enter **Y** to allow batch release processing and waive viewing each queued entry in any review queue associated with the selected section.

In the Review Queue Reporting processor, the batch release prompt displays only if the batch release queue flag is set to active for the section selected.

LABORATORY MENU - SECTION II

This worksheet is used to define features and functions for each section. This is where you determine the menu options for this section and the security level for each.

OPTION # (2-N-O)
Indicate the position this function or section occupies on the section menu by entering a number from one to 16.

B/F (1-A-R)
Enter **B** if this is a bay; **F** if it is a function. A bay consists of a group of tests that are performed in the same work area. A function is a processor used to perform a specific job. Common functions for a section are Workload, Quality Control, Patient Inquiry, Accessioning, and Incomplete Work.

The base table of STAR Laboratory functions includes:

Accessioning	New Order Queue
Ad Hoc Reporting	Order Cancellation
Adv. Micro Batch Reporting	Order Credit
Adv. Micro Result Reporting	Order Entry
Adv. Micro Review Queue Report	Order Inquiry
Anatomic Path Order Management	Panic Notification
Anatomic Path Result Reporting	Patient Care Interface
Archiving	Patient Care Patient Management
Audit - Hemocare --> Lab	Patient Inquiry
Audit - Lab --> Hemocare	Patient Management
Bar Code Functions	PC Downloading
Blood Bank Inventory	Pending Order Cancellation Rev
Case Login	Physician Inquiry - Lookup
Census	Print Archive Patient List Report
Change Your Secret Code	Print/Reprint Order Labels
Clinical Details Audit/Information	Printer Matrix Parameter Table
Collection Batch Management	Professional Billing Input
Collection Summary Report	Quality Control/Workload
Contract Billing	Recall Management
Cytology QA	Ref Lab Review Queue Reporting
Delinquent Work Report	Reference Lab Interface Audit
Department Incomplete Work Report	Repeat Queue

Download Reports	Reprint Accession Labels
Epidemiology Reports	Reprint Instrument Labels
Equipment Quality Control	Requisition Inquiry
GYN Comparison	Result Reporting
Hemocare Interface Utilities	Review Queue Reporting
Histo/Cytotech Process Audit & Report	Revise Order Information
Histo/Cytotech Processing	Sample Quality Control
Histo/Cytotech Processing Reporting	Special Labels
History Cardfile - Interface/s	Special Reports
History Cardfile - Network	Specimen Rejected Patient Reports
Horiz Cum Trend Reports	Specimen Transfer
Incomplete/Delinquent Work	Spooler Management
Incomplete Work	SQL
Interface Functions	SQL - DBA
Long Reports Batch	Start/Stop Interface
Maintenance Functions	Start/Stop Ref Lab Interface
Manual Dial Ref Lab	Summary Reports
Menu Type/Color/Function Keys	System Management Functions
Message to Hemocare	User Preferences
Miscellaneous Charge Report	Vertical Cum Trend Reports
Miscellaneous Charge/Credit	Workload

Indicate the exact wording as it is to appear on the menu.

NOTE: For additional information on the SQL and SQL - DBA functions, refer to the *STAR Vista Reporting/SQL Reference Guide.*

SCREEN TITLE (U-C-R)
Screen Title refers to the word or phrase that appears at the top of the next screen when that menu option is selected. Generally, the menu option and the screen title are the same.

SECURITY (U-C-R)
Indicate the minimum security level required to access this option. Select from the security levels you have designed for your system.

ACCESS CODES (U-C-O)
Indicate the access code (if any) required to access this menu option. Select from those defined for your system.

LABORATORY MENU - SECTION III

This optional worksheet can be used to position the menu options of the section menu. The system automatically places the options in the center of the screen. You are only allowed 16 lines including blanks and functions for a section.

If you are building your own system, you can do the design within the builder. However, if you are not building your own system, you should use the worksheet to ensure the correct placement of the section options.

LABORATORY MENU - BAY I

In most clinical laboratories, laboratory sections are usually divided into functional areas where particular types of testing are conducted. These areas are called bays (work stations).

Many functions offered by STAR Laboratory are structured on the basis of the bay locations where test procedures are performed. Thus, the System Manager, with the help of the section supervisors, must provide specific information about each bay. The Laboratory Menu - Bay worksheets are used for this purpose.

SECTION NAME (U-C-R)
Enter the section name in which the bay is located.

BAY NUMBER (3-N-R)
A unique one- to three-digit number must be assigned to each bay. This number is used internally by the system for organizing data. Numbers should begin with one (1) and increment by one for each new bay. Bays within a laboratory section need not have continuous numbers. The number of bays that can be defined for a section is only limited by the size of the section screen (only 16 options are allowed). For practical purposes, however, if the number of bays per section exceeds 12, another section should be created.

BAY NAME (16-C-R)
Enter the bay name up to 16 alphanumeric characters. A bay may be named to indicate the type of work performed there such as, Blood Gas, Morphology, Manual, Transfusions or the type of instrumentation used there such as, SMA, Coulter, or Bactec. Make it as descriptive as possible.

CHECK PREVIOUS RESULTS CRITERIA

The remainder of this worksheet is used for the Check Previous Results feature. STAR Laboratory allows you to check previous test results on a patient while in result entry. The Check Previous Results (CPR) feature can encompass all test codes, a range of test codes or selected individual test codes. Viewing of previous results is controlled at the bay level.

RANGE I - LOW TEST CODE (4-N-R)
To view all tests done on a patient, enter the lowest test code for the laboratory at Range 1. To limit Check Previous Results to only those tests done within a section, enter the lowest test code for the section (called Section Range 1 on the Laboratory Menu - Section 1 worksheet) at Range 1. To limit viewing to only tests within the bay, enter the lowest test code for the bay. If Check Previous Results should span two ranges, you can use both Range 1 and 2.

RANGE 1 - HIGH TEST CODE (4-N-R)
To view all tests done on a patient, enter the highest test code for the laboratory at Range 1. To limit Check Previous Results to only those tests done within a section, enter the highest test code for the section (called Section Range 1 on the Laboratory Menu - Section 1 worksheet) at Range 1. To limit viewing to only tests within the bay, enter the highest test code for the bay. If Check Previous Results should span two ranges, you can use both Range 1 and 2.

RANGE 2 - LOW TEST CODE (4-N-O)
If two ranges are desired for viewing Check Previous Results, fill in the lowest test code of the second range.

RANGE 2 - HIGH TEST CODE (4-N-O)
This is the highest test code of Range 2 that you wish to view when doing Check Previous Results.

NUMBER OF ACCN'S (U-N-R)
Enter the number of previous accessions to display when using the Check Previous Results feature. To see all accessions, enter a large number such as 999.

SPEC TYPE? (1-C-R)
Check Yes to display the following prompt when using the Check Previous Results feature:

> *View only those tests with the same specimen type?*

This is beneficial for sections such as Microbiology in which multiple specimen types are frequently accessioned on the same test. Check No to prevent the question from being asked (all tests, regardless of specimen type, will be available for review).

VIEW ACROSS DEPARTMENTS (1-C-O)
Check Yes to allow results from another laboratory department to be viewed during result entry. Check No to restrict viewing of tests from another department.

NOTE: This field only applies to multifacility and/or multidepartment laboratories.

SPECIFIC TEST (U-N-O)
If the bay is made up of an assortment of test codes that are not in an easily defined range, you can use the Specific Test codes feature. To do this, list all test codes within the bay that you wish to view. If when resulting, you only want to see the previously ordered results of the test you are resulting, then place nothing in this field as that is the systems default.

ADDITIONAL DEPARTMENT RANGES (4-N-O)
If the View Across Departments field is set to Yes, you can select individual departments and two test code ranges to be viewed for each department selected.

LABORATORY MENU - BAY II

Use this worksheet to assign tests to the bay. Three columns of 17 tests provide a total of 51 tests that can be assigned to a bay.

SECTION NAME (U-C-R)
Enter the name of the section to which the bay belongs.

BAY CODE/NAME (U-C-R)
Enter the code and descriptive name for the bay to which you are assigning tests.

TEST CODE (4-N-R)
Enter the code of the test that is being assigned to this bay.

DISPLAY NAME (56-C-R)
Enter the name as it is to appear on the bay menu for selection. In most cases, display name is the same as the test name; however, the name may be too long for the screen (especially when using three columns). For example, if the test name is Activated Partial Thromboplastin Time, the screen display could be APTT. For a three-column display you are allowed 20 characters for the name. For a two-column display, you are allowed 34 characters and for one column, you are allowed 56 characters for the display name. This abbreviated name does not print on any reports.

LABORATORY MENU - BAY III

Use this worksheet to design the bay menu. You have the option of inserting blank lines, headers, and so on. If you are building your own bays, this worksheet is optional since you design while building.

LABORATORY MENU - RESULT

STAR Laboratory allows you to enter results by selecting an option, or combination of options, from a list of displayed choices. This mechanism, called Menu Selection, simplifies result entry by reducing the clerical component of textual result entry. Menu Selection also reduces the transcription and spelling errors often associated with textual laboratory results while assuring uniformity in result reporting.

Any test result can have a menu designed for it. Use the Laboratory Menu - Result I worksheet to define the text to be displayed and reported along with the associated option numbers. Use the Laboratory Menu - Result II worksheet to position the menu options.

LABORATORY MENU - RESULT I

SECTION NAME (U-C-R)
Enter the section code for which the result menu is being defined.

MENU DESCRIPTION (10-C-R)
Enter the ten alpha/numeric character description which describes the purpose of this
menu since the description is displayed for selection in test building.

Standard Result Menu Options

Complete the following information for each result menu option.

OPTION NUMBER (2-C-R)
Enter the number of this option. Each option number is associated with one menu
response and is determined by its position on the menu. A maximum of 68 (4 cdumns
of 17 options) are available per screen.

SCREEN DISPLAY (U-C-R)
Enter the text to appear on the menu (Screen Display). This is often a shortened
version of the report text. The screen display may be specified using alpha or numeric
characters and in an uppercase and/or lowercase format.

REPORT TEXT (220-C-R)
Each option on the menu translates to a Report Text, which prints on reports. In many
cases, the Report Text is the same as the Screen Display. However, the text displayed
on the menu may be different from the text on the reports. This feature is useful for the
interpretation of test results and for appending professional comments by physicians.
A menu option can translate to an expanded version of the screen display. In this way,
a short phrase on the screen can appear as a complete sentence or short paragraph
on the patient's report.

Menu design is very flexible. The only limit (besides the screen size) is the total
number of characters allowed by "one" test result response. Each test result may
contain up to 220 characters. Therefore, each expansion can occupy up to 220
characters of space, provided that it is used singly (not in combination with another
menu option). When menu options are combined, the total number of characters in the
final expansion may not exceed 220.

The format for the Report Text is identical to the Screen Display. Any characters may
be used as long as the 220-character length is not exceeded.

Special Menu Processing

The following types of special menu processing are available:

MENU TREEING:
Since it is often difficult to list all possible user options on a single result menu screen, a special feature is available that allows definition of a "tree" of menus so that one option on a result menu may invoke another menu, which in turn may invoke another menu, and so on. This significantly increases the number of menu options available to the user.

This special feature is defined in the same manner as that for the basic menu selection feature. Actually, it is the defined menu option that controls its use. Normally, a result menu option contains two parts: the Screen Display and the Report Text. When defining a menu option for treeing, the Screen Display is preceded by a tilde (~) symbol, and, the name of the subsequent menu is defined as the Report Text. As the result menu is built, the tilde symbol in the Screen Display causes the system to recognize that this is an option for menu treeing.   For the Report Text, you will be allowed to select the next menu's name from the list of menus created for your section. The system automatically appends the words, Next Menu to the menu name used in the Report Text field. Refer to the following for an example:

Screen Display: "~Specific Cell Morph"   Report Text: "Next Menu-Specific Morphology II"

~Specific Cell Morph displays as a menu option, and once selected, displays the next menu, Specific Morphology II. It is recommended that the name of the menus reflect their usage.

SPECIAL REPORT TEXT FIELDS
A result menu option can be used to complete multiple results of the same test. In Blood Bank, for example, a single option for the result "ABO Type" can, in addition to completing that result, also fill in the "Rh Type" result as well. A negative urine dipstick can also use this feature.

To use this feature, enter the text for the Screen Display option as usual. Within the Report Text field, enter the text for this result and other components that are to be filled in separated by a carat (^) symbol.

There must be a carat for each result component to be filled in. An example follows.

```
  COMPONENT
    109876 = "ABO Type" with a menu attached containing all ABO and Rh
    combinations
    109877= "Rh Type"
    109878 = "Antibody Screen"
    109879 = "Comment"

    Screen Text: "O +"  \ Menu option for the component number
    Report Text: "O^Pos" /  109876 result name "ABO Type."
    For HOC:    109876,109877
```

When the menu option "O+" Is selected, it will fill result component 109876 with "O" and component 109877 with "Pos."

Following is an example of multiple result fill-in using the same results as in the preceding example:

MENU OPTION

   Screen Display: "O + Antibody Neg"
   Report Text: "O^Pos^Negative"
   For McKesson: 109876,109877,109878

   Screen Display: "Screen Display text for this result"

   Report Text: "Report Text for this result^Report Text for next component to be filled^Report Text for next component to be filled^etc."

The following is another example of the use of multiple results to be filled in with a single selection of a menu option:

Test	Results	Component Number
Urinalysis	pH	108111
	Protein	108112
	Glucose	108113
	Urobilinogen	108114
	Blood	108115

One of the options on the menu for the ph result could be called "5.0 Negative Dipstick." This would be designed as follows:

Screen Display: "5.0 Negative Dipstick"
Report Text: "5.0^Negative^Negative^Negative^Negative"
For McKesson: 108111,108112,108113,108114,108115

By selecting a single option off the first result, you could have the system automatically fill in the other result component fields, thereby saving the technologist time and needless keystrokes.

LABORATORY MENU - RESULT II

This worksheet represents a blank result menu screen, and can be used to design the screen layout for your result menu. Arrange the Screen Display options along with any headers or blank lines necessary. Include the option numbers as well as the Screen Display text. The Screen Display may be done in any format as long as it is within the screen image size limitations: 80 characters wide and 16 lines down. Screen Displays may be grouped to provide ease in locating "like" information on the screen. For example, a menu used to report Microbiology Gram Stain results could have related text grouped as follows: all bacterial identifiers together, all quantitation specifiers together, and all cell types together. In addition, each group may be identified by a menu "header." A header is a title which can be placed in a position just as any specified menu response. However, the header does not have an option number and cannot be selected for result purposes.

A single result report may be a combination of multiple Screen Display options. In addition to "piecing" results together using menu selection alone, free-text may be combined with menu selection responses.

Chapter 5 - Main Test Information

STAR Laboratory Reference Guide - Maintenance Worksheets Volume
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ALLSTAR INFORMATION

For every test code that is valid for creation or exists when the Pre-existing flag is set to Yes, complete the following worksheet:

SERVICE DESCRIPTION (32-AN-R)
Enter the name of the test that identifies the laboratory procedure and is easily recognizable by both laboratory personnel and hospital staff. Enter up to 32 alphanumeric characters. It is recommended the name be less than 25 characters since some areas of the system truncate the name at 25 characters. Do not use a colon (**:**) or semicolon (**;**) in the test name.

ORDERABLE TEST (1-C-O)
Most of the tests will use the table/test code selection; however, in cases where tests are only ordered by the laboratory, you may want to allow only the entry of the test code. Indicate how this test can be selected for order entry by checking one of the following:

- Table/Test Code Selection
- Test Code Required
- Neither
- Table/Test Code (Laboratory Only) Selection

Check Neither for instrument tests created for resulting purposes (since these tests will never be ordered) or to discontinue the use of a test. When set, this option prevents the test from being ordered directly by code entry or by table selection.

POSSIBLE SPECIMENS
Indicate the specimen types for which this test can be ordered by entering specimen name and code. Or, to allow all specimens to be ordered for this test, check Table Selection. Specimen types are based on the Specimen table defined for your system. You may define from one to ten individual specimen types or allow selection from the Specimen table. This field must contain at least one specimen type. From the possible specimens, circle the default specimen type to use for normal ranges. If the default specimen type is not used at accessioning, normal ranges will not be flagged as High, Low, Panic, and will not print on any reports or display in Patient Inquiry. A default specimen type may not be possible or desirable for all tests. For example, since a routine culture can be done on any specimen type, a default specimen type is not needed. Table selection should be required for this type of test.

WARNING: Table selection allows blood and urine specimens to be ordered together. Therefore, do not use it for every test.

DEFAULT SPECIMEN
Enter the default specimen. If the default specimen type is not used at Order Entry, normal ranges do not flag, print on any reports, or display in Patient Inquiry. If you do not define a default, the system forces you to select a specimen type in the Order Entry processor. This field is optional.

BASIC TEST INFORMATION

The Basic Test Form must be completed for all procedures ordered and performed by the laboratory. The information provided on each test is used extensively by all of the system's major processors.

SECTION (3-A-R)
Enter the section code and/or name from which this test code will be defined. Use the Laboratory Menu-Section worksheet located in Menus. While it is possible for a test to be performed in more than one section, only one test code is assigned per test. For example, a spinal fluid profile may be done in Hematology, Chemistry, and perhaps Microbiology. If the ordering test code falls in the Hematology range, this section will be responsible for building and maintaining the test. However, Chemistry and Microbiology may also assign the test to one of their bays for reporting and crosslinking purposes. On management reports, data for the test will be accumulated for the section listed here.

BAY(S) (2-N-R)
List all bays (name and/or code) where this test will appear for resulting. Circle the bay to be used to build the test. At least one bay must be defined per test. Bays may be from different sections. This field is used when defining accession labels, capturing workload, and compiling incomplete work data.

TEST CODE (5-N-R)
Enter a unique numeric code less than five digits that falls within the test code range of the section assigned. This code is used to identify the test throughout STAR Laboratory.

It is not necessary to assign test codes in numeric order. Code assignment may correspond to the numbering scheme used prior to installing STAR Laboratory. Easily remembered numbers are often assigned to commonly ordered tests, for example, assigning test code 2000 to a SMAC profile. You may choose to number tests within the same bay using a subset of the section range. Charge-only tests should also be a subset of the section test code range.

TEST NAME (32-C-R)
Enter the name (up to 32 case alphanumeric characters) used to identify the laboratory procedure. It is recommended the name be less than 25 characters since some areas of the system truncate the name at 25 characters. Do not use a colon (:) or semicolon (;).

Test names are listed alphabetically on many management reports so consider related tests or tests with similar names. Also, since tests can be accessed throughout the system by entering the first characters, the test name should reflect its most common name. For example, it is better to have glucose tests named as follows:

- Glucose, 2 HrPP instead of Post Prandial Glucose
- Glucose, Urine instead of Urine Glucose
- Glucose, CSF instead of Spinal Fluid Glucose

Alternate names can be defined for a test using SIM maintenance. These alternate names are used only for ordering tests and not for sorting management reports.

In general, name the test as simply as possible. For example, to name the test which measures total blood protein, Total Protein, (instead of Total Protein, Blood), allows it to be accessioned for non-blood specimens. Of course, the normal ranges specified for the test accessioned as a non-blood specimen will not print since they are specific for blood specimens.

Tests with normal ranges unique to specimen types should be named to clearly indicate the appropriate test to be accessioned (in order for the correct normal ranges to print on the report). For example, the test name Total Protein, CSF is required since there are distinct normal ranges for total protein on spinal fluid. However, since there are no normal ranges for total protein measurement on other body fluids, the name Total Protein, Body Fluid can be used. A good rule of thumb is, if a test is done on blood, do not list blood as part of the test name. Any other specimen type should be listed to identify the test. In the case of the preceding Total Proteins, you might have three tests with the following names:

- Total Protein

- Total Protein, CSF

- Total Protein, Body Fluid

SHORT NAME (8-C-R)
Enter from one to eight characters which will be used by the system when an abbreviated version of the test name is required. The Short Name is printed on collection and accession labels. Abbreviations are required since the amount of space available is limited and multiple tests can be ordered together.

The short name should be easily recognized by laboratory personnel. For example, the test named Vitamin B12 may be indicated by VB12 or B12. It is recommended that the name be in upper case. Do not use a colon (:) or semicolon (;). The slash (/) is used to separate test names on labels so it should be used with caution. For example, the short name for Prothrombin Time and APTT could be PT/PTT; however, you would not want to use GLU/PP for Glucose, PP since the label name would be GLU/PP/ OTHER TEST. It makes PP look as though it is an orderable test.

While the short name may not identically reflect the test name, it can be used to indicate the procedures that compose the test. For example, a test named Complete Blood Count may be indicated on the master labels as CBCWDIFF indicating the need to perform a Hemogram and Differential.

TEST TYPE (1-C-R)
Indicate the type of test by checking General Laboratory, Advanced Microbiology, Anatomic Pathology, or Advanced Blood Bank. Most tests belong to the General Laboratory category. If you check Advanced Microbiology, Anatomic Pathology or Advanced Blood Bank, complete this form and proceed to the module-specific document.

DEFAULT SECTION (3-A-R)
Enter the three-character section code to which this test will be counted for reports such as Test Count and Turnaround Time reports. This is usually the section assigned to this test.

SPECIMEN COLLECTION REQUIREMENTS (1-C-O)
Collector ID and collection time are always required fields at accessioning. However, the following collection criteria can also be requested at accessioning (check one if it is appropriate for this test):

- Collection Period Required - Some test procedures require that the specimen be collected over a period of time, for example, 24 hour urine collections. This information is called the collection period and is entered in hours. If this option is defined for a test, the Collection Period field will be required at accessioning. Collection period information may be used directly from the accession record in calculating the final test result for a timed specimen eliminating the need to reenter data.

- Set up Microbiology plate ID required - This option is used for Advanced Microbiology tests only. Check this item only if plate labels will be defined based on specimen type for this test. For example, a Routine Culture should require different plate set up for urine versus wound specimens. If this option is checked, define the appropriate labels using worksheets located in the Advanced Microbiology document. If there are not different plate labels based on specimen types, do not select this option and use the base accession label options.

MAXIMUM SPEC AGE (U-AN-O)
Define maximum specimen age (if any) in HHMM format for this test. This is the time allowed between specimen collection and accessioning to ensure valid results.

Many tests have a critical age requirement since specimen quality deteriorates with time. The system calculates specimen age based on collection time and time of accessioning (recorded automatically by the system). If the maximum allowable age has been exceeded, a system message warns the accessioning person of the situation. Depending on how your system is designed, you may be allowed to override the system or someone of higher security level may be required to intervene, such as a technologist or supervisor for accessioning to continue. If the specimen is unacceptable, Specimen Rejection labels are generated indicating specimen rejection.

The format for listing maximum specimen age is HH or MM or HH/MM. Examples: 2H (2 hours) or 120 (120 minutes) or 2/30 (2 hours and 30 minutes). Entry of single numerics will be taken by the system to mean minutes and the system will calculate the hours and minutes for you so be sure to designate if the time is in hours.

ORDER CATEGORY/SAMPLE SIZE (1-C-R)
Every test in the system must be classified into at least one of six ordering categories. The category determines how the test is ordered, which labels print, how it is processed and how reports print. If a test can only be ordered routine, and the clerical staff orders it STAT, STAR Laboratory will not allow the order to be placed. Ordering category selection also determines the types of collection and accession labels to be defined for this test.

NOTE: In an interfaced system, determine what restrictions to place on nursing before limiting ordering categories to only Routine or STAT. In most interfaced environments, all three macro categories are selected.

The only difference between macro and micro is collection and accession label information, specifically the amount to be collected and the container type to be used. If you are interfaced, determine if your HIS allows micro tests to be ordered.

Tests ordered Routine (Macro and Micro) are processed routinely and the primary/ audit report only prints when the test is completed.

Tests defined for the ASAP (Macro and Micro) category are generally ordered as Timed or Today's. ASAP tests can have primary/audit reports print immediately whenever any part of the test is resulted.

The STAT (Macro and Micro) category is reserved for tests to be ordered STAT, collected STAT, processed STAT and reports printed immediately upon completion of any part of the test.

HISTORY CARDFILE (1-C-O)
Indicate whether this test will be used for the History Cardfile processor, and, if so, how and when results will be filed. The options are (check one):

A   Automatically file results in the cardfile upon result acceptance,

R   Prompt the user to file results in the cardfile upon result acceptance, or If you select this option, indicate the default for the prompt by checking:

      Y   To make the default Yes (for placing the results in the cardfile),

      N   To make the default No (for placing the results in the cardfile), or No default to require the user to enter **Y** or **N**.

N   Never file results in the cardfile upon results acceptance. This temporarily disables the cardfile feature.

CARDFILE PRINT QUEUE   (1-C-O)
If you checked option **A** or **R** in field 12, indicate whether cardfile results are automatically placed in the print queue at result verification by checking Yes or No.

Check Yes to automatically add the cardfile to a print queue. Check No to prevent a cardfile from being automatically added to the print queue.

RANGE HEADING (1-A-R)
To use the default range heading for this test code, check **Y**. To assign a range heading other than the default for this test code, enter the Range Headings from the Range Heading worksheet.

MISCELLANEOUS CHARGE PROFESSIONAL FEE (1-A-R)
To associate miscellaneous charge professional fee billing with this test, check Yes .

FORMAT (1-A-R)
Check **Standard**, **Zonal,** or **Offset** for format choices. Advanced Microbiology type tests are automatically set to Standard.

SPECIAL TEST INFORMATION

Complete one Special Test Information for each test.

TEST CODE/NAME (5-N-R)
Enter the test code and name for which the special information is being completed.

MASTER TEST CODE (1-C-O)
Leave this field blank for General and Advanced Blood Bank test types. It is used by the Advanced Microbiology and Anatomic Pathology modules of the system. Refer to those specific documents in the *STAR Laboratory Reference Guide* for more information.

REFERENCE TYPE (1-A-R)
Complete this field only if this is an Interdepartment, Sendout, or Sendout-Interface test. Select Sendout (S), Interdepartment (I), or (R) Ref Lab Interface Referral (General Test only). This field must be completed to define sendout, interdepartmental, or sendout-interface labels and to accumulate the appropriate workload for specimen preparation work.

Sendout tests and sendout-interface tests are not performed within the ordering laboratory nor by another laboratory department within STAR Laboratory. Instead, these tests are sent to a reference laboratory for resulting. Interdepartmental Referral tests are ordered at one department and performed at another laboratory within the system. STAR Laboratory accommodates special handling of these tests by generating mailing (travel) labels/lists, appending the performing laboratory's name to reports, and maintaining a complete audit trail of the specimen's location.

NOTE: For every interdepartmental test, a *like* test must be defined in the performing department. Refer to Interdepartment Test Codes in Chapter 6: Supporting Test Files in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide* for further information.

NUMBER POOL(S) (TABLE)
List the number pool names or codes you want for this test. Use the number pool table previously defined for your laboratory. If this is an Anatomic Pathology test type, circle the number pool to use for case number assignment.

Numbering Pools identify accessioned specimens for sorting, storage and easy retrieval. A number pool number has two parts - a code indicating the number pool name and a number that identifies the accessioned specimen. While accession numbers can never be reused, numbering pool numbers can be recycled according to the laboratory's own criteria. Recycling frequencies may be specified by date and time, or by the absolute value of the number pool itself. The numbering pool number is stored in the audit trail of the specimen and can be viewed in Patient Inquiry.

Number pools appear on the top line of the accession labels, and for each pool indicated, an additional Master Accession label is generated. A single number pool may be associated with more than one test within an accession.

Number pools aid in sorting and storing accessioned specimens for a laboratory section or bay (workstation). For a Chemistry and Hematology section, for example, accessioned specimens may be stored in a central area for all bays, but could easily be retrieved with a CHEM or HEM numbering pool identification. When setting up specimens for aliquoting and bay distribution, racks with number pool sequence can be used for fast distribution and run setups. This is especially helpful for instrument runs which require a numeric run order.

Number pools also help in long-term storage of specimens. In Hematology it is often necessary to store blood specimens for a day and blood smears in a retrievable order for a year; a SLIDE numbering pool, specified to recycle each year, may be used to file the slides in a logical order while a HEM numbering pool may be used to recycle daily. Microbiology, on the other hand, may use several types of numbering pools to keep track of the cultures stored in a variety of incubators and locations. They can also be a useful tool for cataloging surgical specimens in Cytology or Histology. Special Chemistry which frequently freezes specimens for future processing can set racks of specimens in number pool order in the freezer for easy retrieval.

ANATOMIC PATH CASE NUMBER POOL (TABLE/CODE-A-O)
This is used for Anatomic Pathology test types only. Refer to the *Anatomic Pathology Module* of the *STAR Laboratory Reference Guide.*

SINGLE COLUMN PRIMARY FORMAT
Primary Result Reports print test results in one or two column format. Since many tests have more than 13 results (the number of lines allowed per column in a Primary Report), you have the option of printing the primary in two columns or of printing all results in a single column.

Check Yes to print in single column format. Check No to print in two columns.

INQUIRY RESULTS IN REVIEW QUEUE
Do you wish to display results in Patient Inquiry when the test is in a review queue? Check Yes to allow viewing. Check No to prevent display of results which are in a review queue. If you check **No**, the test is suppressed from Check Five inquiry when the test is in a review queue.

INQUIRY RESULT DISPLAY SECURITY
There are some tests within the laboratory that, when processed, the laboratory wishes to suppress the viewing of the results, for example, HTLVIII. This field is optional. When a security level is indicated here, this field limits viewing to employees with that security level or higher. If someone with a lower security level attempts to view this test in Patient Inquiry, the following message displays:

Results not available, please refer inquiry to [performing section]

To use this feature for this test, enter the security level required to view results.

NOTE: These results are available for viewing from STAR Patient Care through a Laboratory Results function. Consideration of the security levels of non-laboratory personnel inquiry to the laboratory should be given before deciding on the display security level.

Choose from the list of security levels defined for your laboratory.

DISPLAY PARTIALS (2-C-O)
You control viewing of tests with a status of Partial within Patient Inquiry. Check Yes to display this test when it has a status of Partial. Check No to prevent display. If you check No and a test is partial, those results will not display in Check Five log test result processing.

PANIC REPORT SECURITY (2-N-O)
STAR Laboratory recognizes Panic Values (numeric results that fall in a range defined by the laboratory as life threatening). To release Panic Values requires a certain security level. Enter the security level required to release a panic value for this test. Choose from the list of security levels defined for your laboratory.

T-CODE SPECIMEN SELECTION (1-A-O)
This field is used to select the location of defined specimens for the auto T-coding process. If the department-level flag is set to allow auto T-coding and an indicator character has been added at the department level, you select either login (L), histotech (H), or result entry (R).

If an indicator at the department level was not entered, but auto T-coding is allowed (the department-level flag allows auto T-coding), you select between login (L) or histotech (H).

This field can only be accessed if the test type is Anatomic Pathology and the department level flag is set to allow auto T-coding. If the test is not an Anatomic Path test type, or the department flag is not set to allow auto T-coding, *N/A* displays in the field, and the system does not allow the field to be edited.

If the test meets the necessary criteria, based on the option selected, the following options are available: *L - Login, H - Histotech, and R - Result Entry.*

SECURITY CROSSLINKS (1-C-O)
Security level crosslinks can be defined to restrict access of certain test results to certain users. How these crosslinks function is controlled by the Crosslink processor. Indicate how this test will be used by checking one:

NOTE: Default refers to the security level attached to the bay for resulting.

Use Defaults (the most commonly used option) allows results to be entered by anyone having the proper security to access the resulting bay.

Use Defaults if user-security X-Links not specified allows result entry by anyone with at least the default security level until user-security crosslinks are defined in the crosslink processor.

Deny access if user-security levels are not specified prevents anyone from entering results until user-security is defined in the crosslink processor.

INCOMPLETES (1-C-O)
This field controls whether or not this test is included in the Incomplete Work Report. Some tests in STAR Laboratory are ordered for billing purposes or extra testing purposes only. To prevent these from being tracked as incompletes, check No. Check Yes to include in the Incomplete Work Report.

DELINQUENT (3-N-O)
This field indicates the time in days after which the selected test is considered delinquent. A test which has been accessioned but does not yet have a status of Done and has exceeded the user defined expected completion time is considered delinquent.

When you access this field, the system displays the following prompt:

Enter number of days after which test is delinquent--

For this field, the minimum entry is 1 day and the maximum entry is 365 days.

NOTE: If Field 13 - Incomplete is defined as No, Field 14 - Delinquent cannot be edited and displays N/A.

SPECIMEN DISPLAY (1-C-O)
This option controls display of the specimen type at result entry and in Patient Inquiry. Display is only recommended for tests which do not have a default specimen type. Displaying the specimen type requires an additional line on the option screen in Patient Inquiry. Therefore, if every test displays the specimen type, the screen can only display half the options for selection. In addition, more system overhead is required to display all of these. It is, however, helpful for tests such as Routine Cultures, Biopsies, Cell Counts, Body Fluids, to have the specimen type display both in Patient Inquiry and result reporting. For both responses, check Yes to display specimen type or No to prevent display.

COLLECTION LABELS

The Order Entry processor serves two main functions:

1. Allows entry of an order for aspecimen to be received in the future, thus simplifying the task of accessioning later.

2. Causes generation of collection labels to assist venipuncture and nursing staffs in positively identifying patient specimens and ensuring that specimens are collected in proper containers under the proper conditions.

Collection labels are designed to facilitate specimen collection. For each order, two types of labels are produced. Master Collection labels list all tests in an order. How many are produced and how these labels are used in determined by the laboratory. The second type, Collection (draw) labels, contain information necessary to collect the specimen (proper amount in the proper container(s) under the proper conditions for the test(s) ordered) and are used to label the container.

Orders belong to one of the following ordering category/sample size combinations (collection specifications are stored for each of the six combinations):

1. Routine, Macro
2. Routine, Micro
3. ASAP, Macro
4. ASAP, Micro
5. STAT, Macro
6. STAT, Micro

TEST CODE & NAME
Enter the test code and name for this worksheet.

COLLECT LABELS (2-N-O)
The number of Master Collection labels is determined by a flag and is the same for all orders. However, thenumber of Collection labels is specific per test per category. One collection label is generated for each set of collection specifications, unless otherwise specified.

Enter the number of labels, press ENTER to calculate the number of collection labels to produce, or enter **S** for Special Instruction only. Calculations are based on the volume needed and container type for this test plus other tests within the order. For example, if this test requires 2.0 ml. of serum, and another test on the same order requires 3.0 ml. of serum, both tests can be collected in the same 10 ml. red top container. The system only produces one label containing both test names for a 10 ml. red top tube.

If the label is only for Special instructions, enter **S** in this field. The prompt moves directly to field 5 to allow you to select the special instruction. None of the other fields are necessary.

CONTAINER TYPE (3-N-O)
The ordering processor always separates tests ordered based on the collection containers.   Tests which are part of the same order but require different specimen containers will have separate labels generated for each container. The field is used to specify the type of container in which the specimen should be collected.

More than one container type may be specified for each test status. The appropriate volume and, if necessary, special instruction, should be specified for each container type.

Indicate the container type code from the Container Types worksheet.

COLLECT VOLUME (U-N-O)
Indicate the minimum amount (in milliliters) of specimen required to perform the test ordered. When several tests are ordered together and require the same container type, the system automatically adds the volumes together. Replicate labels are produced for tests requiring volumes larger than the maximum capacity of the container type and identified as Additional Draw Labels.

For example: (All tests are drawn in a 7ml red top tube)

Test	Number labels	Container holds	Minimum amount	Special Instruct	Total Labels CT	SI	AddDraw
Glucose	1	7	1	1	1	1	
Glucose	1	7	1				
Electrolytes	1	7	5		1		
Glucose	1	7	1				
Amylase	1	7	10		1		1
Glucose	1	7	1	1			
Electrolytes	1	7	5				
BUN/Amylase2	7		5		2	1	2

For tests requiring urine or fluid collection, the volume information is not always employed to determine the number of collection labels required, since a generous sized container is usually provided for collection. The system would therefore generate a single collection label for each container type for this test order.

Collection volume is also used to indicate the number of items required. For example, if two blood smears are to be made at the bedside, enter the whole number two in this field.

ALIQUOT VOLUME
The system stores information regarding the amount of specimen to aliquot for each test. The Aliquot Volume field is used when printing the Specimen Collection Report for collection requirements. If desired, this field can be left blank.

SPECIAL INSTRUCTIONS (3-N-O)
Any special handling required for specimen collection can be printed with the container labels. This information is optional. The special instruction is printed on an additional label containing complete patient demographics, the test name and test status. More than one special instruction may be listed for a test; however, an additional label will print for each.

Indicate the special instruction(s) by entering the code(s) from the Special Instruction table previously defined for your laboratory.

In summary, the three types of labels are:

Master Collection Labels print for each collection and list all tests within that order and complete patient demographics. They can be used for the phlebotomy log or by the nursing staff to indicate which patients have been collected.

Container Labels generate for each type of container to be collected. Each label includes the container type, the number to collect, and the minimum volume required for testing. The test name(s) and performing section are also printed on each label. These labels contain the same patient demographic information as Master Labels.

Special Instruction Labels automatically print for any test requiring special handling. An additional label is printed for each special instruction. These contain the patient's demographics.

Three other types of labels can be generated at order entry: Isolation Labels, Pediatric Labels, and Prompt Labels. The following is an explanation of these labels:

Isolation Labels can be automatically generated with the collection order at label printing for patients in isolation. These warning labels state the type of isolation and the patient's demographics. It is important to note here, that these labels can only be generated if the isolation information is part of the patient's demographics and the Print Isolation Labels flag is activated in the system.

Pediatric Labels required for children's specimens are provided by the system in the form of dye-cut labels which contain one of the following numbers; the accession number, the account number or the unit number.

Prompt Labels can be automatically generated at label printing. This label contains the order comment for the test and the prompt response entered on STAR Patient Care at the time of the order. This label can be printed at order, accession, or both.

These labels are controlled by flags set at the time of installation.

ACCESSION LABELS

The Accession processor is used to:

1. Identify specimens received in the laboratory and define the procedure(s) to be performed on each.

2. Produce accession labels for specimen identification and for creating a Master Accession Log for all specimens received in the laboratory. Additional uses for accession labels can be determined by the laboratory as necessary.

Accession labels are generated to assist in specimen processing. For each accession, two types of labels are generated. Master Accession labels list all tests to be performed. The number of Master Accession labels automatically printed with each order is determined by a flag. However, additional Master labels generate for each number pool specified for the test(s) accessioned. Master accession labels are used in the following ways: one is placed on the master log, to provide a record of the accessioned tests; subsequent labels may be placed on master specimen containers, aliquot tubes or master logs at individual bays.

The second type of accession label, Bay labels, are used to identify the specimens or aliquots with information regarding the tests to be performed.

Orders belong to one of the following ordering category/sample size combinations:

1. Routine, Macro
2. Routine, Micro
3. ASAP, Macro
4. ASAP, Micro
5. STAT, Macro
6. STAT, Micro

Complete the following information for only those ordering category/sample size combinations for which this test can be ordered. For example, a Complete Blood Count can be performed Routine, ASAP, or STAT; therefore, accession label information should be completed for each of these status categories.

Bay Labels

These labels are commonly called the long labels since the information completely fills the label. They are used to label aliquot tubes, master bay logs, bay worksheets and/or instrument run logs. The information on the label indicates to which bay the specimen aliquot should be transported and which tests are to be performed at that bay.

One test may require several accession labels, such as a spinal fluid profile which is sent to various bays for processing. The appropriate test(s) and bay(s) are indicated on each label.

When a CRT is available to enter test results, specimen aliquots serve as their own worklist, thus eliminating the need to write test results on worksheets. However, if a CRT is not available within a processing area, an additional label can be defined to serve as a worksheet label. This label contains all necessary specimen and patient information and can be specially designed to suit the test requirements. For example, the label may contain space to record test results, QC results, or, in the case of a 24Hr urine, the volume of the urine.

Complete label information for each ordering category/sample size defined for this test. During system build, the system only allows you to define labels for these categories.

TEST CODE & NAME (5-N-R)
Enter the test code and name for this worksheet.

BAY-SECTION (U-AN-O)
In most clinical laboratories, the physical space within each laboratory section is divided into functional areas call bays or workstations in which related test procedures are performed. Each test performed by the laboratory is associated with at least one bay. Some tests are performed at more than one bay, either in whole or in part. For example, a Glucose test may be performed in the SMAC Bay, the ASTRA Bay and/or the Manual Chemistry Bay. Various portions of a Creatinine Clearance test may be performed at several bays.

For each ordering category/sample size combination, indicate the usual bay in which the test will be performed by entering the corresponding bay number.

 # OF LABELS (2-N-O)
Any number of bay labels can be printed at the time of accessioning. Enter a whole number in the space provided.

BAY LABEL TEXT (32-AN-O)
Since these labels are most commonly used for aliquoting, the text usually reflects the test name. Specify the text using upper and lower case alphanumeric characters. Colons (:),semicolons (;), up-arrows (^) and commas (,) are not allowed.

These labels can also be used to create worklists or logs for areas which do not have access to a CRT. For example, if the osmometer is located on a counter that does not have easy access to a CRT, you might want to develop a bay label similar to this: OSMO_____Tech_____. Remember, these labels print with complete patient demographics, so there is no need to write log sheets.

Slide Labels

Special labels may be generated in which limited information is required. Patient demographics and test information are printed in the left-most portion of the label producing a label approximately 1x1 inch in size. These labels are ideally suited for slides but may also be designed for worklists or aliquot tubes.

SLIDE POOL (U-N-O)
This field allows you to group tests accessioned together on the same slide label. For example, if a CBC (slide label text DIFF) and a Platelet test (slide label text PLT) are accessioned together, only one slide label prints if a slide pool group is defined for both tests. This label will contain the text DIFF/PLT instead of two individual slide labels (one with DIFF and with PLT).

Enter the number of the slide pool group IF it is different from the default (9 or null). Use the group numbers designated by your laboratory on the Slide Pools Worksheet.

 # OF LABELS (2-N-O)
Any number of slide labels can be printed at accessioning. Enter a whole number in the space provided.

SHORT NAME (8-AN-R)
The fifth line of information on the label can be used to specify an abbreviated name of the test or other information not exceeding eight characters. The name may be specified using any upper or lower case characters except for the colon (:), semicolon (;), up-arrow (^) or comma(,).

NUMBER POOL/SPECIMEN/PATIENT (1-C-O)
Indicate which is to print on the second line of the slide label by entering **N** for number pool, **S** for specimen type, or **P** for patient account number. Only one can print per label. Number pool might be desired on a CBC differential test so that the slide could be easily filed; whereas, the specimen type might be desirable when examining a gram stain smear. The patient number might be desirable for a routine test that is done on blood and has no numbering pool. (As the test is built, the patient number is the default so if nothing is entered here, it will be assumed to be the option of choice.)

NOTE: If the number pool is desired, enter **N** plus the number pool code/name. Select the number pool from those defined for this test. Only one number pool can be indicated per label.

PRINT ORDER (1-A-O)
Indicate whether slide labels print after the individual bay labels for a test (enter **T**) or at the end of all bay labels for the accession (enter **A**). In centralized accessioning, you might want slide labels to print after each test's bay labels. In decentralized accessioning, it might be better to print slide labels at the end of all tests within the accession.

NOTE: If you chose the Slide Pool feature for printing/collapsing all text onto one label, you must specify **A** for all tests. (Refer to the Slide Pools Worksheet.)

INTERDEPARTMENT/SENDOUT LABELS

Use this worksheet for tests defined as Sendout or Interdepartmental Referral tests to indicate the container type, macro volume, micro volume, and a special instruction if necessary.

TEST CODE & NAME
Enter the test code and name for this worksheet.

REFERENCE TYPE (DISPLAY ONLY)
Indicate whether this is a sendout , sendout-interface, or interdepartment test.

REFERENCE LABORATORY (TABLE)
Enter the code and name of the laboratory at which this specimen is to be performed from the table of sendout, sendout-interface, and interdepartmental laboratories created by your laboratory.

REFERENCE CONTAINER   (3-N-O)
Enter the container type code from the table of container types created by your laboratory. This is the sending/mailing container type for transporting the specimen for this test.

MACRO VOLUME (U-N-O)
Enter the macro volume (in milliliters) of specimen to be sent to the performing laboratory.

MICRO VOLUME (U-N-O)
Enter the minimum volume (in milliliters) of specimen to be sent to the performing laboratory.

SPECIAL INSTRUCTION (3-N-O)
Indicate any special handling comments associated with the test by entering a Special Instruction code and description from the table of created by your laboratory. These instructions are for the benefit of the person preparing the specimen for mailing or delivery to the reference laboratory.

STORAGE REQUIREMENTS (2-N-O)
Indicate the storage requirement to assign to this test. This information is used in generating the Travel List Report if the report is sorted by storage requirements. If a specific storage requirement is not defined for the test, the system defaults to *Room Temperature* for the report.

COLLECTION REQUIREMENTS (1-N-O)
Indicate the collection requirements to assign to this test. You can select *V* for *Collection Volume*, *W* for *Weight Required*, or *N* for *None*. If the test is defined as a Sendout or Interdepartment, this field cannot be edited.

Chapter 6 - Supporting Test Files

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RESULT COMPONENTS

To simplify the process of building test files, STAR Laboratory uses the component concept. Result components are the base elements used to make up a test, and are the smallest part of the laboratory system's hierarchy. Components may be used singly or grouped with other components to form tests. Tests are grouped into bays where they will be performed. Bays are grouped into sections such as Chemistry and Hematology. Sections are grouped into a department. Departments may serve one or more facilities.

Result components are built prior to tests. The system always assigns the number to a component and these are unique based on name and/or specimen type of the component. STAR Laboratory provides a base component table (refer to Appendix A: Base Tables Listing in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide*) of approximately 500 components to help make the building easier and faster. This base contains the name, specimen type, and unit of measure. It does **not** contain any normal ranges, delta check information, or panic value information. This table should be reviewed and edited prior to filling out the worksheets. All new components need to be listed on the Result Component worksheet.

NOTE: It is not necessary to create a Number of Blocks component since the number of blocks defined per specimen displays on the results entryscreen and on all patient reports (if the flag is set). Otherwise, result components for Anatomic Pathology tests are used the same as they are for all other tests.

RESULT COMPONENT NAME (30-AN-R)
This is the name of the result component. A maximum of 30 characters (upper/lower case) is allowed; however, due to the way the component name is used in Patient Inquiry and on some reports, it is recommended that the name be abbreviated as much as possible (8-12 characters). Patient Inquiry displays 16 characters if units are included and 22 characters if units are not included. Result entry displays a total of 16 characters (this includes units). Units display 8 characters.

Different component names need to be different component numbers. For example, if you wish to report out a test with Sodium as a component but in another test you want to report Na, the system requires a new component number. The same is true with specimen types.

**SHORT NAME (8-AN-R*)*
This is a one- to eight-character abbreviated name for the component. The system defaults to the first eight characters from the component name entered in the previous field. It is from this field that the builders for the headers for Cumulative Trend Profiles pull the default name. If you need to have the same component with the same criteria but a different short name, you need to create a different version of the component.

UNITS OF MEASURE (3-N-O)
This is the units of measure for this component. Enter the units and/or code from the Result Units table for your laboratory. Each component has its own unique unit of measure. If you need more than one unit for the same component, you need to create a different version of the component.

SPECIMEN TYPE (3-N-O)
This is the specimen type for this component. Enter the name and/or code from the specimen type table for your laboratory. A component can only have one specimen type. (It is possible for a component to not have a specimen type.) If you have more than one specimen type, you need to create more than one component.

QC CONSTITUENT CODE (CAP) (8-N-O)
A constituent is the substance contained in (or a property of) the sample being measured.

A base list of constituents is provided with the system. The laboratory should compare a printed copy of this list to the constituents assayed at their facility. Any constituent that is not on the list and is assayed at your facility should be added to the Constituent file. Each constituent must then be linked to a result component.

DESCRIPTIVE METHOD (5-N-O)
This field is for a descriptive method (equipment or manual) to help distinguish one component from another. The first two digits constitute the CAP Section Code and the last three digits constitute the CAP Method Code.

LOOKUP/CK 5 EXCLUSION (1-A-R)
This field indicates whether you want to use this component for building test lookup groups and whether you want the component available for check five by result searches. Circle Yes to exclude the component from building test code lookup groups and check five processing. Circle No to make these components eligible.

Some components are not clinically significant to be used for such searches (for example, the *comment* or *reviewed by* component). You may also want to exclude components that are in more than 25 reportable test codes. Such components lengthen the response time when you perform a check five by result search or test lookup. Evaluate the value of searching for each component in use in the system and determine which should be excluded.

NOTE: For components you do not exclude from test lookup and check five processing: if you build lookup groups from this component and change this field, STAR Laboratory *does not* remove the tests assigned to a lookup group.

If you are changing a component to be excluded, view the Lookup groups for the inclusion of the component in the groups. Delete the component from the groups first, then exclude the component from Lookup and Check Five processing.

DELTA (1-A-R)
Delta checks are used to monitor a patient's test results for significant changes over a particular period. This is a good tool for maintaining quality assurance of patient samples. Delta checks are done on a component basis. You decide what period of time (in days) the system should searched for that result, as well as the minimum percentage or absolute changes that are acceptable over the specified period. With the presence of delta checks at the time of result reporting, unacceptable changes trigger a review process whereby the system displays the present value, previous value, the delta check limits, and the difference (degree of change) between the present and previous values.

Fill in the following fields with the appropriate response.

>   DELTA: Circle Yes or No.

>   MAXIMUM DAYS:
>   This is the number of days the system searches for a previous value. Seven days are recommended although any number can be entered. A large number of days may impact system response time.

>   CHANGE, PERCENT OR ABSOLUTE:
>   Circle **C** to check for any change from the previous result. The system checks for an exact match between results (including upper and lower case differences) to determine any change. Circle Percent or Absolute. Do you want the system to calculate the percent difference or do you want it to flag on an absolute value each time?

>   DIFFERENCE:
>   This is the numeric value of the percent or absolute difference for the system to calculate.

VALID VALUES (1-A-O)
This field indicates whether valid values are defined for the result component and whether the values are sex related, age related, age/sex related, or not dependent. If no valid values are defined, the system displays *Not Defined* in this field.

NOTE: Once you circle the Valid Values option on the main worksheet to either Age, Sex, Age and Sex or Not Dependent, **fill out the corresponding worksheets based on your selection**.

If the component for which you are defining valid values is assigned to a test, the system creates a future version of the valid value that will not be active until a component update is performed. If the component is not assigned to a test, the system creates an active version that is available when the component is added to a test.

VALID RANGE (15-N-O)
This field is used for defining the low and high valid numeric range for this result component.

Enter the range in *low value-high value* format, separating the numbers with a hyphen (-). Entries for each side of the range can be up to six digits, decimal point, six digits. At resulting, any numeric response outside this range causes the system to generate a warning message.

When resulting, STAR Laboratory does not perform valid range processing with the following component special processing:

- •   Auto Fill ID
- •   Auto Fill ID/required to complete
- •   Date and/or time
- •   Menu Select ID
- •   Word Processing
- •   Units x-matched processing
- •   SNOMED® code

PANIC VALUES (U-AN-O)
This field indicates whether panic ranges are defined for the result component and whether the values are sex related, age related, age/sex related, or not dependent. If no panic values are defined, the system displays *Not Defined* in this field.

NOTE: Once you circle the Panic Values option on the main worksheet to either Age, Sex, Age and Sex or Not Dependent, **fill out the corresponding worksheets based on your selection**.

When resulting, STAR Laboratory does not perform panic processing with the following component special processing:

- •   Auto Fill ID
- •   Auto Fill ID/required to complete
- •   Date and/or time
- •   Menu Select ID
- •   Word Processing
- •   Units x-matched processing
- •   SNOMED code

NORMAL RANGES (U-AN-O)
Refer to the Normal Ranges worksheet in Appendix B: Worksheets in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide*.

RESULT PROCESSING (1-A-O)
This field indicates whether the component is defined as a Recall Management component.

Enter **Yes** if the component is defined as a Recall Management component. Enter the Recall Categories description.

Enter **No** if the component is not defined as a Recall Management component.

NUMBER OF DECIMALS (1-N-O)
This field allows you to specify the number of decimal places (0 - 9) for this component. Zero (0) decimals indicates a whole number. In result entry, if this field is defined, you must enter a result with the exact number of decimal places specified here. A warning message displays in resulting informing you if an incorrect value is entered based on this parameter setting.

EDIT BY (DISPLAY ONLY)
This field contains the name of the person who last edited the component screen. The field remains blank until the component screen has been edited.

EDIT DATE/TIME (DISPLAY ONLY)
This field contains the date and time the component screen was last edited. The field remains blank until the component screen has been edited.

Valid Values - Not Dependent

COMPONENT NAME (30-AN)
This is the name of the result component. A maximum of 30 characters (upper/lower case) is allowed; however, due to the way the component name is used in Patient Inquiry and on some reports, it is recommended that the name be abbreviated as much as possible (8-12 characters). Patient Inquiry displays 16 characters if units are included and 22 characters if units are not included. Result entry displays a total of 16 characters (this includes units). Units display 8 characters.

Different component names need to be different component numbers. For example, if you wish to report out a test with Sodium as a component but in another test you want to report Na, the system requires a new component number. The same is true with specimen types.

COMPONENT # (6-AN)
This is a 6 alphanumeric code for the result component.

RESTRICTION (1-A-R)
This field is used to determine whether you want restricted or unrestricted valid values.

If you select **R**, the system accepts only result entries that are defined on the Valid Values list. A message alerts you when an invalid entry is made during result entry.

If you select **U**, any result entry will be allowed. A flag displays, depending on the following conditions:

- If the value is contained on the Valid Values list, it must match exactly with upper and lower case letters.

- If a flag is associated with the value, the section level flag for displaying result flags must allow for the display.

VALID VALUES (40-AN-R)
This field defines the list of valid values and sets a flag for a specific value.

If a component has a Valid Values list, the system compares the entered result value with the list. The valid value processes only if an exact match, including upper and lower case characters as well as spaces, is found.

FLAG (2-A-O)
Select this column to enter the result flag associated with this valid value.

Valid Values - Sex

COMPONENT NAME (30-AN)
This is the name of the result component. A maximum of 30 characters (upper/lower case) is allowed; however, due to the way the component name is used in Patient Inquiry and on some reports, it is recommended that the name be abbreviated as much as possible (8-12 characters). Patient Inquiry displays 16 characters if units are included and 22 characters if units are not included. Result entry displays a total of 16 characters (this includes units). Units display 8 characters.

Different component names need to be different component numbers. For example, if you wish to report out a test with Sodium as a component but in another test you want to report Na, the system requires a new component number. The same is true with specimen types.

COMPONENT # (6-AN)
This is a 6 alphanumeric code for the result component.

RESTRICTION (1-A-R)
This field is used to determine whether you want restricted or unrestricted valid values.

If you select **R**, the system accepts only result entries that are defined on the Valid Values list. A message alerts you when an invalid entry is made during result entry.

If you select **U**, any result entry will be allowed. A flag displays, depending on the following conditions:

- • If the value is contained on the Valid Values list, it must match exactly with upper and lower case letters.

- • If a flag is associated with the value, the section level flag for displaying result flags must allow for the display.

VALID VALUES (40-AN-R)
This field defines the list of valid values and sets a flag for a specific value.

If a component has a Valid Values list, the system compares the entered result value with the list. The valid value processes only if an exact match, including upper and lower case characters as well as spaces, is found.

MALE and FEMALE (2-A-O)
Select this column to enter the result flag associated with this valid value.

NOTE: If a specimen registered through Specimen Registration does not have a sex defined, the system uses the MALE values for sex related panics.

Valid Values - Age

This worksheet defines age-related valid values. The system automatically builds the Default age range used when an age range is not defined or the specimen being tested does not have an age defined. Default values must be entered for the Default range.

COMPONENT NAME (30-AN)
This is the name of the result component. A maximum of 30 characters (upper/lower case) is allowed; however, due to the way the component name is used in Patient Inquiry and on some reports, it is recommended that the name be abbreviated as much as possible (8-12 characters). Patient Inquiry displays 16 characters if units are included and 22 characters if units are not included. Result entry displays a total of 16 characters (this includes units). Units display 8 characters.

Different component names need to be different component numbers. For example, if you wish to report out a test with Sodium as a component but in another test you want to report Na, the system requires a new component number. The same is true with specimen types.

COMPONENT # (6-AN)
This is a 6 alphanumeric code for the result component.

RESTRICTION (1-A-R)
This field is used to determine whether you want restricted or unrestricted valid values.

If you enter **R**, the system accepts only result entries that are defined on the Valid Values list. A message alerts you when an invalid entry is made during result entry.

If you enter **U**, any result entry will be allowed. A flag displays, depending on the following conditions:

- If the value is contained on the Valid Values list, it must match exactly with upper and lower case letters.

- If a flag is associated with the value, the section level flag for displaying result flags must allow for the display.

VALID VALUES (40-AN-R)
This field defines the list of valid values and sets a flag for a specific value. The system automatically builds the Default age range for values used if an age range is not defined or if the specimen being tested does not have an age defined.

If a component has a Valid Values list, the system compares the entered result value with the list. The valid value processes only if an exact match, including upper and lower case characters as well as spaces, is found.

AGE RANGE (8-AN-R)
This column defines the age range for the values to be entered in the next columns. Age ranges must be defined in sequential order. The starting value of the first range is assumed to be 0 days.

You need to enter only the ending range. The starting value of each subsequent range is incremented by 1 day or year from the previous line, depending on how that range was defined. The maximum value age range is as follows:

- For days, 364 (365 days converts to 1 year on the screen)
- For years/days, 4Y364D
- For years, 198

Although age ranges are defined in days, years/days, and years, the patient's age displays in days, months, and years in Patient Inquiry and on any report that prints the patient's age.

Consider the following when defining age ranges:

- A range entered anywhere from 1 to 4 years must include 364 days (in the #Y###D format) for the patient to be evaluated against the range during the entire time the patient is that age.

For example, if a range is defined as 3Y, the patient is evaluated against the next highest age range at 3 years 1 day. If the range is defined as 3Y364D, the patient is evaluated against that range until 4 years. After 4 years, you can no longer use the #Y###D format.

Ranges defined as 5Y or above assume the entire 364 days. The following error message displays if a range greater than 4 years is entered in this format:

Greater than 5 year/day range not allowed!

- An age range that applies from 0-11 months must be entered in the Days format (*###D*). This range must include the number of days until the patient reaches that month, plus the number of days the patient's age remains in that month's range (29 days).

For example, an age range that applies to a 3-month-old will be defined as 119 days (average 30-day month) plus 29 more days until the patient becomes 4 months old.

The system will not allow date ranges to be entered out of sequence. For example, if you attempt to enter a range of six years after a defined ten-year range, the value will not be accepted and you receive the following message:

Invalid date sequence!

NOTE: You cannot delete the Default range. You can delete all ranges defined or change the dependency if you do not want to use age-related valid values.

FLAG (2-A-O)
Select this column to enter the result flag associated with this valid value.

Valid Values - Sex and Age

This worksheet defines the age related valid values. The system automatically builds the Default age range used when an age range is not defined or the specimen being tested does not have an age defined. The default values must be entered for the Default range.

COMPONENT NAME (30-AN)
This is the name of the result component. A maximum of 30 characters (upper/lower case) is allowed; however, due to the way the component name is used in Patient Inquiry and on some reports, it is recommended that the name be abbreviated as much as possible (8-12 characters). Patient Inquiry displays 16 characters if units are included and 22 characters if units are not included. Result entry displays a total of 16 characters (this includes units). Units display 8 characters.

Different component names need to be different component numbers. For example, if you wish to report out a test with Sodium as a component but in another test you want to report Na, the system requires a new component number. The same is true with specimen types.

COMPONENT # (6-AN)
This is a 6 alphanumeric code for the result component.

RESTRICTION (1-A-R)
This field is used to determine whether you want restricted or unrestricted valid values.

If you enter **R**, the system accepts only result entries that are defined on the Valid Values list. A message alerts you when an invalid entry is made during result entry.

If you enter **U**, any result entry will be allowed. A flag displays, depending on the following conditions:

- If the value is contained on the Valid Values list, it must match exactly with upper and lower case letters.

- If a flag is associated with the value, the section level flag for displaying result flags must allow for the display.

VALID VALUES (40-AN-R)
This field defines the list of valid values and set a flag for a specific value. The system automatically builds the Default age range. This range is used as values if an age range is not defined or if the specimen being tested does not have an age defined.

If a component has a Valid Values list, the system compares the entered result value with the list. The valid value processes only if an exact match, including upper and lower case characters as well as spaces, is found.

AGE RANGE (8-AN-R)
This column defines the age range for the values to be entered in the next columns. Age ranges must be defined in sequential order. The starting value of the first range is assumed to be 0 days.

You need to enter only the ending range. The starting value of each subsequent range is incremented by 1 day or year from the previous line, depending on how that range was defined. The maximum value age range is as follows:

- For days, 364 (365 days converts to 1 year on the screen)
- For years/days, 4Y364D
- For years, 198

Although age ranges are defined in days, years/days, and years, the patient's age displays in days, months, and years in Patient Inquiry and on any report that prints the patient's age.

MALE AND FEMALE (2-A-O)
Select this column to enter the result flag associated with this valid value.

NOTE: If a specimen registered through Specimen Registration does not have an age or sex defined, the system uses the MALE Default values for age/sex related panics.

Panic Values - Not Dependent

COMPONENT NAME (30-AN)
This is the name of the result component. A maximum of 30 characters (upper/lower case) is allowed; however, due to the way the component name is used in Patient Inquiry and on some reports, it is recommended that the name be abbreviated as much as possible (8-12 characters). Patient Inquiry displays 16 characters if units are

included and 22 characters if units are not included. Result ertry displays a total of 16 characters (this includes units). Units display 8 characters.

Different component names need to be different component numbers. For example, if you wish to report out a test with Sodium as a component but in another test you want to report Na, the system requires a new component number. The same is true with specimen types.

COMPONENT # (6-AN)
This is a 6 alphanumeric code for the result component.

LOW (15-N-O)
This field defines and displays the low panic value. The low value must be equal to or less than the high panic value if defined.

HIGH (15-N-O)
This field is used to define and display the high panic value. The high value must be equal to or greater than the low value, if defined.

Panic Values - Sex

COMPONENT NAME (30-AN)
This is the name of the result component. A maximum of 30 characters (upper/lower case) is allowed; however, due to the way the component name is used in Patient Inquiry and on some reports, it is recommended that the name be abbreviated as much as possible (8-12 characters). Patient Inquiry displays 16 characters if units are included and 22 characters if units are not included. Result ertry displays a total of 16 characters (this includes units). Units display 8 characters.

Different component names need to be different component numbers. For example, if you wish to report out a test with Sodium as a component but in another test you want to report Na, the system requires a new component number. The same is true with specimen types.

COMPONENT # (6-AN)
This is a 6 alphanumeric code for the result component.

MALE LOW (15-N-O)
This field is used to define and display the male low panic value. The low value must be equal to or less than the male panic high value, if defined.

MALE HIGH (15-N-O)
This field is used to define and display the male high panic value. The high value must be equal to or greater than the male panic high value, if defined.

FEMALE LOW (15-N-O)
This field is used to define and display the female low panic value. The low value must be equal to or less than the female panic high value, if defined.

FEMALE HIGH (15-N-O)
This field is used to define and display the female high panic value. The high value must be equal to or greater than the female panic high value, if defined.

NOTE: If a specimen registered through Specimen Registration does not have a sex defined, the system uses the MALE values for sex related panics.

Panic Values - Age

This worksheet defines age-related panic values. The system automatically builds the Default age range used when an age range is not defined or the specimen being tested does not have an age defined. Default values must be entered for the Default range.

COMPONENT NAME (30-AN)
This is the name of the result component. A maximum of 30 characters (upper/lower case) is allowed; however, due to the way the component name is used in Patient Inquiry and on some reports, it is recommended that the name be abbreviated as much as possible (8-12 characters). Patient Inquiry displays 16 characters if units are included and 22 characters if units are not included. Result entry displays a total of 16 characters (this includes units). Units display 8 characters.

Different component names need to be different component numbers. For example, if you wish to report out a test with Sodium as a component but in another test you want to report Na, the system requires a new component number. The same is true with specimen types.

COMPONENT # (6-AN)
This is a 6 alphanumeric code for the result component.

AGE RANGE (8-AN-R)
This column defines the age range for the values to be entered in the next columns. Age ranges must be defined in sequential order. The starting value of the first range is assumed to be 0 days.

You need to enter only the ending range. The starting value of each subsequent range is incremented by 1 day or year from the previous line, depending on how that range was defined. The maximum value age range is as follows:

   •   For days, 364 (365 days converts to 1 year on the screen)
   •   For years/days, 4Y364D
   •   For years, 198

Although age ranges are defined in days, years/days, and years, the patient's age displays in days, months, and years in Patient Inquiry and on any report that prints the patient's age.

Consider the following when defining age ranges:

- A range entered anywhere from 1 to 4 years must include 364 days (in the #Y###D format) for the patient to be evaluated against the range during the entire time the patient is that age.

For example, if a range is defined as 3Y, the patient is evaluated against the next highest age range at 3 years 1 day. If the range is defined as 3Y364D, the patient is evaluated against that range until 4 years. After 4 years, you can no longer use the #Y###D format.

Ranges defined as 5Y or above assume the entire 364 days. The following error message displays if a range greater than 4 years is entered in this format:

Greater than 5 year/day range not allowed!

- An age range that applies from 0-11 months must be entered in the Days format (*###D*). This range must include the number of days until the patient reaches that month, plus the number of days the patient's age remains in that month's range (29 days).

For example, an age range that applies to a 3-month-old will be defined as 119 days (average 30-day month) plus 29 more days until the patient becomes 4 months old.

The system will not allow date ranges to be entered out of sequence. For example, if you attempt to enter a range of six years after a defined ten-year range, the value will not be accepted and you receive the following message:

Invalid date sequence!

NOTE: You cannot delete the Default range. You can delete all ranges defined or change the dependency if you do not want to use age-related valid values.

AGE RELATED LOW (15-N-O)
This column defines the age-related low panic value. The low panic must be equal to or less than the high panic value, if defined.

AGE RELATED HIGH (15-N-O)
This column defines the age-related high panic value. The high panic must be equal to or greater than the low panic value, if defined.

If you entered a low panic value, you must enter a higher value in this field.

Panic Values - Sex and Age

This worksheet defines the age related panic values. The system automatically builds the Default age range used when an age range is not defined or the specimen being tested does not have an age defined. The default values must be entered for the Default range.

COMPONENT NAME (30-AN)
This is the name of the result component. A maximum of 30 characters (upper/lower case) is allowed; however, due to the way the component name is used in Patient Inquiry and on some reports, it is recommended that the name be abbreviated as much as possible (8-12 characters). Patient Inquiry displays 16 characters if units are included and 22 characters if units are not included. Result entry displays a total of 16 characters (this includes units). Units display 8 characters.

Different component names need to be different component numbers. For example, if you wish to report out a test with Sodium as a component but in another test you want to report Na, the system requires a new component number. The same is true with specimen types.

COMPONENT # (6-AN)
This is a 6 alphanumeric code for the result component.

AGE RANGE (8-AN-R)
This column defines the age range for the values to be entered in the next columns. Age ranges must be defined in sequential order. The starting value of the first range is assumed to be 0 days.

You need to enter only the ending range. The starting value of each subsequent range is incremented by 1 day or year from the previous line, depending on how that range was defined. The maximum value age range is as follows:

- For days, 364 (365 days converts to 1 year on the screen)
- For years/days, 4Y364D
- For years, 198

MALE LOW (15-N-O)
This field defines the male age-related low panic value. The low value must be equal to or less than the male high panic value, if defined.

MALE HIGH (15-N-O
This field defines the male age-related high panic value. The high value must be equal to or greater than the male low panic value, if defined.

FEMALE LOW (15-N-O)
This field defines the female age-related low panic value. The low value must be equal to or less than the female high panic value, if defined.

FEMALE HIGH (15-N-O)
This field defines the female age-related high panic value. The high value must be equal to or greater than the female low panic value, if defined.

NOTE: If a specimen registered through Specimen Registration does not have an age or sex defined, the system uses the MALE Default values for age/sex related panics.

Normal Ranges

A normal range may be associated with each component, if desired. Normal ranges are reference values which indicate test result limits within which a patient result value may be compared and evaluated as normal or abnormal.

Normal ranges can be specified according to the sex and/or age of the patient. Separate normal ranges may be defined for males and females. Based on the sex of the patient, the system prints or displays the appropriate normal range. In addition, the normal range for each component may be based on patient age. For example, pediatric values are often different than adult values.

The normal range specified for a component need not be a numeric range. In many cases, the normal range is a short phrase, such as "Negative" or "None Detected." In other cases a short paragraph may be included to assist the physician in the interpretation of the procedure. However, the system will not flag abnormal values if non-numeric normal ranges are used.

The normal range may be specified using only alphabetic, numeric or a symbol character, in upper and/or lower case format. Most numeric normal ranges are entered in the format: low limit - high limit; however, this is not a requirement.

COMPONENT NAME (30-AN)
This is the name of the result component. A maximum of 30 characters (upper/lower case) is allowed; however, due to the way the component name is used in Patient Inquiry and on some reports, it is recommended that the name be abbreviated as much as possible (8-12 characters). Patient Inquiry displays 16 characters if units are included and 22 characters if units are not included. Result entry displays a total of 16 characters (this includes units). Units display 8 characters.

Different component names need to be different component numbers. For example, if you wish to report out a test with Sodium as a component but in another test you want to report Na, the system requires a new component number. The same is true with specimen types.

COMPONENT # (6-AN)
This is a 6 alphanumeric code for the result component.

DEFAULT RANGE(S) (135-AN-R)
This field is used to define the default normal range or value.

NOTE: If normal ranges were previously defined, the defined value appears as the default for the transaction, unless you are changing from sex related to non-sex related normals or from non-sex related normals to sex related ones.

Enter normal ranges by entering the lower limit first, then the higher limit separated by a hyphen (-). If the normal value is a single value, enter that value. If the normal range is textual, enter the text.

A limit of 9 lines, 30 characters per line, and an overall limit of 135 characters exists for textual (multi-line) normals that are not sex related. A limit of 9 lines (one line reserved for each sex), 30 characters per line, and an overall limit of 122 characters exist for textual (multi-line) normals that are sex related.

Separate the lines with a (^) or the system parses the lines for you For example, if you use 50 characters and 2 lines for the male value, you will be limited to 72 characters and 7 lines for the female value.

SINGLE VALUE FLAG (1-A-R)
If a single normal value rather than a high/low range is used for this component, this field can define how the single normal value is flagged.

If you select *Abnormal*, values that do not equal the defined value flags with an *A*. If you select *High/Low*. Values less than the normal value flag as *L*, and values greater than the normal value flag as *H*.

NOTE: This field only determines how the system flags when a single normal value is defined. If a range is defined, the system uses High/Low logic regardless of the setting in this field.

VIEW NORMALS (1-A-O)
This field enables you to view the normal ranges for this component, even when the normals are greater than 30 characters or when multi-line normals are defined.

AGE RANGE (8-AN-R)
This column defines the age range for the values to be entered in the next columns. Age ranges must be defined in sequential order. The starting value of the first range is assumed to be 0 days.

Age ranges are defined by days (###D), years/days (#Y###D), and years (###Y). The starting value of the first range is assumed to be 0 days.

You need to enter only the ending range. The starting value of each subsequent range is incremented by 1 day or year from the previous line, depending on how that range was defined. The maximum value age range is as follows:

- For days, 364 (365 days converts to 1 year on the screen)

- For years/days, 4Y364D

- For years, 198

Although age ranges are defined in days, years/days, and years, the patient's age displays in days, months, and years in Patient Inquiry and on any report that prints the patient's age.

Consider the following when defining age ranges:

- A range entered anywhere from 1 to 4 years must include 364 days (in the #Y###D format) for the patient to be evaluated against the range during the entire time the patient is that age.

For example, if a range is defined as 3Y, the patient is evaluated against the next highest age range at 3 years 1 day. If the range is defined as 3Y364D, the patient is evaluated against that range until 4 years. After 4 years, you can no longer use the #Y###D format.

Ranges defined as 5Y or above assume the entire 364 days. The following error message displays if a range greater than 4 years is entered in this format:

Greater than 5 year/day range not allowed!

- An age range that applies from 0-11 months must be entered in the Days format (*###D*). This range must include the number of days until the patient reaches that month, plus the number of days the patient's age remains in that month's range (29 days).

For example, an age range that applies to a 3-month-old will be defined as 119 days (average 30-day month) plus 29 more days until the patient becomes 4 months old.

NOTE: Defaults appear in the prompt if non-sex related normals are defined and you are defining age ranges that are non-sex related, or sex related default normals are defined and you are defining age ranges that are sex related.

If you have non-sex related default normals and define sex related age ranges, no defaults appear in the prompt. If you have sex related default normals and define non-sex related age ranges, no defaults display.

Enter normal ranges by entering the lower limit first, then the higher limit separated by a hyphen (-). If the normal value is a single value, enter that value. If the normal range is textual, enter the text.

A limit of 9 lines, 30 characters per line, and an overall limit of 135 characters exists for textual (multi-line) normals that are not sex related. A limit of 9 lines (one line reserved for each sex), 30 characters per line, and an overall limit of 122 characters exist for textual (multi-line) normals that are sex related.

Separate the lines with a (^) or the system parses the lines for you For example, if you use 50 characters and 2 lines for the male value, you will be limited to 72 characters and 7 lines for the female value.

After you enter the normals, the prompt for *edit/create/delete* displays. The screen is updated with your entries. Multi-line normals display the first 30 characters. If the normal range defined exceeds 30 characters, you can view the normal ranges by using the View option. Note that normals that are defined to be age related can have sex dependent age ranges in them.

SEX-RELATED (1-AN-O)

If the normals are sex-related, enter the male and female values on the appropriate line using one of the formats discussed for default normals. For example:

    Male   20-30
    Female 18-20

RESULT TABLE TYPES

STAR Laboratory allows result entry by selecting from a user-defined table. This is known as table selection, not to be confused with menu selection, for result entry. Result tables are used for results which require more options than available on menu selection (there can be up to 999 options per table). It is important to note that, during resulting, tables require more system overhead than menus. So if a menu will suffice it is best to use a menu rather than a table.

Before a result table can be built, you need to define the type of result table you will be building.

CODE (6-AN-R)
Enter a one- to six-alpha character identification code for the result table. The first character must be alphabetic. The remaining three to five characters can be alphabetic or numeric. If you are defining a table that will contain ID codes of laboratory personnel, the initial character of the code must start with I. While the table is defined with the person's ID code, the system translates this into their name for reporting purposes.

DISPLAY/PRINT HEADING (40-AN-R)
Enter the name of the result table up to 40 alpha/numeric characters and should be descriptive of the table. This name is used to assign the table to the result.

NEXT AUTO NUMBER (3-N-R)
Result tables automatically assign numbers for the table options. The exception is the ID table in which the ID code of the employee is entered instead of a number. Enter the number to increment with each table entry. The table limit is 999 entries.

RESULT TABLES

Once the result table type has been defined, Result Tables can be built.

The Result Tables worksheet is used to define a table of results available for results entry. These tables, once defined, can be assigned to test components using the Special Processing field on the Results and Normals worksheet.

RESULT CODE (7-N-R FOR ID TABLE TYPES OR 3-N-R FOR OTHER TABLE TYPES)
Enter a one- to three-digit numeric code for non-ID result table entries. This can be auto-assigned by the system or you may assign it yourself. If auto-assigning, do not complete this field. If this is an ID table, enter the ID code of the employee up to seven digits and enter the name of the employee as the description.

DESCRIPTION (30-AN-R)
If this is an ID result table, enter the employee name. For non-ID tables, enter a description for this table option up to 30 alphanumeric characters. This description is printed on reports and displays in Patient Inquiry.

RESULTS AND NORMALS

Processing of test results is a major function of STAR Laboratory. A great deal of information regarding test processing may be recorded in the system. Not only is test processing data used in result reporting, this information is also used in most of the other system processors, including Quality Control, Workload and Administrative Report processors.

RESULT INFORMATION

Individual test results must be specified as part of the Master Test File for each test. Up to 252 results can be assigned to a single online test. If the test is non-online, up to 84 results can be assigned. If the user tries to enter more than 84 results on a non-online test, the following error message displays:

Maximum of 84 results defined!

The system allows great flexibility in defining these results. Multiple result categories exist for defining internal, external, required or optional types of results.

In addition to test procedures used for accessioning and reporting of patient results, a Master Instrument test or Machine test must be specified for each instrument that will be connected online to the computer. The Master Instrument test must contain all of the possible test results produced by that instrument. Results should be arranged in the order in which the instrument outputs the data. Often, the Master Instrument test is a procedure which may be ordered as a legitimate test from the Master Test File; however, it might only be used to identify the data from the instrument. In all cases, the Master Instrument test serves as a reference in the distribution of the test results from the instrument into different accession orders which comprise a sum of specimens.

In multidepartment environments, if tests are to be linked as interdepartmental, the order of the results in both tests must be the same.

TEST RESULT FORM

SECTION (3-A-R)
Enter the section name where the test is located.

BAY(S) (2-N-R)
Enter the bay or bays to which the test is assigned.

NAME (30-C-R)
Enter the test name for which the result information is being specified.

TEST CODE (5-N-R OR 30-C-R)
Enter the test code for which the result information is being specified.

RESULT # (2-N-O)

It is suggested that each component be given a result number based on the order in which the test results occur within the test. Number 1 corresponds to the first test result. Subsequent results are numbered sequentially. Since the system allows tests to have more than the 12 results, you may have multiple worksheets for one test. Continue numbering each result from one worksheet to the next (that is, worksheet ONE result options 1-12, worksheet TWO result options 13-24, and so on).

COMPONENT NAME (30-AN-R)

List the components (results) to be used for reporting. Complete the worksheet to reflect the order in which the components are to be printed on Primary and Summary reports and how they appear on the CRT during resulting and viewing.

NOTE: If a test contains a calculation, the components which are a part of the calculation should come before the component being calculated. Circle the component name(s) which are calculated.

If you are using a component listing, you may enter the component name in this field. However, if your component does not have the system assigned number, just list the name in this field.

COMPONENT CODE (6-AN-R)

List the components (results) to be used for reporting. Complete the worksheet to reflect the order in which the components are to be printed on Primary and Summary reports and how they appear on the CRT during resulting and viewing.

If you are using a component listing, you may enter the component number in this field. However, if your component does not have the system assigned number, just list the name in the Name field.

REQUIRED/OPTIONAL and EXTERNAL/INTERNAL (1-A-R)

The next two fields work in combination with each other for defining the result categories. STAR Laboratory allows four different categories of test results. Categories are differentiated by whether the results are required or optional, and whether the results are to print on patient reports and in Patient Inquiry. The four categories are as follows:

Required   This result must be filled in for the test to be completed.

Optional   This result may or may not be filled in for the test to be completed.

Internal   This result (regardless of whether it is required or optional) will not print or display. It is considered internal to the system and can only be viewed in the result entry processor. Another way of referring to this field is Non-printable and Non-viewable. (Laboratory Archive Summary Reports can print internal results. Refer to Chapter 16: Archiving Parameters in the *Maintenance*

Worksheets Volume of the *STAR Laboratory Reference Guide* , for further details.)

External   This result (whether it is required or optional) prints on reports and be available for viewing in Patient Inquiry. Think of this field as a printable and viewable result.

Categories can be combined. Every result must be assigned one of the following combinations.

Required/External -   Results belonging to this group require a response to be entered in every case in order to complete the test. The results appear on those reports and processors used for displaying patient test results.

Optional/External -   Results belonging to this category are used to indicate results which sometimes have a response for certain specimens, but which will not have a response for every specimen. If a response is entered for this result, it appears on those reports and processors used for displaying patient test results.

Many tests have results which are reported depending upon the types of substances identified in the analysis. For example, several types of blood cells exist. However, not all of these cell types are encountered every time a differential is performed. Yet all the cells seen must be reported. Therefore, those cell types which are seldom seen but should be noted are specified as "optional/external" results.

Required/Internal -   This category demands entry of a response in order to complete the test. The information is stored in the system as a permanent part of the test file, but is not available for review through those reports and processors used for displaying patient test results.

This type of result may be used, for example, to assure that a certain procedure is performed before the test is considered complete, and thus prints. An example of this is a WBC estimate result, in which the estimate is not reported to the physician, but is used to enforce internal quality control connection with an individual accession.

Optional/Internal -   Results belonging to this category do not require entry of a response in order to complete the test. In addition, these results do not appear on patient reports or inquiry processors.

This category is often used for results which are employed to perform a calculation. For example, absorbance readings for a

test which are used to calculate the total concentration of a substance are usually specified as "optional/internal" results.

NOTE: Every test in the Master Test File (except those used as Miscellaneous Charge Items) must contain at least one required result. Generally, this is a required, external result.

In the R/O column, indicate the result type by entering **R** for required or **O** for optional. In the I/E column, enter **I** for internal or **E** for external. As you build and use the system, each result is flagged with a system code to reflect the corresponding category. This code displays at result entry to aid the technologist in determining which fields are required, optional, internal and external. The following explains the codes.

REQUIRED EXTERNAL - No Code
OPTIONAL EXTERNAL -   *
REQUIRED INTERNAL -   #
OPTIONAL INTERNAL -   ^
HISTORY CARDFILE

Indicate whether this result is filed in the History Cardfile by entering **Yes** to include it. If it is not to be included, leave the field blank.

SPECIAL PROCESSING (2-N-R)
This field is used to assign any of the system's special processing features to a result. Enter the name of the special processing feature.

ADDENDUM ONLY (1-A-O)
This field determines whether the result will be included with addendum only reports.

Auto Fill ID

This feature attaches an employee ID to the result field. Three options are available for this auto-fill:

- No Edit (ID of user is automatically filled and cannot be edited) Enter **No Edit**.

- Table Edit (ID can be replaced with an ID selected from a table) Enter **Table Edit** and the name and code of the result table.

- Menu Edit (ID can be replaced with an ID selected from a menu) Enter **Menu Edit** and the name of the menu.

Auto Fill ID/Required Completion

This feature automatically attaches the user's ID to the result field and makes the result field **required** for the test to be completed. This option is generally used for the "Released by" result for review queues.

Comment Processing

This feature allows you to report the accession comment if present in a result component field. You can report the accession comment as it was entered. Edit the comment or use tilde {~~} to clear the accession comment from being reported.

Date and/or Time

This feature assigns the result field as a date and/or time result. Enter the number corresponding to the date/time format to appear on reports. Use the following list:

```
1 =  2 Jan 87 0900
2 = 02 Jan 87 0900
3 = Jan 2, 1987 0900
4 = Jan 02, 1987 0900
5 = 1/2/87 0900
6 = 01/02/87 0900
7 = 01/02/87
8 = 2 Jan 87
9 = Jan 2, 1987
```

Free-Form Text

This feature allows free form entry of numeric or textual results. It is the most common option selected and the default for the Special Processing field.

ID Specific Menu

This feature allows you to assign result menus to specific individuals so that, within result entry, the menu which displays depends on either the person signed on or an ID entered in another result field. Enter:

I to determine the menu by the ID of the person signed on Enter name of the Result Menu to use as the default for this result (the one to display when a specific menu is not indicated). Enter the employee(s) to assign ID specific menus and the specific Result Menus to display for each.

R to define the menu to display based on a previous result. Enter an ID result (one that contains an ID code upon result entry) and the associated default Result Menu. Enter the employee(s) and their associated Result Menus.

Menu Selection ID

This feature requires that the result always be used for reporting an ID. It must have a menu composed of ID's attached to it. Enter the name of the ID menu (from the Laboratory Menu - Result worksheets I & II).

Menu Selection

This special processing feature allows the entry of a result by selecting an option or combination of options from a menu. Each result of any test in the Master Test File may have a menu designed for it. Each menu is assigned a name at the time of its creation. This name should be used to associate a specific menu with a specific result. Enter **7** plus the name of the menu (obtained from the Laboratory Menu - Result worksheet).

Multiple Table Selections

This feature allows result entry by selecting option(s) from a table. Enter the name of the result table (obtained from the Result Table worksheet).

Prompt Processing

This feature allows the reporting of a prompt response, if present. A prompt is a question asked on STAR Patient Care during order entry. The response is the data entered to answer the question. This information is passed to STAR Laboratory and is available for viewing and reporting. You can use this special processing to report the response as it was entered on STAR Patient Care, edit the response for result reporting purposes only, or clear the prompt from being reported.

SNOMED Code

Select this feature if this result is to be selected from the SNOMED table. Indicate how many times the system is to prompt for entry of a SNOMED code in result entry by entering a number from one to three. This option is only available for Anatomic Pathology test types.

Security Level Specific Menu

This feature enables you to assign result menus to specific security levels so that the menu that displays within result entry depends on the security of the person signed. Enter the menu to use as the default for this result (the one to display when the user's security level is not one assigned to a specific menu). Enter the security level(s) to assign specific menus.

Table Selection

This feature is similar to the Multiple Table Selections option in that a table can be accessed for result entry. However, it does not provide a choice of multiple options. Only one option can be selected per result. It does provide table access through either the code or alpha lookup. Enter the result table name and either *alpha* or *code.*

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Template Processing

Template processing is used only with Cancer Protocols. This processing allows you to choose a cancer protocol from a defined list while in Result Entry. When Template Processing is chosen, *Template Processing* is displayed in the field. Only one component per test code may be defined with Template Processing.

The Template Processing option does not display unless the SNOMED CT® field is defined as *Yes* in Anatomic Path Parameters.

Word Processing

This feature allows you to select Word Processing and indicate which of the following display options should be used. There are four types of word processing display options:

- The first option displays *all* of the Standard Result Text documents in result reporting when this component is resulted for the test. To select this option, enter **A**.

- The second option uses the interpretive reporting parameters to complete this component with a Standard Result Text document. You can use predefined standard result text based on the value of another result component in the test. To select this option, enter **I**. For more information on interpretive reporting parameters, refer to Chapter 6: Supporting Test Files in the *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide.*

- The third option limits the display of available Standard Result Text to a subgroup. To select this option, enter **S**. These subgroups can be categorized by ID type, based on result field or general subgroup type. The ID type of subgroup displays only when the person resulting the test has established a subgroup using his/her ID code as the subgroup code.

    A subgroup based on the results of another component can display in this result field. The subgroup name must match the result value entered for the component.

    A general subgroup type is not ID code-specific, nor based on results of another component. An example of a general subgroup is *frozen section description.*

- The fourth option is limited to the result component defined in the WP Component field of the Reference Lab Interface Parameters processor. The system automatically displays *Word Proc.- Reference Lab*. Multiline normals, free text, and precanned comments transmitted in the Comment segment of the result transaction from the reference laboratory are filed to this component.

WORKLOAD PROCEDURE CODE (5-N-R)
If you wish to accumulate workload by result, complete this field with the workload procedure code for this test. The code must come from the workload procedure file defined for your system.

ADDENDUM ONLY (1-A-O)
This field determines whether the result will be included with addendum only reports.

CHARGE COMPONENT (5-AN-R)
If you have elected to charge on result, enter the name of the component that initiates the charge for this test. There can be only one charge component per test.

Units Crossmatched Processing

Units X-Matched
Any result component used to process blood product information from Hemocare must be defined with the special processing option Units X-Matched Processing. This is an option in the table that is displayed when you enter this field It is used for ABB test results for crossmatch and non-crossmatch blood components.

Result components defined for serological test results, (for example, ABO/Rh) require no special processing and should be set with the Free form text result type option. Menu selection or table selection resulting may be implemented as a backup option for these result components.

SPECIAL PROCESSING OPTIONS IN RESULTS & NORMALS			
1. Auto Fill ID	6. ID Specific Menu	11. SNOMED Code	16. Valid Values
2. Auto Fill ID/Req'd Comp	7. Menu Selection ID	12. Security Level Specific Menu	17. Units X-Matching Processing
3. Comment Processing	8. Menu Selection	13. Table Selection	
4. Date and/or Time	9. Multiple Table Sections	14. Template Processing	
5. Free Form Text	10. Prompt Processing	15. Word Processing	

CALCULATIONS

One of the features of the Result Reporting Processor is the ability to have the system perform calculations. All common calculations may be performed by the system. The technologist enters the raw data by entering result values and the system calculates the final result based on dilutions, multiplication factors, chamber cell counts, absorbance reading, timed urine procedures, ratios, fluorometric procedures, FTI's and creatinine clearances.

Calculations can be defined for any test having numeric results. A great amount of flexibility is permitted in defining calculations. Factors such as the collection period (entered at accession time), total volume, and dilution factors can be employed.

With the exception of the collection period, all variables of each calculation routine that require data entry MUST BE DEFINED AS RESULTS of the test. Also any result used as part of a calculation, must be listed before the result being calculated. These test results may be specified as any result category. If a test is processed through the Electronically Scheduled Processor (ESP), the dilution factor need not be a result of the test, as it can be specified as a part of the routine ESP processing.

Use this worksheet for single test calculations. (The system can perform batch calculations; however, these are handled through the ESP Processor.)

TEST CODE/NAME (5-N-R)
This is the test code and name of the test which is to contain the calculation.

COMPONENT #/NAME TO BE CALCULATED (5-N-R)
This is the component number and/or name to be calculated. Only one per box is allowed. If the test has more than one calculation, fill out a box for each component to be calculated.

DECIMAL PLACES (1-N-R)
This is the number of decimal places that the component (result) is to be calculated to. For example, one decimal place would calculated a result to the tenths (0.0 places), three would calculate a result to the thousandths (0.000 places). Zero is used when the result is to be a whole number.

COMPONENTS USED FOR CALCULATION (5-N-R)
List the components (results) within the test to be used in the calculation. Do not include the calculated component. Circle the results optional to the calculation, that is, those results only used in the calculation if they exist.

Mathematical manipulation of the data may include addition, subtraction, multiplication, division, squaring of factors, derivation of square root, or any combination of these. In the space provided, specify the formula by writing out the calculation using the components and the appropriate mathematical operators in the exact way it should be calculated. The system performs the calculation from left-to-right. For example, in the expression 2+2/5*6, two would be added to two, divided by five, and then multiplied by six. If a particular operation is to be performed first, it should be enclosed within parentheses. For example, the formula 2+(2/5)*6 would cause two to be divided by five, the two added to the quotient, and the sum multiplied by six.

The following mathematical operators are recognized by the system:

1.   The plus (+) sign indicates addition to the system.
     Example: 2 + 2 = 4

2.   The minus (-) sign indicates subtraction to the system.
     Example: 2 - 2 = 0

3.   The asterisk (*) sign indicates multiplication to the system.
     Example: 2 * 2 = 4

4.   The slash (/) sign indicates division to the system.
     Example: 11 / 5 = 2.2 (carried one decimal place)

5.   The backward slash (\) indicates integer division to the system. (It will only divide to the whole number.)

     Example: 10.5 \ 5 = 2

6.   The left parens ("(") indicates the beginning of an expression that needs to be calculated before the usual left-to-right order. For every left parens there must be a corresponding right parens. There can be more than one set of parens in a calculation.

     Example: 10 + (2 * 8) is calculated as 10 + (16) = 26

7.   The right parens (")") indicates the completion of an expression that needs to be calculated before the usual left-to-right order. For every right parens there must be a corresponding left parenthesis. There can be more than one set of parentheses in a calculation.

     Example: 10 + ((2 * 8) - (6 - 2)) which is calculated as
                10 + ((16) - (4)) which is calculated as
                10 + 12 = 22

8.   The vertical bar (|) sign indicates "to the power of" to the system.

     Example: 10|2 = 100 10 to the power of 2 equals 100
                 2|2 = 4   2 to the power of 2 equals 4

9.   The collection period is required in some tests and is used in the calculation of several tests. The collection period, entered at accessioning, is a variable in the calculation. The system automatically pulls this entry forward to use in the calculation. Unlike most data used for calculation, the collection period need not be a result of the test.

10.   The calculation constant is used to define constant values for a particular calculation record. Constants, values that do not change, are used in every performance of the calculation. The calculation constant is composed of the constant name which appears on the screen in result reporting and the numeric value for that constant. The constant name may be specified in any combination of alpha/numeric or symbol characters and is usually entered in upper/lower case. Indicate the constant value using numeric characters. This constant cannot be edited. Multiple calculation constants can be defined.

11.   Test Constant is used to define constant values for a particular calculation record. These constants differ from the calculation constants in that their values can be edited immediately prior to resulting. This feature is useful in defining specimen and standards dilution factors. The test constant is composed of the constant name which appears on the screen in result reporting and the numeric value for that constant. The constant name can be specified using any combination of alpha/numeric or symbol characters in upper/lower case. The test constant must be indicated using numeric characters. Multiple test constants can be defined.

12.   If the test has a single numeric value used in the calculation, the system allows you to set the value into the calculation without defining it as a constant. Simply write the numeric value in the calculation when you write out the calculation.

13.   In addition to the types of operators previously described, there are also six other functions allowed for calculations. Designate these as you write the calculation. These are as follows: Sine, Cosine, ArcTangent, Exponential, Nat Log, and Square root.

   NOTE: Selection of a function provides an automatic left parenthesis. You must remember to provide a complementary right parenthesis.

   A.   The sine function is a trigonometric function which calculates the sine of the angle (in radians) enclosed in parentheses.

       Example: Sine(2) = .909 (to 3 decimal places)

   B.   The cosine function is a trigonometric function which calculates the cosine of the angle (in radians) enclosed in parentheses.

       Example: Cosine(6) = .960 (to 3 decimal places)

C. The arctangent function is a trigonometric function which calculates the
    angle (in radians) whose tangent equals the value (or values) enclosed in
    parentheses.
    Examples: ArcTangent(5) = 1.373 (to 3 decimal places)
                   if only y coordinate defined

                   ArcTangent(5,3) = 1.030 (to 3 decimal places)
                   if both y (5) and x (3) coordinates defined

D. The exponential function calculates e to the power of the value enclosed in
    parentheses. The value of e is approximately 2.71828.

    Example: Exponential(2) = 7.389 (to 3 places)

E. The natural logarithm function calculates the natural logarithm (to the base
    e) of the value enclosed in parentheses.

    Example: Nat Log(7.389) = 2   (approximate)

F. The square root function calculates the square root of the value enclosed
    in parentheses.

    Example: Sq Root(16) = 4

RESULT NAME EXAMPLE (240-C-R)
Write out the calculation using the name of the results in the calculation. This is
extremely helpful when testing and verifying the calculation. For example: Anion Gap
= Na-(Cl+CO2)

NUMERIC EXAMPLE (240-C-R)
Part of the calculation build involves entry of numeric values as a final verification step.
Enter a sample of the preceding calculation using numeric values for each component
used. In the preceding example, Anion Gap = Na-(Cl+CO2), the sample could be:
Anion Gap = 130-(110+5).

CELL COUNTER KEYPAD ASSIGNMENT

The Automated Keyboard Cell Counter enables you to use the keyboard as a tallying device. When performing a cell count, specific keys are pressed, once for each occurrence of a particular cell. Cell types must be defined as results of the test in which the cell counting feature is to be used. Cell counting results are defined using the same criteria as that used in the Test Results Form. The only difference is that results to be counted MUST be defined as the first results of the cell counting test. If this order of results is undesirable, a separate test only used for cell counting can be defined.

The specific key(s) to use must be defined for each cell counting test. Each key is unique for a particular cell type and corresponds to a result in the test. Within a single test, no two cell types can have the same key assigned. However, the same key can be used in other tests using the cell counter to represent a different cell. (To avoid confusion, it is suggested that the same key be used to count like cells from test to test whenever possible. For example, if key 3 is used to count Segs in the Differential test, key 3 should also be used for Segs in the CSF Cell Count test.)

The worksheet contains the layout of the numeric keypad for the PC keyboard. To define results to be counted, place the result number of the cell to be counted in the appropriate slot. If you wish to use keys not designated on this layout, list them beside the keypad in keypad assignment - result number order. For example, P-12, O-13, I-14, [-15,]-16, and so on. Be sure to use the Test Results worksheet for the correct result numbers.

CELL COUNTER PARAMETERS

The Automated Keyboard Cell Counter enables one to use specified keys on the CRT keyboard as tallying devices. This processor applies particularly to Hematology, where many tests require the enumeration of cell types as seen on a slide or hemocytometer, for example, differentials, reticulocyte counts and eosinophil counts.

Complete a separate worksheet for each test.

TEST CODE/NAME (5-N-R OR 30-C-R)
Enter the test code and name for which the cell counter is being defined.

CELL COUNTER PARAMETERS

DEFAULT NUMBER OF CELLS (4-N-R)
A default number of cells to be counted can be specified for each cell counting test that contains percentage result types. When the default number of cells has been counted (usually 100 for a differential), the system audibly alerts the technologist that this number has been reached and the count is complete, although the system does allow variance from the default if necessary. The default number is only effective for Percentage (%) cell types.

Indicate the default number of cells to count in the space provided, for example, 100 for differentials or 1000 for reticulocytes.

TOTAL RESULT (2-N-R)
If desired, the system can display the total number of cells counted. This feature is particularly useful in interpreting the results of a differential. This information may appear next to a result named *Comment* or a separate result named *Cells Counted* may be specified. In any case, provisions must be made one way or the other, if the number of cells counted is to appear on the final report.

NOTE: If using the Comment result, the number of cells counted only appears if a number other than the default is counted.

Select the option of choice and enter the result option number in the blank.

DISPLAY HEMOGRAM (1-C-R)
To display a profile of previously obtained results on the CRT screen as the cell count is being performed, circle Yes. This information is obtained from a whole blood analyzer instrument or from manual result entry. The profile result display depends on the results specified on the Test Result worksheet for the test which was ordered and is being resulted using the cell counting processor.

If the display of the hemogram results are desired, check **Yes** on the Cell Counter worksheet and also fill out the Hemogram Display Information sheet which follows this section with the appropriate information. This worksheet needs to be given to your installation team.

DECIMAL PLACES (2-N-R)
Indicate how many decimal places to display the percentages for the differential to display.

RESULTS COUNTED TOWARD THE DEFAULT (U-AN-O)
Enter the result number and name of the cells that are counted toward the default.

RESULTS NOT COUNTED TOWARD THE DEFAULT (U-AN-O)
Enter the result number and name of the cells that are not counted for percentages and/or absolutes.

Cells that are not to be counted toward the default and are not to be used in the calculation are not to be entered here. For example, nRBCs are not usually counted toward a default number of cells in a differential nor are they used in calculating the percentages; therefore, do not list them in this field. They only need to be defined in the keypad assignment area of the worksheet.

DISPLAY THE RESULTS IN ABSOLUTES (1-A-R)
Two methods of tallying the number of cells counted may be used. The first method displays the cells counted in a percentage format. An example is the cell type "Segs," where the number of cells counted is represented as a portion of a 100% total. The second method displays the number counted as an absolute count.

Absolute cell counts can only be obtained from those cell types which were enumerated through the use of the cell counting processor. The system will not calculate the absolute value if the cell counting processor has been bypassed and entered manually. It should be noted that the actual WBC count needs to be entered prior to performing the cell count so that absolute counts can be calculated by the system. The following serves as an example:

Total Cells Counted   = 100
Segs Counted   = 65%
#WBCs   = 9000
Absolute Seg Count   = 5850

Check **Yes** if the absolute values are to be calculated or **No** if absolute counts are not desired. If Yes, check **one** of the following:

• The percentage value REPLACES the absolute value.

    Segs   65%

• **Both** the percentage and absolute cell count values appear as separate results. There must be two different result components in the test for each type to be counted.

    Segs (%)65

    Segs   5850

- The absolute value displays **next** to the percentage value.

    Segs   65% (5850)

- Store only the raw values, do not calculate the percentage or absolute values.

    Segs   65

After selecting ONE option, enter the following information for that option:

Mult Factor: Enter the multiplication factor to be used to calculate the absolutes.

Decimals: Enter the number of decimal places you to calculate the absolute.

WBC Result: Enter the number of WBC result to be used to calculate absolutes.

ACTIVATE "RBC" MORPHOLOGY QUESTION (1-A-R)
Once the differential is complete, the system has the ability to activate the question, "Is RBC Morphology Normal?" and to designate the next result field to continue resulting. Indicate whether to prompt by checking **Yes** or **No**.

Checking **Yes** causes the system to automatically place the word *Normal* in the result field for RBC morphology. The cursor automatically advances to the next designated result field, usually passing the results used to describe abnormal red cells. Checking No causes the system to bypass the RBC morphology result and the cursor moves to the next designated result field (generally the first result for abnormal red cells).

When using the RBC Morphology question, it is important to list the differential and morphology results in the proper order. For example:

    Results 10 through 20 are WBC Differential cells.

    Result 21 is the RBC Morphology and is used to activate the question.

    Results 22 through 32 are abnormal RBC Morphology results. (You may have one or more results for RBC Morphology depending on your CBC test.)

    Result 33 is WBC Morphology.

If the morphology question is answered **Yes**, result 21 automatically fills with the word *Normal* and the cursor moves to result 33 for WBC Morphology. If the morphology question is answered **No**, the cursor moves to Result 22 allowing you to enter the description of the abnormal RBCs.

If Yes, indicate the number of the RBC Morphology result and the number of the next result for the cursor if RBCs are normal. Also indicate the next result number for the cursor if the RBC Morphology is abnormal.

HEMOGRAM DISPLAY FOR TEST

Five formats are available for displaying the hemogram. These options are displayed in the order they appear on the CRT screen while doing a differential. Hemogram results must be part of the ordered test. Select the option of choice and enter the corresponding result number on the adjacent line. You may select whichever display options you want; however, there is a maximum of nine results for the display.

Following is an example of the five standard hemogram display formats, which are defined by McKesson:

(1) WBC,RBC,Hgb,Hct,Plt,MCV,MCH,MCHC,RDW
(2) WBC,RBC,Hgb,MCV,MCH,RDW,Plt,Lymp,Gran
(3) WBC,Hgb,Plt,MCV,MCHC,RDW,Lymp,Mono,Gran
(4) WBC,RBC,Hgb,MCV,MCH,Mono,Plt,Lymp,Gran
(5) WBC,RBC,HGB,Hct,MCV,Plt,Lym,Mono,Gran

CROSSLINKS

STAR Laboratory allows definition of equivalent results among different tests. Using this crosslinks feature, a result entered through one test will place the same value into the equivalent result(s) of other tests ordered under the same accession. For example, crosslinks can be used to designate all Sodium results in tests having a serum Sodium result as identical. Therefore, entry of a Sodium value through a single test result causes all identical Sodium results for the Same Accession Number to contain the same value.

Basically, the information requested on this worksheet provides a road map for routing results reported through one test to "equivalent results" of other tests. Those tests which contain results equivalent to the resulting test must be identified. Not only must the tests which can receive the "equivalent" results be identified, but the results and their positions must be indicated. These tests are then considered crosslinked to receiving tests.

This feature also allows online instruments to result numerous tests. Through the crosslinks feature, the system enables you to send only ordered channels from a multi-channel analytical instrument. For example, a 20-channel analyzer can send results to a 6-channel ordered test.

This processor also enables the processing of interdepartmental testing. Tests ordered by one laboratory department and sent to another for resulting, must be crosslinked between the "resulting" test and the "ordered" test. These tests must be identified as interdepartmental tests in the Master Test file and have their tests and/or results identified here to be crosslinked.

To crosslink results between tests with "equivalent" results, identify each resulting test by completing this worksheet. Complete a separate worksheet for each resulting test.

Tests with "common" components can be from different laboratory departments.

Examples of crosslinked tests are:

Tests to be resulted (Ordered)Test Used for Resulting (Resulted)

Chem 6
Chem 7
Chem 12
Lytes   Chemistry On-Line Test
Lytes, BUN, Glucose
Cholesterol
Triglyceride
Lipid Profile

In order to have this capability, the results entered in the resulting test code must fill in the appropriate results in the ordered tests. Crosslinks are the pathway for the results from the resulted test code to the ordered test code.

For Example:

Resulting Test   Ordered test

Chemistry On-Line Test   Chem 6
Results: Results:

Na   ---------------------------------> Na
K   ---------------------------------> K
Cl   ---------------------------------> Cl
CO_2-   ----------------------------------> CO_2
BUN   ---------------------------------> BUN
Glucose   ---------------------------------> Glucose
Creatinine
Albumin
T. Protein
Cholesterol
Triglyceride
HDL

LAB SECTION (3-A-R)
Indicate the section in which the test used for reporting (the sending test) is located.

RESULTING TEST CODE/NAME (5-N-R OR 30-C-R)
Enter the code and name of the test through which crosslinked results may be reported.

CROSSLINK ALL COMMON COMPONENTS TO THE FOLLOWING TESTS
This is a short cut for crosslinking tests with identical components and the only ones to be crosslinked from resulting to ordered. If your system is multidepartment, list the ordering department and test code. (If you are a single department system, you need not list the department.)

ORDERING DEPT (3-A-R)
If your system is multidepartment, enter the department of the ordering test code.

ORDERED TEST CODE/NAME (5-N-R OR 30-C-R)
Enter the code and name of the ordered test to be resulted through the resulting test.

RESULTS OF RESULTING TEST TO BE CROSSLINKED TO ORDERED TEST
List the results to be crosslinked from the resulting test to the ordering test (if all common components are not crosslinked). List the resulting test's result name and the corresponding ordering test's result name to be crosslinked.

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SEC LEVEL (2-N-O)
Security level-specific crosslinks can be defined to restrict access for reporting purposes to certain test results based on the user security level. Specify the security level (using security levels defined for your system) beside the result(s) you wish to restrict. Note this feature should not be invoked for every test, only for those particular tests that require a higher security level of reporting. For example, a Pathologist Interpretation result.

CLEARED RESULTS

The Cleared Results feature allows definition of results to be cleared (removed) when designated results are edited. This feature, when used in conjunction with Review Queues and the Release By field, protects the electronic signatures of those who previously released a report which is later changed. The electronic signature (when that field is indicated as a Cleared Result) is cleared and the test once again is given a Partial status and, therefore, must be released again.

TEST CODE/NAME (5-N-R OR 30-C-R)
Enter the code and name of the test for which cleared results will be used.

RESULT COMPONENT(S) TO BE CLEARED (5-N-R OR 30-C-R)
List the result component(s) by name and code which will be automatically deleted when designated results are edited once the test has a status of Done.

COMPONENTS THAT CLEAR (5-N-R OR 30-C-R)
List the result component(s) by name and code which will cause the cleared results to be deleted.

GROUP ASSIGN - INSTRUMENT

Use the Group Assign - Instrument worksheet to define the instrument group and the accession processing options for Specimen ID processing and Bar Code label printing by test and ordering category.

TEST CODE/NAME
Enter the test code/name.

SPECIMEN ID/BAR CODE
To define Specimen ID processing, enter **I**. To define Bar Code label processing, enter **B**. To define channels to download for this test, enter **D**.

NOTE: The D option appears only if the test is assigned to an automated method that is bi-directional.

ORDERING CATEGORY
Since a test can be run on different instruments (for example, if the ordering category is STAT), you can define the instrument group and the accession processing option for each ordering category. Indicate the ordering category for this assignment. Refer to the Main Test Information worksheet in Appendix B: Worksheets in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide* for the categories defined for this test.

INSTRUMENT GROUP
Using the Instrument Group worksheet, enter the instrument group for this test.

ACCESSION OPTIONS
Depending on the entry you made in the Specimen ID/Bar Code column, select the accession processing option for the ordering category for this test.

Specimen ID

Many instruments have specific requirements for the specimen ID number such as limiting the number of digits allowed. The Specimen ID option accommodates length restrictions for the specimen ID number processed by the instrument or allows you to use another method of defining specimen ID numbers when using Self-Creating Batch for instrument result processing.

With this option, as tests to be performed on the instrument are accessioned, a cross-reference file is created between the specimen ID number and the accession number. When the results (identified by the specimen ID number) are received on STAR Laboratory, the specimen ID number is translated back to the accession number.

As each instrument is defined in the system, requirements for the specimen ID number can be defined. These requirements are obtained from the interface specifications. The options are:

Full Accession Number
Partial Accession Number
User-Assigned ID Number

The partial accession number and the user-assigned ID number options are further defined by the maximum number of digits allowed per specimen ID number. In addition, several test-related options which control this process during accessioning are defined per ordered test code under the column called Accession Options on this worksheet. The options are:

1. No ID assignment
   This option causes no specialized assignment of a specimen ID number at accessioning.

2. Prompt for ID assignment
   This option causes a prompt to display during accessioning.

   For the partial accession number option, the following prompt displays:

   Assign specimen ID XXXX (Y/N) [Y]--

   The value of XXXX is determined by instrument interface parameters.

   For the user-assigned ID number option, the following prompt displays:

   Enter specimen ID of up to X digits or not assign(N)--

   The value of X is determined by instrument interface parameters.

3. No prompt, auto-assign instrument specified ID
   This option automatically generates a specimen ID number during accessioning.

   NOTE: This option is invalid if the instrument is defined to use the user-assigned ID number options for the specimen ID number.

Bar Code

If you are assigning bar code label processing, select from the following accession processing options for printing bar code labels:

1. No instrument labels
   This option results in no generation of instrument bar code labels for this test at accessioning.

2. Prompt for instrument labels print
   This option causes the following prompt to display during accessioning:

   Print all instrument barcode labels? (Y/N) [Y]--

3. No prompt, auto-print instrument labels
   This option causes instrument bar code labels to print when this test is
   accessioned.

Download

If you define channels to download test requests to an analyzer, select from the
following download processing options:

1. Download
   This option results in the downloading of test information, based on the ordering
   category selected (routine, ASAP, or STAT).

2. Add Download Assignment
   This option allows you to choose a bi-directional/automated method of download
   assignment specific to the selected test. After selecting the automated method
   (group), you may activate or inactivate the group at any time.

3. Activate Channels
   This option allows you to add or remove download channels defined previously.

4. Edit Channels
   This option allows you to edit, add, or delete download assignments.

GROUP ASSIGN - WORKSHEET

Use the Group Assign - Worksheet to assign ordered tests to a Batch Worksheet Group. This causes tests to automatically add to the batch. Once the Batch Worksheet Groups are defined, the assignment is made by ordering category (for example, routine, ASAP, or STAT). It is also possible to add an accession to multiple batches by assigning multiple Batch Worksheet Groups to the desired ordering category of the ordered test. An example is a Serology Profile test which contains CRP, RA Factor, ANA, HAA and RPR results. A batch worksheet group can be defined for each of these results so that the accession number is added to a different batch for each resulting test. Each ordering category can be assigned to up to five groups. If the auto-build feature is not used, this assignment is not needed.

TEST CODE/NAME
Enter the test code and name.

ORDERING CATEGORY
Indicate the ordering category for the Batch Worksheet Group. Refer to the Main Test Information worksheet in Appendix B: Worksheets in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide* for the categories defined for this test.

NOTE: The batch test code of the Batch Worksheet Group must be crosslinked to the ordered test code that is assigned to the Batch Worksheet Group for proper resulting to take place.

BATCH WORKSHEET GROUP
Select the Batch Worksheet Group to add to this ordering category.

AUTO BATCH AT ACCESSIONING OPTIONS
Indicate the accessioning option to define for this category and test by entering one of the following numbers:

1   **Do not place in batch at accessioning.** This is used to "turn off" a previous Worksheet Group assignment.

2   **Place in batch only after prompting user during accessioning.** Each time the assigned test/priority is accessioned, it can be added to a batch based on user response to the prompt line explained below.

3   **Automatically place in batch at accessioning without prompting user.** This option automatically places the accession number in the defined batch(es) when the test is accessioned.

Options 2 and 3 are auto-build options. If option 2 is selected, each time a test is accessioned that has an ordering category assigned to a Batch Worksheet group, the following prompt line displays:

   Place the above test(s) into the RPR batch? (Y/N) [Y] --

The default is Yes.

INTERDEPARTMENT TEST CODES

STAR Laboratory's multidepartment concept addresses specimen transfer by allowing order placement and specimen collection in one department and specimen shipment to a performing department. Specimens are tracked by the system and audit information is captured at each step. Results are entered at the performing department and reported to the ordering department.

For a specimen to be transferred from one (ordering) department to another (performing) department, corresponding test codes must exist between the two departments. This is required for setting up the incompletes in the performing department and for specimen tracking between both departments.

Use this worksheet to identify tests to be used for interdepartmental processing and their corresponding and/or alternate departments and test codes. The following fields are required:

DEPARTMENT CODE (3-A-R)
Indicate the ordering department, that is, where the specimen is collected and prepared for transport to the performing department.

INTERDEPARTMENT TEST CODE (5-N-R OR 30-C-R)
Enter the ordering test code that, once collected, will be performed by another department.

CORRESPONDING DEPT (3-A-R)
Indicates the department that **usually** performs the test. (If an alternate department is necessary, complete the information under the "Alternate" column.)

CORRESPONDING TEST CODE (5-N-R OR 30-C-R)
Enter the corresponding test code that will be used for setting up the incomplete file for the corresponding department.

ALTERNATE(S) DEPARTMENT (3-A-R)
Indicate the alternate department(s) that may be used to perform the test.

ALTERNATE(S) TEST CODE (5-N-R OR 30-C-R)
Enter the test code for the alternate department that will be used for setting up the incomplete file for the department.

REVIEW QUEUES

STAR Laboratory allows you to define tests to be queued (stored online) until a supervisor or pathologist reviews and accepts the results. Tests may be manually queued or, using this worksheet, automatically queued according to result entry/edit. To manually queue a test, the technologist simply enters **Q** at result verification. The test is then automatically sent to a predefined queue.

Use the Review Queues worksheet to indicate the appropriate result fields for queue routing.

TEST CODE/NAME (5-N-R OR 30-C-R)
Enter the test code and name to be queued.

COMPONENT NUMBER(S) REQUIRED PRIOR TO QUEUE PLACEMENT
Indicate the result component number(s) which must be completed before the test is sent to a queue. If more than one result is to be used, enter each on a separate line.

REVIEW QUEUE COMPONENT NUMBER
Enter the result component number(s) to be used to indicate which queue to place the test. This is usually an ID result such as Read By or Grossed By. If the test is to be routed to more than one queue, use a separate line for each.

"REVIEWED" COMPONENT NUMBER
Enter the result component number to be filled in when the report is reviewed and released from the queue. This is typically "Reviewed By."

QUEUE FLAG
If one review queue is used per test code, select option 1 here. If multiple queues are used, indicate the route for the test to follow upon queuing by checking one of the following:

  1   Entries are made in all queues simultaneously.

  2   Entries are made only in the first queue in which the "Reviewed" component has not been filled.

  3   Entries are made in all queues, but queues after the first (for which the "Reviewed" component has not been filled) are flagged to indicate that not all previous queues have responses.

Multiple review queue definition:

When option 1, "Entries made in all review queues," is selected for a test, the test queues simultaneously to all queues defined. In the following test example, if results 1, 2 and 4 are completed, the test queues to "Dr. Smith" and "Dr. Jones."

1. Component required to go to queue: RESULTED
2. Performed by (Names the queue): Dr. Smith
3. Reviewed by (Releases from Performed by queue):
4. 2nd Review (Names the queue): Dr. Jones
5. Verified by (Releases from the 2nd Review queue):

When option 2, "Entry made to first queue without results," is selected for a test, the test is queued to the first queue that does not have the component that releases from the queue filled in. In the following example, if results 1, 2, 3 and 4 are completed, the test is queued to the "Dr. Jones" review queue.

1. Component required to go to queue: RESULTED
2. Performed by (Names the queue): Dr. Smith
3. Reviewed by (Releases from Performed by queue): Dr. Brown
4. 2nd Review (Names the queue): Dr. Jones
5. Verified by (Releases from the 2nd Review queue):

When option 3, "Entries made to all, queues without results are flagged," is selected for a test, the test is queued to all queues and is flagged if the component that releases it from the queue filled in but is not filled in for the other queue. In the following example, if results 1, 2, 3 and 4 are completed, the test will be in both queues and is flagged in Dr. Smith's queue.

1. Component required to go to queue: RESULTED
2. Performed by (Names the queue): Dr. Smith
3. Reviewed by (Releases from Performed by queue): Dr. Brown
4. 2nd Review (Names the queue): Dr. Jones
5. Verified by (Releases from the 2nd Review queue):

BILLING INFORMATION

Certain billing information is required per test code when the Contract Billing module is used for invoicing and a billing tape is generated for Laboratory charging. If you are not using Contract Billing for invoicing nor generating a billing tape, this form is not used.

TEST CODE/NAME (5-N-R OR 30-C-R)
Enter the test code or name for the billing information.

EFFECTIVE DATE (SPECIAL PROCESSING)
Enter the date that the billing information becomes active. Midnight processing will update the test with new billing information based upon this date.

BILL CODE
Enter the billing code to be used by the financial system for charging. The length of this code is specified by the System Manager during the initial build of the parameters.

REV DEPT
If the revenue department table has been built and the revenue will be broken down specifically within the laboratory department, enter the revenue department name. McKesson will assist the System Manager in building the revenue department table.

PRICE ALGORITHM
Refer to Chapter 6: Supporting Test Files in the *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide*.

VARIABLE PRICES (7-N-O)
If using Variable Pricing algorithm, you may enter upto four variable prices. Otherwise, leave this field blank.

VARIABLE UNITS (2-N-O)
If you are using the Increments or Timed Charges, enter the variable units to be priced.

FIXED PRICE (7-N-O)
Enter the 7-digit price for the test.

FIXED UNITS (3-N-O)
Enter the number of units after which the fixed price should be charged again.

INTERPRETIVE REPORTING PARAMETERS

The Interpretive Reporting Parameters enable you to report a Standard Result Text document based upon the value of a component within the ordered test.

This example describes how you might set up result criteria for triggering an interpretive report on a CK test. The following table contains criteria for reporting a standard result text in the CK Interpretive component field.

In this example, the following components have criteria defined that can trigger a standard result text to fill in the CK Interpretive component field:

- CK(U/L)

- CK-MB(U/L)

- CK-MB(%).

There are five possible standard result text documents that would be reported in the CK Interpretive component field following the evaluation of the result criteria for the three results:

- CK Normal 45-235

- CK Abnormal >235

- CK-MB High >10

- CK-MB Borderline (5-10)

- CK-MB Normal (0-4).

You would build the criteria outlined in the following table in a hierarchial order in the Interpretive Reporting Parameters maintenance processor. If the firstoption is true - if CK(U/L) is greater than 235 - then the CK Abnormal >235 standard result text document displays when you access the CK Interpretive component field. The evaluation of criteria takes place when you access the component that has the interpretive word processing special processing defined.

If the first option is not true, STAR Laboratory evaluates the next option in the table. The system evaluates these options sequentially until a true value is found. If all options are evaluated and none of them are true, then when you access the CK Interpretive component, the system invokes word processing.

Example of Result Criteria for Interpretive Reporting a CK Interpretive Component field

The following table displays how each of the options could be invoked.

Option Number	Component	Result Criteria	Standard Result Text Document
1	CK (U/L)	>235	CK Abnormal >235
2	CK-MB (U/L)	>10	CK-MB High >10
3	CK-MB (U/L)	=5	CK-MB Borderline (5-10)
4	CK-MB (U/L)	=6	CK-MB Borderline (5-10)
5	CK-MB (U/L)	=7	CK-MB Borderline (5-10)
6	CK-MB (U/L)	=8	CK-MB Borderline (5-10)
7	CK-MB (U/L)	=9	CK-MB Borderline (5-10)
8	CK-MB (U/L)	=10	CK-MB Borderline (5-10)
9	CK-MB (%)	<4	CK-MB Normal (0-4)
10	CK-MB (%)	<10	CK-MB Borderline (5-10)
11	CK-MB (%)	>10	CK-MB High >10
12	CK (U/L)	>44	CK Normal 45-235

For the first option to be invoked, the CK must be over 235 and the other two results could be any result or no result at all. If the CK is under 235, then any of the remaining 11 options could be invoked depending upon how the CK-MB(U/L) and/or CK-MB(%) are resulted.

Example of Results to Trigger the Standard Result Text in the CK Interpretive Component Field

Option Number Invoked	Results For:			
	CK (UL)	CK-MB (U/L)	CK-MB (%)	CK Interpretation
1	>235	Any Result	Any Result	CK Abnormal
2	<235	>10	Any Result	CK-MB High
3	<235	5	Any Result	CK-MB Borderline
4	<235	6	Any Result	CK-MB Borderline
5	<235	7	Any Result	CK-MB Borderline
6	<235	8	Any Result	CK-MB Borderline
7	<235	9	Any Result	CK-MB Borderline
8	<235	10	Any Result	CK-MB Borderline
9	<235	0-4	0-4	CK-MB Normal
10	<235	0-4	5-10	CK-MB Borderline
11	<235	0-4	>10	CK-MB High (>10)
12	45-235	0-4	0-4	CK Normal 45-235

Whenever a result for one of the trigger components, such as (CK (U/L), CK-MB(U/L) or CK-MB(%) are changed or added after you access the interpretive component, a tilde (~) displays for the interpretive component and you must re-access the field to evaluate the new information. For example, if only the CK was entered as 300, and you then accessed the CK Interpretation component, the CK Abnormal >235 document would display in the CK Interpretation field. If you then entered the CK-MB(U/L) as 20, the CK Interpretation field would display a tilde. When you access the CK Interpretation field, the system would evaluate the criteria (CK=300, CK-MB(U/L)=20), and then fill in the CK Abnormal >235 document. Note that even though the standard result document that was selected had been in the field previously, the system must evaluate the new information in case there is a change in the interpretation.

TEST CODE (5-C-R)
Enter the test code and the name of the test (up to 33 characters) for which you are setting up interpretive parameters. You cannot define Advanced Microbiology type tests, order panel masters, or miscellaneous charges as interpretive parameters.

INTERPRETIVE COMPONENT NUMBER/NAME (38-C-R)
If there is more than one component in the test that is defined as using word processing - interpretive parameters, enter up to 38 characters of that component number and name in this field. You can define criteria for multiple interpretive components.

NOTE: The Interpretive Component must follow the result components that are defined as triggers in scrolling screen field.

COMPONENT NUMBER (5-C-R)
Enter the component (trigger) for meeting the criteria for a standard result text you defined in the Interpretive Component Number/Name field. You can use a component multiple times in defining criteria.

The components that you can enter are those that do not have the following special processing attached:

- Word Processing
- Units X Matched
- Date/Time
- SNOMED Code
- Auto Fill
- Auto Filled Required

The criteria and the standard result text description must be different. This component must precede the target component you define in the Interpretive Component Number/ Name field.

RESULT CRITERIA (23-C-R)
This is the defined criteria that must be met in order to trigger the standard result text to be filled into the interpretive component (target component). Valid entries for this field are as follows:

Criteria	Valid Entry for Numeric Results	Valid Entry for Non-Numeric Results
Less than	< followed by up to 20 digits and decimal point	NONE
Greater than	> followed up to 20 digits and decimal point	NONE
Equal to	= followed up to 20 digits and decimal point	= "followed by up to 20 characters and another "
Not equal to	not= followed up to 20 digits and decimal point	not="followed by up to 20 characters and another "
Any entry	*	*

In order to distinguish a textual entry from a numeric entry, when you use the functions *equal* and *not equal*, the information following the equal sign (=) must be in quotes. For example, if you want to trigger off of a textual result that is equal to positive, enter **="Positive"** as the criteria. If you want to trigger off of a textual result that is not equal to a textual result, enter **not="textual result"**. If you enter**="<1.5"** for a trigger criteria, then you must enter the exact entry **<1.5** as a result. Entering a value less than 1.5 would not trigger the criteria.

To enter greater than or equal to a value, you can enter the next highest number and greater than. For example, for a criteria greater than or equal to 10, enter **>9**. The display is the criteria plus up to 20 characters. If you want to include a comment on the patient report whenever a component is resulted regardless of the value, enter an asterisk (*). Use this for reporting test-specific comments.

NOTE: Fewer options result in better system performance.

STANDARD RESULT TEXT (12-C-R)
Enter the code and description for the standard result text.

LONG REPORT PARAMETERS

You can define a Long Report for any test on STAR Laboratory. You can define a Long Report as well as the header and footer elements per test and the result order and placement.

REPORT NAME (30-AN-R)

For each test you can define a report name by a case number pool description or a free-text name. If you do not define a case number pool, you can enter a free-text name up to 30 characters. This report name prints on the second line of the header of the Long Report. If you use the case number, then the report name prints up to the 20 character limit of the case number pool description plus a space, followed by the word *Report*. If a you use a free-text report name, the report name prints up to the 30 character limit of the free-text entry plus a space, followed by the word *Report*.

INCLUDE ORDERING DIAGNOSIS (1-A-R)

Specify if you want the ordering diagnosis entered for this test to print in the report header. Check Yes to include the first 30 characters of the description of the diagnosis. The ordering diagnosis prints on the 11th line of the header. Check No to exclude the ordering diagnosis.

FOOTER (80-C-O)

This field enables you to specify a line of text to print on the fourth line of the Long Report footer. A common use of this field is to print the Director of Pathology or pathologists' names on the report. This footer information can be up to 80 characters and is centered on the line.

ADDITIONAL FOOTER (80-C-O)

This field enables you to specify a line of text to print on the fifth line of the Long Report footer. A common use of this field to print the name and address of the facility on the report.

RESULT ORDER AND PLACEMENT

RESULT (5-C-R)

Enter the component number and the result description in this field.

LINE FEEDS (1-N-R)

Enter the number of line feeds you want on the report between this result name and the result value. If you enter 0, the result prints on the same line as this result name. Enter a value between 0 and 9.

SUPPRESS RESULT NAME (1-A-R)

In this field you can suppress the result name on the report. If the result name is suppressed, the result value begins at the position defined in the Position field. Check Yes to suppress the result name or No to print the result name on the report.

POSITION (1-A-R)
In this field indicate the starting position of the result name. If you suppressed the result name in the Suppress Result Name field, then this position indicates where the result value prints on the report. If you enter **C** to center the result value when the result name is suppressed, the system centers the result value only. If you enter **C** when the result value is not suppressed, the system centers both the result name and the result value. (If the result text exceeds one line when the result name is not suppressed, the system left justifies the text and centers the result name.) The result name is either suppressed or centered. If you enter **T** to select Tab 40 when the result name is suppressed, the system tabs 40 positions and prints the result value only. If you enter **T** when the result value is not suppressed, the system tabs 40 positions and prints the result name and the result value. (If the result text exceeds one line when the result name is not suppressed, the system left justifies the text and tabs 40 positions to print the result name.) The result name is either printed at the tab 40 position or suppressed. If you enter **L** to select Left Margin, then the result value follows the result name.

NOTE: The system left justifies all word processing component result values.

<div align="center">

REPORT COPIES

</div>

BATCH PRINT (1-A-R)
This field defines whether the Long Report for the selected test prints immediately or is filed in the Long Report batch. Enter **Y** for the system to file the long report information to the current batch. Enter **N** for the system to print the long report immediately.

NUMBER OF COPIES (2-N-R)
Enter the number of Long Report copies you want the system to print when the report is completed in Results Entry. You can print up to a maximum of 20 copies. For each copy you enter in this field, specify a report name below.

REPORT COPY NAMES (10-C-C)
If you indicated more than one copy to print, indicate the copy name to print in the upper right corner of the individual copies of the Long Report. The name is usually a description of how that copy is to be used, such as Doctor, Med Rec, Chart, or Laboratory. This name is limited to ten characters.

If you want multiple copies to print without a copy name, enter the word *Blank*.

CHARGE COMPONENT/REPORT DEFINITION

If your laboratory intends to use the Charge on Result/Report charge scheme, use the Charge Component/Rept Def worksheet to define the charge components (for general, Anatomic Pathology and Blood Bank tests) and the charge reports (for Advanced Microbiology) which, when resulted, initiate charge generation.

TEST CODE/NAME
Enter the test code and name.

COMPONENT
Enter the component name/number to define as the charge component. Only one component can be selected.

NOTE: Advanced Microbiology charge report definition is included in the *Advanced Microbiology Module* of the *STAR Laboratory Reference Guide*.

Chapter 7 - Equipment/Instruments

EQUIPMENT TYPES

An Equipment Type specifies a classification or general group of equipment. For example, classifications might include Coulters, Water Baths, Refrigerators, Balances, or ACAs. These classifications are used in Equipment Quality Control, Sample Quality Control and parts of the Workload Processor.

Use this worksheet to classify the various pieces of equipment found within the laboratory. Compile this information by section. In addition, a general list of equipment needs to be compiled containing typewriters, computer equipment and other office machinery. This type of list is usually associated with the Administration or Front Office section of the laboratory, but may be placed wherever it is desired.

CODE (3-A-R)
Enter a unique three-character alpha code. Make it as descriptive as possible especially in the area of instruments. For example, Coulter - COT, ASTRA - AST, Water Baths - WAB. This code will sometimes be used on reports or screen displays instead of the name when space is limited.

DESCRIPTION (30-C-R)
A maximum of 30 characters. Usually it is the manufacturer's name/model number or the specific equipment type. For example, ASTRA, Water Baths, Fisher, HITACHI.

EQUIPMENT/INSTRUMENT (1-A-R)
This field is used to indicate whether or not the equipment type is an instrument that produces results. Check Instrument for all precision equipment and analytical instruments, regardless if they are to be interfaced. This allows the instrument method to be defined and also allows the interface parameters and monitor characteristics to be created during installation. Check Equipment for all equipment that does not produce results such as centrifuges and water baths.

INSTRUMENT METHOD (5-N-O)
Complete this field only if Instrument is checked in the Equipment/Instrument field. This field is used for workload purposes. CAP section is the section which contains the instrument for workload purposes. The Method code comes from the base workload method table or from the one you have created for your laboratory. This is not a required option. The CAP section code is two digits and the method code is three digits.

MONITOR ACTIVE (1-A-C)
Complete this field only if Instrument is checked in the Equipment/Instrument field. The field determines if instrument monitoring is available. This field must be set to Yes to allow the monitor to be started.

MANUAL METHODS

Procedures in the laboratory not performed on an instrument are said to be done manually. Since workload requires that these procedures have a method attached to them, it is necessary to compile a table of manual methods. CAP has defined suffixes for some manual methods. Please refer to your CAP manual.

CODE (6 -A-R)
Enter the four- to six-character alphanumeric code for the manual method.

DESCRIPTION (30-C-R-)
Enter a free-text descriptive name of the manual method. There is no character length limitations.

METHOD (5-N-O)
Enter the CAP section code concatenated with the three-digit CAP suffix. The first two digits of the code denote the CAP section; the last three denote the suffix of the method type.

EQUIPMENT TYPE ASSIGNMENT

Specific pieces of equipment (including instruments) must be assigned to an Equipment Type group and assigned a unique equipment number.

Use this worksheet to further identify specific pieces of equipment within the laboratory. The equipment number will be assigned by the system. This worksheet is also used to create a Master Register of all equipment within the laboratory and can be used as a tracking record if necessary.

EQUIPMENT CODE (3-A-R)
Enter the unique three-character alpha code defined on the previous Equipment Type worksheet.

EQUIPMENT NAME (30-AN-R)
This is the system-assigned specific name for this piece of equipment. It is the name of the equipment type selected plus a counter number. For example, if you select an equipment type of Centrifuges, the system will create an equipment name of Centrifuges #1 for the first one, Centrifuges #2 for the second one, and so on.   To fill in the worksheet, start the counter at 1 and continue from there.

MANUFACTURER/DISTRIBUTOR (30-AN-O)
Enter the manufacturer's name up to 30 alphanumeric characters.

MODEL (15-AN-O)
Enter the model up to 15 alphanumeric characters.

SERIAL NUMBER (15-AN-O)
Enter the manufacturer's serial number up to 15 alphanumeric characters.

PROPERTY NUMBER (15-AN-O)
Enter the hospital's property number or other means of identification up to 15 alpha/ numeric characters.

PURCHASE DATE (8-N-O)
Enter the date the equipment was purchased in MM/DD/YY format.

IN USE DATE (8-N-O)
Enter the actual date the equipment was put into service in MM/DD/YY format.

LOCATION (15-C-O)
Indicate the equipment's location up to 15 characters. This can be any location though is generally a section (Chemistry) or physical location (Washroom, Hallway).

OTHER INFORMATION (34-C-O)
Enter any additional information not covered by the preceding data. For example, you might want to indicate "On loan from Hematology" or "Sent to Hematology 5/1/89."

INSTRUMENT MONITOR CHARACTERISTICS

Instrument Monitor Characteristics enable you to define parameters for each equipment type assignment that will be interfaced to STAR Laboratory. These characteristics are not required for equipment such as Water Baths or Refrigerators.

SECTION CODE/NAME
EQUIPMENT CODE
EQUIPMENT NAME
Enter the above information (previously defined) for each equipment type assignment for which you are defining Instrument Monitor Characteristics.

UPLOAD PORT (4-N-R)
Enter the physical port number that will be used to receive data from the analyzer.

BI-DIRECT (1-A-R)
This field indicates whether or not this interface will be Bi-directional (two-way) both receiving and sending data to and from an analyzer. Circle **Yes** if the interface is bi-directional.

DOWNLOAD PORT (4-N-C)
Complete this field only if Yes was circled for the Bi-Direct field. Enter the physical port number that will be used to send data to the analyzer.

ON-LINE TEST (5-N-C)
This field contains the online test code associated with this equipment type assignment.

NOTE: The user is able to enter greater than 84 components for the online test if the field is filled with a test code value that must be used as the online test. The result components do not have to be built.

MONITOR OPTIONS
This field enables you to select the monitor options. Circle **Yes** to enable the monitor options or circle **No** to disable the monitor options.

DAWNING/DI (1-A-R)
This field indicates whether or not you use the Dawning Technologies hardware/software or the Data Innovations Instrument Manager™ hardware/software to be used in conjunction with this interface. Circle **Yes** if you are.

BASE (1-A-R)
This field indicates whether or not this interface is going to be base or custom. Circle **Yes** to search the STAR Laboratory current library of instrument interfaces. If you cannot find the equipment type that you are interfacing in this library, this field must be set to No. The field must be defined as No when using Data Innovations Instrument Manager.

MICRO INST (TABLE LOOKUP)
Complete this field only if a microbiology instrument is being used for this interface. Currently, STAR Laboratory supports three micro instruments: Api, MicroScan and Vitek.

VITEK REV (2-A-C)
Complete this field only if Micro Inst field is defined and is set to Vitek. Enter the Vitek interface specification revision this interface will use. Currently, STAR Laboratory supports three revisions: AB, AH or AQ.

DATA INNOVATIONS (1-A-C)
This field indicates whether or not the instrument interface uses Data Innovations.

MONITOR ROUTINES

SINGLE (SPECIAL FORMAT-O)
Complete this field only if the Base field was set to No. If this interface can process cups/accessions in a single/stat mode, this field must be defined with a program name. McKesson personnel may have to define.

BATCH (SPECIAL FORMAT-O)
Complete this field only if the Base field was set to No. If this interface can process multiple cups/accessions into the same batch, this field must be defined with a program name. McKesson personnel may have to define.

DOWNLOAD (SPECIAL FORMAT-O)
Complete this field only if the Base field was set to No and the Bidirect field was set to *Yes.* If this interface can send data to an analyzer, this field must be defined with a program that formats the data. McKesson personnel may have to define.

DISPLAY (SPECIAL FORMAT-O)
Complete this field only if you want the system to display special information such as a hemogram during the ESP Report processing. Currently, STAR Laboratory supports one special display of a hemogram.

CONTROL (TABLE LOOKUP-R)
This field indicates the mode that the interface will function. If the interface will process multiple cups/accessions into the same batch, circle BATCH. If the interface can only process one cup/accession at a time, circle SINGLE/STAT.

DAYS TO RE-DOWNLOAD (1-N-R)
This field contains the number of retention days.

When you enter this field, the following prompt displays:

   Enter number of days to retain re-download file? (0-2) [0]--

Pressing ENTER or entering a 0 at the above prompt, the system does not retain a file for re-downloading. If 1 or 2 is entered, the system retains the last 1 or 2 days of previously downloaded accessions.

NOTE: If this field displays an N/A, Field 6 is set to No and you will not be able to edit.

ESP MENU (TABLE LOOKUP-C)
This field indicates what menu will be used once the on-line test is selected from the bay menu. Each selection offers a combination of different functionality based on the mode that was circled in the Control field.

SELF-CREATING MODE (DISPLAY ONLY)
If the menu defined in the ESP Menu field on the preceding screen is a Self-Creating type, the system displays *Yes* in this field.   Define this field as Yes.

TIMEOUT (5-N-R)
Complete this field only if Batch was circled for the Control field. This field indicates the number of minutes the interface remains active after the last transmission from the analyzer. Once met, the interface halts automatically. A zero can be entered for no timeout: the interface will stay active until manually halted by a user.

CHANNELS (3-N-R)
This field indicates the number of channels that will be used for this interface. Here, the word channels refers to the number of results that are defined for the on-line test code defined above.

ID TYPE (SPECIAL FORMAT-O)
Complete this field only if you will be using instrument bar code labels or specimen ID accession numbers with this interface. This field indicates the format of the ID number. Circle F for the full accession number, P for only part of the accession number, or U for a user-defined number. For options P or U, the number of digits must be set. Also, indicate how this ID number will be justified.

ID RETENTION (2-N-C)
Complete this field only if the ID Type field is defined. Enter the number of days to retain the specimen ID cross-reference file.

DEACTIVATE (1-A-R)
This field indicates if you wish to allow the user to select certain channels/results to be deactivated per batch. Circle **No**. From time to time, there may be instances when you may want to deactivate a certain channel/result that is being received from an analyzer. By setting this field to **Yes**, every time the interface is started you are prompted to select channels/results that are to be deactivated for the current batch. STAR Laboratory then ignores any result value sent over that channel for the current batch.

CUSTOM ROUTINE (SPECIAL FORMAT-O)
Complete this field only if **Yes** was circled for the Dawning field. This field can contain a program that is used to further modify results received from an analyzer without customizing the interface. McKesson personnel may have to define.

REPLICATE (3-A-R)
Enter **Y** or ENTER to invoke replicate processing of all multiple entries of the same accession in the instrument batch. Enter **N** to disallow replicate processing if multiple entries of the same accession in the instrument batch exist.

NOTE: As part of post-processing the field will be automatically set to Yes.

CHN#/CHANNEL NAME/UPLOAD/DOWNLOAD (SPECIAL FORMAT-O)
Complete this field only if a program is defined in the Batch field. This field indicates all channels/results that will be received/sent to and from the analyzer. Refer to the analyzer specs when building this information.

TEST METHOD ASSIGNMENT

Use this worksheet to assign all methods used to perform a test. Identify the default method for each test and alternate methods. Building this file causes the system to display all methods at the time of entering the result reporting processor. If alternate methods are defined, the default method will be included in the prompt. By listing all alternate methods, you have the option of selecting a different one than the default if needed. If no alternate methods are defined, the system assumes the default method.

NOTE: Use the Equipment Type and Equipment Type Assignment worksheets for the names of the instrument methods.

SECTION CODE/NAME (20-C-R)
Enter the section that contains this test for method assignment.

TEST CODE/NAME (32-C-R)
Enter either the test code or name to which the method will be assigned.

Default Method

TEST OR BAY (1-C-O)
Indicate whether this method is to be assigned at the bay or test level by first circling Test or Bay. When adding a default method, the system requires you to indicate whether the method is assigned to the test (enter **T**) or to the bay (enter **B**). Most frequently, the method is assigned to the test. Assigning default bay methods is an alternative to assigning alternate methods to the test. When various methods are assigned to multiple bays (rather than assigning alternate methods to the test), the test can be performed via multiple methods and still reflect accurate workload capture, without the extra step of selecting an alternate method.

AUTOMATED OR MANUAL (1-C-O)
Circle Auto or Manual depending on the method type.

METHOD CODE (U-C-O)
Enter the manual method code and description if you circled manual. Enter the equipment type code and description if you circled automated.

ONLINE MONITOR (1-C-O)
Circle **Yes** if the instrument is to be interfaced. Circle **No** if not.

BATCH RESULTING (1-C-O)
Circle **Yes** if this test is to be resulted using the batch resulting function.   This can be used for manual and automated methods. Circle **No** if batch resulting is not to be used.

BATCH RETENTION DAYS (2-N-R)
Enter the number of days to retain the batches online between 1 and 99. Seven is the recommended number of retention days.

ALTERNATE METHOD
For all the alternate equipment methods for this test, complete each of the following:

AUTOMATED OR MANUAL (1-C-O)
Circle Automated or Manual depending on the method type.

METHOD CODE (U-C-O)
Enter the manual method code and description if you circled manual. Enter the equipment type code and description if you circled automated.

ONLINE MONITOR (1-C-O)
Circle **Yes** if the instrument is to be interfaced. Circle **No** if not.

BATCH RESULTING (1-C-O)
Circle **Yes** if this test is to be resulted using the batch resulting function.   This can be used for manual and automated methods. Circle **No** if batch resulting is not to be used.

BATCH RETENTION DAYS (2-N-O)
Enter the number of days to retain the batches online between 1 and 99. Seven is the recommended number of retention days.

BATCH ACCEPT ABNORMALS (1-A-R)
This field retains accessions with test results flagged as abnormal (High, Low, and Abnormal) in the batch during batch acceptance processing. By entering **Y** for *Yes* or ENTER, when the Batch Acceptance function is used to report out a batch assigned to this method, High, Low, and Abnormal results file automatically without further intervention. Entering **N** for *No* causes these results to be retained in the batch. This field cannot be used with the manual method.

When you enter this field, the system displays the following prompt:

   Allow batch acceptance of high/low/abnormal results? (Y/N)[Y]--

ONLINE TEST MONITOR PARAMETERS

Online test monitor parameters include additional information that must be defined for all equipment type assignments that are interfaced.

MONITOR/REPORT (1-A-R)
This field indicates whether or not results can continue to be processed using the ESP Report processor while other results are being received from the analyzer. Circle **Yes**.

MONITOR TYPE (TABLE LOOKUP-R)
Results can be received into STAR Laboratory in one way: by Default Output Channel.

CUPS/MONITOR (1-N-R)
This field indicates the number of cups you want to defined per monitor cycle. "1" is the standard.

AUTO RESULT RELEASE (3-A-R)
Press **N** or ENTER to indicate that auto release of results is not permitted. Enter **Y** for *Yes* to auto release results using the Report Processor.

NOTE: As part of post-processing the field will be set to No.

EDITOR (1-AN-R)
On most ESP Menus, there is an option called "Editor". This field allows you to specify what the default number of decimal places will be, from 0 to 4, when results are displayed. You may choose to use the raw value that was received from the analyzer as well.

REPORTER (1-AN-R)
On most ESP Menus, there is an option called "Result Reporter". This field allows you to specify what the default number of decimal places will be, from 0 to 4, when results are displayed. You may choose to use the raw value that was received from the analyzer as well.

DISPLAY ACCN (3-A-R)
Enter **Y** or ENTER to see all accessions/tests in the batch when using the Report Processor. Enter **N** to disallow the display of the accession/test that has been Done, Canceled, or Rejected when you access the batch through the Report Processor.

NOTE: As part of post processing, the field will be set to Yes.

RESULT/CHANNEL LINK/EDITOR CALCS/REPORTER CALCS
This field indicates, for each result defined for the on-line test, how that result will be modified with decimal places or whether the default value received from the analyzer will be used. You can define how each result will display/file in STAR Laboratory. Also, channel link lets you map/define which channel the analyzer sends that particular result.

RELEASE RANGE (15-C-R)
This field enables you to define the release range for numeric components and valid values. The release range field allows seven digits and a decimal on either side of a dash (-) and no spaces. Textual components, Interpretive Reporting components, and valid ranges may be defined with a "T." Each component must be defined with a release range or with a "T" for the screen to be accepted. No other characters will be accepted. Define a numeric range for calculated components.

If the Auto Result Release flag (field 4) is set to No, this field defines each component with N/A and cannot be edited. The results are not auto released.

NOTE: As part of post-processing the field will be set to N/A.

If the Auto Result Release flag (field 4) is set to Yes, this field allows you to define a release range for numeric components and a text indicator for textual components to be used by the system as references for auto releasing patient results.

DAWNING INTERFACE PARAMETERS

This worksheet should only be used if you use the Dawning Technologies equipment/software in conjunction with STAR Laboratory instrument interfaces.

DESCRIPTION (45-ANP-R)
This field contains the description of the Dawning interface. It should readily identify the analyzers being interfaced.

STATION (TABLE LOOKUP-R)
This field indicates the equipment type assignment being interfaced as well as the Dawning device address. This device address is a three digit number that must correspond to the Analyzer field on the Dawning PC parameters. This field is repeated four times since each Dawning interface can support up to four different analyzers.

PORT # (4-N-R)
This field indicates the physical port number on the CPU to which the Dawning Technologies PC is connected. This should be the same port defined in the Instrument Monitor Characteristics.

INSTRUMENT GROUPS

To activate the Specimen ID and instrument bar code label processing, Instrument Groups must be defined for each instrument that will use bar code labels.

INSTRUMENT GROUP CODE (6-AN-R)

Enter the instrument group code up to six alphanumeric characters. This code can display in accessioning when prompted to place the accession in a batch. Display of the group code and description is controlled by the test code level flag within the Group Assign - Instrument processor.

INSTRUMENT GROUP DESCRIPTION (30-C-R)

Enter the free-text description of the function or purpose of this group, for example, Paramax #1.

GROUP TEST CODE

Indicate the instrument test code that will be used to result ordered tests assigned to this group.

GROUP METHOD

Indicate the specific instrument method for this instrument group. Only one method can be used per Instrument Group. It must be a method assigned to the online test.

INSTRUMENT MANAGER PARAMETERS

This worksheet should only be used with STAR Laboratory Instrument Interfaces.

IM DESCRIPTION (40-AN-R)
Enter an interface description for Instrument Manager. A 40 character or less alphanumeric description may be entered.

PROTOCOL (SPECIAL FORMAT-R)
This is the routine name that communicates with Instrument Manager. Enter the Instrument Manager protocol program or press ENTER for the default that displays in the screen prompt when you access this field.

PORT # (4-N-R)
This is the physical port number on the CPU to which the Instrument Manager PC is connected. This should be the same port number defined in the Instrument Monitor Characteristics processor.

EQUIPMENT CODE/DEVICE ADDRESS
This field provides a critical link between Instrument Manager and the STAR Laboratory system. This field contains the specific equipment code that was defined in the Equipment Type Assignment processor.

Chapter 8 - Workload

NOTE: This chapter includes screens, field explanations, and other documentation for Canadian usage of this product. Generally, the documentation reflects the base (US) product. Documentation for the Canadian version appears in blue. Canadian documentation is further identified by (CN) and (CN Only).

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WORKLOAD PARAMETERS

Before the system captures workload, the data retention parameters must be defined.

Data Retention Parameters

The data retention fields are as follows:

WORKLOAD CAPTURE (1-A-R)
Enter **Y** for Yes to capture workload data at both the employee and section level. Enter **N** for No to capture workload data at the section level only.

DAILY WORKLOAD RETENTION (2-N-R)
Enter the length of time in months to retain workload data, from one to 18 months (one to 25 months for Canadian users). Three months is the recommended data retention period. The default retention period is 13 months.

NOTE: Although workload statistics are purged at the end of the designated retention period, monthly totals are retained for year-to-date information.

Default Workload Procedure Codes

The default workload procedure codes are as follows:

SENDOUT WORKLOAD (9-C-O)
Enter the procedure code (or select the appropriate code from the table created by your laboratory) to assign the sendout workload. If the procedure code has a suffix/method, enter the five numbers and a decimal (**.**), followed by the 3-position numeric suffix. If you do not define the sendout workload at the test level, the system uses this procedure code to assign sendout workload.   Circle Yes to delete the sendout workload code.

SPECIMEN REJECTION (9-C-O)
Assign the specimen rejection workload by entering the procedure code (or selecting the appropriate code from the table created by your laboratory. If the procedure code has a suffix/method, enter the five numbers and a decimal (**.**), followed by the 3-position numeric suffix. Circle Yes to delete the specimen rejection workload code.

(CN ONLY) REGIONAL CROSSREFERENCE (1-A-R)
Enter **Y** to activate regional cross-reference index.

(CN ONLY) REGIONAL CROSSREFERENCE INDEX (5-A-R)
If regional cross-reference is activated, enter a three- to five-character alphabetic code.

(CN ONLY) REGIONAL CROSSREFERENCE INDEX DESCRIPTION (30-AN-R)
If regional cross-reference is activated, enter a description of, up to 30 alphanumeric, upper/lowercase characters.

WORKLOAD CATEGORIES

Workload Categories are groupings of patient type/locations used to store workload data for statistical purposes. The Workload Category table is a base table provided by STAR Laboratory.

US: The base table includes the following nine categories as recommended by CAP:

CODE	DESCRIPTION
1	Inpatients
2	Outpatients
3	Quality Control and Standards
4	Repeats
5	Emergency Room
6	Referral (specimen received)
7	Interstate (specimen received)
8	Regional Laboratories
9	Other

Since only nine workload categories are allowed, items from this list can only be edited. Complete this worksheet only if you do not plan to use the base category list.

CN: The base table for Canadian users includes the following nine categories as recommended by WMS:

CODE	DESCRIPTION
1	Inpatients
2	Outpatients
3	Referred-In
4	QC
5	Cal/Standards
6	Repeats
7	Environ
8	Staff Health
9	Research

Since the system supports 99 categories, complete this worksheet if you plan to add a category to the base list.

The format is as follows:

(CN ONLY) CODE (2-N-R)
Enter the code number (1 to 99) at the prompt:

> *Enter workload category code--*

DESCRIPTION (20-AN-R)
Enter the description for the category.

WORKLOAD ITEMS FOR COUNT

Items for Count define what is to be counted to obtain the raw count for each procedure and to classify the procedure.

STAR Laboratory provides a base table of the CAP Items for Count. The following explanations are based on the CAP "Laboratory Workload Recording Method" source book. Use the worksheet and the base table to add, edit, or delete from this file. The format for the code and description is as follows:

CODE (6-AN-R)
This is a one- to six-character alphanumeric, uppercase field for an abbreviated name of the Item for Count.

DESCRIPTION (30-AN-R)
Enter a description of up to 30 alphanumeric, upper/lowercase characters for the name of the Item for Count.

The base table includes:

CODE   DESCRIPTION

ABSRP   *Absorption* - Used with antibody absorption procedures for each mixture and separation of serum and absorbing cells.

ANTIG   *Antigen* - Generally used in blood bank and immunology to define qualitative or quantitative testing of a specimen for an antigen or its corresponding antibody. It refers to each individual antigen or corresponding antibody listed as applied to each individual specimen tested.

ANTISR   *Antiserum* - Used in microbiology for slide agglutination testing and refers to each serum containing antibodies against a specific antigen or group of antigens.

APPL   *Application* - Used in chemistry for chromatographic procedures (for example, thin layer, paper, column), and pertains to each application of specimen to the medium.

ASPIR   *Aspirate* - Used for fine needle or other aspirated material in cytology to include all processing and preparation of slides from each aspiration performed.

BAG   *Bag* - Used in microbiology and refers to a container used for the disposal of contaminated material.

BATCH   *Batch* - Used in antibody detection to represent a group of tubes processed at the same time in a single fixed-speed centrifuge head with no regard for the number of specimens tested. This is necessary because these tests are usually performed in batches, and an average value per specimen would be totally inadequate when only single specimens were run.

>   **NOTE:** To tally these determinations, each laboratory must develop its own system. It may be possible to tally each time a centrifuge head is run, or each laboratory may develop an average batch size for its operation and divide the total number of each type by this average batch size.

$$\frac{\text{number of specimens}}{\text{number of batches}} = \text{average batch size}$$

BIOBG   *Biobag* - Used in microbiology and refers to a plastic bag with a sealed closure containing a gaseous environment developed by flushing with an appropriate gas from a tank or generated by chemical reactants placed in the container.

BLOCK   *Block* - Used for each block where tissue or sedimented material is embedded for histologic processing. When specified, this includes cutting and staining one slide.

BOTTLE   *Bottle* - Used in microbiology and refers to the container used in a blood culture procedure.

CASE   *Case* - Used for anatomic pathology to describe a body for autopsy or all materials and reports referring to an anatomic pathology, cytology, or cytogenetic specimen.

CELLRG   *Cell Reagent* - Refers to the preparation of a cellular product (for example, reagent red blood cells treated, preserved, or of a specific type; or lymphocytes).

CHART   *Chart* - A book, binder, or clip board in which a patient's active medical history is stored on a nursing unit.

CONST   *Constituent* - Pertains to the analyte or particle being assayed.

DELIV   *Delivery* - Used for each delivery of blood or components by laboratory personnel to another location within the institution.

DILUTE   *Dilution* - Used in some immunologic titrations to define the procedure as related to each dilution tested.

DISC   *Disc* - Used in microbiology to describe a small piece of filter paper impregnated with material that assists in organism identification or susceptibility testing (for example, bacitracin or optichin discs used for presumptive identifications).

DONOR   *Donor* - Used for procedures involving a blood donor.

FILT   *Filtrate* - Used for microporous membrane filtration in cytology to include all steps in the filtration and preparation of slides from the filter.

FUNCT   *Function* - Used to describe an activity or task performed by laboratory personnel (for example, recording temperature readings, washing bench tops).

GRID   *Grid* - Used in electron microscopy to define the preparation or viewing and photography of one grid.

INJ   *Injection* - Used in chemistry and microbiology for gas-liquid and high-pressure liquid chromatography procedures and pertains to each entry of a specimen into the portal of the instrument.

JAR   *Jar* - A glass or plastic container fitted with a lid closure containing a controlled gaseous environment developed by flushing with appropriate gas from a tank or generated by chemical reactants placed in the container.

KARYO   *Karyotype* - Used in cytogenetics for the identification of a satisfactory metaphase, necessary photography, enlarging, and preparation and analysis of the karyotype after the initial three per band.

LOCATN *Location* - A patient care or administrative department located outside the laboratory, within the institution (for example, nursing unit, outpatient clinic, accounting department, medical records).

ORG   *Organism* - Used in microbiology to represent one pure isolate.

PANEL   *Panel* - Used for antibody identification where a panel of reagent red or white blood cells of known antigenicity is used. The unit value is based on the entire panel, usually 8 to 12 cells. For a 13 to 24 cell panel, count as two panels.

PATNT   *Patient* - Used when the presence of the patient is mandatory during the procedure, for example, venipuncture.

PR100   *Per 100* - Pertains to counting 100 elements, for example, bone marrow differential.

PLATE　　*Plate* - Used in immunology and chemistry for counter electrophoresis, immunoelectrophoresis, and so on to define the procedure related to one complete plate.

PBT　　*Plate, Bottle, and Tube* - Used as items for count in microbiology.

A biplate counts as two plates, a quadrant plate counts as four plates.

PRINT　　*Print* - Used for the making of one photographic print.

RTRIP　　*Round trip* - Used when laboratory personnel travel to a location outside the laboratory but within the institution to render technical assistance or procure special specimens and return. Not to be used with other specimen collections values.

ROW　　*Row* - Represents one row of tubes in complement titration.

SLIDE　　*Slide* - Used when material is placed on a slide, for example, tissue, bacteria.

SMEAR　　*Smear* - Used in microbiology and cytology and refers to the material placed on a microscopic slide. There may be more than one smear per slide.

SPEC　　*Specimen* - Is a biological sample for analysis. This item for count is used:

　　a)　when the procedure involves the production of several results or multiple procedures (for example, urinalysis, ABO and Rh(D) typing, animal inoculation)

　　b)　to count the initial handling and clerical processing for anatomic pathology and cytology

　　c)　when the procedure involves a specimen without producing a reportable result (for example, centrifugation in cytology, elution in blood bank)

　　d)　in histology to represent all the tissue removed at one time from a single anatomical site (for example, multiple skin lesions are one specimen)

　　e)　in microbiology when patient material from a single source (for example, throat, wound) is submitted for culture or microscopic examination

SUBS　　*Substance* - Used in chemistry and pertains to each substance for which the procedure is being performed, for example, barbiturates, beryllium.

TEST　　*Test* - A defined activity leading to a result.

TISS   *Tissue* - Used in cytogenetics for additional tissues cultured from a single tissue specimen.

TRAY   *Tray* - Used for preparation of 60 to 72 well trays of test cells for lymphocytoxicity testing.

UNIT   *Unit* - Used in blood bank for each aliquot of donor blood, component or derivative, or associated procedure.

WORKLOAD METHODS/SUFFIXES

The Workload Methods/Suffixes table contains suffix/method codes for the methods by which procedures are assayed and their associated set-up workload unit values are captured. These methods are grouped by CAP section/WMS functional centres.

STAR Laboratory provides a base list of these methods and values based on the CAP "Manual for Laboratory Workload Recording Method." This table is listed under Appendix A: Base Tables Listing. Review the base table and make any additions, edits and deletions necessary either on the worksheet provided or the base printout. If you do not use CAP, you may want to delete the current base table and build your own. The various fields for the workload method types are explained as follows:

(US) SECTION CODE/NAME
(CN) CENTRE CODE/NAME
Each procedure is classified in a CAP section/WMS centre based on the area in which it is most frequently performed. The standard section/centre codes and names for CAP/WMS (base list) display as follows. (Abbreviations for the standard sections/ centres are shown in parentheses). Select the section/centre to which this Method Type will be assigned.

US Section Codes/Names
01   Blood Bank   (BANK)
02   Chemistry   (CHEM)
03   Hematology   (HEMA)
04   Histology   (HIST)
05   Immunology   (IMMU)
06   Microbiology   (MICRO)
09   Specimen Procurement, Preprocessing, Dispatch, and
            Report Delivery   (SPEC)
10   Urine and Feces   (URIN)

CN Centre Codes/Names
01   Anatomical Pathology
02   Clinical Chemistry
03   Hematology
04   Immunohematology
05   Microbiology
06   Immunology
07   Cytogenetics
08   Histocompatibility
09   Specimen Procurement, Receipt and Dispatch

Select one for this field.

(US) CAP SUFFIX CODE (3-N-R)
(CN) WMS METHOD CODE (3-N-R)
Enter the three digit code to be used in conjunction with a five-digit CAP/WMS procedure code number to indicate various concepts and/or procedures: automated instruments, microbiology specimen sources, histology stains, immunological antigens. The most common use is to indicate automated instruments. Users in the United States should refer to your CAP workload documentation for verification and additions to this table.

NOTE: Only one suffix/method code may be assigned per procedure per instrument.

(US) METHOD/SUFFIX DESCRIPTION (35-AN-R)
(CN) METHOD DESCRIPTION (35-AN-R)
Enter the description for the suffix/method code for the method up to 35 alphanumeric characters.

UNIT VALUE (3-N-O)
Enter the unit value (time in minutes) for the suffix code. If you are using CAP/WMS, enter the CAP/WMS unit value associated with this code. If you are not using CAP/WMS, enter your laboratory's unit value for the suffix code.

VALUE INDICATOR (1-C-O)
To indicate how the unit value for the procedure was initially obtained, enter an asterisk (*), **t**, **e** or leave this field blank. These characters are used by STAR Laboratory for unit value flagging: extrapolated (e), temporary (t) and permanent (no flag). The asterisk (*) indicates there is no unit value. These indicators serve no purpose within the system except to flag how the unit value was obtained and to print on some reports.

NOTE: This is an optional field and if you do not use CAP workload recording, you may bypass this altogether. If you do use CAP, these indicators are useful in flagging unit values that may change in future CAP releases.

The following explains the different indicators.

An extrapolated (e) unit value is assigned to a procedure or instrument before standard time studies have been performed. The value may be derived from components of previous time studies on similar procedures or instruments.

A temporary (t) unit value is assigned by the International Workload Committee (MIS Group in Canada) to a procedure or instrument after a limited number of edited time studies have been performed and before enough data are available to calculate a permanent unit value.

A permanent (no flag) unit value is assigned by the International Workload Committee (MIS Group in Canada) to a procedure or instrument after a statistically valid number of edited time studies have been performed.

An asterisk (*) in the unit value field indicates that there is no defined unit value for this procedure.

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NOTE: If you change a unit value, you must revise the indicator field if applicable. This field serves only to indicate the unit value type and has no other impact on workload recording.

(US) ALLOWED CAP CODES FOR METHOD/SUFFIX (5-N-O)
(CN) ALLOWED WMS CODES FOR METHOD (5-N-O)
List the five-digit CAP/WMS procedure codes which can be combined with the suffix code. This can be a single (NNNNN), multiple (NNNNN,NNNNN,NNNNN) or range (NNNNN-NNNNN) of procedure codes or any combination of these choices. If *all* procedure codes can be used for this suffix, leave the field blank. CAP usually indicates the procedure codes that can be combined with a specimen suffix code.

(US) SETUP CAP CODE (5-N-O)
(CN) SETUP WMS CODE (5-N-O)
Enter the five-digit CAP/WMS or hospital code representing the set-up value to be used for this suffix/method.

SETUP UNIT VALUE (3-N-O)
Enter the unit value (time in minutes) this suffx requires for set-up workload. If you are using CAP, you may use the CAP unit value associated with this suffix. Canadian users who are using WMS may use the WMS unit value associated with the specimen with this method. If you are not using CAP/WMS, you may list your laboratory's unit value for the suffix code.

SETUP VALUE INDICATOR (1-C-O)
Enter an asterisk (*), **t**, **e** or leave this field blank to indicate how the set-up unit value was obtained. Refer to the "VALUE INDICATOR (1-C-O)" on page 8-11 field for details on using these characters.

WORKLOAD REGIONAL X-REF CODE (CN ONLY)

This worksheet is used to define the regional crossreference code and description for each workload procedure.

CODE (5-N-R)
Enter a one- to five-digit numeric regional code.

DESCRIPTION (33-AN-R)
Enter a description of up to 33 alpha/numeric characters.

PATIENT TYPE/WORKLOAD CATEGORY

The Patient Type/Workload Category table is used to assign each patient type/location to one of the nine/99 workload categories. Quality control materials and repeats are also assigned to the corresponding workload category using this processor. At the point of workload capture, the patient's type/location determines the category in which to store the workload units.

Referring to the Workload Categories, Patient Types and Room and Bed worksheets, assign each patient type and inhouse location to a Workload Category code.

NOTE: Each patient type and inhouse location must be assigned to a workload category for proper workload capture.

PATIENT TYPE(S)/LOCATION (3-C-R)
Enter the patient type code from the Patient Types worksheet or the nurse station from the Room and Bed worksheet.

(US) WORKLOAD CATEGORY (1-N-R)
(CN) WORKLOAD CATEGORY (2-N-R)
Indicate the workload category to which the patient type/location workload data will be assigned by entering a number from one to nine/99 and the name of the category.

(US) ASSIGN QC CONTROLS TO QUALITY CONTROL CATEGORY? (1-A-R)
(CN) ASSIGN QC CONTROLS TO WORKLOAD CATEGORY? (2-A-R)

US: Check Yes to capture all QC control material's data in the Quality Control workload category. Check No if you do not want to assign QC control data.

CN: Indicate the workload category to which the sample control workload data will be assigned.

(US) ASSIGN QC STANDARDS TO QUALITY CONTROL CATEGORY? (1-A-R)
(CN) ASSIGN QC STANDARDS TO WORKLOAD CATEGORY? (2-N-R)

US: Check Yes to capture all QC control material's data in the Quality Control workload category. Check No if you do not want to assign QC control data.

CN: Indicate the workload category to which the standards workload data will be assigned.

(US) ASSIGN EQUIPMENT QC TO QUALITY CONTROL CATEGORY? (1-A-R)
(CN) ASSIGN EQUIPMENT TO WORKLOAD CATEGORY? (2-N-R)

US: Check Yes to capture all Equipment QC data in the Quality Control workload category. Check No if you do not want to assign Equipment QC data.

CN: Indicate the workload category to which the equipment workload data will be assigned.

(US) ASSIGN PATIENT AND QC REPEATS TO THE REPEATS CATEGORY? (1-A-R)
(CN) ASSIGN PATIENT AND QC REPEATS TO THE WORKLOAD CATEGORY? (2-N-R)

US: Check Yes to place all statistical data identified as repeats in the Repeat category. Check No if you do not want to assign patient and QC repeats to the Repeats category.

CN: Indicate the workload category to which the patient and QC repeat workload data will be assigned.

WORKLOAD COLLECTION TYPES

The Collection types table contains the various methods of collecting specimens for workload recording purposes. Workload should not be tallied when collections are performed by nursing personnel, residents, staff physicians, or others not considered laboratory personnel. STAR Laboratory provides a base table of Collection Types for workload processing based on CAP/WMS. This table can be edited if desired.

US Base Table

CODE	DESCRIPTION	UNIT VALUE	SHORT NAME
89350	Arterial collected by laboratory	12.0	ARL
89335	Capillary - outside of laboratory	14.0 e	COL
89336	Capillary - within laboratory	8.0 e	CIL
89344	Drainage collected by laboratory	6.0	DRL
89338	Micro specimen collection(Swab)	6.0	MSB
89340	Urine - Laboratory collected	6.0	URL
89341	Venous - outside of laboratory	10.0 e	VOL
89343	Venous - within laboratory	4.0 e	VIL

CN Base Table

CODE	DESCRIPTION	UNIT VALUE	SHORT NAME
00212	Venipuncture	8.0	ARL
00214	Capillary puncture	12.0 e	COL

CODE (5-N-R)
In the base table, this is the CAP/WMS code for the collection type. If you are not using CAP/WMS, enter your own five-digit code.

COLLECTION PROCEDURE DESCRIPTION (35-AN-R)
Enter a description of up to 35 alphanumeric, upper/lowercase characters.

SHORT NAME (3-AN-R)
Enter the three-character alphanumeric abbreviation for the collection method. This should reflect the type of collection as logically as possible since it displays for workload at accessioning time.

UNIT VALUE (2-N-R)
Enter the number of laboratory workload units (in minutes) of technical, clerical and aide time required to perform all the activities to complete the defined procedure one time.

UNIT VALUE INDICATOR (1-A-O)
To indicate how the unit value for the procedure was initially obtained, enter an asterisk (*), **t**, **e** or leave this field blank. These characters are used by STAR Laboratory for unit value flagging: extrapolated (e), temporary (t) and permanent (no flag). The asterisk (*) indicates there is no unit value. These indicators serve no purpose within the system except to flag how the unit value was obtained and to print on some reports.

US: This is an optional field and if you do not use CAP workload recording, you may bypass this altogether. If you do use CAP, these indicators are useful in flagging unit values that may change in future CAP releases.

The following explains the different indicators.

An extrapolated (e) unit value is assigned to a procedure or instrument before standard time studies have been performed. The value may be derived from components of previous time studies on similar procedures or instruments.

A temporary (t) unit value is assigned by the International Workload Committee (MIS Group in Canada) to a procedure or instrument after a limited number of edited time studies have been performed and before enough data are available to calculate a permanent unit value.

A permanent (no flag) unit value is assigned by the International Workload Committee (MIS Group in Canada) to a procedure or instrument after a statistically valid number of edited time studies have been performed.

An asterisk (*) in the unit value field indicates that there is no defined unit value for this procedure.

NOTE: If you change a unit value, you must revise the indicator field if applicable. This field only serves to indicate the unit value type and has no other impact on workload recording.

WORKLOAD PROCEDURES

A procedure is a sequence of steps constituting a laboratory activity. Each procedure requires a code number and an item for count. The unit value is optional. Procedures are assigned to a standard CAP section/WMS functional centre and are either automated and manual. An automated procedure is one in which most of the analytical steps are performed by an instrument. A manual procedure is one in which most of the analysis is performed by hand.

Create a table of procedures for your laboratory. If you are using the CAP/WMS manual, you may find it easier to build directly from the book; however, if you are having someone else do the build for you or do not have a CAP/WMS book, you will probably need to fill out the worksheets. The following is a description of the fields on the Workload Procedures worksheet:

(US) SECTION CODE/NAME
(CN) CENTRE CODE/NAME
Each procedure is classified in a CAP section/WMS centre based on the area in which it is most frequently performed. The standard section/centre codes and names for CAP/WMS (base list) display as follows. (Abbreviations for the standard sections/ centres are shown in parentheses).

US Section Codes/Names
01   Blood Bank   (BANK)
02   Chemistry   (CHEM)
03   Hematology   (HEMA)
04   Histology   (HIST)
05   Immunology   (IMMU)
06   Microbiology   (MICRO)
09   Specimen Procurement, Preprocessing, Dispatch, and
            Report Delivery   (SPEC)
10   Urine and Feces   (URIN)

CN Centre Codes/Names
01   Anatomical Pathology
02   Clinical Chemistry
03   Hematology
04   Immunohematology
05   Microbiology
06   Immunology
07   Cytogenetics
08   Histocompatibility
09   Specimen Procurement, Receipt and Dispatch

Enter the appropriate code and name in the blank.

(CN ONLY) EFFECTIVE DATE (15-C-R)
Enter the date when information becomes active. This date can be a past, present, or future date.

PROCEDURE CODE (9-N-R)
Enter the five-digit code for the procedure. If you are using CAP/WMS, you can use the code from their manual or enter your hospital defined code for this procedure. If the procedure is to be assigned a method type, attach the suffix/method code.

PROCEDURE DESCRIPTION (30-AN-R)
This is a 30-character alphanumeric, upper/lowercase description for the procedure.

UNIT VALUE (3-N-O)
This is the time in minutes it takes to perform this procedure.

INDICATOR (1-C-O)
This is the symbol used to indicate how the unit value was obtained. These are the same indicators as those described in the Items for Count worksheet's description. Refer to "WORKLOAD ITEMS FOR COUNT" on page 8-5 for further detail.

(US) ITEM FOR COUNT (U-A-O)
(CN) ITEM FOR COUNT (U-A-R)
Select the item for count from the base table of Items for Count or the one created by your laboratory.

(US) SETUP CAP # (9-N-O)
(CN) SETUP WMS # (9-N-O)
This is the code for the set-up workload value for this procedure. If you are using a CAP/WMS procedure code with a suffix/method, the set-up code must be the same as the one built in the Workload Method Types. For Canadian users, if the procedure being defined is called Setup, you do not need to fill in this or the next field.

SETUP VALUE (2-N-O)
This is the unit value (time in minutes) that is needed by this procedure. If you are using a CAP/WMS procedure code with a suffix/method, the set-up code needs to be the same as the one built in the Workload Method Types. For Canadian users, if the procedure being defined is called Setup, you do not need to fill in this or the previous field.

INDICATOR (1-C-O)
This is the symbol used to indicate how the setup unit value was obtained. These are the same indicators as those described in the Collection Types worksheet's description. Please refer to "WORKLOAD COLLECTION TYPES" on page 8-16 if you need further details.

MISCELLANEOUS WORKLOAD TABLE (1-A-O)
If you are defining a miscellaneous procedure table and want to add this procedure to it, circle YES. If not, circle NO.

NOTE: The miscellaneous procedure table is designed to contain procedures commonly used for manual adjustment of workload. When entering the Manual Workload Adjustment processor, the system asks if this is a miscellaneous procedure and allows you to access this smaller table first rather than requiring you to access the entire procedure table.

(CN ONLY) REGIONAL CROSSREFERENCE CODES (U-N-O)
This is used to link workload procedures to regional cross-reference codes. Up to 30 codes can be assigned to a procedure.

TEST/COLLECTION WORKLOAD

STAR Laboratory records collection, test, and setup workload data for a particular test. The Test/Collection Workload worksheet is used to define this information per test. Many fields on this worksheet will be automatically filled in based on the workload files and tables you have established for your laboratory. If you create this file online, you might not want to fill in the auto-fill fields on your worksheets; however, if you are *not* building this file yourself, you should fill in the auto-fill fields or designate the defaults to be used during the build. All auto-fill fields will be identified in the following descriptions:

TEST CODE/NAME
Indicate the test code/name of the test for which workload data should be collected.

COLLECT TYPE (5-N-R)
Enter the Collection Type from the Workload Collection Types worksheet. This is the usual method of collection.

NUMBER OF COLLECTS (2-N-0)
This is the usual number of collections associated with this test. Enter the number of counts per collection of this test or enter the information associated with the collection type code previously entered.

COLLECT SECTION (3-A-R)
Enter the three-character alphabetic code for the section to receive credit for collection workload.

NOTE: Collection workload, captured at accessioning, is defined by the Collect Section field within the Test/Collection Workload processor. Workload for performing the test, whether defined by test or by result, is always captured for the section within which the test is resulted.

WORKLOAD TYPE (1-C-R)
Indicate how workload is to accumulate: at the test level, or the result level. Circle the option of choice. If Test is selected, assign a procedure code in the following field. If Result is selected, the only additional information needed for this worksheet is the Workload Method Setup field.

TEST WORKLOAD PROCEDURE (9-C-R)
If you selected workload accumulation at the test level in the previous field, assign the workload procedure code in this field from the previously defined list.

WORKLOAD METHOD SETUP (CONDITIONAL)
If workload is to accumulate by test, indicate the setup procedure code.

(CN ONLY) XREF CODE (5-N-O)
If the regional cross-reference index is activated, assign the XREF code associated with the collection type procedure, test workload procedure and the workload setup procedure, if applicable.

WORKLOAD PROCEDURE GROUPS

The Workload Procedure Groups worksheet allows you to organize procedures into distinct groups for tallying workload. Group assignment is optional and used only for reporting purposes. Procedures can be assigned to one group only.

GROUP DESCRIPTION (30-AN-R)
Enter the group description of up to 30 alphanumeric, upper/lowercase characters.

CAP PROCEDURES (9-C-R)
Enter the five-digit procedure codes associated with this group. You may attach the three-digit suffix/method code be preceding it with a decimal. Procedures can only be assigned to one group.

TEST LEVEL WORKLOAD

The Test Level Workload worksheet allows you to define the Billable Test Count value per test for LMIP workload reporting. This value will allow you to exclude tests from the Billable Test Count report and/or accommodate any valid multi-scenario.

BILLABLE TEST COUNT (2-N-R)
Enter the test's billable test count value for LMIP. Most tests have an LMIP count value of one. Tests that are exempt from LMIP workload should be set to zero. Tests defined as charge panels in the Service Item Master (SIM) maintenance processors should be set to a count value consistent with the number of valid CPT codable tests represented by the panel master. Valid values are integers ranging from 0-99. The default is *one*.

Chapter 9 - Quality Control

DEFINITIONS

Component - A result uniquely identified by its name, unit of measure, and specimen type. In STAR Laboratory, result components are linked with the CAP constituent codes used in QAS reporting.

Constituents (QAS) - The substance contained in (or a property of) the sample being measured. A base list of CAP code/ constituents is provided with the system. It is not a complete list; that is, the laboratory may need to add some constituents. Refer to the example. Each constituent must be linked to a result component within the Result Component file of STAR Laboratory.

Control Material - Any material analyzed in the same way as a patient sample for the purpose of evaluating and assuring the quality of an assay. Refer to the example at the end of this section.

Equipment - The name of each piece of equipment and instrument used in the laboratory. This includes analytical instruments as well as centrifuges, refrigerators, incubators, and so on.

Equipment QC - All QC checks relating to equipment/instruments and environmental conditions, for example, daily refrigerator temperature checks.

General Methods (QAS) - The commonly accepted chemical name describing a methodology or procedure used to determine a constituent's level. The General Methods' file is only required if the laboratory is using CAP's QAS and, therefore, must be built using the established CAP codes/methods. General Methods are used in conjunction with Specific Methods to further define a QC file. Refer to the example at the end of this section.

Manual Method - The name of an assay procedure not involving an instrument, such as Sed Rate, urine dipstick, and so on. Manual Methods are used strictly in Workload recording and Quality Control.

Run Frequency - A method of specifying when a QC entry is required based on the number of times the bay or test is selected. For example, if a normal control is required with each run of a glucose, it is set up as a run frequency.

Sample QC - All QC checks relating to controls, standards and blank/zero materials.

Special Profile - A sample QC profile used solely for accession first result entry, for example, in Anatomic Pathology and Advanced Microbiology.

Specific Methods (QAS) - A method description which refers to an instrument name, reagent manufacturer or both. The Specific Methods' file is only required if the laboratory is using CAP's QAS and, therefore, CAP's Specific Method codes must be used to build this file. Refer to the example at the end of this section.

Time Interval - A method of specifying when a QC entry is required based on the time of day. For example, if anelectronic check on the Coulter is required once daily at 6:00 am, it is set up as a time interval for the Coulter bay.

Units of Measure - If using QAS, CAP's Units of Measure codes must be linked to STAR Laboratory's Result Unit codes.

EXAMPLE (using QAS terminology)

		Code
Constituent:	Glucose	290
Unit of Measure:	mg/dl	084
General Method:	Hexokinase	329
Specific Method:	Abbott 100	701
Control Material:	Hyland	HYLL
Standard Material:	Lederle	LEDR
Blank Material:	Deionized H2O	DWAT

QC DATA RETENTION PARAMETERS

QC Data Retention Parameters must be defined before STAR Laboratory system LIVE.

ACTIVATE QC (1-A-R)
Check Y for Yes to activate QC data entry, either for testing or after LIVE. Check N for No.

EQC RETENTION (2-N-R)
Enter the number of months (between one and 13) to retain EQC data. The default is 4.

SQC RETENTION (2-N-R)
Enter the number of months (between one and 13) to retain SQC data. The default is 4.

REQUIRE COMMENT IF QC OUTSIDE 2SD (1-A-R)
Enter **Y** for Yes to require comment entry if sample QC is outside 2 or 3 standard deviation. If this option is Yes, the system requires entry of up to three lines of free text after you accept the outlier. If you enter **N** for No, no comment is required. Required comment processing works the same in Automatic Prompting, the QC Processor, and Online Data Entry.

REQUIRE COMMENT FOR WESTGARD RULES (1-A-R)
Press **N** or press ENTER to display No in the field if a comment is not required when Westgard rules are violated during QC data entry. Enter **Y** if a comment is required during QC data entry if Westgard rules are violated.

DEFER SQC DEFAULT (1-A-R)
Enter **Y** to enter a default response to defer SQC. Enter **N** to avoid deferring to SQC.

DEFER EQC DEFAULT (1-A-R)
Enter **Y** to enter a default response to defer EQC. Enter **N** to avoid deferring to EQC.

FLAG TEXTUAL QC (1-A-R)
Enter **Y** to flag textual QC entries as outliers or invalid responses. Enter **N** to set this field to No and flagging of textual QC does not occur.

CONSTITUENTS/GENERAL/SPECIFIC METHODS

Refer to CAP's list of Constituents, General and Specific Methods as documented in the QAS methodology guidebook to complete these worksheets.

SAMPLE QC MATERIALS/FILES

The Sample QC Materials/Files worksheet is used to collect the information necessary for building the following:

- Control Materials

- Control Files

- Standard Materials

- Standard Files

- Blank Materials

- Blank Files

Worksheets must be separated by the type of sample QC material by method (controls, standards, blank/zero materials).

NOTE: This information can be obtained from the product insert from each sample material.

SQC MATERIAL INFORMATION

The SQC Material information at the top of the worksheet can be entered once and then referenced on subsequent worksheets using the material code; that is, once a code is assigned to the material, it can be carried over to additional worksheets without having to repeat information.

QC TYPE (1-C-O)
Circle the type of Sample QC material: control, standard or blank/zero material.

CAP CONTROL CODE (8-N-R)
Laboratories using QAS must enter a CAP Control Code. This is for sample Control materials only!

CODE (7-N-O)
A code must be assigned to each QC material. These codes are assigned by the user. Codes vary based on the type of material:

Blank	5AN
Standard	6AN
Control	6AN

During actual QC build, the system attaches a prefix to the code for standard and blank materials thereby distinguishing controls, standards and blanks. The prefixes are: $ standard, @ blank. There is no prefix attached to control material codes.

EXAMPLE: Deionized water blank code = @DH2O
Lederle standard material = $LEDERL
Monitrol Level I control =   MON1

DESCRIPTION (40-C-R)
The description, displayed on the screen each time the QC entry is required, may be truncated (shortened) in some places. Therefore, when identifying the brand and level, such as Monitrol High Chemistry Control, place the level directly after the brand name.

INITIAL LOT # (20-C-R)
This field is for the initial lot only. Enter the lot number. The lot number cannot contain slashes (/). This field is required for the initial lot because of Current verses Next lot processing. If no lot number exists, enter the date prepared or received as the lot number. You must update the Next, Current, and Previous lot information through the Quality Control/Workload processor.

MANUFACTURER (30-C-R)
LEVEL (1-C-R)
INITIAL EXP. DATE (DATE-R)
INITIAL MANUFACTURE DATE (DATE-R)
INITIAL DATE RECEIVED (DATE-O)
SECTION ACCESSION # (7-N-O)
WARNING DAYS (3-N-O)
CAP CONTROL CODE (7-N-O)

For each code, enter the manufacturer, level, initial date received, and the initial expiration date (for the initial lot number only). You may also indicate the number of days to warn you before the expiration date. The section to assign the control and the CAP control code can also be entered.

NOTE: If the lot number contains slashes (/), replace them with hyphens (-).

SQC FILES

SQC files contain information related to the individual constituents of the control material. A separate file is assigned to each component and includes the assay method, the target values and units of measure.

EQUIPMENT/MANUAL METHOD CODE
Enter the equipment code or manual method code used to assay the components in this QC material by first circling either Automated or Manual Method and entering the code.

EXAMPLE: For a glucose the equipment = ACA

SQC FILE CODE (4-N-R)
The SQC File Code can be system- or user-assigned. This number is used to reference file data (all information on this line of the worksheet plus the SQC Material information at the top of the worksheet). The SQC File Code will be used in completing

the "Sample QC - Test/Method Profiles" worksheet . If the code is user-assigned, make sure the numbers are not duplicated. It may be helpful to assign a number range for each section of the laboratory, for example, 1-100 for chemistry CONTROL material files, 9101-9201 for hematology STANDARD material files, and so on.

The ranges for the different types of QC materials:

   Control Materials = 1-8999
   Standard Materials = 9000-9899
   Blank/Zero Materials = 9900-9999

COMPONENT NUMBER & UNITS
For each component within this material, list the component number followed by the units of measure.

EXAMPLE: Glucose's component number = 10054A, units = mg/dl

GEN/SPEC METHODS
Both General Specific Methods are optional. If using QAS, enter the CAP General Method code/Specific Method code for this assay.

  EXAMPLE: For a glucose performed on Baker Centrifichem using the hexokinase
            method, the codes are:

            General Method (hexokinase) CAP code = 329
            Specific Method (Baker Centrifichem) CAP code = 090

Enter the codes 329/090 on the line directly under Gen/Spec Methods.

ENTRY FRMT (1-A-R)
   N Numeric (the default response) - This option requires entry of a target mean
      and standard deviation (SD) to be used for QC evaluation. The target CV(%),
      low (-2SD) and High (+2SD) range are calculated from these entries and filled
      in by the system. If this option is used, the CV, Low and High values should not
      be edited since this does not update the target mean and SD. Numeric entry
      is generally used for sample QC.

   R Range - This option allows entry of low and high values corresponding to the
      lower and upper limits of a specified range. The target mean, Standard
      Deviation (SD) and Coefficient of Variation (CV%) are not calculated. Ranges
      are generally used for EQC files such as temperatures and aspiration rates.

   T Textual - This option allows a free-text response or table selection of coded
      results during QC result entry.

   C Check only - This option allows a yes or no response regarding the QC check
      and is generally used for EQC files requiring visual checks such as "Check
      reagent level" or "Check pump tubing."

TARGET VALUES
Enter the target values for this control component (numeric entries only). QC results are compared against target values for acceptance/rejection. Target values are required for QC statistics to be compiled. Two options exist for entering target values:

1) The mean and standard deviation can be entered. The CV, low (-2SD) and high (+2SD) range are calculated based on these.

   EXAMPLE: Glucose's component number = 10054A, units = mg/dl

   The mean for glucose = 89, Std Dev = 3
   Enter 89 in the field for the mean; 3 for Std Dev

   The system automatically calculates the Coefficient of Variation and Low and High endpoints to be CV=3.4, Low=83.0, High=95.0

2) A range (low and high) can be indicated. The values are used for comparison against the QC value for acceptance/rejection.

WORKLOAD (9-C-O)
Indicate the procedure code for the assay (the same as for unknown specimens, unless otherwise stated in CAP Workload standards). Enter the number of times workload credit should be counted for this File.

SAMPLE QC TEST/METHOD PROFILES

The SQC - Test/Method Profiles worksheet is used to gather sample QC information for individual tests. Sets of control, standard and blank materials can be assigned to a test code so that, at designated run frequencies or time intervals for this test, the user is prompted to enter QC values. This worksheet is used to define these profiles (sets).

PROFILE PARAMETERS

TEST CODE/TEST NAME (U-AN-O)
Enter the test code and test name.

ASSIGNED EQUIPMENT/MANUAL METHOD (4-AN-R)
Enter the assay method used for this profile.

EXAMPLE 1: Glucose performed on ACA: ACA code = ACA1
                     Enter ACA1

EXAMPLE 2: Urinalysis - Manual Method code = URI
                     Enter URI

QC PROFILE DESCRIPTOR (40-C-R)
Enter the profile description which best describes this profile. The description should include the QC material(s) and the frequency.

EXAMPLE 1: ACA Monitrol (Daily)

EXAMPLE 2: Controls, Standards (per run)

FREQUENCY/INTERVAL (2-C-O)
Indicate how often this profile will prompt. (The system uses this to automatically prompt for QC entry.)

- If the prompt is to occur on a run basis, that is, when the test is performed, enter the run frequency number.

   EXAMPLE: If the prompt for this QC profile is to occur every time a glucose is run on the ACA, enter **1**; for every other run, enter **2**.

- If the prompt is to occur on a timed basis, indicate Y (year), Mo (month), W (week), D (day), H (hour) or Mi (minute). A combination of these can be used.

   NOTE: A combination of time periods can be used to specify the interval. Extra lines are provided on the worksheet for indicating these.

Next, indicate the next date and time the prompt will occur. If it should come up at the beginning of the day, for example, at 7:00 am, enter that date in MM/DD/YY format plus the time in HHMM. The system will then calculate the date and time intervals based on this. In this example, it could be 04/04/87 0700. Checks would then be prompted every day starting with April 4, 1987 at 7:00 am and again at 3:00 pm and 11:00 pm.

WORKLOAD PROCEDURE CODE (9-C-O)
This is an optional field for assigning workload to the profile. Enter the CAP code and number of counts.

SQC FILE ASSIGNMENT

Use this section of the worksheet to indicate which materials (controls, standards, blank/zero) are to be included in the profile and the sequence in which the system prompts the user to enter their values.

SEQUENCE (2-N-R)
This is used to indicate the order in which files are to be entered for result entry. Indicate the sequence by placing a number starting with 1 beside the first material, 2 for the second, and so forth.

MATERIAL CODE (40-C-R)
Enter the material name for the standard, control or blank/zero.

SQC FILE NAME/COMPONENT NAME
Enter the SQC file name and the component name.

LINK (1-C-O)
Enter the number of the modified Westgard Rule you wish to attach to this component using the rules listed on the following pages.

The following Modified Westgard rules can be applied:

 1) 1:2S Warning
 2) I:2S Rejection
 3) I:3S Rejection
 4) 2:2S Rejection Across Files
 5) R:4S Rejection Within Run
 6) 2:2S Rejection Within Files
 7) 4:1S Rejection Across Files
 8) 4:1S Rejection Within Files
 9) Mean Run Rejection Across Files
10) Mean Run Rejection Within Files
11) 10X Across Files
12) 10X Within Files

Detailed rule explanation:

1) W1:2S Warning

    This is a warning. When activated, any control material value which exceeds either
    + or - 2 standard deviation from the target mean will violate this rule and will display
    the rule as "W1-2S."

2) I:2S Rejection

    This is a rejection. When activated, any control material value which exceeds
    either + or - 2 standard deviation from the target mean will violate this rule and will
    display the rule as "1-2S." (Identical to the first rule except for the "W" preceding
    the rule to indicate a warning, not a rejection.)

3) I:3S Rejection

    When activated, any control material value which exceeds either + or - 3 standard
    deviation from the target mean will violate this rule and will display the rule as
    "1-3S."

4) 2:2SAF Rejection Across Files

    When activated, this rule checks for two consecutive control material values across
    linked files exceeding a 2 SD limit. The number of values used when checking this
    rule varies with the number of linked control material files. In each case, (2, 3 or 4
    linked files), the value being entered in the current file and the last value in the other
    linked files are evaluated. If two values are found that exceed either + or -2
    standard deviation, the rule is violated and will display as "2- 2Saf." (Note, more
    than two values could exceed the 2SD limit when three or four files are linked.)

5) R:4S Rejection Within Run

    When activated, each control material value is compared to the previous control
    value in the same SQC file. If the difference between the two control values
    exceeds 4 standard deviation, the rule is violated and will display as "R-4S."
    Presently, this rule is only applied within control material files.

6) 2:2SWF Rejection Within Files

    When activated, this rule checks the last two consecutive control material values
    within the file. If both values exceed + or - 2 standard deviation from the target
    mean, the rule is violated and will display as "2-2Swf."

7) 4:1SAF Rejection Across Files

When activated, this rule checks for four consecutive control material values across linked files exceeding a 1 SD limit. The number of values evaluated when checking this rule varies with the number of linked control material files as follows:

- Two linked control material files - The last two values from each linked file are evaluated.
- Three linked control material files - The last two values from the current file (file where check is being initiated) and the last value from each of the other two files are evaluated.
- Four linked control material files - The last value from each of the control material files are evaluated. If all four values exceed + or - 1 standard deviation, the rule is violated and displays as "4-1Saf."

If all four values exceed + or - 1 standard deviation, the rule is violated.

8) 4:1SWF Rejection Within Files

When activated, this rule checks the last four consecutive values within the control material file. If all values exceed + or - l standard deviation, the rule is violated and displays as "4-1Swf."

9) MAF Mean Run Rejection Across Files

When activated, the number of values evaluated varies with the number of linked files as follows:

- Two linked control material files - Ten control values are evaluated, the last five values from each file.
- Three linked control material files - Nine control values are evaluated, the last three values from each file.
- Four linked control material files - Eight control values are evaluated, the last two values from each file.

If all evaluated control values differ from the mean by the smallest unit of reportable precision or less, the rule is violated and displays as "MAF." The smallest reportable precision for a result reported as a whole number, ####, is 1. The smallest reportable precision for a result reported as a single decimal, ###.#, is 0.1. The smallest reportable precision for a result reported to two decimal places, ###.##, is 0.01. This pattern can be extrapolated further for results reported to even greater number of significant digits.

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10) MWF Mean Run Rejection Within Files

When activated, this rule evaluates the last ten consecutive control values within the file. If all values differ from the mean by the smallest unit of reportable precision or less, the rule is violated and displays as "MWF." The smallest reportable precision for a result reported as a whole number, ####, is 1. The smallest reportable precision for a result reported as a single decimal, ###.#, is 0.1. The smallest reportable precision for a result reported to two decimal places, ###.##, is 0.01. This pattern can be extrapolated further for results reported to even greater number of significant digits.

11) 10Xaf 10X Across Files

When activated, the number of values evaluated varies with the number of linked files as follows:

- Two linked control material files - Ten control values are evaluated, the last five values from each file.
- Three linked control material files - Nine control values are evaluated, the last three values from each file.
- Four linked control material files - Eight control values are evaluated, the last two values from each file.

If all values evaluated fall on one side of the target mean, the rule is violated and displays as "10af."

12) 10Xwf 10X Within Files

When activated, the last ten control values within the file are evaluated. If all values fall on one side of the target mean, the rule is violated and displays as "10Xwf."

SAMPLE QC SPECIAL PROFILES

The "Accession First" routine eliminates selection of a bay or a test prior to entry of the accession number within results entry. Therefore, QC defined up at the bay or test level is bypassed. To accommodate QC prompting in Accession First results entry, the system allows creation of Special Profiles. One test code per section is used as the Special Profile indicator in Accession First routines. Once the Special Profile is established, whenever Accession First result entry is used, the system prompts for QC file entries based on the parameters set up for this profile.

Use the "Sample QC - Special Profile" worksheet to create such a profile for each section in which accession first result entry will be used. Follow the instructions provided for Sample QC - Test/Method Profiles to complete this worksheet. The only difference is "Section:____" which is listed on the first line. Section refers to the laboratory section in which this Special Profile will be applied in Accession First results entry.

NOTE: The test code/name used for the Special Profile must **not** have any regular sample or equipment QC attached to it. It is recommended that a non-orderable test code be defined (per section) and used solely for the purpose of creating a Special Profile for that section. This test code can also be used for setting up equipment QC for Accession First results entry (refer to "EQUIPMENT QC TEST/METHOD EQUIPMENT" on page 9-21 for further details).

EQUIPMENT QC FILES

Quality Control for analytical instruments, laboratory equipment (such as refrigerators, incubators, and centrifuges) and environmental parameters can be assigned at the bay or test level. QC checks occur based on selection of the bay or test at the frequency (or time interval) defined by the laboratory. The EQC - Files worksheet is used to:

- Set up the EQC files for manual methods or equipment

  - define default schedules (frequency/interval) for EQC file

  - define target values for EQC file

- Assign these files to individual bays or test/methods

NOTE: The Equipment Type, Equipment Type Assignment and Manual Method worksheets must be completed prior to completing this worksheet.

EQUIPMENT CODE/EQUIPMENT NAME (U-AN-O)
Enter the equipment code/name to be assigned EQC files using this worksheet. (Refer to the Equipment Type worksheet in Appendix B: Worksheets in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide* for the equipment code.)

QC SPECIFIC METHOD/BAY
Indicate the method or bay to be assigned to this EQC file.

SECTION (3-AN-R)
Enter the section name or code assigned with the piece of equipment to have QC checked. (Refer to the Equipment Type Assignment worksheet in Appendix B: Worksheets in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide* for this information.)

EQC FILE CODE (4-N-R)
Enter a number from 1 to 8999. This number can be system assigned.

EQC FILE DESCRIPTION (30-C-R)
Enter the parameter to be monitored on this instrument/equipment, for example, Check filter, Clean electrode, Check temperature. The description appears on the screen each time the QC prompt occurs.

ENTRY FORMAT (1-C-R)
Enter the entry format for this QC file. The choices are:

N   Numeric (the default response) - This option requires entry of a target mean and standard deviation (SD) to be used for QC evaluation. The target CV(%), low (-2SD) and High (+2SD) range are calculated from these entries and filled in by the system. If this option is used, the CV, Low and High values should not

be edited since this does not update the target mean and SD. Numeric entry
is generally used for sample QC.

R   Range - This option allows entry of low and high values corresponding to the
     lower and upper limits of a specified range. The target mean, Standard
     Deviation (SD) and Coefficient of Variation (CV%) are not calculated. Ranges
     are generally used for EQC files such as temperatures and aspiration rates.

T   Textual - This option allows a free-text response or table selection of coded
     results during QC result entry.

C   Check only - This option allows a yes or no response regarding the QC check
     and is generally used for EQC files requiring visual checks such as Check
     reagent level or Check pump tubing.

TARGET VALUES (10-C-O)
Enter the target values for this QC file(numeric entries only). QC results are compared
against target values for acceptance/rejection determinations. Two options exist for
entering target values:

1 - The mean and standard deviation can be entered. The CV, low and high range
      are calculated based on these. OR

2 - A range (low and high) can be indicated. The range is used for comparison
      against the QC value for acceptance/ rejection.

VALID VALUES (SCROLLING SCREEN)
The Entry Format field must be set to Textual for you to access this field. This field
displays Defined, if the EQC file has Valid Values designated.

VALID VALUES (15-ANC-R)
Select this column to define and display a valid value for this component. This field
defines the following:

• Acceptable responses (textual or numeric and textual, valid characters include:
   +; -; >; <; =) for the EQC file

The system displays the following prompt:

Enter valid value--

To insert or delete valid values, place the cursor on the valid value. Press the F3 key
to insert a new valid value or press F4 to delete a valid value.

If a component has a Valid Values list, the system compares the entered result value
with the list. The valid value processes only if an exact match, including uppercase
and lowercase characters and spaces, is found.

After the valid value is entered, use the tab or right arrow key to access the Flag column.

FLAG (1-A-R)
This field determines if the valid value is flagged as an outside range. During QC data entry, three outcomes are possible for textual format.

- If an entry is in the valid value's table and considered within range, the entry is filed and no action is required.

- If an entry is in the valid value's table and marked as an outlier, the system displays the following warning message:

    OUTSIDE RANGE!

The entry may be filed to the QC log and is flagged with an R.

- If a response is entered and NOT defined in the valid value's table, the system displays the following warning message:

    INVALID RESPONSE!

The entry cannot be filed.

Select this column to enter the flag associated with the valid value. The system displays the following prompt:

Flag value as outside range? (Y/N)--

Enter **Y** if the valid value is flagged as an outside range, an R displays in the Flag column. If this response is entered in QC data entry, the system displays the following warning message:

OUTSIDE RANGE!

The entry may be filed to the QC log.

Enter **N** if the valid value is not flagged as an outside range or NOT defined in the valid value's table, the response is considered valid and within range. The system displays the following warning message:

INVALID RESPONSE!

The entry cannot be filed to the QC log.

Once you complete the definition of valid values, press the F7 key to exit the Valid Values scrolling screen. If you do not want to do any, more edits, press ENTER. The system displays the following:

Accept this screen? (Y/N) [Y]--

Enter **Y** or press ENTER to accept the entries and return to the QC Files processor screen. Enter **N** to return to the Valid Values screen.

QC WORKLOAD (TABLE LOOKUP)
Enter the workload procedure code associated with this EQC file. The prompt then requires you to specify the number of workload units to count. This field is optional.

TIME INTERVAL (TABLE LOOKUP)
This field specifies automatic prompting of QC entry based on a time interval. This is only used if Next Date/Time Check is used.

Enter the date and time for the first check. Run frequencies, time intervals or a combination of both can be used to indicate how often QC checks will be prompted.

On the line labelled Defaults, indicate the frequency/interval for the QC file. The system will prompt for QC entry based on this information. If the QC prompt should occur at a time interval or run frequency different from the default, use the line labelled Bay to enter the change and the name of the associated bay.

- If the prompt is to occur on a run basis, (when the test is performed), enter the run frequency number. For example, if the prompt for this QC file is to occur every time the ACA is run, enter 1; for every other run, enter 2.

- If the prompt is to occur on a timed basis, check from the following:

  (1) Year (1-2)   (4) Day (1-30)
  (2) Month (1-12)   (5) Hour (1-24)
  (3) Week (1-52)   (6) Minute (1-60)

  A combination of these can be used. For example, if the prompt for thisQC file is to occur daily on every shift, enter **D** and **H** on separate lines. For days, indicate the number of days between checks. For hours, indicate the number of hours between checks.

  Then, indicate the next date and time the prompt will occur. If it should come up at the beginning of the day, for example, at 7:00 am, enter that date in MM/DD/YY format plus the time in HHMM. The system will then calculate the date and time intervals based on this. In this example, it could be 04/04/87 0700. Checks would then be prompted every day starting with April 4, 1987 at 7:00 am and again at 3:00 pm and 11:00 pm.

WORKLOAD PROCEDURE CODE/COUNTS (U-AN-O)
Indicate the workload procedure code for this profile. Then enter the number of times it should be counted with each run of this EQC file as already defined in Workload Procedures. Remember that reagent/serum blanks are included in the unit values per procedure and, as such, must not be counted as separate procedures.

EQUIPMENT QC TEST/METHOD EQUIPMENT

Quality Control for analytical instruments, laboratory equipment (such as refrigerators, incubators, and centrifuges) and environmental parameters can be assigned at the bay or test level. QC checks occur based on selection of the test at the frequency (or time interval) defined by the laboratory or entry of the accession number in Accession First results entry.

NOTE: Equipment QC for Accession First can only be set up at the test level.

The EQC - Test/Method Equipment worksheet is used to:

  •   Set up the EQC files for manual methods or equipment

    -    define default schedules (frequency/interval) for EQC file

    -    define target values for EQC file

  •   Assign these files to individual bays or test/methods

NOTE: The Equipment Type, Equipment Type Assignment and Manual Method worksheets must be completed prior to completing this worksheet.Equipment QC for Accession First can only be set up at the test level.

Use a separate worksheet for each test.

TEST CODE/TEST NAME (U-AN-R)
Enter the test code/name to be assigned EQC files using this worksheet.

NOTE: For Accession First results entry, a non-orderable test code should be defined per section and used solely to assign the EQC file information to be prompted within this section. Use the same test code per section as the one used for Special Profile definition (refer to "SAMPLE QC SPECIAL PROFILES" on page 9-16).

METHOD CODE/NAME   (4-AN-O)
Enter the assay method of the test which is associated with the EQC file information.

EXAMPLE: For a glucose assayed by the ACA, certain ACA equipment QC checks may be required. Therefore, list the ACA and its equipment code on this line.

Separate the EQC files by the test assay method. Use a different subgouping for the different assay methods.

SECTION (3-A-R)
Enter the section code for the equipment QC files to be linked with this test assay method.

EQUIPMENT CODE (4-AN-O)
Enter the code for the equipment associated with this test assay method.

EXAMPLE: If reagents for the Hitachi are stored in a refrigerator (code REF1)
assigned to Hematology (code HEM), the section is HEM and the
equipment code is REF1.

EQC FILE DESCRIPTION (U-AN-O)
Enter the parameter to be monitored on the equipment associated with this test. This
displays each time the QC prompt displays.

ENTRY FORMAT   (1-A-O)
Enter the entry format for this QC file. The choices are:

N   Numeric (the default response) - This option requires entry of a target mean
and standard deviation (SD) to be used for QC evaluation. The target CV(%),
low (-2SD) and High (+2SD) range are calculated from these entries and filled
in by the system. If this option is used, the CV, Low and High values should not
be edited since this does not update the target mean and SD. Numeric entry
is generally used for sample QC.

R   Range - This option allows entry of low and high values corresponding to the
lower and upper limits of a specified range. The target mean, Standard
Deviation (SD) and Coefficient of Variation (CV%) are not calculated. Ranges
are generally used for EQC files such as temperatures and aspiration rates.

T   Textual - This option allows a free-text response or table selection of coded
results during QC result entry.

C   Check only - This option allows a yes or no response regarding the QC check
and is generally used for EQC files requiring visual checks such as "Check
reagent level" or "Check pump tubing."

TARGET VALUES (10-C-O)
Enter the target values for this QC file (numeric entries only). QC results are compared
against target values for acceptance/rejection determinations. Two options exist for
entering target values:

1 - The mean and standard deviation can be entered. The CV, low and high range
are calculated based on these. OR

2 - A range (low and high) can be indicated. The range is used for comparison
against the QC value for acceptance/ rejection.

RECORDING SCHEDULE
This field specifies automatic prompting of QC entry based on a time interval. This is
only used if Next Date/Time Check is used.

Enter the date and time for the first check. Run frequencies, time intervals or a combination of both can be used to indicate how often QC checks will be prompted.

On the line labelled Defaults, indicate the frequency/interval for the QC file. The system will prompt for QC entry based on this information. If the QC prompt should occur at a time interval or run frequency different from the default, use the line labelled Bay to enter the change and the name of the associated bay.

- • If the prompt is to occur on a run basis, (when the test is performed), enter the run frequency number. For example, if the prompt for this QC file is to occur every time the ACA is run, enter 1; for every other run, enter 2.

- • If the prompt is to occur on a timed basis, check from the following:

  (1) Year (1-2)   (4) Day (1-30)
  (2) Month (1-12) (5) Hour (1-24)
  (3) Week (1-52)   (6) Minute (1-60)

  A combination of these can be used. For example, if the prompt for thisQC file is to occur daily on every shift, enter **D** and **H** on separate lines. For days, indicate the number of days between checks. For hours, indicate the number of hours between checks.

  Then, indicate the next date and time the prompt will occur. If it should come up at the beginning of the day, for example, at 7:00 am, enter that date in MM/DD/YY format plus the time in HHMM. The system will then calculate the date and time intervals based on this. In this example, it could be 04/04/87 0700. Checks would then be prompted every day starting with April 4, 1987 at 7:00 am and again at 3:00 pm and 11:00 pm.

WORKLOAD PROCEDURE CODE/COUNTS (U-AN-O)
Indicate the workload procedure code for performing this QC check. Then enter the number of times it is to be counted. For each assay method, enter the method code and name followed by the associated EQC file information.

Chapter 10 - Spooler and Printer Matrix

PRINTER MATRIX

The printer matrix utility allows the user to specify the printer that is used for selected document types. Printers for these documents would otherwise be determined by the printer assignments in the Spooler utilities. Printer matrix can be used for any of the following categories of reports/labels:

- Collection Labels
- Primary Reports
- Remote Primary Reports
- Long Reports
- Microbiology Work-up Labels

Collection labels for a certain priority, such as STAT, can be routed to a printer located in a separate area, such as the STAT Laboratory. By using test code ranges, audit copies of Primary Reports can be routed to printers located within the section where testing is actually performed. In addition, printer matrix can be used to control second copy printing of Primary Reports at remote hospital locations.

A Document Routing Table is used to define printing parameters per report type using the following criteria: test code range, location/patient type and ordering priority. Although any combination (or all) of these criteria can be defined for a report type, criteria are always checked in the following order:

1. Test code range
2. Location or patient type (whichever is specified)
3. Ordering priority

NOTE: 1. Printer matrix cannot be used to route reports to STAR Patient Care printers.

2. Printer matrix cannot be used to set up default printers.

3. Printer matrix only routes collection labels ordered through STAR Patient Care when the printer matrix option is activated for the department. Orders entered through STAR Laboratory can be routed using printer matrix when printer matrix is activated for collection labels under the labels flags.

REPORT TYPE (1-C-R)
Select the report type to be routed using this worksheet.

TEST CODE RANGE (U-N-O)
A low and high test code range can be used to route the report type. Reports (of the type specified) for tests falling within this range will be routed to the specified printer (unless other parameters are defined). Enter a low and high test code range if desired.

PATIENT LOCATION (TABLE LOOKUP - O)
This field specifies the Patient Location(s) to be used in determining where the selected report/label prints. Use this field if the documents from a specific Patient Location(s) need to be routed to a defined printer. When you access this field, the Patient Location table displays.

The Patient Location used in the evaluation is the patient's current location. Make a selection from the Patient Location table to enter the option number of the desired location. You can specify multiple locations, depending on what other criteria you have defined for this option.

NOTE: If the Patient Location of the report/label printing has no influence on this printer selection, leave the field blank.

PATIENT TYPE (TABLE LOOKUP - O)
This field specifies the Patient Type(s) to be used in determining where the selected report/label prints. Use this field if all reports/labels for a specific Patient Type(s) need to be routed to a defined printer.

The patient type used in the evaluation defines the patient's current Patient Type. You may choose multiple types, depending on what other criteria have been defined for this option.

NOTE: If the Patient Type of the report/label printing has no influence on the printer selection, leave the field blank.

PATIENT AGE (TABLE LOOKUP - O)
This field specifies the Patient Age range to be used in determining where the selected report/label prints. Use this field if all reports/labels for a specific Patient Age range need to be routed to a defined printer, such as all pediatric reports/labels print to the printer in the pediatric clinic.

NOTE: The values displayed by the table are defined in the Printer Matrix Parameter Table Data processor. You are required to build the table through the Printer Matrix Parameters Table Data option prior to it displaying in Matrix Selections table.

NOTE: If the patient age of the report/label printing has no influence on the printer selection, leave the field blank.

PRIORITY (1-N-O)
This field specifies the ordering priority to be used in determining where the selected report/label prints. Use this field if all reports/labels with a specific priority need to be routed to a defined printer.

REPORT STATUS (TABLE LOOKUP - O)
This field specifies the Report Status to be used in determining where the selected report/label prints. Use this field if all reports/labels with a specific Report Status need to be routed to a defined printer.

NOTE: If the Report Status of the report/label printing has no influence on the printer selection, leave the field blank.

DAY OF WEEK (TABLE LOOKUP - O)
This field specifies the days of the week to be used in determining where the selected report/label prints. Use this field if all reports/labels printed on a specific day or range of days need to be routed to a defined printer. For example, if the Outpatient department does not have weekend coverage, you can direct all reports/labels to the ER printer on those days.

NOTE: If the day of the week the report/label is printed on has no baring on this printer selection, leave the field blank.

TIME OF DAY (TABLE LOOKUP - O)
This field specifies the time of day range to be used in determining where the selected report/label prints. Use this field if all reports printed within a specific time range need to be routed to a defined printer. This could be useful if all reports from the Urology clinic need to be printed to the Emergency room printer between the hours of 5pm to 8am.

NOTE: The table values displaying are defined using the Printer Matrix Parameter Table Data processor. You must build the table through the Printer Matrix Parameters Table Data option prior to it displaying in this processor.

NOTE: If the time of day the report/label prints has no baring on this printer selection, leave the field blank.

ASSIGNED PRINTER - PORT NUMBER (U-AN-O)
Enter the printer name and port number to which this report will be directed. If no printer is assigned, the default printer for the selected report type will be used to print the report.

STAT ALARM (1-A-O)
If an audible alarm sounds each time this particular report is generated on the printer specified, enter **Yes**. The alarm is commonly used for STAT collection labels. This feature is supported only on selected printers.

PRINTER MATRIX PARAMETER TABLE DATA

The Printer Matrix Parameter Table Data processor enables you to view the existing table data for the printer matrix parameters. It also provides you the flexibility to build the tables for the Patient Age and Time of Day parameters, using values that best fit your document printing needs. Your custom tables displays when you access the parameter criteria fields for your printer matrix.

PATIENT AGE RANGE
Reports/labels can be sent through Printer Matrix to different printers based on a patient age range. The age range is defined using this processor.

CODE (3-AN-R)
This field contains the 3 digit code which identifies the patient age range to be entered. This code displays along with the description as a table selection when defining matrix entries through Printer Matrix Maintenance.

DESCRIPTION (30-C-R)
This field contains the description of the patient age range to be entered. This code displays along with the description as a table selection when defining matrix entries through Printer Matrix Maintenance.

START (3-N-R)
This field contains the starting age for the age range. This field combined with the Stop field defines the age range.

STOP (3-N-R)
This field contains the stopping age for the age range. This field combined with the Start field defines the age range. Starting age must be younger than stopping age.

TIME OF DAY RANGE
Reports/labels can be sent through Printer Matrix to different printers based on a time of day range. The time of day range is defined using this processor.

CODE (3-AN-R)
This field contains the 3 digit code which identifies the time of day range to be entered. This code displays along with the description as a table selection when defining matrix entries through Printer Matrix Maintenance.

DESCRIPTION (30-C-R)
This field contains the description of the time of day range to be entered. This code displays along with the description as a table selection when defining matrix entries through Printer Matrix Maintenance.

START (TIME-R)
This field contains the starting time for the time of day range. This field combined with the Stop field defines the time of day range.

STOP (TIME-R)
This field contains the stopping time for the time of day range. This field combined with the Start field defines the time of day range.

SPOOLER REPORT DEFINITION

The Spooler - Report Definition worksheet is used to assign report types and printing parameters to a report group.

CODE (3-A-R)
Enter the three-character alphabetic code of the report group. Report groups are provided with the base system.

NOTE: The report group code LBN is only created when the Outpatient Charge Documentation enhancement is implemented.

Report group codes/descriptions include:

Code	Description	Code	Description
LAL	Accession Label	LGR	General Reports
LBN	Advanced Beneficiary Notice of Noncoverage (ABN)	LHT	Histotech Process Labels
LAR	Archive Patient Listing	LHR	Histotech Process Reports
LBA	Bar Code Accession Label	LIN	Interface Printers
LBM	Bar Code Adv Micro Label	LDN	Laboratory Download Reports
LBB	Bar Code Specimen Rejection Labels	LNP	Laboratory Network Printer
LBC	Bar Code Collection Labels	LSP	Long Report
LBF	CMS Advanced Beneficiary Notice	LMR	Micro Reports
LBG	Bar Code General Labels	LMM	Micro Work-up Labels

Code	Description	Code	Description
LBH	Bar Code Histotech Labels	LMI	Microbiology Internal Log
LBI	Bar Code Instrument Labels	LPR	Primary Report
LBO	Bar Code Sendout Labels	LRC	Recall Reminder Letters
LBE	Bar Code Spooler Errors Report	LRM	Remote Print Summary Reports
LSL	Call STAT Labels	LRE	Remote Printing Errors
LCN	Census Reports	LSO	Sendout Labels
LCI	Client Report	LBS	Specimen Rejection Labels
LCL	Collection Labels	LSR	Summary Reports
LCU	Cams Report	LTR	Travel List Report
LRP	Draft Long Report		

DESCRIPTION (30-AN-R)
Enter the name of the report group (up to 30 characters).

ACTIVE (1-A-O)
To use this report group, this field must be set to Active.

PRINT TYPE (1-A-O)
A report group can be printed immediately after accepting the results (that is, report generation is automatic), on demand by the user or at a designated time only. Respond to this parameter by checking either Immediate, Demand or Time. Currently, the system only recognizes the Immediate print type.

RETENTION PERIOD (2-N-O)
Enter the number of days this report type will be retained on the system after it is generated. Although the system can retain reports for up to 30 days, a retention period of one to two days is recommended to conserve disk space.

RESTART METHOD (1-C-O)
Printing is sometimes interrupted after initiation. Should this happen, indicate how printing will be restarted: on demand (check Demand), after the last page prior to the interruption (check Last Page), or a complete reprint starting with page 1 (check Reprint).

REPRINT SECURITY (2-N-O)
Enter the security level (from 0 to 80) required to demand report print/reprint.

REPORT TYPE CODE (3-A-O)
Each Report Group must have at least one report type assigned to it. The reports type code must match the group code exactly. For example, under the LCL group, there must be at least one report type which is also coded as LCL. The report type code is a three-character alpha code used to distinguish a defined report by its printer destination for some groups (accession labels, primary reports). Codes can reflect section codes. For example, the various destinations for accession labels may be specified by CHEF (Chem Accession labels), CPR (Central Processing Accession labels) and HEM (Hematology Accession labels). In these cases, the report type code must match the related section code exactly.

REPORT TYPE DESCRIPTION (U-A-O)
Enter the name of the report type by describing either where it will print or the use of the report. For example, Chemistry Accession labels, Central Processing Accession labels and Hematology Accession labels.

Following is a list of the report types (by group) which must be defined on the system:

GROUP: LAL - Accession Labels*
Type Code(s):   Assign a section code for each section to print accession
                  labels, as well as a default type code ("LAL").
Type Desc(s):   <Section Name> Accession Labels

GROUP: LBN - Advanced Beneficiary Notice of Noncoverage
Type Code: LBN
Type Desc: Advanced Beneficiary Notice of Noncoverage (ABN)

GROUP: LBF - CMS Advanced Beneficiary Notice of Noncoverage (ABN)
Type Code: LBF
Type Desc: ABN for CMS form

GROUP: LAR - Archive Patient Listing
Type Code: LAR
Type Desc: Archive Patient Listing

GROUP: LBS - Specimen Rejection Labels
Type Code: LBS
Type Desc: Specimen Rejection Labels

GROUP:	LCI - Client Report (Contract Billing)
Type Code:	LCI
Type Desc:	General Client Report
GROUP:	LAL - Accession Label*
Type Code(s):	Accession Labels can be assigned section codes if they are to be printed in individual sections.
Type Desc(s):	"Section" Accession Labels
GROUP:	LCI - Client Report (Contract Billing)
Type Code:	LCI
Type Desc:	Client Report
Type Code:	LCW
Type Desc:	Gen Client Report (wide)
GROUP:	LCL - Collection Labels*
Type Code:	LCL
Type Desc:	General Collection Label
GROUP:	LCN - Census Reports
Type Code:	LCN
Type Desc:	Census Report
GROUP:	LCU - Cums Report
Type Code:	LCU
Type Desc:	Single Cums
GROUP:	LDN - Laboratory Download Reports
Type Code:	LDN
Type Desc:	Downloaded Reports
GROUP:	LGR - General Reports
Type Code:	LGR
Type Desc:	General Reports
Type Code:	LGW
Type Desc:	General Reports (wide)
Type Code:	SPT
Type Desc:	Anatomic Path Reports
GROUP:	LHR - Histotech Process Report
Type Code:	LHR
Type Desc:	Histotech Process Report
GROUP:	LHT - Histotech Process Labels
Type Code:	LHT
Type Desc:	General Histotech Labels

GROUP: LIN - Interface Printers
Type Code: LIN
Type Desc: Error Printer

* Indicates report types that do not have to be defined if barcoding is in use.

GROUP: LMI - Microbiology
Type Code: LMI
Type Desc: Microbiology Internal Log

Type Code: LMW
Type Desc: Microbiology Wide Reports

Type Code: LMR
Type Desc: Microbiology Reports

GROUP: LMM - Micro Work-up Labels
Type Code: LMM
Type Desc: Microbiology Labels

GROUP: LNP - Laboratory Network Printer
Type Code: LNP
Type Desc: Laboratory Network Printer

GROUP: LPR - Primary Report
Type Code(s):   Primary Reports can be assigned section codes the same as
                 accession labels (see above) if audit copies by section are desired
Type Desc(s):   "Section" Primary Report

GROUP: LRP - Draft Long Report
Type Code: LRP
Type Desc: Draft Long Report

GROUP: LSL - Call STAT Labels*
Type Code: LSL
Type Desc: Call STAT Labels

GROUP: LSO - Sendout Labels
Type Code: LSO
Type Desc: General Sendout Labels

GROUP: LSP - Long Reports
Type Code: LSP
Type Desc: Long Report

GROUP: LSR - Summary Reports
Type Code: LSR
Type Desc: Summary Reports

GROUP: LTR - Travel List Report
Type Code: LTR
Type Desc: Travel List ReporT

* Indicates report types that do not have to be defined if barcoding is in use.

If you are using bar code versions of labels, the following report types must also be defined:

GROUP: LBA - Bar Code Accession Labels
Type Code: Assign a section code for each section to print accession labels, as well as a default type code ("LAL").
Type Desc: <Section Name> Accession Labels

GROUP: LBM
Type Code: LBM
Type Desc: Adv Micro BC Labels

GROUP: LBB - Bar Code Specimen Rejection Labels
Type Code: LBB
Type Desc: Specimen Rejection BC Labels

GROUP: LBC - Bar Code Collection Labels
Type Code: LBC
Type Desc: Collection BC Labels

GROUP: LBG - Bar Code General Labels
Type Code: LBG
Type Desc: General BC Labels

GROUP: LBH - Bar Code Histotech Labels
Type Code: LBH
Type Desc: Histotech BC Labels

GROUP: LBI - Bar Code Instrument Labels
Type Code: LBI
Type Desc: Instrument BC Labels

GROUP: LBO - Bar Code Sendout Labels
Type Code: LBO
Type Desc: Sendout BC Labels

GROUP: LBE - Bar Code Spooler Labels
Type Code: LBE
Type Desc: Bar Code Spooler Error Printer

SPOOLER PRINTER DEFINITION

The Spooler controls report and label generation on STAR Laboratory by routing formatted data to specific printers. Data is also stored for reprinting and multiple-copy printing through the Spooler utility.

The Spooler - Printer Definition worksheet is used to define the default and at least one alternate system printer for each report type (established on the Spooler - Report Definition worksheet).

CODE (3-A-O)
Enter the three-character code of the report group to which the report type belongs.

DESCRIPTION (U-A-O)
Enter the name of the report group (to which the report type belongs).

REPORT TYPE (U-A-O)
Enter the description of the report type to have default and alternate printers assigned.

DEFAULT TYPE/PORT/LOCATION (U-AN-O)
Enter the name/port number/location of the default printer for this report type.

ALTERNATE TYPE/PORT/LOCATION (U-AN-O)
On separate lines, enter the name/port number/location of the alternate printers for this report type.

NOTE: A list of system printers/port #s/locations can be obtained through the System Manager's Functions.

Chapter 11 - Patient Reports

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INTRODUCTION

The worksheets described in this chapter are used to define the parameters and files necessary for STAR Laboratory Patient reports.

REPORTING OF LABORATORY CANCELLED AND REJECTED TESTS

STAR Laboratory offers flexibility in reporting of laboratory cancelled tests and specimen rejected tests. You can use all reports to notify the clinicians of a laboratory cancelled test or a rejected test. Because each laboratory has different needs for reporting laboratory cancelled and rejected tests, STAR Laboratory enables each laboratory to use different patient reports for reporting mechanisms.

The following table represents some potential ways that reports can be set up. X indicates that the cancellations will be included on the report. The cancellations could be all laboratory-generated cancellations or all accession laboratory- generated cancellations. Rejection notices will print on all reports. Use this table as a guide for deciding how you will report laboratory cancelled tests.

REPORT	SCENARIO I	SCENARIO II	SCENARIO III	SCENARIO IV
Primary (Say Yes to Print Primary at cancellation or rejection)	X*			X*
Outpatient Summary	X	X	X	X
Interim Summary			X	X
Physician Summary	X	X	X	X
Contract Patient Report	X	X	X	X
Discharge Summary/ Discharge Cumulative Trend Report	X	X	X	X
Post-Discharge Summary	X	X	X	X
New Work Summary	X	X	X	X
Cumulative Trend Report		X		X

Scenario IV is the strictest interpretation of the CLIA '88 regulation that stipulates the test report must include all laboratory cancelled tests and specimen rejected tests.

* These primary reports will print at the nursing station printer on STAR Patient Care.

When the *Print Primary?* prompt in the cancellation or rejection process is answered yes, STAR Laboratory prints the primary in the laboratory according to the setting of the flag to send results back to STAR Patient Care:

Results To STAR Patient Care Flag Setting	Cancellation or Rejection Primary To STAR Patient Care?
No Results	No
Stats/ASAPS/Force Print Only	Yes
All results	Yes

For more information on setting this flag, refer to Chapter 1: Flags/Utilities in the *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide.*

HORIZONTAL CUM TREND REPORTS

STAR Laboratory provides mechanisms for reporting patient's test results in cumulative fashion. These "Cumulative Trend Reports" are ideal for a patient whose complicated hospital course warrants a chronological summary of selected laboratory results.

Two types of Cumulative Trend Summaries are available. Vertical Cum Trend Reports arrange test names horizontally across the page and list test results vertically down the page in date order. Horizontal Cum Trend Reports arrange the test names vertically down the page and print results by date horizontally across the page.

The laboratory decides which type of Cumulative Trend Summary Report will be used for patient reporting, if either. Once this decision is made, certain parameters must be set for the selected type of report. The worksheets which follow separate these parameters according to Horizontal Cum Trend Reports.

Report Parameters

Careful consideration must be made in completing the Horizontal Cum Trend Flags worksheet since these parameters determine how the report will appear and what information will be included.

I/P ACCUMULATION (1-C-R)
If Cum Trend Reports are **not** to be accumulated online for inpatients, check "NO Online Accumulation."

If Cum Trend Reports are to accumulate **all** inpatients in each batch, check "Online Accumulation of All Patients."

If Cum Trend Reports are to accumulate **only** for patients selectively added to the batch, check "Online Accumulation of Added Patients Only."

O/P ACCUMULATION (1-C-R)
If Cum Trend Reports are **not** to be accumulated online for outpatients, check "NO Online Accumulation."

Does the laboratory wish to accumulate selected outpatient types in each batch? If so, check "Online Accumulation of All Selected Patient Types."

NOTE: Select from previously established outpatient types and insert into Location Print Order. Outpatient in bed patient types that are to print cums need to be defined here.

If Cum Trend Reports are to accumulate ONLY for patients who have been selectively added to the batch, check "Online Accumulation of Added Patients Only."

DIVIDING CHAR (1-C-R)
Indicate the punctuation character (non-alphabetic and non-numeric) which will be used to divide groups of information such as columns. The usual choice is a vertical bar (|); however, a space may also be used.

CORRECTION LOGIC (1-C-R)
Indicate whether corrected results will be flagged and previous results printed in the corrected comment section of the report by checking one of these options:

- Do NOT flag corrected results
- Flag with C and print previous result in the comment
- Flag with C and do NOT print previous result

SORTING LOGIC (1-C-R)
Indicate how test results should be sorted by checking either Collection Time or Accession Time.

I/P CUM RETENTION (1-C-R)
Indicate the method of cum data retention by checking one of the following:

1. Upon Discharge

NOTE: Select this option if Discharge Cums are activated and you want the Discharge Cum to print on the day of discharge, or if Discharge Cums are not activated and you want to delete the patient from the batch at the time of the discharge transaction.

2. Delete Cum information (upon discharge) and upon completion of all work after printing

3. Delete Cum information "X" number of days after discharge (and after printing)

NOTE: If option 2 or 3 is selected, include "DIS" in the Location Print Order.

I/P RETENTION DAYS (1-C-R)
If option 3 is selected for the previous field, enter the number of retention days to hold the cum trend data after the patient is discharged before deleting it from the batch.

STATUS FOR STORAGE (1-C-R)
Indicate the test results to accumulate by checking one of the following:

1   Store ALL tests in Batch
2   Store Partials which have been force printed and completed tests
3   Store Only Completed Tests

ACCN PRINT ORDER (1-C-R)
To print test results with the oldest work listed first followed by accessions in ascending order, check Chronological.

To print test results with the newest work listed first followed by accessions in descending order, check Reverse Chronological.

NON-DEFAULT SPECIMEN (1-C-R)
If non-default specimen types should print in Primary Report Format at the end of the profile, check Yes.

If non-default specimen types should print **within** the profile, that is without distinguishing them from defaults, check No.

PRIMARY GROUPING (1-A-R)
Indicate how to group Primary Report Format Cums by entering **T** for test code or S for specimen type.

PRINT WIDTH (DISPLAY ONLY)
This will be 80 characters.

RESULT COLUMNS (DISPLAY ONLY)
There can be 5 columns.

REPORT DURATION (1-C-R)
Report Duration is the method of determining when work is dropped from one cum report and another cum started. Check one of the following options:

- Use Cum Trend cut-off Logic (cut-off causes a new cum report to start after "X" number of days)

- Do not Use Cum Trend cut-off Logic

NOTE: Complete the remaining questions only if cut-off logic is used.

DURATION TYPE (1-N-O)
Duration Type is the type of "day" to be used in conjunction with the Report Duration logic selected. Options are Hospital Days and Laboratory Days.

If Cut-off logic is used, check one of the following:

- Laboratory Days (equals the number of days laboratory work is actually resulted)

- Hospital Days (equals the number of days since the patient was admitted (each patient has his own cut-off date)

DURATION DAYS (1-N-0)
Enter the number of days to be used in conjunction with cut-off logic. The maximum is 30 days.

DURATION DISCHARGE (1-C-R)
If cut-off or revolving logic is used, the option exists for printing the Entire Cum Report at discharge. This field determines whether or not to print all laboratory work performed during the entire length of stay at discharge. Check **Y** to print the entire length of stay. The entire cum report for the patient will print before it is deleted. Refer to the following note.

Check **N** to not print the entire length of stay. The last cum printed follows the original logic scheme.

NOTE: Deletion depends on the Retention method and days indicated. Remember, if *Delete Upon Discharge* was selected as the Retention method, there is no final cum printing.

DISCHARGE CUMS (1-A-O)
Check Y for Yes to accumulate discharge cums as a separate batch. These reports include prior work and an Incomplete Work list. The Incomplete Work List is produced per patient followed by an incomplete listing of all patients at the end of the batch. A separate batch is also created for the accumulation of any post-discharge work (work resulted after the patient's Discharge Cum Trend report is printed). Check N for No to process discharge patients the same as any other patient within the cumulative batch.

NEW WORK INDICATOR (1-C-R)
If new work is **not** to be indicated by a flag on the report, check "New work NOT flagged."

If new work is to be indicated by a flag, check *New work flagged with* and enter the character to be used. An asterisk (*) is recommended.

PRINT TECH ID (1-C-R)
Indicate if the ID code of the last tech entering results be printed on the Cum by checking Yes or No.

INCLUDE CANCELLED (1-A-R)
Use this field to determine whether or not laboratory cancelled tests print on the Cumulative Trend Report in addition to the specimen rejected tests.   If you check Accn Cancelled, only accession cancelled tests print. If you check All, all cancelled tests print. If you check None, no cancelled tests print.

NOTE: If you are printing discharge cums and check Accn Cancelled, the system will print no automatically cancelled tests on the discharge cum. You must check All if you want automatically cancelled tests on the report.

DIRECTOR'S NAME (45-C-R)
Enter the laboratory director's name. This name prints on the Cum Trend report and can include a title, such as *John W. Smith, M.D.*

Profile Definition

Profile Definition is used to define the profile name and number, number of columns to include and the components to assign to each column. Tests can be automatically mapped (for the department selected) using the information on this worksheet also.

NOTE: Do not attempt to complete these worksheets until all edits to the component files are complete.

PROFILE NUMBER (3-N-R)
Enter a unique code number (up to 3 digits) for each profile. This number does not determine the print order of profiles.

PROFILE NAME (80-C-R)
Enter a name (up to 80 characters) which defines the contents of the profile. The name can only include the following punctuation characters: / - ( ) * or a space. The name cannot include the following: vertical bar (|), or semicolon (;). The profile name prints at the heading of the profile.

COMPONENT NO/SUBHEADER (13-C-R)
Enter the component number and name as it should appear in the column header. On a particular row, you may want to divide components using a subheader. Enter the text for the subheader. The limit is 13 characters.

Unless otherwise specified, the default normal values, units and short name for the component will be used by the system. The following component fields can be edited during the build:

- COMPONENT NAME
  Unless otherwise specified, the short name for the component will be used by the system.

- NORMALS
  Unless otherwise specified, the default normal values for the component will be used by the system. Age/sex-related normals CANNOT be edited. These will be used as specified within the component file and inserted according to the age/sex of the patient. Non-age/ sex-related normals can be edited. Ranges are limited to ten characters. Textual normals can be up to 21 characters.

- UNITS
  Unless otherwise specified, the default units for the component will be used by the system.

AP ALL, SELECT, OR NONE
If all tests containing this component are to be automatically mapped to this profile, check ALL. If no tests are to be mapped, check **None**. If selected tests are to be mapped, enter those test codes.

Test Mapping to Profile

The Test Mapping worksheet is used to indicate those tests which are not automatically mapped within the Profile Definition worksheet.

TEST CODE/NAME (U-C-R)
For each component to be mapped, indicate the test code and name.

COMPONENT NUMBER/NAME (U-C-R)
Enter the component name/number to be mapped from this test.

O/F COM (1-C-0)
If overflow comments should print at the bottom of the profile, enter a check in this column.

REF LAB (1-C-O)
If the name of the reference laboratory should print on the profile, enter a check in this column.

PROFILE #/ROW # (U-N-R)
Enter the profile number and row number in which this result will print (must be a previously defined profile code and name.)

NOTE: Components can be mapped to more than one profile.

Profile Print Order

The Profile Print Order worksheet is used to arrange profiles in the print order within the cumulative trend report. You can arrange profiles in any order. You can also sort them by section by defining a header and listing the profiles to print after that header. These headings will print at the top right portion of each profile. This feature is optional.

Starting at the top left column, enter either the profile number or header description for the first profile to print. Proceed down this column listing the profiles/headers in the desired print order. Once this column is completed, begin at the top of the next column.

Primary Result Report Format

For those tests which do not lend themselves to a profile format, it is possible to produce Primary Result Report images on a Cum Trend Report. To do so, these tests must be routed to follow a particular profile.

Using the Primary Result Report Format worksheet, enter the following information for each test code to be routed using the Primary format:

- Test code
- Test name
- Profile number or header name it will follow

Location Print Order

The Location Print Order worksheet is used to specify the order in which reports will print within the batch of Cum Trend Reports. Only the location prefixes (not individual rooms) need to be indicated.

FACILITY (1-A-O)
Enter the facility code for these locations/patient types.

Using the numbered list provided, indicate the inpatient locations by the nursing station code. Indicate outpatient print order by the appropriate patient type.

Prior Work Definition

Work performed prior to admission as an Inpatient can be included on a Cum report. Use this worksheet to indicate how (if any) prior work is to be determined for inclusion in Cum reports. This definition is also used for Discharge Cums.

DAYS PRIOR TO ADM (3-N-O)
Enter the number of days prior to admission to include the patient's work in the Cum Trend batch. The default is 2 days. For example, if laboratory work performed on an Emergency Room patient up to 5 days prior to admission is to be included on the Cum for that patient, enter **5**.

If no prior accounts are desired, enter **0**. If 0 is entered, the remainder of this worksheet does not apply.

PRINT PRIOR WORK (1-C-O)
If prior work should print when the patient is admitted (as opposed to waiting until inpatient work is resulted), check Yes. If prior work is not to print until work as an Inpatient is resulted, check No.

NOTE: This field is not applicable for Discharge Cums. Prior work prints when the Discharge Cum prints.

PATIENT TYPES (U-C-O)
Enter the patient types for which prior work should print on the Inpatient Cum and Discharge Cum reports.

New Work Report Parameters

The option of printing a summary of all work resulted since the last batch printing of Cum Trend reports is available for both horizontal and vertical cums. Use the New Work Report Parameters worksheet to define the parameters if this report is to be activated.

CUMULATIVE TREND REPORT TYPE
Check either Vertical or Horizontal.

ACTIVE (1-A-R)
Enter **Y** to print New Work Summary Reports. Enter **N** or press ENTER to prevent printing of New Work Summary Reports.

REPORT NAME (30-C-R)
Enter the report name up to 30 characters. The default is *New Work Summary*.

NO. REPORTS (1-N-R)
Enter the number of reports to print batch. The default is one. Extra copies print at the end of the batch.

EXCLUSIONS (SPECIAL FORMAT - O)
Define a range of test codes to be excluded from Outpatient Summary Reports.

SECTION SORTS (SPECIAL FORMAT - O)
An additional screen displays once you access this field. For more information refer to Section Sorts Field in Chapter 12: Patient Reports in the *Maintenance Functions Volume II* of the *STAR Laboratory Reference Guide*.

FORMAT (1-A-R)
Indicate the report print format by checking either Standard, Zonal or Offset.

The standard format is available for all summary reports and prints test data in primary result report format. This is the default format for reports. For more information on this format refer to Chapter 8: Patient Reports in the *General Applications Volume I* of the *STAR Laboratory Reference Guide*.

The zonal format represents numeric result values graphically by marking their location within or outside of the reference range (the "normal" range of results). Low, normal and high ranges display as three columns on the report. Each value is represented by an X within the appropriate column. These graphic columns print on the same line and to the right of the numeric value and the reference range.

The offset format prints numeric result values in one of two columns of the report depending on whether or not the value falls within the normal range.

You must use forms for the header and footer of this report.

COLUMN SEPARATOR (1-A-R)
If you are using the zonal or offset format for the New Work Summary reports, a vertical bar can be used to separate columns of results. To use the vertical bar, enter **Y**. To exclude the vertical bar, enter **N**.

CORRECTION PRINT (1-A-R)
Corrected values can be printed following the current value or at the end of all test information. Check Current Value to print the corrected value following the current value(s) or Test to print the corrected value following the test.

NOTE: Complete the Summary Reports - Section Sorts worksheet if section sorts are to be used.

ADDENDUM PRINT (1-A-R)
Use this field to determine how the addendum is to print on this report. Check Addendum Result Values Only to print only addendum result values on the New Work Report. Check All Result Values to print all of the result values on the New Work Report.

INCLUDE CANCELLED (1-A-R)
Use this field to determine whether or not laboratory cancelled tests print on the New Work Report in addition to the specimen rejected tests. If you check Accn Cancelled, only accession cancelled tests print. If you check All, all cancelled tests print. If you check None, no cancelled tests print.

Post-Discharge Report Parameters

Post-Discharge Work reports contain work resulted after an inpatient has been discharged and is no longer in the Inpatient Discharge Cum Trend batch (the Discharge Cum Trend report has been printed). Using the Post-Discharge Work Report Parameters worksheet, complete the following fields for your facility (fill out a separate worksheet per facility).

REPORT TYPE (1-A-R)
Indicate that you are specifying Post-Discharge Work parameters for a horizontal report.

PARTIALS (1-A-O)
Indicate if tests with a Partial status should be included in all Post-Discharge Work reports by checking Yes or No.

FORMAT (1-A-R)
Indicate the print format for this report as either Standard, Zonal, or Offset.

The standard format is available for all summary reports and prints test data in primary result report format. This is the default format for reports. For more information on this format refer to the *General Applications Volume* of the *STAR Laboratory Reference Guide*.

The zonal format represents numeric result values graphically by marking their location within or outside of the reference range (the normal range of results). Low, normal and high ranges display as three columns on the report. Each value is represented by an X within the appropriate column. These graphic columns print on the same line and to the right of the numeric value and the reference range.

The offset format prints numeric result values in one of two columns of the report depending on whether or not the value falls within the normal range.

COLUMN SEPARATOR (1-A-R)
For zonal or offset formats, a vertical bar can be used to separate columns of results. Check Yes to use the vertical bar or No to exclude it.

CORRECTION PRINT (1-A-R)
Corrected values can be printed following the current value or at the end of all test information. Check Current Value to print the corrected value following the current value(s) or Test to print the corrected value following the test.

NOTE: Complete the Summary Reports - Section Sorts worksheet if section sorts are to be used.

ADDENDUM PRINT (1-A-R)
Use this field to determine how the addendum is to print on this report. Check Addendum Result Values Only to print only addendum result values on the New Work Report. Check All Result Values to print all of the result values on the New Work Report.

INCLUDE CANCELLED (1-A-R)
Use this field to determine whether or not laboratory cancelled tests print on the New Work Report in addition to the specimen rejected tests. If you check Accn Cancelled, only accession cancelled tests print. If you check All, all cancelled tests print. If you check None, no cancelled tests print.

VERTICAL CUM TREND REPORTS

STAR Laboratory provides mechanisms for reporting patient's test results in cumulative fashion. These "Cumulative Trend Reports" are ideal for a patient whose complicated hospital course warrants a chronological summary of selected laboratory results.

Two types of Cumulative Trend Summaries are available. Vertical Cum Trend Reports arrange test names horizontally across the page and list test results vertically down the page in date order. Horizontal Cum Trend Reports arrange the test names vertically down the report and print results by date horizontally across the page.

The laboratory decides which type of Cumulative Trend Summary Report will be used for patient reporting, if either. Once this decision has been made, certain parameters must be set for the selected type of report. The worksheets which follow separate these parameters according to Vertical Cumulative Trend Reports.

Report Parameters

Careful consideration must be made in completing the Vertical Cum Trend Flags worksheet since these parameters determine how the report will appear and what information will be included.

NOTE: Once set, these flags should not be changed.

I/P ACCUMULATION (1-C-R)
If Cum Trend Reports are NOT to be accumulated online for inpatients, check "NO Online Accumulation."

If Cum Trend Reports ARE to accumulate **all** inpatients in each batch, check "Online Accumulation of All Patients."

If Cum Trend Reports are to accumulate **only** for patients who have been selectively added to the batch, check "Online Accumulation of Added Patients Only."

O/P ACCUMULATION (1-C-R)
If Cum Trend Reports are NOT to be accumulated online for outpatients, check "NO Online Accumulation."

Does the laboratory wish to accumulate selected out patient types in each batch? If so, check "Online Accumulation of All Selected Patient Types."

NOTE: Select from previously established outpatient types and insert into Location Print Order.

If Cum Trend Reports are to accumulate **only** for patients who have been selectively added to the batch, check "On-Line Accumulation of Added Patients Only."

DIVIDING CHAR (1-C-R)
Indicate the punctuation character (non-alphabetic or non-numeric) to be used to divide groups of information such as columns. The usual choice is a vertical bar (|); however, a space can also be used.

CORRECTION LOGIC (1-C-R)
Indicate whether corrected results will be flagged and previous results printed in the specific comment section by selecting one of these options:

1   Do NOT flag corrected results
2   Flag with C and print previous result in the comment section
3   Flag with C and do NOT print previous result.

COLLECT/ACCESSION (1-C-R)
Indicate how test results should be sorted by checking either Collection Time or Accession Time.

I/P CUM RETENTION (1-C-R)
Indicate the method of cum data retention by checking one of the following options:

1. Upon Discharge

NOTE: Select this option if Discharge Cums are activated and you want the Discharge Cum to print on the day of discharge, or if Discharge Cums are not activated and you want to delete the patient from the batch at the time of the discharge transaction.
2. Complete = Delete Cum data upon completion of all work after printing.

3. N Days = Delete Cum data X number of days after discharge (and after printing).

NOTE: If option 3 is selected, enter the number of retention days. If option 2 or 3 is selected and Discharge Cums are not activated, be sure to include DIS in the Location Print Order for a Cum Trend report on discharged patients.

I/P RETENTION DAYS (1-C-R)
If option 3 is selected for the previous field, enter the number of retention days to hold the cum trend data after the patient is discharged before deleting it from the batch.

STATUS FOR STORAGE (1-C-R)
Indicate which test results are to accumulate by checking one of the following:

1   Store ALL tests in Batch
2   Store Partials which have been force printed and completed tests
3   Store Only Completed Tests

ACCN PRINT ORDER (1-C-R)
If test results should print with the oldest work listed first followed by accessions in ascending order, check Chronological. If test results should print with the newest work listed first followed by accessions in descending order, check Reverse Chronological.

HEADER LINES (1-N-R)
Indicate the number of header lines by entering either 3 or 4.

NOTE: This decision is made ONCE and will be the same for ALL profiles. The number of header lines cannot vary per facility.

3 lines:	Results	4 lines:	Results
	Units		Units
	Normals		Low Normal
			High Normal

REPORT DURATION (1-C-R)
Indicate the method of determining what work is included on one cum report versus when another cum is started. Check one of the following options:

- Print entire cum trend every time. This prints the all the work on a patient every time the patient prints within the batch.

- Use Cum Trend cut-off logic. Cut-off logic causes a new cum report to be started after N number of days. After N days are reached, the last Cum to print prior to initiation of a new report, "DO NOT DISCARD" prints on each page.

- Use Cum Trend revolving logic. Revolving logic causes the report to include work for only a set number of days. Once this number is reached, work for one day is dropped and another day is added. This method causes work to overlap from one report to the next.

NOTE: Revolving logic requires much more processing time and system overhead than cut-off. If Revolving is selected, the smaller the number of days used as the indicator, the more efficient the processing time.

Complete the remaining questions only if cut-off or revolving logic is used.

DURATION TYPE (2-N-O)
Indicate the type of "day" to use in conjunction with the Report Duration logic selected. The options are Hospital Days, Laboratory Days, or Calendar Days.

When cut-off logic is used, select from the following options:

1. Hospital Days equals the number of days since the patient was admitted (each patient has his own cut-off day).
2. Laboratory Days equals the number of days laboratory work is actually resulted. This is the default.
3. Calendar Days are actual dates entered as a starting date and the number of duration days; therefore, all patients have the same cut-off date. For example, if last Sunday's date is entered and the duration days equal 7, all patients will be cut-off every 7 days on a Sunday.

If revolving logic is used:

1. Hospital and Calendar Days are equivalent when used with Revolving logic, that is, the patient's admission date does not affect the duration days. Hospital/ Calendar refers to the last N days appearing on the report.
2. Laboratory Days equals the number of days laboratory work is actually resulted.

CALENDAR DATE (2-N-O)

NOTE: Complete this information only if Calendar Days was selected.

Enter the starting date for cut-off. For example, 11/16/93.

DURATION DAYS (2-N-O)
Enter the number of days to be used in conjunction with the cut-off and revolving logic. It is recommended that a 14 or less be used.

DURATION DISCHARGE (1-C-R)
If cut-off or revolving logic is used, the option exists for printing the Entire Cum Report at discharge. This field determines whether or not to print all laboratory work performed during the entire length of stay at discharge. Check **Y** to print the entire length of stay. The entire cum report for the patient will print before it is deleted. Refer to the following note.

Check **N** to not print the entire length of stay. The last cum printed follows the original logic scheme.

NOTE: Deletion depends on the Retention method and days indicated. Remember, if Delete Upon Discharge was selected as the Retention method, there is no final cum printing.

DISCHARGE CUMS (1-C-R)
Indicate the printing of discharge cums by checking yes or no.

DIRECTOR'S NAME (45-C-R)
Enter the laboratory director's name. This name prints on the Cum Trend report and can include a title, such as *John W. Smith, M.D*.

INCLUDE CANCELLED (1-A-R)
Use this field to determine whether or not laboratory cancelled tests print on the Cumulative Trend Report in addition to the specimen rejected tests. If you check Accn Cancelled, only accession cancelled tests print. If you check All, all cancelled tests print. If you check None, no cancelled tests print.

NOTE: If you are printing discharge cums and check Accn Cancelled, the system will print no automatically cancelled tests on the discharge cum. You must check All if you want automatically cancelled tests on the report.

Profile Definition

NOTE: Do not attempt to complete these worksheets until all edits to the component files are complete.

Profile Definition allows design of the profile header, definition of number of columns to include and assignment of a component to each column. Tests can be automatically mapped using information on this worksheet also.

To facilitate the design, 8 different worksheet examples are included. Each example presents a different number of columns. Select the worksheet which represents the desired number of columns.

PROFILE NUMBER (3-N-R)
Enter a unique code number (up to 3 digits) for each profile. This number does **not** determine the print order of profiles.

PROFILE NAME (80-C-R)
Enter a name (up to 80 characters) which defines the contents of the profile. (The name cannot include any of the following punctuation characters: colon(:), vertical bar(|) or semicolon(;). The profile name will print at the heading of the profile.

NUMBER OF COLUMNS (1-C-R)
Up to 8 columns can be included on each Vertical Cum Trend Profile.

Use the worksheet example which represents the desired number of columns or use the undivided worksheet and refer to the table at the bottom to determine line placement. Enter a vertical line on the worksheet at the appropriate column(s) to separate the component areas. This will aid in determining if an edit to the component's short name is necessary. Column headers are printed on the worksheet for reference. Note that the maximum number of columns is 8 and that a vertical line is always placed in columns 14 and 80.

COLUMN CHART

# of Columns	Width per Column	Column Lines
8	7	14,22,30,38,46,54,62,70,80
7	8	14,23,32,41,50,59,68,80
6	9	14,24,34,44,54,64,80
5	11	14,296,38,50,62,80
4	14	14,29,44,59,80
3	20	14,35,56,80
2	31	14,46,80
1	65	14,80

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HEADING FORMAT (12-C-O)
Although the number of header lines has already been established (and is the same for all profiles), the actual name of each header line can be different from one profile to the next. The meaning cannot be changed. Only the spelling of the header line can be changed at this point. For example, High Normal could be changed to Therap. Rng.

If the default format is to be used, put a check mark at either the 3 line format or the 4 line format. If a different spelling is desired, enter the new spelling using the blank line across from the appropriate header.

NOTE: Normally, you would not want to rename header lines. However, if you do, the limit is 12 characters per header line.

PROFILE DEFINITION
For each column, enter the following information:

COMPONENT NUMBER/NAME
Enter the component number and name as it should appear in the column header. Unless otherwise specified, the default normal values, units and short name for the component will be used by the system. The following component fields can be edited during the build:

- COMPONENT NAME
  Unless otherwise specified, the short name for the component will be used by the system.

- NORMALS
  Unless otherwise specified, the default normal values for the component will be used by the system. Age/sex-related normals cannot be edited. These will be used as specified within the component file and inserted according to the age/sex of the patient. Non-age/ sex-related normals can be edited. Ranges are limited to ten characters. Textual normals can be up to 21 characters.

- UNITS
  Unless otherwise specified, the default units for the component will be used by the system.

TEST MAPPING INFORMATION
If all tests containing this component are to be automatically mapped to this profile, check All. If no tests are to be mapped, check None. If only selected tests are to be mapped, enter those test codes here.

Test Mapping to Profile

The Test Mapping worksheet is used to indicate those tests which were **not** automatically mapped within the Profile Definition worksheet.

TEST CODE/NAME (U-C-R)
For each component to be mapped, indicate the test code and name.

COMPONENT NUMBER/NAME (U-C-R)
Enter the component name/number to be mapped from this test.

O/F COM (1-C-0)
If overflow comments should print at the bottom of the profile, enter a check in this column.

REF LAB (1-C-O)
If the name of the reference laboratory should print on the profile, enter a check in this column.

PROFILE #/COLUMN # (U-N-R)
Enter the profile number and column number in which this result will print (must be a previously defined profile code and name.)

NOTE: Components can be mapped to more than one profile.

If you want to map one of the result components to appear as a comment in the General comment section of the Cumulative Trend Report, enter the profile number followed by a slash (*/*) and the word *COMMENT.*

You cannot map a component that uses word processing to a column. You can map other components of the test in trend fashion and map the word processing components results to print in the General Comment area of the profile.

Profile Print Order

The Profile Print Order worksheet is used to arrange profiles in the print order within the cumulative trend report. You can arrange profiles in any order. You can also sort them by section by defining a header and listing the profiles to print after that header. These headings can print at the top right portion of each profile. This feature is optional.

Starting at the top left column, enter either the profile number or header description for the first profile to print. Proceed down this column listing the profiles/headers in the desired print order. Once this column is completed, begin at the top of the next column.

Primary Result Report Format

For those tests which do not lend themselves to a profile format, it is possible to produce Primary Result Report images on a Cum Trend Report. To do so, these tests must be routed to follow a particular profile.

Using the Primary Result Report Format worksheet, enter the following information for each test code to be routed using the Primary format:

- Test code
- Test name
- Profile number or header name it will follow

Location Print Order

The Location Print Order worksheet is used to specify the order by location in which reports will print within the batch of Cum Trend Reports. Only the location prefixes (not individual rooms) need to be indicated.

Using the numbered list provided, indicate the inpatient locations by the nursing station code. Indicate outpatient print order by the appropriate patient type.

NOTE: Refer to the Report Parameters worksheet in Appendix B: Worksheets in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide* for the outpatient locations to be inserted.

Prior Work Definition

Work performed prior to admission as an Inpatient can be included on a Cum Report. Use this worksheet to indicate how (if any) prior work is to be determined for inclusion in both the regular Cum Trend and the Discharge Cum Trend reports.

DAYS PRIOR TO ADM (3-N-O)
Enter the number of days prior to admission to include the patient's work in the Cum Trend batch. The default is 2 days. For example, if laboratory work performed on an Emergency Room patient up to 5 days prior to admission is to be included on the Cum for that patient, enter **5**.

If no prior accounts are desired, enter **0**. If 0 is entered, the remainder of this worksheet does not apply.

PRINT PRIOR WORK (1-C-O)
If prior work should print when the patient is admitted (as opposed to waiting until inpatient work is resulted), check Yes.

If prior work is not to print until work as an Inpatient is resulted, check No.

NOTE: This field is not applicable for Discharge Cums. Prior work prints when the Discharge Cum prints.

PATIENT TYPES (U-C-O)
Enter the patient types from which to pull prior work into the Inpatient Cum Reports.

Multiple Print Groups

Multiple batches of Cum Trend Reports can be compiled and printed on different printers. These batches can be for the same or different facilities. The Define Multiple Print Groups worksheet is used to group the locations previously defined Location Print Order into multiple subsets called Print Groups. These groups can then be used to print or reprint a batch of Cum Trend Reports.

PRINT GROUP DESCRIPTION (10-C-R)
Enter a description up to ten characters.

LOCATIONS/PATIENT TYPES (WORKSHEET)
Referencing the Cumulative Trend Reports/Summary Reports - Location Print Order worksheet, list the locations/patient types for each print group.

New Work Report Parameters

The option of printing a summary of all work resulted since the last batch printing of Cum Trend reports is available for both horizontal and vertical cums. Use the New Work Report Parameters worksheet to defined the parameters if this report is to be activated.

CUMULATIVE TREND REPORT TYPE
Check either Vertical or Horizontal.

ACTIVE (1-A-R)
Enter **Y** to print New Work Summary Reports. Enter **N** or press ENTER to prevent printing of New Work Summary Reports.

REPORT NAME (30-C-R)
Enter the report name up to 30 characters. The default is *New Work Summary*.

NO. REPORTS (1-N-R)
Enter the number of reports to print batch. The default is one. Extra copies print at the end of the batch.

EXCLUSIONS (SPECIAL FORMAT - O)
Define a range of test codes to be excluded from Outpatient Summary Reports.

SECTION SORTS (SPECIAL FORMAT - O)
An additional screen displays once you access this field. For more information refer to Section Sorts Field in Chapter 12: Patient Reports in the *Maintenance Functions Volume II* of the *STAR Laboratory Reference Guide*.

FORMAT (1-A-R)
Indicate the print format for this report by checking either Standard, Zonal or Offset. The standard format is available for all five summary reports and prints test data in primary result report format. This is the default format for reports. For more information on this format refer to Chapter 8: Patient Reports in the *General Applications Volume II* of the *STAR Laboratory Reference Guide*.

The zonal format represents numeric result values graphically by marking their location within or outside of the reference range (the normal range of results). Low, normal and high ranges display as three columns on the report. Each value is represented by an X within the appropriate column. These graphic columns print on the same line and to the right of the numeric value and the reference range.

The offset format prints numeric result values in one of two columns of the report depending on whether or not the value falls within the normal range.

You must use forms for the headers and footers of this report.

COLUMN SEPARATOR (1-A-R)
If you are using the zonal or offset format for the New Work Summary reports, a vertical bar can be used to separate columns of results. To use the vertical bar, enter **Y**. To exclude the vertical bar, enter **N**.

CORRECTION PRINT (1-A-R)
Corrected values can be printed following the current value or at the end of all test information. Check Current Value to print the corrected value following the current value(s) or Test to print the corrected value following the test.

NOTE: Complete the Summary Reports - Section Sorts worksheet if section sorts are to be used.

INCLUDE CANCELLED (1-A-R)
Use this field to determine whether or not laboratory cancelled tests print on the Cumulative Trend Report in addition to the specimen rejected tests. If you check Accn Cancelled, only accession cancelled tests print. If you check All, all cancelled tests print. If you check None, no cancelled tests print.

NOTE: If you are printing discharge cums and check Accn Cancelled, the system will print no automatically cancelled tests on the discharge cum. You must check All if you want automatically cancelled tests on the report.

Post-Discharge Work Parameters

Post-Discharge Work reports contain work resulted after an inpatient has been discharged and is no longer in the Inpatient Discharge Cum Trend batch (the Discharge Cum Trend report has been printed). Using the Post-Discharge Work Report Parameters worksheet, complete the following fields for your facility (fill out a separate worksheet per facility).

REPORT TYPE (1-A-R)
Indicate that you are specifying Post-Discharge Work parameters for a vertical report.

PARTIALS (1-A-O)
Indicate if tests with a Partial status should be included in all Post-Discharge Work reports by checking Yes or No.

FORMAT (1-A-R)
Indicate the print format for this report as either Standard, Zonal or Offset.

The standard format is available for all five summary reports and prints test data in primary result report format. This is the default format for reports. For more information on this format refer to Chapter 8: Patient Reports in the *General Applications Volume I* of the *STAR Laboratory Reference Guide*.

The zonal format represents numeric result values graphically by marking their location within or outside of the reference range (the normal range of results). Low, normal and high ranges display as three columns on the report. Each value is represented by an X within the appropriate column. These graphic columns print on the same line and to the right of the numeric value and the reference range.

The offset format prints numeric result values in one of two columns of the report depending on whether or not the value falls within the normal range.

COLUMN SEPARATOR (1-A-R)
For zonal or offset formats, a vertical bar can be used to separate columns of results. Check Yes to use the vertical bar or No to exclude it.

CORRECTION PRINT (1-A-R)
Corrected values can be printed following the current value or at the end of all test information. Check Current Value to print the corrected value following the current value(s) or Test to print the corrected value following the test.

NOTE: Complete the Summary Reports - Section Sorts worksheet if section sorts are to be used.

INCLUDE CANCELLED (1-A-R)
Use this field to determine whether or not laboratory cancelled tests print on the Post-Discharge Work Report in addition to the specimen rejected tests. If you check Accn Cancelled, only accession cancelled tests print. If you check All, all cancelled tests print. If you check None, no cancelled tests print.

FAX PARAMETERS

Use the Fax Parameters worksheet to define and activate the immediate fax function parameters.

NOTE: The Fax Module must be defined for the CPU prior to building these parameters. Your McKesson representative can let you know if this is done.

MAIN PATIENT INQUIRY (1-A-R)
Enter **Y** to allow faxes of primary reports from main patient inquiries; enter **N** to deny faxes from main patient inquiries. The default is **N**.

FREE-TEXT ENTRY (1-A-R)
Enter **Y** to allow free-text entry of fax phone number; enter **N** to deny entry of free-text fax phone number. The default is **N**.

SECTION (DISPLAY ONLY)
This field displays a list of sections for the department.

The following individual fields display in the scrolling section of the screen for each section:

PATIENT INQUIRY (1-A-R)
Enter **Y** to allow faxes of primary report; enter **N** to deny faxes of duplicate primary reports for this section of Patient Inquiry.

RESULT REPORTING (1-A-R)
Enter **Y** to allow faxes of duplicate primary report; enter **N** to deny faxes of duplicate primary reports from this section.

PANIC REPORT (1-A-R)
Enter **Y** to allow faxes of Panic reports; enter **N** to deny faxes of Panic reports from this section.

LONG REPORT (1-A-R)
Enter **Y** to allow faxes of Long reports; enter **N** to deny faxes of Long reports from this section.

NOTE: The long report uses the Archive Summary headers and footers for this report.

LONG REPORT PARAMETERS BY SECTION

AP Section

An Anatomic Pathology type section is one that has case number management or histotech processing associated with the section or that has an Anatomic Pathology type test within the section range.

LONG REPORT (1-A-R)
Indicate whether the Long Report is to be used in Anatomic Path. Check Yes to activate Long Reports. Check No to inactivate Long Reports.

HOSPITAL/PATIENT FORM (1-A-R)
Use this field to print or suppress printing of hospital information and patient demographic information. Four options are available: Print/Print, Print/Suppress, Suppress/Print, and Suppress/Suppress.

CORRECTION PRINT (1-A-R)
Corrected values can be printed following the current value or at the end of all test information. Check Current Value to print the corrected value following the current value(s) or Test to print the corrected value following the test.

NOTE: Complete the Summary Reports - Section Sorts worksheet if section sorts are to be used.

ADDENDUM PRINT (1-A-R)
Use this field to determine how the addendum is to print on this report. Check Addendum Result Values Only to print only addendum result values on the New Work Report. Check All Result Values to print all of the result values on the New Work Report.

NUMBER OF PREPRINTED LINES (2-N-O)
Enter the number of lines to be skipped before the body of the report begins printing.

BATCHES ACTIVE FOR REPRINT (2-N-R)
Enter a number between 1-50 to retain up to 50 batches for reprinting. If you enter zero, N/A displays in this field and the batch print function is inactive for this section.

PRINT SPECIMEN ON REPORTS (1-A-R)
Check the appropriate field to indicate which specimens (if any) you want to print on the report. You can print histotech and/or login specimens. You can also choose to print no specimens.

PRINT THE NUMBER OF BLOCKS ON REPORTS (1-A-R)
Indicate whether the number of blocks should print on primaries and on Anatomic Path Long reports by checking either Yes or No.

PRINT SNOMED DIAGNOSTIC CODES (1-A-R)
Check No to prevent the codes from printing. Check Yes to print the SNOMED codes defined/assigned to the accession at the end of the report in the following format:

Diagnostic Code: T-10000,M-20000,150.3

NOTE: SNOMED CT Codes always print both code and description.

Non-AP Section

LONG REPORT (1-A-R)
Indicate whether the Long Report is to be used in Anatomic Path. Check Yes to activate Long Reports. Check No to inactivate Long Reports.

HOSPITAL/PATIENT FORM (1-A-R)
Use this field to print or suppress printing of hospital information and patient demographic information. Four options are available: Print/Print, Print/Suppress, Suppress/Print, and Suppress/Suppress.

CORRECTION PRINT (1-A-R)
Corrected values can be printed following the current value or at the end of all test information. Check Current Value to print the corrected value following the current value(s) or Test to print the corrected value following the test.

NOTE: Complete the Summary Reports - Section Sorts worksheet if section sorts are to be used.

ADDENDUM PRINT (1-A-R)
Use this field to determine how the addendum is to print on this report. Check Addendum Result Values Only to print only addendum result values on the New Work Report. Check All Result Values to print all of the result values on the New Work Report.

NUMBER OF PREPRINTED LINES (2-N-O)
Enter the number of lines to be skipped before the body of the report begins printing.

BATCHES ACTIVE FOR REPRINT (2-N-R)
Enter a number between 1-50 to retain up to 50 batches for reprinting. If you enter zero, N/A displays in this field and the batch print function is inactive for this section.

SUMMARY REPORTS DEFINITION

The types of Summary Reports include:

- Outpatient Summary Reports
- Interim Summary Reports
- Discharge Summary Reports
- Post-Discharge Reports
- Patient Detail Reports
- Physician Summary Report

Outpatient Summary reports are printed for all outpatients who have had results entered since the last Outpatient Summary report printing. These reports may include all or selected locations/outpatient types. Result format can be standard, zonal or offset format.

Interim Summary reports contain all inpatient laboratory work resulted since the last printing for the location. These reports can be printed for all or selected inpatient locations. Result format can be standard, zonal or offset format.

A Discharge Summary report is printed for each discharged inpatient who has had no laboratory activity for a user-defined number of days. This report consist of all work on the patient for the entire visit. It can also include prior work and an incomplete work list at the end of the patient's work and at the end of the batch. Tests are printed in standard, zonal or offset format and contain audit information legally required for medical records.

Post-Discharge Work reports contain work resulted on discharge inpatients who are not in the Discharge Summary batch. Tests are printed in standard, offset or zonal format and contain audit information legally required for medical records.

A Patient Detail Report contains work for a specific date range, an account, an accession, or the entire unit number for a specific patient.

A Physician Summary Report provides an additional method of delivering copies of patient reports for physicians through batch report printing and through facsimiles.

Section Sort

The Section Sort order specifies the order in which tests will print within each report.

SUMMARY REPORT TYPE (1-A-R)
Check the type of report used with this worksheet.

- Outpatient Summary
- Interim Summary
- Patient Detail
- Contract Patient

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- New Work Summary
- Physician Summary

NOTE: For further information on completing worksheets for the Contract Billing Summary Report, please refer to the *Contract Billing Module* of the *STAR Laboratory Reference Guide*.

NEW PAGE (1-A-R)
Enter **Yes** to begin a new page with this section. Enter **No** to continue with the current page. If you select No, the next section's results print on the same page.

SECTION NAME (40-AN-R)
Enter the section name as it is to display on the summary report. You can enter up to 40 characters in upper/lower case.

SORT ORDER (1-N-R)
Indicate how to sort tests within this section by entering one of the following option numbers:

(1) Specimen Type
(2) Test Order
(3) Chronological Order - oldest accession first
(4) Reverse Chronological Order - most recent accession first

Multiple sorts can be used; however, options 3 and 4 cannot be used together.

TEST RANGE(S) (U-C-R)
Define the test code range(s) for this section by entering the lower code, hyphen, higher code.

NOTE: Multiple low/high ranges can be specified. Use subsequent lines if necessary.

Outpatient Report Parameters

Outpatient Summary Reports contain all patient test values resulted since the last printing. Using the Outpatient Report Parameters worksheet, complete the following fields for your facility (fill out a separate worksheet per facility).

LOC PRINT ORDER (U-AN-R)
The Location Print Order field allows you to define the print order for Outpatient Summary reports. Refer to the Nursing Station Codes worksheet and the Account Number Group Assignment worksheet to list the patient types (regular outpatients and outpatient in bed types) and locations to define the Location Print Order.

EXCLUSIONS (SPECIAL FORMAT-O)
You can define a range of test codes to be excluded from Outpatient Summary Reports. For a range of exclusions, enter the low and high test codes separated by a hyphen. To exclude an individual test, enter the test code.

CONTRACT VENDOR (TABLE LOOKUP)
Use this field to define specific patient types for specific contract vendors to print as part of the contract patient reports. Indicate the contract(s) to be included.

LOC PRINT ORDER (U-AN-R)
The Location Print Order field allows you to define the print order for Outpatient Summary reports. Refer to the Nursing Station Codes worksheet and the Account Number Group Assignment worksheet to list the patient types (regular outpatients and outpatient in bed types) and locations to define the Location Print Order.

FORMAT (1-A-R)
Indicate the print format for this report by checking either Standard, Zonal or Offset.

The standard format is available for all summary reports and prints test data in primary result report format. This is the default format for reports. For more information on this format refer to Chapter 8: Patient Reports in the *General Applications Volume I* of the *STAR Laboratory Reference Guide*.

The zonal format represents numeric result values graphically by marking their location within or outside of the reference range (the normal range of results). Low, normal and high ranges display as three columns on the report. Each value is represented by an X within the appropriate column. These graphic columns print on the same line and to the right of the numeric value and the reference range.

The offset format prints numeric result values in one of two columns of the report depending on whether or not the value falls within the normal range.

If you select the zonal or offset format, you must use forms for the header and footer of this report. If you select the zonal format, the first line of a Normal Range field over 17 characters long is printed on two lines on the report. However, if the result value is greater than the space provided on the report (12 characters), no Normal Range field prints on the report.

PARTIALS (1-A-O)
Indicate if tests with a Partial status should be included in all Outpatient Batch Summary Reports by checking Yes or No.

COLUMN SEPARATOR (1-A-R)
If you are using the zonal or offset format, a vertical bar can be used to separate columns of results. To use the vertical bar, check Yes. To exclude the vertical bar, check No.

CORRECTION PRINT (1-A-R)
Corrected values can be printed following the current value or at the end of all test information. Check Current Value to print the corrected value following the current value(s) or Test to print the corrected value following the test.

NOTE: Complete the Summary Reports - Section Sorts worksheet if section sorts are to be used.

FORMS FLAG - HOSPITAL/PATIENT (1-A-O)
If pre-printed forms are to be used, check Yes to suppress printing of the hospital header. Check No for the header to print on Summary Reports. Check Yes to suppress printing of the patient demographic header, No to print the patient demographic header. This field is not applicable if you are using forms for the header and footer.

ADDENDUM PRINT (1-A-R)
Use this field to determine how the addendum is to print on this report. Check Addendum Result Values Only to print only addendum result values on the New Work Report. Check All Result Values to print all of the result values on the New Work Report.

INCLUDE CANCELLED (1-A-R)
Use this field to determine whether or not laboratory cancelled tests print on the Outpatient Report in addition to the specimen rejected tests. If you check Accn Cancelled, only accession cancelled tests print. If you check All, all cancelled tests print. If you check None, no cancelled tests print.

Interim Report Parameters

Interim Summary Reports include all laboratory data resulted on a patient since the last printing of Summary reports. These reports can be generated on inpatients several times daily and provide interim information prior to Cum reporting. Using the Interim Report Parameters worksheet, complete the following fields for your facility (fill out a separate worksheet per facility).

LOC PRINT ORDER (U-AN-R)
The Location Print Order field allows you to define the print order for Interim Summary reports. Refer to the Nursing Station Codes worksheet and the Account Number Group Assignment worksheet to list the patient types (regular outpatients and outpatient in bed types) and locations to define the Location Print Order.

EXCLUSIONS (SPECIAL FORMAT-O)
You can define a range of test codes to be excluded from Interim Summary Reports. For a range of exclusions, enter the low and high test codes separated by a hyphen. To exclude an individual test, enter the test code.

FORMAT (1-A-R)
Indicate the print format for this report by checking either Standard, Zonal or Offset.

The standard format is available for all summary reports and prints test data in primary result report format. This is the default format for reports. For more information on this format refer to Chapter 8: Patient Reports in the *General Applications Volume I* of the *STAR Laboratory Reference Guide*.

The zonal format represents numeric result values graphically by marking their location within or outside of the reference range (the normal range of results). Low, normal and high ranges display as three columns on the report. Each value is represented by an X within the appropriate column. These graphic columns print on the same line and to the right of the numeric value and the reference range.

The offset format prints numeric result values in one of two columns of the report depending on whether or not the value falls within the normal range.

If you select the zonal or offset format, you must use forms for the header and footer of this report. If you select the zonal format, the first line of a Normal Range field over 17 characters long is printed on two lines on the report. However, if the result value is greater than the space provided on the report (12 characters), no Normal Range field prints on the report.

PARTIALS (1-A-O)
Indicate if tests with a Partial status should be included in all Interim Summary Reports by checking Yes or No.

COLUMN SEPARATOR (1-A-R)
If you are using the zonal or offset format, a vertical bar can be used to separate columns of results. To use the vertical bar, check Yes. To exclude the vertical bar, check No.

CORRECTION PRINT (1-A-R)
Corrected values can be printed following the current value or at the end of all test information. Check Current Value to print the corrected value following the current value(s) or Test to print the corrected value following the test.

NOTE: Complete the Summary Reports - Section Sorts worksheet if section sorts are to be used.

FORMS FLAG - HOSPITAL/PATIENT (1-A-O)
If pre-printed forms are to be used, check Yes to suppress printing of the hospital header. Check No for the header to print on Summary Reports. Check Yes to suppress printing of the patient demographic header, No to print the patient demographic header. This field is not applicable if you are using forms for the header and footer.

ADDENDUM PRINT (1-A-R)
Use this field to determine how the addendum is to print on this report. Check Addendum Result Values Only to print only addendum result values on the New Work Report. Check All Result Values to print all of the result values on the New Work Report.

INCLUDE CANCELLED (1-A-R)
Use this field to determine whether or not laboratory cancelled tests print on the Interim Report in addition to the specimen rejected tests. If you check Accn Cancelled, only accession cancelled tests print. If you check All, all cancelled tests print. If you check None, no cancelled tests print.

Discharge Report Parameters

Discharge Summary Reports provide a summary of all laboratory work performed on an inpatient from the time of admission until a set number of inactive days after discharge. Using the Discharge Report Parameters worksheet, complete the following fields for your facility (fill out a separate worksheet per facility).

ACCUMULATION (1-A-O)

This field determines how patients and work are accumulated for the Discharge Summary report. Enter **A** to accumulate all inpatients and all post-discharge work. Enter **P** to accumulate only the post-discharge work (work resulted after the patient has been assigned a status of DIS). Accumulation of post-discharge work is only necessary when Discharge Cums and Discharge Summaries are not activated since the post-discharge work accumulates automatically when these two reports are activated. Enter **N** to prevent any accumulation of patients.

DAYS OF INACTIVITY BEFORE DISCHARGE SUMMARY (2-N-O)

Unless otherwise specified, Inpatient Discharge Summary Reports will automatically print for all discharged patients who have had no laboratory activity in the last 7 days. If another number of days is desired, indicate that number here. The number can be from 0 to 99. It is recommended that this number not exceed 14 days. If **0** is entered, the report prints on the day of discharge.

PRIOR WORK PATIENT TYPES (U-A-O)

This field specifies that you want prior work for specific patient types on the Discharge Summary report. Enter the patient type codes.

DAYS PRIOR TO ADMISSION (3-N-O)

This field specifies the number of days prior to admission for work to be included for the patient types specified in the Prior Work Patient Types field. McKesson recommends you enter no more than 14 days in this field. The maximum is 365.

EXCLUSIONS (SPECIAL FORMAT - O)

Define a range of test codes to be excluded from Outpatient Summary Reports.

SECTION SORTS (SPECIAL FORMAT - O)

An additional screen displays once you access this field. For more information refer to Section Sorts Field in Chapter 12: Patient Reports in the *Maintenance Functions Volume II* of the *STAR Laboratory Reference Guide.*

FORMAT (1-A-R)

Indicate the print format by checking standard, zonal or offset. The standard format is available for all summary reports and prints test data in primary result report format. This is the default format for reports. For more information on this format refer to Chapter 8: Patient Reports in the *General Applications Volume I* of the *STAR Laboratory Reference Guide.*

The zonal format represents numeric result values graphically by marking their location within or outside of the reference range (the normal range of results). Low, normal and high ranges display as three columns on the report. Each value is represented by an X within the appropriate column. These graphic columns print on the same line and to the right of the numeric value and the reference range.

The offset format prints numeric result values in one of two columns of the report depending on whether or not the value falls within the normal range.

If you select the zonal or offset format, you must use forms for the header and footer of this report. If you select the zonal format, the first line of a Normal Range field over 17 characters long is printed on two lines on the report. However, if the result value is greater than the space provided on the report (12 characters), no Normal Range field prints on the report.

PARTIALS (1-A-O)
Indicate if tests with a Partial status should be included in all Discharge Summary Reports by checking Yes or No.

COLUMN SEPARATOR (1-A-R)
If you are using the zonal or offset format, a vertical bar can be used to separate columns of results. To use the vertical bar, check Yes. To exclude the vertical bar, check No.

CORRECTION PRINT (1-A-R)
Corrected values can be printed following the current value or at the end of all test information. Check Current Value to print the corrected value following the current value(s) or Test to print the corrected value following the test.

NOTE: Complete the Summary Reports - Section Sorts worksheet if section sorts are to be used.

INCOMPLETE WORK LIST OPTIONS (U-C-O)
This field enables you to print incomplete work on the Discharge Summary report. To print an incomplete worklist at the end of the Patient Discharge report, check Within Batch. If you want the incomplete worklist to print at the end of the batch, check End of Batch and enter the number of copies. Check Both to use both options can at once.

FORMS FLAG - HOSPITAL/PATIENT (1-A-O)
If pre-printed forms are to be used, check Yes to suppress printing of the hospital header. Check No for the header to print on Summary Reports. Check Yes to suppress printing of the patient demographic header, No to print the patient demographic header. This field is not applicable if you are using forms for the header and footer.

INCLUDE CANCELLED (1-A-R)
Use this field to determine whether or not laboratory cancelled tests print on the
Discharge Report in addition to the specimen rejected tests. If you check Accn
Cancelled, only accession cancelled tests print. If you check All, all cancelled tests
print. If you check None, no cancelled tests print.

Post-Discharge Report Parameters

Post-Discharge Work reports contain work resulted after an inpatient has been
discharged and is no longer in the Inpatient Discharge Cum Trend batch (the
Discharge Cum Trend report has been printed). Using the Post-Discharge Work
Report Parameters worksheet, complete the following fields for your facility (fill out a
separate worksheet per facility).

REPORT TYPE (1-A-R)
Indicate that you are specifying Post-Discharge Work parameters for a summary
report.

PARTIALS (1-A-O)
Indicate if tests with a Partial status should be included in all Post-Discharge Work
reports by checking Yes or No.

EXCLUSIONS (SPECIAL FORMAT - O)
Define a range of test codes to be excluded from Outpatient Summary Reports.

SECTION SORTS (SPECIAL FORMAT - O)
An additional screen displays once you access this field. For more information refer to
Section Sorts Field in Chapter 12: Patient Reports in the *Maintenance Functions
Volume II* of the *STAR Laboratory Reference Guide*.

FORMAT (1-A-R)
Indicate the print format for this report as either Standard, Zonal or Offset.

The standard format is available for all five summary reports and prints test data in
primary result report format. This is the default format for reports. For more
information on this format refer to Chapter 8: Patient Reports in the *General
Applications Volume I* of the *STAR Laboratory Reference Guide*.

The zonal format represents numeric result values graphically by marking their location
within or outside of the reference range (the normal range of results). Low, normal and
high ranges display as three columns on the report. Each value is represented by an
X within the appropriate column. These graphic columns print on the same line and to
the right of the numeric value and the reference range.

The offset format prints numeric result values in one of two columns of the report
depending on whether or not the value falls within the normal range.

If you select the zonal or offset format, you must use forms for the header and footer of this report. If you select the zonal format, the first line of a Normal Range field over 17 characters long is printed on two lines on the report. However, if the result value is greater than the space provided on the report (12 characters), no Normal Range field prints on the report.

COLUMN SEPARATOR (1-A-R)
If you are using the zonal or offset format, a vertical bar can be used to separate columns of results. Check Yes to use the vertical bar or No to exclude it.

CORRECTION PRINT (1-A-R)
Corrected values can be printed following the current value or at the end of all test information. Check Current Value to print the corrected value following the current value(s) or Test to print the corrected value following the test.

NOTE: Complete the Summary Reports - Section Sorts worksheet if section sorts are to be used.

ADDENDUM PRINT (1-A-R)
Use this field to determine how the addendum is to print on this report. Check Addendum Result Values Only to print only addendum result values on the New Work Report. Check All Result Values to print all of the result values on the New Work Report.

INCLUDE CANCELLED (1-A-R)
Use this field to determine whether or not laboratory cancelled tests print on the Discharge Report in addition to the specimen rejected tests. If you check Accn Cancelled, only accession cancelled tests print. If you check All, all cancelled tests print. If you check None, no cancelled tests print.

Patient Detail Report Parameters

Using the Patient Detail Report Parameters worksheet, complete the following fields:

FORMAT (1-A-R)
Indicate the print format by checking standard, zonal or offset. The standard format is available for all summary reports and prints test data in primary result report format. This is the default format for reports. For more information on this format refer to Chapter 8: Patient Reports in the *General Applications Volume I* of the *STAR Laboratory Reference Guide*.

The zonal format represents numeric result values graphically by marking their location within or outside of the reference range (the normal range of results). Low, normal and high ranges display as three columns on the report. Each value is represented by an X within the appropriate column. These graphic columns print on the same line and to the right of the numeric value and the reference range.

The offset format prints numeric result values in one of two columns of the report depending on whether or not the value falls within the normal range.

If you select the zonal or offset format, you must use forms for the header and footer of this report. If you select the zonal format, the first line of a Normal Range field over 17 characters long is printed on two lines on the report. However, if the result value is greater than the space provided on the report (12 characters), no Normal Range field prints on the report.

EXCLUSIONS (SPECIAL FORMAT - O)
Define a range of test codes to be excluded from Outpatient Summary Reports.

SECTION SORTS (SPECIAL FORMAT - O)
An additional screen displays once you access this field. For more information refer to Section Sorts Field in Chapter 12: Patient Reports in the *Maintenance Functions Volume II* of the *STAR Laboratory Reference Guide*.

COLUMN SEPARATOR (1-A-R)
If you are using the zonal or offset format, a vertical bar can be used to separate columns of results. To use the vertical bar, check Yes. To exclude the vertical bar, check No.

CORRECTION PRINT (1-A-R)
Corrected values can be printed following the current value or at the end of all test information. Check Current Value to print the corrected value following the current value(s) or Test to print the corrected value following the test.

NOTE: Complete the Summary Reports - Section Sorts worksheet if section sorts are to be used.

FORMS FLAG - HOSPITAL/PATIENT (1-A-O)
If pre-printed forms are to be used, check Yes to suppress printing of the hospital header. Check No for the header to print on Summary Reports. Check Yes to suppress printing of the patient demographic header. Check No to print the patient demographic header. This field is not applicable if you are using forms for the header and footer.

Physician Summary Reports

Physician Summary Reports are copies of patient reports to be distributed directly to the physician. These reports can be printed in house or faxed to the physician's office. Each physician can be set up to receive an automatic copy of a patient's laboratory results based upon his role in treating the patient. Also, the physician can define to which office the results are sent and the format of the report. All of one physician's patients will print together following the address facesheet.

If a physician does not want to automatically receive copies of patient's work, a patient can be added to the batch of physician summaries for a physician manually. This can be done at accessioning, result reporting, or using the Physician Batch Management function.

Physician Summary Report Parameters

ACTIVE (1-A-R)
Indicate if you want to activate physician summary reports. If you want to activate physician summary reports, check yes. If you do not want to activate physician summary reports, check no.

COPY TO (1-A-R)
You can add copies of patient laboratory results for a physician at accessioning and resulting. If you want to add an accession for a physician, check accessioning. If you want to be able to add a test for a physician, check resulting. Automatic copies will be added at the time of order. Refer to "Physician Parameters" on page 11-41.

FORMAT (1-N-R)
Indicate the print format for this report by checking either Standard, Zonal, or Offset. This format is used for the physicians that do not have parameters defined. That is, for free text physicians or those physicians who have not indicated a preference in format.

The standard format is available for all summary reports and print test data in primary result report format. This is the default format for reports. For more information on this format, refer to Chapter 8: Patient Reports in the *General Applications Volume I* of the *STAR Laboratory Reference Guide.*

The zonal format represents numeric result values graphically by marking their location within or outside of the reference range (the normal range of results). Low, normal, and high ranges display as three columns on the report. Each value is represented by an X within the appropriate column. These graphic columns print on the same line and to the right of the numeric value and the reference range.

The offset format prints numeric result values in one of two columns of the report depending on whether or not the value falls within the normal range.

PARTIALS (1-A-R)
Indicate if tests with a Partial status should be included in all Physician Summary reports by checking Yes or No. This field is used for all physician's reports regardless of the individual preference of the physician.

COLUMN SEPARATOR (1-A-R)
If a physician or the default format for these reports is offset or zonal, a vertical bar can be used to separate columns of results. To use the vertical bar, check Yes. To exclude the vertical bar, check No. This field is used for all physician's reports using offset or zonal regardless of the individual preference of the physician.

ADDENDUM PRINT (1-A-R)
This field determines how addendum results print on the report. The report may contain only the addendum results or all the results.

LONG REPORT (1-A-R)
If you want the long report for Anatomic Pathology results to print at the end of the patients' summary report, check Yes. To exclude long reports from the Physician Summary batch, check No.

O/P MAXIMUM DAYS (2-N-R)
Indicate how many days you want to hold an outpatient report in the batch if there are incomplete tests on the accession prior to printing. Once the maximum days have been exceeded, then the patient report prints regardless of pending work.

This feature is used to reduce the number of reports sent to a physician on one outpatient.

CORRECTION PRINT (1-A-R)
Corrected values can be printed following the current value or at the end of all test information. Check Current Value to print the corrected value following the current value(s) or Test to print the corrected value following the test.

NOTE: Complete the Summary Reports - Section Sorts worksheet if section sorts are to be used.

INCLUDE CANCELLED (1-A-R)
Use this field to determine whether or not laboratory cancelled tests print on the Physician Summary Report in addition to the specimen rejected tests.   If you check Accn Cancelled, only accession cancelled tests print. If you check All, all cancelled tests print. If you check None, no cancelled tests print.

EXCLUSIONS (SPECIAL FORMAT-O)
You can define a range of test codes to be excluded from Physician Summary reports. For a range of exclusions, enter the low and high test codes separated by a hyphen. To exclude an individual test, enter the test code.

Physician Parameters

Each physician defined in the doctor table can have copies of a patient's work print in the physician summary batch. Copies are automatically generated per the role that the physician plays in treating the patient. The copies can be further defined for particular patient types or contract vendors. A physician can have the patient reports include all work on the patient or only the work that the physician ordered.

For each physician, complete one worksheet.

PHYSICIAN CODE (4-AN-R)
Enter the physician code.

PHYSICIAN NAME (25-ANP-R)
Enter the physician's name.

MAIN REPORT LOCATION (3-A-O)
This field contains the default office location used for determining the format and mode of Physicians Summary Reports. This field is only referenced if the office location has not been defined elsewhere for a specific patient report. The default is the physician's primary office location.

NOTE: If the DEFAULT option has been selected, the system automatically displays PRI-DEFAULT in this field and it cannot be edited.

FORMAT (1-A-R)
The format defined here is used for those physicians who have not defined a personal preference. This includes the override physicians. Check Standard, Zonal, or Offset.

AUTO UPDATE (1-A-0)
This field determines if any new patient types were added to the STAR Patient Care type table. These patient types are automatically added to all/any physicians parameters defined for physician summary reports.

If you enter **Y**, the system displays the following prompt:

Inpatients(I), Outpatients(O), Contracts(C), all(A), or none(N)--

If at the prompt ... is entered	then the system displays the following in the field...
I	Inpatients
O	Outpatients
C	Contracts
A	All
IO	Inpatients/Outpatients
IC	Inpatients/Contracts
OC	Outpatients/Contracts

If you enter one of the options listed in the table, new patient types will be added to the physician selected based on that option.

If you enter **N** or press ENTER, No displays in the field and new patient types are not added to the physician selected.

REPORT LOCATION PARAMETERS (SPECIAL PROCESSING - R)
These parameters are used to define the type of report generation per report location. Printing can be set up differently based on the physician's office. If this physician has no offices defined or no data has been entered the system displays *Undefined* in this field. If the DEFAULT option has been selected, the system displays *Defined* in this field.

REPORT LOCATION (SPECIAL PROCESSING - R)
This field defines the physician's office you are entering parameters for report location. If only one office is defined, or second office processing is not active, the primary office is the only office defined. Printing can be set up differently based on the physician's office. Select Report Generation field for the office you wish to define printing.

NOTE: If the DEFAULT option has been selected, the system automatically displays PRI-DEFAULT in this field and it cannot be edited.

REPORT GENERATION (1-A-R)
This field defines the method in which the system generates the patient reports for the physician.

If you enter **P**, the reports for this physician's office location prints to the local Summary Reports printer in the laboratory when you manually generate a batch of Physician Summary Reports using the Print Physician Summary Reports option. The Remote Location field should not be defined.

If you enter **F**, the reports for this physician's office location are faxed when you manually generate a batch of Physician Summary Reports using the Print Physician Summary Reports option.

If you enter **R**, the remote reports print manually either using the Print Remote Physician Summary Reports function or when the batches are automatically compiled based on the times defined in the Remote Printing Parameters processor. The system also requires you to complete the Remote Location field.

NOTE: If the DEFAULT option has been selected, the system automatically displays Local Print in this field and it cannot be edited.

REMOTE LOCATION (TABLE LOOKUP - C)
This field defines the remote location at which the Physician Summary Reports prints for this report location. If the Report Generation field is set to either Local Print or Fax. This field is not necessary. All remote locations must first be built in the remote locations file and be an active location.

If you set the Report Generation field to Remote Print, and do not enter a Remote Location, the data is not filed.

NOTE: If the DEFAULT option has been selected, the system automatically displays N/A in this field and it cannot be edited.

FACILITY SPECIFIC INFORMATION
For each facility that this physician would have patients, fill out the next section.

ATTENDING, CONSULTING, ORDERING, PRIMARY CARE, ADMITTING, REFERRING
For each of the above treatment roles, the following information needs to be defined:

PRINT (1-A-R)
Include all work on the patient report for this role by checking A. To include only the work ordered by this physician, check O.

PATIENT TYPES (SPECIAL PROCESSING-R)
Per treatment role, the physician can have all patient types, selected patient types or no patient types print reports. Check A for all patient types, Check N for no patient types patient reports accumulate. List the selected patient types if only certain patient types should be included in the batch for the physician with this treatment role.

CONTRACT VENDORS (SPECIAL PROCESSING-R)
Per treatment role, the physician can have all contract vendors, selected contract vendors, or no contract vendors patient reports accumulate. Check A for all contract vendors. Check N for no contract vendors. List the selected contract vendors if only certain vendors should be included in the batch for the physician with this treatment role.

Note that if you set up all outpatient types to accumulate for all physicians with the treatment role of Admitting physician, this is the same as generating Outpatient Summary reports sorted by doctor.

Remote Printing Parameters

Remote Printing allows you to print the Physicians Summary Reports via a modem connection to a printer located at the physician/clinic location.

OUTBOUND MODEM PORTS (TABLE LOOKUP - R)
This field is used to define the port numbers for the modems which the system uses for dialing the remote sites. This feature supports multiple outbound modems. When you access the field, the system displays a 2 column table that displays the modem ports on the CPU with the standard multiple option selection prompt. Up to 4 modems are defined for this field. Since the system displays a table of the available modems, all modem ports MUST be defined at the system level prior to defining these parameters or the table that displays does not contain the remote printing modems.

NOTE: If you delete a modem from this field, make sure you remove the modem definition from each remote location that has the modem specifically defined. If you defined your remote locations with All and you delete a modem from this field, the system requires no updating.

MAX # BATCHES (2-N-R)
This field defines the maximum number of remote printing batches maintained on the system. Once the batch number reaches the maximum number, the system recycles the batch number back to 1. You can reprint any batches maintained on the system and/or print a batch index. How many batches you wish to maintain on the system depend on the balance between available disk space and how long you wish to be able to reprint a previously processed batch of remote reports.

You can enter a number from 10 to 99 with a default of 50. To decide how many batches you wish to keep, determine how many days you want to keep a batch on the system. Multiply this number by the number of automatic print times and the number of facilities you are generating batches for. For example, if you print 4 batches a day, have 2 facilities and wish to keep only 5 days of batches, the maximum number of batches is 40.

Once you are live with this feature and you modify this field to a number smaller than what was previously defined, the change is not reflected until the current uncompiled batch is processed. Then, if the batch number is now the maximum, the system assigns the next batch number based on the new maximum. Additionally, all previous batches with a number greater than the new maximum are deleted. If you increase the maximum, the system continues to increment the batch numbers until the maximum is reached.

STATUS/ERROR MSGS (1-A-R)
This field defines the types of messages you want to print on the remote printing error printer or be available in the View Remote Printing Error processor. The two (2) types of messages are:

- status messages
- error messages

Status messages are informational messages as to the stage/phase of the remote printing process. They include batch compilation beginning and ending messages, remote location beginning, and ending messages. Status messages provide information during initial implementation of the Remote Printing feature or when you are troubleshooting problems with your remote locations.

Error messages inform you when the process has failed and requires some intervention on your part. These messages include:

- notifying you when an outbound modem is not working
- when the system cannot establish a connection with the remote location modem
- if the remote location is not active

For more documentation on the status and error messages printed by the system, refer to Remote Printing Processing in Chapter 8: Patient Reports in the *General Applications Volume I* of the *STAR Laboratory Reference Guide*.

RETAIN ERRORS (2-N-R)
This field defines the number of days for which the system retains a record of the remote printing errors. You can view these errors using the View Remote Printing Errors processor. Based on this parameter, midnight processing deletes those messages older than the retention days.

You can enter from 0 to 10 days with a default of 5 days. If you define this field as 0 days, the system does NOT retain any on-line record of the errors. The system prints them on the defined printer. If you enter any number from 1 to 10, the system retains the errors for today plus the number you define. For example, if you define this field as 3 days and today is 9/7/94, the system deletes the error file at midnight on 9/10/94.

AUTO PRINT ACTIVE? (1-A-R)
This field defines whether the system automatically processes and prints batches for remote printing.

If you enter **Y**, the system automatically processes the report batches for remote printing when the next automatic print time is reached. If you enter **N**, the system does not process any batches automatically even if times are defined. There is no default for this prompt. This flag is used during testing and implementation of the package in the test and live ID's when you have defined automatic print times but do not wish to activate this feature at that time.

Automatic Report Printing:
Fields 6, 7, and 9 determine which Facility and Lab department level flags the system uses for automatic remote printing. The facility flags used for the reports is the facility name, the Facility Director name, and the method used to flag abnormal values on the report. The department flags used are the copy to active flag, Physician's Summary preprinted forms, Physician Summary Parameters, and the Physician Summary printing specifications. If the Doctor file on your system is facility split, Field 9 is used to determine the facility and department. If the Doctor file is not facility split, Fields 6 and 7 are used in the determination. If no data is entered in any of the fields, the system uses the flags from the first entered Lab department and facility when printing the reports.

DEFAULT DEPARTMENT (SPECIAL PROCESSING - C)
This field determines the Lab department flags to be used, if the Doctor file on your system is not facility split, when automatically printing report reports. If the Doctor's table is facility split, the system automatically enters N/A for Field 6, and you must use Field 9 to define the flags to be used. Field 6 is not editable. If the Doctor file is not facility split and you have only one Lab department defined on your system, when you access the field, the department name is automatically entered. You are not allowed to edit the field. If the Doctor file is not facility split and you have more then one Lab department on your system, you are prompted for data entry.

Enter the department whose flags you wish to use for automatic printing.

DEFAULT FACILITY (SPECIAL PROCESSING - C)
This field determines the facility flags to be used, if the Doctor file on your system is not facility split, when automatically printing report reports. If the Doctor's table is facility split, the system automatically enters N/A for Field 7, and you must use Field 9 to define the flags to be used. Field 7 is not editable. If the Doctor file is not facility split and you have only one facility defined on your system, when you access the field, a facility name is automatically entered. You are not allowed to edit the field. If the Doctor file is not facility split and you have more then one facility on your system, you are prompted for data entry.

Enter the facility whose flags you wish to use for automatic printing. The facility name displays in the field.

AUTOMATIC PRINT TIMES (TABLE LOOKUP - R)
This field defines the times that the system automatically compiles remote printing batches, sequentially dials up the remote location(s), and print the report batch for each location. You can define only times on the hour.

FACILITY & DEPARTMENT
This field defines which Lab department's parameters to be used with each facility when automatically printing remote reports. This field is only used if the Doctor table is facility split, otherwise, use Fields 6 and 7 to assign the information.

> **FACILITY**
> This field contains the table of facilities.

> **DEPARTMENT (TABLE SELECTION - C)**
> This field is used to determine which Lab department flags to use with each facility when automatically printing remote reports.

Enter the department code for the department whose flag setting you wish to be used when automatically printing remote reports for this facility. The department name displays in the field.

Remote Location - Add

This processor is used to define the locations for which Physician Summary Reports are printed remotely. A location is subsequently linked to one or more physicians. When you enter the option for Remote Locations and your system is defined with multiple facilities, the system displays a list of the facilities for selection.

CODE (3-AN-R)
This field contains the three character alphanumeric code for the remote location. This code must be unique and in upper case only.

DESCRIPTION (30-ANP-R)
This field contains the description of the remote location.

If you enter lower case alphabetic characters, the system does not convert them to upper case. In other words, the specific upper/lower case is retained. You are not allowed to enter a duplicate description for a remote location.

The description is used in all remote location table displays.

ADDRESS LINE 1 (25-ANP-O)
This field contains the first line of the address for the remote location and is optional.

This data element is captured for informational purposes only.

ADDRESS LINE 2 (25-ANP-O)
This field contains the second line of the address for the remote location and is optional.

This data element is captured for informational purposes only.

CITY (18-AN-O)
This field contains the city in which the remote location is located and is optional.

This data element is captured for informational purposes only.

STATE (2-A-O)
This field contains the state in which the remote location is located and is optional.

Enter the 2 character state abbreviation code.

This data element is captured for informational purposes only.

ZIP (9-NP-O)
This field contains the zip code for the remote location and is optional.

Enter the 5 or 9 digit ZIP code. This data element is captured for informational purposes only.

PHONE NUMBER (11-NP-R)
This field contains the voice phone number (with area code if necessary) forthe remote location. This field is required.

CONTACT (36-ANP-R)
This field defines the name of the person at the remote location to contact when there is a problem with the transmission of the remote reports. This field is required.

Enter the name of the contact person in appropriate upper lower case.

MODEM PHONE # (15-NP-R)
This field contains the phone number for the remote location modem. This phone number is used by the system to dial up the remote location.

Enter the phone number without any punctuation for example no parentheses around the area code and no hyphens (-). The only punctuation character allowed for input in this field is a comma (,). If the outbound modem is configured in such a way that the system must send a character to access an outside line (such as: 9 or 8) this number must be followed by a comma (,). For example: 9,5554075 or 9,14045554075.

VALID MODEM(S) (TABLE LOOKUP - R)
This field defines the valid outbound modems for this remote location. The processing for this field depends on how you defined Field 1 - Outbound modem Ports of the Remote Printing Parameters processor. Even if a single modem is defined in Remote Printing Parameters, the system always displays the table so you can enter **A** for All. Defining this field as All is beneficial since if you add another outbound modem at a later date, you will not have to edit this field for the remote locations. The system automatically uses all modems for all locations defined as All. If the system must dial a long distance number to reach the remote location and you have decided to have the system dial all long distance remote locations using one or more outbound modems defined with a WATTS line, you could enter only those modems defined with the WATTS line.

If you add another outbound modem to your system and you have selected specific modems for this remote location, you must manually add that new modem to this field. If you have defined this field as All, no further edits are required to allow this remote location to access the new modem.

NOTE: If you delete a modem from the Remote Printing Parameters, you must edit all remote locations defined with this modem (except if defined with All).

COPIES (1-N-O)
Enter a number from 1 to 9, indicating the number of copies to go to the location.

ADD'L LOCATIONS (SCROLLING SCREEN - O)
This field defines additional remote locations and the number of copies to print of the report each time it is sent to the initial remote location. If additional locations are specified, the system displays Defined in this field.

LOCATION ACTIVE? (1-A-R)
This field defines whether or not this remote location is active for remote printing processing. This parameter is used when you are implementing a remote location and do not want remote printing processing until a certain date. It can also be used to de-activate remote printing processing in the case where a remote modem is not working. When a remote location is inactive, the reports are then filed to the standard print Physician Summary Reports.

If you enter **Y**, any report copies for physicians linked to this location are filed in the remote print batch of the Physician Summary Reports. Also, when the system

processes remote printing batches (manually or automatically), if the remote location is active and Field 13 - Auto Print Active is defined, the reports are printed remotely.

If you enter **N**, any report copies for physicians linked to this location will not be filed to the remote printing batch. Instead, they will be filed to print when the next batch of standard Physician Summary Reports are printed. Also, if you define this field as No, the system displays No in Field 13 - Auto Print Active. When the system performs remote printing processing and the remote location is not active, the system prints an error message to the remote printing error printer.

AUTO PRINT ACTIVE? (1-A-C)
This field defines whether or not this remote location is processed by the automatic print process. This parameter is used when you are implementing a new remote location after the Remote Printing package is live and you want the reports to file to the remote printing batch but do not want them to be printed remotely automatically. You might use this parameter in the case where a physician's office is closed on the weekend and you do not want the reports to automatically print. You want the reports to compile, but want to wait until Monday and then reprint the reports for the remote location. This field is active only when you defined Field 11 - Location Active as Yes in which case this field is required. Otherwise you cannot access this field.

If you enter **Y**, when the system prints remote reports automatically, all report copies for physicians linked to this remote location are transmitted to the remote printer. If you enter **N**, when the system processes the batch of remote reports automatically, all report copies for physicians linked to this remote location are compiled, but are not transmitted automatically to the remote printer. You have to either manually reprint them remotely or to a local printer.

LABORATORY FORM DATA ELEMENT REPORT USAGE

Textual Elements

The following textual elements can be applied to any form for any report type. The information includes element name, description, length/truncate and an example. Specific information about the element, if applicable, follows in parentheses.

```
   Element                 Description                  Length/Truncate
                           Example
--------------------------------------------------------------------
   LTXACCN1                Accession field #1            7 / No
                           Accn #:
   LTXACCN2                Accession field #2           13 / No
                           Accession No.
   LTXACCT                 Account Number field          7 / No
                           Acct #:
   LTXAGE                  Age field                     3 / No
                           Age
   LTXATPHY                Attending Physician field    14 / No
                           Attending Phys
   LTXBD                   Birthdate field              10 / No
                           Birthdate:
   LTXBLKS                 Blocks field                  7 / No
                           Blocks:
   LTXCLN                  Colon                         1 / No
                           :
   LTXCOLL1                Collected field #1           10 / No
                           Collected:
   LTXCOLL2                Collected field #2            5 / No
                           Coll:
   LTXCOLL3                Collect Time field           11 / No
                           Coll. Time:
   LTXCOLL4                Collect Period field         12 / No
                           Coll Period:
   LTXCOLL5                Date Collected field         14 / No
                           Date Collected
   LTXCOPTO                Copied To field              10 / No
 (Not Available)     Copied To:
   LTXCSNU                 Case Number field            12 / No
                           Case Number:
```

Element	Description Example	Length/Truncate
LTXDASH	Dash -	1 / No
LTXDIR1	Director field #1 Dir	3 / No
LTXDIR2	Director field #2 Director	8 / No
LTXDR1	Doctor field #1 Doctor:	7 / No
LTXDR2	Doctor field #2 Dr	2 / No
LTXDR3	Doctor field #3 M.D.	4 / No
LTXDSDT1	Discharge Date field #1 Discharge Date:	15 / No
LTXDSDT2	Discharge Date field #2 Discharge:	10 / No
LTXDTRPT	Date Reported field Date Reported	13 / No
LTXHIGH	High field High	4 / No
LTXINAT	In At field In at:	6 / No
LTXLALDS	Line of Alternating Dashes - - - - - -	80 / No
LTXLDASH	Line of Dashes -----------	80 / No
LTXLDSH1	Line of Dashes ------------	36 / No
LTXLEQ1	Line of Equal Signs ==========	80 / No
LTXLFARW	Left Arrows field <<	2 / No
LTXLFBRC	Left Brace field {	1 / No
LTXLOC1	Location field #1 Loc:	4 / No
LTXLOC2	Location field #2 Location	8 / No
LTXLPRD	Line of Periods	80 / No

Element	Description Example	Length/Truncate
LTXLTILD	Line of Tildes ~~~~~~~~~~~	80 / No
LTXLUNDL	Line of Underlines _____	80 / No
LTXNORM1	Normal field #1 Normal	6 / No
LTXNORM2	Normal field #2 Normal Range	12 / No
LTXORPHY	Ordering Physician field Ordering Phys	13 / No
LTXOUT1	Outside field #1 Outside	7 / No
LTXOUT2	Outside field #2 Outside Range	13 / No
LTXOUT3	Outside field #3 Abnormal	8 / No
LTXOUTAT	Out At field Out at:	7 / No
LTXPG1	Page field #1 Page	4 / No
LTXPG2	Page field #2 Page-	5 / No
LTXPG3	Page field #3 Pg	2 / No
LTXPHSV1	Physician-Service field #1 Phys-Service:	13 / No
LTXPHSV2	Physician-Service field #2 Phys-Ser:	9 / No
LTXPRD	Period .	1 / No
LTXPTNM1	Patient Name field #1 Name	4 / No
LTXPTNM2	Patient Name field #2 Patient Name	12 / No
LTXPTNM3	Patient Name field #3 Pat Name	8 / No
LTXPTNU	Patient Number Patient Number	14 / No
LTXREC	Received field Received	8 / No

Element	Description Example	Length/Truncate
LTXRES1	Result field #1 Result	6 / No
LTXRES2	Result field #2 Result Name	11 / No
LTXRNG1	Range field #1 Range	5 / No
LTXRNG2	Range field #2 Reference	9 / No
LTXRNG3	Range field #3 Reference Range	15 / Yes
LTXRTARW	Right Arrows field >>	2 / No
LTXRTBRC	Right Brace field }	1 / No
LTXSERV	Service Srv	3 / No
LTXSEX	Sex field Sex	3 / No
LTXSPC1	Specimen field #1 Spec:	5 / No
LTXSPC2	Specimen field #2 Specimen:	9 / No
LTXSPID1	Specimen ID field #1 Specimen ID #	13 / No
LTXSPID2	Specimen ID field #2 Spec ID #:	10 / No
LTXSRC	Source field Source:	7 / No
LTXSTAR	Star *	1 / No
LTXTECH	Tech field Techs	5 / No
LTXTST1	Test field #1 Test	4 / No
LTXTST2	Test field #2 Test Name:	10 / No
LTXUNAC	Unit/Account field Unit#/Acct#:	12 / No

```
     Element            Description                       Length/Truncate
                        Example
     ------------------------------------------------------------------------
     LTXUNIT            Units field                           5 / No
                        Units
     LTXUNIT1           Unit Number field # 1                 6 / No
                        Unit #
     LTXVTBR            Vertical Bar                          1 / No
                        |
     LTXWITH1           Within field #1                       6 / No
                        Within
     LTXWITH2           Within field #2                       12 / No
                        Within Range
```

Summary Report Data Elements

The following data elements can be applied to summary report forms only. The
information includes element name, description, length/truncate and an example.
Specific information about the element, if applicable, follows in parentheses.

```
     Element            Description                       Length/Truncate
                        Example
     ------------------------------------------------------------------------
     LDACCMT            Accession Comment                    45 / No
                        Accn Comment:   CALL E/R WHEN COMPLETE
     (This prints only if an accession comment exists)
     LDACCN1            Accession Number                      9 / No
                        500032
     LDACCN2            Accession Number                     11 / No
                        [500032]
     LDACCT             Account Number                       16 / Yes
                        E900002501424300
     LDAGE              Age                                   4 / Yes
                        28Y
     LDATPHY            Attending Physician                  25 / Yes
                        SMITH,ANN C
     LDBD               Birthdate                             8 / No
                        09/07/62
     LDBLKS             Blocks                                2 / No
                        3
     LDCOLL1            Collect Date & Time                  13 / Yes
                        12/15/90 0800
```

Element	Description Example	Length/Truncate
LDCOLL2	Collect Date 02/11/91	8 / No
LDCOLL4	Collection Period 12hrs	5 / Yes
LDCRTDT	Current Date & Time Wed Mar 13, 1991 08:52 am	25 / No
LDCSNU	Case Number S91-1234	10 / Yes
LDDIR	Director Alex P. Johnson	25 / Yes
LDDSDT	Discharge Date 04/10/90	8 / No
LDHN	Hospital Name General Hospital	30 / Yes
LDINAT	Accession Date & Time 11/12/90 1506	13 / Yes
LDLOC	Location 2S 2201 2	15 / Yes
LDORPHY	Ordering Physician ALEXANDER,JOHN K.	30 / Yes
LDORPHY1	Ordering Physician KELLY,JOSEPH	30 / Yes

(This only prints if ordering physician is different than attending physician)

Element	Description Example	Length/Truncate
LDOUTAT	Completed Date & Time 01/15/91 1530	13 / Yes
LDPG	Page 5	3 / No
LDPG2	Page (New Work Summary Only) 3	3 / No
LDPTNM	Patient Name Alexander,JR,John E.	30 / Yes
LDRFPHY	Referring Physician ADAMS,JOHN K.	25 / Yes
LDRPTNM	Report Name Single Contract Patient Report	45 / Yes
LDSEX	Sex M	1 / No

```
    Element          Description                    Length/Truncate
                     Example
    ----------------------------------------------------------------
     LDSPC           Specimen                       30 / Yes
                     Blood-Arterial
     LDSRV           Service                         3 / No
                     MED
     LDTECH          Tech                           22 / Yes
                     V1234/T4008
     LDTST1          Test Name                      31 / Yes
                     ELECTROLYTES
     LDTST2          Test Name                      79 / No
                     >> BLOOD CULTURE <<
     LDUNAC          Unit/Account                   30 / Yes
                     H10000204/H1000025421
```

Cumulative Trend Report

The following data element information is grouped by report type. Each section lists the available data elements for that particular report. An asterisk (*) following the header/footer information indicates it is used on the base version of the form.

The information includes data element name, description, length/truncate (Y or N), header/footer indicator and an example. Specific information about the data element, if applicable, follows in parentheses.

```
Element       Description           Length/Truncate   Header/Footer
              Example                                 H=Header F=Footer
----------------------------------------------------------------------
LGRHNM        Hospital Name          80 / Y               H*, F
              GENERAL HOSPITAL
   (The entire line is used with this element - centered)
LGRDAT        Current Date & Time    80 / Y               H*, F
               Mon May 21, 1990 09:26 am
   (The entire line is used with this element - centered)
LCUMFRTO      Cum Header from DT to DT   80 / N           H*
              Cumulative Trend Report from 07/13/90 1431 to 07/19/90 1618
   (The entire line is used with this element - centered)
LPTNMFLD      Patient Name Field     13 / Y               H*, F
              Patient Name:
LGRPTNAD      Patient Name           30 / N               H*, F*
              SMITH,JR,JOHN R
LSECTPAGE     Section-Page Number    25 / N               H*
              Chemistry-Page 1
LMEDRECFLD    Medical Rec Number Field  10 / N            H*, F
              Med Rec #:
LUNITNUM      Unit Number            15 / N               H*, F*
              100023021
LADMFLD       Admission Date Field    4 / N               H*, F
              Adm:
```

```
   Element      Description           Length/Truncate   Header/Footer
     Example                                            H=Header F=Footer
   --------------------------------------------------------------------
   LADMDATE     Admission Date          8  / N              H*, F
                05/21/90
   LLOCFLD      Location Field          9  / N              H*, F
                Location:
   LPTLOC       Patient Location        20 / N              H*, F
                2E 2004 1
   LPHYSVFLD    Physician - Service Field  13 / N           H*, F
                Phys-Service:
   LDOCSERV     Doctor - Service        40 / N              H*, F
                DALLKE,WENDALL E - MEDICAL
   LACCTPREV    Account Number (Prev Inc)  80 / N           H*
                Acct #:        A90000212    Previous Accounts Included
                (The entire line is used with this element)
   LGRSTR        Line of Stars          80 / Y              H*, F
                **********************
                (The entire line is used with this element)
   LGRDIR       Director Name           45 / Y              H , F*
                John W. Alexander, M.D.
   LPATLOC      Patient Location        30 / N              H , F*
                3N 3001 1
                (The Discharge Date will print one space after
                 the location if the patient is discharged)
   LDONOTDIS    Do Not Discard          14 / N                   F*
                DO NOT DISCARD
   LGRSBD       Sex and Birthdate       12 / Y              H , F*
                (M-09/07/62)
   LGRRPTF      Report Name (Footer)    45 / Y                   F*
                Cumulative Trend Report
   LDOCTOR      Attending Doctor        30 / Y              H , F*
                Dr. ALEXANDER,BOB
   LACCTFLD     Account Number Field    7  / N              H , F
                Acct #:
   LACCTNUM     Account Number          15 / N              H , F
                E12345678901234
   LDISDATE     Discharge Date          8  / N              H , F
                10/31/90
   LDISFLD      Discharge Date Field    8  / N              H , F
                Dis Date
   LFOOTNOTE    Micro Footnote          80 / N                   F
                S=Susceptible   M=Moderate   R=Resistant
                (The entire line is used with this element)
   LGRDR        Attending Doctor        20 / N              H , F
                ALEXANDER,BOB
   LGRLOC       Location Field          4  / Y              H , F
                Loc:
   LGRPG        Page Field              5  / Y              H , F
                Page:
```

```
Element       Description            Length/Truncate      Header/Footer
  Example                            H=Header F=Footer
------------------------------------------------------------------------
LGRPTNA       Patient Name Field        9  / N               H , F
  Pat Name:
LGRRPT        Report Name (Header)     80  / Y               H
  Cumulative Trend Report
  (The entire line is used with this element - centered)
LGRUAN        Unit/Acct Number Field   14  / Y               H , F
  Unit #/Acct #:
LPRLINE       Line of Dashes           75  / N               H , F
  ------------------------
  (The entire line is used with this element)
LPRPBD        Patient Birthdate        11  / Y               H , F
  (09/07/1962)
LPRPDT        Current Date & Time      16  / N               H , F
  Oct 31,1990 1500
LSECTPAGEF    Section-Page Number (Footer)25 / N                 F
              Serology-Page 3
```

Discharge Cumulative Trend Report

```
Element       Description            Length/Truncate      Header/Footer
              Example                H=Header F=Footer
------------------------------------------------------------------------
LGRHNM        Hospital Name            80  / Y              H*, F
              GENERAL HOSPITAL
              (The entire line is used with this element - centered)
LGRDAT        Current Date & Time      80  / Y              H*, F
              Mon May 21, 1990 09:26 am
              (The entire line is used with this element - centered)
LCUMFRTO      Cum Header from DT to DT  80  / N             H*
              Discharge Cumulative Trend Report from 07/13/90 1431 to
              07/19/90 1
              (The entire line is used with this element - centered)
LPTNMFLD      Patient Name Field       13  / Y              H*, F
              Patient Name:
LGRPTNAD      Patient Name             30  / N              H*, F*
              SMITH,JR,JOHN R
LSECTPAGE     Section-Page Number      25  / N              H*
              Chemistry-Page 1
LMEDRECFLD    Medical Rec Number Field 10  / N              H*, F
              Med Rec #:
LUNITNUM      Unit Number              15  / N              H*, F*
              100023021
LADMFLD       Admission Date Field      4  / N              H*, F
              Adm:
LADMDATE      Admission Date            8  / N              H*, F
              05/21/90
LDISFLD       Discharge Date Field      8  / N              H*, F
              Dis Date
```

```
    Element          Description             Length/Truncate      Header/Footer
                     Example                                   H=Header F=Footer
    ------------------------------------------------------------------------
    LDISDATE         Discharge Date           8  / N               H*, F
                     10/31/90
    LPHYSVFLD        Physician - Service Field 13 / N              H*, F
                     Phys-Service:
    LDOCSERV         Doctor - Service         40 / N               H*, F
                     DALLKE,WENDALL E - MEDICAL
    LGRSTR           Line of Stars            80 / Y               H*, F
                     **********************
                     (The entire line is used with this element)
    LGRDIR           Director Name            45 / Y               H , F*
                     John W. Alexander, M.D.
    LDONOTDIS        Do Not Discard           14 / N                    F*
                     FINAL PRINT
    LGRSBD           Sex and Birthdate        12 / Y               H , F*
                     (M-09/07/62)
    LGRRPTF          Report Name (Footer)     45 / Y                    F*
                     Discharge Cumulative Trend Report
    LDOCTOR          Attending Doctor         30 / Y               H , F*
                     Dr. ALEXANDER,BOB
    LACCTFLD         Account Number Field      7 / N               H , F
                     Acct #:
    LACCTNUM         Account Number           15 / N               H , F
                     E123456789012345
    LFOOTNOTE        Micro Footnote           80 / N                    F
                     S=Susceptible   M=Moderate   R=Resistant
                     (The entire line is used with this element)
    LGRDR            Attending Doctor         20 / N               H , F
                     ALEXANDER,BOB
    LGRLOC           Location Field            4  / Y              H , F
                     Loc:
    LGRPG            Page Field                5  / Y              H , F
                     Page:
    LGRPTNA          Patient Name Field        9  / N              H , F
                     Pat Name:
    LGRRPT           Report Name (Header)     80 / Y               H
                     Discharge Cumulative Trend Report
                     (The entire line is used with this element - centered)
    LGRUAN           Unit/Acct Number Field   14 / Y              H , F
                     Unit #/Acct #:
    LPATLOC          Patient Location         30 / N               H , F
                     3N 3001 1
                     (The Discharge Date will print one space after
                     the location if the patient is discharged)
    LPRLINE          Line of Dashes           75 / N               H , F
                     -------------------------
                     (The entire line is used with this element)
    LPRPBD           Patient Birthdate        11 / Y               H , F
                     (09/07/1962)
```

Element	Description Example	Length/Truncate	Header/Footer H=Header F=Footer
LPRPDT	Current Date & Time Oct 31,1990 1500	16 / N	H , F
LPTLOC	Patient Location 2E 2004 1	20 / N	H , F
LSECTPAGEF	Section-Page Number (Footer) Serology-Page 3	25 / N	F

New Work Report

Element	Description Example	Length/Truncate	Header/Footer H=Header F=Footer
LGRHNM	Hospital Name GENERAL HOSPITAL (The entire line is used with this element - centered)	80 / Y	H*, F
LGRDAT	Current Date & Time Mon May 21, 1990 09:26 am (The entire line is used with this element - centered)	80 / Y	H*, F
LGRRPT	Report Name (Header) New Work Summary (The entire line is used with this element - centered)	80 / Y	H*
LPTNMFLD	Patient Name Field Patient Name:	13 / Y	H*, F
LGRPTNAD	Patient Name SMITH,JR,JOHN R	30 / N	H*, F*
LSECTPAGE	Section-Page Number Chemistry-Page 1	25 / N	H*
LMEDRECFLD	Medical Rec Number Field Med Rec #:	10 / N	H*, F
LUNITNUM	Unit Number 100023021	15 / N	H*, F*
LLOCFLD	Location Field Location:	9 / N	H*, F
LPTLOC	Patient Location 2E 2004 1	20 / N	H*, F
LPHYSVFLD	Physician - Service Field Phys-Service:	13 / N	H*, F
LDOCSERV	Doctor - Service DALLKE,WENDALL E - MEDICAL	40 / N	H*, F
LACCTFLD	Account Number Field Acct #:	7 / N	H*, F
LACCTNUM	Account Number E123456789012345	15 / N	H*, F
LLASPRTDAT	Cum Last Print Date Last Cum Print: 06/18/90 1300 pm	35 / N	H*
LGRSTR	Line of Stars ********************** (The entire line is used with this element)	80 / Y	H*, F

Element	Description Example	Length/Truncate	Header/Footer H=Header F=Footer
LGRDIR	Director Name John W. Alexander, M.D.	45 / Y	H , F*
LPATLOC	Patient Location 3N 3001 1 (The Discharge Date will print one space after the location if the patient is discharged)	30 / N	H , F*
LGRSBD	Sex and Birthdate (M-09/07/62)	12 / Y	H , F*
LGRRPTF	Report Name (Footer) New Work Summary	45 / Y	F*
LDOCTOR	Attending Doctor Dr. ALEXANDER,BOB	30 / Y	H , F*
LDISDATE	Discharge Date 10/31/90	8 / N	H , F
LDISFLD	Discharge Date Field Dis Date	8 / N	H , F
LFOOTNOTE	Micro Footnote S=Susceptible M=Moderate R=Resistant (The entire line is used with this element)	80 / N	F
LGRDR	Attending Doctor ALEXANDER,BOB	20 / N	H , F
LGRLOC	Location Field Loc:	4 / Y	H , F
LGRPG	Page Field Page:	5 / Y	H , F
LGRPTNA	Patient Name Field Pat Name:	9 / N	H , F
LGRUAN	Unit/Acct Number Field Unit #/Acct #:	14 / Y	H , F
LPRLINE	Line of Dashes ------------------------- (The entire line is used with this element)	75 / N	H , F
LPRPBD	Patient Birthdate (09/07/1962)	11 / Y	H , F
LPRPDT	Current Date & Time Oct 31,1990 1500	16 / N	H , F
LSECTPAGEF	Section-Page Number (Footer) Serology-Page 3	25 / N	F

Post Discharge Work Summary

```
Element          Description           Length/Truncate      Header/Footer
                 Example                               H=Header F=Footer
--------------------------------------------------------------------------
LGRHNM           Hospital Name              80 / Y              H*, F
                 GENERAL HOSPITAL
                 (The entire line is used with this element - centered)
LGRDAT           Current Date & Time        80 / Y              H*, F
                 Mon May 21, 1990 09:26 am
                 (The entire line is used with this element - centered)
LGRRPT           Report Name (Header)       80 / Y              H*
                 Post Discharge Summary Report
                 (This element will include the section if
                 section sorts are used. The entire line is
                 used with this element - centered)
LGRPTNA          Patient Name Field         9  / N              H*, F
                 Pat Name:
LGRPTNAD         Patient Name               30 / N              H*, F*
                 SMITH,JR,JOHN R
LGRPG            Page Field                 5  / Y              H*, F
                 Page:
LGRPGD           Page Number                3 /  Y              H*
                 5
LGRUAN           Unit/Acct Number Field     14 / Y              H*, F
                 Unit #/Acct #:
LUNITACC         Unit Number/Account Number 30 / N              H*, F*
                 100023021/E9000212000
LDISFLD          Discharge Date Field       8  / N              H*, F
                 Dis Date
LDISDATE         Discharge Date             8  / N              H*, F
                 10/31/90
LPHYSVFLD        Physician - Service Field  13 / N              H*, F
                 Phys-Service:
LDOCSERV         Doctor - Service           40 / N              H*, F
                 DALLKE,WENDALL E - MEDICAL
LGRSTR           Line of Stars              80 / Y              H*, F
                 **********************
                 (The entire line is used with this element)
LGRDIR           Director Name              45 / Y              H , F*
                 John W. Alexander, M.D.
```

```
Element          Description            Length/Truncate        Header/Footer
                 Example                                       H=Header F=Footer
------------------------------------------------------------------------------
LPATLOC          Patient Location           30 / N                 H , F*
                 3N 3001 1
                 (The Discharge Date will print one space after
                 the location if the patient is discharged)
LGRSBD           Sex and Birthdate          12 / Y                 H , F*
                 (M-09/07/62)
LGRRPTF          Report Name (Footer)       45 / Y                     F*
                 Post Discharge Summary Report
LDOCTOR          Attending Doctor           30 / Y                 H , F*
                 Dr. ALEXANDER,BOB
LACCTFLD         Account Number Field        7 / N                 H , F
                 Acct #:
LACCTNUM         Account Number             15 / N                 H , F
                 E123456789012345
LFOOTNOTE        Micro Footnote             80 / N                     F
                 S=Susceptible   M=Moderate   R=Resistant
                 (The entire line is used with this element)
LGRDR            Attending Doctor           20 / N                 H , F
                 ALEXANDER,BOB
LGRLOC           Location Field              4 / Y                 H , F
                 Loc:
LGRPG            Page Field                  5 / Y                 H , F
                 Page:
LPTLOC           Patient Location           20 / N                 H , F
                 2E 2004 1
LPRLINE          Line of Dashes             75 / N                 H , F
                 ------------------------
                 (The entire line is used with this element)
LPRPBD           Patient Birthdate          11 / Y                 H , F
                 (09/07/1962)
LPRPDT           Current Date & Time        16 / N                 H , F
                 Oct 31,1990 1500
LSECTPAGEF       Section-Page Number (Footer)25 / N                    F
                 Serology-Page 3
```

Discharge/Interim/Outpatient Summary

```
Element          Description            Length/Truncate        Header/Footer
                 Example                                       H=Header F=Footer
------------------------------------------------------------------------------
LGRHNM           Hospital Name              80 / Y                 H*, F
                 GENERAL HOSPITAL
                 (The entire line is used with this element - centered)
LGRDAT           Current Date & Time        80 / Y                 H*, F
                 Mon May 21, 1990 09:26 am
                 (The entire line is used with this element - centered)
```

```
     Element          Description            Length/Truncate        Header/Footer
                      Example                                     H=Header F=Footer
     ---------------------------------------------------------------------------
     LGRRPT           Report Name (Header)      80 / Y                 H*
                      Outpatient Summary Report
                      (This element will include the section if
                      section sorts are used. The entire line is
                      used with this element - centered)
     LGRPTNA          Patient Name Field         9 / N                 H*, F
                      Pat Name:
     LGRPTNAD         Patient Name              30 / N                 H*, F*
                      SMITH,JR,JOHN R
     LGRPG            Page Field                 5 / Y                 H*, F
                      Page:
     LGRPGD           Page Number                3 / Y                 H*
                      5
     LGRUAN           Unit/Acct Number Field    14 / Y                 H*, F
                      Unit #/Acct #:
     LUNITACC         Unit Number/Account Number 30 / N                H*, F*
                      100023021/E9000212000
     LGRLOC           Location Field             4 / Y                 H*, F
                      Loc:
     LPATLOC          Patient Location          30 / N                 H*, F*
                      3N 3001 1
              (The Discharge Date will print one space after the
           location if the patient is discharged)
     LPHYSVFLD        Physician - Service Field 13 / N                 H*, F
                      Phys-Service:
     LDOCSERV         Doctor - Service          40 / N                 H*, F
                      DALLKE,WENDALL E - MEDICAL
     LGRSTR           Line of Stars             80 / Y                 H*, F
                      **********************
                      (The entire line is used with this element)
     LGRDIR           Director Name             45 / Y                 H , F*
                      John W. Alexander, M.D.
     LGRSBD           Sex and Birthdate         12 / Y                 H , F*
                      (M-09/07/62)
     LGRRPTF          Report Name (Footer)      45 / Y                    F*
                      Post Discharge Summary Report
     LDOCTOR          Attending Doctor          30 / Y                 H , F*
                      Dr. ALEXANDER,BOB
     LACCTFLD         Account Number Field       7 / N                 H , F
                      Acct #:
     LACCTNUM         Account Number            15 / N                 H , F
                      E123456789012345
     LDISFLD          Discharge Date Field       8 / N                 H , F
                      Dis Date
     LDISDATE         Discharge Date             8 / N                 H , F
                      10/31/90
     LFOOTNOTE        Micro Footnote            80 / N                    F
                      S=Susceptible   M=Moderate   R=Resistant
                      (The entire line is used with this element)
```

```
Element          Description           Length/Truncate        Header/Footer
                 Example                                       H=Header F=Footer
--------------------------------------------------------------------------
LGRDR            Attending Doctor          20 / N                 H , F
                 ALEXANDER,BOB
LGRPG            Page Field                5  / Y                 H , F
                 Page:
LPRLINE          Line of Dashes            75 / N                 H , F
                 -------------------------
                 (The entire line is used with this element)
LPRPBD           Patient Birthdate         11 / Y                 H , F
                 (09/07/1962)
LPRPDT           Current Date & Time       16 / N                 H , F
                 Oct 31,1990 1500
LSECTPAGEF       Section-Page Number (Footer)25 / N                  F
                 Serology-Page 3
```

Patient Detail Report

```
Element          Description           Length/Truncate        Header/Footer
                 Example                                       H=Header F=Footer
--------------------------------------------------------------------------
LGRHNM           Hospital Name             80 / Y                 H*, F
                 GENERAL HOSPITAL
                 (The entire line is used with this element - centered)
LGRDAT           Current Date & Time       80 / Y                 H*, F
                 Mon May 21, 1990 09:26 am
                 (The entire line is used with this element - centered)
LGRRPT           Report Name (Header)      80 / Y                 H*
                 Outpatient Summary Report
                 (This element will include the section if
                 section sorts are used. The entire line is
                 used with this element - centered)
LGRPTNA          Patient Name Field        9  / N                 H*, F
                 Pat Name:
LGRPTNAD         Patient Name              30 / N                 H*, F*
                 SMITH,JR,JOHN R
LGRPG            Page Field                5  / Y                 H*, F
                 Page:
LGRPGD           Page Number               3 /  Y                 H*
                 5
LGRUAN           Unit/Acct Number Field    14 / Y                 H*, F
                 Unit #/Acct #:
LUNITACC         Unit Number/Account Number 30 / N                H*, F*
                 100023021/E9000212000
LGRLOC           Location Field            4  / Y                 H*, F
                 Loc:
LPATLOC          Patient Location          30 / N                 H*, F*
                 3N 3001 1
                 (The Discharge Date will print one space after
                 the location if the patient is discharged)
```

Element	Description	Length/Truncate	Header/Footer
	Example		H=Header F=Footer

Element	Description	Length/Truncate	Header/Footer
LPHYSVFLD	Physician - Service Field	13 / N	H*, F
	Phys-Service:		
LDOCSERV	Doctor - Service	40 / N	H*, F
	DALLKE,WENDALL E - MEDICAL		
LGRSTR	Line of Stars	80 / Y	H*, F
	***********************		
	(The entire line is used with this element)		
LGRDIR	Director Name	45 / Y	H , F*
	John W. Alexander, M.D.		
LGRSBD	Sex and Birthdate	12 / Y	H , F*
	(M-09/07/62)		
LGRRPTF	Report Name (Footer)	45 / Y	F*
	Post Discharge Summary Report		
LDOCTOR	Attending Doctor	30 / Y	H , F*
	Dr. ALEXANDER,BOB		
LACCTFLD	Account Number Field	7 / N	H , F
	Acct #:		
LACCTNUM	Account Number	15 / N	H , F
	E123456789012345		
LDISFLD	Discharge Date Field	8 / N	H , F
	Dis Date		
LDISDATE	Discharge Date	8 / N	H , F
	10/31/90		
LFOOTNOTE	Micro Footnote	80 / N	F
	S=Susceptible M=Moderate R=Resistant		
	(The entire line is used with this element)		
LGRDR	Attending Doctor	20 / N	H , F
	ALEXANDER,BOB		
LGRLOC	Location Field	4 / Y	H , F
	Loc:		
LGRPG	Page Field	5 / Y	H , F
	Page:		
LPRLINE	Line of Dashes	75 / N	H , F

	(The entire line is used with this element)		
LPRPBD	Patient Birthdate	11 / Y	H , F
	(09/07/1962)		
LPRPDT	Current Date & Time	16 / N	H , F
	Oct 31,1990 1500		
LPTLOC	Patient Location	20 / N	H , F
	2E 2004 1		
LSECTPAGEF	Section-Page Number (Footer)	25 / N	F
	Serology-Page 3		

Primary Report

```
    Element         Description           Length/Truncate       Header/Footer
                    Example                                  H=Header F=Footer
    ----------------------------------------------------------------------
    LPRLINE         Line of Dashes              75 / N                H*, F*
                    ------------------------
                    (The entire line is used with this element)
    LPRHD           Laboratory/Hospital Name    70 / N                H*, F
                    General Hospital
                    (The entire line is used with this element)
    LPRTEMP         Remote Print (Temp)          4 / N                H*
                    TEMP
    LPRRT           Report Completion Time      27 / N                H*, F
                    Completed: 10/22/90 1500
    LPRVPI          Venipuncturist ID            7 / N                H*, F
                    V1107
    LPRTID          Resulting Techs             16 / Y                H*
                    T2201,7610**
    LPRROUT         Route Report To             21 / Y                H*
                    Route to: 1N-101-A
    LPRSPC          Specimen Type               30 / Y                H*
                    Spec. Type: Blood
    LPRSPCN         Anatomic Path Case #        12 / N                H*
                    {S93-1234}
                    (Header/Single Column primary only)
    LPRCT           Collection Time             25 / N                H*, F
                    Collected: 01/15/90 1336
    LPRCOLP         Collection Period            4 / N                H*, F
                    24Hr
    LPRACN          Accession Number            10 / N                H*, F
                    [20140]
    LPRRH           Result Name Header          11 / N                H*
                    Result name
    LPRRVH          Result Value Header          6 / N                H*
                    Result
    LPRNRH          Normal Range Header          7 / N                H*
                    N/Range
    LPRRHS          Result Name Header (2nd Col)11 / N                H*
                    Result name
    LPRRVHS         Result Value Header(2nd Col) 6 / N                H*
                    Result
    LPRNRHS         Normal Range Header(2nd Col) 7 / N                H*
                    N/Range
    LPROCAT         Order Category               6 / N                    F*
                    *ASAP*
    LPRACT          Accession Date/Time         21 / N                H , F*
                    A/Date: 04/30/90 1500
    LPRPDT          Current Date & Time         16 / N                H , F*
                    Oct 31,1990 1500
    LPRPN           Patient Name                15 / Y                H , F*
                    SMITH,JR,BOB
```

Element	Description Example	Length/Truncate	Header/Footer H=Header F=Footer
LPRPBD	Patient Birthdate (09/07/1962)	11 / Y	H , F*
LPRRTYP	Report Type *PARTIAL	10 / N	F*
LPRTN	Test Name CBC W/DIFF	20 / N	F*
LPRPAN	Patient Account Number A1000413219	13 / N	F*
LPRPLOC	Patient Location 2N 230 B	11 / Y	H , F*
LPRCOPY	Report Copy Type (Audit)	5 / N	F*
LPRPAGE	Page Number 1/2	3 / N	F*

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Chapter 12 - Collection Walk Order

NURSE STATION GROUPS

Each time a pooled set of orders is printed within Order Management, STAR Laboratory sorts the orders according to hospital location. The Nursing Station Groups form is used to specify which locations (nursing stations) are associated with each other. A group may consist of from one to as many as all nursing stations. The order that nursing stations are assigned to a group determines the order in which collection labels print within the batch. Refer to the following diagram.

```
                          Collection Label Pool
              ┌──────────────────────┴──────────────────────┐
           Batch 1                                        Batch 2
   (Nursing Station Group)                       (Nursing Station Group)
    ┌────────┼────────┐                            ┌──────────┴─────────┐
Station A  Station B  Station C                Station D          Station E
    │
 Room 1
 Room 3
 Room 2
 Room  4
```
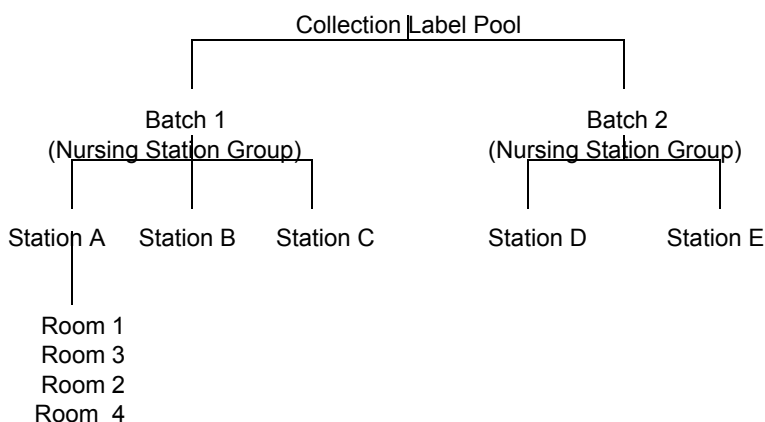
NURSE STATION GROUP NAME (10-AN-R)
Enter a 1-10 character nursing station group name which reflects the stations it contains. For example, ICU/CCU nursing station group contains both ICU and CCU nursing stations. This field will be a free text entry within the build.

NURSE STATIONS (3-AN-R)
Enter the name (or three letter code) of each nursing station to assign to this group. Within the build process, the location file displays for station selection. Therefore it is important to use the actual nursing station name used in the location file on the form to avoid confusion. A location file print-out is recommended.

NOTE: Collection labels for nurse stations not assigned to a group print in a batch tagged "Miscellaneous."

ROOM AND BED ORDER

The room and bed file within a nursing station is used to further define the collection label print order. For example, if odd numbered rooms are located on one side of the hall and even numbered ones on the other, it might be more convenient to collect all odd numbered rooms together and all even ones together.

NURSE STATION (3-AN-R)
Enter the three character code or the name (up to 18 characters) of the nursing station. Be consistent between the Room and Bed and the Nursing Station Groups forms.

ROOM # (4-N-R)
Enter the hospital room number up to four characters. It must match the room number in format for the location file.

BED # (2-AN-R)
Enter the two character bed identifier. The identifier, for example, 1, 2, A, B, must match the location file.

Chapter 13 - Archiving Parameters

ARCHIVE RETENTION DAYS PER PATIENT TYPE

This worksheet is for defining the default patient type retention days and the retention days for each patient type (if different from the default). It also is for defining the number of Archive Account Retention days.

Patient type retention days are the number of days the clinical data (test results) for a given account remains on disk after the account is inactive and before it is to be archived. The exact number of days depends upon the frequency of archive runs and the retention days for the selective tests.

At the time the account is inactivated, the system checks to see if laboratory work was ordered on the account. If no laboratory work has been ordered, the account is not placed in the queue for archiving. If the account does have laboratory work ordered, it is placed in the queue. All accounts placed in the queue are filed by the calculated date to be archived. This date is calculated by adding the number of retention days for the patient type to the current date.

NOTE: Default retention days are used if retention days have not been defined for the patient type.

STAR Laboratory allows the archiving and removal of patient data in addition to results and test data. All cross-references maintained on the system are purged once the clinical data has been archived and deleted. (The system does retain enough information on all accounts so that they can be accessed in Patient Inquiry and Archive Inquiry processors for their archive and purge dates for retrieval from microfiche.) The archived date can be accessed in the Archived Inquiry processor and used to retrieve data from the microfiche. The STAR Laboratory System retains the patient medical information as long as an account has laboratory data in the historical cardfile or has a test that falls within the test code range of those tests that the laboratory has specified to keep online for a longer period of time. If there is no data in the cardfile and the patient does not have a test that falls within the test code range, STAR Laboratory allows STAR Patient Care to archive and then purge the patient from the system. The purging of an archived patient is done as part of midnight processing. A user defined parameter called the Archived Accounts Retention Days parameter indicates the time period that the patient file remains on disk after an account's test data has been purged. This can be up to 90 days.

System performance is improved by decreasing the amount of disk space used by the patient file. This capability is available in network, interface, and stand-alone environments.

Field Explanations for worksheet

FACILITY
Since retention days can be defined differently for each facility, a worksheet will have to be filled out for each facility. Enter your facility's name.

PATIENT TYPE DEFAULT RETENTION DAYS
This field is for defining the number of retention days from 1 to 3650 days (1 day to 10 years) you want for the default.

ACCOUNT RETENTION DAYS
This field is for defining the Archived Accounts Days parameter. This represents the number of days between the purging of a patient's test data and the purging of their medical data. 30 days is the recommended amounts and is the system default. Enter the number of days from 1 to 90.

PATIENT TYPES RETENTION DAYS
These two columns are for listing the patient type and the number of retention days for that patient type. Use the three letter patient type code and the number of days for result retention for that patient type.

NOTE: You only need to list the patient types that are different from the default.

ARCHIVE SELECTIVE TEST CODES AND RANGES

This worksheet is used to define the test codes and/or ranges of test codes for which results are to remain on disk for a longer time period after the account is archived.

NOTE: The retention period for the selected test should be longer than the retention period for the account.

For example, if the retention period for an account is 90 days and a selected test on the account has a retention period of 2 years (730 days), the account and the results for all tests (including the selected test) are archived 90 days after the account has been inactivated. All results except the ones for the selected test are then removed from the system. The results for the selected test are retained on disk for the defined additional time period, in this case 640 days. The results for this test can be viewed in Patient Inquiry and used for data based searches; however, it cannot be edited or changed in any way. Once this number of days has been reached, the results are deleted from the disk. Since they were originally archived with the account and since no editing is allowed once the test has reached an archive status, they are not archived again.

Field Explanations for Worksheet

RETENTION PERIOD (4-AN-O)
This field is for entering the retention period for which the selected test code(s) are to be retained. The retention period may be entered in either months or years. To indicate a retention period in months, enter a number from 1 to 12 immediately followed by **M** (for example, 2**M**). For a retention period in years, enter the number immediately followed by **Y** (for example, 5**Y**).

TEST CODE/RANGE (U-AN-O)
This field is for entering the test code or test code range for tests that are to be retained for the time period in the previous field. Enter a test code or test code range.

DATA ELEMENTS FOR ARCHIVE LAB SUMMARY

Each test printed on the Archive Lab Summary report contains all of the basic tracking data that is included on the other Summary reports. However, for the purpose of archiving and microfiching, additional data elements pertaining to the test can also be defined to appear on the Archive Summary Report. These elements appear following the test results.

The following is an explanation of the additional data elements of a test that can be included on the Archive Lab Summary report. On the worksheet, check Yes if you wish this element to appear on the summary. Check no if you do not wish the element to appear on the Archive Lab Summary report.

Field Explanations

TRANSPORT
This field is for including the date and time and the ID of the person who processed an interdepartmental specimen to send to the performing department using the Specimen Transfer processor.

TRANSPORT REC
This field is for including the date and time and the ID of the person who received an interdepartmental specimen in the performing department and processed it using the Specimen Transfer processor.

SENDOUT
This field is for including the date and time and the ID of the person who processed a sendout test using the Specimen Transfer processor.

1ST PARTIAL
This field is for including the date and time and the ID of the person who first entered results for the test.

TRANSFER FROM ACCT
This field is for including the account number from which an accession has been transferred.

ORDER
This field is for including the comment entered at Order Entry on the Archive Summary Report.

UNCOLLECTED
This field is for including the uncollected reason on the Archive Summary Report.

ACCESSION
This field is for including the accession comment on the Archive Summary Report.

TRANSPORT
This field is for including the transport comment on the Archive Summary Report.

SENDOUT
This field is for including the sendout comment on the Archive Summary Report.

PROMPT/RESP
This field is for including the order prompt and response on the Archive Summary Report.

CORRECTED RESULTS DATA
This field is for including the corrected resultdata which includes corrected result, tech ID, and date/time of correction on the Archive Summary Report.

PANIC RESULTS DATA
This field is for including the panic result data which includes result name, panic value, called at date and time, run by ID, called/approved by ID, and the called to ID on the Archive Summary Report.

HISTOTECH DATA
This field is for including the histotech data which includes the name and number of blocks and the processes used on the test.

DIAGNOSIS IN HEADER
This field is for including the diagnosis in the header of the Archive Summary Report.

NUMBER POOL
This field is for including the number pool numbers used within the test on the Archive Summary Report.

PAT TYPE AT ORDER
This field is for including the patient type at the time of order on the Archive Summary Report.

ORDER DIAGNOSIS
This field is for including the ordering diagnosis for the test at the time of order on the Archive Summary Report.

SPEC LOC
This field is for including the specimen location for the test on the Archive Summary Report.

ORDER INFO
This field is for including the ordering information for a test on the summary report. This information includes accession number/internal account number/order number_result file key/order priority code;name/ordering facility/ordering department.

ORDER LOC
This field is for including the ordering location of the test on the Archive Summary Report.

DUP/CONF AUDIT
To include the Duplicate/Conflict audit, check **Yes.**

DUPS/CONTS
To include a list of duplicate/conflict accession test confirmations, check **Yes**.

INTERNAL RESULTS
This field is for the inclusion of any internal results that have been resulted on a test to be included on the Archive Summary Report.

INTERNAL LOGS
This field is for the inclusion of the **last** internal log created for the test. The internal log of each test follows the test on the report. This report always prints on a new page and prints in two columns if necessary. It goes to a second column when there are more than 32 entries for the log. This field should only be checked if you have Advanced Microbiology.

OLD ACCT#
Check Yes if you want to print accession numbers on the Archive Summary Report for tests that were reordered as a result of specimen rejection processing.

NEW ACCT #
Check Yes if you want to print the accession numbers on the Archive Summary Report for tests that had a new order placed as a result of specimen rejection processing.

Chapter 14 - Test Code Lookup Parameters

LOOKUP GROUPS

The Lookup Groups Worksheets enable you to build Lookup Groups based on multiple tests from different sections. By specifying day search limitations, you define the day (number of days prior to the current day) on which you want the system to begin searching for the Test Lookup Group in the Patient Inquiry processor.

LOOKUP GROUP CODE (6-AN-R)
Enter code for the lookup group you want to define.

LOOKUP GROUP DESCRIPTION (25-AN-R)
Enter corresponding description for the lookup group up to 25 characters. This is the description that displays in the Test Lookup Parameters screen in Patient Inquiry.

TEST CODES (5-N-R)
Enter the test codes you want to assign to the lookup group. You can enter up to 25.

DEPARTMENT CODE (3-N-R)
Enter the 3-digit performing department code for the assigned test.

TEST CODE DESCRIPTION (25-C-R)
Enter the corresponding description for each test code you enter.

COMPONENT NUMBER (5-N-O)
Enter the component number you want to use to assign tests to the lookup group. This indicates what test you assigned to the lookup group as a result of building the group using a component.

COMPONENT DESCRIPTION (25-C-O)
Enter the corresponding description for each component code you enter.

DAY SEARCH LIMITATION/ACTIVATION

MAIN PI DAYS (4-N-R)
Enter the number of days you want the system to search for test codes when you use the Test Code Lookup in the Patient Inquiry processor. This field controls the default begin date on the Test Lookup Parameter screen. It is suggested that a begin date of 180 days prior to current date is appropriate. Enter a number from 1 to 999.

NOTE: In a network environment, STAR Patient Care accesses the Main Patient Inquiry function. McKesson recommends that you set the Day Search Limitation parameter relatively short. This reduces the possibility of:

- A STAR Patient Care user generating a long Test Code Lookup Report across the network

- A physician downloading a large file to his PC.

SECTION (20-C-R)
Enter the sections you want to define the day search limitation.

OF DAYS (4-N-R)
You can enter up to 9999 days. This is the number of days to begin the search for test codes when you access Test Code Lookup within a section. For example, a search that you access from the Anatomic Pathology Patient Inquiry processor may need to be set for more days that when you access a search from Chemistry.

Chapter 15 - Sales Commission

SALES COMMISSION PARAMETERS

Use this worksheet to activate sales commission processing and establish the retention date for sales commission data. Complete one worksheet for each facility.

ACTIVE (1-A-R)
This field activates the capturing of the sales commission data. Check Yes to activate sales commission processing. Check No to inactivate this process.

DATA RETENTION (3-N-C)
This field determines the number of days that sales commission data is available online. Once you assign the physicians/contracts to a salesperson and enter the activation and deactivation dates, STAR Laboratory begins to accumulate the data. Use this field to conserve disk space. You can retain data for a maximum number of days (up to 999). This field is required once you set the Active field to Yes. When sales commission data reaches this retention period, STAR Laboratory deletes the data at midnight processing. The default is 60 days.

The purge date for each physicians/contract is based on the following calculation:

Deactivation date + Data Retention date = Purge date

For example, if the deactivation date for Dr. Jones is 5/1/93 and the data retention is set to 60 days, the purge date is 7/1/93. If you change the Data Retention field, the system recalculates the purge date.

SALES COMMISSION FOR FINANCIAL CLASSES

Use this worksheet with the Define Sales Commission Percentages processor, which assigns the percentage of commission that is paid to a salesperson based on the total amount of dollars billed to a physician for each eligible financial class associated with an outpatient.

FINANCIAL CLASS CODE (1-A-R)
Enter the one-letter code for the financial class.

DESCRIPTION (33-C-R)
Enter the description for the financial class.

MAXIMUM DOLLAR AMOUNT (6-N-R)
The percentage of sales commission that is paid is based on the total amount of dollars that are billed for laboratory tests for the financial class. This field enables you to enter the total amount of dollars billed. The implied starting minimum amount is 0 dollars. The last maximum dollar amount you enter should be set high enough to accurately reflect the total amount of dollars that could possibly be billed for laboratory tests. If the last maximum dollar entry was 65000.00 with 2.5 percent sales commission and the total amount of dollars billed exceeded 65000.00, sales commission will not be captured. The following example shows how to enter each maximum dollar amount and how the system displays the amount on the screen:

Number Entered:	Displays As:
10	10.00
200	200.00
2500	2500.00
10000	10000.00
49999	49999.00
999999	999999.00

STAR Laboratory assumes the minimum amount for the next maximum dollar entry will be one dollar more than the previous maximum dollar amount. For example, if you enter 300.00 as the first maximum dollar amount, the minimum for the next greater maximum dollar entry will be 301.00. The processor will take the total number of dollars billed and find the figure in the Maximum Dollar Amount field that is less than or equal to that total and apply the appropriate percentage of sales commission.

The following example explains how this process works:

Maximum Dollar Amount Entered	Equals Total Amount Billed for Laboratory Tests	Percentage of Sales Commission Paid
10000	$0 to $10,000	1.0
30000	$10,001 to $30,000	2.0
49999	$30,001 to $49,999	3.0
75000	$50,000 to $75,000	3.5
80000	$75,001 to $80,000	4.0
100000	$80,001 to $100,000	4.5
999999	$100,001 to $999,999	5.0

% SALES COMMISSION (4-NC-C)
In this field enter the percentage of sales commission that is associated with a defined maximum dollar amount. You can enter the sales commission percentage from 0.0 to 99.9.

SALES PERSONNEL/PHYS/CONTRACTS

Use this worksheet with the Define Sales Personnel/Phys/Contracts processor, which builds the table of Sales Personnel and links the personnel to the physicians/contracts that have purchased the outpatient laboratory services. You can also enter the activation and deactivation dates for the sales commission data to be captured for each sales person.

SALESPERSON ID CODE (9-AN-R)
Enter the code for the salesperson in this field.

SALESPERSON (25-AC-R)
Enter the salesperson's name in LAST, FIRST MI format.

ACTIVE (1-A-R)
Check Yes to assign physicians/contracts. STAR Laboratory accumulates sales commission data. Check No to indicate that the salesperson is no longer active and the system no longer accumulates sales commission data.

If you re-assign physicians/contracts to another salesperson, you can inactivate the salesperson that currently has those physicians/contracts assigned. To do this, enter the current date as the inactivation date (which is the default), or enter a future date. Once the inactivation date is reached, the system no longer captures sales commission for those accounts associated with the inactivated salesperson.

NOTE: STAR Laboratory deletes all sales commission data for the inactivated salesperson when this inactivation date is reached. If you enter the current date as the inactivation date, your changes become effective at midnight processing.

When you re-assign the physicians/contracts, the system ensures that those physicians/contracts are not assigned to an active salesperson. In addition, the activation date you enter must be after the inactivation/deactivation date that was entered for the inactivated salesperson.

PHYSICIAN (A-25-C)
Enter the name of the physician. The physician can be assigned to only one active salesperson.

CONTRACT (25-AN-C)
Enter the contract code. You cannot assign both the Physician and Contract fields on the same line. You must choose to enter a contract type rather than a physician.

ACTIVATE (DATE-R)
This field is the date STAR Laboratory begins accumulating the sales commission data. Enter either the current date or a future date.

DEACTIVATION (DATE FORMAT-R)

You can inactivate individual physicians/contracts that are assigned to a particular salesperson and you can re-assign those accounts to other sales personnel.

Appendix A - Base Tables Listing

The base tables are provided for your use during the design and implementation of your STAR Laboratory System. These base tables can be edited as needed. If you choose not to use a base table, you must build your own. The base tables include:

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COMMENT TABLE

```
Code              Description
----              ----------------------------
003               Difficult patient
005               Drawn above IV
004               Hard to stick
006               Patient not fasting
007               Patient on heparin
```

CONTAINER TYPES (LAB)

```
Code            Description
----            -----------------------------
047             24 Hr Urine 1g BA
013             24Hr Urine On Ice
011             24Hr Urine+30ml HCL
009             24Hr Urine+4BA Tabs
010             24Hr Urine+4SBF Tabs
012             24Hr Urine+5g NaCo3
008             24Hr Urine-No Pres
027             72Hr Stool Container
019             Alcohol Container
026             Blood Culture Bottle
005             Blue (Citrated)
022             Culturette Anaerobe
021             Culturette Swab
033             Filter Paper
018             Formalin Container
006             Gray (Na Fluor)
003             Green (Heparin)
038             GTT 1 Hr
037             GTT 1/2 Hr
039             GTT 2 Hr
040             GTT 3 Hr
041             GTT 4 Hr
042             GTT 5 Hr
043             GTT 6 Hr
015             Heparin Capillaries
002             Lavender (EDTA)
029             Non-Sterile Container
004             Red (Large-No Pres)
001             Red (No Pres)
045             Red/Lav
016             Routine Stool
007             Routine UA
035             Scotch Tape Stick
036             Slide
031             Slide-Finger Stick
030             Slide-Gram Stain
020             Slide-PAP Smear
046             Special Container
032             Special Hem Tube
023             Sputum Collection Kit
028             Sterile Container
```

CONTAINER TYPES (LAB)

```
Code                Description
----                -----------------------------
014                 Sterile CSF Tube
024                 Sterile Urine Container
048                 Sterile Urine Container (CC)
034                 Sweat Collection Cup
044                 Syringe
017                 Tissue Jar-Saline
025                 Tracheal Suction
```

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RESULT UNIT CODES

```
Code              Description
----              -------------------
001               /100 WBC
002               /12 Hr
003               /cmm
004               /HPF
005               /LPF
006               %
094               % dye excreted
007               % of Total
087               % Uptake
086               1000/mm3
008               cc
009               cells/ul
010               CH100 U/ml
011               CH50 units
012               ct/min
013               cu microns
014               cumm
015               Ehrlich Units
016               Ehrlich Units/24 Hr
017               EL Value
018               EU/dl
019               fl
020               gm
021               gm/24 Hr
022               gm/5 Hr
023               gm/dl
024               gm/L
088               Index of Normal
025               IU
092               IU/dl
026               IU/L
027               IU/ml
028               M/ccm
029               mcg
030               mcg/24 Hr
031               mcg/dl
032               mcg/L
033               mcg/ml
091               mega/mm3
035               mEq/24 Hr
036               mEq/Hr
```

RESULT UNIT CODES

```
Code            Description
----            --------------------
034             mEq/L
037             mg%
038             mg/24 Hr
039             mg/dl
095             mg/kg/24H
040             mg/L
041             mg/ml
042             mill/cumm
043             mill/ml
044             minutes
045             mIU/ml
046             ml
047             ml/24 Hr
048             ml/kg
049             ml/min
050             mm Hg
051             mm/Hr
090             mmol/kg
052             mmol/L
053             mOsm/kg
054             mOsm/L
055             mU/ml
056             ng/dl
057             ng/ml
058             ng/ml/Hr
059             nmol/L
060             pg
061             pg/ml
062             pH Units
089             Ratio
063             seconds
064             Sigma Units
065             Somogyi Units/Hr
066             thou/cm
067             thou/cmm
096             Titer
068             Todd Units
069             U/2 Hr
070             U/dl
071             U/L
```

RESULT UNIT CODES

```
Code            Description
----            -------------------
072             U/ml
073             u3
074             uEq/L
075             ug/24 Hr
076             ug/dl
077             ug/L
078             ug/ml
079             uIU/ml
080             umol/L
081             units
093             units/Hr
082             uU/ml
083             uug
084             uug/dl
085             volumes %
097             X(10)3
```

SPECIAL INSTRUCTIONS

```
Code            Description
----            ---------------------------------------
001             Acid Clean Plastic Container
002             Acute Serum Must Accompany Specimen
003             Air Dry Do Not Flame
004             Allow to air dry for 2 hours
005             Avoid contact with rubber
006             Avoid Contamination with blood
007             Avoid hemolysis
008             Bleeding time       minutes
009             Collect both blood and urine
010             Collect in acid washed container
011             Collect in dark container
012             Deliver within 15 minutes
013             DO NOT draw on Fridays or Weekends
014             DO NOT draw/spin/store in glass
015             DO NOT SPIN!!!!
016             DO NOT transfer to another tube
017             DO NOT use alcohol prep
018             Draw 2 samples on ice
019             Draw blood at designated time
020             Draw blood during urine collection
021             Draw in chilled tube
022             Draw on ice
023             Draw without tourniquet
024             Fasting specimen only
025             Freeze Immediately
026             Freeze stool and swab immediately
027             Immediately transport at room temp
028             Indicate source
029             Invert gently several times
030             Maintain 37 degrees, draw control
031             Maintain sterility, send promptly
032             Mix gently
033             Mix tubes & immediately put on ice!
034             Must draw blood with CSF
035             No Preservative
036             Notify Section Before drawing
037             Place aliquot in plastic vial
038             Place plasma in plastic vial--Freeze
039             Place plasma in plastic vial-Refrig
040             Place serum in plastic vial-Freeze
041             Place serum in plastic vial-Refrig
```

SPECIAL INSTRUCTIONS

```
Code            Description
----            ---------------------------------------
042             Preweigh Container
043             Protect from light
044             Protect from light/spin/separate/refrig
045             Record Total Volume
046             Refrigerate
047             REFRIGERATE IMMEDIATELY
048             Requires a normal control
049             Seal both ends of capillary tube
050             Send entire specimen
051             Send frozen and protect from light
052             Send frozen in dry ice
053             Send frozen serum
054             Send frozen urine
055             Send Heparinized blood
056             Send in original tubes-DO NOT OPEN!!
057             Send on wet ice!!
058             Send unfixed specimen to Lab
059             Send whole blood
060             Send within 24 hours
061             Separate immediately!!
062             Special diet restrictions!!
063             Special draw!! Consult Pathologist!!
064             Specify Supine      Upright
065             Spin in refrigerated centrifuge
066             Spin/Separate/Freeze
067             Store at 4 degrees C
068             Store at room temperature
069             Transfer under a biological hood
070             Transport to Lab at 37 Degrees
071             Tube must be filled!!
072             Use non-alcoholic antiseptic swab
073             Void 1st am urine-collect 2nd
```

SPECIMENS

```
Code            Description
----            -------------------
003             A-Line
004             Abscess
005             Amniotic Fluid
006             Anal
007             Appendix
008             Arm
009             Ascitic Fluid
010             Aspirate
011             Autopsy
012             Axillary
013             Bartholin Cyst
014             Bile
015             Biopsy
001             Blood
016             Blood/Urine
017             Body Fluid
018             Bone
019             Bone Marrow
020             Breast
021             Bronchial Brushing
022             Bronchial Washing
023             Buccal Smear
024             Calculi
025             Cath Tip
026             Cervix
027             Colostomy
028             Conjunctiva
029             Cord Blood
030             CSF
031             CSF/Blood
032             Cul de sac
033             Cvp Line
034             Cyst
035             Decubitus
036             Deep Wound
037             default
038             Dialysate
039             Drainage
040             Duodenal
041             Ear
042             Emesis
043             Empyema
```

SPECIMENS

```
Code            Description
----            -------------------
044             Endocervical
045             Endometrium
046             Endotracheal
047             Environmental
048             Epididymis
049             Epiglottis
050             Esophageal
051             Exudate
052             Eye
053             Fallopian tube
054             Fluid
055             Food
056             Foreign Object
057             Frozen Section
058             Gall Bladder
059             Gastric
060             Gastric Washing
061             Genital
062             Gingiva
063             Groin
064             Hair
065             Hemorrhoids
066             Intestine
067             IUD
068             Kidney
069             Labia
070             Leg
071             Lesion
072             Lipoma
073             Liver
074             Lochia
075             Lung
076             Lung Aspirate
077             Lymph Node
078             Lymphoma
079             Mouth
080             Nails
081             Nasal
082             Nasopharyngeal
083             Needle Aspirate
084             Oral
085             Otic/Ear
```

SPECIMENS

```
Code            Description
----            -------------------
086             Ovary
087             Pancreas
088             PAP Smear
089             Paracentesis
090             Pelvis
091             Penile drainage
092             Penis
093             Pericardial
094             Perineum
095             Peritoneal
096             Pharynx
097             Placenta
098             Pleural
099             Prostate
100             Prothesis
101             Pus
102             Pustule
103             Rash
104             Rectal Swab
105             Saliva
106             Scotch Tape Prep
107             Scrapings
108             Scrotum
109             Seminal Fluid
110             Sinus
111             Sinus Drainage
112             Skin
113             Sputum
114             Sputum Expectorated
115             Sputum Induced
116             Stomach
117             Stone
118             Stool
119             Sweat
120             Synovial Fluid
121             Thoracentesis
122             Throat
123             Thyroid
124             Tissue
125             Toe
```

SPECIMENS

```
Code            Description
----            -------------------
126             Tongue
127             Tonsils
128             Tracheal Aspirate
129             Transtracheal Aspira
130             Ulcer
131             Umbilicus
132             Urethral
133             Urinary Calculus
002             Urine
134             Urine Bladder
135             Urine Cath
136             Urine CC
137             Urine Left Kidney
138             Urine Right Kidney
139             Urine Suprapubic
140             Uterus
141             Vagina
142             Vaginal Cuff
143             Vulva
144             Wound
145             Wound Deep
146             Wound Superficial
```

SQC CONSTITUENTS (CAP)

Code	Description
200	11-DESOXYCORTISOL
342	17-ALPHA HYDROXYPROGESTERONE
346	17-HYDROXYSTEROID
396	17-KETOSTEROIDS
340	5-HYDROXYINDOLEACETIC ACID
500	5-NUCLEOTIDASE
717	ACETAMINOPHEN
006	ACID PHOSPHATASE
009	ACID PHOSPHATASE-IMMUNOLOGIC
014	ALBUMIN
016	ALCOHOL (ETHYL)
018	ALDOLASE
020	ALDOSTERONE
021	ALDOSTERONE, URINE
022	ALKALINE PHOSPHATASE
026	ALPHA-1-ANTITRYPSIN
015	ALPHA-2-MACROGLOBULIN
028	ALPHA-FETOPROTEIN
648	ALT (SGPT)
032	AMIKACIN
042	AMMONIA
050	AMYLASE
053	AMYLASE, URINE
036	AMYTRIPTYLINE
058	ANDROSTENEDIONE
065	ANTITHROMBIN III
532	APTT, PTT
062	ARSENIC
646	AST (SGOT)
070	BARBITURATE
080	BICARBONATE (CALCULATED)
086	BILIRUBIN
088	BILIRUBIN (DIRECT-CONJUGATED)
087	BILIRUBIN, NEONATAL
094	BROMIDE
188	C3 COMPLEMENT
190	C4-COMPLEMENT
104	CALCIUM
106	CALCIUM, IONIZED
107	CALCIUM, URINE
108	CARBAMAZEPINE
110	CARBAMAZEPINE, FREE

SQC CONSTITUENTS (CAP)

```
Code            Description
----            -----------------------------
115             CARBOXYHEMOGLOBIN
120             CAROTENE
118             CEA (CARCINOEMBRYONIC ANTIGEN)
128             CERULOPLASMIN
129             CHLORAPHENICOL
130             CHLORIDE
134             CHLORIDE, URINE
132             CHOLESTEROL
138             CHOLINESTERASE
168             CK-BB-ISOENZYME
171             CK-MB-ISOENZYME
167             CK-MM-ISOENZYME
166             CO2
150             COPPER
151             COPPER, URINE
158             CORTICOSTERONE
010             CORTICOTROPIN (ACTH)
160             CORTISOL
170             CREATINE KINASE (CK)
172             CREATININE
815             CREATININE, URINE
835             D-XYLOSE, URINE
204             DESIPRAMINE
196             DHEA
198             DHEA-SO4
210             DHT (DIHYDROTESTOSTERONE)
205             DIBUCAINE
206             DIGITOXIN
208             DIGOXIN
215             DISOPYRAMIDE
220             DOXEPIN
224             ESTRADIOL
228             ESTRIOL
227             ESTRIOL, UNCONJUGATED
229             ESTRIOL, URINE
232             ESTRONE
824             ETHCHLORVYNOL
236             ETHOSUXIMIDE
250             FDP (FIBRIN DEGRADATION PRODUC
245             FERRITIN
```

SQC CONSTITUENTS (CAP)

```
246              FIBRINOGEN
254              FOLIC ACID
258              FSH (FOLLICLE-STIMULATING HORM
274              GAMMA GT
278              GASTRIN
280              GENTAMICIN
290              GLUCOSE
295              GLUCOSE, CSF
296              GLUCOSE, URINE
285              GLYCOSYLATED HEMOGLOBIN
298              GRANULOCYTES
300              GROWTH HORMONE
308              HAPTOGLOBIN
142              HCG
144              HCS (CHORIONIC SOMATOMAMMOTROP
312              HEMATOCRIT
314              HEMOGLOBIN
802              HEMOGLOBIN RATIO
330              HEMOGLOBIN, TOTAL
336              HYDROXYBUTYRIC DEHYDROGENASE
358              IMIPRAMINE
350              IMMUNOGLOBIN A (IGA)
353              IMMUNOGLOBIN G (IGG)
354              IMMUNOGLOBIN M (IGM)
351              IMMUNOGLOBULIN D (IGD)
352              IMMUNOGLOBULIN E (IGE)
362              INSULIN
368              IRON
372              IRON BINDING CAPACITY, UNSATUR
370              IRON BINDING CAPACITY/TOTAL
380              KANAMYCIN
406              LACTIC ACID
408              LACTIC DEHYDROGENASE (LD)
411              LD 1 ISOENZYME
412              LD 2 ISOENZYME
413              LD 3 ISOENZYME
414              LD 4 ISOENZYME
415              LD 5 ISOENZYME
418              LEAD
426              LEUCUINE AMINOPEPTIDASE (LAP)
446              LH (LUTEOTROPIN)
428              LIDOCAINE
430              LIPASE
434              LIPIDS, TOTAL
443              LIPOPROTEIN LOW DENSITY (LDL)
```

SQC CONSTITUENTS (CAP)

Code	Description
442	LIPOPROTEIN VERY LOW DENSITY
438	LIPOPROTEIN, ALPHA
439	LIPOPROTEIN, BETA
440	LIPOPROTEIN, PRE-BETA
441	LIPOPROTEINS HIGH DENSITY (HDL)
444	LITHIUM
447	LYMPHOCYTES
450	MAGNESIUM
452	MAGNESIUM, URINE
454	MCH
456	MCHC
458	MCV
803	MCV RATIO
460	MEAN PLATELET VOLUME
475	METHOTREXATE
478	MONOCYTES
480	MYOGLOBIN
005	N-ACETYLPROCAINAMIDE
485	NETILMICIN
490	NORDOXEPIN
495	NORTRIPTYLINE
510	O2 SATURATION, OXYGEN
518	OSMOLALITY
520	OSMOLALITY, URINE
901	OTHER THAN LISTED
525	OXYHEMOGLOBIN
529	PARATHYROID HORMONE
534	PCO2
540	PH
541	PH, URINE
542	PHENOBARBITAL
546	PHENYLALANINE
549	PHENYTOIN
551	PHENYTOIN, FREE
560	PHOSPHOHEXOISOMERASE (PHI)
564	PHOSPHOLIPIDS
568	PHOSPHORUS
567	PHOSPHORUS, URINE
570	PLASMINOGEN
572	PLATELETS
614	PO2
576	POTASSIUM
583	POTASSIUM, URINE

SQC CONSTITUENTS (CAP)

```
Code            Description
----            -----------------------------
586             PRIMIDONE
588             PROCAINAMIDE
590             PROGESTERONE
594             PROLACTIN
596             PROPRANOLOL
601             PROTEIN, ALBUMIN
602             PROTEIN, ALPHA-1 GLOBULIN
603             PROTEIN, ALPHA-2 GLOBULIN
604             PROTEIN, BETA GLOBULIN
606             PROTEIN, GAMMA GLOBULIN
610             PROTEIN, GLOBULIN, TOTAL
608             PROTEIN, TOTAL
834             PROTEIN, URINE
605             PROTEIN,CSF
612             PROTHROMBIN TIME
620             QUINIDINE
628             RDW (CALCULATE)
805             RED BLOOD CELL RATIO
626             RED CELL COUNT (RBC)
630             RENIN ACTIVITY (PLASMA)
640             SALICYLATE
650             SODIUM
658             SODIUM, URINE
660             SPECIFIC GRAVITY, URINE
652             SULFAPRYRIDINE
711             T UPTAKE
716             T3 UPTAKE
712             T3 UPTAKE/INDEX
664             TESTOSTERONE
668             THEOPHYLLINE0
841             THROMBIN TIME
680             THYROXINE (T4)
682             THYROXINE BINDING GLOBULIN
685             THYROXINE, (T4) NEONATAL
690             THYROXINE, FREE
700             TOBRAMYCIN
702             TRANSFERRIN
704             TRIGLYCERIDE
708             TRIIODOTHYRONINE (T3)
678             TSH (THYROTROPIN)
720             UREA
726             UREA NITROGEN
```

SQC CONSTITUENTS (CAP)

```
Code            Description
----            -----------------------------
728             UREA NITROGEN, URINE
730             URIC ACID
732             URIC ACID, URINE
736             VALPROIC ACID
740             VANCOMYCIN
744             VANILLYLMANDELIC ACID
752             VITAMIN B12
806             WBC RATIO
760             WHITE CELL COUNT (WBC)
790             ZINC
792             ZINC, URINE
```

WORKLOAD COLLECTION TYPES

```
Code               Description                    Unit Value
----               --------------------           ---------
89350              Arterial collected by lab      12.0
89335              Capillary - outside of lab     14.0 e
89336              Capillary - within lab         8.0 e
89344              Drainage collected by lab      6.0
89338              Micro specimen Collection(Swab) 6.0
89340              Urine - Lab collected          6.0
89341              Venous - outside of lab        10.0 e
82350              Venous - within Lab            4.0 e
89343              Venous - within Lab            4.0 e

* = No unit value assigned, t = temporary value, e = extrapolated value
```

WORKLOAD ITEMS FOR COUNT

```
Code            Description
------          -----------------------------
ABSRP           Absorption
ANTIG           Antigen
ANTISR          Antiserum
APPL            Application
ASPIR           Aspirate
BAG             Bag
BATCH           Batch
BIOBAG          Biobag
BLOCK           Block
BOTTLE          Bottle
CASE            Case
CELLRG          Cell Reagent
CHART           Chart
CONST           Constituent
DELIV           Delivery
DILUTE          Dilution
DISC            Disc
DONOR           Donor
FILT            Filtrate
FUNCT           Function
GRID            Grid
INJ             Injection
JAR             Jar
KARYO           Karyotype
LOCATN          Location
ORG             Organism
PANEL           Panel
PATNT           Patient
PR100           Per 100
PLATE           Plate
PBT             Plate, Bottle and Tube
PRINT           Print
RTRIP           Round trip
ROW             Row
SLIDE           Slide
SMEAR           Smear
SPEC            Specimen
SUB             Subculture
SUBST           Substance
TEST            Test
TISS            Tissue
TRAY            Tray
TUBE            Tube
UNIT            Unit
```

WORKLOAD METHOD TYPES

Code	Method Description	Unit Value	Setup Code	Setup Value
02-012	Abbott ABA 100	1.0	82410	2.5
02-030	Abbott ABA 200	*	82410	*
02-013	Abbott ABA 50	1.0	82410	2.5
06-083	Abbott Avantage Procedure codes: 87516,87520,87522			
06-094	Abbott MS-2 Procedure codes: 87514,87518,87520,87522			
05-150	Abbott Quantum I	*		
05-155	Abbott Quantum II	*		
02-018	Abbott TDX (extraction required)	t 1.0	82410	t 1.2
02-049	Abbott TDX (no extraction required)	t 0.5	82410	t 1.2
02-025	Abbott VP	t 0.5	82410	t 2.5
03-069	American Dade AUTO FI Procedure codes: 85610,85730,85220-85280,85378	t 6.5		
02-102	American Dade Paramax	*	82410	*
02-087	American Instrument Rotochem	1.0	82410	3.0
02-068	American Monitor KDA (ATS Mode)	t 0.1	82410	t 2.7
02-069	American Monitor KDA (single batch)	t 0.6	82410	t 1.9
02-023	American Monitor Parallel	*	82410	*
06-081	Analytab Uniscept Procedure codes: 87516	*		
06-092	Auto SCAN-3 (w/o data management) Procedure codes: 87516	t 6.5		

WORKLOAD METHOD TYPES

```
Unit    Setup Setup
Code          Method Description                        Value  Code  Value
------        ------------------                        ------ ----- ------
06-088        Auto SCAN-3 (with data management)        t 13.0
              Procedure codes: 87516


02-084        Baker Diagnostics Centrifichem 500        1.0    82410 3.0


03-055        Baker MK-4/HC                             t 7.5
              Procedure codes: 85571


03-051        Baker Series 130                          *
              Procedure codes: 85020,85030,85050


03-050        Baker Series 150                          *
              Procedure codes: 85020,85030,85050,85055


03-053        Baker Series 5000                         *
              Procedure codes: 85020,85030,85050,85055


03-052        Baker Series 7000                         *
              Procedure codes: 85020,85030,85050,85055


03-054        Baker Series 810 Platalet Analyzer        *
              Procedure codes: 85570


03-085        BBL Fibrometer                            t 5.0
              Procedure codes: 85610,85730,85220-85280,85378


06-097        BBL Sceptor
              Procedure codes: 87514,87516


03-068        BD Ultra-Flo 100                          t 5.0
              Procedure codes: 85570


02-098        Beckman Astra 4                           *      82410 *


02-096        Beckman Astra 8                           0.1    82410 2.1


02-027        Beckman CI/CO2 Analyzer                   t 0.6  82410 t 1.3


02-022        Beckman Creatinine Analyzer               *


02-031        Beckman E4A Electrolyte Analyzer          *      82410 *
```

WORKLOAD METHOD TYPES

Code	Method Description	Unit Value	Setup Code	Setup Value
02-015	Beckman Glucose Analyzer	2.5		
02-028	Beckman Glucose/BUN Analyzer	t 0.6	82410	t 1.3
05-050	Beckman Immunochemistry Analyzer	8.0		
02-043	Beckman klinaflame Procedure codes: 82420,84821			
02-016	Beckman Urea Analyzer	2.5		
02-008	Becton Dickinson ARIA II	*	82410	*
03-061	BioData Coagulation Profiler Procedure codes: 85220-85280,85378,85610,85613,85730,85670	*		
03-076	BMD/Hycel Hycel Counter 300 Procedure codes: 85020,85030,85050	t 3.0		
02-039	Boehringer 8700	e 0.2	82410	e 2.0
02-090	Boehringer Hitachi 705	t 0.2	82410	t 2.5
02-079	Corning 158 Procedure codes: 82884	*		
02-063	Corning 165 Procedure codes: 82884	12.0		
02-067	Corning 168 Procedure codes: 82882	4.0		
02-064	Corning 175 Procedure codes: 82882	4.0		
02-074	Corning 178 Procedure codes: 82882	*		
02-017	Corning 920 Chloride Analyzer	*		

WORKLOAD METHOD TYPES

```
                                                    Unit   Setup Setup
Code          Method Description                    Value  Code  Value
------        ------------------                    ------ ----- ------
03-089        Corning LARC                          t 7.4
              Procedure codes: 85008

02-046        Corning Na/K/Li Analyzer
              Procedure codes: 82420,84821

03-048        Coulter diff 4                        *
              Procedure codes: 85008

03-049        Coulter diff3 50                      *
              Procedure codes: 85008

03-059        Coulter M430                          *
              Procedure codes: 85020,85030,85050,85055

03-078        Coulter Model FN                      3.0
              Procedure codes: 85020,85030

03-070        Coulter Model S                       3.0
              Procedure codes: 85015

03-075        Coulter Model S-Plus                  t 3.0
              Procedure codes: 85016

03-087        Coulter Model S-Plus II               t 4.0
              Procedure codes: 85017

03-042        Coulter Model S-Plus IV               e 4.0
              Procedure codes: 85018

03-071        Coulter Model S-Senior                3.0
              Procedure codes: 85015

03-043        Coulter P 260                         *
              Procedure codes: 85020,85030,85050,85055

03-044        Coulter S 550                         *
              Procedure codes: 85015
```

WORKLOAD METHOD TYPES

Code	Method Description	Unit Value	Setup Code	Setup Value
03-057	Coulter S 560 Procedure codes: 85015	*		
03-046	Coulter S 7120 Procedure codes: 85015	*		
03-045	Coulter S 770 Procedure codes: 85015	*		
03-058	Coulter S 790 Procedure codes: 85015	*		
03-081	Coulter Thrombocounter Procedure codes: 85571	t 5.0		
03-079	Coulter ZBI Procedure codes: 85020,85030,85571	3.0		
06-095	Diagnostic RepliScan II System Procedure codes: 87516	*		
02-035	Du Pont ACA	0.5	82410	2.5
02-034	Du Pont ACA IV	*	82410	*
02-083	Electro Nucleonics Flexigem	*	82410	*
02-085	Electro Nucleonics Gemeni	t 1.0	82410	t 1.0
02-086	Electro Nucleonics Gemsaec	1.0	8241	3.0
02-082	Electro Nucleonics Gemstar	*	82410	*
01-030	Fenwal CS 3000 Procedure codes: 86386	t	203.0	
03-072	Fisher Hem-alyzer Procedure codes: 85020,85030,85050	0.5		

WORKLOAD METHOD TYPES

Code	Method Description	Unit Value	Setup Code	Setup Value
06-085	General Autobac I Procedure codes: 87518	7.0		
06-096	General Autobac IDX Procedure codes: 87518,87520			
06-086	General Autobac MTS 12/18 Procedure codes: 87518,87520			
03-084	General Coag-a-mate (dual channel) Procedure codes: 85613	t 4.0		
03-041	General Coag-a-mate 2001 Procedure codes: 85610,85730	*		
03-067	General Coag-a-mate X-2 Procedure codes: 85220-85280,85378,85610,85613,85730,85670	*		
03-086	General Coag-a-mate(single channel) Procedure codes: 85610,85730	t 3.0		
03-088	Geometric Data Hematrak Procedure codes: 85008	t 4.0		
04-007	Giemsa/Gram Stain			
02-032	Gilford 202	t 1.0	82410	t 2.5
02-033	Gilford 203	t 1.0	82410	t 2.5
02-019	Gilford 3400	1.0	82410	2.5
02-020	Gilford 3500	1.0	82410	2.5
02-029	Gilford Impact 400	*	82410	*
02-037	Gilford Optimate	*	82410	*
02-026	Gilford System 3	*	82410	*

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WORKLOAD METHOD TYPES

Code	Method Description	Unit Value	Setup Code	Setup Value
02-021	Gilford System 4	1.0	82410	2.5
02-024	Gilford System 5	*	82410	*
01-012	Groupamatic Model 50 Procedure codes: 86082	t 1.5		
01-022	Haemonetics Model 15 Procedure codes: 86670	*		
01-024	Haemonetics Model 17 Procedure codes: 86670	*		
01-050	Haemonetics Model 30 Procedure codes: 86383,86400,86401			
02-038	Hycel 10	t 0.1	82410	t 2.3
02-058	Hycel 17	t 0.1	82410	t 2.3
02-048	Hycel HMA 16	t 0.1	82410	t 2.3
01-017	IBM 2991 Procedure codes: 86276	*		
01-020	IBM 2991 (Program) Procedure codes: 86670	t 20.0		
01-060	IBM 2997 Procedure codes: 86385	t280.0		
05-051	IDT FIAX Fluorometer	8.0		
02-057	IL 1301 Procedure codes: 82882	*		
02-075	IL 1302 Procedure codes: 82882	*		

WORKLOAD METHOD TYPES

```
                                                    Unit    Setup  Setup
Code         Method Description                     Value   Code   Value
------       -------------------                    ------  -----  ------
02-044       IL 143
             Procedure codes: 82420,84821

02-070       IL 213                                 20.0
             Procedure codes: 82886

02-009       IL 282 Co-Oximeter                     t 3.2
             Procedure codes: 84696

02-071       IL 313                                 20.0
             Procedure codes: 82886

02-072       IL 329                                 20.0
             Procedure codes: 82886

02-092       IL 343
             Procedure codes: 82420,84821

02-073       IL 413                                 20.0
             Procedure codes: 82886

02-042       IL 443
             Procedure codes: 82420,84821

02-076       IL 446 CI/CO2 Analyzer                 *       82410    *

02-080       IL 508/504                             *       82410    *

02-097       IL 513                                 12.0
             Procedure codes: 82884

02-047       IL 643
             Procedure codes: 82420,84821

02-078       IL 713                                 *
             Procedure codes: 82884

02-095       IL 813                                 4.0
             Procedure codes: 82882
```

WORKLOAD METHOD TYPES

```
                                                       Unit   Setup Setup
Code          Method Description                       Value  Code  Value
------        ------------------                       ------ ----- ------
02-094        IL 817                                   4.0
              Procedure codes: 82882

02-077        IL 919 Gluc/BUN/Creat Analyzer           *      82410 *

02-041        IL 943
              Procedure codes: 82420,84821

02-088        IL Multistat                             e 0.2  82410 e  2.0

06-089        Johnston Bactec 460 (Neiserria ID)
              Procedure codes: 87512,87514

06-090        Johnston Bactec 460, Bactec 461          t 6.5
              Procedure codes: 87512

02-091        Kodak Ektachem 400 Analyzer              t 0.2  82410 t  1.2

02-103        Kodak Ektachem 700                       *      82410 *

02-014        LKB Reaction Rate Analyzer               1.0    82410 2.5

02-987        METHOD FOR TESTING                       10.0   10000 10.0

06-093        Micro Media Micro Coder I                t 6.0
              Procedure codes: 87518

06-084        Micro Scan Touch Scan                    *
              Procedure codes: 87518

03-065        MLA Electra 600                                   *
              Procedure codes: 85220-85280,85610,85730,85731

03-064        MLA Electra 700                                   *
              Procedure codes: 85220-85280,85378,85610,85613,85670,85730

02-001        NOS or Single Channel Flame Photome
              Procedure codes: 82882,82884,82886,84295

02-045        Nova 1 Na/K Analyzer                     *      82410   *
```

WORKLOAD METHOD TYPES

Code	Method Description	Unit Value	Setup Code	Setup Value
02-003	Nova 3 CI/CO2 Analyzer	*	82410	*
02-005	Nova 4 + 4 Electrolyte Analyzer	*	82410	*
02-004	Nova 4 Electrolyte Analyzer	t 0.1	82410	t 3.0
02-007	Orion Model 1020 Na/K Analyzer	*	82410	*
03-082	Ortho ELT-8 Procedure codes: 85016	t 3.0		
03-063	Ortho ELT-800 Procedure codes: 85017	*		
03-077	Ortho Hemac 3000-630L Procedure codes: 85015	t 3.0		
03-083	Ortho Hemac 4000 Procedure codes: 85015	t 3.0		
02-081	Perkin Elmer Amylase/Lipase Analyze	*	82410	*
02-066	Photovolt Stat Ion	t 0.2	82410	t 1.4
02-099	PM America Polimak II	t 0.5	82410	t 1.5
02-061	Radiometer ABL-1 Procedure codes: 82882	4.0		
02-062	Radiometer ABL-2 Procedure codes: 82882	4.0		
02-059	Radiometer ABL-3 Procedure codes: 82882	*		
02-060	Radiometer ABL-30 Procedure codes: 82882	*		
02-052	Radiometer BMS 3/MK2 Procedure codes: 82886	20.0		

WORKLOAD METHOD TYPES

```
                                                    Unit   Setup Setup
Code          Method Description                    Value  Code  Value
------        ------------------                    ------ ----- ------
02-089        Roche COBAS BIO                        t  0.6 82410 t  1.8

03-056        Sequoia Turner Cell Dyne               *
              Procedure codes: 85015,85570,85571

03-062        Sherwood/Lancer Coagulyzer             t  3.0
              Procedure codes: 85610,85730,85220-85280

03-060        Sherwood/Lancer Fibrinogen Analyzer    *
              Procedure codes: 85378

06-600        Source Biopsy

06-602        Source Cerebrospinal fluid

06-604        Source Environmental

06-606        Source Genital

06-608        Source Other 1

06-610        Source Other 2

06-612        Source Other 3

06-614        Source Other 4

06-616        Source Respiratory-other

06-618        Source Sputum

06-620        Source Sterile fluid-other

06-622        Source Stool

06-624        Source Throat

06-626        Source Urine

06-628        Source Wound
```

WORKLOAD METHOD TYPES

```
                                                  Unit   Setup Setup
Code          Method Description                  Value  Code  Value
------        ------------------                  ------ ----- ------
02-006        Syva Advance                        *      82410 *

02-101        Syva QST                            e 5.0  82410

02-011        Technicon Auto An.(dual op. single)

02-050        Technicon Auto Analyzer

02-010        Technicon Auto Analyzer (single ch)

01-011        Technicon AutoAnalyzer
              Procedure codes: 86082

03-047        Technicon H 6000                    *
              Procedure codes: 85018

03-074        Technicon Hemalog-Model 10          2.0
              Procedure codes: 85016

03-073        Technicon Hemalog-Model 8           2.0
              Procedure codes: 85016

02-055        Technicon SMA 12/60                 4.0
              Procedure codes: 82400

02-056        Technicon SMA 18/60                 t 6.0
              Procedure codes: 82400

02-051        Technicon SMA 6/60                  4.0
              Procedure codes: 82400

02-054        Technicon SMA II/C                  *
              Procedure codes: 82400

02-065        Technicon SMAC                      2.5
              Procedure codes: 82400

02-036        Technicon Stat Lyte                 t  0.2 82410 t  2.0

06-087        Vitek Auto Microbic System (AMS)
              Procedure codes: 87514,87518,87520

02-093        Worthington Chemetrics              *      82410 *
```

WORKLOAD CATEGORIES

```
Code            Description
----            --------------------
005             EMERGENCY ROOM
001             INPATIENTS
007             INTERSTATE
009             OTHERS
002             OUTPATIENTS
003             QC & STANDARDS
006             REFERRAL
008             REGIONAL LA
004             REPEATS
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Component #    Component Name              Units          AgeNR     Specimen      Short name
-------------------------------------------------------------------------------------------
10187A         11-Desoxycortisol          ug/dl                    Urine         11-Desox
10242A         11-Hydroxyandosterone      mg/24 Hr                 Urine         11-Hydst
10241A         11-Hydroxyetiocholanolone  mg/24 Hr                 Urine         11-Hydro
10244A         11-Ketoandrosterone        mg/24 Hr                 Urine         11-Ketad
10243A         11-Ketoetiocholanolone     mg/24 Hr                 Urine         11-Ketch
10299A         17-Hydroxycorticosteroids  ug/dl                    Blood         17-Hydro
10096A         17-Ketosteroid             mg/L                     Blood         17-Ketos
10312A         17-Ketosteroid             mg/L                     Urine         17-Ketos
10095A         17-OH Steroid              mg/L                     Urine         17-OH St
10198A         17-OH-Progesterone         ng/ml                    Blood         17-OH-Pr
10044A         5-HIAA                     mg/L                     Urine         5-HIAA
10072A         5-Nucleotidase             U/L                      Urine         5-Nucleo
10317A         5-Nucleotidase             units                    Blood         5-Nucleo
10352A         A/G Ratio                                           Blood         A/G Rati
10353A         ABO                                                 Blood         ABO
10181A         ACTH                       pg/ml                    Blood         ACTH
10003A         ALT                        U/L                      Blood         ALT
10355A         ANA Titer                                           Blood         ANA Tite
10108A         APTT                       seconds                  Blood         APTT
10356A         ASO Titer                  Todd Units               Blood         ASO Tite
10013A         AST                        U/L                      Blood         AST
10112A         Acetaminophen              ug/ml                    Blood         Acetamin
10220A         Acetone                    mg/dl                    Blood         Acetone
10273A         Acetone                    mg/dl                    Urine         Ur Acet
10002A         Acid Phos                  U/L                      Blood         Acd Phos
10001A         Acid Phos, Immunologic     ng/ml                    Blood         Acd Phos
10004A         Albumin                    gm/dl                    Blood         Albumin
10272A         Albumin                    mg/24 Hr                 Urine         Ur Album
10345A         Albumin                    mg/dl                    CSF           Albumin
10123A         Alcohol, Ethyl             mg/dl                    Blood         Eth Alc
10005A         Aldolase                   U/L                      Blood         Aldolase
10172A         Aldosterone                ng/ml                    Blood         Aldoster
10173A         Aldosterone                ug/24 Hr                 Urine         Ur Aldos
10006A         Alk Phos                   U/L                      Blood         Alk Phos
10007A         Alpha-1 Antitrypsin        mg/L                     Blood         A-1-A
10008A         Alpha-2-Macroglobulin      mg/dl                    Blood         A-2-M
10174A         Alpha-Fetoprotein          U/ml                     Blood         Alpha-Fe
10354A         Alpha-Fetoprotein          ug/dl                    Amniotic Fluid Alpha-Fe
10271A         Alpha-amino Acid Nitrog    mg/24 Hr                 Urine         A-A AcNt
10274A         Alpha-amino Acid Nitrog    mg/dl                    Blood         A-A AcNt
10113A         Amikacin                   ug/ml                    Blood         Amikacin
10114A         Amitriptylin               ng/ml                    Blood         Amitript
10446A         Amitriptylin               ng/ml                    Urine         Amitript
10009A         Ammonia                    umol/L                   Blood         Ammonia
10270A         Ammonia Nitrogen           mEq/24 Hr                Urine         Amm Nito
10357A         Amphetamine                                         Blood         Amphetam
10010A         Amylase                    Somogyi Units/Hr         Urine         Ur Amyla
10012A         Amylase                    U/L                      Blood         Amylase
10358A         Amylase/Creat              %                        Blood/Urine   Amy/Crea
10175A         Androstenedione            ng/ml                    Blood         Androste
10359A         Anion Gap                                           Blood         AnionGap
10360A         Aniso                                               Blood         Aniso
10361A         Antibody ID                                         Blood         AntibdID
10011A         Antithrombin III           %                        Blood         Anti III
10115A         Arsenic                    ug/ml                    Urine         Ur Arsen
10275A         Arsenic                    ug/dl                    Blood         Arsenic
10269A         Ascorbic Acid              mg/dl                    Urine         Ur Ascor
10276A         Ascorbic Acid              mg/dl                    Blood         Ascorbic
10364A         Aty Lymphs                 %                        Blood         Aty Lymp
10282A         BSP                        %                        Blood         BSP
10365A         BUN/Creat                                           Blood         BUN/Crea
10503A         Background                 %                                      Backgrnd
10339A         Bands                      %                        Blood         Bands
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Component #    Component Name              Units         AgeNR      Specimen       Short name
------------------------------------------------------------------------------------------
C10116A        Barbiturate                 mg/dl                    Urine          Ur Barbi
10277A         Barbiturate                                         Blood          Barbitur
10278A         Base Excess                 mEq/L                    Blood          Base Exc
10279A         Base Total                  mEq/L                    Blood          Base Tot
10369A         Basophilic Stip                                      Blood          Baso Sti
10368A         Basos                       %                        Blood          Basos
10268A         Bence Jones Protein                                  Urine          BenJonPt
10267A         Beryllium                   ug/24 Hr                 Urine          Berylliu
10148A         Bicarbonate, Calculated     mmol/L                   Blood          Bicarbon
10348A         Bile                                                 Stool          Bile
10280A         Bile Acids                  mg/dl                    Blood          Bile Aci
10014A         Bili Direct                 mg/dl                    Blood          Dir Bili
10281A         Bili Indirect               mg/dl                    Blood          Ind Bili
10015A         Bili Neonatal               mg/dl                    Blood          Neo Bili
10266A         Bili Qual                                            Urine          Qual Bil
10016A         Bilirubin                   mg/dl                    Blood          Tot Bili
10370A         Blasts                      %                        Blood          Blasts
10335A         Bld Time (Duke)             minutes                  Blood          Bld Time
10334A         Bld Time (Ivy)              minutes                  Blood          Bld Time
10265A         Blood, Occult                                        Urine          Ur Blood
10417A         Blood, Occult                                        Stool          St Blood
10017A         Bromide                     mg/dl                    Blood          Bromide
10371A         C-Peptide                   mg/dl                    Blood          C-Peptid
10372A         C-Reactive Prot             mg/dl                    Blood          CRP
10036A         C3 Complement               mg/dl                    Blood          C3 Compl
10037A         C4 Complement               mg/dl                    Blood          C4 Compl
10176A         CEA                         ng/ml                    Blood          CEA
10030A         CK                          U/L                      Blood          CK
10031A         CK-BB-Isoenzyme             %                        Blood          CK-BB-Is
10032A         CK-MB-Isoenzyme             U/L                      Blood          CK-MB-Is
10033A         CK-MM-Isoenzyme             %                        Blood          CK-MM-Is
10373A         CMV Ab                      Titer                    Blood          CMV Ab
10029A         CO2                         mmol/L                   Blood          CO2
10375A         Calcitonin                  pg/ml                    Blood          Calciton
10018A         Calcium                     mg/dl                    Blood          Calcium
10020A         Calcium                     mg/dl                    Urine          Ur Calc
10019A         Calcium, Ionized            mg/dl                    Blood          Ioniz Ca
10117A         Carbamazepine               ug/ml                    Blood          Carbamaz
10507A         Carbamazepine, Free         mg/dl                    Blood          Fr Carb
10283A         Carbon Dioxide              mmol/L                   Blood          Car Diox
10149A         Carboxyhemoglobin           %                        Blood          Carboxyh
10021A         Carotene                    ug/dl                    Blood          Carotene
10376A         Casts                       /LPF                     Urine          Casts
10262A         Cathecholamines             ug/dl                    Urine          Cathecho
10346A         Cell Ct                                              CSF            Cell Ct
10381A         Cells Ctd                                            Blood          Cells Ct
10022A         Ceruloplasmin               mg/dl                    Blood          Ceroplm
10363A         Character                                            Urine          Characte
10118A         Chloramphenicol             ug/ml                    Urine          Chloramp
10023A         Chloride                    mEq/L                    Blood          Chloride
10024A         Chloride                    mEq/L                    Urine          Ur Chlor
10347A         Chloride                    mEq/L                    CSF            CSF Chlo
10025A         Cholesterol                 mg/dl                    Blood          Cholest
10284A         Cholesterol, Esters         %                        Blood          Chol Est
10026A         Cholinesterase              IU/ml                    Blood          Cholines
10285A         Citrate Acid                mg/dl                    Urine          Citrate
10489A         Clinical Data                                                       Cl Data
10490A         Clinical Information                                                Cl Info
10337A         Clot Lysis                                           Blood          Clot Lys
10336A         Clot Retraction             %                        Blood          Clot Ret
10374A         Clot Time                   minutes                  Blood          Clot Tim
10382A         Cocaine                     mg/L                     Blood          Cocaine
10383A         Codeine                     mg/L                     Blood          Codeine
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Component #   Component Name              Units        AgeNR     Specimen        Short name
------------------------------------------------------------------------------------------
10362A        Color                                              Urine          Color
10384A        Comment                                                           Comment
10366A        Coombs Direct                                      Cord Blood     Dir Coom
10385A        Coombs Indirect                                    Cord Blood     Coombs I
10027A        Copper                      ug/dl                  Blood          Copper
10028A        Copper                      ug/dl                  Urine          Ur Coppe
10261A        Copper, 24H                 ug/24 Hr               Urine          24H Copp
10260A        Coproporphyrin              ug/24 Hr               Urine          Coropor
10386A        Corr WBC                    thou/cmm               Blood          Corr WBC
10179A        Corticosterone              ug/dl                  Blood          Corticos
10180A        Cortisol                    ug/dl                  Blood          Cortisol
10387A        Cortisol                    ug/24 Hr               Urine          Ur Cort
10258A        Creat 24Hr                  mg/kg/24H              Urine          24H Cret
10287A        Creat Clearance             ml/min                 Blood/Urine    Creat Cl
10259A        Creatine                    ug/24 Hr               Urine          Creatine
10286A        Creatine                    mg/dl                  Blood          Creatine
10034A        Creatinine                  mg/dl                  Blood          Creat
10035A        Creatinine                  mg/dl                  Urine          Ur Creat
10492A        Crossmatch X1                                      Blood          X MatchI
10493A        Crossmatch X2                                      Blood          XMatch 2
10494A        Crossmatch X3                                      Blood          XMatch 3
10495A        Crossmatch X4                                      Blood          XMatch 4
10496A        Crossmatch X5                                      Blood          XMatch 5
10497A        Crossmatch X6                                      Blood          XMatch 6
10288A        Cryoglobulins                                      Blood          Cryoglob
10380A        Crystals                    /LPF                   Urine          Crystals
10256A        Cystine, Qual                                      Urine          Qual Cys
10257A        Cystine, Quant              mg/24 Hr               Urine          Quant Cy
10105A        D-Xylose                    %                      Urine          D-Xylose
10388A        D-Xylose                    mg/dl                  Blood          D-Xylose
10182A        DHEA                        ng/ml                  Blood          DHEA
10183A        DHEA-SO4                    ng/ml                  Blood          DHEA-SO4
10186A        DHT                         ng/ml                  Blood          DHT
10491A        Date                                                              Date
10119A        Desipramine                 ng/ml                  Blood          Desipram
10445A        Desipramine                 ng/ml                  Urine          Desipram
10255A        Diacetic Acid                                      Urine          Diacetic
10488A        Diagnosis                                                         Dx
10120A        Dibucaine                   %                      Blood          Dibucain
10184A        Digitoxin                   ng/ml                  Blood          Digitox
10185A        Digoxin                     ng/ml                  Blood          Digoxin
10121A        Disopyramide Phosphate      ug/ml                  Blood          Disop Po
10448A        Dopamine                    mg/L                   Blood          Dopamine
10449A        Dopamine                    mg/L                   Urine          Dopamine
10122A        Doxepin                     ng/ml                  Blood          Doxepin
10447A        Doxepin                     ng/ml                  Urine          Doxepin
10389A        Du                                                 Blood          Du
10340A        Eos                         %                      Blood          Eos
10254A        Epinephrine                 ug/24 Hr               Urine          Epinephr
10450A        Epinephrine                 pg/ml                  Blood          Epinephr
10377A        Epiths                      /LPF                   Urine          Epiths
10188A        Estradiol                   pg/ml                  Blood          Estradio
10189A        Estriol, Total              ng/ml                  Blood          Tot Estr
10190A        Estriol, Unconjugated       ng/ml                  Blood          Unco Est
10191A        Estriol, Urine              ug/24 Hr               Urine          Ur Estro
10253A        Estrogens, Total            ug/24 Hr               Urine          Estrogen
10192A        Estrone                     pg/ml                  Blood          Estrone
10124A        Ethchlorvynol               mg/L                   Blood          Ethchlor
10125A        Ethosuximide                ug/ml                  Blood          Ethosuxi
10245A        Etiocholanolone             mg/24 Hr               Urine          Etiochol
10451A        Euglobulin                                         Blood          Euglobul
10109A        FDP                         ug/ml                  Blood          FDP
10247A        FSH                         IU/L                   Blood          FSH
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Component #   Component Name              Units        AgeNR     Specimen        Short name
-------------------------------------------------------------------------------------------
10390A        FTA Abs                                            CSF             FTA Abs
10391A        FTA Abs                                            Blood           FTA Abs
10392A        Factor IX                   %                      Blood           FactorIX
10393A        Factor V                    %                      Blood           Factor V
10394A        Factor VII                  %                      Blood           Fac VII
10395A        Factor VIII                 %                      Blood           Fac VIII
10396A        Factor X                    %                      Blood           Factor X
10397A        Factor XI                   %                      Blood           Fac XI
10398A        Factor XII                  %                      Blood           Fac XII
10251A        Fat                                                Urine           Ur Fat
10252A        Fat                                                Stool           St Fat
10290A        Fatty Acid, Free            uEq/L                  Blood           Free Fat
10289A        Fatty Acids, Total          mmol/L                 Blood           Tot FatA
10193A        Ferritin                    ng/ml                  Blood           Ferritin
10399A        Fetal Mat Hgb                                      Blood           Fet Hgb
10400A        Fetal Screen                                       Blood           Fetal Sc
10110A        Fibrinogen                  mg/dl                  Blood           Fibrinog
10250A        Fluoride                    mg/24 Hr               Urine           Fluoride
10291A        Fluoride                    mg/dl                  Blood           Fluoride
10292A        Folate                      ng/ml                  Blood           Folate
10194A        Folic Acid                  ng/ml                  Blood           Folic Ac
10401A        Fribin Split Prod           ug/ml                  Blood           FSP
10498A        Frozen Section                                                     Froz Sec
10249A        Fructose                    mg/24 Hr               Urine           Fructose
10295A        G6PD                        units                  Blood           G6PD
10305A        GTT 1Hr                     mg/dl                  Blood           GTT 1Hr
10434A        GTT 1Hr                     mg/dl                  Urine           GTT 1Hr
10306A        GTT 2Hr                     mg/dl                  Blood           GTT 2Hr
10435A        GTT 2Hr                     mg/dl                  Urine           GTT 2Hr
10304A        GTT 30min                   mg/dl                  Blood           GTT 30mi
10433A        GTT 30min                   mg/dl                  Urine           GTT 30mi
10307A        GTT 3Hr                     mg/dl                  Blood           GTT 3Hr
10436A        GTT 3Hr                     mg/dl                  Urine           GTT 3Hr
10308A        GTT 4Hr                     mg/dl                  Blood           GTT 4Hr
10437A        GTT 4Hr                     mg/dl                  Urine           GTT 4Hr
10309A        GTT 5Hr                     mg/dl                  Blood           GTT 5Hr
10438A        GTT 5Hr                     mg/dl                  Urine           GTT 5Hr
10310A        GTT 6Hr                     mg/dl                  Blood           GTT 6Hr
10439A        GTT 6Hr                     mg/dl                  Urine           GTT 6Hr
10432A        GTT Fast                    mg/dl                  Urine           GTT Fast
10303A        GTT Fasting                 mg/dl                  Blood           GTT Fast
10038A        Gamma GT                    U/L                    Blood           Gamma GT
10294A        Gamma Globulin              gm/dl                  Blood           Gamma Gl
10196A        Gastrin                     pg/ml                  Blood           Gastrin
10126A        Gentamicin                  ug/ml                  Blood           Gentamic
10293A        Globulins, Total            gm/dl                  Blood           Tot Glob
10039A        Glucose                     mg/dl                  Blood           Glucose
10040A        Glucose                     mg/dl                  CSF             CSF Gluc
10041A        Glucose                     mg/dl                  Urine           Ur Gluc
10480A        Glucose PP                  mg/dl                  Blood           Glu PP
10296A        Glutamyl Transferase        IU/L                   Blood           Glut Tra
10297A        Glutathione                 mg/dl                  Blood           Glutathi
10402A        Glutethimide                mg/L                   Blood           Glutethi
10042A        Glyco Hemoglobin            %                      Blood           GlycoHgb
10156A        Granulocytes                %                      Blood           Gran
10499A        Grossed by                                                         Gross by
10197A        Growth Hormone              ng/ml                  Blood           Grow Hor
10298A        Guanase                                            Blood           Guanase
10452A        HAM Test                    %                      Blood           HAM Test
10045A        HBD                         U/L                    Blood           HBD
10403A        HCG Qual                                           Blood           HCG Qual
10177A        HCG Quant                   IU/L                   Urine           HCG
10247A        HCS                         ng/ml                  Urine           HCS
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Component #   Component Name               Units       AgeNR    Specimen       Short name
------------------------------------------------------------------------------------------
10065A        HDL                          mg/dl                Blood          HDL
10404A        HLA-B27 Ag                                        Blood          HLA-B27
10405A        HTLV 3 Ab                                         Blood          HTLV 3Ab
10043A        Haptoglobin                  mg/dl                Blood          Haptoglb
10157A        Hct                          %                    Blood          Hct
10406A        Heinz Bodies                                      Blood          Heinz Bo
10219A        Hemoglobin Ratio             Ratio                Blood          Hgb Rati
10150A        Hemoglobin, Total            gm/dl                Blood          Tot Hgb
10453A        Hemosiderin                                       Urine          Hemoside
10454A        Hep B Surface Antigen                             Blood          HBsAg
10455A        Herpes Virus                 Titer                Blood          Herpes V
10158A        Hgb                          gm/dl                Blood          Hgb
10457A        Hypo                                              Blood          Hypo
10051A        IBC, Total                   ug/dl                Blood          Tot IBC
10052A        IBC, Unsaturated             ug/dl                Blood          Uns IBC
10458A        Ictotest                                          Urine          Ictotest
10046A        IgA                          mg/dl                Blood          IGA
10047A        IgD                          mg/dl                Blood          IGD
10199A        IgE                          IU/ml                Blood          IgE
10048A        IgG                          mg/dl                Blood          IgG
10049A        IgM                          mg/dl                Blood          IgM
10127A        Imipramine                   ng/ml                Blood          Imiprami
10459A        Influenza A Ab               Titer                Blood          Flu A
10460A        Influenza B Ab               Titer                Blood          Flu B
10200A        Insulin                      uU/ml                Blood          Insulin
10300A        Insulin 30 min               mg/dl                Blood          30m Ins
10301A        Insulin 90 min               mg/dl                Blood          90m Ins
10407A        Interpretation                                                   Interpre
10302A        Iodine                       ug/dl                Blood          Iodine
10050A        Iron                         ug/dl                Blood          Iron
10128A        Kanamycin                    ug/ml                Blood          Kanamyci
10408A        Ketone                       mg/dl                Urine          Ketone
10409A        L.E. Cells                                        Blood          L.E. Cel
10060A        LAP                          U/L                  Blood          LAP
10054A        LD                           U/L                  Blood          LD
10055A        LD1-Isoenzyme                U/L                  Blood          LD1-Isoe
10056A        LD2-Isoenzyme                %                    Blood          LD2-Isoe
10057A        LD3-Isoenzyme                %                    Blood          LD3-Isoe
10058A        LD4-Isoenzyme                %                    Blood          LD4-Isoe
10059A        LD5-Isoenzyme                U/L                  Blood          LD5-Isoe
10066A        LDL                          mg/dl                Blood          LDL
10410A        LDL/HDL                                           Blood          LDL/HDL
10201A        LH                           IU/L                 Blood          LH
10248A        LH                           IU/L                 Urine          LH
10053A        Lactic Acid                  mmol/L               Blood          Lact Acd
10411A        Lactic Acid                  mg/dl                CSF            Lact Acd
10240A        Lactose                      mg/24 Hr             Urine          Lactose
10129A        Lead                         ug/L                 Urine          Lead
10311A        Lead                         ug/dl                Blood          Lead
10130A        Lidocaine                    ug/ml                Blood          Lidocain
10061A        Lipase                       IU/dl                Blood          Lipase
10062A        Lipids, Total                mg/dl                Blood          Tot Lipd
10063A        Lipo Alpha                   %                    Blood          Alpha Lp
10064A        Lipo Beta                    %                    Blood          Beta Lip
10067A        Lipo Pre-Beta                %                    Blood          PreBetaL
10331A        Liquefaction                 minutes              Seminal Fluid  Liquefac
10069A        Lithium                      mmol/L               Blood          Lithium
10159A        Lymphs                       %                    Blood          Lymphs
10412A        Lymphs                       %                    CSF            Lymphs
10413A        Lymphs                       %                    Body Fluid     Lymphs
10160A        MCH                          pg                   Blood          MCH
10161A        MCHC                         %                    Blood          MCHC
10162A        MCV                          fl                   Blood          MCV
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Component #   Component Name              Units        AgeNR       Specimen        Short name
--------------------------------------------------------------------------------------------
10163A        MCV Ratio                   Ratio                    Blood           MCV Rati
10164A        MPV                         fl                       Blood           MPV
10415A        Macro                                                Blood           Macro
10313A        Macroglobulins              mg/dl                    Blood           Macroglo
10070A        Magnesium                   mEq/L                    Blood           Magnesiu
10071A        Magnesium                   mEq/L                    Urine           Ur Mag
10461A        Malaria Smear                                        Blood           MaleriaS
10239A        Melanin                                              Urine           Melanin
10462A        Meprobamate                 mg/L                     Blood           Meprobam
10463A        Meprobamate                 mg/L                     Urine           Meprobam
10464A        Mercury                     ug/dl                    Blood           Mercury
10465A        Mercury                     ug/L                     Urine           Mercury
10264A        Metanephrines               mg/24 Hr                 Urine           Metaneph
10466A        Metas                       %                        Blood           Metas
10467A        Methaqualone                mg/L                     Blood           Methaqua
10468A        Methaqualone                                         Urine           Methaqua
10314A        Methmoglobin                mg/dl                    Blood           Methmogl
10131A        Methotrexate                ug/ml                    Blood           Methotre
10414A        Microcyt                                             Blood           Microcyt
10504A        Microscopic Exam                                                     Microsco
10456A        Mono Test                                            Blood           MonoTest
10165A        Monos                       %                        Blood           Monos
10238A        Mucin                       mg/24 Hr                 Urine           Mucin
10324A        Mucin Clot                                           Synovial Fluid  Mucin Cl
10315A        Mucoprotein                 mg/dl                    Blood           Mucoprot
10469A        Mycoplasma                  Titer                    Blood           Mycoplas
10421A        Myelos                      %                        Blood           Myelos
10202A        Myoglobin                   ng/ml                    Blood           Myoglobi
10237A        Myoglobin                   ng/ml                    Urine           Myoglobi
10132A        N-Acetylprocainamide        ug/ml                    Blood           N-Acetyl
10316A        NPN                         mg/dl                    Blood           NPN
10133A        Netilmicin                  ug/ml                    Blood           Netilmic
10134A        Nordoxepin                  ng/ml                    Urine           Nordoxep
10263A        Norepinephrine              ug/24 Hr                 Urine           Norepine
10135A        Nortriptylin                ng/ml                    Blood           Nortript
10152A        O2 Saturation               %                        Blood           O2 Satur
10073A        Osmolality                  mOsm/kg                  Blood           Osmo
10074A        Osmolality                  mmol/kg                  Urine           Ur Osmo
10341A        Osmotic Frag                %                        Blood           Osmo Fra
10151A        Oxyhemoglobin               %                        Blood           Oxyhemog
10153A        PCO2                        mm Hg                    Blood           PCO2
10077A        PHI                         U/L                      Blood           PHI
10155A        PO2                         mm Hg                    Blood           PO2
10235A        PSP                                                  Urine           PSP
10203A        PTH                         pg/ml                    Blood           PTH
10418A        Pentobarbital               mg/L                     Blood           Pentobar
10236A        Pentoses                    mg/kg/24H                Urine           Pentoses
10136A        Phenobarbital               ug/ml                    Blood           Phenobar
10076A        Phenylalanine               mg/dl                    Blood           Phenylal
10234A        Phenylpyruvic Acid                                   Urine           Phen Acd
10137A        Phenytoin                   ug/ml                    Blood           Phenytoi
10078A        Phospholipids               mg/dl                    Blood           Phosphol
10079A        Phosphorus                  mg/dl                    Blood           Phosphor
10080A        Phosphorus                  mg/dl                    Urine           Ur Phosp
10471A        Plasma Cells                %                        Blood           Plasma C
10333A        Plasma Volume               ml/kg                    Blood           Plsm Vol
10506A        Plasminogen                 mg/ml                    Blood           Plasmino
10166A        Platelets                   1000/mm3                 Blood           Platelet
10419A        Plt Est                                              Blood           Plt Est
10472A        Poik                                                 Blood           Poik
10473A        Poly                                                 Blood           Poly
10081A        Potassium                   mEq/L                    Blood           K
10082A        Potassium                   mmol/L                   Urine           Ur K
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--------------------------------------------------------------------------------------------
10474A       Potassium 24H                mEq/L                  Urine          24HUr K
10231A       Pregnancy Test                                     Urine          Pg Test
10230A       Pregnanediol                 mg/24 Hr               Urine          Pregnand
10229A       Pregnanetriol                mg/24 Hr               Urine          Pregnane
10138A       Primidone                    ug/ml                  Urine          Primidon
10475A       Pro Comsumption              seconds                Blood          Pro Coms
10111A       Pro Time                     seconds                Blood          Pro Time
10139A       Procainamide                 ug/ml                  Blood          Procaina
10204A       Progesterone                 ng/ml                  Blood          Progeste
10205A       Prolactin                    ng/ml                  Blood          Prolacti
10420A       Promyelo                     %                      Blood          Promyelo
10232A       Prophobilinogen              mg/24 Hr               Urine          Prophobi
10233A       Prophobilinogen, Screening                         Urine          Scn Prop
10140A       Propranolol                  ng/ml                  Blood          Proprano
10083A       Prot Alb                     %                      Blood          Alb Prot
10085A       Prot Alpha-1 Glob            %                      Blood          Alpha1GL
10086A       Prot Alpha-2 Glb             %                      Blood          Prot Al2
10087A       Prot Beta Glb                %                      Blood          Prot Bet
10088A       Prot Gamma Glb               %                      Blood          Gamma Gb
10089A       Prot Globulin T              gm/dl                  Blood          Tot GbPt
10478A       Prot OX-19                   Titer                  Blood          ProtOX19
10476A       Prot OX-2                    Titer                  Blood          ProtOX2
10477A       Prot OX-K                    Titer                  Blood          ProtOX-K
10090A       Prot Total                   gm/dl                  Blood          Tot Prot
10084A       Protein                      mg/dl                  CSF            CSF Prot
10091A       Protein                      mg/dl                  Urine          Ur Prote
10479A       Pseudocholinest              IU/ml                  Blood          Pseudoch
10318A       Pyruvate                     mg/dl                  Blood          Pyruvate
10141A       Quinidine                    ug/ml                  Blood          Quinidin
10167A       RBC                          mega/mm3               Blood          RBC
10470A       RBC Fragility                Titer                  Blood          RBC Frag
10422A       RBC Morph                                           Blood          RBC Morp
10168A       RBC Ratio                    Ratio                  Blood          RBC Rati
10379A       RBCs                         /HPF                   Urine          RBCs
10444A       RBCs                         /cmm                   CSF            RBCs
10169A       RDW                                                 Blood          RDW
10423A       RPR                          Titer                  Blood          RPR
10500A       Read by                                                            Read by
10332A       Red Cell Volume              ml/kg                  Blood          RBC Vol
10228A       Reducing Substances          mg/dl                  Urine          Red Subs
10424A       Reducing Substances          mg/dl                  Stool          Red Subs
10206A       Renin Activity               ng/ml                  Blood          Renin Ac
10342A       Retic Ct                     %                      Blood          Retic Ct
10425A       Retics                       %                      Blood          Retics
10426A       Reviewed by                                                        Review b
10427A       Rh                                                  Blood          Rh
10367A       Rh/Du                                               Blood          Rh/Du
10430A       Rubella Titer                Titer                  Blood          Rubella
10142A       Salicylate                   mg/dl                  Blood          Salicyla
10501A       Screened by                                                        Scn by
10343A       Sed Rate                     mm/Hr                  Blood          Sed Rate
10338A       Segs                         %                      Blood          Segs
10428A       Sickle Cell                                         Blood          SickleCe
10429A       Smooth Muscle Ab                                    Blood          SmMusAb
10505A       SNOMED Code                                                        SNOMEDCd
10092A       Sodium                       mEq/L                  Blood          Na
10093A       Sodium                       mmol/L                 Urine          Ur Na
10227A       Solids, Total                gm/24 Hr               Urine          T Solids
10502A       Source                                                             Source
10094A       Spec Gravity                                        Urine          Spec Gra
10328A       Sperm Count                                         Seminal Fluid  Sperm Ct
10326A       Sperm Morph                  %                      Seminal Fluid  Spm Moph
10327A       Sperm Motility               %                      Seminal Fluid  Spm Motl
```

```
Tue Apr 17, 1990 11:10 am     Simple Result Component Report      Page 8
                              Sorted Alphabetically


Component #    Component Name              Units          AgeNR    Specimen         Short name
-------------------------------------------------------------------------------------------
10481A         Spheros                                             Blood            Spheros
10431A         Streptozyme                Titer                    Blood            Streptoz
10319A         Sulfahemoglobin                                     Blood            Sulfahem
10143A         Sulfapyridine              mg/L                     Blood            Sulfapyr
10207A         T Uptake                                            Blood            T Uptake
10214A         T3                         ng/ml                    Blood            T3
10215A         T3 Uptake                  % Uptake                 Blood            T3 Uptak
10216A         T3 Uptake, Index           Index of Normal          Blood            T3 Up/Ix
10210A         T4                         ug/dl                    Blood            T4
10213A         T4, Neonatal               ug/dl                    Blood            T4 Neona
10209A         TSH                        uU/ml                    Blood            TSH
10482A         Target Cells               %                        Blood            Target C
10208A         Testosterone               ng/ml                    Blood            Testoste
10483A         Tetracyline                                         Blood            Tetracyl
10144A         Theophylline               ug/ml                    Blood            Theophyl
10320A         Thiocyanate                                         Blood            Thiocyan
10218A         Thrombin Time              seconds                  Blood            Throm Tm
10211A         Thyroxine Binding Globulin ug/ml                    Blood            TBG
10212A         Thyroxine, Free            ng/ml                    Blood            Free Thy
10226A         Titratable Acidity         mEq/24 Hr                Urine            Tit Acdt
10145A         Tobramycin                 ug/ml                    Blood            Tobramyc
10484A         Toxic Gran                                          Blood            Toxic Gr
10097A         Transferrin                mg/dl                    Urine            Transfer
10098A         Triglycerides              mg/dl                    Blood            Triglyce
10349A         Trypsin                                             Stool            Trypsin
10485A         Turbidity                                                            Turbidit
10099A         Urea                       mmol/L                   Urine            Urea
10100A         Urea Nitrogen              mg/dl                    Blood            BUN
10101A         Urea Nitrogen              mg/dl                    Urine            Ur UN
10487A         Urea Nitrogen              mg/24 Hr                 Urine            BUN
10102A         Uric Acid                  mg/dl                    Blood            Uric Acd
10103A         Uric Acid                  mg/dl                    Urine            Ur UricA
10486A         Uric Acid                  gm/24 Hr                 Urine            Uric Acd
10224A         Urobilinogen               mg/24 Hr                 Urine            24H Urob
10350A         Urobilinogen               mg/24 Hr                 Stool            St Urobi
10223A         Urobilinogen 2Hr           Ehrlich Units            Urine            2H Urobl
10351A         Urobilinogen Qual                                   Stool            Qual Uro
10225A         Uropepsin                  units/Hr                 Urine            Uropepsi
10222A         Uroporphyrins              ug/24 Hr                 Urine            Uroporph
10440A         VDRL Quant                 Titer                    Blood            VDRL Qt
10441A         VDRL Quant                 Titer                    CSF              VDRL Qt
10442A         VDRL Screen                Titer                    CSF              VDRL Scr
10068A         VLDL                       mg/dl                    Blood            VLDL
10104A         VMA                        mg/L                     Urine            VMA
10146A         Valproic Acid              ug/ml                    Blood            Valproic
10147A         Vancomycin                 ug/ml                    Blood            Vancomyc
10325A         Viscosity                                           Synovial Fluid   Viscosit
10321A         Vitamin A                  ug/dl                    Blood            Vit A
10217A         Vitamin B12                pg/ml                    Blood            B12
10322A         Vitamin C                  mg/dl                    Blood            Vit C
10329A         Volume                     ml                       Seminal Fluid    Volume
10221A         Volume, Total              ml/24 Hr                 Urine            Volume
10171A         WBC                        1000/mm3                 Blood            WBC
10170A         WBC Ratio                  Ratio                    Blood            WBC Rati
10378A         WBCs                        /HPF                    Urine            WBCs
10443A         WBCs                        /cmm                    CSF              WBCs
10323A         Xylose                     mg/dl                    Blood            Xylose
10344A         Zeta Sed Rate              %                        Blood            Zeta Sed
10106A         Zinc                       ug/dl                    Blood            Zinc
10107A         Zinc                       ug/dl                    Urine            Ur Zinc
10416A         nRBC                        /100 WBC                Blood            nRBC
10075A         pH                         pH Units                 Urine            Ur pH
10154A         pH                         pH Units                 Blood            pH
10330A         pH                         pH Units                 Seminal Fluid    pH7
```

Appendix B - Worksheets

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Proprietary to McKesson - Subject to Confidentiality Agreement

STAR Laboratory Reference Guide - Maintenance Worksheets Volume
B–4   *Release 17.0*   *October 2011*
Proprietary to McKesson - Subject to Confidentiality Agreement

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Proprietary to McKesson - Subject to Confidentiality Agreement

FLAGS/UTILITIES

Flags - System Options

Complete one worksheet for the entire system.

Multiple-Departments and/or Multiple-Facilities? _____ Yes _____ No

Releases? _____ Yes _____ No

Advanced Micro Contract? _____ Yes _____ No

Advanced Blood Bank Interface? _____ Yes _____ No

Reference Lab Interface? _____ Yes _____ No

Anatomic Pathology Module? _____ Yes _____ No

Text Processing Module? _____ Yes _____ No

Review Reports (Special Searches)? _____ Yes _____ No

Blood Bank Inventory Module?   Yes   No

Report Writer Module? _____ Yes _____ No

Contract Billing Module? _____ Yes _____ No

Networked System? _____ Yes _____ No

SQL? _____ Yes _____ No

Instrument Licenses _____

Multiple ABB Tests Per Accession?   Yes   No

Flags - General Department

Complete this portion of this worksheet for each department in the system.

NOTE: The Lab LIVE and Advanced Micro Live fields in the Flags - General Department
       maintenance functions processor can only be changed by your McKesson
       representative. Those fields are not part of this worksheet. For more information
       see your McKesson representative.

Department Code/Name: _____

Printer Matrix? _____ Yes _____ No

Table Display of Sections? _____ Yes _____ No

Adv Bld Bank Interface? ___ W(estern Star) ___ H(emocare) ___ L(HL7) ___ N(one)

Reference Lab Interface? _____ Yes _____ No

Canc Uncoll Midnight? _____ Yes _____ No

Charge Scheme: _____ Order _____ Accession _____ Resulting

Misc Charges to HIS? _____ Yes _____ No

Default Charge Location: _____

Duplicate/Conflict Checking? _____ Yes _____ No

Dup/Conf Collection Retention: _____

Clinical Questions Active?   Yes   No

NOTE: This field automatically displays yes or no based on the Order Details flag in
      the SIM department on Order Management

Report Clinical Questions: _____ Yes _____ No

Panic Notification: _____ Yes _____ No

NOTE: System-level flags associated with General Department information are found on the
      Flags - System Flags worksheet.

Flags - Cardfile

```
Security Level:_____

Queue Retention Days (0-7):_____ Days

Status Retention Days (1-30):_____ Days

Beginning Accession (9000000000):_____

Ending Accession (9999999999):_____
```

Flags - Collection Batch

Complete one worksheet for each department in the system.

Create Batch Parameters

Timeframe to search for future orders_____

Create/Print_____ Create

_____ Location

Sort Mode _____ With orders per batch

_____ Number of collections

Assigned Batch Printer: _____

Other Batch Parameters

Next batch number:_____

Timeframe to view future orders:_____ minutes

Batch Inclusion Time:_____ minutes

Collapse Time: _____ minutes

Collection Time: _____ minutes

Consolidation Search: _____ minutes

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Flags - Date of Service

Complete one worksheet for each department in the system.

Use Date of Service: (Y/N)

Effective Date:

Flags - Labels

Complete one worksheet for each department in the system.

Collection Labels

Coll Label Print:___ Single
                ___ Three Across

\# Master Labels (0-9):

Cutout # Type: ____ Account #
            ____ Unit #
            ____ Collection #

Use Ptr Matrix? ____ Yes ____ No

Coll Labels at Ord/Accn? ____ Yes ____ No

Collection Label Matrix? ____ Yes ____ No (This prompt displays only if you answer Yes to Use Ptr Matrix and Coll Labels at Ord/Accn prompts.)

Coll Labels # Type:____ Account Number
               ____ Unit Number

Nurse-Collect Print? ____ Yes ____ No

Accession Labels

Accession Label Time:____ Accession
                 ____ Collection
                 ____ Request

\# Master Accn Labels (0-9): ____ Accn Isolation Labels____ Yes ____ No

Other Labels

Specimen Rejection Labels?____ Yes ____ No

Call STAT Labels? ____ Yes ____ No

Consolidation Labels? ____ Yes ____ No

Prompt Labels: ____ Ordering
            ____ Accessioning
            ____ Both

Labels with Comments: ____ Ordering
                    ____ Accessioning
                    ____ Both

Interdepartment/Sendout Labels

Interdpt Accn Label: ____ Accessioning (in collecting dept)
                   ____ Check-In   (in performing dept)

Transfer Labels at Accn? ___Yes ___No

Sendout Labels at Accn? ___Yes ___No

Facility Code: Department Code: _____

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Flags - Order/Accession

Complete one worksheet for each department in the system.

Ordering

Tests per Accession (1-20): _____

MICRO Sample Order? ____ Yes ____ No

HIS Auto Cancel? ____ Yes ____ No

Accessioning

Accession Comment Display? ____ Yes ____ No

Accession Collection Request? ____ Yes ____ No

Accession Collection Display? ____ Yes ____ No

Accession Collector ID? ____ Yes ____ No

MICRO Sample Accession? ____ Yes ____ No

Specimen Edit? ____ Yes ____ No

View Clinical Questions: ____ Yes ____ No

Both (Ordering and Accessioning)

Free-Text Doctor? ____ Yes ____ No

Standard Order/Accession Labels: ____ Standard ____ User-Defined

Duplicate/Conflict Security: _____

Facility Code: _____ Department Code: _____

Flags - Patient Inquiry/Primary

Complete one worksheet for each department in the system.

By Department

Patient Inquiry Orders? _____ Yes _____ No

Remote Printer Matrix? _____ Yes _____ No

By Facility: Facility _____

STAT/ASAP Partial? _____ Suppress _____ Print

Abnormals Flags: _____ Star (*)
                          _____ Characters
                          _____ Do Not Flag

Results to PT CARE: _____ No Results
                          _____ STATs/ASAPs/Force Prints Only
                          _____ All Results

PT CARE Result Window: _____ Hrs

Discharge Outpatient Primaries for These O/P Types: _____

_____

_____

By System

Range Header Default: _____

Information Windows: Inpatient Search Days (1-999) _____

                     Outpatient Search Days (1-999) _____

Flags - Report Queue

```
Default for Accept Question in the Review Queue Processor
                         _____  Accept

                         _____  Force Print
```

Flags - Specimen Rejection

```
Default Automatic Reorder: _____  Automatic
                           _____  Ask Question
                           _____  No Reorder
Exception Reorder:Facility: _____

              Exception by:_____  Patient Type
                           _____  Vendor

      Patient Type/Vendor              Reorder Option
                                   (1=Auto 2=Ask Question 3=None)

      _____          _____
      _____          _____
      _____          _____
      _____          _____
      _____          _____
      _____          _____
      _____          _____
      _____          _____

                   Facility:_____

              Exception by:_____  Patient Type
                           _____  Vendor

      Patient Type/Vendor              Reorder Option
                                   (1=Auto 2=Ask Question 3=None)

      _____          _____
      _____          _____
      _____          _____
      _____          _____
      _____          _____
      _____          _____
      _____          _____
      _____          _____


Retention Parameter: _____  Months
```

Flags - System Flags

Complete this worksheet once for the entire system.

NOTE: You cannot access the Delta Check and Historization fields on the STAR Laboratory
      Maintenance Functions processors. Only your McKesson representative can complete
      those fields.

Delta Check? (McKesson representative use only.) _____ Yes _____ No

Miscellaneous Charging? _____ Yes _____ No

Historization? (McKesson representative use only.) _____ Yes _____ No

Force Secret Code at Bar Code Sign-on? _____ Yes _____ No

Valid Range? _____ Yes _____ No

Valid Value? _____ Yes _____ No

Result Flagging: _____ Resulting _____ Ordered

Recall Management Live: _____ Yes _____ No

Flags - Word Processing

Complete one worksheet for each department.

Softkey Editor Line Length: _____

Spaces for Tab (3-10): _____

Sections for Department Use Header?

_____	_____ Yes	_____ No
_____	_____ Yes	_____ No
_____	_____ Yes	_____ No
_____	_____ Yes	_____ No
_____	_____ Yes	_____ No
_____	_____ Yes	_____ No
_____	_____ Yes	_____ No
_____	_____ Yes	_____ No

Flags - Incomplete Priority Print Order

```
                    Priorities

        _____

        _____

        _____

        _____

        _____

        _____

        _____

        _____

        _____

        _____

        _____

        _____

        _____

        _____

        _____
```

Flags - Professional Billing

Activate Professional Billing: _____ Yes _____ No

Professional Billing Report Retention (1-12): _____ months

Section Default Rendering MD/Prof Misc Chg

Section   Default Rendering MD   Prof Misc Chg

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

Data Retention Parameters

Misc. Charge/Credit Retention (2-7): _____ Days

PU Cancels/Specimen Rejection included in Physician Utilization Reports_____ Yes _____ No

Activate Physician Utilization: _____ Yes _____ No

PU Retention (1-12): _____ Months

Collection Batches (2-99): _____ Days

Valid Value/Range Retention (1-12): _____ Months

Revise Order Retention (1-365): _____ Days

Revise Ref Facility Retention (1-365): _____ Days

TABLES

This part of Appendix B starts the Tables Worksheets.

Container Types

```
Use this worksheet to enter container types NOT found in the base table.
   Code           Description            Short Name         Max Vol
   (3N)             (30A/N)                (8A/N)             (3N)

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____

  _____    _____    _____    _____
```

Range Headings

Use this worksheet to enter range headers for your system.

Code	Description	Short Desc
(1N)	(20AN)	(11AN)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Result Unit Codes

Use this worksheet to enter result units NOT found in the base table.

Code	Description	CAP Code
(3N)	(20A/N/P)	(3N)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special Instructions

Use this worksheet to enter special instructions NOT found in the base table.

Code (3N)   Description (40A/N)

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

Specimen Types

Use this worksheet to enter specimen types NOT found in the base table.

Code (3N)   Description (19A/N)

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

Ordering Priorities

For the following responses, use the legend listed below the column to indicate your
answer: Date/Time Entry, Ordering Category, Future Collection, Label Print, and
Accession at Order.

 NOTE: When entering Priority Name, punctuation is NOT allowed.

Default Code Time	Collapse Desc Status	Short Accession Desc. at Order?	Start Add'l Chrg	Date/Time Entry	Order Recurring	Cutoff Time	Add'l Days	Category/ Status	Label/Req Gener.
____ _____	_____ _____	_____ Yes	_____ No	_____	_____	_____	_____	_____	_____
____ _____	_____ _____	_____ Yes	_____ No	_____	_____	_____	_____	_____	_____
____ _____	_____ _____	_____ Yes	_____ No	_____	_____	_____	_____	_____	_____
____ _____	_____ _____	_____ Yes	_____ No	_____	_____	_____	_____	_____	_____
____ _____	_____ _____	_____ Yes	_____ No	_____	_____	_____	_____	_____	_____
____ _____	_____ _____	_____ Yes	_____ No	_____	_____	_____	_____	_____	_____
____ _____	_____ _____	_____ Yes	_____ No	_____	_____	_____	_____	_____	_____
____ _____	_____ _____	_____ Yes	_____ No	_____	_____	_____	_____	_____	_____
____ _____	_____ _____	_____ Yes	_____ No	_____	_____	_____	_____	_____	_____
____ _____	_____ _____	_____ Yes	_____ No	_____	_____	_____	_____	_____	_____
____ _____	_____ _____	_____ Yes	_____ No	_____	_____	_____	_____	_____	_____
____ _____	_____ _____	_____ Yes	_____ No	_____	_____	_____	_____	_____	_____
____ _____	_____ _____	_____ Yes	_____ No	_____	_____	_____	_____	_____	_____

```
            B=Date & Time       1=Routine Enter #        1=Immediate
            D=Date              2=ASAP    Future         2=Collect-Time Based
            T=Time              3=STAT    Days           3=Collection Pool
            N=Neither                     (1-2)
```

Sendout/Interdepartment Laboratories

Complete a set for each sendout/interdepartment laboratory.

Code (3N): _____ Laboratory Name (30A/N): _____

Referral Type: ____ Sendout   ____ Interdepartment Referral

Interdepartment: _____   _____

Address line 1: _____

Address line 2: _____

Address line 3: _____

Sendout Workload Procedure Code:(5N) _____

****

Code (3N): _____ Laboratory Name (30A/N): _____

Referral Type: ____ Sendout   ____ Interdepartment Referral

Interdepartment: _____

Address line 1: _____

Address line 2: _____

Address line 3: _____

Sendout Workload Procedure Code (5 N): _____

****

Code (3N): _____ Laboratory Name (30A/N): _____

Referral Type: ____ Sendout   ____ Interdepartment Referral

Interdepartment: _____

Address line 1: _____

Address line 2: _____

Address line 3: _____

Sendout Workload Procedure Code (5N): _____

Number Pools

Use this worksheet to identify case number pools which can be used for
accessioned specimens.

Pool Code (1A/N): _____ Description (19A/N): _____

Current Value: _____ Reset if Pool Number Greater Than: _____

Reset Pool Number To: _____ Frequency: _____

Next Reset Date: _____

Pool Code (1A/N): _____ Description (19A/N): _____

Current Value: _____ Reset if Pool Number Greater Than: _____

Reset Pool Number To: _____ Frequency: _____

Next Reset Date: _____

Pool Code (1A/N): _____ Description (19A/N): _____

Current Value: _____ Reset if Pool Number Greater Than: _____

Reset Pool Number To: _____ Frequency: _____

Next Reset Date: _____

Pool Code (1A/N): _____ Description (19A/N): _____

Current Value: _____ Reset if Pool Number Greater Than: _____

Reset Pool Number To: _____ Frequency: _____

Next Reset Date: _____

Slide Pools

Use this worksheet to identify sets of numbers which can be used to group tests that have been accessioned together and can appear on the same slide label.

         Code (1N)   Description (20 A/N)

       _____   _____

       _____   _____

       _____   _____

       _____   _____

       _____   _____

       _____   _____

       _____   _____

Predefined Results

Complete a line for each Predefined Result to be used in results entry.

Result Code   Description
 (3 A/N)   (20 A/N)

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

Miscellaneous Charge Items

Complete one line for each chargeable item to be used as Supplemental Charges.

Section Code: _____   Miscellaneous Code Range: _____ - _____

Charge/SIM Code	Description (20 A/N)	Billing Code (8N)	Price ($NNNNN.NN)	Pro Fee Indicator
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___
_____		_____	|__|__|__|__|·|__|__|	___

Non-Laboratory Collector Codes

Use this worksheet for any non-laboratory personnel who collect blood for
your laboratory.

        Code (4N)   Description (20 A/N)

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

Shifts

Complete one worksheet for each department.

Shift Code (1N)   Description (20 A/N)   Start Time

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

Standard Result Text

```
Code (12 N): _____

Description (25 C): _____

Text (U C): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
```

Standard Result Subgroups

```
Code (12 AN): _____

Description (25 C): _____
```

```
                 Grouped Standard Result Text
      Code (12 AN)           Description (25 C)

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____

      _____       _____
```

Comment Table

Use this worksheet to define the various comments that can be used in the
ordering or accessioning process.

```
        Code (3N)                Description (20 A/N)

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____

        _____               _____
```

Financial Classes

Use this worksheet to define the patient type exceptions for financial classes eligible
for sales commission. Define one worksheet per financial class.

Financial Class Code (1 A): _____

Description (33 C): _____

Patient Type Exceptions

Code (3 C)	Description (33 C)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Recall Categories

Use this worksheet to define the recall category for each procedure in the laboratory that requires follow-up tests.

Recall Category Code: _____

Recall Category Description: _____

Recall Category Information

Delinquent Queue Retention: _____Deletion Audit Retention: _____

Reminder Letter Module/Type (Select from table): _____

Recall Types

Use this worksheet to define the recall types to assist you in specifying when a patient needs to return for follow-up testing.

Recall Category: _____ Recall Type Code: _____

Recall Description: _____

Recall Type Information

Hold Period: _____ (D)ays _____ (M)onth _____ (Y)ears (P)rompt (N)one

Recall Follow-up Tests: Department   Test code

                          _____   _____

                          _____   _____

                          _____   _____

                          _____   _____

                          _____   _____

Excluded Patient Type: _____ Facilities

Exclude Patient Types

_____   _____   _____   _____   _____

_____   _____   _____   _____   _____

_____   _____   _____   _____   _____

First Reminder: _____ days Second Reminder: _____ days

Third Reminder: _____ days

Patient First Letter: _____ Patient Second Letter: _____

Patient Third Letter: _____

Physician Letters: First   Second   Third
                    Detail/Summary Detail Summary Detail Summary

    Ordering   _____   _____   _____

    Attending   _____   _____   _____

Recall Deletion Reasons

This worksheet defines the recall deletion reason used for tracking purposes when you
delete a patient from a recall queue.

Code: _____

Description: _____

Recall Component/Test Listing

Use this worksheet to provide a means for determining which tests have a component defined for Recall Management special processing.

Recall Category   Hardcopy: Yes   No   Default Printer: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

EMPLOYEE FILES

Security Levels

Complete this worksheet by listing all security levels.

Screen Name	Security Name	Security Level
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Access Codes

Access Name   Access Name

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____

Section/Shifts

Complete one worksheet for each department.

     Section/Shift Name   Secret Code Valid

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

_____   _____ (days)

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Positions

Complete one worksheet for each department.

Position Name	Default Security Level	Allow special office personnel access?	
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No

Other Parameters

Complete one worksheet for each department.

Top Management Security Level:* _____

    Allow special office personnel access? ___ Yes ___ No

    Access Code(s):** _____ _____ _____ _____

Security Level to Add Employees:* _____

    Allow special office personnel access? ___ Yes ___ No

    Access Code(s):** _____ _____ _____ _____

Security Level to Edit Access Codes:* _____

    Allow special office personnel access? ___ Yes ___ No

    Access Code(s):** _____ _____ _____ _____

Default Employee Area Code: _____

Default Employee City: _____

Default Employee State: _____

* = Select from Security Levels worksheet

** = Select from Access Codes worksheet

Personnel Record/Employee Demographics

Complete one worksheet for each employee.

Personnel Record

ID Code (7AN): _____

Employee Name (22C): _____ Initials: (3A) _____

              (Last,First   Middle Initial)

Employee #:_____ STAR Environments: _____

_____   _____   _____   _____

Default to STAR Environments: _____   Termination Dates: _____

O.S. ID Code: _____   Position: _____

Section/Shift:_____   Advanced Blood Banker: ____ Yes ____ No

Initial Menu: ____ Department   ____ Section (Name_____)

Main Menu Return: ___ Yes   ___ No

Security Level: _____   Allow special office personnel access? ___ Yes ___ No

Access Codes: _____ _____ _____ _____ _____ _____

Department Access: _____ _____ _____

Patient Facilities: _____ _____ _____ _____ _____

NPIIR: Patient Name: Restricted _____   Not restricted _____

        Medical Record Number: Restricted _____   Not restricted _____

        Account Number: Restricted _____   Not restricted _____

        Corporate Number: Restricted _____   Not restricted _____

        Social Security Number: Restricted _____   Not restricted _____

        Address,City,State,Zip: Restricted _____   Not restricted _____

        Phone Number: Restricted _____   Not restricted _____

        Patient Type: Restricted _____   Not restricted _____

        Height/Weight: Restricted _____   Not restricted _____

        Sex/Marital Status: Restricted _____   Not restricted _____

        Admission/Discharge Date: Restricted _____   Not restricted _____

        Physician Information: Restricted _____   Not restricted _____

Employee Demographics

Professional Designation (20 A/N):_____

Social Security Number: _____

Registry or License Number: _____

Hire Date: _____   Birthdate: _____

Street Address: _____

City: _____   State: _____   Zip: _____

Home Phone: _____   Anniversary Date: _____

Pay Code/Pay Scale/Step: _____   Pay Rate: _____

MENUS

Laboratory Menu - Main I

Complete one worksheet for each laboratory department.

Option #	S/F	Menu Option	Screen Title	Security
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____

Laboratory Menu - Main II

```
Use this worksheet to design placement of screen display options.
          1         2         3         4         5         6         7
0123456789012345678901234567890123456789012345678901234567890123456789012345678


--------------------------------------------------------------------------------0
--------------------------------------------------------------------------------1
--------------------------------------------------------------------------------2
--------------------------------------------------------------------------------3
--------------------------------------------------------------------------------4
--------------------------------------------------------------------------------5
--------------------------------------------------------------------------------6
--------------------------------------------------------------------------------7
--------------------------------------------------------------------------------8
--------------------------------------------------------------------------------9
--------------------------------------------------------------------------------0
--------------------------------------------------------------------------------1
--------------------------------------------------------------------------------2
--------------------------------------------------------------------------------3
--------------------------------------------------------------------------------4
--------------------------------------------------------------------------------5
```

Laboratory Menu - Section I

Complete one worksheet for each section in the laboratory.

Lab Section Code (3A): _____   Section Name(20 A/N): _____

Charting Code (1A): _____   Accumulate Workload: ____ Section ____ Neither

Misc Charges at Accn: Yes No   Misc Charges Warning Message: Yes No

Low section range 1: _____ High section range 1: _____

Low section range 2: _____ High section range 2: _____

Activate EQC: Yes No   EQC Security (DCO): _____

Activate SQC: Yes No   SQC Security (DCO): _____

Panic Report Security: Yes No   If "Yes" enter level: _____

Flag at Resulting: Yes No   Validity Override: Yes No

Low ordering range 1: _____ High ordering range 1: _____

Low ordering range 2: _____ High ordering range 2: _____

Low Misc. Charge Code: _____HI Misc. Charge Code: _____

PI Display: Yes No   Test Lookup Search: _____ days

Partial Correction: Yes No

Batch Release Queue: Yes No

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Laboratory Menu - Section II

```
Complete one worksheet for each laboratory department.

Option #: _____

Menu Option (choose one):  Function   Bay   _____

Screen title: _____

Security:  Minimum security level: _____

           Special personnel access: Yes   No    Required clearance code: Yes    No

           Access code:  Activate    Deactivate
```

Laboratory Menu - Section III

```
Use this worksheet to design placement of screen display options.
 Section:_____
          1         2         3         4         5         6         7
01234567890123456789012345678901234567890123456789012345678901234567890123456789012345678
                      -         --------------------------------------------------0
                      -         --------------------------------------------------1
                      -         --------------------------------------------------2
                      -         --------------------------------------------------3
                      -         --------------------------------------------------4
                      -         --------------------------------------------------5
                      -         --------------------------------------------------6
                      -         --------------------------------------------------7
                      -         --------------------------------------------------8
                     -          --------------------------------------------------9
                     -          --------------------------------------------------0
                     -          --------------------------------------------------1
                     -          --------------------------------------------------2
                     -          --------------------------------------------------3
                     -          --------------------------------------------------4
                     -          --------------------------------------------------5
```

Laboratory Menu - Bay I

```
Complete a set for each bay.
Section Name: _____
Bay Number: _____   Bay Name (16 A/N): _____
```

Check Previous Results Information

```
                            Low Test Code        High Test Code
        Range 1:        _____   _____
        Range 2:        _____   _____
Number of Accessions: _____     Check Type?  ___ Yes  ___ No
View Across departments?  ___ Yes  ___ No
Specific Test to View? ___ Yes  ___ No
Specific Test Codes to View: _____ _____ _____ _____ _____ _____ _____
 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Additional Department Ranges? ___ Yes  ___ No


Department: _____
        Low Range 1: _____  High Range 1: _____
        Low Range 2: _____  High Range 2: _____


Department: _____
        Low Range 1: _____  High Range 1: _____
        Low Range 2: _____  High Range 2: _____


Department: _____
        Low Range 1: _____  High Range 1: _____
        Low Range 2: _____  High Range 2: _____
```

Laboratory Menu - Bay II

Complete one worksheet for each bay in the laboratory. You may need multiple
worksheets for a single bay.

Section Name: _____ Bay Code/Name: _____

Test Code	Display Name	Test Code	Display Name	Test Code	Display Name
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Laboratory Menu - Bay III

```
 Use this worksheet to design placement of screen display options.

 Bay Name: _____

          1         2         3         4         5         6         7
0123456789012345678901234567890123456789012345678901234567890123456789012345678
(    )------------------------------------------------------------------------0
(    )------------------------------------------------------------------------1
(    )------------------------------------------------------------------------2
(    )------------------------------------------------------------------------3
(    )------------------------------------------------------------------------4
(    )------------------------------------------------------------------------5
(    )------------------------------------------------------------------------6
(    )------------------------------------------------------------------------7
(    )------------------------------------------------------------------------8
(    )------------------------------------------------------------------------9
(    )------------------------------------------------------------------------0
(    )------------------------------------------------------------------------1
(    )------------------------------------------------------------------------2
(    )------------------------------------------------------------------------3
(    )------------------------------------------------------------------------4
(    )------------------------------------------------------------------------5
(    )------------------------------------------------------------------------6
```

Laboratory Menu - Result I

Complete one worksheet for each menu to be used in results entry

Section: _____

Menu Description (10 C): _____

Opt #	Screen Display	Report Text
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Laboratory Menu - Result II (2 Columns)

Use this worksheet to design placement of screen display options.

Menu Name: _____   Menu Code: _____

```
          1         2         3         4         5         6         7
0123456789012345678901234567890123456789012345678901234567890123456789012345678
(    ) -------------------------------(    ) --------------------------------------0
(    ) -------------------------------(    ) --------------------------------------1
(    ) -------------------------------(    ) --------------------------------------2
(    ) -------------------------------(    ) --------------------------------------3
(    ) -------------------------------(    ) --------------------------------------4
(    ) -------------------------------(    ) --------------------------------------5
(    ) -------------------------------(    ) --------------------------------------6
(    ) -------------------------------(    ) --------------------------------------7
(    ) -------------------------------(    ) --------------------------------------8
(    ) -------------------------------(    ) --------------------------------------9
(    ) -------------------------------(    ) --------------------------------------0
(    ) -------------------------------(    ) --------------------------------------1
(    ) -------------------------------(    ) --------------------------------------2
(    ) -------------------------------(    ) --------------------------------------3
(    ) -------------------------------(    ) --------------------------------------4
```

Maximum number headers/options/blanks = 30

Maximum display text per column = 34

Laboratory Menu - Result II (3 Columns)

Use this worksheet to design placement of screen display options.

Menu Name: _____   Menu Code: _____

```
          1         2         3         4         5         6         7
0123456789012345678901234567890123456789012345678901234567890123456789012345678
(   ) --------------------(   ) --------------------(   ) --------------------0
(   ) --------------------(   ) --------------------(   ) --------------------1
(   ) --------------------(   ) --------------------(   ) --------------------2
(   ) --------------------(   ) --------------------(   ) --------------------3
(   ) --------------------(   ) --------------------(   ) --------------------4
(   ) --------------------(   ) --------------------(   ) --------------------5
(   ) --------------------(   ) --------------------(   ) --------------------6
(   ) --------------------(   ) --------------------(   ) --------------------7
(   ) --------------------(   ) --------------------(   ) --------------------8
(   ) --------------------(   ) --------------------(   ) --------------------9
(   ) --------------------(   ) --------------------(   ) --------------------0
(   ) --------------------(   ) --------------------(   ) --------------------1
(   ) --------------------(   ) --------------------(   ) --------------------2
(   ) --------------------(   ) --------------------(   ) --------------------3
(   ) --------------------(   ) --------------------(   ) --------------------4
```

Maximum number headers/options/blanks = 45
Maximum display text per column = 20

Laboratory Menu - Result II (4 Columns)

Use this worksheet to design placement of screen display options.

Menu Name: _____   Menu Code: _____

```
          1         2         3         4         5         6         7
0123456789012345678901234567890123456789012345678901234567890123456789012345678
( ) --------------( ) -------------( ) -------------( ) ----------------0
( ) --------------( ) -------------( ) -------------( ) ----------------1
( ) --------------( ) -------------( ) -------------( ) ----------------2
( ) --------------( ) -------------( ) -------------( ) ----------------3
( ) --------------( ) -------------( ) -------------( ) ----------------4
( ) --------------( ) -------------( ) -------------( ) ----------------5
( ) --------------( ) -------------( ) -------------( ) ----------------6
( ) --------------( ) -------------( ) -------------( ) ----------------7
( ) --------------( ) -------------( ) -------------( ) ----------------8
( ) --------------( ) -------------( ) -------------( ) ----------------9
( ) --------------( ) -------------( ) -------------( ) ----------------0
( ) --------------( ) -------------( ) -------------( ) ----------------1
( ) --------------( ) -------------( ) -------------( ) ----------------2
( ) --------------( ) -------------( ) -------------( ) ----------------3
( ) --------------( ) -------------( ) -------------( ) ----------------4
```

Maximum number headers/options/blanks = 60

Maximum display text per column = 14

MAIN TEST INFORMATION

ALLSTAR Information

```
Service Description: _____

Orderable Tests: (check one) _____ Table and Code (B)

                             _____ Code Only (C)

                             _____ Neither (N)

                             _____ Table and Code (L) - Lab Only

Possible Specimens (or Table Selection _____):  (Circle the Default Specimen)

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

Default Reference Facility: _____
```

Basic Test Information

```
Complete a separate worksheet for each test.

Section: _____         Bay(s): _____

Code (5N): _____     Test Name(32C): _____

Short Name(8C): _____

Test Type:___ General Laboratory

          ___ Adv Micro                    Default Sect
          ___ Anatomic Path
          ___ Adv Blood Bank

Specimen Collection Requirements:  _____ Collection Period Required
                                   _____ Setup Microbiology plate ID required

Maximum Specimen Age (in HHMM):  _____

Order Category/Sample Size:  ____ Routine    ____ ASAP       ____ STAT
                             ____ " Micro    ____ " Micro   ____ " Micro

History Cardfile _____ Automatically
                _____ Prompt (Default ___ No   ___ Yes)
                _____ Never File Results

Cardfile Print Queue ___ Yes ___ No

Range Heading:  Use default? ___ Yes ___ No
               (if No, specify range header: _____)

Miscellaneous Charge Professional Fee ___ Yes ___ No
```

Special Test Information

```
Complete a separate worksheet for each test.

Test Code/Name: _____   Master Test Code: _____

Reference Type (1-A-R): _ Sendout (S)
                        _ Interdepartment Referral (I)
                        x Ref Lab Interface Referral (R) (General Test Only)

Number Pools: _____ _____ _____ _____ _____ _____ _____ _____

Anatomic Path Case Number Pool (U-A-O): _____

Single Col. Primary (1-A-R): ___ Y  ___ N

Inq. Results in Rev.Q (1-A-R): ___ Y ___ N

Inq. Result Display Security (2-N-O): _____

Display Partials (1-A-R): ___ Y ___  N   Panic Report Security (2-N-O): _____

Security Crosslinks (1-N-O): ____

____ Use Default security crosslinks

____ Use Defaults crosslinks if user-security crosslinks are not specified

____ Deny access if user-security crosslinks are not specified

Incomplete (1-A-R): ___ Y ___ N

Specimen Display - Delinquent (3-N-O): _____

Specimen Display - Resulting (1-A-O): ___ Y ___ N

Specimen Display - Patient Inquiry (1-A-O): ___ Y ___ N
```

Collection Labels

Complete one worksheet for each test in the laboratory.

Test Code/Name:_____/_____

Status	# Collect Labels	Container Type/Code	Collect Vol (ml)	Aliquot Vol (ml)	Special Instruct.(code)
Routine					
Routine Micro					
ASAP					
ASAP Micro					
STAT					
STAT Micro					

Accession Labels

Complete one worksheet for each test in the laboratory.

Test Code/Name:_____/_____

Bay Labels

Status	Bay #	# Labels	Bay Label Text (32 A/N)
Routine	_____	_____	_____
	_____	_____	_____
Routine Micro	_____	_____	_____
	_____	_____	_____
ASAP	____	_____	_____
	____	_____	_____
ASAP Micro	_____	_____	_____
	_____	_____	_____
STAT	_____	_____	_____
	_____	_____	_____
STAT Micro	_____	_____	_____
	_____	_____	_____

Slide Labels

Status	Slide Pool	# of Labels	Short Name(8)	(N)umber Pool/ (S)pecType/(Pt #)	Print Order
Routine	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Routine Micro	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
ASAP	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
ASAP Micro	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
STAT	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
STAT Micro	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

INTERDEPARTMENT/SENDOUT LABELS

Complete this worksheet for each test defined as a sendout, sendout-interface, or
interdepartment test.

```
  Test Code: _____    Name: _____

 Reference Type: _____

 Reference Type: _ Sendout (S)
                 _ Interdepartment Referral (I)
                 _ Ref Lab Interface Referral (R) (General Test Only)

 Reference Container(s): _____

 Macro Volume (4-N-O): ___

 Special Instruction:_____


 Storage Requirements (2-N-O): __

 __ 1-Room Temperature
 __ 2-Frozen
 __ 3-Refrigerated
 __ Other (specify user-defined storage requirement type)


 Collection Requirements (1-N-O) (For Reference Lab Interface tests only): _


 _ Collection Volume (V)
 _ Weight (W)
 _ None (N)
```

NOTE: The Collection Requirements values are system-defined values.

SUPPORTING TEST FILES

Result Components

Complete one set for each result component.

Result Component Name (30 A/N): _____

Short Name (8 A/N): _____

Units of Measure: _____

Specimen Type: _____

QC Constituent Code: _____

Descriptive Method: _____

Lookup/CK 5 Exclusion: Yes   No

Delta: Yes   No   Maximum Days: _____

 Difference (select one): ChangePercentage _____%   Absolute _____

Valid Values: Age   Sex   Both (Age/Sex)   Not Dependent
(refer to Valid Values Worksheets)

Valid Range: _____ - _____

Panic Values: Age   Sex   Both (Age/Sex)   Not Dependent

(refer to Panic Values Worksheets)

Normal Ranges (refer to Normal Ranges Worksheets)

Result Processing: Yes   No

If "Yes," enter Recall Category description: _____

Number of Decimals (0-9): _____

VALID VALUES - NOT DEPENDENT

Complete a worksheet for each component.

Component Name: _____   Component #: _____

Restriction: _____ Restricted _____ Unrestricted

Valid Values	Flag (circle one for each Valid Value)					
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic
_____	Abnormal	High	High Panic	Low	Low Panic	Panic

VALID VALUES - SEX

Complete a worksheet for each component.

Component Name: _____   Component #: _____

Restriction: _____ Restricted _____ Unrestricted

    Valid Values   Male   Female
                              (Select one for each Valid Value)
                   (1)Abnormal (2)High (3)High Panic (4)Low (5)Low Panic (6)Panic

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

    _____   _____   _____

VALID VALUES - AGE

Complete a worksheet for each component.

Component Name: _____   Component #: _____

Restriction: _____ Restricted _____ Unrestricted

Valid Values   Age Range   Flag
                        (Select one for each Valid Value)
                (###D)Days, (###Y)Years,   (1)Abnormal (2)High (3)High Panic
                 (#Y###D)Years/Days   (4)Low (5)Low Panic (6)Panic

_____   _____   ____

_____   _____   ____

_____   _____   ____

_____   _____   ____

_____   _____   ____

_____   _____   ____

_____   _____   ____

_____   _____   ____

_____   _____   ____

_____   _____   ____

_____   _____   ____

_____   _____   ____

_____   _____   ____

_____   _____   ____

_____   _____   ____

_____   _____   ____

VALID VALUES - AGE AND SEX

Complete a worksheet for each component.

Component Name: _____   Component #: _____

Restriction: _____ Restricted _____ Unrestricted

Valid Values   Age Range   Male   Female
                                  (Select one for each Valid Value)
                          (###D)Days, (###Y)Years, (1)Abnormal (2)High (3)High Panic
                          (#Y###D)Years/Days   (4)Low (5)Low Panic (6)Panic

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

_____   _____   ____   ____

PANIC VALUES - NOT DEPENDENT

Complete a worksheet for each component.

Component Name: _____   Component #: _____

Panic Values

Low   High

_____   _____

PANIC VALUES - SEX

Complete a worksheet for each component.

Component Name: _____   Component #: _____

Sex Related Panic Values

	Male			Female	
Low	High		Low	High	
_____	_____		_____	_____	

PANIC VALUES - AGE

Complete a worksheet for each component.

Component Name: _____   Component #: _____

Age Related Panic Values

Age Range   Low   High

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

_____   _____   _____

PANIC VALUES - SEX AND AGE

Complete a worksheet for each component.

Component Name: _____   Component #: _____

Age/Sex Related Panic Values

Age Range	Male Low	High	Female Low	High
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

NORMAL RANGES

Complete a worksheet for each component with age/sex-related normal values.

Component Name: _____   Component #: _____

Default Range(s): Normals _____

                             _____

                        OR

        Male _____

                  _____

        Female _____

                  _____

Single Value Flag: Abnormal   High/Low   View Normals: Yes   No

Age Related Normals

Age Range (###D)Days, (###Y)Years, (###Y###D)Years/Days	Normal Range Non-Sex Related	Sex Related Male	Female
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MULTI-LINE NORMALS

```
Complete one set for each component with multiple lines of normal values:

Total of 135 characters
Maximum of 9 lines (separate by ^)
Thirty characters per line


 Component

 Number/Name:_____/_____
 _____
 _____
 _____


 Component

 Number/Name:_____/_____
 _____
 _____
 _____


 Component

 Number/Name:_____/_____
 _____
 _____
 _____


 Component

 Number/Name:_____/_____
 _____
 _____
 _____
```

Result Tables/Table Types

Complete one or more worksheets for each table to be used in results entry.

Code (6A): _____

Table Display Name (26A/N): _____

Next auto: _____

Result Code (3N)	Description (30 A/N)

Results and Normals

Complete at least one worksheet for each test.

Section: _____   Bay(s): _____ _____ _____

Name: _____ Test Code: _____

Result #	* Component Code/Name	Req/ Opt	Ext/ Int	History Cardfile	** Special Processing	Workload	Addendum Only
____	_____	__	__	__	_____	____	__
____	_____	__	__	__	_____	____	__
____	_____	__	__	__	_____	____	__
____	_____	__	__	__	_____	____	__
____	_____	__	__	__	_____	____	__
____	_____	__	__	__	_____	____	__
____	_____	__	__	__	_____	____	__
____	_____	__	__	__	_____	____	__
____	_____	__	__	__	_____	____	__

 *Circle those components to be calculated

**Enter menu/table name corresponding to the feature (if applicable):

      Auto fill ID   Multiple table selections
      Auto fill ID/required complete   Prompt processing
      Comment processing   SNOMED
      Date &/or time   Security level specific menu
      Free form text   Table selection
      ID specific menu   Units X-Match Processing
      Menu selection ID   Valid Values
      Menu selection   Word Processing

If charging upon resulting, write in the component number which will initiate
charging: _____

Calculations

Complete a set for each test involving a calculation.

Test Code/Name: _____/_____

Component #/name being calculated: _____/_____ Decimal places: ___

Components used for calculation: (Circle the ones optional to the calculation)

_____ _____ _____ _____ _____ _____ _____

Calculation (Use component #s): _____

_____

Result Name Example: _____

_____

Numeric Example: _____

Test Code/Name: _____/_____

Comp #/name being calculated: _____/_____ Decimal places: ___

Components used for calculation: (Circle the ones optional to the calculation)

_____ _____ _____ _____ _____ _____ _____

Calculation (Use component #s): _____

_____

Result Name Example: _____

_____

Numeric Example: _____

Cell Counter

Complete at least one worksheet for each test involving the cell counter.

 Name: _____ Test Code: _____

Cell Counter Parameters

 Default Number: _____

 Total Result: (circle one and enter the result option number)

 (1) Automatic insertion of cells counted into the "Cells Counted" result.
     Enter result number of "Cells Counted" result: _____

 (2) Automatic insertion of "DIFF DONE ON ___ CELLS" in the "Comment" result.
     Enter result number of "Comment" result: _____

 Display Hemogram (circle one): Yes   No   Decimal Places: _____

 Results Counted Toward Default   Results NOT Counted Toward Default

   Result#/Name   Result#/Name

 _____/_____   _____/_____

 _____/_____   _____/_____

 _____/_____   _____/_____

Display results in absolutes: ___ Yes ___ No

If "Yes," complete one line below: Multiplication   Decimal   WBC
                                        Factor   Places   Result #

 ___ Replace % with absolutes   _____   _____   _____
 ___ Display % and absolute separately _____   _____   _____
 ___ Place absolute next to %   _____   _____   _____
 ___ Store raw values   _____   _____   _____

RBC Morphology: ___ Yes   ___ No

 If "Yes": Result number for Red Cell Morphology: _____
            Result Number for NORMAL Morphology: _____
            Result Number for ABNORMAL Morphology: _____

Keypad Assignment

Enter the result numbers to be counted toward default beside appropriate key:

 7_____   8_____   9_____   -_____
 4_____   5_____   6_____   ,_____
 1_____   2_____   3_____
 0_____   ._____

Hemogram Display Information Sheet

Currently there are five options for displaying hemogram. These options are displayed
below in the order they would appear on the CRT screen while doing a differential. In
order to display, these results must be part of the ordered test. Select the format of
choice and enter the corresponding result number on the adjacent line. You may select
whichever display formats you desire; however, there is a maximum of nine(9) results for
the display.

Format 1:

    WBC_____   RBC_____   Hgb_____   Hct_____   Plt_____

        MCV_____   MCH_____   MCHC_____   RDW_____

Format 2:

    WBC_____   RBC_____   Hgb_____   MCV_____   MCH_____

        RDW_____   Plt_____   Lymph_____   Gran_____

Format 3:

    WBC_____   Hgb_____   Plt_____   MCV_____   MCHC_____

        RDW_____   Lymph_____   Mono_____   Gran_____

Format 4:

    WBC_____   RBC_____   Hgb_____   MCV_____   MCH_____

        Mono_____   Plt_____   Lymph_____   Gran_____

Format 5:

    WBC_____   RBC_____   Hgb_____   MCV_____   MCH_____

        Plt_____   Lym_____   Mono_____   Gran_____

Crosslinks

Complete a worksheet for each test involving a crosslink.

Section:_____

Resulting Test Code/Name: _____/_____

Crosslink all common components to the following tests:

Department	Test Code	Department	Test Code	Department	Test Code
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Ordering Dept:_____ Ordered Test

Code/Name:_____/_____

Results of resulting test to be crosslinked to ordered test:

Resulting		Ordered	Sec Level	Resulting		Ordered	Sec Level
_____	--->	_____	_____	_____	--->	_____	_____
_____	--->	_____	_____	_____	--->	_____	_____
_____	--->	_____	_____	_____	--->	_____	_____
_____	--->	_____	_____	_____	--->	_____	_____
_____	--->	_____	_____	_____	--->	_____	_____
_____	--->	_____	_____	_____	--->	_____	_____
_____	--->	_____	_____	_____	--->	_____	_____
_____	--->	_____	_____	_____	--->	_____	_____
_____	--->	_____	_____	_____	--->	_____	_____

Cleared Results

Test Code	Result Components to be cleared	Result Component that cleared

Group Assign - Instrument

```
This worksheet is used to define the instrument group and accession processing options
per test.
```

Test Code/ Name	Specimen ID/ Bar Code	Ordering Category	Instrument Group	Accession Options
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Group Assign - Worksheet

This worksheet is used to define the instrument group and accession processing options per test.

Test Code/ Name	Ordering Category	Worksheet Group	Accession Option
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Interdepartment Test Codes

Complete one line for each interdepartment test.

Interdepartment (Ordering)	Corresponding (Performing)		Alternate(s) (Alt Performing)	
Test Code	Dept	Test Code	Dept	Test Code
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Review Queues

```
This Worksheet is used to specify the criteria to be used for Review Queue placement per
test. Use as many lines as necessary per test.
```

Test Code/ Name	Comp Number(s) Required Prior to Review Queue Placement	Review Queue Component Number	"Reviewed" Component Number	Queue Flag
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Billing Information

Test Code	Effective Date	Bill Code	Rev Dept	Price Algorithm	Variable Price	Variable Units	Fixed Price	Fixed Units
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—

Interpretive Reporting Parameters

Complete one worksheet for each test and interpretive component for which you are setting
up interpretive parameters. Multiple worksheets are required if more than one
interpretive component/test is defined.

Test Code: _____

Interpretive Component Number/Name: _____

Component Number	Result Criteria	Standard Result Text
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Long Report Parameters (1 of 2)

Complete this worksheet (pages 1 and 2) for each test.

Report Name: _____

(Case number pool name or free text name)

Include Ordering Diagnosis: Yes _____   No _____

Footer: _____

Additional Footer: _____

RESULT ORDER AND PLACEMENT

Result: _____

Line Feeds: _____   Suppress Result Name: Yes _____   No _____

Position: Centered _____   Tab 40 _____   Left Margin _____

Result: _____

Line Feeds: _____   Suppress: Yes _____   No _____

Position: Centered _____   Tab 40 _____   Left Margin _____

Result: _____

Line Feeds: _____   Suppress: Yes _____   No _____

Position: Centered _____   Tab 40 _____   Left Margin _____

Result: _____

Line Feeds: _____   Suppress: Yes _____   No _____

Position: Centered _____   Tab 40 _____   Left Margin _____

Result: _____

Line Feeds: _____   Suppress: Yes _____   No _____

Position: Centered _____   Tab 40 _____   Left Margin _____

(See next page for Report Copy parameters)

Long Report Parameters (2 of 2)

Complete this worksheet (pages 1 and 2) for each test.

REPORT COPIES

Batch Print: ____Yes ____No

Number of Copies: _____

Report Copy Name 1: _____

Report Copy Name 2: _____

Report Copy Name 3: _____

Report Copy Name 4: _____

Report Copy Name 5: _____

Report Copy Name 6: _____

Report Copy Name 7: _____

Report Copy Name 8: _____

Report Copy Name 9: _____

Report Copy Name 10: _____

Report Copy Name 11: _____

Report Copy Name 12: _____

Report Copy Name 13: _____

Report Copy Name 14: _____

Report Copy Name 15: _____

Report Copy Name 16: _____

Report Copy Name 17: _____

Report Copy Name 18: _____

Report Copy Name 19: _____

Report Copy Name 20: _____

Charge Component/Report Definition

```
Test Code/Name          Result Component to use for charge

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____

_____             _____
```

EQUIPMENT/INSTRUMENTS

Equipment Types

Complete a set for each type of laboratory equipment.

Section Name: _____

```
*************************************************************************
Code (3A): _____   Equipment Name (30A/N): _____

Equipment: _____         Instrument: _____

If "Inst" enter CAP Section: _____ & CAP Method Code: _____


*************************************************************************
Code (3A): _____   Equipment Name (30A/N): _____

Equipment: _____         Instrument: _____

If "Inst" enter CAP Section: _____ & CAP Method Code: _____


*************************************************************************
Code (3A): _____   Equipment Name (30A/N): _____

Equipment: _____         Instrument: _____

If "Inst" enter CAP Section: _____ & CAP Method Code: _____


*************************************************************************
Code (3A): _____   Equipment Name (30A/N): _____

Equipment: _____         Instrument: _____

If "Inst" enter CAP Section: _____ & CAP Method Code: _____


*************************************************************************
Code (3A): _____   Equipment Name (30A/N): _____

Equipment: _____         Instrument _____

If "Inst" enter CAP Section: _____ & CAP Method Code: _____
*************************************************************************
```

Manual Methods

Use this worksheet to enter Manual Methods.

Section: _____

Code (4N)	Description	Method
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Equipment Type Assignment

Complete a set for each piece of laboratory equipment.

Section Code/Name: _____

Code (3A): _____ Equipment Name (30A/N): _____

Manufacturer/Dist: _____

Model: _____ Serial Number: _____

Property Number: _____ Purchase Date: _____

In-Use Date: _____ Location: _____

Other Information: _____

Code (3A): _____ Equipment Name (30A/N): _____

Manufacturer/Dist: _____

Model: _____ Serial Number: _____

Property Number: _____ Purchase Date: _____

In-Use Date: _____ Location: _____

Other Information: _____

Code (3A): _____ Equipment Name (30A/N): _____

Manufacturer/Dist: _____

Model: _____ Serial Number: _____

Property Number: _____ Purchase Date: _____

In-Use Date: _____ Location: _____

Other Information: _____

Instrument Monitor Characteristics (1 of 2)

Complete a set for each equipment-type assignment that will be interfaced.

Section code/name: _____

Equipment Code: _____ Equipment Name: _____

Upload Port: _____   Bi-Direct: YES   NO   Download Port: _____

On-line Test code/name: _____

Monitor Options: YES   NO

Dawning/DI: YES   NO

Base: YES   NO

Micro Inst: API   MICROSCAN   VITEK   N/A

Vitek Rev: AB   AH   AQ   N/A

Data Innovations: YES   NO

Control: SINGLE/STAT   BATCH

Days to Re-Download (0-2): _____ days

ESP Menu:
Select one of the following choices.

_____ Standard
      Manual Tray Load*Monitor*Edit*Result Reporter*Manual Result
      Worksheet*Utilities*Batch Acceptance

_____ Bi-Directional/Self-Creating with Worksheet
      Download*Monitor*Result Reporter*Manual Result*Worksheet
      Utilities*Batch Acceptance

_____ Self-Creating with Worksheet
      Monitor*Result Reporter*Manual Result*Worksheet*Utilities
      Batch Acceptance

_____ Self-Creating with Stat/Editor/Worksheet
      Monitor*Edit*Result Report*Manual Result*Stat Monitor
      Worksheet*Utilities*Batch Acceptance

_____ Self-Creating for Adv Micro
      Monitor*Utilities

_____ Standard with STAT
      Manual Tray Load*Monitor*Edit*Result Reporter *Manual Result
      Stat Result*Worksheet*Utilities*Batch Acceptance

_____ Self-Creating
      Monitor*Result Reporter*Manual Result*Utilities

_____ Analysis
      Manual Tray Load*Monitor*Edit*Analysis*Result Report
      Manual Result*Worksheet*Utilities*Batch Acceptance

See Instrument Monitor Characteristics page 2 for more ESP menu choices.

Instrument Monitor Characteristics (2 of 2)

```
ESP Menu (continued)
     _____ Self-Creating with Editor
          Monitor*Edit*Result Report*Manual Result*Utilities

     _____ Self-Creating with Editor/Worksheet
          Monitor*Edit*Result Report*Manual Result*Worksheet
          Utilities*Batch Acceptance

     _____ Bi-Directional/Self-Creating
          Download*Monitor*Result Report*Manual Result*Utilities

     _____ Bi-Directional/Self-Creating with Editor
          Download*Monitor*Editor*Result Report*Manual Result
          Utilities

     _____ Bi-Directional/Self-Creating with Editor/Worksheet
          Download*Monitor*Editor*Result Report*Manual Result
          Worksheet*Utilities*Batch Acceptance

Timeout:  # of minutes _____      No timeout _____

Channels: _____

ID Type:  Full    Partial    User

          # of digits 4-12 (required only for Partial or User): _____

          Justification:  Zero   Space   Left

ID Retention: _____ days

Deactivate:   YES    NO

Replicate:    YES    NO

Chn#(3N)   Channel Name(30AN)          Upload Code(6ANP)   Download Code(6ANP)

_____      _____      _____           _____

_____      _____      _____           _____

_____      _____      _____           _____

_____      _____      _____           _____

_____      _____      _____           _____

_____      _____      _____           _____

_____      _____      _____           _____
```

Test Method Assignment

Complete this worksheet to assign default and alternate methods for a test.

Section: _____

Test: _____

	Default Method	Alternate Method	Alternate Method
Level:	Test Bay		
Method Type:	Auto Manual	Auto Manual	Auto Manual
Method Code:	_____	_____	_____
On-line Monitor:	Yes No	Yes No	Yes No
Batch Resulting:	Yes No	Yes No	Yes No
Batch Retention:	_____ Days	_____ Days	_____ Days
Batch Accept Abnormals (1A):	Yes No	Yes No	Yes No

Test:_____

	Default Method	Alternate Method	Alternate Method
Level:	Test Bay		
Method Type:	Auto Manual	Auto Manual	Auto Manual
Method Code:	_____	_____	_____
On-line Monitor:	Yes No	Yes No	Yes No
Batch Resulting:	Yes No	Yes No	Yes No
Batch Retention:	_____Days	_____Days	_____Days
Batch Accept Abnormals (1A):	Yes No	Yes No	Yes No

Online Test Monitor

Use this worksheet for each on-line test code.

On-line test: _____   Equip Type Assignment: _____

Monitor/Report: YES   NO

Monitor Type: Default Output Channel

Cups/Monitor (1): _____

Auto Result Release: YES   NO

Default # of channels: _____

Editor: # of decimal places _____   Raw Value _____

Reporter: # of decimal places _____   Raw Value _____

Display All Accessions/Tests: YES   NO

On-line Test Result	Channel Link	(0 to 4 decimals or "D"efault) Editor Calc	Reporter Calcs
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Release Range: _____   or   "T"
                 (Numeric)

Dawning Interface Parameters

Complete a set for each Dawning interface.

Interface #: _____

Description: _____

Equipment Type Assignment: _____   Dawning Device Address: _____

Equipment Type Assignment: _____   Dawning Device Address: _____

Equipment Type Assignment: _____   Dawning Device Address: _____

Equipment Type Assignment: _____   Dawning Device Address: _____

Port #: _____

Instrument Groups

Use this worksheet to define Instrument Groups.

Group Code (6AN)	Group Description (30AN)	Test Code	Group Method

Instrument Manager Parameters

Complete a set for each Instrument Manager.

Instrument Manager: _____

Description: _____

Equipment Type Assignment: _____   Dawning Device Address: _____

Equipment Type Assignment: _____   Dawning Device Address: _____

Equipment Type Assignment: _____   Dawning Device Address: _____

Equipment Type Assignment: _____   Dawning Device Address: _____

Port #: _____

WORKLOAD

Workload Parameters

```
Workload Capture:    ____ at section level
                     ____ at employee and section level
                     ____ no workload capture
 (US) Daily Workload Retention (1-18 months): _____
 (CN) Daily Workload Retention (1-25 months): _____
 Sendout Workload (NNNN.NNN): _____._____
Delete Sendout Workload?   YES   NO
 Specimen Rejection (NNNN.NNN): _____._____
Delete Specimen Rejection?    YES   NO
 (CN Only) Regional Cross-reference Index
Activate regional cross-reference index?    YES   NO
Enter regional cross-reference index        YES   NO
Enter regional cross-reference index description (30 AN)
```

Workload Categories (US Only)

Use this worksheet to edit the base Workload Categories (optional).

   NOTE:CAP allows no more than 9 (nine) Workload Categories.

Base Description	New Description (20A/N)
Inpatient	_____
Outpatient	_____
Quality Control and Standards	_____
Repeats	_____
Emergency Room	_____
Referral (Specimen Received)	_____
Interstate (Specimen Received)	_____
Regional Laboratories	_____
Other	_____

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Workload Categories (CN Only)

Use this worksheet to edit the base Workload Categories (optional).

   NOTE:WMS allows up to 99 Workload Categories.

   Base Description   New Description (20A/N)
   Inpatient   _____
   Outpatient   _____
   Referred-In   _____
   QC   _____
   Cal/Standards   _____
   Repeats   _____
   Environ   _____
   Staff Health   _____
   Research   _____
   Other   _____
   Other   _____
   Other   _____
   Other   _____
   Other   _____
   Other   _____
   Other   _____
   Other   _____
   Other   _____
   Other   _____
   Other   _____
   Other   _____
   Other   _____

Workload Items for Count

Use this worksheet to enter Workload Items for Count NOT found in the base table.

        Code (1-6 A/N)   Description (30A/N)

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

Workload Methods/Suffixes (US Only)

Use this worksheet to add to the base table of CAP Workload Method Types.

CAP Section Code/Name: _____

CAP Suffix Code (3N)	Method Suffix Description (35A/N)	Unit Value	Indicator (*,t,e)	Allowed CAP Codes	Setup CAP #	Setup Value	Indicator (*,t,e)
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Workload Methods/Suffixes (CN Only)

Use this worksheet to add to the base table of WMS Workload Method Types.

WMS Functional Centre Code/Name: _____

WMS Method Code (3N)	Method Suffix Description (35A/N)	Unit Value	Ind. (*,t,e)	Allowed WMS Codes	Setup WMS #	Setup Value	Ind. (*,t,e)	Item for Count
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____	_____	_____

Workload Regional X-Ref Code (CN Only)

Use this worksheet to add to define the regional index codes and descriptions of workload procedures.

```
 Code (1-5 N)                   Description  (33A/N)
```

Code (1-5 N)	Description (33A/N)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Type/Workload Category

Using the Workload Categories and the Patient Types worksheets, assign each patient. Type
code to a Workload Category code.

        Patient Type(s)/Locations   Workload Category

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

        _____   _____

Assign QC Controls to Quality Control/Workload Category?   ___ Yes ___ No

Assign QC Standards to Quality Control/Workload Category?   ___ Yes ___ No

Assign Equipment QC to Quality Control/Workload Category?   ___ Yes ___ No

Assign Patient and QC repeats to Repeats/Workload Category? ___ Yes ___ No

Workload Collection Types

Use this worksheet to change the base Workload Collection Types.

```
CAP Code      Collect Procedure         Short Name  Unit Value  Indicator
  (5N)        Description(35A/N)           (3A/N)      (NN.N)     (*, t, e)

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____

_____  _____  _____  _____  _____
```

Workload Procedures (US Only)

Use this worksheet to add to the base table of CAP Workload Procedure codes or to create
your own.

 CAP Section Code/Name: _____

Proc Code	Procedure Description	Unit Value	Indicator (*,t,e)	Item for Count	Setup CAP #	Setup Value	Indicator (*,t,e)	Misc. Workload Table?	
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No
_____	_____	_____	-_____	_____	_____	_____	-_____	Yes	No

Workload Procedures (CN Only)

Use this worksheet to add to the base table of WMS Workload Procedure codes or to create your own.

WMS Functional Centre Code/Name: _____

```
Effect. Proc   Procedure  Unit   Ind.    Item Setup  Setup Ind.    Misc.
Date    Code   Desc.      Value  (*,t,e) for  WMS #  Value (*,t,e) Workload?
_____  _____  _____  _____  _____   _____ _____ _____ _____      Yes   No
```

    Regional Cross Reference Codes

```
        ____   ____  ____  ____   ____  ____  ____  ____  ____  ____
        ____   ____  ____  ____   ____  ____  ____  ____  ____  ____
        ____   ____  ____  ____   ____  ____  ____  ____  ____  ____
```

```
Effect. Proc   Procedure  Unit   Ind.    Item Setup  Setup Ind.    Misc.
Date    Code   Desc.      Value  (*,t,e) for  WMS #  Value (*,t,e) Workload?
_____  _____  _____  _____  _____   _____ _____ _____  _____     Yes   No
```

    Regional Cross Reference Codes

```
        ____   ____  ____  ____   ____  ____  ____  ____  ____  ____
        ____   ____  ____  ____   ____  ____  ____  ____  ____  ____
        ____   ____  ____  ____   ____  ____  ____  ____  ____  ____
```

```
Effect. Proc   Procedure  Unit   Ind.    Item Setup  Setup Ind.    Misc.
Date    Code   Desc.      Value  (*,t,e) for  WMS #  Value (*,t,e) Workload?
_____  _____  _____  _____  _____   _____ _____ _____   _____    Yes   No
```

    Regional Cross Reference Codes

```
        ____   ____  ____  ____   ____  ____  ____  ____  ____  ____
        ____   ____  ____  ____   ____  ____  ____  ____  ____  ____
        ____   ____  ____  ____   ____  ____  ____  ____  ____  ____
```

Test/Collection Workload (US Only)

Use this worksheet to assign collection, test, and setup workload data.

Test Code/Name	Collect Type	No. of Collects	Collect Section	Workload Type	Test Workload Procedure	Workload Method Setup
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____
_____	_____	_____	_____	T R	_____	_____

Test/Collection workload (CN Only)

Use this worksheet to assign collection, test, and setup workload data.

Test Code/Name	Collect Type	No. of Collects	Collect Section	Workload Type	Test Workload Procedure	Workload Method Setup
_____	_____	_____	_____	T R	_____	_____

X-Ref Code   Regional Cross Reference Codes

_____   ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

         ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

         ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Test Code/Name	Collect Type	No. of Collects	Collect Section	Workload Type	Test Workload Procedure	Workload Method Setup
_____	_____	_____	_____	T R	_____	_____

X-Ref Code   Regional Cross Reference Codes

_____   ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

         ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

         ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Test Code/Name	Collect Type	No. of Collects	Collect Section	Workload Type	Test Workload Procedure	Workload Method Setup
_____	_____	_____	_____	T R	_____	_____

X-Ref Code   Regional Cross Reference Codes

_____   ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

         ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

         ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Workload Procedure Groups

Use this worksheet to list workload procedures into groups for which workload reports can be ordered.

Group Description (30A/N): _____

CAP/WMS Procedures:

Group Description (30A/N): _____

CAP/WMS Procedures:

Group Description (30A/N): _____

CAP/WMS Procedures:

Test Level Workload

Use this worksheet to list LMIP Billable Test Count values for each test.

```
Test Code Name        Billable Test Count

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____

_____        _____
```

QUALITY CONTROL

QC Data Retention Parameters

```
Quality Control                 Activate QC? ____ Yes  ____ No

EQC Retention (1-13): _____ Months

SQC Retention (1-13): _____ Months

Require Comment if QC Outside 2SD (1A): ____ Yes  ____ No

Require Comment if for Westgard Rules (1A): ____ Yes  ____ No

Defer SQC Default  (1A): ____ Yes  ____ No

Defer EQC Default  (1A): ____ Yes  ____ No

Flag Textual QC  (1A): ____ Yes  ____ No
```

General Methods Table

Complete one line for each General Method. A General Method is the commonly accepted
name that describes the procedure used to determine a constituent's level.

Code	Description
(3N)	(30A/N)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Specific Methods Table

Complete one line for each Specific Method. A Specific Method is the instrument or
reagent system using the General Method that determines a constituent's level.

Code	Description
(3N)	(30A/N)

  _____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

Constituents Table

Complete one line for each Constituent code. Or enter Constituent codes directly from
CAP's list.

```
    Code                            Description

    (3N)                            (30A/N)

    _____            _____

    _____            _____

    _____            _____

    _____            _____

    _____            _____

    _____            _____

    _____            _____

    _____            _____

    _____            _____

    _____            _____

    _____            _____

    _____            _____

    _____            _____

    _____            _____

    _____            _____

    _____            _____

    _____            _____
```

Sample QC Materials/Files

SAMPLE QC MATERIAL

(Control, Std or Blank/Zero)   (Control Material Only)

Code: _____   CAP Control Code: _____

Material: _____   Description: _____

Initial Lot #: _____   Manufacturer: _____   Level: _____

Initial Exp. Date: _____   Initial Manufacture Date: _____

Warning Days: _____   Initial Date Received: _____

Section Accession #: _____

SAMPLE QC FILES

Automated or Manual Method Code: _____

SQC File Code Auto-Assigned	Component Number/Name	Gen/Spec Methods	Entry Format N,R,T,C	Target Values Mean/S D (numeric) (only)	Low/High (range) (only)	Workload Proc Code/Cts
____	_____	_____	_____	____/____	____/____	_____/____
____	_____	_____	_____	____/____	____/____	_____/____
____	_____	_____	_____	____/____	____/____	_____/____
____	_____	_____	_____	____/____	____/____	_____/____
____	_____	_____	_____	____/____	____/____	_____/____
____	_____	_____	_____	____/____	____/____	_____/____
____	_____	_____	_____	____/____	____/____	_____/____
____	_____	_____	_____	____/____	____/____	_____/____
____	_____	_____	_____	____/____	____/____	_____/____
____	_____	_____	_____	____/____	____/____	_____/____

Sample QC - Test/Method Profiles

PROFILE PARAMETERS

Test Code/Name: _____   Method: _____

QC Profile Descriptor   Run   Time   # of   Workload
                          Freq   Interval Intervals   Proc Code   Counts

_____   _____   Y ____   _____   _____ _____

                                  M ____   _____

                                  W ____   _____

                                  D ____   _____

                                  H ____   _____

                                  M ____   _____

SQC FILE ASSIGNMENT

Sequence	Material Code (C,$S,@B)	SQC File #	Component	Link
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____

Sample QC - Special Profiles

PROFILE PARAMETERS

Test Code/Name: _____ Method: _____

Section: _____

QC Profile Descriptor	Run Freq	Time Interval	# of Intervals	Workload Proc Code	Counts
_____	_____	Y _____	_____	_____	_____
		M _____	_____		
		W _____	_____		
		D _____	_____		
		H _____	_____		
		M _____	_____		

SQC FILE ASSIGNMENT

Sequence	Material Code (C,$S,@B)	SQC File #	Component	Link
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Equipment QC Files

```
Equipment Code/Name: _____

QC Specific Method/Bay: _____

Section: _____
```

	TARGET VALUES						**TIME INTERVAL**			**WORKLOAD**	
EQC File Code/ Description	*Entry Format	Mean	Std Dev	CV	Low –2SD	High +2SD		Run Freq	Time Itvl	#of Itvls	Proc Code	#of Cts

```
_____ _____ ____ ___ __ ____ ____ (Def) ____ _____  ____ ___   ___

          Section/Bay _____  ____ _____ ____ ___   ___

_____ _____ ____ ___ __ ____ ____ (Def) ____ _____ ____ ___   ___

          Section/Bay _____  ____ _____ ____ ___   ___

_____ _____ ____ ___ __ ____ ____ (Def) ____ _____ ____ ___   ___

          Section/Bay _____  ____ _____ ____ ___   ___

_____ _____ ____ ___ __ ____ ____ (Def) ____ _____ ____ ___   ___

          Section/Bay _____  ____ _____ ____ ___   ___

_____ _____ ____ ___ __ ____ ____ (Def) ____ _____ ____ ___   ___

          Section/Bay _____  ____ _____ ____ ___   ___

_____ _____ ____ ___ __ ____ ____ (Def) ____ _____ ____ ___   ___

          Section/Bay _____  ____ _____ ____ ___   ___

_____ _____ ____ ___ __ ____ ____ (Def) ____ _____ ____ ___   ___

          Section/Bay _____ ____ _____ ____ ___  ___
```

```
Valid Values:  Outside Range

              YES     NO

Workload Procedure Code: _____  # of units _____


* Entry Format (N, R, T, C)
```

EQC - Test /Method Equipment

Complete one worksheet for each test.

Test Code: _____   Test Name: _____

TARGET VALUES

```
                                             Time Interval   Workload
Sect Equip EQC File    Entry      Std    Low High Run  Time #of  Proc #of
     Code  Descriptor  Format  Mean Dev CV -2SD +2SD Freq Itvl Itvls Code Cts
   (Method Code/Name: _____)

____ _____ _____ _____ ____ ___ __ ____ _____ ____ ____ _____ ____ ___

____ _____ _____ _____ ____ ___ __ ____ _____ ____ ____ _____ ____ ___

____ _____ _____ _____ ____ ___ __ ____ _____ ____ ____ _____ ____ ___

____ _____ _____ _____ ____ ___ __ ____ _____ ____ ____ _____ ____ ___

____ _____ _____ _____ ____ ___ __ ____ _____ ____ ____ _____ ____ ___

____ _____ _____ _____ ____ ___ __ ____ _____ ____ ____ _____ ____ ___
```

TARGET VALUES

```
                                             Time Interval   Workload
Sect Equip EQC File    Entry      Std    Low High Run  Time #of  Proc #of
     Code  Descriptor  Format  Mean Dev CV -2SD +2SD Freq Itvl Itvls Code Cts
   (Method Code/Name: _____)

____ _____ _____ _____ ____ ___ __ ____ _____ ____ ____ _____ ____ ___

____ _____ _____ _____ ____ ___ __ ____ _____ ____ ____ _____ ____ ___

____ _____ _____ _____ ____ ___ __ ____ _____ ____ ____ _____ ____ ___

____ _____ _____ _____ ____ ___ __ ____ _____ ____ ____ _____ ____ ___

____ _____ _____ _____ ____ ___ __ ____ _____ ____ ____ _____ ____ ___

____ _____ _____ _____ ____ ___ __ ____ _____ ____ ____ _____ ____ ___
```

SPOOLER AND PRINTER MATRIX

Printer Matrix

This form is used to build the document routing table.

Report Type: ___ LAL - Accession Label   ___ LBI - Barcode Instrument Label ___
LPR - Primary Reports

   ___ LBA - Barcode Accession Label ___ LBS - Spec Reject Labels   ___
LRP - Drft Long Report

   ___ LBB - Barcode Spec Reject Label___ LCL - Collection Labels   ___
LSP - Long Reports

   ___ LBC - Barcode Collection Label ___ LCU - Cum Report   ___
LSR - Summary Reports

Test Code Range	Location	Patient Type	Age	Priority	Report Status	Day of Week	Time of Day	Assigned Printer	Alarm Number
_____-_____	____	____	____	_____	_____	_____	_____	_____-____	_____
_____-_____	____	____	____	_____	_____	_____	_____	_____-____	_____
_____-_____	____	____	____	_____	_____	_____	_____	_____-____	_____
_____-_____	____	____	____	_____	_____	_____	_____	_____-____	_____
_____-_____	____	____	____	_____	_____	_____	_____	_____-____	_____
_____-_____	____	____	____	_____	_____	_____	_____	_____-____	_____
_____-_____	____	____	____	_____	_____	_____	_____	_____-____	_____
_____-_____	____	____	____	_____	_____	_____	_____	_____-____	_____
_____-_____	____	____	____	_____	_____	_____	_____	_____-____	_____

Printer Matrix Parameter Table Data

```
Complete one worksheet for each patient age or time of day.
             Code    Desc. Start  Stop
Patient Age: ____    ____   _____  ____

             ____    ____   _____  ____

             ____    ____   _____  ____

             ____    ____   _____  ____


Time of Day: ____    ____   _____  ____

             ____    ____   _____  ____

             ____    ____   _____  ____

             ____    ____   _____  ____
```

SPOOLER Report Definition

```
This worksheet is used to set up the report group code classifications.


Code: _____   Description: _____

Active: ___ Yes   Print Type: ___ Immediate  Retention Period: _____
        ___ No                ___ Demand                        (days)
                              ___ Time


Restart Method: ___ Demand      Reprint Security: _____
                ___ Last Page
                ___ Reprint


Code  Report Type Description            Code  Report Type Description
____-_____        ____-_____
____-_____        ____-_____
____-_____        ____-_____
____-_____        ____-_____
____-_____        ____-_____
____-_____        ____-_____
____-_____        ____-_____
____-_____        ____-_____
____-_____        ____-_____
```

SPOOLER Printer Definition

```
This worksheet is used to set up printers for each report type.

Code: _____     Description: _____

Report Type: _____

Default Type: _____   Port #: ____   Location: _____


     Alternate Type         Port #      Location
     _____        _____      _____
     _____        _____      _____
     _____        _____      _____
     _____        _____      _____
     _____        _____      _____
     _____        _____      _____
     _____        _____      _____
     _____        _____      _____
     _____        _____      _____
     _____        _____      _____
     _____        _____      _____
```

PATIENT REPORTS

Horizontal Cum Trend Report Parameters

This worksheet is used to indicate which options are desired for Horizontal Cums.


```
I/P ACCUMULATION:         _____ 1-No online accumulation
   (check one)            _____ 2-Online accumulation of all patients
                          _____ 3-Online accumulation of added patients only

O/P ACCUMULATION:         _____ 1-No online accumulation
   (check one)            _____ 2-Online accumulation of all patients
                          _____ 3-Online accumulation of added patients only
OUTPATIENT TYPES: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

DIVIDING CHAR (must be non-alpha, non-numeric character): _____

CORRECTION LOGIC:         _____ 1-Do NOT flag corrected results
   (check one)            _____ 2-Flag with "C" and print previous result
                          _____ 3-Flag with "C" but do not print previous result

COLLECT/ACCESSION:  _____ Collection Time  _____ Accession Time

I/P CUM RETENTION:        _____ 1-Upon discharge
   (check one)            _____ 2-Complete
                          _____ 3-"N" number of days after printing
                                    (enter I/P RETENTION days: _____)

STATUS FOR STORAGE:       _____ 1-Store all tests in batch
   (check one)            _____ 2-Store forced prints and completed tests
                          _____ 3-Store Only Completed Tests

ACCN PRINT ORDER:  _____ CHRONOLOGICAL  _____ REVERSE CHRONOLOGICAL

NON-DEFAULT SPECIMEN? _____ YES _____ NO   PRIMARY GROUPING: ___(T)  ___(S)

REPORT DURATION:    * _____ 1-Use cumulative trend cutoff logic
   (check one)          _____ 2-Do not use cum trend cutoff logic

* NOTE:Complete Duration Type & Duration Days only if #1 was checked above.

DURATION TYPE: _____ 1-Hospital Days          DURATION DAYS (N): _____
               _____ 2-Laboratory Days

DURATION DISCHARGE: _____ Yes _____ No

DISCHARGE CUMS: _____ Yes _____ No

NEW WORK INDICATOR:       _____ 1-New work NOT flagged
   (check one)            _____ 2-New work flagged with _____

PRINT TECH ID? _____ Yes _____ No

INCLUDE CANCELLED: _____ Accn Cancelled  _____ All  _____ None
   (check one)

DIRECTOR'S NAME: _____
```

Horizontal Cumulative Trend Profile Definition

Use this worksheet to indicate placement of components for Horizontal Cum Trends.

Profile Number (3N): _____

Name (80 A/N): _____

```
Component Number     Map All,         (Specify if other than default)
or Subheader Name    Select(*)    Comp Name          Units       Normals
  (13 A/N)           or None      (13 A/N)          (7 A/N)     (10 A/N)
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
_____  _____  _____ (_____) _____
```

* If select, list test numbers to be mapped on subsequent lines

Horizontal Cumulative Trend Profile Test Mapping

Use this worksheet to define individual test codes for Horizontal Cum Profiles.

Profile Code(3N)/Name(80A/N): _____/_____

Test Code/Name	Component #/Name	O/F Ref Com Lab	Profile#/Row #
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____
_____/_____	_____/_____	___ ___	_____

Cumulative Trend Report Profile Print Order

Indicate the desired print order of profiles within Cumulative Trend Batches.

Cumulative Trend Report - Primary Result Report Format

Indicate the print order of tests not defined in a Cumulative Trend Profile.

```
 TEST CODE            TEST NAME                           PROFILE
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
                                          FOLLOWS
--------------------------------------------------------------------------
```

Cumulative Trend Reports/Summary Reports - Location Print Order

Referring to the Nursing Station Codes worksheet and to the Account Number Group

Assignment worksheet, indicate the order in which reports will be generated within Cumulative Trend and Summary Reports batches.

1-	11-	21-
2-	12-	22-
3-	13-	23-
4-	14-	24-
5-	15-	25-
6-	16-	26-
7-	17-	27-
8-	18-	28-
9-	19-	29-
10-	20-	30-

Cumulative Trend Prior Work Definition

This worksheet is used to indicate which patient types to print with the inpatient work on the Cum Trend and Discharge Cum Trend reports.

Days prior to Admission to include on cumulative (N): _____

Print prior work before inpatient work is resulted? _____ Yes _____ No

Patient types to include as prior work:

      _____   _____   _____   _____   _____

      _____   _____   _____   _____   _____

      _____   _____   _____   _____   _____

      _____   _____   _____   _____   _____

Facility Code: _____ Department Code: _____

New Work Report Parameters

This worksheet is used to define the parameters required to print a New Work Summary
report with each Cum Batch printing. This report is optional.

Cumulative Trend Report type: ___ Horizontal ___ Vertical

Active: ___ Yes ___ No

Report Name: _____   No. Reports: _____

Exclusions: _____   _____   _____   _____   _____

             _____   _____   _____   _____   _____

             _____   _____   _____   _____   _____

Format: ____Standard   Column Separator: ___ Yes ___ No
         ____Zonal
         ____Offset

Correction Print: ____ Current Value   ____ Test

Addendum Print: ____ Addendum Result Values Only ____ All Result Values

Include Cancelled: ____ Accn Cancelled ____ All ____ None
   (check one)

Post-Discharge Report Parameters

This worksheet is used to define the parameters required to print a Post-Discharge Work report.

Report Type: ____ Horizontal ____ Vertical ____ Summary

Partials: ___ Yes ___ No

 Format: ___ Standard   Column Separator: ___ Yes ___ No
         ___ Zonal
         ___ Offset

Correction Print: ___ Current Value ___ Test

Addendum Print: ___ Addendum Result Values Only ___ All Result Values

Include Cancelled: ___ Accn Cancelled ___ All ___ None
   (check one)

Vertical Cum Trend Report Parameters

```
Indicate the options desired for Vertical Cum Trend reports.

I/P ACCUMULATION:             _____ 1-No online accumulation
   (check one)                _____ 2-Online accumulation of all patients
                              _____ 3-Online accumulation of added patients only


I/P ACCUMULATION:             _____ 1-No online accumulation
   (check one)                _____ 2-Online accumulation of all patients
                              _____ 3-Online accumulation of added patients only


OUTPATIENT TYPES:   _____ _____ _____ _____ _____ _____ _____ _____ _____ _____


DIVIDING CHAR (must be non-alpha, non-numeric character): _____


CORRECTION LOGIC:             _____ 1-Do NOT flag corrected results
   (check one)                _____ 2-Flag with "C" and print previous result
                              _____ 3-Flag with "C" but do not print previous result


COLLECT/ACCESSION (check one):  _____ Collection Time  _____ Accession Time

I/P CUM RETENTION:            _____ 1-Upon Discharge
   (check one)                _____ 2-Delete Cum information upon completion of
                                      all work after printing
                              _____ 3-Delete Cum information "N" number of days
                                      after printing (enter I/P RETENTION days:_____)

STATUS FOR STORAGE:          _____ 1-Store ALL tests in batch
   (check one)                _____ 2-Store forced prints and completed tests
                              _____ 3-Store only Completed Tests


ACCN PRINT ORDER:_____ Chrono _____ Reverse Chrono   HEADER LINES (3-4): _____

REPORT DURATION:             _____ 1-Print entire cumulative trend
   (check one)                _____ 2-Use cumulative trend CUTOFF logic
                              _____ 3-Use cumulative trend REVOLVING logic


NOTE:Complete remaining questions only if CUTOFF or REVOLVING is used.

DURATION TYPE:               _____ 1-Hospital Days
  (check one)                 _____ 2-Laboratory Days
                              _____ 3-Calendar Days


CALENDAR DATE: _____/_____/_____ (Complete only if calendar days are used)

DURATION DAYS: (N) _____ days  DURATION DISCHARGE: ____ Yes ____ No

DISCHARGE CUMS ____ Yes ____ No

DIRECTOR'S NAME: _____

INCLUDE CANCELLED: _____ Accn Cancelled  _____ All  _____ None
   (check one)
```

Vertical Cumulative Trend Profile Definition

Use this worksheet to design placement of columns for Vertical Cum Trend reports.

Profile Number (3N): _____

Profile Name (80 A/N): _____

Number of Columns: _____ (Refer to chart at bottom of worksheet for column spacing)

HEADING FORMAT

```
            3 line format:                        4 line format
              (specify if other than default headings) 12A/N

        Results  _____        Results     _____
        Units    _____        Units       _____
        Normals  _____        Low Normal  _____
                                           High Normal _____
```

PROFILE DEFINITION

```
        1      2        3        4        5        6        7        8
        45678901234567890123456789012345678901234567890123456789012345678901234567890
        |                                                                |
Comp # |                                                                |
        |----------------------------------------------------------------|
Name   |                                                                |
        |----------------------------------------------------------------|
Units  |                                                                |
        |----------------------------------------------------------------|
Normal |                                                                |
        |----------------------------------------------------------------|
Normal |                                                                |
        |----------------------------------------------------------------|
        1      2        3        4        5        6        7        8
        45678901234567890123456789012345678901234567890123456789012345678901234567890
```

COLUMN CHART

# of Columns	Width per Column	Column Lines
8	7	14,22,30,38,46,54,62,70,80
7	8	14,23,32,41,50,59,68,80
6	9	14,24,34,44,54,64,80
5	11	14,26,38,50,62,80
4	14	14,29,44,59,80
3	20	14,35,56,80
2	31	14,46,80
1	65	14,80

8 COLUMNS - VERTICAL CUMULATIVE TREND PROFILE DEFINITION

Use this worksheet to design placement of columns for Vertical Cum Trend reports.

Profile Number (3N): _____

Profile Name (80 A/N): _____

HEADING FORMAT

```
        3 line format:                        4 line format
         (specify if other than default headings) 12A/N

    Results   _____      Results      _____
    Units     _____      Units        _____
    Normals   _____      Low Normal   _____
                                        High Normal  _____
```

8 COLUMN PROFILE DEFINITION

```
        1       2           3           4           5           6           7           8
        45678901234567890123456789012345678901234567890123456789012345678901234567890
        |       |       |       |       |       |       |       |       |
Comp #  |       |       |       |       |       |       |       |       |
        |-------|-------|-------|-------|-------|-------|-------|---------|
Name    |       |       |       |       |       |       |       |       |
        |-------|-------|-------|-------|-------|-------|-------|---------|
Units   |       |       |       |       |       |       |       |       |
        |-------|-------|-------|-------|-------|-------|-------|---------|
Normal  |       |       |       |       |       |       |       |       |
        |-------|-------|-------|-------|-------|-------|-------|---------|
Normal  |       |       |       |       |       |       |       |       |
        |-------|-------|-------|-------|-------|-------|-------|---------|
        1    2  |    3      | 4     | 5     | 6     | 7          | 8
        45678901234567890123456789012345678901234567890123456789012345678901234567890
```

TEST MAPPING INFORMATION

```
ALL     _____ _____ _____ _____ _____ _____ _____ _____
NONE    _____ _____ _____ _____ _____ _____ _____ _____
SELECT  |_____|_____|_____|_____|_____|_____|_____|_____|
        |_____|_____|_____|_____|_____|_____|_____|_____|
        |_____|_____|_____|_____|_____|_____|_____|_____|
        |_____|_____|_____|_____|_____|_____|_____|_____|
```

7 COLUMNS - VERTICAL CUMULATIVE TREND PROFILE DEFINITION

Use this worksheet to design placement of columns for Vertical Cum Trend reports.

Profile Number (3N): _____

Profile Name (80 A/N): _____

HEADING FORMAT

```
          3 line format:                    4 line format
            (specify if other than default headings) 12A/N
    Results  _____        Results    _____
    Units    _____        Units      _____
    Normals  _____        Low Normal _____
                                       High Normal _____
```

7 COLUMN PROFILE DEFINITION

```
        1       2        3        4        5        6        7        8
        45678901234567890123456789012345678901234567890123456789012345678901234567890
         |       |        |        |        |        |        |        |
Comp #|  |        |        |        |        |        |        |        |
      |--------|--------|--------|--------|--------|--------|-----------|
Name  |  |        |        |        |        |        |        |        |
      |--------|--------|--------|--------|--------|--------|-----------|
Units |  |        |        |        |        |        |        |        |
      |--------|--------|--------|--------|--------|--------|-----------|
Normal|  |        |        |        |        |        |        |        |
      |--------|--------|--------|--------|--------|--------|-----------|
Normal|  |        |        |        |        |        |        |        |
      |--------|--------|--------|--------|--------|--------|-----------|
        1       2  |      3  |      4|       5        |6        |7       8
        45678901234567890123456789012345678901234567890123456789012345678901234567890
```

TEST MAPPING INFORMATION

```
ALL     _____ _____ _____ _____ _____ _____ _____
NONE    _____ _____ _____ _____ _____ _____ _____
SELECT |_____|_____|_____|_____|_____|_____|_____|
       |_____|_____|_____|_____|_____|_____|_____|
       |_____|_____|_____|_____|_____|_____|_____|
       |_____|_____|_____|_____|_____|_____|_____|
```

6 COLUMNS - VERTICAL CUMULATIVE TREND PROFILE DEFINITION

Use this worksheet to design placement of columns for Vertical Cum Trend reports.

Profile Number (3N): _____

Profile Name (80 A/N): _____

HEADING FORMAT

```
        3 line format:                         4 line format
           (specify if other than default headings) 12A/N
    Results   _____         Results    _____
    Units     _____         Units      _____
    Normals   _____         Low Normal _____
                                         High Normal _____
```

6 COLUMN PROFILE DEFINITION

```
        1       2         3         4         5         6         7         8
        45678901234567890123456789012345678901234567890123456789012345678901234567890
         |       |         |         |         |         |         |         |
Comp #|       |         |         |         |         |         |         |
        |---------|---------|---------|---------|---------|---------|---------------|
Name  |       |         |         |         |         |         |         |
        |---------|---------|---------|---------|---------|---------|---------------|
Units |       |         |         |         |         |         |         |
        |---------|---------|---------|---------|---------|---------|---------------|
Normal|       |         |         |         |         |         |         |
        |---------|---------|---------|---------|---------|---------|---------------|
Normal|       |         |         |         |         |         |         |
        |---------|---------|---------|---------|---------|---------|---------------|
        1       2       | 3       | 4       | 5       | 6       | 7         8
        45678901234567890123456789012345678901234567890123456789012345678901234567890
```

TEST MAPPING INFORMATION

```
ALL      _____ _____ _____ _____ _____ _____
NONE     _____ _____ _____ _____ _____ _____
SELECT |_____|_____|_____|_____|_____|_____|
       |_____|_____|_____|_____|_____|_____|
       |_____|_____|_____|_____|_____|_____|
       |_____|_____|_____|_____|_____|_____|
```

4 COLUMNS - VERTICAL CUMULATIVE TREND PROFILE DEFINITION

Use this worksheet to design placement of columns for Vertical Cum Trend reports.

Profile Number (3N): _____

Profile Name (80 A/N): _____

HEADING FORMAT

```
        3 line format:                       4 line format
         (specify if other than default headings) 12A/N
   Results  _____        Results    _____
   Units    _____        Units      _____
   Normals  _____        Low Normal _____
                                       High Normal _____
```

5 COLUMN PROFILE DEFINITION

```
        1       2         3         4         5         6         7         8
        45678901234567890123456789012345678901234567890123456789012345678901234567890
        |         |         |         |         |         |                 |
Comp # |         |         |         |         |         |                 |
        |----------|----------|----------|----------|-----------------|
Name   |         |         |         |         |         |                 |
        |----------|----------|----------|----------|-----------------|
Units  |         |         |         |         |         |                 |
        |----------|----------|----------|----------|-----------------|
Normal |         |         |         |         |         |                 |
        |----------|----------|----------|----------|-----------------|
Normal |         |         |         |         |         |                 |
        |----------|----------|----------|----------|-----------------|
        1       2 |       3 |       4         5         6 |       7         8
        45678901234567890123456789012345678901234567890123456789012345678901234567890
```

TEST MAPPING INFORMATION

```
ALL     _____  _____  _____  _____  _____
NONE    _____  _____  _____  _____  _____
SELECT |_____|_____|_____|_____|_____|
       |_____|_____|_____|_____|_____|
       |_____|_____|_____|_____|_____|
       |_____|_____|_____|_____|_____|
```

3 COLUMNS - VERTICAL CUMULATIVE TREND PROFILE DEFINITION

Use this worksheet to design placement of columns for Vertical Cum Trend reports.

Profile Number (3N): _____

Profile Name (80 A/N): _____

HEADING FORMAT

```
        3 line format:                    4 line format
          (specify if other than default headings) 12A/N
    Results  _____      Results     _____
    Units    _____      Units       _____
    Normals  _____      Low Normal  _____
                                     High Normal _____
```

4 COLUMNS PROFILE DEFINITION

```
        1       2        3        4        5        6        7        8
        4567890123456789012345678901234567890123456789012345678901234567890
        |              |              |              |                   |
Comp #  |              |              |              |                   |
        |--------------|--------------|--------------|-------------------|
Name    |              |              |              |                   |
        |--------------|--------------|--------------|-------------------|
Units   |              |              |              |                   |
        |--------------|--------------|--------------|-------------------|
Normal  |              |              |              |                   |
        |--------------|--------------|--------------|-------------------|
Normal  |              |              |              |                   |
        |--------------|--------------|--------------|-------------------|
        1       2       |3       4    |   5       |6       7            8
        4567890123456789012345678901234567890123456789012345678901234567890
```

TEST MAPPING INFORMATION

```
ALL      _____  _____  _____  _____
NONE     _____  _____  _____  _____
SELECT  |_____|_____|_____|_____|
        |_____|_____|_____|_____|
        |_____|_____|_____|_____|
        |_____|_____|_____|_____|
        |_____|_____|_____|_____|
```

2 COLUMNS - VERTICAL CUMULATIVE TREND PROFILE DEFINITION

Use this worksheet to design placement of columns for Vertical Cum Trend reports.

Profile Number (3N): _____

Profile Name (80 A/N): _____

HEADING FORMAT

```
        3 line format:                        4 line format
          (specify if other than default headings) 12A/N
    Results  _____        Results     _____
    Units    _____        Units       _____
    Normals  _____        Low Normal  _____
                                         High Normal _____
```

3 COLUMN PROFILE DEFINITION

```
        1       2       3       4       5       6       7       8
        45678901234567890123456789012345678901234567890123456789012345678 90
         |                   |                  |                       |
Comp #|                   |                  |                       |
         |-------------------|------------------|-----------------------|
Name  |                   |                  |                       |
         |-------------------|------------------|-----------------------|
Units |                   |                  |                       |
         |-------------------|------------------|-----------------------|
Normal|                   |                  |                       |
         |-------------------|------------------|-----------------------|
Normal|                   |                  |                       |
         |-------------------|------------------|-----------------------|
        1       2       3   |   4       5   |   6       7       8
        45678901234567890123456789012345678901234567890123456789012345678 90
```

TEST MAPPING INFORMATION

```
ALL      _____ _____ _____
NONE     _____ _____ _____
SELECT  |_____|_____|_____|
        |_____|_____|_____|
        |_____|_____|_____|
        |_____|_____|_____|
        |_____|_____|_____|
```

Vertical Cumulative Trend Profile Test Mapping

Use this worksheet to define individual test code(s) for Vertical Cum Profiles.

Profile Code(3N)/Name (80A/N): _____/_____

Test Code/Name	Component #/Name	O/F Ref	Profile#/Column#
		Com Lab	

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

_____/_____ _____/_____ ___ ___ _____

Cumulative Trend Report- Profile Print Order

Indicate the desired print order of profiles within Cumulative Trend Batches.

Cumulative Trend Report - Primary Result Report Format

```
Indicate the print order of tests not defined in a Cumulative Trend Profile.


  TEST CODE            TEST NAME                        PROFILE
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
                                              FOLLOWS
-----------------------------------------------------------------------------
```

Cumulative Trend Reports/Summary Reports - Location Print Order

Referring to the Nursing Station Codes worksheet and to the Account Number Group
Assignment worksheet, indicate the order in which reports will be generated within
Cumulative Trend and Summary Reports batches.

1-	11-	21-
2-	12-	22-
3-	13-	23-
4-	14-	24-
5-	15-	25-
6-	16-	26-
7-	17-	27-
8-	18-	28-
9-	19-	29-
10-	20-	30-

Cumulative Trend Prior Work Definition

This worksheet is used to indicate which patient types to print with the inpatient work on the Cum Trend and Discharge Cum Trend reports.

Days prior to Admission to include on cumulative (N): _____

Print prior work before inpatient work is resulted? _____ Yes _____ No

Patient types to include as prior work:

      _____   _____   _____   _____   _____

      _____   _____   _____   _____   _____

      _____   _____   _____   _____   _____

      _____   _____   _____   _____   _____

Facility Code: _____   Department Code: _____

Vertical Cum Trend Reports - Multiple Print Groups

This worksheet is used to group locations into multiple subsets called Print Groups.
These groups can be used to print or reprint a batch of Cum Trend reports.

Print Group 1 Description: _____

Locations/Patient Types: _____ _____ _____ _____ _____ _____

      _____ _____ _____ _____ _____ _____ _____ _____

      _____ _____ _____ _____ _____ _____ _____ _____

Print Group 2 Description: _____

Locations/Patient Types: _____ _____ _____ _____ _____ _____

      _____ _____ _____ _____ _____ _____ _____ _____

      _____ _____ _____ _____ _____ _____ _____ _____

Print Group 3 Description: _____

Locations/Patient Types: _____ _____ _____ _____ _____ _____

      _____ _____ _____ _____ _____ _____ _____ _____

      _____ _____ _____ _____ _____ _____ _____ _____

Print Group 4 Description: _____

Locations/Patient Types: _____ _____ _____ _____ _____ _____

      _____ _____ _____ _____ _____ _____ _____ _____

      _____ _____ _____ _____ _____ _____ _____ _____

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Fax Parameters

This worksheet is used to define the STAR Laboratory Immediate Fax parameters.

Is fax available from Main Patient Inquiry? ____ Yes ____ No

Is Free-Text Entry available?   ____ Yes ____ No

Section	Patient Inquiry	Result Reporting	Panic Report	Long Report
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Long Report Parameters by Section - AP Section

Complete each line for these items concerning the Anatomic Pathology module by either checking Yes or No, entering a response or checking the appropriate answer.

Activate Long Report: ___ Yes   ___ No

Hospital/Patient Form?   ___ Print/Print

                         ___ Print/Suppress

                         ___ Suppress/Print

                         ___ Suppress/Suppress

Correction Print: ___ Current Value   ___ Test

Addendum Print: ____ Addendum Result Values Only   ____ All Result Values

Number of preprinted lines for report title (1-12): _____

Batches Active for Reprint (1-50): _____

Print specimens on reports? ___ Histotech

                            ___ Login

                            ___ Both

                            ___ No Specimens

Print the number of blocks on reports? ____ Yes ____ No

Print SNOMED Diagnostic Codes? ____ Yes ____ No

Completion Date: _____   Initials: _____

Long Report Parameters by Section - Non-AP Section

Complete each line for these items by either checking Yes or No, entering a response or checking the appropriate answer.

    Activate Long Report: ___ Yes   ___ No

    Hospital/Patient Form?   ___ Print/Print

                             ___ Print/Suppress

                             ___ Suppress/Print

                             ___ Suppress/Suppress

    Correction Print: ___ Current Value   ___ Test

    Addendum Print: ____ Addendum Result Values Only   ____ All Result Values

    Number of preprinted lines for report title (1-12): _____

    Batches Active for Reprint (1-50): _____

    Completion Date: _____   Initials: _____

Section Sort

Complete one worksheet for each department in the system.

Report Type: (check one)

                   ____ Outpatient Summary
                   ____ Discharge Summary
                   ____ Interim Summary
                   ____ Patient Detail
                   ____ New Work Report
                   ____ Physician Summary

New Page	Section Name	Sort Order	Test Ranges Low Range/High Range	
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Outpatient Report Parameters

Complete one worksheet for each department in the system.

Location Print Order – Referring to the Nursing Station Codes worksheet and to the Account Number Group Assignment worksheet, indicate the order in which reports will be generated within Cumulative Trend and Summary Reports batches.

```
--------------------------------------------------------------------------
  1-                        | 11-                       | 21-
--------------------------|---------------------------|--------------------
  2-                        | 12-                       | 22-
--------------------------|---------------------------|--------------------
  3-                        | 13-                       | 23-
--------------------------|---------------------------|--------------------
  4-                        | 14-                       | 24-
--------------------------|---------------------------|--------------------
  5-                        | 15-                       | 25-
--------------------------|---------------------------|--------------------
  6-                        | 16-                       | 26-
--------------------------|---------------------------|--------------------
  7-                        | 17-                       | 27-
--------------------------|---------------------------|--------------------
  8-                        | 18-                       | 28-
--------------------------|---------------------------|--------------------
  9-                        | 19-                       | 29-
--------------------------|---------------------------|--------------------
 10-                        | 20-                       | 30-
--------------------------------------------------------------------------
```

Exclusions: _____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Contract Vendor: _____

Format: ____ Standard   Partials?   ____ Yes ____ No
        ____ Zonal   Column separator? ____ Yes ____ No
        ____ Offset   Correction Print: ____ Current Value
                                                   ____ Test

Forms Flag: Suppress hospital header? ____ Yes ____ No
            Suppress patient demographic header? ____ Yes ____ No

Addendum Print: _____ Addendum Result Values Only _____ All Result Values

Include Cancelled: _____ Accn Cancelled _____ All _____ None
    (check one)

Interim Report Parameters

Complete one worksheet for each department in the system.

Location Print Order – Referring to the Nursing Station Codes worksheet and to the Account Number Group Assignment worksheet, indicate the order in which reports will be generated within Cumulative Trend and Summary Reports batches.

1–	11–	21–
2–	12–	22–
3–	13–	23–
4–	14–	24–
5–	15–	25–
6–	16–	26–
7–	17–	27–
8–	18–	28–
9–	19–	29–
10–	20–	30–

Exclusions: _____   _____   _____   _____   _____

            _____   _____   _____   _____   _____

            _____   _____   _____   _____   _____

Format: ____ Standard   Partials?   ____ Yes ____ No
        ____ Zonal   Column separator?   ____ Yes ____ No
        ____ Offset   Correction Print: ____ Current Value
                                                      ____ Test

Forms Flag: Suppress hospital header? ____ Yes ____ No
             Suppress patient demographic header? ____ Yes ____ No

Addendum Print: ____ Addendum Result Values Only ____ All Result Values

Include Cancelled: _____ Accn Cancelled _____ All _____ None
     (check one)

Discharge Report Parameters

Complete one worksheet for each department in the system.

Accumulation? ____ (A, P or N)   Days of Inactivity: ____

Patient types to include as prior work:

_____   _____   _____   _____   _____

_____   _____   _____   _____   _____

_____   _____   _____   _____   _____

_____   _____   _____   _____   _____

Days prior to Admission to include on Discharge Cumulative (N): _____

Exclusions: _____   _____   _____   _____   _____

_____   _____   _____   _____   _____

_____   _____   _____   _____   _____

Format: ____ Standard   Partials? ___ Yes ___ No
____ Zonal   Column separator? ___ Yes ___ No
____ Offset   Correction Print: ___ Current Value
____ Test

Incomplete Worklist Options: ____ Within Batch

____ End of Batch

____ Both

Forms Flag: Suppress hospital header? ____ Yes ____ No
Suppress patient demographic header? ____ Yes ____ No

Include Cancelled: _____ Accn Cancelled   _____ All _____ None
    (check one)

Patient Detail Report Parameters

Complete one worksheet for each department in the system.

Format: _____ Standard
        _____ Zonal
        _____ Offset

Exclusions: _____ _____ _____ _____ _____

            _____ _____ _____ _____ _____

            _____ _____ _____ _____ _____

Column separator? ____ Yes ____ No
Correction Print: ____ Current Value
                  ____ Test

Forms Flag: Suppress hospital header? _____ Yes _____ No
            Suppress patient demographic header? _____ Yes _____ No

Post-Discharge Report Parameters

Complete a separate worksheet for each facility in your system.

Report Type: _____ Partials: _____ Yes
                          _____ No

Exclusions: _____ _____ _____ _____ _____

                   _____ _____ _____ _____ _____

                   _____ _____ _____ _____ _____

Format: _____ Standard   Column separator? ____ Yes ____ No
        _____ Zonal   Correction Print: ____ Current Value
        _____ Offset   ____ Test

Addendum Print: _____ Addendum Result Values Only   _____ All Result Values

Include Cancelled: _____ Accn Cancelled
                   _____ All
                   _____ None

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Physician Summary Report Parameters

Complete one worksheet.

Active? ___ Yes ____ NoCopy to at Accessioning? ____ Ordering? ___

Format: ____ Standard   Partials?   ____ Yes ____ No
        ____ Zonal   Column Separator? ____ Yes ____ No
        ____ Offset   Addendum Print   ____(Addendum Only)
                                              _____(All)

Long Report?   ____ Yes ____ No

O/P Maximum Days _____

Correction Print: ____ Current Value ___ Test

Include Cancelled: _____ Accn Cancelled   _____ All _____ None
    (check one)

Exclusions:

_____ - _____

_____ - _____

_____ - _____

_____ - _____

_____ - _____

_____ - _____

_____ - _____

_____ - _____

_____ - _____

Remote Printing Parameters

```
Outbound Modem Ports: _____

Max # Batches: _____   Status/Error Msgs: ___ B(oth)  ___ E(rror Only)

Retain Errors: _____ days   Auto Print Active? __ Yes  __ No

Default Department: _____  Default Facility: _____

Automatic Print Times: _____

Facility: _____       Department: _____

          _____                   _____

          _____                   _____

          _____                   _____
```

Physician Parameters (1 of 2)

```
Complete one worksheet for each physician.

Physician Code: _____

Physician Name: _____

Main Report Location: _____/_____

Format:      _____ Standard
             _____ Zonal
             _____ Offset
Auto Update: ____ Yes (Specify Patient Type)  ____ No

     Patient Type: __ I(npatient) __ O(utpatient) __ C(ontract) __ A(ll) __ N(one)

Report Location Parameters
                 Report Location: _____

                 Report Generation: __ P(Local Print) __ F(FAX) __ R(Remote Print)

                 Remote Location: _____

                 Report Location: _____

                 Report Generation: __ P(Local Print) __ F(FAX) __ R(Remote Print)

                 Remote Location: _____

For Facility: _____

As Attending:
    Work      _____ All _____ Ordered Only
    Print for _____ All patient types
              _____ No patient types
              _____ Specify patient types: _____ _____ _____ _____ _____ _____
    Print for _____ All Contract Vendors
              _____ No Contract Vendors
              _____ Specify Contract Vendors: _____ _____ _____ _____ _____ _____


As Consulting:
    Work      _____ All _____ Ordered Only
    Print for _____ All patient types
              _____ No patient types
              _____ Specify patient types: _____ _____ _____ _____ _____ _____
    Print for _____ All Contract Vendors
              _____ No Contract Vendors
              _____ Specify Contract Vendors: _____ _____ _____ _____ _____ _____
```

Physician Parameters (2 of 2)

Complete one worksheet for each physician.

Physician Code: _____

Physician Name: _____

For Facility: _____

As Ordering:
    Work   ____ All ____ Ordered Only
    Print for ____ All patient types
              ____ No patient types
              ____ Specify patient types: _____ _____ _____ _____ _____ _____
    Print for ____ All Contract Vendors
              ____ No Contract Vendors
              ____ Specify Contract Vendors: _____ _____ _____ _____ _____ _____

As Primary Care:
    Work   ____ All ____ Ordered Only
    Print for ____ All patient types
              ____ No patient types
              ____ Specify patient types: _____ _____ _____ _____ _____ _____
    Print for ____ All Contract Vendors
              ____ No Contract Vendors
              ____ Specify Contract Vendors: _____ _____ _____ _____ _____ _____

As Admitting:
    Work   ____ All ____ Ordered Only
    Print for ____ All patient types
              ____ No patient types
              ____ Specify patient types: _____ _____ _____ _____ _____ _____
    Print for ____ All Contract Vendors
              ____ No Contract Vendors
              ____ Specify Contract Vendors: _____ _____ _____ _____ _____ _____

As Referring:
    Work   ____ All ____ Ordered Only
    Print for ____ All patient types
              ____ No patient types
              ____ Specify patient types: _____ _____ _____ _____ _____ _____
    Print for ____ All Contract Vendors
              ____ No Contract Vendors
              ____ Specify Contract Vendors: _____ _____ _____ _____ _____ _____

Laboratory Form Data Element Worksheet

```
                              HEADER
     Report Name: _____


     Line #    Beg Col    End Col          Data Element
     ----------------------------------------------------------------
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
     _____    _____     _____      _____
```

Laboratory Form Data Element Worksheet

```
                              FOOTER
     Report Name: _____


     Line #   Beg Col   End Col              Data Element
     ----------------------------------------------------------------

     _____   _____    _____      _____

     _____   _____    _____      _____

     _____   _____    _____      _____

     _____   _____    _____      _____

     _____   _____    _____      _____

     _____   _____    _____      _____

     _____   _____    _____      _____

     _____   _____    _____      _____

     _____   _____    _____      _____

     _____   _____    _____      _____

     _____   _____    _____      _____

     _____   _____    _____      _____

     _____   _____    _____      _____

     _____   _____    _____      _____

     _____   _____    _____      _____
```

Remote Location - Add

Complete one worksheet for each remote location needed.

Code: _____

Description: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Phone Number: **(   )**_____

Contact: _____

Modem Phone #: **(   )**_____

Valid Modem(s): _____

Copies (1-9): _____

Additional Location (Code): _____

Location Active? ____ Yes ____ NoAuto Print Active? ____ Yes ____ No

COLLECTION WALK ORDER

Nursing Station Groups

Complete as many worksheets as necessary.

Nurse Station Group Name	Nurse Station Group Name	Nurse Station Group Name	Nurse Station Group Name
_____	_____	_____	_____
Nurse Station	Nurse Station	Nurse Station	Nurse Station
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Nurse Station Group Name	Nurse Station Group Name	Nurse Station Group Name	Nurse Station Group Name
_____	_____	_____	_____
Nurse Station	Nurse Station	Nurse Station	Nurse Station
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Room and Bed Order

Complete one worksheet for each nursing station. If there is no difference in the walk order for collections and the walk order of the nursing station, you can print the location file for room and bed order and use that rather than rewriting all rooms and beds.

NURSING STATION: _____

Room #	Bed #	Room #	Bed #	Room #	Bed #	Room #	Bed #
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

ARCHIVING

Archive Retention Days per Patient Type

```
        Patient Type DEFAULT Retention Days:   _____  Days (1-3650)

        Archive Account Retention Days:        _____  Days (1-90)


List patient type and retention days that differ from the default:


        Patient Type    Retention Days      Patient Type    Retention Days
        _____    _____      _____    _____
        _____    _____      _____    _____
        _____    _____      _____    _____
        _____    _____      _____    _____
        _____    _____      _____    _____
        _____    _____      _____    _____
        _____    _____      _____    _____
        _____    _____      _____    _____
        _____    _____      _____    _____
        _____    _____      _____    _____
        _____    _____      _____    _____
        _____    _____      _____    _____
        _____    _____      _____    _____
        _____    _____      _____    _____
        _____    _____      _____    _____
```

Archive Selective Test Codes and Ranges

Retention Period Test Code/Range   Retention Period Test Code/Range

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

_____ _____   _____ _____

Data Elements for Archive Lab Summary

Yes	No			Yes	No		
___	___	1	Transport	___	___	14	Diagnosis in Header
___	___	2	Transport Rec	___	___	15	Number Pool
___	___	3	Sendout	___	___	16	Pat Type at Order
___	___	4	1st Partial	___	___	17	Order Diagnosis
___	___	5	Order	___	___	18	Spec Loc
___	___	6	Uncollected	___	___	19	Order Info
___	___	7	Accession	___	___	20	Order Loc
___	___	8	Transport	___	___	21	Dup/Con Audit
___	___	9	Sendout	___	___	22	Dups/Confs
___	___	10	Prompt/Resp	___	___	23	Internal Results
___	___	11	Panic Results Data	___	___	24	Internal Logs
___	___	12	Panic Results Data	___	___	25	Old Accn #
___	___	13	Histotech Data	___	___	26	New Accn #

TEST CODE LOOKUP

Lookup Groups

Lookup Code: _____   Description: _____

Component Code: _____   Description: _____

Dept	Test Code	Description
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Day Search Limitation/Activation

Department: _____

Main Patient Inquiry Days: _____

Section   Number of Days

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

SALES COMMISSION

Sales Commission Parameters

Complete a separate worksheet for each facility in your system.

Facility: _____

Check Yes below to enable the capturing of sales commission and enter a retention date
for that data. Check No below to disable sales commission processing.

Active: Yes _____   No _____

Data Retention: _____

Sales Commission For Financial Classes

Complete one worksheet for each financial class. Enter a dollar amount and percentage
for each maximum dollar amount in sales commission.

 Financial Code: _____ Description: _____

         Maximum Dollar Amount   % Sales Commission

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

         _____   _____

Sales Personnel/Phys/Contracts

Salesperson ID Code: _____ Salesperson: _____

Active: Yes _____   No _____

Physician	Contract	Activate	Inactivate
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

▪ **R e a d e r C o m m e n t F o r m** ▪

We value your suggestions for improving our documentation. Please use this form to evaluate the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide* for Release 17.0.

Topic	Poor	Fair	Good	Excellent
Organization of information	❑	❑	❑	❑
Accuracy of information	❑	❑	❑	❑
Completeness of information	❑	❑	❑	❑
Clarity of information	❑	❑	❑	❑
Amount of overview information	❑	❑	❑	❑
Explanation of processes	❑	❑	❑	❑

Are there parts of this manual that could be made more helpful to you? Please explain.

_____

_____

_____

_____

_____

Other Comments:

_____

_____

_____

Thanks for your help in improving the documentation.

Your Name and Position

_____

Hospital/Organization
Name

_____

Telephone Number

_____

May we contact you?   Yes or No (circle one)

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│   Place   │
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STAR 2000 Documentation Team
McKesson
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