LABORATORY
ANATOMIC PATHOLOGY (AP)
MODIFICATIONS/ENHANCEMENTS
TO ADDRESS PSI-04-025

USER GUIDE

PATCH LR*5.2*317

Version 5.2

June 2007

Department of Veterans Affairs
VistA Health Systems Design & Development

Preface

The Veterans Health Information Systems and Architecture (Vist*A*) Laboratory Anatomic Pathology (AP) Modifications/Enhancements To Address PSI-04-025 Patch LR*5.2*317 User Guide Version 5.2 provides the Department of Veterans Affairs Medical Center (DVAMC) Information Resource Management (IRM) staff, Laboratory Information Manager (LIM), and other DVAMC users with a straightforward means for using the software application. This User Guide is intended for use in conjunction with the VistA Laboratory Anatomic Pathology (AP) Electronic Signature Patch LR*5.2*259 User Manual.

Intended Audience:

The intended audience for this documentation includes users of the VistA Laboratory Anatomic Pathology software application, Laboratory Application Coordinators, Veterans Health Information Systems and Technology Architecture (VistA) sites' Information Resource Management (IRM), VHA Office of Information (OI) Health Systems Design & Development (HSD&D), and Enterprise VistA Support (EVS).

VistA Blood Bank Clearance

VistA BLOOD BANK SOFTWARE V5.2 DEVICE PRODUCT LABELING STATEMENT

VistA Laboratory Package patch LR*5.2*317 contains changes to software controlled by VHA DIRECTIVE 2004-053, titled VISTA BLOOD BANK SOFTWARE. Changes include:

File	Sub-file	Field	Field Name	Action
63	63.207	.03	RELEASE SUPP REPORT MODIFIED	New Field
63	63.324	.03	RELEASE SUPP REPORT MODIFIED	New Field
63	63.817	.03	RELEASE SUPP REPORT MODIFIED	New Field
63	63.907	.03	RELEASE SUPP REPORT MODIFIED	New Field

All of the above changes have been reviewed by the VISTA Blood Bank Developer and found to have no impact on the VISTA BLOOD BANK SOFTWARE control functions.

RISK ANALYSIS: Changes made by patch LR*5.2*317 have no effect on Blood Bank software functionality, therefore RISK is none.

EFFECT ON BLOOD BANK FUNCTIONAL REQUIREMENTS: Patch LR*5.2*317 does not alter or modify any software design safeguards or safety critical elements functions.

POTENTIAL IMPACT ON SITES: This patch contains changes to 0 routines and 1 file identified in Veterans Health Administration (VHA) Directive 2004-053, group B listing. The changes have no effect on Blood Bank functionality or medical device control functions. There is no adverse potential to sites.

VALIDATION REQUIREMENTS BY OPTION:
There are no validation requirements associated with this patch.

MINIMAL TEST CASE SCENARIOS BY OPTION, INCLUSIVE OF ALL CONTROL FUNCTIONS:
There are no test case scenarios associated with this patch.

Orientation

This section addresses package-or audience-specific notations or directions (e.g., symbols used to indicate terminal dialogues or user responses) and software and documentation retrieval information.

Screen Captures

The computer dialogue appears in Courier font, no larger than 10 points.
Example: `Courier font 10 points`

User Response

User entry response appears in boldface type Courier font, no larger than 10 points.
Example: `Boldface type`

Return Symbol

User response to computer dialogue is followed by the <RET> symbol that appears in Courier font, no larger than 10 points, and bolded.
Example: <RET>

Tab Symbol

User response to computer dialogue is followed by the symbol that appears in Courier font, no larger than 10 points, and bolded.
Example: <Tab>

References

Following is a list of related VHA HSD&D documentation that can also be found in the VistA Documentation Library (VDL) under the Clinical heading:

- VistA Laboratory Anatomic Pathology Electronic Signature Patch LR*5.2*259 Installation Guide and User Manual V. 5.2
- VistA Laboratory Anatomic Pathology User Manual V. 5.2
- VistA Laboratory User Manual V. 5.2
- VistA CPRS Text Integration Utility V. 1
- VistA CPRS Authorization/Subscription Utility V. 1

Software and Documentation Retrieval Information

VistA Laboratory AP Modifications/Enhancements to Address PSI-04-025 Patch LR*5.2*317 User Guide and software\distributions are as follows:

NOTE: All sites are encouraged to use the File Transfer Protocol (FTP) capability. Use the FTP address "download.vista.med.va.gov" (without the quotes) to connect to the first available FTP server where the files are located.

Software Retrieval

VistA Laboratory AP Modifications/Enhancements to Address PSI-04-025 Patch LR*5.2*317 software is distributed by Packman.

Documentation Retrieval

VistA Laboratory AP Modifications/Enhancements to Address PSI-04-025 Patch LR*5.2*317 User Guide is available at the following Office of Information Field Offices (OIFOs) ANONYMOUS.SOFTWARE directories:

OI Field Office	FTP Address	Directory
REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED
REDACTED	REDACTED	REDACTED

Documentation Retrieval Formats

VistA Laboratory AP Modifications/Enhancements to Address PSI-04-025 Patch LR*5.2*317 User Guide files are exported in the following retrieval formats:

File Names	Contents	Retrieval Formats
LAB_52_317_UG.doc	VistA Laboratory Anatomic Pathology (AP) Modifications/ Enhancements to Address PSI-04-025 Patch LR*5.2*317 User Guide	BINARY
LAB_52_317_UG.pdf	VistA Laboratory Anatomic Pathology (AP) Modifications/ Enhancements to Address PSI-04-025 Patch LR*5.2*317 User Guide	BINARY

VistA Website Locations:

VistA Laboratory AP Modifications/ Enhancements to Address PSI-04-025 Patch LR*5.2*317 User Guide is accessible in MS Word (.doc) and Portable Document Format (.pdf) at the following VistA locations:

Laboratory Version 5.2 Home Page

REDACTED

VistA Documentation Library (VDL)

www.va.gov/vdl/

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Introduction

Overview

VistA Laboratory Anatomic Pathology (AP) Modifications/Enhancements to Address PSI-04-025 Patch LR*5.2*317 is created in response to the two patient safety issues that arose from the release and implementation of the VistA Laboratory Anatomic Pathology Electronic Signature Patch LR*5.2*259. This patch changed the location and the method by which Anatomic Pathology SF515 supplementary reports are added.

The patient safety issues are described as follows:

Patient Safety Issue #1:
Laboratory personnel assigned the Modify released report [LRAPMRL] option and the LRAPMOD security key released by Patch LR*5.2*259 allowed editing/adding supplementary reports to the original Anatomic Pathology and Autopsy Protocol released report. This access opened up the potential for errors in which the released report could be accidentally modified when a supplementary report was added.

Patient Safety Issue #2:
Due to the release of the VistA Laboratory Anatomic Pathology Electronic Signature Patch LR*5.2*259 the original Anatomic Pathology SF515 or Autopsy Protocol released reports are **NOT** viewable in VistA Computer Patient Records System (CPRS) application during the time a supplementary report is being added.

Patch LR*5.2*317 resolves this problem by removing the supplementary report addition functionality from the *Modify released reports [LRAPMRL] option* and placing the functionality back to the *Supplementary Report, Anat Path [LRAPDSR] option* for Cytology, Electron Microscopy, and Surgical Pathology released reports and the *Autopsy supplementary report [LRAPAUSR] option* for Autopsy released reports.

Another concern had to do with the addition of a supplementary report to a released Anatomic Pathology report, which unreleased the original report and made it unavailable for viewing in Computerized Patient Record System (CPRS). The time span in which the original report remained unavailable for viewing by the Providers could be crucial. It was considered a major patient safety issue if a doctor, who was with a patient, was not able to view the report at that time.

Patch LR*5.2*317 resolves this problem by leaving the original Anatomic Pathology and Autopsy Protocol released report in the released status during the time a supplementary report is being added. The original Anatomic Pathology and Autopsy Protocol released report remains available for viewing in CPRS during this time.

Test Sites

The VistA Laboratory AP Modifications/Enhancements to Address PSI-04-025 Patch LR*5.2*317 tested by the following Veteran Affairs Medical Centers (VAMCs):

Test Sites (At least One Integrated Site)	Operating System Platform	Test Site Size
REDACTED	CACHE/VMS	LARGE
REDACTED	CACHE/VMS	LARGE/Integrated Site
REDACTED	CACHE/VMS	LARGE
REDACTED	CACHE/VMS	MEDIUM
REDACTED	CACHE/VMS	MEDIUM

Enhancements and Modifications

VistA Laboratory AP Modifications/Enhancements to Address PSI-04-025 Patch LR*5.2*317 software release corrects two patient safety issues for AP Surgical Pathology, Cytology, Electron Microscopy, and Autopsy supplementary reports and print options. These two patient safety issues were created by the release of VistA Laboratory Anatomic Pathology Electronic Signature Patch LR*5.2*259.

Enhancements:

The following file enhancement is created to support the resolution of the patient safety issue PSI-04-025 within VistA Laboratory Anatomic Pathology Cytopathology, Electron Microscopy, Surgical Pathology, and Autopsy sections:

1. LAB DATA file (#63):

LAB DATA file (#63), SUPPLEMENTARY REPORT sub-file (#1.2) for Anatomic Pathology has been **modified** to add the following four **new** fields:

- Cytopathology
- Electron Microscopy
- Surgical Pathology
- Autopsy

New Fields

Electron Microscopy

```
#63.02 -- EM SUB-FILE
63.207,.03      RELEASE SUPP REPORT MODIFIED 0;3 SET

                                '1' FOR YES;
                                '0' FOR NO;
                LAST EDITED:    SEP 09, 2004
                DESCRIPTION:    This flag will be set to '1' when a released
                                supplementary report is modified. It is
                                removed when the modified supplementary
                                report is released.
```

Autopsy

```
#63.324 -- AUTOPSY SUPPLEMENTARY REPORT SUB-FILE
63.324,.03    RELEASE SUPP REPORT MODIFIED 0;3 SET

                              '1' FOR YES;
                              '0' FOR NO;
              LAST EDITED:    SEP 08, 2004
              DESCRIPTION:    This flag will be set to '1' when a released
                              supplementary report is modified. It is
                              removed when the modified supplementary
                              report is released.
```

Surgical Pathology

```
#63.08 -- SURGICAL PATHOLOGY SUB-FILE
63.817,.03      RELEASE SUPP REPORT MODIFIED 0;3 SET

                              '1' FOR YES;
                              '0' FOR NO;
                LAST EDITED:  SEP 09, 2004
                DESCRIPTION:  This flag will be set to '1' when a released
                              supplementary report is modified. It is
                              removed when the modified supplementary
                              report is released.
```

Cytopathology

```
#63.09 -- CYTOPATHOLOGY SUB-FILE
63.907,.03      RELEASE SUPP REPORT MODIFIED 0;3 SET

                              '1' FOR YES;
                              '0' FOR NO;
                LAST EDITED:  SEP 09, 2004
                DESCRIPTION:  This flag will be set to '1' when a released
                              supplementary report is modified.  It is
                              removed when the modified supplementary
                              report is released.
```

Modifications:

The following Anatomic Pathology and Autopsy options are **modified** to resolve patient safety issue PSI-04-025 within the Cytopathology, Electron Microscopy, Surgical Pathology, and Autopsy sections of the VistA Laboratory Anatomic Pathology module:

1. Modify released pathology report [LRAPMRL] option

This option was created to allow **editing** of a released pathology report. The current version of the released report is retained in TIU. A new version of the report is created once the modified report has been released. If the report diagnosis has been modified, a banner is displayed showing MODIFIED DIAGNOSIS. The LRAPMOD security key must be assigned to provide authorized users access to this option.

Patient Safety Issue #1:
Laboratory personnel assigned the Modify released report [LRAPMRL] option and the LRAPMOD security key released by Patch LR*5.2*259 allowed editing/adding supplementary reports to the original released Anatomic Pathology and Autopsy Protocol report. This access opened up the potential for errors in which the original released report could be accidentally modified when a supplementary report was added.

Patient Safety Issue #1 Correction:
The Modify released pathology report [LRAPMRL] option is **modified** to remove the "Edit SUPPLEMENTARY REPORTS? NO//" prompt. This resolves the first patient safety issue by separating the entry of supplementary reports from the option used to modify reports.

Modification of a released SF515 or Autopsy Protocol report is NOT allowed when a supplementary report is being added to that report. Once the supplementary report is released, the Modify released pathology report [LRAPMRL] option is used to modify the released report. A WARNING MESSAGE appears when a user attempts to modify a report that has a supplementary report underway.

The data in released reports is unchangeable after the report is electronically signed. If data needs to be updated, then it is necessary to develop a "modified" report for modified data through the Modify released pathology report [LRAPMRL] option or a supplementary report for added data through the Supplementary Report, Anat Path [LRAPDSR] option for SF515 reports and the Autopsy supplementary report [LRAPAUSR] option for Autopsy protocol reports. **Note:** Both modified and supplementary reports will require a new electronic signature.

2. Supplementary Report, Anat Path [LRAPDSR] option

This option is used to add a supplementary report to any existing unreleased anatomic pathology accession.

The Supplementary Report, Anat Path option [LRAPDSR] option is **modified** to add supplementary reports on released Anatomic Pathology reports for Cytology, Electron Microscopy, and Surgical Pathology.

Patient Safety Issue #2:
The original released Anatomic Pathology SF515 report is not viewable in the Computer Patient Records System (CPRS) during the time a supplementary report is being added to a released report. Users are unable to view the original Anatomic Pathology SF515 report during this time.

Patient Safety Issue #2 Corrections:
The Supplementary Report, Anat Path [LRAPDSR] option is modified to allow the entry of supplementary reports on released SF515 reports for Cytopathology, Electron Microscopy, and Surgical Pathology sections. Also, the Autopsy supplementary report [LRAPAUSR] option shall be modified to allow entry of supplementary reports on released Autopsy Protocol reports for the Autopsy section. The addition of supplementary report(s) to a released report will not unrelease the original report while the supplementary report is in progress. The original report remains viewable in CPRS, until the supplementary report is released. Then a new version of the original report includes the supplement replace the old original report for viewing in CPRS. This resolves the second patient safety issue.

Supplementary Report, Anat Path [LRAPDSR] option "DATE REPORT COMPLETED:" prompt Removal:
The Supplementary Report, Anat Path option [LRAPDSR] option for Cytology, Electron Microscopy, and Surgical Pathology is **modified** to add supplementary reports on released reports. Editing the DATE REPORT COMPLETED date is not allowed when adding a supplemental to a released report. The prompt "DATE REPORT COMPLETED:" is removed from the Supplementary Report, Anat Path option for entry of supplementary reports on released reports. A supplementary report cannot be added to a released SF515 report that is being modified. Audit Trail information is stored on supplementary reports added to released reports. Supplementary reports added to released reports are clearly identified as being a "supplementary report".

Anatomic Pathology Supplementary Report Audit Trail:
Audit information is stored on the AP supplementary report added to a released AP SF515 report. AP supplementary reports added to released AP SF515 reports is clearly identified as being a "SUPPLEMENTARY" report.

3. Supplementary report release, anat path [LRAPRS] option

This option is used to release supplementary reports for Surgical Pathology, Cytopathology, and Electron Microscopy, and Autopsy**.**

The Supplementary report release, anat path [LRAPRS] option that releases a supplementary report is **modified** to also release the original report. Supplementals will no longer require a separate second release of the original report. An electronic signature code is entered for each separate, unreleased supplementary report before the main report is released. The addition of a supplemental report will not alter any information on the original report. There is a supplementary report and a new original report including the supplement. The name of the pathologist responsible for adding the supplement does not have to be the same pathologist who is responsible for the original report. However, the new full report including the supplement requires a new electronic signature and not necessarily by the pathologist responsible for the full report. Releasing the supplementary report triggers the creation and storage of the new report in TIU. Upon release, the supplementary report is viewable in CPRS as part of the original report. The original report remains separate and untouched in TIU.

4 Autopsy supplementary report [LRAPAUSR] option

This option is used to allow entry of a supplementary report for a released autopsy.

Patient Safety Issue #2:
The original Autopsy Protocol report is not viewable in the Computer Patient Records System (CPRS) during the time a supplementary report is being added. Users are unable to view the original Autopsy Protocol report during this time.

Patient Safety Issue #2 Corrections:
This patient safety issue is resolved by leaving the released Autopsy Protocol reports in the released status during the time a supplementary report is being added. This has been accomplished by removing the supplementary report **add** functionality from the Modify released reports [LRAPMRL] option and placing the **add** functionality back in the Autopsy supplementary report [LRAPAUSR] option for the Autopsy section.

The Autopsy supplementary report [LRAPAUSR] option contains the following modification:

DATE REPORT COMPLETED Prompt Removed:
This option is **modified** NOT to allow editing of the "DATE REPORT COMPLETED" prompt date when adding an autopsy supplemental to a released Autopsy Protocol report. The 'DATE REPORT COMPLETED:' prompt is REMOVED from this option.

Autopsy Supplementary Report New AUDIT TRAIL Information:
This option is **modified** to display the following **new** Audit information when an AUTOPSY has been released and a supplementary report is added or modified: '**`This AUTOPSY has been released. Supplementary report additions/modifications will create an audit trail.'`**

Autopsy Protocol Report being modified must be released before Autopsy Supplementary Report is added:
This option is **modified** to include the following **new** information when an Autopsy Protocol report is being modified: '**`This Autopsy Protocol report is currently being modified; it must first be released before Supplementary report can be added.'`**

Autopsy Protocol Report Supplement displaying new 'SUPPLEMENTARY' text:
This option is **modified** as follows: Electronically signed Autopsy Protocol report displays only the last final report. The Autopsy Protocol report contains all modifications and supplements. The final Autopsy Protocol report supplement is clearly marked as "**SUPPLEMENTARY**" when a supplemental report is added. The previous report is retained electronically; however, the report is only available to Laboratory personnel assigned the required security key.

Autopsy Protocol Report displaying new 'MODIFIED' text:
This option is **modified** as follows: Electronically signed Autopsy Protocol report displays only the last final report. The Autopsy Protocol report contains all modifications and supplements. The final Autopsy Protocol report is clearly marked as **"MODIFIED"** when the report is modified. The previous report is retained electronically; however, the report is only available to Laboratory personnel assigned the required security key.

Released Autopsy Protocol Report Viewable in CPRS:
This option is **modified** not to unrelease a Released Autopsy Protocol report when Autopsy supplementary reports are being added. The original released Autopsy Protocol report remains viewable in CPRS until the added Autopsy supplementary report is released. The added Autopsy supplementary report replaces the original released Autopsy Protocol report for viewing in CPRS.

AP Print Options Modifications:

The following three AP print options are **modified** to resolve patient safety issue PSI-04-025 regarding supplementary reports added to an original released report **not** displaying a header at the top of the reports for Cytopathology, Electron Microscopy, Surgical Pathology, and Autopsy.

5. Print all reports on queue [LRAP PRINT ALL ON QUEUE] option

This option prints a report listing the clinical history and gross description for review for patients on the cumulative report print queue, as well as final reports for patients, and completed autopsy reports. For final reports; if the final report is electronically signed and stored in TIU, the report will be pulled from TIU. Otherwise, the report will be generated from the data stored in the LAB DATA file (#63). The option asks if a 'Final Office Copy' should be printed. The 'Final Office Copy' prints SNOMED codes on a separate page since they are no longer printed on the SF515. The header of the 'Final Office Copy' report is **modified** to indicate that a supplementary report has been added to the bottom of the report.

Example:
```
*+* SUPPLEMENTARY REPORT HAS BEEN ADDED *+*
*+* REFER TO BOTTOM OF REPORT *+*
```

6. Print single report only [LRAP PRINT SINGLE] option

This option prints a list of any pathology accessions in cytopath, electron microscopy, and surgical pathology for cumulative reports for micro exams. Also prints final reports and completed autopsy reports. For final reports, if the report has been electronically signed and stored in TIU, the report will be pulled from TIU. Otherwise, the report will be generated from the data stored in the LAB DATA (#63) file. This option asks if a 'Final Office Copy' should be printed. The 'Final Office Copy' prints SNOMED codes on a separate page since they are no longer printed on the SF515.. The header of the report is modified with the following statement:

Example:
```
*+* SUPPLEMENTARY REPORT HAS BEEN ADDED *+*
*+* REFER TO BOTTOM OF REPORT *+*
```

7. Print final path reports by accession # [LRAPFICH] option

This option allows printing final path reports from one accession to another within the same calendar year. This option can be used to make tapes for microfiche. The header of the report is **modified** with the following statement:

Example: `*+* SUPPLEMENTARY REPORT HAS BEEN ADDED *+*`
`*+* REFER TO BOTTOM OF REPORT *+*`

Use of the Software

VistA Laboratory Anatomic Pathology (AP) Modifications/Enhancements to Address PSI-04-025 Patch LR*5.2*317 software release contains the following options modifications including screen captures for AP Surgical Pathology, Cytology, Electron Microscopy, and Autopsy sections.

Required Security Keys

Security keys are used to restrict user's access to specific areas/options of Anatomic Pathology. The following security keys **must** be assigned to authorized users requiring access to the VistA Laboratory Anatomic Pathology functionality:

Security Key	Access
LRLAB security key:	Allows access to the main Laboratory [LRMENU] menu.
LRANAT security key:	Allows access to the main Anatomic Pathology [LRAP] menu
LRAPSUPER security key:	Gives an authorized user access to the Supervisor, anat path [LRAPSUPER] submenu where the *Turn Electronic Signature On/Off* [LRAP ESIG SWITCH] option is located.
LRLIASON security key:	Gives an authorized user access to the *Turn Electronic Signature On/Off* [LRAP ESIG SWITCH] option.
LRAPMOD security key:	This security key gives an authorized user access to the *Modify released pathology report* [LRAPMRL] option.
LRVERIFY security key:	Required by anyone verifying lab results (i.e., gives an authorized user access to anatomic pathology setup tasks and gives authorization to electronically sign Autopsy Protocol, SF 515, and supplementary released reports).
PROVIDER security key:	Gives an authorized user access to anatomic pathology setup tasks and gives authorization to electronically sign Autopsy Protocol, SF 515, and supplementary released reports. It also enables the authorized signer to be listed as the Provider of the pathology case in the TIU report document. Without this key, the authorized signer is not allowed to sign or release a report.

Electronic Signature Code Setup

1. Authorized User **must** possess the **LRVERIFY key** to access the anatomic pathology setup tasks and provide authorization to electronically sign Autopsy Protocol, SF 515, and supplementary released reports.

2. Authorized User **must** possess the **PROVIDER key**.

3. Enter an **ELECTRONIC SIGNATURE CODE** field **(#20.4)** in the signer's **NEW PERSON** file **(#200)**.

4. The **PROVIDER CLASS (#53.5)** field in the signer's **NEW PERSON file (#200) must** include either "PHYSICIAN" or "CYTOTECHNOLOGIST."

5. If the PROVIDER CLASS field includes "PHYSICIAN," **the PERSON CLASS (#8932.1)** multiple field of the **NEW PERSON file (#200)** must point to one of the following entries in the **PERSON CLASS file (#8932.1):**

```
77          Physicians (M.D. and D.O.)
               Physician/Osteopath
                    Pathology, Anatomic & Clinical
 78          Physicians (M.D. and D.O.)
               Physician/Osteopath
                    Pathology, Anatomic
 79          Physicians (M.D. and D.O.)
               Physician/Osteopath
                    Pathology, Anatomic & Laboratory Medicine
 81          Physicians (M.D. and D.O.)
               Physician/Osteopath
                    Pathology, Chemical
 82          Physicians (M.D. and D.O.)
               Physician/Osteopath
                    Pathology, Clinical
 84          Physicians (M.D. and D.O.)
               Physician/Osteopath
                    Dermatopathology
 86          Physicians (M.D. and D.O.)
               Physician/Osteopath
                    Hematology: Pathology
 89          Physicians (M.D. and D.O.)
               Physician/Osteopath
                    Neuropathology
```

6. If the PROVIDER CLASS field includes "CYTOTECHNOLOGIST," the **PERSON CLASS multiple field (#8932.1)** of the **NEW PERSON file (#200) must** point to the following entry in the **PERSON CLASS file (#8932.1):**

```
430  Technologists, Technicians and Other Technical Service
                Specialist/Technologist, Pathology
                Cytotechnology
```

Laboratory DHCP [LRMENU] Menu

The Laboratory DHCP [LRMENU] menu contains the Anatomic Pathology [LRAP] menu.

Anatomic Pathology [LRAP] Menu

The Anatomic Pathology [LRAP] menu contains the main AP options. Each option includes submenus.

Example: The Anatomic Pathology [LRAP] menu contains shortcut numbers and synonyms that may be used to quickly select menus and options.

```
Select Laboratory DHCP Menu Option: ?<ENTER>

   1      Phlebotomy menu ...
   2      Accessioning menu ...
   3      Process data in lab menu ...
   4      Quality control menu ...
   5      Results menu ...
   6      Information-help menu ...
   7      Ward lab menu ...
   8      Anatomic pathology ...
   9      Blood bank ...
   10     Microbiology menu ...
   11     Supervisor menu ...
   LSM    Lab Shipping Menu ...

Enter ?? for more options, ??? for brief descriptions, ?OPTION for help text.

Select Laboratory DHCP Menu Option: 8<ENTER> Anatomic pathology

                            ANATOMIC PATHOLOGY MENU
Select Anatomic pathology Option: ?<ENTER>

   D      Data entry, anat path ...
   E      Edit/modify data, anat path ...
   I      Inquiries, anat path ...
   L      Log-in menu, anat path ...
   P      Print, anat path ...
   R      SNOMED field references ...
   S      Supervisor, anat path ...
   V      Verify/release menu, anat path ...
   C      Clinician options, anat path ...
   W      Workload, anat path ...

Enter ?? for more options, ??? for brief descriptions, ?OPTION for help text.
```

Modify released pathology report [LRAPMRL] option

This option was created to allow **editing** of a released pathology report. The current version of the released report is retained in TIU. A new version of the report is created once the modified report has been released. If the report diagnosis has been modified, a banner is displayed showing **MODIFIED DIAGNOSIS**. The **LRAPMOD** security key **must** be assigned to provide authorized users access to this option.

Patient Safety Issue #1:
Laboratory personnel assigned the Modify released report [LRAPMRL] option and the LRAPMOD security key released by Patch LR*5.2*259 allowed editing/adding supplementary reports to the original released Anatomic Pathology and Autopsy Protocol report. This access opened up the potential for errors in which the original released report could be accidentally modified when a supplementary report was added.

Patient Safety Issue #1 Correction:
The Modify released pathology report [LRAPMRL] option is **modified** to remove the "Edit SUPPLEMENTARY REPORTS? NO//" prompt. This resolves the first patient safety issue by separating the entry of supplementary reports from the option used to modify reports. Modification of a released SF515 or Autopsy Protocol report is not allowed when a supplementary report is being added to that report. Once the supplementary report is released, the Modify released pathology report [LRAPMRL] option is used to modify the released report. A WARNING MESSAGE appears when a user attempts to modify a report that has a supplementary report underway. The data in released reports shall be unchangeable after the report is electronically signed. If data needs to be updated, then it is necessary to develop a "modified" report for modified data through the Modify released pathology report [LRAPMRL] option or a supplementary report for added data through the Supplementary Report, Anat Path [LRAPDSR] option for SF515 reports and the Autopsy supplementary report [LRAPAUSR] option for Autopsy protocol reports. Both modified or supplementary reports will require a new electronic signature.

The following corrections resolved patient safety issue #1:

Example #1: This example is displaying that the **'Edit SUPPLEMENTARY REPORTS? NO//' prompt** has been REMOVED within the Modify released pathology report [LRAPMRL] option.

```
CHOOSE 1-5: 1 <ENTER> LRAP     Anatomic pathology

                            ANATOMIC PATHOLOGY MENU

   D      Data entry, anat path ...
   E      Edit/modify data, anat path ...
   I      Inquiries, anat path ...
   L      Log-in menu, anat path ...
   P      Print, anat path ...
   R      SNOMED field references ...
   S      Supervisor, anat path ...
   V      Verify/release menu, anat path ...
   C      Clinician options, anat path ...
   W      Workload, anat path ...

Select Anatomic pathology Option: E<ENTER> Edit/modify data, anat path

   LI     Edit log-in & clinical hx, anat path
   MM     Modify released pathology report
   SC     Edit anat path comments


Select Edit/modify data, anat path Option: MM<ENTER> Modify released
pathology report


                        Modify Released Pathology Reports

                                     NOTICE

   This option allows modification of a verified/released pathology report.
   Continuing with this option will unrelease the report and flag the report
   as modified even if the data is unchanged.  It will also be queued to the
   final report queue so that it may be verified/released again.

Do you wish to continue? NO// YES <ENTER>

Select ANATOMIC PATHOLOGY SECTION: SURGICAL PATHOLOGY <ENTER>

                     SURGICAL PATHOLOGY (NSP)

     Select one of the following: <ENTER>

          1         Edit Report
          2         Edit Diagnosis

Enter selection: 1// <ENTER>  Edit Report

Edit etiology, function, procedure & disease? NO// <ENTER>

Data entry for 2005 ? YES//<ENTER> (YES)
```

```
Select Accession Number/Pt name: 5<ENTER> for 2005

   LRPATIENT, FOUR                000-87-5675         DOB: Mar 03, 1953
     Collection Date: Mar 15, 2005@10:55
          Acc #: NSP 05 5

            Tissue Specimen(s):<ENTER>
               EAR
     Test(s):  SURGICAL PATH REPORTING
               SURGICAL PATHOLOGY LOG-IN

PATIENT LOCATION: 3N//<ENTER>
SURGEON/PHYSICIAN: LRPHYSICIAN, ONE//<ENTER>
SPECIMEN SUBMITTED BY: LRPHYSICIAN, TWO//<ENTER>
Select SPECIMEN: EAR//<ENTER>
  SPECIMEN: EAR//<ENTER>
Select SPECIMEN:<ENTER>
BRIEF CLINICAL HISTORY:<ENTER>
  1>
PREOPERATIVE DIAGNOSIS:<ENTER>
  1>
OPERATIVE FINDINGS:<ENTER>
  1>
POSTOPERATIVE DIAGNOSIS:<ENTER>
  1>
DATE/TIME SPECIMEN RECEIVED: MAR 15,2005@10:55//<ENTER>
PATHOLOGIST: LRPATHOLOGIST, ONE//<ENTER>
RESIDENT PATHOLOGIST:<ENTER>
Select COMMENT: <ENTER>
Select DELAYED REPORT COMMENT: <ENTER>
Select ORGAN/TISSUE: PERICARDIAL FLUID// <ENTER>
  ORGAN/TISSUE: PERICARDIAL FLUID// <ENTER>
  Select MORPHOLOGY: CARBUNCLE// <ENTER>
    MORPHOLOGY: CARBUNCLE// <ENTER>
  Select MORPHOLOGY: <ENTER>
  Select SPECIAL STUDIES:
Select ORGAN/TISSUE: <ENTER>
Select ICD DIAGNOSIS: <ENTER>
DATE REPORT COMPLETED: MAR 15,2005// <ENTER>
Edit GROSS DESCRIPTION? NO// <ENTER>
Edit MICROSCOPIC DESCRIPTION? NO// <ENTER>
Edit FROZEN SECTION? NO// <ENTER>
Enter CPT CODING? NO// <ENTER>
```

Example #2: The Modify released pathology report [LRAPMRL] option example is displaying the following **new** WARNING MESSAGE whenever a user attempts to modify a supplementary report that is **not** released**:** **"Supplementary report Feb. 22, 2005 has not been released. Cannot modify the report."**

```
CHOOSE 1-5: 1 <ENTER> LRAP     Anatomic pathology

                            ANATOMIC PATHOLOGY MENU

   D       Data entry, anat path ...
   E       Edit/modify data, anat path ...
   I       Inquiries, anat path ...
   L       Log-in menu, anat path ...
   P       Print, anat path ...
   R       SNOMED field references ...
   S       Supervisor, anat path ...
   V       Verify/release menu, anat path ...
   C       Clinician options, anat path ...
   W       Workload, anat path ...

Select Anatomic pathology Option: E <ENTER> Edit/modify data, anat path

   LI      Edit log-in & clinical hx, anat path
   MM      Modify released pathology report
   SC      Edit anat path comments

Select Edit/modify data, anat path Option: MM <ENTER> Modify released
pathology report


                        Modify Released Pathology Reports

                                      NOTICE

   This option allows modification of a verified/released pathology report.
   Continuing with this option will unrelease the report and flag the report
   as modified even if the data is unchanged.  It will also be queued to the
   final report queue so that it may be verified/released again.

Do you wish to continue? NO// YES <ENTER>

Select ANATOMIC PATHOLOGY SECTION: CYTOPATHOLOGY <ENTER>

                     CYTOPATHOLOGY (NCY)

     Select one of the following: <ENTER>

          1         Edit Report
          2         Edit Diagnosis

Enter selection: 1// <ENTER>  Edit Report

Edit etiology, function, procedure & disease? NO// <ENTER>

Data entry for 2004 ? YES// <ENTER> (YES)
```

```
Select Accession Number/Pt name: 2 <ENTER> for 2004

   LRPATIENT,ONE                      000-77-6445         DOB: Apr 04, 1944
     Collection Date: Jan 21, 2004
          Acc #: NCY 04 2
     Tissue Specimen(s):
               CYTO
               PAP
     Test(s):  CYTOLOGY
               PAP SMEAR
               CYTOLOGY REPORTING

Supplementary report FEB 22, 2005 has not been released.
Cannot modify the report.

Select Accession Number/Pt name:
```

Supplementary Report, Anat Path [LRAPDSR] option

Use this option to add a supplementary report to any existing unreleased anatomic pathology accession.

Patient Safety Issue #2:
The original released Anatomic Pathology SF515 report is not viewable in the Computer Patient Records System (CPRS) during the time a supplementary report is being added to a released report. Users are unable to view the original Anatomic Pathology SF515 report during this time.

Patient Safety Issue #2 Corrections:
The Supplementary Report, Anat Path [LRAPDSR] option is **modified** to allow the entry of supplementary reports on released SF515 reports for Cytopathology, Electron Microscopy, and Surgical Pathology sections. Also, the Autopsy supplementary report [LRAPAUSR] option shall be modified to allow entry of supplementary reports on released Autopsy Protocol reports for the Autopsy section. The addition of supplementary report(s) to a released report will not unrelease the original report while the supplementary report is in progress. The original report remains viewable in CPRS, until the supplementary report is released. Then a new version of the original report includes the supplement replace the old original report for viewing in CPRS. This resolves the second patient safety issue.

The Supplementary Report, Anat Path option [LRAPDSR] option for Cytology, Electron Microscopy, and Surgical Pathology is **modified** to add supplementary reports on released reports. Editing the DATE REPORT COMPLETED date is not allowed when adding a supplemental to a released report. The prompt "DATE REPORT COMPLETED:" is removed from the Supplementary Report, Anat Path option for entry of supplementary reports on released reports. A supplementary report cannot be added to a released SF515 or an Autopsy Protocol report that is being modified. Audit Trail information is stored on supplementary reports added to released reports. Supplementary reports added to released reports are clearly identified as being a "supplementary report".

NOTES:

A Modified Report is an electronically signed report containing **changes** to information previously verified on an original SF515 report. These changes become part of the original released SF515 report.

A Supplemental Report is an electronically signed report that **adds** additional information to the original released SF515 report. Additional information added to the original released SF515 report does not change any data that is previously verified. The supplement report becomes part of the original released SF515 report.

Example #1: Using the Supplementary Report, Anat Path [LRAPDSR] option to **add** a supplementary report to an original released SF515 report displays the following **new** text:
"This report is currently being modified; it must first be released before supplementary report can be added."

```
Select Laboratory DHCP Menu Option: 8<ENTER> Anatomic pathology

Select Anatomic pathology Option: D<ENTER>  Data entry, anat path

   AU     Data entry for autopsies ...
   BS     Blocks, Stains, Procedures, anat path
   CO     Coding, anat path ...
   GD     Clinical Hx/Gross Description/FS
   GM     FS/Gross/Micro/Dx
   GS     FS/Gross/Micro/Dx/SNOMED Coding
   GI     FS/Gross/Micro/Dx/ICD9CM Coding
   OR     Enter old anat path records
   SR     Supplementary Report, Anat Path
   SS     Spec Studies-EM;Immuno;Consult;Pic, Anat Path


Select Data entry, anat path Option: SR<ENTER> Supplementary Report, Anat
Path
Select ANATOMIC PATHOLOGY SECTION:    CYTOPATHOLOGY<ENTER>

                    CYTOPATHOLOGY (NCY)


Enter Etiology, Function, Procedure & Disease ? NO//<ENTER>   (NO)

Data entry for 2006 ? YES//N<ENTER>  (NO)
Enter YEAR: 2004<ENTER>  (2004)


Select Accession Number/Pt name: LRPATIENTONE, AP<ENTER> 4-4-44  000112222 NO
     MILITARY RETIREE
LRPATIENTONE, AP ID: 000-11-2222
AGE: 61  DATE OF BIRTH: APR 4,1944
PATIENT LOCATION: 3N// ^<ENTER>

Select Accession Number/Pt name: 34<ENTER>  for 2004
LRPATIENTONE, AP  ID: 000-11-2222
Specimen(s):<ENTER>
PAP

This CYTOPATHOLOGY report is currently being
modified; it must first be released before Supplementary
report can be added.

Select Accession Number/Pt name:^<ENTER>
```

Example #2: The Supplementary Report, Anat Path [LRAPDSR] option is used to add a Supplementary report to an original released SF515 report which creates the **new** AUDIT TRAIL displaying the following text: "**This CYTOPATHOLOGY report has been released. Supplementary report additions/modifications will create an audit trail.**"

```
Select Laboratory DHCP Menu Option: 8<ENTER> Anatomic pathology

                              ANATOMIC PATHOLOGY MENU

Select Anatomic pathology Option: D<ENTER> Data entry, anat path
   AU     Data entry for autopsies ...
   BS     Blocks, Stains, Procedures, anat path
   CO     Coding, anat path ...
   GD     Clinical Hx/Gross Description/FS
   GM     FS/Gross/Micro/Dx
   GS     FS/Gross/Micro/Dx/SNOMED Coding
   GI     FS/Gross/Micro/Dx/ICD9CM Coding
   OR     Enter old anat path records
   SR     Supplementary Report, Anat Path
   SS     Spec Studies-EM;Immuno;Consult;Pic, Anat Path

Select Data entry, anat path Option: SR<ENTER>  Supplementary Report, Anat
Path

Select ANATOMIC PATHOLOGY SECTION:    CYTOPATHOLOGY<ENTER>

                     CYTOPATHOLOGY (NCY)
Enter Etiology, Function, Procedure & Disease ? NO//<ENTER>  (NO)

Data entry for 2005 ? YES//<ENTER>  (YES)

Select Accession Number/Pt name:  LRPATIENTONE, AP<ENTER>  4-4-44  000112222
NO
     MILITARY RETIREE
LRPATIENTONE,AP ID: 000-11-2222
AGE: 61  DATE OF BIRTH: APR 4,1944
PATIENT LOCATION: 3N// ^<ENTER>
Specimen(s):<ENTER>
NOSE

Select ORGAN/TISSUE:<ENTER>

This CYTOPATHOLOGY report has been released.
Supplementary report additions/modifications will create an audit trail.

Select SUPPLEMENTARY REPORT DATE:<ENTER>
```

Supplementary report release, anat path [LRAPRS] option

This option releases supplementary reports for Surgical Pathology, Cytopathology or Electron Microscopy. If all supplementary reports that exist for the chosen accession have already been released or if no supplementary reports exist for the accession, the user will be notified.

The Supplementary Report, Anat Path option [LRAPDSR] option is **modified** to add supplementary reports on released Anatomic Pathology reports for Cytology, Electron Microscopy, and Surgical Pathology.

Patient Safety Issue #2:
The original released Anatomic Pathology SF515 report is not viewable in the Computer Patient Records System (CPRS) during the time a supplementary report is being added to a released report. Users are unable to view the original Anatomic Pathology SF515 report during this time.

Patient Safety Issue #2 Corrections:
The Supplementary Report, Anat Path [LRAPDSR] option is modified to allow the entry of supplementary reports on released SF515 reports for Cytopathology, Electron Microscopy, and Surgical Pathology sections. Also, the Autopsy supplementary report [LRAPAUSR] option shall be modified to allow entry of supplementary reports on released Autopsy Protocol reports for the Autopsy section. The addition of supplementary report(s) to a released report will not unrelease the original report while the supplementary report is in progress. The original report remains viewable in CPRS, until the supplementary report is released. Then a new version of the original report includes the supplement replace the old original report for viewing in CPRS. This resolves the second patient safety issue.

Supplementary Report, Anat Path option [LRAPDSR] option "DATE REPORT COMPLETED:" prompt Removal:
This option is **modified** NOT to allow Editing of the "DATE REPORT COMPLETED" date when adding an AP supplemental to a released Anatomic Pathology SF515 report. The prompt "DATE REPORT COMPLETED:" is removed from this option. An AP supplementary report cannot be added to a released SF515 report that is being MODIFIED.

Anatomic Pathology Supplementary Report Audit Trail:
Audit information is stored on the AP supplementary report added to a released AP SF515 report. AP supplementary reports added to released AP SF515 reports is clearly identified as being a "SUPPLEMENTARY" report.

Example #1: This example displays the release process involved in releasing a supplementary report using the Supplementary report release, anat path [LRAPRS] option when ELECTRONIC SIGNATURE is turned **ON:** **Enter your Current Signature Code: ###### SIGNATURE VERIFIED...Released**

```
Select Verify/release menu, anat path Option: RS <Enter> Supplementary report
release, anat path

                    Release Supplementary Pathology Reports

 Select ANATOMIC PATHOLOGY SECTION: CYTOPATHOLOGY<Enter>

                    CYTOPATHOLOGY (NCY)

 Data entry for 2004 ? YES//<Enter> (YES)

 Select Accession Number/Pt name: 2 <Enter> for 2004
 LRPATIENT,ONE  ID: 000-77-6445
 Specimen(s): <Enter>
 PAP

 Select SUPPLEMENTARY REPORT DATE: JUN 23, 2004// <Enter>   JUN 23, 2004

 Enter your Current Signature Code: ######  SIGNATURE VERIFIED...Released

                     *** Main Report Release ***

 *** Report is being processed for storage in TIU.  One moment please. ***

                   *** Report storage in TIU is complete. ***

                            *** Report released. ***

 Do you wish to send an alert? NO//<Enter>
```

Example #2: This example displays the release process involved in releasing a supplementary report using the Supplementary report release, anat path [LRAPRS] option when ELECTRONIC SIGNATURE is turned **OFF**: ***** Main Report Has Been Released *****

```
Select Verify/release menu, anat path Option: RS<ENTER> Supplementary report
release, anat path

                     Release Supplementary Pathology Reports

 Select ANATOMIC PATHOLOGY SECTION: CYTOPATHOLOGY <ENTER>

                     CYTOPATHOLOGY (NCY)

 Data entry for 2004 ? YES//<ENTER> (YES)

 Select Accession Number/Pt name: 5<ENTER> for 2004
 LRPATIENT3,THREE  ID: 000-87-5675
 Specimen(s):<ENTER>
 TOE

 Select SUPPLEMENTARY REPORT DATE: JUL 10, 2004//<ENTER>   JUL 10, 2004

 Release supplementary report? NO//YES<ENTER>...Released


                *** Main Report Has Been Released ***


  *** Report is being processed for storage in TIU. One moment please.***

                   *** Report storage in TIU is complete. ***
                            *** Report released. ***

Do you wish to send an alert? NO//<ENTER>
```

Autopsy supplementary report [LRAPAUSR] option

This option is used to allow entry of a supplementary report for a released autopsy.

Patient Safety Issue #2:
The original Autopsy Protocol report is not viewable in the Computer Patient Records System (CPRS) during the time a supplementary report is being added. Users are unable to view the original Autopsy Protocol report during this time.

Patient Safety Issue #2 Corrections:
This patient safety issue is resolved by leaving the released Autopsy Protocol reports in the released status during the time a supplementary report is being added. This has been accomplished by removing the supplementary report **add** functionality from the Modify released reports [LRAPMRL] option and placing the **add** functionality back in the Autopsy supplementary report [LRAPAUSR] option for the Autopsy section.

The Autopsy supplementary report [LRAPAUSR] option contains the following modification:

1. DATE REPORT COMPLETED Prompt Removed:

This option is **modified** NOT to allow editing of the "DATE REPORT COMPLETED" prompt date when adding an autopsy supplemental to a released Autopsy Protocol report. The 'DATE REPORT COMPLETED:' prompt is REMOVED from this option.

2. Autopsy Supplementary Report New AUDIT TRAIL Information:

This option is **modified** to display the following **new** Audit information when an AUTOPSY has been released and a supplementary report is added or modified: '**`This AUTOPSY has been released. Supplementary report additions/modifications will create an audit trail.'`**

3. Autopsy Protocol Report being modified must be released before Autopsy Supplementary Report is added:

This option is **modified** to include the following **new** information when an Autopsy Protocol report is being modified: '**`This Autopsy Protocol report is currently being modified; it must first be released before Supplementary report can be added.'`**

4. Autopsy Protocol Report Supplement displaying new 'SUPPLEMENTARY' text:

This option is **modified** as follows: Electronically signed Autopsy Protocol report displays only the last final report. The Autopsy Protocol report contains all modifications and supplements. The final Autopsy Protocol report supplement is clearly marked as "**SUPPLEMENTARY**" when a supplemental report is added. The previous report is retained electronically; however, the report is only available to Laboratory personnel assigned the required security key.

5. Autopsy Protocol Report displaying new 'MODIFIED' text:

This option is **modified** as follows: Electronically signed Autopsy Protocol report displays only the last final report. The Autopsy Protocol report contains all modifications and supplements. The final Autopsy Protocol report is clearly marked as **"MODIFIED"** when the report is modified. The previous report is retained electronically; however, the report is only available to Laboratory personnel assigned the required security key.

6. Released Autopsy Protocol Report Viewable in CPRS:

This option is **modified** not to unrelease a Released Autopsy Protocol report when Autopsy supplementary reports are being added. The original released Autopsy Protocol report remains viewable in CPRS until the added Autopsy supplementary report is released. The added Autopsy supplementary report replaces the original released Autopsy Protocol report for viewing in CPRS.

Example #1: This option is **modified** NOT to allow editing of the "DATE REPORT COMPLETED" prompt date when adding an autopsy supplemental to a released Autopsy Protocol report. The 'DATE REPORT COMPLETED:' prompt is REMOVED from this option.

```
                              ANATOMIC PATHOLOGY MENU
   D      Data entry, anat path ...
   E      Edit/modify data, anat path ...
   I      Inquiries, anat path ...
   L      Log-in menu, anat path ...
   P      Print, anat path ...
   R      SNOMED field references ...
   S      Supervisor, anat path ...
   V      Verify/release menu, anat path ...
   C      Clinician options, anat path ...
   W      Workload, anat path ...

Select Anatomic pathology Option: D <ENTER> Data entry, anat path
   AU     Data entry for autopsies ...
   BS     Blocks, Stains, Procedures, anat path
   CO     Coding, anat path ...
   GD     Clinical Hx/Gross Description/FS
   GM     FS/Gross/Micro/Dx
   GS     FS/Gross/Micro/Dx/SNOMED Coding
   GI     FS/Gross/Micro/Dx/ICD9CM Coding
   OR     Enter old anat path records
   SR     Supplementary Report, Anat Path
   SS     Spec Studies-EM;Immuno;Consult;Pic, Anat Path-

Select Data entry, anat path Option: AU <ENTER> Data entry for autopsies
   PD     Provisional anatomic diagnoses
   AP     Autopsy protocol
   AS     Autopsy protocol & SNOMED coding
   AI     Autopsy protocol & ICD9CM coding
   AF     Final autopsy diagnoses date
   SR     Autopsy supplementary report
   SS     Special studies, autopsy

Select Data entry for autopsies Option: SR<ENTER> Autopsy supplementary
report
                     AUTOPSY (NAU)

Data entry for 2005 ? YES//<ENTER> (YES)

Select Accession Number/Pt name: 2<ENTER> for  2005
LRPATIENT, THREE  ID: 000-23-3584

This AUTOPSY has been released.  Supplementary report additions/modifications
will create an audit trail.

Select SUPPLEMENTARY REPORT DATE:<ENTER>
```

Example #2: The Autopsy supplementary report [LRAPAUSR] option is **modified** to display the following **new** Audit information when an AUT`OPSY has been released and a supplementary report is added or modified: '**This AUTOPSY has been released. Supplementary report additions/modifications will create an audit trail.**'

```
                              ANATOMIC PATHOLOGY MENU
   D      Data entry, anat path ...
   E      Edit/modify data, anat path ...
   I      Inquiries, anat path ...
   L      Log-in menu, anat path ...
   P      Print, anat path ...
   R      SNOMED field references ...
   S      Supervisor, anat path ...
   V      Verify/release menu, anat path ...
   C      Clinician options, anat path ...
   W      Workload, anat path ...

Select Anatomic pathology Option: D <ENTER> Data entry, anat path
   AU     Data entry for autopsies ...
   BS     Blocks, Stains, Procedures, anat path
   CO     Coding, anat path ...
   GD     Clinical Hx/Gross Description/FS
   GM     FS/Gross/Micro/Dx
   GS     FS/Gross/Micro/Dx/SNOMED Coding
   GI     FS/Gross/Micro/Dx/ICD9CM Coding
   OR     Enter old anat path records
   SR     Supplementary Report, Anat Path
   SS     Spec Studies-EM;Immuno;Consult;Pic, Anat Path-

Select Data entry, anat path Option: AU <ENTER> Data entry for autopsies
   PD     Provisional anatomic diagnoses
   AP     Autopsy protocol
   AS     Autopsy protocol & SNOMED coding
   AI     Autopsy protocol & ICD9CM coding
   AF     Final autopsy diagnoses date
   SR     Autopsy supplementary report
   SS     Special studies, autopsy

Select Data entry for autopsies Option: SR<ENTER> Autopsy supplementary
report
                     AUTOPSY (NAU)

Data entry for 2005 ? YES//<ENTER> (YES)

Select Accession Number/Pt name: 2<ENTER> for  2005
LRPATIENT, THREE  ID: 000-23-3584

This AUTOPSY has been released.  Supplementary report additions/modifications
will create an audit trail.

Select SUPPLEMENTARY REPORT DATE:<ENTER>
```

Example #3: The Autopsy supplementary report [LRAPAUSR] option is **modified** to include the following **new** information: '**This Autopsy Protocol report is currently being modified; it must first be released before Supplementary report can be added.**'

```
                              ANATOMIC PATHOLOGY MENU
   D       Data entry, anat path ...
   E       Edit/modify data, anat path ...
   I       Inquiries, anat path ...
   L       Log-in menu, anat path ...
   P       Print, anat path ...
   R       SNOMED field references ...
   S       Supervisor, anat path ...
   V       Verify/release menu, anat path ...
   C       Clinician options, anat path ...
   W       Workload, anat path ...

Select Anatomic pathology Option: D <ENTER> Data entry, anat path
   AU      Data entry for autopsies ...
   BS      Blocks, Stains, Procedures, anat path
   CO      Coding, anat path ...
   GD      Clinical Hx/Gross Description/FS
   GM      FS/Gross/Micro/Dx
   GS      FS/Gross/Micro/Dx/SNOMED Coding
   GI      FS/Gross/Micro/Dx/ICD9CM Coding
   OR      Enter old anat path records
   SR      Supplementary Report, Anat Path
   SS      Spec Studies-EM;Immuno;Consult;Pic, Anat Path-

Select Data entry, anat path Option: AU <ENTER> Data entry for autopsies
   PD      Provisional anatomic diagnoses
   AP      Autopsy protocol
   AS      Autopsy protocol & SNOMED coding
   AI      Autopsy protocol & ICD9CM coding
   AF      Final autopsy diagnoses date
   SR      Autopsy supplementary report
   SS      Special studies, autopsy

Select Data entry for autopsies Option: SR <ENTER> Autopsy supplementary
report

                     AUTOPSY (NAU)

Data entry for 2005 ? YES//<ENTER> (YES)

Select Accession Number/Pt name:1 <ENTER> for  2005
LRPATIENT, TWO  ID: 000-98-4345

This AUTOPSY report is currently being modified; it must first be released
before Supplementary report can be added.

Select Accession Number/Pt name:<ENTER>
```

Example #4: The Autopsy supplementary report [LRAPAUSR] option is **modified** as follows: Electronically signed Autopsy Protocol report displays only the last final report. The Autopsy Protocol report contains all modifications and supplements. The final Autopsy Protocol report supplement is clearly marked as "**SUPPLEMENTARY**" when a supplemental report is added. The previous report is retained electronically; however, the report is only available to Laboratory personnel assigned the required security key (Required security keys included in the Use of the Software section).

```
Select chart component: LABS <ENTER>      Labs
Searching the patient's chart ...

                              ---- BLOOD BANK ----
ABO Rh:

No UNITS assigned/xmatched


                            |---     AHG(direct)     ---|   |-AHG(indirect)-|
  Date/time     ABO Rh    POLY IgG  C3   Interpretation   (Antibody screen)
   ---------       --- --    ---- ---  ---  --------------   ----------------

                           ---- AUTOPSY ----

Select: Next Screen// <ENTER>    NEXT SCREEN

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
     CLINICAL RECORD |                  AUTOPSY PROTOCOL
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
Date died: Jul 28, 1994                 | Autopsy date: MAY 01, 2007@11:21
Resident: LRAPPROVIDE, ONE              | FULL AUTOPSY  Autopsy No. NAU 07 2
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

****************************** MODIFIED REPORT
******************************

                  *+* SUPPLEMENTARY REPORT HAS BEEN ADDED *+*
                       *+* REFER TO BOTTOM OF REPORT *+*

CLINICAL DIAGNOSIS:

Select: Next Screen// <ENTER>       NEXT SCREEN

     CLINICAL DIAGNOSES
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

PATHOLOGICAL DIAGNOSIS:

     PATHOLOGICAL DIAGNOSES
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

SUPPLEMENTARY REPORT DATE: SEP 14, 2001@10:44
              *+* SUPPLEMENTARY REPORT HAS BEEN ADDED/MODIFIED *+*
(Added/Last modified: Sep 14, 2001 10:44 typed by YOUNG,TIM)
     Supplementary report text.  Supplementary report text.  Supplemental
```

Example #5: The Autopsy supplementary report [LRAPAUSR] option is **modified** as follows: Electronically signed Autopsy Protocol report displays only the last final report. The Autopsy Protocol report contains all modifications and supplements. The final Autopsy Protocol report is clearly marked as **"MODIFIED"** when the report is modified. The previous report is retained electronically; however, the report is only available to Laboratory personnel assigned the required security keys (Please see Security Key List included in this User Guide).

NOTE: First – verify supplementary reports for Autopsy.

```
Select Anatomic pathology Option: V <ENTER> Verify/release menu, anat path

Select Verify/release menu, anat path Option: ?<ENTER>

   RR     Verify/release reports, anat path
   RS     Supplementary report release, anat path
   LU     List of unverified pathology reports
   CPT    LAB CPT BILLING

Enter ?? for more options, ??? for brief descriptions, ?OPTION for help text.

Select Verify/release menu, anat path Option: RS<ENTER>   Supplementary
report release, anat path

                    Release Supplementary Pathology Reports


Select ANATOMIC PATHOLOGY SECTION: AUTOPSY <ENTER>

                    AUTOPSY (NAU)


Data entry for 2007 ? YES//<ENTER>  (YES)

Select Accession Number/Pt name: 2 <ENTER>  for 2007
LRAPPATIENT, TWO ID: 000-00-2222


Select SUPPLEMENTARY REPORT DATE: MAY 01, 2007// <ENTER>   MAY 01, 2007


Enter your Current Signature Code:    SIGNATURE VERIFIED...Released

Select SUPPLEMENTARY REPORT DATE: SEP 14, 2001@10:44//<ENTER>   SEP 14,
2001@10:44


Enter your Current Signature Code:    SIGNATURE VERIFIED...Released

                         *** Main Report Release ***
```

```
   *** Report is being processed for storage in TIU.  One moment please. ***


                  *** Report storage in TIU is complete. ***

                           *** Report released. ***

Do you wish to send an alert? NO// <ENTER>

Select Accession Number/Pt name: <ENTER>

Then display report and check for "MODIFIED"
And "SUPPLEMENTARY"- displayed in CPRS: <ENTER>

                           ---- AUTOPSY ----

Select Action: Next Screen// <ENTER>     Next Screen


- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
     CLINICAL RECORD |                 AUTOPSY PROTOCOL
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
Date died: Jul 28, 1994                | Autopsy date: MAY 01, 2007@11:21
Resident: LRAPPROVIDER, ONE            | FULL AUTOPSY Autopsy No. NAU 07 2
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

**************************** MODIFIED REPORT ********************************

                  *+* SUPPLEMENTARY REPORT HAS BEEN ADDED *+*
                       *+* REFER TO BOTTOM OF REPORT *+*
```

Example #6: The Autopsy supplementary report [LRAPAUSR] is **modified** not to unrelease a Released Autopsy Protocol report when Autopsy supplementary reports are being added. The original released Autopsy Protocol report remains viewable in CPRS until the added Autopsy supplementary report is released. The added Autopsy supplementary report replaces the original released Autopsy Protocol report for viewing in CPRS.

```
Select Data entry, anat path Option: AU<ENTER> Data entry for autopsies

Select Data entry for autopsies Option: ?<ENTER>

   PD     Provisional anatomic diagnoses
   AP     Autopsy protocol
   AS     Autopsy protocol & SNOMED coding
   AI     Autopsy protocol & ICD9CM coding
   AF     Final autopsy diagnoses date
   SR     Autopsy supplementary report
   SS     Special studies, autopsy

Enter ?? for more options, ??? for brief descriptions, ?OPTION for help text.

Select Data entry for autopsies Option: SR <ENTER>   Autopsy supplementary
report

                    AUTOPSY (NAU)

Data entry for 2007 ? YES//<ENTER>      (YES)

Select Accession Number/Pt name: 2 <ENTER>   for 2007
LRAPPATIENT, ONE  ID: 000-00-1111


This AUTOPSY has been released.  Supplementary report additions/modifications
will create an audit trail.

Select SUPPLEMENTARY REPORT DATE: SEP 14, 2001@10:44//T<ENTER>  MAY 01, 2007
SUPPLEMENTARY REPORT DATE: MAY 1,2007// <ENTER>
DESCRIPTION: <ENTER>
  1>THIS IS TESTING THAT THE REPORT IS VIEWABLE IN CPRS 5/1/07
  2>
EDIT Option: <ENTER>

Select Accession Number/Pt name: <ENTER>

Select Data entry for autopsies Option: <ENTER>

Select Data entry, anat path Option: <ENTER>

Select Anatomic pathology Option: <ENTER>

Select Laboratory DHCP Menu Option: <ENTER>

Select Core Applications Option: CPRS Manager Menu <ENTER>

Select CPRS Manager Menu Option: CL <ENTER>    Clinician Menu
```

```
Select Clinician Menu Option: ? <ENTER>

   OE      CPRS Clinician Menu
   RR      Results Reporting Menu
   AD      Add New Orders
   RO      Act On Existing Orders
   PP      Personal Preferences ...

Select Clinician Menu Option: OE <ENTER>    CPRS Clinician Menu

Patient Selection             May 01, 2007@16:17:12   Page:    1 of    1
Current patient: ** No patient selected **

     Patient Name                    ID        DOB            Room-Be
     No patients found

          Enter the number of the patient chart to be opened        >>>
+   Next Screen           CV  Change View ...       FD  Find Patient
-   Previous Screen       SV  (Save as Default List)Q   Close

Select Patient: Change View// FD <ENTER>      Find Patient
Select PATIENT NAME: LRAPPATIENT, TWO   3-21-66  000001111  NO  NSC VETERAN

This patient died Jul 28, 1994!
Do you wish to continue? NO// YES<ENTER>

Searching the patient's chart

     Allergies/Adverse Reactions             |
     No assessment available                 |
                                             |
     Patient Postings                        |
     <None>                                  |
                                             |
     Recent Vitals                           |
     No data available                       |
                                             |
     Recent Immunizations                    |
                                             |
     Eligibility                             |
     Not Service Connected                   |


Select: Next Screen// <ENTER>    NEXT SCREEN

NW  Enter New Allergy/ADR CV  (Change View ...)     SP  Select New Patient
AD  Add New Orders        CC  Chart Contents ...    Q   Close Patient Chart

Select: Chart Contents//  <ENTER>     Chart Contents
Cover Sheet                   May 01, 2007@16:17:24      Page:    2 of    2
LRAPPATIENT, TWO        000-00-1111                      3/21/66(28)
PrimCare: UNKNOWN                          PCTeam:

+    Item                                    Entered
                                            |
          Enter the numbers of the items you wish to act on.
```

```
  Cover Sheet         Orders              Imaging             Reports
  Problems            Meds                Consults
  Notes               Labs                D/C Summaries


Select chart component: LABS <ENTER>      Labs
Searching the patient's chart ...

                             ---- BLOOD BANK ----
ABO Rh:

No UNITS assigned/xmatched


                           |---     AHG(direct)     ---|   |-AHG(indirect)-|
  Date/time     ABO Rh    POLY IgG  C3   Interpretation   (Antibody screen)
   ---------       --- --    ---- ---  ---  --------------   ----------------

                           ---- AUTOPSY ----


Select: Next Screen// <ENTER>    NEXT SCREEN

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
     CLINICAL RECORD |                  AUTOPSY PROTOCOL
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
Date died: Jul 28, 1994                 | Autopsy date: MAY 01, 2007@11:21
Resident: LRAPPROVIDE, ONE              | FULL AUTOPSY  Autopsy No. NAU 07 2
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

****************************** MODIFIED REPORT
******************************

                  *+* SUPPLEMENTARY REPORT HAS BEEN ADDED *+*
                       *+* REFER TO BOTTOM OF REPORT *+*

CLINICAL DIAGNOSIS:


Select: Next Screen// <ENTER>       NEXT SCREEN

     CLINICAL DIAGNOSES
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

PATHOLOGICAL DIAGNOSIS:

     PATHOLOGICAL DIAGNOSES
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

SUPPLEMENTARY REPORT DATE: SEP 14, 2001@10:44
              *+* SUPPLEMENTARY REPORT HAS BEEN ADDED/MODIFIED *+*
(Added/Last modified: Sep 14, 2001 10:44 typed by YOUNG,TIM)
     Supplementary report text.  Supplementary report text.  Supplemental

Select: Next Screen//  <ENTER>      NEXT SCREEN

     report text.  Supplementary report text.  Supplementary report text.
```

```
     Supplementary report text.  Supplementary report text.  Supplementary
     report text.  Supplementary report text.  Supplementary report text.
     Supplementary report text.  Supplementary report text.  Supplementary
     report text.  Supplementary report text.  Supplementary report text.
     Supplementary report text.


LRAPPATIENT, TWO               000-00-1111         DOB: Mar 21, 1966
Acc: NAU 07 2                  AUTOPSY DATA        Age:  28
Date/time Died                                     Date/time of Autopsy
Jul 28, 1994                   FULL AUTOPSY        MAY 01, 2007@11:21
Resident: LRAPRESIDENT, ONE                     Senior: LRAPRESIDENT, SENIOR

Select: Next Screen//  <ENTER>   NEXT SCREEN

DEAD SPACE AIR
IMMUNOPEROXIDASE 3 Date: DEC 10, 2001@15:42
          This is a special study.  This is a special study.  This is
          a special study.  This is a special study.  This is a
          special study.  This is a special study.  This is a special
          study.  This is a special study.  This is a special study.
          This is a special study.  This is a special study.  This is
          a special study.  This is a special study.  This is a

Select: Next Screen//   <ENTER>       NEXT SCREEN

/es/ LRAPPROVIDE, ONE

Signed MAY 01, 2007@11:33:52
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Pathologist: LRAPPATHOLOGIST, TWO                lra| Date MAY 01, 2007
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
BONHAM, TX                                                AUTOPSY PROTOCOL

Select: Next Screen//  <ENTER>         NEXT SCREEN

NW  Order New Lab Tests   CV  Change View ...       SP  Select New Patient
AD  Add New Orders        CC  Chart Contents ...    Q   Close Patient Chart

Lab Cumulative Display        May 01, 2007@16:17:54       Page  7 of  7
LRAPPATIENT, TWO               000-00-1111                      3/21/66(28)
PrimCare: UNKNOWN                            PCTeam:
                     Current View: 11/02/06 thru 05/01/07
+
Patient: LRAPPATIENT, TWO              000-00-1111  SEX:M  DOB:Mar 21, 1966
BLOOD BANK         Physician: LRAPPHYSICIAN, ONE         AGE AT DEATH: 28

          Enter ?? for more actions
Select: Chart Contents//    Chart Contents ...
  Cover Sheet         Orders              Imaging             Reports
  Problems            Meds                Consults
  Notes               Labs                D/C Summaries
```

Electronic Signature Switch Turned ON Changes for Printing/Viewing Supplementary Reports

NOTE: Some print functions have changed for printing or viewing supplementary reports with the electronic signature switch ON. With the electronic signature switch turned ON, released reports are stored in TIU and final print functions retrieve prints from TIU. Therefore, when a supplementary report is added but not yet released, it cannot be viewed or printed using the final report print options, and as a result the following print functions have changed:

a. Unreleased supplementary reports will go to the preliminary print queue, instead of the final print queue.

b. Unreleased supplementary reports are printed/viewed using the preliminary report print options.

c. The *Print final path reports by accession # [LRAPFICH]* option will not display/print unreleased supplementary reports.

Print all reports on queue [LRAP PRINT ALL ON QUEUE] option

This option prints a report listing the clinical history and gross description for review for patients on the cumulative report print queue, as well as final reports for patients and completed autopsy reports. For final reports; when the report has been electronically signed and stored in TIU the report will be pulled from TIU. Otherwise, the report will be generated from the data stored in LAB DATA file (#63). This option asks if a 'Final Office Copy' should be printed. The 'Final Office Copy' prints SNOMED codes on a separate page since they are no longer printed on the SF515 report.

Example: This option report header is **modified** with the following **new** header statement:

```
*+* SUPPLEMENTARY REPORT HAS BEEN ADDED *+*
*+* REFER TO BOTTOM OF REPORT *+*
```

```
Select Anatomic pathology Option: P Print, anat path<ENTER>

Select Print, anat path Option: PQ Print all reports on queue<ENTER>
Select ANATOMIC PATHOLOGY SECTION: SURGICAL PATHOLOGY

1. Preliminary reports
2. Final reports
Select 1 or 2 : 2<ENTER>
Is this a final office copy? YES// NO<ENTER>
SURGICAL PATHOLOGY FINAL PATIENT REPORTS
Add/Delete reports to/from print queue for 2005 ? NO//<ENTER>   (NO)
Save final report list for reprinting ? NO//<ENTER>   (NO)

------------------------------------------------------------------------------
MEDICAL RECORD | SURGICAL PATHOLOGY Pg 1
```

```
---------------------------------------------------------------------------
Submitted by: LRPHYSICIAN, FOUR Date obtained: Jan 06, 2005 11:52
---------------------------------------------------------------------------
Specimen (Received Jan 06, 2005 11:52):
TAIL
*++ SUPPLEMENTARY REPORT HAS BEEN ADDED *++
*++ REFER TO BOTTOM OF REPORT *++
---------------------------------------------------------------------------
Brief Clinical History:
---------------------------------------------------------------------------
Preoperative Diagnosis:
---------------------------------------------------------------------------
Operative Findings:
---------------------------------------------------------------------------
Postoperative Diagnosis:
Surgeon/physician: LRPHYSICIAN, ONE

PATHOLOGY REPORT
Laboratory: REGION 7 ISC,TX (KRN) Accession No. NSP 05 1
---------------------------------------------------------------------------
FROZEN SECTION:
FROZEN ENTRY
GROSS DESCRIPTION:
GROSS ENTRY
SURGICAL PATH DIAGNOSIS:
SURG PATH ENTRY
Supplementary Report:
Date: Jan 02, 2005
*++ SUPPLEMENTARY REPORT HAS BEEN ADDED/MODIFIED *++
(Added/Last modified: Jan 06, 2005 12:05 signed by LRPATHOLOGIST, THREE)
JAN 2 SUPP ADDED AFTER RELEASE OF MAIN; ESIG SWITCH OFF.
---------------------------------------------------------------------------
(End of report)
LRPHYSICIAN, TWO Abr| Date Jan 06, 2005
---------------------------------------------------------------------------
LRPATIENT, ONE STANDARD FORM 515
ID:000-99-0000 SEX: DOB:03/05/1955 AGE: 50 LOC:5N
ADM:AUG 6,1993 DX:SDFLKJ PCP: LRPHYSICIAN, ONE
```

Print single report only [LRAP PRINT SINGLE] option

This option prints a list of any pathology accessions in cytopath, electron microscopy, and surgical pathology for cumulative reports for micro exams. Also prints final reports and completed autopsy reports. For final reports, if the report has been electronically signed and stored in TIU, the report will be pulled from TIU. Otherwise, the report will be generated from the data stored in the LAB DATA (#63) file. The option asks if a 'Final Office Copy' should be printed. The 'Final Office Copy' prints SNOMED codes on a separate page since they are no longer printed on the SF515.

Example: This option report header is **modified** with the following **new** header statement:

```
*++ SUPPLEMENTARY REPORT HAS BEEN ADDED *++
*++ REFER TO BOTTOM OF REPORT *++
```

```
Select Print, anat path Option: PS Print single report only <ENTER>

Select ANATOMIC PATHOLOGY SECTION: SURGICAL PATHOLOGY <ENTER>

1. Preliminary reports
2. Final reports
Select 1 or 2 : 2<ENTER>
Is this a final office copy? YES// NO<ENTER>
SURGICAL PATHOLOGY FINAL PATIENT REPORTS
Select Patient Name: LRPATIENT, ONE <ENTER>LRPATIENT,ONE 3-5-55 000990000 NSC
VETERAN

LRPATIENT, ONE ID: 000-99-0000 Physician: LRPHYSICIAN, ONE
AGE: 50 DATE OF BIRTH: MAR 5,1955
Ward on Adm: 5N Service: DERMATOLOGY
Adm Date: AUG 6,1993@14:05 Adm DX: SDFLKJ
Present Ward: 5N Primary MD: LRPHYSICIAN, TWO

Specimen(s) Count # Accession # Date Obtained
TAIL ( 1) NSP 05 1 Jan 06, 2005 11:52
Choose Count #(1-5): 1<ENTER>
Accession #: NSP 05 1 Date Obtained: Jan 06, 2005 11:52

DEVICE: HOME// <ENTER>


--------------------------------------------------------------------------------
MEDICAL RECORD | SURGICAL PATHOLOGY Pg 1
--------------------------------------------------------------------------------
Submitted by: LRPHYSICIAN, FOUR Date obtained: Jan 06, 2005 11:52
--------------------------------------------------------------------------------
Specimen (Received Jan 06, 2005 11:52):
TAIL
*++ SUPPLEMENTARY REPORT HAS BEEN ADDED *++
*++ REFER TO BOTTOM OF REPORT *++
--------------------------------------------------------------------------------
Brief Clinical History:
--------------------------------------------------------------------------------
Preoperative Diagnosis:
--------------------------------------------------------------------------------
```

```
Operative Findings:
------------------------------------------------------------------------------
Postoperative Diagnosis:

Surgeon/physician: LRPHYSICIAN, ONE

==============================================================================
PATHOLOGY REPORT
Laboratory: REGION 7 ISC,TX (KRN) Accession No. NSP 05 1
------------------------------------------------------------------------------
FROZEN SECTION:
FROZEN ENTRY
GROSS DESCRIPTION:
GROSS ENTRY
SURGICAL PATH DIAGNOSIS:
SURG PATH ENTRY
Supplementary Report:
Date: Jan 02, 2005
*** SUPPLEMENTARY REPORT HAS BEEN ADDED/MODIFIED ***
(Added/Last modified: Jan 06, 2005 12:05 signed by LRPATHOLOGIST, THREE)
JAN 2 SUPP ADDED AFTER RELEASE OF MAIN; ESIG SWITCH OFF.
------------------------------------------------------------------------------
(End of report)
LRPHYSICIAN, TWO Abb| Date Jan 06, 2005
------------------------------------------------------------------------------
LRPATIENT, ONE STANDARD FORM 515
ID:000-99-0000 SEX: DOB:03/05/1955 AGE: 50 LOC:5N
ADM:AUG 6,1993 DX:SDFLKJ PCP: LRPHYSICIAN, ONE
```

Print final path reports by accession # [LRAPFICH] option

This option allows printing final path reports from one accession to another within the same calendar year. This option can be used to make tapes for microfiche.

Example: This option example is displaying the following **new** header statement when a supplementary report has been added to a final pathology report:

****+ SUPPLEMENTARY REPORT HAS BEEN ADDED +****
****+ REFER TO BOTTOM OF REPORT +****

```
Select Print, anat path Option: PA <ENTER>Print final path reports by
accession #


Select ANATOMIC PATHOLOGY SECTION: SURGICAL PATHOLOGY

Is this a final office copy? YES// NO <ENTER>

Select Accession YEAR: 05 (2005) <ENTER>

Start with accession #: 1 <ENTER>

Go to accession #: 1 <ENTER>

DEVICE: HOME// <ENTER>

------------------------------------------------------------------------------
MEDICAL RECORD | SURGICAL PATHOLOGY Pg 1
------------------------------------------------------------------------------
Submitted by: LRPHYSICIAN, FOUR Date obtained: Jan 06, 2005 11:52
------------------------------------------------------------------------------
Specimen (Received Jan 06, 2005 11:52):
TAIL
**+ SUPPLEMENTARY REPORT HAS BEEN ADDED +**
**+ REFER TO BOTTOM OF REPORT +**
------------------------------------------------------------------------------
Brief Clinical History:
------------------------------------------------------------------------------
Preoperative Diagnosis:
------------------------------------------------------------------------------
Operative Findings:
------------------------------------------------------------------------------
Postoperative Diagnosis:
Surgeon/physician: LRPHYSICIAN, ONE

==============================================================================
PATHOLOGY REPORT
Laboratory: REGION 7 ISC,TX (KRN) Accession No. NSP 05 1
------------------------------------------------------------------------------
FROZEN SECTION:
FROZEN ENTRY
GROSS DESCRIPTION:
GROSS ENTRY
SURGICAL PATH DIAGNOSIS:
SURG PATH ENTRY
```

```
Supplementary Report:
Date: Jan 02, 2005
*** SUPPLEMENTARY REPORT HAS BEEN ADDED/MODIFIED ***
(Added/Last modified: Jan 06, 2005 12:05 signed by LRPATHOLOGIST, THREE)
JAN 2 SUPP ADDED AFTER RELEASE OF MAIN; ESIG SWITCH OFF.
------------------------------------------------------------------------------
(End of report)
LRPHYSICIAN, TWO Abr| Date Jan 06, 2005
------------------------------------------------------------------------------
LRPATIENT, ONE STANDARD FORM 515
ID:000-99-0000 SEX: DOB:03/05/1955 AGE: 50 LOC:5N
ADM:AUG 6,1993 DX:SDFLKJ PCP: LRPHYSICIAN, ONE
```

Glossary

The following glossary of terms is related to VistA Laboratory Anatomic Pathology (AP) Modifications/Enhancements to Address PSI-04-025 Patch LR*5.2*317 software release:

Glossary of Terms	Description
Accession Area:	A functional area or department in the laboratory where specific tests are performed. The accession area defines the departmental designation contained in each accession.
Accession Number:	A unique alpha-numeric (combination of letters and numbers) assigned to an individual patient specimen when it is received in the laboratory. The accession is assigned by the computer and contains the laboratory departmental designation, the date, and an accession number. This accession serves as identification of the specimen as it is processed through the laboratory. (Example: HE 09121). It also associates billable items with a specific billable event such as an outpatient visit or an inpatient stay.
ADPAC:	Automated Data Processing Application Coordinator
Alert:	Brief on-line notice issued to users as they complete a cycle through the menu system. Alerts are designed to provide interactive notification of pending computing activities, such as the need to reorder supplies or review a patient's clinical test results. Along with the alert message is an indication that the View Alerts common option should be chosen to take further action.
AP:	Anatomic Pathology

Glossary of Terms	Description
Anatomic Pathology Reports:	Anatomic Pathology reports (also called AP reports) include reports for all sections: Surgical Pathology, Cytology (Cytopathology), Electron Microscopy, and Autopsy Pathology sections.
API:	Application Programming Interface
Audit Trail:	A chronological record of computer activity automatically maintained to trace the use of the computer.
Authorized Signer:	A user who has been granted proper authority to sign out and release anatomic pathology reports. In general, authorized signers are pathologists and cytotechnologists (i.e., cytotechnologists for negative GYN only).
Authorized User:	A user who has been granted access to a menu option or options, and/or the user is properly defined in the system to perform a function.
Computerized Patient Record System:	Computerized Patient Record System (CPRS) is a VistA software application that facilitates the entry, review, and modification of patient-related information, as well as a means of ordering services such as lab tests.
CPRS:	Computerized Patient Record System
CPT:	Current Procedural Terminology
Current Procedural Terminology:	Current Procedural Terminology (CPT) is a uniform system of codes (such as identifiers) associated with specific procedures (such as tests).
DBIA:	Data Base Integration Agreement
DSM:	Digital Standard Mumps

Glossary of Terms	Description
Electronic Signature:	A code, entered by a user, which represents his or her legally binding signature.
Encryption:	Scrambling data or messages with a cipher or code so that they are unreadable without a secret key. In some cases encryption algorithms are one directional; they only encode and the resulting data cannot be unscrambled (e.g., access/verify codes).
Free Text:	The use of any combination of numbers, letters, and symbols when entering data.
Global:	In the MUMPS language, a global is a tree-structured data file stored in the common database on the disk
HSD&D:	Health Systems Design & Development
ICD-9:	International Classification of Disease, 9th edition
NT:	New Technology
OI:	Office of Information
Sections:	Anatomic Pathology (AP) work is divided into four areas or sections: Surgical Pathology, Cytology (Cytopathology), Electron Microscopy, and Autopsy Pathology.
Security Key:	Level of security that can be applied to menu options. Options can be locked with a security key. Only users given the appropriate key can use a locked option. If the user does not have the key, then even if the locked option is on the user's menu, the user cannot to use it. Options that provide specialized or supervisory access are usually locked with a security key.

Glossary of Terms	Description
SF 515:	Standard Form 515. Anatomic Pathology report format design for the Cytology, Electron Microscopy, and Surgical Pathology sections.
SNOMED:	Systematized Nomenclature of Medicine
SNOMED CT:	Systemized Nomenclature of Medicine Clinical Terms
Supplementary Report:	An electronically signed report that adds additional data to the original report. The additions do not change any data that had been previously verified. This supplement becomes part of the whole report.
TIU:	Text Integration Utility
VA:	Department of Veterans Affairs
VA FileMan:	A set of programs used to enter, maintain, access, and manipulate a (also called database management system consisting of files. A package of on-line VA FileMan) computer routines written in the MUMPS language which can be used as a stand-alone database system or as a set of application utilities. In either form, such routines can be used to define, enter, edit, and retrieve information from a set of computer-stored files.
VAMC:	Department of Veterans Affairs Medical Center
VC:	Veterans Center
VDL:	VistA Documentation Library
VDSI:	VistA Data Systems and Integration

Glossary of Terms	Description
VHA:	Veterans Health Administration
VistA:	Veterans Health Information Systems and Technology Architecture
VistA Laboratory:	Entire Laboratory application consisting of the following modules: Anatomic Pathology, Microbiology, and Routine Clinical Lab.