Improving Population Health Through Enhanced Targeted Regional Decision Support

Review of DOCS4DOCS Work Flow
Reportable Conditions Forms

October 4, 2012

Regenstrief Medical Informatics
The **Source** for Medical Informatics

Clinical Messaging/Public Health Communication

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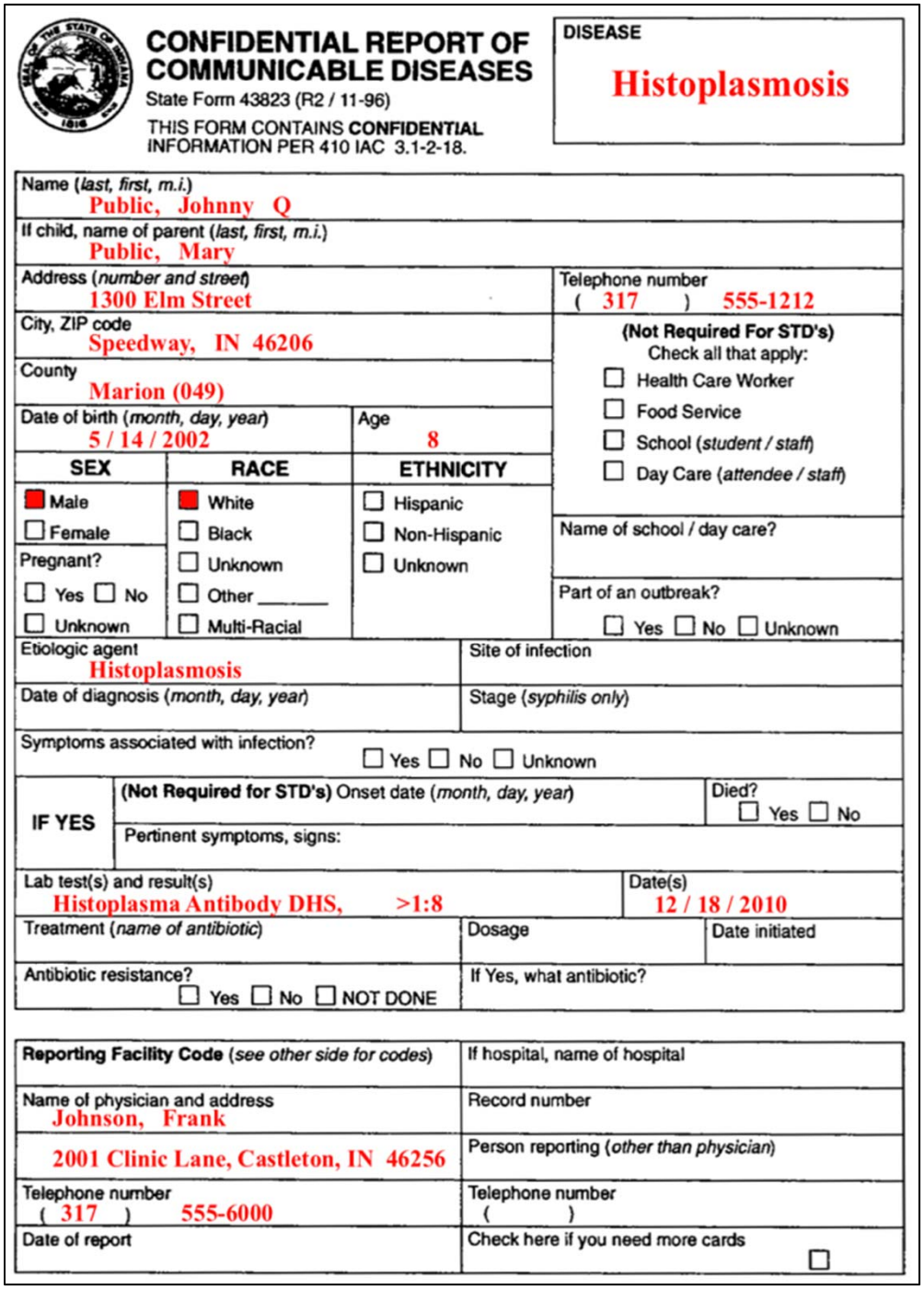

CONFIDENTIAL REPORT OF COMMUNICABLE DISEASES
State Form 43823 (R2 / 11-96)
THIS FORM CONTAINS **CONFIDENTIAL** INFORMATION PER 410 IAC 3.1-2-18.

DISEASE: Histoplasmosis

Name (*last, first, m.i.*): Public, Johnny Q
If child, name of parent (*last, first, m.i.*): Public, Mary
Address (*number and street*): 1300 Elm Street
Telephone number: (317) 555-1212
City, ZIP code: Speedway, IN 46206
County: Marion (049)
Date of birth (*month, day, year*): 5 / 14 / 2002
Age: 8

SEX	RACE	ETHNICITY
■ Male	■ White	☐ Hispanic
☐ Female	☐ Black	☐ Non-Hispanic
Pregnant?	☐ Unknown	☐ Unknown
☐ Yes ☐ No	☐ Other _____	
☐ Unknown	☐ Multi-Racial	

(Not Required For STD's)
Check all that apply:
☐ Health Care Worker
☐ Food Service
☐ School (*student / staff*)
☐ Day Care (*attendee / staff*)

Name of school / day care?

Part of an outbreak? ☐ Yes ☐ No ☐ Unknown

Etiologic agent: Histoplasmosis
Site of infection
Date of diagnosis (*month, day, year*)
Stage (*syphilis only*)
Symptoms associated with infection? ☐ Yes ☐ No ☐ Unknown

IF YES
(Not Required for STD's) Onset date (*month, day, year*)
Died? ☐ Yes ☐ No
Pertinent symptoms, signs:

Lab test(s) and result(s): Histoplasma Antibody DHS, >1:8
Date(s): 12 / 18 / 2010
Treatment (*name of antibiotic*)
Dosage
Date initiated
Antibiotic resistance? ☐ Yes ☐ No ☐ NOT DONE
If Yes, what antibiotic?

Reporting Facility Code (*see other side for codes*)
If hospital, name of hospital
Name of physician and address: Johnson, Frank
2001 Clinic Lane, Castleton, IN 46256
Record number
Person reporting (*other than physician*)
Telephone number: (317) 555-6000
Telephone number ( )
Date of report
Check here if you need more cards ☐

Sample Pre-populated Reporting Form

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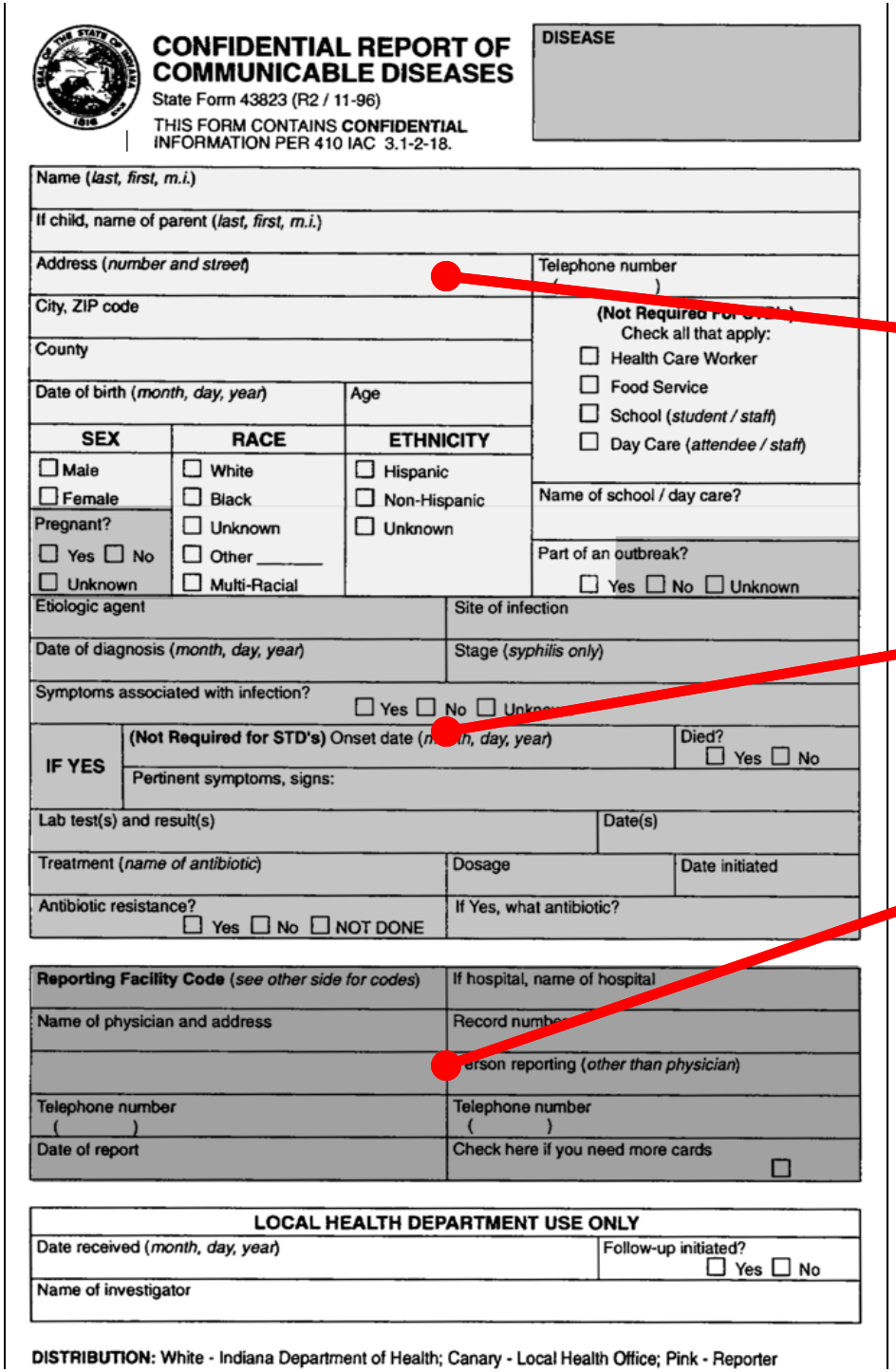

CONFIDENTIAL REPORT OF COMMUNICABLE DISEASES

State Form 43823 (R2 / 11-96)

THIS FORM CONTAINS **CONFIDENTIAL** INFORMATION PER 410 IAC 3.1-2-18.

DISEASE

Name (*last, first, m.i.*)

If child, name of parent (*last, first, m.i.*)

Address (*number and street*)

Telephone number ( )

City, ZIP code

(Not Required For STD's)

Check all that apply:

- ☐ Health Care Worker
- ☐ Food Service
- ☐ School (*student / staff*)
- ☐ Day Care (*attendee / staff*)

County

Date of birth (*month, day, year*)

Age

SEX	RACE	ETHNICITY
☐ Male	☐ White	☐ Hispanic
☐ Female	☐ Black	☐ Non-Hispanic
	☐ Unknown	☐ Unknown
	☐ Other _____	
	☐ Multi-Racial	

Pregnant? ☐ Yes ☐ No ☐ Unknown

Name of school / day care?

Part of an outbreak? ☐ Yes ☐ No ☐ Unknown

Etiologic agent

Site of infection

Date of diagnosis (*month, day, year*)

Stage (*syphilis only*)

Symptoms associated with infection? ☐ Yes ☐ No ☐ Unkn

IF YES

(Not Required for STD's) Onset date (*month, day, year*)

Died? ☐ Yes ☐ No

Pertinent symptoms, signs:

Lab test(s) and result(s)

Date(s)

Treatment (*name of antibiotic*)

Dosage

Date initiated

Antibiotic resistance? ☐ Yes ☐ No ☐ NOT DONE

If Yes, what antibiotic?

Reporting Facility Code (*see other side for codes*)

If hospital, name of hospital

Name of physician and address

Record numb

erson reporting (*other than physician*)

Telephone number ( )

Telephone number ( )

Date of report

Check here if you need more cards ☐

LOCAL HEALTH DEPARTMENT USE ONLY

Date received (*month, day, year*)

Follow-up initiated? ☐ Yes ☐ No

Name of investigator

DISTRIBUTION: White - Indiana Department of Health; Canary - Local Health Office; Pink - Reporter

Patient Demographics

Clinical Data

Provider Demographics

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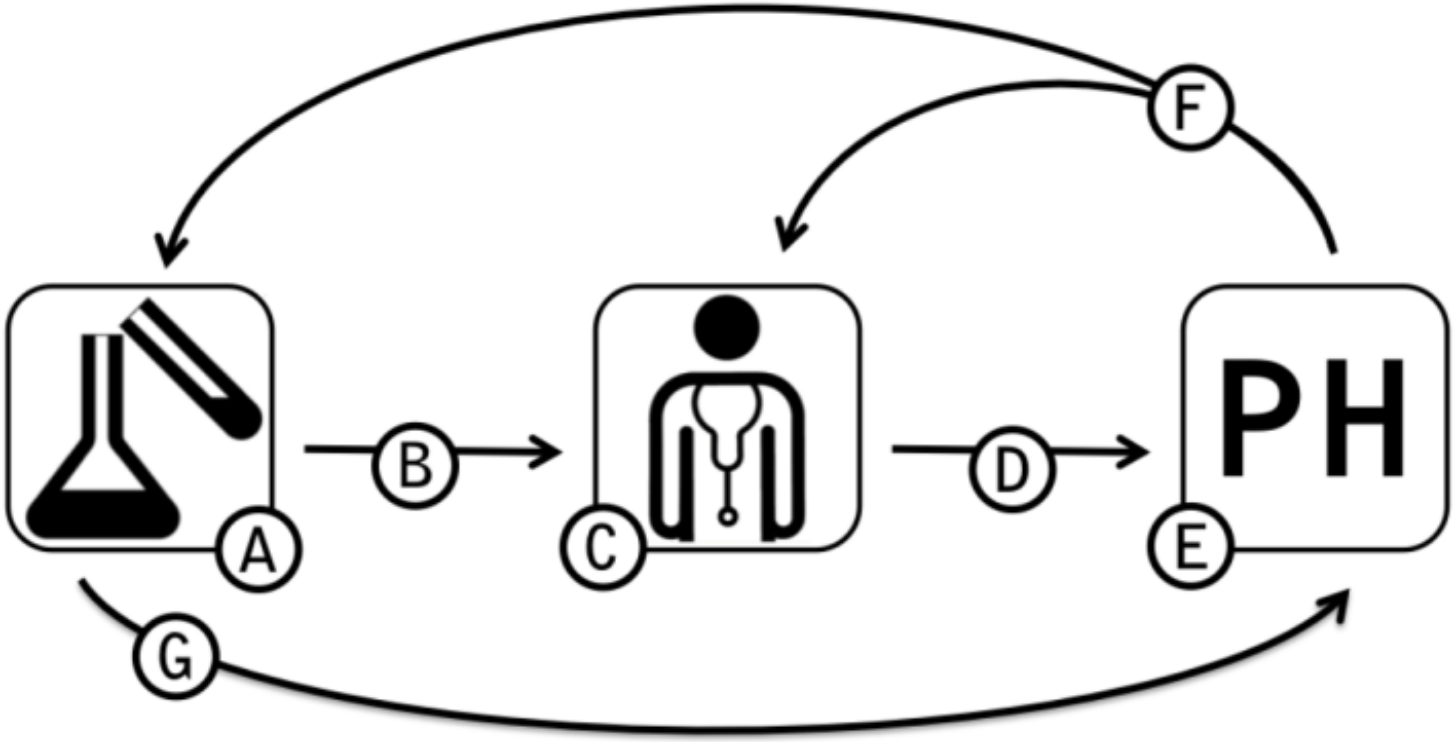
Understanding Reporting Workflow



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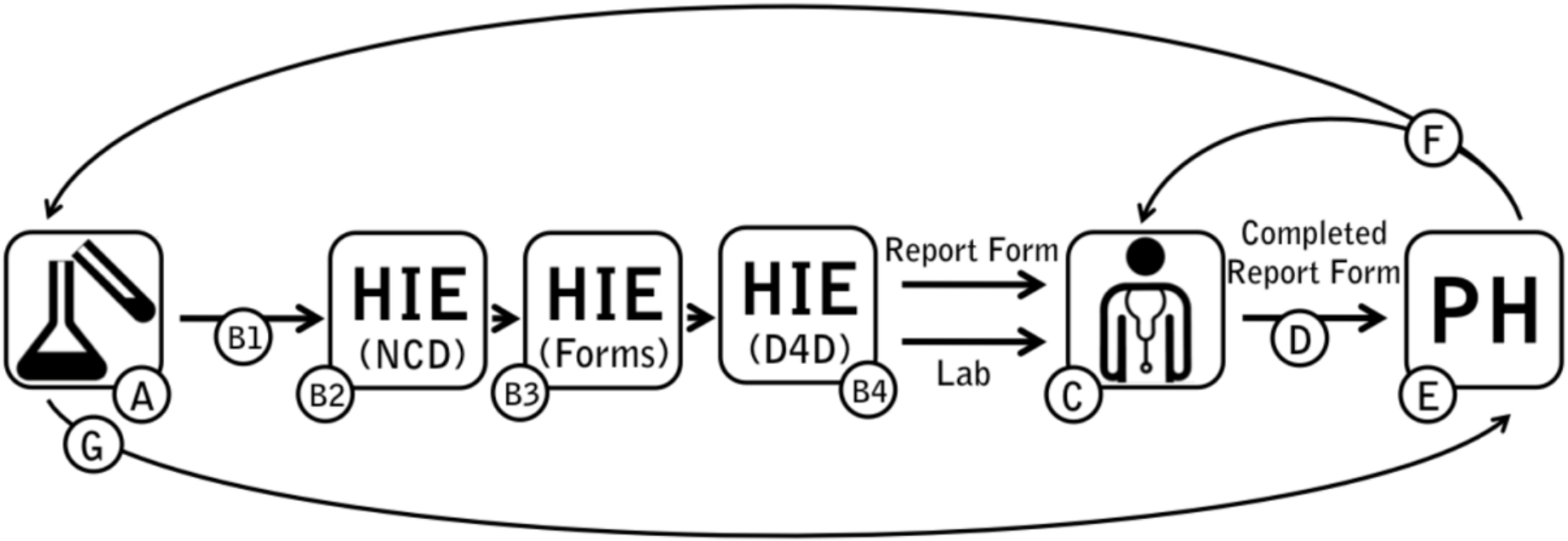
Pre-populated form Information flow



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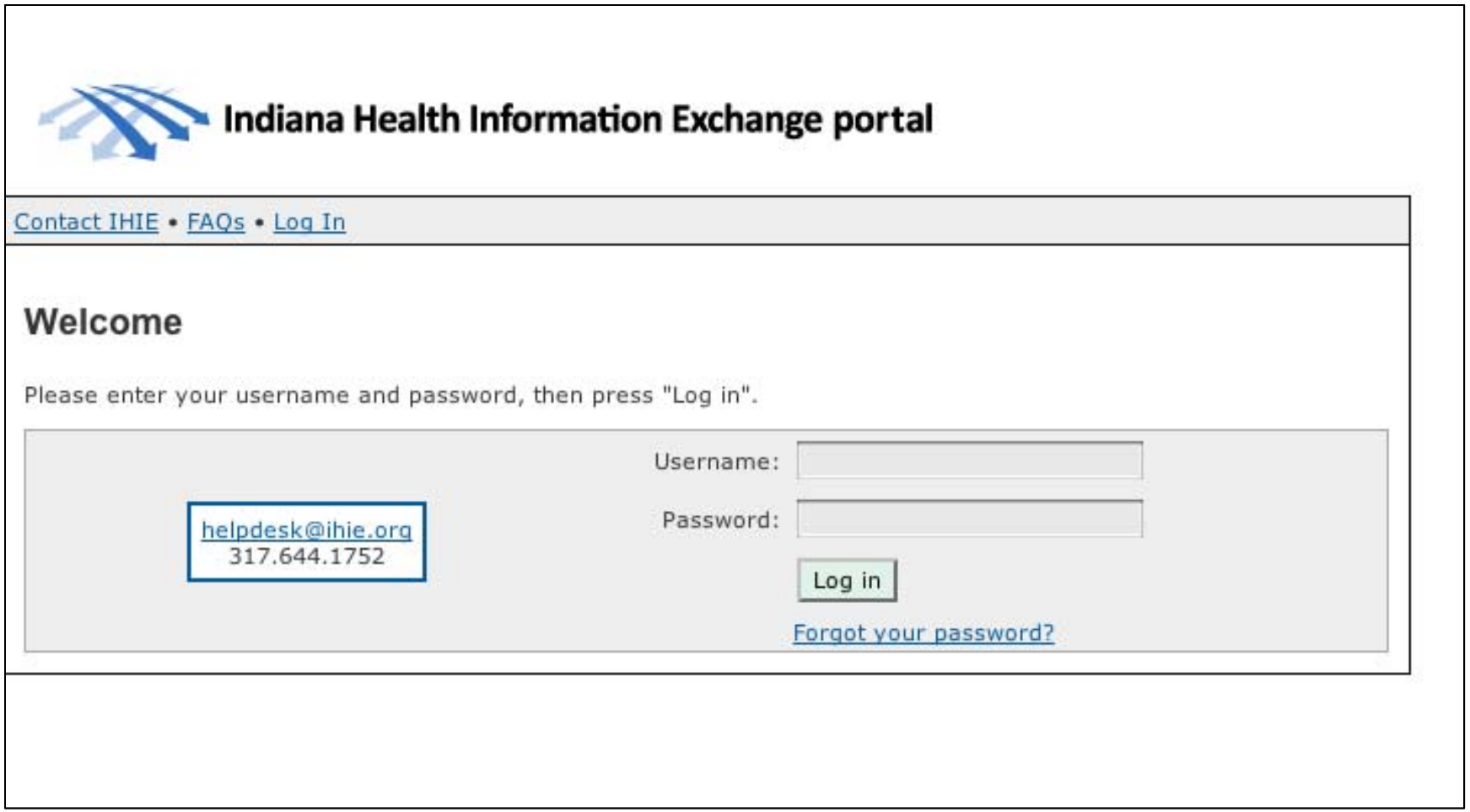
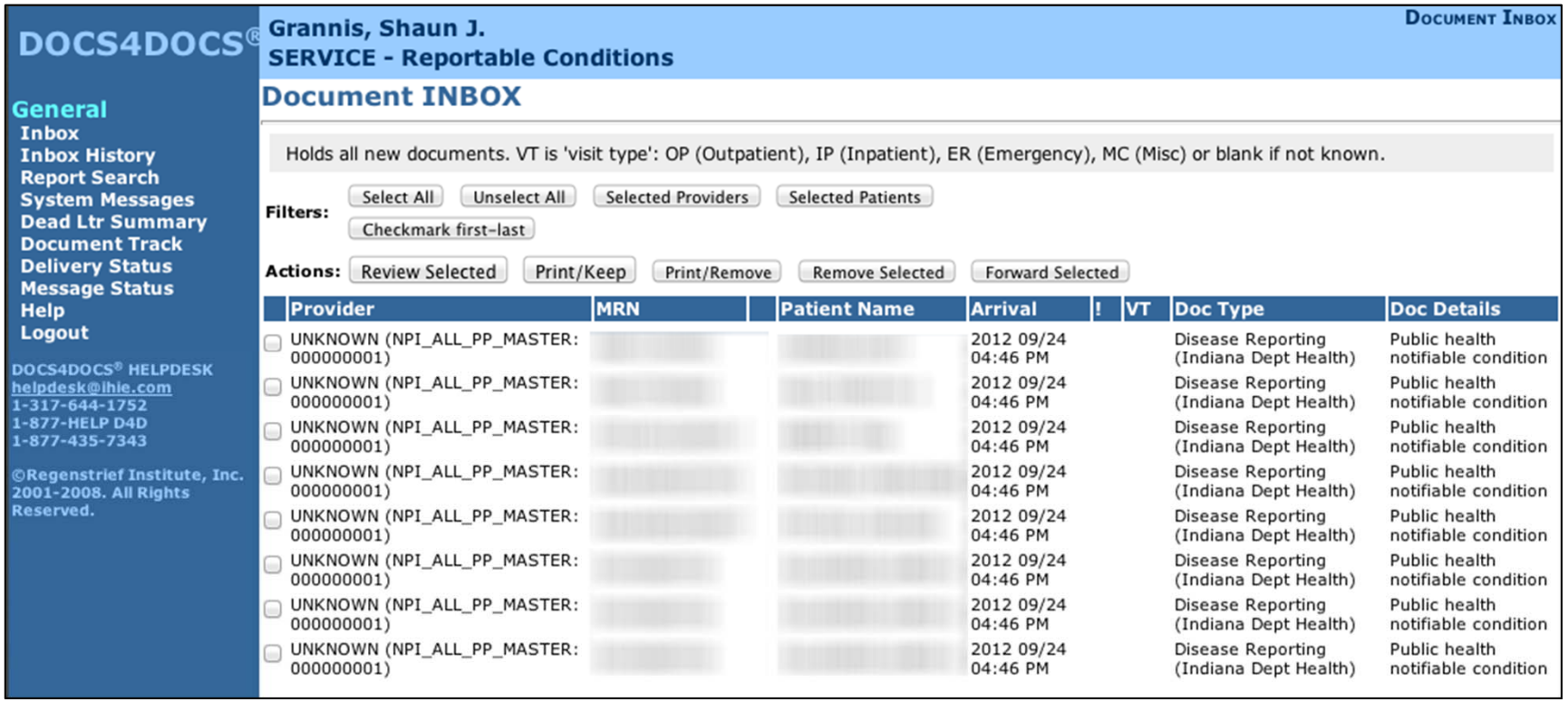
Login Screen



Inbox


DOCS4DOCS®
Grannis, Shaun J.
SERVICE - Reportable Conditions
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General
Inbox
Inbox History
Report Search
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Dead Ltr Summary
Document Track
Delivery Status
Message Status
Help
Logout
DOCS4DOCS® HELPDESK
helpdesk@ihie.com
1-317-644-1752
1-877-HELP D4D
1-877-435-7343
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Document INBOX
Holds all new documents. VT is 'visit type': OP (Outpatient), IP (Inpatient), ER (Emergency), MC (Misc) or blank if not known.
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Select All
Unselect All
Selected Providers
Selected Patients
Checkmark first-last
Actions:
Review Selected
Print/Keep
Print/Remove
Remove Selected
Forward Selected
Provider
MRN
Patient Name
Arrival
!
VT
Doc Type
Doc Details
UNKNOWN (NPI_ALL_PP_MASTER: 000000001)
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Disease Reporting (Indiana Dept Health)
Public health notifiable condition

Notifiable Report