RESOURCE AND PATIENT MANAGEMENT SYSTEM

Radiology/Nuclear Medicine

(RA)

User Manual

Version 5.0
July 2004

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Preface

The Radiology package supports administrative functions related to processing patients for radiological examinations. It automates tedious tasks previously performed manually, providing increased efficiency, accuracy, and completeness in the data entry and tracking of radiology exams. Exam results are readily available online to a broad range of authorized users throughout the facility.

- Some of the highlights of the Radiology package features include:

- Online patient registration for exams

- Automatic printing of flash cards and jacket labels

- Transcription of patient radiological reports

- Daily activity log, exam status reports, incomplete/delinquent exam reports, and unverified/unreleased exam reports

- Workload reports generated by various criteria such as personnel, film usage, exam area, and ward

- Reports by procedures, diagnostic codes, and radiologists for quality improvement

- Online physician verification of radiological exam reports through electronic signatures

- Fully integrated with the Patient Care Component

- Procedures identified with CPT codes to facilitate billing

This software application will work in conjunction with the existing Resource and Patient Management (RPMS) applications and the distribution of the package will be IHS-wide.

SECURITY

This package does not impose any additional legal requirements on the user, nor does it relieve the use of any legal requirements. Names and social security numbers used in the examples are fictitious.

This package requires access and verify codes to access the system. These can be obtained from your supervisor or site manager. In addition, security keys are assigned with your access codes. They are required to perform certain options in the Patient Registration application. Some options within the application are "locked", i.e., the user is unable to access the option without the appropriate security key.

1.0 Introduction

1.1 Implementation Checklist

We suggest using the checklist to make sure you don't miss any necessary steps in implementation. If your site implemented version 4.5, use the Update V. 4.5 to 5.0 Installation Checklist. If this is a first time installation or setup of this program, use the Virgin Installation Checklist.

1.2 Supervisor Menu

Options are shown using their external name (the name users see) with the internal name in brackets. This is an example of what you might see:

Division Parameter Set-up

[RA SYSDIV]

There are four main menus used for implementation and maintenance of this software. The IRM menu also plays a role in implementation, but it is addressed in the technical manual. Each option in the four menus is explained in the following chapters. They are exercised during implementation and throughout the use of the software to maintain or update the files.

- The first menu is the System Definition menu. It contains options to set up and view Division and Imaging Location parameters and to add new cameras, equipment or rooms to the system.

- The second is the Rad/Nuc Med Personnel menu in which you can enter or edit the classification and access of clerks, technologists, residents, and staff. It also contains print options to obtain a listing of each of these categories.

- The third is the Utility Files Maintenance menu, which contains options to add and edit:

  - Complication types
  - Diagnostic codes
  - Exam statuses activation and parameters
  - Film types
  - Label/header/footer formats
  - Major AMIS codes
  - Nuclear Medicine parameters
  - Order entry procedures

- Procedures and their characteristics
- Procedure messages
- Procedure modifiers
- Reasons for cancellation
- Report distribution queues
- Sharing agreements and contracts
- Standard reports
- Valid imaging stop codes

- The fourth, the Maintenance Files Print menu is used in conjunction with these add/edit options to display the contents of the files.
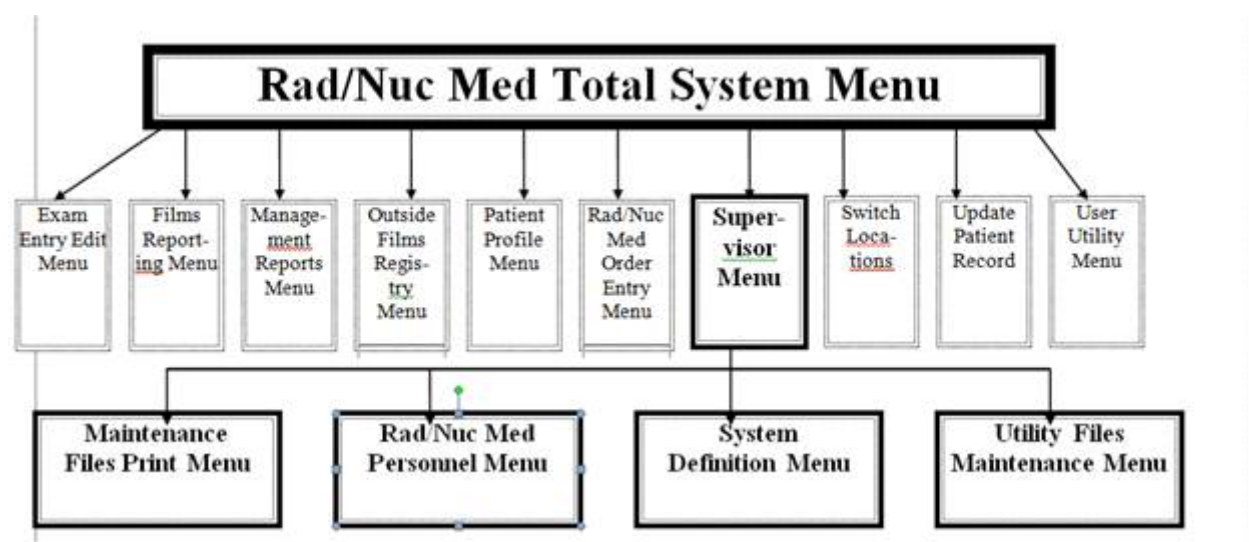
Complication Type List	Classification Enter/Edit	Camera/Equip/Rm Entry/Edit	Complication Type Entry/Edit
Diagnostic Code List	Clerical List	Division Parameter Set-up	Diagnostic Code Enter/Edit
Examination Status List	Interpreting Resident List	List of Cameras/ Equip/Rms	Examination Status Entry/Edit
Film Sizes List	Interpreting Staff List	Location Parameter List	Film Type Entry/Edit
Label/Header/ Footer Format List	Technologist List	Location Parameter Set-up	Label/Header/ Footer Formatter
Major AMIS Code List		Print Division Parameter List	Major AMIS Code Entry/Edit

Modifier List   Nuclear Medicine
                                                                   Setup Menu✓

Nuclear Medicine List   Order Entry Procedure
Menu✓   Display Menu✓

Procedure File Listings✓   Procedure Enter/Edit

Report Distribution   Procedure Message
Lists   Entry/Edit

Sharing Agreement   Procedure Modifier
/Contract List   Entry

Standard Reports Print   Reason Edit

                                                                   Reports Distribution
                                                                   Edit

                                                                   Sharing Agreement
                                                                   /Contract Entry/Edit

                                                                   Standard reports
                                                                   Entry/Edit

                                                                   Valid Imaging Stop
                                                                   Codes Edit

1.2.1 Division, Location, Imaging Type Definitions

There are three terms you must be familiar with in order to understand how this package functions. They are division, imaging type, and imaging location.

A division is defined as a major unit of an institution that requires separate management. In most instances, there is only one division at a given medical center that is also referred to as the site. Integrated sites usually require at least one division defined per site. The Division Parameter Setup and Location Parameter Setup options allow you to tailor the package to fit the particular needs of your department. All parameters are specific to the division, which allows you, as the coordinator, to select the parameters you want to utilize with either a YES or NO response.

An imaging location is defined as a physical location where a procedure can be performed. Each location has its own set of parameters defining location-specific criteria (e.g., label/header/footer formats, printer devices for flash cards, jacket labels requests and reports, and how many labels to print). An imaging location may be associated with only one Division and only one imaging type.

An imaging type must be assigned to each procedure and each imaging location. Therefore, many imaging types can be active within a single division. Imaging types other than General Radiology and Nuclear Medicine should only be "activated" if they indeed are imaging types used at your facility and report procedures and/or workload separately from the other imaging types. In other words, if you want CT scans to be on separate workload reports rather than on general radiology workload reports, then you should activate the CT Scan imaging type (by associating locations that do CT Scans with the imaging type of CT scan, and assigning CT scan procedures an imaging type of CT Scan). Imaging types are limited in this package to the following:

IMAGING TYPE	ABBREVIATION
Angio/Neuro/Interventional	ANI
Cardiology Studies (Nuc Med)	CARD
CT Scan	CT
General Radiology	RAD
Magnetic Resonance Imaging	MRI
Nuclear Medicine	NM
Ultrasound	US
Vascular Lab	VAS
Mammography	MAM

> You should not attempt to add any additional imaging types to this list.

It is important to know how to activate an imaging type. When at least one imaging location and one or more procedures have been assigned a new imaging type, that imaging type becomes "active".

Here is a schematic graph illustrating the relationships:
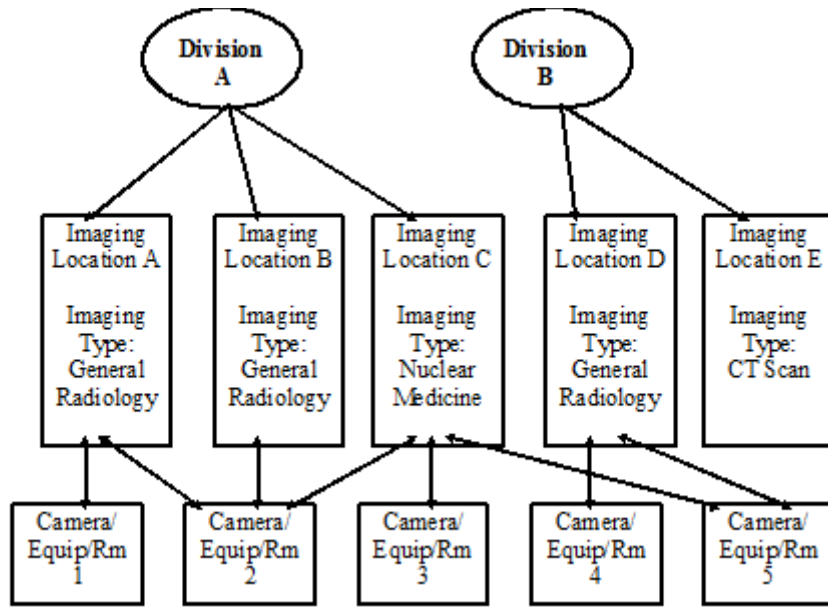
> **Note:** The imaging type of any given procedure will determine in which imaging locations it may be registered and performed.

Example: If the imaging type for procedure X is General Radiology, it can be registered in imaging locations A, B, and D.

1.2.2   Parent/Descendent Exam and Print Sets (+)

A major enhancement to this version is a single combined report for a set of related procedures. This is a "print set" mechanism for entering a single report for all descendent cases registered from a parent order (See Procedure Enter/Edit, section 7.10.3 for more information on parent procedures). For detailed information on Parent/Descendent Exams and Print Sets, refer to section 9.1. The ability to create a separate report for each procedure ordered under a single parent procedure still exists.

1.2.3   Radiopharmaceuticals (+)

Another important addition with this version is the ability to enter and edit information specific to radiopharmaceuticals for Nuclear Medicine. A new menu, the Nuclear Medicine Setup menu, under the Utility Files Maintenance Menu, allows the site to define parameters for radiopharmaceuticals concerning lot number, route and site of administration, and source/vendor. The addition of radiopharmaceutical fields has a major effect on case and status edits for Nuclear Medicine and Cardiology Studies Imaging Types. For more complete information, refer to section 11.0.

2.0   Implementation Checklist

2.1   Virgin Installation

1. Before the site manager loads this system into production, you should read this manual, read over the installation instructions listed here, and complete any related worksheets. The software should be installed in a training environment first so you can familiarize yourself with the setup procedure and train users as much as possible before going live.

2. Before you begin the process of building your files, you should consult with your site manager to be sure you have access to the proper security keys (RA MGR, RA ALLOC and RA VERIFY) and have been assigned the Rad/Nuc Med Total System menu.

3. (For sites using radiopharmaceuticals only) Provide the pharmacy supervisor with a list of the radiopharmaceuticals and work with the radiology supervisor to enter them into the Drug file. For an example of Radiopharmaceutical entries in the Drug file, see page 198. The entries should be assigned one of the following VA Classifications under Diagnostic Agents, using the worksheets in A.5.

    - DX200: Radiopharmaceuticals, Diagnostic

    - DX201: Imaging Agents (in vivo), Radiopharmaceuticals

    - DX202: Non-Imaging Agents Radiopharmaceuticals

4. Edit parameters for each division at your facility using the Division Parameter Setup option in section 5.0.

5. Edit parameters for each Imaging Location by using the Location Parameter Setup option in section 5.1.1.5.

6. Use the Examination Status Entry/Edit option (section 7.4) for each imaging type that you activate at your facility. Read the information on examination status tracking first, including the Case Edits and Status Tracking chapter, so that you understand the implications of activating an imaging type. You should have the exam status worksheets in Appendix A.5 filled out ahead of time so that this part of the setup goes smoothly.

7. Review the rest of the options in the System Definition menu and the Utility Files Maintenance menu and make any changes that are appropriate for your site. Worksheets can be found at the back of this manual beginning in Appendix A.5 .

8. Use the print options in the System Definition menu, Rad/Nuc Med Personnel menu, and the Maintenance Files Print menu to obtain dated hard copies of the data for your records.

9. Determine the menus and/or options you need to assign to each of your users and give the list to your site manager. There are a number of job-related menus (such as clerk, fileroom, radiologist, ward, technologist, etc.) exported with this package. See the technical manual for more information on these menus. You may want to review the Mailman bulletins provided by the Radiology/Nuclear Medicine software with your site manager so mail groups with the appropriate members can be setup.

10. This item is extremely important and should be done as soon as the above steps are complete. No user will be able to sign-on to the Radiology/Nuclear Medicine package unless he or she is assigned at least one imaging location.

Use the Classification Enter/Edit option in the Rad/Nuc Med Personnel Menu and give each user access to whatever imaging locations they work with. You may wish to assign the RA ALLOC key to transcriptionists if they need to enter reports for all imaging locations.

11. Continue training your users.

2.2   Update Installation

This implementation checklist assumes that you have fully implemented version 4.0 and now want to review for implementation the new functionality available in this version.

Before your site manager loads this version into production:

1. Review the release notes to acquaint yourself with any changes that were made to this version of the software and update the users to those changes.

2. Review all new items in this manual (those designated by a plus (+) sign) and read the chapters on Single Reports for Parent/Descendent Exams and Print Sets, and Case Edits and Status Tracking. Also, Procedure Enter/Edit in this manual and Report Entry/Edit and Diagnostic Code and Interpreter Edit by Case No. in the user manual are affected by print sets.

3. Edit parameters for each division at your facility by using the option Division Parameter Set-up. Refer to the chapter in this manual on that option (under System Definition Menu) for information. There are new fields, so be sure to review the changes to see what you need to edit. It is strongly recommended that you turn on the 'SUBMIT REQUEST TO:' prompt by answering 'YES' to the 'ASK IMAGING LOCATION:' prompt that appears during division parameter setup.

4. Edit parameters for each imaging location by using the option Location Parameter Set-up. Refer to the chapter in this manual on that option for information. There are new fields, so be sure to review the changes to see what you need to edit. If you activate new imaging types, you will need to add at least one imaging location for each new imaging type.

5. If you intend to activate any Imaging Type other than General Radiology, use the option Examination Status Entry/Edit for that Imaging Type. You should have the exam status worksheets (in the back of this manual) filled out ahead of time so that this part of the setup goes smoothly.

6. Review the rest of the options in the System Definition Menu and the Utility Files Maintenance Menu for any changes to those options that you need to address in this version. The following are of particular importance:

   a. You will have to review the procedure modifiers. Edit each modifier and assign all appropriate imaging types to the modifier to make it selectable by users for orders and cases of those imaging type. Refer to the section in this manual explaining the Procedure Modifier Entry option under the Utility Files Maintenance Menu for more information. Especially consider assigning all active imaging types to the Portable, Operating Room, and Bilateral modifiers since these can mean additional workload credit.

   b. Since stop codes have been moved to the Rad/Nuc Med Procedures file #71, you should run the new report, Invalid CPT/Stop Code List, and use the Procedure Enter/Edit option to correct any problems. Refer to the Procedure Enter/Edit section of this manual, which is under the Utility Files Maintenance Menu for more information.

   c. The menu RA MOREMENUS has been removed with this version, so you may want to ask IRM if any user's names appeared in the installation message and make sure those users have been given an appropriate replacement menu.

   d. If you are activating one or more new imaging types during this installation, you will need to change the imaging types of the appropriate procedures to match the newly activated imaging type. If these procedures are on the Common Procedure list, you will first have to remove them from the Common Procedure list, then, later, add them to a new Common Procedure list for the newly activated imaging type. (Radiology/Nuclear Medicine Version 4.5 allows 40 common procedures per imaging type, and all procedures on a given list of 40 must have the same imaging type.) If you are using OE/RR Version 2.5 and Radiology quick order protocols, you will have to re-edit the Common Procedure file and re-create the quick order protocols for all procedures where the imaging type changed. Refer to the Order Entry Procedure Display Menu section of this manual for help.

e. If you are activating new imaging type(s), you should make sure that IRM gives you a report entitled "Exam Status Imaging Type Inconsistencies", which is generated by using the 'Imaging Type Mismatch Report' option. Use it to track to completion active cases where the procedure has a newly activated imaging type. Once these cases no longer appear on the report, they will be counted towards the correct imaging type on workload reports. You can request IRM to add this to one of your menus if you feel you are going to use it frequently during the first month or so after installation.

> **Note:** Activation of new imaging types can take several hours of radiology supervisor work. Activation of previously unused imaging types is not a requirement for installation. It can be done at a later date, but should be done during off-hours when system usage is light, or when Rad/Nuc Med users are off the system. (Activation of a new imaging type is accomplished when at least one imaging location and one or more procedures are assigned the new imaging type.)

7. This item is extremely important and should be done as soon as the above steps are complete. No user will be able to sign-on to the Radiology/Nuclear Medicine package unless s/he is assigned at least one imaging location. Use the option Classification Enter/Edit in the Rad/Nuc Med Personnel Menu now and give each user access to whatever imaging locations they work with. It may be desirable to assign the RA ALLOC key to transcriptionists if they need to enter reports for all imaging locations.

8. Use the print options in the System Definition Menu, Rad/Nuc Med Personnel Menu, and the Maintenance Files Print Menu to obtain dated hard copies of the data for your records.

9. You may want to review the Mailman bulletins provided by the Radiology/Nuclear Medicine software with IRM so mail groups with the appropriate members can be set up. There are two new bulletins with this release—RAD/NUC MED CREDIT STOP ERROR and RAD/NUC MED REQUEST HELD.

10. Read through the rest of the radiologist supervisor's guide to acquaint yourself with the types of information available to you.

> **Note:** When you print workload reports please remember that the separation of workload figures by imaging type supported in version 5.0 will take effect only on exams entered after you activate the new imaging types. For example, if an exam was entered before 5.0 was installed, and/or even if it was entered after 5.0 was installed but the new imaging type was not activated at the time of the install, the exam will be counted under its old imaging type (in most cases the old imaging type will be General Radiology). To include only exams entered after the new imaging types were activated, the beginning date entered at the date range prompts when generating the report must be after the date when the new imaging types were activated.

11. (Only for sites using Radiopharmaceuticals) Radiology/Nuclear Medicine accesses the Pharmacy Drug file #50 for radiopharmaceuticals and their associated VA Classifications; therefore, the Drug file must contain all the radiopharmaceuticals used at your site. Provide the Pharmacy radiology supervisor with a list of the radiopharmaceuticals and work with the radiology supervisor to enter them into the Drug file. When entering Radiopharmaceuticals into the Drug file, it is recommended to enter the Nuclide then the Pharmaceutical as the Drug Name and also a synonym to make it easier for Radiopharmaceuticals to be retrieved. For an example of the Drug file entries for Radiopharmaceuticals from one of the test sites, see Appendix A.9. The worksheet can be found in Appendix A.8.

    The Radiopharmaceuticals should be assigned one of the following VA Classifications under Diagnostic Agents:

    - DX200: Radiopharmaceuticals, Diagnostic
    - DX201: Imaging Agents (in vivo), Radiopharmaceuticals
    - DX202: Non-Imaging Agents Radiopharmaceuticals (see Appendix A.8).

12. If a status's order is removed through the Examination Status Entry/Edit option but the Appear on Status Tracking field is set to YES, exams in that status will be available for edit through the Status Tracking of Exams option. The inactivated status will be processed after the active statuses. The purpose of this feature is to allow processing of exams to complete if they are in an inactive status and the case edit options do not prompt for the required fields to allow data entry to complete the cases. If your site has a large volume of historic cases that fall into this category, you may want to make sure the Appear on Status Tracking field is set to NO prior to the installation of this version.

13. Print the Active Procedure List (Short) to get a list of Nuclear Medicine procedures that can be used to fill out your worksheets for procedure setup.

> **Note:** IHS is not currently performing Nuclear Medicine procedures. Please skip step 11.

14. It will be necessary to train the technologists and transcriptionists in handling case and report entry/edits for print sets. This should be done in your training account prior to installing live.

    The technologists must be made aware of the following:

    - If an exam is added through the Add Exam to Last Visit option, and the last visit was a printset/parent, the added exam becomes part of the printset. The report will be a single one even if the added exam is quite different from the substance of the parent.

    - If there are two parent requests of the same Imaging Type, do not use the Add Exam to Last Visit option to add the procedures of the second parent to the first. Doing this will create a single report for all procedures from both parents, and the second request will never be completed because all descendants will apply to completing the first request.

    While you do the setup required after installation, imaging service users must be off the system. You should prepare as much as possible to minimize the downtime for imaging service users.

    The following is a listing and discussion of all the new functionality that you may want to edit in setting up this version. It is strongly suggested that you review the following checklist and complete any worksheets prior to the actual setup. Then use the completed checklist and worksheets during the setup.

2.2.1   Division Parameter Setup

For general information about these items, see section 5.1.1.1.

AUTO E-MAIL TO REQ. PHYS?

If you want to automatically send Radiology/Nuclear Medicine findings when they are verified to the requesting physician via e-mail, you need to type yes in the "Auto E-mail to Req Phys?" field.

Division	E-Mail Findings

RPHARM DOSE WARNING MESSAGE

If you want to display a message other than the default message to the user when the radiopharmaceutical dose falls outside the range of the Low Adult Dose and the High Adult Dose, enter the message at the "RPHARM DOSE WARNING MESSAGE" prompt.

Note: This field is only applicable to sites currently using radiopharmaceuticals. If your site does not currently use radiopharmaceuticals, skip this prompt.

These fields reside in the Default Radiopharmaceuticals multiple in the Rad/Nuc Med Procedures file. Use the Procedure Enter/Edit option to adjust these values. The default message is:

This dose requires a written and signed directive by a physician.

If you have changed the message in the system, write the new message in the space provided below.

Message: _____

_____

_____

2.2.2   Location Parameter Setup

For general information about these items, see section 5.1.1.5.

ALLOW RELEASED/UNVERIFIED

If you want to be able to display unverified reports to users outside the imaging service, type yes at the "Allow Released/ Unverified:" prompt. This field was moved to the imaging location parameters. If this field, as a division parameter, contained a yes response, then all the imaging locations for that division will contain a yes response in this location parameter field as a default. Otherwise, the default in this field will be no.

Location	Send Alert	Allow Released/Unverified

Location	Send Alert	Allow Released/Unverified

STAT REQUEST ALERT RECIPIENTS

List any Radiology/Nuclear Medicine personnel that should receive an alert whenever a STAT request is submitted to the imaging location at the "Stat Request Alert Recipients:" prompt. Bypass this step if you don't want alerts sent.

> **Note:** To receive a STAT request alert, recipients must have a Radiology/Nuclear Medicine personnel classification. To use this feature, the "Ask Imaging Location" division parameter must be set to yes and CPRS (OE/RR V. 3.0 or higher) must be installed.

Locations:	Recipients:

URGENT REQUEST ALERTS?

If you want to send alerts to selected personnel whenever there is a STAT request, type yes at the "Urgent Request Alerts?" prompt. Personnel designated to receive STAT request alerts will also receive URGENT alerts.

Note: To use the Urgent Request Alerts feature, the "Ask Imaging Location" division parameter must be set to YES and CPRS (OE/RR V. 3) or higher must be installed.

2.2.3   Diagnostic Code Enter/Edit

For general information about this item, see section 7.3.

INACTIVE

Print out a list of your diagnostic codes using the Diagnostic Code List option. If you want to inactivate any of the codes, so they do not appear as selections to the users, highlight them and refer to that list when responding to the "Inactive:" prompt.

2.2.4   Examination Status Entry/Edit

For general information about this item, see section 7.4.

Editing this option takes a great deal of preparation. Make sure you read the information in the chapters Examination Status Entry/Edit and Case Edits and Status Tracking (section 11.0). Use the worksheet (Appendix A), when defining your changes.

A new imaging type, Mammography, was exported with this version. If you intend to activate Mammography as an imaging type, then be sure to include it when defining your changes to status tracking.

Note:	This installation will turn on the "Ask Radiopharmaceuticals and Dosages" parameter for all nuclear medicine and cardiology studies procedures. All other new parameters will be off. In order for nuclear medicine technologists to accurately enter radiopharmaceuticals, all radiopharmaceuticals used at your site must be entered into the Pharmacy Drug file.

The new fields to edit for all imaging types are as follows:

- GENERATE EXAMINED HL7 MESSAGE

- ASK MEDICATIONS & DOSAGES

- ASK MEDICATION ADMIN DT/TIME & PERSON

There are a number of new fields for Nuclear Medicine. If your facility wants to record data in most or all of the new radiopharmaceutical data fields, you will have to use Status Tracking to edit cases. Only through status tracking will you be able to control which prompts are asked at which statuses. In order to provide simplicity and avoid extra undesirable prompts at facilities that want to enter a minimum set of radiopharmaceutical data, the case editing options (Case No. Exam Edit and Edit Exam by Patient) do not prompt for all the new Nuclear Medicine fields. Instead, only the radiopharmaceutical, dose administered, date/time of dose administration, and person who administered dose will be consistently asked for nuclear medicine or cardiology studies cases. However, if data has already been entered via status tracking in other nuclear medicine related fields, the case edits will prompt for those fields to allow correction of erroneous radiopharmaceutical data already entered. In addition, if the procedure parameter so specifies, the case edits will prompt for radiopharmaceutical dose prescribed, prescribing physician, and witness to dose administration.

The new fields to edit for Nuclear Medicine and Cardiology Studies imaging types are as follows:

- Radiopharms & dosages required

- Activity drawn required (radiopharm)

- Drawn dt/time and person required (radiopharm)

- Admin dt/time/person required (radiopharm)

- Route/site required (radiopharm administered)

- Lot no. Required (radiopharm)

- Volume/form required (radiopharm)

- Ask radiopharmaceuticals and dosages

- Ask activity drawn (radiopharmaceutical)

- Ask drawn dt/time & person (radiopharmaceutical)

- Ask admin dt/time & person (radiopharmaceutical)

- Ask route/site of admin (radiopharm)

- Ask lot no. (radiopharm)

- Ask Volume/Form (Radiopharm)

- Print dosage ticket when exam reaches this status

> **Note:** Printing of the dosage ticket requires that a valid print
> device assigned to the location (see IRM Menu, Device
> Specifications for Imaging Locations option, Dosage Ticket
> Printer prompt) and YES answered for the
> Radiopharms/Dosages Required field at the status you are
> editing (or lower).

Even if you do not make changes to the exam status parameters, select the option for each imaging type. This will trigger the Data Inconsistency Report and identify all problems. You can type the caret (^) at the Select an Examination Status prompt as shown here:

```
Select an Imaging Type: NUCLEAR MEDICINE

Select an Examination Status: ^

 _____ Checking order numbers used for status progression _____
            within : NUCLEAR MEDICINE

      Required order numbers are in place.

                   Data Inconsistency Report For Exam Statuses

DEVICE: HOME// (Enter a printer name)
```

Figure 2-1: Examination Status Entry/Edit (Checklist Example)

2.2.5   Label/Header/Footer Formatter

For general information about this item, see section 7.6.

There are a number of new fields available that could be added to labels, headers, or footers:

- Long Case Number Barcode
- Resident Signature Name
- Staff Signature Name
- Verifying Signature Name
- Verifying Signature Title
- Patient Address Line 1
- Patient Address Line 2
- Patient Address Line 3

2.2.6   Nuclear Medicine Setup Menu

For general information about this item, see section 8.9.

> IHS does not currently perform Nuclear Medicine procedures. This menu will not appear in your program and the sections that refer to it should be bypassed at this time.

This menu contains four options. Routes and sites of administration of radiopharmaceuticals were exported with this version. Review the data in those files using the print options Route of Administration List option and the Site of Administration List option before adding more entries. Worksheets for all four options are available in Appendix A.10. Add sites and vendors/sources before adding routes and lot numbers. Sites should be entered before routes so they will be selectable as valid sites for a route and lot numbers can be associated with vendors/sources. Also, routes and sites must be available for the next step, Procedure Enter/Edit. You may also want to request that your site manager add the Lot Number Enter/Edit as a secondary menu option for the Nuclear Medicine technologists.

2.2.7   Procedure Enter/Edit

For general information about this item, see section 7.10.3.

This is another complex setup that requires considerable preparation. If you plan to use the nuclear medicine features, you will need to enter radiopharmaceutical parameters on the appropriate procedures. Use the worksheet on page 194, making as many copies as necessary.

> IHS does not currently perform Nuclear Medicine procedures. Recommendations that refer to these procedures should be bypassed at this time.

The new fields to edit for all imaging types are as follows:

- Single report

- Prompt for meds

- Default medication

- Educational description

- Display educational description

> **Note:** If you turn parent procedures into printsets by typing yes to the "Single Report" prompt, the printset features will only take effect on cases registered after V. 5.0 is installed.

The new fields to edit for Nuclear Medicine and Cardiology Studies Procedures are as follows:

- SUPPRESS RADIOPHARM PROMPT

- PROMPT FOR RADIOPHARM RX

- DEFAULT RADIOPHARMACEUTICAL

    – LOW DOSE

    – HIGH DOSE

    – USUAL DOSE

    – ROUTE

    – FORM

If your site uses parent procedures and you want a single report for all descendents, you can use the Print File Entries (PFE) option to obtain a list of parent procedures, or you can use one of the existing procedure listing options to get complete data for all active procedures.

```
Select Supervisor Menu Option:  Print File Entries

OUTPUT FROM WHAT FILE: (file name)// RAD/NUC MED PROCEDURES
SORT BY: NAME// TYPE OF PROCEDURE
START WITH TYPE OF PROCEDURE: FIRST// P  PARENT
GO TO TYPE OF PROCEDURE: LAST// P  PARENT
  WITHIN TYPE OF PROCEDURE, SORT BY:
FIRST PRINT FIELD: NAME
THEN PRINT FIELD: DESCENDENTS       (multiple)
  THEN PRINT DESCENDENTS SUB-FIELD: .01  DESCENDENTS
  THEN PRINT DESCENDENTS SUB-FIELD: <RET>
THEN PRINT FIELD: <RET>

  *************************
Heading (S/C): RAD/NUC MED PROCEDURES LIST  Replace <RET>
START AT PAGE: 1// <RET>
DEVICE: (device name)
```

Figure 2-2: Procedure Enter/Edit (Checklist Example)

2.2.8   Reason Edit

For general information about this item, see section 7.11.

If your site is running CPRS (OE/RR V. 3.0), you will want to review the Reason Edit chapter and decide what to do with the new Nature of Order Activity field.

2.2.9   Activating Mammography

If you activate the new imaging type Mammography, be sure to enter any modifiers you want for that Imaging type using the option Procedure Modifier Entry.

2.2.10   Printing Request Cancellations

If you want Request Cancellations to print, give your site manager a list showing which printer for each imaging location should be used to print them. They will enter these via their IRM menu using the Device Specifications for Imaging Location option.

3.0   Screening Methods

Most options are screened by a combination of imaging type, division, and imaging location. Others are screened by ownership. Division, imaging type, and location screening methods are based on the following criteria.

- The set of locations the user is privileged to access (entered by the radiology supervisor or site manager through the Classification Enter/Edit option). Anyone who owns the RA ALLOC key can access all imaging locations so it isn't necessary to assign imaging locations to owners of this key. (Appropriate owners are radiology supervisors and transcriptionists.)

- The sign-on location must be a location to which the user has access.

- The user's imaging type access set and division access set are calculated by the system based on the imaging locations to which the user has access. They include all the imaging types and divisions of all the locations in the user's access set. For example, if a user only has access to the General Radiology "X-RAY 1" imaging location in division A, the system will calculate access as follows:

  - If the user selects an option that is screened by location, he or she will only be able to access exam data within X-RAY 1.

  - If the user selects an option that is screened by imaging type, he or she will be able to access data that is within general radiology regardless of location or division. This means the user could access more than one location if there are multiple locations of that imaging type.

  - If the user selects an option that is screened by imaging type and Division, he or she will be able to access data within Division A and General Radiology Imaging Type regardless of location.

  - If the user selects a non-screened option or an option screened by ownership of a report, batch, etc., the location/imaging type/division screening will have no effect.

So far we have the following variations of screening:

Method No.   Description

- Ownership (usually of reports or report batches)

- Some variation of single location screening. This method is usually used for the Register Patient for Exams option because the imaging type of the selected procedure must match the imaging type of the sign-on location. This method is also used for the Add Exams to last Visit option because the sign-on location must match the location of the exams previously entered for the visit.

- Selected location(s): Locations selected must be in the user's location access set and must have an imaging type that matches the imaging type of the sign-on location. This method is used for Exam Status Display/Tracking options and will be used for some of the reports that have to do with Orders/Requests. (Exam status options must work with one imaging type at a time since the exam statuses are now imaging-type specific.) Default response at location selection prompt is "ALL", which means all locations to which the user has access.

- Sign-on imaging type: The user is only allowed to select patients and/or cases with an imaging type that matches the imaging type of his or her sign-on location. This screening method is used for the remainder of the case edit/view/cancel options.

- Selected Imaging Types: If user can only access one imaging type, the system will default to that imaging type without prompting. If the user can access multiple imaging types, the user is prompted to select one or more imaging types. Default response is "ALL", which means that all imaging types to which the user has access.

- Division and Imaging Type selection: The user first selects one or more divisions from his or her division access list (if only one division is accessible, the system will default to it rather than prompt the user). Next, the user selects one or more imaging type(s) from his or her imaging type access list (which may now be further restricted, since the user may have chosen a division in which not all of his or her accessible imaging types are active). This method was used for the Daily Report option, the Complication Report option, the Abnormal Report option, and, so far, will be used for most workload and management reports on exams that have at least progressed to the registration stage. This method is also used for transcriptionist options. Default responses to the division and imaging type selection prompts are "ALL", which means all to which the user has been given access privileges.

- Menu option allocation: The use of this method is at the discretion of the site.

- Division selection.

For quick reference, here is a list of options and their screening methods:

Menu Option	Screening Method	Key Needed
Access Erroneous Reports	N/A	(On Supervisor menu only)
Cancel a Request	None	
Create a Batch	None	
Delete a Report	None	RA MGR
Delete Printed Batches by Date	None	RA MGR
Display Rad/Nuc Med Procedure Information	None	

Menu Option	Screening Method	Key Needed
Display a Rad/Nuc Med Report	None	
Display Patient Demographics	None	
Distribution Queue Menu (all options)	None	
Enter Last Past Visit Before VISTA	None	
Exam Deletion	None	RA MGR
Exam Profile (selected sort)	None	
Hold a Request	None	
Inquire to File Entries (FileMan)	N/A	(On Supervisor menu only)
Jacket Labels	None	
List Exams with Inactive/Invalid Statuses	N/A	(On Supervisor menu only)
List Reports in a Batch	None	
Maintenance Files Print Menu (all options)	N/A	(On Supervisor menu only. If appropriate, printout will show imaging type)
Nuclear Medicine List Menu (all options)	None	
Nuclear Medicine Setup Menu (all options)	None	
Outside Films Profile	None	
Outside Films Registry Menu (all options)	None	
Pending/Hold Rad/Nuc Med Request Log	None	
Print a Batch of Reports	None	
Print File Entries (FileMan)	N/A	(On Supervisor menu only)
Print Rad/Nuc Med Requests by Date	None	
Print Selected Requests by Patient	None	
Print Worksheets	None	
Profile of Rad/Nuc Med Exams	None	
Rad/Nuc Med Personnel Menu (all options)	N/A	(On Supervisor menu only)
Request an Exam	None	
Schedule a Request	None	
Search File Entries (FileMan)	N/A	(On Supervisor menu only)
Select Report to Print by Patient	None	
System Definition Menu (all options)	N/A	(On Supervisor menu only. If appropriate, edits will be by Imaging Type)
Test Label Printer	None	
Transcription Report	None	

Menu Option	Screening Method	Key Needed
Unverify a Report for Amendment	None	RA MGR
Update Patient Record	None	
Verify Batch	None	RA VERIFY
View Exam by Case No.	None	
Ward/Clinic Scheduled Request Log	None	
Utility Files Maintenance Menu (all options)	N/A	(On Supervisor menu only)
Add/Remove Report from Batch	1	
Delete Printed Batches	1	
On-line Verifying of Reports	1	RA VERIFY
Resident On-line Pre-Verification	1	RA VERIFY
Add Exams to Last Visit	2	
Register Patient for Exams	2	
Detailed Request Display	3	
Exam Status Display	3	
Log of Scheduled Requests by Procedure	3	
Status Tracking of Exams	3	
Switch Locations	None	
Cancel an Exam	4	
Case No. Exam Edit	4	
Diagnostic Code and Interpreter Edit by Case No.	4	
Duplicate Flash Card	4	
Draft Report (Reprint)	4	
Edit Exam by Patient	4	
Indicate No Purging of an Exam/Report	4	
Mass Override Exam Status	4	RA MGR
Override a Single Exam Status to	4	RA MGR
Update Exam Status	4	(On Supervisor Menu only)
Abnormal Exam Report	6	

Menu Option	Screening Method	Key Needed
Complication Report	6	
Daily Log Report	6	
Delinquent Status Report	6	
Examination Statistics	6	
Functional Area Workload Reports (all rpts)	6	
Incomplete Exam Report	6	
Personnel Workload Reports (all options except the Transcription Report)	6	
Report Entry/Edit	6	
Special Reports (all except AMIS reports)	6	
Unverified Reports	6	
Verify Report Only	6	RA VERIFY
AMIS Code Dump by Patient	8	
AMIS Report	8	

> **Note:** The RA ALLOC key enables a user to access the broadest possible set of locations, imaging types, and divisions possible with any given option. It is the equivalent of having access to all imaging locations.

4.0   Security Keys

4.1   RA ALLOC

Ownership of the RA ALLOC key overrides the location access security given to personnel through Classification Enter/Edit. Owners of the RA ALLOC key have expanded access to imaging locations, imaging types, and divisions. In the case of most workload reports, this means that they can select from a list of all divisions and imaging types to include on the report. In the case of various edit and ordering functions, it means that they can select from all locations within the imaging type to which they are currently signed on through the "Select sign-on location" prompt.

4.2   RA MGR

The RA MGR key gives the user access to supervisor-type functions. These functions include:

- Editing completed exams

- Adding an exam to a visit that is older than yesterday

- Showing the user all non-completed exams, not just those associated with the user's current Division, during execution of the "status tracking" function.

- Updating the exam status of an exam to complete

- Deleting exams

- Deleting reports

- Unediting reports

- Entering a report on a cancelled exam if site parameters don't allow it

- Deleting printed batches by date

4.3   RA VERIFY

The RA VERIFY key allows users to verify reports.

4.4   RAOVERALL

Key to main Radiology menu.

5.0   Supervisor Options

5.1   Defining and Maintaining Your System Parameters

In this chapter, we will show you how to define your system parameters using the Division Parameter Set-up option, the Location Parameter Set-up option, and the Camera/Equip/Rm Entry/Edit option. Once you have defined and entered or edited your system parameters, you should use the print options in the System Definition Menu to create a dated hard copy of the parameters.

New divisions, locations, or cameras/equipment/rooms may be added or their parameters edited at any time. Therefore, these options are used for file implementation and maintenance. If this is not a completely new implementation of the software, you should take this time to review your system parameters for any necessary updating of the files. In particular, check those items that appear in this manual with a plus sign (+).

5.1.1   Setting up Division Parameters (DPS)

The Division Parameter Setup option [RA SYSDIV] is used to define a division's unique information. The Radiology/Nuclear Medicine module was designed to handle the functions of multiple divisions within a medical center, even though most medical centers have only one division. As a result, the program is structured around the division concept. Therefore, even if you are a single division medical center, you must enter at least one division using this option.

All imaging types and locations associated with this division are affected by the parameters in this option. For instance, if a clinical history message is entered, the message will appear for any type of procedure ordered, whether it is for general radiology, nuclear medicine, ultrasound, etc. If you require the impression on the report, it will be required on reports from all imaging types.

An existing division may be edited or a new division may be entered through this option. All divisions must be in the Institution file (# 4). The following is a listing of division parameters and a brief explanation for each.

5.1.1.1   Division-wide Order Entry Parameters

```
Division-wide Order Entry Parameters:
-------------------------------------
ASK 'IMAGING LOCATION': YES//
TRACK REQUEST STATUS CHANGES: YES//
CLINICAL HISTORY MESSAGE: "Please enter the reason for this exam in the
Clinical
 History"  Replace
```

Figure 5-1: Setting Division-wide Order Entry Parameters

Ask 'Imaging Location'

The Ask 'Imaging Location' field determines whether or not the "Submit Request To:" prompt appears when a procedure is requested. If this field is set to yes, the user will be required to enter the name of the imaging location where the request is to be sent and printed at the time they request an exam. The user will only be allowed to choose from imaging locations whose imaging type matches the imaging type of the procedure. It is strongly recommended that you type yes in this field.

If you do not answer this prompt, the system default is no and the "Submit Request To:" prompt will not appear to the user. If this field is set to yes, the division will be able to implement alerts on STAT and URGENT requests once CPRS (OE/RR V. 3) is installed.

> Setting this field to no will make order tracking more difficult and is not recommended.

Track Request Status Changes

If the Track Request Status Changes field is set to yes, this parameter establishes the collection of the date and time of request status changes. Request status changes pertain solely to the physician's order and whether it is in one of the following statuses: discontinued, complete, hold, pending, active, scheduled, unreleased. Request status changes can be used to find the status of an order at any given time in the past.

If you choose to bypass this prompt, the system default is no and the system will not keep track of request status change information, automatically add the dates and times of status changes, or add the name of the user requesting the change in status.

Clinical History Message

The Clinical History Message field contains an optional free-text message (5-70 characters in length) that is displayed just prior to the prompt for the clinical history field. This is often used to remind the user that specific information is needed in the patient's clinical history.

If you bypass this field, no message will appear prior to the user seeing the prompt for the clinical history.

5.1.1.2   Exam Entry/Edit Parameters

```
Exam Entry/Edit Parameters:
---------------------------
DETAILED PROCEDURE REQUIRED: yes//
ASK 'CAMERA/EQUIP/RM': yes//
AUTO USER CODE FILING: yes//
TRACK EXAM STATUS CHANGES: yes//
```

```
ASK EXAM STATUS TIME: no//
TIME LIMIT FOR FUTURE EXAMS:
```

Figure 5-2: Setting Exam Entry/Edit Parameters

Detailed Procedure Required

If the Detailed Procedure Required field is set to yes, the entry of a parent, series, or detailed procedure type will be required. If this field is set to no, procedures with the broad procedure type will be accepted during order entry as a valid entry. Depending on Examination Status file parameters, you can require that the procedure be changed to either a series or detailed procedure by the staff for the examination to acquire a specific status. Again think about users entering orders; will they be able to discriminate between the more specific detailed and series type procedure, or will they be more comfortable selecting a general procedure name from the broad types?

If you choose to bypass this prompt, the system default is no and users will be able to request broad-type procedures.Ask 'Camera/Equip/Rm'

When the Ask 'Camera/ Equip/Rm' parameter is set to yes, the "Primary Camera/Equip/Rm" prompt will appear when a user is entering data about the examination in status tracking. If you want to track camera, equipment, or room use for each procedure, type yes at this prompt, keeping in mind that the user may still bypass the question if he or she chooses to do so.

> **Note:** The examination status parameters can be set to require this data before an exam can progress to a Complete (or other) status.

If you accept the field default (No), the user will not see the "Primary Camera/Equip/Rm:" prompt.

Auto User Code Filing

If the Auto User Code Filing parameter is set to yes, the user's sign-on access code is used automatically for the activity logs. If the parameter is set to no, users will be asked to enter access codes during various processes. This feature was used in older versions to minimize security risks of unattended, logged-in terminals and multiple users sharing one terminal. This precaution should not be necessary at most sites now, and this field should be set to yes.

Track Exam Status Changes

Setting this parameter to Yes results in the recording of the dates/times of examination status changes. These statuses pertain to the exam, not the request. Statuses are defined by the site using the Examination Status Entry/Edit option. Examples of statuses that might be defined are Called for Exam, Cancelled, Complete, Examined, Transcribed, Waiting for Exam, etc.

If you choose to bypass this field, the system will not automatically record the dates and times of status changes and who made the changes.

Ask Exam Status Time

If the Track Exam Status Changes parameter is set to yes, the Ask Exam Status Time parameter will appear. Setting the Ask Exam Status Time parameter to yes will force the system ask the user the time of the status change. The Date/Time is added to the Status Change Dt/Time subfile and to the activity log.

If this field is set to no or bypassed, the system automatically uses the current date and time and the prompt for time will not appear. This data is added only to the activity log.

Time Limit for Future Exams

The Time Limit for Future Exams parameter sets the time (up to 168 hours/ 1 week) in the future during which a patient can be registered for an exam. If this prompt is bypassed, the user will not be able to register a patient for a future date or time. Generally, registering a patient is done when the patient arrives at the imaging location. Registering a patient is not the same as scheduling a patient for a procedure, which takes any future date the user chooses.

> **Note:** Registering patients in advance opens the possibility for exam updating before the exam really takes place. This can cause a failure in workload crediting. Registration more than 24 hours in the future is not recommended.

5.1.1.3 Films Reporting Parameters

```
Films Reporting Parameters:
---------------------------
ALLOW STANDARD REPORTS: yes//
ALLOW BATCHING OF REPORTS: yes//
ALLOW COPYING OF REPORTS: yes//
IMPRESSION REQUIRED ON REPORTS: yes//
ALLOW VERIFYING BY RESIDENTS: no//
ALLOW RPTS ON CANCELLED CASES?: no//
WARNING ON RPTS NOT YET VERIF?: yes//
AUTO E-MAIL TO REQ. PHYS?: yes//
ALLOW E-SIG ON COTS HL7 RPTS: no//
INTERPRETING STAFF REQ'D?: NO//
ALLOW E-SIG ON COTS HL7 RPTS: no//
```

```
INTERPRETING STAFF REQ'D?: YES// ?
```

Figure 5-3: Setting Films Reporting Parameters

Allow Standard Reports

If the Allow Standard Reports parameter is set to yes, transcriptionists will be able to select a standard report when using the Report Entry/Edit (EDT) option. Use the Standard Reports Entry/Edit option to build a standard report with a report text that is often used. An example of a standard/routine exam might be, Normal Chest with the text reading "Chest exam is within normal limits". If there are a number of such exams reported, allowing the transcriptionists this ability saves time. These standard reports are discussed in section 7.14.

Allow Batching Of Reports

If the Allow Batching of Reports field is set to yes, transcriptionists can group reports for easy, organized access or printing. If changes must be made, the transcriptionist can look for the report within a batch rather than by keeping track of record numbers and patient names. This function provides a timesaving way to organize work.

Allow Copying Of Reports

If the Allow Copying of Reports parameter is set to yes, contents of one report can be copied to another. If a patient has had more than one test and the report text and impression of one report are needed for another, this function saves transcription time. This function places the entire report text and impression text of the selected report into the one the user is editing. The text can then be further edited. The clinical history will be moved from the patient's current exam record to the report record, not from the copied report.

Impression Required On Reports

Set the Impression Required On Reports parameter to yes if you want an impression to be required on a report in order for it to become verified and for the exam to progress to the Complete status.

If this parameter is set to yes, refer to the Examination Status parameter instructions to set up the Complete status (at least) to require an impression.

It is highly recommended that this parameter be set to yes. When reports are purged from the system, the clinical history and report text are deleted. Only the impression is retained on line.

Allow Verifying By Residents

Set the Allow Verifying By Residents to yes if you want to allow interpreting residents to verify their own reports while doing online report verification. If you do set this parameter to yes and set the resident's individual Allow Verifying of Others parameter (in the New Person file), to yes, the resident will be allowed to verify other interpreting physicians' reports in addition to his or her own.

> Warning: It is recommended that residents NOT be allowed to verify reports because of the legal implications of report verification.

Allow Rpts on Cancelled Cases?

If the Allow Rpts on Cancelled Cases? field is set to yes, any user can enter a report on a cancelled exam. If this parameter is set to no, only users who have the RA MGR key can edit or enter a report on a cancelled case.

Warning On Rpts Not Yet Verif? (+)

If the Warning on Rpts Not Yet Verif? field is set yes, results reports in all statuses except "Verified" will contain the status under the body of the printed report, surrounded by asterisks. This function can be helpful in making sure that unverified report copies are not placed in patient charts or mistakenly interpreted as final results. (This is not a new feature. Only the name was changed.)

Auto Email to Req. Phys? (+)

If this field is set to Yes, the system will automatically send the Radiology/Nuclear Medicine findings report to the requesting physician via email at the time it is verified. If this field is left blank, verified reports will not be emailed to the requesting physician.

Allow E-Sig on COTS HL7 RPTS

If this field is set to YES, the system will automatically add the Electronic Signature Block printed name of the Verifying Physician that signed the report being transmitted to Radiology/Nuclear Medicine via an HL7 interface to a COTS voice reporting system. This parameter is only checked for COTS HL7 interfaces that use the Generate/Process Routine 'RAHLTCPB' in the subscriber protocol.

Note: The HL7 COTS interfaces supported by this option are the IBM MedSpeak interface released with patch RA*5*4 and the TalkStation and PowerScribe interfaces released with patch RA*5*12. See the appropriate appendix in the Rad/Nuc Med Technical Manual for additional information on these interfaces.

Interpreting Staff Req'd?

Is Interpreting Staff Required for this Division?

5.1.1.4 Miscellaneous Division Parameters

Print Flash Card For Each Exam

To have one flash card automatically printed with each registration of a case for all imaging locations, set this parameter to Yes. To allow the printing of more than one flash card, set this parameter to No and use the Location Parameter Setup option to enter the number you want printed for each location

Print Jacket Lbls W/Each Visit

Indicate to the system that a jacket label be printed with each visit (may include many cases/exams) by setting this parameter to Yes. The number of labels printed will be the same as the entry in the How Many Jacket Lbls Per Visit location parameter.

Contrast Reaction Message

This is an optional free-text field to be used for entering a warning message that will be displayed each time a patient who has had a reaction to contrast medium is registered for a procedure that uses a contrast medium.

If you bypass this field, no message will be displayed.

Rpharm Dose Warning Message (+)

This field contains the message displayed to the user when the registered dose falls outside the acceptable dose range for the radiopharmaceutical. The fields that establish the acceptable dose range can be found in the Default Radiopharmaceuticals multiple in the Rad/Nuc Med Procedures file. Use the Procedure Enter/Edit option to adjust these values. If no values exist for a procedure, this message will have no effect.

5.1.1.5 HL7 Applications Associated with this Division

HL7 RECEIVING APPLICATION

This field should only be set if using routing Logic with the Radiology HL7 subscriber protocols (File #101). (See the Radiology/Nuclear Medicine V. 5.0 HL7 Manual for further details.)

If using routing logic then only the HL7 Receiving Applications defined here will receive Radiology HL7 messages for this Division. If routing logic IS being USED, But no hl7 receiving applications are Defined, then Radiology HL7 messages for the Division will not be created.

If no applications are entered and routing logic is not set up (this is the normal setup), then the system assumes that all HL7 applications should receive HL7 messages created in this Division.

> **Note:** If in doubt, do not set this field.

5.1.1.6   Imaging Locations Associated with this Division

IMAGING LOCATION

This field should contain all imaging locations associated with this division. To determine the locations available for your selection before editing this field, you can obtain a list using the Print File Entries option on the Supervisor menu.

Only those locations in the Hospital Location file #44 whose Type field is set to Clinic and whose Pattern Date field is set to Null will appear in this list. Also, print the Inactivate Date so you can avoid locations that have been inactivated.

```
OUTPUT FROM WHAT FILE: RAD/NUC MED PROCEDURES// HOSPITAL LOCATION
                                        (148 entries)
SORT BY: NAME// 2  TYPE
START WITH TYPE: FIRST// CLINIC    USES INTERNAL CODE: C
GO TO TYPE: LAST// CLINIC    USES INTERNAL CODE: C

  WITHIN TYPE, SORT BY: PATTERN      (multiple)

  PATTERN SUB-FIELD: .01  PATTERN DATE
  START WITH PATTERN DATE: FIRST// @
  GO TO PATTERN DATE: LAST// @
    WITHIN PATTERN DATE, SORT BY: <RET>
STORE IN 'SORT' TEMPLATE: <RET>
FIRST PRINT FIELD: NAME
THEN PRINT FIELD: INACTIVATE DATE
THEN PRINT FIELD: <RET>
******************************
Heading (S/C): HOSPITAL LOCATION LIST  Replace <RET>
START AT PAGE: 1// <RET>
DEVICE: (Printer name)
```

If you are in the process of editing this field in the Division Parameter Set-up option, entering one or two question marks will list your location choices.

New locations may also be entered in the Imaging Locations file #79.1 at this step. Entry of new imaging locations should be coordinated with your site manager. An imaging location must be defined in the division parameters through entry at this step in order to process examinations from that location. Once an imaging location is associated with a division, all the division parameters become those of the location, unless stated otherwise.

At the completion of your edits, the program checks each imaging location associated with the division for invalid locations. A valid imaging location has a Type field set to Clinic and has no appointment patterns. An error message will appear for any invalid imaging location. Any problem not fixed will result in failure to credit of procedures in that location. Correct the problem, then run through the Division Parameter Set-up option again to make sure the location returns without error.

Two fields from the Division parameters directly impact the location parameters: Print Flash Card for Each Exam and Print Jacket Lbls W/Each Visit. If the flag for the first parameter is set to Yes, then one flash card will be printed automatically for each examination and you will not be asked to enter an amount to print through the Location Parameters Setup option. If the Print Jacket Lbls W/Each Visit division parameter is set to Yes, jacket labels will be printed for each examination. The number of labels printed will be determined by the entry in the How Many Jacket Lbls Per Visit location parameter.

> **Note:** Whenever changes are made to the Division parameters, any users currently signed on to the system who want to use the new changes must exit and reenter the package or use the Switch Locations option to make the new parameters take effect.

Here is an example of how the division parameters might be set up. Enter one or two question marks at the prompt if you need more information. There are a good number of default answers for your convenience. They are suggestions as to what is a usual answer, but you can change them. Pressing the Return key accepts the default as it is.

```
Prompt/User Response   Discussion
Division Parameter Set-up

Select Division: NEW DIVISION         ILLINOIS         VAMC       234
  Are you adding 'NEW DIVISION' as a new RAD/NUC MED DIVISION (the 2ND)? Y
(YES)

   Type the name or station number of the division you want to set up.
Division-wide Order Entry Parameters:
-----------------------------------
ASK 'IMAGING LOCATION': yes// <RET>
   Answering Yes is recommended so that all requests will be associated with
an imaging location for report sorting and request tracking purposes.

TRACK REQUEST STATUS CHANGES: no// <RET>


CLINICAL HISTORY MESSAGE: Enter clinical history relevant to the procedure.


Exam Entry/Edit Parameters:
--------------------------
DETAILED PROCEDURE REQUIRED: no// <RET>



ASK 'CAMERA/EQUIP/RM': no// yes


AUTO USER CODE FILING: yes// <RET>


TRACK EXAM STATUS CHANGES: no// Y  yes
```

```
ASK EXAM STATUS TIME: no// Y  yes
   Because we answered Yes to the previous prompt, this question comes up
next.
This prompt would not appear if we had responded No to tracking exam
changes.


TIME LIMIT FOR FUTURE EXAMS: 12
   We will allow cases to be registered 12 hours in advance of the current
date/time.

Films Reporting Parameters:
---------------------------
ALLOW STANDARD REPORTS: no// Y yes




ALLOW BATCHING OF REPORTS: yes// <RET>


ALLOW COPYING OF REPORTS: yes// <RET>


IMPRESSION REQUIRED ON REPORTS: yes// <RET>
   The impression is saved even though report texts and clinical histories
may be purged.  Type Yes at this prompt to prevent users from verifying and
completing reports before an impression is entered.


ALLOW VERIFYING BY RESIDENTS: no// <RET>


ALLOW RPTS ON CANCELLED CASES?: no// <RET>
   If you answer No to this prompt, only users with the RA MGR key may enter
reports on cancelled cases.

WARNING ON RPTS NOT YET VERIF?: yes// <RET>   If this field is set to Yes,
the status of the results report will be printed on the output.

AUTO E-MAIL TO REQ PHYS? yes// <RET>    If this field is set to Yes, the
report will be automatically sent to the Requesting Physician via e-mail at
the time it is verified.

Miscellaneous Division Parameters:
--------------------------------------------------
PRINT FLASH CARD FOR EACH EXAM: no// <RET>

PRINT JACKET LBLS W/EACH VISIT: no// <RET>

CONTRAST REACTION MESSAGE: ***WARNING*** THIS PATIENT HAS HAD CONTRAST
MEDIA REACTIONS




RPHARM DOSE WARNING MESSAGE: THIS DOSE DEVIATES FROM THE PRESCRIBED RANGE
AS OUTLINED IN THE DEPARTMENTAL PROCEDURES MANUAL, AND REQUIRES A SIGNED,
DATED, AND WRITTEN DIRECTIVE BY AN AUTHORIZED PHYSICIAN.
   This message cannot exceed 70 characters.
```

```
This is a word-processing field and may be as long as you like.
Imaging Locations Associated with this Division:
--------------------------------------------------
Select IMAGING LOCATION: ?
 Answer with IMAGING LOCATIONS
   You may enter a new IMAGING LOCATIONS, if you wish
   Enter a location for this Division.
 Answer with IMAGING LOCATIONS, or TYPE OF IMAGING




   To obtain a list of locations available to you, enter a question mark (?)
at this prompt.  The entries in the Imaging Location file display with
their Imaging Types in parentheses to the right.  Entering two question
marks (??) will display a list of all possible selections.  If you do not
see the location that you want, it is either not in the Hospital Location
file or the Type field of the Hospital Location file does not contain
Clinic.
Choose from:
    X-RAY         (GENERAL RADIOLOGY-499)
    NUC MED LOC      (NUCLEAR MEDICINE-639)
    ULTRASOUND       (ULTRASOUND-499)
    MAGNETIC RESONANCE IMAGING        (MAGNETIC RESONANCE IMAGING-499)
    NUC        (NUCLEAR MEDICINE-499)
    FLUORO       (GENERAL RADIOLOGY-499)
    RAD        (GENERAL RADIOLOGY-639)
    CAT SCAN        (CT SCAN-499)
    US          (ULTRASOUND-578)

   You may enter a new IMAGING LOCATIONS, if you wish
     Select the appropriate location.
     The entry selected must be set up as an
     'Imaging' type in the Hospital Location file.

Select IMAGING LOCATION: X-RAY   (GENERAL RADIOLOGY-499)
         ...OK? yes//  <RET> (YES)
         GENERAL RADIOLOGY

Location is already assigned to the HINES IRMFO Division! ??
   Remember a location can only belong to one division.  This message is
telling us that X-RAY already belongs to Hines IRMFO.

Select IMAGING LOCATION: US          (ULTRASOUND-578)
       ...OK? yes// <RET> (YES)
       ULTRASOUND
 Are you adding 'US' as a new IMAGING LOCATIONS (the 1ST for this RAD/NUC
MED DIVISION)? Y  (YES)

Select IMAGING LOCATION:  RAD       (GENERAL RADIOLOGY-639)
       ...OK? yes//  <RET> (YES)
       GENERAL RADIOLOGY
 Are you adding 'RAD' as a new IMAGING LOCATIONS (the 2ND for this RAD/NUC
MED DIVISION)? Y  (YES)

Select IMAGING LOCATION: <RET>

Division Parameters have been set!

Imaging Location X-RAY is OK.

Imaging Location ULTRASOUND is OK.
```

```
Imaging Location CAT SCAN is OK.
```

5.1.2   Print Division Parameter List

[RA SYSDIVLIST]

Once all of the parameters are set for each of your divisions, use this option to print a
dated hardcopy of the settings for reference. Any time you make a change to the
parameters, it is useful to keep a copy for historical reference. Here we show the
settings for New Division and Hines CIO Field Office, two new divisions.

```
Prompt/User Response   Discussion
Print Division Parameter List

DEVICE: (Printer Name)  RIGHT MARGIN: 80// <RET>

Rad/Nuc Med Division List                    AUG 17,1994  14:44   PAGE 1
----------------------------------------------------------------------------
--

Division: NEW DIVISION
--------
  Track Request Status Changes    : NO
  Track Exam Status Changes       : yes
  Ask for Exam Status Time        : yes
  Print Flash Card For Each Exam  : no
  Ask for 'Imaging Location'      : NO
  Auto User Code Filing           : yes
  Require Detail Procedure...
        ...upon   Initial Exam Entry: no
  Print Jacket Labels w/each Visit: no
  Ask for 'Camera/Equipment/Room' : yes
  Allow Rpts on Cancelled Exams?  : no
  Auto e-mail to Req. Physicians? : yes
  Time Limit For Future Exams...
                     ...in Hours: 0
  Allow Standard Rpts          : yes
  Allow Batching               : yes
  Allow Copying                : yes

Rad/Nuc Med Division List                    AUG 17,1994  14:44   PAGE 2
----------------------------------------------------------------------------
--

  Impression Required          : yes
  Allow Verifying              : no

  Contrast Message:
  ----------------
    ***WARNING*** THIS PATIENT HAS HAD CONTRAST MEDIA REACTIONS

  Clinical History Message:
  ------------------------
    ***Enter clinical history relevant to procedure***

  Resource Device:
```

```
    ----------------
    RAD RESOURCE DEVICE

  Radiopharmaceutical Dose Warning Message:
  -----------------------------------------
    THIS DOSE DEVIATES FROM THE PRESCRIBED RANGE AS OUTLINED IN THE
    DEPARTMENTAL PROCEDURES MANUAL, AND REQUIRES A SIGNED, DATED, AND
WRITTEN
    DIRECTIVE BY AN AUTHORIZED PHYSICIAN.

  Imaging Locations:
  ------------------
    US
    RAD
    NUC

Rad/Nuc Med Division List                        AUG 17,1994  14:44    PAGE 3
------------------------------------------------------------------------------
--

Division: HINES CIO FIELD OFFICE
--------
  Track Request Status Changes    : YES
  Track Exam Status Changes       : yes
  Ask for Exam Status Time        : yes
  Print Flash Card For Each Exam  : no
  Ask for 'Imaging Location'      : YES
  Auto User Code Filing           : yes
  Require Detail Procedure...
       ...upon   Initial Exam Entry: no
  Print Jacket Labels w/each Visit: no
  Ask for 'Camera/Equipment/Room' : yes
  Allow Rpts on Cancelled Exams?  : no
  Auto e-mail to Req. Physicians? : yes
  Time Limit For Future Exams...
                      ...in Hours: 96
  Allow Standard Rpts             : yes
  Allow Batching                  : yes
  Allow Copying                   : yes

Rad/Nuc Med Division List                        AUG 17,1994  14:44    PAGE 4
------------------------------------------------------------------------------
--

  Impression Required             : yes
  Allow Verifying                 : yes

  Contrast Message:
  -----------------
    ***WARNING*** THIS PATIENT HAS HAD CONTRAST MEDIA REACTIONS

  Clinical History Message:
  -------------------------
    **CLINICAL HISTORY IS MANDATORY**

  Resource Device:
  ----------------

  Radiopharmaceutical Dose Warning Message:
  -----------------------------------------
```

```
Imaging Locations:
------------------
  X-RAY
  ULTRASOUND
  MAGNETIC RESONANCE IMAGING
  FLUORO
  CAT SCAN
```

5.1.3   Camera/Equipment/Room Entry/Edit

[RA SYSEXROOM]

This option is used to enter cameras, equipment, and/or rooms that are used by the
department. It will provide the list of choices for a user when entering a patient's
procedure if the Ask Camera/Equip/Room field (Division Parameters Setup option)
contains a Yes response. If you have already decided that tracking this information is
not important to your service, then skip this option.

While defining the parameters in each imaging location (Location Parameter Setup),
you will be asked to enter any cameras, equipment, and/or rooms associated with the
location. Each can be associated with one or more locations, since some sites use the
same room across locations, imaging types, and divisions. Cameras, equipment,
and/or rooms cannot be deleted through this option. You can, however, inactivate
them by removing them from the imaging location through the Location Parameter
Setup option.

Camera/Equip/Room

Enter new cameras, equipment, or rooms at this prompt. This field is directly
associated with one or more imaging locations.

Camera/Equip/Rm Description

Enter a description (3 - 40 characters in length) to describe the type of camera,
equipment, room, or procedures performed.

Enter one or two question marks (?) to obtain a list of selections already in the file

```
Camera/Equip/Rm Entry/Edit
Select Camera/Equip/Room: ??

Choose from:
   CAMERA 1       Triple Head Spect Scanner
   CAT SCAN       PICKER PQ200 SCANNER
   INP1 X-RAY      GASTRO X-RAYS
   INP2 X-RAY      BROKEN LEG X-RAYS
   MAMMOGRAPHIC      Used in mammography exams.
   MRI ROOM       MAGNETIC RESONANCE IMAGING ROOM
   NUC1      HEART IMAGING
   NUC2      BRAIN IMAGING
   OUTP1 X-RAY      X-RAYS ONLY IN THIS ROOM
```

```
    OUTP2 X-RAY      ACCIDENT X-RAYS
  PORTABLE        PORTABLE

    This field contains the name of this
    camera/equipment/room.  Names must be between
    1 and 30 characters in length.
Select Camera/Equip/Room: PORTABLE II
  Are you adding 'PORTABLE II' as a new CAMERA/EQUIP/RM (the 12TH)? Y
(YES)
```

This field can be used to describe this camera/equipment/room and define what types
of procedures may be performed there. "Triple Head Spect Scanner" is an example of
a description.

```
CAMERA/EQUIP/RM: PORTABLE II// <RET>
```

```
DESCRIPTION: Portable used in Surgery// <RET>
```

```
Select Camera/Equip/Rm: <RET>
```

5.1.4   List of Cameras/Equip/Rms

[RA SYSEXLIST]

Once you complete your entries for the Camera/Equip/Rm file #78.6, use this option
to print a dated hard copy of the file contents.

```
List of Cameras/Equip/Rms

DEVICE: (Printer Name)    RIGHT MARGIN: 80// <RET>
```

```
Imaging Camera/Equipment/Room List              AUG 18,1994  08:08    PAGE 1
CAMERA/EQUIP/RM    RAD/NUC MED DIVISION     LOCATION
-----------------------------------------------------------------------------
--

CAMERA 1          HINES INFORMATION SY    X-RAY
CAT SCAN          HINES INFORMATION SY    CAT SCAN
INP1 X-RAY        HINES INFORMATION SY    X-RAY
INP1 X-RAY        HINES INFORMATION SY    FLUORO
INP2 X-RAY        HINES INFORMATION SY    X-RAY
MRI ROOM          HINES INFORMATION SY    MAGNETIC RESONANCE I
NUC1              NEW DIVISION            NUC MED LOC
NUC2              NEW DIVISION            NUC MED LOC
NUC2              HINES INFORMATION SY    NUC
OUTP1 X-RAY       HINES INFORMATION SY    X-RAY
OUTP1 X-RAY       HINES INFORMATION SY    FLUORO
```

```
OUTP2 X-RAY          HINES INFORMATION SY     X-RAY
PORTABLE             NEW DIVISION             NUC MED LOC
PORTABLE             HINES INFORMATION SY     X-RAY
PORTABLE             HINES INFORMATION SY     ULTRASOUND
   PORTABLE II          **UNASSIGNED**            **UNASSIGNED**
```

> **Note:** "PORTABLE II", created on the previous page, appears on
> this list as "**UNASSIGNED**". This is because
> "PORTABLE II" has not been assigned an imaging
> location. All camera, equipment, and rooms that have been
> entered in the Camera/Equip/Rm file but not assigned to
> any imaging location will appear at the end of this list.
>
> **Note:** A camera, equipment, or room can belong to more than one
> division/location as demonstrated in the chart.

5.1.5   Location Parameter Setup

[RA SYSLOC]

The Radiology/Nuclear Medicine program is designed to handle multiple locations
within a Division. Each location must have its own set of parameters. The Location
Parameter Setup option is used to define imaging location parameters for new
locations and edit location parameters for existing locations. At least one location
must be entered for each division. The following is a listing of location parameters
and brief explanations.

Location

An existing location may be edited or a new location may be entered at this prompt.
Before entering a new location, use the Print File Entries option on the Supervisor
menu to see what locations are already in the file. Print the imaging type entries in
the Hospital Location file #44, sort by type (from CLINIC to CLINIC), and print
name and inactivate date. Any location with a CLINIC type is available for you to
select at this prompt. For a location that you need but that is not listed, you will need
to create it using this Location Parameter Setup option. When a new location is
selected, for the purpose of workload crediting, it will automatically be flagged as an
"occasion of service" clinic in File 44. If there are appointment patterns, a duplicate
clinic of the same name will automatically be added in File 44 and marked "occasion
of service."

When you add a new location that is not in the Hospital Location file, you must also
enter a Hospital Location Type. The "Hospital Location Type:" prompt should
always be answered with CLINIC.

5.1.5.1   Flash Card, Jacket Label, and Exam Label Parameters

> **Note:** Labels can be printed from the Duplicate Flash Card option even if the site parameters are not set up to print labels.
>
> **Note:** Printers for flash cards, jacket labels, requests, and reports for each imaging location are set up with the Device Specifications for Imaging Locations option on the IRM menu. If no printers have been assigned, you will get a message "No default flash card printer has been assigned. Contact IRM."

If, you answered Yes to the "Print Flash Card For Each Exam:" prompt and/or the "Print Jacket Lbls W/Each Visit:" prompt under the Division Parameters, you will not see the "How Many..." prompt.

How Many (Flash Cards, Jacket Labels) Per Visit

This field requires a whole number between 0 and 10 to establish a parameter for printing the number of cards and/or labels needed for each patient visit at this location.

This question will not appear if you entered Yes at the "Print Flash Card For Each Exam:" prompt in the division parameters, and this location is associated with the division. Bypassing each of these prompts or entering 0 will suppress the printing of the item.

How Many Exam Labels per Exam

Exam labels are printed for each registered case. This field should be filled with a whole number between 0 and 9.

Default (Flash Card, Jacket Label, Exam Label) Format

A default format can be entered for each card or label type. Each time cards or labels are printed for an exam registered to this location, they will be printed using the specified format. Formats for each card or label type may be designed using the option Label/Header/Footer Formatter.

5.1.5.2   Order Entry Parameters

This parameter identifies the printer used to print request forms (form 519) as procedures are ordered. It is set up through the "Request Printer Name:" prompt in the Device Specifications for Imaging Locations option on the IRM Menu. If a printer has not been assigned to this prompt, a message will tell you to contact IRM.

5.1.5.3   Report Parameters

Default Report Header Format

A report header format can be selected that will be printed at the top of all patient result reports printed from this location. Header formats can be designed using the option Label/Header/Footer Formatter.

Default Report Footer Format

This is a report footer format that will be printed at the bottom of all patient result reports printed from this location. Footer formats can be designed using the option Label/Header/Footer Formatter.

Report Left Margin

This is a column number that indicates the left margin of patient result reports. This only affects the left margin for the impression, report text, and clinical history.

Report Right Margin

The number entered in this field is used as the report right margin. This affects the right margin for the impression, report text, and clinical history.

Print DX Codes In Report?

If this field is set to YES, all primary and secondary diagnostic codes associated with the exam will be printed on the exam report. Since the primary diagnostic code may be printed in exam report headers and footers, you may also need to change report header and footer setups to get the diagnostic codes printed exactly as you wish. If this field is set to No, you can include the primary diagnostic code in headers or footers by using the Label/Header/Footer Formatter.

> **Note:** The device for this parameter is set up through the Device Specifications for Imaging Locations option on the IRM menu. If a printer has not been assigned to this prompt, a message will tell you to contact IRM.

Voice Dictation Auto-Print

If this field is set to Yes, and voice dictation is used to enter a report, a copy of the report will be automatically printed on the device defined in the Report Print Name field.

5.1.5.4   Cameras, Equipment, and Rooms Used by this Location

Camera/Equip/Rm

This multiple field will contain all cameras, equipment, or rooms associated with this Imaging Location. Cameras, equipment, and rooms already entered through the Camera/Equip/Rm Entry/Edit option may be used or new ones can be entered at this prompt.

5.1.5.5   Default CPT Modifiers used by this Location

Default CPT modifier(s) entered for this location will be automatically entered into each exam record during exam registration when the following three conditions are met:

- There is no default CPT Modifier for this exam's procedure.
- This location is the current sign-on (or switched-to) location.
- The CPT Modifier is active on the date that the exam was registered.

Values entered for this field is screened only for the CPT Modifier's active status, using the date when this option is used. They can't be screened by compatibility with CPT Codes, because there is no CPT Code associated with a location. The default values entered here may be rejected later during exam registration, when the default CPT Modifier(s) are screened via the exam procedure's CPT CODE and the date when the registration was done. If a default value is rejected, the following message will appear:

** Unable to enter default CPT Modifier __ (Modifier name) **

5.1.5.6   Recipients of the 'Stat' Alert for this Location

Stat Request Alert Recipients (+)

To receive a stat request alert, recipients must have a Radiology/Nuclear Medicine personnel classification. They will receive an alert whenever a STAT request is submitted to this imaging location. To use this feature, the "Ask Imaging Location" division parameter must be set to YES, and OE/RR Version 3.0 or higher must be installed.

Allow 'Released/Not Verified'

This Imaging Location parameter can be set to Yes to allow reports to have the "RELEASED/NOT VERIFIED" status, permitting the displaying and printing of the report to users outside of the imaging service even if it is not yet verified. This field was moved from the division parameters.

Inactive

This field should only be used if an imaging location is no longer used. If a date is entered in this field, the imaging location will not be available for selection at exam registration or request submission (i.e. the "Submit Request To" prompt will not allow ordering clinicians to choose this location for request printing.) However, users can still select an inactive location to process exams previously registered to it.

5.1.5.7   Imaging Type for this Location

Type of Imaging

This field contains the type of imaging done at this location. Assign one of the following imaging types to your location:

- Angio/Neuro/Interventional

- CT Scan

- General Radiology

- Magnetic Resonance Imaging

- Cardiology Studies (Nuc Med)

- Nuclear Medicine

- Ultrasound

- Vascular Lab

- Mammography

This Location parameter should contain the name of the type of imaging from the Imaging Type file (#79.2). If this field is filled in, the system automatically adds the proper imaging type on the registration record. Only procedures assigned the same imaging type can be registered to the location.

Assigning a new imaging type (i.e. one not previously selected for any other location) implies that procedures of the new Imaging Type are performed under a separate service or section at your site, and separate workload report is desired. For instance, at some sites ultrasound may be done separately from radiology, and it would be appropriate to assign the Ultrasound imaging type to one or more locations. Once the Ultrasound imaging type is activated in this way, and procedures designated as Ultrasound imaging type have been registered, the system will report ultrasound workload separately from Radiology workload.

> **Note:** The Cardiology Studies imaging type should NOT be assigned to a location unless nuclear cardiology studies are done under a service other than Nuclear Medicine.

> **Note:** The software was designed to handle nuclear cardiology alone, and therefore other types of cardiology examinations such as echocardiography should not be entered into the system. Further, local modifications to add imaging types are strongly discouraged due to the complexity of the underlying code and associated workload implications.

Be cautious about assigning an imaging type to a location that has not previously used it. This activates the new imaging type. Imaging workload reports, enter/edit options, and screen displays are all separated by their imaging types. Be sure this is how your service wants to handle the package. Once this package is loaded, users sign on to a specific location, which is associated with an imaging type. Procedures are also associated with an imaging type. The best option is to look at workload for each imaging type and each location. Are each now treated almost separately from all others?

Credit Method

This field indicates the type of credit this location receives for examinations. The default is REGULAR (code 0), which means that for this imaging location both the exam and the interpretation are done at your facility. If this imaging location has been set up to register exams done in another facility, with the imaging interpretation only done at this facility, enter code 1 (Interpretation Only). If exams are done in this location but interpretation is done elsewhere, enter code 3 (Technical Component Only). If both the exam and the interpretation are done elsewhere and exams entered for this imaging location are entered only for record-keeping purposes, enter code 2 (No Credit).

DSS ID

This field is used to identify the general outpatient area where an imaging exam was done. It is used only by DSS, and only when processing outpatients. It is roughly equivalent to the stop codes previously used for crediting outpatient exams. Only entries also in the Imaging Stop Codes file #71.5 are valid.

> Note: There are three things you must remember to do now:

- For every location you set up, be sure each is assigned to a Rad/Nuc Med Division in file #79 using the Division Parameter Setup option.

- Printers may not be set up for every location. If you see the following message when editing this option, you will need to provide IRM with the name of the location and determine with IRM which printer(s) should be used to print labels when exams are registered in this location and which printer should print requests submitted to this location. Also, a default results report printer may be assigned.

```
No default flash card printer has been assigned. Contact IRM.
```

- Whenever changes are made to the location parameters, any users currently signed on to the system who want to use the new location must use the Switch Locations option or exit and reenter the package to make the new parameters take effect.

Here is an example of editing a new location:

Enter two question marks (??) to obtain a list of imaging locations already set up. The imaging type of each location appears to the right of the location name.

```
Location Parameter Setup

Select Location: ??


Choose from:
   X-RAY         (GENERAL RADIOLOGY-449)
   NUC MED LOC      (NUCLEAR MEDICINE-639)
   ULTRASOUND      (ULTRASOUND-449)
   MAGNETIC RESONANCE IMAGING      (MAGNETIC RESONANCE IMAGING-449)
   NUC       (NUCLEAR MEDICINE-449)
   FLUORO       (GENERAL RADIOLOGY-449)
   WESTSIDE XRAY      (GENERAL RADIOLOGY-639)
   CAT SCAN       (CT SCAN-449)
   US       (ULTRASOUND-578)
   RAD       (GENERAL RADIOLOGY-578)

This field points to the Hospital Location File, and contains the name of
this location.
```

You also get a list of all available locations that are in the Hospital Location file#44 with a Clinic Type field.

```
Choose from:
   CAT SCAN
   FLUORO
   MAGNET
   MAGNETIC RESONANCE IMAGING
   MAMMOGRAPHY
   NUC MED LOC
   NUCLEAR MEDICINE
   ULTRASOUND
   US
   WESTSIDE XRAY
   X-RAY

Name given by user to any ward, clinic, fileroom, operating room or other
location within a VA facility.
```

```
Select Location: MAMMOGRAPHY
  Are you adding 'MAMMOGRAPHY' as a new IMAGING LOCATIONS (the 10TH)? Y
(Yes)
```

```
    IMAGING LOCATIONS TYPE OF IMAGING: ?
      Enter an Imaging Type for this location.
 Answer with IMAGING TYPE TYPE OF IMAGING, or ABBREVIATION
Choose from:
    ANGIO/NEURO/INTERVENTIONAL
    CARDIOLOGY STUDIES (NUC MED)
    CT SCAN
    GENERAL RADIOLOGY
    MAGNETIC RESONANCE IMAGING
    NUCLEAR MEDICINE
    ULTRASOUND
    VASCULAR LAB
    MAMMOGRAPHY

    IMAGING LOCATIONS TYPE OF IMAGING: GENERAL RADIOLOGY

*    Since you have added a new Imaging Location, remember to assign    *
*    it to a Rad/Nuc Med Division through Division Parameter Set-up.    *


LOCATION: MAMMOGRAPHY// <RET>


Flash Card Parameters:
----------------------
HOW MANY FLASH CARDS PER VISIT: 1
```

Whenever you have a question about what to enter, use one or two question marks (?)
to see you information about the prompt. Here we are given a list of available
formats. If there are no format option selections, you can build some using the option
Label/Header/Footer Formatter.

```
DEFAULT FLASH CARD FORMAT: ??
      This 'locations' parameter can contain the
      default format (from the 'Flash
      Cards Formats' file) to be used when queuing a
      flash card to print.  This format is the
      default 'flash card' for the current location.

Choose from:
    EXAM LABEL1
    FLASH1 FORMAT
    FOOTER1
    HEADER1
    JACKET1 FORMAT
    TEST FORMAT

DEFAULT FLASH CARD FORMAT: FLASH1 FORMAT
```

This is the notice telling you that no printer has been assigned by IRM to this location
for use as a flash card printer

```
No default flash card printer has been assigned. Contact IRM.
```

```
Jacket Label Parameters:
------------------------
HOW MANY JACKET LBLS PER VISIT: 1

DEFAULT JACKET LABEL FORMAT: JACKET1 FORMAT

No default jacket label printer has been assigned. Contact IRM.

Exam Label Parameters:
----------------------
HOW MANY EXAM LABELS PER EXAM: 1// <RET>

DEFAULT EXAM LABEL FORMAT: EXAM LABEL1

Exam label printer is always the same as the flash card printer.

Order Entry Parameters:
----------------------

No default request printer has been assigned. Contact IRM.
```

5.1.6   Location Parameter List

[RA SYSLOCLIST]

After setting up all your locations, you should print out a hard copy of the data. Make sure printers have been designated for each location where appropriate and each location has been given a division. Any location not assigned to a division will not appear on this report. Note the sort order of this listing: imaging type, division, imaging location.

In this example, we are eliminating locations that belong to Nuclear Medicine. We accepted the default (All) because it was easier to eliminate the 2 Nuclear Medicine locations than it was to enter the 5 Radiology locations.

The following sample is just one page from a printout.

```
Location Parameter List
Do you wish to include inactive Imaging Locations? No// <RET>   NO

Select Imaging Location: All// <RET>

Another one (Select/De-Select): -nuc
     1    NUC
     2    NUC MED LOC
Choose 1-2: 2                    (NUCLEAR MEDICINE-449)

Another one (Select/De-Select): -nuc              (NUCLEAR MEDICINE)

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


DEVICE:  (Enter printer)   RIGHT MARGIN: 80// <RET>
```

```
Imaging Location List                          OCT 10,1996  09:14    PAGE 7
--------------------------------------------------------------------------
--
                   Location: X-RAY
                   Division: HINES INFORMATION SYSTEMS CTR
                   Inactivation Date:
               Imaging Type: GENERAL RADIOLOGY
              Credit Method: Regular Credit
                     DSS ID: X-RAY
                   Allow 'Released/Unverified': no


     Flash Card Parameters:                   Jacket Label Parameters:
     ---------------------                    ------------------------
     Default Printer: P-DOT MATRIX BACK       Default Printer : P-DOT
MATRI
     Cards Per Visit:   4                     Labels Per Visit: 0
     Default Format : TESTALL                 Default Format  : JACKET1
FOR


     Exam Label Parameters:                   Order Parameters:
     ---------------------                    -----------------
     Default Printer: [Flash Card Printer]    Default Printer:  LINE
     Labels Per Exam:  0                      Cancelation Ptr:  P-DOT
MATRI
     Default Format : EXAM LABEL1


                                              Radiopharmaceutical
     Reporting Parameters:                    Dosage Ticket Parameters
     --------------------                     ------------------------
     Default Printer: P-DOT MATRIX BACK       Default Printer:
     Default Header: HEADER1
     Default Footer: FOOTER1
     DX Codes in Rpt: yes
     Voice Dictation auto-print: yes


     Allowable Cam/Equip/Rms For This Location:
     -----------------------------------------
          OUTP1 X-RAY
          OUTP2 X-RAY
          INP1 X-RAY
          INP2 X-RAY
          PORTABLE
          CAMERA 1
          RALPH'S HOUSE


     'Stat' Alert Recipients For This Location:   Urgent Request Alerts?:
yes
     -----------------------------------------
          HOYER,CINDY
          MORTON,SELINA
          CEBEL,GREG
```

All the labels and formats were built using the option Label/Header/Footer Formatter and reside in the LBL/HDR/FTR Formats file #78.2.

(Device settings may override these margins.) For typical usage or 8 1/2 x 11 paper, margins of 10 and 70 are common

```
Report Parameters:
------------------
DEFAULT REPORT HEADER FORMAT: HEADER1
DEFAULT REPORT FOOTER FORMAT: FOOTER1


REPORT LEFT MARGIN: 10// <RET>
REPORT RIGHT MARGIN: 70// <RET>

PRINT DX CODES IN REPORT?: ??
If this field is set to Yes, all primary and secondary diagnostic codes
associated with the exam will be printed on the exam report.  (Note: Since
the primary diagnostic code may be printed in exam report headers and
footers, you may also need to change report header and footer set-ups to
get the diagnostic codes printed exact as you wish.)
     Choose from:
        Y        yes
        N        no
PRINT DX CODES IN REPORT?: Y  yes

No default report printer has been assigned. Contact IRM.
Cameras/Equip/Rooms Used by this Location:
------------------------------------------
Select CAMERA/EQUIP/RM: ??

This field contains a list of cameras/equip/rms (from the 'Camera/Equip/Rm'
file) that can be chosen when entering data for exams done in this
'location'.
Cameras/equip/rms can be used by more than one 'location'.

Choose from:
   CAMERA 1      Triple Head Spect Scanner
   CAT SCAN      PICKER PQ200 SCANNER
   INP1 X-RAY     GASTRO X-RAYS
   INP2 X-RAY      BROKEN LEG X-RAYS
   MAMMOGRAPHIC      Used in mammography exams.
   MRI ROOM      MAGNETIC RESONANCE IMAGING ROOM
   NUC1      HEART IMAGING
   NUC2      BRAIN IMAGING
   OUTP1 X-RAY      X-RAYS ONLY IN THIS ROOM
   OUTP2 X-RAY      ACCIDENT X-RAYS
   PORTABLE       PORTABLE
   PORTABLE II      Portable used in Surgery
   PORTABLE III      PORTABLE IN ECC

This field contains the name of this camera/equipment/room.  Names must be
between 1 and 30 characters in length.

Select CAMERA/EQUIP/RM: MAMMOGRAPHIC          Used in mammography exams.
  Are you adding 'MAMMOGRAPHIC' as a new CAMERAS/EQUIP/RMS (the 1ST for
this IMAGING LOCATIONS)? Y  (YES)

Select CAMERA/EQUIP/RM: <RET>
```

Only persons with Radiology/Nuclear Medicine personnel classification can be
entered at this prompt.

If this field is set to Yes, then all the users in the Stat Request Alert Recipients field
be sent an alert for urgent requests.

```
Recipients of the 'Stat' Alert for this Location:
-------------------------------------------------
Select STAT REQUEST ALERT RECIPIENTS: CLERK,ALICE

Select STAT REQUEST ALERT RECIPIENTS: <RET>


URGENT REQUEST ALERTS?: y  yes
```

Typing Yes in this field permits the displaying of any report from this location to
users outside of the Imaging service even if it is not verified.

```
ALLOW 'RELEASED/UNVERIFIED': no// <RET>
```

If this location is now inactive, enter the date when it became inactive

```
INACTIVE: <RET>
TYPE OF IMAGING: GENERAL RADIOLOGY// <RET>
```

Type:

- 0   Regular Credit
- 1   Interpretation Only
- 2   No Credit
- 3   Technical Component

Only

```
CREDIT METHOD: 0
```

Only entries also in the Imaging Stop Codes file #71.5 are valid as selections.

```
DSS ID: 703
Select Location: <RET>
```

5.1.7   Location Parameter List

[RA SYSLOCLIST]

After setting up all your locations, you should print out a hard copy of the data. Make
sure printers have been designated for each location where appropriate and each
location has been given a division. Any location not assigned to a division will not
appear on this report. Note the sort order of this listing: imaging type, division,
imaging location.

In this example, we are eliminating locations that belong to Nuclear Medicine. We
accepted the default (All) because it was easier to eliminate the 2 Nuclear Medicine
locations than it was to enter the 5 Radiology locations.

```
Location Parameter List
Do you wish to include inactive Imaging Locations? No// <RET>  NO

Select Imaging Location: All// <RET>

Another one (Select/De-Select): -nuc
     1   NUC
     2   NUC MED LOC
Choose 1-2: 2                    (NUCLEAR MEDICINE-449)

Another one (Select/De-Select): -nuc              (NUCLEAR MEDICINE)

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


DEVICE:  (Enter printer)   RIGHT MARGIN: 80// <RET>
```

The following sample is just one page from a printout.

```
Imaging Location List                          OCT 10,1996  09:14    PAGE 7
--------------------------------------------------------------------------
--

                  Location: X-RAY
                  Division: HINES INFORMATION SYSTEMS CTR
                  Inactivation Date:
             Imaging Type: GENERAL RADIOLOGY
            Credit Method: Regular Credit
                    DSS ID: X-RAY
                  Allow 'Released/Unverified': no


    Flash Card Parameters:                    Jacket Label Parameters:
    ---------------------                     -----------------------
    Default Printer: P-DOT MATRIX BACK        Default Printer : P-DOT
MATRI
    Cards Per Visit:   4                      Labels Per Visit: 0
    Default Format : TESTALL                  Default Format  : JACKET1
FOR


    Exam Label Parameters:                    Order Parameters:
    ---------------------                     ----------------
    Default Printer: [Flash Card Printer]     Default Printer:  LINE
    Labels Per Exam:  0                       Cancelation Ptr:  P-DOT
MATRI
    Default Format : EXAM LABEL1
```

```
                                              Radiopharmaceutical
     Reporting Parameters:                    Dosage Ticket Parameters
     --------------------                     ------------------------
     Default Printer: P-DOT MATRIX BACK       Default Printer:
     Default Header: HEADER1
     Default Footer: FOOTER1
     DX Codes in Rpt: yes
     Voice Dictation auto-print: yes


     Allowable Cam/Equip/Rms For This Location:
     ------------------------------------------
          OUTP1 X-RAY
          OUTP2 X-RAY
          INP1 X-RAY
          INP2 X-RAY
          PORTABLE
          CAMERA 1
          RALPH'S HOUSE


     'Stat' Alert Recipients For This Location:   Urgent Request Alerts?:
yes
     ------------------------------------------
          HOYER,CINDY
          MORTON,SELINA
          CEBEL,GREG
```

6.0   Rad/Nuc Med Personnel Menu

6.1   Overview

This menu is used to assign and track classifications of personnel who work in Diagnostic Radiology and Nuclear Medicine Services. There is only one edit option in this menu, Classification Enter/Edit. The other four options provide dated, hard copies of the data.

6.1.1   Classification Enter/Edit

[RA PNLCLASS]

This function allows you to enter or edit personnel and their corresponding classifications. An employee will usually have only one user classification assigned to him or her at a given time; however, more than one classification per employee is allowed, as long as the Interpreting Resident classification and the Interpreting Staff classification are not assigned to the same employee.

The Imaging Location Access prompt was changed to Rad/Nuc Med Location Access.

There are currently four classifications the personnel can be placed under.

- Technologist

- Interpreting Resident

- Interpreting Staff

- Clerk

All users requiring an electronic signature code (generally physician staff) should be assigned the XUSESIG option of KERNEL by the site manager.

All users of this package must be assigned Radiology/Nuclear Medicine location access. If they do not have at least one Radiology/Nuclear Medicine location, they will not be able to access the system.

Whenever a user is on the system and their Radiology/Nuclear Medicine location access is edited via this option, that user must exit the package and reenter or use the Switch Locations option to have the new Radiology/Nuclear Medicine location access take effect.

The prompts for technologist and clerk are identical, so only one example is shown here:

```
Classification Enter/Edit

Select Personnel: ??

Choose from:
   ABCDE,BOB
   ALLEN,STEVEN
   ...
   '^' TO STOP:  ^
```

Multiple classifications for one person are not usually necessary. Certain exam field
edits are screened by classification. For example, only people who have a
technologist classification are valid choices at the technologist prompt during case
edits. Occasionally, residents are also classified as technologists because they act as
technologists. Radiology supervisors sometimes give themselves multiple
classifications for testing purposes.

```
Select Personnel: RUDY,RUDDY E.

Select RAD/NUC MED CLASSIFICATION: ??

Defines the role of this individual in the Radiology/Nuclear Medicine
world.

Choose from:
        T  technologist
        R      resident
        S         staff
        C         clerk

Select RAD/NUC MED CLASSIFICATION: T  (technologist)
  Are you adding 'technologist' as a new RAD/NUC MED
  CLASSIFICATION (the 1ST for this NEW PERSON)? Y
  (YES)

Select RAD/NUC MED CLASSIFICATION: <RET>
```

```
Select RAD/NUC MED CLASSIFICATION: T  (technologist)
  Are you adding 'technologist' as a new RAD/NUC MED
  CLASSIFICATION (the 1ST for this NEW PERSON)? Y
  (YES)

Select RAD/NUC MED CLASSIFICATION: <RET>
```

```
Choose from:
X-RAY        (GENERAL RADIOLOGY-449)
   NUC MED LOC     (NUCLEAR MEDICINE-639)
   ULTRASOUND      (ULTRASOUND-449)
   MAGNETIC RESONANCE IMAGING       (MAGNETIC RESONANCE IMAGING-449)
```

```
   NUC       (NUCLEAR MEDICINE-449)
   FLUORO      (GENERAL RADIOLOGY-449)
   WESTSIDE XRAY      (GENERAL RADIOLOGY-639)
   CAT SCAN       (CT SCAN-449)
   US       (ULTRASOUND-578)
   RAD       (GENERAL RADIOLOGY-578)
```

Since this employee can access Mammography and Mammography is within the
General Radiology imaging type, this employee will have access to the exam data
belonging to the Mammography location and, in options where access is determined
by imaging type, this employee will also be able to view data for all of General
Radiology.

```
Select IMAGING LOCATION ACCESS: MAMMOGRAPHY                GENERAL
RADIOLOGY
  Are you adding 'MAMMOGRAPHY' as a new IMAGING
  LOCATION ACCESS (the 1ST for this NEW PERSON)? Y
  (YES)

Select IMAGING LOCATION ACCESS: <RET>

RAD/NUC MED INACTIVE DATE: <RET>
```

```
Select Personnel: ARMOR,JOHN
```

The same prompts appear for both resident and staff. Here is an example of data
entry for resident.

```
Select RAD/NUC MED CLASSIFICATION: R  (resident)
  Are you adding 'resident' as a new RAD/NUC MED
  CLASSIFICATION (the 1ST for this NEW PERSON)? Y
  (YES)

Select RAD/NUC MED CLASSIFICATION: <RET>
Select IMAGING LOCATION ACCESS: MAMMOGRAPHY                GENERAL
RADIOLOGY
  Are you adding 'MAMMOGRAPHY' as a new IMAGING
  LOCATION ACCESS (the 1ST for this NEW PERSON)? Y
  (YES)

Select IMAGING LOCATION ACCESS: <RET>

RAD/NUC MED INACTIVE DATE: <RET>

STAFF REVIEW REQUIRED: ??
     This field applies to 'Interpreting Resident'
     personnel. If it contains a 'yes',
     an interpreting staff is required to
     review this resident's report results.
     Choose from:
       Y        yes
       N        no
STAFF REVIEW REQUIRED: Y  yes

ALLOW VERIFYING OF OTHERS: ??
```

```
If this field is set to 'YES' and the 'ALLOW VERIFYING BY RESIDENTS'
Division parameter is also set to 'YES' then this resident is allowed to
verify reports associated with another interpreting physician.  (If both
parameters are set to 'YES' the 'On-line Verifying of Reports' option will
prompt the user to 'Select Interpreting Physician:' allowing the user to
select an interpreting physician other than him/herself.) If this field is
set to 'NO' then this resident is only allowed to verify his/her own
reports.  If the Division parameter 'ALLOW VERIFYING BY RESIDENT' is set to
'NO' then regardless of how this field is set, the resident will not be
allowed to verify other interpreting physicians' reports.

If the user is classified as Interpreting Staff, s/he will always be
allowed to select another interpreting physician's name and reports if this
field is set to 'YES'.
     Choose from:
       y         YES
       n         NO
ALLOW VERIFYING OF OTHERS: NO

Select Personnel: <RET>
```

6.1.2   Clerical List

[RA PNLCLERK]

6.1.3   Interpreting Resident List

[RA PNLRES]

6.1.4   Interpreting Staff List

[RA PNLSTAFF]

6.1.5   Technologist List

[RA PNLTECH]

Each personnel type is printed in the same manner. Here is an example of the
interpreting resident list. Keep in mind that ownership of the RA ALLOC key means
the user has access to every imaging location, even though none may be assigned to
him or her.

```
Select Rad/Nuc Med Personnel Menu Option: INT
    1     Interpreting Resident List
    2     Interpreting Staff List
Choose 1-2: 1  Interpreting Resident List

DEVICE:    (Printer Name)     RIGHT MARGIN: 80// <RET>


INTERPRETING RESIDENT LIST                        AUG 18,1994  15:18    PAGE 1
                            STAFF
```

```
                  INACTIVE     REV      RAD/NUC MED
NAME              DATE         REQ'D    CLASSIF.      IMAGING LOC ACCESS
-----------------------------------------------------------------------------
--


ARNOT,BOB                                resident      X-RAY
    Rad/Nuc Med Keys:
-----------------------------------------------------------------------------
--

ARMOR,JOHN                      yes      resident      MAMMOGRAPHY
    Rad/Nuc Med Keys:
-----------------------------------------------------------------------------
--

BILL,GARY                       no       technologist
                                         resident      ULTRASOUND
                                  X-RAY
    Rad/Nuc Med Keys:  RA ALLOC
-----------------------------------------------------------------------------
--

CEBEL,GREGORY                   no       resident      X-RAY
    Rad/Nuc Med Keys:
```

7.0   Utility Files Maintenance Menu

7.1   Overview

New data may be added or edited via these options at any time throughout the use of the software. These options are therefore used for file maintenance as well as implementation. If this is not a new implementation of the software, you should take this time to review their contents for any necessary updating of the files. In particular, check those items that appear with the plus sign (+).

This menu has corresponding options in the Maintenance Files Print Menu. As with the edit options on the System Definition menu, you may want to use the Maintenance Files Print menu to print a dated hard copy of the data entered in each file to keep your own record of changes.

7.2   Complication Type Entry/Edit

[RA COMPEDIT]

This function allows the coordinator to enter or edit complication types that may occur during an exam. This option will produce the selection list you see when prompted for a complication type in the Case No. Exam Edit and Edit Exam by Patient options. These two options are used to associate complication types with specific examinations.

When there is a contrast medium reaction, the patient's record in the Adverse Reaction Tracking package will be automatically updated to indicate the patient has had a contrast media reaction. As a result, every time the patient is registered for a procedure that may involve contrast media, the user will be warned and s/he should then take the appropriate action. (The system uses AMIS categories of procedures to determine whether contrast media may be used for a given procedure.)

Two complications are exported with the system: Contrast Reaction and No Complication. Other site-specific entries can be added using this function. You should not delete or change complication type names.

A list of complication types can be obtained through the Complication Type List option.

Before adding a new complication, check to see what your site already has in the file. In this example, there are four complications. Pregnancy is not there, so we add that to the file.

```
Complication Type Entry/Edit
```

```
Select COMPLICATION TYPES: ??

Choose from:
   CONTRAST REACTION
   NAUSEA AND VOMITING
   NO COMPLICATION
   SEVERE MORBIDITY

     This field contains the name of the type of
     complication that may be associated with an
     exam.

     Initially, the system contains two complication
     types:  'Contrast Reaction', and 'No
     Complication'.  Other complication types may be
     entered by the rad/nuc med coordinator at each
     site and can be 3 to 30 characters in length.
```

If the Contrast Medium Reaction field is set to Yes, when a patient's exam complication field is edited to include this complication, the Adverse Reaction Tracking package interface will be triggered so that contrast media can be recorded as an allergy/reaction for this patient.

The Complication Report also uses this field to determine how many patient reactions were due to contrast media.

```
Select COMPLICATION TYPES: PREGNANCY
  Are you adding 'PREGNANCY' as a new COMPLICATION
  TYPES (the 5TH)? Y  (Yes)

COMPLICATION: PREGNANCY// <RET>




CONTRAST MEDIUM REACTION?: ?
     Enter 'Y' for YES if the complication is a contrast medium reaction.
     Choose from:
       Y        YES
       N        NO
CONTRAST MEDIUM REACTION?: N  NO

Select COMPLICATION TYPES: <RET>
```

> **Note:** All contrast media allergies and reactions are stored in the
> Adverse Reaction Tracking (ART) package rather than in
> the Radiology/Nuclear Medicine package. The automatic
> interface to the ART package will add contrast media to the
> patient's allergy records when a Rad/Nuc Med user enters
> this reaction through the Update Patient Record option or
> when entering complications marked as contrast media type
> reactions. However, there are other data items that most
> facilities require to complete the record or to submit an
> FDA report. It is suggested that one person from the
> Imaging department be responsible for following up on
> contrast media reactions. This person should be a member
> of the GMRA VERIFY DRUG ALLERGY and GMRA
> P&T COMMITTEE FDA mail groups so that he or she
> receives bulletins on patient reactions to contrast media.
> This person should be given the necessary ART key(s) and
> menu option(s) to enter additional information in a
> consistent manner and verify the data. Talk to IRM and
> your Clinical Coordinator to set this up.

7.3   Diagnostic Code Enter/Edit

[RA DIAGEDIT]

This function allows the coordinator to enter/edit diagnostic codes used in reports.
This file builds the selection list the user sees when prompted for a diagnostic code.

The following is the list of diagnostic codes that are loaded as part of the initialization
process:

- Normal

- Minor Abnormality

- Major Abnormality, No Attn. Needed

- Abnormality, Attn. Needed

- Major Abnormality, Physician Aware

- Undictated Films Not Returned, 3 Days

- Unsatisfactory/Incomplete Exam

- Possible Malignancy, Follow-up Needed

An Inactive field was added so that a code could be inactivated and no longer appear
as a selection for the user. Entries should not be deleted. The names of entries
should also not be changed once in production, since this could affect their meaning
in historical data.

Entering a diagnostic code for each case serves a number of purposes.

Diagnostic codes can be used to generate alerts to the requesting clinician whenever an examination has an abnormal result. In this option, you may designate which diagnostic codes trigger these alerts. More than one code may be designated to trigger an alert message.

If the site decides to enter a diagnostic code for exams, database searches using VA FileMan can be performed using the Diagnostic Code field of the exam record in the search criteria. For example, the database can be searched for all CHEST PA&LAT procedures which have a diagnostic code of "Normal", or all that are "Unsatisfactory/Incomplete Exam".

Each case can be assigned multiple diagnostic codes. This allows you to not only indicate the urgency of the problem, but the nature of the problem as well, assuming you create the appropriate additional diagnostic codes. Diagnostic codes can also be used to flag teaching cases or other interesting cases if you create the appropriate diagnostic codes (example: Teaching Case).

Diagnostic codes that have a Yes in the Print on Abnormal Report field will result in exams with those codes appearing on an abnormal report that can be used for follow up and tracking.

We want to add a diagnostic code for overexposure. Let's first see what the file contains by typing two question marks (??) at the Diagnostic Codes prompt. Codes 1 - 8 were exported with the software. Code #9 was added by the site.

We want to add a code so we enter the name of the code in 3 - 40 characters.

```
Diagnostic Code Enter/Edit

Select DIAGNOSTIC CODES: ??

Choose from:
   1          NORMAL
   2          MINOR ABNORMALITY
   3          MAJOR ABNORMALITY, NO ATTN. NEEDED
   4          ABNORMALITY, ATTN. NEEDED
   5          MAJOR ABNORMALITY, PHYSICIAN AWARE
   6          UNDICTATED FILMS NOT RETURNED, 3 DAYS
   7          UNSATISFACTORY/INCOMPLETE EXAM
   8          POSSIBLE MALIGNANCY, FOLLOW-UP NEEDED
   9          POSSIBLE MALIGNANCY, FOLLOW-UP CRITICAL

     This field contains a short diagnostic code to
     indicate the results of the interpreting
     physician's analysis of the images.  Diagnostic
     codes can be between 3 and 40 characters in
     length and can be used as a basis for database
     searches.  (i.e.. How many 'Normal' chest exams
     were performed during a specific time period?)
```

```
        Eight diagnostic codes are included with the
        original package.  Other site-specific
        diagnostic codes may be entered by the rad/nuc
        med coordinator at each site.
```

It will be the 10th code.

We have an opportunity to change the code number if we want and edit the name.
Some facilities use special code # ranges for each Imaging Type (e.g., 50-59 for CT,
90-99 for MRI).

```
Select DIAGNOSTIC CODES: OVEREXPOSURE, MECH ERROR
  Are you adding 'OVEREXPOSURE, MECH ERROR' as
    a new DIAGNOSTIC CODES (the 10TH)? Y  (Yes)

   DIAGNOSTIC CODES NUMBER: 10// <RET>

DIAGNOSTIC CODE: OVEREXPOSURE, MECH ERROR
                                    Replace <RET>
```

We can give the code a longer description, 1 - 80 characters.

```
DESCRIPTION: OVEREXPOSURE DUE TO A MECHANICAL ERROR
```

Should exams given this code print on the Abnormal Exam Report? If yes, then enter
a Yes at this prompt

```
PRINT ON ABNORMAL REPORT: Y  YES
```

Do you want this code to generate an alert to the requesting physician? For this
example, an alert is not needed.

For more information about alerts, refer to OE/RR and Kernel documentation.

```
GENERATE ABNORMAL ALERT?: N  NO


INACTIVE: <RET>


Select DIAGNOSTIC CODES: <RET>
```

7.4   Examination Status Entry/Edit

[RA EXAMSTATUS]

The Examination Status file #72 contains various statuses for each Imaging Type. An examination status is a designated point from the time a case is registered in an Imaging Location (Waiting for Exam) through its completion (Complete). These statuses do not include request statuses such as Pending and Hold or results reporting statuses such as Draft and Verified. If your site decides to activate any imaging type other than General Radiology, then you must use this option to define how the statuses will work for each Imaging Type activated. If this is a virgin installation of the software, General Radiology should be treated no differently than the other imaging types.

When the system is initialized, the statuses will be setup but not activated for each exported imaging type (excluding General Radiology, which is activated).

> **Note:** 6 statuses will exist in the file for each of the 9 Imaging Types (i.e., 54 total statuses, 6 per imaging type). This makes it possible for the status parameter setup to be tailored differently for each imaging type.

The fields you edit in this option generally fall into three basic categories:

- Fields that indicate what data is mandatory for an exam to progress to the given status.

- Which prompts should be asked of the user when trying to move an exam into the given status (applies to the Status Tracking option only).

- Fields that indicate to the various workload report routines whether an exam in a particular exam status should be used in the compilation of that report.

Except for the imaging type, examination status, user key needed, and default next status fields, all responses are answered with a Yes/No answer or can be bypassed.

This version of the software changes the appearance of a number of the prompts by using the title for the prompt instead of the actual Name field.

> **Note:** Only the Status Tracking of Exams option will follow the status parameters for the "Ask" prompts. The Case No. Exam Edit option or the Edit Exam by Patient option will not do this. All three options will follow the Require parameters to progress to the next status.

Imaging Type

Statuses are defined for each imaging type. You begin in this option by telling the system that activated imaging type you want to edit. Remember, an imaging type is activated when one or more imaging locations and one or more procedures have been assigned to it.

Examination Status

This field is the current exam status being defined. When the software is installed, the required entries of the Examination Status file are created for each imaging type:

- There is a status with an order of "1" (Waiting for Exam) for each imaging type. This is the status that the module will place an exam in upon registration regardless of which data has been entered.

- There is a status with an order of "9" (Complete) for each imaging type. When an exam reaches this status, then the module considers the exam complete and the exam can no longer be called up by case number. The case number can then be reused.

- There is a status with an order of "0" (Cancelled) for each imaging type. Cancelled case numbers are also reused.

If you intend to assign statuses other than the above three, a numbering system of 2 through 8 is used to assign each status. The higher the number assigned to a status, the more complete the exam should be.

The statuses Called for Exam, Examined, and Transcribed are also installed with the software and appear as part of the selection list. No order numbers are installed for Called for Exam, Examined, or Transcribed statuses. They are available for your use but are not required for status tracking to function. If you apply an order number to any one of these three statuses, you will activate that status. We suggest you use the worksheet provided at the back of this manual to plan your strategy when implementing new IMAGING TYPES and/or statuses.

Order in Sequence Of Status Progression

This field contains the logical order that this exam status falls into. The order of the progression is set up by your site and must be a number from 2 through 8. If this field is left blank, then the Exam Status Tracking function will not use the status you selected.

Should This Status Appear In Status Tracking

For any statuses that you activate, consider typing Yes at this prompt. If it is set to Yes, the Appears on Status Tracking field will cause exams of that status to come up for edit in the Status Tracking option. If left blank or set to No, exams of that status will be bypassed. If, for example, you answer No or bypass this field for every status, you would see nothing on Status Tracking.

Unless there is some site-specific reason to do otherwise, all sites should have Waiting for Exam appear on status tracking, because a newly registered exam is automatically set to it. Examined is a status that sites often want to appear in Status Tracking. The system does not allow Complete and Cancelled statuses to appear on status tracking.

An example of when this field would be set to NO is for a status called Transcribed. Many times after a report is transcribed it may not be verified for a day or two and the number of Transcribed exams may get very large. If Transcribed was displayed in the status tracking function, then the system performance would suffer because all these exams would have to be processed and displayed.

User Key Needed To Move an Exam To This Status

When extra protection is desired on an exam status, use this field to define the security key. If this field is set to a valid security key, then the user will need that key in order to move an exam into this status.

If a key is desired, IRM will have to create it and allocate it to the appropriate users. It is the coordinator's responsibility to enter this key into this field after IRM creates it. The key name must start with "RA".

Default Next Status for Exam

This field contains the name of the next status that the current status can advance to, after the parameters of that next status are met. The next status must be active, i.e., it must have data for the parameter Order in Sequence of Status Progression. The Exam Status Tracking function uses this field in determining which prompts should be displayed for edit by the user. For example, if the "Default Next Status" is Examined for a case in the Waiting for Exam status, the Status Tracking option will prompt for all the "Ask…" fields you have set to YES for the Examined status.

> **Note:** If you do not enter a "Default next status for exam", the user will be asked to choose a next status during status tracking. Most sites choose a default next status that requires the most possible data entry at one session. For example, the default next status for Waiting for Exam might be Examined, and the default next status for Examined might Complete.

The more default next statuses you use, the more times a user will have to use the status tracking option to force the exam to go to the next status. However, if you go to the other extreme and make Waiting for Exam's default next status Complete, you may not get a fine enough granularity of status differentiation for status tracking.

A simple but viable setup would be the following:

Appear on Status Tracking:	Default Next Status:
Waiting for Exam	Examined
Examined	Complete

Can an Exam Be Cancelled While In This Status?

While an exam is in this status, should the user be allowed to cancel an exam? Answer with YES to allow cancelling and NO to disallow cancelling. If no entry is made in this field for the current status, then the user will not be allowed to cancel the exam.

Generate Exam Alert for Requesting Physician

This field contains a YES if the exam status should generate an alert to the requesting physician that the patient has been examined.

Generate Examined HL7 Message (+)

If an HL7 message should be generated when a patient is examined, enter a YES at this prompt. The usual purpose of this field is to identify the status where images have been collected. The HL7 message recipient is usually a vendor-supplied PACS or other system that needs this HL7 message to trigger some action. There are other events that automatically trigger different HL7 messages to be sent by Rad/Nuc Med. These are fully discussed in the technical manual.

Status Change Requirements

Technologist Required

This field may be set to YES to require that the name of the Technologist must be entered in order for an exam to be moved into the current status being defined.

Resident or Staff Required

This field may be set to YES to require that an Interpreting Resident or Staff Physician be entered in order for an exam to be moved into the current status being defined.

Detailed Procedure Required

This field may be set to YES to require that a Detailed Procedure type be entered in order for an exam to be moved into the current status being defined. If the Division parameter requiring that a Detailed Procedure type be entered when ordering an exam is set to YES, then the Division requirement takes precedence over this requirement.

Film Entry Required

This field may be set to YES to denote that Film Entry is required in order for an exam to be moved into the current status being defined.

Diagnostic Code Required

This field may be set to YES to require that the Primary Diagnostic Code be entered in order for an exam to be moved into the current status being defined.

Camera/Equip/Rm Required

This field may be set to YES to require that the Camera/Equip/Rm be entered in order for an exam to be moved into the current status being defined.

Procedure Modifiers Required

This field should be set to YES if an exam requires at least 1 procedure modifier be entered in order for an exam to be moved into the current status being defined.

CPT Modifiers Required

This field should be set to YES if an exam requires at least 1 CPT modifier be entered in order for an exam to be moved into the current status being defined.

Radiopharmaceuticals Requirements

The following Radiopharmaceutical prompts only appear if you are editing the Imaging Types of Nuclear Medicine or Cardiology Studies.

Radiopharms & Dosages Required (+)

This field may be set to YES to require that the Radiopharmaceuticals and Dosages be entered in order for an exam of this Imaging Type to be moved into the current status being defined.

To override the requirement for radiopharmaceutical on an individual procedure, set the "Suppress Radiopharm Prompt" field of the Rad/Nuc Med Procedure file to "1" for that procedure using Procedure Enter/Edit option.

Activity Drawn Required (Radiopharm) (+)

This field may be set to YES to require that the Activity Drawn be required in order for an exam of this Imaging Type to be moved into the current status being defined.

Drawn Dt/Time and Person Required (Radiopharm) (+)

This field may be set to YES to require that the Date/Time of the measure and the Person who measured the dose be entered in order for an exam of this Imaging Type to be moved into the current status being defined.

Admin Dt/Time/Person Required (Radiopharm) (+)

This field may be set to YES to require that the Date/Time of Dose Administration and the Person who administered the dose be entered in order for an exam to be moved into the current status being defined.

Route/Site Required (Radiopharm Administered) (+)

This field may be set to YES to require that the Route of Administration and Site of Administration be entered in order for an exam of this Imaging Type to be moved into the current status being defined.

> **Note:** If a selected route has no associated site, this requirement is ignored.

Lot No. Required (radiopharm) (+)

This field may be set to YES to require that the Lot No. be entered in order for an exam of this Imaging Type to be moved into the current status being defined.

Volume/Form Required (Radiopharm) (+)

This field may be set to YES to require that the Volume and Form be entered in order for an exam of this Imaging Type to reach the current status being defined.

> You must use the reporting feature of the system as a prerequisite for the following three requirements:

Report Entered Required

This field may be set to YES to require that an exam have an entry in the Rad/Nuc Med Reports file #74. This does not mean that the report text field of the report record must be populated.

Impression Required

This field may be set to YES to require that a report impression be entered in order for an exam to be moved into the current status being defined. For each imaging type, the impression should be required at some point (probably for the Transcribed or Complete status). Since the report text can be purged, it is strongly advised that an impression be mandatory with each exam.

Verified Report Required

This field may be set to YES to require that the report be verified in order for an exam to be moved into the current status being defined.

Status Tracking Functions

Depending on how each site sets up the following fields, the user may or may not be prompted for the data while using the exam status tracking function.

Ask For Technologist

If this field is set to YES, then the user will be prompted for the Technologist in order to update an exam to this status.

Ask For Interpreting Physician

If this field is set to YES, then the user will be prompted for both the Resident and Staff Interpreting Physicians in order to update an exam to this status.

Ask For Procedure

If this field is set to YES, then the user will be prompted for the Procedure in order to update an exam to this status.

Ask For Film Data

If this field is set to YES, then the user will be prompted for the Film Data in order to update an exam to this status.

Ask For Diagnostic Code

If this field is set to YES, then the user will be prompted for the Primary Diagnostic Code in order to update an exam to this status. If a Primary Diagnostic code is entered, another prompt will appear asking for a Secondary Diagnostic Code.

Ask For Camera/Equip/Rm

If this field is set to YES, then the user will be prompted for the Camera/Equip/Rm in order to update an exam to this status.

Ask For Procedure Modifiers

If this field is set to YES, then the user will be prompted for Procedure Modifiers in order to update an exam to this status.

Ask For CPT Modifiers

If this field is set to YES, then the user will be prompted for CPT Modifiers in order to update an exam to this status.

Ask For User Code

If this field is set to YES, then the user will be prompted for the User Code in order to update an exam to this status.

Ask Medications & Dosages (+)

This parameter works in conjunction with a parameter on the Rad/Nuc Med Procedure file #71. If this field is set to YES, and the "Prompt for Meds" field of the procedure (in the Rad/Nuc Med Procedure file #71) is set to YES, then the user will be prompted for the medication and dose in order to update an exam of this imaging type to this status.

Ask Medication Admin Dt/Time & Person (+)

If this field is set to YES, then the user will be prompted for the Date and Time the medication was administered and the Person who administered the dose in order to update an exam of this Imaging Type to this status. However, this will only happen if medications and dosages were entered.

The following Radiopharmaceutical prompts only appear if you are editing the Nuclear Medicine or Cardiology Studies imaging types.

Ask Radiopharmaceuticals and Dosages (+)

If this field is set to YES, then the user will be prompted for the Radiopharmaceutical and Dose in order to update an exam of this imaging type to this status.

To override this parameter, and turn OFF the prompt for radiopharmaceuticals on an individual procedure, set the "Suppress Radiopharm Prompt" field of the Rad/Nuc Med Procedure file to "1" for that procedure using the Procedure Enter/Edit option.

Ask Activity Drawn (Radiopharmaceutical) (+)

If this field is set to YES and a Radiopharmaceutical has been entered, then the user will be prompted for the activity drawn in order to update an exam of this imaging type to this status.

Ask Drawn Dt/Time & Person (Radiopharmaceutical (+)

If this field is set to YES and a Radiopharmaceutical has been entered, then the user will be prompted for the Date/Time of measure and Person who measured the dose when updating an exam of this Imaging Type to this status.

Ask Admin Dt/Time & Person (Radiopharmaceutical) (+)

If this field is set to YES and a Radiopharmaceutical has been entered, then the user will be prompted for the date/time of dose administration and the person who administered the dose in order to update an exam of this Imaging Type to this status.

Ask Route/Site of Admin (Radiopharm) (+)

If this field is set to YES and a Radiopharmaceutical has been entered, then the user will be prompted for the route of administration and site of administration in order to update an exam of this imaging type to this status.

Ask Lot No. (Radiopharm) (+)

If this field is set to YES and a Radiopharmaceutical has been entered, then the user will be prompted for the Lot No. in order to update an exam of this Imaging Type to this status.

Ask Volume/Form (Radiopharm) (+)

If this field is set to YES and a Radiopharmaceutical has been entered, then the user will be prompted for volume and form in order to update an exam of this imaging type to this status.

Management Report Criteria

When the workload report routine is processing an exam that is in the exam status currently being defined, it will check the following associated parameters to determine whether to include the exam in the report compilation.

Cancelled and/or complete exams will be included on any report addressed in this option if the field for Cancelled and/or Complete contains a YES. The only exception to this is the Delinquent Status Report. Cancelled and complete exams will not be included on the Delinquent Status report even if you type YES in the "Delinquent Status Report?" field for the Cancelled and/or Complete statuses.

Clinic Report Should Include Exams of This Status

Set this parameter to YES, to indicate that exams with the exam status currently being defined should be included in the Clinic Workload report.

PTF Bedsection Report Should Include Exams of This Status

Set this parameter to YES to indicate that exams with the exam status currently being defined should be included in the PTF Bedsection Workload report.

Service Report (Workload) Should Include Exams of This Status

Set this parameter to YES, to indicate that exams with the exam status currently being defined should be included in the Service Workload report.

Sharing/Contract Report (Workload) Should Include Exams of This Status

Set this parameter to YES, to indicate that exams with the exam status currently being defined should be included in the Sharing/Contract Workload report.

Ward Report (Workload) Should Include Exams of This Status

Set this parameter to YES, to indicate that exams with the exam status currently being defined should be included in the Ward Workload report.

Film Usage Report (Workload) Should Include Exams of This Status

Set this parameter to YES, to indicate that exams with the exam status currently being defined should be included in the Film Usage Workload report.

Technologist Report (Workload) Should Include Exams of This Status

Set this parameter to YES to indicate that exams with the exam status currently being defined should be included in the Technologist Workload report.

AMIS Report (Workload) Should Include Exams of This Status

Set this parameter to YES, to indicate that exams with the exam status currently being defined should be included in the AMIS Workload report.

Detailed Procedure Report (Workload) Should Include Exams of This Status

Set this parameter to YES, to indicate that exams with the exam status currently being defined should be included in the Detailed Procedure Workload report.

Camera/Equip/Rm Report Should Include Exams of This Status

Set this parameter to YES, to indicate that exams with the exam status currently being defined should be included in the Camera/Equip/Rm Workload report.

Physician Report Should Include Exams of This Status

Set this parameter to YES, to indicate that exams with the exam status currently being defined should be included in the Physician Workload report.

Resident Report Should Include Exams of This Status

Set this parameter to YES, to indicate that exams with the exam status currently being defined should be included in the Resident Workload report.

Staff Report Should Include Exams of This Status

Set this parameter to YES, to indicate that exams with the exam status currently being defined should be included in the Staff Workload report.

Delinquent Status Report Should Include Exams of This Status

Set this parameter to YES, to indicate that exams with the exam status currently being defined should be included in the Delinquent Status report.

Radiopharmaceutical Dosage Ticket Print Control

The following radiopharmaceutical prompt only appears if you are editing the Nuclear Medicine or Cardiology Studies imaging types.

Print Dosage Ticket When Exam Reaches This Status (+)

If an exam of this imaging type that uses radiopharmaceuticals reaches this status and this field is set to YES, a dosage ticket will be printed if the following criteria are also true:

- A valid print device has been assigned to the imaging location.

- The Radiopharms/Dosages Required field contains a Yes at this (or lower) status for this imaging type.

7.4.1   Exported Setup

The following setup is exported for all imaging types. Any setup already done by your site will be left untouched. Recommended answers are shown for all fields, but you will have to fill in the unanswered fields. The shaded fields only apply to imaging type file entries whose Radiopharmaceuticals Used field is set to YES (Nuclear Medicine and/or Cardiology Studies). This field is not editable.

> Note: The Statuses are populated, but not activated.

If imaging types other than General Radiology are activated at your medical center, you will have to assign order numbers to any additional statuses you will be using, indicate whether the statuses should appear on Status Tracking, assign a default next status for each, and if you feel it is necessary, review all the other parameters associated with the statuses.

Field: **Statuses:**

	Can-celled	Waiting for Exam	Called for Exam	Exam-ined	Tran-scribed	Com-plete
Order in sequence of status progression	0	1				9
Should this Status appear in Status Tracking		Y				
User Key needed to move an exam to this status						
Default next status for exam						

	Can-celled	Waiting for Exam	Called for Exam	Exam-ined	Tran-scribed	Com-plete
Can an exam be cancelled while in this status	Y	Y	Y			
Generate exam alert for requesting physician						
Generate Examined HL7 Message						
Data Requirements for this Status	-----	-----	-----	-----	-----	-----
Technologist Required			Y	Y	Y	Y
Resident or Staff Required					Y	Y
Detailed Procedure Required				Y	Y	Y
Film Entry Required				Y	Y	Y
Diagnostic Code Required					Y	Y
Camera/Equip/RM Required					Y	Y
Radiopharms & Dosages required						
Activity Drawn required (Radiopharm)						
Drawn Dt/Time and Person required (Radiopharm)						
Admin Dt/Time/Person required (Radiopharm)						
Route/Site required (Radiopharm administered)						
Lot No. required (Radiopharm)						
Volume/Form required (Radiopharm)						
Report Entered required					Y	Y
Impression required						Y
Verified Report required						Y
To Move to this Status	-----	-----	-----	-----	-----	-----
Ask for Technologist			Y	Y		
Ask for Interpreting Physician					Y	
Ask for Procedure				Y		
Ask for Film Data				Y		
Ask for Diagnostic Code					Y	
Ask for Camera/Equip/RM				Y		
Ask for User Code						
Ask Medications & Dosages						
Ask Medication Admin Dt/Time & Person						
Ask Radiopharmaceuticals and Dosages				Y		
Ask Activity Drawn (Radiopharmaceutical)						
Ask Drawn Dt/Time & Person (Radiopharm)						
Ask Admin Dt/Time & Person (Radiopharm)						

	Can-celled	Waiting for Exam	Called for Exam	Exam-ined	Tran-scribed	Com-plete
Ask Route/Site of Admin (Radiopharm)						
Ask Lot No. (Radiopharm)						
Ask Volume/Form (Radiopharm)						
Exams in this Status should appear on these Reports	-----	-----	-----	-----	-----	-----
Clinic Report		Y	Y	Y	Y	Y
PTF Bedsection Report		Y	Y	Y	Y	Y
Service Report (Workload)		Y	Y	Y	Y	Y
Sharing/Contract Report (Workload)		Y	Y	Y	Y	Y
Ward Report (Workload)		Y	Y	Y	Y	Y
Film Usage Report (Workload)		Y	Y	Y	Y	Y
Technologist Report (Workload)		Y	Y	Y	Y	Y
AMIS Report (Workload)		Y	Y	Y	Y	Y
Detailed Procedure Report (Workload)		Y	Y	Y	Y	Y
Camera/Equip/Rm Report		Y	Y	Y	Y	Y
Physician Report		Y	Y	Y	Y	Y
Resident Report		Y	Y	Y	Y	Y
Staff Report		Y	Y	Y	Y	Y
Delinquent Status Report		Y	Y	Y	Y	
Radiopharmaceutical Dosage Ticket Print Control	-----	-----	-----	-----	-----	-----
Print Dosage Ticket when exam reaches this status						

```
The following example takes you through the entries for the Complete Status
when setting up the Nuclear Medicine imaging type.  Remember, the prompts
for radiopharmaceuticals will only appear when the imaging type is Nuclear
Medicine or Cardiology Studies.
Examination Status Entry/Edit
Select an Imaging Type:    NUCLEAR MEDICINE


Select an Examination Status: COMPLETE     Imaging Type: NUCLEAR MEDICINE
                                Order: 9
         ...OK? Yes// <RET>  (Yes)
Name of Current Exam Status: COMPLETE// <RET>
Order in sequence of status progression: 9// <RET>
Should this Status appear in Status Tracking ?: NO// <RET>
User Key needed to move an exam to this status: <RET>
Default next status for exam: <RET>
Can an exam be cancelled while in this status ?: NO// <RET>
Generate exam alert for requesting physician ?: NO// <RET>
Generate Examined HL7 Message:

     Status Change Requirements
     --------------------------
     Please indicate which of the following is required
     in order to place an exam into the 'COMPLETE' status:

Technologist Required ?: YES// <RET>
```

```
Resident Or Staff Required ?: YES// <RET>
Detailed Procedure required ?: YES// <RET>
Film Entry Required ?: NO// <RET>
Diagnostic Code Required ?: NO// <RET>
Camera/Equip/Rm Required ?: NO// <RET>

      (Radiopharmaceutical requirements)

Radiopharms & Dosages required ?: YES// <RET>
Activity Drawn required (Radiopharm) ?: YES// <RET>
Drawn Dt/Time and Person required (Radiopharm) ?: YES// <RET>
Admin Dt/Time/Person required (Radiopharm) ?: YES// <RET>
Route/Site required (Radiopharm administered) ?: YES// <RET>
Lot No. required (Radiopharm) ?: YES// <RET>
Volume/Form required (Radiopharm) ?: YES// <RET>

   WARNING: You must use the reporting feature of the system as
           a prerequisite for the following requirements:
Report Entered required ?: YES// <RET>
Impression required ?: YES// <RET>
Verified Report required ?: YES// <RET>

      Status Tracking Functions
      -------------------------
      Please indicate which of the following should be asked when
      changing an exam's status to 'COMPLETE' while using
      the 'status tracking' feature:

Ask for Technologist ?: YES// <RET>
Ask For Interpreting Physician ?: YES// <RET>
Ask for Procedure ?: YES// <RET>
Ask For Film Data ?: NO// <RET>
Ask For Diagnostic Code ?: YES// <RET>
Ask For Camera/Equip/Rm ?: NO// <RET>
Ask for User Code ?: NO// <RET>
Ask Medications & Dosages ?: YES// <RET>
Ask Medication Admin Dt/Time & Person ?: YES// <RET>

      (Radiopharmaceutical functions)

Ask Radiopharmaceuticals and Dosages ?: YES// <RET>
Ask Activity Drawn (Radiopharmaceutical) ?: YES// <RET>
Ask Drawn Dt/Time & Person (Radiopharmaceutical) ?: YES// <RET>
Ask Admin Dt/Time & Person (Radiopharmaceutical) ?: YES// <RET>
Ask Route/Site of Admin (Radiopharm) ?: YES// <RET>
Ask Lot No. (Radiopharm) ?: YES// <RET>
Ask Volume/Form (Radiopharm) ?: YES// <RET>

      Management Report Criteria
      --------------------------
      Please indicate which of the following workload reports should
      include exams with the 'COMPLETE' status:

Clinic Report should include exams of this status ?: YES// <RET>
PTF Bedsection Report should include exams of this status ?: YES// <RET>
Service Report (Workload) should include exams of this status ?: YES//
<RET>
Sharing/Contract Report (Workload) should include exams of this status ?:
YES// <RET>
Ward Report (Workload) should include exams of this status ?: YES// <RET>
```

```
Film Usage Report (Workload) should include exams of this status ?: YES//
<RET>
Technologist Report (Workload) should include exams of this status ?: YES//
<RET>
AMIS Report (Workload) should include exams of this status ?: YES// <RET>
Detailed Procedure Report (Workload) should include exams of this status ?:
YES// <RET>
Camera/Equip/Rm Report should include exams of this status ?: YES// <RET>
Physician Report should include exams of this status ?: YES// <RET>
Resident Report should include exams of this status ?: YES// <RET>
Staff Report should include exams of this status ?: YES// <RET>
Delinquent Status Report should include exams of this status ?: YES// <RET>

      Radiopharmaceutical Dosage Ticket Print Control
      -----------------------------------------------

Print Dosage Ticket when exam reaches this status ?: NO// <RET>

Select an Examination Status: <RET>

          Checking order numbers
 _____ and Default Next Status used for status progression _____
          within : NUCLEAR MEDICINE

     Required order numbers are in place.


               Data Inconsistency Report For Exam Statuses

DEVICE: HOME//   (enter a printer or <RET> to display on screen)
```

```
                                                      Page: 1
                                                      Date: Sep 17,
1997

               Data Inconsistency Report For Exam Statuses
================================================================================
=====


          Checking order numbers
 _____ and Default Next Status used for status progression _____
          within : NUCLEAR MEDICINE

     Required order numbers are in place.



               Exam Status Data Inconsistencies Not Found.
```

The following example shows a setup with inconsistencies as demonstrated in the
Data Inconsistency report that follows the setup:

```
Select an Imaging Type: NUCLEAR MEDICINE
Select an Examination Status:    COMPLETE  Imaging Type: NUCLEAR MEDICINE
                                 Order: 9
Name of Current Exam Status: COMPLETE// <RET>
Order in sequence of status progression: 9// <RET>
```

```
Should this Status appear in Status Tracking ?: NO// <RET>
User Key needed to move an exam to this status: <RET>
Default next status for exam: <RET>
Can an exam be cancelled while in this status ?: NO// <RET>
Generate exam alert for requesting physician ?: NO// <RET>
Generate Examined HL7 Message: <RET>

     Status Change Requirements
     --------------------------
     Please indicate which of the following is required
     in order to place an exam into the 'COMPLETE' status:

Technologist Required ?: YES// <RET>
Resident Or Staff Required ?: YES// <RET>
Detailed Procedure required ?: YES// <RET>
Film Entry Required ?: YES// <RET>
Diagnostic Code Required ?: YES// <RET>
Camera/Equip/Rm Required ?: YES// <RET>

     (Radiopharmaceutical requirements)

Radiopharms & Dosages required ?: NO// <RET>
Activity Drawn required (Radiopharm) ?: NO// <RET>
Drawn Dt/Time and Person required (Radiopharm) ?: NO// <RET>
Admin Dt/Time/Person required (Radiopharm) ?: NO// <RET>
Route/Site required (Radiopharm administered) ?: NO// <RET>
Lot No. required (Radiopharm) ?: NO// <RET>
Volume/Form required (Radiopharm) ?: NO// <RET>

   WARNING: You must use the reporting feature of the system as
            a prerequisite for the following requirements:

Report Entered required ?: YES// <RET>
Impression required ?: NO// <RET>
Verified Report required ?: YES// <RET>

     Status Tracking Functions
     -------------------------
     Please indicate which of the following should be asked when
     changing an exam's status to 'COMPLETE' while using
     the 'status tracking' feature:

Ask for Technologist ?: YES// <RET>
Ask For Interpreting Physician ?: YES// <RET>
Ask for Procedure ?: NO// <RET>
Ask For Film Data ?: YES// <RET>
Ask For Diagnostic Code ?: YES// <RET>
Ask For Camera/Equip/Rm ?: NO// <RET>
Ask for User Code ?: NO// <RET>
Ask Medications & Dosages ?: NO// <RET>
Ask Medication Admin Dt/Time & Person ?: NO// <RET>

     (Radiopharmaceutical functions)

Ask Radiopharmaceuticals and Dosages ?: NO// <RET>
Ask Activity Drawn (Radiopharmaceutical) ?: NO// <RET>
Ask Drawn Dt/Time & Person (Radiopharmaceutical) ?: NO// <RET>
Ask Admin Dt/Time & Person (Radiopharmaceutical) ?: NO// <RET>
Ask Route/Site of Admin (Radiopharm) ?: NO// <RET>
Ask Lot No. (Radiopharm) ?: NO// <RET>
Ask Volume/Form (Radiopharm) ?: NO// <RET>
```

```
      Management Report Criteria
      --------------------------
      Please indicate which of the following workload reports should
      include exams with the 'COMPLETE' status:

Clinic Report should include exams of this status ?: YES// <RET>
PTF Bedsection Report should include exams of this status ?: YES// <RET>
Service Report (Workload) should include exams of this status ?: YES//
<RET>
Sharing/Contract Report (Workload) should include exams of this status ?:
YES// <RET>
Ward Report (Workload) should include exams of this status ?: YES// <RET>
Film Usage Report (Workload) should include exams of this status ?: YES//
<RET>
Technologist Report (Workload) should include exams of this status ?: YES//
<RET>
AMIS Report (Workload) should include exams of this status ?: YES// <RET>
Detailed Procedure Report (Workload) should include exams of this status ?:
YES// <RET>
Camera/Equip/Rm Report should include exams of this status ?: YES// <RET>
Physician Report should include exams of this status ?: YES// <RET>
Resident Report should include exams of this status ?: YES// <RET>
Staff Report should include exams of this status ?: YES// <RET>
Delinquent Status Report should include exams of this status ?: NO// <RET>

      Radiopharmaceutical Dosage Ticket Print Control
      -----------------------------------------------

Print Dosage Ticket when exam reaches this status ?: NO// <RET>


Select an Examination Status: <RET>
```

When exiting this option, you receive a report on the consistency of the data you entered. In the example shown here, several inconsistencies are noted and may or may not require correction for the status tracking function to work properly.

```
       Checking order numbers
_____ and Default Next Status used for status progression _____
            within : NUCLEAR MEDICINE

      Required order numbers are in place.

                  Data Inconsistency Report For Exam Statuses

DEVICE: HOME// (Enter a Device)
```

```
                                                          Page: 1
                                                          Date: May 20,
1997

                  Data Inconsistency Report For Exam Statuses
===============================================================================
==
```

```
  _____ Warning on reaching Complete _____
         within : NUCLEAR MEDICINE

     The following are permissible, but could lead to failure to
     complete cases when prompts are not answered in lower status(es).

     STATUS          PROMPT                                      DATA
     ------          ------                                      -----
-
     EXAMINED        ASK FOR INTERPRETING PHYS?                    Y
                     RESIDENT OR STAFF REQUIRED?                   N

     EXAMINED        ASK FOR FILM DATA?                            Y
                     FILM ENTRY REQUIRED?                          N

     EXAMINED        ASK FOR DIAGNOSTIC CODE?                      Y
                     DIAGNOSTIC CODE REQUIRED?                     N

     EXAMINED        ASK FOR CAMERA/EQUIP/RM?                      Y
                     CAMERA/EQUIP/RM REQUIRED?                     N

     TRANSCRIBED     ASK FOR CAMERA/EQUIP/RM?                      Y
                     CAMERA/EQUIP/RM REQUIRED?                     N

     COMPLETE        ASK FOR CAMERA/EQUIP/RM?                      N
                     CAMERA/EQUIP/RM REQUIRED?                     Y


         Checking order numbers
_____ and Default Next Status used for status progression _____
         within : NUCLEAR MEDICINE

     Required order numbers are in place.


                 Exam Status Data Inconsistencies Not Found.
```

In the sample report above, if status tracking were used to enter data, the parameters
would potentially allow users to leave the Camera/Equip/Rm field blank in every
Status Tracking edit session and never get a prompt at the final edit session. This
would result in the exam staying in the Transcribed status. A better solution would be
to change the Ask For Camera/Equip/Rm field to YES on the Complete status or
change the Camera/Equip/Rm Required field on the Transcribed and Examined
statuses to YES.

7.4.2   Example Status Tracking Sessions

The following sessions show how four statuses are affected by changes in data.

These are the assigned statuses for the examples:

```
Status            Order     Default Next Status

WAITING FOR EXAM      1        TRANSCRIBED
CALLED FOR EXAM       3      TRANSCRIBED
```

```
TRANSCRIBED          7      COMPLETE
COMPLETE          9
```

Backing Down to Lower Status

Deleting data previously entered may cause an exam status to back down to a lower
status.

```
Enter Case #, Status, (N)ext status, '^' to Stop: NEXT// 521

Case # being tracked: 521

Name: BARNIQ,FRANK W                      Case #  : 521
Division : HINES CIO FIELD OFFICE         Location: ULTRASOUND A
Procedure: ECHOGRAM ABDOMEN COMPLETE (Detailed)
   ***** Old Status: CALLED FOR EXAM
   ***** New Status: TRANSCRIBED
Do you wish to continue? YES// <ret>
    PRIMARY INTERPRETING RESIDENT: <ret>
    PRIMARY INTERPRETING STAFF: <ret>
    Select FILM SIZE: <ret>
    PRIMARY DIAGNOSTIC CODE: <ret>
    PRIMARY CAMERA/EQUIP/RM: <ret>
    Select TECHNOLOGIST: BIELLY,GARY// @
   SURE YOU WANT TO DELETE? Y  (Yes)
    Select TECHNOLOGIST: <ret>
   No 'technologist'              entered for this exam.
   No 'film data'                entered for this exam.
   No 'camera/equip/room'        entered for this exam.
   No 'report'                   entered for this exam.
      ...exam status backed down to 'WAITING FOR EXAM'
      STATUS CHANGE DATE/TIME: JUN 10,1997@10:06// <ret>
...Status backed down for case #: 521
```

Upgrading Status but Not to Default Next Status

A case may be upgraded to a status that is not its DEFAULT NEXT STATUS, if that
case's data satisfy all required data for a status that's higher than the old status, but
lower than the default next status.

```
Case # being tracked: 521

Name: BARNIQ,FRANK W                      Case #  : 521
Division : HINES CIO FIELD OFFICE         Location: ULTRASOUND A
Procedure: ECHOGRAM ABDOMEN COMPLETE (Detailed)
   ***** Old Status: WAITING FOR EXAM
   ***** New Status: TRANSCRIBED
Do you wish to continue? YES// <ret>
    PRIMARY INTERPRETING RESIDENT: <ret>
    PRIMARY INTERPRETING STAFF: <ret>
    Select FILM SIZE: <ret>
    PRIMARY DIAGNOSTIC CODE: <ret>
    PRIMARY CAMERA/EQUIP/RM: <ret>
    Select TECHNOLOGIST: BIELLY,GARY
    Select TECHNOLOGIST: <ret>
   No 'film data'                entered for this exam.
   No 'camera/equip/room'        entered for this exam.
```

```
   No 'report'                      entered for this exam.
   No 'camera/equip/room'           entered for this exam.
   No 'report'                      entered for this exam.

      ...though upgraded, new status level (CALLED FOR EXAM)
     is not as high as the desired level (TRANSCRIBED)

       STATUS CHANGE DATE/TIME: JUN 10,1997@10:06// <ret>
...Status successfully changed for case #: 521
```

Status Unchanged

A case's status will remain the same, if no data had been added to, nor deleted from
it.

```
Exam Status Tracking Module           Division: HINES CIO FIELD OFFICE
 Date    : 06/10/97  11:15 AM          Status  : CALLED FOR EXAM
 Locations: ULTRASOUND A

Case #   Date      Patient                Procedure            Equip/Rm
------   ----      -------                ---------            --------
521       9:55 AM  BARNIQ,FRANK W         ECHOGRAM ABDOMEN COMPLETE

Enter Case #, Status, (N)ext status, '^' to Stop: NEXT// 521

Case # being tracked: 521

Name: BARNIQ,FRANK W                      Case #  : 521
Division : HINES CIO FIELD OFFICE         Location: ULTRASOUND A
Procedure: ECHOGRAM ABDOMEN COMPLETE (Detailed)
   ***** Old Status: CALLED FOR EXAM
   ***** New Status: TRANSCRIBED
Do you wish to continue? YES// <ret>
    PRIMARY INTERPRETING RESIDENT: <ret>
    PRIMARY INTERPRETING STAFF: WILLIAMS,CATHY// <ret>
    Select SECONDARY INTERPRETING STAFF: <ret>
    Select FILM SIZE: <ret>
    PRIMARY DIAGNOSTIC CODE: NORMAL// <ret>
    Select SECONDARY DIAGNOSTIC CODE: <ret>
    PRIMARY CAMERA/EQUIP/RM: <ret>
    Select TECHNOLOGIST: BIELLY,GARY// <ret>
   No 'film data'                   entered for this exam.
   No 'camera/equip/room'           entered for this exam.
      ...exam status not changed??
...Status unchanged for case #: 521
```

Qualifies for Higher Status Than Default Next Status

A case may have enough data to qualify for a higher status than its DEFAULT NEXT
STATUS, but Status Tracking will not allow the case to be upgraded to a status
higher than the DEFAULT NEXT STATUS. If this should occur, a message will be
displayed to remind the user to re-edit this case.

```
 Exam Status Tracking Module           Division: HINES CIO FIELD OFFICE
 Date    : 06/10/97  11:16 AM          Status  : CALLED FOR EXAM
 Locations: ULTRASOUND A
```

```
Case #   Date      Patient               Procedure            Equip/Rm
------   ----      -------               ---------            --------
521        9:55 AM  BARNIQ,FRANK W       ECHOGRAM ABDOMEN COMPLETE


Enter Case #, Status, (N)ext status, '^' to Stop: NEXT// 521


Case # being tracked: 521


Name: BARNIQ,FRANK W                     Case #  : 521
Division : HINES CIO FIELD OFFICE        Location: ULTRASOUND A
Procedure: ECHOGRAM ABDOMEN COMPLETE (Detailed)
    ***** Old Status: CALLED FOR EXAM
    ***** New Status: TRANSCRIBED
Do you wish to continue? YES// <ret>
     PRIMARY INTERPRETING RESIDENT: <ret>
     PRIMARY INTERPRETING STAFF: WILLIAMS,CATHY// <ret>
     Select SECONDARY INTERPRETING STAFF: <ret>
     Select FILM SIZE: 2
      1    2X12
      2    2X4
      3    2X6
CHOOSE 1-3: 1
       AMOUNT(#films or cine ft): 1
     Select FILM SIZE: <ret>
     PRIMARY DIAGNOSTIC CODE: NORMAL// <ret>
     Select SECONDARY DIAGNOSTIC CODE: <ret>
     PRIMARY CAMERA/EQUIP/RM: PORTABLE          PORTABLE
     Select TECHNOLOGIST: BIELLY,GARY// <ret>

This case also qualifies for higher status(es) :
     COMPLETE

Since Status Tracking can only upgrade one status level at a time,
please edit this exam again.

       STATUS CHANGE DATE/TIME: JUN 10,1997@11:18//
...Status successfully changed for case #: 521


 Exam Status Tracking Module          Division: HINES CIO FIELD OFFICE
 Date    : 06/10/97  11:18 AM         Status  : CALLED FOR EXAM
 Locations: ULTRASOUND A

Case #   Date      Patient               Procedure            Equip/Rm
------   ----      -------               ---------            --------

Enter Case #, Status, (N)ext status, '^' to Stop: NEXT// N


 Exam Status Tracking Module          Division: HINES CIO FIELD OFFICE
 Date    : 06/10/97  11:18 AM              Status  : TRANSCRIBED
 Locations: ULTRASOUND A

Case #   Date      Patient               Procedure            Equip/Rm
------   ----      -------               ---------            --------

20      06/20/94  FINE,LARRY           ZZLINE ULTRASOUND
PORTABLE
169     01/19/95  MCINTYRE,CHRISTINE   ECHOGRAM ABDOMEN COMPLETE   FRANK'S
521        9:55 AM  BARNIQ,FRANK W       ECHOGRAM ABDOMEN COMPLETE
PORTABLE
```

```
Enter Case #, Status, (N)ext status, '^' to Stop: NEXT// 521


Case # being tracked: 521

Name: BARNIQ,FRANK W                           Case #  : 521
Division : HINES CIO FIELD OFFICE       Location: ULTRASOUND A
Procedure: ECHOGRAM ABDOMEN COMPLETE (Detailed)
    ***** Old Status: TRANSCRIBED
    ***** New Status: COMPLETE
Do you wish to continue? YES// <ret>
     PRIMARY INTERPRETING RESIDENT: <ret>
     PRIMARY INTERPRETING STAFF: WILLIAMS,CATHY// <ret>
     Select SECONDARY INTERPRETING STAFF: <ret>
     Select FILM SIZE: 2X12// <ret>
       FILM SIZE: 2X12// <ret>
       AMOUNT(#films or cine ft): 1// <ret>
     Select FILM SIZE: <ret>
     PRIMARY DIAGNOSTIC CODE: NORMAL// <ret>
     Select SECONDARY DIAGNOSTIC CODE: <ret>
     PRIMARY CAMERA/EQUIP/RM: PORTABLE// <ret>
     Select TECHNOLOGIST: BIELLY,GARY// <ret>
       STATUS CHANGE DATE/TIME: JUN 10,1997@11:18// <ret>
...Status successfully changed for case #: 521
   ...will now designate request status as 'COMPLETE'...
     Visit credited.

          ...request status successfully updated.
```

7.5   Film Type Entry/Edit

[RA FILMEDIT]

This function allows you to edit existing film types and enter new film types. These film types build the list of choices that the technologist can choose from when selecting a film size during the Status Tracking of Exams, Edit Exam by Patient, and Case No. Exam Edit options to indicate which films were used during a procedure.

An entry should be an identifying name or size. To speed up processing, assign each film type a name with unique characters at the beginning of the entry. If your medical center wants to get a report showing exams that did not use films, an entry of NO FILMS on this list is an appropriate choice. Once a film size has been entered through this option, it cannot be deleted; however, it can be inactivated. Also, enter a corresponding wasted film for each film size.

Enter two question marks (??) if you want a list of film sizes already entered at your site. The entry should be 3-30 characters in length.

```
Select FILM SIZES: 10X12
  Are you adding '10X12' as a new FILM SIZES (the 46TH)? Y  (Yes)
FILM: 10X12// <RET>
```

If this field contains a YES, it indicates that this is cine film. Cine film is treated differently in compiling the AMIS reports and the Film Usage reports.

```
IS THIS A 'CINE' FILM SIZE?: NO
```

If this field contains a YES, it indicates that this film is used for fluoro. Exams where this film size is entered are assumed to be fluoro not requiring the use of films. Leaving this field blank is the same as answering No.

```
FLUORO ONLY?: <RET>
```

If this film size entry should no longer be needed, enter a date here to inactivate it. That will remove it from the user selections.

If the film type is active, there should be no entry in this field.

```
INACTIVATION DATE: <RET>
```

Bypass this field, as shown here, if this film size is NOT a wasted type. If this field contains a YES, it indicates that the film will be considered a wasted film type and will be excluded from the Film Usage report. Instead, it will be included on the Wasted Film Report.

If a film size is already associated with a wasted film size, the former cannot also be set to a wasted film size by answering "YES" at this prompt. For this example, the wasted film size is 10X12.

```
WASTED FILM?: <RET>
```

Distinguish all wasted film in the same way, such as using "W-" before the name of its counterpart.

```
Select FILM SIZES: W-10X12

  Are you adding 'W-10X12' as a new FILM SIZES (the 46TH)? Y  (Yes)

FILM: W-10X12// <RET>
IS THIS A 'CINE' FILM SIZE?: NO
FLUORO ONLY?: <RET>
INACTIVATION DATE: <RET>
7.6   Label/Header/Footer Formatter
[RA FLASHFORM]
```

Enter the corresponding film. Typing 10X12 here means that when a technician types W-10X12 on a case, it is the 10X12 size that has been wasted.

```
WASTED FILM?: Y  YES

ANALOGOUS UNWASTED FILM SIZE: 10X12
```

When you exit this option, a screen similar to the following example is displayed:

```
Select FILM SIZES: <RET>
```

```
Relationship between 'Unwasted Film Size' and 'Corresponding Wasted
FilmSize':

    'Unwasted Film Size'                'Corresponding Wasted Film Size'
------------------------------------------------------------------------
--

    10X12                               W-10X12
    11X14                               W-11X14
    14X17                               W-14X17
    2X12                                W-2X12
    2X4                                 W-2X4
    2X6                                 unassociated with a 'Wasted Film'
type
    ....
 Enter RETURN to continue or '^' to exit: <RET>
```

7.6   Label/Header/Footer Formatter

[RA FLASHFORM]

The Label/Header/Footer Formatter option is used to enter and edit flash card, jacket and examination label formats, and headers and footers. A format specifies the data you want printed and how you want it printed on each type of card or label.   Headers are the line or lines of information at the top of a result report (i.e., usually patient name, social security number, etc.). Footers are the information printed at the bottom of a report (i.e., patient name, examination date, page number, etc.).

The header, footer, and label format specifications that you enter by using the Label/Header/Footer Formatter option are stored in the Label Print Fields file #78.7. Various programs use these specifications when printing exam results reports and the labels that are printed at the time an exam is registered.

On the following page is a list of the choices you have for formatting flash cards, exam labels, jacket labels, headers and footers. When the data depends on the availability of a specific requirement, we've also included what that requirement is.

Label Print Fields:	Requirement:
Age of Patient	Date of Birth entered in PIMS
Attending Physician at Order	Must be entered in PIMS
Attending Physician Current	Must be entered in PIMS

Label Print Fields:	Requirement:
Case Number	Case must be registered
Case Number Barcode	Case must be registered, printer hardware must be capable of printing barcodes, printer device definition must be set up by IRM to support barcode printing
Current Date/Time	
Current Patient Location	
Date of Birth	Date of Birth entered in PIMS
Date of Exam	Case must be registered
Date Report Entered	After report is entered
Date Reported	After report is entered
Diagnostic Code	After diagnostic codes are entered
Exam Modifiers	Modifiers must be entered
Free Text	
Hospital Division (Institution)	
Imaging Location	Exam must be registered
Last Time this Exam Performed	
Last Visit for any Exam	
Long Case Number	Case must be registered
Long Case Number Barcode	

Label Print Fields:	Requirement:
Name of Patient	
Page Number	
(+) Patient Address Line 1	First line of street address must be entered in PIMS
(+) Patient Address Line 2	Second and third lines of address must be entered in PIMS
(+) Patient Address Line 3	City, State, and Zip must be entered in PIMS
Primary Physician at Order	Must be entered in PIMS
Primary Physician Current	Must be entered in PIMS
Procedure	
Procedure Barcode, 30 chars	Printer hardware must be capable of printing barcodes, printer device definition must be set up by IRM to support barcode printing
Procedure Barcode, 60 chars	Printer hardware must be capable of printing barcodes, printer device definition must be set up by IRM to support barcode printing
Report Status	Report must be entered
Request Entered Date/Time	
Requesting Area	
Requesting Physician	
Resident	Must be entered

Label Print Fields:	Requirement:
Resident Signature	Report must be entered and verified by resident
(+) Resident Signature Name	Must be verified by resident, then looks for Signature Block Printed Name or defaults to name from the .01 field of File 200.
Service	
Sex of Patient	Must be entered in PIMS
SSN of Patient	Must be entered in PIMS
SSN of Patient Barcode	Printer hardware must be capable of printing barcodes, printer device definition must be set up by IRM to support barcode printing
Staff Radiologist	Primary Staff must be entered
Staff Signature	Report must be entered and verified by staff
(+) Staff Signature Name	Must be verified by a staff member, then looks for Signature Block Printed Name or defaults to name from the .01 field of File 200.
Technologist	Must be entered in Exam Edit option
Usual Patient Category	Must be entered via Update Patient Record
Verified Date	Report must be verified
Verifying Electronic Signature	Report must be verified

Label Print Fields:	Requirement:
Verifying Radiologist	Report must be verified
Verifying Signature	Report must be verified
Verifying Signature Block	Report must be verified
(+) Verifying Signature Name	Must be verified, then uses Signature Block Name.
(+) Verifying Signature Title	Must be verified, then uses Signature Block Title from the New Person file #200.

When you specify formats you can also enter a title to be printed for each field. When the field is printed, the title will precede the actual data. The positioning of each field on the page is site-specific. If no title is entered at this step, a default title is filled in by the system. If no title is desired, type NONE when you are prompted for a title. This might be useful when printing the patient's address since the default would be PATIENT ADDRESS LINE 1, etc.

You will be prompted for row and column positions. These positions determine how your flash card or label is formatted. There can be a maximum of 66 rows from top to bottom of a page in a format but you must limit the number of rows used to fit on your labels and/or results report headers and footers. There can be a maximum of 80 columns across a page in a format, but labels usually allow less than 80 columns.

After you have selected all the fields you need, you will be asked the number of rows in the format. Be sure to answer with the highest row number you have assigned. This is necessary so that the print program will know how much space to allow on a page for headers and footers.

After a format has been entered or edited, the system will display a test version of the format, so that you can see what it will actually look like and make any necessary changes.

When you enter location setup parameters into the system, the Imaging Locations file #79.1 stores information specifying which specifications in the Label Print Fields file #78.7 should be used to print the following formats:

- Default Flash Card Format

- Default Exam Label Format

- Default Jacket Label Format

- Default Report Header Format

- Default Report Footer Format

These parameters are set through the Location Parameter Setup option.

> **Note:** When designing a card or label for a specific purpose, keep in mind which data will be available at the time the card or label is printed. For instance, if the card is going to be printed at the time of registration, the system will not know the name of the technologist. Therefore, the technologist will not print out on the form even if you include the technologist field when defining the format. See the chart on the preceding page for data requirements for the fields.

Fields that should be printed twice in any one format should be enclosed in double quotes (e.g., a second Free Text field would be typed "FREE TEXT"). The Free Text field can be used to enter a statement that will serve as a heading or to indicate an area on the flash card where a comment or description should be entered. When this statement is entered as free text, it will be interpreted by the system exactly as you enter it. You must then specify what will appear by entering the free text through the Literal Text sub-field. For example, if you make the Free Text field a part of the jacket label format and type ***RETURN TO FILE ROOM*** at the "Literal Text:" prompt, then ***RETURN TO FILE ROOM*** will print on all jacket labels using the format.

Before setting your parameters, design your format on paper, adding spacing, counting characters for alignment, etc. Use graph paper to makes it easier to count characters, lines, columns, and spaces. You can use the spacebar key to adjust spacing; see the example below.

This example illustrates how to create following flash card format. Note the plan to line up data by using spaces between the field and the colon.

```
NAME      :    SSN :
EXAM DATE:                        CASE:
PROCEDURE:

COMMENTS  :




REQUESTING PHYS:
```

> **Note:** The system refers to anything you design as a Flash Card Format even if it is a label or report header.

Type two question marks (??) to obtain a list of formats already designed by your site instead of creating a new format.

```
Label/Header/Footer Formatter

     >>> Label/Header/Footer Formatter <<<
Select FLASH CARD FORMATS FORMAT NAME: FLASH & COMMENT
```

This is the 7th format on file. They all can be selected or edited at any time.

```
  Are you adding 'FLASH & COMMENT' as a new FLASH CARD FORMATS (the 7TH)? Y
(Yes)

FORMAT NAME: FLASH & COMMENT// <RET>
```

The first field a free text field.

```
Select FIELD: FREE TEXT

  Are you adding 'FREE TEXT' as a new PRINT FIELDS
  (the 1ST for this FLASH CARD FORMATS)? Y  (Yes)
```

It will print on row 5 and begin printing in column 2.

```
  ROW: 5

  COLUMN: 2
```

It will be printed as COMMENTS :. Add one space between the S and the colon to line up colons and data that will be printed to the right of the colons.

```
  LITERAL TEXT: COMMENTS<sp>:<sp>
```

Requesting Physician will be the second field

```
Select FIELD: REQUESTING PHYSICIAN

  Are you adding 'REQUESTING PHYSICIAN' as
  a new PRINT FIELDS (the 2ND for this FLASH CARD
  FORMATS)? Y  (Yes)
```

It will print in row 10, column 2 as "REQUESTING PHYS: ". Add a space after the colon before hitting the <RET> key.

```
  ROW: 10
  COLUMN: 2

  TITLE (OPTIONAL): REQUESTING PHYS:<sp>
```

There are five spaces between NAME and the colon and one space after the colon to line up colons and data.

```
Select FIELD: NAME OF PATIENT
  Are you adding 'NAME OF PATIENT' as a new PRINT
  FIELDS (the 3RD for this FLASH CARD FORMATS)? Y
  (Yes)
  ROW: 1
  COLUMN: 2
  TITLE (OPTIONAL): NAME<sp><sp><sp><sp><sp>:<sp>
```

There is one space between SSN and the colon and one after the colon.

```
Select FIELD: DATE OF EXAM
  Are you adding 'DATE OF EXAM' as a new PRINT FIELDS
  (the 5TH for this FLASH CARD FORMATS)? Y  (Yes)
  ROW: 2
  COLUMN: 2
  TITLE (OPTIONAL): EXAM DATE:<sp>

Select FIELD: PROCEDURE
  Are you adding 'PROCEDURE' as a new PRINT FIELDS
  (the 6TH for this FLASH CARD FORMATS)? Y  (Yes)
  ROW: 3
  COLUMN: 2
  TITLE (OPTIONAL): PROCEDURE:<sp>
```

When you finish adding fields, press the Return key

```
Select FIELD: CASE NUMBER
  Are you adding 'CASE NUMBER' as a new PRINT FIELDS
  (the 7TH for this FLASH CARD FORMATS)? Y  (Yes)
  ROW: 2
  COLUMN: 40
  TITLE (OPTIONAL): CASE:<sp>
```

Find the field with the highest row number and enter that number here. In this case it was Requesting Physician.

```
Select FIELD: <RET>

NUMBER OF ROWS IN FORMAT: 10
```

Then the format of the flash card is displayed

```
      ...format 'FLASH & COMMENT' has been compiled.

<<<<<<----------------------------Column No.-----------------------------
>>>>>>

0--------1---------2---------3---------4---------5---------6---------7-----
----8
1        0         0         0         0         0         0         0
0

 NAME     : JONES,JOHN                      SSN : 382-38-3342
 EXAM DATE: DEC 13,1984  14:30              CASE: JONES,MARY
 PROCEDURE: 1A - SKULL
```

```
 COMMENTS :




 REQUESTING PHYS: DOE,JOE
```

The new patient address label print fields are useful for printing mailing labels for
reminder postcards, mammography follow-up, etc.

The order of field entry does not matter. For example, the items on the 7th row may
be entered before rows 1-6 because the compiler reorders them per your numbering
instructions.

7.7   Major AMIS Code Entry/Edit

[RA MAJORAMIS]

This function only allows you to edit existing AMIS codes. AMIS (Automated
Medical Information System) codes are used in the compilation of various workload
reports, including the AMIS report.

When the system is first installed, all necessary entries and data associated with each
entry will be part of the module. This option should only be used if VA Headquarters
changes the AMIS code description or weight.

```
Enter the code you want to edit.
Only make changes that have been made by VA Headquarters
Major AMIS Code Entry/Edit

Select MAJOR RAD/NUC MED AMIS CODES DESCRIPTION:
                                      GASTROINTESTINAL

DESCRIPTION: GASTROINTESTINAL// <RET>

WEIGHT: 6//

Select MAJOR RAD/NUC MED AMIS CODES DESCRIPTION:<RET>
```

7.8   Nuclear Medicine Setup Menu

7.8.1   Overview

This menu contains the options to build and manage the Nuclear Medicine
radiopharmaceutical lot numbers, routes and sites of administration, and vendor
source.

A number of Routes of Administration and Sites of Administration were exported with the software. Print the contents of their respective files (Route of Administration #71.6 and Site of Administration #71.7) using the Route of Administration List and Site of Administration List options before you attempt to add data. You may edit the names of the routes and sites, but you may not delete them.

Add sites (Site of Administration Enter/Edit option) before adding routes of administration since the sites must be in place so that you can select them during route edits and associate them with routes. Likewise, vendors/sources must be in place before editing lots.

7.8.2   Lot (Radiopharmaceutical) Number Enter/Edit (+)

[RA NM EDIT LOT]

This option allows you to enter lot numbers for the radiopharmaceuticals used at your facility. Before entering new lots, you may need to first use the Vendor/Source (Radiopharmaceutical) Enter/Edit option to enter sources.

You can also enter a new Lot number or ID here

```
Lot (Radiopharmaceutical) Number Enter/Edit

Select RADIOPHARMACEUTICAL LOT NUMBER/ID: 048

Are you adding '048' as a new RADIOPHARMACEUTICAL LOT (the 26TH)? y  (Yes)

RADIOPHARMACEUTICAL LOT SOURCE: UNIVERSITY LABS
```

Select a source from the list that you built using the Vendor/Source (Radiopharmaceutical) Enter/Edit option

```
Are you adding '048' as a new RADIOPHARMACEUTICAL LOT (the 26TH)? y  (Yes)

RADIOPHARMACEUTICAL LOT SOURCE: UNIVERSITY LABS


NUMBER/ID: 048// <RET>
SOURCE: UNIVERSITY LABS// <RET>
```

When a lot is no longer being used, enter an expiration date.

```
EXPIRATION DATE:
```

Entering one or two question marks (?) here will give you a list of active radiopharmaceuticals that you can associate with this lot.

```
RADIOPHARM: SULFUR COLLOID TC-99M        DX201
```

```
Select RADIOPHARMACEUTICAL LOT NUMBER/ID:
```

7.8.3   Route of Administration Enter/Edit (+)

[RA NM EDIT ROUTE]

Use this option to build and manage a list of routes of administration and their corresponding sites of administration. You may want to use the Site of Administration Enter/Edit option first to define sites that will be associated with the routes you enter here.

> **Note:** If no sites are associated with a particular route and status
>   tracking parameters require/ask a route/site, the status
>   parameter is ignored.

```
Route of Administration Enter/Edit

Select ROUTE OF ADMINISTRATION NAME: INTRAVENOUS
Are you adding 'INTRAVENOUS' as a new ROUTE OF ADMINISTRATION (the 19TH)? Y
(Yes)
NAME: INTRAVENOUS// <RET>
Select SYNONYMS: <RET>

   Current parameters for entry of sites for this route :

     PROMPT FOR FREE TEXT SITE?    =
     VALID SITES OF ADMINISTRATION =

                    -- NOTE --
         If 'PROMPT FOR FREE TEXT SITE?' is 'Y',
         then users will not be given a selection
         of predefined 'VALID SITES'

     Select one of the following:

         P          PROMPT FOR FREE TEXT SITE?
         V          VALID SITES OF ADMINISTRATION

Edit which field: VALID SITES OF ADMINISTRATION
Select VALID SITES OF ADMINISTRATION: ??

     Valid sites of drug administration for this route of administration
     should be entered here.  During case edits, users will be restricted
to
     selecting only sites entered here when this route of administration is
     used.

Choose from:
   CERVICAL SUBARACHNOID SPACE
   ENDOTRACHEAL TUBE
   GALL BLADDER
   LEFT ANTECUBITAL FOSSA
   . . .
Select VALID SITES OF ADMINISTRATION: LEFT JUGULAR
Select VALID SITES OF ADMINISTRATION: RIGHT JUGULAR
```

```
Select VALID SITES OF ADMINISTRATION: (etc.) <RET>
```

7.8.4   Site of Administration Enter/Edit (+)

[RA NM EDIT SITE]

Use this option to build a list of sites for the administration of radiopharmaceuticals.
You can also enter a synonym for the site, so users have a choice of terms for
selection. This list is used by the Route of Administration Enter/Edit option in the
Valid Sites of Administration field.

```
Site of Administration Enter/Edit

Select SITE OF ADMINISTRATION NAME: LEFT JUGULAR
  Are you adding 'LEFT JUGULAR' as a new SITE OF ADMINISTRATION (the 36TH)?
Y  (Yes)
NAME: LEFT JUGULAR//
Select SYNONYM: <RET>

Select SITE OF ADMINISTRATION NAME:
```

7.8.5   Vendor/Source (Radiopharmaceutical) Enter/Edit (+)

[RA NM EDIT SOURCE]

Use this option to build a list of vendors, pharmacies or other sources for the
radiopharmaceuticals used in your facility. This list is used by the Lot
(Radiopharmaceutical) Number Enter/Edit option in the Radiopharmaceutical Lot
Source field.

```
Vendor/Source (Radiopharmaceutical) Enter/Edit

Select RADIOPHARMACEUTICAL SOURCE VENDOR/PHARMACY: CHEMICALS INC.
  Are you adding 'CHEMICALS INC.' as
    a new RADIOPHARMACEUTICAL SOURCE (the 11TH)? Y  (Yes)
VENDOR/PHARMACY: CHEMICALS INC.// <RET>

Select RADIOPHARMACEUTICAL SOURCE VENDOR/PHARMACY:
```

7.9   Order Entry Procedure Display Menu

7.9.1   Overview

This menu contains the options to manage the common procedure display used in
either OE/RR or in the Request an Exam option.

7.9.2   Common Procedure Enter/Edit

[RA COMMON PROCEDURE]

The most frequently ordered procedures are setup in a common procedure display to make ordering a Rad/Nuc Med procedure easier for the ordering clinician. You may enter as many procedures into the Common Procedure file as you wish, however, you may only use sequence numbers from 1 to 40 per imaging type. Only procedures with sequence numbers are displayed; therefore, the maximum number of common procedures that can be displayed is 40 per imaging type.

This menu option may be used to add and/or remove (inactivate) procedures from the display (Common Procedure list) users see when entering requests. Procedures should not be deleted from this file, just inactivated. Active common procedure entries require a sequence number to tell the system the order in which they should be displayed on the screen. When you type YES at the "Inactivate from List:" prompt, the system will automatically remove the procedure's sequence number and automatically re-sequence the active common procedures when you exit the option.

If you want to assign a particular sequence number to a new entry on the Common Procedure list, you should reassign the sequence numbers of all procedures on the list that follow the insertion point and assign the selected sequence number to the new entry. For example, if you have 10 entries on your Common Procedure list and you wish to enter a new procedure as sequence number 8, you could reassign sequence numbers 8, 9, and 10 to numbers 11, 12, and 13 and then assign number 8 to the new entry. The entire manual realignment of sequence numbers should be completed before you exit the option, because exiting the option sets the order in which the procedures will be displayed.

The system will automatically re-sequence the numbers to remove any numbering gaps when you exit this option. For example, if you exit the option with 10 active common procedures for the Vascular Lab imaging type and they have sequence number 3, 5, 6, 7, 10, 20, 35, 37, 38, 40, the automatic re-sequencing will replace their order numbers with 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 respectively.

The Radiology/Nuclear Medicine Request an Exam option will display these procedures in the order in which you sequence them. Version 2.5 of OE/RR will also display an identically numbered common procedure list. Version 3.0 of OE/RR will display the same common procedures; however, they will always appear in alphabetical order. If the same clinicians will be using both OE/RR version 3.0 and the Request and Exam option, you may wish to number the procedures (through this option) so that their names are alphabetized.

If you are running version 2.5 of OE/RR, you may also establish a procedure as an orderable item in the OE/RR package through this option.

> **Note:** If you are running a version of OE/RR higher than 2.5, you
> will not see any prompts for creating protocols. Creating
> quick order protocols for OE/RR version 3.0 and beyond
> will be done through OE/RR and is no longer possible
> through Radiology/Nuclear Medicine package.

You will be prompted for the name the procedure can be ordered through OE/RR by
the imaging location where the procedure will be performed, the category of exam,
the requested date of exam, the mode of transport of the patient, the urgency status of
the exam, whether isolation procedures are required, or the modifiers associated with
the procedure. You must enter a name and imaging location or the procedure will not
be accepted as an orderable item. After establishing a procedure as an OE/RR
orderable item, you should use the Create OE/RR Protocol from Common Procedure
option to setup the orderable item (protocol) in the OE/RR package. You may not
edit a protocol once it has been created through the Create OE/RR Protocol from
Common Procedure option.

There is no limit to the number of entries that may be added to the Rad/Nuc Med
Common Procedure file #71.3. Any procedure entered into this file (with or without
a sequence number) can be converted into an OE/RR protocol, thus making the
procedure an orderable item selectable by any user requesting an exam through
OE/RR. When you establish an orderable item through this option and then create a
protocol through the Create OE/RR Protocol from Common Procedure option
(version 2.5 only), you are building a quick order. This means you may select the
protocol through OE/RR and have certain information already associated with the
procedure.

Before you add a new entry to the Common Procedure List, you should use the
Display Common Procedure List option to obtain a list of procedures and their
sequence numbers. This list will help you determine where you want the new entry
placed and what sequence numbers can be used.

```
Common Procedure Enter/Edit

Select one of the following Imaging Types:
    GENERAL RADIOLOGY
    NUCLEAR MEDICINE
    ULTRASOUND
    CT SCAN
    CARDIOLOGY STUDIES (NUC MED)

Select IMAGING TYPE: NM  NUCLEAR MEDICINE
```

> Note; The procedures already entered as Common Procedures
> appear with their sequence number to the right. If no
> sequence number is listed, that procedure has been
> "inactivated" from the common procedure list.

```
Select RAD/NUC MED COMMON PROCEDURE: ??
   PARATHYROID SCAN     (3)
   GASTROESOPHAGEAL REFLUX STUDY   (2)
   GI BLOOD LOSS-ACUTE GI BLEED   (5)
   WHOLE BLOOD VOLUME    (4)
   LYMPHATIC/LYMPH NODE IMAGING  (no sequence number)
   HEPATOBILIARY SCAN (HIDA SCAN)    (6)
   ESOPHAGEAL MOTILITY   (7)
   CARDIAC SHUNT DETECTION   (8)
   CEREBRAL BLOOD FLOW   (1)

    You may enter a new RAD/NUC MED COMMON PROCEDURE
    if you wish.  Enter a procedure name.  Only
    active procedures may be selected.
 Answer with RAD/NUC MED PROCEDURES NAME
 Do you want the entire RAD/NUC MED PROCEDURES
             List? NO
Select RAD/NUC MED COMMON PROCEDURE: BONE SCAN
                                  (NM  Broad  )
  Are you adding 'BONE SCAN' as
    a new RAD/NUC MED COMMON PROCEDURE (the 19TH)? Y
                                               (Yes)
```

When adding a new procedure, simply bypass this prompt. To remove a procedure
from the Common Procedure list, enter YES at this prompt.

```
PROCEDURE: BONE SCAN// <RET>

INACTIVATE FROM LIST: <RET>

SEQUENCE NUMBER: 12// <RET>
```

Typing yes will make this procedure an orderable protocol in OE/RR. All prompts
below this are for the purpose of defining data to establish a quick order protocol. If
you answer NO to this prompt, none of the prompts below will appear. (This prompt
and the ones below will not appear if your site has installed a version of OE/RR
higher than 2.5.)

```
Do you wish to establish this procedure as a quick order item in OE/RR?
No// YES
```

This text will appear to the user ordering the exam.

```
NAME OF ORDERABLE ITEM: BONE SCAN
```

If there are no specific modifiers that go with this exam, you can bypass this prompt.

```
Select MODIFIERS: <RET>
```

The exam request will be printed at the location entered here.

```
IMAGING LOCATION: ?
Enter the Imaging Location for this procedure.
```

```
The Imaging Type of the procedure and the Imaging Type of the location must
be the same.
 Answer with IMAGING LOCATIONS TYPE OF IMAGING
Choose from:
  NUC MED LOC      (NUCLEAR MEDICINE-449)
  NUC              (NUCLEAR MEDICINE-639)
```

In this example, the default (Inpatient) is correct, so we press the Return key to
bypass this prompt.

```
IMAGING LOCATION: NUC

CATEGORY OF EXAM: ?
     If an entry is not made for this field, the
     category of 'Inpatient' will
     automatically be entered for each request
     generated from the protocol that
     is built for this procedure.
     Choose from:
       I          INPATIENT
       O          OUTPATIENT
       C          CONTRACT
       S          SHARING
       E          EMPLOYEE
       R          RESEARCH
CATEGORY OF EXAM: <RET>
```

If the default (Today) is correct, press the Return key to bypass this prompt.

```
REQUESTED DATE: ?
     If an entry is not made in this field, the date
     of today (TODAY) will automatically be
     entered for each request generated from the
     protocol that is built for this procedure.
     Choose from:
       TODAY    TODAY
       TODAY+1  TOMORROW
REQUESTED DATE: <RET>
```

If the default (Ambulatory) is acceptable, press the Return key to bypass this prompt.

```
MODE OF TRANSPORT: ?
     If an entry is not made in this field, the mode
     of transport of 'ambulatory' will
     automatically be entered for each request
     generated from the protocol that
     is built for this procedure.
     Choose from:
       a          AMBULATORY
       p          PORTABLE
       s          STRETCHER
       w          WHEEL CHAIR
MODE OF TRANSPORT: <RET>
```

If isolation is not required, press the Return key.

```
ISOLATION PROCEDURES: ?
     If an entry is not made in this field, a value
     of 'NO' (isolation procedures not required)
     will automatically be entered for each request
     generated from the protocol that is built for
     this procedure.
     Choose from:
       y          YES
       n          NO
ISOLATION PROCEDURES: <RET>
```

If routine is acceptable, press the Return key.

```
REQUEST URGENCY: ?
     If an entry is not made in this field, a request
     urgency of 'ROUTINE' will automatically
     be entered for each request generated from the
     protocol that is built for this procedure.
     Choose from:
       1          STAT
       2          URGENT
       9          ROUTINE
REQUEST URGENCY: <RET>

Select RAD/NUC MED COMMON PROCEDURE: <RET>
```

7.9.3   Create OE/RR Protocol from Common Procedure

[RA CREATE OE/RR PROTOCOL]

> **Note:** This option is functional only if OE/RR Version 2.5 is
> installed. If a higher version of OE/RR is installed, this
> option is not available and the system will display a
> message to that effect.

This option is used to create orderable items (protocols) in the Order Entry/Results
Reporting (OE/RR) package V 2.5 based upon entries in the Rad/Nuc Med Common
Procedures file. When you choose this option, the entire list of procedures in the
Rad/Nuc Med Common Procedure file is presented for your selection as shown
below. Press the <RET> key until your choice comes up. Then select the number of
that choice. The example in section 7.9.2 added Bone Scan to the file. In the
example below, a protocol will be created for it.

```
          Create an OE/RR Protocol from a Radiology/Nuclear Medicine
          Common Procedure

1     ACUTE GI BLOOD LOSS IMAGING
2     ANGIO CAROTID CEREBRAL UNILAT S&I
3     ANGIO CERVICOCEREBRAL CATH CP
4     ARTHROGRAM KNEE CP
5     BONE AGE
6     BRAIN IMAGING COMPLETE STUDY WITH VASCULAR FLOW, PLANAR
7     CHEST STEREO PA
```

```
8     ECHOCARDIOGRAM M-MODE COMPLETE
9     MAMMOGRAM BILAT
10    RADIONUCLIDE THERAPY, HYPERTHYROIDISM
11    ABDOMEN 1 VIEW
12    ARTHROGRAM ANKLE S&I
13    ANGIO CORONARY BILAT INJ S&I
14    ECHOGRAM ABDOMEN COMPLETE
15    RADIONUCLIDE THERAPY, THYROID SUPPRESSION
Type '^' to STOP, or
Choose from 1-15: <RET>
16    BRAIN IMAGING, PLANAR ONLY
17    BONE SCAN
18    ACROMIOCLAVICULAR J BILAT
Type '^' to STOP, or
Choose from 1-18: 17

Processing the BONE SCAN procedure.

  Located in the RA (RADIOLOGY/NUCLEAR MEDICINE) namespace.
RA584 BONE SCAN PROTOCOL Created
```

7.9.4   Display Common Procedure List

[RA DISPLAY COMMON PROCEDURES]

This option allows you to see the common procedure list that the users will see when they are requesting a procedure through OE/RR version 2.5 or the Radiology/Nuclear Medicine package. OE/RR version 3.0 will also display the same procedures, but they will be in alphabetical order instead of the order assigned through the Order Entry Procedure Display menu.

```
Select one of the following Imaging Types:
   GENERAL RADIOLOGY
   NUCLEAR MEDICINE
   ULTRASOUND
   CT SCAN
   CARDIOLOGY STUDIES (NUC MED)

Select IMAGING TYPE: GENERAL RADIOLOGY


      COMMON RADIOLOGY/NUCLEAR MEDICINE PROCEDURES (GENERAL RADIOLOGY)
      ----------------------------------------------------------------
 1) ACUTE GI BLOOD LOSS IMAGING        7) ECHOGRAM ABDOMEN COMPLETE
 2) ANGIO CAROTID CEREBRAL UNILAT S&   8) RADIONUCLIDE THERAPY, THYROID
SU
 3) ANGIO CORONARY BILAT INJ S&I       9) ABDOMEN 1 VIEW
 4) ARTHROGRAM ANKLE S&I              10) MAMMOGRAM BILAT
 5) BRAIN IMAGING, PLANAR ONLY        11) BONE AGE
 6) CHEST STEREO PA                   12) BONE SCAN


Press RETURN to continue...<RET>
```

7.10   Procedure Edit Menu

7.10.1   Overview

This menu contains the options to define and manage data for procedures.

7.10.2   Cost of Procedure Enter/Edit (+)

[RA PROCOSTEDIT]

This function allows you to apply a cost to procedures. Unit cost and total cost appear on the Procedure/CPT Statistics report [RA CPTSTATS].

You are asked for an imaging type, the procedure you want to edit, and the cost. Only procedures matching the selected imaging type(s) can have their cost edited. Select procedures by entering either the CPT code for the procedure or the procedure name.

```
Cost of Procedure Enter/Edit

Select Imaging Type: All// <ret>

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

Select RAD/NUC MED PROCEDURES NAME: 71020          CHEST X-RAY   CHEST 2
VIEWS PA&LAT     (RAD  Detailed) CPT:71020
COST OF PROCEDURE: 99.98
```

7.10.3   Procedure Enter/Edit

[RA PROCEDURE]

This function allows you to enter new procedures into the system and to edit existing procedures. Entries in this file are used as the allowable selections for users at any Procedure prompt. This prompt appears as part of the Request an Exam, Register an Exam, Add Exam to Last Visit, Case No. Exam Edit, and the Exam Status Tracking options.

Rad/Nuc Med Procedures Name

You can only edit the name of the procedure if the procedure was added by your site; if the procedure was distributed by the package, editing the name field is not allowed. Entries are related to Imaging Types. If the same procedure is done by two different locations of differing Imaging Types then you need to enter them with slightly different names but with the same CPT and AMIS codes:

- US - Carotid doppler

- VAS - Carotid doppler

Type of Imaging

This field is used to associate a particular imaging type to a procedure. Each procedure can only be associated with one imaging type. You may enter a new procedure with a slightly different name to make it show up for a second imaging type.

Example: You want Carotid Doppler for Ultrasound and for Vascular Lab. One procedure can be called Carotid Doppler and assigned to the Ultrasound Imaging Type and the other VAS - Carotid Doppler with the Vascular Lab Imaging Type.

If you have activated a new imaging type and are changing the imaging type of procedures to match the new imaging type, you will also have to deactivate these procedures from the Common Procedure list (if they are common procedures). They can later be put on a separate new common procedure list under the new imaging type. Refer to Common Procedure Enter/Edit (section 7.9.2) for more information.

Type of Procedure

There are four types of procedures:

- Detailed: Procedure is associated with an AMIS code and must have a CPT (Current Procedural Terminology) code assigned to it.

- Series: Procedure is associated with more than one AMIS code and must have a CPT code assigned to it. It is recommended that the Type of Procedure field be set to Series for all procedures with more than one AMIS code. In addition to being reported under each AMIS code, the procedures with multiple AMIS codes are also tallied in the "Series of AMIS Codes" line item of the AMIS report. Setting these procedures as a Series type serves as a reminder to users. The AMIS Report counts each Series procedure the same as the Detailed procedure in the body of the report, but an additional line tallies the Series procedures by themselves. The Bilateral, Operating Room, and Portable modifiers are not allowed for Series procedures as that would cause the AMIS Report to be incorrect.

  Broad: Procedure is mainly used by the receptionist, clerk, or ordering clinician when scheduling a patient for an exam. It is used when s/he is not exactly sure which Detailed or Series procedure will be performed. However, before the exam can be considered Complete, the procedure should be changed to a Detailed or Series in order to insure adequate workload credit to your facility. Broad procedures are not associated with a CPT or AMIS codes. These prompts will not be seen if the user selects Broad as the procedure type. If no CPT code is entered for a Detailed or Series procedure, the procedure type is automatically changed to Broad.

If the Division parameter requiring a Detailed or Series procedure upon initial exam registration is set to YES, then the ordering party will not be able to select a Broad procedure.

- Parent: Procedure is used for ordering purposes only. It must have descendents (other procedures of Detailed or Series type) that are actually registered. Parent procedures are used to simplify the ordering process when a group of related procedures must be done. (See Parent/Descendent Exam and Printsets, page 143.) Similar to Broad procedures, they act as temporary placeholders. When a parent order is requested, the system automatically finds all the descendants and the parent itself is never actually registered.

When creating a Parent procedure, make the parent name slightly different than any of its descendents so the system will accept it as a new procedure. Remember, when you are creating a Parent, no CPT code is entered; therefore, it will not be registered. All descendents must be either Detailed or Series Type with a CPT code.

Example:

- Parent: Arthrogram of the Shoulder (or Arthrogram - Shoulder)
- Descendents:73040, 23350

Modality

This is a new field that only appears when you are defining either Detailed or Series type procedures. Each procedure can have more than one modality. The modality data is used by the Imaging package to produce a modality work list that will help to correctly identify a patient. If you are not running the Imaging package at your site, you may bypass this field.

+ Single Report

This is a new field that only appears when you define a procedure as a Parent procedure. If this field is left unanswered, then the reporting of the procedure's descendents will be put into separate reports, as in the previous version. If this field is answered YES, then the reporting of the procedure's descendents will be combined into one report, where the case records for these descendents will have the same data for report text, impression, pre-verifier, verifier, staff (primary and secondary), residents (primary and secondary), diagnoses, and all other report-related fields.

Health Summary With Request

This field points to the Health Summary Type file. When a procedure is requested, this field is checked for an associated Health Summary Type and, if one exists, it is printed along with the request. You can select an appropriate Health Summary Type here. If necessary, you may need to check with your clinical coordinator for help in setting up useful health summary formats.

Synonym

One or more synonyms may be associated with a procedure. At any Procedure prompt, a synonym can be entered to select a procedure if you have predefined the synonym here.

+Prompt For Meds

This is a new field. It only appears for procedures that are Detailed or Series. If this field is set to YES, case edits will prompt for medications administered for this procedure. To make Status Tracking prompt for medications administered, this field must be set to YES and the Examination Status parameter "Ask Medications & Dosages" must be set to YES for one or more statuses of the procedure's Imaging Type.

+Default Medication

This is a new field. It only appears for procedures that are Detailed or Series. Use this field to enter any medications when they are usually used for the procedure. Radiopharmaceuticals may not be entered in this field. Medications, if defined here, are entered automatically into the patient exam record by the system during registration.

+ Default Med Dose

This field will only appear if you enter a Default Medication. If a default dose is entered, it will be automatically entered on the patient's exam record at the time the procedure is registered. Acceptable format: 99999.999 [unit of measure]. The unit of measure may be between 1-30 characters in length. Example: 2.5 mg

+Suppress Radiopharm Prompt

This is a new prompt that only applies to Detailed or Series procedures with an Imaging Type that uses radiopharmaceuticals (i.e., nuclear medicine or cardiology studies). If the exam status setup for the affected Imaging Types specifies that radiopharmaceutical data should be asked and/or required to progress to various statuses, this field can be used to over-ride that requirement for a particular procedure.

Available categories are defined as follows:

0 or blank

Ask for radiopharmaceutical if and when exam status parameters specify (this is the default).

1

Suppress the Radiopharmaceutical prompt. Never ask or require Radiopharmaceutical even if exam status parameters specify that a Radiopharmaceutical should be entered. Even if default Radiopharmaceuticals are entered for the procedure they will not be automatically entered on the exam record by the system when the case is registered.

+   □Prompt For Radiopharm Rx

This is a new prompt that only applies to Detailed or Series procedures with an Imaging Type that uses radiopharmaceuticals (nuclear medicine or cardiology studies). It controls whether case edit and status tracking options prompt for prescribing physician, prescribed radiopharmaceutical dose, and witness to the dose administration. If you answer YES to this field, prescriber and witness prompts will appear for any radiopharmaceuticals entered for this procedure. (For example, a witness is necessary for a Total Body Iodine procedure so you would answer YES at this field for that procedure.) If this field is left blank, prescriber and witness prompts will not appear. If this field is set to YES, Status Tracking will prompt during each edit session until the data is entered; case edits will always prompt, even if the data has already been entered.

+   □Default Radiopharmaceutical

This is a new prompt that only applies to Detailed or Series procedures with an Imaging Type that uses radiopharmaceuticals (nuclear medicine or cardiology studies). It will be automatically entered as a radiopharmaceutical on patients' nuclear medicine exam records during registration. This information can be changed, if necessary, during case edit. If nothing is entered in this field, no radiopharmaceuticals will be automatically entered during registration for this procedure.

> **Note:** The radiopharmaceutical is the only data item that is
> actually automatically entered on the patient exam record
> during registration. No dosage amounts or routes of
> administration are entered automatically; however, they
> will appear as default responses.

+ Low Adult Dose (in mCi)

This is the lowest usual adult dosage commonly associated with this radiopharmaceutical when administered for this procedure. The system will display this value and the high adult dose when asking for the actual dosage during case editing. If the dosage entered for an exam falls outside of the usual high/low range, the person editing the case will see a warning message. If you do not want a warning to appear no matter how low the dosage entered, do not enter a low range dosage here.

+ High Adult Dose (in mCi)

This is the highest usual adult dosage commonly associated with this radiopharmaceutical when administered for this procedure. The system will display this value and the low adult dose when asking for the actual dosage during case editing. If the dosage entered for an exam falls outside of the usual high/low range, the person editing the case will see a warning message. This is a mandatory data item.

+ Usual Dose (in mCi)

This is the usual dosage (in mCi) associated with this radiopharmaceutical. It will appear as an informational item on the screen just before the user is prompted for the actual Dose. If nothing is entered in this field, no usual dose information will be displayed. The usual dose you enter here must fall within the Low Adult Dose and High Adult Dose described above.

+ Default Route Of Administration

This is the route of administration commonly associated with this radiopharmaceutical for this procedure. It will appear as the default response when the route of administration is asked during case editing. If nothing is entered in this field, no default route of administration will be displayed.

+ Default Site Of Administration

This is the bodily site for administering the radiopharmaceutical for the procedure being defined. The system will use this for the default response during case editing. If nothing is entered here, there will be no default response to the Site of Administration question during case editing.

+ Default Form

This is the form of this Radiopharmaceutical when used in this procedure. If entered, it will be used as the default answer to the "Form" prompt during case edits.

AMIS Code

This field contains the valid AMIS code(s) from the Major AMIS Codes file associated with this exam procedure. There may be more than one AMIS code associated with each procedure. If the procedure type is Detailed, there will be one AMIS code. If the procedure type is Series, there will be more than one AMIS code. Broad and Parent types of procedures have no AMIS code.

AMIS Weight Multiplier

You are not likely to change an AMIS Weight Multiplier unless VA HEADQUARTERS rules the change. However, if you add a new procedure, you must determine from VA Headquarters guidelines what should be entered at this prompt.

This field contains a number (0-99) to indicate to the various workload report routines how many times to multiply the weighted work units associated with the AMIS code. The weight for each AMIS code is stored in the Major Rad/Nuc Med AMIS Code file.

Most multipliers will be 1. However, there are some that are greater than 1. For example, the procedure called Upper GI + Small Bowel has the AMIS code 9-Gastrointestinal which has a weight of 6 work units. But, the AMIS multiplier is 2. Therefore on the workload reports, the site will get credit for 12 weighted work units each time it is performed.

Radiology Central Office has directed that the weighted work unit for Ultrasound procedures involving multiple organs in the same visit can be counted only once if the organs are located close to each other (i.e. Liver and Gallbladder).

Bilateral

This field contains a YES to indicate that this is a bilateral procedure or a NO if it is not a bilateral procedure. If it contains a YES, then the system multiplies the AMIS weight by 2. No harm is done by indicating the Multiplier as 2 and Bilateral as YES. The system will only use 2 as the multiplier, not (2*2).

CPT CODE

Only detailed and series procedures require a CPT Code so this prompt will only appear when editing a detailed or series procedure. This field is screened to ensure that the CPT Code is active on the date that this option was used.

Default CPT Modifiers (PROC)

Default CPT Modifier(s) entered for this procedure will be automatically entered into the exam record during exam registration. This field is screened to ensure that the CPT Modifier is active on the date that this option was used, and that it is compatible with the CPT CODE for this procedure.

Staff Review Required

If the procedure requires an interpreting staff physician's review of the resident's report, even though the division parameter is set to allow residents to verify reports, enter a YES at this prompt. (Refer to Personnel Classification and Division Parameter Set-up for other factors that control whether residents can verify reports.) This field does not appear with Broad or Parent procedures.

Rad/Nm Phys Approval Required

If YES is entered at this prompt, when a request for this procedure is entered, the request will require the name of the approving physician. This name will print on the request form.

Required Flash Card Printer

This field contains the name (1-20 characters) of the location where the flash cards for this procedure are to be printed. Normally, the flash cards are printed at the reception desk, however, for particular procedures the flash cards may be printed at a different location such as where the exam is to be performed. This field does not appear with Parent procedures since Parent procedures are not registered.

> **Note:** The exam labels will print out on the flash card printer associated with the imaging location parameter.

Required Flash Card Format

If a flash card format has been defined, you can associate a specific format with this procedure. Otherwise the format defined for the location will be used. This field does not appear with Parent procedures, since flash cards are only printed during registration and parent procedures are never registered.

Film Type

This field contains a default value of the type of film from the Film Sizes file that is usually needed for this procedure. During the exam registration process, the system checks this field for a film type. If film type exists, then it is automatically entered into the Film Type field of the exam record. The entry in the exam record can be edited. Only procedures that are performed a relatively high number of times, such as Chest PA&LAT, should have data entered for this field. This field does not appear with Parent procedures since parent procedures are never registered.

Normal Amount Needed For Exam

This field contains the default value (a number from 1 through 10) of the normal amount of film usually required for this procedure. During the exam registration process, the system checks this field for data. If data is present, then the information in this field is stuffed into the "Number Used" field of the exam record. The technologist is allowed to modify this data after performing the exam. Only procedures that are performed a relatively high number of times should have data entered for this field. The procedure CHEST PA&LAT is a good example.

Message

You can select a message from the Rad/Nuc Med Procedure Message file for this procedure that will automatically appear at the time of the request and will be printed on the request form.

Descendents

This field only appears with Parent procedures. Enter any Detailed or Series procedures that make up the set. Remember that the Parent procedure is a placeholder for ordering and will not be registered, so all procedures to be registered must be entered as descendents.

> **Note:** To add a second procedure that is the same as one already entered, enter either the CPT code or the procedure name in quotes as shown here:

```
Select DESCENDENTS: FOOT 2 VIEWS// ?
 Answer with DESCENDENTS
Choose from:
   ANKLE 2 VIEWS
   FOOT 2 VIEWS
   TOE(S) 2 OR MORE VIEWS

     You may enter a new DESCENDENTS, if you wish
```

```
      Enter a procedure name which is related to the parent procedure.
      Select only active detailed or series procedures of the same
      imaging type as the parent.
 Answer with RAD/NUC MED PROCEDURES NAME, or CPT CODE, or SYNONYM
 Do you want the entire RAD/NUC MED PROCEDURES List? n  (No)
Select DESCENDENTS: FOOT 2 VIEWS//"FOOT 2 VIEWS"
```

+ Educational Description

This is a new field used to describe the procedure and give information about its
purpose in confirming or eliminating various diagnoses. It may be used for
educational purposes by clinicians who are trying to familiarize themselves with
imaging procedures that are available. If you enter an educational description, you
are also asked if you want to "Display Educational Description When Ordered".
Entering YES at that field displays the description along with any Procedure
Message during the ordering process.

Note: If you are using the Screen Editor to add an Educational
Description and you want a list of items, to keep the list
from wrapping add a space (<sp>) before each item as
shown in the following example:

```
When ordering this procedure, we recommend the following steps be taken:
<sp>1)  Do this first.
<sp>2)  Next do this.
<sp>3)  Etc.
```

Display Educational Description When Ordered

This field determines whether or not the Educational Description of a procedure
should be displayed along with the procedure message (if any) at the time the
procedure is ordered. Enter YES to display the description with the procedure
message, NO to not display the description.

Inactivation Date

If the procedure has an inactivation date prior to the current date, then the
procedure is not a valid choice and will not appear on the list of active procedures
when displayed to the user. Entering an inactivation date makes the procedure
invisible to users so it cannot be selected. This should only be done if the
procedure becomes obsolete or should not be ordered or performed at your site.
You can enter a future date. This is useful if for example a CPT becomes inactive
on January 1 and you want to enter it earlier than that date. Inactivation takes
effect at midnight of the date you enter.

Here is an example of a Nuclear Medicine, Detailed procedure. The prompts for
radiopharmaceuticals only appear when the procedure has an Imaging Type of
Nuclear Medicine or Cardiology Studies:

```
Select RAD/NUC MED PROCEDURES NAME:    ACUTE GI BLOOD LOSS IMAGING      (NM
Detailed) CPT:78278
NAME: ACUTE GI BLOOD LOSS IMAGING  Replace <RET>
TYPE OF IMAGING: NUCLEAR MEDICINE// <RET>
```

```
TYPE OF PROCEDURE: DETAILED// <RET>
HEALTH SUMMARY WITH REQUEST: INPATIENT// <RET>
Select SYNONYM: INPT// <RET>
PROMPT FOR MEDS: YES//<RET>
Select DEFAULT MEDICATION: LIDOCAINE 0.5% W/EPI INJ MDV// <RET>
  DEFAULT MEDICATION: LIDOCAINE 0.5% W/EPI INJ MDV// <RET>
▯▯▯ DEFAULT MED DOSE: <RET>


   Reminder --

   Selection of 'Suppress' for 'SUPPRESS RADIOPHARM PROMPT' will result in
   the deletion of all default radiopharmaceutical information for this
   procedure.

SUPPRESS RADIOPHARM PROMPT: Always// <RET>
PROMPT FOR RADIOPHARM RX: YES// <RET>
Select DEFAULT RADIOPHARMACEUTICAL: SULFUR COLLOID TC-99M// PERCHLORACAP
250MG
   CAPS              DX201


         ...OK? Yes// <RET>  (Yes)

  DEFAULT RADIOPHARMACEUTICAL: PERCHLORACAP 250MG CAPS
         // <RET>
  LOW ADULT DOSE (in mCi): 2// <RET>
  HIGH ADULT DOSE (in mCi): 5// <RET>
     Input a 'Usual Dose' value within the range of: 2-5
  USUAL DOSE (in mCi): 3// <RET>
  DFLT ROUTE OF ADMINISTRATION: ORAL// <RET>
  DEFAULT SITE OF ADMINISTRATION: MOUTH// <RET>
  DEFAULT FORM: Solid (Other)// <RET>
Select DEFAULT RADIOPHARMACEUTICAL:<RET>
Select AMIS CODE: NUCLEAR MEDICINE// <RET>
  AMIS CODE: NUCLEAR MEDICINE// <RET>
  AMIS WEIGHT MULTIPLIER: 1// <RET>
Select AMIS CODE: <RET>
CPT CODE: 78278// <RET>
STAFF REVIEW REQUIRED: NO// <RET>
RAD/NM PHYS APPROVAL REQUIRED: NO// <RET>
REQUIRED FLASH CARD PRINTER: <RET>
REQUIRED FLASH CARD FORMAT: ER FORMAT// <RET>
Select FILM TYPE: 11X14// <RET>
  FILM TYPE: 11X14// <RET>
  NORMAL AMOUNT NEEDED FOR EXAM: 1// <RET>
Select FILM TYPE: <RET>
Select MESSAGE: CALL DR. SMITH BEFORE ORDERING THIS PROCEDURE// <RET>
EDUCATIONAL DESCRIPTION:
This test is designed to LOCATE the site of KNOWN GI bleeding, NOT to
determine whether there IS GI bleeding.

  Edit? NO// <RET>
DISPLAY EDUCATIONAL DESCRIPTION WHEN ORDERED: YES// <RET>
INACTIVATION DATE: <RET>
```

Here is an example of a Parent procedure entry:

```
Select RAD/NUC MED PROCEDURES NAME: AORTAL FEMORAL RUNOFF
  Are you adding 'AORTAL FEMORAL RUNOFF' as
   a new RAD/NUC MED PROCEDURES (the 737TH)? Y  (Yes)
    RAD/NUC MED PROCEDURES TYPE OF PROCEDURE: P  PARENT
```

```
NAME: AORTAL FEMORAL RUNOFF  Replace <RET>
TYPE OF IMAGING: GENERAL RADIOLOGY
TYPE OF PROCEDURE: PARENT// <RET>
SINGLE REPORT: YES
HEALTH SUMMARY WITH REQUEST: <RET>
Select SYNONYM: <RET>
RAD/NUC MED PHYS APPROVAL REQUIRED: NO// <RET>
Select MESSAGE: <RET>
Select DESCENDENTS: 75625   CONTRAST X-RAY EXAM OF AORTA  AORTO ABD TRANS L
W/SERIAL FILMS S&I     (Detailed) CPT:75625
  Are you adding 'AORTO ABD TRANS L W/SERIAL FILMS S&I' as
    a new DESCENDENTS (the 1ST for this RAD/NUC MED PROCEDURES)? Y  (Yes)
Select DESCENDENTS: 36200    PLACE CATHETER IN AORTA  AORTA, CATHETER
(FEMORAL OR AXILLARY APPROACH)     (Detailed) CPT:36200
  Are you adding 'AORTA, CATHETER (FEMORAL OR AXILLARY APPROACH)' as
    a new DESCENDENTS (the 2ND for this RAD/NUC MED PROCEDURES)? Y  (Yes)
Select DESCENDENTS: 75716   ARTERY X-RAYS, ARMS/LEGS  ANGIO EXTREMITY BILAT
S&I     (Detailed) CPT:75716
  Are you adding 'ANGIO EXTREMITY BILAT S&I' as
    a new DESCENDENTS (the 3RD for this RAD/NUC MED PROCEDURES)? Y  (Yes)
Select DESCENDENTS: <RET>

EDUCATIONAL DESCRIPTION:
  No existing text
  Edit? NO// <RET>
INACTIVATION DATE: <RET>
```

7.10.4   Procedure Message Entry/Edit

[RA PROCMSGEDIT]

This option is used to enter, edit and delete messages related to procedures. These
messages are used at the time of request to alert the requester of special requirements
related to the procedure. The requirements may be other tests that need to be done
before the procedure or special approval needed to request the procedure.

Messages entered through this option are associated with procedures in the Rad/Nuc
Med Procedures file using the Procedure Enter/Edit option. Multiple messages can
be associated with one procedure.

> **Note:** Procedure messages cannot be deleted from this file.
> Instead, use the Procedure Enter/Edit option to remove the
> message from the procedure.

In this example, we show you how to add a new message. It must be 3 to 240
characters in length. Do not begin the message with any special characters such as
"*" or "#". Use letters or numbers only.

> **Note:** It is strongly recommended that the first 30 characters of
> the message text be unique to facilitate selection of entries.

```
Select RAD/NUC MED PROCEDURE MESSAGE TEXT: ??
```

```
Choose from:
   Patient must be NPO after midnight before test
   Patient must have RUQ pain, fever, elevated WBC
   Patient must not have eaten within 3 hours
   This test is not useful for assessing CHRONIC
   cholecystitis!

     This field contains messages concerning special
     requirements when ordering a procedure.
     One or more of these messages can be tied to a
     procedure in the RAD/NUC MED PROCEDURES
     file (#71).

Select RAD/NUC MED PROCEDURE MESSAGE TEXT: Make sure the patient has not
eaten for 3 hours prior to the test to avoid a false positive result!

  Are you adding 'Make sure the patient has not eaten for 3 hours prior to
the test to avoid a false positive result!' as a new RAD/NUC MED PROCEDURE
MESSAGE (the 17TH)? Y  (Yes)

TEXT: Make sure the patient has not eaten for 3 hours prior to the test to
avoid a false positive result!  Replace <RET>

Select RAD/NUC MED PROCEDURE MESSAGE TEXT: <RET>
```

• Procedure Modifier Entry
    [RA MODIFIER]

This option allows the entry of new modifiers to the Procedure Modifier file (#71.2).
Procedure modifiers are used to further describe the procedure. Frequently used
modifiers include Right, Left, Bilateral, Portable, etc. This file provides the list of
selections for the prompt "Select MODIFIERS" found in the exam edit options. An
examination report will show any modifiers that have been entered for that
examination.

You cannot delete a modifier. To make it inactive for an Imaging Type, type an at
sign (@) at the prompt "Select TYPE OF IMAGING" for the Imaging Type you
want.

If all Imaging Types are deleted from the "TYPE OF IMAGING:" field for a
modifier, users will not be able to select it for any exams.

Enter a modifier 2-30 characters in length

```
Select Procedure Modifier: CORONAL
  Are you adding 'CORONAL' as a new PROCEDURE
  MODIFIERS (the 11TH)? Y  (Yes)

Select TYPE OF IMAGING: ?
 Answer with TYPE OF IMAGING
     You may enter a new TYPE OF IMAGING, if you wish
     Enter the Imaging Type(s) for which this
     modifier is valid.
```

```
 Answer with IMAGING TYPE TYPE OF IMAGING, or ABBREVIATION
Choose from:
    ANGIO/NEURO/INTERVENTIONAL
    CARDIOLOGY STUDIES (NUC MED)
    CT SCAN
    GENERAL RADIOLOGY
    MAGNETIC RESONANCE IMAGING
    NUCLEAR MEDICINE
    ULTRASOUND
    VASCULAR LAB
    MAMMOGRAPHY
```

Type the name of one or more Imaging Types that will use this modifier.

```
Select TYPE OF IMAGING: GENERAL RADIOLOGY
Select TYPE OF IMAGING: <RET>
```

If this modifier would mean that the procedure is done bilaterally or in the operating room or with portable equipment, select the appropriate response here. AMIS credit is doubled when a procedure or exam has a bilateral modifier. Operating room and portable exams are counted under both the exams AMIS category and the operating room or portable AMIS category.

```
AMIS CREDIT INDICATOR: ?
     If this modifier receives extra AMIS credit,
     enter the type of credit indicator it requires.
     Choose from:
       b          BILATERAL
       o          OPERATING ROOM
       p          PORTABLE
AMIS CREDIT INDICATOR: <RET>


Select Procedure Modifier: <RET>
```

7.11   Reason Edit

[RA REASON EDIT]

This option allows entry of new reasons in the Rad/Nuc Med Reason file (#75.2) for placing orders on hold and for canceling orders and exams. A reason can be flagged for display during a "Hold" action only, during a "cancel" action only, or be allowed for both.

The Nature of Order Activity

This prompt determines actions that OE/RR version 3.0 will take when it is
notified that an order was held or canceled by the imaging service. This prompt
will not appear unless OE/RR V. 3.0 or higher is installed on your system. The
Nature of Order Activity you enter here may trigger or suppress OE/RR V. 3.0
printing of a chart copy of the hold or cancel order. It may also trigger or
suppress OE/RR V. 3.0 alerting the original requesting physician that his/her
electronic signature is needed. The master file of Nature of Order Activities
resides within the OE/RR V. 3.0 software and may be configured differently at
each facility. The radiology supervisor should coordinate Nature of Order
Activity setup with the OE/RR V. 3.0 or clinical coordinator.

> Do not delete entries from this file. Do not change the meaning of
> an entry by editing the "Reason" field after the Rad/Nuc Med
> software is in use.

You can enter a new reason, 3-70 characters in length, or select a reason to edit.

```
Select RAD/NUC MED REASON: ANESTHESIA CONSULT NEEDED        Synonym: ANES

REASON: ANESTHESIA CONSULT NEEDED  Replace <RET>

TYPE OF REASON: GENERAL REQUEST// ?

Enter the type of reason, '1' for cancel, '3' for hold, or '9' for general.
     Choose from:
        1          CANCEL REQUEST
        3          HOLD REQUEST
        9          GENERAL REQUEST

TYPE OF REASON: GENERAL REQUEST// <RET>
SYNONYM: ANES// <RET>

NATURE OF ORDER ACTIVITY: ?
     Enter the code that most closely describes this reason when used to
hold or cancel an order.

                             Require       Print      Print on
  Nature of Order Activity   Signature   Chart Copy   Summary
  ------------------------   ---------   ----------   --------
   WRITTEN                                               x
   VERBAL                        x           x           x
   TELEPHONED                    x           x           x
   SERVICE CORRECTION
   POLICY                                    x           x
   DUPLICATE
   REJECTED
   PHYSICIAN ENTERED             x           x           x
   AUTO
     Choose from:
       w        WRITTEN
       v        VERBAL
       p        TELEPHONED
       s        SERVICE CORRECTION
       x        REJECTED
```

```
        d       DUPLICATE
        i       POLICY
        e       PHYSICIAN ENTERED
        a       AUTO
NATURE OF ORDER ACTIVITY: x  REJECTED


Select RAD/NUC MED REASON:
```

7.12   Reports Distribution Edit

[RA DISTEDIT]

The distribution queue functionality of this package makes it possible to print results reports by ward, clinic, file room, etc. If a distribution queue is activated, at the time a report is verified, it will automatically be placed in the appropriate queue(s). This option allows you to edit specific report distribution queues. The types of distribution queues which can be edited are the following:

- Clinic Reports

- File Room

- Medical Records

- Other than Ward or Clinic

- Requesting Physician

- Ward Reports

Information that may be edited for the distribution queues include: a top of page message, the category of reports to be included in the queue, and the date after which the distribution queue should become inactivated.

Select the queue you want to edit.

```
Select REPORT DISTRIBUTION QUEUE NAME: ??

Choose from:
   CLINIC REPORTS
   FILE ROOM
   MEDICAL RECORDS
   OTHER THAN WARD OR CLINIC
   REQUESTING PHYSICIAN
   WARD REPORTS

Select REPORT DISTRIBUTION QUEUE NAME: FILE ROOM

TOP OF PAGE MESSAGE: ***** Radiology File Room Distribution *****
          Replace <RET>

CATEGORY OF REPORTS: ALL REPORTS// ??
     This field contains the categories available for
     rad/nuc med reports.
     Choices are : 'I' for inpatient, 'O' for
```

```
      outpatient, 'N' for non ward or clinic, 'A'
      for all reports.
      Choose from:
        I          INPATIENT
        O          OUTPATIENT
        N          NON WARD OR CLINIC
        A          ALL REPORTS
CATEGORY OF REPORTS: ALL REPORTS// I   INPATIENT
```

As long as a queue is active, when results reports are verified, the Report Distribution file will be populated with the reports that belong in the active queues. As long as no inactivation date is entered here, the distribution queue is active.

> **Note:** If your facility is not using Distribution Queues, you should
> enter an Inactivation Date. This will avoid an accumulation
> of unwanted reports in the distribution queues.

```
INACTIVATION DATE: T   (AUG 29, 1994)


Select REPORT DISTRIBUTION QUEUE NAME: <RET>
```

7.13   Sharing Agreement/Contract Entry/Edit

[RA SHARING]

This function allows you to enter new sharing agreements/contracts into the system and edit existing ones.

A Sharing Agreement between two sites might be a situation where both facilities share the cost and maintenance of a particular piece of equipment. An example would be a mobile MRI that goes from site to site.

In Contract Agreement, one site is solely responsible for the equipment's cost and maintenance and is reimbursed for each examination performed on a patient from the other facility.

> **Note:** A patient whose category of exam is "Contract" or
> "Sharing", must have an entry from this file associated with
> the exam.

When the category of an exam is "Contract" or "Sharing" agreement and an exam's Contract/Sharing Source field is entered, that exam will be included in the Sharing Agreement/Contract Report. Users must choose one of the agreements you enter here. To make the exam category "Contract" or "Sharing", the category of exam must be edited when the exam is ordered or during registration or case edit.

Check to make sure your entry is not already in the file by entering "??" at the first prompt.

```
Select Agreement/Contract:  ??

Choose from:
   LFL CONTRACTORS
   MEMORIAL HOSPITAL

Select Agreement/Contract: UNIVERSITY HOSPITAL
  Are you adding 'UNIVERSITY HOSPITAL' as
    a new CONTRACT/SHARING AGREEMENTS (the 3RD)? Y  (Yes)

AGREEMENT NAME: UNIVERSITY HOSPITAL// <RET>

TYPE OF AGREEMENT: ??
     Choose from:
       S         SHARING
       C         CONTRACT
TYPE OF AGREEMENT: S   SHARING

INACTIVATION DATE: <RET>
```

7.14   Standard Reports Entry/Edit

[RA STANDRPTS]

This function allows you to enter new standard reports or to edit existing ones. These are generic reports (e.g., normal chest) that may be inserted into a procedure report. They are site specific, meaning the Imaging Services decide what reports are to be standard and what the text of the report should be. Any Division or Imaging Location may use any standard report. A standard report may be used as the entire report or may serve as a starting point for a report.

These standard reports are used by the transcriptionist in the Report Entry/Edit option of the Films Reporting Menu. If the transcriptionist selects a standard report for a specific exam, the report and impression fields will be filled in for that exam.

The transcriptionist will only be given the "Select 'Standard' Report to Copy" prompt during the Report Enter/Edit function, if the Division parameter Allow Standard Reports is set to "YES".

Standard Report Strategies:

- May be an entire report (e.g., "Normal Chest")

- May include standard information that is in every report for a given procedure (e.g., how an UGI, B.E., or Nuc Med procedure was performed, what was injected, what images were obtained). Then specifics of the case will be added in the dictation. (If you are using this strategy, you do not necessarily have to put in a standard impression.)

- Could have a standard report for each test for each attending, if you want, since each may have his/her own wording preference.

Enter the name of a report 3-30 characters in length.

```
Select STANDARD REPORTS: NORMAL CHEST
  Are you adding 'NORMAL CHEST' as a new STANDARD
  REPORTS (the 3RD)? Y  (Yes)
   STANDARD REPORTS REPORT NUMBER: 3// <RET>
STANDARD REPORT: NORMAL CHEST// <RET>
```

If you are using the VA FileMan screen editor, this is what will appear next. A line editor will be different. Please contact IRM if you have questions concerning screen or line editing

```
---------------------------------------------------------------------------
--
REPORT TEXT:
  No existing text
  Edit? NO// YES
```

```
=============================================================================
==[ WRAP ][ INSERT ]=< REPORT TEXT >[ <PF1>H=Help ]
=======T=======T=======T=======T=======T=======T=======T=======T=======T===
=TChest exam is within normal limits.


Saving text ...
-----------------------------------------------------------------------------
--
```

```
IMPRESSION:
  No existing text
  Edit? NO// YES
```

```
=============================================================================
==
[ WRAP ][ INSERT ]=< IMPRESSION >[ <PF1>H=Help ]
=======T=======T=======T=======T=======T=======T=======T=======T=======T===
=TNormal Chest X-Ray.
Saving text ...
-----------------------------------------------------------------------------
--
```

7.15   Valid Imaging Stop Codes Edit

[RA VALID STOP CODES]

The Imaging Stop Codes file #71.5 must be updated every year around October 1 when VA Headquarters MAS issues revised stop codes (also known as DSS ID) and after your IRM installs the yearly PIMS maintenance patch that updates the stop codes in the Clinic Stop file #40.7. You may add and delete entries from the Imaging Stop Codes file using this option.

Only stop codes entered here will be valid selections when editing the DSS ID field in the option Location Parameter Set-Up (Imaging Locations file).

```
Valid Imaging Stop Codes Edit

Select IMAGING STOP CODES VALID CODE: ??

Choose from:
  NUCLEAR MEDICINE   109
  PET     146
  RADIONUCLIDE THERAPY    144
  ULTRASOUND   115
  VASCULAR LABORATORY   421
  X-RAY   105

     Only stop codes valid for imaging should be
     entered in this file.
     When a stop code becomes invalid, it should be
     deleted from this file.
     When a new stop code becomes valid for imaging
     procedures, it should be added to this file.
     Entries are used as a selection list when
     editing procedure stop codes, and to screen the
     principal clinic edit of Imaging Locations.
```

Your list of choices contains the entries in the Clinic Stop file #40.7.

```
Choose from:
   ADMITTING/SCREENING      102
   ADULT DAY HEALTH CARE      190
   ALCOHOL SCREENING      706
   ALCOHOL TREATMENT-GROUP      556
   ...



Select IMAGING STOP CODES VALID CODE: MAMMOGRAM         703
  Are you adding 'MAMMOGRAM' as a new IMAGING STOP CODES (the 5TH)? Y
(Yes)
VALID CODE: MAMMOGRAM//

Select IMAGING STOP CODES VALID CODE: <RET>
```

8.0   Maintenance Files Print Menu

8.1   Overview

This menu corresponds to the Utility Files Maintenance menu. Each option allows you to print out a dated, hard copy of the data from the related file.

8.2   Complication Type List

[RA COMPRINT]

This option provides a list of the complications from the Complication Types file #78.1 and whether or not each is considered a Contrast Medium Reaction.

For more information on complication types, refer to the chapter on Complication Type Entry/Edit.

Type the name of the device you wish to print/ view the complication type list on at the "Device:" prompt. A sample list is included below.

```
Complication Types                            SEP 30,1996  08:52    PAGE 1
                                  CONTRAST
                                  MEDIUM
COMPLICATION                      REACTION?
------------------------------------------------------------------------------
--

CONTRAST REACTION                 YES
NAUSEA AND VOMITING               NO
NO COMPLICATION                   NO
PREGNANCY                         NO
SEVERE MORBIDITY                  NO
```

8.3   Diagnostic Code List

[RA DIAGP]

This option lists the contents of the Diagnostic Codes file #78.3.

For more information diagnostic codes, refer to the chapter on Diagnostic Code Enter/Edit.

Type the name of the device you wish to print/ view the diagnostic code list on at the "Device:" prompt. A sample list is included below.

```
Diagnostic Codes                              SEP 30,1996  08:53    PAGE 1

                                                  PRINT
```

```
                                                        ON
GENERATE
                                                        ABNORMAL
ABNORMAL
NUMBER    DIAGNOSTIC CODE                               REPORT
ALERT?
--------------------------------------------------------------------------------
--
   1     NORMAL                                         NO
There were no problems for this exam!
--------------------------------------------------------------------------------
--
   2     MINOR ABNORMALITY                              NO
There was a slight abnormality in this exam!
--------------------------------------------------------------------------------
--
   3     MAJOR ABNORMALITY, NO ATTN. NEEDED             NO
There was a major problem, but no attention was needed!
--------------------------------------------------------------------------------
--
   4     ABNORMALITY, ATTN. NEEDED                      YES         YES
There was a major problem, and attention is necessary!
--------------------------------------------------------------------------------
--
   5     MAJOR ABNORMALITY, PHYSICIAN AWARE             NO
There is a major problem, and the doctor is aware of it!
--------------------------------------------------------------------------------
--
   6     UNDICTATED FILMS NOT RETURNED, 3 DAYS          NO
--------------------------------------------------------------------------------
--
   7     UNSATISFACTORY/INCOMPLETE EXAM                 YES
This exam was either unsatisfactory or incomplete!
--------------------------------------------------------------------------------
--
   8     POSSIBLE MALIGNANCY, FOLLOW-UP NEEDED          YES
A possible malignancy was noted.  Follow-up action should be taken.
--------------------------------------------------------------------------------
--
   9     POSSIBLE MALIGNANCY, FOLLOW-UP CRITICAL
Follow-up must be done, and documented
--------------------------------------------------------------------------------
--
  10     OVEREXPOSURE, MECH ERROR                       YES         NO
OVEREXPOSURE DUE TO A MECHANICAL ERROR
--------------------------------------------------------------------------------
--
```

> **Note:** A blank in the "Print on Abnormal Report" column or the
> "Generate Abnormal Alert?" column is the same a "NO".

8.4   Examination Status List

[RA EXAMSTATUSP]

This option lists the contents of the Examination Status file #72. It lists all contents of the Examination Status file whether or not the Imaging Types and statuses are activated. Our example shows only one of the Imaging Types that has been activated. For more information on exam statuses, refer to the chapter on Examination Status Entry/Edit.

This report now allows printing by selected Imaging Types. Type the name of the device you wish to print/ view the Examination Status list on at the "Device:" prompt. A sample list is included below.

```
                          Examination Statuses                    Page: 1
                     Run Date: Jan 27, 1997 8:45:12 am
-----------------------------------------------------------------------------
--
           Type Of Imaging: NUCLEAR MEDICINE

Status: ***CANCELLED***                               Order: 0
Default Next Status:                                  User Key Needed:
Generate Examined HL7 Message:
Generate Exam Alert:                                  Allow Cancelling?:
YES
Appear On Status Tracking?: NO                        Print Dosage Ticket:
NO

ASK ON STATUS TRACKING:              REQUIRED FOR CHANGE TO THIS STATUS:
-----------------------              ----------------------------------

         WORKLOAD REPORTS THAT USE THIS STATUS IN ITS COMPLETION:
         ---------------------------------------------------------
              AMIS


Status: ***WAITING FOR EXAM***                        Order: 1
Default Next Status: EXAMINED                         User Key Needed:
Generate Examined HL7 Message:
Generate Exam Alert: NO                               Allow Cancelling?:
YES
Appear On Status Tracking?: YES                       Print Dosage Ticket:
NO

ASK ON STATUS TRACKING:              REQUIRED FOR CHANGE TO THIS STATUS:
-----------------------              ----------------------------------

         WORKLOAD REPORTS THAT USE THIS STATUS IN ITS COMPLETION:
         ---------------------------------------------------------
              CLINIC
              PTF BEDSECTION
              SERVICE
              SHARING/CONTRACT
              WARD
              FILM USAGE
              TECHNOLOGIST
              AMIS
              DETAILED PROCEDURE
              CAMERA/EQUIP/RM
              PHYSICIAN
              RESIDENT
              STAFF
```

```
                                                    DELINQUENT STATUS
```

```
                        Examination Statuses                     Page: 2
                     Run Date: Jan 27, 1997 8:45:12 am
--------------------------------------------------------------------------
--

Status: ***EXAMINED***                                 Order: 2
Default Next Status: TRANSCRIBED                        User Key Needed:
Generate Examined HL7 Message: YES
Generate Exam Alert: NO                                 Allow Cancelling?: NO
Appear On Status Tracking?: YES                         Print Dosage Ticket:
YES

ASK ON STATUS TRACKING:                 REQUIRED FOR CHANGE TO THIS STATUS:
-----------------------                 -----------------------------------
    TECHNOLOGIST                            TECHNOLOGIST
    PROCEDURE                               DETAILED PROCEDURE
    FILM DATA                               FILM ENTRY
    CAMERA/EQUIP/RM                         CAMERA/EQUIP/RM
    MEDICATIONS & DOSAGES                   RADIOPHARMS/DOSAGES
    MED ADM DT/TIME/PERSON
    RADIOPHARMS AND DOSAGES
    ADM DT/TIME/PERSON
    LOT NO.

        WORKLOAD REPORTS THAT USE THIS STATUS IN ITS COMPLETION:
        --------------------------------------------------------
            CLINIC
            PTF BEDSECTION
            SERVICE
            SHARING/CONTRACT
            WARD
            FILM USAGE
            TECHNOLOGIST
            AMIS
            DETAILED PROCEDURE
            CAMERA/EQUIP/RM
            PHYSICIAN
            RESIDENT
            STAFF
            DELINQUENT STATUS

Status: ***TRANSCRIBED***                              Order: 3
Default Next Status: COMPLETE                           User Key Needed:
Generate Examined HL7 Message:
Generate Exam Alert: YES                                Allow Cancelling?: NO
Appear On Status Tracking?: NO                          Print Dosage Ticket:
NO

ASK ON STATUS TRACKING:                 REQUIRED FOR CHANGE TO THIS STATUS:
-----------------------                 -----------------------------------
    TECHNOLOGIST                            TECHNOLOGIST
    INTERPRETING PHYS                       REPORT ENTERED
    PROCEDURE                               IMPRESSION
    FILM DATA                               RESIDENT OR STAFF
    DIAGNOSTIC CODE                         DETAILED PROCEDURE
    CAMERA/EQUIP/RM                         FILM ENTRY
    MEDICATIONS & DOSAGES                   CAMERA/EQUIP/RM
```

```
                            Examination Statuses                    Page: 3
                      Run Date: Jan 27, 1997 8:45:12 am
--------------------------------------------------------------------------------
--

    MED ADM DT/TIME/PERSON                     RADIOPHARMS/DOSAGES
    RADIOPHARMS AND DOSAGES
    ACTIVITY DRAWN
    DRAWN DT/TIME/PERSON
    ADM DT/TIME/PERSON
    ROUTE/SITE OF ADM
    LOT NO.
    VOLUME/FORM

        WORKLOAD REPORTS THAT USE THIS STATUS IN ITS COMPLETION:
        ----------------------------------------------------------
            CLINIC
            PTF BEDSECTION
            SERVICE
            SHARING/CONTRACT
            WARD
            FILM USAGE
            TECHNOLOGIST
            AMIS
            DETAILED PROCEDURE
            CAMERA/EQUIP/RM
            PHYSICIAN
            RESIDENT
            STAFF
            DELINQUENT STATUS

Status: ***COMPLETE***                                Order: 9
Default Next Status:                                  User Key Needed:
Generate Examined HL7 Message:
Generate Exam Alert: NO                               Allow Cancelling?: NO
Appear On Status Tracking?: NO                        Print Dosage Ticket:
NO

ASK ON STATUS TRACKING:                     REQUIRED FOR CHANGE TO THIS STATUS:
-----------------------                     -----------------------------------
    TECHNOLOGIST                                TECHNOLOGIST
    INTERPRETING PHYS                           REPORT ENTERED
    PROCEDURE                                   VERIFIED REPORT
    FILM DATA                                   IMPRESSION
    DIAGNOSTIC CODE                             RESIDENT OR STAFF
    CAMERA/EQUIP/RM                             DETAILED PROCEDURE
    MEDICATIONS & DOSAGES                       FILM ENTRY
    MED ADM DT/TIME/PERSON                      CAMERA/EQUIP/RM
    RADIOPHARMS AND DOSAGES                     RADIOPHARMS/DOSAGES
    ACTIVITY DRAWN
    DRAWN DT/TIME/PERSON
    ADM DT/TIME/PERSON
    ROUTE/SITE OF ADM
    LOT NO.
    VOLUME/FORM
```

```
                            Examination Statuses                    Page: 4
```

```
                        Run Date: Jan 27, 1997 8:45:12 am
--------------------------------------------------------------------------------
--

          WORKLOAD REPORTS THAT USE THIS STATUS IN ITS COMPLETION:
          -------------------------------------------------------
                CLINIC
                PTF BEDSECTION
                SERVICE
                SHARING/CONTRACT
                WARD
                FILM USAGE
                TECHNOLOGIST
                AMIS
                DETAILED PROCEDURE
                CAMERA/EQUIP/RM
                PHYSICIAN
                RESIDENT
                STAFF
                DELINQUENT STATUS
```

8.5   Film Sizes List

[RA FILMP]

This option lists the contents of the Film Sizes file #78.4.

For more information on films, refer to the chapter on Film Type Entry/Edit. Type
the name of the device you wish to print/ view the Film Sizes list on at the "Device:"
prompt. A sample list is included below.

```
Film Size Specifications                        SEP 30,1996  08:55    PAGE 1
                        F                 W
                        l                 a
                    C   u                 s
                    i   o                 t  Analogous
                    n   r                 e  Unwasted Film
Film                e   o  Inactivation Dt d  Size
--------------------------------------------------------------------------
--
10X12               N
11X14               N
14X17               N
2X12                N
2X4                 N     JUL 5,1996
2X6                 N
3X FILMS            N
CHROMATIC           N
CINE                Y
DENTAL              N
FLUORO ONLY         N
NO FILMS            N
W-10X12             N                     Y  10X12
W-11X14             N                     Y  11X14
W-14X17             N                     Y  14X17
W-2X12              N                     Y  2X12
W-2X4               N     JUL 5,1996      Y  2X4
```

```
W-2X6                 N                            Y   2X6
W-3X FILMS            N                            Y   3X FILMS
W-CHROMATIC           N                            Y   CHROMATIC
W-CINE                Y                            Y   CINE
W-DENTAL              N                            Y   DENTAL
W-FLUORO ONLY         N                            Y   FLUORO ONLY
```

8.6   Label/Header/Footer Format List

[RA FLASHFORMP]

This option prints the contents of the Flash Card Formats file #78.2.

For more information on formats, refer to the chapter on Label/Header/Footer
Formatter. Type the name of the device you wish to print/ view the
Label/Header/Footer Format list on at the "Device:" prompt. A sample list is
included below.

```
Exam Label/Report Header/Report Footer/Flash Card Formats
                                        SEP 30,1996  08:55    PAGE
1
  FIELD                        ROW COL  TITLE
                                                    TEXT
------------------------------------------------------------------------------
--
        FORMAT NAME: ER FORMAT
  NAME OF PATIENT                1   2  NAME    :
  SSN OF PATIENT                 1  40  SSN :
  DATE OF EXAM                   2   1  EXAM DATE:
  TECHNOLOGIST                   2  40  TECH:
  PROCEDURE                      3   1  PROCEDURE:
  FREE TEXT                      5   2            COMMENTS :
  VERIFYING RADIOLOGIST         10   2  INTERPRETER:
```

```
Exam Label/Report Header/Report Footer/Flash Card Formats
                                        SEP 30,1996  08:55    PAGE
2
  FIELD                        ROW COL  TITLE
                                                    TEXT
------------------------------------------------------------------------------
--
        FORMAT NAME: EXAM HEADER
  FREE TEXT                      1   1             EXAM REPORT
  NAME OF PATIENT                1  15  PATIENT:
  CURRENT DATE/TIME              1  50  DATE:
  SSN OF PATIENT                 2   1  SSN:
  ATTENDING PHYSICIAN AT ORDER   2  40  Att at Order:

  REQUESTING PHYSICIAN           3   1  REQ PHYS:
  ATTENDING PHYSICIAN CURRENT    3  40  Att Current:

  REQUEST ENTERED DATE/TIME      4   1
  CURRENT PATIENT LOCATION       5   1
```

8.7   Major AMIS Code List

[RA MAJORAMISP]

This option lists the contents of the Rad/Nuc Med AMIS Codes file #71.1.

For more information on AMIS codes, refer to the chapter on Major AMIS Code
Entry/Edit. Type the name of the device you wish to print/ view the Major AMIS
Code list on at the "Device:" prompt. A sample list is included below.

```
Major AMIS Codes                              SEP 30,1996  08:56    PAGE 1
MAJOR
 AMIS
 CODE   DESCRIPTION                                       WEIGHT
 --------------------------------------------------------------------------
 --
   1    SKULL,INC.SINUS,MASTOID,JAW,ETC                     3
   2    CHEST-SINGLE VIEW                                   1
   3    CHEST MULTIPLE VIEW                                 2
   4    CARDIAC SERIES                                      3
   5    ABDOMEN-KUB                                         2
   6    OBSTRUCTIVE SERIES                                  3
   7    SKELETAL-SPINE & SACROILIAC                         3
   8    SKELETAL-BONE & JOINTS                              2
   9    GASTROINTESTINAL                                    6
  10    GENITOURINARY                                       6
  11    CHOLECYSTOGRAM,ORAL                                 5
  12    CHOLANGIOGRAM                                      10
  13    LAMINOGRAM                                          5
  14    BRONCHOGRAM                                         5
  15    DIGITAL SUBTRACTION ANGIOGRAPHY                    15
  16    ANGIOGRAM,CATH- CEREBRAL                           15
  17    ANGIOGRAM,CATH- VISCERAL                           20
  18    ANGIOGRAM,CATH- PERIPHERAL                         10
  19    VENOGRAM                                           15
  20    MYELOGRAM                                          10
  21    COMPUTED TOMOGRAPHY                                 8
  22    INTERVENTIONAL RADIOGRAPHY                         20
  23    ULTRASOUND,ECHOENCEPHALOGRAM                        7
  24    OTHER                                               5
  25    EXAMS IN OPER.SUITE AT SURGERY                      1
  26    PORTABLE (BEDSIDE) EXAMINATIONS                     1
  27    NUCLEAR MEDICINE                                    1
```

8.8   Modifier List

[RA MODIFIERP]

This option lists the contents of the Procedure Modifiers file #71.2.

For more information on modifiers, refer to the chapter on Procedure Modifier Entry.
Type the name of the device you wish to print/ view the Modifier list on at the
"Device:" prompt. A sample list is included below.

```
Procedure Modifiers                              NOV 18,1996  13:52    PAGE 1
                                   AMIS CREDIT
NAME                               INDICATOR
--------------------------------------------------------------------------------
--

         TYPE OF IMAGING: CARDIOLOGY STUDIES (NUC MED)
RIGHT

         TYPE OF IMAGING: CT SCAN
RIGHT

         TYPE OF IMAGING: GENERAL RADIOLOGY
BILATERAL EXAM                     BILATERAL
PORTABLE EXAM                      PORTABLE
OPERATING ROOM EXAM                OPERATING ROOM
LEFT
RIGHT
TEST                               PORTABLE
TEST BILATERAL                     BILATERAL
TEST OR                            OPERATING ROOM
NEW ONE                            OPERATING ROOM
OBLIQUE
```

8.9   Nuclear Medicine List Menu

Use this menu in conjunction with the Nuclear Medicine Setup Menu.

8.9.1   Lot (Radiopharmaceutical) Number List (+)

[RA NM PRINT LOT]

This option prints a list of entries in the Radiopharmaceutical Lot file #71.9. The file is exported without data. It prints in 132-column format.

```
RADIOPHARMACEUTICAL LOT
MAY 30,1997  12:59    PAGE 1
NUMBER/ID                     RADIOPHARMACEUTICAL
KIT #            EXPIRATION DATE     INACTIVE
--------------------------------------------------------------------------------
----------------------------------------------------------

         SOURCE: CHEMICALS INC.
5535
123598Y34512548
1234                               TECHNETIUM Tc99m SESTAMIBI
JAN 20,1997

         SOURCE: DUPONT
PER 1234                           PERCHLORACAP 250MG CAPS
235
456                                SULFUR COLLOID TC-99M
445             DEC 31,1997        YES
```

```
MAA 7136                        TECHNETIUM Tc99m ALBUMIN AGGREGATED
1-5
7635                            TECHNETIUM Tc99m MEDRONATE
MDP 6136P                       TECHNETIUM Tc99m MEDRONATE
100                                       YES
MDP 6137P                       TECHNETIUM Tc99m MEDRONATE
100              JAN 20,1997
MDP 6137P                       TECHNETIUM Tc99m MEDRONATE
101              JAN 13,1997
DTPA 1234                       TECHNETIUM Tc99m PENTETATE


       SOURCE: SQUIBB
12345                           TECHNETIUM Tc99m ALBUMIN AGGREGATED
333              JAN 22,1997
MDP 6137P                       TECHNETIUM Tc99m MEDRONATE                   1
```

8.9.2   Route of Administration List (+)

[RA NM PRINT ROUTE]

This option prints a list of entries in the Route of Administration file #71.6. A
number of routes were exported with this version of the software.

```
ROUTE OF ADMINISTRATION                        JAN 21,1997  08:36    PAGE 1
NAME
    SITES OF ADMIN                             PROMPT
--------------------------------------------------------------------------
--

CATHETER
    URINARY BLADDER
G-TUBE                          (synonym)  GASTROSTOMY TUBE
                                (synonym)  FEEDING TUBE
INHALATION                      (synonym)  VENTILATOR
    MOUTH
    TRACHEAL TUBE
    NOSE
    ENDOTRACHEAL TUBE
    TRACHEOSTOMY
INTRA-ARTICULAR                 (synonym)  JOINT
                                (synonym)  ARTICULAR
    LEFT HIP
    RIGHT HIP
    LEFT KNEE
    RIGHT KNEE
    LEFT WRIST
    RIGHT WRIST
    LEFT SHOULDER
    RIGHT SHOULDER                                  Yes
INTRADERMAL                     (synonym)  SKIN     Yes
INTRALESIONAL                                       Yes
INTRAMUSCULAR                   (synonym)  IM
                                (synonym)  I.M.
    RIGHT FOREARM
    LEFT FOREARM
    LEFT SHOULDER
    RIGHT SHOULDER
```

```
     LEFT HIP
     RIGHT HIP
INTRAOCULAR                     (synonym)  EYE
     RIGHT EYE
     LEFT EYE
INTRAPERITONEAL                 (synonym)  PERITONEAL
INTRAPLEURAL                    (synonym)  PLEURA
     LEFT PLEURA
     RIGHT PLEURA
INTRATHECAL                     (synonym)  SPINAL
     LUMBAR SUBARACHNOID SPACE
     CERVICAL SUBARACHNOID SPACE
```

8.9.3   Site of Administration List (+)

[RA NM PRINT SITE]

This option prints a list of entries in the Site of Administration file #71.7. A number
of sites were exported with this version of the software.

```
SITE OF ADMINISTRATION                     JAN 21,1997  08:36    PAGE 1
NAME                          (SYNONYM)
-----------------------------------------------------------------------------
--

CERVICAL SUBARACHNOID SPACE   SUBARACHNOID SPACE
ENDOTRACHEAL TUBE             ETT
                              E.T.T.
GALLBLADDER                   GB
                              G.B.
INTRAOCULAR                   EYE
LEFT ANTECUBITAL FOSSA        L. ANTECUBITAL FOSSA
                              L ANTECUBITAL FOSSA
                              ANTECUBITAL FOSSA
LEFT ARM                      L ARM
                              L. ARM
                              ARM
LEFT BUTTOCK                  L BUTTOCK
                              L. BUTTOCK
                              BUTTOCK
LEFT DELTOID                  L DELTOID
                              L. DELTOID
                              DELTOID
LEFT EYE                      L. EYE
                              L EYE
                              EYE
LEFT FEMORAL                  L. FEMORAL
                              L FEMORAL
                              FEMORAL
                              L. GROIN
                              L GROIN
                              GROIN
LEFT FOOT                     L. FOOT
                              L FOOT
                              FOOT
LEFT FOREARM                  L. FOREARM
                              L FOREARM
                              FOREARM
```

```
LEFT GLUTEUS                        L GLUTEUS
                                    L. GLUTEUS
                                    GLUTEUS
LEFT HAND                           L. HAND
                                    L HAND
                                    HAND
```

8.9.4   Vendor/Source (Radiopharmaceutical) List (+)

[RA NM PRINT SOURCE]

This option prints a list of entries in the Radiopharmaceutical Source file #71.8. The file is exported without data.

```
RADIOPHARMACEUTICAL SOURCE                         JAN 21,1997  08:37    PAGE 1
VENDOR/PHARMACY
-----------------------------------------------------------------------------
-

CHEMICALS INC.
DUPONT
NATURAL CHEMICALS LABORATORY
PHARM-A-LOGIC (OFF SITE)
SQUIBB
UNIVERSITY LABS
UNIVERSITY NUCLEAR PHARMACY
```

8.10   Procedure File Listings

All of these reports access data in the Rad/Nuc Med Procedures file #71. Many of the following printouts are lengthy. "Q"ueuing these reports to be printed after hours should be considered.

8.10.1   Active Procedure List (Long)

[RA PROCLONG]

This option prints a listing of all active procedures, their CPT and AMIS codes, AMIS weight multiplier, whether it is a bilateral procedure or a CT of the head or body, the type of procedure (broad, series, detailed or parent), flash card information, and whether review of the report and approval of the request is required. The report is sorted by AMIS category, then procedure name. It is a lengthy printout, so queuing the output should be considered.

This report now allows printing by selected Imaging Types. Type the name of the device you wish to print/ view the Active Procedure list on at the "Device:" prompt. This device must be a 132-column device. A sample list is included below.

```
Active Radiology/Nuclear Medicine Procedures (Long)
DEC 13,1996  08:43    PAGE 1
```

```
CPT
CT
CODE     PROCEDURE                              AMIS CODE
MULTIPLIER     BILATERAL      HEAD/BODY
--------------------------------------------------------------------------
---------------------------------------------

78278    ACUTE GI BLOOD LOSS IMAGING        27 - NUCLEAR MEDICINE
1

     Type of Procedure        :      DETAILED
     Required Flash Card Printer:
     Required Flash Card Format :    ER FORMAT
     Cost of Procedure        :
     Health Summary With Request:    INPATIENT
     Staff Review of Reports Req:    NO
     Rad Approval of Request Req:    NO
     Type of Imaging          :      NUCLEAR MEDICINE
     Suppress Radiopharm Prompt :    Always
     Prompt for Radiopharm RX   :    YES
     Default Radiopharmaceutical:    PERCHLORACAP 250MG CAPS
      Usual Dose              :      3
      Dflt Administration Route :    ORAL
      Dflt Administration Site  :    MOUTH
      High Adult Dose         :      5
      Low Adult Dose          :      2
      Default Form            :      Solid (Other)
     Prompt for Medication?    :
     Descendents              :
     Procedure Message        :
     Educational Description   :      This test is designed to LOCATE the
site of KNOWN GI
                                 bleeding, NOT to determine whether there
IS GI bleeding.
```

8.10.2   Active Procedure List (Short)

[RA PROCSHORT]

This is a list of active procedures, sorted by AMIS category and procedure name. Since the report can be lengthy, consider queuing the output. Only procedures with an AMIS code are included.

This report now allows printing by selected Imaging Types. Type the name of the device you wish to print/ view the Active Procedure list on at the "Device:" prompt. This device must be a 132-column device. A sample list is included below.

```
Active Radiology/Nuclear Medicine Procedures (Short)             SEP
30,1996 10:54  PAGE 1
CPT
CODE   PROCEDURE     AMIS CODE    MULT    BILAT    CT  IMG TYPE
--------------------------------------------------------------------------
----------------------------
76062 BONE SURV COMP (INCL APPENDIC 1 -SKULL,INC.SINUS,MASTOID,JAW,ET 1
RAD
```

```
--------------------------------------------------------------------------------
-------------------------------
76061 BONE SURV LMTD (E.G. METASTATI   1 -SKULL,INC.SINUS,MASTOID,JAW,ET 1
RAD
--------------------------------------------------------------------------------
-------------------------------
```

8.10.3   Alpha Listing of Active Procedures

[RA ALPHALIST]

As you can see by the example below, this is a shorter, alphabetical listing of the active procedures. Since the report can be lengthy, consider queuing the output.

This report now allows printing by selected Imaging Types. Type the name of the device you wish to print/ view the Alpha Listing of Active Procedures on at the "Device:" prompt. This device must be a 132-column device. A sample list is included below.

```
Alpha Listing of Active Procedures                  SEP 30,1996 10:54  PAGE 1
   CPT
NAME   CODE     AMIS CODE MULT BILAT CT  IMG TYPE
--------------------------------------------------------------------------------
------------------
ABDOMEN 1 VIEW  74000  5   ABDOMEN-KUB   1            RAD
--------------------------------------------------------------------------------
------------------
ABDOMEN 2 VIEWS 74010  5   ABDOMEN-KUB   1            RAD
--------------------------------------------------------------------------------
------------------
ABDOMEN FOR FETAL AGE 1 VIEW 74720  5   ABDOMEN-KUB   1            RAD
--------------------------------------------------------------------------------
------------------
ABDOMEN FOR FETAL AGE MULT VIEWS 74725  5   ABDOMEN-KUB   1            RAD
--------------------------------------------------------------------------------
------------------
ABDOMEN MIN 3 VIEWS+CHEST 74022  2   CHEST-SINGLE VIEW   1            RAD
     6   OBSTRUCTIVE SERIES  1
--------------------------------------------------------------------------------
------------------
ACROMIOCLAVICULAR J BILAT 73050  8   SKELETAL-BONE & JOINTS 1  YES
RAD
```

8.10.4   Barcoded Procedure List (+)

[RA BARPROCPRINT]

If your site uses barcodes, use this option to print a list of barcoded CPTs and/or Procedures for a selected Imaging Type.

To print barcoded procedure list, you will need to know the height (in vertical lines) of the barcode output on the printer to be used. If you don't know the height of the barcode, you need to print a test version and count the lines as shown here:

If you don't know the height of the barcodes printed at your site, enter YES to obtain a sample barcode.

```
Do you wish to print a sample barcode for the purpose of determining the
height (in vertical lines) of the barcode? No// YES
```

You may need to contact IRM for the name of a printer for barcodes.

```
Select a printer with barcode setup: HOME
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)
```

Exit the option and get the printout of the test barcode. Here's an example

```
Requested Start Time: NOW// <RET> (DEC 11, 1996@12:46:25)
     Request Queued, Task #: 35507

Enter the height of the barcode: ^
```

```
Barcode test print
   Printed on: Dec 11, 1996   Page 1
----------------------------------------------------------------------------
-
LINE 1
LINE 2
LINE 3
LINE 4
LINE 5
LINE 6
LINE 7
LINE 8
LINE 9
LINE 10
TEST BARCODE PRINT     BarcodeBarcodeBarcodeBarcodeBarcode
                       BarcodeBarcodeBarcodeBarcodeBarcode
                       BarcodeBarcodeBarcodeBarcodeBarcode
                       TEST BARCODE PRINT
LINE 1
LINE 2
LINE 3
LINE 4
LINE 5
LINE 6
LINE 7
LINE 8
LINE 9
LINE 10
```

Using the line counts printed above and below the example barcode to determine how many vertical lines the barcode occupies (include the procedure name line printed below the barcode), it appears to be 4 lines. Now you can print a list of barcodes used by your Imaging Type. Return to the option.

```
To print barcoded procedure list, you will need to know the height (in
vertical lines) of the barcode output on the printer to be used.

Do you wish to print a sample barcode for the purpose of determining the
height (in vertical lines) of the barcode? No// <RET>

Enter the height of the barcode: 4

     Select one of the following:

          C          CPT barcode
          P          Procedure barcode
          B          Both barcodes
Which of the above would you like to print?: Both

Select the data element you wish to sort by: ??

Enter 'C' to sort by the CPT Code, or 'P' to sort by the
procedure.

     Select one of the following:

          C          CPT Code
          P          Procedure

Select the data element you wish to sort by: Procedure

Select Imaging Type: GENERAL RADIOLOGY

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

Select Procedure: ALL

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

Select a printer with barcode setup: (Enter the barcode printer name)
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

Requested Start Time: NOW// <RET> (DEC 11, 1996@12:47:58)
     Request Queued, Task #: 35508
```

8.10.5   Inactive Procedure List (Long)

[RA INACPRCLONG]

This output is the same as that for Active Procedure List (Long) only these procedures have all been inactivated. Since the report can be lengthy, consider queuing the output.

This report now allows printing by selected Imaging Types. Type the name of the
device you wish to print/ view the Inactive Procedures list on at the "Device:"
prompt. This device must be a 132-column device. A sample list is included below.

```
Inactive Radiology/Nuclear Medicine Procedures (Long)              SEP
30,1996 10:54  PAGE 1
CPT             CT
CODE  PROCEDURE     AMIS CODE    MULTIPLIER   BILATERAL HEAD/BODY
------------------------------------------------------------------------------
-----------------------------------

70350 CEPHALOGRAM ORTHODONTIC 1 -SKULL,INC.SINUS,MASTOID,JAW,ET 1

  Type of Procedure          :     DETAILED
  Required Flash Card Printer:
  Required Flash Card Format :
  Cost of Procedure          :
  Health Summary With Request:
  Staff Review of Reports Req:
  Rad Approval of Request Req:
  Type of Imaging            :     GENERAL RADIOLOGY
  Prompt for Medications     :
  Descendents                :
  Procedure Message          :
  Educational Description    :
```

8.10.6   Invalid CPT/Stop Code List

[RA INVALID CPT/STOP]

This option prints a list of Invalid CPT or Stop Codes. When generating the report,
you can choose to include procedures that already have been marked Inactive (by
entering an inactive date through the option Procedure Entry/Edit). It should be noted
that the system sees procedure and CPTs as two separate entities. In other words, an
active procedure can have a valid or invalid CPT associated with it. This report will
print a warning if a Parent procedure has no Descendents, and if a detailed or series
procedure has no AMIS code(s). It will also tell you if an Imaging Location setup
doesn't meet criteria for workload crediting.

This option prints a list of Radiology/Nuclear Medicine Procedures with missing or
invalid CPT's and DSS ID's, and Imaging Locations pointing to Hospital Locations
with inappropriate set-up parameters. Broad, parent and inactive procedures are not
required to have codes. To be valid, DSS ID's must be in the Imaging Stop Codes file
71.5; CPT's must be nationally active.

This report now allows printing by selected Imaging Types. Type the name of the
device you wish to print/ view the Invalid CPT/Stop Code list on at the "Device:"
prompt. A sample list is included below.

```
            RADIOLOGY/NUCLEAR MEDICINE INVALID CPT AND STOP CODES
Run Date: Sep 30, 1996@13:41:04                                    Page:
1


ABDOMEN FOR FETAL AGE 1 VIEW (Detailed, RAD)
     Invalid CPT 74720


ABDOMEN FOR FETAL AGE MULT VIEWS (Detailed, RAD)
     Invalid CPT 74725


ANGIO CERVICOCEREBRAL SELECT 1 VESSEL S&I (Detailed, RAD)
     No CPT entered.
     No stop code(s) entered.


ANGIO CERVICOCEREBRAL SELECT 2 VESSEL S&I (Type missing, Imaging Type
missing)
     Invalid CPT 75654


     . . . Etc.


Imaging Type(s): GENERAL RADIOLOGY


TOTAL INVALID CPT CODES:  53
TOTAL MISSING CPT CODES:   1
TOTAL BROKEN POINTERS TO CPT CODES:  0
TOTAL PARENT PROCEDURES W/O DESCENDENTS:  0
TOTAL SERIES AND/OR DETAILED PROCEDURES W/O AMIS CODES:  3
```

> **Note:** Remember to review the entries in the Imaging Stop Codes
> file #71.5every year in October to make sure they agree
> with VA HQ rules. If the entries in file 71.5 are not
> accurate, this report will not be accurate.

```
Imaging Location: MAMMOGRAPHY
   700-series noncredit Stop Code being used
```

8.10.7   List of Inactive Procedures (Short)

[RA INACPRCSHORT]

This output is the same as Inactive Procedure List (Long) excluding the Type of
Procedure, Required Flash Card Printer, Required Flash Card Format, Staff Review
of Reports Req, and Rad Approval of Request Req fields. Since the report can be
lengthy, consider queuing the output.

This report now allows printing by selected Imaging Types. Type the name of the
device you wish to print/ view the Inactive Procedures list on at the "Device:"
prompt. This device must be a 132-column device. A sample list is included below.

```
Inactive Radiology/Nuclear Medicine Procedures (Short)              SEP
30,1996 10:54   PAGE 1
CPT
CODE   PROCEDURE     AMIS CODE     MULT  BILAT  CT     IMG TYPE
```

```
--------------------------------------------------------------------------------
-----------------------------
70350 CEPHALOGRAM ORTHODONTIC 1 -SKULL,INC.SINUS,MASTOID,JAW,ET 1
RAD
--------------------------------------------------------------------------------
-----------------------------
70355 PANOREX    1 -SKULL,INC.SINUS,MASTOID,JAW,ET 1                RAD
```

8.10.8   Parent Procedure List (+)

[RA PARENT PROCEDURE LIST]

The Parent Procedure List includes only parent type procedures and all fields applicable to parent procedures that are included on the Active Procedure long listing. It shows whether they are printsets (i.e., Single Report = Yes), whether a health summary is associated with it for printing with the request, whether Radiology/Nuclear Medicine approval is required to order it, its imaging type, all descendants and their CPT codes, and the educational description.

Parent Procedure List

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

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


      Select one of the following:

          A          Active
          I          Inactive
          B          Both

Select Procedure Status: A  Active


DEVICE: HOME// (Printer Name)

Active Parent Procedure List                   MAY 29,1997  08:02    PAGE 1
        Parent Name
```

```
----------------------------------------------------------------------------
--
        C&P SPINAL SURVEY
      Single Report      : YES
      Hlth Summary w Req. :
      Rad Approval of Req.: NO
      Type of Imaging    : GENERAL RADIOLOGY
      Descendants        : (72040) SPINE CERVICAL MIN 2 VIEWS
                           (72070) SPINE THORACIC 2 VIEWS
                           (72100) SPINE LUMBOSACRAL MIN 2 VIEWS
      Procedure Message  :
```

```
      Educational Desc    : THIS STUDY IS USED FOR C&P WHEN A COMPLETE SPINE
                            IS NEEDED FOR RATINGS
-----------------------------------------------------------------------------
--
          BONE SCAN PARENT
      Single Report       : YES
      Hlth Summary w Req. :
      Rad Approval of Req.: NO
      Type of Imaging     : NUCLEAR MEDICINE
      Descendants         : (78306) BONE IMAGING, WHOLE BODY
                            (78990) PROVISION OF DIAGNOSTIC RADIONUCLIDES
      Procedure Message   :
      Educational Desc    : Patient should drink 32 ounces of fluid after
                            Radionuclide injection and before imaging.
Patient
                            is imaged 2 to 3 hours after the radionuclide
                            injection.
```

8.10.9   Procedure Message List

[RA PROCMSGPRINT]

This option prints the contents of the Rad/Nuc Med Procedure Message file #71.4. If there is a large number of entries in this file, consider queuing the output.

Type the name of the device you wish to print/ view the Inactive Procedures list on at the "Device:" prompt. If you type Q at the "Device:" prompt, you will be prompted for a printer and a time. A sample list is included below.

```
RAD/NUC MED PROCEDURE MESSAGE LIST                 SEP 30,1994  13:42    PAGE 1
TEXT
-----------------------------------------------------------------------------
--

If the patient has not eaten for more than 36 hours or is on TPN, please
inform Nuclear Medicine Service so CCK can be administered.

If the patient is on morphine, you cannot assess for CBD obstruction since
it will cause spasm of the Sphincter of Oddi.

Make sure the patient has not eaten for 3 hours prior to the test, to avoid
a false positive result!

Patient must be NPO after midnight the night before the test!

Patient must have RUQ pain, fever, elevated WBC

Patient must not have eaten within 3 hours of this test!

This test is useful in assessing for ACUTE cholecystitis only, not chronic
cholecystitis! Try US for chronic cholecystitis.
```

8.10.10 Series of Procedures List

[RA PROCSERIES]

This list is the same as the Active Procedure List (Long) except it contains only
Series procedures.

Type the name of the device you wish to print/ view the Inactive Procedures list on at
the "Device:" prompt. This device must be a 132-column device. If you type Q at
the "Device:" prompt, you will be prompted for a printer and a time. A sample list is
included below.

```
Radiology/Nuclear Medicine Procedures (Series Only)              SEP
30,1994 10:54  PAGE 1
CPT             CT
CODE  PROCEDURE     AMIS CODE    MULTIPLIER   BILATERAL HEAD/BODY
----------------------------------------------------------------------------
----------------------------------
76062 BONE SURV COMP (INCL APPENDIC 1 -SKULL,INC.SINUS,MASTOID,JAW,ET 1

  Type of Procedure         :     SERIES
  Required Flash Card Printer:
  Required Flash Card Format :
  Staff Review of Reports Req:
  Rad Approval of Request Req:
  Type of Imaging           :     GENERAL RADIOLOGY
  Descendents               :
  Procedure Message         :
----------------------------------------------------------------------------
----------------------------------76061  BONE SURV LMTD (E.G. METASTATI
  1 -SKULL,INC.SINUS,MASTOID,JAW,ET 1

  Type of Procedure         :     SERIES
  Required Flash Card Printer:
  Required Flash Card Format :
  Staff Review of Reports Req:
  Rad Approval of Request Req:
  Type of Imaging           :     GENERAL RADIOLOGY
  Descendents               :
  Procedure Message         :
```

8.11 Report Distribution Lists

[RA DISTP]

This option displays data in the Report Distribution Queue file #74.3.

For more information on report distribution, refer to the chapter on Reports
Distribution Edit. Type the name of the device you wish to print/ view the Inactive
Procedures list on at the "Device:" prompt. A sample list is included below.

```
Report Distribution Queue List                 FEB 10,1997  12:51    PAGE 1
                               CATEGORY OF          INACTIVATION
NAME                           REPORTS              DATE
```

```
TOP OF PAGE MESSAGE
--------------------------------------------------------------------------------
--

CLINIC REPORTS                     OUTPATIENT

***** Clinic Distribution *****
================================================================================
==
FILE ROOM                          INPATIENT

***** Radiology File Room Distribution *****
================================================================================
==
MEDICAL RECORDS                    ALL REPORTS

***** MAS Medical Records Room Distribution *****
================================================================================
==
OTHER THAN WARD OR CLINIC          NON WARD OR CLINIC

***** Non Ward or Clinic Reports *****
================================================================================
==
REQUESTING PHYSICIAN               ALL REPORTS


================================================================================
==
WARD REPORTS                       INPATIENT

***** Ward Distribution *****
================================================================================
==
```

8.12   Sharing Agreement/Contract List

[RA SHARINGP]

This option prints data from the Contract/Sharing Agreement file #34. Type the name
of the device you wish to print/ view the Inactive Procedures list on at the "Device:"
prompt. A sample list is included below.

For more information on sharing agreements and contracts, refer to the chapter on
Sharing Agreement/Contract Entry/Edit.

```
Contract/Sharing Agreements                      OCT  3,1996  09:40    PAGE 1
                                 TYPE OF    INACTIVATION
AGREEMENT NAME                   AGREEMENT  DATE
--------------------------------------------------------------------------------
--

CONTRACTOR LFL                   CONTRACT
MEMORIAL HOSPITAL                 SHARING
UNIVERSITY HOSPITAL               SHARING
```

8.13   Standard Reports Print

[RA STANDPRINT]

This option prints data from the Standard Reports file #74.1. Type the name of the device you wish to print/ view the Inactive Procedures list on at the "Device:" prompt. A sample list is included below.

For more information on standard reports, refer to the chapter on Standard Reports Entry/Edit.

```
Standard Reports List                     OCT  3,1996  09:40    PAGE 1
REPORT
NUMBER   STANDARD REPORT
--------------------------------------------------------------------------
--

   1    NORMAL CHEST - PA/LAT
Report Text:
   PA and Lateral views of the chest were obtained.  The bones and soft
tissues are unremarkable.  The cardiac silhouette is normal in size.  The
lung fields are clear bilaterally.
Impression:
   Normal Chest X-ray.
```

```
Standard Reports List                     OCT  3,1996  09:40    PAGE 2
REPORT
NUMBER   STANDARD REPORT
--------------------------------------------------------------------------
--
2     NORMAL LUMBAR SPINE
Report Text:
   The disc spaces are normal.  There is no spondylolysis or
spondylolisthesis.
Impression:
   Normal lumbar sacral spine.
```

9.0   9.0 Radiology HL7 Menu

This menu is used to manage HL7 messages created and received by the
Radiology/Nuclear Medicine v5.0 package.

9.1   Rad/Nuc Med HL7 Voice Reporting Errors

[RA HL7 VOICE REPORTING ERRORS]

This option displays HL7 messages received from Voice Recognition Reporting
Tools (MedSpeak, PowerScribe, TalkStation, etc.) which have been rejected by
RPMS Radiology. These messages are stored in the HL7 Message Exceptions file
#79.3.

Further options are available to allow the list to be printed and individual messages
can be resent and/or deleted.

This report allows printing by selected Voice Reporting Application, Date and
Radiology User.

```
Rad/Nuc Med HL7 Voice Reporting Exception List
```

Enter the name of a Voice Reporting Application (File #771) or press the <RET> key
to select all applications.

```
Select Voice Reporting Application: ALL// RA-CLIENT-TCP

Another one (Select/De-Select): RA-TALKLINK-TCP

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

Enter a date to begin reporting from.

```
Exception starting date/time: JAN1     (JAN 01, 1999)
```

Enter the most recent date/time to report on or press the <RET> key to accept the
default of now.

```
Exception ending date/time:   NOW// <RET> (JUN 11, 1999@12:18:26)
```

Individual users can be selected for reporting. (Entries associated with unknown users
will always be displayed). Alternatively, press the <RET> key to display all users.

```
Select Radiology User: ALL// TAYLOR,CAMERON
Another one (Select/De-Select): <RET>
```

```
HL7 Voice Reporting Errors    Jun 11, 1999 12:18:38        Page:    1 of
1

     Date        Time      Patient                       Case#  User

     HL7 Voice Reporting Application: MEDSPEAK

1.   MAR 12,1999 11:17:20  NAMEB,PATIENT                1111   TAYLOR,CAMERON
     Error: Event Protocol Pointer (field #773,8) missing

2.   MAR 23,1999 14:53:16  Not known                    ?????  Not Known
     Error: Missing Exam Date and/or Case Number

3.   MAR 23,1999 15:08:38  NAMEA,PATIENT                1      Not Known
     Error: Invalid Provider Name

     HL7 Voice Reporting Application: TALKSTATION

4.   MAR 16,1999 13:45:28  NAMEC,PATIENT                2022   TAYLOR,CAMERON
     Error: Case Number Invalid
 Enter ?? for more actions
PL  Print Exceptions List FS  First Screen        UP  Prev HL7 Exception
RS  Resend HL7 Message    NS  Next Screen         DN  Next HL7 Exception
DE  Delete HL7 Exception  LS  Last Screen         Q   Quit
Select Action: Next Screen//
```

List Manager will display the next page of HL7 Exceptions in the center screen.

```
Select Action: Next Screen// <RET>
```

List Manager will jump to the last screen of entries in the file.

```
Select Action: Next Screen// LS
```

List Manager will re-display the first screen of entries shown above.

```
Select Action: Quit// FS
```

Scroll down through each entry individually

```
Select Action: Next Screen// <↓>
```

Scroll back up through each entry individually.

```
Select Action: Next Screen// <↑>
```

The entire list will be sent to a printer. (Each Sending Application will start on a
separate page).

Print immediately or request the job to start later.

```
Select Action: Next Screen// PL
```

```
Select Device: (enter a printer)

Do you want your output QUEUED? NO// Y (YES)

Requested Start Time: NOW// <RET>
     Request Queued, Task #: 81303
```

```
============================================================================
==
 HL7 Voice Reporting Errors
Page: 1
 (MEDSPEAK - RADIOLOGY/NUCLEAR MEDICINE)          Printed: JUN 11, 1999
14:03

============================================================================
=

 Exception Date:   MAR 12,1999 at 11:17:20      User: TAYLOR,CAMERON
 Patient Name:     NAMEB,PATIENT                 Case: 1111
 Reason Rejected:  Event Protocol Pointer (field #773,8) missing

 Exception Date:   MAR 23,1999 at 14:53:16      User: Not Known
 Patient Name:     Not known                     Case: ?????
 Reason Rejected:  Missing Exam Date and/or Case Number

 Exception Date:   MAR 23,1999 at 15:08:38      User: Not Known
 Patient Name:     NAMEA,PATIENT                 Case: 1
 Reason Rejected:  Invalid Provider Name


============================================================================
==
 HL7 Voice Reporting Errors
Page: 2
 (TALKSTATION - RADIOLOGY/NUCLEAR MEDICINE)       Printed: JUN 11, 1999
14:03

============================================================================
=

 Exception Date:   MAR 16,1999 at 13:45:28      User: TAYLOR,CAMERON
 Patient Name:     NAME,PATIENT1                 Case: 2022
 Reason Rejected:  Case Number Invalid

 Exception Date:   MAR 19,1999 at 15:12:25      User: TAYLOR,CAMERON
 Patient Name:     NAME,PATIENT2                 Case: 2098
 Reason Rejected:  Missing Exam Date

 Exception Date:   MAR 23,1999 at 14:38:57      User: TAYLOR,CAMERON
 Patient Name:     NAME,PATIENT3                 Case: 1111
 Reason Rejected:  Invalid Procedure

 Exception Date:   MAR 23,1999 at 15:07:53      User: TAYLOR,CAMERON
 Patient Name:     NAME,PATIENT4                 Case: 22
 Reason Rejected:  Invalid Diagnostic Code

 Exception Date:   APR  5,1999 at 15:37:09      User: TAYLOR,CAMERON
 Patient Name:     NAME,PATIENT3                 Case: 278
 Reason Rejected:  Report already on file
```

```
Exception Date:   APR  6,1999 at 14:39:14        User: TAYLOR,CAMERON
Patient Name:     NAME,PATIENT3                  Case: 278
Reason Rejected:  Report already on file
```

To re-send a message from the list,

Select an entry from the list. Once re-sent it cannot be re-selected. A message similar
to "Message Re-submitted on JUN 11, 1999@14:15:51" is displayed instead of the
rejection reason.

```
Select Action: Next Screen// RS

Select HL7 Exception (1-34) :9
     Re-sending Message #3749...
```

To permanently delete an exception report entry, select an entry from the list.

Once deleted it cannot be re-selected. A message similar to "Reported Exception
Deleted on JUN 11, 1999@14:22:40" is displayed instead of the rejection reason

```
Select Action: Next Screen// DE

Select HL7 Exception (1-34) :10
     Deleting Exception...
```

9.2   Resend Radiology HL7 Message

[RA HL7 MESSAGE RESEND]

There are many reasons why an HL7 message may not reach its attempted
destination. This option allows you to re-send HL7 messages for such cases. The
option will prompt for a Radiology case and will then build a new HL7 message in
the hope that it will reach the subscribing applications this time.

```
Enter Case Number: 120400-111
```

```
Choice   Case No.       Procedure                   Name
Pt ID
------   --------    ---------               ----------------      ----
--
 1       120400-111     ABDOMEN FOR FETAL AGE 1 V PATIENT,TEST
9999
     ===================================================================
Re-Broadcast the 'EXAM REGISTERED' HL7 message for this case??? YES// y
YES
```

A confirmation prompt is displayed. Enter "Y" to Continue or "N" to cancel. The
prompt will either read:

EXAM REGISTERED,

EXAM CANCELLED, or

REPORT VERIFIED depending on the current exam and report status.

10.0   Parent/Descendent Exam and Printsets (+)

10.1   Definition

An exam set or print set contains a Parent procedure and its Detailed or Series descendent procedures. Requesting a Parent will automatically cause each descendent to be presented for registration as separate cases under a single visit date and time. If the parent is defined to be a print set, the collection and printing of all common report related data between the descendents is seen as one entity.

10.2   Common Data for Print Sets

For a print set, a single report is entered regardless of how many descendent cases are registered. Common data for all cases in a print set includes all fields recorded in the Rad/Nuc Med Report file #74 and a few fields in the Rad/Nuc Med Patient file #70: report text, impression, diagnostic codes, primary and secondary residents and staff, verifier, pre-verifier, clinical history, verification and pre-verification date/time and physician, transcriptionist, no-purge indicator, reported date, report status, and exam date/time. For print sets, case-related fields that are common data (residents, staff, diagnostic codes, etc.) are now editable only through report editing functions, and are no longer editable via case editing options. This is necessary to insure that there is no opportunity for users to enter different data in these fields for each case in a print set.

10.3   Non-Common Data for Print Sets

Non-common data still exists for each procedure in a print set. Non-common data includes modifiers, case number, exam status, complications, film, and most other fields that can be edited separately for each case.

10.4   Single Report Setup for Print Sets

When setting up Parent type procedures through the Procedure Enter/Edit option, page 101, you will see a new prompt, "SINGLE REPORT:", that should be set to YES to indicate that reporting for the registered descendents of the parent procedure will be combined into a single report, making it a print set. If the field is left blank, a separate report will be required for each registered descendent and the cases will NOT be treated as a print set. When descendents are registered in the Rad/Nuc Med Patient file #70, the "MEMBER OF SET" field on the case record is set automatically by the system as follows:

- 1   Descendent procedure, separate reports required

- 2   Descendent procedure, single report for all cases under this exam date/time

- Blank   Not a descendent, separate report required

Selection of any member of a print set in report related functions will bring up certain identifying information (case numbers, procedures) for all cases in the print set.

Report printouts and displays are modified for print sets to show all non-common data (such as procedure names and modifiers) on one report. The report print format for print sets has been changed to include each procedure and its modifiers. Residents, staff, and diagnoses are printed once for each print set because they are the same for cases in the print set. The same changes have been made to screen displays of reports, to email messages containing reports, and to the retained erroneous report that is stored on the report record before amending it.

If a report for a print set is deleted, each exam in the print set will show that its report was deleted.

If a user tries to create a report for a cancelled case, and the cancelled case belongs to a print set where the other cases of the print set already have a report, then the cancelled case will refer to the same report as the rest of the print set if the Division parameter allows reports on cancelled cases, or the user owns the RA MGR security key.

If neither of these conditions is true, the cancelled case will NOT have a report associated with it. If a cancelled case is selected via a voice recognition system, and the case is part of a print set, the user will not be able to enter a report. Instead, an error message will be transmitted notifying him to use VISTA for reporting on this case.

10.5   Special Character Designation for Print Sets

All options that do case lookups and displays will now show special characters to the left of the case number column for cases belonging to a print set.

> **Note:** These will only appear on cases that are entered after the installation of V. 5.0.

This also includes the List Reports in a Batch option and the Distribution Queue Menu options: Clinic Distribution List, Ward Distribution List, and Unprinted Reports List. The Register an Exam and Display Patient Demographics options also display special characters for cases in a print set when the list of the last five procedures is displayed. Options such as Status Tracking do NOT display the special characters because cases of the same print set may be in different statuses and therefore would not appear on the same screen.

In the example below, "+" denotes the first case registered in a set of descendents, and "." appears to the left of the rest of the descendents in the set. Only print sets are displayed this way. So, if the parent procedure's "SINGLE REPORT" field is not set (i.e., if it is left blank), there will be no special characters to the left of the case number. The sequence of case numbers/procedures within a print set are shown in the same order as they were registered regardless of whether the lookup is from an exam edit or report edit/print options.

```
Sample look-up display:

   Case No.      Procedure                   Exam Date
  -----------   ------------                -------------
1    122        HAND 3 OR MORE VIEWS         03/23/96
2   +113        ANKLE 2 VIEWS                04/30/96
3   .114        FOOT 2 VIEWS                 04/30/96
4   .115        TOE(S) 2 OR MORE VIEWS       04/30/96
5    81         NECK SOFT TISSUE             05/03/96
```

10.6   HL7 Interface

The HL7 interface to the voice recognition systems is changed so that the voice recognition system screen showing active cases for a selected patient will display cases belonging to a print set. For more complete information on the interface, refer to the Rad/Nuc Med Technical Manual.

The PACS/Imaging interface is changed to include multiple OBR and OBX segments for each individual procedure when a single HL7 message broadcasting an imaging report must account for all the cases in a print set.

10.7   Registration

During registration, a single Detailed, Series, or Broad procedure request can be replaced by a parent-printset from the same Imaging Type and the predefined descendant(s) can either be registered or discarded for other procedures by doing the following steps:

1. Enter "Pn" at the prompt, where "P" indicates that you want to trigger the parent-printset registration feature and "n" is the request number. The request must NOT be a parent. Only one "n" value is allowed. You will then see a prompt for a parent procedure.

2. Enter a parent procedure of the same imaging type as the requested procedure. The parent must be predefined as a printset.

3. Then proceed to register the predefined descendant(s) OR, discard (^) its descendant(s) and register any descendants you choose when it asks you for more procedures to add on.

The list of requests displayed will have a "+" in front of procedures that are printset parents. (A "+" will not display in front of non-printset parents.) After the replacement printset parent is registered, all outstanding orders that have matching procedures to any just registered will be displayed as a reminder that these may be duplicates and might have to be cancelled.

See the session capture that shows the use of Pn in the chapter Register Patient for Exams, Radiology/Nuclear Medicine User Manual.

10.8   Editing Data

During exam edit, each individual case can be retrieved and edited separately. When editing a case or Diagnostic Code on a case that is a member of a print set, no entering or editing will be allowed on common data. Common data may only be entered and edited through Report Entry/Edit since it must be the same for all cases in the print set. The Report Entry/Edit option now displays all case numbers, exam statuses and procedures that belong to the same print set as the case selected.

When common data is entered through Report Entry/Edit all print set cases' statuses will be updated accordingly. A screen display will warn transcriptionists that all cases are being updated with the same common data. Case editing options only update the status of the individual case being edited; case editing no longer allows editing of report-related fields that are common to all cases in the print set, and, therefore, case editing cannot affect the status of other cases in the print set.

10.9   Labels, Headers, Footers

Label Print field output on printed labels and report headers and footers is modified to print a "+" next to data that is non-common to indicate that the data is part of a related set. This was done because multiple values cannot be printed in the restricted space available in report headers and footers, or on labels. Label print fields affected (case number, procedure, last time this exam performed, long case number, technologist, resident, staff radiologist, and exam modifiers) will have a YES in the new "UNIQUE" field #6 on the Label Print Fields file #78.7. This un-editable field is released with data and should NOT need further tailoring by the site.

10.10   VA Fileman Prints/Inquiries

The same "+" is used for computed fields on the Rad/Nuc Med Report file #74 when output is generated using VA FileMan Inquire or Print options. An example of this would be using VA FileMan to print File #74's Primary Camera/Equip/Rm computed field. Since the data for this field could be different for each case in a print set, only the data from the first case registered is printed, and a "+" is printed next to it to indicate there could be different Primary Camera/Equip/Rms in other members of the print set.

Any case number in a print set can be used in VA FileMan lookups of the Rad/Nuc Med Report file #74 to retrieve a report for the print set. A new "OTHER CASE#" field #4.5 has been added to this file, and contains all case numbers for a print set report other than the case number already in the "DAY/CASE#" field #.01.

10.11 Add Exams to Last visit

The Add Exams to Last Visit option now allows cases to be added to exam sets as long as no report has been entered yet for any of the cases. No new order will be created; the added case will point to the same order as the rest of the cases in the exam set. This is true for print sets, as well as exam sets that require separate reports for each case.

10.12 CPRS Interface for Printsets

The Rad/Nuc Med OE/RR V. 3.0 (CPRS) interface includes functionality to make it plain to the user that a single report applies to multiple procedures.

10.13 Imaging/Multi-Media Interface Effects on Printsets

If your facility is running the Imaging interface, a placeholder ("stub") report will be created to hold the image IDs as soon as the images are collected. From that point on, a lowercase "i" will appear next to the procedure on various lookup screens, but the stub report is otherwise transparent to the user. If you need to delete a printset exam member, you will not be allowed to since a stub report exists. However, you can cancel the case instead.

11.0   Case Edits and Status Tracking

11.1   Overview

The case edit and status tracking options can vary considerably due to the way the system is set up at your site. By defining Division parameters using Division Parameter Set-up [RA SYSDIV], procedure parameters using the Procedure Enter/Edit [RA PROCEDURE] option, and status parameters using the Examination Status Entry/Edit [RA EXAMSTATUS] option you can control a great deal of what the user sees when doing case edits or updating the status of a record. The flow of prompts you see in the case edit and status tracking sections of the user manual may not reflect what your user sees. This chapter is dedicated to providing you some insight into the system response to variations in setup.

11.2   Taking Control

The case edit options always follow the same logic; you have little control over what is asked and when it is asked. Case No. Exam Edit and Edit Exam by Patient will prompt for data items that are automatically entered by the system during registration (such as inpatient, ward, bed section, etc.) and data already entered previously. This gives the opportunity to change incorrect data. Complications can also be entered in the case edit options.

To gain control of what and when specific fields appear for editing, you should set up statuses via Examination Status Enter/Edit and use Status Tracking of Exams to enter case information. In other words, always use Status Tracking of Exams for entering case data if you want to control the data flow. Use Case Edit options when you want to edit complications and fields already populated. If your facility does not use Status Tracking, you must make sure Exam Status Parameters don't require any fields that are not asked in the Case Edit options or else you will have problems getting cases to Complete.

11.3   Stuffing Data and Default Responses

Stuffed data is data that automatically becomes an entry in the record because certain conditions are met. Depending on the data that is stuffed, it may or may not be editable. For instance, the sign-on user name may be stuffed but not editable, whereas the requested detailed procedure may be stuffed but it is editable at registration. Default responses may be stuffed data, or they may be provided as the most logical response to a prompt (e.g., Default Response//) and only become part of the record when you strike the <RET> key to accept it. Some data items such as Default Radiopharmaceutical, can be set up through Procedure Enter/Edit to be automatically entered (stuffed) on a patient exam record. Other data items, such as radiopharmaceutical dose, form etc., are not stuffed into the record, but will appear as default responses if defined for a procedure.

Only detailed and series procedures are capable of having stuffed and default responses. Therefore, a parent does not have default responses, but its descendents can have them. A broad procedure cannot have default responses. However, if the requested broad procedure is changed to a detailed procedure at registration, then the user can benefit from the detailed procedure's default answers. If the procedure is changed later on, during case edits or status tracking, the user will need to check the data in the default fields to verify accuracy.

(+) The fields that can have responses stuffed when entering data are Film Size, Radiopharmaceuticals, and Med Administered. The default data for these fields are entered via the option Procedure Enter/Edit. If the procedure is not a Nuclear Medicine or Cardiology Studies procedure, then radiopharmaceuticals cannot be associated with it.

(+) If a radiopharmaceutical and/or medication was stuffed during registration and then the procedure was later changed, the program will delete the stuffed data and display information messages on the screen.

11.4   Radiopharmaceutical Logic (+)

The following radiopharmaceutical logic pertains only to those procedures that use radiopharmaceuticals. There are three parameters that work in conjunction to determine what prompts the user sees:

Whether the user is asked for radiopharmaceuticals,

When the user is asked for radiopharmaceuticals, and

If radiopharmaceuticals are required.

Suppress Radiopharm Prompt, edited via the option Procedure Enter Edit, determines whether or not the user is asked for a radiopharmaceutical. It can contain Always (0 or Null (no answer entered)) or Never (1) using the following definitions:

- 0   Always (same as Null) ask for Radiopharmaceutical if and when exam status parameters specify (this is the default).

- 1   Never ask (suppress the radiopharmaceutical prompts) or require Radiopharmaceutical even if exam status parameters specify that a Radiopharmaceutical should be entered. If default Radiopharmaceuticals are entered for the procedure they will not be automatically entered on the exam record by the system when the case is registered.

- Ask Radiopharms and Dosages (while in a specific status), edited via the option Examination Status Entry/Edit, can contain a YES (when trying to progress to this status, ask it) or NULL (don't ask it).

- Radiopharms/Dosages Required, edited via the option Examination Status Entry/Edit, determines if entry of a radiopharmaceutical is required. It can contain either a YES (it is required) or NULL (it is not required). This determines whether it is required to progress to the status.

To suppress asking/requiring radiopharmaceuticals on an individual procedure, you must enter NEVER on the procedure field, Suppress Radiopharm Prompt. Status Tracking and Case Edit both skip radiopharmaceutical prompts if NEVER is entered. Status update logic will also skip over the radiopharmaceutical requirement if NEVER is in the field, even if the Exam Status, Radiopharms/Dosages Required?, parameters are set to YES. Also, Registration will not stuff default radiopharmaceuticals if NEVER is in that field, even if default radiopharmaceuticals have been entered on the procedure file. The Procedure Enter/Edit option will delete any default radiopharmaceuticals previously entered for this procedure if this field is NEVER.

11.5   Medication Logic (+)

Medication logic pertains to all types of procedures. There are two parameters that work in conjunction to determine what prompts the user sees:

Whether the user is asked for medications, and

When the user is asked for medications.

Prompt for Meds (Rad/Nuc Med Procedure file #71, field #5), edited via the option Procedure Enter Edit, determines whether or not the user is asked for a medication.

Ask Medications & Dosages? (Examination Status file #72, field #.27), edited via the option Examination Status Entry/Edit, can contain a YES (when in this status, ask it) or NULL (don't ask it).

Medication prompts will only appear if both Ask Medications & Dosages and Prompt for Meds are set to YES. Case Edits and Status Tracking both use Prompt for Meds, but Case Edits will always ask (and re-ask on additional edit sessions), whereas Status Tracking will only present the medication prompt for the appropriate status as set up in File #72. Medications do not affect status updates because they are never required.

11.6   Radiopharm Prescription & Prescribing Physician/Dose Logic (+)

This logic affects only those procedures that use radiopharmaceuticals. There is only one determining factor:

Whether the user is asked for the prescribing physician and prescribed dose.

Examination Status parameter fields concerning prescriptions for radiopharmaceuticals do not exist. A single field on the Rad/Nuc Med Procedure file #71, Prompt for Radiopharm RX, field #19, is used for determining prompting logic. During the Status Tracking session where the dose administered has been entered, Status Tracking will ask for prescription data only if Field #19 is set to YES. Once prescription data is entered, Status Tracking will no longer prompt for prescription data in subsequent edits; however, if only one prescription field (physician or dose) is entered, Status Tracking will continue to ask both fields at every subsequent edit session. Case edits will always ask for prescription data if Field #19 is set to YES. In both Case Edits and Status Tracking, a warning will continue to display if the dose administered is outside of the high/low range. Prescription data do not affect status updates because it cannot be required.

11.7   Population of Imaging Exam Data

Patient Exam Data Field	Automatically Entered	Dx Code Edit	Asked in Case Edits	Asked in Case Edits only if already populated	Asked in Status Tracking if "Ask" param is set to YES	Cannot be asked in Status Trking
Visit:						
Exam Date						X
Type of Imaging	When registered					X
Hospital Division	When registered					X
Imaging Location	When registered					X
Examinations:						
Case Number	When registered					X
Procedure		X			X	

Patient Exam Data Field	Automatically Entered	Dx Code Edit	Asked in Case Edits	Asked in Case Edits only if already populated	Asked in Status Tracking if "Ask" param is set to YES	Cannot be asked in Status Trking
Exam Status	After each edit of case and report.					X
Category of Exam	When registered		X			X
Barium Used?	When registered if AMIS = 9		If AMIS = 9			X
Ward	When registered if inpatient			X		X
Service	When registered if inpatient			X		X
Bedsection	When registered if inpatient			X		X
Principal Clinic	When registered if outpatient		If category = opt	X		X
Contract/Sharing Source	When registered if entered on request			Also asked if category = contract/sharing		X
Research Source	When registered if entered on request			Also asked if category = research		X
Contrast Media Used	When registered if AMIS 10, 11, 12, 14, 16, 17, 18, 19, 20		If AMIS 4, 15, 21, 22			X
Imaging Order	When registered					X
Primary Interpreting Staff		If NOT a printset			If NOT a printset	
Secondary Interpreting Staff		If NOT a printset			If NOT a printset	
Primary Interpreting Resident		If NOT a printset			If NOT a printset	
Secondary Interpreting Residents		If NOT a printset			If NOT a printset	
Primary Diagnostic Code		If NOT a printset			If NOT a printset	
Secondary Diagnostic Codes		If NOT a printset			If NOT a printset	
Requesting Physician	When registered		X			X
Complication			X			X

Patient Exam Data Field	Automatically Entered	Dx Code Edit	Asked in Case Edits	Asked in Case Edits only if already populated	Asked in Status Tracking if "Ask" param is set to YES	Cannot be asked in Status Trking
Complication Text			When a complication is entered			X
Primary Camera/Equip/Rm			If division param = YES		X	
Requested Date	When registered					X
Requesting Location	When registered					X
Visit	When complete					X
Dosage Ticket Printed?	When printed					X
HL7 Examined Msg Sent?	When sent					X
Film Size Data:						
Film Size	When registered if set up on procedure		X		X	
Amount (#films)	When registered if set up on procedure		X		X	
Exam Status Times						
Status Change Date/Time	After each status change if division param = NO				If division param = YES	
New Status	X					X
Computer User	X					X
Activity Log						
Log Date	If division param = YES					X
Type of Action	X					X
Computer User	X					X
Modifiers	When registered, from request		X			X
Technologist		X	X		X	
Medications						
Med Administered	If procedure defaults set up		If procedure param for meds = YES		If procedure param for meds = YES	

Patient Exam Data Field	Automatically Entered	Dx Code Edit	Asked in Case Edits	Asked in Case Edits only if already populated	Asked in Status Tracking if "Ask" param is set to YES	Cannot be asked in Status Trking
Med Dose			If procedure param for meds = YES		If procedure param for meds = YES	
Date/Time Med Administered				X	If procedure param for meds = YES	
Person Who Administered Med				X	If procedure param for meds = YES	
Clinical History for Exam	When registered, from request					
Radiopharmaceuticals						
Radiopharms	When registered, if procedure defaults set up		If procedure param Suppress Radiopharm = NO		If procedure param Suppress Radiopharm = NO	
Fields below are asked only if a radiopharm is entered. Radiopharms and related fields only apply to procedures of Nuclear Medicine or Cardiology Studies.						
Prescribed Dose by MD Override			If procedure Rx param = YES		If not already entered, and if procedure Rx param = YES	
Prescribing			If procedure Rx param =		If not already	

Patient Exam Data Field	Automatically Entered	Dx Code Edit	Asked in Case Edits	Asked in Case Edits only if already populated	Asked in Status Tracking if "Ask" param is set to YES	Cannot be asked in Status Trking
Physician			YES		entered, and if procedure Rx param = YES	
Activity Drawn				X	X	
Date/Time Drawn				X	X	
Person Who Measured Dose				X	X	
Dose Administered			X		X	
Date/Time Dose Administered			X		X	
Person Who Administered Dose			X		X	
Witness to Dose Administration			If procedure Rx param = YES		If not already entered, and if procedure Rx param = YES	
Route of Administration				X	X	
Site of Administration				X	X (unless no predefined sites for route, and Free Text site param is OFF)	
Site of Admin Text				X	X	
Lot No.				X	X	
Volume				X	X	
Form				X	X	

12.0   Outpatient Workload Crediting

12.1   Imaging Stop Codes File 71.5

This file contains the stop codes that can be used by imaging services. They are determined by MAS, VA Headquarters. You can edit these stop codes via the option Valid Imaging Stop Codes Edit and delete any not used at your site. It provides the list of selections for stop codes assignment to Imaging Locations. Upkeep of this file is entirely up to you, the radiology supervisor. It is not a pointed-to file (meaning preservation of its data does not affect reports, etc.) therefore entries should be deleted if they don't need to be on the selection list.

12.2   Invalid CPT/Stop Code List

The report option Invalid CPT/Stop Code List under the Procedure File Listings menu should be used as a tool to review the validity of procedure CPTs, Imaging Location setup, and several other "sanity checks". Warnings and errors on this report must be addressed in order to properly credit imaging workload at your facility.

This report shows any CPTs that are nationally inactive, missing, or have broken pointers. It prints warnings for Parent type procedures with no Descendents, and for detailed or series procedures with no AMIS code(s). The report will also tell you if there are any Imaging Locations with incorrect DSS IDs (i.e., Stop codes not in the Imaging Stop Codes file), and if an Imaging Location is not pointing to a Hospital Location file #44 entry marked as Occasion of Service.

12.3   Valid Imaging Stop Codes Edit

All stop codes are determined by the Medical Administration Office in VA Headquarters which updates the contents of the Clinic Stop file #40.7 every October 1 via a software release. After IRM installs the software that updates that file, you can use the option Inquire to File Entries to get a listing of the entries in File #40.7 and check them against entries in your Imaging Stop Codes file #71.5. If there are any changes, you need to update File #71.5 by deleting the ones that have become obsolete and adding the codes that correspond to the imaging services done at your site via the option Valid Imaging Stop Codes Edit. If you add new Stop Codes, it is your responsibility to first verify that the codes are recognized as valid for Imaging Services by MAS, VA Headquarters.

12.4   Location Parameter Edit

Whenever you use the Location Parameter Edit option to edit or set up an Imaging Location, the software automatically checks the "pointed to" entry in the Hospital Location file #44. You should see a short message such as "Location is OK" after editing. If the software detects a problem, it will attempt to correct the problem, possibly by creating a new File #44 entry for the Imaging Location to point to. This will happen if someone has erroneously entered appointment patterns for the File #44 location. If the Stop Codes don't agree, the Stop Code entry in File #44 will be overwritten to match the DSS ID entered by the radiology supervisor. If an error cannot be resolved by the software, you will see a message telling you to take some action. If the software can fix the problem, you will see a message telling you what was done.

12.5   Options that can Potentially Trigger Crediting

- Case No. Exam Edit

- Edit Exam by Patient

- Report Entry/Edit

- On-line Verifying of Reports

- Verify Report Only

- Status Tracking of Exams

- Update Exam Status

- Diagnostic Code Entry by Case No.

- Resident On-line Pre-verification

- Verify Batch

- Report Entry through vendor supplied Voice Recognition Systems

12.6   Crediting

- Rad/Nuc Med sends data to the PCC (Patient Care Component) package whenever an exam's status progresses to Complete.

- Using the option Mass Override Exam Status or Override a Single Exam Status to Complete does not result in any stop code or CPT crediting.

- Crediting is only filed for outpatients.

- The following data is mandatory for each case:

  - Detailed Procedure with a valid CPT code

  - Primary Interpreting Staff or Primary Interpreting Resident

- Patient
- Exam Date/Time
- PCC
- Requesting Location
- The PCC package sends the Scheduling Package the crediting data that needs to be transmitted to Austin.
- If PCC accepts the Rad/Nuc Med crediting data, a value will be written to the Visit field #27 of the Rad/Nuc Med Patient file #70 on that case. If not, the failure bulletin is sent to recipients.
- If descendent cases are registered for a given exam date/time, each case may be either Complete or Cancelled before data is sent to PCC.

12.7   Errors

There is a bulletin (RAD/NUC MED CREDIT FAILURE) that can be used to notify a mail group of credit errors generated specifically through Radiology/Nuclear Medicine. Your IRM should set up a mail group that includes the radiology supervisor, or whoever will be responsible for researching and resolving crediting problems.

> **Note:** For more information on outpatient crediting, please see the PCC and Scheduling documentation.

13.0   Troubleshooting

13.1   On-line Verifying of Reports

The following is a chart using various parameter set-ups in the options Division Parameter Set-up and Classification Enter/Edit to show how On-line Verifying of Reports is affected. If selecting another physician's reports in on-line verifying is not working the way you feel it should, check this chart to see what you need to change.

Division Parameter Set-up Allow Verifying by Residents	Classifi-cation Enter/Edit Allow Verifying of Others	Classification Enter/Edit Classification of User logged on	Depending on parameters, the physician using on-line verification may or may not be allowed to select another physician's reports. First prompts displayed when On-line Verifying of Reports is selected
Y	Y	Resident	Select Interpreting Physician*
N	N	Resident	Interpreting Residents are not allowed to verify reports.
Y	N	Resident	Select one of the following: 1 Pre-verified... 2 Draft... 3 ...
N	Y	Resident	Interpreting Residents are not allowed to verify reports.
Y	Y	Staff	Select Interpreting Physician
N	N	Staff	Select one of the following: 1 Pre-verified... 2 Draft... 3 ...
Y	N	Staff	Select one of the following: 1 Pre-verified... 2 Draft... 3 ...
N	Y	Staff	Select Interpreting Physician

The Select Interpreting Physician prompt allows the user to choose another physician and review that physician's reports. If this isn't the first prompt displayed, the user cannot edit another physician's reports.

Physician Title on Reports: The title that prints to the right of the physicians' names on the results report is taken from the New Person File #200 Signature Block Title field #20.3. So, if you find that incorrect titles are printing, have the user or IRM edit this field.

Workload Reports: Please note that the separation of workload figures by imaging type supported in version 4.5 will take effect only on exams entered after the radiology supervisor activates the new imaging types. For example, if an exam was entered before the new imaging type was activated, the exam will be counted under its old imaging type. To include only exams entered after the new imaging types were activated, the beginning date entered at the date range prompts when generating the report must be after the date when the new imaging types were activated.

For most workload reports that are sortable/selectable by one-many-all, division and imaging type, the division totals page will only print if there is more than one imaging type in the division. If there is only one imaging type in the division, the imaging type total page is used for the division total.

The following reports calculate workload counts (i.e., exam counts, patient visit counts, and weighted work units) in a similar way:

Functional Area Workload Reports...
- Clinic Report
- PTF Bedsection Report
- Service Report
- Sharing Agreement/Contract Report
- Ward Report

Personnel Workload Reports...
- Physician Report
- Resident Report
- Staff Report
- Technologist Report
- Transcription Report

Special Reports...
- Camera/Equip/Rm Report

- Data must fall within the date range selected.

- Exam Status file (#72) parameters are checked to see if the case's exam status is one that should cause the exam to appear on the report.

- Exam status must have an Imaging Type the user has selected or defaulted to, and the exam's division must be one the user selected or defaulted to.

- Checks the Category of Exam to identify the patient category (inpatient, outpatient, research, or other). The personnel reports identify the patient as an inpatient or outpatient. The functional reports identify the patient as an inpatient, outpatient, research, or other. The clinic report will ignore a case if the category is inpatient. The ward, bedsection, and service reports will ignore a case if the category is outpatient or other.

- Ignores the case if the procedure does not exist in the Rad/Nuc Med Procedure file (#71). (This would mean there is a broken pointer type of data corruption problem in the record.) Theoretically, this shouldn't happen. If it does, it means that someone completely deleted a procedure.

- .Ignores the case if there are no AMIS codes associated with the procedure. (AMIS codes can be entered using the Procedure Enter/Edit option.)

- Ignores the case on the Sharing Agreement/Contract report if the pointed to entry in the Contract/Sharing Agreements file (#34) does not exist. ("Does not exist" means there is a broken pointer type of data corruption, which happens when someone inadvertently deletes an entry from the Contract/Sharing Agreements file.) If no contract/sharing source was entered, the case is reported under other

- Calculates the weighted work units (WWUs). The AMIS Weight Multiplier field of the Rad/Nuc Med Procedures file contains a number (0-99) to indicate to the various workload report routines how many times to multiply the weighted work units associated with the AMIS code. The Weight for each AMIS code is stored in the Weight field of the Major Rad/Nuc Med AMIS Code file.

  Most multipliers will be 1. However, there are some that are greater than 1. For example, a procedure called Upper GI and Small Bowel might have AMIS code 9-Gastrointestinal that has a Weight of 6 work units, and an AMIS Weight Multiplier of 2. Therefore, on the workload reports, the site will get credit for 12 weighted work units (WWUs) each time it is performed. If there are multiple AMIS codes for the procedure, each AMIS Weight Multiplier is multiplied by the AMIS weight, then the results are summed.

  Depicted below is a sample of the exam/procedure/AMIS data relationship. Using this sample, the WWUs for the exam would be 12, and the exam would count as 2 exams.

Rad/Nuc Med exam data stored in Rad/Nuc Med Patient file #70:	Procedures stored in Rad/Nuc Med Procedures file #71:	AMIS categories stored in Rad/Nuc Med Major AMIS Codes file #71.1:
----------------------------------	--	--------------------------------

Patient: Joe Veteran   Procedure:
  Procedure: ---------------->   **Upper GI**
  Exam Modifiers: (none)   AMIS codes data:
                        AMIS Code(s): ------------->   Desc: Gastrointestinal
                        AMIS Weight Multiplier: **2**   Weight: **6**
                        Bilateral:
                        CT Head or Body:

In the above example, this would be the calculation for Weighted Work Units: 6 X 2 = 12.

The modifiers (operating room, portable, and bilateral) have special meaning and cause increased counts. If the AMIS Weight Multiplier is less than 2, "bilateral" affects the WWUs by multiplying the AMIS Weight Multiplier by 2. The result is multiplied by the AMIS code's "Weight". In the sample above, if the procedure had been bilateral, WWUs would never have been affected. Here's step-by-step how it works:

It finds all the AMIS codes associated with each procedure. If no AMIS weight has been entered, the default is 1.

If bilateral (i.e., the procedure's "Bilateral" field is set to "YES" or a bilateral modifier was entered during exam ordering or case editing), the multiplier value (AMIS Weight Multiplier) is doubled.

For each AMIS code on the procedure, it multiplies the weight times the weight multiplier of each code, then sums the products (if more than one AMIS code on the procedure).

- Increments the counts for division, Imaging Type report, procedure etc.

- If more than one AMIS code exists for the procedure, the appropriate exam category count is incremented by one. If only one AMIS code for the procedure, increment the patient count by the weight multiplier.

- Cases with more than one technologist, resident, and staff will be incremented accordingly with a message warning that the total number of exams and weighted work units will be higher in these personnel reports than the other workload reports.WWUs are printed on all functional area reports, the Technologist Report, and the Camera/Equip/Rm Report. WWUs do not apply to the Physician, Resident, Staff and Transcription Reports.

  Abnormal Exam Report: This report includes only those exams that have a Diagnostic Code whose "PRINT ON ABNORMAL REPORT" field in the Diagnostic Codes file #78.3 is set to "YES".

Delinquent Status Report: There are times when an exam seems like it should be in the Complete status when it is actually in a Transcribed or lower status. The following steps describe how this might happen.

1. A case is registered; the status is Waiting for Exam.

2. The exam is completed quickly and images are sent to the radiologist or nuclear medicine physician before status tracking or case edit is used.

3. The transcriptionist enters the report, but the status either cannot be upgraded because the case has not been edited by the technician or cannot be upgraded to the status immediately before Complete.

4. The report is verified, but the technician still has not done case edit or status tracking, so the exam remains in some status lower than Complete.

5. The technician now uses status tracking (not Case No. Edit or Edit Exam by Patient). Status tracking pushes the exam status to Examined (or whatever the next ordered status is) because it is designed to push the status to the next ordered status rather than the highest possible status.

6. Status Tracking will display all higher status(es) for which this exam now qualifies. However, if the technician does not follow up with additional status tracking edits of the same case, the case stays in Examined or Transcribed (or whatever) and goes into the "black hole" until it shows up on the Delinquent Status report.

Another scenario circumstance that may cause the same finding:

If status tracking cannot account for incomplete cases, the other possibility is that an error occured on a tasked job that was supposed to update the status. This is likely if there are very few occurrences. Since status update tasks call so many other programs, the error might not even show evidence to IRM that Radiology/Nuclear Medicine is responsible. This could be reconstructed based on log subfiles that are populated (if the logs are turned on) together with careful scrutiny of the error log that IRM can access.

Use the Delinquent Status report regularly to catch this infrequent happening.

14.0   Stop Task (TaskMan) (+)

One of the new features in this version is the ability of the user to stop tasks. All reports that can consume a significant amount of CPU/print time are now stoppable through the Stop Task action of the TaskMan User [XUTM USER] option under the User's Toolbox [XUSERTOOLS] menu. The enhanced report logic checks for a stop flag during processing that is done before printing actually begins as well as during printing. You can get to this menu from any menu prompt in the Radiology/Nuclear Medicine software simply by typing TBOX. Here is an example of how it works. Note that TBOX is a Common Option under the menu.

```
Exam Entry/Edit Menu ...
          Films Reporting Menu ...
          Management Reports Menu ...
          Outside Films Registry Menu ...
          Patient Profile Menu ...
          Radiology/Nuclear Med Order Entry Menu ...
          Supervisor Menu ...
          Switch Locations
          Update Patient Record
          User Utility Menu ...

Select Rad/Nuc Med Total System Menu Option: ??

          Exam Entry/Edit Menu ... [RA EXAMEDIT]
          Films Reporting Menu ... [RA RPT]
          Management Reports Menu ... [RA MGTRPTS]
          Outside Films Registry Menu ... [RA OUTSIDE]
          Patient Profile Menu ... [RA PROFILES]
          Radiology/Nuclear Med Order Entry Menu ... [RA ORDER]
          Supervisor Menu ... [RA SUPERVISOR]
          Switch Locations [RA LOC SWITCH]
          Update Patient Record [RA PTEDIT]
          User Utility Menu ... [RA USERUTL]

You can also select a secondary option:

          Rad/Nuc Med Total System Menu ... [RA OVERALL]
          Radiology/Nuclear Med Order Entry Menu ... [RA ORDER]
          Supervisor Menu ... [RA SUPERVISOR]
          Utility Files Maintenance Menu ... [RA MAINTENANCE]

Or a Common Option:

   TBOX    User's Toolbox ... [XUSERTOOLS]
   VA      View Alerts [XQALERT]

             Press 'RETURN' to continue, '^' to stop: <RET>
          Continue [XUCONTINUE]
             **> Reverse lock ZZLUKE
          Halt [XUHALT]
          MailMan Menu ... [XMUSER]
          Restart Session [XURELOG]
          Time [XUTIME]
          Where am I? [XUSERWHERE]
```

```
Select Rad/Nuc Med Total System Menu Option: tbox   User's Toolbox


          Display User Characteristics
          Edit User Characteristics
          Electronic Signature code Edit
          Menu Templates ...
          Spooler Menu ...
          Switch UCI
          TaskMan User
          User Help

Select User's Toolbox Option: taskMan User


Select TASK: ??

Please wait while I find your tasks...searching...finished!

1: (Task #35437) DQ^RAFLH, DQ^RAFLH.  Device LINE.  POC,POC.
   From 12/09/96 at 13:58,  By you.
   Waiting for device _LTA1707:
------------------------------------------------------------------------------
--
2: (Task #35591) ENTASK^RAMAINP, Rad/Nuc Med Active Procedures (Long).
   Device LINE.  POC,POC.  From 12/13/96 at 8:42,  By you.  Unscheduled by
you.
------------------------------------------------------------------------------
--
3: (Task #35680) DQ^RAFLH, DQ^RAFLH.  Device LINE.  POC,POC.
   From 12/16/96 at 13:08,  By you.  Unscheduled by you.
------------------------------------------------------------------------------
--
4: (Task #35823) DQ^RAFLH, DQ^RAFLH.  Device LINE.  POC,POC.
   From 12/20/96 at 8:26,  By you.  Unscheduled by you.
------------------------------------------------------------------------------
--
5: (Task #35825) PRTORD^RAORDQ, PRTORD^RAORDQ.  Device FIELD SUPPORT.
POC,POC.
   From 12/20/96 at 8:30,  By you.  Completed 12/20/96 at 8:31.
------------------------------------------------------------------------------
--
6: (Task #35826) DQ^RAFLH, DQ^RAFLH.  Device LINE.  POC,POC.
   From 12/20/96 at 8:31,  By you.  Unscheduled by you.
------------------------------------------------------------------------------
--
Press RETURN to continue or '^' to exit: ^

Select TASK: 1  DQ^RAFLH

                Taskman User Option

                     Display status.
                     Stop task.
                     Edit task.
                     Print task.
                     List own tasks.
                     Select another task.

                Select Action (Task # 35437): stop   Stop task.
```

```
Task unscheduled and stopped.

                Taskman User Option

                     Display status.
                     Stop task.
                     Edit task.
                     Print task.
                     List own tasks.
                     Select another task.

                Select Action (Task # 35437): <RET>


          Display User Characteristics
          Edit User Characteristics
          Electronic Signature code Edit
          Menu Templates ...
          Spooler Menu ...
          Switch UCI
          TaskMan User
          User Help

Select User's Toolbox Option: <RET>


          Exam Entry/Edit Menu ...
          Films Reporting Menu ...
          Management Reports Menu ...
          Outside Films Registry Menu ...
          Patient Profile Menu ...
          Radiology/Nuclear Med Order Entry Menu ...
          Supervisor Menu ...
          Switch Locations
          Update Patient Record
          User Utility Menu ...

Select Rad/Nuc Med Total System Menu Option:
```

Appendix A: Worksheets

A.1   Division Parameters

Division: _____

Parameter	Parameter Set Equal to:	YES	NO

===

Division-wide Order Entry Parameters:

ASK IMAGING LOCATION: ___   ___

TRACK REQUEST STATUS CHANGES: ___   ___

CLINICAL HISTORY MESSAGE: _____

_____

Exam Entry/Edit Parameters:

DETAILED PROCEDURE REQUIRED: ___   ___

ASK 'CAMERA/EQUIP/RM':   ___   ___

AUTO USER CODE FILING: ___   ___

TRACK EXAM STATUS CHANGES: ___   ___

ASK EXAM STATUS TIME: ___   ___

TIME LIMIT FOR FUTURE EXAMS: ___   ___

Films Reporting Parameters:

ALLOW STANDARD REPORTS: ___   ___

ALLOW BATCHING OF REPORTS: ___   ___

ALLOW COPYING OF REPORTS: ___   ___

IMPRESSION REQUIRED ON REPORTS: ___   ___

ALLOW VERIFYING BY RESIDENTS: ___   ___

ALLOW RPTS ON CANCELLED CASES?:   ___   ___

WARNING ON RPTS NOT YET VERIF?:   ___   ___

AUTO E-MAIL TO REQ. PHYS?:   ___   ___

DIVISION PARAMETERS (CONTINUED)

Division: _____

Parameter	Parameter Set Equal to:	YES	NO

Miscellaneous Division Parameters:

PRINT FLASH CARD FOR EACH EXAM: ___   ___

PRINT JACKET LBLS W/EACH VISIT: ___   ___

CONTRAST REACTION MESSAGE: _____

_____

RPHARM DOSE WARNING MESSAGE: _____

_____

Imaging Locations Associated with this Division:

_____

_____

_____

_____

A.2   Camera/Equip/Room

NAME: DESCRIPTION:

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

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_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

        _____

                _____

A.3   Location Parameters

Imaging Location: _____

Imaging Type: _____   Principal Clinic: _____

Parameter   Parameter Set Equal to
===

Flash Card Parameters

HOW MANY FLASH CARDS PER VISIT: 0   1   2   3   4   5   6   7   8   9   10

DEFAULT FLASH CARD FORMAT: _____

Jacket Label Parameters

HOW MANY JACKET LBLS PER VISIT: 0 1 2 3 4 5 6 7 8 9 10

DEFAULT JACKET LABEL FORMAT: _____

Exam Label Parameters

HOW MANY EXAM LABELS PER VISIT: 0 1 2 3 4 5 6 7 8 9

DEFAULT EXAM LABEL FORMAT: _____

Report Parameters

DEFAULT REPORT HEADER FORMAT: _____

DEFAULT REPORT FOOTER FORMAT: _____

REPORT LEFT MARGIN: _____

REPORT RIGHT MARGIN: _____

PRINT DX CODES IN REPORT?:   YES: ____ NO: ____

VOICE DICTATION AUTO-PRINT: YES: ____ NO: ____

Imaging Location: _____

Parameter   Parameter Set Equal to
===

Cameras/ Equipment/Rooms Used by this Imaging Location:

_____   _____

_____   _____

_____   _____

_____   _____

Recipients of the 'Stat' Alert for this Location

STAT REQUEST ALERT RECIPIENTS:

_____   _____

_____   _____

_____   _____

URGENT REQUEST ALERTS?:   YES: _____ NO: _____

ALLOW 'RELEASED/NOT VERIFIED':   YES: _____ NO: _____

Credit and DSS Parameters

CREDIT METHOD: _____

DSS ID: _____

A.4   Classification

NAME   **(Resident/Staff/Clerk/Technologist)**   **ACCESS**
==

_____

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_____

A.5   Blank Examination Status Worksheet

Imaging Type:_____

Field: **Statuses:**

	Can-celled	Waiting for Exam	Called for Exam	Exam-ined	Tran-scribed	Com-plete
Order in sequence of status progression						
Should this Status appear in Status Tracking						
User Key needed to move an exam to this status						
Default next status for exam						
Can an exam be cancelled while in this status						
Generate exam alert for requesting physician						
Generate Examined HL7 Message						
Data Requirements for this Status	-----	-----	-----	-----	-----	-----
Technologist Required						
Resident Or Staff Required						
Detailed Procedure Required						
Film Entry Required						
Diagnostic Code Required						
Camera/Equip/RM Required						
Radiopharms & Dosages required						
Activity Drawn required (Radiopharm)						
Drawn Dt/Time and Person required (Radiopharm)						
Admin Dt/Time/Person required (Radiopharm)						
Route/Site required (Radiopharm Administered)						
Lot No. required (Radiopharm)						
Volume/Form required (Radiopharm)						
Report Entered Required						
Impression Required						

Verified Report Required						
To Move to this Status	-----	-----	-----	-----	-----	-----
Ask for Technologist						
Ask for Interpreting Physician						
Ask for Procedure						
Ask for Film Data						
Ask for Diagnostic Code						
Ask for Camera/Equip/RM						
Ask for User Code						
Ask Medications & Dosages						
Ask Medication Admin Dt/Time & Person						
Ask Radiopharmaceuticals and Dosages						
Ask Activity Drawn (Radiopharmaceutical)						
Ask Drawn Dt/Time & Person (Radiopharm)						
Ask Admin Dt/Time & Person (Radiopharm)						
Ask Route/Site of Admin (Radiopharm)						
Ask Lot No. (Radiopharm)						
Ask Volume/Form (Radiopharm)						
Exams in this Status should appear on these Reports	-----	-----	-----	-----	-----	-----
Clinic Report						
PTF Bedsection Report						
Service Report (Workload)						
Sharing/Contract Report (Workload)						
Ward Report (Workload)						
Film Usage Report (Workload)						
Technologist Report (Workload)						
AMIS Report (Workload)						
Detailed Procedure Report (Workload)						
Camera/Equip/RM Report						
Physician Report						
Resident Report						
Staff Report						
Delinquent Status Report						
Radiopharmaceutical Dosage Ticket Print Control	-----	-----	-----	-----	-----	-----
Print Dosage Ticket when exam reaches this status						

A.6   Examination Statuses

Below is the set of exam statuses as released for each Imaging Type. Note: They are populated, but not activated. To activate, assign an Order number, a Default Next Status, and indicate that it should Appear on Status Tracking

Field: **Statuses:**

	Can-celled	Waiting for Exam	Called for Exam	Exam-ined	Tran-scribed	Com-plete
Order in sequence of status progression	0	1				9
Should this Status appear in Status Tracking		Y				
User Key needed to move an exam to this status						
Default next status for exam						
Can an exam be cancelled while in this status	Y	Y	Y			
Generate exam alert for requesting physician						
Generate Examined HL7 Message						
Data Requirements for this Status	-----	-----	-----	-----	-----	-----
Technologist Required			Y	Y	Y	Y
Resident Or Staff Required					Y	Y
Detailed Procedure Required				Y	Y	Y
Film Entry Required				Y	Y	Y
Diagnostic Code Required					Y	Y
Camera/Equip/RM Required					Y	Y
Radiopharms & Dosages required						
Activity Drawn required (Radiopharm)						
Drawn Dt/Time and Person required (Radiopharm)						
Admin Dt/Time/Person required (Radiopharm)						
Route/Site required (Radiopharm administered)						
Lot No. required (Radiopharm)						
Volume/Form required (Radiopharm)						
Report Entered required					Y	Y
Impression required						Y
Verified Report required						Y
To Move to this Status	-----	-----	-----	-----	-----	-----
Ask for Technologist			Y	Y		
Ask for Interpreting Physician					Y	
Ask for Procedure				Y		

Ask for Film Data				**Y**		
Ask for Diagnostic Code					**Y**	
Ask for Camera/Equip/RM				**Y**		
Ask for User Code						
Ask Medications & Dosages						
Ask Medication Admin Dt/Time & Person						
Ask Radiopharmaceuticals and Dosages				**Y**		
Ask Activity Drawn (Radiopharmaceutical)						
Ask Drawn Dt/Time & Person (Radiopharm)						
Ask Admin Dt/Time & Person (Radiopharm)						
Ask Route/Site of Admin (Radiopharm)						
Ask Lot No. (Radiopharm)						
Ask Volume/Form (Radiopharm)						
Exams in this Status should appear on these Reports	-----	-----	-----	-----	-----	-----
Clinic Report		**Y**	**Y**	**Y**	**Y**	**Y**
PTF Bedsection Report		**Y**	**Y**	**Y**	**Y**	**Y**
Service Report (Workload)		**Y**	**Y**	**Y**	**Y**	**Y**
Sharing/Contract Report (Workload)		**Y**	**Y**	**Y**	**Y**	**Y**
Ward Report (Workload)		**Y**	**Y**	**Y**	**Y**	**Y**
Film Usage Report (Workload)		**Y**	**Y**	**Y**	**Y**	**Y**
Technologist Report (Workload)		**Y**	**Y**	**Y**	**Y**	**Y**
AMIS Report (Workload)		**Y**	**Y**	**Y**	**Y**	**Y**
Detailed Procedure Report (Workload)		**Y**	**Y**	**Y**	**Y**	**Y**
Camera/Equip/Rm Report		**Y**	**Y**	**Y**	**Y**	**Y**
Physician Report		**Y**	**Y**	**Y**	**Y**	**Y**
Resident Report		**Y**	**Y**	**Y**	**Y**	**Y**
Staff Report		**Y**	**Y**	**Y**	**Y**	**Y**
Delinquent Status Report		**Y**	**Y**	**Y**	**Y**	
Radiopharmaceutical Dosage Ticket Print Control	-----	-----	-----	-----	-----	-----
Print Dosage Ticket when exam reaches this status						

A.7   Procedure Setup

(This worksheet addresses only the new fields, except Single Report that is only seen when editing Parent Procedures. Remember, the radiopharmaceutical prompts are only used with Nuclear Medicine/Cardiology Studies Imaging Type procedures.)

Procedure: _____

==

PROMPT FOR MEDS: YES ____   NO ____

DEFAULT MEDICATION: _____   DOSE: _____

SUPPRESS RADIOPHARM PROMPT: ASK (O) ____   NEVER ASK (1) ____

PROMPT FOR RADIOPHARM RX: YES ____   NO ____

*DEFAULT RADIOPHARMACEUTICAL: _____

    LOW DOSE: _____   HIGH DOSE: _____   USUAL DOSE: _____
    ROUTE: _____   SITE: _____   FORM: _____

EDUCATIONAL DESCRIPTION: _____
_____
_____
_____

DISPLAY EDUCATIONAL DESCRIPTION: YES ____   NO ____
    Default Radiopharmaceutical is the only field automatically "stuffed" (added to the
    record) in the case data. Low, High, and Usual doses are displayed for information
    during exam edits, and route, site, and form will appear as defaults during exam edits.

A.8   Radiopharmaceuticals

Provide a list of radiopharmaceuticals and their synonyms to your pharmacy
supervisor so that the pharmaceuticals can be added to the Drug file #50 along with
their VA Classification of DX200, DX201, or DX202. See an example of
Radiopharmaceutical entries with synonyms in the Drug file in the next section.

_____

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A.9   Example Radiopharmaceutical Drug Classifications

The following is an example of the radiopharmaceutical entries in the Drug file from one of our test sites.

```
NUC MED RADIOPHARMS IN DRUG FILE
VA CLASS  GENERIC NAME
---------------------------------------------


DX200      Tc99m SODIUM PERTECHNETATE
                 Synonym: SODIUM PERTECHNETATE
                 Synonym: TECHNETIUM
                 Synonym: TC99M

DX200      Tc99m MEDRONATE
                 Synonym: MDP
                 Synonym: TC99M

DX200      Tc99m PENTETATE (DTPA)
                 Synonym: DTPA
                 Synonym: TC99M

DX200      TL-201 THALLOUS CHLORIDE
                 Synonym: TL201
                 Synonym: THALLIUM
                 Synonym: Tl

DX200      Tc99m MEBROFENIN
                 Synonym: TC99M
                 Synonym: HIDA
                 Synonym: MEBROFENIN

DX200      Tc99m ALBUMIN COLLOID
                 Synonym: TC99M
                 Synonym: ALBUMIN COLLOID
                 Synonym: AC

DX200      Tc99m SULFUR COLLOID
                 Synonym: TC99M

DX200      Tc99m SESTAMIBI
                 Synonym: TC99M
                 Synonym: SESTAMIBI

DX200      Ga-67 GALLIUM CITRATE
```

```
                    Synonym: GA67

DX200     I-123 SODIUM IODIDE
                    Synonym: SODIUM IODIDE
                    Synonym: I123

DX200     I-131 SODIUM IODIDE
                    Synonym: SODIUM IODIDE
                    Synonym: I131

DX200     Xe-133 XENON GAS
                    Synonym: XE133
                    Synonym: XENON

DX200     In-111 PENTETATE (DTPA)
                    Synonym: IN111
                    Synonym: INDIUM

DX200     In-111 OXINE
                    Synonym: IN111
                    Synonym: INDIUM

DX200     Co-57 CYANCOBALAMIN
                    Synonym: CO57
                    Synonym: CO-57
                    Synonym: COBALT 57
                    Synonym: CYANCOBALAMIN

DX200     Tc99m LABELLED WBC's
                    Synonym: TC99M
                    Synonym: WBC

DX200     In-111 LABELLED WBC's
                    Synonym: WBC
                    Synonym: INDIUM

DX200     Tc99m ALBUMIN AGGREGATED
                    Synonym: TC99M
                    Synonym: MAA

DX200     Tc99m EXAMETAZIME (CERETEC)
                    Synonym: TC99M
                    Synonym: CERETEC

DX200     Tc99m BICISATE (NEUROLITE)
                    Synonym: TC99M
                    Synonym: NEUROLITE

DX200     Tc99m LABELLED RBC's
                    Synonym: TC99M
                    Synonym: RBC
                    Synonym: SODIUM PERTECHNETATE

DX200     Tc99m SODIUM PERTECHNETATE/Cold Pyrolite
                    Synonym: TC99M
                    Synonym: PYP

DX200     In-111 OctreoScan
                    Synonym: INDIUM
                                Synonym: OCTREOSCAN
```

A.10   Nuclear Medicine Setup (+)

Sites of Administration	Synonym(s)

Vendor	**Source**

Routes of Administration

ROUTE: _____   (P)rompt for Free Text or (V)alid Site: ____
    Synonyms: Valid Sites:

    _____   _____ _____ _____
    _____   _____ _____ _____
    _____   _____ _____ _____
    _____   _____ _____ _____
    _____   _____ _____ _____

ROUTE: _____   (P)rompt for Free Text or (V)alid Site: ____
    Synonyms: Valid Sites:

    _____   _____ _____ _____
    _____   _____ _____ _____

_____   _____   _____   _____
_____   _____   _____   _____
_____   _____   _____   _____

ROUTE: _____   (P)rompt for Free Text or (V)alid Site: ____
    Synonyms: Valid Sites:

    _____   _____   _____   _____
    _____   _____   _____   _____
    _____   _____   _____   _____
    _____   _____   _____   _____
    _____   _____   _____   _____

ROUTE: _____   (P)rompt for Free Text or (V)alid Site: ____
    Synonyms: Valid Sites:

    _____   _____   _____   _____
    _____   _____   _____   _____
    _____   _____   _____   _____
    _____   _____   _____   _____
    _____   _____   _____   _____

Appendix B: Frequently Asked Questions

Many of the following questions were originally asked over E-Mail. The following should be viewed as possible solutions to handle various conditions, but not necessarily the only way or the best solution at every site. When in doubt, consult with your hospital IRM Service.

B.1   Imaging Types

Question:

How do I deactivate an Imaging Type that we have been using?

Answer:

Assigning an Imaging type not previously used to locations and procedures "activates" that Imaging Type. That causes workload reports for that Imaging Type to be separately reported. Imaging Types also affect the enter/edit options and screen displays. When a user signs on to the computer, s/he signs on under a specific location and Imaging Type which affects the data the user can see or edit.

Once an Imaging Type has been "activated" and used by registering cases to the associated location, it takes a great deal of effort and time to deactivate the Imaging Type.

If an Imaging Type is to be deactivated, these are the steps that must be taken. We'll use the example of wanting to deactivate Ultrasound (there may be one or more Ultrasound Imaging locations) and send everything to General Radiology.

1. First and foremost, DO NOT DELETE THE IMAGING TYPE, LOCATION(S), OR ASSOCIATED PROCEDURES. Whenever you have the urge to delete, remember that deletion causes loss of historical data and possible database corruption.

2. All procedures are associated with an Imaging Type. In our example scenario, any procedure with an Imaging Type of Ultrasound will need to be changed to an Imaging Type of General Radiology by using the option Procedure Enter/Edit. This must be done to prevent additional procedures from being registered in the Ultrasound location(s).

3. Sign on under each Ultrasound location (or use the Switch Locations option) and check for all pending cases for that location using the option Pending/Hold Rad/Nuc Med Request Log. Print a list of these for tracking purposes.

4. As patients arrive, sign on under the location(s) you want to send the pending cases to and register each of the cases at the selected location (in this case General Radiology locations). You can either use existing General Radiology locations or add a new one using the option Location Parameter Set up. Over time, all the requests that were submitted to the Ultrasound location(s) should be registered in a General Radiology location.

5. You can use the Exam Status Display or Status Tracking of Exams options to find all cases in progress for the Ultrasound location(s). Close out, gradually, all the cases in the locations for the Imaging Type that will be deactivated.

B.2   Procedures

B.2.1   Can I Edit the Procedures?

Answer:

You can only edit the name field if the procedure was added by the site. Any procedure with a YES in field #8 (Original Procedure) was distributed with the package and editing the name field is not allowed.

If no CPT Code is entered, the procedure type is automatically changed to "Broad". "Series" procedures may have multiple AMIS codes. A "Parent" procedure must have descendents.

If you want to use the same procedure in two different Imaging Locations with different Imaging Types, enter procedure names slightly differently but use the same CPT and AMIS codes.

B.2.2   What Are Broad Procedures?

"I know that they do not have associated CPT or AMIS codes. I gather that they are to be used PRELIMINARILY, and then changed to detailed procedures. Is this correct? This would seem to make sense only if a site is using remote on-line order requests (either OE/RR or from within the Radiology package)."

Answer:

When ward/clinic clerks are transcribing written chart orders to VISTA, they are not always able to correlate the provider's written order to a Radiology Procedure found in the computer. Rather than halting the process and trying to find the provider for a further clarification, etc., a 'Broad' procedure may be ordered with an explanation in the Clinical History field."

B.2.3   How Do I Restrict Users To Request Only Broad Procedures?

"The main problem is that there are many similar procedures and requesting physicians usually will not know the difference between them. In fact, they CANNOT know what we will ultimately decide to do for the patient." "...I think the best option for Nuclear Medicine is to list only the broad procedures "bone scan", "renal scan", etc. Then WE will choose which detailed procedure to convert it to. This is one of the ways in which Nuclear Medicine needs differ from those of Radiology, since, as was mentioned, many of their procedures are straight forward enough so that the requester CAN be given a choice of the detailed procedure."

Answer:

You can use the Rad/Nuc Med Common Procedure file to implement this. "Enter broad procedures as the only "active" ones in the Rad/Nuc Med Common Procedure file. That way, only the broad ones will be displayed when the ordering party sees the order screen."

"In addition, if your site is using OE/RR, then you should make sure the Quick Order protocols (if there are any set up) only use broad procedures. Although that wouldn't completely prohibit ordering of series and detailed procedures, people are much more likely to choose from what they can see on the screen."

B.2.4   Can You Explain The Conversion From A Broad Procedure Request To Detailed Or Series?

Answer:

The conversion to a detailed or series procedure takes place at registration or during case editing and/or Status Tracking of Exams.

"When the patient is registered, (the Imaging Service) can clear up the murkiness by switching the order to Series or Detailed procedure."

"I would also assign a msg. (procedure message) to each of the Broad procedures that requests a Clinical History that spells out the exact exam they are looking for. This Clinical History could then be used, in conjunction with the expertise of the imaging department, to decide which Detailed procedures to switch to."

B.2.5   How Can I Show Physicians Which Preps to Order When They Order Procedures?

When a physician orders a procedure, I want the physician to also see what the preps are for that procedure so the preps can be ordered at the same time. For instance, an angiogram should "show you how many IV units are needed for that test." How do I do that?

Answer:

A message can be displayed with any radiology/nuclear medicine procedure. Build your message(s) using the option Procedure Message Entry/Edit. Then use the option Procedure Enter/Edit to assign the message(s) to the procedure. When ordering a procedure that has one or more messages, the message is displayed as soon as the procedure is selected.

B.3   Case Numbers

B.3.1   Can I Have Two Active Cases With The Same Case Number?

Answer:

A case number can be assigned to two different cases, although it normally should not happen. Case numbers for completed cases are reused so this is what has taken place:

- Case X is completed and its case number is reused by Case Y.

- Case Y is not completed yet when Case X is "Unverified", which reopens it with the same case number. Both cases are active and identified by the same case number.

This will not cause problems but may be confusing when attempting to pull up a record by its case number. In this situation, be sure to verify the name of the patient whose report you want to work with, to make sure you have the correct case.

B.3.2   Why Are Our Case Numbers Reaching The Ten Thousands?

In the past case numbers were usually two or three digits.

Answer:

Case numbers for Completed cases are deleted each week and are then available for reuse. It appears that your cases are not reaching the status of Complete.

Using the option Examination Status Entry/Edit in the Utility Files Maintenance menu, check your exam statuses for Complete within each Imaging Type. Any item under Status Change Requirements that contains a YES is required data for a case to reach the status of Complete. Also check the Status Tracking Functions items; if data must be present for a case to reach Complete, then the user must be asked for that data. Here is an example of what you will find in that option. Note the data in bold print.

```
Examination Status Entry/Edit
Select an Imaging Type: nucLEAR MEDICINE

Select an Examination Status: COMPLETE    Imaging Type: NUCLEAR MEDICINE
                                Order: 9
         ...OK? Yes//    (Yes)
```

```
Name of Current Exam Status: COMPLETE//
Order in sequence of status progression: 9//
Should this Status appear in Status Tracking ?: NO
          //
User Key needed to move an exam to this status:
Default next status for exam:
Can an exam be cancelled while in this status ?: NO
          //
Generate exam alert for requesting physician ?: NO
          //
Generate Examined HL7 Message:

     Status Change Requirements
     --------------------------
     Please indicate which of the following is required
     in order to place an exam into the 'COMPLETE' status:

Technologist Required ?: YES//
Resident Or Staff Required ?: YES//
Detailed Procedure required ?: YES//
Film Entry Required ?: YES//
Diagnostic Code Required ?: NO//
Camera/Equip/Rm Required ?: YES//

     (Radiopharmaceutical requirements)

Radiopharms & Dosages required ?: YES//
Activity Drawn required (Radiopharm) ?: NO//
Drawn Dt/Time and Person required (Radiopharm) ?: NO//
Admin Dt/Time/Person required (Radiopharm) ?: NO//
Route/Site required (Radiopharm administered) ?: NO//
Lot No. required (Radiopharm) ?: NO//
Volume/Form required (Radiopharm) ?: NO//

   WARNING: You must use the reporting feature of the system as
           a prerequisite for the following requirements:
Report Entered required ?: YES//
Impression required ?: YES//
Verified Report required ?: YES//

     Status Tracking Functions
     -------------------------
     Please indicate which of the following should be asked when
     changing an exam's status to 'COMPLETE' while using
     the 'status tracking' feature:

Ask for Technologist ?: YES//
Ask For Interpreting Physician ?: YES//
Ask for Procedure ?: YES//
Ask For Film Data ?: YES//
Ask For Diagnostic Code ?: YES//
Ask For Camera/Equip/Rm ?: YES//
Ask for User Code ?: NO//
Ask Medications & Dosages ?: YES//
Ask Medication Admin Dt/Time & Person ?: YES//

     (Radiopharmaceutical functions)

Ask Radiopharmaceuticals and Dosages ?: YES//
Ask Activity Drawn (Radiopharmaceutical) ?: YES//
Ask Drawn Dt/Time & Person (Radiopharmaceutical) ?: YES//
```

```
Ask Admin Dt/Time & Person (Radiopharmaceutical) ?: YES//
Ask Route/Site of Admin (Radiopharm) ?: YES//
Ask Lot No. (Radiopharm) ?: YES//
Ask Volume/Form (Radiopharm) ?: YES//

     Management Report Criteria
     --------------------------
     Please indicate which of the following workload reports should
     include exams with the 'COMPLETE' status:

Clinic Report should include exams of this status ?: YES// ^
```

One site keeps on top of their Incomplete cases by running the Incomplete Exam Report within the Daily Management Reports menu several times a day. It helps them "to track down lost or misplaced films in order to get them read and also to see if a Technician accidentally forgot to case edit." They correct any errors daily.

B.4   Requesting/Scheduling Requests

B.4.1   What is the Procedure for Requesting/ Scheduling Requests?

Answer:

The following is an example of the work flow at one VAMC:

- Request comes to Radiology via VISTA.

- Request goes into Waiting to be Scheduled bucket. (i.e., Request status = Pending)

- Techs are responsible daily for scheduling their area (e.g. CT tech gets all CT requests, US gets US requests, etc.) All other requests go to the regular staff techs for scheduling.

- Inpatients get called down the same day, unless they are for Fluoro or some other exam needing prep. Then they are given a date in the computer using the option Schedule a Request. Note: we do NOT give a time for inpatient appointments. They simply are ON CALL. As a rule, they are called first before our outpatients show up.

- Outpatient requests are given a date and a time in the Schedule a Request option and also we go in to the Scheduling package under Make an Appointment and give it the same date and time. (Use of the Scheduling package is optional.)

- All outpatients are printed appointment letters by the techs and our letters have the preps on them also. (Done through the Scheduling package)

- If a patient calls and cannot come in, the tech puts the request on hold using the Hold a Request option and you can choose whatever reasons you want from your file. They also write on the request that the patient was unable to come. It then goes back to the Waiting to be scheduled bucket, and gets rescheduled as above with letters and all. If a patient fails to report, we do the same thing and give him another appointment.

- If a patient fails to report two times, we use the option Cancel a Request and return the request to the attending physician.

This makes it great because seldom are there any requests in a Pending status for very long, and you can easily see if you have missed someone. Also, once it is in a Scheduled status you can easily tell your workload for any given day, and also find out by date or by patient when a test is scheduled."

B.4.2   How Can I Handle Routine Requests For No Shows Of Patients That Have Called In For A Re-Appointment?

Is there a way for the user to edit the desired/requested date of the request if the x-ray is desired on the day of the appointment?

Answer:

"Under the Rad/Nuc Med Order/Entry menu you can schedule a request. It will list pending requests and you choose which ones you want to schedule, then it will prompt you for date and time desired. One thing, if these requests already have a schedule date, you must place them on hold first, then move to schedule."

B.4.3   Are Sites Using a Suspense File for the Schedule a Request Option?

For those who are using the Schedule a Request option, do your "MAS people have it and are you keeping a suspense file for your hard copies of rescheduled requests?"

Answer:

One site stated they use a suspense file: "The only reason we do is if the computer system should happen to go down, we can enter from the printed requests in our back-up system and continue business as usual without having to try to get patient charts for routine x-rays.

Another site had this to say: "We put the hard copies in an accordion type file for the day of the month it was scheduled. If a patient is a no show, we put the request on hold and reschedule it once if they fail to report a second time, we d/c the request with reason: Patient failed to report. "

B.4.4   Once An X-Ray Request Has Been Scheduled, Can The Scheduled Date On The Request Be Changed?

Answer:

Yes. You can change the scheduled date again, but it takes a few extra steps. If you have a request for which the scheduled date must be changed, use the Rad/Nuc Med Order/Entry menu and place the request on Hold (Hold a Request option). Then use the Schedule a Request option and enter the new date.

B.5   Printing/Batching/Etc.

B.5.1   Can I have Angiograms and Venograms queued to a printer in the Vascular Lab after the report has been transcribed?

Answer:

One view: "Are angios and venos done in a separate location? If so, they will print to the report printer assigned for that location. Or, you can Batch all the angios and venos in the same Batch, and then print this Angio/Veno Batch anytime to any printer.

Distribution Queues are for distribution of verified reports and are broken up by inpatient/outpatient/file room/etc. You wouldn't be able to get angios/venos broken out by using Distribution Queues.

Another view:

Your transcriptionists could use Batch names such as 'transcriptionist name/radiology section/date' or whatever scheme your folks feel comfortable with to distinguish the batches. Read up on Batches in the radiology supervisor's guide, especially the management of same so you can set up a proper print/purge scenario at your VAMC that will get the job done but not allow the Report Batches file to grow too large.

In addition to the above, we would like to stress the fact that verifying a report triggers its placement into the Distribution Queue. If a site leaves reports Released/Unverified, it will not be able to use the Distribution Queue.

B.6   Purging Records

B.6.1   What are the Reference Times for Purging?

Can anyone doing transcription within Radiology Service give me some input reference time frame for purging as follows:

- Activity log cut off

- Report log cut off

- Clinical history cut off

- Tracking time cut off. (Exam status changes)

- After the report goes the impression remains forever -- IRMS needs to get some purging done and I would sure like some input if possible from other stations

Answer:

There are many ways to handle purging. Here are a few of the examples from the sites:

- We "have the report purge set to coincide with when we purge the film files. That is 5 years."

- Activity log cut of: 999 days

- Report cut off: 999 days

- Clinical history:999 days

- Tracking cut off: 999 days

- Order data cut off: 30 days

- Activity log cut-off: 90 days

- Report cut-off: 1825 days

- Clinical History: 90 days

- Tracking time cut-off: 90 days

- Order data cut-off: 30 days

- "We started full purges of everything over a year old but have now moved to doing it every six months. Do be careful that you have ensured that impressions are supplied. We were getting a lot of 'Refer to report such-and-such' and, of course, it would have been purged too. You will only be able to purge those exams that are Complete, so there may be some clean up to do before you can proceed. If you're really timid, you could archive the global on tape, until you're confident of your procedure."

B.6.2   How Do I Handle Referring Report Text When Purging?

Answer:

A very important issue was raised. If you plan to purge report text after a period of time, leaving only the impression, make sure that the radiologists know this (and keep reminding them). I have seen many dictation where the impression read something like "As above", which obviously is not that helpful if "the above" has been deleted! In fact, you must specifically warn those who dictate not to do this.

Another view:

Use the Indicate No Purge option when the physician dictates the impression as "see above report.

> **Note**:   Transcriptionists need to be trained to do this.

B.7   Verifying Reports

B.7.1   Who Can Verify A Report?

"I would like some input about who can verify a report. Can it be only the radiologist who dictated and signed the report? Or can a radiologist sign other radiologists' reports?"

Answer:

"Radiologists can verify their own reports and, if the site parameters are turned on, a radiologist may also be given the ability to verify other radiologists' reports."

B.7.2   How Do I Print Contract Radiologist's Titles on Reports?

"How can I get the titles of contract radiologists to appear on the report without local modifications?"

Answer:

"The Rad/Nuc Med software uses the Signature Block Title field in the New Person file #200 as the title printed to the right of each primary and secondary staff and resident's name. You can edit this field so that it shows that a person classified as Radiology/Nuclear Medicine resident or staff is a contract radiologist."

(See the Troubleshooting section for more detail)

B.8   Hold/Cancelled/Pending/Scheduled

Question:

Does anyone use the Pending/Hold Rad/Nuc Med Request Log (used to be Log of Pending Radiology Requests)?

Answer:

"We use this list extensively. We also print it to each ward every evening at 8 pm. The nurses love it . They can run down the list and make sure that patients that are to be NPO, are. We haven't had a miss in the last year. We also print to the lab a 5 am each morning. They look for the CTs and Specials and draw these patients early. By the time the patient is ready to be done, the lab work is ready. It has really helped."

Question:

"What do you do in the event the patient is Scheduled. These don't show up on a Pending report. We have so many patients scheduled and the floors "forget" to give the patients preps.

Answer:

One site: "There is a option Log of Scheduled Requests by Procedure. We print one for us and each ward prints one daily (Ward/Clinic Scheduled Request Log) to prep the next day's patients. This will group GIs, CTs, BEs, Chests, etc. together and gives the patient name, SSN, procedure, patient location and time of appointment. For inpatients when we schedule a request we give date only with no time since they are On Call. We do give outpatients a time of course. Since we have instituted this, we have had little or no repeat preps, since all shifts have this option and it saved us work all around."

Another site:

"We are on full ward and clinic order entry which includes scheduling. The wards just call for special things like BEs, IVPs, etc. and we give them a date, and they enter the request in the pending file for that date.

Question:

"After you schedule a request, there should be a way of looking at it and seeing the time and date of the appointment. As it stands now, you can see that it is scheduled but unless you print out days forward, you cannot find the appointment."

Answer:

"Go under Detailed Request Display either by patient or date. If you have ... given it a time and date, it will appear on the Detailed Request Display. Just select the # of the request (it will have an "s" in the column for status)". Enter Yes at the prompt "Do you wish to display request status tracking log?".

Question:

How is workload credited for the Transcription Report?

Answer:

The transcriptionist that initiates/creates the report is credited with the total number of lines regardless of how many transcriptionists may have contributed to the report. The length of each line is summed and divided by 75 to determine the total number of lines. The number of lines counted is always the current number of lines in the report. So, if lines have been added, changed, or deleted, only the final number of lines are counted at the time the Transcription Report is run.

B.9   Doubling Workload Credit

B.9.1   What Is The Modifier Effect On Special Reports?

Question:

When exactly is the workload credit doubled in the system?

Answer:

The following reports do a calculation that will double workload counts if the Bilateral modifier is used and the AMIS weight multiplier associated with the procedure AMIS pair is 1 or "blank":

- Physician Report [RA WKLPHY]

- Resident Report [RA WKLRES]

- Exam Room Report [RA WKLROOM]

- Staff Report [RA WKLSTAFF]

- Technologist Report [RA WKLTECH]

- PTF Bedsection Report [RA LWKLBEDSEC]

- Clinic Report [RA LWKLCLINIC]

- Service Report [RA LWKLSERVICE]

- Sharing Agreement/Contract Report [RA LWKLSHARING]

- Ward Report [RA LWKLWARD]

- Cost Distribution Report [RA CDR REPORT]

- Film Usage Report [RA FILMUSE]

- AMIS Code Dump by Patient [RA AMISDUMP]

- AMIS Report [RA AMIS]

- Detailed Procedure Report [RA WKLPROCEDURE]

B.10   Effect of Portable and Operating Room Modifiers

B.10.1   Which Workload Reports Are Affected And How?

Answer

The AMIS Report and the AMIS Code Dump by Patient are affected. In the AMIS Code Dump by Patient when an AMIS Code is selected all procedures not in that AMIS category are usually bypassed. However, if the user selects either AMIS category 25 (Operating Room) or 26 (Portable) then all exams that meet the other criteria, regardless of the AMIS code of the procedure performed, will be included if the exam contains an Operating Room or Portable type of modifier. Therefore, if an ankle x-ray (AMIS code 8) is done, and a modifier of the "Operating Room" type was entered for the exam, then that exam will show up under and AMIS Code Dump by Patient when AMIS code 25 is selected and when AMIS Code 8 is selected.

In the AMIS Report and Detailed Procedure Report (Detailed Procedure Workload Report) the same procedure described above would be counted under both AMIS code 8 and AMIS code 25.

B.11   Complications

B.11.1   How Do You Delete An Exam Complication?

This patient who has never had a reaction to contrast dye has a contrast reaction message come up when a CT is done."

Answer:

Use the Update Patient Record option. Enter NO at the question Contrast Medium Allergy. The Adverse Reaction Tracking package will automatically create an Entered in Error record.

B.12   Contracting Out

B.12.1   How Are Contracted Out Mammograms Handled Through RPMS?"

Answer:

One site: "Once the appointment is made, our scheduling clerk enters a request through RPMS from the handwritten consult. When the results are mailed back, the study is registered in to get a case no. Under case edit, No Room used is entered along with No Films with a 0. After this is completed, the clerk then enters the report into the system from the copy stating at the beginning of the report that THIS STUDY WAS PERFORMED AT ... BY DRS., etc. The report is then verified. MRIs are handled the same way in order to make the reports for these exams readily available to the medical staff."

Another site:

"We also indicate under category (IP, OP, etc.) that they are a contract source and the contractor's name. That way they are separated from the actual workload performed on site."

B.13   Research

B.13.1   How Do We Register Visits For Research Purposes?

Answer:

Register any patient involved in research as a Research patient in the Exam Category field.

B.14   General Editing Helpful Hints

B.14.1   How Do I Keep Text From Wrapping In The Screen Editor?

Answer:

On each new line, enter a space <sp> before entering the text as in the following example:

```
    When ordering this procedure, we recommend the following steps be taken:
    <sp>1)  Do this first.
    <sp>2)  Next do this.
    <sp>3)  Etc.
```

B.14.2   How Do I Add A Second Identical Entry In A Multiple Entry Field?

Answer:

Enter the second, third, etc. entry in quotes as shown here:

```
Select DESCENDENTS: FOOT 2 VIEWS// ?
 Answer with DESCENDENTS
Choose from:
   ANKLE 2 VIEWS
   FOOT 2 VIEWS
   TOE(S) 2 OR MORE VIEWS

    You may enter a new DESCENDENTS, if you wish
    Enter a procedure name which is related to the parent procedure.
    Select only active detailed or series procedures of the same
    imaging type as the parent.
 Answer with RAD/NUC MED PROCEDURES NAME, or CPT CODE, or SYNONYM
 Do you want the entire RAD/NUC MED PROCEDURES List? n  (No)
Select DESCENDENTS: FOOT 2 VIEWS//"FOOT 2 VIEWS"
```

Appendix C: Stop Task (TaskMan)

One of the new features in this version is the ability of the user to stop tasks. All reports that can consume a significant amount of CPU/print time are now stoppable through the Stop Task action of the Taskman User [XUTM USER] option under the User's Toolbox [XUSERTOOLS] menu. The enhanced report logic checks for a stop flag during processing that is done before printing actually begins as well as during printing. You can get to this menu from any menu prompt in the Radiology/Nuclear Medicine software simply by typing TBOX. Here is an example of how it works. Note that TBOX is a Common Option under the menu.

```
Exam Entry/Edit Menu ...
          Films Reporting Menu ...
          Management Reports Menu ...
          Outside Films Registry Menu ...
          Patient Profile Menu ...
          Radiology/Nuclear Med Order Entry Menu ...
          Supervisor Menu ...
          Switch Locations
          Update Patient Record
          User Utility Menu ...

Select Rad/Nuc Med Total System Menu Option: ??

          Exam Entry/Edit Menu ... [RA EXAMEDIT]
          Films Reporting Menu ... [RA RPT]
          Management Reports Menu ... [RA MGTRPTS]
          Outside Films Registry Menu ... [RA OUTSIDE]
          Patient Profile Menu ... [RA PROFILES]
          Radiology/Nuclear Med Order Entry Menu ... [RA ORDER]
          Supervisor Menu ... [RA SUPERVISOR]
          Switch Locations [RA LOC SWITCH]
          Update Patient Record [RA PTEDIT]
          User Utility Menu ... [RA USERUTL]

You can also select a secondary option:

          Rad/Nuc Med Total System Menu ... [RA OVERALL]
          Radiology/Nuclear Med Order Entry Menu ... [RA ORDER]
          Supervisor Menu ... [RA SUPERVISOR]
          Utility Files Maintenance Menu ... [RA MAINTENANCE]

Or a Common Option:

   TBOX   User's Toolbox ... [XUSERTOOLS]
   VA     View Alerts [XQALERT]

              Press 'RETURN' to continue, '^' to stop: <RET>
          Continue [XUCONTINUE]
            **> Reverse lock ZZLUKE
          Halt [XUHALT]
          MailMan Menu ... [XMUSER]
          Restart Session [XURELOG]
          Time [XUTIME]
          Where am I? [XUSERWHERE]
```

```
Select Rad/Nuc Med Total System Menu Option: tbox   User's Toolbox


          Display User Characteristics
          Edit User Characteristics
          Electronic Signature code Edit
          Menu Templates ...
          Spooler Menu ...
          Switch UCI
          TaskMan User
          User Help

Select User's Toolbox Option: taskMan User


Select TASK: ??

Please wait while I find your tasks...searching...finished!

1: (Task #35437) DQ^RAFLH, DQ^RAFLH.  Device LINE.  POC,POC.
   From 12/09/96 at 13:58,  By you.
   Waiting for device _LTA1707:
--------------------------------------------------------------------------
----
2: (Task #35591) ENTASK^RAMAINP, Rad/Nuc Med Active Procedures (Long).
   Device LINE.  POC,POC.  From 12/13/96 at 8:42,  By you.  Unscheduled by
you.
--------------------------------------------------------------------------
----
3: (Task #35680) DQ^RAFLH, DQ^RAFLH.  Device LINE.  POC,POC.
   From 12/16/96 at 13:08,  By you.  Unscheduled by you.
--------------------------------------------------------------------------
----
4: (Task #35823) DQ^RAFLH, DQ^RAFLH.  Device LINE.  POC,POC.
   From 12/20/96 at 8:26,  By you.  Unscheduled by you.
--------------------------------------------------------------------------
----
5: (Task #35825) PRTORD^RAORDQ, PRTORD^RAORDQ.  Device FIELD SUPPORT.
POC,POC.
   From 12/20/96 at 8:30,  By you.  Completed 12/20/96 at 8:31.
--------------------------------------------------------------------------
----
6: (Task #35826) DQ^RAFLH, DQ^RAFLH.  Device LINE.  POC,POC.
   From 12/20/96 at 8:31,  By you.  Unscheduled by you.
--------------------------------------------------------------------------
----
Press RETURN to continue or '^' to exit: ^

Select TASK: 1  DQ^RAFLH

               Taskman User Option

                    Display status.
                    Stop task.
                    Edit task.
                    Print task.
                    List own tasks.
                    Select another task.

               Select Action (Task # 35437): stop  Stop task.
```

```
Task unscheduled and stopped.

              Taskman User Option

                    Display status.
                    Stop task.
                    Edit task.
                    Print task.
                    List own tasks.
                    Select another task.

              Select Action (Task # 35437): <RET>


         Display User Characteristics
         Edit User Characteristics
         Electronic Signature code Edit
         Menu Templates ...
         Spooler Menu ...
         Switch UCI
         TaskMan User
         User Help

Select User's Toolbox Option: <RET>


         Exam Entry/Edit Menu ...
         Films Reporting Menu ...
         Management Reports Menu ...
         Outside Films Registry Menu ...
         Patient Profile Menu ...
         Radiology/Nuclear Med Order Entry Menu ...
         Supervisor Menu ...
         Switch Locations
         Update Patient Record
         User Utility Menu ...

Select Rad/Nuc Med Total System Menu Option:
```

Glossary

Active

An order status that occurs when a request to perform a procedure on a patient has been registered as an exam, but before it has reached a status of Complete.

Activity log

A log of dates and times data was entered and/or changed. The Radiology/Nuclear Medicine system is capable of maintaining activity logs for reports, exam status changes, imaging type parameter changes, purge dates, outside film registry activity, and order status changes.

Alert

Alerts consist of information displayed to specific users triggered by an event. For example, alerts pertaining to Rad/Nuc Med include the Stat Imaging Request alert, an Imaging Results Amended alert, and an Abnormal Imaging Results alert. The purpose of an alert is to make a user aware that something has happened that may need attention. Refer to Kernel and OE/RR documentation for more information about alerts.

AMIS code

For imaging, one of 27 codes used to categorize procedures, determine which procedures use contrast media, calculate workload crediting and weighted work units. AMIS codes are determined by VA Central Office and should not be changed at the medical centers.

AMIS weight multiplier

A number associated with a procedure-AMIS code pair that is multiplied by the AMIS code weighted work units. If the multiplier is greater than 1, a single exam receives multiple exam credits.

Attending physician

The Radiology/Nuclear Medicine software obtains this data from the PIMS package, which is responsible for its entry and validity. Refer to the PIMS package documentation for more information and a description of the meaning of this term as it applies to RPMS.

Batch

In the Radiology/Nuclear Medicine system, a batch is a set of results reports. Transcriptionists may create batches to keep similar reports together and cause them to print together. One possible purpose might be to print all reports dictated by the same physician together.

Bedsection

See PTF Bedsection.

Bilateral

A special type of modifier that can be associated with an exam, a procedure, or an AMIS code. When an exam is bilateral due to one of the aforementioned associations, workload credit and exam counts are doubled for that exam on most workload and AMIS reports.

Broad procedure

A non-specific procedure that is useful for ordering when the ordering party is not familiar enough with imaging procedures to be able to specify the exact procedure that is to be performed. Before an exam status can progress to Complete, the imaging service must determine a more specific procedure and change the exam procedure to reflect the actual Detailed or Series procedure done. Depending on site parameters, broad procedures may or may not be used at a given facility. Also see Detailed and Series procedure.

Bulletin

A special type of mail message that is computer-generated and sent to a designated user or members of a mail group. Bulletins are usually created to inform someone of an event triggered by another user's data entry, or exam and request updates that require some action on the part of the bulletin recipient.

CPT code

See Current Procedural Terminology

Camera/Equipment/Room

The specific room or piece of equipment used for a patient's imaging exam. Each is associated with one or more imaging locations. The Radiology/Nuclear Medicine system supports, but does not require users to record the camera/equipment/room used for each exam.

Cancelled

A status that can be associated with an exam. Also see Discontinued.

Case number

A computer-generated number assigned to the record generated when one patient is registered for one procedure at a given date/time. Note that when multiple procedures are registered for a patient at the same date/time, each procedure will be given a different case number. Case numbers will be recycled and reused by a new patient/procedure/date instance when the exam attains a Complete status.

Category of exam

For the purposes of this system, category of exam must be Outpatient, Inpatient, Contract, Sharing, Employee, or Research. Several workload and statistical reports print exam counts by category. Others use the category to determine whether exams should be included on the report.

Clinic

Hospital locations where outpatients are cared for. In VISTA, clinics are represented by entries in the Hospital Location file (#44). Radiology/Nuclear Medicine Imaging Locations, represented by entries in the Imaging Location file (#79.1), are a subset of the Hospital Location file.

Clinical history

Data entered in the Radiology/Nuclear Medicine system during exam ordering and exam edit. Usually entered by the requesting party to inform the imaging service why the exam needs to be done and what they hope to find out by doing the exam.

Clinical history message

Text that, if entered in system parameter setup, will always display when the user is prompted for clinical history. Generally used to instruct the user on what they should enter for clinical history.

Common procedure

A frequently ordered procedure that will appear on the order screen. Up to 40 per imaging type are allowed by the system. Other active Rad/Nuc Med procedures are selectable for ordering, but only the ones designated as common procedures and given a display sequence number will be displayed prior to selection.

Complete

A status that can be attained by an order or an exam.

Complication

A problem that occurs during or resulting from an exam, commonly a contrast medium reaction.

Contract

A possible category of exam when imaging services are contracted out.

Contrast medium

A radio-opaque injectable or ingestible substance that appears on radiographic images and is helpful in image interpretation. It is used in many imaging procedures.

Contrast reaction message

A warning message that will display when a patient who has had a previous contrast medium reaction is registered for a procedure that uses contrast media. The message text is entered during Rad/Nuc Med division parameter setup.

Credit stop code

See Stop Code. Also see PIMS package documentation.

Current Procedural Terminology (CPT

A set of codes, published annually by the American Medical Association, that includes Radiology/Nuclear Medicine procedures. Each active detailed or series procedure must be assigned a valid, active CPT code to facilitate proper workload crediting. In RPMS, CPT's are represented by entries in the CPT file #81.

Descendent

A type of Rad/Nuc Med procedure. One of several associated with a 'Parent' type of procedure. The descendent procedures are actually registered and performed. Also see Parent.

Desired date (of an order)

The date the ordering party would like for the exam to be performed. Not an appointment date. The imaging service is at liberty to change the date depending on their availability.

Detailed procedure

A procedure that represents the exact exam performed, and is associated with a CPT code and an AMIS code.

Diagnostic code

Represented, for the purposes of this system, by entries in the Diagnostic Codes file (#78.3). Diagnostic codes describe the outcome of an exam, such as normal, abnormal. A case may be given one or more (or no) diagnostic code(s).

Discontinued

An order status that occurs when a user cancels an order.

Distribution queue

A mechanism within the Radiology/Nuclear Medicine system that facilitates printing results reports at various hospital locations, such as the patient's current ward or clinic, the file room, and medical records.

Division, Rad/Nuc Med

A subset of the VISTA Institution file (#4). Multi-divisional sites are usually sites responsible for imaging at more than one facility.

Draft

A report status that is assigned to all Rad/Nuc Med results reports as soon as they are initially entered into the system, but before they are changed to a status of Verified or (if allowed) Released/Not Verified.

DSS ID

Formerly Stop Code associated with each procedure, now DSS ID associated with each Imaging Location.

Electronic signature code

A security code that the user must enter to identify him/herself to the system. This is required before the user is allowed to electronically verify Rad/Nuc Med reports. This is not the same as the Access/Verify codes.

Exam label

One of 3 types of labels that can be printed at the time exam registration is done for a patient. Also see jacket label, flash card.

Exam set

An exam set contains a Parent procedure and its Detailed or Series descendent procedures. Requesting a Parent will automatically cause each descendent to be presented for registration as separate cases under a single visit date and time.

Exam status

The state of an exam that describes its level of progress. Valid exam statuses are represented in this system by entries in the Examination Status file (#72). Examples are ordered, cancelled, complete, waiting for exam, called for exam, and transcribed. The valid set of exam statuses can, to a degree, be tailored by the site. There are many parameters controlling required data fields, status tracking and report contents that are determined when the parameters of this file are set up. There are separate and different set of statuses for requests and reports.

Exam status parameter setup

See Exam status.

Exam status time

The date/time when an exam's status changes, triggered by exam data entry that can be done through over a dozen different options.

Film size

Represented by entries in the Film Sizes file (#78.4) in this system. Used to facilitate film use/waste tracking.

Flash card

One of 3 labels that can be generated at the time an exam is registered for a patient. The flash card was named because it can be photographed along with an x-ray, and its image will appear on the finished x-ray. Helpful in marking x-ray images with the patient's name, SSN, etc. to insure that x-rays are not mixed up.

Flash card formatter

The name given to the option/mechanism that allows users to define formats for labels and for headers and footers on results reports. Users can specify which fields to print at various columns and lines on the label or report header/footer.

Footer

The last lines of the results report, the format of which can be specified using the Flash card formatter.

Format

The specification for print locations of fields on a printed page. In this system, print formats can be specified using the Flash card formatter.

Header

The top lines of the results report, the format of which can be specified using the Flash card formatter.

Health Summary

Refers to a report or VISTA software package that produces a report showing historical patient data. Can be configured to meet various requirements. Refer to the Health Summary documentation for more information.

Hold

An order status occurring when a users puts an order on hold, indicating that a study should not yet be done or scheduled, but that it will likely be needed in the future.

Hospital location

Represented in VISTA by entries in the Hospital Location file (#44). Rad/Nuc Med locations are a subset of the Hospital Location file.

Imaging location

One of a subset of Hospital Locations (See Hospital location) that is represented in the Imaging Location file #79.1, and is a location where imaging exams are performed.

Imaging type

For the Rad/Nuc Med software, the set of valid imaging types is:

ANGIO/NEURO/INTERVENTIONAL

GENERAL RADIOLOGY

MAMMOGRAPHY

NUCLEAR MEDICINE

ULTRASOUND

VASCULAR LAB

CARDIOLOGY STUDIES (NUC MED)

CT SCAN

MAGNETIC RESONANCE IMAGING

These are the imaging types that are supported by this version of the software. Each imaging location and procedure may be associated with only one imaging type.

Impression

A short description or summary of a patient's exam results report. Usually mandatory data to complete an exam. The impression is not purged from older reports even though the lengthier report text is.

Inactivate

The process of making a record in a file inactive, usually by entering an inactive date on that record or deleting a field that is necessary to keep it active. When a record is inactive, it becomes essentially "invisible" to users. Procedures, common procedures, modifiers, and exam statuses can be inactivated.

Inactivation date

A date entered on a record to make it inactive. See Inactivate.

Information Resources Management

> The service within VA hospitals that supports the installation, maintenance, troubleshooting, and sometimes local modification of VISTA software packages and the hardware that they run on.

Interpreting physician

(also Interpreting Resident, Interpreting Staff)

> The resident or staff physician who interprets exam images.

IRM

> See Information Resources Management.

Jacket label

> One of the 3 types of labels that can be generated at the time an exam is registered for a patient. Usually affixed to the x-ray film jacket. (See also exam label, flash card.)

Key

> See security key.

Label print fields

> Fields that are selectable for printing on a label, report header, or report footer on formats that are designed using the Flash card formatter. Also see Flash card formatter.

Mode of transport

> The patient's method of moving within the hospital, (ambulatory, wheelchair, portable, stretcher) designated at the an exam is ordered.

Modifier

> Additional information about the characteristics of an exam or procedure (such as bilateral, operating room, portable, left, right). Also see bilateral, operating room, portable.

No purge indicator

> A flag that can be set on the exam record to force the purge process to bypass the record. Guarantees that the record will not be purged when a historic data purge is scheduled by IRM. Also see Purge.

Non-credit stop code

> Certain stop codes, usually for health screening, that do not count toward workload credit. If a non-credit stop code is assigned to a procedure, another credit stop code must also be assigned. Also see Stop code.

OE/RR

> See Order Entry/Results Reporting.

On-line verification

> The option within the Radiology/Nuclear Medicine package that allows physicians to review, modify, and electronically sign patient result reports.

Operating room

> A special type of procedure modifier, that, when assigned to an exam will cause the exam to be included in workload/AMIS reports under both the AMIS code of the procedure and under the AMIS code designated for Operating Room.

Order

> The paper or electronic request for an imaging exam to be performed.

Order Entry

> The process of requesting that one or more exams be performed for a patient. Order entry for Radiology/Nuclear Medicine procedures can be accomplished through a Rad/Nuc Med software option or through a separate VISTA package, Order Entry/Results Reporting (OE/RR).

Order Entry/Results Reporting

> A VISTA package that performs that functions of ordering for many clinical packages, including Radiology/Nuclear Medicine.

Outside films registry

> A mechanism in this system that allows users to track films done outside of the medical center. This can also be accomplished through the VISTA Records Tracking package. Refer to Records Tracking documentation for more information.

Parent procedure

> A type of Rad/Nuc Med procedure that is used for ordering purposes. It must be associated with Descendent procedures that are of procedure type Detailed and/or Series. At the time of registration the descendent procedures are actually registered. Setting up a parent procedure provides a convenient way to order multiple related procedures on one order. Parent/descendent procedure relationships must be set up ahead of time during system definition and file tailoring by the radiology supervisor.

Pending

> An order status that every Rad/Nuc Med order is placed in as soon as it is ordered through this system's ordering option. This system also receives orders from the OE/RR system and places them in a pending status.

Portable

A special type of procedure modifier, that, when assigned to an exam will cause the exam to be included in workload/AMIS reports under both the AMIS code of the procedure and under the AMIS code designated for Portable.

Pre-verification

The process whereby a resident reviews a report and affixes his/her electronic signature to indicate that the report is ready for staff (attending) review, facilitated through an option in this system for Resident Pre-verification.

Primary Interpreting Staff/ Resident

The attending or resident primarily responsible for the interpretation of the case. (See also Secondary Interpreting Staff/Resident.)

Primary physician

The Radiology/Nuclear Medicine software obtains this data from the PIMS package, which is responsible for its entry and validity. Refer to the PIMS package documentation for more information and a description of the meaning of this term as it applies to RPMS.

Principal clinic

For the purposes of the Radiology/Nuclear Medicine system, this term is usually synonymous with 'referring clinic'. However, for the purposes of crediting, it is defined as the DSS (clinic/stop) code that is associated with the imaging location where the exam was performed.

Print set

A print set contains a Parent procedure and its Detailed or Series descendent procedures. If the parent is defined to be a print set, the collection and printing of all common report related data between the descendents is seen as one entity.

Problem draft

A report status that occurs when a physician identifies a results report as having unresolved problems, and designates the status to be Problem Draft. Depending on site parameters, a report may be designated as a Problem Draft due to lack of an impression. Also see Problem statement.

Problem statement

When a results report is in the Problem Draft status, the physician or transcriptionist is required to enter a brief statement of the problem. This problem statement appears on report displays and printouts.

Procedure

For the purposes of this system, a medical procedure done with imaging technology for diagnostic purposes.

Procedure message

Represented in this system by entries in the Rad/Nuc Med Procedure Message file (#71.4). If one or more procedure messages are associated with a procedure, the text of the messages will be displayed when the procedures is ordered, registered, and printed on the request form. Useful in alerting ordering clinicians and imaging personnel of special precautions, procedures, or requirements of a given procedure.

Procedure type

A characteristic of a Rad/Nuc Med procedure that affects exam processing and workload crediting. See Detailed, Series, Broad, and Parent.

PTF Bedsection

See PIMS documentation.

Purge

The process that is scheduled at some interval by IRM to purge historic computer data. In this system, purges are done on results report text, orders, activity logs, and clinical history.

Registration (of an exam)

The process of creating a computer record for one or more patient/procedure/visit date-time instances. Usually done when the patient arrives at the imaging service for an exam.

Released/not verified

A results report status that may or may not be implemented at a given medical center. Reports in this status may be viewed or printed by hospital staff outside of the imaging service.

Report batch

See Batch.

Report status

The state of a report that describes its progress level. Valid report statuses in this system are Draft, Problem draft, Released/not verified (if the site allows this status), and Verified. The status of a report may affect the status of an exam. Also see Exam status. Exams and requests each have a separate and different set of statuses.

Request

Synonymous with order. See Order.

Request status

The state of a request (order) that describes its progress level. Valid request statuses in this system are Unreleased(only if created through OE/RR), Pending, Hold, Scheduled, Active, Discontinued, and Complete. Reports and exams each have a separate and different set of statuses.

Request urgency

Data entered at the time an exam is ordered to describe the priority/criticality of completing the exam quickly (i.e. Stat, Urgent, Routine).

Requesting location

Usually the location where the patient was last seen or treated (an inpatient's ward, or an outpatient's clinic). All requesting locations are represented by an entry in the VISTA Hospital Location file (#44). The requesting location may be, but is usually not an imaging location.

Requesting physician

The physician who requested the exam.

Research source

A research project or institution that refers a patient for a Radiology/Nuclear Medicine exam.

Scheduled

 An order status that occurs when imaging personnel enter a date when the exam is expected to be performed.

Secondary Interpreting Staff/Resident

This generally refers to an attending/resident who assisted or sat in on review of the case, but is not primarily responsible for it. It may also be used to indicate a second reviewer of the case, for quality control or peer review purposes.

Security key

Represented by an entry in the VISTA Security Key file. Radiology/Nuclear Medicine keys include RA MGR, RA ALLOC, and RA VERIFY. Various options and functionalities within options require that the user "own" a security key.

Staff

Imaging Attending.

Staff review (of reports

The requirement where an attending imaging physician is required to review the reports written by a resident imaging physician.

Standard report

Represented in this system by entries in the Standard Reports file (#74.1). Standard reports can be created by the radiology supervisor during system definition and set-up. If the division setup specifies that they are allowed, transcriptionists will be offered a selection of standard report text and impressions to minimize data entry effort.

Status tracking

The mechanism within this system that facilitates exam tracking from initial states to the complete state. radiology supervisors must specify during exam status parameter setup which statuses will be used, which data fields will be required to progress to each status, which data fields will be prompted, and exams of which statuses will be included on various management reports.

Stop code

Member of a coding system designed by VA Central Office to aid in determining workload and reimbursement of the medical centers. Stop codes are controlled by VA Central Office MAS. The set of valid stop codes is revised October 1 of each year. At this time the PIMS package developers issue a maintenance patch to the software updating the file containing stop codes. Imaging stop codes are represented by entries in the Valid Imaging Stop Code file #71.5. Imaging stop codes are a subset of the Clinic Stop file #40.7. See PIMS documentation for more information.

Synonym

In the Radiology/Nuclear Medicine package, synonyms are alternate terms that can be associated with procedures for the purposes of convenient look-up/retrieval. A given procedure may have more than one synonym, and a given synonym may be used for more than one procedure.

Technologist

Radiology/Nuclear Medicine personnel who usually are responsible for performing imaging exams and entering exam data into the system.

Time-out

The amount of time allowed before a user is automatically logged out of the system if no keystrokes are entered. This is a security feature, to help prevent unauthorized users from accessing your VISTA account in case you forget to log off the system or leave your terminal unattended.

Transcribed

An exam status that may occur when a results report is initially entered into the system for an exam. If this status is not activated at the site, it will not occur.

Unreleased

An order status that occurs when an exam order is created, but no authorization to carry out the order has been given. This is possible only if the order is created through the OE/RR software.

Verification

For the purposes of this system, the process of causing a results report to progress to the status of Verified. This happens when a physician affixes his/her electronic signature to the report, or when a transcriptionist, with the proper authorization, enters the name of a physician who has reviewed and approved a report. This is analogous to a physician signing a paper report.

Verified

A results report status that occurs at the time of verification. A report is verified when the interpreting physician electronically signs the report or gives his/her authorization that the report is complete and correct. Also see Verification.

VISTA

Veterans Health Information Systems and Technology Architecture. Formerly known as DHCP.

Waiting for exam

An exam status that occurs as soon as the exam is first registered. The system automatically places all exams in this status upon registration.

Ward

The hospital location where an inpatient resides. In VISTA, wards are a subset of the Hospital Location file (#44).

Weighted work unit

he number that results from multiplying the weight of a procedure's AMIS code with the procedure's AMIS weight multiplier for that AMIS code. If a procedure has more than one AMIS code, the multiplication is done for each and the results are summed.

Workload credit

A general term that can refer to either the stop code or CPT type of workload credit that is used in the VA to calculate reimbursement to medical centers for work done, or the AMIS crediting used by the AMIS workload system.

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

Email: support@ihs.gov