Magentus

CORE CRIS

Reception Module

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Introduction

Purpose

The CRIS CORE – Reception module is used to accept orders, requests, and appointments on the day of the patient's attendance when the examination(s) are due to take place. It is also possible to enter requests directly via this module in the event of paper requests and scan the any relevant supporting documents for future reference.

This document also covers how to interpret the Patient Details screen, and Events screen to highlight the purpose and meaning of all fields, icons and other key functions which are encountered within the CRIS system. Registering patients or updating demographics is extremely rare via the CRIS system however this document does cover this functionality for use by private clinics, customers with bi-directional PAS/HIS/PIMS interfaces and for testing / training purposes within the testing and training environments.

Audience

This document has been designed to inform users on the intended purpose and use of the Reception Module for use in the CRIS Live, Testing or Training Environments.

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Reception

The CRIS application is a patient-based information system, and it is therefore possible to attend patient's details via any mode. **RECEPTION MODE** is however, recommended for users who are exclusively responsible for attending patients and generating labels prior to their examination, as CRIS will automatically display or highlight the most appropriate screens and buttons.

To enable **Reception Mode** click on **Options** in the main CRIS 'Menu' screen, select **Mode**, followed by **Reception**.

Please note: CRIS system will automatically default to the MODE last used when the user was logged in.

Patient Searching/Registering

Before attending a patient, you should establish if the patient's details already exist on CRIS or PAS. If not, the patient will need to be registered on PAS (if applicable) before a new attendance can be created in CRIS.

To **search for the patient**, you should aim to enter as much information as is available into the relevant fields in the 'Main CRIS menu' screen of CRIS. You can also search using any relevant Patient identifier (CRIS, Hospital, NHS, CHI, or Event E-) and in the absence of this type of information the recommended search is Surname, Forenames and DOB.

It is also possible to search using any combination of Surname, Forename, or Date of Birth. This includes DOB only searching or DOB in combination with gender but is only advised as the final resort to confirm the patient does not exist via CRIS prior to proceeding to a PAS registration.

DOB can be entered using any of the following formats:

16041976	16/04/1976	16/4/76	16 4 1976
160476	16/04/76	16 4 76	

Once you have populated a field press the [**Enter**] key to move to the next. Press the [**Enter**] key in the last field (Sex) of Patient Demographics to initiate the patient search.

Depending on what information has been entered, the combined CRIS patient search provides patient matches based on the following:

- Closest Surname, Forename, DOB combinations
- Transposed Surname Forename (i.e. John Smith, instead Smith John)
- Soundex - Phonetic matching
- PAS - Patient from the HIS, PMI, PAS (Displayed in Green)
- Duplicate CHI/NHS numbers

Results are then ranked according to the closest possible match. CRIS Radiology records are displayed in **Blue**, Unlinked PAS records in **Green**, and Duplicate Radiology records in **Grey**.

Please note: Occasionally you will also see blue CRIS Patient records highlighted in yellow which indicates that a PAS record has been linked to a CRIS record, and the demographic details have been amended via CRIS but not via PAS (i.e. there is a discrepancy between the two systems which should be corrected via PAS).

It is also possible to re-order each column of the search results by clicking on any appropriate heading to order it numerically or alphanumerically, or by clicking the [**All Surname**] to return all patients sharing the same Surname, irrespective of Forename(s) or DOB entered, or [**All Forename**] ignoring Surname or DOB.

Selecting an Existing Radiology Patient Record (Displayed in blue)

These patients will already have an existing record on CRIS and will be displayed in blue. If there is already a hospital number associated with the record (shown in the '**HospNo'** column), you should highlight their record using the mouse, or by using [**Down/Up Arrow**] keys on the keyboard and click the [**Select**] function button. It is also possible to highlight a patient and press [**Enter**] on the keyboard or double-click on a patient to load their record.

If the blue CRIS record does not have a hospital number, you must establish if a matching ***green*** PAS record exists in the search. If it does you can continue to load the blue record and you will be prompted to LINK the CRIS to PAS record. Alternatively, if no ***green*** PAS record is visible, you should clear the screen and register the patient on PAS before returning to CRIS and searching again to display and link the PAS record.

PAS/HIS Linking

If an interface exists to the Trust PAS/HIS (Hospital Information Systems) and the patient is not already linked to PAS record a '**Match Patient**' screen may appear upon selecting the patient. This contains a list of patients with similar demographic details who are already registered on PAS (displayed in green).

If none of the patient's details match the patient you have loaded, click on [**Don't Match**] However, depending on local working practice you will likely need to register your patient on your local PAS in order to acquire a hospital number for your site.

If the patient details from **PAS/HIS are more up-to-date** click on [**Update**]

If **all patient details from PAS/HIS match** the CRIS details, click on [**Match**]

If the cris details are correct and the PAS/HIS details are incorrect press [**F5**] to clear the screen. It will then be necessary to update the PAS System with the correct patient demographics. Once PAS has been updated, reload your patient on CRIS using [**F9**] and click [**Match**] as all details should now match.

Please note: CRIS > PAS Linking is explained in more detail via CRIS_CRIB_CM_288_Linking Patients CRIS_PAS_MAG_V3.0

Alternatively, if you do not have a PAS/HIS interface or bi-directional PAS/HIS interface you should register and update patient demographics via CRIS.

Bi-Directional / Two Way Demographic Interfaces are rare. However, in the event that your Trust or Site does have the ability to update PAS from RIS you should follow all of the above steps except in the scenario where the CRIS details are correct, and the PAS/HIS details are wrong. If this is the case, you should click [**Match**] to ensure that PAS is updated to match the CRIS demographic details and proceed to update the CRIS record as normal. This will then update the PAS demographics, but this will only work if you have a bi-directional / Two Way Demographic interface.

Grey records indicate records that were once duplicate records and have subsequently been amalgamated. Choosing a grey 'duplicate' record will automatically redirect to the reciprocal lead parent record.

Please note: In the event that you have selected the wrong patient record, simply click on the Search tab / screen or use [Alt - Arrow] to navigate back to the search screen in order to choose an alternative patient record.

Creating a New Patient in CRIS Via the Patient Details Tab

Please note: This is only applicable to sites who do not have a PAS interface otherwise all registrations and demographic updates must take place via PAS.

If no appropriate matches are displayed, or you already know the patient has never been registered on CRIS click on the [**New Patient**] function button, or press [**Esc**] to begin entering their full details onto CRIS via the 'Patient Details' screen.

Complete all relevant demographic details as follows before proceeding to register an attendance:

Field Name	Required Information
Surname Forename Date of Birth	Complete as appropriate, or press [**Enter**] to the next field if pre-populated. The patient's age is displayed as months and years if the patient is less than 3 years old.
Date of Death	This field is typically populated from PAS / HIS or can be entered manually to mark the record as deceased.
Sex	Enter **F** (female) or **M** (male), other options include **U** (unknown) and **I** (indeterminate) the latter being restricted to use with postnatal registrations.
Ethnic Origin	Press [**F4**] to select from the prompt list, or press [**Enter**] to the next field if not applicable.
Title	Press [**F4**] to select from the prompt list, or press [**Enter**] to the next field if not applicable.
Language	Press [**F4**] to select from the prompt list, or press [**Enter**] to the next field if not applicable.
[Change Status To] Patient's Status	To register that the patient's demographic details have been verified with the patient, click on the [**Unchecked**] button in the 'Change Status To' field. This will change the **U** to a **C** in the Patient's Status box and change the button to read [**Checked**]. Alternatively, if you would like to ensure that the patient's demographic details are checked during their next visit - click on the [**Checked**] button, this will change the **C** in the patient's status field to a **U** [**Unchecked**] and will display a "Patient not checked" message whenever the record is re-loaded. **Please note:** If your site does not use this facility, the field will be blank.
Restricted Access	To restrict access to the patient's address details and to all reports, click on the box next to the 'Restricted Access' field and [**Save Patient**].
Hospital No	If a one-way PAS / HIS interface exist, you should ensure the Patient is registered via PAS / HIS and link the CRIS record to the relevant PAS / HIS record. If a two-way directional PAS / HIS is in place the Hospital Number will be updated upon registration via PAS / HIS.
CHI No NHS Number	If known, enter this information to facilitate future searches.
Practice	If known, enter the code for the patient's own GP, otherwise press the prompt key [**F4**] to search. The system allows you to search for a GP practice by GP Surname and / or Practice by entering only the first few characters, or full name/practice to display a list of all possible matches to select from. To select a practice and GP, highlight the required GP followed by their relevant practice and click [**OK**].
GP	This information is linked to the Practice Field and will be automatically entered once the practice and GP are selected.
Current Ward	This information is linked to the Event Details and will be automatically entered once the event is attended.

Current Referrer	This information is linked to the Event Details and will be automatically entered once the event is attended.
Contact Address	
Telephone	Complete as appropriate, or press [**Enter**] to the next field if pre-populated.
Work Telephone	Complete as appropriate, or press [**Enter**] to the next field if not applicable.
Mobile Phone Email	Complete as appropriate, or press [**Enter**] to the next field if not applicable. This field is used in conjunction with the HSS Communicator to send SMS/Email Appointment reminders. **Consent**: The default value is ☒ to indicate **not recorded** or **does not consent**. You should therefore click to change to ☑ which indicates **consent has been given** by the patient and enables the communicator to send SMS messages/email if this functionality is in operation. If you wish to record that the patient does not consent, you should leave the ☒ and record this using a Patient Alarm of 'DNC – Does not consent'.
Postcode	Enter the patient's postcode in two parts, pressing the [**Spacebar**] in between. Upon pressing [**Enter**] the system will attempt to automatically enter the patient's domestic address if the Post Code database is present. Otherwise, it will be necessary to enter the address manually following the post code entry. **Please note:** If the postcode is not known this field can be left blank.
Address	If the address has been automatically entered, simply insert the house name or number. If not automatically entered, enter the address in the lines provided.
Home Address: This section is to record a home address in addition to contact address if required.	
Postcode	Enter the patient's postcode in two parts, pressing the [**Spacebar**] in between. Upon pressing [**Enter**] the system will attempt to automatically enter the patient's domestic address if the Post Code database is present. Otherwise, it will be necessary to enter the address manually following the post code entry. **Please note:** If the postcode is not known this field can be left blank.
Address	If the address has been automatically entered, simply insert the house name or number. If not automatically entered, enter the address in the lines provided.
Next of Kin Address: This section is to record Next of Kin (NOK) details if required.	
Surname Forename	Enter the Surname and Forenames of the patients NOK.
Relationship	Enter details of the relationship between the patient and NOK.
Telephone Work Telephone Mobile Phone	Enter an appropriate contact number as applicable.
Postcode	Enter the patient's postcode in two parts, pressing the [**Spacebar**] in between. Upon pressing [**Enter**] the system will attempt to automatically enter the patient's domestic address if the Post Code database is present. Otherwise, it will be necessary to enter the address manually following the post code entry. **Please note:** If the postcode is not known this field can be left blank.
Address	If the address has been automatically entered, simply insert the house name or number. If not automatically entered, enter the address in the lines provided.

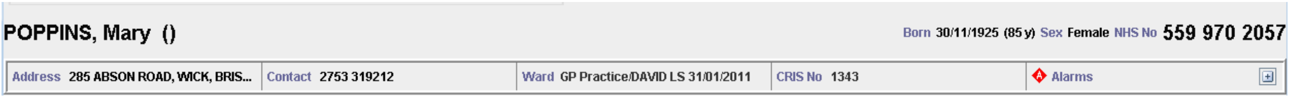
Having entered all appropriate information, press [**Enter**] or click on the [**New Event**] function button.

Viewing a Patient Record

Having loaded the required patient record, the 'Patient Banner' will be loaded and the 'Events' screen will appear to display the patient's complete history.

Patient Banner

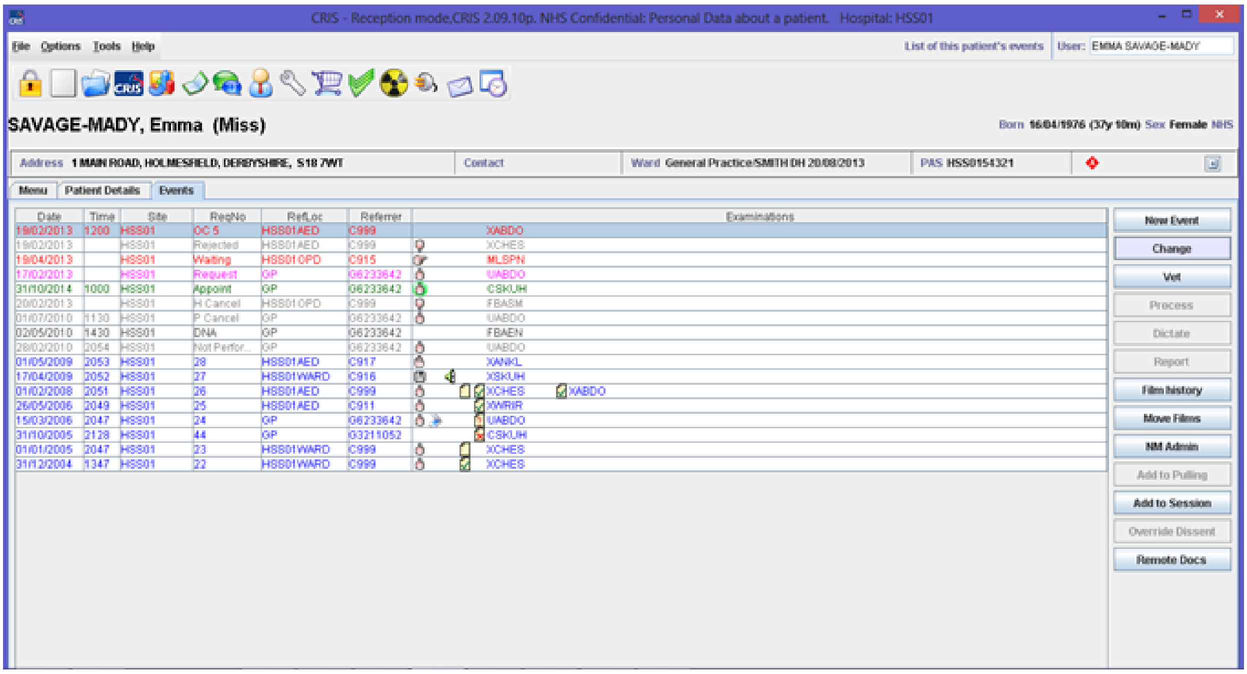
The new **Patient Banner** is a mandated NHS standard which is designed to "provide key information in a consistent and unambiguous manner, allowing patients to be accurately identified and matched with their associated record".



You can expand the displayed information by double-clicking on one of the banners section titles (e.g. 'Address', 'Contact', 'Ward' or 'PAS'), or by clicking on the '**+**' button in the 'Alarms' section; the banner will expand and display information from the 'Patient Details' tab.

If populated, the 'Telephone' contact from the 'Patient Details' will be displayed in the 'Patient Banner', if not then the 'Mobile Phone', 'Work Telephone' or 'Email Address' will be displayed depending on which are populated in the 'Patient Details' tab / screen.

Events List / Request History



The Patient 'Event' list is designed to provide a comprehensive overview of the Patient's entire history including the following events:

Type of Event	Colour	Description
Outstanding Orders	Red text	Electronic Orders awaiting vetting. Date and Time indicates the date and time ordered.
Outstanding Waiting List		Requests currently on the Waiting List. Date and Time indicates the date and time the request was placed on the

		waiting list. Hovering over the date will typically show the date created, and breach date information.
Booked Appointments	Green text	Booked Appointments. Date and Time indicates the appointment date and time. Hovering over the date will typically show the date created, and breach date information.
Request (received)	Pink Text	Received Request either entered directly from paper requests, or electronic orders which have now been acknowledged as received by the department. Hovering over the date will typically show the date created, and breach date information.
Rejected Orders	Grey Text	Rejected electronic orders. Date and time indicate the date and time the order was originally requested.
Hospital Cancellations (H Cancel)	Grey Text	Appointments / Orders which are Cancelled / Rejected by the Hospital / Department show as H Cancel. The date and time is either - the date and time of the order / request, or the original appointment prior to cancellation.
Patient Cancellations (P Cancel)	Grey Text	Appointments cancelled by the Patient show as P Cancel. The date and time is either - the date and time of the order / request, or the original appointment prior to cancellation. **Please note:**_Patient cancellations which go on to be rebooked (i.e. Patient Change cancel) have the effect of resetting the waiting time clock.
Not Performed	Grey Text	Not Performed events are requests that have been attended upon that patient's arrival but the examination has not gone ahead for a particular reason (i.e. Prep not followed, patient was unable to cooperate, machine failure etc.).
DNA	Dark Grey Text	Events which have not been attended by midnight on the day of the booked appointment automatically change into a DNA overnight. All DNAs should be vetted manually daily and rebooked or marked as DNA' card returned to prevent them continuing to be counted in waiting list figures.
Attendances	Blue Text	Attendances are displayed in reverse chronology to show a full history of all Examinations that the patient has undergone. The date and time indicate the date and time the examination(s) took place.

Entering or Accepting Requests

Having loaded the relevant patient record you have two options:

Option 1: Select an existing Event (i.e. an Order, Request or Appointment)

For this option you will simply need to locate the relevant event via the 'Events' list and click the [**Change**] function button to load the event and verify / amend the details as applicable.

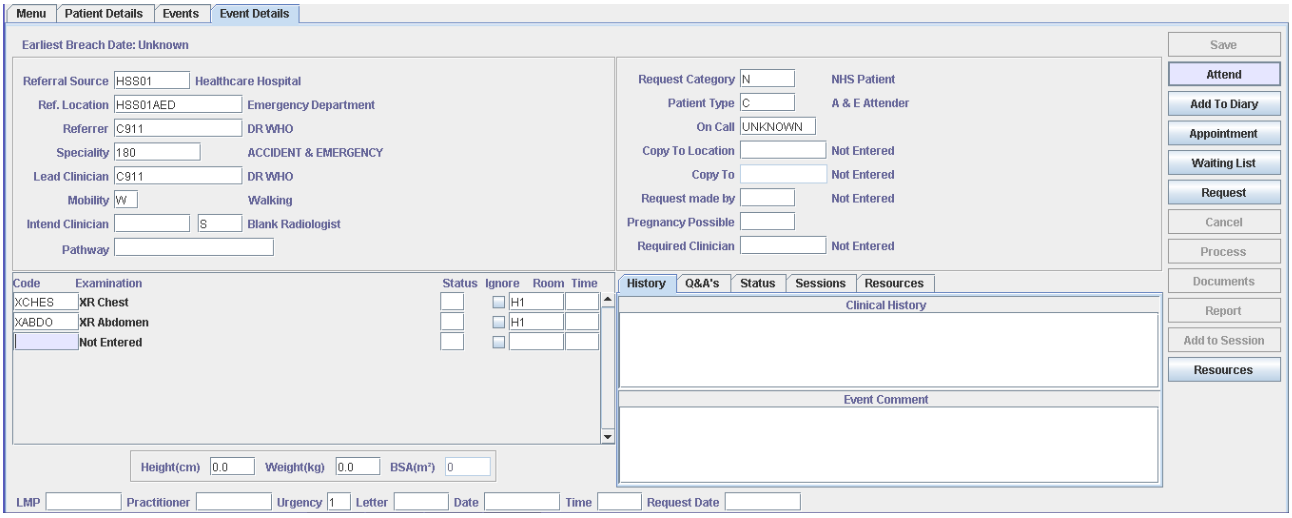
Please note: Electronic orders appear as a separate line for each exam, consequently, to select multiple orders for the same patient you should hold down the [**Ctrl**] key and left mouse click to select the required orders before clicking [**Change**].

Option 2: Book on an Attendance Direct from a Paper Request

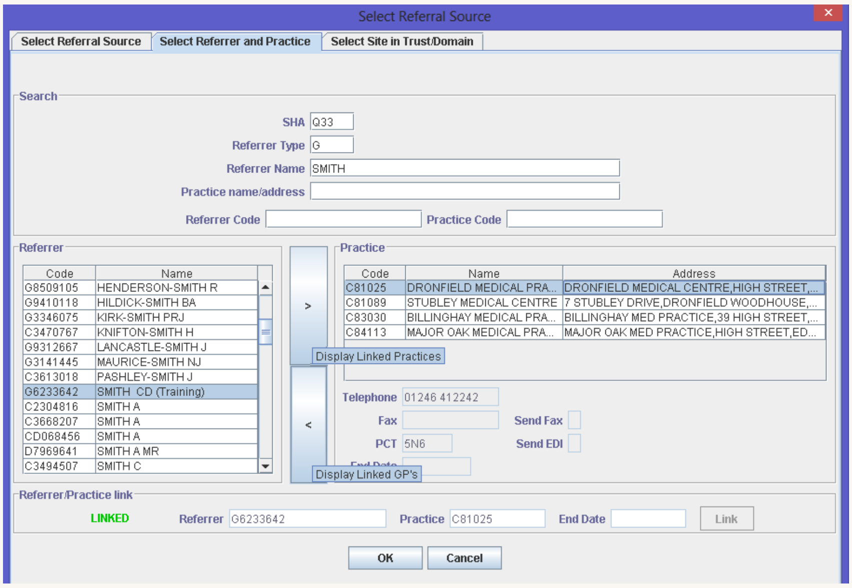
To enter a new attendance from a paper request (i.e. GP Walk-in Clinics or requests from other Hospitals) click [**New Event**] and proceed to complete the required fields as applicable. If you miss any 'Mandatory' (*****) fields the system will alert you to this upon saving the record and give you the opportunity to complete all required details before proceeding.

Overview of Event Details Screen

Having clicked [**Change**] or selected [**New Event**] the 'Event Details' screen will load. This is the equivalent to an electronic or paper request and contains all relevant fields and information required to proceed to attend the patient for an examination.



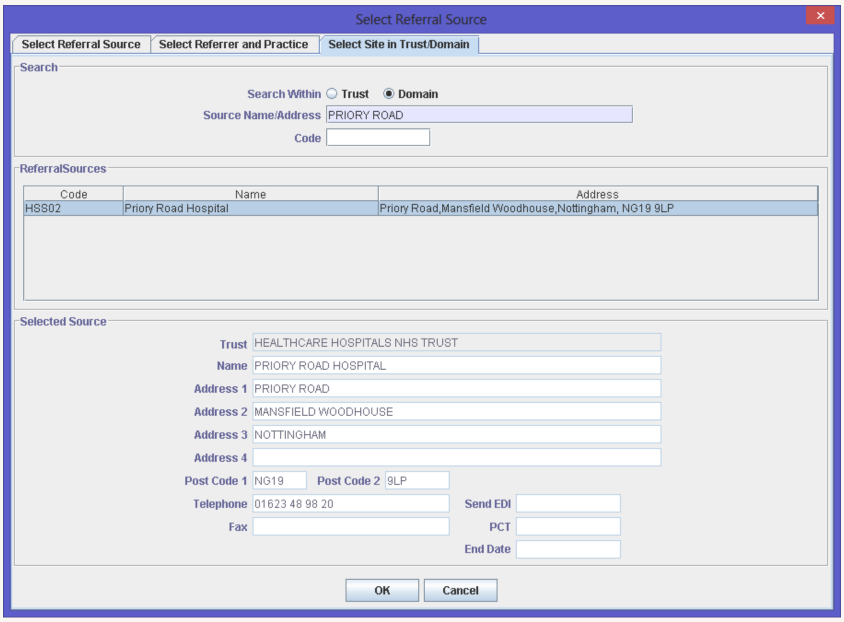
FIELD	DESCRIPTION
Referral Source*	**For internal requests** press [**Enter**] and move to the 'Referring Location' field. **For primary care (GP / Dental) requests** press [**F4**] as this prompt list will default to the following **'Select Referrer and Practice'** tab / screen as this is the most common type of External Referral.



You should enter Referrer Type '**G**' for GP or '**D**' for Dental then enter the referrers Surname + First Initial (if known) followed by [**Enter**]. This will display a list of all matching Referrers and upon selecting one, the referrer and their associated Practices will be displayed. Once the correct referrer and practice is highlighted click [**OK**] to select.

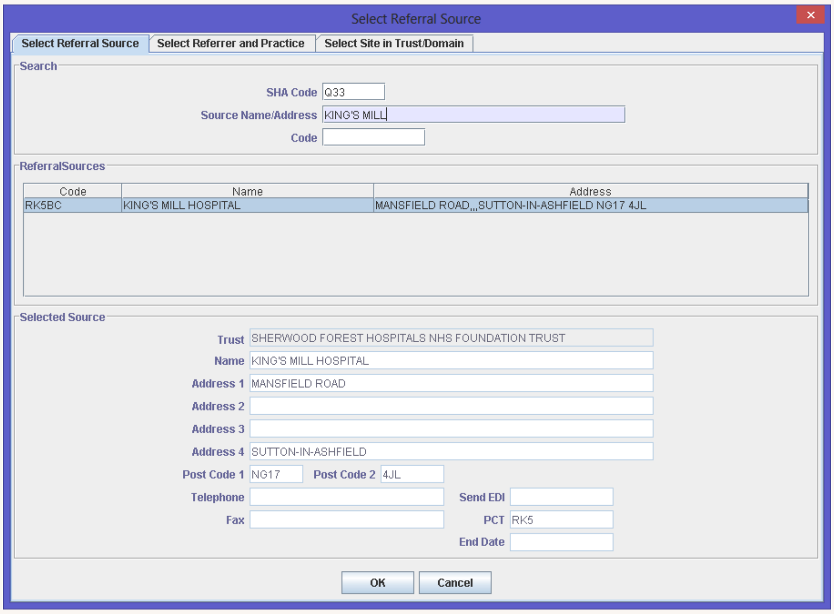
It is also possible to search using the **Practice Name/Address** field and enter the practice name or the first part of the address (i.e. Stubley Medical or Stubley Drive). The [**>**] Arrow will display Practices Linked to Referrers, and the [**<**] will display Referrers linked to the Practice.

For external referrals from hospitals within your Trust or outside of your Trust but in the same CRIS domain / region press [**F4**] and choose **'Select Site in Trust / Domain'**. Select [**Domain**] from the 'Search Within' option before entering the required details via 'Source Name / Address' and pressing [**Enter**] to action the search.

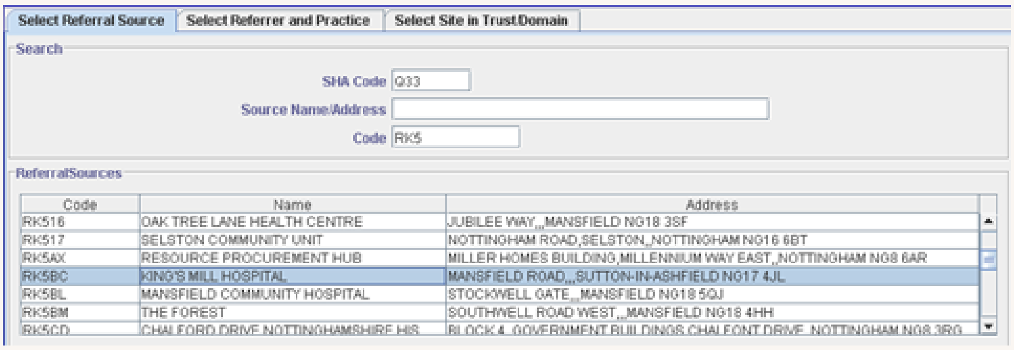


Please note: The term Domain refers to other Hospitals and Trust who are all hosted on the same Consortium Wide CRIS System. If the hospital you are searching for is not within the Consortium you should use the 'Select Referral Source' tab / screen.

For external referrals from hospitals outside of your region, press [**F4**] and choose the **'Select Referral Source'** tab / screen. Amend the SHA (Region) Code by typing the code directly or using the [**F4**] prompt to display a list of available SHA / Regions. You should then enter the required details via 'Source Name / Address' and press [**Enter**] to action the search.



It is also possible search using part of the Trust code if known – i.e. RK5 for Sherwood Forest Hospitals NHS Trust which would then return all referral locations within that Trust as follows:



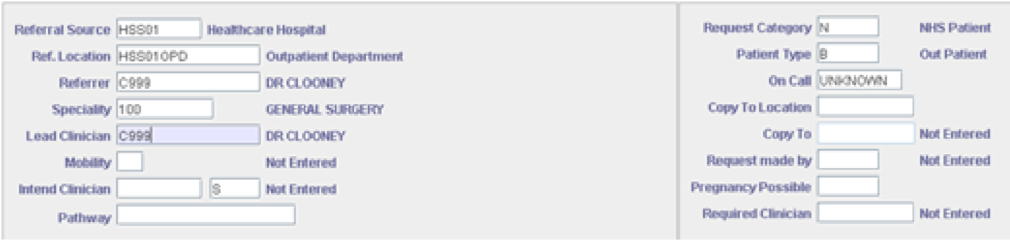
Please note: Removing the SHA code would enable you to search the entire Referral Sources database but will take longer than when filtered by SHA / region.

Referring Location*

Primary Care (i.e. GP/ Dental) referrals will automatically populate this field based on the selection made via the 'Referral Source' [**F4**] search.

For Secondary care and External Referral input the relevant referring location (ward/department) by typing the code directly, or press [**F4**] to display a list of available options.

Having completed this field, Request Category and Patient Type and on-call will be completed automatically, although you can amend these fields as necessary by clicking on them and selecting/entering an alternative option.



Please note: You should inform the RIS System Manager if these categories are incorrect as this can be amended within the System Tables so it is correct for future use.

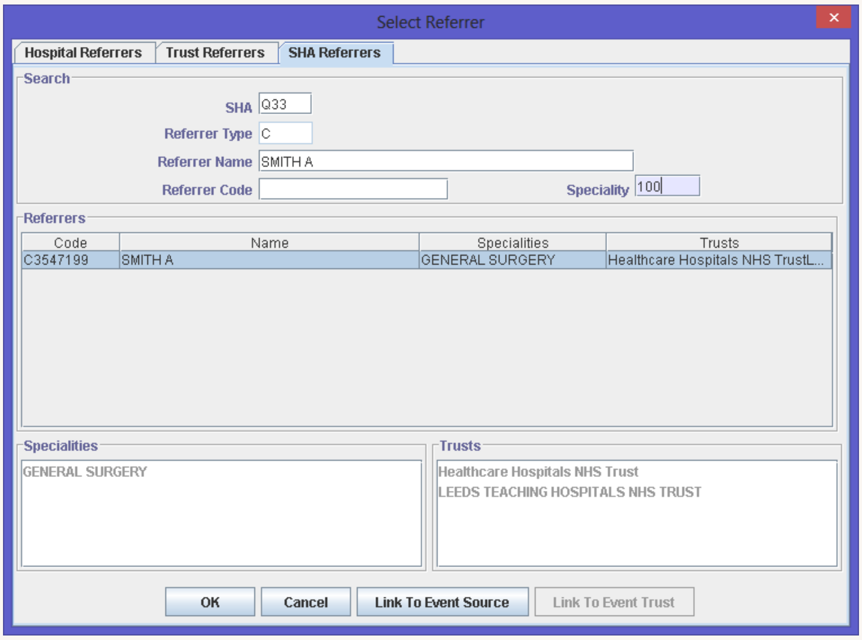
Referrer*

GP referrals will automatically populate this field based on the GP search via the 'Referral Source' field.

For Internal or other External Referrals, you should either type their referrer code if known or more commonly press [**F4**] to display the 'Select Referrer' search screen. The 'Select Referrer' search allows begin using SURNAME INITIAL (i.e. SMITH A) and where applicable combine with a Specialty if required (i.e. to refine the results).

This will usually default to the 'Trust Referrers' screen if the Referrer has been linked to the Trust already, or alternatively will extend to the 'SHA (Regional) Referrers' tab.

The SHA filter can be amended or removed if you wish to search outside your region, but you should ensure that you have selected the correct referrer.



Having found the correct referrer click [**OK**] to return the Event details screen and continue entering the attendance.

	Please note: If the referrer should be linked to your Trust but is still linked to their previous place of work you should either log this for correction by your RIS System Manager or click [**Link to Event Trust**] and [**Link to Event Source**] if you have sufficient security clearance to access these buttons.
Specialty	This field should default to the specialty of the referrer selected. However, if the referrer's specialty is different to the default, press [**F4**] then [**F3**] to show all Specialties, and select from the list displayed.
Lead Clinician	This field can be used to enter an alternative clinician who has overall responsibility for the requested examination, as required. This will default if the referrer has been marked as a Senior Clinician in the CRIS System Tables.
Mobility	Complete if known, Mobility is also used by the CRIS Portering Module.
A & E No	Complete only if applicable **Please note:** This field can be displayed or omitted from the screen as required.
Intend Clinician	Used to specify the intended (reporting) clinician for reporting worklists. If this field is not completed the Event will be marked as 'Unallocated'.
Report Urgency (Adjacent to Int. Clinician)	It is now possible to assign a Reporting Urgency which is independent of the existing 'Scheduling' urgency. This can be assigned to the event at the point of entry onto the system and amended at any point throughout the process prior to final confirmation via the Post Processing Screen after the examination has taken place.
Pathway	This field is designed to receive Pathway ID from PAS via the OBX order message. If this is not implemented via the existing PAS, the Pathway ID can be entered manually. **Please note:** This field can be displayed or omitted from the screen as required.
Request Category*	This field is defaulted automatically based on the Referral Location and displays the request category of the Event (i.e. NHS or Private). It can be amended either manually by typing directly or pressing [**F4**] prompt to display a list of available codes.
Patient Type*	This field is defaulted automatically based on the Referral Location and displays the displays the patient type of the Event (i.e. Outpatient or In Patient). Press the [**F4**] prompt to display a list of available codes.
On Call	This field defaults automatically upon saving the event based on the attendance time and the on-call times defined via the XR Setting RECEPT.OnCallTimes. It can be amended retrospectively where applicable.
Copy To Location	This is an optional field designed to enable you to specify that a second copy of the report should be sent to an alternative referrer in addition to the original Referring Clinician (i.e. GP for an AED attendance). This field should be used in conjunction with the 'Copy To' field and CRIS will automatically print a second copy of the report with the address of the selected location. Press [**F4**] to display and select from a list of locations.
Copy To	This field is used to enter the details of the referrer the second copy of the report is to be sent to using the [**F4**] prompt to display and select from a list of referrers.
Request Made By	This field is also located on the right-hand side of the screen and is designed to enable you to record how the request was received into the department by typing directly or using the [**F4**] prompt to display a list of available codes.
Pregnancy Possible (Legacy field)	This field is also located on the right-hand side of the screen and can be used to record if the patient has been asked if she may be pregnant for medico-legal/IR(ME)R purposes if required. This is however a legacy field as this is more

	routinely recorded via the Post Processing screen once the patient has been asked at the time of Examination.
Required Clinician	This field is designed for use in conjunction with the CRIS Resource Module to ensure that a specific clinician is available to perform the examination(s). If a clinician is entered via this field the associated resource will automatically be inserted for the event, although it will still be possible to assign additionally resources as necessary. Alternatively – this field can be used in isolation from the CRIS Resource Module to indicate the clinician that is required as a preference on the day, for booking staff to consider when making the appointment.

Examination Details

Having completed the patient's referral details, you can proceed to enter all relevant EXAMINATION(S) by pressing [**Enter**]. It is mandatory to enter at least one examination; otherwise it will not be possible to save the event.

CRIS can store an unlimited amount of examinations for each attendance entered. To enter an examination simply type in the examination code (if known), or press [**F4**] in the Code field of the 'Event Details' tab / screen to access the search options:

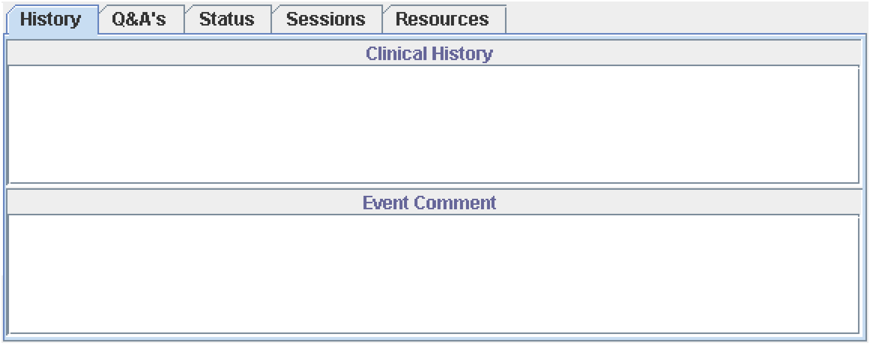
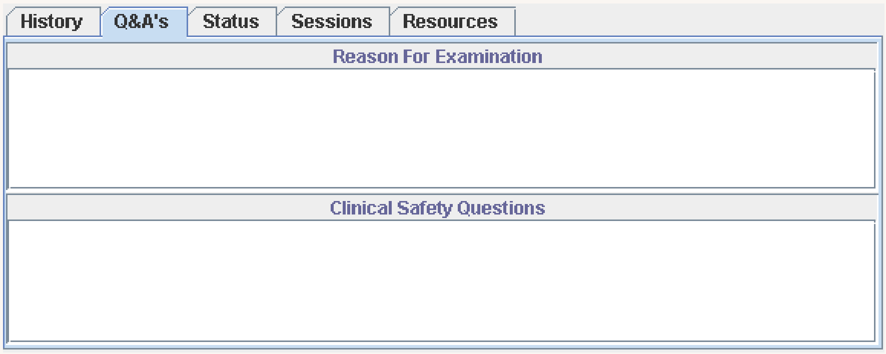
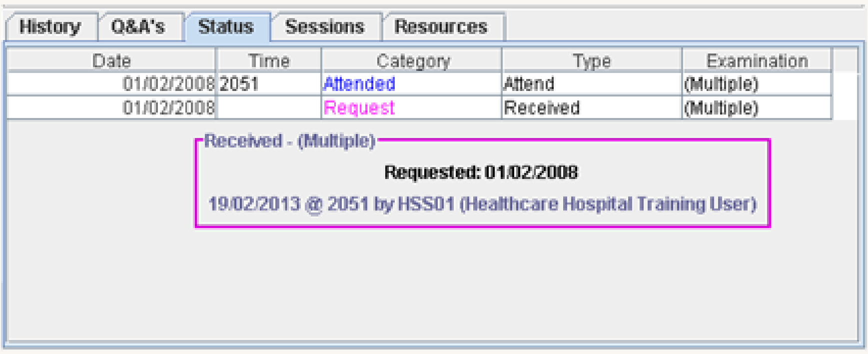
Search for an Examination using [F4]	
Exam List	Provides a complete list of all codes and description. To navigate through this list use the scrollbars, arrow-down, page-down or type as much as you know to perform an alphabetical search.
Body Map	To use, click on the relevant area of the body, to filter the exam list by exams appropriate to that part of the anatomy. **Please note:** To clear the filter and return to the complete exam list, click anywhere in the black area surrounding the body map.
Modality Search	To use, click on the appropriate modality to filter the exam list accordingly. **Please note:** To clear the filter and return to the complete exam list, click on [**Blank Modality**].
Keyword	To use press [**F4**] again or click on the 'Filter' field and type a keyword (i.e. chest) and press [**Enter**]. **Please note:** To clear the filter, remove the keyword and press [**Enter**].

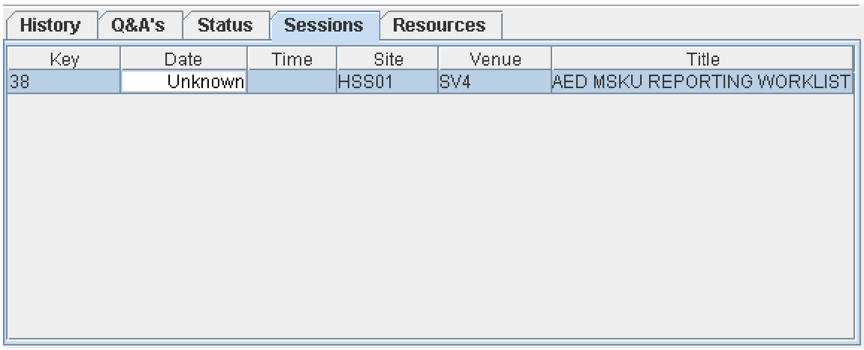
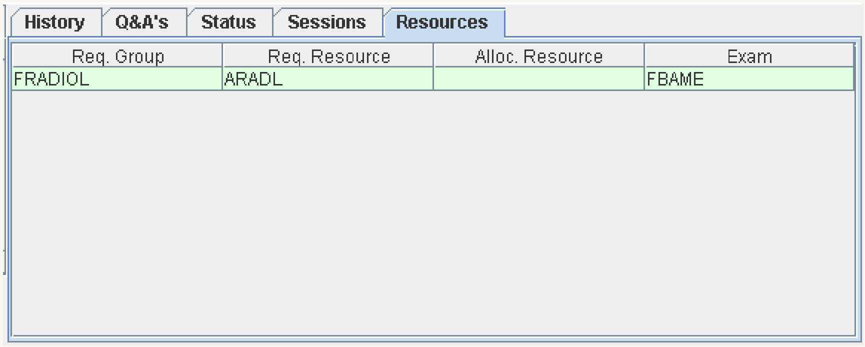
When you have found the examination you require, highlight it via the exam list and either double-click or press [**Enter**] to select.

You should then proceed to complete the Room the examinations will be performed in as this is used to populate the PACS Worklists in each Examination Room.

Additional Fields via the Event Details Screen

Field	Description
Height	This field is used in conjunction with weight to calculate the 'Patient Body Surface Area'. Enter Patients height in centimetres. **Please note:** If you prefer working in feet and inches, enter patient's height in feet space inches to convert to centimeters.
Weight	Enter Patients weight in Kilograms. **Please note:** If you prefer working in Stones enter the number of stones space pounds to convert to Kilograms.
BSA(m^2)	Body Surface Area is automatically calculated when Height and weight are entered.
LMP	Last Menstrual Period which should be entered if known for applicable examinations. You will also be prompted to enter this information in certain circumstances but can override the request based on the appropriate security override. This field is also used to calculate EDD (Estimated Date of Delivery) when the CRIS Obstetric Ultrasound system is in use.
Practitioner	Prior to Attendance this field is used to specify who should Vet / Justify the request to proceed based on IRMER guidelines. However, at the time of attendance this field should already be populated with the person who has vetted / justified the request. It is still possible to continue without completing this field but it is recommended that if known it should be recorded, although the final stage to complete this detail is via the Post Processing screen after the examination has taken place.
Urgency	This is **Scheduling Urgency** assigned to the event when it was first received and entered onto the system. At the time of Attendance, it can be used to convey reporting urgency, but this should really be undertaken via the **Report Urgency** (Adjacent to Intended Clinician).
Letter	Not applicable to the time of Attendance. This is used to specify an alternative letter at the time of making an appointment.
Date Time	This is automatically completed upon saving the Attendance or can be amended for correction purposes subject to having the appropriate security privileges.
Request Date	It is important to enter the Request Date as the **date the request was made** prior to attending the patient. If the request was entered into the system prior to attendance this date should already be visible. This date is used in calculating waiting times and is therefore essential though not mandatory.

Clinical History	The **Clinical History** field can be used to manually enter clinical history, or will display all relevant clinical history and associated order details when electronic ordering is in place. 
Event Comment	The **Event Comment** is a free text field designed to enable the user to record any pertinent information regarding the event at any stage of the process up to the point of verifying the report, and even beyond assuming you have sufficient security privileges.
Q&A's - Reason for Examination	The **Reason for Examination** field can be used to manually enter the reason the examination has been requested or will display all associated details when electronic ordering is in place provided that the OCS is capable of sending segmented (OBX5) message. 
Q&A'S - Clinical Safety Questions	The **Clinical Safety Questions** field can be used to manually enter any clinical safety questions and answers or will display all associated details when electronic ordering is in place provided that the OCS is capable of sending segmented (OBX6/7) messages.
Status History	The Status History displays a full audit trail of everything that has taken place from the creation of the event to its current status including date, time and user details. This is very useful for clerical, clinical and RIS system managers for data checking, or via statistical reports. 

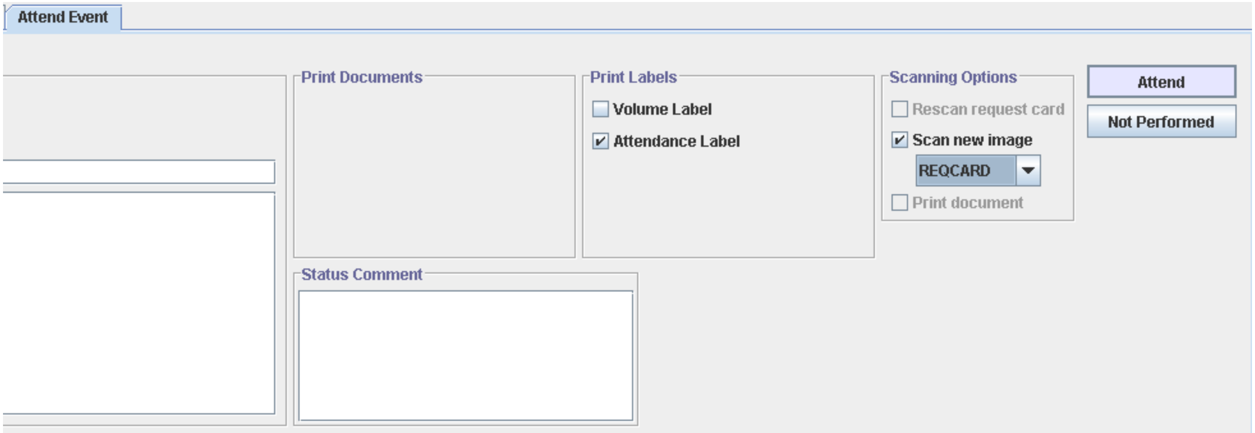
Sessions Module (if applicable)	If an event / patient record is assigned to a Session this will be displayed via the **'Sessions'** tab in the **<u>'Event Details'</u> screen** next to the 'Status' history. This shows all the sessions that the selected event is part of. You can also double click on the record via the 'Session' tab to display / update any 'Outcome Actions' assigned to the event following the session / meeting.  It is also possible to right click the session and choose **'Show in Management'** to display the Session Module.
Resource Module (if applicable)	If the Resource Module is in use this section of the screen will display any resources assigned / required to perform the examination.  You will be prompted upon attending a patient if the required resource is no longer available, you can then choose to override this restriction if appropraite by clicking the [**Resource**] function button ticking ignore followed by [**Save**]. You will then be allowed to proceed to attend the patient.

Attending the Event

Once you have completed all required information, you should either press [**Enter**] through the remaining fields and on the [**Attend**] function button or click on it using the mouse.

Please note: Because it is possible to perform different functions within each screen, you should disregard any fields or function buttons, which are not applicable to the task you are undertaking. You should also be aware if you are not using RECEPTION MODE, the [Attend] function button might not be defaulted automatically.

Upon clicking [**Attend**] the final 'Attend Event' screen will appear. If you do not need to scan any documents, you should proceed to click the [**Attend**] function button to complete the attendance and save the event.



Scanning a Request Card or Other Document

Alternatively, if you have the facilities to scan requests cards (or other documents) onto the CRIS system, you should place the request card / document in the scanner and click to the '**Scan New Image**' tick box in the 'Scanning Options' section of the screen prior to clicking on [**Attend**].

Marking an Event as [Not Performed] – e.g. Abandoned

If the patient has attended for their examination(s) but it has been necessary to ABANDON all procedures (e.g. In the event the patient had not followed required preparation or is uncooperative) it is possible to mark the attendance as [**Not Performed**]. To do this load the required patient, select the appropriate ATTENDANCE and click [**Change**] followed by [**Save**] via Event Details. You should then click [**Not Performed**] and confirm your intention to mark the attendance as 'Not Performed' via the resulting warning message.

Please note: By choosing 'OK' this event will be marked as Not Performed. This may result in this event NOT being reported. It is also possible to record a free text comment explaining the appropriate circumstances via the 'Status Comment'. You should also be aware that marking a record as 'Not Performed' does typically send a message to PAS/OCS, but not to PACS interfaces and you should therefore ensure you test this process with all relevant 3rd party systems to see how this is received, if at all.

ADDITIONAL FUNCTIONS	
Changing Patient Details	Load patient record and navigate to the 'Patient Details' tab/screen, make any required amendments and click on the [**Save Patient**] button, followed by [**F5**] to clear the screen.

	Please note: In most cases you should only amend Patient Demographics via the PAS, not RIS system and will often be prohibited from undertaking this action based on security settings.
Recording Patient Consent - *New*	The default value is an **X** – to indicate **not recorded** or **does not consent**. You should therefore click to change to a ✓ which indicates **consent has been given** by the patient and enables the communicator to send SMS messages if this functionality is in operation. If you wish to record that the patient does not consent, you should leave the **X** and record this using a Patient Alarm of 'DNC – Does not consent' followed by [**Save Patient**].
Adding a patient Alarm	Load the relevant patient record and navigate to the 'Patient Details' tab/screen. Choose the [**Add**] function button adjacent to the Alarms box and select an appropriate Alarm code, enter any additional text as required, and click [**OK**] followed by [**Save Patient**].
Recording 'Date of Death'	Load the relevant patient record and navigate to the 'Patient Details' tab/screen. Enter the relevant date in DOD field and click on the [**Save Patient**] Function button, followed by [**F5**] to clear the screen.
View Demographic History	It is also possible to view all changes to a patient's demographic details, by navigating to the 'Patient Details' tab/screen and clicking on the [**History**] function key. **Please note:** Whenever a patients Surname is changed, their previous name is displayed adjacent to the Surname field in 'Patient Details' for future reference.
Change the date and time of an existing attendance	Load the relevant patient record and navigate to the 'Events' tab/screen. Change the date and time of the event and click on the [**Attend**] function button to print changed labels if required.
Backlog attendances (Retrospective data entry)	Choose [**Backlog Mode**] from the 'Tools' menu, enter the required date and press [**Enter**] to set backlog mode to enable retrospective data entry. Enter all outstanding attendances as normal and click on the [**Cancel Backlog Mode**] function button.
Change, Add or Delete an examination	Load the relevant patient record, highlight the required attendance via the 'Events' screen and press [**Enter**] to or click on the [**Change**] function button. Change, or delete any existing examinations codes, or press [**Enter**] to insert a new examination before clicking on the [**Attend**] function button to print a set of changed labels.
Rescan / Enter a Request Card Retrospectively.	To rescan a request card or enter a request card against an attendance retrospectively - Click the [**Documents**] function button via the 'Events' screen and click either [**Scan New Document**] or [**Replace Document**] followed by [**Save**].
Print Extra labels Print Report/Letter	Load the relevant patient record and navigate to the 'Events' tab/screen. Select the required attendance/event. Right click and choose an appropriate option from the function menu.
View Reports 	To view reports held against the patient record, press [**F12**] or click the icon to display the CRIS Report viewer. It is also possible to view other patients' reports by entering their CRIS number and pressing [**Enter**]. The report viewer can be closed by pressing [**F12**], clicking the [**X**] on the window, or selecting the 'Auto close viewer' option.

CRIS ICONS (Displayed against attendances/events)		
Scanned Image		Indicates that an Image or document has been held against the event.
Justified		Indicates an examination which has been officially marked as 'Justified' according to IRMER. This icon is available with or without the Vetting Module but can only be undertaken by a relevant clinician.
Accepted		Indicates that the examination either does not require Vetting according to IRMER or has been 'Accepted' according to IRMER. When seen in conjunction with the green highlight this indicates that the examination has been both accepted and marked as justified by an appropriate clinician. This icon is available with or without the Vetting Module but can only be undertaken by a relevant clinician.
Rejected		This icon indicates that the request has been Rejected. This icon is available with or without the Vetting Module but can only be undertaken by a relevant clinician.
Referred		This icon indicates that the request has been referred via the Vetting Module.
On Hold		This icon indicates that the request has been placed On Hold via the Vetting Module.
Injected		The injected icon appears once a Nuclear Medicine injection (i.e. Isotope) has been allocated using the Nuclear Medicine Module and disappears once the event is Post Processed.
Post Processed		This icon indicates that a Radiographer / Sonographer has clicked [Action] via the [Unprocessed] work list. This means they are designating themselves as the Operator who will perform and process the examination – it can therefore be inferred that the examination is either taking place or has recently taken place.
		Indicates the attendance has been processed (IRMER - Room, Radiographer, Film, Dosage etc.) and the image has been 'Verified' for release to PACS for reporting / viewing purposes.
Dictated Reports		If using CRIS digital dictation this icon indicates that the radiologist has dictated a report, which is now waiting to be typed by the secretary.
		This icon indicates that the radiologist has dictated a report via an external source which is now waiting to be typed by the secretary.
		Indicates a partial dictation saved by the reporting clinician, which still needs completing.
		Indicates an Addendum dictation added after a formal report has been issued.
		This icon only appears once the report has been typed and verified and indicates that the RIS System Administrator has deleted the original voice file.
Provisional Report		Indicates that a report has been produced, but not yet authorized.
Verified Report		Indicates that an authorized report exists for the attendance.
Addendum		Indicates that a report has been produced, and authorized but has been subsequently changed and is now awaiting re-authorization.
Suspended		Indicates that the report has been temporarily placed 'on hold' by the Radiologist.
Unchecked		Indicates that the report has been passed for checking by a 2nd Consultant.
Locked		Indicates a report which is currently 'locked' for viewing, reporting, or editing.