Policy Statement	It is the policy of the Department of Pathology to scan items into Meditech that are not available in the computer system by normal means, as applicable.
Purpose	To provide an electronic copy of patient records in the Electronic Medical Record (EMR) and Electronic Legal Record (ELR), as applicable.
Scope	Items for scanning include, but are not limited to, non-interfacing test results, requisitions, and account specific patient information.
Responsibility	It is the responsibility of the associates in the Referral Testing Area to ensure that these steps are completed accurately as outlined in the following procedure.
Related Documents	LADM 2102 R Document Scanning

Documents for Scanning
The following documents should be scanned into Meditech.
  ➢ Any reference laboratory results that do not come across an interface.
  ➢ Maternal Screening Forms
  ➢ Cytogenetics History/Requisition Forms
  ➢ Any pictorial results that are deemed clinically relevant by a pathologist.

Form IDs
The following Form IDs should be used for identification of scanned documents.
  ➢ CDCHROMOANALREP – Chromosome Report
  ➢ CDELECTROPHGRA – Electrophoresis Graph
  ➢ CDFISHANALYSREP – FISH Report
  ➢ CDFLOCYTOMETREP – Flow Cytometry Report
  ➢ CDLABREFAMENDRE – Amended Reference Lab Report
  ➢ CDLABMATSCREEN – Maternal Screen Form
  ➢ CDMISCLABREPORT – Misc Lab Report
  ➢ CDPCRANALYSREPO – PCR Report
  ➢ ORDCYTOGENICS – Bone Marrow Requisition
  ➢ CDTSPOTTBTEST – TSPOT TB Testing Report
  ➢ CDNTDSCREEN – NTD First Trimester Screen
  ➢ CDJAKPANEL – JAK2 Reflexive Panel Report
  ➢ CDBCRABLSUMMARY – BCRABL Summary Report
  ➢ CDPRECISIONPNL – Signature Genomics Precision Panel
  ➢ LABRAPIDCHRTEST – Insight Rapid Chromosome Test

St. Agnes Hospital, 900 S. Caton Avenue, Baltimore, MD 21229

P:\labadmin\Quality Management\CORE\CORE QSE 2-Documents & Records\Reference Lab Sendouts\SEND 2000 Q Document Scanning.doc

- ➢ LABLIVERFIBROSI – Liver Fibrosis
- ➢ LABORGAMIACPRO – Organic/Amino Acid Profile
- ➢ LABNEOTYPEPANEL – Neo Type Panel

Audits

Random audits will be completed to insure that all information is going into the patient's medical record with the correct Form Id. A minimum of 10 records will be reviewed each quarter.

St. Agnes Hospital, 900 S. Caton Avenue, Baltimore, MD 21229

P:\labadmin\Quality Management\CORE\CORE QSE 2-Documents & Records\Reference Lab Sendouts\SEND 2000 Q Document Scanning.doc

Oxford (snap) T-SPOT Ordering

http://copia.mytbtest.com

Place order:

1. Manage orders → Order patient sample→ Type patient's last name in the "Patient*" blank at top of screen

2. If no records are found, hit *New Patient* button at bottom of screen → enter the date of birth, sex and put the *SA* or *LO* number in the "Patient MRN*" field → *Save*

3. Enter the physician name in the "Physician Name*" field. The system will search for the name. If the physician is not on the provided list, enter Unlisted Provider. The physician name will need to be entered in the Comments.

4. Click *Comments* → Click *Add* → type accession # → type the physician name, if required → check the boxes *" Display on lab report*" and *"Display on requisition and manifest"* →Click *Save*

5. Click the drop down beside "Is this test billed to insurance?*" → Select No

6. Type "TB" in the Type 'TB' and hit Enter field

7. Click Save at the bottom of the page

8. Hit Save at the bottom of the Clinical Information window that pops up

9. Cancel the Print that pops up

10. Click on the Collect Samples at the bottom of the screen

11. Enter the collection time and click Save

Create manifest:

1. Go to Manage Samples → Create manifest

2. Click the drop down beside "Lab*" and select Oxford Diagnostics Laboratories

3. Check all specimens to be sent (choose up to six per manifest. Create separate manifests for each box) → hit Print (the manifest will pop up) → click the Print Manifest button (be sure to print 2 copies!)

4. Put one copy in box, and other in designated binder.

Retrieve results:
1. Go to V*iew Results* tab → choose *Location Inbox* (all results from past 3 days that have not been acknowledged will appear; to view older results, click "Show Filter" at top, and adjust date)

2. Click Select in the tool bar at the top of the list to select all samples listed → Click Print Selected button

3. Mark the results you have printed as "acknowledged"; these results should then disappear when the screen is refreshed.

Providing Outside Pathologists Patient Information

The following steps must be completed in order to provide outside pathologists with the need patient information for result interpretation. These steps should be followed for any testing that is interpreted by a SAH or HCT pathologist in the absence of Dr. Seibel.

1. Order and process the samples as required by the reference laboratory.
2. Complete the HCT Hematopathology Consult Form. This form is found on the computer desktop in the Hemepath folder.
3. After completing the form, save the document in the Hemepath folder using the format Last name, Specimen number and test ordered (*e.g.* Jones 13R-27 flow).
4. Log into the HCT Web Email Server https://mail.hctpath.com/owa using the user name Sahsendout.
5. Select Contacts on the bottom left side of the screen.
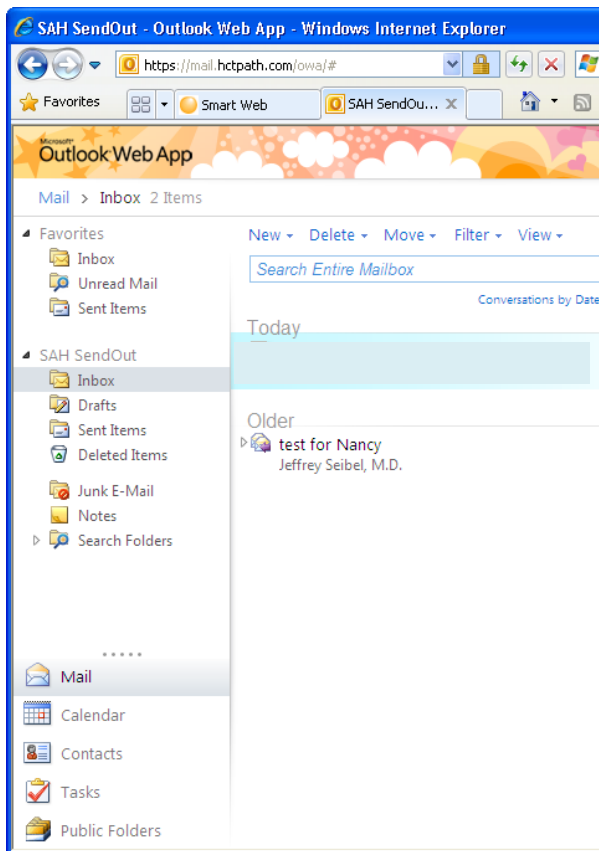

6. **Select DL – Heme Pathologists and any additional required pathologists. All names should be highlighted. No other names can be entered unless it is an hctpath email account.**
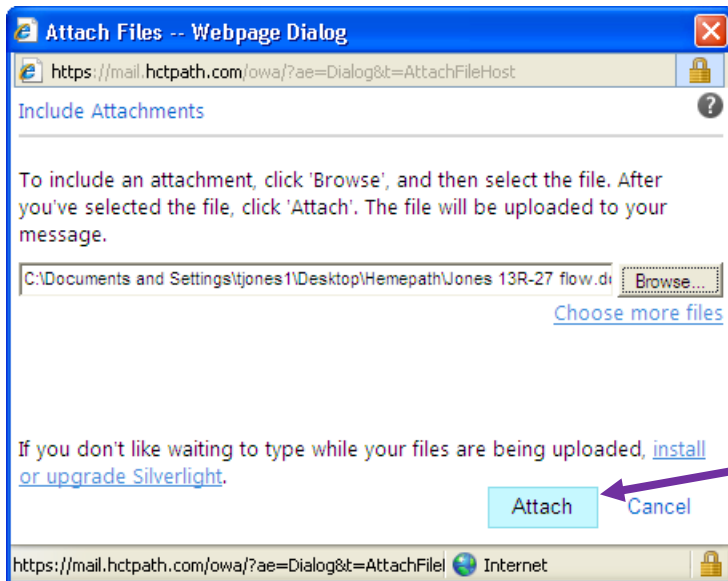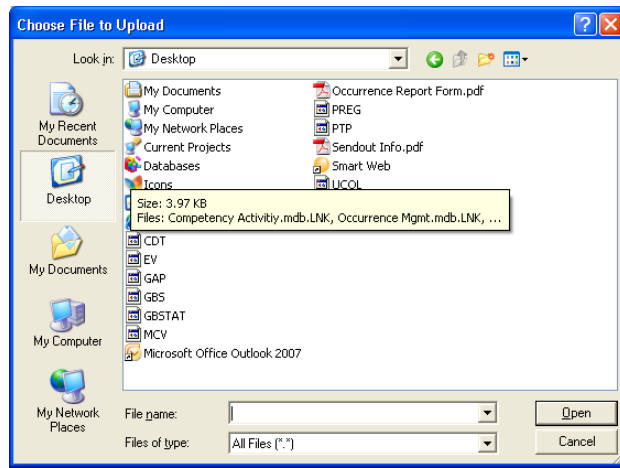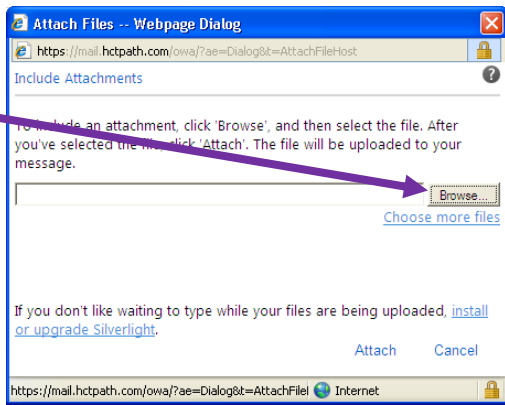7. After highlighting, right click and select New Message
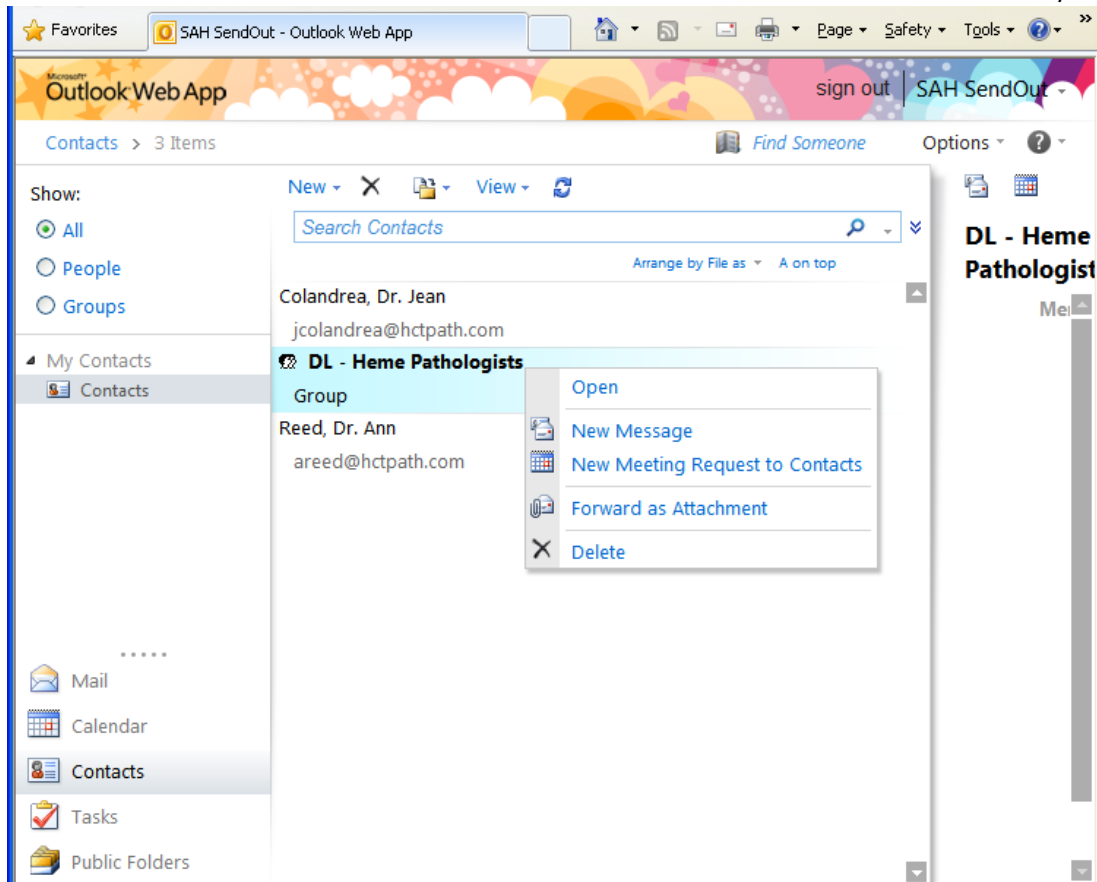
8. The subject line should say Saint Agnes [test type] – Patient Last Name, Accession Number and Todays' date
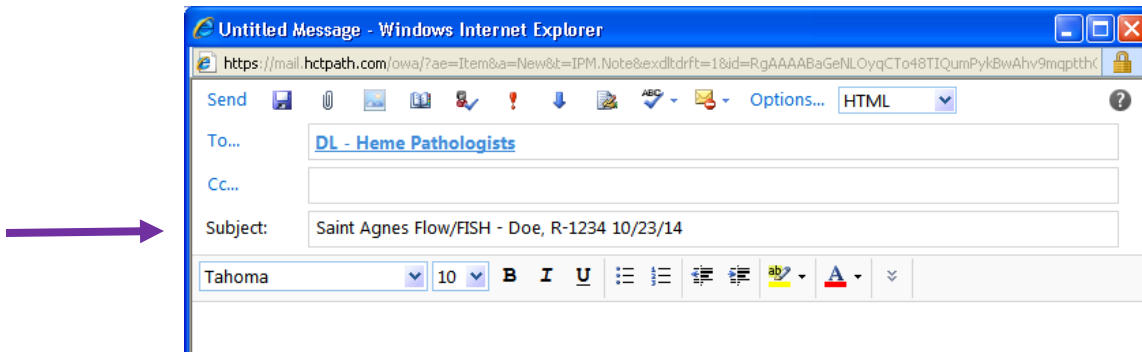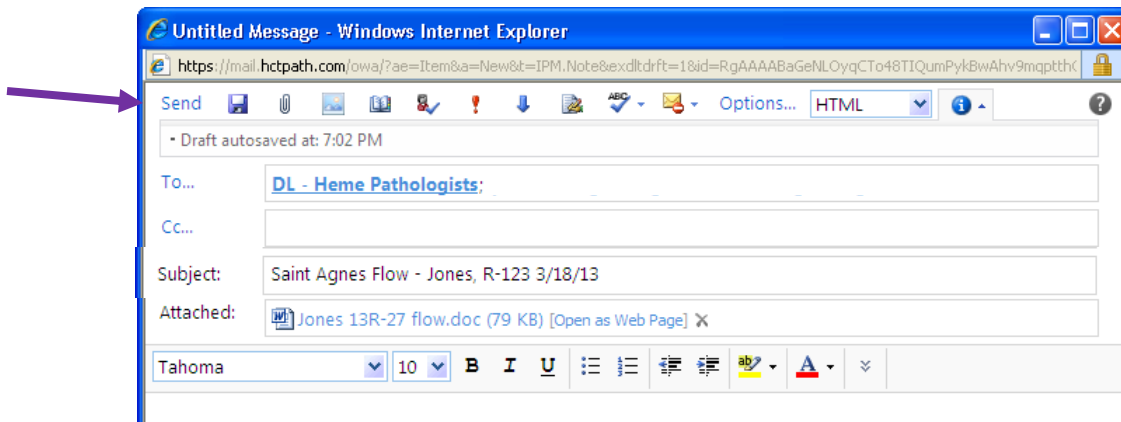

9. Click on the paperclip to attach your consultation form.
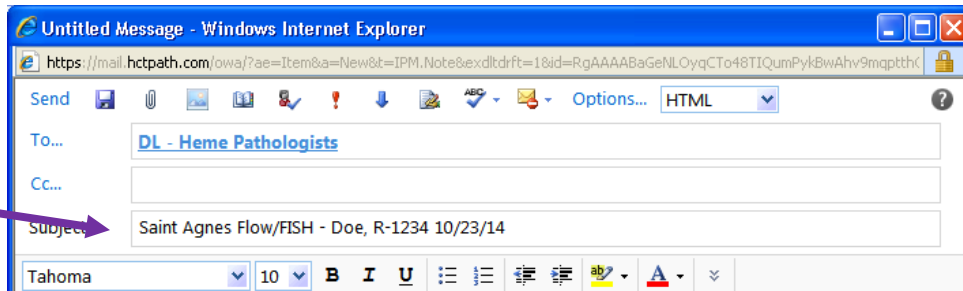
10. Click on Browse and find the Hemepath folder on the desktop. Identify the file that you created and double click and then click Attach.

11. The file will display on the screen. Click Send.

12. The email account should be reviewed often during the day to check to see if additional information is required or if the testing/interpretation is complete.
13. The completed interpretation will be sent back through email. Print out the Adobe file and give the report to the pathologist covering Dr. Seibel. (Usually Dr. Reed or Dr. Colandrea.)
14. Normal result verification and scanning procedures should be followed after the above steps are completed.