

exa-PACS • exa-RIS

# Feature Summary

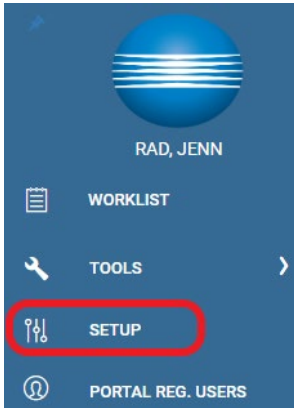
## Study Forms

© 2023 Konica Minolta Healthcare Americas, Inc.

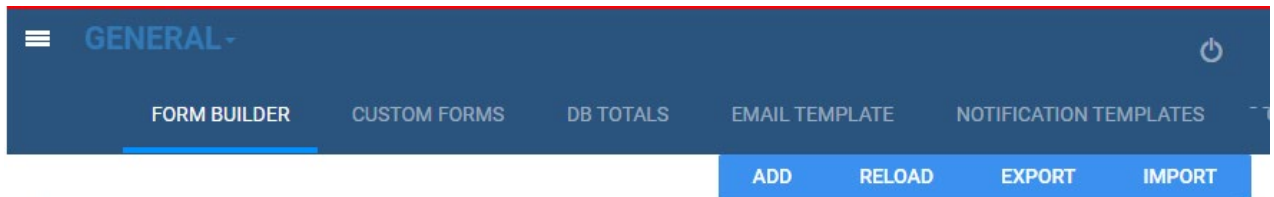
## Create a study form

You can create a study form for printing (such as a patient check-in form), or for electronic use within Exa PACS/RIS (such as in the patient portal).

1. On the navigation (“burger”)  menu, select **SETUP**.



2. Select **Office > General > FORM BUILDER > ADD**.



- Type a **Form Name** and select the **ASSIGN** sub-tab.
- Select a **Document Type**.
- In the various categories, select the following options:

**Allow ALL with Empty** – The form is available in the patient chart even if no corresponding criterion (e.g. “Provider”) is specified.

**Allow ALL without Empty** – The form is available in the patient chart ONLY if a corresponding criterion is specified.

**Dropdown list:** The form is available in the patient chart if the specific criterion you select is specified.

**EXAMPLE:** My Facility has a form that is required for all Medicare patients.

Viewable on Patient Portal

Insurance  4GA,AFFINITY MEDICARE ADVANTAGE

Provider \*  BCADVBLUE CROSS MEDICARE ADVANTAGE

Allow All with Empty

Allow All without Empty

Physician \* "Allow All with Empty"

Allow All with Empty

Allow All without Empty

CPT Codes \* "Allow All with Empty"

Allow All with Empty

Allow All without Empty

ICD Codes \* "Allow All with Empty"

Allow All with Empty

Allow All without Empty

Form Name\* Breast Questionnaire

PROPERTIES **ASSIGN** MERGE FIELDS

Document Type Patient Forms

Viewable on Patient Portal

Auto Assign to Study

Insurance Allow All With Empty

Provider \* Search Carrier

Allow All with Empty

Allow All without Empty

Physician \* Allow All With Empty

Search Physician

Allow All with Empty

Allow All without Empty

CPT Codes \* Allow All With Empty

Select CPT

Allow All with Empty

Allow All without Empty

ICD Codes \* Allow All With Empty

Select ICD

Allow All with Empty

Allow All without Empty

Markets 6 SELECTED -

Facilities \* 10 SELECTED -

Modalities Select modality +

MG X MR X US X

Male Patient Only

Female patient Only

Mammo Patient Only

### Add a header to the form

To add a header to your form, select **Header**.

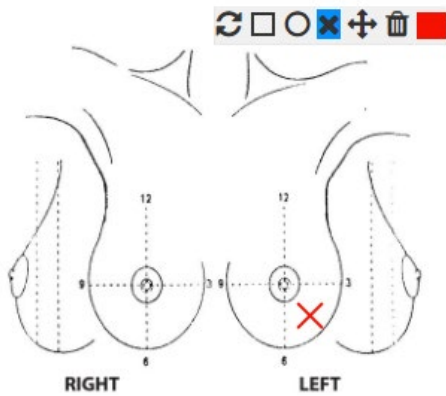
- To add a logo, on the **PROPERTIES** tab, select **CHANGE LOGO**.
- To add merge fields, type text in the **Text** box and then select **ASSIGN** to add merge fields. Switch between the two areas to keep typing text and adding merge fields.

### Add information to the body of the form

Use the following buttons to add controls to the form for displaying or gathering information.



Add images to the form. Users of the form can view and mark up the images.



Checkbox

Add checkboxes, such as for answering multi-choice questions.

- 11.- DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS:
- ANOREXIA OR BULIMIA
  - ASTHMA OR EMPHYSEMA
  - END STAGE RENAL DISEASE
  - HYPERPARATHYROIDISM
  - HYSTERECTOMY
  - INFLAMMATORY BOWEL DISEASES
  - ANY SEIZURE DISORDERS
  - CANCER

Radio Button

Add selectable options, such as for answering yes-or-no questions.

- DO YOU HAVE RHEUMATOID ARTHRITIS?  YES  NO

Text Box

Add text boxes for gathering information from the user of the form.

CURRENT HEIGHT  WEIGHT / LB.

Text Area

Add scrollable text, such as for legal agreements. When a user opens the form, text areas appear as follows.

**AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**

I hereby assign to the above named office, those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with treatment rendered. I request

Free Text

Add non-scrollable text. When a user opens the form, text areas appear as follows.

**AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**

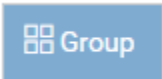
I hereby assign to the above named office, those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with treatment rendered. I request that payment of authorized benefits be made directly to the medical provider named above on my behalf.

I FULLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL AMOUNTS NOT OTHERWISE PAID BY MY INSURANCE CARRIER.

I certify that the information about me to be released to the Health Care Finance Administration or other health care coverage entity, any information needed for this or any related health care claim in writing or verbally. I further understand and agree to pay for services or amounts due when appropriate. These charges could include amounts applied to my annual deductible co-payment amounts, and charges denied as not covered by my insurance program or deemed medically unnecessary. I understand that well care is not covered by Medicare or many other health insurance programs.

I hereby authorize release of my films and/or medical records as needed for subsequent medical care. In the event of positive findings, I authorize my attending physician to release the results of my biopsy-surgery to my referring physician named above for their records.

If someone other than the patient is signing this authorization, please state relationship with patient and the reason patient is unable to sign.



Group multiple controls (images, merge fields, radio buttons, etc.) together.

**Example: In the form builder**

Study Type: **StudyDescription** Diagnosis Code(s): **SICDCodes**

Right  12  
 3  
 6  
 9

Left  12  
 3  
 6  
 9

**Example: When viewing the form**

Please check any areas where you are feeling any pain/discomfort:

Right  12  
 3  
 6  
 9

Left  12  
 3  
 6  
 9

**Add a footer to the form**

You can add merge fields or any text options in the footer, including the signature line.

1. Select **Footer**.

SAVE SAVE & CLOSE PRINT PREVIEW BACK

Form Name\* CT Screening Form

Image Checkbox Radio Button Text Box Text Area Free Text Group Header +20px Separation Footer Inactive

PROPERTIES ASSIGN MERGE FIELDS

Text

\$\$StudyFormSignature\$\$ \$\$DateAndTime\$\$

Spacing

Line Height: 2px

RESET

Style

Font: Helvetica

Font Size: 14

Bold  Italic  Underline

Text Align: Right

Computed Tomography (CT) Screening

PATIENT: \$\$FirstName\$\$ \$\$LastName\$\$  
DOB: \$\$DOB\$\$ MRN: \$\$Mrm\$\$  
ACCESSION: \$\$AccessionNo\$\$  
REFERRING PHYSICIAN: \$\$Ref\_PhyNameOrderFML\$\$

exa

CHIEF COMPLAINT/REASON FOR STUDY:

No  Yes Is your reason for this explain related to an injury? Date of injury: \_\_\_\_\_

How were you injured?  MVA  Work  Other

No  Yes Have you had any surgeries? Please list: \_\_\_\_\_

No  Yes Do you have any pain? Please explain \_\_\_\_\_

No  Yes History of cancer? Please explain \_\_\_\_\_

No  Yes Do you have diabetes?

No  Yes History of kidney failure?

Technologist:

\_\_\_\_\_

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

\$\$StudyFormSignature\$\$ \$\$DateAndTime\$\$

Signature in a completed form:

EDIT SIGNATURE PRINT SAVE FAX SAVE TO PATIENT DOCUMENTS

exa

NAME: Test, Danielle  
Study Description: Cervical Spine 2-3 Views

Please check if you have any of the following?

Pacemaker, wires, defibrillator  
 Brain aneurysm clip  
 Eye implant / Eye surgery  
 Artificial heart valve  
 Magnetic implant

Untitled

\_\_\_\_\_

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign to the above named office, those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with treatment rendered. I request

Recipient Signature: Information reviewed and verified on 2019-09-10 by JRH (patient)

*Jennifer Test*