

Rehabilitation Outcomes Management System (ROMS 2.0) User Guide

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Secure Login

Login

Username

Password

Login

Enter in user credentials per your facility/organization. If login is unsuccessful, contact your organization's representative.

Enter/Admit a New Patient:

Once you are logged in to ROMS 2.0 click on the +New Patient/Admit button. Fill out the visible fields on the form. The fields indicated with a red asterisk are required to be able to submit the form.

Intermountain ROMS | Rehabilitation Outcomes Management System

Search by Last Name or Patient ID or Account Number Show only: Active Discharged Search + New Patient/Admit

New Patient/Admit

Patient ID * Patient ID

Account/Billing # * Account/Billing #

Gender * Male Female

Last Name * Last Name

First Name * First Name

Birth Date * Birth Date

Admission Date * 06/18/2018

Insurance Type Insurance Type

Treating Therapist * Treating Therapist

Facility/Department * Facility/Department

Referring Physician * Search for physicians by last name or first name

Submit Reset Cancel

When you are finished, select the 'Submit' button to create a new patient. Select the 'Reset' button if you wish to clear all the values in the form and begin again. Select 'Cancel' if the you wish to go back to the Home screen.

For locations that use a Case #, please enter this into the Account/Billing # field. This number is unique to the admission and can change each time. Patient ID should always remain the same, for each of the patient's admits.

If the Referring Physician is not available in the drop-down, select 'Provider Not Found' and then add the name to the Referring Physician Name field.

Referring Physician *
PROVIDER NOT FOUND, PROVIDER NOT FOUND (M)

Referring Physician Name *
Last Name, First Name

Note: Even though a patient may be registered in your EMR or scheduling software, they still need to be entered into your ROMS database, so you must fill out their patient ID manually.

Patient readmission:

New Patient/Admit

Patient ID *
99999
Patient already exists. Click to re-admit this patient.

Account/Billing # *
Account/Billing #
Account/Billing # is required!

Gender *
 Male Female

Admission Date *
06/18/2018

Last Name *
TEST

Insurance Type
Insurance Type

First Name *
TEST

Treating Therapist *
Treating Therapist
Therapist is required!

Birth Date *
02/04/1975

Facility/Department *
Facility/Department
Facility/Department is required!

Referring Physician *
Search for physicians by last name or first name
Referring Physician is required!

Submit **Reset** **Cancel**

If the patient ID you enter is found in the database due to a previous visit, the application will populate the 'Gender', 'Last Name', 'First Name' and 'Birth Date' fields with values from the previous visit. The admission date field will default to the present date.

Click on 're-admit' highlighted in the above screenshot and fill in the remaining fields on the form.

You will be able to edit all fields except the 'Patient ID', 'Gender', 'Last Name', 'First Name', and 'Birth Date'. Enter values for 'Account/Billing #', 'Insurance Type', 'Treating Therapist', 'Facility/Department', and 'Referring Physician' and click 'Submit'. The fields marked with a red asterisk are required to be filled in order to successfully submit the form.

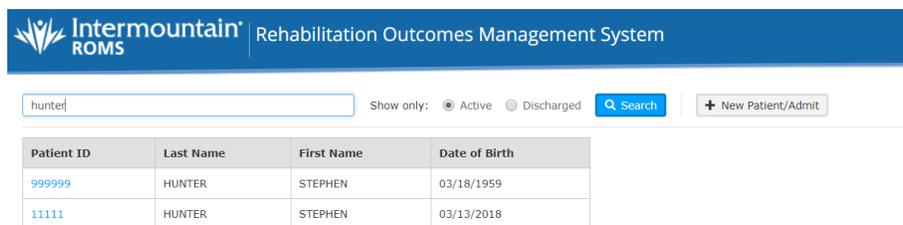
Searching for an Existing Patient

After successfully logging in, you should be on the Patient Search / Home page.



Enter in the patient's 'Last Name', 'Patient ID', or 'Account Number' into the search box and click on the 'Search' button.

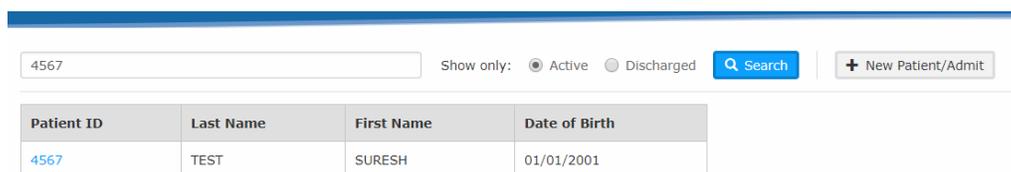
You may enter in partial values in the above search field for 'Last Name', but your resulting list will most likely be long.



Patient ID	Last Name	First Name	Date of Birth
999999	HUNTER	STEPHEN	03/18/1959
11111	HUNTER	STEPHEN	03/13/2018

e.g. Searching for the last name 'Hunter' will pull up all patients with that last name. The search is not performed on the 'First Name' of the patient.

For numbers, the whole 'Patient ID' is required for the search to return a successful result.



Patient ID	Last Name	First Name	Date of Birth
4567	TEST	SURESH	01/01/2001

Entering the complete and correct patient ID '4567' will return the patient.

Click on the correct 'Patient ID' link in the results table to move to that patient's summary screen.

Patient ID	Last Name	First Name	Date of Birth
4567	TEST	SURESH	01/01/2001

Note: there may be only one patient, or many patients. Select the correct patient.

Reviewing Patient Data

Clicking the 'Patient ID' link shown in the above screenshot will open up the patient summary screen shown below.

Admissions

Admit Date	Department	Account	Discharge Date	Therapist
5/04/2018	Central Salem	134	Review to Discharge	Ball, Jason
4/23/2018	Central Salem	1234	Review to Discharge	Ball, Jason
4/16/2018	Corvallis	1111	Review to Discharge	Bidgood, Kyle

Outcome Scores

Survey Date	Survey Type	Survey Score	Pain Score	K Modifier	Startback Risk	FABQ		
						Activity Score	Work Score	Total Score
05/29/2018	KNEE	42	3	CM (80-99%)				
05/29/2018	QDASH	36.4	2	CL (60-79%)				
05/09/2018	MDQ	0	0	CH (0%)				
05/04/2018	MDQ	65	5	CM (80-99%)				
05/04/2018	MDQ	100	10	CM (100%)				

Classifications

Classification	Primary

Editing/Deleting Patient Information

The patient review screen includes basic identifying information for the patient. You may edit this information by clicking on the Patient 'Name' link highlighted below:

Admis

Adm
5/04
4/23
4/16

Clicking on the Patient Name link will open a form where patient information can be edited. All fields are editable.

Once the fields required are changed, click on the 'Submit' button to record the changes.

Edit Patient

Patient ID *
4567

Gender *
 Male Female

Last Name *
test

First Name *
suresh

Birth Date *
01/01/2001

Submit **Cancel**

To go back to the patient review screen without making any changes, click on 'Cancel'.

Choosing an Admission

The table under 'Admissions' on the patient summary screen consists of all admissions for the chosen patient (both active and discharged). By default, the most recent admission is on the top of the list. By selecting the radio button to the left of the admission line, the corresponding survey data will be visible below this table in the Outcome Scores and Classification tables.

Admissions ReAdmit

	Admit Date	Department	Account	Discharge Date	Therapist
<input checked="" type="radio"/>	5/04/2018	Central Salem	134	Review to Discharge	Ball, Jason
<input type="radio"/>	4/23/2018	Central Salem	1234	Review to Discharge	Ball, Jason
<input type="radio"/>	4/16/2018	Corvallis	1111	Review to Discharge	Bidgood, Kyle

Editing/Deleting Admission Information

To edit or delete a selected admission, click on the Admit Date link, highlighted below.

Admissions

ReAdmit

	Admit Date	Department	Account	Discharge Date	Therapist
<input checked="" type="radio"/>	5/04/2018	Central Salem	134	Review to Discharge	Ball, Jason
<input type="radio"/>	4/23/2018	Central Salem	1234	Review to Discharge	Ball, Jason
<input type="radio"/>	4/16/2018	Corvallis	1111	Review to Discharge	Bidgood, Kyle

The following screen opens up on clicking the 'Admit Date' link.

The screenshot shows the 'Edit Admit' form with the following fields:

- Patient ID ***: 4567
- Account/Billing # ***: 134
- Gender ***: Male Female
- Admission Date ***: 05/04/2018
- Last Name ***: test
- Insurance Type**: Industrial
- First Name ***: suresh
- Treating Therapist ***: Ball Jason
- Birth Date ***: 01/01/2001
- Facility/Department ***: PT Northwest - Central Salem
- Referring Physician ***: Search for physicians by last name or first name

Buttons at the bottom: Submit, Delete, Cancel.

The following fields for patient information are not editable: Patient ID, Gender, Last Name, First Name, Birth Date

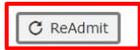
The following fields for admission are editable: Account/Billing #, Admission Date, Insurance Type, Treating Therapist, Facility/Department, Referring Physician

You may change values in the editable fields and click 'Submit' to record the changes to an admission. Clicking 'Delete' on this screen will delete the admission. Once an admission is deleted, all associated outcomes scores/assessments and classifications will also be deleted. To go back to the patient summary screen without making any changes to the admission, click 'Cancel'.

Readmitting a Patient

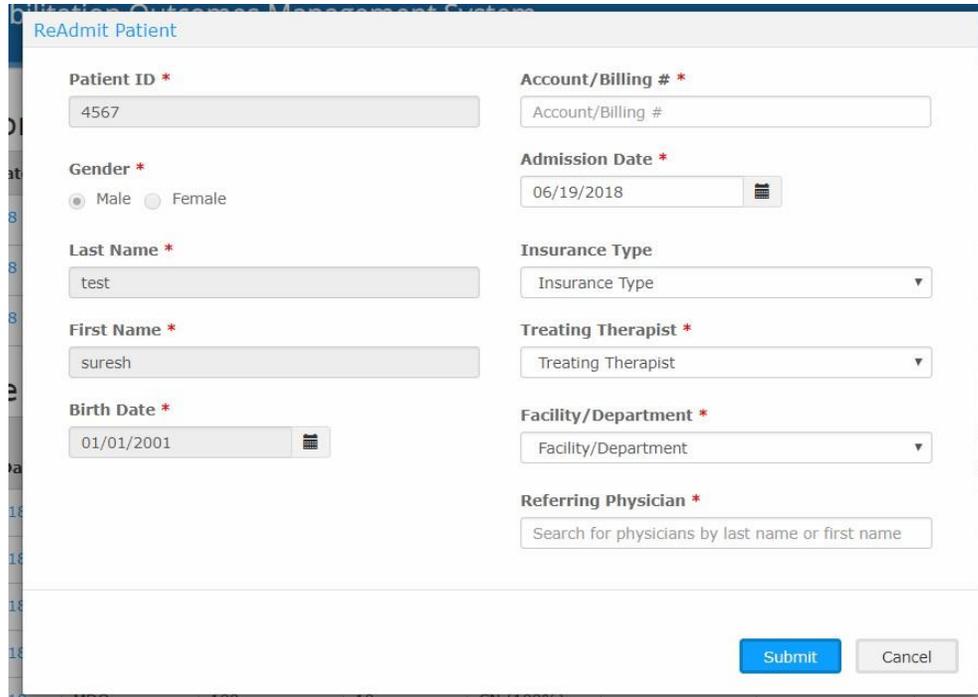
To start a new admission for a patient from the patient summary screen click the 'ReAdmit' button highlighted below.

Admissions



	Admit Date	Department	Account	Discharge Date	Therapist
<input checked="" type="radio"/>	5/04/2018	Central Salem	134	Review to Discharge	Ball, Jason
<input type="radio"/>	4/23/2018	Central Salem	1234	Review to Discharge	Ball, Jason
<input type="radio"/>	4/16/2018	Corvallis	1111	Review to Discharge	Bidgood, Kyle

The following form will appear.

A screenshot of a web form titled "ReAdmit Patient". The form is divided into two columns. The left column contains fields for Patient ID (4567), Gender (radio buttons for Male and Female), Last Name (test), First Name (suresh), and Birth Date (01/01/2001). The right column contains fields for Account/Billing #, Admission Date (06/19/2018), Insurance Type (dropdown), Treating Therapist (dropdown), Facility/Department (dropdown), and Referring Physician (search field). A "Submit" button is at the bottom right, and a "Cancel" button is to its left.

The following fields for patient information are not editable: Patient ID, Gender, Last Name, First Name, Birth Date

The following fields for admission information are editable: Account/Billing #, Admission Date, Insurance Type, Treating Therapist, Facility/Department, Referring Physician

The admission fields marked with a red asterisk are required to be filled to save a new admission record. Once admission details are populated, click 'Submit' to save the record.

To go back to the patient review screen without saving a new admission, click 'Cancel'.

Entering a Patient Outcomes Score Manually

To add a new Outcome score to a patient's admission manually, ensure the correct admission is selected in the admission table, then click the 'Add Manual Score' button highlighted below.

Admissions

ReAdmit

	Admit Date	Department	Account	Discharge Date	Therapist
<input checked="" type="radio"/>	5/04/2018	Central Salem	134	Review to Discharge	Ball, Jason
<input type="radio"/>	4/23/2018	Central Salem	1234	Review to Discharge	Ball, Jason
<input type="radio"/>	4/16/2018	Corvallis	1111	Review to Discharge	Bidgood, Kyle

Outcome Scores

Add Manual Score

Start e-Survey

Comparison Report

Patient Report

	Survey Date	Survey Type	Survey Score	Pain Score	K Modifier	Startback Risk	FABQ		
							Activity Score	Work Score	Total Score
	05/29/2018	KNEE	42	3	CM (80-99%)				
	05/29/2018	QDASH	36.4	2	CL (60-79%)				
	05/09/2018	MDQ	0	0	CH (0%)				
	05/04/2018	MDQ	65	5	CM (80-99%)				
	05/04/2018	MDQ	100	10	CM (100%)				

An 'Outcomes Assessment Score' window will open.

The user must choose an assessment 'Type' from the dropdown list shown below.

Outcome Assessment Score

Type *

- DISABILITY OF ARM, SHLDR, HAND
- FEAR-AVOIDANCE BELIEFS Q.
- KNEE OUTCOME SURVEY
- LOWER EXTREMITY FUNC SCALE
- MODIFIED LOW BACK DISABILITY QUESTIONNAIRE
- NECK DISABILITY INDEX
- Quick DASH
- Start Back Tool

Submit Reset Cancel

Once chosen, the required fields for that particular type of assessment are visible. The user may manually enter the score of the assessment or utilize the calculator (if available) to help in calculating assessment score. The fields marked with a red asterisk are required to be populated to submit an assessment. Once populated, click 'Submit' to save the assessment.

Outcome Assessment Score

Type * DISABILITY OF ARM, SHLDR, HAND

Date * 07/25/2017

Assessment Score * 3

Pain Score * (or Visual Analog Scale) 8

Enter another survey for this patient

DASH Calculator

Sum of Circled Responses *

Number of Completed Responses *

Calculate

Submit Reset Cancel

Outcome Scores

Add Manual Score

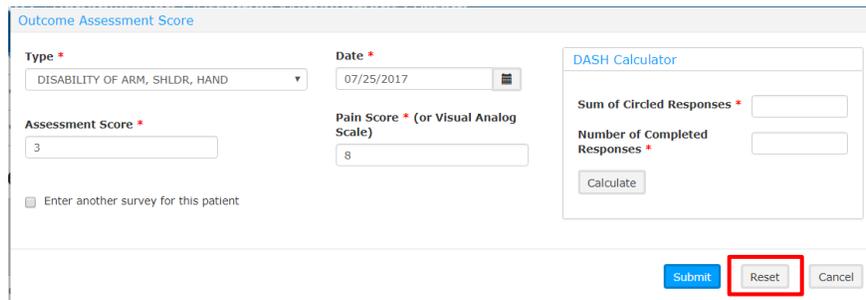
Start e-Survey

Patient Report

Survey Date	Survey Type	Survey Score	Pain Score	K Modifier	Startback Risk	FABQ		
						Activity Score	Work Score	Total Score
 02/14/2018	DASH	64	8	CM (80-99%)				
 02/09/2018	NECK	0	6	CH (0%)				
 02/06/2018	LEFS	0	4	CN (100%)				

The manual survey will be indicated by the Pencil icon to the right of the survey details, as seen above.

Clicking 'Reset' in the form, will clear values in 'Type', 'Assessment Score' and 'Pain Score' fields.



Outcome Assessment Score

Type *
DISABILITY OF ARM, SHLDR, HAND

Date *
07/25/2017

Assessment Score *
3

Pain Score * (or Visual Analog Scale)
8

Enter another survey for this patient

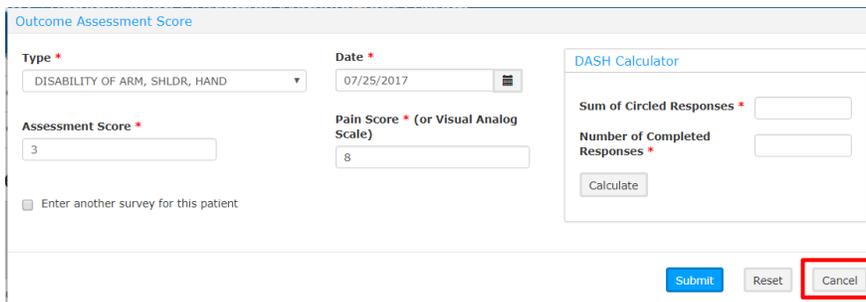
DASH Calculator

Sum of Circled Responses *
Number of Completed Responses *

Calculate

Submit Reset Cancel

Clicking 'Cancel' will close the dialog box.



Outcome Assessment Score

Type *
DISABILITY OF ARM, SHLDR, HAND

Date *
07/25/2017

Assessment Score *
3

Pain Score * (or Visual Analog Scale)
8

Enter another survey for this patient

DASH Calculator

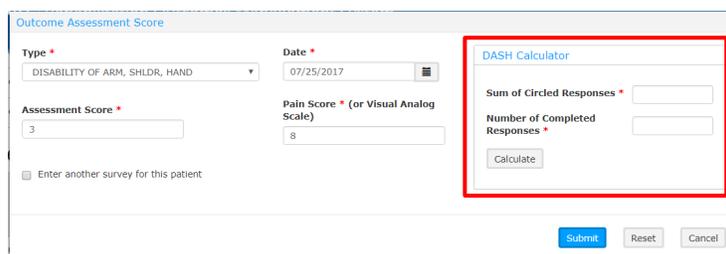
Sum of Circled Responses *
Number of Completed Responses *

Calculate

Submit Reset Cancel

Assessment Score Calculators are available for only DASH, Quick DASH, Knee and MDQ assessments.

DASH Assessment Score Calculator



Outcome Assessment Score

Type *
DISABILITY OF ARM, SHLDR, HAND

Date *
07/25/2017

Assessment Score *
3

Pain Score * (or Visual Analog Scale)
8

Enter another survey for this patient

DASH Calculator

Sum of Circled Responses *
Number of completed Responses *

Calculate

Submit Reset Cancel

Quick DASH Assessment Score Calculator

The screenshot shows the 'Outcome Assessment Score' form for 'Quick DASH'. The 'Type' dropdown is set to 'Quick DASH' and the 'Date' is '12/13/2017'. The 'Assessment Score' is '2' and the 'Pain Score' is '10'. A red box highlights the 'Quick DASH Calculator' section on the right, which contains two input fields: 'Sum of Circled Responses *' and 'Number of Completed Responses *', with a 'Calculate' button below them. At the bottom, there is a 'Submit' button, a 'Reset' button, and a 'Cancel' button. A checkbox labeled 'Enter another survey for this patient' is located below the 'Assessment Score' field.

Knee Assessment Score Calculator

The screenshot shows the 'Outcome Assessment Score' form for 'KNEE OUTCOME SURVEY'. The 'Type' dropdown is set to 'KNEE OUTCOME SURVEY' and the 'Date' is '07/25/2017'. The 'Assessment Score' is '3' and the 'Pain Score' is '8'. A red box highlights the 'Knee Outcome Calculator' section on the right, which contains two input fields: 'Sum of Circled Responses (if all 14 questions filled out)' and 'Number of Completed Responses (if only 13 questions filled out)', with a 'Calculate' button below them. At the bottom, there is a 'Submit' button, a 'Reset' button, and a 'Cancel' button. A checkbox labeled 'Enter another survey for this patient' is located below the 'Assessment Score' field.

MDQ Assessment Score Calculator

The screenshot shows the 'Outcome Assessment Score' form for 'MODIFIED LOW BACK DISABILITY QUESTIONNAIRE'. The 'Type' dropdown is set to 'MODIFIED LOW BACK DISABILITY QUESTIONNAIRE' and the 'Date' is '02/14/2018'. The 'Assessment Score' is 'Assessment Score' and the 'Pain Score' is 'Pain Score'. A red box highlights the 'MDQ Outcome Calculator' section on the right, which contains two input fields: 'Sum of Circled Responses (if all 10 questions filled out)' and 'Sum of Circled Responses (if one section is missing)', with a 'Calculate' button below them. At the bottom, there is a 'Submit' button, a 'Reset' button, and a 'Cancel' button. A checkbox labeled 'Enter another survey for this patient' is located below the 'Assessment Score' field.

If you would like to enter more than one type of score for a patient admission, check the 'Enter another survey for this patient' checkbox highlighted below before you hit submit and the screen will be ready for another assessment score entry.

The screenshot shows the 'Outcome Assessment Score' form for 'FEAR-AVOIDANCE BELIEFS Q.'. The 'Type' dropdown is set to 'FEAR-AVOIDANCE BELIEFS Q.' and the 'Date' is '07/25/2017'. The 'Physical Activity Score' is 'Physical Activity Score' and the 'Work Scale Score' is 'Work Scale Score'. A red box highlights the checkbox labeled 'Enter another survey for this patient' located below the 'Physical Activity Score' field. At the bottom, there is a 'Submit' button, a 'Reset' button, and a 'Cancel' button.

Generating e-Survey

In ROMS, a user can generate an e-survey which patients can take electronically using an iPad. The score for an assessment will be automatically calculated, stored in the database and visible on the Outcome scores table.

To add a new outcome score to a patient's admission electronically, ensure the correct admission is selected in the Admissions table, then click the 'Start e-Survey' button highlighted below.

Admissions ReAdmit

	Admit Date	Department	Account	Discharge Date	Therapist
<input checked="" type="radio"/>	5/04/2018	Central Salem	134	Review to Discharge	Ball, Jason
<input type="radio"/>	4/23/2018	Central Salem	1234	Review to Discharge	Ball, Jason
<input type="radio"/>	4/16/2018	Corvallis	1111	Review to Discharge	Bidgood, Kyle

Outcome Scores Add Manual Score **Start e-Survey** Comparison Report Patient Report

	Survey Date	Survey Type	Survey Score	Pain Score	K Modifier	Startback Risk	FABQ		
							Activity Score	Work Score	Total Score
	05/29/2018	KNEE	42	3	CM (80-99%)				
	05/29/2018	QDASH	36.4	2	CL (60-79%)				
	05/09/2018	MDQ	0	0	CH (0%)				
	05/04/2018	MDQ	65	5	CM (80-99%)				
	05/04/2018	MDQ	100	10	CM (100%)				

'Add Electronic Survey' window will open. Select the survey to be generated and click 'Generate QR Code' highlighted below.

Add Electronic Survey

Select the Survey for the Patient to Complete*

- FEAR-AVOIDANCE BELIEFS Q.
- KNEE OUTCOME SURVEY
- LOWER EXTREMITY FUNC SCALE
- MODIFIED LOW BACK DISABILITY QUESTIONNAIRE
- NECK DISABILITY INDEX
- QUICK DASH
- START BACK TOOL

Generate QR Code Cancel

A unique QR code is generated.

Scan QR Code on a mobile device



To open the generated survey on a tablet, use a QR code reader app on the device. (Note: You may have to install a QR reader app). Scan the QR code using the app. The QR code will expire after it has been scanned once. Once the patient successfully submits the survey, the survey results will show in the Outcome scores table.

Outcome Scores

[Add Manual Score](#) [Start e-Survey](#) [Patient Report](#)

	Survey Date	Survey Type	Survey Score	Pain Score	K Modifier	Startback Risk	FABQ		
							Activity Score	Work Score	Total Score
	02/14/2018	NECK	0	0	CH (0%)				
	02/14/2018	DASH	64	8	CM (80-99%)				
	02/09/2018	NECK	0	6	CH (0%)				

Surveys taken on the iPad have the iPad icon highlighted above. While a survey is in progress, or pending submission, the icon will be orange. Once the survey is complete, the icon will be green.

Editing/Deleting a Patient Outcomes Score

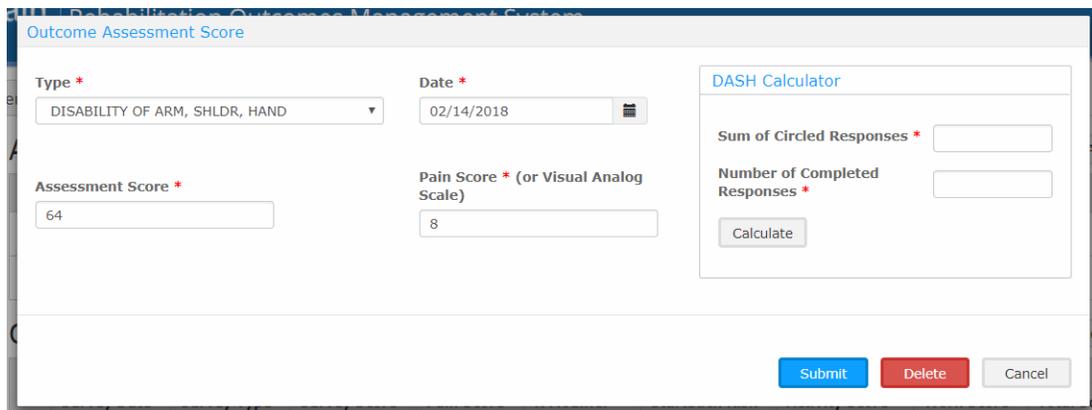
To edit or delete an existing outcome score click on the 'Survey Date' link highlighted below.

Outcome Scores

[Add Manual Score](#) [Start e-Survey](#) [Patient Report](#)

	Survey Date	Survey Type	Survey Score	Pain Score	K Modifier	Startback Risk	FABQ		
							Activity Score	Work Score	Total Score
	02/14/2018	NECK	0	0	CH (0%)				
	02/14/2018	DASH	64	8	CM (80-99%)				
	02/09/2018	NECK	0	6	CH (0%)				

The 'Outcome Assessment Score' window will open for manually entered scores. The user can alter the desired fields on this screen and click 'Submit' to save the changes. Clicking 'Delete' will remove the outcome completely.



The Patient responses window will open for e-Surveys. From this screen, the user can choose to 'Edit' patient responses, 'Delete' the e-Survey or 'Cancel' out of the screen. The can also choose to 'Print' the patient responses using the button in the upper right corner of the window.

To Edit a patient’s responses, click the ‘Edit’ button, make the necessary selection changes, and click ‘Save’.

Clicking ‘Delete’ will remove the outcome, and all responses, completely.

Entering a Treatment Classification

To enter a new classification, click on the ‘+ New’ button highlighted below.

Classifications		+ New
Classification		Primary
Cervical - Conservative - TreatmentClassification - ChronicNeckPain(>4weeks)withROMrestrictions - - - -		no
Elbow - Conservative - Bone - Reumatoid Arthritis - - - -		yes

The ‘Add/Edit Classification’ window opens up.

In this window, the user first selects a treatment category from a drop down. Once a treatment category is selected, the list of classifications pertaining to the chosen treatment category is available.

If a surgical treatment category is selected, then 'Surgery Date' will be requested. If a non-surgical category is selected, the application will ask for 'Date of Injury/Onset'.

Select # of previous episodes/surgeries from the drop-down.

Designate the chosen classification as 'Primary' with options of 'Yes' or 'No'.

Note: Only one primary classification will be allowed per admission. The application defaults to 'Yes' as the primary classification choice.

Completing Chronic Pain Assessment

There are two questions associated with this assessment which are asked with every classification designation. You may not see the second question, depending on the answers to the first.

For example: If the answer to 'Duration of pain symptoms' is 'less than 1 month' or '1-3 months' then the second question will not be visible and the pain label on the bottom will be 'Pain: ACUTE'.

Chronic Pain Assessment

Duration of pain symptoms *

Less than 1 month
 1-3 months
 More than 3 months

Pain: ACUTE

If the answer to 'Duration of pain symptoms' is 'More than 3 months' then the second question will appear. Based on the answer to the second question the pain label may be 'Pain: ACUTE' or 'Pain: CHRONIC'. This information is saved in the database for future queries, but is not visible on the patient review page.

Chronic Pain Assessment

Duration of pain symptoms *

Less than 1 month
 1-3 months
 More than 3 months

How often has the pain interfered with regular daily activities during the past 6 months?

Less than half the days
 Half the days or more than half the days

Pain: CHRONIC

Editing/Deleting a Treatment Classification

From the patient summary screen click on the 'Classification' link highlighted below on the classification you wish to delete or edit.

Classifications + New

Classification	Primary
Cervical - Conservative - TreatmentClassification - ChronicNeckPain(>4weeks)withROMrestrictions - - - -	no
Elbow - Conservative - Bone - Rheumatoid Arthritis - - - -	yes

The 'Add/Edit Classification' window will open up.

Values that are not editable: 'Treatment Category' and 'Classification'

All the other values will be editable. The user can change values and click 'Submit' to save the changes. To remove the classification, click 'Delete'. To go back to the patient summary screen without making any changes, click 'Cancel'.

Note: Deleting a classification will only delete the classification in the database. All other information associated with the encounter will remain.

Discharging a Patient

To discharge a patient, ensure the active admission is selected on the patient summary screen. Then click on the 'Review to Discharge' link highlighted below.

Admissions ReAdmit

	Admit Date	Department	Account	Discharge Date	Therapist
<input checked="" type="radio"/>	5/04/2018	Central Salem	134	Review to Discharge	Ball, Jason
<input type="radio"/>	4/23/2018	Central Salem	1234	Review to Discharge	Ball, Jason

A 'Discharge Patient' window will appear.

Discharge Patient

For: test, suresh
DOB: 01/01/2001
Admit Date: 5/04/2018

Discharge Date *

Total Number Of Visits *

Total Charges *

Review the patient information. Fill out the 'Discharge Date' which defaults to today's date, the 'Total Number of Visits' and the 'Total Charges'.

To save the information, click 'Submit'. The patient will now have a discharge date populated in the therapy admissions table.

To Edit the discharge Date and/or other details:

Click on the 'Discharge Date' link highlighted below.

Admissions ReAdmit

	Admit Date	Department	Account	Discharge Date	Therapist
<input checked="" type="radio"/>	5/04/2018	Central Salem	134	6/19/2018	Ball, Jason
<input type="radio"/>	4/23/2018	Central Salem	1234	Review to Discharge	Ball, Jason

The Discharge Patient window pops up. All of the fields are editable. Note: The Discharge date must be on or after the Admit date.

Click 'Save' to record the changes, 'Reset' to clear the fields, or 'Cancel' to return to the patient summary screen.

Patient Reports

Patient Report

The Patient Report displays the outcome scores and pain scores as a line graph over time for each manual entry and e-Survey submitted.

Comparison Report

The Comparison Report compares the most recent e-Survey responses and individual response values with the previously taken e-Survey responses and individual response values.

A green checkmark indicates improvement, an orange horizontal line indicates no change, and a red x indicates worse than before.

To access these reports, click on the Patient Report or Comparison Report button above the Outcomes table.

The screenshot shows the 'Admissions' section with a table of patient records and a 'ReAdmit' button. Below it is the 'Outcome Scores' section with buttons for 'Add Manual Score', 'Start e-Survey', 'Comparison Report', and 'Patient Report'. The 'Comparison Report' and 'Patient Report' buttons are highlighted with a red box. Below the buttons is a table of survey data.

Admissions							ReAdmit
	Admit Date	Department	Account	Discharge Date	Therapist		
<input checked="" type="radio"/>	5/04/2018	Central Salem	134	Review to Discharge	Ball, Jason		
<input type="radio"/>	4/23/2018	Central Salem	1234	Review to Discharge	Ball, Jason		
<input type="radio"/>	4/16/2018	Corvallis	1111	Review to Discharge	Bidgood, Kyle		

Outcome Scores							FABQ		
	Survey Date	Survey Type	Survey Score	Pain Score	K Modifier	Startback Risk	Activity Score	Work Score	Total Score
<input checked="" type="checkbox"/>	05/29/2018	KNEE	42	3	CM (80-99%)				
<input checked="" type="checkbox"/>	05/29/2018	QDASH	36.4	2	CL (60-79%)				
<input checked="" type="checkbox"/>	05/09/2018	MDQ	0	0	CH (0%)				
<input checked="" type="checkbox"/>	05/04/2018	MDQ	65	5	CM (80-99%)				
<input checked="" type="checkbox"/>	05/04/2018	MDQ	100	10	CM (100%)				

To access additional reports of a patient, click on the 'Reports' which is available in the header 'Options' dropdown.



The reports page opens in a new window of the browser. Currently this link will take you to the reports page from ROMS V1 with no changes in functionality.

Administration Functions

To access the administrative functions, click on the 'Admin' which is available in the header 'Options' dropdown.

The admin page opens in a new window of the browser. Currently this tab will take you to the admin page from ROMS V1 with no changes in functionality.

Note: New reporting and admin functionality is being developed and will be available in the future.

Additional Information

The user guide is available in the header by clicking '(?)Help'

For any other questions/comments about the application, or to report an issue, please use the following guidelines:

1. General users should first direct questions to designated 'power users' to vet the question or issue and make sure that it is valid and not just a training need.
2. Once the issue is determined to be valid, please use the below guidelines:
 - For all ROMS related general questions and communications, please send an email to info@intermountainroms.com
 - For production issues and enhancement requests, please send an email to support@intermountainroms.com

For the production support emails, please use the following template so that we can directly create an incident/request and expedite the requests:

- Subject: 'Level of Criticality' – 'Customer Name' – 'Short description of the issue'
 - Example: Major – PTNW – User cannot login to ROMS
 - Use the following criticality guidelines:
 - Critical – work stopped; needs to be addressed asap. (i.e. ROMS down, cannot access the application.)
 - Major – work delayed with no workaround identified
 - Minor – work affected but a workaround is available; not urgent
 - Request – use this for things that would be nice to have that we can incorporate into the application at a future date.
- Body of the email: please be as specific as possible with the details of the issue or request. Include specific usernames, steps to reproduce, etc. as needed.
- **NOTE** - please only send one issue or request per support email, as it generates a ticket into our incident management system automatically.

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