Mobile Worker Manual

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Before you begin

Program staff will load CommCare onto phones before field activities begin; look for the CommCare icon to get started.

You should be provided a username and password, which you must remember in order to access the TT Tracker. Usernames and passwords may be specific to an individual or to each phone - program staff will let you know either way.

TT Tracker Basics

Main Menu

Once logged in, you will see the main screen with the options to *Start*, *Sync with Server*, and *Log Out of CommCare*. There is also an option to Update TT Tracker App, which is found in a supplemental menu.

1. **Start**: Select this to access the forms needed for field work. This is the main component of the TT Tracker.

2. **Sync with Server**: To upload new records you have recorded and download records recorded by other surgeons and recorders you must sync the app with the system server. This must be done regularly; users are advised to sync the TT Tracker at the beginning and at the end of each outreach day at a minimum. Not syncing means that patient information will not be up-to-date, which can impact outreach activities.

3. **Log out of Commcare**: To secure data security, you can sign out of the TT Tracker App but remember you must sign back in when there is still network - before going to the field - or you won’t be able to access the app.

**Tips and Tricks:**

The Sync with Server box will show how many records are waiting to be synced

- After attempting to sync, the box will give a confirmation message that the sync was successful or show an error message if it was not
- Once successful the box will show the time of the most recent sync
4. **Update App**: Updating is required when a change has been made (i.e. changing survey questions, etc.); this will not occur regularly and you will be advised by supervisors that a change has been made and that the TT Tracker must be updated. However, you can always check for updates to the TT Tracker to ensure nothing has been missed.

- Depending on the format of the phone the Update App menu can be accessed using the button at the top right of the main screen or using the bottom left button of the screen.
- If a new version is available, you can download it. Once completed, you can sign back into the app and re-download patient files.

What is syncing?

- Once a mobile user is assigned designated areas, all of the information in those areas will be visible and stored on the phone.
- When a phone is synced, it sends any new information recorded on the phone since the last sync and receives any new information recorded on other phones since the last sync.
- If a phone is unable to sync, the information is only accessible on the phone where the information was entered. If the Registration/Evaluation information is entered on Phone 3, the surgery information MUST be entered on Phone 3.
Tips and Tricks:
A code should be recorded on the paper version of the diagnostic record along with the patient ID. The code should include CC (for CommCare) the initials of the user entering the information and the phone on which the information was entered. All phones must be given a number so the next outreach worker entering surgery information will know which phone the patient information needs to be entered.

Moving Between Screens
Use the blue arrows at the top of the screen to move forward or backward in the forms. If you move backwards far enough to reach the beginning of the form you will see a Red X. If selected, the TT Tracker will ask if you want to exit without saving, or if you’d rather stay in the form. If you’ve accessed a form by mistake, you can simply exit the form without saving. If you move forward and reach the end of the form, the TT Tracker will confirm that you wish to submit the form.

You must hit COMPLETE in order for the form to be saved.

Required Questions
In order to limit the amount of answers missed in a survey a number of key questions have been listed as required – you won’t be able to move ahead without answering them.

Forms and Records Access
The TT Tracker is made up of forms based on the templates supported by the ICTC. Each form serves a purpose at a different timepoint within an outreach activity. The primary forms include Patient Registration & Evaluation, Surgery, and Follow-ups at 24-hour, 7-14 day, and 3-6 month timepoints. Questions on the forms will ask all relevant questions for the specific activity, first for the right eye, followed by the left. An additional set of forms under Surgery Session are included for starting and ending a surgery session; these forms are used less frequently, though completing a Session form is required in order to record any new patient. Forms are accessed through a main menu—we’ll go through the structure now in the order they appear.
Accessing and Completing Forms

This section is organized based on the order in which the forms may be used for an outreach.

Session Management

Though the Surgery Session menu is not used as frequently as the others, it is essential for program activities as there must be an open session to which new patients can be added. Before an outreach activity begins, the Open Session form should be completed by ONE person working in the coverage area; all phones must then be synced so that the session information is available for all workers. At the conclusion of an outreach activity (e.g. the surgical camp or the month-long static site outreach has ended), one individual must close the session by completing the Close Session form.

Accessing Session Forms

To access the forms to open a session:

- Select Session Management
- Select the relevant form to complete
  1. Open Session
  2. Update Session
  3. Close Session

Open Session

Will be used to open a session prior to starting an outreach activity. One designated individual will create the session and share the name of that new session will all workers so that everyone knows where to register new patients for the outreach activity.

**Open Session Questions**

1. Enter the name of the village where Site/Session is located
2. Enter the name of the Site/Session
3. Are you currently located at the site?

If yes: GPS coordinates can be captured. However, if the TT Tracker is unable to locate acceptable GPS coordinates, you can skip the question by selecting cancel and/or using the blue arrow to the right.

If no: GPS coordinates capture is skipped.
4. Start date of outreach

**Remember**

*If session is started in advance, date should be the actual start date of the activities, not the date when the Session Start form was completed.*

5. Site type
6. District

**Tips and Tricks**

Each Session is given a unique Session ID which will appear on all users’ phones. The Session ID will appear alongside the Session name given at the beginning of the form. Mobile workers should record the Session Name and ID to ensure all patients are registered to the correct outreach session.

**Update Session**

If changes must be made to the name, location, or start date of a Session, it can be corrected using Update Session. The Update Session form is identical to the Open Session—all information (except the Session ID) can be changed here. Information entered at Open Session will appear pre-filled on the Update Session form; only update the information that must be changed.

Due to network limitations, sessions will be created prior to traveling to the field. Update Session can be used to capture GPS coordinates, if possible, if coordinates were not already captured.

**Close Session**

Will be used to close a session at the end of an outreach activity. One designated person will close the session. Once closed, the session will be removed from the Sessions list and no additional patients can be registered to it.

**Close Session Questions**

1. Do you want to remove this session due to duplication?
2. Are you currently located at the Session?
3. End date of outreach
4. Number of women presented (total women screened, with and without TT)*
5. Number of men presented (total men screened, with and without TT)*

*Taken from general register at surgical site
Remember
If session ended after the end date has passed, date should be adjusted to the actual end date of the activities, not the date when the Session Close form was completed.

Patient Registration
If a patient is suspected of having trichiasis in one or both eyes, he/she will be registered. The Patient Registration form includes demographic information. Patients will be given an ID which can be used for future visits to link treatment records.

Accessing Patient Registration Form

Scroll through the list of the open Sessions or use the search bar to search for the session by Session Name or Session ID. Patients MUST have a Session selected to be registered. If the correct Session where a Patient should be registered cannot be found (due to syncing errors, etc.), register the patient to the Temporary Session.

What is a Temporary Session?
When a patient is registered, he/she must be assigned to a Session, or the current outreach site. If the correct Session cannot be found in the list of open Sessions, the patient should be assigned to the Temporary Session. The Temporary Session is an open Session where unmatched records can be registered. The patient registration and following screening and surgical forms can then be added to the patient record. The patient record will be saved in the Temporary Session until the Data Manager/Administrator reassign the patient to the correct Session.

Tips and Tricks
When completing the Patient Registration, make sure to record the Session ID to where the patient should be REASSIGNED if known. This will inform the Data Manager to where the patient should be moved in the application.
Once the session has been selected and confirmed, complete the Registration questions

1. Does patient already have a Patient ID?
   a. If NO, complete the full registration information. Most patients will not have an existing Patient ID
   b. If YES patient has ID, enter Patient ID
   c. Patient ID must be in ALL CAPITAL LETTERS, with no spaces or dashes
   d. TT Tracker will search records on the phone for the Patient ID entered

   If the patient is found on the phone, the existing demographic information can be copied into a new registration to save time. You will still have to add new evaluation information for the current visit. See next page for more information about registering patients with existing patient IDs

2. Enter Patient Name
3. Patient Age
4. Sex
5. Patient Region
6. Patient District
7. Patient Village
8. Who owns the phone with which we can contact the patient?
9. Phone Number
10. Patient ID provided
11. Additional notes/comments

Some questions will have follow-up questions that appear, depending on the response. E.g. if a contact phone is available, select who it belongs to and then record the phone number. If no phone is available, Phone Number will not be asked.

Tips and Tricks
The Patient ID should be recorded on all paper forms being used (i.e. patient diagnosis sheet, patient follow-up reminder card, etc.)

If you are ready to complete the evaluation, you can continue filling out the Evaluation form immediately after the Registration form without having to go back to the Main Menu. If you are NOT ready to enter the evaluation information, finish and close the Registration form; you can complete the Evaluation form later.
**Need to Know: Registration Special Cases**

**Registering patients with existing patient IDs**

In some of the examples below, patients will have existing Patient IDs. First, it is important to remember that if a patient returns for a new examination and treatment, *a new registration will need to be completed!* In short, a Patient Registration is a registration for a treatment event for the patient.

**Existing Patient ID Scenarios**

- Patient requires surgery on the other eye, not previously operated
- Patient developed TT again in a previously operated eye
- Patient previously refused and now accepts surgery

If the existing Patient ID is available, it can be entered into the application. IDs must be entered in CAPITAL letters with numbers and no spaces or dashes.

The TT Tracker will search for records stored on the phone with that patient ID. If the patient ID is found, the registration information can be populated into the new registration form.

Once the new registration is completed, both records for the patient will appear separately, though in a row, on the TT Tracker. Make sure to select the correct record when completing additional forms for the patient.

If the information located is incorrect, or the information is not found, all information must be re-recorded (name, age, residence, etc.) and a new Patient ID will be assigned to the record.

**Reasons why Patient Record Cannot be Found**

- Patient returns after 7 months
- Patient ID not entered in all capital letters and/or dashes are used
- Phones are not properly synced

**Tips and Tricks**

If the patient ID entered is not found, include the ID in the notes section of the Registration Form. The Data Manager can try and match the two patient records and apply the existing ID.
**Need to Know: Registration Special Cases**

**Why Two Registrations for One Patient?**

It is possible that a patient will attend a surgical camp for treatment and return at a later date because he/she developed TT in the other eye, or finally accepted surgery in the second eye after first refusing. If a patient returns (for more than follow-up visits) the new treatment activities must be recorded.

If a patient returns for a new treatment and the surgeon updates the information in the existing patient record without registering the patient again, the information from the first visit will be ERASED. The new treatment record would replace the record of the first treatment visit. To save both treatment visits (surgery one and surgery two), two registrations need to be completed. If the same patient ID is used for both treatment visits, programs can see both patient records together in a list, which will allow all information for both treatments to be saved separately.

**Registering Patient to Temporary Session**

When a patient is registered, he/she must be assigned to a Session, or the current outreach site. If the correct Session cannot be found in the list of open Sessions, the patient should be assigned to the Temporary Session.

The Temporary Session is an open Session where unmatched records can be registered. The patient registration and following screening and surgical forms can then be added to the patient record. The patient record will be saved in the Temporary Session until the Administrator reassigns the patient to the correct Session.

If a patient is registered to Temporary Session, enter the correct Session where the patient should be reassigned when asked.
Patient Management

The Patient Management folder houses all other relevant forms for patients:

- Patient Summaries (to review what information has already been entered)
- Surgical outreach forms (evaluation and surgery)
- Follow-up forms (24-hour, 7-14 day, 3-6 month)
- Close out patient form

Patient Summaries

The main use of these summaries is to view all of the information that has already been entered for a patient before adding to/updating their record. You can also use these Patient Summaries to confirm that information for the patient has been entered correctly. Finally, if a patient is returning for another treatment within six months of their first treatment but their Patient ID is unknown, you can search here to retrieve the Patient ID for the new registration.

After selecting Patient Management, scroll through the list of patients or use the search bar to search the patient name or ID. There may be duplicate names, so make sure to look at the Session ID to confirm the correct treatment session has been selected.

Information related to the recommended treatment and days since surgery appear on the main patient list so you can easily choose the right patient record.

- **R/L:** Use the information provided in this column to know what action is recommended for each eye. If a letter appears in the space for right or left, eye, a recommendation was made for that given eye. If no letter appears, that eye did not require any intervention
  - S: Surgery
  - E: Epilation
  - R: Referral
  - X: Refusal

- **DSS:** This column provides users with the *Days Since Surgery* for each patient so that the user can see how many days it has been since that treatment took place.
  - If a "0" appears, that signifies that the eye received surgery today.
  - If no number appears under DSS, this means that no surgery form was completed for the patient. This may be due to the form not yet being completed, the form was missed, or surgery was not recommended for or accepted by the patient.
Select the patient that needs to be evaluated. The patient treatment record will automatically appear when you select the patient to be reviewed.

To view the different forms that have been entered, select the correct tab at the top of the screen, or swipe across the screen to view the next form. If a form has not yet been completed for a patient, the information for that form will be blank.

Images above are various tabs of a patient’s treatment record: Tab 1: Registration; Tab 2: Evaluation; Tab 3: Surgery; and Tab 4 (blank) is the yet to be completed 7-14 day follow-up form.

Once you’ve confirmed the correct patient treatment record has been selected and have reviewed the necessary information in preparation for the current activity, select the form that must be completed for the patient.

**Tips and Tricks**

For every new evaluation a patient receives in order to receive treatment, a new Patient Registration form must be completed. If a patient has visited camps for treatment on two separate occasions, the patient may have two registrations available on the phone. Ensure that you’ve selected the correction record.
Record Evaluation

The Evaluation Form includes all required information needed to determine whether a patient has trichiasis and requires surgery or other treatment.

It can be found in two locations: as a continuation of the Registration Form (see Registration Form) or as a separate Form on the Forms List. So, if the Evaluation Form is completed as a continuation of the Registration, you can skip the form access instructions immediately below.

Accessing Record Evaluation Form

Step 1: Select Patient Management and scroll or search for a patient record
Step 2: Review the registration information entered for the patient to confirm the correct record has been selected.
Step 3: Select Record Evaluation

Remember
If a patient’s evaluation information has already been entered on a form, submitting the form again would REPLACE the existing form. Make sure you are entering the correct Form for the correct Patient for the correct.

Complete the Evaluation questions
1. Is the [right/left] eye suspected of TT?
2. How many [right/left] upper lid eyelashes touch the eyeball?
3. Is there evidence of epilation of inturned [right/left] upper lid eyelashes?
4. Has this patient had lid surgery before on the [right/left] eye?
5. Is there a scar consistent with a previous operation for upper [right/left] lid trichiasis?
6. When you evert the eyelid, is there obvious scarring of the [right/left] upper tarsal conjunctiva?
7. Is there trichiasis of the [right/left] lower eyelid?
8. For the [right/left] eye, what actions are required?

Questions will be asked of each eye individually—if an eye is not suspected of TT, the follow-up questions will not be asked.
Depending on the actions required, additional follow-up questions specific will be asked. Follow-up questions may be for each eye or may be asked after both eyes.

**Surgery (Patient Accepted)**
- Does patient consent to surgery?
- Will surgery happen today?

**Surgery (Patient Refused)**
- Why did patient refuse surgery?

**Epilation**
- Did you train the patient to epilate; train a family member to epilate the patient; give the patient or family member epilating forceps?

**Referral**
- Reason for referral (Lower TT, <15 years old, recurrent TT, other)
- Where was patient referred?

**No Management**
- Why was no management required?
Record Surgery

When a patient has been recommended for surgery, the user will record the surgery details in the Record Surgery Form. This is done once per registration. If a patient returns for another surgery at a later date, a new registration and subsequent evaluation and surgery form must be completed.

Accessing Record Surgery Form

Step 1: Select Patient Management and scroll or search for a patient record

Step 2: Review the registration and evaluation information entered for the patient to confirm the correct record has been selected.

Step 3: Select Record Surgery

Remember
If a patient’s evaluation information has already been entered on a form, submitting the form again would REPLACE the existing form. Make sure you are entering the correct Form for the correct Patient for the correct.

Complete the Surgery Questions

1. Did the activity you are recording occur today?
2. Surgeon performing the operation
   » Select from a list of surgeons
     • If surgeon is not listed, select Unknown/Not listed.
     • If name is known, type the name of the surgeon conducting surgery.
     • If surgeon is unknown, skip to the next question using the blue arrow to the right, leaving the question blank.
3. Was an operation performed on the [right/left] upper eyelid?

If the eye did receive surgery, additional surgery-related questions will be asked. Some questions are eye-specific while others are asked for ANY of the operated eyes. Eye-specific questions appear immediately after while overall questions are asked after answered for right/left eye are answered.
Tips and Tricks

The TT Tracker provides helpful messages to help ensure that you are recording the correct procedure for the correct eye. When recording surgery, if surgery was NOT recommended or was refused, a message will appear: [Right/Left] was not recommended/accepted for surgery. Make sure to always carefully read the questions and the messages on the screen before completing the question(s).

4. What type of surgery was performed on the [right/left]
5. Was the [right/left] eyelid margin fragment detached at one or both ends?
6. Was there excessive bleeding in the [right/left] eye?
7. Was there any other complication on the [right/left] eye?
8. For eyes with lower TT, was lower TT operated on site?
   Only asked if one or both eyes had lower TT at evaluation

9. What suture material was used for eyes operated on?
10. Was tetracycline eye ointment given?
11. Was oral azithromycin given?
12. Additional notes/comments

Questions apply for either or both eyes that are operated--only asked once at the conclusion of surgery form.
Record Patient Follow-ups

Different follow-up forms are utilized for each of the three follow-up time points required for TT surgery: 24-hour, 7-14 day, 3-6 month. Though all follow-up forms include different survey questions, each is accessed in a similar manner and each form begins with the same questions to determine time and place of follow-up.

There are two ways that the follow-up forms can be accessed:

1. Patient Management
2. Due for Follow-up Lists (See due for follow-up list)

If accessing follow-up forms through the Patient Management menu, all three follow-up forms are accessed in the same way:

Step 1: Select Patient Management and scroll or search for a patient record
Step 2: Review the registration and evaluation information entered for the patient to confirm the correct record has been selected.
Step 3: Select [24 hour, 7-14 day, or 3-6 month] Follow up
Complete 24-hour follow-up questions

1. Date of 24 hour follow-up
2. Enter the name of the location where the follow-up is taking place
3. Record the location (GPS).
   » If you are not at the follow-up location, skip to next question.
   » If follow-up is taking too long to capture or is not within acceptable distance, skip to next question.
4. Who is conducting the follow-up?
   » Select from a list of surgeons
   » If surgeon is not listed, select Not listed.
      • Type the name of the surgeon conducting follow-up.
      • If surgeon is unknown, select Unknown.
5. Right/left] eye visual acuity
   » If unable to take visual acuity, select blue arrow to the right to skip.
6. Looking at the eye, was there surgery performed on the [right/left] eye 1-3 days ago?

If Yes, eye was operated:

The below questions are only asked if the eye was operated 1-3 days ago.

7. How many [right/left] upper lid eyelashes touch the eyeball?
8. Is there any sign of bleeding in the [right/left] eye?
9. Are there any signs of infection in the [right/left] eye?
10. Is there a lid contour abnormality in the [right/left] eye?
11. Is there under-correction in the [right/left] eye?
12. Is there excessive over-correction in the [right/left] eye?
13. Is there the desired slight over-correction in the [right/left] eye?

If surgery is conducted correctly, desired slight overcorrection should be YES

14. What actions are required for the [right/left] eye?

If No, eye was not operated, surgery follow-up questions are skipped.

If eye was recommended for epilation, additional question is asked:

7. How many [right/left] upper lid eyelashes touch the eyelid?
   » If 1+, describe location of lashes

Tips and Tricks

If at least one eye was not recommended for surgery, a reminder message will appear at the end of the form to help users:

NOTE: If a patient’s eye was not previously operated but now requires surgery, please counsel the patient and complete a new registration and surgery record.
**Complete 7-14 day follow-up questions**

1. Date of 7-14 day follow-up
2. Enter the name of the location where the follow-up is taking place
3. Record the location (GPS).
   - If you are not at the follow-up location, skip to next question.
   - If follow-up is taking too long to capture or is not within acceptable distance, skip to next question.
4. Who is conducting the follow-up?
   - Select from a list of surgeons
   - If surgeon is not listed, select Not listed.
     - Type the name of the surgeon conducting follow-up.
     - If surgeon is unknown, select Unknown.
   - If unable to take visual acuity, select blue arrow to the right to skip.
6. Looking at the eye, was there surgery performed on the [right/left] eye 7-14 days ago?

**If Yes, eye was operated:**
The below questions are only asked if the eye was operated 7-14 days ago.

7. How many [right/left] upper lid eyelashes touch the eyeball?
8. Is there contour abnormality of the [right/left] upper eyelid?
9. Is there over-correction of the [right/left] upper eyelid?
10. Is there trichiasis of the [right/left] lower eyelid?
11. For the [right/left] eye, what actions are required based on the evaluation?
12. Have you recommended further follow-up before the normal 3-6 month follow-up?

    Select all actions that apply, based on assessment

**Patients should return for a 3-6 month follow-up. If you recommend an ADDITIONAL follow-up BEFORE the standard 3-6 month follow-up due to a complication/issue, select YES. If assessment is okay, select NO.**

**If No, eye was not operated, surgery follow-up questions are skipped.**

**If eye was recommended for epilation, additional question is asked:**

7. How many [right/left] upper lid eyelashes touch the eyelid?
   - If 1+, describe location of lashes

**Tips and Tricks**
If at least one eye was not recommended for surgery, a reminder message will appear at the end of the form to help users:

**NOTE:** If a patient’s eye was not previously operated but now requires surgery, please counsel the patient and complete a new registration and surgery record.
Complete 3-6 month follow-up questions

1. Date of 3-6 month follow-up
2. Enter the name of the location where the follow-up is taking place
3. Record the location (GPS).
   » If you are not at the follow-up location, skip to next question.
   » If follow-up is taking too long to capture or is not within acceptable distance, skip to next question.
4. Who is conducting the follow-up?
   » Select from a list of surgeons
   » If surgeon is not listed, select Not listed.
      • Type the name of the surgeon conducting follow-up.
      • If surgeon is unknown, select Unknown.
   » If unable to take visual acuity, select blue arrow to the right to skip.
6. Looking at the eye, was there surgery performed on the [right/left] eye 3-6 months ago?

If Yes, eye was operated:
The below questions are only asked if the eye was operated 3-6 months ago.
7. How many [right/left] upper lid eyelashes touch the eyeball?
8. Is there a granuloma (or several granulomata) on the [right/left] upper eyelid?
   » If granuloma is present, Was granuloma removed?
9. Is there contour abnormality of the [right/left] upper eyelid?
10. Is there over-correction of the [right/left] upper eyelid?
11. Is there trichiasis of the [right/left] lower eyelid?
12. Are there actions required for the [right/left] eye based on the evaluation?
   » If yes, What actions are required based on the evaluation?

If No, eye was not operated, surgery follow-up questions are skipped.

If eye was recommended for epilation, additional question is asked:
7. How many [right/left] upper lid eyelashes touch the eyelid?
   » If 1+, describe location of lashes

Tips and Tricks
If at least one eye was not recommended for surgery, a reminder message will appear at the end of the form to help users:

NOTE: If a patient’s eye was not previously operated but now requires surgery, please counsel the patient and complete a new registration and surgery record.
Due for Follow-up Lists

Due for Follow-up lists will show you who is designated for follow-up visits in your coverage area. The lists are automatically calculated based on the date of surgery.

Once the follow-up form is completed, the patient will automatically be removed from the due for follow-up list. Remember, patients will only appear on the list if they are within the time window for that follow-up:

- 24-hour: 1-3 days
- 7-14 day: 6-21 days
- 3-6 month: 3-7 months

Tips and Tricks

If a patient does not appear on the list but requires follow-up, you should access the follow-up form via the Patient Management menu and record the follow-up there; the follow-up form can still be completed even if the patient does not appear on the due for follow-up list.
Close out Patient

There are situations instances when a patient record may need to be closed so that they no longer appear on the phone. If agreed upon by a program, a mobile worker can close out a patient record so that it will no longer appear on the phone, due to:

» Duplicate patient: If a patient has been entered twice in error. Be careful when completing the closeout form and review all necessary information before removing the duplicate record!
» Patient deceased: If you learn during follow-up that a patient is deceased, record that the patient has passed and he/she will no longer appear on any follow-up lists.
» Permanent refusal: If a patient refused treatment and continues to refuse treatment and subsequent follow-ups, you can remove them from the patient list.
» Referral treatment confirmed: If a patient was referred to another health facility for treatment you can document that they have received the necessary treatment so that they will no longer appear on the patient list.
» Refusal patient accepted surgery: If patient refused surgery but has now accepted, the refusal record can be closed so that the surgery record is the only record to be saved on the phone.
» Permanent move out of country: If a patient moves out of the country permanently and can no longer be followed-up, you can record the move so that the patient does not appear on future follow-up lists.

Remember
- The patient information will still be saved in the TT Tracker online (unless closed for duplication).
- Patient closeout should ONLY be used if approved by a program
- This form should NOT be used if a patient simply cannot be found when follow-up is attempted.

Accessing the Closeout form:

1. Do you want to remove/close the patient on the TT Tracker?
   » If no, exit the form or select continue and the form will close and no changes made.
   » If yes, then the survey continues
2. Why should the patient be removed/closed?
3. Provide the name of the person completing the closeout form.
Editing Existing Forms

If a form has been submitted and contains incorrect information, users will be able to edit information on all of the following forms: Registration, Evaluation, Surgery, 24-hour follow-up, 7-14 day follow-up, 3-6 month follow-up. The process for accessing the form to be edited is the identical to accessing the form for the first time. You must select the form that contains the error so that it can be updated.

Step 1: Select Patient Management and scroll or search for a patient record

Step 2: Review the registration and evaluation information entered for the patient to confirm the correct record has been selected.

Step 3: Select the form containing errors that must be updated.

The information already submitted will appear pre-filled on the form. Change ONLY the information that must be changed; the remaining information will remain filled with the information that is correct and should not be changed.

Once the errors have been changed, continue to the end of the form and select to save changes.

Remember

* This should be used to correct errors as they occur so that upon leaving the outreach activity, the information is accurate.
* The TT Tracker will record who made the changes so that, in the event that there is an issue, it can be tracked back to the Mobile Worker entering the information.
Web Data Entry
You can add and/or update patient records on a computer when signed into CommCare online.

If you're entering records from paper, it's actually faster to use the Web App than the phone since all of the questions appear on one screen rather than individual questions on multiple phone screens. The data entry follows the same progression as the phone data entry, starting with patient registration and evaluation for each patient, followed by surgery record, then the relevant 24-hour, 7-14 day, or 3-6-month follow-up.

The web-based version utilizes the same data access controls as the mobile phone, limiting access to individuals with a username and password and following the same coverage area designations for patient records.

Login information for the Web App is included below.

1. Log in to CommCareHQ (www.commcarehq.org/a/tt-tracker-country/login/) using your given username and password.

2. Select the TT Tracker icon

3. Select the form to be completed. The process to access the forms is the same as on the TT Tracker app.
Web Entry vs Phone Entry

Web entry and phone entry contain the same information and follow-up/skip logic; all questions asked on the phone are also asked on the Web, in the same order. The only difference is that all information on the Web entry can be visible on one page; on the phone the questions are separated on different phone screens you must click through.

Phone Entry Format

Web Entry Format

When using the Web entry, conditional follow-up questions will appear on the screen, depending on the response given. Make sure you are aware of the follow-up questions that may appear so they can be answered before submitting the form.