CataTrack User Manual

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In the event that this step is necessary, before the activity begins...

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 CataTrack. Usernames and passwords may be specific to an individual or to each phone - program staff will let you know either way.

CataTrack 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 CataTrack 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 CataTrack.

2. **Sync with Server:** To upload new records and download patient files 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 CataTrack at the beginning and at the end of each day at a minimum. Not syncing means that patient information will not be up-to-date, which can impact future activities.

3. **Log out of Commcare:** For purposes of data security, you can sign out of the CataTrack App. You can connect without an Internet connection to access the application.

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

**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.
administrators that a change has been made and that CataTrack must be updated. However, you can always check for updates 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 health facilities, all of the information in those health facilities 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. For instance, if the Registration/Preoperative information is entered on Phone 3 and the phones are not synced, the Intraoperative information MUST also 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 CT (for CataTrack), 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 worker entering surgery information will know which phone the patient information needs to be entered onto.
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, CataTrack 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, CataTrack will confirm that you wish to submit the form.

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

Required Questions

In order to limit the amount of answers missed in a form, 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

CataTrack is made up of forms based on the templates provided by the Department of Paediatric Ophthalmology and Strabismus of Kaduna National Eye Centre and the Ophthalmology Department of Sokoto Usmanu Danfodiyo University Teaching Hospital. Each form serves a purpose at a different timepoint within a cataract surgery. The primary forms include Patient Registration & Preoperative Information (Evaluation/Diagnosis/Screening), Intraoperative Information, and Follow-ups at 24-hour, 1 week, 6 week, 3 month and 6 month timepoints. Questions on the forms will ask all relevant information for the specific activity, first for the right eye, followed by the left eye. An additional set of forms under Facility Management are included for creating and closing reporting periods at the facility where the surgeries will take place.
Accessing and Completing Forms

This section is organized based on the order in which the forms may be used for a cataract surgery.

Facility Management

This choice on the menu is only displayed for users with higher-level privileges assigned to them. Since cataract surgery is held in a known health facilities, this option will not need to be used often and will not be displayed by default.

Though the Facility Management menu is not used as frequently as the others, it is essential for program activities as there must be an existing facility to which new patients can be added. Before the activity begins, the Create Facility form should be completed by ONE person (working in a new facility not yet created or the Administrator); all phones must then be synced so that the facility information is available for all workers.

Accessing Facility Forms

To access the forms to create a facility:

- Select Facility Management
- Select the relevant form to complete
  1. Create Facility
  2. Update Facility
  3. Close Facility

Create Facility

Will be used to create a facility prior to starting cataract surgeries. One designated individual will create the facility ONCE and share the name of that [new] facility to all workers so that everyone knows where to register new patients for the surgeries.

Create Facility Questions

1. Enter the address where the health facility is located.
2. Enter the name of the Facility.
3. Capture the GPS coordinates of the facility.

If you are currently located at the facility: GPS coordinates can be captured. However, if CataTrack 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.
Update Facility

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

Close Facility

Will be used to close a facility at the end of all surgical activities. One designated person will close the facility. Once closed, the facility will be removed from the Facilities list and no additional patients can be registered to it.

Close Facility Questions

1. Do you want to remove this facility due to duplication?
2. Are you currently located at the facility?

Remove Facility due to Duplication

If yes (duplicate): The facility will be flagged for PERMANENT REMOVAL by Data Manager. This should be selected if the Facility was created in error and was not used to register patients.

If no (duplicate): The facility will be closed, but the information will be saved in CataTrack for reporting.

Tips and Tricks

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

If a patient is suspected of having cataract 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

<table>
<thead>
<tr>
<th>Facility ID</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA-0Z-19</td>
<td>District Hospital 123</td>
</tr>
<tr>
<td>AA-0Z-21</td>
<td>Facility Hospital</td>
</tr>
<tr>
<td>AA-MW-5</td>
<td>Kalafo Session</td>
</tr>
<tr>
<td>AA-0Z-18</td>
<td>Mombasa Facility</td>
</tr>
<tr>
<td>AA-0Z-11</td>
<td>My session CTC</td>
</tr>
<tr>
<td>AA-MW-7</td>
<td>NEC</td>
</tr>
<tr>
<td>AA-0Z-15</td>
<td>Session Test 128</td>
</tr>
</tbody>
</table>

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

What is a Temporary Facility?

When a patient is registered, he/she must be assigned to a Facility where he/she will be evaluated and/or operated. If the correct facility cannot be found in the list of created facilities, the patient should be assigned to the Temporary Facility.

The Temporary Facility is a Facility 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 Facility until the Data Manager/Administrator reassigns the patient to the correct Facility.

Tips and Tricks

When completing the Patient Registration, make sure to record the Facility ID to where the patient should be REASSIGNED if known. This will inform the Data Manager where the patient should be moved in the application.
Once the facility 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. CataTrack 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 preoperative information for the current visit.**

   See next page for more information about registering patients with existing patient IDs.

2. Date of registration
3. Name
4. Age (in **years** or in **months** if age < 1 year)
5. Sex
6. Patient State
7. Patient LGA
8. Patient Village
9. Informant
10. Who owns the phone with which we can contact the patient?
11. Phone Number
12. SMS Language
13. Enumerator Name
14. Patient ID provided
15. Additional notes/comments

**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 registration, you can continue filling out the Preoperative Information immediately after the Registration form without having to go back to the Main Menu. If you are NOT ready to enter the preoperative information, finish and close the Registration form; you can complete it later.
Need to consider: Phone number

A phone number can be recorded to help with locating the patient they are due for a follow-up and appointment reminders via SMS.

Patients or their relatives/village leaders will receive SMS reminder alerts 3 days before Week 1, Week 6, Month 3 and Month 6 follow-up.

The phone number must be **13 characters long** and begin with 234, the country code.

**No punctuation, no dashes, no leading zero and no spaces are allowed!**
Need to Know: Registration Special Cases

Registering patients with existing patient IDs

In some of the examples below, patients 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 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.

CataTrack 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 CataTrack. 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 (2) Registrations for ONE Patient?

It is possible that a patient will attend an Eye Care Center or Health Facility for treatment and return at a later date because he/she developed cataract 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 replace the record of the first treatment visit.

To save both treatment visits (FIRST intraoperative information and SECOND intraoperative information), two registrations need to be completed. If the same patient ID is used for both treatment visits, physicians 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 Facility

When a patient is registered, he/she must be assigned to a Facility, or the current facility where the surgeries take place. If the correct facility cannot be found in the list of created facilities, the patient should be assigned to the Temporary Facility.

The Temporary Facility is a facility where unmatched records can be registered. The patient registration and following preoperative and intraoperative information can then be added to the patient record. The patient record will be saved in the Temporary Facility until the Administrator reassigns the patient to the correct Facility.

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

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

- Patient Summaries
- Preoperative and Intraoperative Information
- Follow-up forms (24-hour, Week 1, Week 6, Month 3 and Month 6)
- 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 Facility ID to confirm the correct treatment facility 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 if a surgery 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
  - **X:** Refusal
  - **-:** Not suspected/Not yet evaluated

- **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 reviewed. The patient treatment record will automatically appear when you select the patient.

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: Preop. Info; Tab 3: Intraop. Info.; and Tab 4 (blank) is the yet to be completed 24 hour 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 new preoperative information, a new Patient Registration form must be completed. If a patient has visited an health facility for treatment on two separate occasions, the patient may have two registrations available on the phone. Ensure that you’ve selected the correct record.
Preoperative Information *(Ophtalmic Evaluation)*

The Preoperative Information includes all required information needed to determine whether a patient has cataract 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*. If the Preoperative Information is completed as a continuation of the Registration, you can skip the form access instructions immediately below.

Accessing Preoperative Information

**Complete the Preoperative questions**

1. [Right/Left] eye Visual Acuity
2. [Right/Left] eye IOP
4. Is the [right/left] eye suspected of cataract?
5. Co-morbid [Right/Left] eye conditions: Nystagmus, Strabismus, Microptalmos, Corneal opacity/scar
6. [Right/Left] eye Biometry: Keratometry (K1, K2), Axial length, IOL Power
7. [Right/Left] eye Diagnosis/Aetiology of cataract
8. [Right/Left] eye Consent
9. Name of the enumerator
Depending on the consent, additional follow-up questions will be asked. Follow-up questions may be for each eye or may be asked after both eyes.

Consent GIVEN
- Does patient consent to surgery?

Consent REFUSED
- Why did patient refuse surgery?

Patient's consent for right eye surgery
- Given
- Refused
Intraoperative Information *(Surgery)*

When a patient has been given his/her consent for surgery, the user will record the surgery details in the Intraoperative Information form. This is done once per registration. If a patient returns for another surgery at a later date, a new registration and subsequent opthalmic evaluation and surgery form must be completed.

Accessing Intraoperative Information

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

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

**Step 3:** Select Intraoperative Information.

**Remember**

If a patient’s intraoperative 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.

Complete the Surgery Questions

1. Date of the surgery
2. Surgeon performing the operation
   - Select from a list of surgeons
     - If surgeon is not listed, select *Not listed*.
     - If name is known, select from the list, the name of the surgeon conducting surgery.
     - If surgeon is unknown, select *Unknown and 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] eye?

If the eye received 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 questions on each eye while overall questions are asked after answered for right/left eye are answered.
CataTrack 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, the following 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. [Right/Left] eye Biometry : Keratometry (K1, K2), Axial length, IOL Power***

5. What type of surgery was performed on the [right/left] eye?

6. [Right/Left] eye Complications

7. Was there any other complication on the [right/left] eye?

8. Name of the enumerator

9. Additional notes/comments

*** This question is asked during surgery if the surgeon did not fill in this information during the ophthalmic evaluation.
Record Patient Follow-ups

Different follow-up forms are utilized for each of the 5 follow-up time points required for paediatric cataract surgery: 24-hour, week 1, week 6, month 3 and month 6. 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 five 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, preoperative and intraoperative information entered for the patient to confirm the correct record has been selected.
Step 3: Select [24 hour, 1 Week, 6 Week, 3 month or 6 month] Follow up
**Complete 24-hour follow-up questions**

1. Date of 24 hour follow-up
2. 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.

3. [Right/Left] eye Visual Acuity
   - If the patient has very low vision, put 999 to display the type of visual impairment to select: Counting Fingers (CF), Hand Motion (HM), Light Perception (LP), No Light Perception (NLP), Blind (BL).
4. [Right/Left] eye Anterior Chamber
5. [Right/Left] eye Posterior Segment
6. [Right/Left] eye Additional surgical procedures
7. Name of the enumerator
8. Additional notes/comments

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

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**Tips and Tricks**

If at least one eye was not recommended for surgery, the following 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 Week 1 follow-up questions**

1. Date of Week 1 follow-up
2. Was there surgery performed on the [right/left] eye a week ago?

**If YES, eye was operated:**
The below questions are only asked if the eye was operated 1 Week ago.

3. [Right/Left] eye Visual Acuity
   » If the patient has very low vision, put 999 to display the type of visual impairment to select: Counting Fingers (CF), Hand Motion (HM), Light Perception (LP), No Light Perception (NLP), Blind (BL).
4. [Right/Left] eye Anterior Chamber
5. [Right/Left] eye Posterior Segment
6. [Right/Left] eye Additional surgical procedures***
7. Have you recommended further follow-up before the normal Week 6 follow-up?
   » If Yes, Please provide further follow-up date
8. Did patient return for this Week 1 Follow-up because you received a SMS reminder?
9. Name of the enumerator
10. Additional notes/comments

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

*** Question 6 is only asked if the information was not entered during 24 hour follow-up.

**Tips and Tricks**

If at least one eye was not recommended for surgery, the following 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 Week 6 follow-up questions**

1. Date of Week 6 follow-up
2. Was there surgery performed on the [right/left] eye 6 weeks ago?

**If YES, eye was operated:**
The below questions are only asked if the eye was operated 6 Weeks ago.

3. [Right/Left] eye Visual Acuity
   » If the patient has very low vision, put 999 to display the type of visual impairment to select: Counting Fingers (CF), Hand Motion (HM), Light Perception (LP), No Light Perception (NLP), Blind (BL).

4. [Right/Left] eye Refraction with BCVA
   » If the patient has very low vision, put 999 to display the type of visual impairment to select: Counting Fingers (CF), Hand Motion (HM), Light Perception (LP), No Light Perception (NLP), Blind (BL).

5. [Right/Left] eye Anterior Chamber
6. [Right/Left] eye Posterior Segment
7. [Right/Left] eye Additional surgical procedures***
8. Have you recommended further follow-up before the normal Month 3 follow-up?
   » If Yes, Please provide further follow-up date
9. Did patient return for this Week 6 Follow-up because you received a SMS reminder?
10. Name of the enumerator
11. Additional notes/comments

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

***Question 7 is only asked if the information was not entered during 24 hour and Week 1 follow-up.

**Tips and Tricks**
If at least one eye was not recommended for surgery, the following 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 Month 3 follow-up questions**

1. Date of Month 3 follow-up
2. Was there surgery performed on the [right/left] eye 3 months ago?

**If YES, eye was operated:**
The below questions are only asked if the eye was operated 3 months ago.

3. [Right/Left] eye Visual Acuity
   » If the patient has very low vision, put 999 to display the type of visual impairment to select: Counting Fingers (CF), Hand Motion (HM), Light Perception (LP), No Light Perception (NLP), Blind (BL).
4. [Right/Left] eye Refraction with BCVA
   » If the patient has very low vision, put 999 to display the type of visual impairment to select: Counting Fingers (CF), Hand Motion (HM), Light Perception (LP), No Light Perception (NLP), Blind (BL).
5. [Right/Left] eye Anterior Chamber
6. [Right/Left] eye Posterior Segment
7. [Right/Left] eye Additional surgical procedures
8. Have you recommended further follow-up before the normal Month 6 follow-up?
   » If Yes, Please provide further follow-up date
9. Did patient return for this Month 3 Follow-up because you received a SMS reminder?
10. Name of the enumerator
11. Additional notes/comments

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

**Tips and Tricks**
If at least one eye was not recommended for surgery, the following 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 Month 6 follow-up questions**

1. Date of Month 6 follow-up
2. Was there surgery performed on the [right/left] eye 6 months ago?

If **YES**, eye was operated:
The below questions are only asked if the eye was operated 6 months ago.

3. **[Right/Left] eye Visual Acuity**
   » If the patient has very low vision, put 999 to display the type of visual impairment to select: Counting Fingers (CF), Hand Motion (HM), Light Perception (LP), No Light Perception (NLP), Blind (BL).

4. **[Right/Left] eye Refraction with BCVA**
   » If the patient has very low vision, put 999 to display the type of visual impairment to select: Counting Fingers (CF), Hand Motion (HM), Light Perception (LP), No Light Perception (NLP), Blind (BL).

5. **[Right/Left] eye Anterior Chamber**
6. **[Right/Left] eye Posterior Segment**
7. **[Right/Left] eye Additional surgical procedures***
8. Did patient return for this Month 6 Follow-up because you received a SMS reminder?
9. Name of the enumerator
10. Additional notes/comments

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

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**Tips and Tricks**

If at least one eye was not recommended for surgery, the following 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 the health facility. 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
- Week 1: 6-21 days
- Week 6: 6-7 weeks
- Month 3: 3-4 months
- Month 6: 6-7 months

Once the patient is selected from one of the five lists (24-hour, Week 1, Week 6, Month 3 and Month 6), the follow-up form is identical to the Record Follow-up form from the Patient Management menu.

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/facility, 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 away and he/she will no longer appear on any follow-up lists.

» **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.

**Complete Close out Patient Questions:**

1. **Do you want to remove/close the patient on the app?**
   - 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.

**Remember**

* The patient information will still be saved in the CataTrack online (unless closed for duplication).
* Patient closeout should ONLY be used if approved by a program/facility
* This form should NOT be used if a patient simply cannot be found when follow-up is attempted.
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, Preoperative Information, Intraoperative Information, 24-hour follow-up, Week 1 follow-up, Week 6 follow-up, Month 3 follow-up and Month 6 follow-up. The process for accessing the form to be edited is 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 in each tab, the 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 **FINISH** to save changes.

**Remember**

* This should be used to correct errors as they occur so that upon the end of the activity, the information is accurate.
* CataTrack 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.
Forms cannot be updated indefinitely—**after 5 days**, forms will no longer appear on the phone so they cannot be used to update a patient record. However, for some users, it is possible when creating their account to give them the privilege of not removing the form in the phone and to be able to make changes beyond this period. If an error is observed beyond the 5-day timeframe, users should discuss the issues with the administrator; changes can still be made, if required, by the administrator on CataTrack cloud system. Form updates are tracked in the CommCare system; any changes that are made will be recorded and can be reviewed by administrators in case there are any issues.
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, Week 1, Week 6, Month 3 or Month 6 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 data access designations for patient records.

Login information for the Web App is included below.

1. Log in to CommCareHQ (www.commcarehq.org/a/catatrack/login/) using your given username and password.
2. Select the CataTrack icon
3. Select the form to be completed. The process to access the forms is the same as on the CataTrack mobile 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.