EMS Solution Suite™

Basic Training Manual for:

Southeast Ohio EMS District

Revised October 27, 2008

PATIENT DOCUMENTATION & INFORMATION MANAGEMENT SYSTEM

HealthWare Solutions™
EMS Solution
Basic Training Manual

HealthWare Solutions™ represents a new vision in medical management information systems. Co-Founded by James Hubbard, *HealthWare Solutions* reflects his dedication and commitment to EMS as symbolized by the company's mission:

To improve the quality, efficiency and cost-effectiveness of emergency medical care by providing state-of-the-art information management and communication services to Public Safety, Fire Service, EMS Providers, Hospitals, Trauma Centers, and Governing Agencies.

*** This manual is designed to give users an introduction to the process of creating, editing and uploading Patient Care Records using EMS Solution 2000™. If you have questions outside the scope of this manual, please ask your trainer, or refer to the documentation provided with your software or the Help menu in EMS Solution 2000™.**

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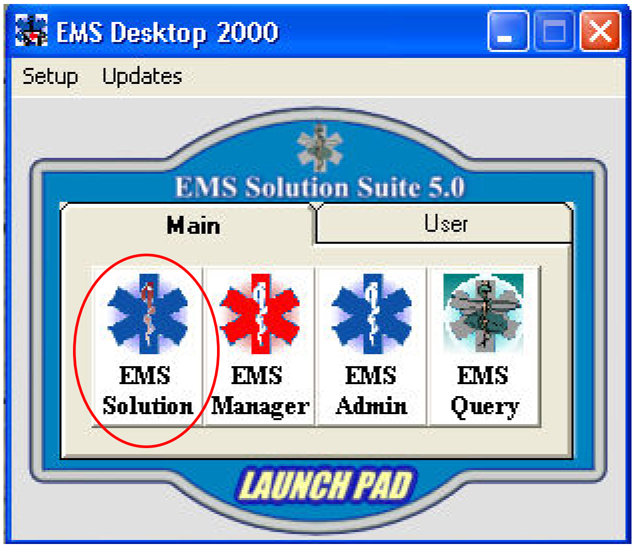
1. Log in to EMS Solution

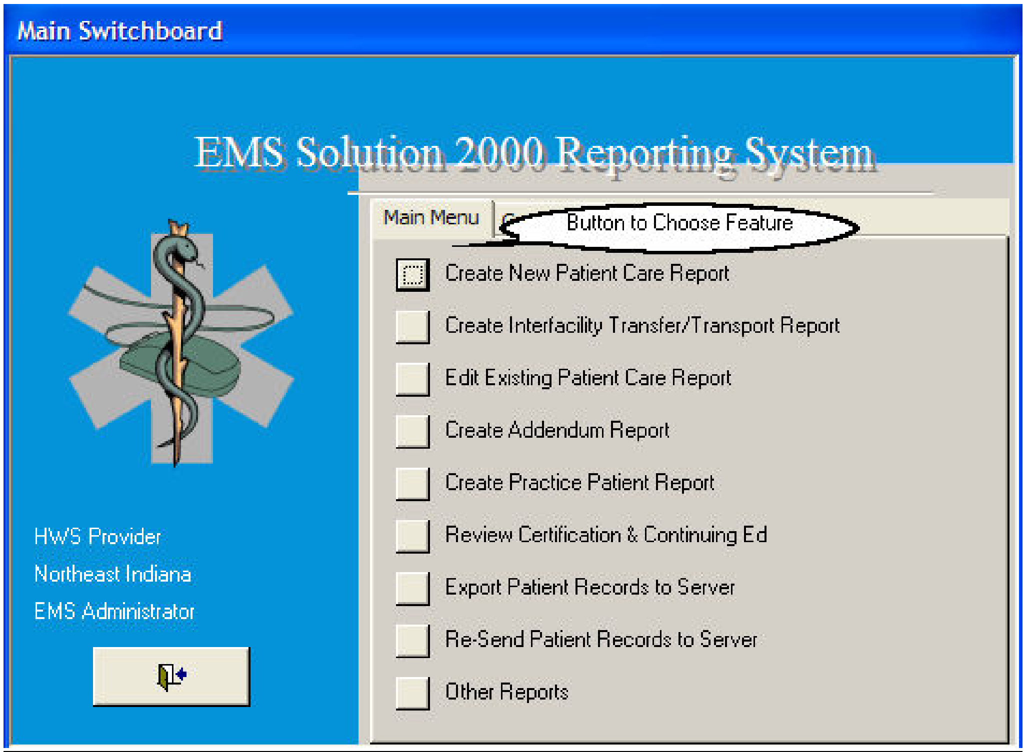


To open the program, double-click the blue "EMS Solution" icon on the computer's desktop. You can also click the "EMS Solution" icon on the EMS Solution **Launch Pad** (EMS Desktop window). The **Security Log-in** window will appear after the program launches:

Once you enter your **last name** and last 4 digits of your SSN as **password**, the **Main Switchboard** on the next page will appear.

NOTE: It is possible to open more than one copy of EMS Solution. Please be sure that you only click the Launch Pad once, and double-check that you only have one copy of the program open by checking the taskbar at the bottom of the screen.

2. Features



Create a New Patient Care Report: Use this function to create a new PCR for a 9-1-1 field response.

Create Interfacility Transfer/Transport Report: This will be used for **interfacility transports only**.

Edit Existing Patient Care Report: View or modify an existing report. Modifying a report is time dependent, and you will only be able to view those PCRs that you have authored. As a HIPAA regulation, you will be prompted to enter a reason for opening or printing a report.

Create Addendum Report: Add information to a locked report with an addendum to the PCR.

Create Practice Report: This feature allows you or personnel being trained to practice using the HealthWare Solutions system. Data written into a practice report does not get saved in the main database, and cannot be recalled after you close the program, so please **DO NOT use this function to document actual patient runs**. *Please use this practice function for ALL practice on the system after your primary training session*.

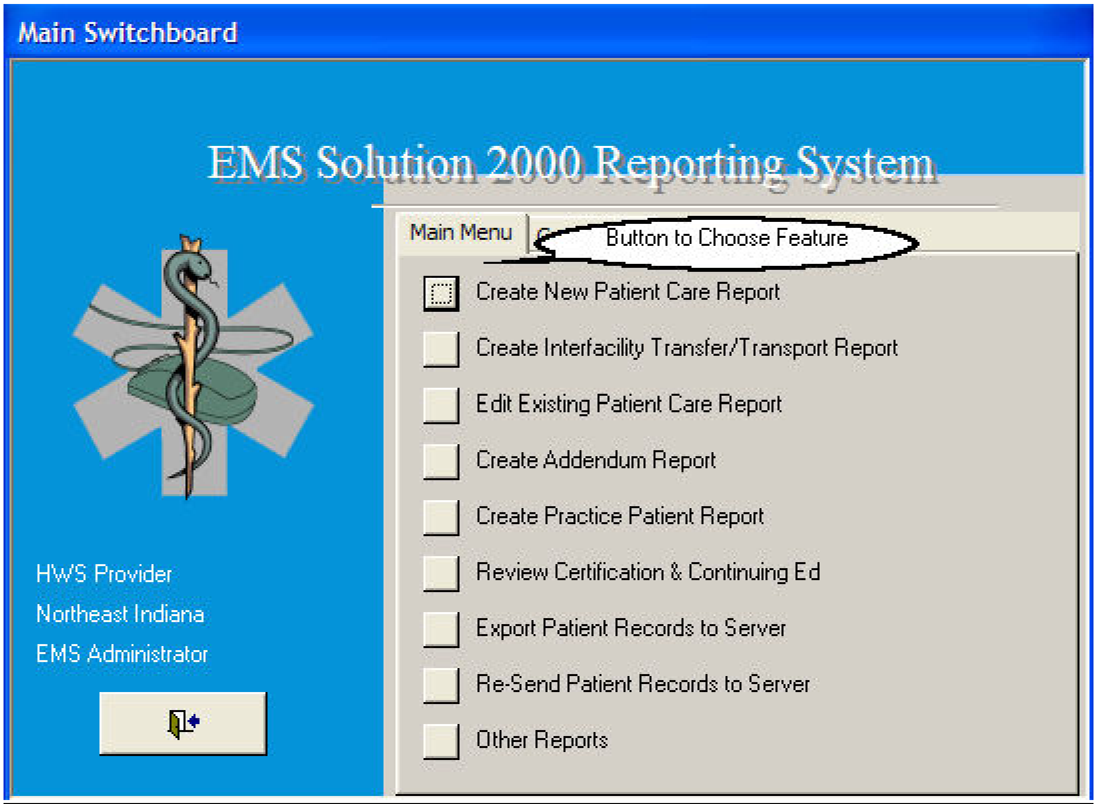
Review Certification and Continuing Ed: Allows you to review your continuing education and print and non-certified copy of your CEUs to date.

Export Patient Records to Server: Submit PCRs to the server if you have multiple runs to submit.

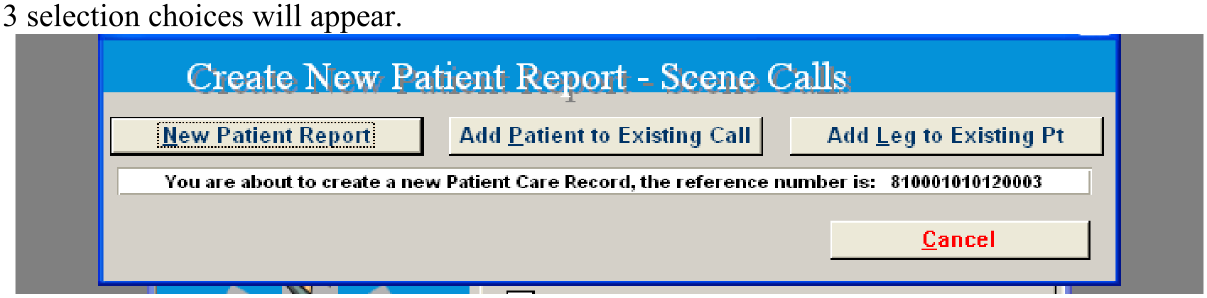
Re-Send Patient Records to Server: You can use this selection to resend records to the server if there is a problem, or if you needed to amend the PCRs.

Other Reports: Supply usage reports and PCRs that are on the local machine can be viewed with this function.

3. Using Patient Care Reports



To open a new PCR, select “Create New Patient Care Report” on the **Main Switchboard**. A popup box with 3 selection choices will appear.



You will click Number 1 – **New Patient Report:**

Add Patient to Existing: IS NOT USED BY SEOEMS
Add Leg to Existing: IS NOT USED BY SEOEMS

Navigation Tips

When working with PCRs, use the **Tab** key on the keyboard to help you quickly and effectively maneuver through the fields. The F4 key will open your Pick Lists. The **Enter** key and arrow keys select and highlight the different options in lists. You can also use the mouse to do all of the highlighting and selecting.

🛠 **TIP:** In general, the more you use the keyboard, the more rapidly you will complete the document. Learning to use the keyboard also makes you less apt to miss fields. If you notice that the tab order is not working properly, try rebooting the computer when it is convenient to do so.

Fields

Fields are individual sections or lines in the program where data is collected. Data is collected and stored in a variety of fields:

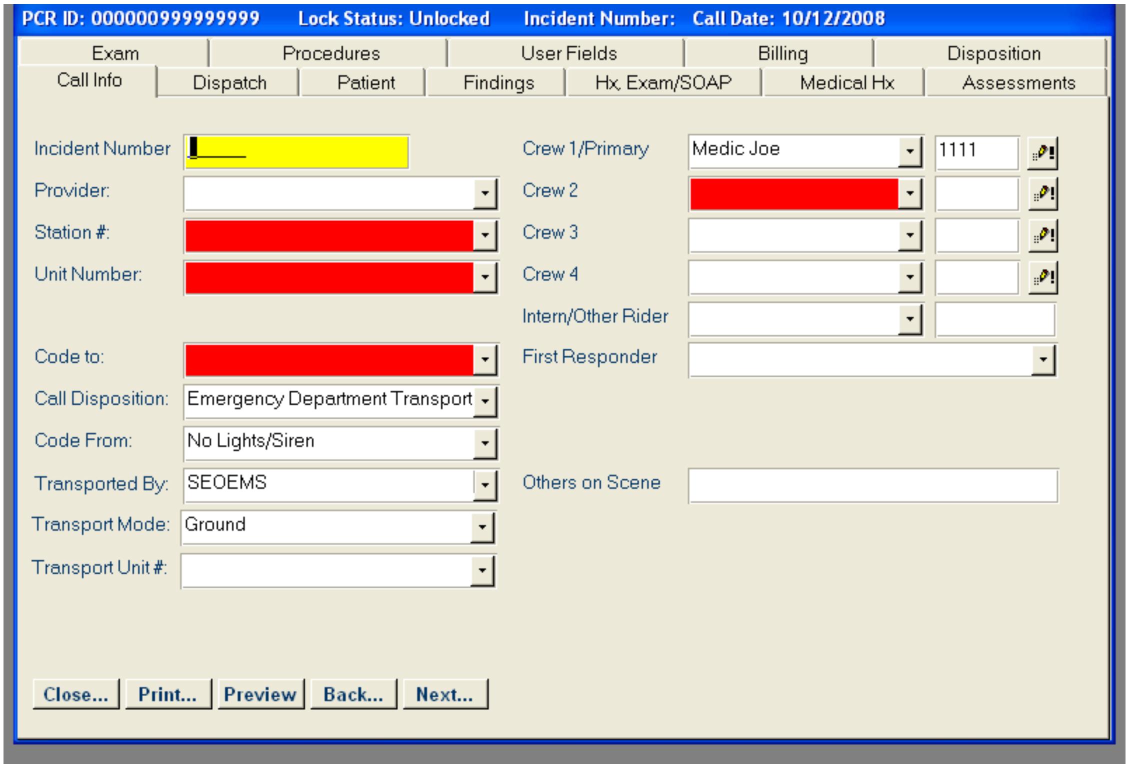
- ***Text Boxes*** – A field that looks like a plain white box. Text boxes will accept any data, considered "free text". Just type the desired text.
- ***Pick Lists*** (drop-down lists) –  Fields with a hidden list. In most cases, you must select an item from the list. Several methods for selecting text are available. **F4** will open the Pick Lists.
- ***Check Boxes*** – ☑ These fields are selected by clicking in the box or pressing the **Spacebar**.
- ***Colored Fields*** – All fields turn YELLOW when the cursor is active. Your system administrator may set color indicators for blank fields. This will inform you whether the field MUST be filled in, or whether it is merely advised or suggested. (**Example:** In the **Call Info** tab on the next page, **RED** indicates a mandatory field.)

At the bottom of every page is a series of buttons:

Close – allows you to close out if you need to go before you are done with the PCR. You can close out of a PCR at any point, and the data is saved automatically.
Print – allows you to print the PCR at any point.
Preview – allows you to view how the printed form will look.
Back – takes you to the previous tab (to **Call Info** from **Dispatch**, for example).
Next – takes you to the next tab.
Shortcut Keys (Quick Keys) – These key combinations allow you to enable functions of the program without always selecting with the mouse or with **Tab**. When a button in the program has an underlined letter, you can select **Alt** and the underlined letter to use that function (in the button below, **Alt-E**). **Alt-N** or **Alt-B** combinations also work to toggle to the next or previous (respectively) tabs.

Call Info Tab

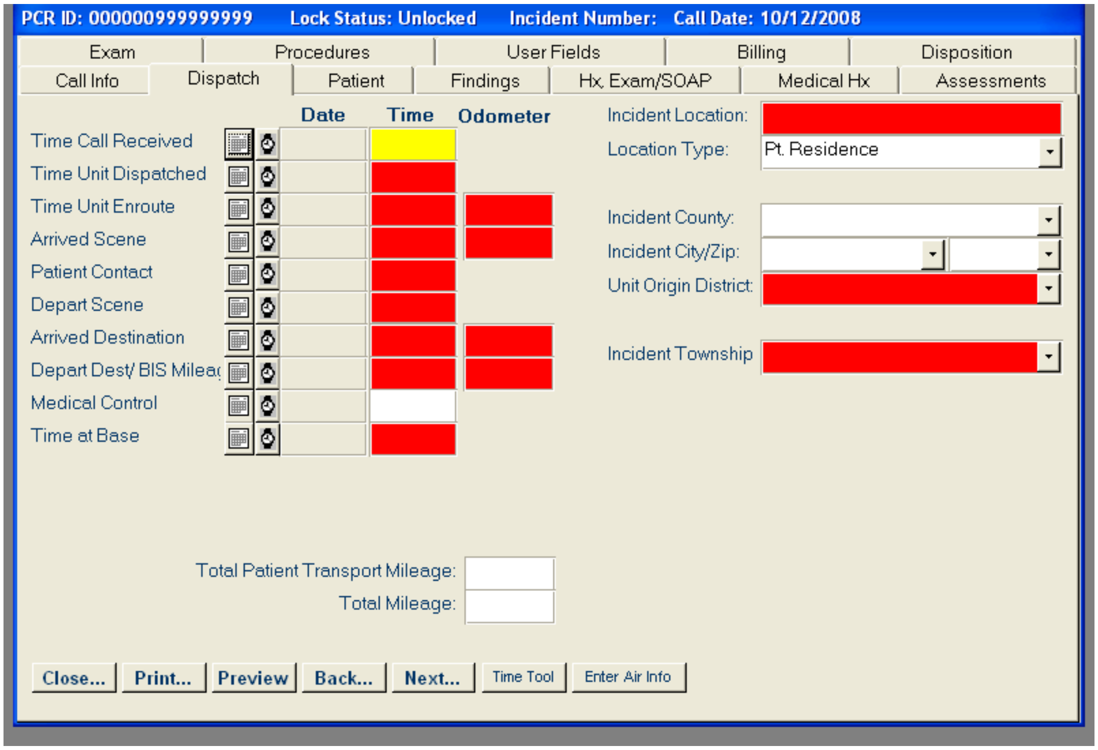
The program will open up into the **Call Info** tab. (See the selection of 12 tabs across the top of the window.) Your cursor will always start in the first field of the page, which in this case is the "Incident Number" field.



Solutions Field	**SEOEMS INPUT DATA**
Incident Number	Run Number
Provider	SEOEMS (from pick list or typed in) No other selection is valid in this field
Station #	Station Number
Unit Number	Truck Number
Code To:	Select the mode of response to the call. Lights/Siren should be used most of the time
Call Disposition	Select Emergency Department Transport, Refuse Treatment/Transport, Treat/No Transport, Call Cancelled, Dead at Scene, Treated/Transferred Care or Dry Run/ No Patient Contact. **If no patient choose Dry Run.**
Code From	Select the mode of response to TF
Transported by	Will default to SEOEMS and should only contain SEOEMS
Transport Mode	Default is Ground but you may select Roto Air Ambulance or Non-Transport if applicable
Transported unit #	Truck number, unless your call disposition is a non-transportable selection. (this field will be blank)
Crew1/Primary	Will default to the employee who signed into Solutions. You will sign the run report here also by clicking the pencil box when using this program with the toughbooks.
Crew 2	Enter second crew member (and have them sign the run report as noted above)
Crew 3 and 4	Enter additional crew member as needed. Students (who have a SEOEMS ID) will be entered in either of these fields also.
Intern /Other Rider	**Do not enter anything into this field**
First Responder	Use the Pick List to choose any First Responder Agencies on your scene
Others on scene	Use to document any additional resources on scene if desired

Dispatch Tab

This page will open with the cursor in the top time slot. You will not see some of the fields in the screen shot below unless your system administrator has enabled them in EMS Manager 2000™.



The **Calendar** button allows you to quickly enter the date in these fields. When you select the **Calendar** button and click **OK**, the current date will appear in the field immediately to the left. If the date is incorrect (if you are catching up on documenting a call that occurred before midnight, and it is now 0015 hours, for example) you will need to change it.
There is a button at the bottom of the page called **Time Tool**. The **Time Tool** allows you to select a time from a list and insert it into the time fields in your report.

Solutions Field	SEOEMS INPUT DATA
Time Call Received	Enter the time the Dispatch Center received the call
Time Unit Dispatched	Enter your **Alert Time**
Time Unit Enroute	Enter your **Time Out**
Arrived Scene	Enter the time you **Arrived Scene**
Patient Contact	Enter the time you made **Patient Contact**, may be same as arrived scene
Depart Scene	Enter your **Depart Scene Time**
Arrived Destination	Enter your **Arrive TF Time**
Depart Dest/BIS mileage	Enter your **Depart TF Time**
Medical Control	Enter a time you contacted medical control – not mandatory
Time at Base	Enter your **Back In Service Time**
Odometer Readings	
Box 1	Mileage upon alert
Box 2	Mileage upon reaching site
Box 3	Mileage upon reaching TF
Box 4	Mileage upon Back In Service (BIS)
Incident Location	Address where you were dispatched, can be different from patient's address if you were dispatched to a scene.

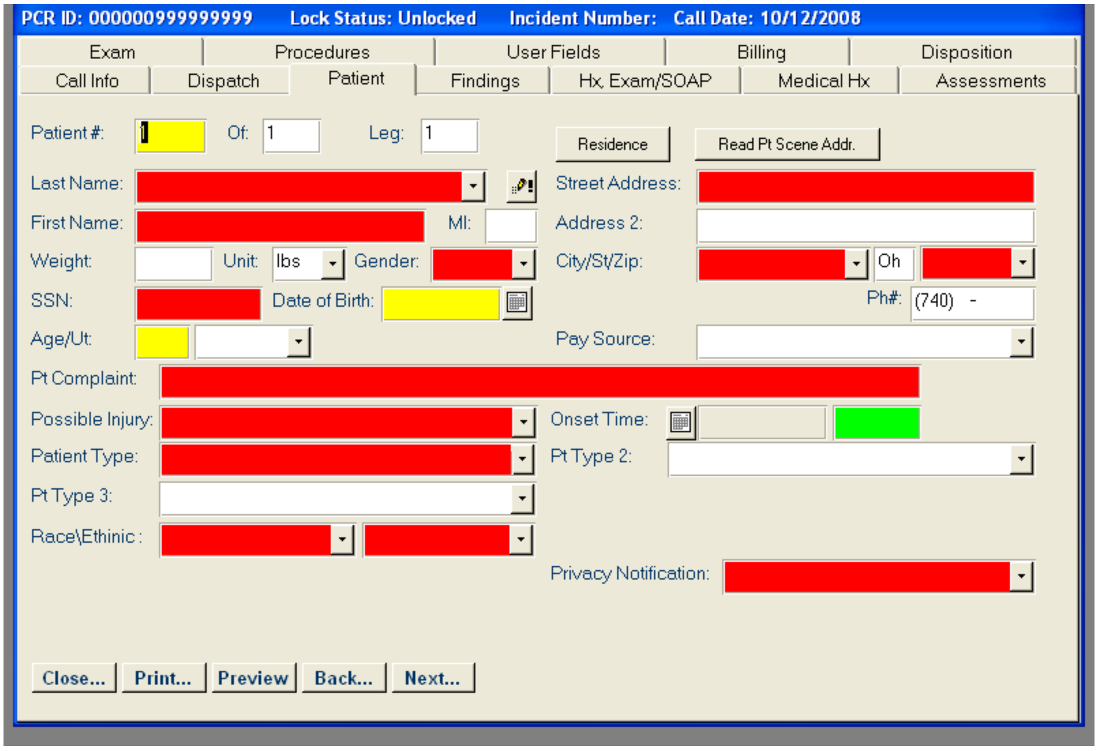
Location Type	Select from Pick List the description of your scene type
Incident County	Select from the Pick List the County that your run is in
Incident City/Zip	Select from the Pick List the City/Zip that your run is in YOU MIGHT NOT HAVE A ***CITY/ZIP*** BUT YOU WILL ALWAYS HAVE A ***COUNTY*** AND ***TOWNSHIP***.
Unit Origin District	Select from the Pick List. IF you were enroute (or had arrived) Area Coverage when this run was alerted you will chose the Area Coverage location you were enroute to(or had arrived at). All other locations will be selected as **Station**
Incident Township	Select from the Pick List the Township you responded to

The **Enter Air Info** button at the bottom of the page cannot be turned off. And can be utilized to add aeromedical information if you utilized air transport for your patient. It is not mandatory.

You are now done with the **Call Dispatch** page. If you select **Tab** once, the cursor will move to the **Next** button at the bottom of the window. Selecting **Tab** again will move you to the **Patient** page.

Patient Tab

The Patient tab allows you to collect the personal information about the person you contact on the call.



Patient #__ Of__: This will be "1 of 1 and should not be changed. Select the **Tab** key to move to the next field

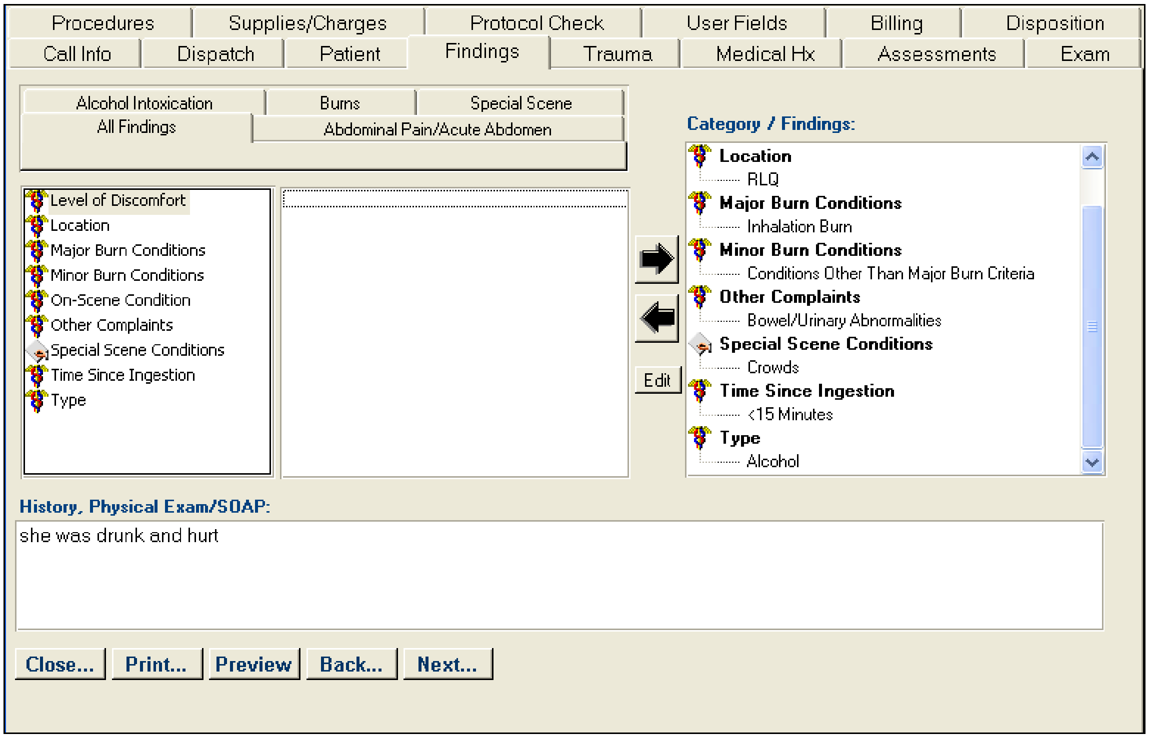
<u>Leg</u>: This will always be "1" and should not be changed. Select the **Tab** key to move to the next field

Solutions Fields	SEOEMS INPUT DATA
Last Name	Enter the patient's last name. If this patient has been input into this computer you will be able to select from the drop down list and modify as needed **Click on the pencil icon to the right to have your patient sign authorizing medical treatment if you are using the toughbooks for your run report**
First Name	Enter the patient's first name. Hit Tab and enter MI if known
Weight	Enter patient's weight
Unit	Lbs. is default, can be changed using the Pick List
Gender	Choose M or F
SSN	Enter patient's SSN
Date of Birth	Enter DOB, you can use calendar button to right of field if you desire
Age/ut	Will be auto calculated, UT is years/months/days/weeks/hours
Street Address	Enter the patient's street address , IF it is the same as your Incident Location you can "click" on the "read pt. scene address" and it will auto fill.
City/State/Zip	Enter patient's information. IF "read pt. scene address was selected this will be filled in
Ph#	Enter patient's phone number
Pay Source	Not used in SEOEMS
Patient Complaint	Enter the patient's Chief Complaint here.
Possible Injury	Select Yes or No
Onset Time	Enter the time that symptoms began

Patient Type	Use Pick List to chose a 'field diagnosis' for your patient. Mandatory to have one field diagnosis.
Patient Type 2	Use Pick List to chose a second 'field diagnosis' if applicable
Patient Type 3	Use Pick List to chose a third 'field diagnosis' if applicable
Race/Ethnicity	Use Pick List to enter patient's race TAB the use Pick List to enter patient's ethnicity
Privacy Notification	Chose Yes, No or NA about whether or not you gave the patient the Notice of Privacy Practice sheet. If No or NA chosen you will need to enter a reason.

You are now done with the **Patient** page. If you select **Tab** once, the cursor will move to the **Next** button at the bottom of the window. Selecting **Tab** again will move you to the **Findings** page.

Findings Tab



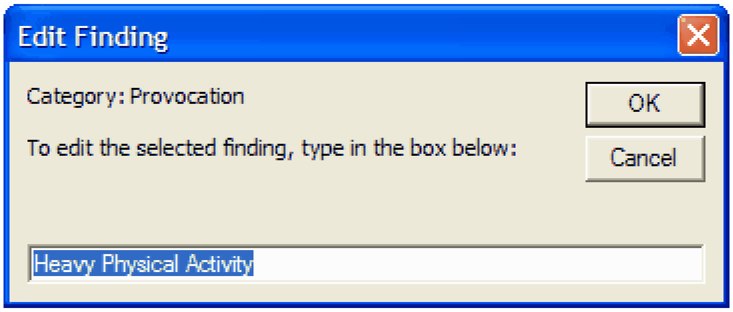
A list of body systems will appear for every Patient Type (field diagnosis). The "Special Scene Conditions" selection and other items in the Category column (at left) can help describe certain aspects encountered at the scene. You may not need to use this section in every case.

There should be an inner tab on the page for each patient type you choose, in addition to the *All Findings* and *Special Scene* tabs. If these do not appear, make sure there is a "Patient Type" chosen in the **Patient** tab on the previous page.

When you tab to this page, the *All Findings* inner tab is displayed, and the first item in the Category column will be highlighted. If you touch this selection the mouse the list of modifiers will appear in the Findings column (middle). Tab to that column; use the up/down arrows to move through the list. Use the **Spacebar** on your keyboard to highlight the modifiers that apply to your patient. Tab two more times, and you will be on the right arrow between the middle and right boxes. The **Enter** key will now move all of the selections to the Category/Findings column (Selected Items Tree).

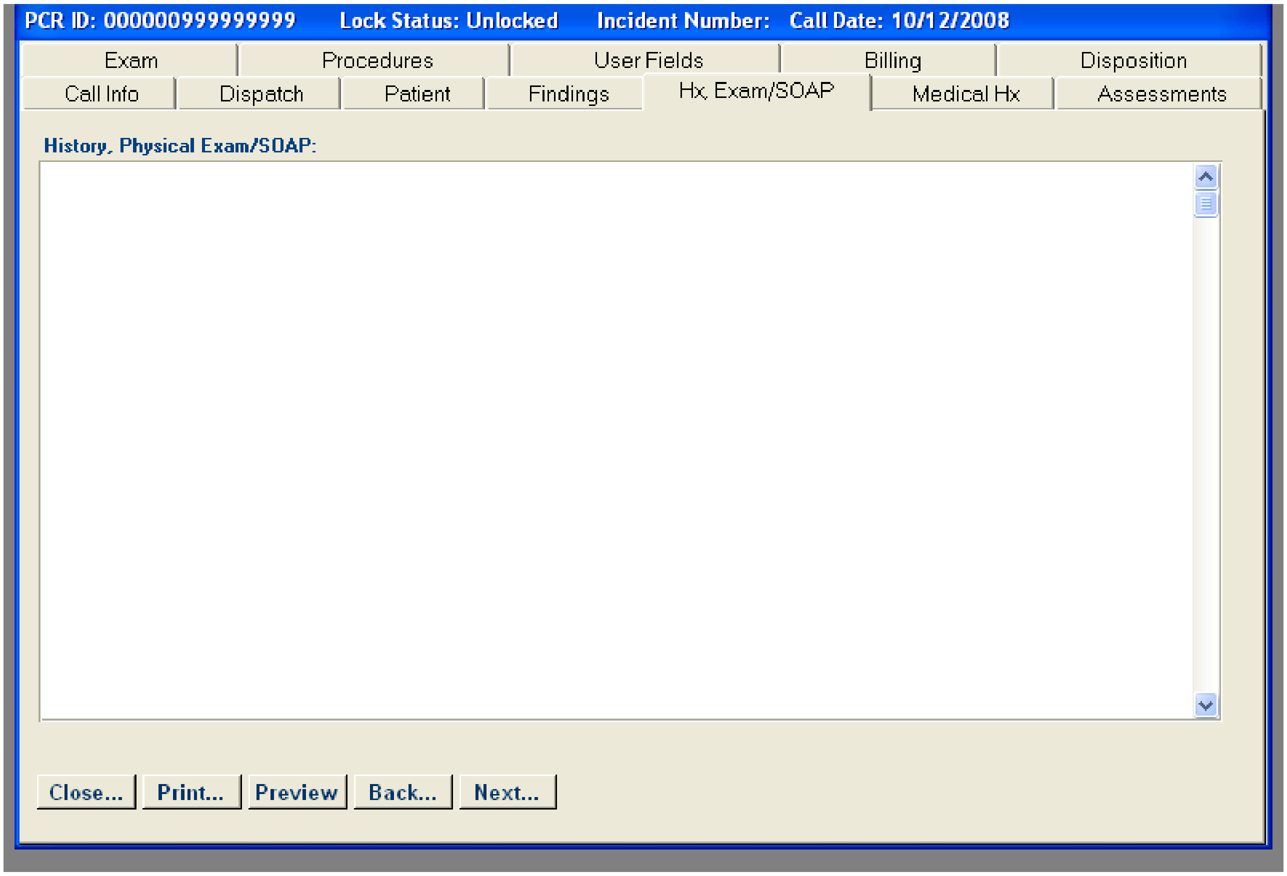
Alternatively, you can also use the mouse to do all of the highlighting and selecting. In general, the more you use the keyboard, the more rapidly you will complete the document. If the tab order is not working properly, try rebooting the computer when convenient.

If you have a selected modifier in the Selected Items Tree, and you wish to delete it, highlight that item with your mouse and press the left-arrow button between the tree and the Findings column. To add a comment to a selected modifier in the tree, select the item then press the **Edit** button between the columns. An edit window will appear. Press the right-arrow key on the keyboard to deselect the item, and type your comment on the line. Press **OK** or **Enter** to add the new text.



Continue the above steps until you have entered all of the symptoms – **both pertinent positives as well as pertinent negatives – that apply to your patient**. You are then done with the **Findings** page. Select the **Tab** key to move to the next field.

Hx, Exam/SOAP Tab

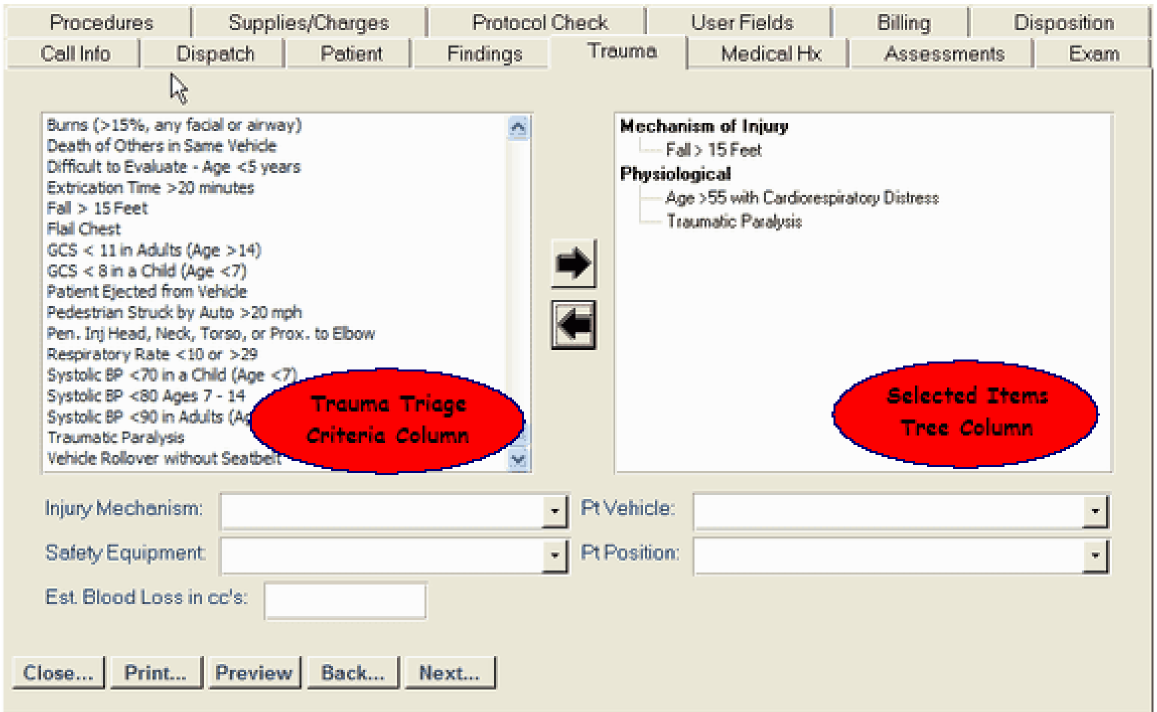


<u>Hx/Exam/Soap:</u> This area is for you to write your narrative. You can use lower case, upper case or a combination of both to enter your text. Select the **Tab** key to move to the next field.

If you chose "Trauma" for the Patient Type on the **Patient** page, then **Trauma** is the next page. If not, then **Medical Hx** is the next page.

Trauma Tab

If your "Patient Type" is purely medical, you will not see this page.



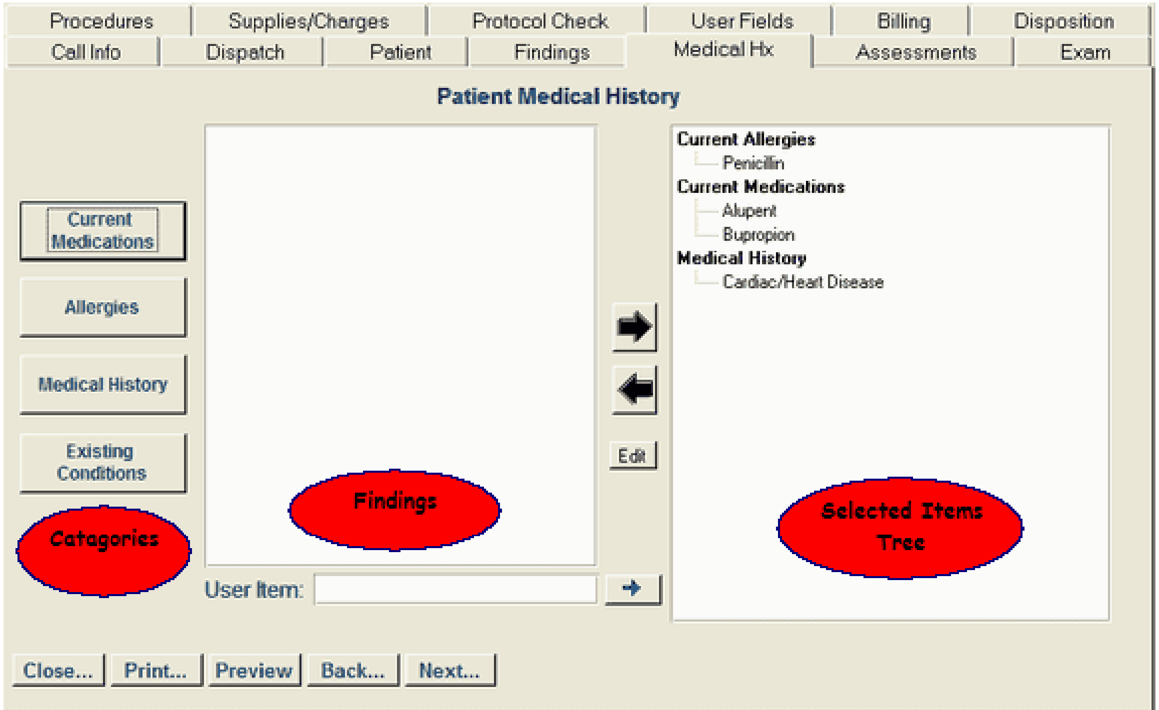
When you enter the **Trauma** page, you will be asked to chose from the Category Box general criteria for Trauma Triage Protocol. After selecting each general criteria the Triage Box will contain specific parameters that pertain to TTP. You can scroll down the list with the up- and down-arrow keys and select all that apply by pressing the **Spacebar** on the keyboard. IF your patient did not meet the TTP select "Other" in the Category Box and you can then opt to click on "**does not meet trauma triage criteria**". Once you have selected all that apply, press **Tab** once to move to the right-arrow button and press **Enter** to fill your selections into the Selected Items Tree.

Pressing **Tab** again will take you through the remaining fields on this page. The information on this page helps to document mechanism of injury for the receiving hospital, calculates trauma score for the patient, and supplies required data-collection elements to the State.

When you have completed all of the fields on this page, tab down to **Next**, then tab to the next page.

Medical Hx Tab

This tab allows you to document the existing conditions and current medications for the patient, as well as allergies and a history of medical problems and treatments.



When you tab onto the **Medical Hx** page, your cursor will highlight the **Current Medications** button. Pressing **Enter** or using your mouse will open the medication list in the left column. You can scroll with the up- and down-arrow keys and select all that apply by using the **Spacebar** on the keyboard. You can also type in a letter to go to the first in the list of medications that start with that letter. **Tab** again takes you to the right-arrow button, and **Enter** will fill in all of your medication choices.

If you want to write in a medication, tab down to the "User Item" field. This is a free-text field. Tab over to the right-arrow button just right of this line and press **Enter**. This will fill in the new medication. This process can be repeated for additional entries.

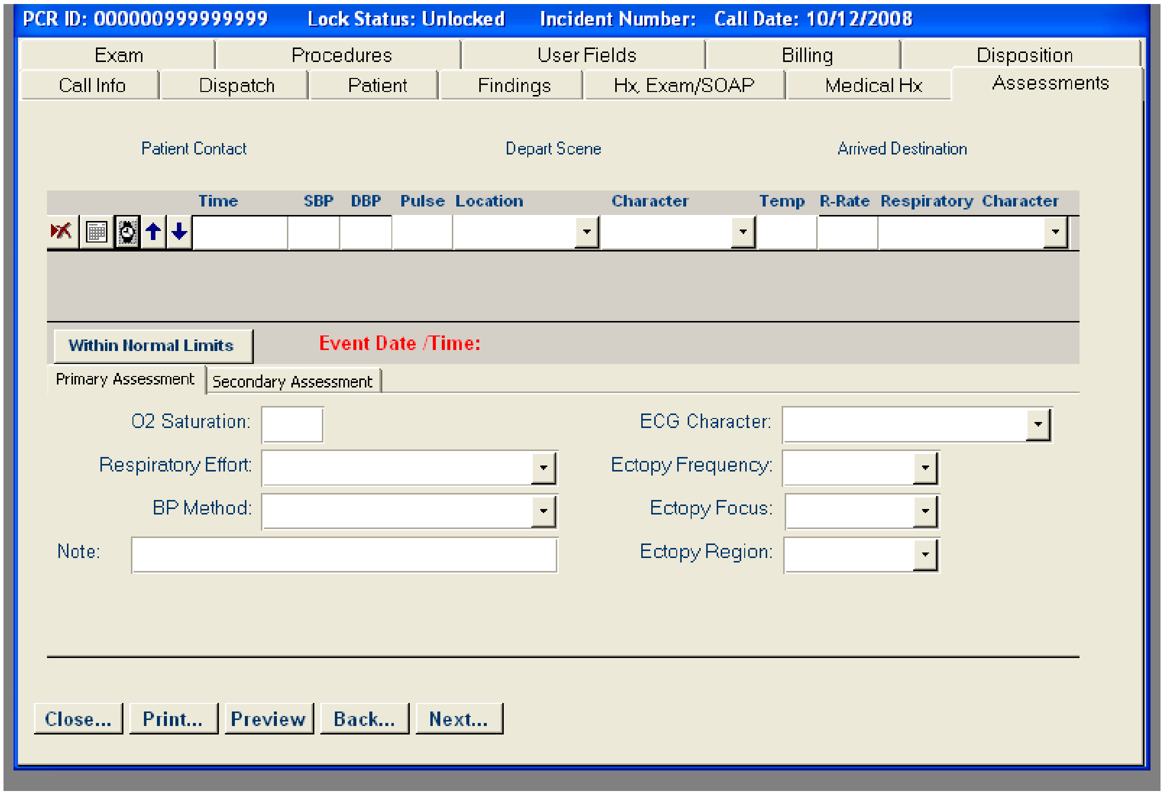
Now press the **Allergies** button, and follow the same steps as in the explanation for the **Current Medications** button. Repeat the same process for the **Medical History** button as well. The **Existing Conditions** button was designed for the interfacility transfer of Medicare/Medicaid patients, but some of the selections may apply appropriately to 9-1-1 patients as well. If you choose to use this feature, use the same procedure as the other buttons on this page.

When you are done with this page, tab down to the **Next** button, then tab to the next page.

Assessments Tab

When you tab onto the **Assessments** page, your cursor will land on the little wristwatch icon. Press this button to fill in the "Patient Contact" time, if it was entered on the **Dispatch** page. Pressing **Enter** or the up/down-arrow buttons will adjust this time.

If this time was never entered on the **Dispatch** page, then this "wristwatch" function will not work on this page. If the time was entered, you will see it on this page.



Tab to the time field. If the wristwatch function did not apply to you, you can enter the time here in military time. Make sure your cursor is in the first-digit position. Tab next to the "SBP" and "DBP" fields. Blank or "P" for palpation is acceptable in the DBP field. Tab to "Pulse", and "Location" (of pulse) fields. When the cursor is in the location field, the **F4** button will reveal the drop-down list choices, or you can type the first character(s) of your desired choice to fill it in. Tab ahead to the "R-Rate", and "Character" fields (the oxygen saturation is be documented on the **Procedures Detail** area of this page)

<u>Procedure Details :</u> Complete this portion of the Assessment Tab for each set of vital signs you record. **ALSO**, omplete the Secondary Assessment "mini tab" for each set of vital signs. If your patient's Secondary Assessment is normal you may click on the "Within Normal Limits" button above these "mini tabs" and WNL criteria will be filled in for your secondary assessment.

You can now insert additional assessments, if appropriate for your patient. Press the second wristwatch button, and a new assessment slate will appear (the original one is still available and can be recalled by putting your cursor in any of the fields in the first line).

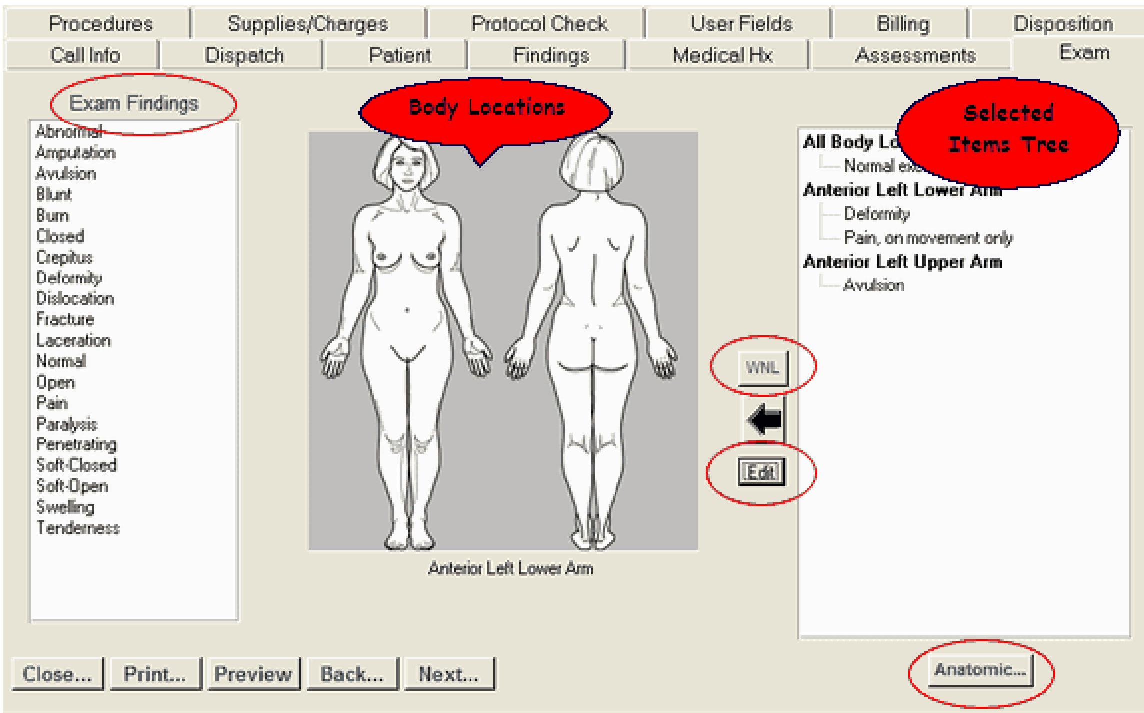
You can do as many assessments as are appropriate for your particular patient.

When you are finished with this page, tab down to the **Next** button, and tab to the next page.

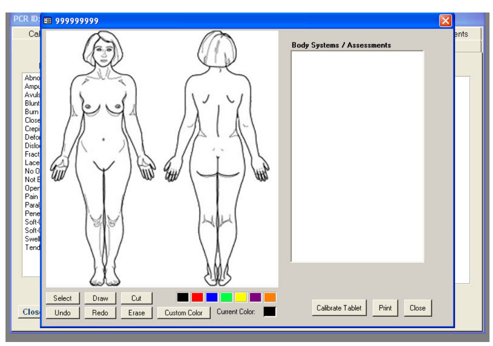
Exam Tab

You do not need to document findings for every body system, but appropriate documentation practices would dictate documenting normal findings and pertinent negatives, even for patients with totally normal exams. For this reason, it is not recommended to use the **WNL** (within normal limits) button between the middle and right-hand columns.

When you tab into the **Exam** page, your cursor will land on the first exam finding in the left column use the up and down arrow keys to choose the appropriate finding then click on the body part to apply this finding to.



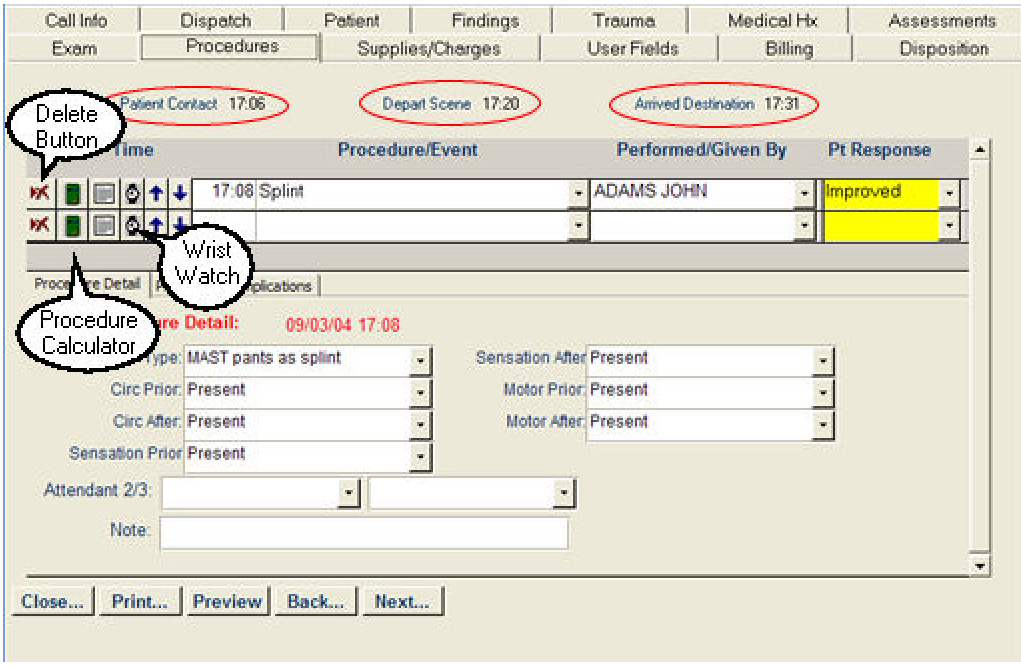
The last function on this page is the **Anatomic** button in the bottom-right corner of the screen. Pressing this button brings up anterior/posterior views, which display the body type appropriate for your patient (male/female, adult/child). This is not a mandatory function, but you can call this up to document things that are hard to put into words – diffuse burns, abrasions or rashes come to mind. This function will not print up as part of the trip sheet, but they can be printed manually to turn in with the run report at the hospital.



When you are through with the **Exam** page, tab down to the **Next** button, and go on to the next page.

Procedures Tab

This page documents all of the procedures you perform, in order of time. Procedures without a documented time print first – in alphabetical order. To portray an accurate sequence of events, make sure that the times are relative to each other when you document them.



When you tab into the **Procedures** page, your cursor will land on the first wristwatch icon, which works just as it does on the **Assessments** page. Again, this function will only work if you entered times back on the **Dispatch** page. If you did not, you can enter the times manually on this page.

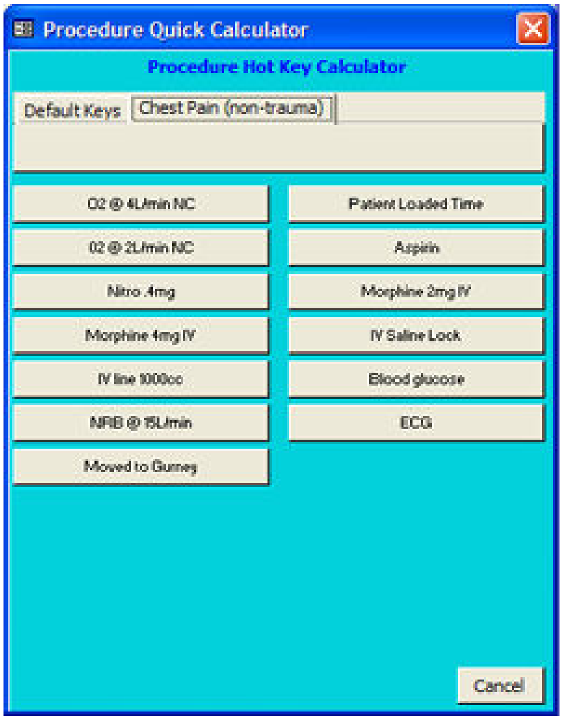
Tab over and enter the first procedure from the pick list. Tab to "Performed/Given By". Every procedure requires you to assign someone as having done a specific procedure. The pick list will give you choices of everyone who is entered on the **Call Info** page as Attendant, Driver, Crew 3, Crew 4, and First Responder..

Pressing tab again takes you to the "Pt Response" field. You need to enter whether the patient improved, worsened, or had no change with each procedure.

Another tab takes you to the bottom portion of the screen. Here, there are a variety of fields that will change from procedure to procedure, that help define the procedure and/or its relative success. Most of these fields are mandatory, and will not allow you to proceed if they are left blank. It would be a good idea to get in the habit of filling them in on the first pass, as it will save a lot of time if you don't need to go back to correct the omission(s).

Pressing on the second wristwatch icon will open up another procedure line and give a time of one minute later than the first procedure. (If you want to delete a procedure line, press the red "X" at the left end of that line). You can adjust this time using the **Enter** key or up/down-arrow buttons or by typing a new time.

You will need to become familiar with all of the procedures on the list so you can select choices that are the most appropriate for the care you gave the patient.



Another option on this page is called the **Procedure Calculator**. Pressing the calculator icon just to the left of the wristwatch icon activates it. This will pull up the **Procedure Quick Calculator** window as seen above. These calculators can be set up for any "Patient Type", or can be available for all "Patient Types" if set up that way.

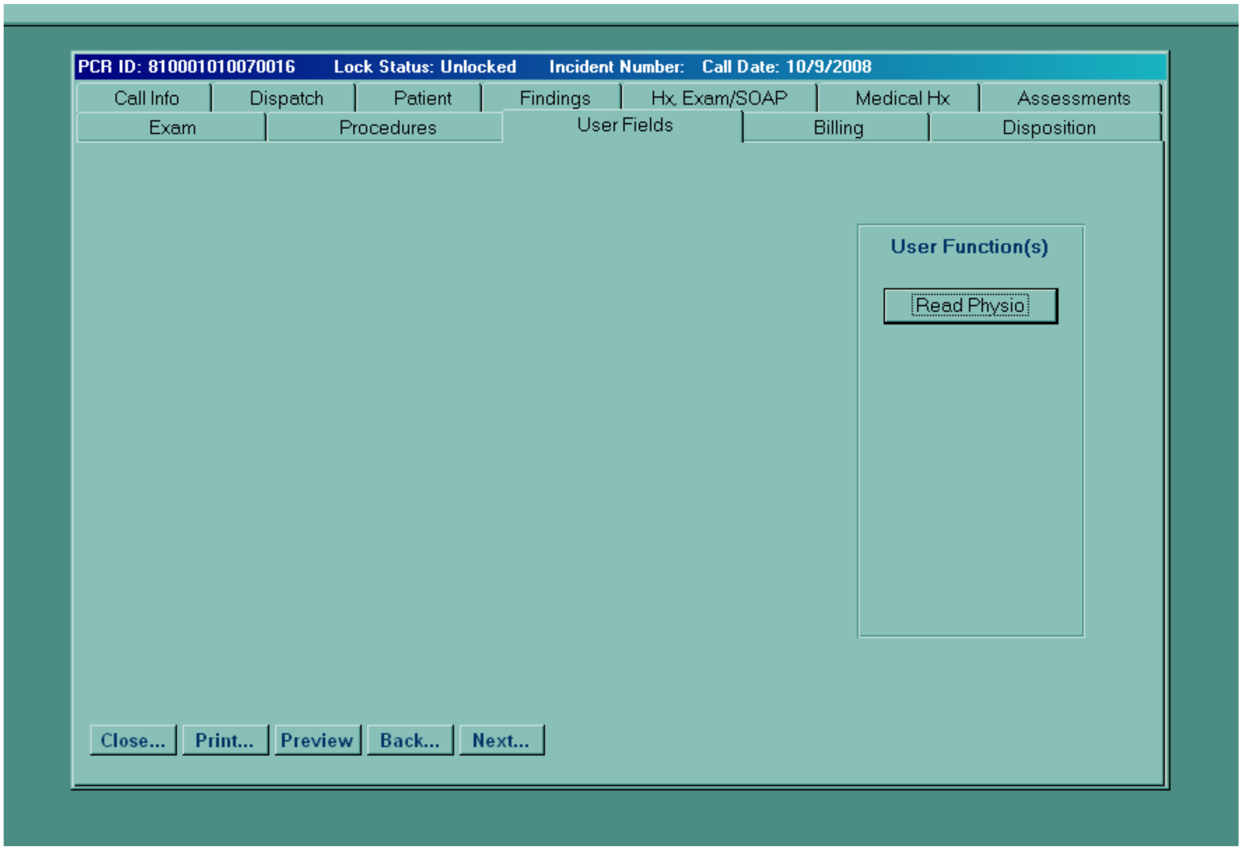
The calculator is designed to be a reminder of what procedures the protocol suggests may need to be done. Simply click on the buttons that apply to your patient, and the calculator starts the procedure lines for you. You still need to go back and fill in the procedure details, so you need to decide if you think it is easier to use the calculator or not. If this becomes a popular option, more calculator windows can be created.

You can enter an unlimited number of procedures for any patient. **REMEMBER** that each **ATTEMPT** at a procedure requires each own procedure line.

When you are done with the procedure page, tab down to the **Next** button, and tab to the next page.

User Fields Tab

This page contains the button you will select in order to electronically attach your LP12 ECG code summary to the PCR

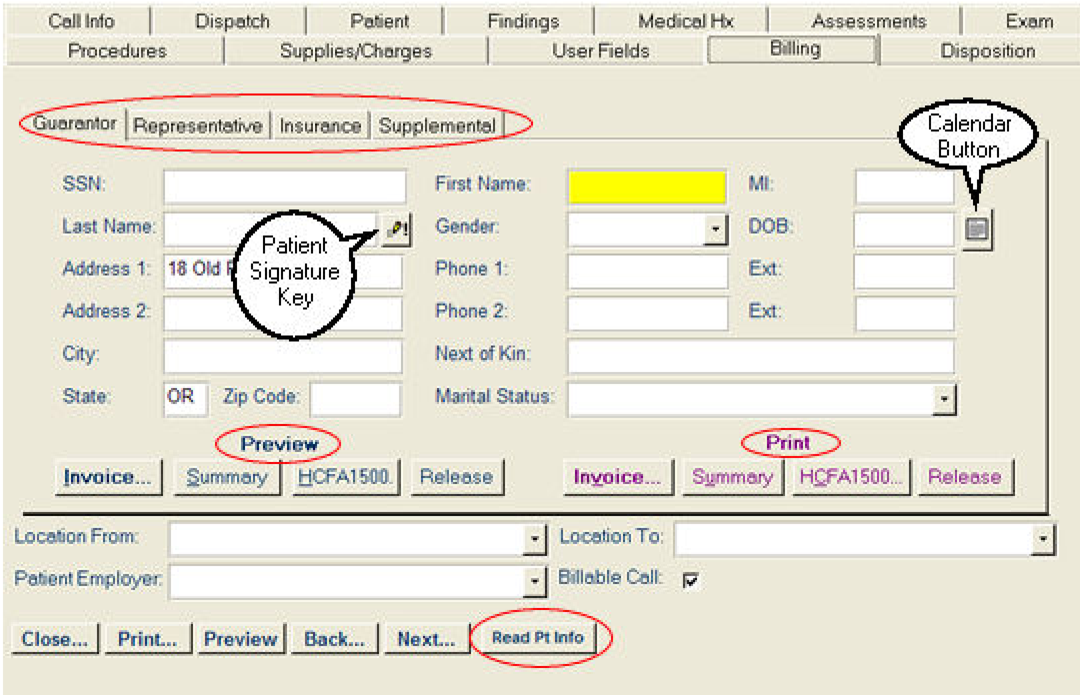


You will be using the toughbook to upload your LP12 code summary into your ePCR. Directions for completing this is in the Toughbook Input Manual.

When you are done with the User Fields page, tab down to the **Next** button, and tab to the next page.

Billing Tab

The **Billing** tab allows you to fill in patient payment information and print invoices, billing summaries, HCFA forms and release documentation. Four 'mini tabs' within the page separate it. Each collects a different set of information.



When you enter the Billing Tab your cursor lands on SSN box of the **Guarantor.** Most of the time this should already be completed on your toughbooks.

Representative allows you an area to document a worker's compensation claim, by collecting information on the facility and representative giving authorization of the claim. **This most likely will not be utilized in the field.**

Insurance gives you a place to document the coverage information for the patient. When you begin entering insurance information, a new row will appear below the current field to allow you to document secondary companies/policies. There may be a Pick List with Insurance Company for you to choose from. Enter as much information as you have.

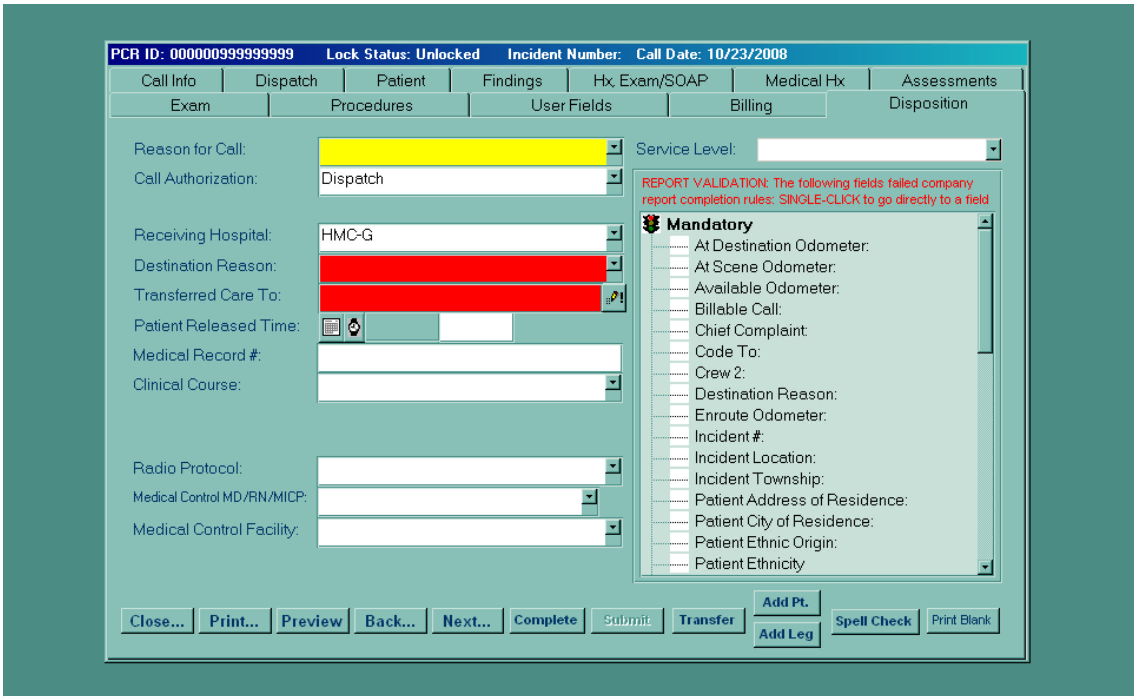
Supplemental is not used by the field.

No other boxes are used by the field.

When you are done with the Billing page, tab down to the **Next** button, and tab to the next page.

Disposition Tab

This tab gives you a place to document additional information about the call, including authorization and destination information.



Solutions Field	SEOEMS INPUT DATA
Reason for Call	This is the reason you were Dispatched, not necessarily the same as what you found when you arrived on scene. Important to choose if you were sent on area coverage, special detail, lift assist, or backup due to pt. condition.
Call Authorization	This will default to Dispatch and should not be changed unless your patient was a walk-in patient
Receiving Hospital	Choose from the Pick List the TF you transported to
Destination Reason	Choose from the Pick List the reason for transporting the TF you chose
Transferred Care to	Type in the name of the nurse/doctor signing as receiving this patient from you. Click on the pencil icon next to the name and have the nurse/doctor sign. (if you are using the toughbook in the field)
Service Level	Chose ALS or BLS based on the level of service on this run

Report Validation Box:

You can find any Mandatory/Suggested etc information that still needs to be entered into your report in this area. Click on the field information and it will take you to the space for that information.

PLEASE NOTE: There is information that is needed on each Patient Care Report that is not listed here as mandatory. If you have the information you are required to enter it to make a complete Patient Care Report.

Please remember that your entire run report will need to be completed in EMS Solutions (you may start with StatPad if you choose) and that this is your LEGAL document (like the paper form is now) for this run.

The **Close**, **Print**, **Preview**, **Back**, and **Next** buttons work just as they do on all of the previous pages.

After you are satisfied with your data input, you are ready to submit your run to the HQ SERVER.

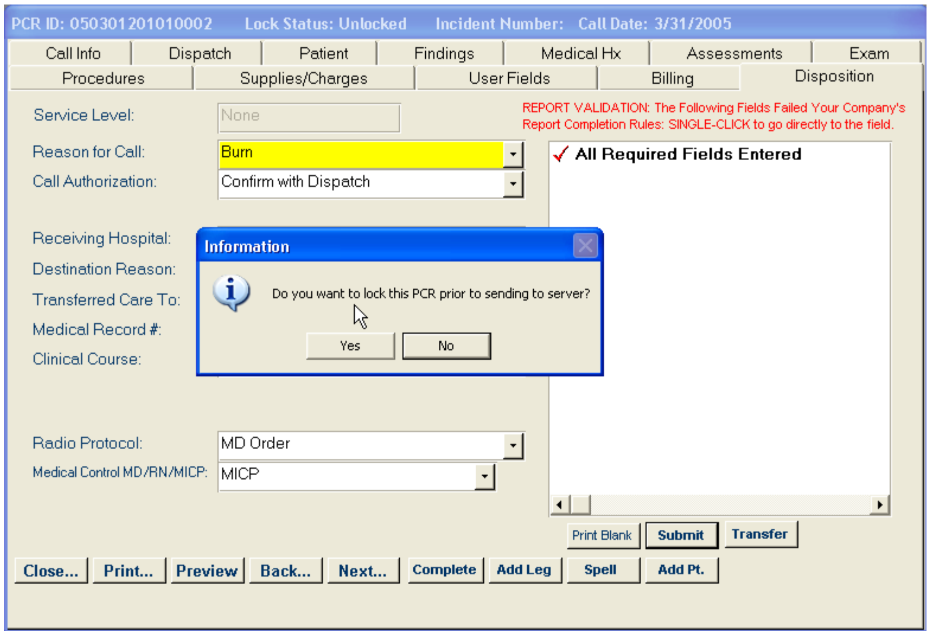
4. Export Records to Server

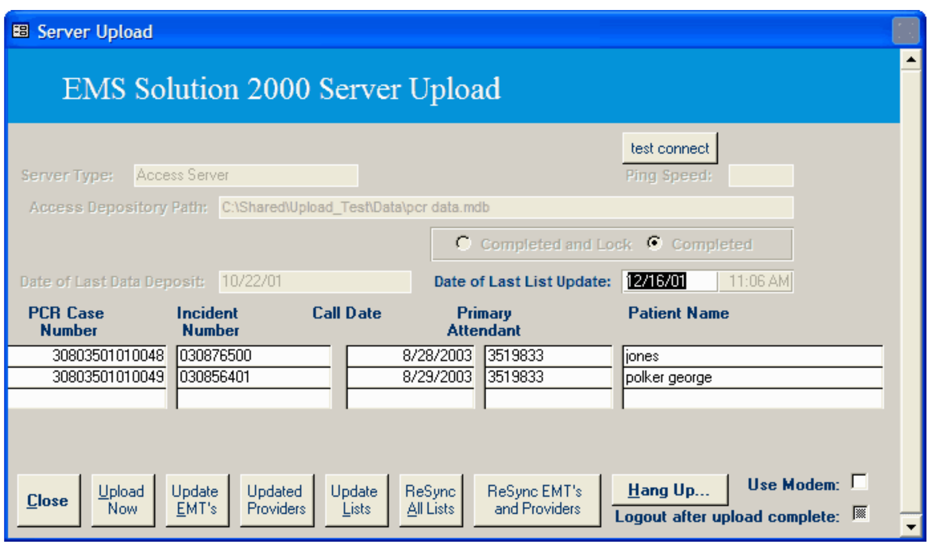
Submit Records from Desktop

On the **Disposition** page CLICK **Complete**

The **Submit** button will NOW be available for you to submit your report to HQ's server.

Click on the **Submit** button.





The **Server Upload** window will be displayed. If you are connected to the server, you can select **Upload Now** and submit your ePCR to HQ's server.

Important Reminders:

Remember to put your station number, run number and date of service on the hospital face-sheet (or to do an incident report if you were unable to get a face-sheet) and fax it to billing at 740-446-8282. Then place the face-sheet in the lock box for mailing to HQ.

Also, if you have any photos from your run (injury or accident scene) write the station number, run number and date of service on them and staple them to the face-sheet before placing it into the lock box.

****Directions for Importing your LP12 Data into your toughbook ePCR.

1. Attach USB from LP12 (GREY round input port on the back of the LP12 right side –same side as the code summary button) to a USB port on the toughbook.
2. Open Solutions on the toughbook and Choose Edit an Existing Patient Care Report (you will have to give a reason for editing). Choose the report you are finishing.
3. Go to the User Fields Tab and click on the Read Physio button. You will be taken to the Physio Interface.
4. **Turn on your LP12.** Click the Options button.
5. Choose Archives and hit Enter then choose Yes to enter patient archives.
6. Click on Send Data button
7. Choose Patient and click Enter
8. Find your patient and click Enter
9. Click on the Upload button on the **TOUGHBOOK.**
10. On LP12 move back up to the top at "Send", click Enter. At the bottom of this screen will be the word 'connecting' and on the toughbook physio interface screen near the bottom left is a % status indicator. When it reaches 100% you have successfully imported your data.
12. Click on the Next button on the top right screen on your toughbooks and make sure that the ECG you just uploaded is highlighted.
13. Click on the Next button on the top right screen on your toughbooks
14. Click on the Next button on the top right screen on your toughbooks and you should now be at the screen on the toughbook that has an Exit button on the top right. Click this Exit button.
15. Close out of the Physio Interface screen by clicking the small X in the upper right corner and turn off the LP12.
16. You are now ready to transfer your ePCR from the toughbook to the desktop for completion (if not already complete) and transfer to the HQ Server. **SEE PAGE 11 of Toughbook Manual for Directions**