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HOPE Consortium

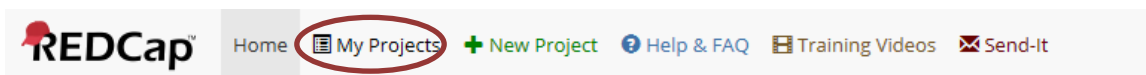
REDCap

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Logging into REDCap

1. In web browser enter URL: <https://redcap.mcrf.mfldclin.edu/redcap/birc/>
2. Enter username and password.
3. Click “Log In”.
4. Click “My Projects”.



5. Under Project Title click “HOPE Consortium”.

Listed below are the REDCap projects to which you currently have access. Click the project title to open the project. [Read more](#)
To review which users still have access to your projects, visit the [User Access Dashboard](#).

My Projects Organize					
Filter projects by title					
Project Title	Records	Fields	Instrument	Type	Status
HOPE Consortium	50	234	13 forms		



6. Under Project Bookmarks tab click “Dashboard”.

Searching/Adding a Patient

1. You are now on the HOPE Patient Dashboard. Enter patient’s name into Search box.


HOPE Participant Dashboard


Additional Statuses

- Participant is Pregnant
- Participant is an IV Drug User

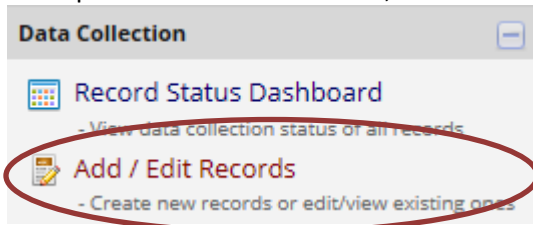
Show entries

Search:

2. If the correct patient name is found, click  next to the name of the patient you wish to view. *Note: if the patient was previously enrolled in the HOPE consortium but has left the program they will show as RED and must be re-consented.*

Denver, John Test	Red means closed and must be re-consented	Gurney	
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- If the patient name is not found, click the “Add/Edit Records” button under the Data Collection tab.



- Click “Add new record”.

Total records: 50

Choose an existing Record ID: -- select record --

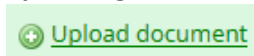
Add new record

- Click the Consent/Intake Entry clear dot under intake and consent.

Data Collection Instrument	Intake and Consent	ASAM Assessment	PPS Episode of Care	PPS Service Detail	WHOQoL-BREF	Care Coordination	Summary of Strength and needs	Referral Information	SUDDS-5 TAAD-5	Communication Log
Consent/Intake form	<input type="radio"/>									
Demographic Form	<input type="radio"/>									
Status Update form	<input type="radio"/>									
Care Coordination Referral Form						<input type="radio"/>				
Care Coordination Office Form						<input type="radio"/>				
Strength Needs Form							<input type="radio"/>			
Communication Log										<input type="radio"/>
Who-QoL BREF Scored					<input type="radio"/>					
PPS Episode Details			<input type="radio"/>							
PPS Service Detail				<input type="radio"/>						
ASAM Placement Criteria		<input type="radio"/>								
Suddstaad									<input type="radio"/>	
Referral Information								<input type="radio"/>		

Consent/Intake Form

- Upload the Consent Form. **First be sure you have the document stored on your computer before uploading.** Once the document is on your computer, click “Upload document”.



- Click “Browse” and find the file saved on your computer. Once the file is selected, click “Upload document”. *Note: the document cannot be viewed until the save button is clicked.*

Upload document

Please upload the HOPE Consortium Consent Form
(hope_consent_upload)

Select a file then click the 'Upload Document' button

Browse...

Upload document (Max file size: 32 MB)

- Fill in the date that the patient is consenting to enter the program. *Note: this date must be earlier than any other date entered into REDCap for REDCap to function properly.*

- Enter Patients status: Click "Active".
- If the form is complete, change the form status to Complete. If the form is not complete, mark the status as incomplete.

Form Status

Complete?

Incomplete
Unverified
Complete

Save & Exit Form Save & ...

-- Cancel --

- Once this page is complete, click "Save & Exit Form".
- Immediately after clicking "Save & Exit Form", the following box will appear.

New Record (1/3): Release of Information Required.

You are in the process of creating a new record. This patient must have a signed release of information form before data can be entered into REDCap.

Please go to the ROI form to update this document.

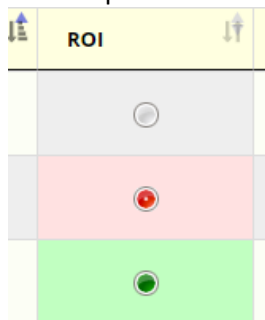
Go to ROI Form

- Click "Go to Demographics form".

Release of Information (ROI)


- The ROI must be updated every year. The dashboard will show an ROI bubble. The following key indicates the action needed:
 - Clear: no action is needed.
 - Red: no ROI on file or ROI is overdue.
 - Green: ROI needs to be updated soon.

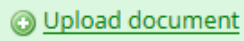
After 11 months since the previous ROI signature, the bubble will turn green alerting you that it is time to update the ROI consent. Hovering over the bubble will give details regarding the signed ROI.



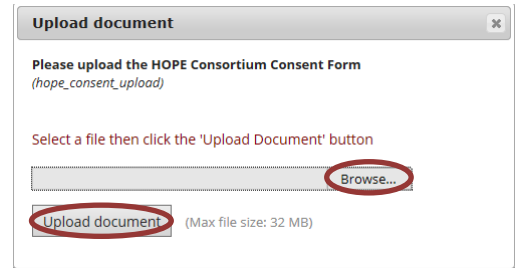
- If the ROI is expired click the open button in the dashboard.

Wall, Daniel Michael	Bagdad		Open
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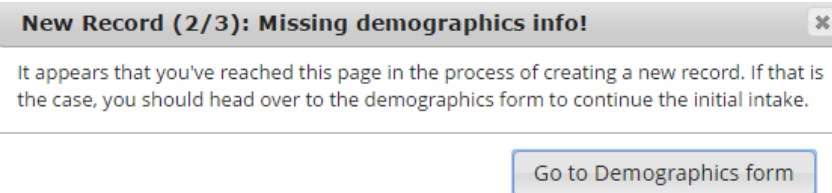
- Click the  button located at the top of the page.
- Enter the Date of the ROI.
- Upload the ROI Form. **First be sure you have the document stored on your computer before uploading.** Once the document is on your computer, click “Upload document”.



- Click “Browse” and find the file saved on your computer. Once the file is selected, click “Upload document”. *Note: the document cannot be viewed until the save button is clicked.*
- If the form is complete, change the form status to Complete. If the form is not complete, mark the status as incomplete.



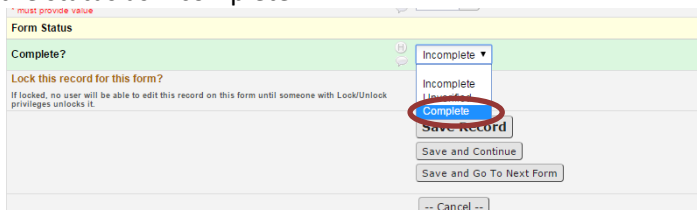

- Once this page is complete, click “Save & Exit Form”.
- Immediately after clicking “Save & Exit Form”, the following box will appear.



- Click “Go to Demographics form”.

Demographics Form

- Fill out the demographics form completely. Some fields in this form are used in PPS reporting so it is important to fill in all known information.
- If the form is complete, change the form status to Complete. If the form is not complete, mark the status as incomplete.



3. Once this page is complete, click “Save & Exit Form”.

Save & Exit Form

4. Immediately after clicking “Save & Exit Form”, the following box will appear.

NEW RECORD (3/3): Missing additional status info! ✕

You're almost there! Now we just need the additional info that lives in the **Status Update Form**. To finish the intake process for this patient, let's head over to that form.

[Go to Status Update form](#)

5. Click “Go to Status Update form”.

Status Update Form

1. Note “All fields you would like to update” are automatically checked. This is important for PPS Reporting. Fill in all known information.
2. If the form is complete, change the form status to Complete. If the form is not complete, mark the status as incomplete.

* must provide value

Form Status

Complete?

Lock this record for this form?
If locked, no user will be able to edit this record on this form until someone with Lock/Unlock privileges unlocks it.

Incomplete
Incomplete
Unverified
Complete

Save Record

Save and Continue

Save and Go To Next Form

-- Cancel --

3. Once this page is complete, click “Save & Exit Form”.

Save & Exit Form

4. You are now on the HOPE Patient Dashboard.

Updating Patient Status:

There may be occasions where the patient status needs to be updated. The following items can be updated at any time.

<input type="checkbox"/> Address	<input type="checkbox"/> Co-Existing Mental Illness
<input type="checkbox"/> Arrests	<input type="checkbox"/> Number of Minor Children
<input type="checkbox"/> Deaf or hard of hearing	<input type="checkbox"/> Pregnancy Status
<input type="checkbox"/> Employment	<input type="checkbox"/> Probation status
<input type="checkbox"/> Insurance information	<input type="checkbox"/> Residential Treatment
<input type="checkbox"/> Living arrangement	<input type="checkbox"/> Support Group

Updating a Status:

1. Click the “Status Update” button.

Participant Summary [+ Status Update](#) [Toggle Substance Info](#)

2. Complete the date and select the area(s) you wish to update.

The screenshot shows a form titled 'Record ID 55'. A large blue arrow points from the text 'Select item(s) to update' to a list of checkboxes on the right. Below this, a smaller blue arrow points from the text 'Date' to a date input field. The date field has a calendar icon and a 'Today' button. The form also includes instructions: 'Please check all fields you would like to update.' and 'If this is initial entry please check all boxes'. A red asterisk indicates that a value must be provided for certain fields.

Record ID 55

Select item(s) to update

Please check all fields you would like to update.

If this is initial entry please check all boxes

* must provide value

- ☐ Address
- ☐ Arrests
- ☐ Deaf or hard of hearing
- ☐ Employment
- ☐ Insurance information
- ☐ Living arrangement
- ☐ Co-Existing Mental Illness
- ☐ Number of Minor Children
- ☐ Pregnancy Status
- ☐ Probation status
- ☐ Residential Treatment
- ☐ Support Group

Date of Status

Date

* must provide value

Today M-D-Y

3. Fill in all fields.
4. Click "Save and Exit form".
5. In this example pregnancy status was updated to post-partum. The update now appears in the patient summary.

The screenshot shows a patient summary form with various fields. A blue box highlights the 'Pregnancy Status' field, which is set to 'Postpartum'. Other fields include 'Address', 'County of Residence', 'Postpartum Date', 'Postpartum Status', 'Does the baby reside with the mother?', 'Neonatal Abstinence Syndrome (NAS)', 'IV Drug Use', 'Currently in Residential Treatment', 'Primary Drug of Choice', 'On Probation', 'Parole officer name', and 'Mental Health Issues'.

Address: 4564 Seaway Road
Cavour 54103

County of Residence: Oneida County

Pregnancy Status: Postpartum

Postpartum Date: 02/02/2017

Postpartum Status: Live Birth

Does the baby reside with the mother? Yes

Neonatal Abstinence Syndrome (NAS): Yes

IV Drug Use: Yes

Currently in Residential Treatment: No

Primary Drug of Choice: Opiates

On Probation: Yes

Parole officer name: Leila Deering

Mental Health Issues: No

6. Once a patient is past their known due date the alert below will appear.

Note: Participant is pregnant, with an estimated delivery date of 01/19/2017
Participant is past the expected due date. Please update this information.

Patient Financial Navigator (PFN):

Within the status update form there is a refer to Patient Financial Navigator, which is an employee who will work with patients and their insurance information. **When do you refer to PFN?** You refer to PFN anytime you have a patient who has an insurance concern, high deductible, no insurance, or has insurance questions.

1. To refer to PFN click the Refer to PFN button.

Refer to Patient Financial Navigator?
❗ Patient is eligible for referral to PFN.


[Refer to PFN](#)


2. Once you click the button you receive a Success message.


Success! Patient referred to PFN


Updating a Phone Number:

1. To update a phone number click on the “Demographics” button.

 **Miss Ariel Deering** [Demographics](#)


 Patient is currently enrolled in Care coordination

 (555) 555-5555

 (555) 555-5555

Okay to leave voicemail: **Yes**

Okay to text message: **Yes**

 01/07/1987 (30)

Alternate Contact Information

Eric Husband -5555555555

2. Find the phone number to update, erase the previous number and add the new number.

Home Phone Number:	<input type="text" value="(555) 555-3333"/>
Cell Phone number	<input type="text" value="(555) 555-5555"/>

3. Click “Save and Exit form”.

[Save & Exit Form](#)

Patient Detail Dashboard Overview

1. The patient detail dashboard gives an at-a-glance view of all patient data from multiple forms. The patient summary information can be updated by clicking the “Status Update” button.

[+ Status Update](#)

2. Substance Information can be found by clicking the “Toggle Substance Info” Button.

Patient Summary [+ Status Update](#) [▼ Toggle Substance Info](#)

<u>Primary Substance</u>		<u>Secondary Substance</u>		<u>Tertiary Substance</u>	
Problem	02 Alcohol	Problem	04 Marijuana/THC	Problem	10 LSD
Usual Route of Administration	01 - Oral	Usual Route of Administration	03 - Inhalation	Usual Route of Administration	09 - Unknown
Use Frequency	Daily	Use Frequency	1-3 days in the past month	Use Frequency	Unknown
Age of First Use	24	Age of First Use	5	Age of First Use	85

[Update Substance Information](#)

- To update the Substance information, click the “Update Substance Information” button.
You will then be redirected to the demographics form.

[Update Substance Information](#)

Refer to Care Coordination

Once the patient is entered into the system they can be referred to care coordination. The following steps will walk you through the referral.

- Click the “Refer to Care Coordination” button.

Mrs. HOPE Test [Demographics](#)

⊘ Patient is neither referred to or enrolled in Care coordination

[+ Refer to Care coordination](#)

📞 No phone or no number provided

📱 No cell phone number provided

Okay to leave voicemail: **No**

Okay to text message: **No**

📅 02/11/1992 (25)

- Complete all questions on the form.

- Upload a copy of the Release of Medical Information (RMI). First be sure you have the document stored on your computer before uploading. Once the document is on your computer, click “Upload document”.

[Upload document](#)

- Click browse and find the file saved on your computer. Once the file is selected, click Upload document. *Note: the document cannot be viewed until the save button is clicked.*

Upload document ✕

Attach Copy of Signed RMI 1 (rmi_attach_1)

Select a file then click the 'Upload Document' button

[Choose File](#) | No file chosen

[Upload document](#) (Max file size: 32 MB)

- If the form is complete, change the form status to Complete. If the form is not complete, mark the status as incomplete.

Form Status
Complete?

Incomplete
Unverified
Complete

[Save & Exit Form](#)
[Save & ...](#)


[-- Cancel --](#)

[Save & Exit Form](#)

- Once this page is complete, click “Save & Exit Form”.
- You are now redirected back to the patient dashboard. *Note: the message under the patient’s name has changed. The referral has been sent to care coordination and will assign the patient to a care coordinator.*

 Patient has been referred to Care coordination, but not yet assigned

Note: there may be times when the following message is displayed.

 This patient was closed from CC on **12/20/2016**. Please complete a referral form to re-enroll them into CC

This means that the patient has left care coordination for a certain reason. The choice to refer to care coordination is active again and the option to make a new referral to care coordination is available, if needed. The reason why patient left care coordination is available to view by closing the care coordination tab and pushing the toggle button.

Patient Data Entry Forms Communication Log

The purpose of the communication log is to document visit(s), both attended and no show. The following steps will walk you through completing the communication log.

Creating a New Entry:

1. Click on Communication Log and select the "New Visit Entry" button.

[+ New Visit Entry](#)

Patient Data Entry Forms

[Care Coordination](#) [Communication Log](#) [UDT](#) [WHOQOL-BREF](#) [PPS](#) [ASAM](#) [SUDDS-5/TAAD-5](#) [Referral Info](#) [Consent/Intake](#)

2. Enter the date of the visit.
3. Indicate if the patient attended his/her appointment.
4. Select the type of contact & location.
5. Indicate if there are medication or care plan changes.
6. Enter any brief appointment notes. **Full documentation will be done in the chart.
7. If the form is complete, change the form status to Complete. If the form is not complete, mark the status as incomplete.

Form Status	Incomplete Unverified Complete
Complete?	<input checked="" type="radio"/> Complete
Save & Exit Form Save & ...	
-- Cancel --	

8. Once this page is complete, click “Save & Exit Form”.

Save & Exit Form

9. You are now redirected back to the patient dashboard. Click on the Communication Log to view the visit you just entered.

Updating a Patient Visit:

Each patient will have a visit summary tab for each visit. A sample summary is shown below and is color-coded by visit type.

The screenshot shows the 'Communication Log' interface. At the top, there is a '+ New Visit Entry' button. Below it, a legend identifies visit types by color: AODA visit (red), Group Visit (blue), Urine Screen (yellow), MAT visit (green), Mental Health Therapist (purple), Psychologist (pink), Psychiatrist (orange), 1:1 Care Coordination (grey), Team Meeting-Care Coordination (dark red), and Tipline (teal). A 'No Show' flag is also indicated.

The 'Visit Tabs' section on the left lists several visits with their dates and types. A callout points to a 'No Show Flag' on a visit dated 01/05/2017. Another callout points to a visit labeled 'Instance 3' (PSYT) dated 01/03/2017, stating 'This means date is missing for this entry'.

The main area displays the details for the selected visit (02/11/2017, AODA visit). The details include: Date of Contact? 02/11/2017, Type of Contact? AODA visit, Appointment Notes: Did the patient attend his/her appointment? Yes, Unable to connect with patient, Reason you could not connect by phone? MAT Medication UDT, Non-prescribed medications, Illicit Substances, Was there a Medication Change? No, Please explain the medication change, Was there a Care Plan Change? No, Please explain the change in plan, Date of Tipline, Type of Tip Reported, and a Link button.

10. If a visit summary tab displays “Instance”, that means that a date is missing. Click on the tab and then click the Link button on the bottom of the log to update. [Link](#)

The screenshot shows the 'Date of Contact?' form field. The field is highlighted with a red oval. Below the field, there is a red asterisk and the text '* must provide value'. To the right of the field, there is a calendar icon and a 'Today' button.

11. The tab is now updated with a date.


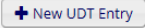
The screenshot shows the updated 'Visit Tabs' list. The visit previously labeled 'Instance 3' (PSYT) is now dated 01/03/2017 and is highlighted with a red oval. The other visits in the list remain the same.

UDT

1. To view UDT information click on the UDT tab.

Patient Data Entry Forms

The screenshot shows the top navigation bar with tabs: Care Coordination, Communication Log, UDT (circled in red), WHOQOL-BREF, PPS, ASAM, SUDDS-5/TAAD-5, Referral Info, and Consent/Intake. Below the navigation bar is a header for 'Communication Log (UDT)' with a '+ New UDT Entry' button. A table with five columns is visible: Date of Contact?, MAT Medication UDT, Non-prescribed medications, Illicit Substances, and Form.

2. This displays all UDT information. To view the form, click  in the form column.
3. To record a new patient visit, click the New UDT Entry button. 
4. Enter the date of the assessment.
5. Complete all questions on form.
6. If the form is complete, change the form status to Complete. If the form is not complete, mark the status as incomplete.

The screenshot shows a dropdown menu for 'Form Status' with options: Incomplete, Unverified, and Complete (circled in red). Below the dropdown are buttons: 'Save & Exit Form', 'Save & ...', and '-- Cancel --'.

7. Once this page is complete, click "Save & Exit Form". 


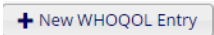
WHOQOL-BREF

The purpose of the WHOQOL-BREF is to clearly see changes in individual scores over time and report outcomes of WHOQOL-BREF changes.

1. To view WHOQOL-BREF information click on the WHOQOL-BREF tab.

Patient Data Entry Forms

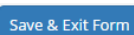
The screenshot shows the top navigation bar with tabs: Care Coordination, Communication Log, UDT, WHOQOL-BREF (circled in red), PPS, ASAM, SUDDS-5/TAAD-5, Referral Info, and Consent/Intake. Below the navigation bar is a header for 'Communication Log (UDT)' with a '+ New UDT Entry' button. A table with five columns is visible: Date of Contact?, MAT Medication UDT, Non-prescribed medications, Illicit Substances, and Form.

2. This displays all WHOQOL-BREF information. To view the form, click  that is next to the date.
3. To record a new patient visit, click the “New WHOQOL Entry” button. 
4. Enter the date of the assessment.
5. Complete all questions on form.
6. If the form is complete, change the form status to Complete. If the form is not complete, mark the status as incomplete.



The screenshot shows a dropdown menu for the 'Form Status' field. The menu is open, showing three options: 'Incomplete', 'Unverified', and 'Complete'. The 'Complete' option is highlighted with a red circle. Below the dropdown are three buttons: 'Save & Exit Form', 'Save & ...', and '-- Cancel --'.

7. Once this page is complete, click “Save & Exit Form”.

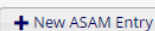


ASAM

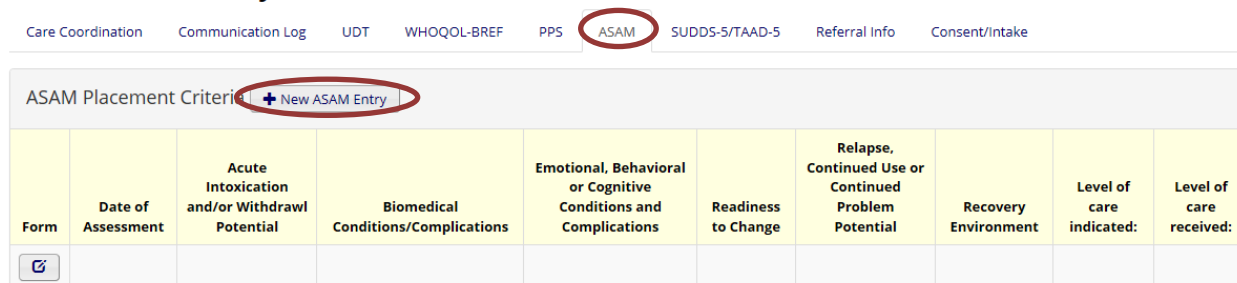
This displays the results of each ASAM dimension score and the level of care indicated and received.

Creating a New Entry:

1. Click on the tab ASAM and select



Patient Data Entry Forms



The screenshot shows the 'Patient Data Entry Forms' interface. At the top, there are several tabs: 'Care Coordination', 'Communication Log', 'UDT', 'WHOQOL-BREF', 'PPS', 'ASAM', 'SUDDS-5/TAAD-5', 'Referral Info', and 'Consent/Intake'. The 'ASAM' tab is selected and circled in red. Below the tabs, there is a section titled 'ASAM Placement Criteria' with a '+ New ASAM Entry' button circled in red. Below this is a table with 10 columns: 'Form', 'Date of Assessment', 'Acute Intoxication and/or Withdrawal Potential', 'Biomedical Conditions/Complications', 'Emotional, Behavioral or Cognitive Conditions and Complications', 'Readiness to Change', 'Relapse, Continued Use or Continued Problem Potential', 'Recovery Environment', 'Level of care indicated:', and 'Level of care received:'. The 'Form' column has a dropdown menu with the 'eye' icon selected.

2. Enter the date of the assessment.
3. Complete all questions on form.
4. If the form is complete, change the form status to Complete. If the form is not complete, mark the status as incomplete.



The screenshot shows a dropdown menu for the 'Form Status' field. The menu is open, showing three options: 'Incomplete', 'Unverified', and 'Complete'. The 'Complete' option is highlighted with a red circle. Below the dropdown are three buttons: 'Save & Exit Form', 'Save & ...', and '-- Cancel --'.

- Once this page is complete, click "Save & Exit Form".

Save & Exit Form

Updating a Record:

- If you need to update or view a form, click



. You will then be taken to the ASAM form.

- When complete, click "Save & Exit Form".

Save & Exit Form

SUDDS-5/TAAD-5

- Click on the tab SUDDS-5/TAAD-5 and select

+ New SUDDS-5 TAAD-5 Entry

Patient Data Entry Forms

Care Coordination Communication Log UDT WHOQOL-BREF PPS ASAM **SUDDS-5/TAAD-5** Referral Info Consent/Intake

SUDDS-5/TAAD-5 + New SUDDS-5 TAAD-5 Entry

Form	Date of assessment	Alcohol	Cannabis	Cocaine	Stimulants--amphetamine or other	Inhalants	Opioids	Sedatives/hypnotics/anxiolytic	Hallucinogens: Phencyclidine/other
	01/01/2017	Mild: 305.00 (F10.10)	No diagnosis	Moderate: 304.20 (F14.20)	Moderate: 304.40 (F15.20)	Mild: 305.90 (F18.10)	Mild: 305.50 (F11.10)	Mild: 305.40 (F13.10)	No diagnosis

- Enter the date of the assessment.
- Complete all questions on form.
- If the form is complete, change the form status to Complete. If the form is not complete, mark the status as incomplete.

Form Status

Complete?

Incomplete
Unverified
Complete

Save & Exit Form Save & ...

-- Cancel --

- Once this page is complete, click "Save & Exit Form".

Save & Exit Form

Updating a Record:

- If you need to update or view a form click



You will then be taken to the ASAM form.

- When complete, click "Save & Exit Form".

Save & Exit Form

Referral Information

The purpose of this tab is to track all referrals for the patient's treatment. Follow the steps below to create a new referral.

1. Click + New Referral button.
2. Enter the date of the referral.
3. Complete the questions on the form.
4. If the form is complete, change the form status to Complete. If the form is not complete, mark the status as incomplete.



The screenshot shows a form titled "Referral Information" with a "+ New Referral" button. Below the title, there is a dropdown menu for "Form Status" with options: "Incomplete", "Unverified", and "Complete". The "Complete" option is highlighted with a red circle. Below the dropdown, there are buttons for "Save & Exit Form", "Save & ...", and "-- Cancel --".

5. Once this page is complete, click "Save & Exit Form".

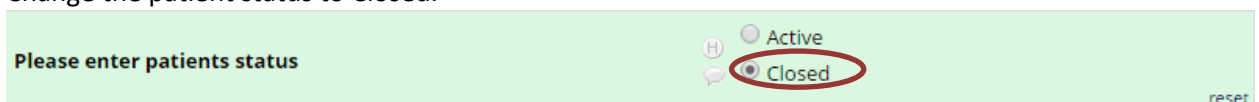
Save & Exit Form

Patient Closed Out From Program

If a patient withdraws consent, completes the program, or is deceased, they should be closed out from the program. *Note: once closed no further data will be collected on a patient and they must be re-consented to HOPE before additional data can be collected.* Complete the following steps to close a patient from the program.

1. Go to the participant detail dashboard and click
2. You will then be redirected to the consent/intake form.
3. Change the patient status to Closed.

Consent & Close

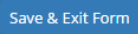


The screenshot shows a form titled "Please enter patients status" with two radio button options: "Active" and "Closed". The "Closed" option is highlighted with a red circle. There is a "reset" link in the bottom right corner.

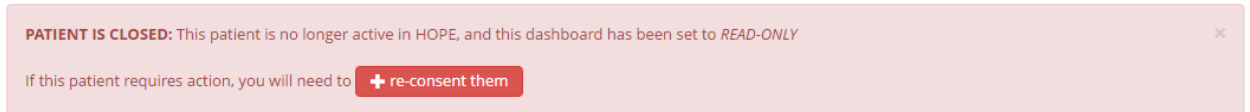
4. Complete the form to close the patient.
5. If the form is complete, change the form status to Complete. If the form is not complete, mark the status as incomplete.



The screenshot shows a form titled "Referral Information" with a dropdown menu for "Form Status" with options: "Incomplete", "Unverified", and "Complete". The "Complete" option is highlighted with a red circle. Below the dropdown, there are buttons for "Save & Exit Form", "Save & ...", and "-- Cancel --".

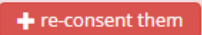
6. Once this page is complete, click “Save & Exit Form”. 

7. You will now notice the following alert under the patient’s name.



8. Additionally, all other update buttons have been de-activated and you cannot update any information on this patient until they are re-consented.

Re-enrolling a Patient who has been closed out:

1. Click the  button found on the patient detail dashboard.
2. Complete the consent/intake form and upload new consent.
3. If the form is complete, change the form status to Complete. If the form is not complete, mark the status as incomplete.

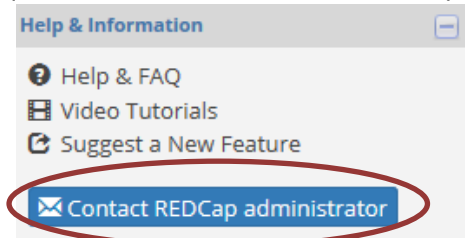
A screenshot of a form status dropdown menu. The menu is open, showing three options: "Incomplete", "Unverified", and "Complete". The "Complete" option is highlighted with a red oval. Below the dropdown, there are three buttons: "Save & Exit Form", "Save & ..." (with a dropdown arrow), and "-- Cancel --".

4. Once this page is complete, click “Save & Exit Form”. 

Frequently Asked Questions

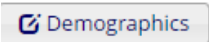
Q1. How do I get further help or ask a specific question?

A. The easiest way to ask a question is to look at the lower left hand side of your screen under Help & Information. Click the Contact REDCap Administrator button. An email will open. Type your question and the email will be directly sent to the REDCap Support Team.



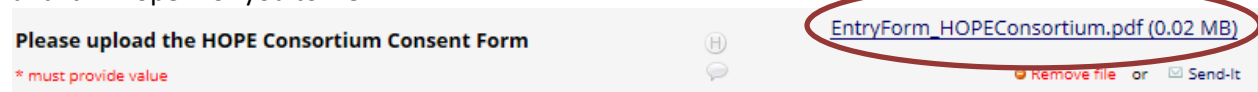
Q2: How do I update a phone number?

A: Phone numbers are found in the demographics form because we will over write this data. Select the [Demographics](#) button and update the phone number as you see fit.



Q3: How can I see the Consent in the REDCap database?

A: Push the [Consent & Close](#) button. This will bring you to the consent and intake form. Click the file and it will open for you to view.



Q4: Why is the patient highlighted in red in the HOPE Patient Dashboard list?

A: This means the patient is closed from the REDCap Consortium. You can still view the data but a new consent must be obtained to collect further data.

