REQUEST FOR NEW OR REVISION OF MEDICAL RECORD FORM

All forms or revisions to a Medical Record must include this request form.

Date of Request: _______________

1. Clinic or Office requesting this Form:______________________________________

2. Who are the intended users of the Form (individual, requesting clinic, all clinics)?
   _______________________________________________________________
   _______________________________________________________________

3. What is the purpose of the Form? _______________________________________
   _______________________________________________________________

4. Where will this form be located in the Medical Record? Paper or Electronic?
   _______________________________________________________________

5. Which EMR (Cerner or Centricity)? _______________________________________

6. Who will be completing the form when applicable? _______________________
   _______________________________________________________________

7. Who will be scanning the paper completed form into the EMR when applicable?
   _______________________________________________________________

8. Are there any copyright issues to be considered or disclosed? ______________
   _______________________________________________________________

9. Does it need to be translated into Spanish? _______________________________
   _______________________________________________________________

10. Is the Medical Director (if applicable) in agreement with the creation or revision of
    the form? Circle: Yes or No

11. Has the form been formatted with all the elements indicated in Policy 5.21?
    _______________________________________________________________
Submission: E-mail requests for paper forms to the Medical Records Department, and for electronic forms to the Clinical Information Systems Office.