Texas Tech Physicians of EL PASO

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)?

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   ____

3. What is the purpose of the Form? ______________________________________

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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?

    ____

Requester Signature Date

Clinic Manager Signature Date

Clinic Medical Director/Department Chair Signature Date

Submission: E-mail requests for paper forms to the Medical Records Department, and for electronic forms to the Clinical Information Systems Office.