

## REQUEST FOR NEW OR REVISED FORM

<b>SECTION I: General Information</b>	
<b>DATE:</b> <input type="checkbox"/> New Form <input type="checkbox"/> Revised Form <b>DEPARTMENT CREATING/REVISING FORM:</b>	<b>POC &amp; EXTENSION:</b>
<b>PURPOSE OF FORM:</b> <input type="checkbox"/> Administrative use only ( <i>This form will not be placed in patient's inpatient/outpatient medical record</i> ) <input type="checkbox"/> Patient Care form ( <i>This form will be placed in the patient's medical record</i> )	<b>MUST LIST ALL GUIDANCES, DIRECTIVES, INSTRUCTIONS, AND REFERENCES PERTAINING TO FORM</b> ( <i>Can not leave blank</i> )
<b>FORM TITLE:</b> <input type="checkbox"/> Current Form # ( <i>bottom right side of form</i> ) is: _____ <input type="checkbox"/> Must attach copy of current form  <input type="checkbox"/> <b>NO</b> Form # (Must contact Command Forms Manager) <input type="checkbox"/> There are <b>NO</b> other form(s) similar or created for its' similar purpose. <b>Command Forms Manager: Initial/Date:</b>	

<b>SECTION II: What Departments and/or Specialties will use this information or be affected by this form?</b>			
Clinical	Nursing	Ancillary Services	Administrative
<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Outpatient Nursing Services (ED, Family Practice Clinic, Immunization Clinic)	<input type="checkbox"/> Case Management	<input type="checkbox"/> Administrative
<input type="checkbox"/> ENT	<input type="checkbox"/> Inpatient Nursing Services (4OB, MS5, ICU)	<input type="checkbox"/> Health Promotions	<input type="checkbox"/> Finance
<input type="checkbox"/> Family Practice	<input type="checkbox"/> Perioperative Nursing Services (APU Services, MOR/PACU)	<input type="checkbox"/> Nutrition/Dietician	<input type="checkbox"/> HIPAA/Legal
<input type="checkbox"/> General Surgery	<input type="checkbox"/>	<input type="checkbox"/> Laboratory/Bld Bank	<input type="checkbox"/> MS/SK Resources
<input type="checkbox"/> Internal Medicine	<input type="checkbox"/>	<input type="checkbox"/> Occupational/Physical Therapy	<input type="checkbox"/>
<input type="checkbox"/> Mental Health		<input type="checkbox"/> Pharmacy	
<input type="checkbox"/> Orthopedics		<input type="checkbox"/> Radiology	
<input type="checkbox"/> OB/Gyn		<input type="checkbox"/> Respiratory	
<input type="checkbox"/> Ophthalmology		<input type="checkbox"/> CSSR	
<input type="checkbox"/> Pediatrics			

**Department Heads/Specialty(s) are to initial/date above when the purpose, content, process, and any avoidable replication/duplication of form(s) have been addressed and agreed upon by the affected services.**

**Note: ALL APPLICABLE DEPARTMENTS/SPECIALITIES MUST AGREE WITH NEW/REVISED FORM PRIOR TO SECTION III**

<b>SECTION III:</b>			
NO.	TO:	SIGNATURE	DATE:
<b>1</b>	Department Head: Will this form go into inpatient, outpatient or military record? <input type="checkbox"/> Yes, continue <input type="checkbox"/> No, skip to 6		
<b>2</b>	Risk Management Code 00QM	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved: Reason	
<b>3</b>	Inpatient/Outpatient Records	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved: Reason	
<b>4</b>	Pharmacy and Therapeutics Committee Meeting Date:	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved: Reason	
<b>5</b>	Medical Records Review Committee Meeting Date:	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved: Reason	
<b>6</b>	Forms Manager, (to acknowledge routed properly and/or external routing is needed)	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved: Reason	
<b>7</b>	Assigned Form # by Forms Manager is:		

If you would like the form printed after approval, provide NHBREM 5600/4

NHBREM 5600/3(Rev4/09)