St. Peter's Health

2475 Broadway • Helena, MT 59601

Request for Approval of New or Revised Medical Record Form

Route completed forms and attachments to the Medical Records Director.

Requestor/Author:	Department:
Telephone:	Department Director's Signature:
Date Submitted:	Date Received in Medical Records:

This form is a:

___ new form (proof of the proposed form is attached)
___ pilot form   Proposed length of the pilot is ______ weeks.
___ revised form (Attach copy of current form and proof of proposed form)
___ combination of forms (attach copies of all current forms and a proof of the proposed form)

Form Title   Form Number (if revision)
What is the intended purpose and use of the form?
Does this form reflect current knowledge in the field? ___Yes ___No
Is there another active form for the same purpose or procedure? ___Yes ___No If yes, attach a copy and describe why the other form will not work:
Does the form comply with all for specifications listed in the attached policy? ___Yes ___No If no, please state why:
Is this a multipart form? ____Yes ____No If so, list the distribution for each part.
Who is responsible for completing and signing the form? (for example; physician, respiratory therapist or nurse)
What is the estimated monthly usage of the form? ____ copies.
New Forms Only: How is this information currently being documented?
Revised or Combination Forms Only: Will existing stock be used up? ___Yes ___No State the reason for the revision or combination of forms.
List the medical departments and provider groups that will be affected by the proposed form on the back of this form. Note the date they reviewed and accepted the contents of the form.

List all departments that will use or will be affected by the proposed form.
Note the date the contents were reviewed and accepted.

Department Name	Date of Acceptance
Department Name	Date of Acceptance
Department Name	Date of Acceptance
Department Name	Date of Acceptance

List the medical departments and provider groups that will be affected by the proposed form.
Note the date they reviewed and accepted the contents of the form.

Medical Department or Provider Group	Date of Acceptance
Medical Department or Provider Group	Date of Acceptance
Medical Department or Provider Group	Date of Acceptance
Medical Department or Provider Group	Date of Acceptance

Forms Committee Approval

Presented for final approval on ___________. Approved? ___Yes ___No

Reason not approved____