INVISION System Change Request (SCR) Form

Section I: Requestor's Information

Date: _____ / _____ / _____      Date Desired: _____ / _____ / _____
Name: __________________________________________________  Department:  ____________________________
Title:  __________________________________________________ Phone: 675 - ________ Priority:  ________
(High, Middle, Low)

Section II: This Change Will Impact:

☐ PM – Patient Management/ Reg  ☐ OE – Order Entry  ☐ PA – Patient Accounting  ☐ RSS – Resource Scheduling
☐ LCR – Lifetime Clinical Records  ☐ Nursing  ☐ Ancillary/Foreign Sys:
☐ Other: _________________________________________ (ex: Physician Billing, Lab, Radiology, etc.)

Section III: Request Short Description:

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Section IV: Reason For Change:

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

I have taken the entire hospital into consideration before making this request. I have collected as much information as possible in order to provide complete and detailed information to Computer Services. This not only reflects the interest of my area but other areas that may be affected by this change. I recognize that it is my responsibility to make all necessary parties aware of this change before the request is submitted to Computer Services. I understand that inconsistent procedural issues throughout the hospital may prolong any project accepted by Computer Services. Computer Service’s ‘estimated complete date’ is strictly an estimate based on the detailed information obtained on the SCR and the current workload in Computer Services at the time this request is submitted.

Computer Services will not be held responsible for changes I have requested that may have a hospital-wide impact. I understand, as the requestor, I will be the key contact concerning this request.

______________________________________   _________________________________________   ____ /____ /____
Requestor’s Signature                Requestor’s Dept. Head                             Date
Section VI: Hospital Representative Signatures

I understand the recommended request and its impact / non-impact on the area I represent. I will take responsibility for distributing this information to the appropriate individuals in my area.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim Green, Hosp. Adm. – Admit/Reg Rep</td>
<td>Date</td>
<td>Clyde Oathout, Hosp Billing Dir – Financial Rep</td>
</tr>
<tr>
<td>Betty Johnson, Hosp. Adm. – Prof Serv Rep</td>
<td>Date</td>
<td>Pamela Simmons, Nursing</td>
</tr>
<tr>
<td>Theresa Deloach, Cl Mgr – Faculty Clinic Rep</td>
<td>Date</td>
<td>Charlotte Alford, Cl Mgr – Eye Clinic Rep</td>
</tr>
<tr>
<td>Beverly Wallace, Director – Medical Records</td>
<td>Date</td>
<td>Steve Conrad, M.D. – Emergency Med</td>
</tr>
<tr>
<td>Patricia Williams, Hosp Adm. – ACD Rep</td>
<td>Date</td>
<td>Ron Plaisance, Phy Billing Dir. – IDX Rep</td>
</tr>
<tr>
<td>Pamela Simmons, Nursing</td>
<td>Date</td>
<td>Linda Brown, Cl Mgr – CCC / FP Rep</td>
</tr>
</tbody>
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Fax request form to 675-8268. Questions? Call the HelpDesk – 5470, option #1