Royal Melbourne Hospital - Health Information Services

# Supporting statement for approval of Quality Assurance Study

Form to be completed if access to medical records is required (Item 2.7 on QA Application Form)

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| --- | --- | --- |
| QA Ref No. (provided by Office for Research | |  |
| Project Short Title |  | |

HIS Services and Charges

1. All Notes from the 15 Nov 2015 are on ECM/Epic (scanned medical record)
2. Records retrieval fee’s (cost centre must be provided)

* $3 per paper medical record retrieval (first 50 no charge)
* No charge for viewing medical record notes on ECM/EMR

1. Assistance with sample selection (i.e. from disease index) – negotiated if required
2. To request paper medical records, email list of UR numbers to RMH - HIS Special Requests, [SpecialRequests@mh.org.au](mailto:SpecialRequests@mh.org.au)

Conditions

1. Records must be viewed in the HIS department unless otherwise approved by a HIS manager
2. 48 hours’ notice required to retrieve records
3. The approval to view records must be produced on each occasion of retrieval
4. Records must be released for clinical care at any time
5. Records are available to view for 7 days only
6. A maximum of 20 records can be viewed at any one time

Details of this Project:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Principal Investigator: | |  | | | | | | |
| Number of records to be reviewed: | |  | | | | | | |
| Select one of the following: | Epic EMR only  Paper Medical Records  EMR *and* Paper Medical Records | | | | | | | |
| Expected Commencement Date of study | | |  | | | Expected Completion Date of study | |  |
| Is any other assistance required from HIS for this study? | | | | |  | | | |
| List names of RMH staff reviewing records | | | |  | | | | |
| Cost Centre for funds transfer **OR** Contact Name & billing address for external invoices | | | | | | |  | |

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| --- | --- | --- | --- |
| Based on the above information, HIS quotation for this study is: | | $ | |
| HIS Operations Manager | | | |
|  |  | |  |
| Name | Signature | | Date |

*THIS FORM WILL NOT BE ACCEPTED UNLESS SIGNED BY THE HIS MANAGER.*

Investigator Certification

I, the investigator:

* accept the charges and conditions as specified above
* approve Cost Centre funds transfer to MRM-P0202-61905

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| --- | --- | --- |
|  |  |  |
| Name | Signature | Date |