



Form Approval Routing Sheet

Instructions

1. Please use this routing sheet as a cover page for all forms.
2. Form should follow order of committees as listed.
3. Form must have internal stakeholder approval before submission (Quality, Medical Records, Nursing).
4. Each committee must approve the form with department head signature.
5. It is the responsibility of the department/requestor to obtain all required signatures and return to final approved form to the Chairperson of Forms Committee before any form can be reproduced.
6. WorkflowOne provides 2 proofs at no cost for items they produce, after the second proof they charge \$48.00 per round of corrections. All excess proofing charges will be the responsibility of the initiating department(s).

Contact Information:

Date: _____ Submitted by: _____
 Extension: _____ Department/Cost Center: _____
 Date Needed: _____ Department Needing Form: _____
 Chairperson: _____ Chairperson Signature: _____

Form Information:

Form Name: _____
 Current Form: YES NO If Yes, Workflow # _____
 Carbon Needed 1PLY 2PLY 3PLY If Yes, Color(s) Needed _____
 Average Number of copies used per year _____ Part of Final Medical Record YES NO

Standard Questions:

1. What is the purpose of the form? _____

2. Benefits of new or revised form? _____
3. Could a current form be revised to eliminate the creation of a new form? YES NO
4. Does another form exist that is similar or contains similar information? YES NO _____
5. List all departments that will use these forms? _____
6. Was input on this form obtained from the above listed departments? YES NO
7. What area of the Medical Record should the form be placed? _____
8. Has it been reviewed for "approved and not to be used" abbreviations? YES NO

Committee Approvals

FORMS YES NO

Monitor standardization, quality and consistency.

Meets the 1st Tuesday of every Month

Date Presented: _____

Pharmacy Approval: Medication, Dosage and Terminology Correct YES NO

Director of Medical Records Signature:

Date: _____

MEDICAL RECORDS YES NO

Meets the 2nd Wednesday of every Month

Date Presented: _____

Physician Approval: Recommendation to send to other committees? NO

YES: MEC PI CVS DOM DOS PNT OTHER: _____

Director of Medical Records Signature:

Date: _____

DEPT. of MEDICINE YES NO

Meets the 1st Wednesday of every Month

Date Presented: _____

Physician Approval: Recommendation to send to other committees? NO

YES: MEC PI CVS DOM DOS PNT OTHER: _____

Department of Medicine Signature:

Date: _____

DEPT. of SURGERY YES NO

Meets the 3rd Thursday of every Month

Date Presented: _____

Physician Approval: Recommendation to send to other committees? NO

YES: MEC PI CVS DOM DOS PNT OTHER: _____

Department of Surgery Signature:

Date: _____

PNT (Pharmacy, Nutrition and Therapy) YES NO

Meets the 4th Thursday of every Month

Date Presented: _____

PNT Committee Chair Signature:

Date: _____

Patient Information Council YES NO

Meets the 4th Tuesday of every Month

Date Presented: _____

PI Committee Chair Signature:

Date: _____

MEC (Medical Executive) YES NO

Meets the 1st Wednesday of every Month

Date Presented: _____

Medical Executive Chair Signature:

Date: _____