**Process for requesting patient build in TRN1, TRN2 or PRC Environments.**

**Please note: Patient build requests without a ServiceNow request will not be processed.**

1. **CREATE A SERVICENOW REQUEST FOR EPIC TRAINING PATIENT BUILD.**
2. **COMPLETE THE FORM BELOW AND E-MAIL TO THE TRAINING TEAM AT THE E-MAIL LISTED BELOW.**

*Please complete the form below with information needed for your training patient and return the form to* *Alexis.Kotschevar@hcmed.org* *no later than* ***2 weeks\**** *prior to scheduled training session. The EPIC team will contact you directly with any questions and when the patient build is complete. It is your responsibility to do any testing of your training patient prior to any scheduled training.*

*\*Please note if a large amount of information is requested, we may need to extend the time it takes for the patient build.*

Please complete all of the information in the section below:

|  |  |
| --- | --- |
| **Date of session**:        | **Time:**  |
| **Reoccurring session:** **[ ] Yes** **[ ]  No** | **If yes, dates are:**  |
| **Number of participants:**  | **Audience (Physicians, RN’s, etc.):**  |
| **Example of patient needed (MRN)\*\*:**  | **Encounter/Admission Date(s) to be copied:**  |

Please complete the grid below with specific information needed for your patient. Please include dates and/or times of the information requested when possible or applicable.

Please note that we can add most lab results, EKG, Echo, imaging reports, etc.; however, we cannot add actual images or links to images.

**\*\*IMPORTANT:** If you need specific results and/or notes on patients, you MUST provide either a patient MRN that we can use as an example to copy this information, or provide the actual results you want to appear in the patient’s record.

|  |  |  |
| --- | --- | --- |
| **Data** | **Needed****Y/N** | **If Yes, please add detailed description of items needed** |
| Demographics | **[ ]  Yes****[ ]  No** | **Age or DOB:** **Sex:** **[ ]  Male** **[ ]  Female** **Preferred Language:** **Marital Status:** **Ethnicity/Race:** **PCP:**  |
| Inpatient or Ambulatory | **[ ] Yes [ ]  No** | If inpatient, what unit does patient need to be admitted to? Was patient seen in the ED first?       |
| Scheduled Clinic Appointments  | **[ ] Yes [ ]  No** | If patient(s) need to be scheduled for a clinic visit – please Include days of the week, department/clinic needed, & type of visit (i.e. follow up, new patient, nurse visit, etc.)        |
| **Data** | **Needed****Y/N** | **Description** |
| OR Cases | **[ ] Yes [ ]  No** | If patient(s) need to be scheduled for an OR case, please include days of the week, name of procedure, etc.       |
| Vitals | **[ ] Yes [ ]  No** | Include how many sets of vitals you need recorded – if required, please specify day and/or times.       |
| CT/MRI/X-ray | **[ ] Yes [ ]  No** |       |
| EKG/Echo/Cardio Studies | **[ ] Yes [ ]  No** |       |
| Labs | **[ ] Yes [ ]  No** |       |
| ED notes | **[ ] Yes [ ]  No** |       |
| Consult notes | **[ ] Yes [ ]  No** |       |
| Admission notes | **[ ] Yes [ ]  No** |       |
| Progress notes | **[ ] Yes [ ]  No** |       |
| Office Visit Notes | **[ ] Yes [ ]  No** |       |
| OR procedure | **[ ] Yes [ ]  No** |       |
| Problems | **[ ] Yes [ ]  No** |       |
| Allergies | **[ ] Yes [ ]  No** |       |
| Current Medications | **[ ] Yes [ ]  No** |       |
| History: Social, Past Medical, Surgical and Family | **[ ] Yes [ ]  No** |       |
| Immunizations | **[ ] Yes [ ]  No** |       |
| Health Maintenance | **[ ] Yes [ ]  No** |       |
| Orders (ex: Meds, Procedures, PT, Referrals, etc.) | **[ ] Yes [ ]  No** |       |
| Other clinical Information(Must specify) | **[ ] Yes [ ]  No** |       |