eResults Termination Form (v3)

Use this form to Terminate electronic result delivery to an EMR system. Forms should be submitted 10 or more business days prior to termination date. PHCCA@nshealth.ca or Fax 902-407-3019

PLEASE PRINT

Section 1: Provider Identification *All fields Required*					**Provider PMB or Location #:**	
Last Name:		First Name:			Middle Initial:	
Discipline: (MD, NP, RN-AP, RPh etc.)				Phone Number:		
Provider's Email Address:						
Does provider currently receive results at other locations: ☐ No ☐ Yes						
After this requested change, how many locations/clinics will provider work at:						

Section 2: Clinic & Termination Information *All fields Required*			
EMR Vendor:	☐ QHR/Accuro ☐ TELUS/Med Access: ☐ Other: _____		
Clinic Name:			
Clinic Contact Name:		Contact Number:	
Contact Email:			
Requested Stop Date: (mm/dd/yy)		EMR Instance / Citrix ID: (If known)	
Deliver results by:	☐ Fax (Include AutoFax form for faxing) Fax#: **or** ☐ Mail Mailing Address: **or** ☐ N/A (Results will print at site) **or** ☐ Do not send further results, deactivate me in hospital systems (College license inactive)		
Comments:			

The clinic fax number or mailing address will be used for paper delivery once your request to terminate eResults has been processed unless otherwise specified.

Once you are no longer licensed in the college, you may be automatically deactivated in the hospital systems, in which case, no further reports may be sent.

Section 3: Provider Signature ***All fields Required***	
Provider Name:	
Provider Signature:	

For Providers with results at multiple clinics

- Please ensure the PMB / Location Number located at the top of the page is the PMB / Location number associated with the clinic you want to terminate. For primary locations, the PMB# will be the same number as your college # if you are a physician.
- If you are changing clinics, please fill out the eResults Route section of the eResults Request form, instead of this form.

Form Submission

1. Sections 1, 2 and 3 are mandatory sections, with Section 3 requiring the provider's signature.
2. Please include an **Autofax form** if results will be faxed going forward.

Please submit the completed request form and questions to the eResults Service Delivery Team:

eResults Service Delivery Team (PHCCA)

Fax: **(902) 407-3019**
email: PHCCA@nshealth.ca
Website: https://www.cdha.nshealth.ca/physicians/eresults-health-care-providers

CLIENT/HEALTH CARE PROVIDER AGREEMENT
AUTOFAXING OF LAB AND DIAGNOSTIC IMAGING REPORTS

Please attach to Assyst Service Request or FAX the completed form to the LIS Coordinator/LAB Manager/ Designate at the number below.

Initial the appropriate action box

START - AUTOFAX The undersigned agrees to:

☐

- participate in a program that will FAX laboratory and diagnostic imaging reports (when available) to his or her facility's FAX machine.
- ensure the security of the confidential information being transmitted by FAX by placing the receiving FAX unit in a secure location, accessible **ONLY** to the undersigned or appropriate designated persons and to inform the laboratory or DI department of any planned changes to fax numbers or client/physician information.

NOTE:

- ***Laboratory Services, Diagnostic Imaging department or NSHA-IM/IT*** *is unable to phone the receiving client either immediately prior to transmission or immediately after transmission for confirmation of receipt of information.*
- *If the FAX fails after several attempts, the reports will print to the site's designated printer. The site's department will distribute these reports to the appropriate Health Care Provider.*
- *A plain paper FAX machine is required.*
- *Diagnostic Imaging reports will fax immediately upon reaching a signed status. Lab reports will print at designated print times.*

CHANGE - AUTOFAX NUMBER The undersigned requests:

☐

- a change to the fax number presently in use for autofaxing.

Previous Fax#:_____ **New Fax#:** _____

STOP - AUTOFAX The undersigned agrees to:

☐

- Stop participation in the above program which will end the faxing of laboratory and diagnostic imaging reports to his or her facility's FAX machine. Reports will now be printed to the site's designated printer in the relevant department (Lab or Diagnostic Imaging).

Completion of this section confirms your agreement to assume responsibility for the appropriate actions listed above:

Client/Health Care Provider (print): _____ PMB #: _____

Date of Request: _____ Office Phone #: _____ **Office Fax #**: _____

Address: _____

Signature of Client/Health Care Provider: _____

Did you confirm a test fax to the Office Fax # above? ☐ **Yes** ☐ **No**

Contact Person (print): _____ Phone Number: _____

Fax Number to return to LAB: _____

Signature of LIS Coordinator/Facility Manager/Lab Contact: _____

Revised JUNE 2021

IM/IT recommends that the Site LAB keep a copy of the completed form on file.
Allow UP TO 14 days to implement the appropriate changes.