All Mount Lebanon Hospital- University Medical Center (MLH-UMC) staff, students, residents, and physicians must complete and submit this form prior to any contact through calling, recording, or transcribing done for patients of MLH-UMC. All requests must be received a minimum of 15 days prior to the event for scheduling purposes. *

For all requests, MLH-UMC representatives must be supported by a physician active at MLH-UMC, and refer to guidelines for research study.

A- Requestor Details

Name of Requestor: _____

Department/Specialty/Education/Function:

_____

Contact Number: _____

Email: _____

Affiliated Institution/University: _____

Signature of Requestor: _____

Research staff involved in study:

B- Project Details

Project Title:

_____

_____

Reason for the access/ Purpose of data collection:

_____

_____

Data Collection Method:

- ☐ Laserfiche
- ☐ PACS
- ☐ HIS
- ☐ LIS
- ☐ Hard copy of the medical record
- ☐ Online survey
- ☐ Interviews of medical staff
- ☐ Interviews of patients
- ☐ Other: _____

Project Start Date: ____/____/_____

Project End Date: ____/____/_____

Requested patient data/information from Medical Records Department/IT:

- ☐ Case #
- ☐ Department
- ☐ File Number
- ☐ Gender
- ☐ Date of Birth

- ☐ First Name, Middle Name, Family Name
- ☐ Entry Date
- ☐ Exit Date
- ☐ Doctor Name
- ☐ Diagnosis Description
- ☐ **ICD-10:_____
- ☐ Other: _____

Patient Data Requested Period: from ____/____/_____ to ____/____/_____
Number of entries requested: _____
Approximate time per call: _____ minutes (if applicable)
** ICD-10 codes included are provided by the Medical Records Department- Ms. Zeina Baz ext: 17088 or Mrs. Tanya Abdallah ext: 11131

C- Call details

SMS Template:
Invitation to participate in a research study by Dr _____, Subject: _____ Expected call on _____Thank you for your cooperation.

- ☐ I understand that contact with patients should be done within the stated hours
  Monday to Friday 10 am to 7 pm Saturday 10 am to 1 pm Sunday/Holidays NO CALLS
- ☐ I hereby promise that all the information I access will be used confidentially and only as needed to perform my legitimate duties

Completed requests must be presented to the Ethics Committee.
You will require Ethics Committee approval prior to project start date in order to activate the SMS to patients and a valid landline for use.

*Unauthorized or improper portrayal of the hospital environment and image is considered a breach in privacy, regulations, and property rights. It is subject to legal action as per management.

Required Documents:

University ID/National ID for each participant
Study/Thesis Proposal
Case Report Form/Data Collection Sheet
Informed Consent Form
Dean's /Referral Letter for Study/Thesis
GB-F-01: Confidentiality Agreement for each participant
Curriculum Vitae of all Professional participants
Copy of Ethics' Committee approval, if other sites are involved
GCP certificate for Human Research Subject: www.crt.nihtraining.com. For each participant.

Signature of the Applicant	Signature of the Head of Department
Name: **Date:**	**Name:** **Date:**

Signature of the Medical Record Responsible	Signature of the Hospital's Board Representative
Name: **Date:**	**Name:** **Date:**