

Medical University of South Carolina - OCIO-Information Services
vOACIS Data Change Form

PURPOSE:

The purpose of this form is to formally request a correction to data that has been entered incorrectly into a patient's record.

Requestor's Name: _____ Credentials: _____
(PLEASE PRINT) (RN, MD, CA, PCT, RT, etc.)

Phone: _____ Department/Division: _____

PROCEDURE:

Indicate requested change by filling out ALL **applicable** fields below with the exception of the shaded areas. **Return the completed form to OCIO-IS:** faxing to **792-8315** or send via campus mail to OCIO-IS, Harborview Office Towers, Suite 210. **Note:** Only one request per form. (Additional copies of this form can be found at the following URL: <http://www.musc.edu/infoservices/forms> You may also call the Support Desk at 792-9700).

SELECT ONE:

- LAB MICRO PATH ENC RAD TRANS (List Method) _____
(Health Scribe, OACIS Transcription Macro, etc.)
- OTHER _____

ACTION:

- MOVE DELETE CHANGE

FROM:	
Patient Name:	_____
MRN:	_____
Patcom #:	_____
Report Type:	_____
Date of Note:	_____
FillerNum:	_____
SID:	_____
PID:	_____
acctNum:	_____
encntrSID:	_____

TO:	
Patient Name:	_____
MRN:	_____
Patcom #:	_____
Report Type:	_____
Date of Note:	_____
FillerNum:	_____
SID:	_____
PID:	_____
acctNum:	_____
encntrSID:	_____

Additional Comments:

Requestor's Signature: _____ Date: _____

Approving Supervisor: _____

Supervisor's Signature: _____ Date: _____

For Office Use Only
OACIS LoginID _____ Tech's Initials: _____ Date Completed: _____