NL Health Services

HEALTHe NL User Registration Form
*** Incomplete forms will not be processed. All fields are required. ***
Please scan/email all registration forms to identity.management@nlchi.nl.ca

HEALTHe NEWFOUNDLAND AND LABRADOR

Reason of request: New account   Change of access*   Change of name
* If you selected Change of access, or Change of name specify your current HEALTHe NL User ID_____
In addition, if Change of access was selected, your manager needs to complete "Change of access" section at the bottom of this page.

Personal Health Information Act (PHIA) Training completed?   **Yes**
PHIA training is mandatory. If not completed see instructions on page two section 1

Do you require access to **myCCath** to submit/manage e-referrals to the Cardiac Catheterization Lab.   Yes   *(if yes, see section 2)*
Do you require access to **iScheduler** for Telehealth?   Yes   *(if yes, see section 3)*
Do you require access to iScheduler for **Vascular Lab eOrdering appointment visibility**?   Yes   *(if yes, see section 4)*
Do you work internally at the **Vascular Lab**?   Yes   *(if yes, see section 5)*
*Are you a primary care physician or nurse practitioner and require access to **eConsult**?*   Yes   *(if yes, see section 6)*
Do you require access to **Central Intake** to submit/manage Ophthalmology e-referrals?   Yes   (if yes, see section 7)
If you selected "Yes" above, see appropriate instructions in sections listed next to each question.

Mrs.   Ms.   Mr.   Dr.   First Name _____ Middle Name _____ Last Name _____

Occupation   If Other, Specialist, or Telehealth Scheduler was selected in the occupation field specify _____   Specify second specialty (if applicable) or other occupation (if not listed on the prior field) _____

License # (i.e. CPSNL,ARNNL) _____   Employee # (For RHA employee's only) _____

Facility Name (No abbreviations. Full business name required.)_____   Department Name/Clinic Type (Full department name required i.e. Surgery - 4NB) _____

Facility Address _____ City/Town _____ Postal Code _____

Facility Ph. _____   Cell Ph. _____   Email Address _____

_____ | _____ | YYYY-MM-DD _____
User's Legal First and Last name | User's Signature | Date

Manager/Clinical Educator: Please review pages1-4 prior to approving the user's request.

_____ | _____ | YYYY-MM-DD _____
Manager/Clinical Educator First, Last Name | Manager/ Clinical Educator Signature | Date
Not required for physicians or dentists

_____ | _____
Manager/ Clinical Educator Phone | Manager/ Clinical Educator Email adress
Not required for physicians or dentists

CHANGE OF ACCESS

If change of access, or "other" occupation was selected, manager to explain reason for change of access, or request of access. **Please note:** if change of access pertains to Vascular Lab eOrdering, please refer to page 3.

_____
_____
_____
_____
_____

If change of access, or "other" occupation was selected, manager to check additional access needed:

Clinical Documents.
Laboratory Reports.
Diagnostic Imaging Reports.
Encounters.
Medication Profiles & Immunizations.
Search capabilities by first name and last name.

If you are requesting HEALTHe NL access, or change of name please email only page one (completed). If you are requesting HEALTHe NL access, and/or myCCath and/or iScheduler, and/or Vascular Lab and/or eConsult email back page 1 and 2 with the appropriate section completed.

IN OFFICE USE ONLY   Change Manager Name: _____   Account Validation:

Comments: _____
_____
_____
_____

1. Change of Access: Approved*   Not approved
   * Role to assign _____
2. IOR group: Approved   Not approved
3. Full Search: Approved   Not approved
Other: _____

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Section 1 - PHIA Training

- All HEALTHe NL users are required to complete "**Custodian-Direct Contact with Personal Health Information**" PHIA training.
- PHIA training can be accessed at: http://nlchi.skillbuilder.ca/courses/list
- Click "**Sign Up**" to register, or "**Sign In**" if you have already have an account.

Section 2 - myCCath Users   **If the myCCath approval section below is not completed, access cannot be granted**

If you require access to myCCath, send your completed HEALTHe NL registration form to the Cath Lab Coordinator at *myCCath.registration@easternhealth.ca* for approval.

myCCath approval section (To be completed by a myCCath approver ONLY)   Approved   Not Approved

Approved by: _____   Signature: _____   Date: ___YYYY-MM-DD___

Comments: _____

_____

Section 3 - iScheduler Users   ****If the iScheduler approval section below is not completed, access cannot be granted****

If you require access to iScheduler, email your completed HEALTHe NL registration form to the Telehealth Coordinator in your zone for approval.

Telehealth Coordinators contact information:

- **Eastern Zone:** telehealth@easternhealth.ca   • **Western Zone:** telehealth@westernhealth.nl.ca
- **Central Zone:** telehealth@centralhealth.nl.ca   • **Labrador-Grenfell Health:** telehealth@lgheal th.ca

iScheduler Approval section (to be completed by a Telehealth Coordinator ONLY)   Approved   Not Approved

Approved by: _____   Signature: _____   Date: ___YYYY-MM-DD___

Comments: _____

_____

Section 4 - Vascular Lab Appointment Visibility- iScheduler·

Are you an iScheduler eSuite user?   Yes   No (If yes, enter username: _____)

Section 5 - Vascular Lab Staff

If you work at the Vascular Lab and require access to eOrdering, please complete the steps below:

1. Are you an iScheduler eSuite user?   Yes   No (If yes, enter username: _____)

2. Please identify your role at the Vascular Lab:

    Vascular Surgeon   Vascular Lab Scheduling Admin   Vascular Lab Clerk

    Vascular Lab Technician   Vascular Lab Nurse Practitioner

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Section 6 - eConsult Primary Care Providers   **Attention: Only Physicians and Nurse Practitioners may submit eConsults.**

Do you use Med Access EMR?   Yes   No

If yes to the above: Do you use more than 2 Med Access EMR Systems?   Yes   No

                Do you use the same Med Access EMR system on a regular basis?   Yes   No

                Do you require access to HEALTHe NL outside of your EMR?   Yes   No

Please provide your Med Access EMR username(s) _____ & Site ID(s): _____)

Section 7 - Central Intake   ****If the Central Intake approval section below is not completed, access cannot be granted****

If you require access to Central Intake, send your completed HEALTHe NL registration form to *askCentralIntake@nlhealthservices.ca* for approval. If the Central Intake approval section below is not completed, access cannot be granted.

Service line: _____   Access Zone: EZ   WZ   CZ   LGZ   Provincial

Access Type: Create/ Update   Read Only   Organization: NLHS   Private Office/Clinic

Central intake approval section (To be completed by a Central Intake approver ONLY)

Approved by: _____   Signature: _____   Date: ___YYYY-MM-DD___

Comments: _____

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CONFIDENTIALITY AND ACCEPTABLE USE

The information collected on this form will be used to support the operation of HEALTHe NL, the provincial Electronic Health Record (EHR), including user identification, account management and auditing. This information may also be used for planning and analytics purposes.

As a user of HEALTHe NL, you agree to:

- Comply with all statutory, regulatory and policy requirements to keep confidential any identifying information.
- Notify the Centre's Service Desk if you no longer require access to HEALTHe NL.
- Review the available education and training material on an ongoing basis.
- Understand that unauthorized disclosure of identifying information obtained through HEALTHe NL may result in penalties as described in relevant legislation and/or termination of access.

This agreement outlines your responsibilities regarding the access, use and disclosure of the personal health information contained within HEALTHe NL. Additional information on the Personal Health Information Act can be found at http://www.health.gov.nl.ca/health/PHIA/. By signing above you agree that you understand and agree to comply with below terms/conditions and that all information provided during the registration process is accurate and true.

Acceptable Use: You agree to not access, collect, use, or disclose any clinical or other personal health information maintained in HEALTHe NL for any purpose or in any way other than those authorized under appropriate legislation, policies, and standards of practice.
You agree that you will not use HEALTHe NL for an illegal or improper purpose, or take steps that would have a negative impact on the security, integrity or functioning of HEALTHe NL.

Confidentiality: You agree to treat as confidential all information collected, used and disclosed in association with HEALTHe NL, whether verbal or written, and will not participate in or permit the unauthorized release, publication or disclosure of that information to any person, corporation or other entity under any circumstances except as authorized by legislation, policies, and standards of practice.

Passwords: You agree to keep your password absolutely confidential; it is for your use alone. You agree not to distribute or share your username and password with anyone.

If your password becomes known: You agree that if you suspect someone else knows your password you will notify the Centre's Service Desk at 1-877-752-6006 or in person at 70 O'Leary Ave. St. John's as soon as possible and follow the instructions provided to you.

Provincial EHR Limitations: You are aware that HEALTHe NL consolidates information from various source systems province-wide. While efforts are made to ensure accuracy and completeness, HEALTHe NL is not exhaustive and should not be relied upon as a sole information source in providing care. Patient data may exist in other RHAs, community health, private clinics or pharmacy databases. I recognize accepting a password gives me authorized access to confidential electronic information.

iScheduler/ Telehealth Users
You recognize that approval of this access application, and assignment of a User ID and password, besides giving you access to Telehealth iScheduler from HEALTHe NL, it gives you authorized access to information in the Telehealth iScheduler application. You understand that this allows you to access confidential information and you accept that it is your responsibility to ensure the total confidentiality of all information accessed from the Telehealth iScheduler application. You are aware that disclosure of your Telehealth iScheduler/ HEALTHe NL User ID and/or password, or the use of another user's password is considered a breach of security for which you will be held accountable.

Your application will be processed within 10-15 business days. If you have not been contacted within this time frame, please contact us as there may be an error with your application. Phone: 1-877-752-6006; Email: identity.management@nlchi.nl.ca

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