

PROMIS SYSTEM ACCESS

New User – create new account

1. Review and sign **Confidentiality Agreement** (page 1)
2. Complete and sign **User Account Request** (page 2). Ensure areas with an asterisk* are completed.
3. Ensure signature of **Manager, Medical Director** or **Alternate PROMIS Authorizer** has signed both forms. If you are unsure of approved authorizers, please contact PROMIS Support.
4. **Scan/email or Fax** completed forms to PROMIS Support.
5. You will be contacted with a PROMIS Help Desk ticket reference number and account information within 1-2 business days. For Transplant patient access, completion of request may take up to 5 business days to allow for additional approvals to be completed.

Existing User – name change, system access updates or cancellation of account

1. Complete and sign **User Account Request** (page 2). Ensure areas with an asterisk* are completed where applicable.
2. Ensure signature of **Manager, Medical Director** or **Alternate PROMIS Authorizer** has signed both forms. If you are unsure of approved authorizers, please contact PROMIS Support.
3. **Scan/email or Fax** completed forms to PROMIS Support.
4. You will be contacted with a PROMIS Help Desk ticket reference number and account information within 1-2 business days. For Transplant patient access, completion of request may take up to 5 business days to allow for additional approvals to be completed.

Contacting PROMIS Support

For more information about PROMIS user accounts, including where to find various forms, please contact the PROMIS Support Team.

Tel (604) 806-8868

Toll-free (855) 806-8868

Fax (604) 806-8849

support@bcpra.ubc.ca

PROMIS Support is available to assist you Monday through Friday, excluding stat holidays, from 8am to 5pm.

CONFIDENTIALITY AGREEMENT

The User of Patient Record Outcome Management Information System (PROMIS) acknowledges that BC Provincial Renal Agency (BCPRA) and BC Transplant (BCT) have a legal and ethical responsibility to safeguard the privacy of all patients who have records on the system and to protect the confidentiality of their health and other personal information. BCPRA, and BCT as public bodies, are subject to the provisions of the Freedom of Information and Protection of Privacy Act and the Human Tissue Gift Act.

Computerized records and information are subject to the same requirements as written information. The User of PROMIS will hold in confidence any information supplied by BCPRA and BCT whether labelled as confidential information or not, including any health information or personal information on any patient, and any information on health care providers.

The User of PROMIS, with access to information about patients, Donors and Donor families may only obtain information that is necessary for job duties and performance. Viewing any information other than that required performing a job function is a violation of the PHSa confidentiality policy, even if one keeps the information to oneself and does not disclose it to any other person.

Access to health information/records is limited to designated renal unit personnel, BCPRA and BCT personnel and to patient if required. The users may disclose patient health information, according to their roles, to other designated personnel and patient.

The User of PROMIS agrees to adhere to all policies, procedures or standards issued by BCPRA and BCT. The Province of British Columbia or the Ministry of Health are covered by the provisions of the FIPPA and PIPEDA, the Human Tissue and Gift Act and E-Health as related to the confidentiality, privacy or security of information. **Policies pertaining to PROMIS users can be found on the PROMIS portal at <https://promis.phc.bc.ca>.**

If the user remains with the organization but changes position or requires a change in access, the page attached with title "User Account Requests" will need to be completed with the date of change, the new role/position, and faxed to the Support Desk.

I have read and understood the above and agree to the conditions as stated. I agree to keep personal passwords confidential.

NAME OF USER: _____

SIGNATURE: _____ **Date:** _____

I have the authority and consent that this user be granted the ability to have access to patients as pertains to their job role and centre(s). I agree to review their access bi-annually.

MANAGER / MEDICAL DIRECTOR / ALTERNATE AUTHORIZER NAME: _____

SIGNATURE: _____ **Date:** _____

USER ACCOUNT REQUEST: New Change Cancel ***Please complete**

* Start Date: _____ End Date: _____

* Legal Name First: _____ Middle: _____ *Last: _____

Name Change from: _____

* Work Phone: _____ (Ext) _____ * Email: _____

* Work Location(s) (hospital): _____

* Office/Clinic: _____

Other Management Centre(s) required: _____

*** Position(s):**

- | | | |
|--|--|--|
| <input type="checkbox"/> Administrative Assistant | <input type="checkbox"/> Dietitian | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Administrative Assistant (BCT) | <input type="checkbox"/> Director | <input type="checkbox"/> Pharmacy Technician |
| <input type="checkbox"/> BCPRA Staff | <input type="checkbox"/> Kinesiologist | <input type="checkbox"/> Pharmacist (BCT) |
| <input type="checkbox"/> BC Transplant Staff | <input type="checkbox"/> Licensed Practical Nurse | <input type="checkbox"/> Pharmacist (Macdonald's Rx) |
| <input type="checkbox"/> Clerk | <input type="checkbox"/> Living Donor Coordinator (BCT) | <input type="checkbox"/> Physician – MSP # _____ |
| <input type="checkbox"/> Clerk (BCT) | <input type="checkbox"/> Manager | <input type="checkbox"/> Physician Fellow |
| <input type="checkbox"/> Clinical Coordinator | <input type="checkbox"/> Manager (BCT) | <input type="checkbox"/> Physiotherapist |
| <input type="checkbox"/> Clinical Coordinator (BCT) | <input type="checkbox"/> Medical Lab Technologist | <input type="checkbox"/> Researcher |
| <input type="checkbox"/> Clinical Nurse Leader | <input type="checkbox"/> Nurse Clinician | <input type="checkbox"/> Respiratory Therapist |
| <input type="checkbox"/> Clinical Nurse Leader (BCT) | <input type="checkbox"/> Nurse Clinician (BCT) | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Data Management Clerk (BCT) | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Sonographer |
| <input type="checkbox"/> Data Management Coordinator | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Vascular Access Coordinator |
| <input type="checkbox"/> Data Management Coordinator (BCT) | <input type="checkbox"/> Organ Donation Specialist (BCT) | |

* BC Transplant Clinic: Yes (Pre-Tx: Post-Tx:) No

Specific Access: E-charting Clinic Scheduling Dialysis Schedule Update Read Only

*** Programs You Work In: (check off which are required)**

Add	Remove	RENAL	Add	Remove	OTHER	Add	Remove	TRANSPLANT
<input type="checkbox"/>	<input type="checkbox"/>	Hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney
<input type="checkbox"/>	<input type="checkbox"/>	Home Hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>	Emergency Planning	<input type="checkbox"/>	<input type="checkbox"/>	Kidney-Pancreas
<input type="checkbox"/>	<input type="checkbox"/>	Peritoneal Dialysis				<input type="checkbox"/>	<input type="checkbox"/>	Liver
<input type="checkbox"/>	<input type="checkbox"/>	CKD/Predialysis				<input type="checkbox"/>	<input type="checkbox"/>	Heart
		CARDIAC			TRANSPLANT DONORS	<input type="checkbox"/>	<input type="checkbox"/>	Pancreas
<input type="checkbox"/>	<input type="checkbox"/>	Healthy Heart	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Donor	<input type="checkbox"/>	<input type="checkbox"/>	Pancreas Islet
<input type="checkbox"/>	<input type="checkbox"/>	Rehab	<input type="checkbox"/>	<input type="checkbox"/>	Liver Donor	<input type="checkbox"/>	<input type="checkbox"/>	Single Lung
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Office				<input type="checkbox"/>	<input type="checkbox"/>	Double Lung
						<input type="checkbox"/>	<input type="checkbox"/>	Bowel
						<input type="checkbox"/>	<input type="checkbox"/>	Cluster

* User Signature: _____ * Date Signed: _____

I have the authority and consent that this user be granted the ability to have access to patients as pertains to their job role and centre(s). I agree to review their access bi-annually.

* Manager/Medical Director/Alt. Authorizer: _____ * Date signed: _____

INTERNAL USE ONLY:	BC Transplant:
User ID: _____	<input type="checkbox"/> CIS-Fullview <input type="checkbox"/> CIS-PreTx <input type="checkbox"/> CIS-Regional <input type="checkbox"/> CIS-Donor
Roles: _____	<input type="checkbox"/> Other roles: _____
_____	<input type="checkbox"/> Patient Access Only
Ticket: _____ Date: _____	Date: _____ PROMIS Training Required <input type="checkbox"/>
PROMIS Authorizing Signature: _____	Authorizing Name: _____
	Authorizing Signature: _____