

**Privacy Review - Quality Improvement Intake Form***Please submit form and supporting documents to* [privacy@providencehealth.bc.ca](mailto:privacy@providencehealth.bc.ca) *with subject line: Privacy Review –Quality Initiative Intake Form) in MICROSOFT WORD FORMAT*

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| *PHC PIA-202-* |

**\* If you know your project is research and is being reviewed by the REB, completing this form is not necessary.**

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| **Physician name & Position/Role:** |  |
| **Email:** |  |
| **Project Title:** |  |
| **Contact Person for Privacy Office during the review of the intake form (e.g. PQI Advisor):** |  |
| **Date:** |  |

1. Provide short description of your project and goal of the QI project?
   1. Purpose of the project (*describe in 1-3 sentences*):
   2. Source for data collection *(e.g. Cerner, SCM, PARIS, paper charts)* :
   3. Data elements (*patient name, PHN, MRN, DOB, address, postal code, phone number*):
   4. Will they be in identifiable format *(is it DOB or age, etc)*:
   5. Use of project data (*e.g. to reference or to access patient records, to email questionnaires to patients, etc.*):
   6. Access to identifiable records (*who will have access to the records e.g. providers, coordinators, nurses, etc.*)
   7. Storage of project data (*e.g. hospital network, laptop, REDCap, third party, etc.*):
   8. Retention of project data ( *how long will it be stored*):
   9. Destruction of the project data at the end of the project *(e.g. when, how, who, etc.*):
2. Is an operational leader (*Program Director, Operations Director, Patient Care Manager)* aware of this QI project that relates to their program area? (*NOTE: This is not the Physician Program Director or Lead Physician, rather an individual responsible at the operational level)* :

*Based on the scope of the project and the sensitivity of the information, the Privacy Office may require an additional privacy review.*

***By signing below, the authorized signatory confirms that the information provided of this Quality Improvement intake form is accurate and complete to the best of his/her knowledge.***

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| **Signature of Authorized Signatory ( physicians/ project owner)** |  | **Title of Authorized Signatory** |  |
| **Name of Authorized Signatory** |  | **Date** |