

# OUTPATIENT CLINIC PROFILE

**Instructions:** A completed Outpatient Clinic Profile form is necessary to create clinics. It is also used to edit specifics of existing clinics. To ensure that your clinic is accurately established and/or edited, you must provide all of the information requested below and return this profile as soon as possible.

**DIVISION:**  Baltimore  Fort Howard  Perry Point  Cambridge  Glen Burnie

## CLINIC

Name_____	
Abbreviation_____	Location (Floor/Room)_____
Service_____	Phone extension_____

## PROVIDER(S) please print

_____	_____
(last name, first name, MI)	(last name, first name, MI)
_____	_____
(last name, first name, MI)	(last name, first name, MI)
_____	_____
(last name, first name, MI)	(last name, first name, MI)
_____	_____
(last name, first name, MI)	(last name, first name, MI)

## APPOINTMENT TYPE

<input type="checkbox"/> Regular	<input type="checkbox"/> Prima Facia	<input type="checkbox"/> Collateral
<input checked="" type="checkbox"/> Research	<input type="checkbox"/> C&P	<input type="checkbox"/> Employee
<input type="checkbox"/> Class II	<input type="checkbox"/> Sharing Agreement	<input type="checkbox"/> Organ Donor

**SCHEDULE**

Date clinic will begin: \_\_\_\_\_  
Month/day/year

Clinic begins: 8:30 a.m. Clinic ends: 5:00 p.m.

Day(s) clinic meets:  Mon.  Tues.  Wed.  Thurs.  Fri.  Sat.

Schedule in increments of:  10 min.  15 min.  20 min.  30 min.  1 hr.

Number of patients; X per slot (increment) \_\_\_\_\_ per day (total)

Maximum days for future booking:  30  60  90  180  365

Maximum overbooks per day: 0 Allowable consecutive "no shows": \_\_\_\_\_

"No Show" automatically re-booked: \_\_\_\_\_ yes  no

Schedule on holidays:  yes  no \*Clinic access restricted:  yes  no

\*If clinic access is restricted, provide names of *Additional Privileged Users* from you service:

\_\_\_\_\_  
(last, first, MI) (last, first, MI)

\_\_\_\_\_  
(last, first, MI) (last, first, MI)

**DEFAULT DIAGNOSIS:** none

**SPECIAL INSTRUCTIONS** (to be included in DHCP Appointment Management)

none  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REQUIREMENTS FOR CLINIC (check all that apply)**

<input type="checkbox"/> Encounter Forms (optional)
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**DECISION SUPPORT SYSTEM (DSS) complete, sign, date & return within 2 business days.**

Stop Code _____	Credit Stop Code _____
_____	_____
DSS Site Coordinator	Date

**APPROVAL (Required)**

_____	_____
Service Chief	Date