Office of Clinical Integration & Evidence-based Practice
Guideline Request Form

Requestor Information

Requestor Name, Credentials and Title: _____

Requestor E-mail: _____

Requestor Hospital and Department: _____

Request Date: _____

Intervention

Requested Topic/Disease Process: _____

Clinical Questions for Evidence Review (if known): _____
Frame in PICO (Population, Intervention, Comparison, Outcome) format, if possible

Target Population: _____

Clinical Background (Describe the clinical reasons for the request. What problems will be resolved?):

_____

Desired Outcome (Provide details on what you would like the outcome to be based on this intervention):

_____

Primary Stakeholders (Include names of individuals impacted by the intervention who may be willing to serve as content experts on interprofessional guideline development team): _____

Is an oversight group currently in place, or is there a plan to form a group to oversee guideline sustainability? (If so, please explain): _____

Request Urgency/Required Delivery Time: _____

Does an OHSU Health System site-specific guideline/protocol/order set currently exist for this topic?

_____

Impact

The OHSU Health System enterprise goals relate to the following domains: access, value, people, and academics.

Please specify below the area(s) this request will impact (please check all that apply and provide rationale):

☐ Direct impact on strategic organizational priority? (If yes, please describe):

_____

Office of Clinical Integration & Evidence-based Practice
Guideline Request Form
Impact (cont.)

☐ Externally mandated measure(s)/required reporting program(s)/publicly reported measure(s)? (If yes, please specify): _____

☐ High volume of patients impacted? (If yes and available, please provide data):

_____

☐ High cost disease process or potential for significant cost reduction? (If yes and available, please provide data):

_____

☐ High unwanted variability or inconsistent care? (If yes, please describe):

_____

☐ Quality or patient safety concern? (If yes, please describe):

_____

☐ Potential for use across OHSU Health System? (If yes, please describe):

_____

☐ Potential for improved patient and/or provider satisfaction? (If yes, please describe):

_____

☐ Other (If yes, please provide specific details):

_____

SUBMIT CLEAR

OFFICE OF CLINICAL INTEGRATION AND EBP USE ONLY

Processing Date: _____

Clinical Integration Network Review Date: _____

Priority Score: _____

Anticipated Guideline Start Date: _____

Date Requestor Notified: _____