

## INSTRUCTIONS



## OFFICE OF LOGISTICS MANAGEMENT (OLM)

## MLM Clinical Product Request Form – LM-7

Reference #C:

<b>Submit Form:</b>	You must complete this Form On-Line. Hand written Forms will be rejected. Mail, Fax or PDF the entire package to: Fax: 679-1993 or Mail to: Resource Management – LB058 - MC 2012		
Requester's Name:		Title:	
Department:			
Phone Number:		Fax Number:	
Room Number:		Mail Code:	
Email Address:			
<b>SECTION I:</b>			
<b>Where would this product be used:</b>			
<input type="checkbox"/> Invasive Procedure Unit <input type="checkbox"/> Non-Invasive Unit <input type="checkbox"/> Med-Surg Unit <input type="checkbox"/> Clinics <input type="checkbox"/> All Areas			
Type of Product		Request Type	
<input type="checkbox"/> Medical Disposable		<input type="checkbox"/> New Item to Stock	
<input type="checkbox"/> Non-Medical		<input type="checkbox"/> Non-Stock to Stock	
<input type="checkbox"/> Lab Disposable		<input type="checkbox"/> New Item Non-Stock	
<input type="checkbox"/> Dental Disposable		<input type="checkbox"/> Vendor Direct (Specials)	
<input type="checkbox"/> Equipment/Instruments		<input type="checkbox"/> Delete Product	
<input type="checkbox"/> PAR Office Supplies		<input type="checkbox"/> Vendor/Manufacturer Change	
<input type="checkbox"/> Other:			
Priority:	<input type="checkbox"/> Essential	<input type="checkbox"/> Important	<input type="checkbox"/> Desirable
	<input type="checkbox"/> Other:		
Does this item replace or duplicate a current stock item?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes":	Warehouse #:	Vendor #:	
Justification for product introduction:		<input type="checkbox"/> New Service	
<input type="checkbox"/> Code/Policy Compliance		<input type="checkbox"/> Improved Services	
<input type="checkbox"/> Standardization/Utilization		<input type="checkbox"/> Cost Savings	
<input type="checkbox"/> Change "to" or "from" Disposable/Reusable		<input type="checkbox"/> Increased Usage	
<input type="checkbox"/> Other:		<input type="checkbox"/> Cost Avoidance	
<input type="checkbox"/> Other:		<input type="checkbox"/> Improved Safety	
<b>Important Notice to Department Head/Manager:</b>			
<ul style="list-style-type: none"> <li>Please include a written justification for the introduction of this product. Committee(s) that have approved the change or addition; What it is used for; Cost Savings; Improved Services; Patient Safety; etc. Include the justification with this form when faxing or mailing to Office of Logistics Management.</li> <li>Fax 679-1993    Mail: LB058 - MC2012    PDF: <a href="#">Dkrdq.Ej ctrpg*edkrdqB wej eQf w-</a>    Questions: 89; /3; ; :</li> </ul>			
<b>Required Signatures:</b>			<b>Date</b>
1. Department Head			
_____ Typed Name - Mandatory			_____
2. Department Business Manager			
_____ Typed Name - Mandatory			_____
3. Physician			
_____ Typed Name - Mandatory			_____



## MLM Clinical Product Request Form – MM-7

Reference #C:

## SECTION II: Product Information

Product Description:										
Vendor:				Manufacturer:						
Catalog Number:					Approximate Cost:					
Preferred Unit of Measure:		<input type="checkbox"/> Bottle <input type="checkbox"/> Case <input type="checkbox"/> Each <input type="checkbox"/> Package <input type="checkbox"/> Custom Pack <input type="checkbox"/> Box <input type="checkbox"/> Dozen <input type="checkbox"/> Kit <input type="checkbox"/> Other:								
Contract Source:		<input type="checkbox"/> GPO:			<input type="checkbox"/> Other:					
Is current product being used on a contract:				<input type="checkbox"/> Yes <input type="checkbox"/> No   If "Yes":						
Contract Source:		Contract Expires On:								
Custom Made?		<input type="checkbox"/> Yes <input type="checkbox"/> No			Average Monthly Usage:					
Unit of Measure:		Lead Time (days):								
Does product contain Latex: <input type="checkbox"/> Yes <input type="checkbox"/> No				FDA Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Will product have contact with or be used to inject/extract blood/body fluids: <input type="checkbox"/> Yes <input type="checkbox"/> No										
Is this product department specific: <input type="checkbox"/> Yes <input type="checkbox"/> No										
If "No", please attach a listing of other Hospital or Clinical units that would use this product:										
Is product a patient charge item: <input type="checkbox"/> Yes <input type="checkbox"/> No										
Does product require special handling/storage: <input type="checkbox"/> Yes <input type="checkbox"/> No   If "Yes", elaborate:										
Coding:	FY		Fund		Org		Program		Account	
<b>Required Signatures:</b>								<b>Date</b>		
1. Logistics Management								_____		
Typed Name - Mandatory								_____		
2. Purchasing Services								_____		
Typed Name - Mandatory								_____		
3. Epidemiology Manager								_____		
Typed Name - Mandatory								_____		