

MENTAL HEALTH AND ADDICTION INFORMATION SYSTEM (MHAIS)

ACCOUNT REQUEST FORM

Call the Service Desk 1-888-316-7446 (local 306-337-0600) if you are unclear about any fields below
 The Service Desk will complete the request within five business days from receiving the request.
 Return Via Email: ServiceDesk@eHealthSask.ca

User Information

Type of request (check one): ☐ New User ☐ Modify User ☐ Change in Permissions (Roles)
☐ Deactivate User ☐ Activate User ☐ Demographic Changes
☐ Change in Record Access

User's Full Name printed:		Work Phone #:	
Email Address:		Primary Area:	

Environment: ☐ Production ☐ User Acceptance Test (UAT) ☐ Train

Multi-Region / Multi-Module Access

Secondary Network Account Access:

Only required if user is logging into MHAIS from multiple (former) regional network accounts.

Multi-Module: ☐ User has an existing LTC account and will continue requiring access.
☐ User has an existing LTC account and no longer requires access.
☐ User has an existing LTC account and I am not sure if they still require access.

Provider Information

☐ **Provider User** Address required for all providers (Hover mouse over Address Lines' text boxes for description)

Note: Designation appears behind employee's name on charting activities such as Progress Notes.

Address Line 1:		City:	
Address Line 2:		Province:	
Address Line 3:		Postal Code:	

User Roles and Supplemental Access

Job Description:

Professional Designation: , , Other:

User Role: (Choose All That Apply)

(Hover mouse over the check box to see role description)

Roles

<input type="checkbox"/> ALL - Base User	<input type="checkbox"/> CMH - CRT Team	<input type="checkbox"/> IMH - ADT and HIM
<input type="checkbox"/> ALL - Clinical Professional	<input type="checkbox"/> CMH - HIM	<input type="checkbox"/> IMH - Inpatient Care and Therapies
<input type="checkbox"/> ALL - Medical Office Assistant	<input type="checkbox"/> CMH - Intake	<input type="checkbox"/> IMH - Inpatient Nurse
<input type="checkbox"/> ALL - Psychiatry/Psychology	<input type="checkbox"/> ALL - Regional Super User	

Supplemental Access

Master Record

<input type="checkbox"/> ALL - Clinical Lead Toolkit <input type="checkbox"/> ALL - Document Management <input type="checkbox"/> ALL - eHR Viewer <input type="checkbox"/> ALL - Personnel/Provider Admin <input type="checkbox"/> ALL - Service Registry Admin <input type="checkbox"/> ALL - Third Party Notes	<input type="checkbox"/> ALL - Progress Notes View Only <input type="checkbox"/> ALL - Progress Notes Add/Edit <input type="checkbox"/> CMH - Community Nurse <input type="checkbox"/> CMH - Demographic Admin <input type="checkbox"/> IMH - Facility Administration	<input type="checkbox"/> ALL - Combined View <input type="checkbox"/> ALL - Master Record
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Allowed Organizations / Facilities

Record Access: (Choose All That Apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> * Mental Health Master Record | <input type="checkbox"/> IMH NB - Battlefords Mental Health Centre | <input type="checkbox"/> CMH Young Offenders |
| <input type="checkbox"/> Community Mental Health & Addictions | <input type="checkbox"/> IMH NB - Saskatchewan Hospital | <input type="checkbox"/> IMH SHNB Remand |

Service Authorization

Authorized Approver's Information:

Name: _____	_____
	Work Phone Number
Signature: _____	_____
(Not required if emailed from Approver's email address)	Date (YY/MM/DD)

Additional Comments: