



## eResults Termination Form (v2)

Use this form to Terminate electronic result delivery to an EMR system. Forms should be submitted 10 or more business days prior to termination date. [PHCCA@nshealth.ca](mailto:PHCCA@nshealth.ca) or Fax 902-407-3019

**PLEASE PRINT**

<b>Section 1: Provider Identification *All fields Required*</b>				<b>Provider PMB#:</b> (Location specific)		
Last Name:		First Name:		Middle Initial:		
Discipline: (MD, NP)				Phone Number:		
Provider's Email Address:						
Does provider currently receive results at other locations: <input type="checkbox"/> No <input type="checkbox"/> Yes						
After the requested change, how many locations will provider receive results at:						

<b>Section 2: Clinic &amp; Termination Information *All fields Required*</b>			
EMR Vendor:		<input type="checkbox"/> QHR/Accuro <input type="checkbox"/> TELUS/Med Access: <input type="checkbox"/> Other: _____	
Clinic Name:			
Clinic Contact Name:		Contact Number:	
Contact Email:			
<b>Requested Stop Date:</b> (mm/dd/yy)		EMR Instance / Citrix ID: (If known)	
<b>Deliver results by:</b>		<input type="checkbox"/> Fax Fax#: _____ (Include AutoFax form for faxing)  <b>or</b> <input type="checkbox"/> Mail Mailing Address: _____  <b>or</b> <input type="checkbox"/> N/A (Results will print at site)	
Comments:			

The clinic fax number or mailing address will be used for paper delivery once your request to terminate eResults has been processed unless otherwise specified. The date used will be the same date eResults has been terminated.

Section 3: Provider Signature <b>*All fields Required*</b>	
Provider Name:	
Provider Signature:	

**For Providers with results at multiple clinics**

- Each location receiving results requires a unique PMB#
- Please ensure the PMB# located at the top of the page is the PMB number associated with the clinic you want to terminate. For primary locations, the PMB# will be the same number as your college # if you are a physician.
- If you are changing clinics, please fill out the eResults Route section of the eResults Request form, instead of this form.

**Form Submission**

1. Sections 1, 2 and 3 are mandatory sections, with Section 3 requiring the provider's signature
2. Please include an **Autofax form** if results will be faxed going forward

**Please submit the completed request form and questions to the eResults Service Delivery Team:**

**eResults Service Delivery Team (PHCCA)**

**Fax:** (902) 407-3019

**email:** [PHCCA@nshealth.ca](mailto:PHCCA@nshealth.ca)

**Website:** <https://www.cdha.nshealth.ca/physicians/eresults-health-care-providers>