**CRF-CPEST CLINICAL INQUIRY REQUEST FORM**

CCPC-16-15-Attachment 2

For all clinical inquiries, programs must complete the following information and submit to CRFPU Nurse Consultant, JoAnn Johnston at [JoAnn.Johnston@Maryland.gov](mailto:JoAnn.Johnston@Maryland.gov) (please cc CRFPU Program Manager, Cindy Domingo, at [Cindy.Domingo@Maryland.gov](mailto:Cindy.Domingo@Maryland.gov) and your program’s Technical Lead, either [Lacey.Christian@Maryland.gov](mailto:Lacey.Christian@Maryland.gov) or [Dwayne.Selph@Maryland.gov](mailto:Dwayne.Selph@Maryland.gov)). Please do not include any client unique identifying information on this form.

**Date of Request:** Enter original date inquiry is submitted to DHMH.

**Program Name:** Local Health Department or Funded Program Name.

**Requestor:** Enter program staff name. **Requestor’s Contact:** Enter e-mail & phone #.

**CDB ID#:** Enter CDB ID # Note: Data must be entered in the CDB for comprehensive review.

**Has all data been entered and uploaded in the CDB? **

*Prior to submitting your clinical inquiry, please ensure the following are completed:*

* CDB has complete client and clinical information entered (to date).
* All clinical reports are uploaded.
* Nurse’s notes include summary of Nurse Case Manager follow-up to date.

**Program’s Clinical Inquiry:**

Enter description of the clinical inquiry here.

**CRFPU Staff Additional Notes:** *To be completed by DHMH’s CRF Nurse or CRF staff*

**CRFPU Clinical Reviewer Response:** *To be completed by DHMH’s CRF Nurse or designated clinical staff*