

## Trauma Program Office

### **Data Request Worksheet**

Date of Request: \_\_\_\_\_ Date Needed: \_\_\_\_\_  
Name: \_\_\_\_\_ Department: \_\_\_\_\_  
Phone: \_\_\_\_\_ Pager Number: \_\_\_\_\_

Brief Description of  
Research: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Research  
Study: \_\_\_\_\_

What Time Period  
Does Data Need to  
Cover?: \_\_\_\_\_

What Fields  
Does Data Need to be  
Sorted?: \_\_\_\_\_

What Variables do you need to see on the report?  
(Please see next page and check data variables needed.)

\_\_\_\_\_

*University of Kentucky Hospital Policy HPO5-13, Release of Medical Records for  
Research and Study Projects and HIPPA 164.5129(i) and 164.528.*

Researchers may access protected health information under HIPPA regulations, provided that the researcher completes a "Researchers' Assurance of HIPPA Compliance" form to document their agreement to comply with HIPPA requirements.

The Trauma Program Office requires Data Request worksheets be submitted no less than two weeks prior to date needed.

**Specific Data Variables** (Please check all required)

- |  |   |
|--|---|
| <input type="checkbox"/> Age                               | <input type="checkbox"/> Sex  |
| <input type="checkbox"/> Race                              | <input type="checkbox"/> Cause of Injury  |
| <input type="checkbox"/> Place of Injury                   | <input type="checkbox"/> County of Injury   |
| <input type="checkbox"/> Referring Hospital                | <input type="checkbox"/> Referring Arrival Time/Date  |
| <input type="checkbox"/> Referring Hospital Discharge Date | <input type="checkbox"/> Referring Physician  |
| <input type="checkbox"/> Transport Agency                  | <input type="checkbox"/> Transportation Mode<br>(Amb/Heli Scene v. Referred)                  |
| <input type="checkbox"/> Scene Times                       | <input type="checkbox"/> Trauma Type (Blunt/Penetrating)                                      |
| <input type="checkbox"/> Risk Factors                      | <input type="checkbox"/> Protective Devices   |
| <input type="checkbox"/> Admitting Service                 | <input type="checkbox"/> Diagnosis  |
| <input type="checkbox"/> Body Regions Injured              | <input type="checkbox"/> ICD9 Codes/Description   |
| <input type="checkbox"/> Injury Severity Score (ISS)       | <input type="checkbox"/> Trauma Score   |
| <input type="checkbox"/> Revised Probability of Survival   | <input type="checkbox"/> Vital Signs (Scene/ED)   |
| <input type="checkbox"/> Outcome                           | <input type="checkbox"/> UK Arrival Time/Date   |
| <input type="checkbox"/> UK Discharge Time/Date            | <input type="checkbox"/> Admission by Shift/Weekday/Month                                     |
| <input type="checkbox"/> Procedures and Results (ED/OR)    | <input type="checkbox"/> ETOH   |
| <input type="checkbox"/> Crystalloids/Colloids             | <input type="checkbox"/> Time Lapses (Between: Procedures/<br>Transfers/Injury and Treatment) |
| <input type="checkbox"/> Complications                     |   |

Please describe any other information that you might need to see that is not listed above:

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Reporting Format: Print  ASCII  Excel