Routine Data Request

1515 SW Archer Rd
Box 100108
Gainesville, Florida 32610-0108
352-733-0872
e-mail: yorkdl@shands.ufl.edu

PERSON REQUESTING INFORMATION:

INSTITUTION:

DEPARTMENT:

ADDRESS:

PHONE: FAX: EMAIL:

DATE OF REQUEST: DATE NEEDED:

INFORMATION REQUESTED:

DATA POINTS and ICD-9 CODES TO BE USED:

PURPOSE OF INQUIRY:

PREFERRED FORMAT (electronic or hard copy; spreadsheet or report with narrative)

I understand that confidentiality policies require that information which would reveal a patient's identity not be released. Any information which I have requested will be destroyed when I have completed the goals stated above in a manner that protects confidentiality of the information. I will abide by all Shands Healthcare System policies. I will acknowledge the Trauma Program Database as the source of the above requested data both in written text, and oral presentations. I will in no form reproduce this information for others, into electronic databases, or sub-reports of any type.

Signature of data requester: _____

PLEASE ALLOW 15 WORKING DAYS FROM RECEIPT OF THIS FORM FOR RETURN OF DATA.

Submit to: **Shands at the University of Florida**
Trauma Registry
P O Box 100108
Gainesville, Fl 32610

FOR REGISTRY USE

Date received: _____ Report prepared by: _____

Date completed: _____ Total time used: _____

Delivery date: _____

Revised 10/01/2012