

Northern Ohio Trauma System Data Request Form

Study Type (check one)	<input type="checkbox"/> Research – Defined as systematic investigation, including research development, testing, and evaluation designed to contribute to scientific <u>publication</u> or <u>public</u> dissemination. (Output: publication or public dissemination)		
	<input type="checkbox"/> Quality Improvement – Defined as systematic, data-guided improvement activities designed to implement ways to improve clinical care, patient safety, and health care operations at the <u>local</u> setting. (Output: internal process improvement)		
Researcher names and associated institution(s)	Name	CREC Cert Date	Institution
Working hypothesis			
Inclusion criteria			
Exclusion criteria			
Major outcomes to be studied			
Basic outline of analysis to be performed			
Intended destination of work	<input type="checkbox"/> Abstract	<input type="checkbox"/> Poster	<input type="checkbox"/> Presentation
	<input type="checkbox"/> Journal Article	<input type="checkbox"/> Non-Academic Article	<input type="checkbox"/> Internal NOTS use
	<input type="checkbox"/> Other (describe):		

“right patient, right place, right time”



By signing this form, you, as the Requestor, acknowledge that the NOTS Research Committee must approve any submissions of your final work product for publication or public dissemination, as per the Research Committee Policy for Public Dissemination of Findings.

Your request will go before the Research Committee during the next meeting. Meeting dates can be found on the NOTS website.

Date of request	
Requestor name	
Requestor phone	
Requestor email	
Requestor signature	

Approvals

Cleveland Clinic System Representative	
Name	
Signature	
MetroHealth System Representative	
Name	
Signature	
University Hospitals Health System, Inc. Representative	
Name	
Signature	

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Attachment A: Available NOTS Data Fields

Please put an “X” next to each data field being requested.

X	Data point
	Patient arrival date
	Patient arrival time
	Birthdate
	Age
	Gender
	Injury zip
	Mode of arrival
	Arrived with signs of life?
	ICD-10 mechanism code
	Trauma type
	ED Disposition
	ISS
	Transfer in?
	If yes, from what facility?
	ED LOS
	Hospital LOS
	ICU LOS
	Alcohol level*
	Drugs tested positive*
	Hospital disposition
	If transfer out, to what facility?
	Patient discharge date
	Patient discharge time
	Discharge status
	Full AIS Injury Code
	AIS Body Region

*These fields may be submitted in an inconsistent format. The NOTS Data Specialist will work with the requestee if these fields are needed.

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