McLaren Flint

Clinical Data Request Form

Date _____ Requestor: (please print) _____

1. Case Report/Project/Study Objective _____

_____

_____

2. Are you planning to publish the results of this case report/project/study? ☐ Yes ☐ No

   Information to be used for research requires patient authorization or waiver of authorization from the Institutional Review Board (IRB) or Privacy Board.

3. Do you need volume data to determine the feasibility of this case report/project/study?

   ☐ Yes – [1] I need to know the volume of patients in a population,
   [2] I do not need Protected Health Information (PHI) at this time.

   Time Period: _____

   Patient population definition: _____

   _____

   ☐ No – I wish to proceed with obtaining PHI. Go to step #4.

Protected Health Information
Birthdate
Name
Social Security Number

4. I have already obtained IRB approval for my study per: (Please provide a copy of IRB approval letter.)

   _____
   Signature of Principal Investigator

5. I need the following data elements for the time period: _____

☐ Name	☐ Patient Type (Inpatient, Outpatient, ER, Clinic)	☐ Admit Source
☐ Account Number (encounter, billing)	☐ ICD-9 Diagnosis Codes	☐ Other
☐ Medical Record Number	☐ ICD-9 Procedure Codes	
☐ Birthdate	☐ Attending Physician	
☐ Age	☐ Outpatient/ER Physician	
☐ Length of stay	☐ Admitting Physician	
☐ Payor	☐ Consulting Physicians	
☐ Race	☐ Procedure Physician (surgeon)	
☐ Sex	☐ Procedure Date	
☐ Disposition	☐ Admit Diagnosis	
☐ Admit Date	☐ Code Status (Pt Care Category)	
☐ Discharge Date	☐ Care unit	

6. I wish to receive the requested information via:

   ☐ Email _____ or

   ☐ U.S. Mail _____ or

   ☐ Pick up or ☐ Mailbox in Physicians' Lounge or ☐ Other _____

7. _____ Phone: _____
   Signature of Requestor

8. Data Contact Person: _____

   Department: _____ Phone: _____

   Send completed form to the McLaren Flint Quality Management Department. Phone: 810-342-2005