**Data Request Questionnaire Retrospective Chart Review**

1. **What is the IRB #?** (Type the 8digit IRB ePROST#. If the identifier starts with “SITE” then include the word “SITE”)
2. **Is this project JHS Approved?**
3. **Principal Investigator’s/ Requestors Name:**
4. **Principal Investigator’s/ Requestors Department:**
5. **If applicable, who is the Study Coordinator?**
6. **Study Team Members:**
Provide the list of Study Team Members(Last, First) who are listed in the IRB entry for this Retrospective Chart Review.
7. **Do the study team members accessing the data request have a JHS account and VPN access ( If no please email** (JHS-CTO-Research-Tickets@jhsmiami.org **stating this so we can begin the contractor access process) ?**
8. **Title or Brief Summary of Request:**
9. **Is this a funded project, if no please provide a short explanation?**
10. **What is the Study Team requesting from IT (MRN or MRN + additional data elements) ( For additional Data Elements only\*Please attach IRB approved DCS and highlight columns that you are requesting JHS IT to complete \*)**
11. **Inclusion/Exclusion Criteria (Please provide the inclusion/exclusion criteria):**
12. **Date Range of Medical Records Requested for Review:**
13. **Gender(M/F):**
14. **Age Range (1-150):**
15. **Race:**
16. **Ethnicity:**
17. **Patient Type (Emergency Department, Inpatient, discharged, Outpatient, Deceased):**
18. **ICD-9 Codes (If none put N/A):**
19. **ICD-10 Codes (IF DATE RANGE FOR DATA INCLUDES >2015 please include ICD-9 Code)?:**
20. **Procedure Codes (CPT) (If none put N/A):**
21. Procedure Codes (DRG) **(If none put N/A)**:
22. **Laboratory Tests (If none put N/A):**
23. **Medications (If none put N/A):**
24. **Implants or Devices (If none put N/A):**
25. **Facility? (Jackson Health System (All Facilities), Jackson Memorial, Holtz Women’s & Children’s, Jackson Behavioral Health, Jackson North, Jackson South, Jackson West, Ambulatory Care Clinics, Urgent Care Clinics, Other:):**
26. **Any additional Instruction:**

1. **Expected Timeline for data request to be completed (When do you expect or require the data pull to be completed):**
2. **2-3 Example FIN # for Patient type (This will assist JHS IT in validating the data pull):**
3. **How many records approved for this study (This is located in the IRB approved Protocol)?**
4. **Availability for a zoom meeting to discuss data pull?**
5. **Is there an estimated budget needed for this study? Y/N**
6. **What is the expected completion date?**