



## ICC Report/Data Request Form

**Requestor:** *(primary contact for report)*

Name:	<input type="text"/>
Organization:	<input type="text"/>
Email:	<input type="text"/>
Phone:	<input type="text"/>

**Date of Request:**

Date:	<input type="text"/>
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**Desired Delivery Date:** *(Desired delivery date. Actual date may vary based on the complexity of the request, any further report specification, and current reporting workload.)*

Date:	<input type="text"/>
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**Frequency:** *(check the appropriate box...)*

One time only	<input type="checkbox"/>
Annual	<input type="checkbox"/>
Semi-annual	<input type="checkbox"/>
Quarterly	<input type="checkbox"/>
Bi-weekly	<input type="checkbox"/>
Weekly	<input type="checkbox"/>
Other:	<input type="text"/>

**Instructions:** This form is a multi-purpose document to initiate a data request from the ICC. ICC staff may contact you for additional documentation or other clarifications. Some questions in this document may not be relevant to your request. Please use "N/A" for any non-relevant fields.

**Purpose of Report\*:**

Relevant background information:

What issue are you studying?

What is your population of interest? Intervention of Interest? Outcome of Interest?

Where and how will the data be presented? Who is the audience? *(Internal use, public forum, conference, website, published journal article, etc.)*

\* Data requested must be used in compliance with the HIPAA and other federal/state regulations and existing agreements between the requestor and the ICC regarding use of patient information.

**IRB Approval:** (will the requested data be used in research that requires Institutional Review Board approval? If yes, then please attach IRB approval forms)



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Yes

No

Comments

**PHI:** *(Does the data requested include Protected Health Information?)*

Yes

No

**Other Organizations:**

List organizations other than your own whose data will be listed or sorted by organization names:

*A signature or attached letter of approval is required from a key representative of each organization listed.*

Signature(s):

Date:



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**Program Evaluation:** Are you requesting that the ICC conduct a program evaluation, or do you plan to use the data obtained from ICC for a program evaluation? (please specify in the comments. Also if you are requesting a program evaluation, complete the Program Evaluation Questionnaire).

Yes

No

Comments

**Criteria:**

**Narrative Description:** (What information you need to be included in the report)

**Indicators:**

**Parameters:**

Time period:	
Patient age range:	
Patient diagnoses (ICD9 codes):	
Encounter types:	
Locations:	
(more)...	

**Output Data Fields:** (Which data fields do you want displayed, and in what grouping?)

Data Fields to Display

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
More...	

**Additional Comments:**

Please include an additional information that you feel may be relevant regarding these 99 individuals.



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## ICC Office Use Only:

Work Effort (*In hours*):

Primary Staff Person Assigned

## ICC Director Pre-Review

*Initial*

- IRB Requirements satisfied
- All relevant signatures/letters of approval obtained
- All definitions determined (e.g. ranges, ICD9 codes, etc.)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ICC Analyst Post Review

*Initial*

- Benchmarked against other data for accuracy
- Statistical Significance checked
- Definitions used are listed on report

Internal QA: Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
QA with Report Requester: Signature: \_\_\_\_\_ Date: \_\_\_\_\_