DoDTR Data Request Form

Specified data items below MUST be listed within your IRB protocol or PI Determination documents.

REQUESTOR INFORMATION

Name: _____ **Military Title:** _____ **Submission Date:** _____

Medical Facility/Duty Station: _____ **Requested Date:** _____

Military Phone: _____ **Military Email:** _____

Purpose of Request: ☐ Research ☐ Performance Improvement ☐ Other: _____

Hypothesis:

REQUESTED INFORMATION

Population Data

Date Range of Query: From _____ To _____ | **PHI or Non PHI:** ☐ PHI Identified, includes SSN ☐ Non PHI Unidentified

Theater: ☐ OIF ☐ OEF ☐ OND ☐ Other: _____

Data required from MTF Level: ☐ All MTFs (Level I-V) Specify Other MTF Level or Name: _____

Patient Category: ☐ All U.S. Military ☐ U.S. Army ☐ U.S. Air Force ☐ U.S. Navy ☐ U.S. Marine Corps ☐ U.S. Coast Guard ☐ Local Civilian ☐ Coalition Forces ☐ NATO Military ☐ Other: _____

Military Service: ☐ Yes ☐ No | **Military Rank:** ☐ Yes ☐ No | **Job Description:** ☐ Yes ☐ No

Data Elements

Gender: ☐ Yes ☐ No | **Age:** ☐ Yes ☐ No | **Injury Month/Year:** ☐ Yes ☐ No

Battle vs. Non-Battle: ☐ Yes ☐ No | **Max ISS Score (2005):** ☐ Yes ☐ No | **Max AIS Severity by Body Region (2005):** ☐ Yes ☐ No

Mechanism of Injury, Dominant: ☐ Yes ☐ No **If yes:** ☐ All ☐ Explosive Device ☐ GSW ☐ MVC ☐ Fall ☐ Other: _____

Type of Injury, Dominant: ☐ Yes ☐ No **If yes:** ☐ All ☐ Penetrating ☐ Blunt ☐ Burn ☐ Other

Arrival Transport/ Prehospital Data: ☐ Vital Signs ☐ Procedures ☐ Intubated ☐ Medications ☐ Mode of Transport
MTF: ☐ All MTFs ☐ Other: _____

ICD 9 Injury Codes: ☐ Yes ☐ No **If yes:** ☐ All Codes ☐ Other: _____ **MTF:** ☐ All MTFs ☐ Other: _____

AIS Injury Codes: ☐ Yes ☐ No **If yes:** ☐ All Codes ☐ Other: _____ **MTF:** ☐ All MTFs ☐ Other: _____

ICD 9 Procedure Codes: ☐ Yes ☐ No **If yes:** ☐ All Codes ☐ Other: _____ **MTF:** ☐ All MTFs ☐ Other: _____

Burn Information: ☐ Yes ☐ No **If yes:** ☐ Codes ☐ Lund & Browder Chart **MTF:** ☐ All MTFs ☐ Other: _____

Blood Products: ☐ Yes ☐ No **If yes:** ☐ 1st 24 hrs at MTF ☐ Total Transfused at MTF ☐ Est. Blood Loss at 1st Operative Procedure ☐ THAM ☐ Factor VII ☐ TXA **MTF:** ☐ All MTFs ☐ Other: _____

Complications: ☐ Yes ☐ No **If yes:** ☐ All Comp ☐ Other: _____ **MTF:** ☐ All MTFs ☐ Other: _____

ED Initial Status: ☐ Yes ☐ No **If yes, specify Vital Signs and /or Lab values:**

ED Vital Sign Values: ☐ SBP ☐ DBP ☐ Pulse Rate ☐ Temperature ☐ SaO_2 ☐ GCS

Status at time vitals taken: ☐ Paralytic Agents ☐ Respiration Assist ☐ Type of Resp Assist / ☐ Sedated ☐ Intubated ☐ Intubation Method

ED Lab Values: ☐ INR ☐ HCT ☐ Hgb ☐ Platelet Count ☐ BG pH ☐ $PaCO_2$ ☐ PaO_2 ☐ Base Deficit/Excess ☐ ABG Drawn ☐ VBG Drawn

MTF: ☐ All MTFs ☐ Other: _____

(Data Elements continued on next page.)

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REQUESTED INFORMATION, Data Elements continued

Discharge Status: ☐ Yes ☐ No **If yes:** ☐ Discharge from ☐ Discharge to ☐ Discharge condition ☐ Final discharge

Hospital Days: ☐ Yes ☐ No **Ventilator Days:** ☐ Yes ☐ No **ICU Days:** ☐ Yes ☐ No

Disch Vital Sign Values: ☐ SBP ☐ DBP ☐ Pulse Rate ☐ Temperature ☐ SaO_2 ☐ GCS

Status at time vitals taken: ☐ Paralytic Agents ☐ Respiration Assist ☐ Type of Resp Assist / ☐ Sedated ☐ Intubated ☐ Intubation Method

Disch Lab Values: ☐ INR ☐ HCT ☐ Hgb ☐ Platelet Count

☐ BG pH ☐ $PaCO_2$ ☐ PaO_2 ☐ Base Deficit/Excess ☐ ABG Drawn ☐ VBG Drawn

MTF: ☐ All MTFs ☐ Other: _____

Additional Information

Insert additional requested data not provided above:

COMPLETE MOU/MOA INSTITUTIONAL OFFICIAL INFORMATION

Name: _____ **Commander Title:** _____

Name of Official Institutional Command Officer for MOU/MOA

Facility Address

Street: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Submit DoDTR Data Request Form to:

usarmy.jbsa.medcom-aisr.mbx.jts-dodtr-data-request@mail.mil

JTS USE ONLY

Date request received: _____ **Date data compiled:** _____

Date data furnished: _____ **Time to compile:** _____

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