Revised on 7May2018

WRHA Medicine Information Management & Re

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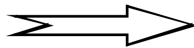

ATTENTION: ***Julie Mojica,*** Statistician (Phone 204-787-1690)
Trish Ostryzniuk, Regional Manager (Phone 204-787-3055
Fax: (204) 787-2823

Medicine Database Information Request Form

Please complete all sections.

Date of Request: ______________________ Date Information required by: ______________
(Allow at least 2 weeks for completion of request)

Submitted by: ______________________ Department: ______________ Phone: ______

Who is the request for? ______________________ Department: ______________ Phone: ______
(if different from above)

List all others who will have access to this data: ⇒ ☐

Intended use of data :

Check the item and elaborate further in the space below.

☐ Research Project - *Please attached the followin*
1.Copy of Research Ethics Boards' Approval Form
2.Copy of Research Proposal/Protocol Summary

☐ Teaching ☐ Resource Utilization

☐ Audit/Evaluation/Review ☐ Others - *Please specify.*

Specific Data Requested?

Time Period: Start ____________ End ______
(mm/dd/yyyy) (mm/d

Hospital & Unit: ☐ ALL below

HSC:	☐ A4	☐ D4	☐ H4	☐ H4H
	☐ D5	☐ B3	☐ EMIP	
STB:	☐ E6	☐ E5	☐ B5	☐ EMIP
GRA:	☐ N3	☐ N5	☐ S3	☐ EMIP
VIC:	☐ N4	☐ S5	☐ N5	

Type of Report: ☐ Combined Report ☐ Individu

Summary statistics required? ☐ YES ☐ NO
(Include N , Mean, Standard Deviation, Sum, Minimum, Maximum)

Further Data Details *(please indicate below and back).*

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Patient chart log required *(Includes Initials, Chart, DOB, Admit & Discharge Date, Hospital, Unit)* ? ☐ YES ☐ NO

How would you like this information sent to you?

- Mail ☐ Your address:
- Pick up ☐
- Fax* ☐ Your Fax #
- Email* ☐ Your Hospital Email Address

**For summary statistics request only*

Have been asked before to give feedbacks on the data?
☐ YES ☐ NO

Do not fill-up the area below this line.

APPROVED YES ☐ NO ☐

Fee Applicable YES ☐ NO ☐

Am $ __

Authorization Signature

Medicine Info Mgt & Research

Medicine Database Info Request No. ____________

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