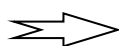




Revised on 18Apr2023

WRHA Critical Care Information Management & Research

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Critical Care 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 following:
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/dd/yyyy)

Hospital & Unit: ☐ ALL Below

HSC: ☐ MICU ☐ SICU ☐ IICU

STB: ☐ ICMS ☐ ICCS ☐ ACCU

☐ GRA

Type of Report: ☐ Combined Report ☐ Individual Reports

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

Further Data Details (please indicate below and back).

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 # _____

Have been asked before to give feedbacks on the data?

☐ YES ☐ NO

➡ Email* ☐ Your Hospital Email Address: _____
 *For summary statistics request only

Do not fill-up the area below this line.

Authorization Signature

Critical Care Info Mgt & Research

APPROVED

YES ☐ NO ☐

Fee Applicable

YES ☐ NO ☐

Amount

\$ _____

CC Database Info Request No. _____