**Date:** Thursday, March 19, 2015

**Requester Contact Information\*:**

Name: SAMPLE

Department: Pediatrics

Email *(UPHS or PSOM)*: SAMPLE@email.chop.edu Phone: 215-XXX-XXXX

Previous Report Name / ticket #:

Request Approved By:

**Request Title\*: Very-Low Birthweight Infant Study**

**Purpose\*:**

Please provide specific details on the objectives or abstract of your request. This will better help us meet your specific needs.

|  |
| --- |
| We are preparing to submit for a K award investigating nutrition delivered to Very-low birthweight infants in the intensive nursery along with an intervention to improve this nutrition delivery. |

**Type of Analysis \****(Please indicate the appropriate type):*

|  |  |
| --- | --- |
| Compliance, QA, Patient Care |  |
| Funded IRB Approved Research *(attach IRB Approval and Protocol)* |  |
| Non-funded IRB Approved Research *(attach IRB Approval and Protocol)* |  |
| Preparatory Research | X |
| Professional Billing |  |
| Other (Describe):  |  |

**Research Program -** Is the PI performing this study for a thesis for a mentored degree program, eg the MPH, MSCE, MSHP, MSME, or PhD? **NO**

**Expected Report Delivery Date:**

**Report Format** *(e.g. Excel, flat file, PDF, etc)***: Raw data (csv’s)**

**Report Frequency** - *Ambulatory Clinical Reports Only*

 *( ) One-Time Ad-Hoc ( ) Scheduled*

*­­­­­­­­­­­­­­­­­­­­­­­­* *For schedule reports how often:* ***Once***

*Who will the report get distributed to (email address):* ***michelj@email.chop.edu***

**Define Parameters Required\***

 *Note: The more specific you can be the better our team will be able to meet your needs in an expedited manner. If you are not specific in your criteria(s), the request may be denied and delay the process.*

|  |  |  |
| --- | --- | --- |
| ***Criteria*** | ***Display?*** | ***Description / Exclusions / Limitations / Filters*** |
| **MRN** | N | Unique identifier requested, but can be masked MRN |
| **Visit ID** | Y |  |
| **Patient Class(es)***Please select only which class(es) you will need.* | IP |  **Inpatient**⃝ Outpatient⃝ Emergency |
| **Age** *or DOB ranges* |  |  |
| **Gender** | Y |  |
| **Race** | Y |  |
| **Department(s)***Provide department numbers not just names.* | N | Intensive Care only |
| **Provider(s)***Provide ID’s not just names.* | N |  |
| **Date(s)***Include in the specific range and date types (eg, admit, order, result)* | 1/1/2011-2/28/2014 | 2 Year’s worth based on Discharge Date |
| **Procedure***Please include the specific procedure codes. (ICD9 is preferred for inpatient)* | Y | 38.92 (umbilical Vein Catheterization)99.15 (Parenteal Infusion of concentrated nutritional substances) |
| **Diagnosis***Please include the specific ICD-9 codes including all decimal points. Do not simply include ranges or wildcards.* | Y | 765.10, 765.11, 765.12, 765.13, 765.14, 765.15, 765.16, 765.17, 765.18, 765.19, V213.0, V213.1, V213.2. V213.3, V213.4, V213.5, 765.00 |
| **Orders** | Y | Parenteral Nutrition, Diet Orders, IV fluid orders |
| **Medication***Please list as it is ordered within the UPHS EMR’s – medication id’s preferred* | N |  |
| **Lab Result***Please list the lab as it is ordered within the UPHS EMR’s.* | Y | Na, K, Phos, Calcium, Chloride, Glucose, Bicarb, Magnesium |
| **Other** | N |  |
| **Other** | N |  |
| **Other** | Y | Inpatient weight, heights, BMI |
| **Other** | N |  |
| **Other** | Y | Length of Stay |

**Fields to display on report**

|  |  |  |
| --- | --- | --- |
| MRN | Patient Name | Admit/Disch Date |
| ICU Transfer Unit, Date | Diagnosis Code/Description, Date | Lab Result Code/Desc, Date, Value |
|  |  |  |
|  |  |  |

**Data calculations needed** *(e.g. average, sum, etc) None*

**Data Grouping** *(e.g. by patient, by day, by procedure, by Department, etc) By patient*

**Report Layout** *(draw out/describe as expected)***:**

**Raw data in rows is fine, we can perform our own data analysis and manipulation**