

Data Request Form for the Joint Trauma System DoD Trauma Registry

REQUESTOR INFORMATION			
Name: _____	Title: _____	Organization: _____	Date: _____
Medical Facility/Duty Station: _____		Requested Date: _____	
Phone: _____	Email: _____	DHA DSAA Number: _____	
Purpose of Request: <input type="checkbox"/> Research <input type="checkbox"/> Performance Improvement <input type="checkbox"/> Other: _____			
Project Title _____			
Data User Name: _____		Title: _____	
SPONSOR INFORMATION All non-military requestors must have a military sponsor.			
Name: _____	Title: _____	Phone: _____	
Sponsor Organization _____		Email: _____	
REQUESTED INFORMATION			
Population Data			
Date Range of Query: From _____ To _____		PHI or Non PHI: <input type="checkbox"/> PHI Identified, includes SSN <input type="checkbox"/> Non PHI Unidentified	
Military Operations: <input type="checkbox"/> OIF <input type="checkbox"/> OEF <input type="checkbox"/> OND <input type="checkbox"/> OFS <input type="checkbox"/> OIR <input type="checkbox"/> Other: _____			
Data required from Level of Care: <input type="checkbox"/> All (Role I-V) Specify Other Role or Name: _____			
Patient Category: <input type="checkbox"/> All U.S. Military <input type="checkbox"/> U.S. Army <input type="checkbox"/> U.S. Air Force <input type="checkbox"/> U.S. Navy <input type="checkbox"/> U.S. Marine Corps <input type="checkbox"/> U.S. Coast Guard <input type="checkbox"/> Local Civilian <input type="checkbox"/> Coalition Forces <input type="checkbox"/> NATO Military <input type="checkbox"/> Other: _____			
Military Service: <input type="checkbox"/> Yes <input type="checkbox"/> No		Military Rank: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Job Description: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Specified data elements below MUST be listed within your IRB protocol or PI Determination documents.			
Note: For more data elements, refer to the data dictionary at https://jts.health.mil/assets/docs/forms/DoDTR-Data-Dictionary-External.pdf To arrange a conference contact JTS using the e-mail address on the bottom of page 2.			
Data Elements			
Gender: <input type="checkbox"/> Yes <input type="checkbox"/> No		Age: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Injury Month/Year: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Battle vs. Non-Battle: <input type="checkbox"/> Yes <input type="checkbox"/> No		Max ISS Score (2005): <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Max AIS Severity by Body Region (2005): <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mechanism of Injury, Dominant: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> All <input type="checkbox"/> Explosive Device <input type="checkbox"/> GSW <input type="checkbox"/> MVC <input type="checkbox"/> Fall <input type="checkbox"/> Other: _____			
Type of Injury, Dominant: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> All <input type="checkbox"/> Penetrating <input type="checkbox"/> Blunt <input type="checkbox"/> Burn <input type="checkbox"/> Other: _____ <input type="checkbox"/> Mounted/Dismounted			
Arrival Transport/ Prehospital Data: <input type="checkbox"/> Vital Signs <input type="checkbox"/> Date <input type="checkbox"/> Time <input type="checkbox"/> Care Location <input type="checkbox"/> POI <input type="checkbox"/> Transport			
Vital Sign Values: <input type="checkbox"/> SBP <input type="checkbox"/> DBP <input type="checkbox"/> Pulse Rate <input type="checkbox"/> Temperature <input type="checkbox"/> SaO2 <input type="checkbox"/> GCS <input type="checkbox"/> Respiratory Rate <input type="checkbox"/> Pain Scale			
<input type="checkbox"/> Procedures <input type="checkbox"/> Date <input type="checkbox"/> Time <input type="checkbox"/> Care Location <input type="checkbox"/> POI <input type="checkbox"/> Transport			
<input type="checkbox"/> Medications <input type="checkbox"/> Date <input type="checkbox"/> Time <input type="checkbox"/> Care Location <input type="checkbox"/> POI <input type="checkbox"/> Transport			
<input type="checkbox"/> Mode of Transport <input type="checkbox"/> Date <input type="checkbox"/> Time <input type="checkbox"/> Care Location <input type="checkbox"/> POI <input type="checkbox"/> Transport			
Level of Care: <input type="checkbox"/> All Roles <input type="checkbox"/> Other: _____			
ICD 9/10 Injury Codes: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Include Non-Trauma			
<small>Note: ICD 10 codes are not available prior to an <i>injury</i> date of 1 March 2017</small>			
If yes: <input type="checkbox"/> All Codes <input type="checkbox"/> Burn <input type="checkbox"/> Other: _____		Level of Care: <input type="checkbox"/> All Roles <input type="checkbox"/> Other: _____	
AIS Injury Codes: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes: <input type="checkbox"/> All Codes <input type="checkbox"/> Other: _____		Level of Care: <input type="checkbox"/> All Roles <input type="checkbox"/> Other: _____	
ICD 9/10 Procedure Codes: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes: <input type="checkbox"/> All Codes <input type="checkbox"/> Other: _____		Level of Care: <input type="checkbox"/> All Roles <input type="checkbox"/> Other: _____	
Date _____ Time _____		Location _____	
<small>Note: ICD 10 codes are not available prior to an <i>injury</i> date of 1 March 2017</small>			
<small>(Data Elements continued on next page.)</small>			

Joint Trauma System Internal Use Only

