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: ☐ Research ☐ Performance Improvement ☐ 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:** ☐ PHI Identified, includes SSN ☐ Non PHI Unidentified

Military Operations: ☐ OIF ☐ OEF ☐ OND ☐ OFS ☐ OIR ☐ Other: _____

Data required from Level of Care: ☐ All (Role I-V) Specify Other Role 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

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

Sex: ☐ 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: _____ ☐ Mounted/Dismounted

Arrival Transport/ Prehospital Data: ☐ Vital Signs ☐ Date ☐ Time ☐ Care Location ☐ POI ☐ Transport

Vital Sign Values: ☐ SBP ☐ DBP ☐ Pulse Rate ☐ Temperature ☐ SaO_2 ☐ GCS ☐ Respiratory Rate ☐ Pain Scale
☐ Procedures ☐ Date ☐ Time ☐ Care Location ☐ POI ☐ Transport
☐ Medications ☐ Date ☐ Time ☐ Care Location ☐ POI ☐ Transport
☐ Mode of Transport ☐ Date ☐ Time ☐ Care Location ☐ POI ☐ Transport

Level of Care: ☐ All Roles ☐ Other: _____

ICD 9/10 Injury Codes: ☐ Yes ☐ No ☐ Include Non-Trauma

Note: ICD 10 codes are not available prior to an *injury* date of 1 March 2017

If yes: ☐ All Codes ☐ Burn ☐ Other: _____ ***Level of Care:*** ☐ All Roles ☐ Other: _____

AIS Injury Codes: ☐ Yes ☐ No

If yes: ☐ All Codes ☐ Other: _____ ***Level of Care:*** ☐ All Roles ☐ Other: _____

ICD 9/10 Procedure Codes: ☐ Yes ☐ No

If yes: ☐ All Codes ☐ Other: _____ ***Level of Care:*** ☐ All Roles ☐ Other: _____

Date _____ Time _____ Location _____

Note: ICD 10 codes are not available prior to an *injury* date of 1 March 2017

(Data Elements continued on next page.)

Joint Trauma System Internal Use Only

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REQUESTOR INFORMATION

Name: _____ **Title:** _____ **Organization:** _____ **Date:** _____

REQUESTED INFORMATION, Data Elements continued

Blood Products: ☐ Yes ☐ No

If yes: ☐ 1st 24 hrs at MTF ☐ Total Transfused at MTF ☐ Est. Blood Loss at 1st Operative Procedure Per MTF

☐ Factor VII ☐ Date ☐ Time

☐ TXA ☐ Date ☐ Time

Level of Care: ☐ All Roles ☐ Other: _____

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

ED Data Elements: ☐ Yes ☐ No **ED Admission:** ☐ Date ☐ Time **ED Initial Status:** ☐ Yes ☐ No

Specify Vital Signs and /or Lab values:

ED Vital Signs Recorded: ☐ Date ☐ Time

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

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

Level of Care: ☐ All Roles ☐ Other: _____

Discharge Data Elements: ☐ Yes ☐ No **Discharge:** ☐ Date ☐ Time

Discharge Status: ☐ Yes ☐ No ☐ Discharge from ☐ Discharge to ☐ Discharge condition ☐ Final discharge

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

Discharge Vital Signs Recorded: ☐ Date ☐ Time

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

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

Discharge Lab Values: ☐ INR ☐ HCT ☐ Hgb ☐ Platelet Count ☐ BG pH ☐ $PaCO_2$ ☐ PaO_2 ☐ Base Deficit/Excess

Level of Care: ☐ All Roles ☐ Other: _____

Additional Information

Insert additional requested data not provided above:

Submit DoDTR Data Request Form to: dha.jbsa.healthcare-ops.list.jts-data-enterprise@health.mil

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