Tumor Registry Research/Special Request Form

Please complete the following request for data from the Methodist Healthcare Tumor Registry. Following review by the Tumor Registry management and Methodist Healthcare IRB Administration, you will be notified of the status of your request and how to proceed. ***All areas must be completed and all required documents submitted for your request to be considered***. Send your completed form and documents to:

Methodist Healthcare IRB Administration
1325 Eastmoreland Suite 374
Memphis, TN 38104 telephone: 901-516-2323 fax: 901-516-2456

1. Check one reason for request:
   - ☐ Research study
   - ☐ Case report for possible publication
   - ☐ General investigation for internal use– **not for** publication
   - ☐ General investigation for internal use- ***possible*** publication
   - ☐ Other: ____

2. Check from which source data is being requested:
   - ☐ Paper records
   - ☐ Microfilm records
   - ☐ Electronic/Cerner records
   - ☐ Records from an MH Tumor Registry or database **only**
     Specify: ____________________

3. Brief description of research study/project/investigation/request.

   Explain why this data is needed.

4. Does the request involve collection of personal health information (PHI)?
   - ☐ No
   - ☐ Yes
     List PHI elements to be collected: __________________________________
     or attach a copy of data collection tool

5. Is this an IRB approved research study?

   ☐ No
   ☐ Yes Identify the approving IRB: ______________________________________
   IRB address: ______________________________________
   Date of initial IRB approval: ______________
   Approval date expiration: ______________
   Indicate type of approval granted by IRB: ☐ Full approval
   ☐ Expedited approval
   ☐ Exemption certification

   Must attach copy of IRB approval letter to this request.

6. Is a separate informed consent required by the IRB for the collection of data?

   ☐ No
   ☐ Yes **If yes, must attach a copy of the IRB approved informed consent form.**

7. Specify what information is being requested.
   Check all that apply and be specific as to the data desired. May attach data collection tool.

   ____ a. From complete medical record(s) regarding:
   [**List the exact data requested**]

   ____
   Number of records requested: ____________
   Date of record(s) requested: ___/___/___ to ___/___/___

   ____ b. From partial medical record(s) regarding:
   [**List the exact data requested**]

   ____
   Number of record(s) requested: ______________
   Date of record(s) requested: ___/___/___ to ___/___/___

   ____ c. From patient list regarding (specify patient name(s), DRG code, etc.)
   [**List the exact data requested**]:

   ____
   Date of record(s) requested: ___/___/___ to ___/___/___

   ____ d. Data from medical records regarding:
   [**List the exact data requested**]

   ____
   Date of record(s) requested: ___/___/___ to ___/___/___

8. What changes/outcomes/results are expected to occur as a result of the proposed data request?

10. List all individuals who will be obtaining or reviewing the data. **Print or type names.**

Name: ______________________________ Contact number: __________________
MH credentials: ☐ Yes ☐ No

Name: ______________________________ Contact number: __________________
MH credentials: ☐ Yes ☐ No

Name: ______________________________ Contact number: __________________
MH credentials: ☐ Yes ☐ No

11. Name, address and contact information for individual requesting data. **Print or type.**
Name: __________________________________
Address: __________________________________
____
MH credentials: ☐ Yes ☐ No

Telephone: __________________ Pager/Beeper: ___________________
Fax: _____________ Email: ____

12. Name, address and contact information for **principal investigator** if this is a research study.
Name: __________________________________
Address: __________________________________
____
MH credentials: ☐ Yes ☐ No

Telephone: __________________ Pager/Beeper: ___________________
Fax: _____________ Email: ____

13. List name and contact information for person to whom the data/report will be given:
Name: __________________________________
Address: __________________________________
____
MH credentials: ☐ Yes ☐ No

Telephone: __________________ Pager/Beeper: ___________________
Fax: _____________ Email: ____

By signing this request you are agreeing to abide by all MH compliance and ethical standards.

________________________________ _______________
Printed name of person making request Date

____
Signature of person making request

________________________________ _______________
Printed name of principal investigator Date
(if research study only)

____
Signature of principal investigator

Stipulations:

1) Once approval is obtained the request must be submitted to the Tumor Registry Manager within 7 working days after approval or the request is forfeited unless approved by the Manager.
2) If the request is determined to require Methodist Healthcare Institutional Review Board (MHIRB) approval, the MHIRB approval does not ensure that the Tumor Registry will provide the data. If the request exceeds the departmental capabilities at the time of the request the request may be delayed or denied by the Tumor Registry Manager.

Please do not write below this line. For use by MHIRB and Tumor Registry Administration

_____ Request is **APPROVED** as submitted.

______________________________ _______________
MHIRB Administration Date

______________________________ _______________
Tumor Registry Manager Date

The Tumor Registry will provide the data at the rate of __________ .

Tumor Registry request number: ____________________________

______ Request is **approved but <u>DELAYED.</u>**

_____________________________ _________________
MHIRB Administration Date

_____________________________ _________________
Tumor Registry Manager Date

Contact Tumor Registry Manager at _____________ to arrange a date to obtain data.

Tumor Registry request number: __________________________

_____ Request is **DENIED** for the following reason(s):

- ☐ IRB approval required before consideration. Contact MHIRB Administration for process and resubmit with all required information.
- ☐ Required information missing: ____________________________________
  Resubmit with all required information.
- ☐ Request exceeds capability of Tumor Registry to provide data.
- ☐ Request not in keeping with MH policies or values or mission.

_____________________________ _________________
MHIRB Administration Date

_____________________________ _________________
Tumor Registry Manager Date

Tumor Registry request number: __________________________

Date sent to person making request: _______________ via ☐ Fax ☐ Mail