

**UH Chart Review Registration Form\***

For individuals who don’t already have access to charts and/or need access to new data sets you must submit an application to the Medical Informatics Committee. Please contact Doris Fernandez ([fernand1@uhnj.org](mailto:fernand1@uhnj.org)) ext. 2-9525) for additional information and application.

**Please scan and e-mail the completed and signed form to** [**OCRAreview@njms.rutgers.edu**](mailto:OCRAreview@njms.rutgers.edu)**.** A description of additional requirements for registering your study with University Hospital may be found at:  <http://njms.rutgers.edu/research/clinical_research_admin.cfm>

**PLEASE COMPLETE THIS DOCUMENT ELECTRONICALLY**

***(Handwritten Submissions of this form are “unacceptable”***

**Research Trial Investigator Information**

(Check all record systems that will be accessed for the study)

**EPIC**  **SOVERA  PACS**  **LOGICIAN  TRANSCRIPTS  OTHER**

**PAPER RECORDS (NOTE: Charges will be incurred for retrieval)**

PI Name:       Telephone# **RU/UH** email

Co/PI Name:       Telephone# **RU/UH** email

Study Coordinator (if not PI): :      Telephone #:       **RU/UH** email

Department/Division: WIRB/IRB Protocol#

Protocol Title:

In order to access University Hospital medical records, all personnel must have completed their annual Compliance, Ethics and HIPAA training.

A copy of your WIRB/IRB letter of approval must be provided to the Medical Records department upon request for access to records.

Please provide a list of the names and emails (**rutgers.edu/uhnj.org only**) of all persons that will access the UH medical record system(s). These individuals must also be listed on the WIRB/eIRB letter of approval for this study:

NAME EMAIL NAME EMAIL

**UH Chart Review Registration Form (con’t)**

**Are reports from IST required**?  **No,** →

Describe how you will collect the data**:**

**Yes,** →Complete the following to provide in as much detail as possible about the data being requested

**[a] Patient Class to be enrolled:** Inpatient OutpatientSame Day SurgeryMedical Procedures

Emergency DepartmentAncillary (Radiology/Lab) Ambulatory Care**:**

**[b] Specific Time Frame: from:**       **to:**      (note: dates must match eIRB approved protocol)

**[c] Specific ages:** All  18 or older  Other

**[d] Gender:  All**  Male (only)  Female (only)

**[e] Race** All  Specify

**[f] Discharge status:**  All  Discharged Alive  Discharged Deceased  Discharged AMA

**[g] Specific information requested:**

**ICD-9 Codes (specify)**

**ICD-10 Codes (specify)**

**CPT Codes (specify)**

**Comments/Narrative**

**NOTE:** Physicians and/or pertinent staff in the above mentioned protocol have agreed to access only those records to which he/she is authorized and not inquire access nor report on, or extract information that is not consistent within the research job functions and responsibilities. Violation of these conditions may constitute grounds for disciplinary action, up to and including termination of employment.

**I certify that I have completed all the necessary annual -** **Compliance, Ethics and HIPAA** **training programs**:

Principal Investigator Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Request Date: \_\_\_\_\_\_\_\_\_\_\_\_