Waianae Coast Comprehensive Health Center
Data Request Form

Date: Requestor/Title: Department: Phone/Ext: _____

Date Needed By: Nature of Request:

Intended Use/Justification:

- ☐ Grant Application
- ☐ Research (Attach approval letter from WCCHC IRB)
- ☐ Quality Improvement Data Analysis – Indicate Committee or Department:
- ☐ Educational Activity – Specify:
- ☐ Other – Specify:

Information Fields Required (Limit request to the minimum necessary to fulfill the requirements of the purpose of the request):

☐ Last Name	☐ First Name	☐ Ethnicity	☐ PCP	☐ Location ID	☐ Patient Phone
☐ Patient Number	☐ Gender	☐ Date of Service	☐ Insurance	☐ Patient Age	☐ Patient Address
☐ Guarantor Number	☐ ICD-9 Code	☐ Procedure Code	☐ # of Encounters	☐ Patient Birthdate	
☐ Other: (Specify)					
☐ Other: (Specify)					

Requested Distribution Format:

- ☐ Hardcopy printed format
- ☐ Data file using: Excel, ACCESS, Summary Data (via e-mail) or Other Application:

Sort Report By: _____

- ☐ Summary Data Only

Identify User and Encounter or Visit:

User	**Encounter or Visit**	**Date Range:**
☐ All WCCHC users	☐ All encounters (including enabling)	
☐ Capitated users	☐ Any chargeable encounter	
☐ 3+ primary care + OB and assigned to WCCHC	☐ Enabling service encounters	
☐ 3+ visits (excluding enabling)	☐ Capitated	
☐ 3+ visits (including enabling)	☐ Exclude ER encounters	
☐ 1+ visit (excluding enabling)	☐ Exclude Lab encounters	
☐ PCP assigned	☐ Exclude Xray encounters	
☐ Other:	☐ Other:	

Comments: (If previous reports have been generated or you have a sample layout, attach to request).

Approval Signatures (E-mail will be accepted from Dept. Director, Researcher, or Committee Chair)

Department Director, Researcher, or Committee Chair:	Date:	Information Systems:	Date: