YALE UNIVERSITY SCHOOL OF MEDICINE / YALE–NEW HAVEN HOSPITAL
CANCER DATA REPOSITORY (TUMOR REGISTRY)

REQUEST FOR INFORMATION

A. REQUESTER INFORMATION

Requesting Investigator (Print): _____ Date of Request: _____/_____/_____

Department: _____ Campus Address: _____

Telephone: _____ Email Address: _____ Yale Cancer Center Member: Y N

B. CASE SELECTION CRITERIA

Identify the search parameters/criteria for identifying cases. The more specific you are, the more likely you will get what you want.
(Note that all tumors in the Cancer Data Repository are coded using the ICD-O coding system. Ideal example: "All patients with a malignant mixed Mullerian tumor of the ovary (ICD-O site code = C569; ICD-O morphology codes: 89503, 89513, 89803) initially diagnosed between Jan 1, 1990 and Jan 1, 2000.")

C. INFORMATION REQUESTED

List the data elements you would like for each of the cases identified.
(Example: last name, first name, YNHH medical record number, date of birth, date of initial diagnosis, date first seen at YNHH, etc.)

D. DATA FORMAT (How would you like to receive the data requested?)

___ Printed list

___ Tab-delimited text file via email (NOTE: email will be sent to the address above ONLY if it is a Yale University or YNHH email address.)

E. AUTHORIZATION/ATTESTATION (select one)

___ I am requesting only aggregate or anonymized information (no further approval needed).

___ I certify that I am requesting this information strictly for treatment, payment, quality assurance, or other healthcare operations within Yale University / Yale-New Haven Hospital. The results of this search will NOT be used for case finding preparatory to research, or for actual research purposes. This information will not be released outside of this institution. Approval of department chair, section chief, or vice president is required.

Approved by: _____ _____ _____/_____/_____
Signed (Chair/Section Chief/Vice President) *Print Name* *Date*

___ I am requesting this information for research purposes. Human Investigation Committee (HIC) approval/exemption required. *(Complete and submit this form to the HIC in conjunction with the research proposal).*
I accept full responsibility for the appropriate handling, storage, and disposal of the information provided to me as a result of this data request. I attest that I will only release this information to other HIC approved investigators, will only use this information for the scope of the approved protocol, and neither I nor any other investigator will use this information, alone or in combination with other information, to attempt to obtain information not approved by the terms of the research protocol.

_____ _____ _____/_____/_____
Signed (Investigator) *Print Name* *Date*

To be completed by the Human Investigation Committee (HIC) (required for any data requests for research purposes):

Protocol #:_____ Approval Date: _____/_____/_____ Expiration Date: _____/_____/_____
I certify that the data requested on this form falls within the scope of the approval of the above protocol, that the requestor of this information is an approved investigator on that protocol, and that the HIC approves release of this information to the investigator by the Cancer Data Repository staff.

_____ _____ _____/_____/_____
Signed (HIC Staff) *Print Name* *Date*
Does release of this data from the Cancer Data Repository to the investigator qualify as a disclosure accountable under HIPAA? _____

To be completed by the CaDR Staff:

Request Completed by:_____ Date Completed: _____/_____/_____ # Cases Identified: _____

Comments: _____