

## DEMOGRAPHICS AND PATIENT INFORMATION

*Note to SCL Users: The selection pop-up boxes in SCL are in an easy pull down menu format. Underlined fields contain pop-up boxes. If data must be entered in a field before an abstract can be added to the database, the selection pop-up box will automatically be displayed when tabbing through the field. To activate the selection pop-up box, right click using your mouse in the appropriate box. SCL users are ensuring the highest level of quality edit checks by activating the various selection pop-up boxes. For specific detailed instructions for SCL, refer to the User's Guide.*

### DATE OF ADMIT/ DATE OF FIRST CONTACT (NAACCR ITEM #580)

#### **Description**

The date of first admission/contact with the reporting facility for diagnosis and/or treatment of this cancer. If previously diagnosed/treated elsewhere, the date of first admission to your facility with diagnoses of active cancer.

#### **Explanation**

This data item allows the facility to document the first contact with the patient. It can be used to measure the time between admission and when the case is abstracted and the length of time between the first contact and treatment.

#### **Coding Instructions**

1. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

#### **Example:**

Record the admit date of January 22, 2008 as 01222008.

2. Enter the date (month, day, century and year) of the first admission to your facility for a diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with active cancer or receiving cancer treatment.
3. A date **must** be entered in this field. If the patient was never an inpatient, enter the date of the first outpatient visit e.g., biopsy, x-ray, laboratory test at your facility with active cancer.
4. For autopsy-only or death certificate-only cases, use the date of death as the date of first contact.
5. For "read only" or "pathology only" cases, use the date the specimen was collected. These are cases where a specimen is sent over to be read by the pathology department and the patient is never seen or admitted at the reporting facility. These cases are reportable if the pathology department generates revenue for the reporting facility and is **NOT** a free standing entity. The class of case should be coded to 7 and the reporting source would be 3.

*Note: Document in your Policy and Procedure Manual if you have an agreement with any facilities sending their specimens to your pathology department as “read only”, but they are still responsible for reporting those cases to the TCR.*

*Note: FORDS instructions differ from TCR instructions. FORDS requires that Date of First Contact be recorded as the date of diagnosis if diagnosis is made at the reporting facility. TCR will continue to instruct that the date be recorded as the admit date if the diagnosis is made at the reporting facility. It is understood that ACoS facilities will continue to follow the rules according to FORDS.*

**Examples:**

- a. A patient is admitted to the hospital on January 31, 2008 with chest pains. On February 2, 2008 a CT scan shows that the patient has a lung mass consistent with malignancy. Record the date of first contact as 01312008.
- b. A patient has a biopsy in a staff physician’s office on March 17, 2008 and the specimen is sent to the reporting facility’s pathology department on that same day. The pathologist reads the specimen as malignant melanoma. The patient enters the same reporting facility on March 21, 2008 for a wide re-excision. Record the date of first contact as 03172008.
- c. A patient has a lymph node biopsy at a small hospital on May 15, 2008. The specimen is sent to your hospital to be evaluated in your pathology department. The pathologist reports diffuse large b-cell lymphoma. The patient never enters your hospital. Record 05152008 as date of first contact.

**REGISTRY/ACCESSION NUMBER (NAACCR ITEM #550) (FORDS pg. 33)**

**Description**

A registry or accession number is a unique number assigned to identify each patient regardless of the number of primary cancers.

**Explanation**

This data item serves as a reference number to protect the identity of the patient.

**Coding Instructions**

1. The first four digits identify the calendar year of the admission the patient was first seen at the facility for a reportable diagnosis. The following five digits identify the numerical order in which the case was entered into the registry. Each year’s accession/registry number will start with 00001.

**Example:**

200800001 would indicate the first 2008 case reported from a facility.

2. SCL automatically assigns a registry number according to the year of admission. This field can be edited to assign the correct registry number.
3. **Do not** assign a new registry number to a patient previously reported to the TCR with a new primary cancer. SCL users will need to refer to the *SCL User's Guide* for instructions on entering multiple primaries.

### **REPORTING FACILITY NUMBER (NAACCR ITEM #540) (FORDS pg. 208)**

#### **Description**

Identifies the facility or institution reporting the case.

#### **Explanation**

This data item is used for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

#### **Coding Instructions**

1. Enter the three-digit facility number assigned by the TCR.
2. If you do not know your facility number, contact your Health Service Region office or the Central Office in Austin.

### **TYPE OF REPORTING SOURCE (NAACCR ITEM #500) (SEER pgs. 23–25)**

#### **Description**

This data item identifies the source documents used to abstract the case being reported. This will not necessarily be the document that identified the case but the document that provided the best information.

#### **Explanation**

This field provides the source of the documents used to report the case, e.g., inpatient or outpatient charts, cases diagnosed in physician's offices, patients diagnosed at autopsy, pathology report only or diagnosed by death certificate only.

## Coding Instructions

1. Enter the code for the source of the facility and/or documents used to abstract the case.

CODE	DEFINITION OF REPORTING SOURCES
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records
2	Radiation Treatment Centers or Medical Oncology Centers (Facility or Private)
3	Laboratory Only (Facility or Private)
4	Physician's Office/Private Medical Practitioner
5	Nursing/Convalescent Homes, Hospice
6	Autopsy Only
7	Death Certificate Only
8	Other hospital outpatient units/surgery centers

*Note: Assign codes in priority order: 1, 2, 8, 4, 3, 5, 6, and 7 if more than one source is used.*

### Definitions:

**Managed health plan:** HMO or other health plan (e.g. Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally (in a unit record) and is available to the abstractor.

**Physician office:** Examinations, tests and limited surgical procedures may be performed in a physician's office. If called a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

**Serial Record:** The office or facility stores information separately for each patient encounter.

**Surgery center:** Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. The patient does not stay overnight.

**Unit record:** The office or facility stores information for all of a patient's encounters in one record.

### Examples:

- a. A patient is admitted to your facility and expires before any treatment is rendered. An autopsy is performed and cancer is found in the lung. Code the reporting source to 6 (autopsy only). The autopsy report is the only document used for your cancer information. The patient was not known to have cancer prior to the autopsy.
- b. A patient is admitted to your facility and is diagnosed with lung cancer. Code the reporting source to 1 (Facility Inpatient/ Outpatient or Clinic). All documents in the medical record are used to gather the cancer information.

**MEDICAL RECORD NUMBER (NAACCR ITEM #2300) (FORDS pg. 36)****Description**

The number assigned to a patient's medical record by the reporting facility.

**Explanation**

This number identifies the individual patients within a reporting facility. It allows a reporting facility to easily locate a patient's health information. This health information is referenced when abstracting or updating a cancer case or to help identify multiple reports and primaries on the same patient.

**Coding Instructions**

1. Enter the eleven digit medical record number used to identify the patient's first admission with active cancer and/or on cancer treatment. Medical record numbers with less than 11 digits and alpha characters are acceptable.
2. If a number is not available (outpatient clinic charts or ER visit reports), enter OP in this field. See the list below for other optional medical record identifiers.
3. Optional medical record identifiers:

CODE	DEFINITION
RT	Radiation Therapy department patient without a medical record number
SU	One-day surgery clinic patient without a medical record number
UNK	Medical record number unknown

**CLASS OF CASE (NAACCR ITEM #610) (FORDS pgs. 5–6 or 83–84)****Description**

Class of case identifies the role of the reporting facility in the patient's diagnosis and treatment.

**Explanation**

This data item divides case records into analytic and non-analytic categories. Class of case has ten categories, 0–9. The class of case determines which cases should be included in the analysis of the facility's cancer experience. The analytical cases (classes 0, 1 and 2) are those cases that were first diagnosed and/or treated at the facility. They are analyzed because the facility was involved in the diagnostic and therapeutic decision-making. Non-analytical cases (classes 3–7) are usually excluded from a facility's routine treatment or survival statistics.

**Coding Instructions**

1. *Analytical cases (classes 0, 1, and 2):* Diagnosed at the reporting facility and/or received any of the first course of treatment at the reporting facility. Abstracting for class of case 0 and 1 is to be completed within six months of diagnosis. This allows for treatment information to be

documented in the patient's medical record. Abstracting for class of case 2 is to be completed within six months of first contact with the reporting facility.

*Note: A facility network clinic or outpatient center belonging to the facility is considered part of the facility.*

2. *Non-analytical cases (classes 3, 4, 5, 6, 7):* Diagnosed and received all of the first course of treatment at another facility, or cases which were diagnosed and/or received all or part of the first course of treatment at the reporting facility prior to the registry's reference date (reference date applies to ACoS facilities, facilities striving for ACoS certification, or facilities that follow ACoS standards and do not seek certification). Abstracting for non-analytical cases should be completed within six months of first contact with reporting facility.

*Note: Per TCR reporting guidelines, non-analytical cases are reportable by all facilities if the case was not diagnosed prior to 1995, and there is documentation of active cancer or if the patient received cancer directed therapy.*

*Note: Non-analytical cases (classes 8 and 9) are to be used solely by the central registry.*

### Class of Case Definitions

ANALYTIC CASES	
<b>Class 0</b>	<p><b>Diagnosed at the reporting facility and all of first course of treatment was performed elsewhere.</b></p> <p><i>Cases include:</i></p> <ul style="list-style-type: none"> <li>• Patients who choose to be treated elsewhere.</li> <li>• Patients referred elsewhere for treatment due to lack of special equipment; proximity of a patient's residence to the treatment center; financial, social or rehabilitative considerations, etc.</li> </ul>

**ANALYTIC CASES**

**Class 1** **Diagnosed at the reporting facility and had all or part of the first course of treatment at the reporting facility or was never treated at all.**

*Cases include:*

- Patients whose treatment plan is watchful waiting.
- Patients who refused any treatment or for whom no treatment is planned.
- Patients who were untreatable due to age, advanced disease, or other medical conditions.
- Specific therapy was recommended but not received at the reporting facility and it is unknown if therapy was ever administered.
- It is unknown if therapy was recommended or administered.
- Patients diagnosed but not treated at the reporting facility and all or part of the first course of treatment was received at a staff physician's office. "**Staff physician**" refers to any physician with admitting privileges at the reporting facility.
- Patients diagnosed in a staff physician's office and then treated at the reporting facility.
- Patients diagnosed and treatment plan developed and documented at the reporting facility. Therapy was delivered elsewhere in accordance with the treatment plan.

*Note: ACoS facilities should include cases in which patients are diagnosed at the reporting facility prior to the registry's reference date and all or part of the first course of treatment was received at the reporting facility after the registry's reference date.*

**ANALYTIC CASES**

**Class 2** **First diagnosed elsewhere and all or part of the first course of treatment given at the reporting facility.**

*Cases include:*

- The reporting facility administered all or part of the first course of treatment.
- The reporting facility administered palliative care in lieu of, or as part of, first course treatment.

**NON-ANALYTIC CASES**

**Class 3** **First diagnosed and all of the first course of treatment administered elsewhere. Patients are seen at the reporting facility for additional therapy or management, and have active disease and/or are on cancer treatment.**

*Cases include:*

- No information on first course of treatment. The patient is treated or managed at the reporting facility for an unrelated condition and has active disease and/or on cancer treatment.
- The reporting facility developed a treatment plan or provided a "second opinion", but the diagnosis and treatment was provided elsewhere.

<b>Class 3</b> cont'd	<ul style="list-style-type: none"> <li>The reporting facility is treating or managing the recurrence, progression, or subsequent treatment of a previously diagnosed malignancy.</li> </ul> <p><i>Note: If your facility does not deliver any of the first course of treatment, class of case is coded to 3. Do not code to 9.</i></p>
<b>Class 4</b>	<p><b>Patients who were first diagnosed and received their first course of therapy at the reporting facility before the registry's reference date. The reporting facility manages or treats a recurrence or progression of that cancer after the registry's reference date.</b></p> <p><i>Cases include:</i></p> <ul style="list-style-type: none"> <li>Patients for whom the reporting facility manages or treats a recurrence or progression of disease after the reference date.</li> <li>Patients for whom it is unknown whether the reporting facility delivered the first course of treatment prior to the reference date.</li> </ul> <p><i>Note: This class applies to ACoS facilities and/or facilities with a cancer program and reference date only.</i></p>
<b>Class 5</b>	<b>First diagnosed at autopsy.</b> Prior to autopsy, no suspicion or diagnosis of cancer.
<b>Class 6</b>	<b>Diagnosed and entire first course of treatment completed in a staff physician's office.</b> Staff physician refers to any physician with admitting privileges at the reporting facility.

**NON-ANALYTIC CASES**

<b>Class 7</b>	<p><b>Pathology report only.</b> Patient does not enter the reporting facility at any time for diagnosis or treatment.</p> <p><i>Note: This category excludes cases diagnosed at autopsy.</i></p>
<b>Class 8</b>	<p><b>Diagnosis established only by death certificate.</b></p> <p><i>Note: Used by central registries only.</i></p>
<b>Class 9</b>	<p><b>Unknown.</b> Sufficient detail for determining class of case is not stated in medical record.</p> <p><i>Cases include:</i></p> <ul style="list-style-type: none"> <li>Unknown if previously diagnosed or treated.</li> <li>Previously diagnosed, date unknown.</li> </ul> <p><i>Note: Used by central registries only.</i></p>

### Class of Case Examples

CODE	REASON
0	Reporting facility admits patient due to dizziness and falling. The patient receives clinical workup which includes CT and MRI of the brain. The results are positive for brain metastasis. The patient is discharged to hospital B for treatment for lung cancer with brain metastasis.
1	Reporting facility admits patient with hemoptysis. Workup reveals adenocarcinoma. The patient undergoes surgery followed by radiation therapy at the reporting facility.
2	Patient was diagnosed and treated at another facility for primary breast cancer. The patient then comes to the reporting facility for radiation.
3	Patient was diagnosed and treated for primary bladder cancer prior to admission to reporting facility. Reporting facility admits patient for cystectomy for recurrent bladder cancer.
5	Patient admitted to reporting facility with chest pain and expires. Autopsy performed at reporting facility identifies patient has pancreatic cancer.
7	Reporting facility pathology department receives a tissue sample for evaluation which is positive for malignant melanoma. The patient was never seen/admitted at reporting facility.

### LAST NAME (NAACCR ITEM #2230) (FORDS pg. 39)

#### Description

Identifies the last name of the patient.

#### Explanation

This data item is used as a patient identifier.

#### Coding Instructions

1. Enter the last name of the patient in **CAPITAL LETTERS**. Blanks, spaces, hyphens, apostrophes, and punctuation marks **are** allowed.

#### Examples:

- a. Record De Leon with space as DE LEON
- b. Record O'Hara with apostrophe as O'HARA
- c. If Janet Smith marries Fred Jones and changes her name to Smith-Jones record SMITH-JONES with the hyphen.

2. Do not leave blank. If the patient's last name is not known, enter UNKNOWN in this field. This should be done only as a last resort. Every resource should be exhausted to obtain this information.

*Note: Document in **TEXT REMARKS - OTHER PERTINENT INFORMATION**: last name unknown.*

**FIRST NAME** (NAACCR ITEM #2240) (FORDS pg. 40)

**Description**

Identifies the first name of the patient.

**Explanation**

This data item is used to differentiate between patients with the same last name.

**Coding Instructions**

1. Enter the first name of the patient in **CAPITAL LETTERS**.
2. Do not use punctuation.
3. If the patient's first name is unknown, enter UNKNOWN. Do not leave blank. This should be done only as a last resort. Every resource should be exhausted to obtain this information.

*Note: Document in **TEXT REMARKS - OTHER PERTINENT INFORMATION**: first name unknown.*

**MIDDLE NAME** (NAACCR ITEM #2250) (FORDS pg. 41)

**Description**

Identifies the middle name or middle initial of the patient.

**Explanation**

This data item is used to differentiate between patients with identical first and last names.

**Coding Instructions**

1. Enter the middle initial if the complete middle name is not provided.
2. Do not use punctuation.
3. If the patient does not have a middle name or initial, or it is unknown, leave blank.

**MAIDEN NAME (NAACCR ITEM #2390)****Description**

Identifies the female patients who are or have been married.

**Explanation**

This data item is useful for matching multiple records for the same patient and is useful in identifying Spanish/Hispanic origin.

**Coding Instructions**

1. Enter the maiden name of female patients who are or have been married if the information is available. Blanks, spaces, hyphens, apostrophes, and punctuation marks **ARE** allowed.
2. If the patient does not have a maiden name, or it is unknown, leave blank.

**ALIAS NAME (NAACCR Item #2280)****Definition**

Records an alternate name or “AKA” (also known as) used by the patient, if known. Note that maiden name is entered in Name-Maiden [2390].

**Explanation**

A patient may use a different name or nickname. These different names are aliases. This item is useful for matching multiple records on the same patient.

**Coding Instructions**

1. Leave blank if not applicable.
2. Record the last name followed by a blank space and then the first name.
3. Mixed case, embedded spaces, hyphens and apostrophes are allowed.
4. No other special characters are allowed.

**Examples:**

- a. Ralph Williams uses the name Bud Williams. Record Williams Bud in the **NAME-ALIAS** field.
- b. Janice Smith uses the name Janice Brown. Record Brown Janice in the **NAME-ALIAS** field.
- c. Samuel Clemens uses the name Mark Twain. Record Twain Mark in the **NAME-ALIAS** field.

**STREET ADDRESS** (NAACCR ITEM #2330) (FORDS pg. 42)**Description**

Identifies the patient's address (number and street) at the time of diagnosis.

**Explanation**

Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes. A patient's physical address takes precedence over a post office box. If a patient has multiple primary tumors the address may be different if diagnosed at different times. Do not update this field if the patient moves after diagnosis.

*Note: ACoS facilities are required to provide information for this field regardless of class of case.*

**Coding Instructions**

1. Enter the number and street of the patient's residence at the time the cancer is diagnosed in **25 characters or less**.
2. Only use the post office box or the rural mailing address when the physical address is not available. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Every effort should be made to obtain complete valid address information.
3. Punctuation marks are limited to periods, slashes, hyphens and pound signs in this field.
4. If the address contains more than 25 characters, omit the least important elements, such as the apartment or space number.
5. **Do not** omit elements needed to locate the address in a census tract, such as house number, street, direction or quadrant, and street type.
6. Abbreviate as needed using standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service (USPS). These include but are not limited to:

ABBREV.	DEFINITION	ABBREV.	DEFINITION	ABBREV.	DEFINITION
APT	Apartment	FL	Floor	S	South
AVE	Avenue	N	North	SE	Southeast
BLDG	Building	NE	Northeast	SQ	Square
BLVD	Boulevard	NW	Northwest	ST	Street
CIR	Circle	PLZ	Plaza	STE	Suite
CT	Court	PK	Park	SW	Southwest
DEPT	Department	PKWY	Parkway	UNIT	Unit
DR	Drive	RD	Road	W	West
E	East	RM	Room		

**Example:**

Patient's street address is 1232 Southwest Independence Apartment 400.

Record: 1232 SW Independence Apt 400

**Patients with an Unknown Address:**

7. If the patient's address is not available in the medical record, record **NO ADDRESS** or **UNKNOWN**. **Do not** leave blank. These cases should be rare and every effort should be made to obtain a valid address. The address data fields for these cases should be recorded as the city **Unknown**, the state as **ZZ**, the zip code should be **99999** and the FIPS as **999**. **Do not record the reporting facility's city, state, zip and FIPS.**
8. Be aware that an excessive amount of unknown addresses will result in additional efforts by TCR staff to obtain a valid address which may include contacting the reporting facility or managing/following physician.

*Note: Document in **TEXT REMARKS - OTHER PERTINENT INFORMATION**: Patient address is unknown.*

9. **Do not** update this data item for the first primary if the patient's address changes with subsequent admissions or subsequent primaries.
10. For helpful complete address information log onto <http://zip4.usps.com/zip4/welcome.jsp>.

**Persons with More than One Residence:**

These include snowbirds that live in the south for the winter months, sunbirds that live in the north during the summer months, and people with vacation residences which they occupy for a portion of the year.

11. Code the residence where the patient spends the majority of time (usual residence).
12. If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.

**Persons with No Usual Residence:**

Homeless people and transients are examples of persons with no usual residence.

13. Code the patient's residence at the time of diagnosis as unknown.

*Note: Under pertinent information document that patient is homeless. An unknown address is not the same as homeless.*

**Temporary Residents:**

14. Code the place of usual residence rather than the temporary address for:

**Migrant** workers

Persons **temporarily residing** with family during cancer treatment

**Military** personnel on **temporary** duty assignment

**Boarding school** students below the college level (code the parent's residence)

15. Code the residence where the student is living while attending **college**.

16. Code the address of the institution for **Persons in Institutions**.

Persons who are incarcerated

Persons who are physically handicapped, mentally retarded, or mentally ill who are residents of homes, schools, hospitals, or wards.

Residents of nursing and rest homes

Long-term residents of other hospitals such as Veteran's Administration (VA) hospitals

**Persons in the Armed Forces and on Maritime Ships (Merchant Marine):**

17. **Armed Forces**—For military personnel and their family members, code the address of the military installation or surrounding community as stated by the patient.

18. **Personnel Assigned to Navy, Coast Guard, and Maritime Ships**—The US Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and its homeport. Refer to US Census Bureau Publications for detailed rules at [www.census.gov](http://www.census.gov).

**ADDRESS AT DX—SUPPLEMENTAL** (NAACCR ITEM #2335) (FORDS pg. 43)**Description**

Provides the ability to store additional address information such as the name of a place or facility (a nursing home or name of an apartment complex).

**Explanation**

A registry may receive the name of a facility instead of a proper street address containing the street number, name, direction, or other elements necessary to locate an address on a street file for the purpose of geocoding.

**Coding Instructions**

1. Do not use this data item to record the number and street address of the patient.
2. Do not update this data item if the patient's address changes.

3. If this address space is not needed, leave blank.

**CITY (NAACCR ITEM #70) (FORDS pg. 44)**

**Description**

Identifies the name of the city or town in which the patient resides at the time of diagnosis. Do not update this field if the patient moves after being diagnosed.

**Explanation**

Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes.

**Coding Instructions**

1. Enter the city of residence at the time the cancer is diagnosed.
2. Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting.
3. If the patient has multiple primaries, the address may be different for subsequent primaries.

*Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.***

**STATE (NAACCR ITEM #80) (FORDS pgs. 45–46)**

**Description**

Identifies the patient's state of residence at the time of diagnosis/admission. This field should not be updated if the patient moves after being diagnosed.

**Explanation**

It allows for analysis of geographic and environmental studies and inclusion in state and national cancer publications/studies.

**Coding Instructions**

1. Record the appropriate **two-letter abbreviation** for state of residence at the time of diagnosis.
2. If the patient is a resident of Mexico or Canada, record the appropriate **two-letter abbreviation** for the country of residence at time of diagnosis/admission. If the province or territory of Canada is known, record the abbreviation. See page 51 for a list of Canadian Provinces/Territories.

3. If the patient is a foreign resident, other than Mexico or Canada, record either **XX** or **YY** depending on the circumstance. Refer to the table below for specific instructions.
4. If the patient has multiple primaries, the state of residence may be different for subsequent cases.

**Note:** Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded as **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.**

CODE	DEFINITION
TX	If the state in which the patient resides at the time of diagnosis and treatment is Texas, then use the USPS code for the state of Texas.
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
CD	Resident of Canada, NOS; Use the specific abbreviation of Canadian Provinces/Territories if this information is provided.
MX	Resident of Mexico.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Mexico and Canada, and the country is <b>known</b> .
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Mexico and Canada, and the country is <b>unknown</b> .
ZZ	Residence unknown.

**Examples:**

- a. A patient's country of residence is documented as France; record **XX** in the state field.
- b. Documentation in the patient's medical record states the patient is a resident of a foreign country and no other address documentation provided; record **YY** in the state field.
- c. The patient's medical record states the patient lives in the United States or in a territory, commonwealth, or possession of the United States and no other address documentation is provided; record **US** in the state field.
- d. If every valid attempt has been made to obtain the address and it is still unknown, record **ZZ** in the state field.

**Canadian Provinces/Territories:**

Province/Territory	Abbreviation	Province/Territory	Abbreviation
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NF	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS		

**State and Territory Abbreviations:**

(Refer to the ZIP Code directory for further listings).

STATE	STATE	STATE	STATE	STATE	STATE
Alabama	AL	Kentucky	KY	North Dakota	ND
Alaska	AK	Louisiana	LA	Ohio	OH
Arizona	AZ	Maine	ME	Oklahoma	OK
Arkansas	AR	Maryland	MD	Oregon	OR
California	CA	Massachusetts	MA	Pennsylvania	PA
Colorado	CO	Michigan	MI	Rhode Island	RI
Connecticut	CT	Minnesota	MN	South Carolina	SC
Delaware	DE	Mississippi	MS	South Dakota	SD
District of Columbia	DC	Missouri	MO	Tennessee	TN
Florida	FL	Montana	MT	Texas	TX
Georgia	GA	Nebraska	NE	Utah	UT
Hawaii	HI	Nevada	NV	Vermont	VT
Idaho	ID	New Hampshire	NH	Virginia	VA
Illinois	IL	New Jersey	NJ	Washington	WA
Indiana	IN	New Mexico	NM	West Virginia	WV
Iowa	IA	New York	NY	Wisconsin	WI
Kansas	KS	North Carolina	NC	Wyoming	WY

OTHER U.S. TERRITORIES	
American Samoa	AS
Guam	GU
Puerto Rico	PR
Virgin Islands	VI

**ZIP CODE** (NAACCR ITEM #100) (FORDS pg. 47)**Description**

Identifies the postal code of the patient's address at the time of diagnosis/admission. If the patient has multiple tumors, the postal code may be different for each tumor.

**Explanation**

It allows for the analysis of cancer clusters, geographic or environmental studies and health services research.

**Coding Instructions**

1. Enter the patient's zip code at time of diagnosis/admission. Enter the nine-digit extended zip code if known. If recording the full nine-digit zip code, **no dash** should be placed between the first five and the last four digits. The five-digit zip code is allowed if this is all the information available.
2. If the zip code is not available, refer to the *National Zip Code Directory* or to the USPS Web site, [www.usps.gov](http://www.usps.gov). This website is useful in obtaining missing address information in order to record a complete address.
3. If the patient is a resident of a foreign country at the time of diagnosis, record **88888** for the zip code.

*Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available do not leave blank. The address data fields for these cases should be recorded as **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.*

CODE	DEFINITION
123456789	The patient's nine-digit U.S. extended postal code. Do not record dashes.
88888	Permanent address in a country other than Canada, United States, or U.S. possessions.
99999	Resident of the United States (including its possessions, etc.) or Canada and the postal code cannot be verified using the <i>National Zip Code Directory</i> of the USPS Web site at <a href="http://zip4.usps.com/zip4/welcome.jsp">http://zip4.usps.com/zip4/welcome.jsp</a> .
99999	After every effort is made to obtain a valid address the information remains unknown.
M6G2S8	The patient's valid six character Canadian postal code left justified followed by three blanks.

**Examples:**

- a. A patient's country of residence is documented as France; record 88888 in the zip code field.

- b. A patient's address is in Canada and the zip code cannot be verified; record 99999 in the zip code field.
- c. A patient's address is not documented in the medical record and remains unknown after researching all your facility's resources; record 99999 in the zip code field.

### **FIPS COUNTY CODE AT DIAGNOSIS** (NAACCR ITEM #90) (FORDS pg. 48)

#### **Description**

Identifies the county of the patient's residence at the time of diagnosis. If the patient has multiple tumors, the county codes may be different for each tumor.

#### **Explanation**

This data item may be used for epidemiological purposes (e.g., to measure the cancer burden in a particular geographical area).

#### **Coding Instructions**

1. Enter the appropriate three-digit code for the county of residence. Use codes issued by the Federal Information Processing Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas*. This publication is available at: [www.epa.gov/enviro/html/codes/state.html](http://www.epa.gov/enviro/html/codes/state.html).
2. Refer to *Appendix C* for the list of Texas FIPS county codes.
3. If the patient has multiple tumors, the FIPS county codes may be different for each tumor.
4. Enter the three-digit code 998 if the patient lives out of state, but the address is unknown.
5. For facilities using SCL, the FIPS code will automatically display when the city and zip is entered.
6. Do not update this data item if the patient's county of residence changes after diagnosis.
7. ACoS facilities following the FORDS' guideline to code the country of residence geocode (see Appendix G) in this data field for non-U.S. residents, **MX**, **CD** and **XX** will be accepted by the TCR Edits.

**Note:** Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded as *Unknown* in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.**

CODE	DESCRIPTION	DEFINITION
001–507	County at diagnosis	Valid Texas FIPS code
998	Outside state/country & code is unknown	Known town, city, state, or country of residence, but county code not known <b>AND</b> a resident outside the state of Texas (must meet all criteria)
999	Unknown county	The county is unknown and not documented in the patient's medical record

**SOCIAL SECURITY NUMBER** (NAACCR ITEM #2320) (FORDS pg. 37)

**Description**

Identifies the patient by social security number.

**Explanation**

This item is used by the TCR in internal processes such as linking for resolution of duplicate primaries and consolidation.

**Coding Instructions**

1. Every effort should be made to obtain the social security number. Research all resources from your facility for this information.
2. Enter the patient's nine-digit social security number in this field.
3. If the social security number is unavailable or unknown, enter all 9's in this field.
4. A patient's Medicare number may not be identical to the person's social security number.
5. Do not put dashes or slashes in this field.

**Note:** Social security numbers are used for Medicare benefits. Suffix A on a social security number indicates the number is the patient's Medicare number. Other suffixes identify another person's Medicare number under which the patient may be entitled to receive benefits. **Take caution to enter the patient's social security number and not the spouse's or guardian's number.**

The following are not allowed:

- First 3 digits= 000 or 666
- Fourth and fifth digits= 00
- Last four digits= 0000
- First digit= 8 or 9 (except for 9999999999)

**DATE OF BIRTH** (NAACCR ITEM #240) (FORDS pg. 57; SEER pgs. 36–37)**Description**

Identifies the patient's month, day, century and year of birth.

**Explanation**

This item is used by the TCR to match records, and to calculate age at diagnosis.

**Coding Instructions**

1. Punctuation marks (slashes, dashes, etc.) are not allowed.
2. The patient's date of birth **must be entered**. Cases cannot be processed without the date of birth.
3. Unknown birth date 99999999 will no longer be accepted by the TCR edits.
4. If month and/or day of birth are not known, code 9's; the year **must be entered** in full (99991960).

CODE	DEFINITION
MMDDCCYY	The date of birth is the month, day, and year the patient was born. The first two digits are the month, the third and fourth digits are the day, the fifth and sixth digits are the century, and the seventh and eighth digits are the year.

**Examples:**

- a. The patient's date of birth is June 30, 1942, record 06301942.
- b. The patient is admitted on June 15, 2008 and states he is 60 years old. The medical record does not have a date of birth. Subtract 60 from 2008 to calculate the year of birth as 1948 and record 99991948 as the date of birth.
- c. The medical record contains only the year of birth–1927; record 99991927 as the date of birth. The TCR Edits will no longer accept unknown for the year of birth. Every effort must be made to obtain this information. This information is critical for analysis.

**PLACE OF BIRTH** (NAACCR ITEM #250) (FORDS pg. 56; SEER pg. 35)**Description**

Identifies the patient's place of birth.

**Explanation**

Birthplace is used to ascertain ethnicity, identify special populations at risk for certain types of cancers, and epidemiological analyses.

## Coding Instructions

1. Record the patient's place of birth (if available) using the *SEER Geo-codes* in *Appendix G*. If the place of birth is unknown, code to 999.
2. Use the most specific code.

*Note: At the time SEER assigned Geo-codes in the 1970's, the United States owned or controlled islands in the Pacific. Many of these islands are now independent and controlled by countries other than the United States. The original codes are used for these islands to preserve historic information. The names have been annotated to show the new political designation. The alphabetic list displays the correct code.*

### RACE 1 (NAACCR ITEM #160) (FORDS pg. 59; SEER pgs. 39-43)

#### Description

Identifies the primary race of the person.

#### Explanation

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow accurate national comparisons. Race is defined by specific physical, hereditary and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

## Coding Instructions

Record the two-digit code to identify the primary race(s) of the patient in fields race 1, race 2, race 3, race 4, and race 5. The five race fields allow for coding of multiple races consistent with the Census 2000.

1. Race 1 is the field used to compare with race data on cases diagnosed prior to January 1, 2001.
2. The race field is used in conjunction with *Spanish/Hispanic Origin*. Both items must be coded. All tumors for the same patient should have the same race code.
3. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white (01) in the next race field.
4. If a person's race is a combination of Hawaiian and any other race(s), code race 1 as 07 Hawaiian and code the other race(s) in race 2, race 3, race 4, and race 5 as appropriate.
5. If no race is stated in the medical record or available from other sources in your facility, review the documentation for a statement of a race category such as patient described as a "Hispanic female."

6. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do NOT code a patient stated to be Hispanic or Latino as 98 (Other Race) in race 1 and 88 in race 2–race 5.
7. Code 03 should be used for any person stated to be Native American or (western hemisphere) Indian, whether from North, Central, South, or Latin America.
8. Death certificate information may be used to supplement ante mortem race information only when race is coded unknown in the patient record or when the death certificate information is more specific.
9. In using the patient name to determine race:
  - a. Do not code race from name alone, especially for females with no maiden name given.
  - b. A Spanish name alone may not be used to determine the race code. A statement about race or place of birth must be documented.
10. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to code the non-white first.
11. If only one race is reported for a person, race 2–race 5 must be coded to 88.
12. If race 1 is coded to 99 unknown, race 2–race 5 must also be coded 99 unknown.
13. A unique race code (other than 88 or 99) can be coded only once in race 1 through race 5.
14. Document the specified race code in the **TEXT REMARKS - OTHER PERTINENT INFORMATION** field. A more specific race that is not included in the list of race code such as 96 Other Asian, 97 Pacific Islander, or 98 Other Race should be documented as well.

CODE	RACE	CODE	RACE
01	White	20	Micronesian, NOS
02	Black	21	Chamorroan
03	American Indian, Aleutian, Eskimo	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
09	Asian Indian, Pakistani, Sri Lankan	31	Fiji Islander
10	Vietnamese	32	New Guinean
11	Laotian	96	Other Asian, including Asian NOS, and Oriental NOS
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean (Cambodian)	98	Other
14	Thai	99	Unknown

- The **White** category usually includes Mexican, Puerto Rican, Cuban, Arab, and all other Caucasians.
- The **Black** category includes the designation African-American.

#### Examples:

RACE CODE	EXPLANATION
01	A patient was born in Mexico of Mexican parentage. A patient stated to be German-Irish.
02	A black female patient. A specific race code (other than blank or 99) must not occur more than once. For example, do not code Black in race 1 for one parent and Black in race 2 for the other parent.
04	A patient is of Chinese and Korean ancestry. Code Race 1 as Chinese, code 04. Code Race 2 as Korean, code 08.
05	A patient has a Japanese father and a Caucasian mother. Code 05 Japanese in the Race 1 field and 01 Caucasian in the Race 2 field.
05	The race is recorded as Oriental or Asian and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation. Code the race based on birthplace information as this is more specific.
07	A patient's race is a combination of Hawaiian and any other race(s), code Race 1 to 07 Hawaiian, and Race 2–Race 5 as appropriate.
11	A patient is stated to be Asian-American born in Laos. Code Race 1 as 11, Laotian, because it is more specific than 96, Asian, NOS.
99	A patient's race is unknown. Code Race 1 as Unknown, code 99. Race 2–Race 5 must also be coded 99. If a patient has a Spanish last name and she is stated to be a native of Indiana, code to 99, Unknown, because nothing is known about her race.

**RACE 2, RACE 3, RACE 4, RACE 5** (NAACCR ITEMS #161, 162, 163, 164) (FORDS pgs. 61–64; SEER pgs. 44–48)

**Description**

Identifies the patient's additional races. Race is defined by specific physical, heredity, and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

**Explanation**

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow accurate national comparisons.

**Coding Instructions**

1. Record the two-digit code to identify a multi-racial patient.
2. Race is analyzed with *Spanish/Hispanic Origin*. Both items must be recorded. All tumors for the same patient should have the same race code.
3. All resources in the facility must be used to determine the race of the patient.
4. If more than the *race 1* code is entered, and if any race is **99**, then all race codes (*race 1, 2, 3, 4* and *5*) must be **99**. If more than the *race 1* code is entered, and if any race codes (for *race 2, 3, 4* and *5*) are **88** (no further race documented), then all **subsequent** race codes must also be **88**.
5. If a person's race is a combination of Hawaiian and any other race(s), code race 1 as 07 Hawaiian and code the other race(s) in race 2, race 3, race 4, and race 5 as appropriate.
6. If no race is stated in the medical record or available from other sources in your facility, review the documentation for a statement of a race category such as patient described as a "Hispanic female."
7. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do NOT code a patient stated to be Hispanic or Latino as 98 (Other Race) in race 1 and 88 in race 2–race 5.
8. Code 03 should be used for any person stated to be Native American or (western hemisphere) Indian, whether from North, Central, South, or Latin America.
9. Death certificate information may be used to supplement ante mortem race information only when race is coded unknown in the patient record or when the death certificate information is more specific.
10. In using the patient name to determine race:

- a. Do not code race from name alone, especially for females with no maiden name given.
  - b. A Spanish name alone may not be used to determine the race code. A statement about race or place of birth must be documented.
11. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to code the non-white first.
  12. If only one race is reported for a person, Race 2–Race 5 must be coded to 88.
  13. If race 1 is coded to unknown 99, Race 2–Race 5 must also be coded unknown 99.
  14. A unique race code (other than 88 or 99) can be coded only once in race 1 through race 5.
  15. Document the specified race code in the **TEXT REMARKS - OTHER PERTINENT INFORMATION** text field. A more specific race that is not included in the list of race codes such as 96 Other Asian, 97 Pacific Islander, or 98 Other Race should be documented as well.

CODE	RACE	CODE	RACE
01	White	20	Micronesian, NOS
02	Black	21	Chamorroan
03	American Indian, Aleutian, Eskimo	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
09	Asian Indian, Pakistani, Sri Lankan	31	Fiji Islander
10	Vietnamese	32	New Guinean
11	Laotian	88	No further race documented
12	Hmong	96	Other Asian, including Asian NOS, and Oriental NOS
13	Kampuchean (Cambodian)	97	Pacific Islander, NOS
14	Thai	98	Other
		99	Unknown

**SPANISH/HISPANIC ORIGIN** (NAACCR ITEM #190) (FORDS pg. 65; SEER pg. 50)

**Description**

Identifies persons of Spanish or Hispanic origin. If a patient has multiple tumors, all records should have the same code.

**Explanation**

This is used to identify whether or not the person should be classified as *Hispanic* for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the 01 (White category) of *race*.

**Coding Instructions**

1. The information is coded from the medical record or is based on Spanish/Hispanic names.
2. Review all sources available to determine the correct code, including stated ethnicity as Hispanic.
3. Origin on the death certificate, birthplace and information about life history and language spoken should be considered.
4. Coding Spanish surname or origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.
5. Refer to the list of Spanish/Hispanic surnames on the TCR website at: [www.dshs.state.tx.us/tcr/publications/2006crhb/2006HB-AppxM.pdf](http://www.dshs.state.tx.us/tcr/publications/2006crhb/2006HB-AppxM.pdf)

CODE	DESCRIPTION
0	Non-Spanish; non-Hispanic (includes Portuguese and Brazilian)
1	Mexican (includes Chicano, NOS)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic (includes European)
6	Spanish, NOS, Hispanic, NOS; Latino, NOS. There is evidence, other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1–5.
7	Spanish surname only. The only evidence of the person's Hispanic origin is surname or maiden name and there is no other information the person is not Hispanic. Ordinarily for central registry use only.
8	Dominican Republic (effective with diagnosis on or after 1/1/2005)
9	Unknown whether Spanish or not; not stated in patient record

**Note:** Use *code 0* if patient has a Spanish/Hispanic name and there is reason to believe he/she is *not* Hispanic e.g., patient is Filipino, patient is a woman known to be non-Hispanic who has a Hispanic married name.

6. Use codes 1–5 if specific ethnicity is known.
7. Use code 6 when you know the patient is Hispanic but cannot classify him/her to codes 1–5.
8. Use code 7 if race in the medical record is classified as White and he/she has a Spanish/Hispanic last name. Ordinarily used at the central registry level.

9. Use code 9 when Spanish/Hispanic origin is not documented or is unknown.

**Examples:**

- a. Patient's last name is Gonzales and the medical record states the patient was born in Mexico; code to 1.
- b. Patient's medical record states race as Hispanic, without mention of whether his/her origin was Mexico, Puerto Rico, Cuba, etc.; code to 6.
- c. Patient's medical record states patient is White/Caucasian and the last name is Gonzales; code to 7.

*Note: Persons of Spanish/Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.*

**SEX** (NAACCR ITEM #220) (FORDS pg. 66; SEER pg. 54)

**Description**

Identifies the gender of the patient at the time of diagnosis.

**Explanation**

The code must be gender-specific to the primary site, e.g., prostate carcinoma— male; ovarian carcinoma—female for the purposes of calculating sex-specific rates.

**Coding Instructions**

1. Record the patient's gender as indicated in the medical record.

CODE	DEFINITION
1	Male
2	Female
3	Other (Hermaphrodite)
4	Trans-sexual
9	Not Stated/Unknown

*Note: Trans-sexual is defined as surgically altered gender.*

**TEXT REMARKS - OTHER PERTINENT INFORMATION** (NAACCR ITEM #2680)

**Description**

Includes text area for information that is coded on the patient's disease and adequate or appropriate space is not provided for supporting text. Overflow or problematic coding issues can be documented in this text field.

**Explanation**

Information documenting the disease process should be entered manually from the medical record and not be generated from coded values. Such documentation may include additional staging information, additional treatment documentation, documentation of race and sex, history of the disease, comments regarding lack of information in the medical record and cause of death. The name of the facility that referred the patient to your facility or the name of the facility the patient was referred to for further care may be documented in this data field. See the Text Documentation Section on page 139 for detailed instructions.

**PHYSICIAN MANAGING** (NAACCR ITEM #2460)**Description**

Records the identification number of the physician responsible for the patient's work-up and treatment plan, and for directing the delivery of patient care for this cancer. The TCR requires the physician's state license number.

**Explanation**

The managing physician is the first contact for obtaining information on the care of this cancer. This information may be used for outcome studies.

**Coding Instructions**

1. Record the state license number of the physician responsible for the overall management of the patient's care during diagnosis and/or treatment for this cancer. Physician license numbers for Texas can be found at the following web site: [www.docboard.org/tx/df/txsearch.htm](http://www.docboard.org/tx/df/txsearch.htm).
2. Cancer reporter's using third party software must check with their vendor to ensure the physician's state license number transmits to the TCR.
3. This field must be populated for cases diagnosed 2006 and forward. If the information is unknown code 99999 and document in the text field that the managing physician is unknown.

**PHYSICIAN FOLLOW UP** (NAACCR ITEM #2470) (FORDS pg. 76)**Description**

Identifies the physician currently responsible for the patient's medical care. The TCR requires the physician's state license number.

**Explanation**

The follow-up (or "following") physician is the first contact for obtaining information on the patient's status. This information may be used for outcome studies.

### Coding Instructions

1. Record the state license number of the physician currently responsible for the patient's care. Physician license numbers for Texas can be found at the following web site:  
[www.docboard.org/tx/df/txsearch.htm](http://www.docboard.org/tx/df/txsearch.htm)
2. Cancer reporters using third party software must check with their vendor to ensure the physician's state license number transmits to the TCR.
3. This field must be populated for cases diagnosed 2006 and forward. If the information is unknown code 99999 and document in the text field that the follow up physician is unknown.

### **FACILITY REFERRED FROM** (NAACCR ITEM #2410) (FORDS pg. 85)

#### **Description**

Identifies the facility that referred the patient to the reporting facility.

#### **Explanation**

Each facility's ID number is unique. The number assigned will be the TCR facility number. The information is used to document and monitor referral patterns.

### Coding Instructions

1. Document the name of the facility that referred the patient to **your** facility under **TEXT REMARKS - OTHER PERTINENT INFORMATION**.
2. If the facility is unknown or the patient was not referred, also document this under **TEXT REMARKS - OTHER PERTINENT INFORMATION**.

*Note: For Class of Case 0 and 1 cases, the appropriate documentation is "patient not referred."*

CODE	DEFINITION
5102999999	Patient referred from Anywhere Facility
0000000000	Patient was not referred to the reporting facility from another facility.
0099999999	Patient was referred, but the referring facility's ID number is unknown.

#### **Example:**

Patient referred from Daytown Hospital (this facility is not one of the choices from the selection pop-up box), code 0099999999 and document under **TEXT REMARKS - OTHER PERTINENT INFORMATION** - Patient referred from Daytown Hospital, Daytown, Texas.

#### **Notes:**

- a. Referral and transfer are not the same. A patient may request a transfer to another

*facility; for example, a facility closer to home. This would not be considered a referral.*

- b. *For SCL, if the facility that referred the patient is not one of the choices listed in the selection pop-up box; document the name of the facility that referred the patient under **TEXT REMARKS - OTHER PERTINENT INFORMATION.***

**FACILITY REFERRED TO** (NAACCR ITEM #2420) (FORDS pg. 86)

**Description**

Identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

**Explanation**

Each facility's ID number is unique. The number assigned will be the TCR facility number. The information is used to document and monitor referral patterns.

**Coding Instructions**

1. Document the name of the facility that the patient was referred to for further care after discharge from your facility under **TEXT REMARKS - OTHER PERTINENT INFORMATION.**
2. If the facility is unknown or the patient was not referred, also document this under **TEXT REMARKS - OTHER PERTINENT INFORMATION.**

*Note: For Class of Case 3 and autopsy-only cases, the appropriate documentation is "patient not referred."*

CODE	DEFINITION
5220999999	Patient referred to Anywhere Facility.
0000000000	Patient was not referred to another facility.
0099999999	Patient was referred, but the facility's ID number is unknown.

*Note: For SCL users, if the facility where the patient was referred to is not listed in the selection pop-up box; document the name of the facility where the patient was referred to under **TEXT REMARKS - OTHER PERTINENT INFORMATION.***

**Example:**

Patient was referred to Daytown Hospital (this facility is not one of the choices from the selection pop-up box), code 0099999999 and document under **TEXT REMARKS - OTHER PERTINENT INFORMATION - Patient referred to Daytown Hospital, Daytown, Texas.**

**SEQUENCE NUMBER** (NAACCR ITEM #560) (FORDS pgs. 34–35)**Description**

Indicates the chronological sequence of all reportable neoplasms (malignant and non-malignant) over the lifetime of the patient regardless of when or where the case was diagnosed. Each neoplasm is assigned a different number. Sequence number 00 indicates patient has only one reportable malignant neoplasm. Reportable neoplasms not included in the facility registry are also allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the facility's reference date.

**Explanation**

This data item is used to distinguish among cases having the same registry numbers, to select patients with only one primary tumor for certain follow-up studies and to analyze factors involved in the development of multiple tumors.

**Coding Instructions**

1. Codes 00–59 and 99 indicate reportable cases of malignant or in situ behavior.
2. Code 00 if the patient has a single reportable primary. If the patient develops a subsequent reportable primary, change the code for the first primary from 00 to 01, and number subsequent primaries sequentially.
3. If two or more reportable primaries are diagnosed simultaneously, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
4. Codes 60–88 indicate non-malignant neoplasms (benign and borderline) that are reportable by agreement cases (e.g., those cases required by state registries). All benign or borderline neoplasms diagnosed/admitted to your facility should be sequenced according to this guideline. This includes benign and borderline CNS neoplasms.
5. Code 60 if the patient has a single non-malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first primary from 60 to 61, and number subsequent non-malignant primaries sequentially (62, 63...).
6. Sequence numbers should be reassigned in the database if the facility learns later of an unaccessioned tumor that would affect the sequence.
7. The **Sequence Number** refers to the number of malignant or non-malignant primaries **in the patient's lifetime**.

<b>MALIGNANT NEOPLASMS</b>		
<b>ONE PRIMARY</b>	<b>MORE THAN ONE PRIMARY</b>	<b>SEQUENCE UNKNOWN</b>
00 One primary only	01 First of two or more primaries	99 Unspecified
	02 Second of two or more primaries	
	03 Third of three or more primaries	

<b>NON-MALIGNANT NEOPLASMS</b>		
<b>ONE PRIMARY</b>	<b>MORE THAN ONE PRIMARY</b>	<b>SEQUENCE UNKNOWN</b>
60 One primary only	61 First of two or more primaries	88 Unspecified
	62 Second of two or more primaries	
	63 Third of three or more primaries	

*Note: Squamous and/or basal cell carcinoma of the skin (except genital sites) is no longer considered when assigning the appropriate sequence number.*

**Examples:**

- a. A person is diagnosed with one malignant primary. *Code the sequence number to 00.*
- b. A person was diagnosed with lung cancer in 2001. A colon cancer is diagnosed in 2008. *Code the sequence number of the colon cancer to 02 and change the sequence number of the lung cancer to 01.*
- c. A person was diagnosed with breast cancer in April 2007 and metastasis to the lungs in June 2007. Since the lung is a metastatic site and not a second primary, it would not be abstracted. *Code the sequence number of the breast cancer to 00.*
- d. A person was diagnosed with signet ring cell carcinoma of the bladder in 2004. In 2008, this person developed a benign meningioma in the temporal area of the brain. *Code the bladder to a sequence number of 00, and code the brain to a sequence number of 60.*
- e. A person was diagnosed with carcinoma of the stomach in 2003, squamous cell carcinoma of the left forearm (a non-reportable neoplasm) in 2005, and non-Hodgkin's lymphoma in 2008. *Code the sequence number of the stomach to 01. The sequence number of the left forearm would not be sequenced, abstracted or reported. Code the sequence number of the lymphoma to 02.*
- f. A person was diagnosed with a benign meningioma in June 2007. MRI at your facility in 2008 shows no change. *Code the sequence number to 60 for the benign meningioma.*

**OTHER PRIMARY TUMORS (SITE, MORPHOLOGY, DATE) NAACCR ITEM #2220)****Description**

State-specific data field to capture information on other reportable tumors.

**Explanation**

Records tumor specific information on other reportable tumors in the patient's lifetime.

**Coding Instructions**

Record the site, morphology, and date of other primaries. **Do not** include metastatic lesions or the primary currently being reported in this field. **Do not** leave this area blank due to lack of specific information. Record the information you have available.

**Examples:**

- a. The patient had a history of duct cell carcinoma of the left breast in 2005 and is admitted in 2008 for adenocarcinoma of the lung. Complete an abstract on the lung tumor, and record duct cell carcinoma, left breast, 2005 in this area.
- b. The patient has a history of prostate cancer, no date is given and no specific morphology is given. Patient is admitted in 2008 with a malignant melanoma of left leg. Document: history of prostate cancer, unknown date.

**PRIMARY PAYER AT DIAGNOSIS (NAACCR Item #630) (FORDS pgs. 67-68)****Definition**

Identifies the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

**Explanation**

This item is used in financial analysis and as an indicator for quality and outcome analyses. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires the patient admission page to document the type of insurance or payment structure that will cover the patient while being cared for at the hospital.

**Coding Instructions**

1. Record the type of insurance reported on the patient's admission page.
2. If more than one payer or insurance carrier is listed on the patient's admission page, record the first.
3. If the patient's payer or insurance carrier changes, do not change the initially recorded code.

## 4. Consult with your facility's billing department if the primary payer information is unclear.

CODE	DEFINITION
01	Not insured
02	Not insured, self pay
10	Insurance, NOS
20	Private Insurance: Managed Care, HMO, or PPO
21	Private Insurance: Fee-for-Service
31	Medicaid
35	Medicaid-Administered through a Managed Care plan
60	Medicare without supplement, Medicare, NOS
61	Medicare with supplement, NOS
62	Medicare-Administered through a Managed Care plan
63	Medicare with private supplement
64	Medicare with Medicaid eligibility
65	TRICARE
66	Military
67	Veterans Affairs
68	Indian/Public Health Services
99	Insurance status unknown

**Examples:**

- a. An indigent patient is admitted with no insurance coverage. Code the **PRIMARY PAYER AT DIAGNOSIS** as 01.
- b. A patient is admitted for treatment and the patient admission page states the primary insurance carrier is an HMO. Code the **PRIMARY PAYER AT DIAGNOSIS** as 20.
- c. A 65-year old male patient is admitted for treatment and the patient admission page states the patient is covered by Medicare with additional insurance coverage from a PPO. Code the **PRIMARY PAYER AT DIAGNOSIS** as 62.
- d. Patient comes to your facility originally diagnosed with prostate cancer in 2000. Now he has bone metastasis. Code the **PRIMARY PAYER AT DIAGNOSIS** as 99 because we do not have this information from the facility where originally diagnosed.