Research Data Warehouse (RDW) Data Dictionary

TABLE_NAME	COLUMN_NAME
ACCOUNT	This table contains hospital account information from the EPIC HAR and CLM master files.
ALLERGY	The ALLERGY table contains the allergies noted for patients.
ALLERGY_REACTION	The ALLERGY_REACTION table contains the reactions to allergies noted for patients.
CPT_PROCEDURE	The Current Procedural Terminology procedure table contains one row for each CPT™ procedure associatd with the hospital account.
DIAGNOSIS	The diagnosis table contains one row for each billing diagnosis associatd with the hospital account.
DIAGNOSIS_INFO	The DIAGNOSIS_INFO table lists all diagnoses for all patients. It looks at encounters, the problem list, professional and hospital claims, the hospital account, the hospital admission diagnosis list, surgical cases, medical history, and referrals to collect the diagnoses. It stores how many times a diagnosis was recorded for a particular patient from a particular source and also the first and the last date it was recorded from any source.
FAMILY_HX	The FAMILY_HX table contains data recorded in the family history contacts entered in the patient's chart during an clinical system encounter. Note: This table is designed to hold a patient's history over time; however, it is most typically implemented to only extract the latest patient history contact.
HNO_NOTE	This table contains the Clinical notes as a single large text field. Join to HNO_NOTE_INFO for the metadata about the notes.
HNO_NOTE_INFO	This table contains the metatdata regarding a note. Join to HNO_NOTE for the actual note.
IMMUNIZATION	The IMMUNIZATION table contains contains immunizations administered through clinical system, imported, or reported by patient, but not ordered/administered via clinical system.
LAB_RESULT	This table contains information on orders and results for Labs, Micro, and Point of Care
MEDICAL_HX	The MEDICAL_HX table contains data from medical history contacts entered in clinical system patient encounters. Since one patient encounter may contain multiple medical history contacts, each contact is uniquely identified by a patient encounter serial number and a line number.
MED_ADMIN	This table contains information on medication administration.
MED_AVS	The MED_AVS table contains the list of medications in the after visit summary (AVS) where the ordering date coincides with the encounter date range for RDW
MED_CURRENT	The MED_CURRENT table is a list of a patient's current medications from the last time a user reviewed the patient's medications. Refreshed monthly.
MED_DISPENSE	This table contains information about the dispensed medications for orders.
MED_ORDER	This table contains information on medication orders.
NOTE	This table contains the impression or narrative as a single large text field. Join to ORDERS for the metadata about the notes.

NOTE_RSLT	This table contains the extended result comments or full report as a single large text field. Join to ORDERS or LAB_RESULT for the metadata about the notes.
OBSERVATION	The observations table contains the measured values for specific groups of observations including vitals and smoking details.
OB_DELIVERY_RECORD	The OB_DELIVERY_RECORD table contains information relevant to a baby's delivery record on one row.
ORDERS	This table contains information on orders excluding Labs, Micro, and Point of Care
ORDER_RESULT	This table contains information on results from clinical system orders excluding Labs, Micro, and Point of Care.
PATIENT	The PATIENT table contains one record for each patient and consists of demographics,registration information, and other information.
PHENOTYPE	The PHENOTYPE table is updated monthly and contains indicators if chronic conditions exist for a patient. Secondly, the table contains the calculated Charlson Index
PNEG_MEDICAL_HX	The PNEG_MEDICAL_HX table contains data from pertinent negative medical history contacts entered in clinical system patient encounters. Since one patient encounter may contain multiple medical history contacts, each contact is uniquely identified by a patient encounter serial number and a line number.
PNEG_SURGICAL_HX	The PNEG_SURG_HX table contains pertinent negative surgical history data from history contacts entered in clinical system patient encounters. Since one patient encounter may contain multiple surgical history contacts, each contact is uniquely identified by a patient encounter serial number and a line number.
PROBLEM_LIST	The PROBLEM_LIST table contains data from patients problem lists in the clinical system.
PROCEDURE	The procedure table contains one row for each procedure associatd with the hospital account.
QSTN_ANS	The QSTN_ANS table contains the questions and answers for questionnaire answer records. Table is update monthly with answered questions. Test patient and erroneous encounter answers are not excluded. Join to the metadata table QSTN_INFO to exclude test patient and erroneous encounter answers.
QSTN_INFO	The QST_INFO table contains the metadata for questionaires. This table contains rows for completed forms. Forms for test patients and erroneous visits are excluded. Refreshed monthly.
RESEARCH_PERMISSION	The Research Permission table contains the contact and biobank permission preferences.
RSCH_ENROLLMENT	The table contains patient enrollments in research studies, including status, alias, start and end dates, and last modified user and instant.
RSCH_ENROLL_HX	The RSCH_ENROLL_HX table contains a history of changes to information pertaining to a patient's enrollment in a research study.
RSCH_STUDY	The table contains information on research studies at MUSC.
RSCH_VISIT	This table contains the visits that are linked to a research study.
SMOKE_HX	The smoking history contains the most recent smoking history for patients

SOCIAL_HX	The SOCIAL_HX table contains one row per history encounter in your system, regardless of history encounter type (e.g. surgical, social, family etc).
SURGICAL_HX	The SURGICAL_HX table contains data from medical history contacts entered in clinical system patient encounters. Since one patient encounter may contain multiple medical history contacts, each contact is uniquely identified by a combination of the patient encounter serial number , and a line number.
VISIT	The visit table contains one row for each patient encounter where the visit status is complete or null. The table does not include cancelled visits, documentaion visits, etc.
VISIT_MEASURE	This table contains the vitals and measurements stored on the encounter table.
VISIT_REASON	The VISIT_REASON table contains the data entered as the Reason for Visit for a clinical system encounter.One patient encounter may have multiple reasons for visit; the LINE is used to identify each reason for visit within an encounter.
VITAL	The vitals table contains the minimum, maximum and median vitals per day for encounters. Three rows per encounter.

Research Data Warehouse (RDW) Data Dictionary

TABLE_NAME	COLUMN_NAME	COMMENTS	IN_I2B2
ACCOUNT	ACCOUNT_NUM	The hospital account ID.	
ACCOUNT	ADMIT_DATE	The admission date and time	
ACCOUNT	COVERAGE_ID	The unique ID assigned to the coverage record. Use to join to	
ACCOUNT	DISCH_DATE	The discharge date and time	
ACCOUNT	LAST_UPDATE_DATE	The last update timestamp for the	
ACCOUNT	PATIENT_CLASS	Base classification of the patient visit: I (INPATIENT), O (OUTPAITIENT), E	
ACCOUNT	PATIENT_ID	The ID number of the patient for the	
ACCOUNT	PATIENT_TYPE	Further classification of the patient visit: 104 (OBSERVATION), 107	
ACCOUNT	PRIMARY_BENEFIT_PLAN_ID	The code of the benefit plan associated with the dates effective for this row. Get the name from	
ACCOUNT	PRIMARY_PAYOR_ID	The unique ID of the payor, join to REF_COVERAGE_PAYOR_PLAN using COVERAGE_ID to get the	
ACCOUNT	PRIMARY_SERVICE	Category for the primary medical service: 225 (DRM-DERMATOLOGY),227 (MED-	
ACCOUNT	PRIMARY_VISIT_ID	The contact serial number associated with the primary patient contact on the	
ACCOUNT	SECONDARY_SERVICE	Category for the secondary medical service: 225 (DRM-DERMATOLOGY),227 (MED-	
ACCOUNT	TOTAL_ACCOUNT_BALA	The current balance on the hospital	
ACCOUNT	TOTAL_ADJUSTMENTS	The total of all adjustments on the	
ACCOUNT	TOTAL_CHARGES	The total of all charges on the hospital	
ACCOUNT	TOTAL_PAYMENTS	The total of all payments on the	
ALLERGY	ALLERGEN_ID	The unique ID assigned to the allergen	
ALLERGY	ALLERGEN_NAME	The name of the allergen.	Y
ALLERGY	ALLERGEN_TYPE	The type of allergen (DRUG, DRUG	
ALLERGY	ALLERGY_DELETE_CMT	Stores the free text comment why an allergy was deleted from a patient's	
ALLERGY	ALLERGY_DELETE_RSN	Stores the category reason for deleting an allergy. Example: ENTRY DETERMINED TO BE CLINICALLY INSIGNIFICANT, ENTRY	
ALLERGY	ALLERGY_ID	The unique ID used to identify the	
ALLERGY	ALLERGY_SEVERITY	This item stores the severity of an	
ALLERGY	ALLERGY_STATUS	The status category number for this allergy record. The status can be	
ALLERGY	ALLERGY_TYPE	The allergy type category value, describing the nature or character of the allergy. Example: ALLERGY,	

ALLERGY	ENTERED_DATE	The date and time the allergy was entered into the patient's record. NOTE: If an allergy record is	
ALLERGY	ENTRY_USER_ID	The unique ID of the clinical system user who entered this allergy into the	
ALLERGY	LAST_UPDATE_DATE	The last update timestamp for the	
ALLERGY	NOTED_DATE	The date the patient made it known that they had experienced an allergic	
ALLERGY	PATIENT_ID	Unique identifier for each patient; used	
ALLERGY	REACTION_CMT	Contains the free text reaction comments. The actual reaction category value responses are stored	
ALLERGY_REACTION	ALLERGY_ID	The unique ID used to identify the allergy record. Join to ALLERGY on	
ALLERGY_REACTION	LAST_UPDATE_DATE	The last update timestamp for the	
ALLERGY_REACTION	LINE	The line number for the reaction with this record. Multiple reactions can be	
ALLERGY_REACTION	REACTION	The category value corresponding to the type of reaction.Example:	
CPT_PROCEDURE	ACCOUNT_NUM	Hospital accounting record for the	
CPT_PROCEDURE	CPT_CODE	A CPT™ code stored in the hospital	Y
CPT_PROCEDURE	CPT_DATE	A date associated with a CPT™ code	
CPT_PROCEDURE	CPT_MODIFIERS	A modifier or modifiers associated with a CPT™ code stored in the hospital	
CPT_PROCEDURE	CPT_PERF_PROV_ID	The ID number of a performing provider associated with a CPT™	
CPT_PROCEDURE	CPT_QUANTITY	Quantity of the CPT™ code.	
CPT_PROCEDURE	CPT_VISIT_ID	Unique identifier for the patient encounter when the CPT™ procedure	
CPT_PROCEDURE	LAST_UPDATE_DATE	The last update timestamp for the	
CPT_PROCEDURE	LINE	Since multiple CPT™ codes can be stored in one hospital account, each	
CPT_PROCEDURE	PATIENT_ID	Unique identifier for each patient; used	
CPT_PROCEDURE	PRIMARY_DX_ID	The primary diagnosis id associated with the procedure. Join to	
CPT_PROCEDURE	PROC_NAME	The name of each procedure from the Clarity EAP table, the	Y
CPT_PROCEDURE	VISIT_ID	Unique identifier for the patient	
CPT_PROCEDURE	VOID_DATE	The date the transaction was voided	
DIAGNOSIS	ACCOUNT_NUM	Hospital accounting record for the	
DIAGNOSIS	COMORBIDITY_TYPE	Specifies if the diagnosis is a non-complication/comorbidity ("NO)"), complication/comorbidity ("CC"), or	
DIAGNOSIS	COMORBIDITY_YN	Specifies if the diagnosis is a non-complication/comorbidity ("N"), complication/comorbidity ("Y"), or	
DIAGNOSIS	DX_CODE	The billing code for the diagnosis	Y
DIAGNOSIS	DX_CODE_SET	The billing coding set for the diagnosis	
DIAGNOSIS	DX_DATE	The date the diagnosis was observed	

DIAGNOSIS	DX_ID	Unique Identifier for diagnosis and links to the referecne table:	
DIAGNOSIS	DX_NAME	The name or description of the	Y
DIAGNOSIS	DX_POA	Indicator if the diagnosis was present	
DIAGNOSIS	DX_SOURCE	Values set to : 1 (Primary Billing), 2	
DIAGNOSIS	LAST_UPDATE_DATE	The last update timestamp for the	
DIAGNOSIS	LINE	Since multiple final ICD diagnoses can be stored in one hospital account, each diagnosis will have a unique line	Y
DIAGNOSIS	PATIENT_ID	Unique identifier for each patient; used	
DIAGNOSIS	ROM	Risk of Mortality: 1 (MINOR), 2	Y
DIAGNOSIS	SOI	Severity of illness: 1 (MINOR), 2	Y
DIAGNOSIS	VISIT_ID	Unique identifier for the patient	
DIAGNOSIS_INFO	DX_ID	The unique ID of the diagnosis record; join to REF_DX for ICD codes.	
DIAGNOSIS_INFO	FIRST_DATE	The first date on which this diagnosis was recorded, from any source.	
DIAGNOSIS_INFO	FIRST_DATE_CLM_DX	The first date on which this diagnosis appeared on the patient's hospital	
DIAGNOSIS_INFO	FIRST_DATE_ENC_DX	The first date on which this diagnosis appeared on the patient's encounter	
DIAGNOSIS_INFO	FIRST_DATE_INV_DX	The first date on which this diagnosis appeared on a professional claim for	
DIAGNOSIS_INFO	FIRST_DATE_PROB_LIST	The first date on which this diagnosis appeared on the patient's problem list.	
DIAGNOSIS_INFO	FIRST_DATE_REF_DX	The first date on which this diagnosis appeared on a referral related to the	
DIAGNOSIS_INFO	FIRST_DT_HSP_ACT_DX	The first date on which this diagnosis appeared on the patient's hospital	
DIAGNOSIS_INFO	FIRST_DT_HSP_ACT_EXTINJ	The first date on which this diagnosis appeared on the patient's hospital	
DIAGNOSIS_INFO	FIRST_DT_HSP_ADM_DX	The first date on which this diagnosis appeared on the patient's hospital	
DIAGNOSIS_INFO	FIRST_DT_MED_HIST_DX	The first date on which this diagnosis appeared on the patient's medical	
DIAGNOSIS_INFO	FIRST_DT_OR_CASE_DX	The first date on which this diagnosis appeared on the patient's surgical	
DIAGNOSIS_INFO	LAST_DATE	The last date on which this diagnosis was recorded, from any source.	
DIAGNOSIS_INFO	LAST_DATE_CLM_DX	The last date on which this diagnosis appeared on the patient's hospital	
DIAGNOSIS_INFO	LAST_DATE_ENC_DX	The last date on which this diagnosis appeared on the patient's encounter	
DIAGNOSIS_INFO	LAST_DATE_INV_DX	The last date on which this diagnosis appeared on a professional claim for	
DIAGNOSIS_INFO	LAST_DATE_PROB_LIST	The last date on which this diagnosis appeared on the patient's problem list.	
DIAGNOSIS_INFO	LAST_DATE_REF_DX	The last date on which this diagnosis appeared on a referral related to the	

DIAGNOSIS_INFO	LAST_DT_HSP_ACT_DX	The last date on which this diagnosis appeared on the patient's hospital	
DIAGNOSIS_INFO	LAST_DT_HSP_ACT_EXTINJ	The last date on which this diagnosis appeared on the patient's hospital	
DIAGNOSIS_INFO	LAST_DT_HSP_ADM_DX	The last date on which this diagnosis appeared on the patient's hospital	
DIAGNOSIS_INFO	LAST_DT_MED_HIST_DX	The last date on which this diagnosis appeared on the patient's medical	
DIAGNOSIS_INFO	LAST_DT_OR_CASE_DX	The last date on which this diagnosis appeared on the patient's surgical	
DIAGNOSIS_INFO	NUM_CLM_DX	The number of times this diagnosis appeared on the patient's hospital	
DIAGNOSIS_INFO	NUM_ENC_DX	The number of times this diagnosis appeared on the patient's encounter	
DIAGNOSIS_INFO	NUM_HSP_ACT_DX	The number of times this diagnosis appeared on the patient's hospital	
DIAGNOSIS_INFO	NUM_HSP_ACT_EXTINJ	The number of times this diagnosis appeared on the patient's hospital	
DIAGNOSIS_INFO	NUM_HSP_ADM_DX	The number of times this diagnosis appeared on the patient's hospital	
DIAGNOSIS_INFO	NUM_INV_DX	The number of times this diagnosis appeared on a professional claim for	
DIAGNOSIS_INFO	NUM_MED_HIST_DX	The number of times this diagnosis appeared on the patient's medical	
DIAGNOSIS_INFO	NUM_OR_CASE_DX	The number of times this diagnosis appeared on the patient's surgical	
DIAGNOSIS_INFO	NUM_PROBLEM_LIST	The number of times this diagnosis appeared on the patient's problem list.	
DIAGNOSIS_INFO	NUM_REF_DX	The number of times this diagnosis appeared on referrals related to the	
DIAGNOSIS_INFO	PATIENT_ID	The unique ID assigned to the patient;	
FAMILY_HX	AGE_OF_ONSET	This is the age of onset of the family member documented with a history of	
FAMILY_HX	FAM_HX_SRC	Family Medical History Source Category Description: Provider (1),	
FAMILY_HX	FAM_HX_SRC_CODE	Family Medical History Source Category Code: 1 (Provider), 2	
FAMILY_HX	FAM_RELATION_NAME	This is the first and/or last name of the patient's family member.This column is free-text and is meant to be used together with the RELATION_C category to form a unique key for the	
FAMILY_HX	FHX_CONTACT_DATE	The date of this contact in calendar	
FAMILY_HX	FHX_LNK_VISIT_ID	The Contact Serial Number of the encounter in which the history was created/edited. If the history was	
FAMILY_HX	FHX_VISIT_ID	A unique serial number for this	
FAMILY_HX	LAST_UPDATE_DATE	The time this patient family history record was pulled into enterprise	

FAMILY_HX	LINE	The line number to identify the family history contact within the patient's record. NOTE: A given patient may	
FAMILY_HX	MEDICAL_HX	The category description associated with the Problem documented in the	
FAMILY_HX	MEDICAL_HX_CODE	The category code associated with the Problem documented in the patient's	
FAMILY_HX	PATIENT_ID	Unique identifier for each patient; used	
FAMILY_HX	RELATION	The category value description associated with the family member who has or had this problem: Father	
FAMILY_HX	RELATION_CODE	The category value code associated with the family member who has or had this problem: 2 (Father), 4	
HIV_REGISTRY	FIRST_INCLUDE_DTTM	The instant at which the registry data record was included in the registry. This is cleared each time the registry data record is removed from the	
HIV_REGISTRY	LAST_UPDATE_DATE	The instant at which the registry was last updated for this registry data	
HIV_REGISTRY	PATIENT_ID	The ID number of the patient in the	
HIV_REGISTRY	PATIENT_REGISTRY_STATUS	The status category (Active, Inactive) for the patient in the HIV registry.	
HIV_REGISTRY	REGISTRY_ID	The unique ID of the registry record	
HIV_REGISTRY	REGISTRY_NAME	Name of the Registry Configuration	
HNO_NOTE	CONTACT_DATE	The date of this contact in calendar	
HNO_NOTE	FULL_TEXT	The full plain text of the note. All	
HNO_NOTE	NOTE_CSN_ID	The unique contact serial number for	
HNO_NOTE	NOTE_ID	The unique ID of the note record	
HNO_NOTE_INFO	AMB_NOTE_YN	Indicates whether the note is an ambulatory note. Y indicates that the note's encounter context is	
HNO_NOTE_INFO	AUTHOR_TYPE	The author type	
HNO_NOTE_INFO	CREATE_INSTANT_DTT	The instant when the note is created	
HNO_NOTE_INFO	CURRENT_AUTHOR_ID	The current author of the note.	
HNO_NOTE_INFO	DATE_OF_SERVICE	The date of service associated with	
HNO_NOTE_INFO	DELETE_INSTANT_DTT	The instant when the note is deleted.	
HNO_NOTE_INFO	ENC_VISIT_ID	The unique contact serial number for the patient encounter to which the	
HNO_NOTE_INFO	INPATIENT_DATA_ID	The ID of the INP record associated	
HNO_NOTE_INFO	IP_NOTE_TYPE	The note type description associated with this note. Applies mostly to	
HNO_NOTE_INFO	IP_NOTE_TYPE_CODE	The note type code associated with this note. Applies mostly to inpatient	
HNO_NOTE_INFO	LAST_UPDATE_DATE	The date and time when this row was created or last updated in Clarity.	
HNO_NOTE_INFO	LST_FILED_INST_DTTM	The instant the note was last edited	
HNO_NOTE_INFO	NOTE_AUTHOR	The name of the author of the note	
HNO_NOTE_INFO	NOTE_ID	The unique ID of the note record	

HNO_NOTE_INFO	NOTE_PURPOSE	The description forthe note purpose: Normal (1), Cosign (2), Appendum	
HNO_NOTE_INFO	NOTE_PURPOSE_CODE	The numeric code for the note purpose: 1 (Normal), 2 (Cosign), 3	
HNO_NOTE_INFO	NOTE_TYPE	The note type description associated with this note. Applies to ambulatory.	
HNO_NOTE_INFO	NOTE_TYPE_CODE	The note type code associated with	
HNO_NOTE_INFO	PATIENT_ID	The unique ID of the patient who is	
IMMUNIZATION	BODY_SITE	Code for the body site: 17 (ORAL), 14	
IMMUNIZATION	DEFER_REASON	Category value indicating the reason for deferring the immunization, e.g.	
IMMUNIZATION	DOSE	The immunization dosage (amount	
IMMUNIZATION	DOSE_AMOUNT	Immunization dose amount.	
IMMUNIZATION	DOSE_UNIT	Immunization dose unit.	
IMMUNIZATION	ENTRY_DATE	The date the immunization was recorded in the patient's chart. NOTE: If an immunization record is	
IMMUNIZATION	EXPIRATION_DATE	Date upon which this immunization	
IMMUNIZATION	EXTERNAL_ADMIN	Category value indicating the source of verification of external administration of immunization, e.g.	
IMMUNIZATION	GIVEN_BY_USER_ID	The unique ID of the system user who administered the immunization.	
IMMUNIZATION	IMMUNE_ID	The unique ID of the immunization	
IMMUNIZATION	IMM_ABBR	The abbreviation of the immunization	Y
IMMUNIZATION	IMM_DATE	The date and time the immunization	
IMMUNIZATION	IMM_HISTORIC_ADM_YN	Indicates whether the immunization administration is a historical	
IMMUNIZATION	IMM_ID	The unique ID of the immunization	
IMMUNIZATION	IMM_NAME	The name of the immunization	
IMMUNIZATION	IMM_STATUS	The category value associated with immunization: GIVEN, DELETED, DEFERRED, REFUSED, PARTIALLY	
IMMUNIZATION	IMM_TYPE	The type of immunization (i.e. ADULT or PEDIATRIC) that defines the	
IMMUNIZATION	IMM_VISIT_ID	The unique contact serial number of the most recent patient encounter	
IMMUNIZATION	LAST_UPDATE_DATE	The last update timestamp for the	
IMMUNIZATION	MED_ADMIN_COMMENT	Free text comment regarding the	
IMMUNIZATION	NDC_CODE	NDC number code associated with the	
IMMUNIZATION	NDC_NUM_ID	NDC number ID associated with the	
IMMUNIZATION	ORDER_DATE	The date the order was placed, if null the order is outside the clinical order	
IMMUNIZATION	ORDER_ID	Order ID for immunization ordered. Null for patient reported, imported	
IMMUNIZATION	ORDER_SOURCE	Category (PROC or MED) for the	
IMMUNIZATION	PATIENT_ID	Unique identifier for each patient; used	
IMMUNIZATION	ROUTE	The immunization route (IM,SQ,etc.)	

IMMUNIZATION	VISIT_ID	The unique contact serial number for the primary visit associated with the	
LAB_RESULT	ACCESSION_NUMBER	The accession number associated	
LAB_RESULT	AUTHRZING_PROV_ID	The unique ID of the provider	
LAB_RESULT	DEPARTMENT_ID	The ID of the department for the encounter. If there are multiple departments for the encounter, this is	
LAB_RESULT	FACILITY	Referring facility name	
LAB_RESULT	FACILITY_ID	Referring facility numeric identifier	
LAB_RESULT	LAB_CODE	A numeric identifer associated with	
LAB_RESULT	LAB_NAME	The description for the numeric identifer associated with this lab	
LAB_RESULT	LAB_STATUS	The status category number of the result: 1 (In Progress), 2 (Preliminary result) , 3 (Final result), 4 (Edited), 5	
LAB_RESULT	LAB_VISIT_ID	Unique identifier for the patient	
LAB_RESULT	LAST_UPDATE_DATE	The last update timestamp for the	
LAB_RESULT	LINE	The line number of each result	
LAB_RESULT	LOINC	Free text LOINC code associated with	Y
LAB_RESULT	ORDERING_PROV_ID	The ID of the lab order's ordering	
LAB_RESULT	ORDER_CLASS	The order class category number of the procedure order: 1 (Normal), 2	
LAB_RESULT	ORDER_CPT_CODE	The procedure code associated with this order, as of the ordering date. This is not a true CPT code, but the value	
LAB_RESULT	ORDER_DATE	The date when the order was placed	
LAB_RESULT	ORDER_ID	The unique ID of the order	
LAB_RESULT	ORDER_PROC	The description of the procedure code	
LAB_RESULT	ORDER_PROC_CODE	The procedure code associated with	
LAB_RESULT	ORDER_STATUS	The status category number of the order: 2 (Sent), 3 (Resulted), 5	
LAB_RESULT	ORDER_TYPE	The order type category description for	
LAB_RESULT	ORDER_TYPE_CODE	The order type category number for	
LAB_RESULT	ORD_DATE_REAL	Numeric version of the date with decimal values to handle mulitple	
LAB_RESULT	PATIENT_ID	Unique identifier for each patient; used	
LAB_RESULT	PRIORITY	The overall priority category number for the procedure order: 1 (ASAP), 2	
LAB_RESULT	REFERENCE_HIGH	The highest acceptable value for each	
LAB_RESULT	REFERENCE_LOW	The lowest acceptable value for each	
LAB_RESULT	REFERENCE_NORMAL	This is a free-text item which allows you to enter a reference range without tying it to a "low" or "high" value. For example, it could be a string ("negative"), a list of choices ("Yellow,	
LAB_RESULT	REFERENCE_UNIT	The units for each result component	Y
LAB_RESULT	REFERRING_PROV_ID	The unique ID of the provider who has referred this lab order, i.e. the referring	

LAB_RESULT	RESULT_DATA_TYPE	The data-type category number for the result component type. Supported result component types are 0 (string),	
LAB_RESULT	RESULT_DATE	The date the technician ran the tests	
LAB_RESULT	RESULT_FLAG	The category value associated with a flag code corresponding to a standard HL7 code to mark each component	
LAB_RESULT	RESULT_IN_RANGE_YN	A Yes/No category value to indicate whether a result has been verified to be within its reference range. This item is set by the interface when the result	
LAB_RESULT	RESULT_NUMERIC	A numeric representation of the value returned for each component where	Y
LAB_RESULT	RESULT_STATUS	The status category number of the result: 2 (Preliminary), 3 (Final), 4	
LAB_RESULT	RESULT_TEXT	The value returned for each result component, in short free text format	
LAB_RESULT	SERVICE_AREA	The service area description of the department in which the appointment	
LAB_RESULT	SERVICE_AREA_CODE	The service area code of the department in which the appointment	
LAB_RESULT	SPECIMEN_DATE	The date the specimen was collected.	
LAB_RESULT	SPECIMEN_SOURCE	The source category number for the procedure order: 135 (Nasopharynx,	
LAB_RESULT	SPECIMEN_TYPE	The specimen type category number for the procedure order: 4567 (Blood),	
LAB_RESULT	VISIT_ID	Unique identifier for the patient	
MEDICAL_HX	DX_ID	The unique ID of the diagnosis record (EDG .1) associated with the medical history contact. Note: This is NOT the	
MEDICAL_HX	DX_NAME	The name for the diagnois.	
MEDICAL_HX	LAST_UPDATE_DATE	The time this patient history record was pulled into enterprise reporting or	
MEDICAL_HX	LINE	The line number of the medical history contact within the encounter. Note: A given patient may have multiple	
MEDICAL_HX	MEDICAL_HX_DATE	The free-text date entered in clinical system’s Medical History window for the diagnosis. This field is free-text	
MEDICAL_HX	MED_HX_SOURCE	The category description for the medical history's source for the patient	
MEDICAL_HX	MED_HX_SOURCE_CODE	The category code for the medical history's source for the patient record.:	
MEDICAL_HX	MHX_CONTACT_DATE	The date of this contact in calendar	
MEDICAL_HX	MHX_LINK_VISIT_ID	The Contact Serial Number of the encounter in which the history was created/edited. If the history was	
MEDICAL_HX	MHX_VISIT_ID	A unique serial number for this	
MEDICAL_HX	PATIENT_ID	Unique identifier for each patient; used	

MED_ADMIN	ACCOUNT_NUM	Hospital accounting record for the	
MED_ADMIN	ADMIN_SITE	The site category number used for the administration. Example: 1 (Left Arm),	
MED_ADMIN	ADMIN_STATUS	The medication action category number associated with this	
MED_ADMIN	DOSE	The dose value of the administration.	
MED_ADMIN	DOSE_UNIT	The category number for the dose unit of a medication that corresponds with the DOSE column. Example: 3 (MG),	
MED_ADMIN	INFUSION_RATE	The rate at which the medication was	
MED_ADMIN	INFUSION_RATE_UNIT	The unit category number associated with the infusion rate of the	
MED_ADMIN	INPATIENT_DATA_ID	The unique ID of the inpatient data store record - applies to EPIC inpatient	
MED_ADMIN	LAST_UPDATE_DATE	The day and time the order record was	
MED_ADMIN	LINE	The sequential line count for the administration. There can be multiple	
MED_ADMIN	MEDADMIN_VISIT_ID	Unique identifier for the patient encounter for the medication	
MED_ADMIN	MEDORDER_VISIT_ID	Unique identifier for the patient	
MED_ADMIN	MED_ADMIN_DATE	The user-specified time that the action	
MED_ADMIN	MED_ADMIN_DEPT	The unique ID of the login department of the documenting user of the	
MED_ADMIN	MED_CODE	The unique ID of the medication record that is associated with this	
MED_ADMIN	MED_DESC	The description of the ordered	
MED_ADMIN	MED_DURATION	The length of time the administration	
MED_ADMIN	MED_DURATION_UNIT	The length of time the administration took to complete or infuse. Example: 1	
MED_ADMIN	MED_ORDER_ID	The unique ID of the order record associated with the medication order	
MED_ADMIN	NOT_GIVEN_REASON	The reason category number associated with the use of a specific	
MED_ADMIN	PROVIDER_ID	The "billing provider" for a given	
MED_ADMIN	ROUTE	The route category number associated	
MED_ADMIN	VISIT_ID	Unique identifier for the patient	
MED_AVS	AVS_ALL_REVIEWED_YN	This stores whether or not the last printed AVS included orders that were	
MED_AVS	AVS_HAS_CHANGES_YN	This stores whether or not there were any relevant discharge reconciliation	
MED_AVS	AVS_PRINTED_YN	This stores whether or not the AVS	
MED_AVS	DEPARTMENT	The ID number of the unit of the event record at the effective time. Join to	
MED_AVS	DISCHARGE_DATE	The hospital discharge date and time	
MED_AVS	DISCH_ATTEND_PROV_ID	The provider id for the attending at time of discharge. Join to	
MED_AVS	EVENT_DATE	The instant when the event occurred.	
MED_AVS	GROUP_NAME	The name of the category value for the medication. Resume, CHanged, New,	

MED_AVS	LAST_UPDATE_DATE	The day and time the order record was	
MED_AVS	LINE	The sequential line for the after visit summary. There can be multiple lines	
MED_AVS	LOCATION	The unique ID of the location that serves as the parent in your facility's	
MED_AVS	MEDICATION_ID	The unique ID of the medication record that is associated with this	
MED_AVS	MED_NAME	The name of the medication as it	
MED_AVS	MED_ORDER_ID	The unique medication order id of the order record associated with this after	
MED_AVS	MED_VISIT_ID	Unique identifier for the patient	
MED_AVS	ORDER_CHANGED_YN	This stores whether or not the order	
MED_AVS	ORDER_REVIEWED_YN	This stores if the order was reviewed	
MED_AVS	PATIENT_ID	Unique identifier for each patient; used	
MED_AVS	SNP_ACCOUNT_NUM	Hospital accounting record for the primary patient encounter; may be	
MED_AVS	SNP_VISIT_ID	Unique identifier for the patient	
MED_CURRENT	LINE	The line number for the information associated with this record. Multiple	
MED_CURRENT	MEDS_LAST_REV_DATE	The date the medication list was last	
MED_CURRENT	MED_DESC	The description of the reviewed	
MED_CURRENT	MED_ORDER_DATE	The date and time the order was	
MED_CURRENT	MED_ORDER_ID	The medication order associated with	
MED_CURRENT	MED_REVIEWER_NAME	The medication reviewer name	
MED_CURRENT	MED_REVIEW_VISIT_ID	The visit associated with the	
MED_CURRENT	PATIENT_ID	Unique identifier for each patient; used	
MED_CURRENT	PROV_ID	The provider id for the medication list	
MED_CURRENT	TAKING_YN	Indicates whether the associated medication order was marked as taking at the most recent time of	
MED_DISPENSE	ACCOUNT_NUM	Hospital accounting record for the	
MED_DISPENSE	CONTACT_DATE_REAL	A unique, internal contact date in decimal format. The integer portion of the number indicates the date of the contact. The digits after the decimal distinguish different contacts on the	
MED_DISPENSE	DISPENSE_DATE	The instant of the pharmacy action.	
MED_DISPENSE	DISPENSE_QTY	The quantity of the dispensed	
MED_DISPENSE	DISPENSE_QTY_UNIT	The category number for the medication unit of this	
MED_DISPENSE	DISPENSE_TYPE	The category number for the type of this component. Example: 1 (Base), 2	
MED_DISPENSE	DISP_MED_CODE	The unique ID of the medication that is related to this component action (the	
MED_DISPENSE	DISP_MED_DESC	The description of the dispensed	
MED_DISPENSE	DISP_NDC_CSN	The NDC CSN of the dispensed	
MED_DISPENSE	LAST_UPDATE_DATE	The day and time the order record was	
MED_DISPENSE	LINE	The sequential line count for the dispensing. There can be multiple	

MED_DISPENSE	MEDORDER_VISIT_ID	Unique identifier for the patient	
MED_DISPENSE	MED_ORDER_ID	The unique ID of the order record associated with the medication order	
MED_DISPENSE	ORDERING_MODE	The category number for the ordering mode of the order (i.e. Outpatient, Inpatient). Note that Outpatient orders can be placed from an Inpatient	
MED_DISPENSE	SUPPLY_DAYS	When a prescription is filled in an integrated pharmacy, a fill contact is created in the order and all fill information is saved to this fill contact. A prescription can have multiple fills.	
MED_DISPENSE	VISIT_ID	Unique identifier for the patient	
MED_ORDER	ACCOUNT_NUM	Hospital accounting record for the	
MED_ORDER	AUTH_PROV_ID	The id of the authorizing provider	
MED_ORDER	AUTH_PROV_NAME	The name of the authorizing provider	
MED_ORDER	DISPENSE_QUANTITY	This item stores the discrete quantity to dispense. Use with	
MED_ORDER	DISPENSE_UNIT	This item stores the category for the discrete dispense unit. Use with DISPENSE_QUANTITY. Example: 3	
MED_ORDER	DOSE	The discrete dose for a medication as entered by the user in the orders	Y
MED_ORDER	DOSE_UNIT	The category number for the dose unit of a medication that corresponds with the DOSE column. Example: 3 (MG),	
MED_ORDER	END_DATE	The date when the medication order is	
MED_ORDER	FREQUENCY	The unique ID of the discrete frequency record associated with this	
MED_ORDER	INSTRUCTIONS	Patient instructions for the prescription as entered by the user in the orders	
MED_ORDER	LASTDOSE	Comments for the last administered	
MED_ORDER	LAST_UPDATE_DATE	The day and time the order record was	
MED_ORDER	MED_CODE	The unique ID of the medication record that is associated with this	
MED_ORDER	MED_DESC	The description of the order.	Y
MED_ORDER	MED_ORDER_ID	The unique ID of the order record associated with this medication order.	
MED_ORDER	MED_VISIT_ID	Unique identifier for the patient	
MED_ORDER	ORDERING_MODE	The category number for the ordering mode of the order (i.e. Outpatient, Inpatient). Note that Outpatient orders can be placed from an Inpatient	
MED_ORDER	ORDER_CLASS	The category number for the order class. Example: 1 (NORMAL), 3	
MED_ORDER	ORDER_DATE	The date and time the order was	
MED_ORDER	ORDER_REASON	The diagnosis associated with	
MED_ORDER	ORDER_STATUS	The category number for the current status of an order. Example: (1)	

MED_ORDER	PATIENT_ID	Unique identifier for each patient; used	
MED_ORDER	PHARMACY_ID	The unique ID of the pharmacy record that is associated with this medication order. This column is frequently used to link to the RX_PHR table. This field is only populated if the clinical system user selects a specific pharmacy from	
MED_ORDER	PHARMACY_NAME	The name of the pharmacy associated	
MED_ORDER	PRIORITY	The category number for the priority assigned to an order. Example: 1	
MED_ORDER	QUANTITY	The quantity of the prescription being dispensed as entered by the user in the orders activity. Relates to	
MED_ORDER	REFILLS	The number of refills allowed for this prescription as entered by the user in the orders activity. Example: 200001	
MED_ORDER	ROUTE	The category number for the route of administration of a medication.	
MED_ORDER	START_DATE	The date when the medication order is	
MED_ORDER	VISIT_ID	Unique identifier for the patient	
NOTE	CONTACT_DATE	The date of this contact in calendar	
NOTE	FULL_TEXT	The full plain text of the note. All	
NOTE	NOTE_TYPE	The type of note: IMP for impression,	
NOTE	ORDER_DATE_REAL	An internal value used to maintain the most recent current version of the	
NOTE	ORDER_ID	The order number associated with the	
NOTE_RSLT	COMPONENT_ID	A numeric identifer associated with	
NOTE_RSLT	FULL_TEXT	The full plain text of the note. All	
NOTE_RSLT	LINE	The line number of each result	
NOTE_RSLT	NOTE_SOURCE	An internal value to indicate if the source of the comment is ORDER_RES_CMT (CMT) or	
NOTE_RSLT	NOTE_TYPE	The tyoe of note: PATHOLOGY AND CYTOLOGY, ECG, MICROBIOLOGY,	
NOTE_RSLT	ORDER_DATE_REAL	The order date in a manner to handle muliple orders on the same day for the order. The integer portion of the number specifies the date of the	
NOTE_RSLT	ORDER_ID	The order number associated with the	
NOTE_RSLT	RESULT_DATA_TYPE	The data-type category number for the result component type. Supported result component types are 0 (string),	
NOTE_RSLT	RESULT_DATE	The date the technician ran the tests	
NOTE_RSLT	RESULT_NUMERIC	A numeric representation of the value returned for each component where	
NOTE_RSLT	RESULT_TEXT	The value returned for each result component, in short free text format	
OBSERVATION	ABNORMAL	Stores whether or not the value is abnormal. Values are 1 (Yes) or null	

OBSERVATION	ACCOUNT_NUM	Hospital accounting record for the	
OBSERVATION	FLOWSHEETID	The unique ID of the for the measurements recorded on the	
OBSERVATION	INPATIENT_DATA_ID	Unique id to link related items to the	
OBSERVATION	LAST_UPDATE_DATE	The last update timestamp for the	
OBSERVATION	LINE	The line count for the item. It is unique for the instance of the flowsheet	
OBSERVATION	OBSERVATION_DATE	The instant the reading was taken.	
OBSERVATION	OBSERVATION_DISPLAY_NAME	The display name fiven to the measured item	
OBSERVATION	OBSERVATION_GROUP	Logical grouping for the observations. Examples: VITAL, SMOKE, etc.	
OBSERVATION	OBSERVATION_ID	The unique ID for the flowsheet data record. Example: 11 is height, 14 is	
OBSERVATION	OBSERVATION_NAME	The name given to the measured item	Y
OBSERVATION	OBSERVATION_VALUE	The actual value of the flowsheet	Y
OBSERVATION	OBS_VISIT_ID	Unique identifier for the patient encounter associated with the	
OBSERVATION	PATIENT_ID	Unique identifier for each patient; used	
OBSERVATION	TEMPLATE_ID	The unique ID of the flowsheet template which was used to record the	
OBSERVATION	UNITS	This determines the units that will display with the value in the additional	
OBSERVATION	VALUE_TYPE	This determines the type of data in the record (i.e. numeric, string,	
OBSERVATION	VISIT_ID	Unique identifier for the patient	
OB_DELIVERY_RECORD	ANESTH_CONC	A comma delimeted list of all anesthesia methods for the baby. Ex.	
OB_DELIVERY_RECORD	APGAR1	The Apgar score (0-10) at 1 minute	
OB_DELIVERY_RECORD	APGAR10	The Apgar score (0-10) at 10 minutes	
OB_DELIVERY_RECORD	APGAR5	The Apgar score (0-10) at 5 minutes	
OB_DELIVERY_RECORD	AUGMENT_CONC		
OB_DELIVERY_RECORD	BABY_ID	The patient ID of the baby; used to link to other tables on PATIENT_ID	
OB_DELIVERY_RECORD	BABY_VISIT_ID	The visit id associated with the baby's	
OB_DELIVERY_RECORD	BIRTHWT	The baby's birth weight in grams	
OB_DELIVERY_RECORD	CERVRIPE_CONC	A comma delimeted list of all cervical ripening methods for the baby. Ex.	
OB_DELIVERY_RECORD	DELMETHOD_CODE	The code of the delivery method used	
OB_DELIVERY_RECORD	DELMETHOD_NAME	The name of delivery method used	
OB_DELIVERY_RECORD	DELREC_ID	The baby's delivery record ID	
OB_DELIVERY_RECORD	DEL_DTTM	The delivery time of the baby.	
OB_DELIVERY_RECORD	DEPT_ID	The ID of the department where the	
OB_DELIVERY_RECORD	EPISIO_CONC	A comma delimeted list of all episiotomy methods for the baby. Ex.	
OB_DELIVERY_RECORD	GA	The gestational age at birth in weeks	
OB_DELIVERY_RECORD	INDUCT_CONC	A comma delimeted list of all induction methods for the baby. Ex. Cervidil,	

OB_DELIVERY_RECORD	LACER_CONC	A comma delimeted list of all laceration methods for the baby. Ex.	
OB_DELIVERY_RECORD	LAST_INSUPD_DATE	The timestamp associated with an insert or the last update of the row	
OB_DELIVERY_RECORD	LIVING	The living status of the baby. Example: null, Yes, Neonatal Demise, Fetal	
OB_DELIVERY_RECORD	MOM_ID	The patient ID of the mom; used to link to other tables on PATIENT_ID	
OB_DELIVERY_RECORD	MOM_VISIT_ID	The visit id associated with the mom's	
OB_DELIVERY_RECORD	OB_DELIV_MD_NAME	The name of the provider who was responsible for delivering this infant	
OB_DELIVERY_RECORD	OB_DEL_DELIV_MD_ID	The unique ID of the provider who was responsible for delivering this infant	
OB_DELIVERY_RECORD	PREG_EPISODE_ID	The mother's pregnancy episode ID	
ORDERS	ACCESSION_NUMBER	The accession number associated	
ORDERS	AUTHRZING_PROV_ID	The unique ID of the provider	
ORDERS	DEPARTMENT	The name of the department for the encounter. If there are multiple	
ORDERS	DEPARTMENT_ID	The ID of the department for the encounter. If there are multiple departments for the encounter, this is	
ORDERS	ENCOUNTER_TYPE	Category type for the patient encounter associated with the ORDER_VISIT_ID: 3 (HOSPITAL	
ORDERS	IMPRESSION_YN	Y for Yes or N for No indicating if there is are impression notes associated	
ORDERS	INPATIENT_DATA_ID	Unique id to link related items to the	
ORDERS	LAST_UPDATE_DATE	The last update timestamp for the	
ORDERS	NARRATIVE_YN	Y for Yes or N for No indicating if there is a narrative associated with the	
ORDERS	ORDERING_PROV_ID	The ID of the order's ordering provider.	
ORDERS	ORDER_CLASS	The order class category of the procedure order: HOSPITAL PERFORMED,ANCILLARY	
ORDERS	ORDER_DATE	The date when the order was placed	
ORDERS	ORDER_ID	The unique ID of the order	
ORDERS	ORDER_PROC	The description of the procedure code	
ORDERS	ORDER_PROC_CODE	The procedure code associated with	
ORDERS	ORDER_STATUS	The status category of the order: CANCELED, COMPLETED, SENT,	
ORDERS	ORDER_TYPE	The order type category description for	
ORDERS	ORDER_TYPE_CODE	The order type category number for	
ORDERS	ORDER_VISIT_ID	Unique identifier for the patient	
ORDERS	PATIENT_ID	Unique identifier for each patient; used	
ORDERS	PRIORITY	The priority of the order: ROUTINE, STAT, ASAP, TIMED, TODAY, ADD-	
ORDERS	PROC_ID	The unique internal identifier of the procedure record corresponding to this	
ORDERS	PROC_START_DATE	The date and time when the procedure	

ORDERS	RADIOLOGY_STATUS	The status category of the imaging orders: FINAL, EXAM ENDED,	
ORDERS	REFERRING_PROV_ID	The unique ID of the provider who has referred this order, i.e. the referring	
ORDERS	RESULT_DATE	The most recent date and time when the procedure order was resulted.	
ORDERS	SPECIALTY_DEPARTMENT	The category number for the requested medical specialty of the	
ORDERS	SPECIMEN_DATE	The date the specimen was collected.	
ORDERS	SPECIMEN_SOURCE	The specimen source category number for the procedure order:	
ORDERS	SPECIMEN_TYPE	The specimen type category for the procedure order: TISSUE, BLOOD,	
ORDERS	VISIT_ID	Unique identifier for the patient primary billing encounter. Can be null	
ORDER_RESULT	COMPONENT_COMMENT	Contains the comments associated with an order COMPONENT_ID, i.e. this is the comments associated with a specific order component's results. If	
ORDER_RESULT	COMPONENT_ID	A numeric identifer associated with	
ORDER_RESULT	COMPONENT_NAME	The description for the numeric identifer associated with this	
ORDER_RESULT	LAB_STATUS	The status category number of the result: 1 (In Progress), 2 (Preliminary result) , 3 (Final result), 4 (Edited), 5	
ORDER_RESULT	LAST_UPDATE_DATE	The last update timestamp for the	
ORDER_RESULT	LINE	The line number of each result	
ORDER_RESULT	LOINC	Free text LOINC code associated with	
ORDER_RESULT	ORDER_ID	The unique ID of the order,	
ORDER_RESULT	ORD_DATE_REAL	Numeric version of the date with decimal values to handle mulitple	
ORDER_RESULT	REFERENCE_HIGH	The highest acceptable value for each	
ORDER_RESULT	REFERENCE_LOW	The lowest acceptable value for each	
ORDER_RESULT	REFERENCE_NORMAL	This is a free-text item which allows you to enter a reference range without tying it to a "low" or "high" value. For example, it could be a string ("negative"), a list of choices ("Yellow,	
ORDER_RESULT	REFERENCE_UNIT	The units for each result component	
ORDER_RESULT	RESULT_DATA_TYPE	The data-type category number for the result component type. Supported result component types are 0 (string),	
ORDER_RESULT	RESULT_DATE	The date the technician ran the tests	
ORDER_RESULT	RESULT_FLAG	The category value associated with a flag code corresponding to a standard HL7 code to mark each component	

ORDER_RESULT	RESULT_IN_RANGE_YN	A Yes/No category value to indicate whether a result has been verified to be within its reference range. This item is set by the interface when the result	
ORDER_RESULT	RESULT_NUMERIC	A numeric representation of the value returned for each component where	Y
ORDER_RESULT	RESULT_STATUS	The status category number of the result: 2 (Preliminary), 3 (Final), 4	
ORDER_RESULT	RESULT_TEXT	The value returned for each result component, in short free text format	
ORDER_RESULT	RSLT_VISIT_ID	Unique identifier for the patient	
ORDER_RESULT	SERVICE_AREA	The service area description of the department in which the appointment	
ORDER_RESULT	SERVICE_AREA_CODE	The service area code of the department in which the appointment	
ORDER_RESULT	VISIT_ID	Unique identifier for the patient	
PATIENT	ADD_LINE_1	First line of patient address	
PATIENT	ADD_LINE_2	Second line of patient address	
PATIENT	BIRTH_DATE	Patient date of birth	
PATIENT	CITY	City where the patient lives	
PATIENT	COUNTRY	Code corresponding to the country	
PATIENT	COUNTY	Code corresponding to the county	
PATIENT	DEATH_DATE	Patient date of death	
PATIENT	EMAIL_ADDRESS	The patient’s e-mail address.	
PATIENT	GENDER	Code for gender; values are F, M, U,	Y
PATIENT	GENDER	Code for gender; values are F, M, U,	Y
PATIENT	HISPANIC	Code for hispanic ethnicity; valid	Y
PATIENT	HOME_PHONE	The patient’s home phone number.	
PATIENT	LANGUAGE	Code for language; valid codes are	
PATIENT	LAST_UPDATE_DATE	The time this patient record was pulled into enterprise reporting or date of last	
PATIENT	MARITAL_STATUS	Code for marital status; valid codes	Y
PATIENT	MILITARY_STATUS	Code for marital status; valid codes	Y
PATIENT	MOBILE_PHONE	The patient’s mobile phone number.	
PATIENT	PATIENT_ID	Unique identifier for each patient; used	
PATIENT	PATIENT_MRN	Patient Medical Record Number	
PATIENT	PATIENT_STATUS	The category value of the patient status. Possible statuses include alive	Y
PATIENT	PAT_FIRST_NAME	Patient first name	
PATIENT	PAT_LAST_NAME	Patient last name	
PATIENT	PAT_MIDDLE_NAME	Patient middle name	
PATIENT	PAT_NAME	Patient full name: Last name, First	
PATIENT	PAT_NAME_SUFFIX	The suffix to the patient name, e.g. Jr.,	
PATIENT	PRELIM_COD_DX_ID	The preliminary cause of death diagnosis id, join to REF_ICD_DX for	
PATIENT	RACE	Code for race: Codes are numeric 1-	Y
PATIENT	REC_CREATE_DATE	The date the patient record was	

PATIENT	REG_DATE	The date on which the last patient verification occurred. If a patient was verified and then re-verifed at a later date, this column will show the re-	
PATIENT	RELIGION	Code for religion; valid codes are null	Y
PATIENT	RESEARCH_ID	The research id is populated for dummy records for billing purposes Used to link to CLARITY_RSH. It will	
PATIENT	SSN	The patient's Social Security Number. This number is formatted as 999-99-	
PATIENT	STATE	State abbreviation where the patient	
PATIENT	WORK_PHONE	The patient's work phone number.	
PATIENT	ZIP	The ZIP Code area in which the	
PHENOTYPE	ACQ_HYPOTHR	Y (yes) or NULL (no) indicator if the chronic condition Acquired	Y
PHENOTYPE	ACUTE_MI	Y (yes) or NULL (no) indicator if the chronic condition Acute Myocardial	Y
PHENOTYPE	AFIB	Y (yes) or NULL (no) indicator if the chronic condition Atrial Fibrillation	Y
PHENOTYPE	ALZHEIMER	Y (yes) or NULL (no) indicator if the chronic condition Alzheimer's Disease	Y
PHENOTYPE	ALZHEIMER_DEMENTIA	Y (yes) or NULL (no) indicator if the chronic condition Alzheimer's Disease and Related Disorders or Senile	Y
PHENOTYPE	ANEMIA	Y (yes) or NULL (no) indicator if the chronic condition Anemia exists for a	Y
PHENOTYPE	ASTHMA	Y (yes) or NULL (no) indicator if the chronic condition Asthma exists for a	Y
PHENOTYPE	BPH	Y (yes) or NULL (no) indicator if the chronic condition Benign Prostatic	Y
PHENOTYPE	BREAST_CANCER	Y (yes) or NULL (no) indicator if the chronic condition Female / Male	Y
PHENOTYPE	CATARACT	Y (yes) or NULL (no) indicator if the chronic condition Cataract exists for a	Y
PHENOTYPE	CHARLSON_INDEX	Calculated Charlson Index score with weights applied to comobordity groups	Y
PHENOTYPE	CHARLSON_INDEX_NOAGEADJ	Calculated Charlson Index score with weights applied to comobordity groups	Y
PHENOTYPE	CKD	Y (yes) or NULL (no) indicator if the chronic condition Chronic Kidney	Y
PHENOTYPE	COLORECTAL_CANCER	Y (yes) or NULL (no) indicator if the chronic condition Colorectal Cancer	Y
PHENOTYPE	COPD	Y (yes) or NULL (no) indicator if the chronic condition Chronic Obstructive Pulmonary Disease and	Y
PHENOTYPE	DEPRESSION	Y (yes) or NULL (no) indicator if the chronic condition Depression exists for	Y
PHENOTYPE	DIABETES	Y (yes) or NULL (no) indicator if the chronic condition Diabetes exists for a	Y

PHENOTYPE	ENDOMETRIAL_CANCER	Y (yes) or NULL (no) indicator if the chronic condition Endometrial Cancer	Y
PHENOTYPE	GLAUCOMA	Y (yes) or NULL (no) indicator if the chronic condition Glaucoma exists for	Y
PHENOTYPE	HEART_FAILURE	Y (yes) or NULL (no) indicator if the chronic condition Heart Failure exists	Y
PHENOTYPE	HIP_PELVIC_FRACTURE	Y (yes) or NULL (no) indicator if the chronic condition Hip/Pelvic Fracture	Y
PHENOTYPE	HYPERLIPIDEMIA	Y (yes) or NULL (no) indicator if the chronic condition Hyperlipidemia	Y
PHENOTYPE	HYPERTENSION	Y (yes) or NULL (no) indicator if the chronic condition Hypertension exists	Y
PHENOTYPE	ISCHEMIC_HEART_DISEASE	Y (yes) or NULL (no) indicator if the chronic condition Ischemic Heart	Y
PHENOTYPE	LUNG_CANCER	Y (yes) or NULL (no) indicator if the chronic condition Lung Cancer exists	Y
PHENOTYPE	OSTEOPOROSIS	Y (yes) or NULL (no) indicator if the chronic condition Osteoporosis exists	Y
PHENOTYPE	PATIENT_ID	Unique identifier for the patient. Used	
PHENOTYPE	PROSTATE_CANCER	Y (yes) or NULL (no) indicator if the chronic condition Prostate Cancer	Y
PHENOTYPE	RA_OA	Y (yes) or NULL (no) indicator if the chronic condition RA/OA (Rheumatoid	Y
PHENOTYPE	STROKE	Y (yes) or NULL (no) indicator if the chronic condition Stroke / Transient	Y
PNEG_MEDICAL_HX	DX_NAME	The name for the diagnois.	
PNEG_MEDICAL_HX	LAST_UPDATE_DATE	The time this patient history record was pulled into enterprise reporting or	
PNEG_MEDICAL_HX	LINE	The line number for the information associated with this contact. Multiple	
PNEG_MEDICAL_HX	PATIENT_ID	Unique identifier for each patient; used	
PNEG_MEDICAL_HX	PNEG_MED_HX_SRC	The category description for the pertinent negative medical history's source for the patient record.: Provider	
PNEG_MEDICAL_HX	PNEG_MED_HX_SRC_CODE	The category code for the pertinent negative medical history's source for the patient record.: 1 (Provider), 2	
PNEG_MEDICAL_HX	PNEG_MHX_CONTACT_	The date of this contact in calendar	
PNEG_MEDICAL_HX	PNEG_MHX_DX_ID	The unique ID of the diagnosis record associated with the pertinent negatives medical history contact. Note: This is NOT the ICD9/10	
PNEG_MEDICAL_HX	PNEG_MHX_LNK_VISIT_ID	The Contact Serial Number of the encounter in which the history was created/edited. If the history was	
PNEG_MEDICAL_HX	PNEG_MHX_VISIT_ID	A unique serial number for this	
PNEG_SURGICAL_HX	LAST_UPDATE_DATE	The time this patient history record was pulled into enterprise reporting or	

PNEG_SURGICAL_HX	LINE	The line number for the information associated with this contact. Multiple	
PNEG_SURGICAL_HX	PATIENT_ID	Unique identifier for each patient; used	
PNEG_SURGICAL_HX	PNEG_SURG_HX_ID	The unique ID of the procedure record associated with the pertinent	
PNEG_SURGICAL_HX	PNEG_SURG_HX_SRC	The category description for the pertinent negative surgical history's source for the patient record.: Provider	
PNEG_SURGICAL_HX	PNEG_SURG_HX_SRC_CODE	The category code for the pertinent negative surgical history's source for the patient record.: 1 (Provider), 2	
PNEG_SURGICAL_HX	PROC_CODE	Procedure code documented in the patient's pertinent negative surgical	
PNEG_SURGICAL_HX	PROC_NAME	Procedure namw documented in the patient's pertinent negative surgical	
PNEG_SURGICAL_HX	PSHX_CONTACT_DATE	The contact date of the encounter associated with this pertinent surgical surgical history contact. Note: There	
PNEG_SURGICAL_HX	PSHX_VISIT_ID	The unique contact serial number for this contact. This number is unique	
PROBLEM_LIST	CHRONIC_YN	Yes/No indicates whether or not this	
PROBLEM_LIST	DX_CODE	The code for the problem diagnosis	Y
PROBLEM_LIST	DX_CODE_SET	The coding set for the problem	
PROBLEM_LIST	DX_ID	Unique Identifier for diagnosis and links to the referecne table:	
PROBLEM_LIST	DX_NAME	The name or description of the	Y
PROBLEM_LIST	DX_POA	Indicator if the diagnosis was present	
PROBLEM_LIST	ENTRY_DATE	The date the problem was entered into the patient’s medical record. or was last edited (i.e., a change was made,	
PROBLEM_LIST	HOSPITAL_PL_YN	Yes/No Is this problem a hospital	
PROBLEM_LIST	LAST_UPDATE_DATE	The last update timestamp for the	
PROBLEM_LIST	NOTED_DATE	The date the problem was first diagnosed. By default, this is the date of the encounter during which the problem was added to the problem list. The intent of this field is to allow users	
PROBLEM_LIST	PATIENT_ID	Unique identifier for each patient; used	
PROBLEM_LIST	PL_VISIT_ID	The unique contact serial number of the most recent patient encounter	
PROBLEM_LIST	PRINCIPAL_PL_YN	Yes/No Is this problem the principal	
PROBLEM_LIST	PRIORITY	The category value associated with the relative severity of the problem. Example: 1 (high), 2 (medium), or 3 (low)). This field shows the category	
PROBLEM_LIST	PROBLEM_CLASS	The category value associated with additional information for the problem,	
PROBLEM_LIST	PROBLEM_LIST_ID	The unique ID of this Problem List	

PROBLEM_LIST	PROBLEM_STATUS	The category value associated with the problem's current state: 1 (Active),	Y
PROBLEM_LIST	RESOLVED_DATE	The date the problem was resolved	
PROBLEM_LIST	STAGE_DESC	Description of the cancer for the associated stage in the STAGE_ID	
PROBLEM_LIST	STAGE_ID	The unique ID of the cancer stage record (STG .1) associated with the	
PROBLEM_LIST	VISIT_ID	The main encounter closest to or the same as the problem encounter.	
PROCEDURE	ACCOUNT_NUM	Hospital accounting record for the	
PROCEDURE	LAST_UPDATE_DATE	The last update timestamp for the	
PROCEDURE	LINE	Since multiple final ICD procedures can be stored in one hospital account,	
PROCEDURE	PATIENT_ID	Unique identifier for each patient; used	
PROCEDURE	PROC_CODE	The billing code for the procedure	Y
PROCEDURE	PROC_CODE_SET	The billing coding set for the	Y
PROCEDURE	PROC_DATE	The date the procedure was	
PROCEDURE	PROC_ID	Unique Identifier for ICD procedures and links to the reference table:	
PROCEDURE	PROC_NAME	The name or description of the	Y
PROCEDURE	PROC_PERF_PROV_ID	The identifier for the performing	
PROCEDURE	PROC_VISIT_ID	Unique identifier for the patient encounter when the procedure was	
PROCEDURE	VISIT_ID	Unique identifier for the patient	
QSTN_ANS	ANSWER_ID	The unique ID of the questionnaire answer record. Used to join to the	
QSTN_ANS	FORM_ID	The id of the form (questionnaire).	
QSTN_ANS	QUESTION_DISPLAY	The question that the user sees	
QSTN_ANS	QUESTION_LINE	Line count of the answers in the	
QSTN_ANS	QUESTION_NAME	The name of the question record.	
QSTN_ANS	QUEST_ANSWER	The answer to the question for this	
QSTN_ANS	QUEST_ID	The unique ID of the question for this	
QSTN_INFO	ANSWER_ID	The unique ID of the questionnaire answer record. Used to join to the	
QSTN_INFO	CONTACT_DATE	The contact date for the visit	
QSTN_INFO	ENCOUNTER_TYPE	The description for the encounter type associated with the questionnaire	
QSTN_INFO	FORM_NAME	The name of the form (questionnaire).	
QSTN_INFO	LOS_PROC_CODE	The procedure code for the primary	
QSTN_INFO	LOS_PROC_NAME	The description of the procedure code for the primary LOS (level of service).	
QSTN_INFO	PARENT_MSG_CREATED_DATE		
QSTN_INFO	PATIENT_ID	The unique patient identifier used to	
QSTN_INFO	QSTN_VISIT_ID	The visit id associated with the	
QSTN_INFO	QUESTION_INSTANT	The instant a question was answered.	
RESEARCH_PERMISSION	BIO_BANK_PREF	The patient's preference that their left over tissue may be used in de-	Y

RESEARCH_PERMISSION	CONTACT_PREF	The patient's preference to be contacted for research: 1 (Yes), 2	Y
RESEARCH_PERMISSION	LAST_UPDATE_DATE	The date the row was inserted into this table. This table is refreshed	
RESEARCH_PERMISSION	PATIENT_ID	Unique identifier for each patient; used	
RESEARCH_PERMISSION	PREFERENCE_DATE	The date the preferences were	
RESEARCH_PERMISSION	RECORD_ID	Unique identifier for research	
RSCH_ENROLLMENT	ENROLL_COMMENT	Comment associated with the	
RSCH_ENROLLMENT	ENROLL_END_DATE	End date of the patient's enrollment in	
RSCH_ENROLLMENT	ENROLL_ID	The unique ID of the patient	
RSCH_ENROLLMENT	ENROLL_START_DATE	Start date of the patient's enrollment in	
RSCH_ENROLLMENT	ENROLL_STATUS	Enrollment status category. Values include: IDENTIFIED, SCREEN FAILURE, CONSENTED - IN	Y
RSCH_ENROLLMENT	LAST_UPDATE_DATE	The last update timestamp for the	
RSCH_ENROLLMENT	PATIENT_ID	Unique ID of the associated patient	
RSCH_ENROLLMENT	REC_CREATE_DATE	Research record create date	
RSCH_ENROLLMENT	RESEARCH_ID	Unique ID of the associated Research Study record. Use to join to	
RSCH_ENROLLMENT	STUDY_ALIAS	Patient's alias for the study enrollment.	
RSCH_ENROLL_HX	ENROLL_ID	The unique ID of the patient enrollment record for this row. Use to	
RSCH_ENROLL_HX	HX_ENROLL_STATUS	The status catagory. This value can	
RSCH_ENROLL_HX	HX_MOD_DTTM	Instant that the enrollment information	
RSCH_ENROLL_HX	HX_MOD_END_DT	A history of end date changes for the	
RSCH_ENROLL_HX	HX_MOD_START_DT	A history of start date changes for the	
RSCH_ENROLL_HX	HX_MOD_VISIT_ID	A history of the changes to the comments note record associated with	
RSCH_ENROLL_HX	LINE	The line number for the information associated with this record. Multiple	
RSCH_ENROLL_HX	NOTE_ID	The note identfier associated with	
RSCH_ENROLL_HX	NOTE_TEXT	Comment associated with the	
RSCH_STUDY	BILLING_CONTACT	The billing contact person associated	
RSCH_STUDY	IRB_APPROVAL_NUM	The IRB approval identifier.	
RSCH_STUDY	LAST_UPDATE_DATE	The last update timestamp for the	
RSCH_STUDY	NCT_NUM	The National Clinical Trials Number is a registry number specified for all	Y
RSCH_STUDY	PI_ID	The internal id for the prinicipal investigator, use to join to the	
RSCH_STUDY	PI_NAME	The principal investigator's full name	
RSCH_STUDY	RECORD_STATUS	The record status category. Values include: INACTIVE, DELETED,	
RSCH_STUDY	REC_CREATE_DATE	Research record create date	
RSCH_STUDY	RESEARCH_ID	The unique ID number of research	
RSCH_STUDY	RESEARCH_NAME	The name of the research study	Y
RSCH_STUDY	RMID	Research Mater ID (RMID); used to	
RSCH_STUDY	STUDY_CODE	External ID for research study. MUSC source is Sparc. This code will appear	

RSCH_STUDY	STUDY_STATUS	The research study status category. Values include: ACTIVE,	
RSCH_STUDY	STUDY_TYPE	The category of study type derived from Sparc questions. Values include:	
RSCH_VISIT	CONTACT_DATE	The date of this contact in calendar	
RSCH_VISIT	ENROLL_ID	The unique ID of the patient enrollment record; link to	
RSCH_VISIT	LAST_UPDATE_DATE	The last update timestamp for the	
RSCH_VISIT	LINE	The line number for the information associated with this contact. Multiple pieces of information can be	
RSCH_VISIT	MANUAL_LINK_YN	Indicates whether the non-inferred columns of this table are based on manual user linkage. Y indicates that a	
RSCH_VISIT	PATIENT_ID	Unique identifier for each patient; used	
RSCH_VISIT	PAT_ENC_DATE_REAL	A unique contact date in decimal format. The integer portion of the number indicates the date of contact. The digits after the decimal distinguish different contacts on the same date	
RSCH_VISIT	RESEARCH_ID	The unique ID of the research study linked to this patient encounter. This	
RSCH_VISIT	RSCH_VISIT_ID	Unique identifier for the research visit. Join to VISIT for more information.	
SMOKE_HX	CHEW_YN	Y if the patient uses chewing tobacco.	
SMOKE_HX	CIGARETTES_YN	Y if the patient uses cigarettes. N if the	
SMOKE_HX	CIGARS_YN	Y if the patient smokes cigars. N if the	
SMOKE_HX	CONTACT_DATE	The date of this contact in calendar	
SMOKE_HX	LAST_UPDATE_DATE	The time this patient social history record was pulled into enterprise	
SMOKE_HX	PATIENT_ID	Unique identifier for each patient; used	
SMOKE_HX	PIPES_YN	Y if the patient smokes a pipe. N if the	
SMOKE_HX	SMOKELESS_QUIT_DAT	The date on which the patient quit	
SMOKE_HX	SMOKELESS_TOB_USE	Stores the patient's usage of smokeless tobacco. Data may include,	Y
SMOKE_HX	SMOKELESS_TOB_USE_NAME	Stores the patient's usage of smokeless tobacco. Data may include,	
SMOKE_HX	SMOKING_QUIT_DATE	The date on which the patient quit	
SMOKE_HX	SMOKING_START_DATE	The date on which the patient started	
SMOKE_HX	SMOKING_TOB_USE	Stores the patient's usage of smoking tobacco. Data may include, 1 (Current Everyday Smoker), 2 (Current Some	Y
SMOKE_HX	SMOKING_TOB_USE_NAME	Stores the patient's usage of smoking tobacco. Data may include, Current Everyday Smoker (1), Current Some	
SMOKE_HX	SNUFF_YN	Y if the patient uses snuff. N if the	
SMOKE_HX	SOCIAL_HX_LINK_VISIT_ID	The Contact Serial Number of the encounter in which the history was created/edited. If the history was	

SMOKE_HX	SOCIAL_HX_VISIT_ID	A unique serial number for this	
SMOKE_HX	TOBACCO_COMMENT	Free-text comments regarding the	
SMOKE_HX	TOBACCO_PAK_PER_DY	The number of packs of cigarettes the patient smokes per day, or null if the	
SMOKE_HX	TOBACCO_SRC	Source for Tobacco History. Values include: 1 (Provider), 2 (Patient), 3	
SMOKE_HX	TOBACCO_SRC_NAME	Source for Tobacco History. Values include: Provider (1), Patient (2),	
SMOKE_HX	TOBACCO_USED_YEAR	The number of years a patient has	Y
SMOKE_HX	TOBACCO_USER	The category value associated with the patient’s tobacco use. Data may include, 1 (Yes), 2 (Never), 3 (Not	Y
SMOKE_HX	TOBACCO_USER_NAME	The category description associated with the patient’s tobacco use. Data may include, Yes (1), Never (2), Not	
SOCIAL_HX	ABSTINENCE_YN	Y if the patient practices abstinence. N	
SOCIAL_HX	ALCOHOL_OZ_PER_WK	The fluid ounces of alcohol the patient	
SOCIAL_HX	ALCOHOL_SRC	Source description or alcohol history. Values include: 1 (Provider), 2	
SOCIAL_HX	ALCOHOL_SRC_CODE	Source code for alcohol history. Values include: 1 (Provider), 2	
SOCIAL_HX	ALCOHOL_USE	The category value associated with the patient's alcohol use. Data may	
SOCIAL_HX	ALCOHOL_USE_CODE	The category value associated with the patient's alcohol use. Data may	
SOCIAL_HX	CONDOM_YN	Y if the patient uses a condom during sexual activity. N if the patient does	
SOCIAL_HX	CONTACT_DATE	The contact date of the encounter associated with this pertinent surgical surgical history contact. Note: There	
SOCIAL_HX	DIAPHRAGM_YN	Y if the patient uses a diaphragm. N if	
SOCIAL_HX	DRUG_SRC	Source description or drug history. Values include: 1 (Provider), 2	
SOCIAL_HX	DRUG_SRC_CODE	Source code for drug history. Values include: 1 (Provider), 2 (Patient), 3	
SOCIAL_HX	FEMALE_PARTNER_YN	Y if the patient has a female sexual partner. N if the patient does not.	
SOCIAL_HX	ILLICIT_DRUG_FREQ	The times per week the patient uses	
SOCIAL_HX	ILL_DRUG_USER	The category description associated with the patient's use of illicit drugs.	
SOCIAL_HX	ILL_DRUG_USER_CODE	The category value associated with the patient's use of illicit drugs. Data	
SOCIAL_HX	IMPLANT_YN	Y if the patient uses an implant as a form of birth control. N if the patient	
SOCIAL_HX	INJECTION_YN	Y if the patient uses an injection as a form of birth control. N if the patient	
SOCIAL_HX	INSERTS_YN	Y if the patient uses inserts as a form of birth control. N if the patient does	
SOCIAL_HX	IUD_YN	Y if the patient uses an IUD. N if the	

SOCIAL_HX	IV_DRUG_USER_YN	Y if the patient is an IV drug user. N if	
SOCIAL_HX	LAST_UPDATE_DATE	The time this patient history record was pulled into enterprise reporting or	
SOCIAL_HX	MALE_PARTNER_YN	Y if the patient has a male sexual	
SOCIAL_HX	PATIENT_ID	Unique identifier for each patient; used	
SOCIAL_HX	PILL_YN	Y if the patient uses birth control pills.	
SOCIAL_HX	RHYTHM_YN	Y if the patient uses the rhythm method as a form of birth control. N if	
SOCIAL_HX	SEXUALLY_ACTIVE		
SOCIAL_HX	SEXUALLY_ACTIVE_CO		
SOCIAL_HX	SEX_SRC	This columns stores the person (e.g. provider, patient, legal guardian) who provided sexual activity information for	
SOCIAL_HX	SEX_SRC_CODE		
SOCIAL_HX	SOCIAL_HX_LINK_VISIT_ID	The Contact Serial Number of the encounter in which the history was created/edited. If the history was	
SOCIAL_HX	SOCIAL_HX_VISIT_ID	A unique serial number for this	
SOCIAL_HX	SPERMICIDE_YN	Y if the patient uses spermicide. N if	
SOCIAL_HX	SPONGE_YN	Y if the patient uses a sponge as a form of birth control. N if the patient	
SOCIAL_HX	SURGICAL_YN	Y if the patient uses a surgical method of birth control such as hysterectomy,	
SOCIAL_HX	UNKNOWN_FAM_HX_YN	Y if the patient's family history is unknown by the patient. N otherwise.	
SOCIAL_HX	YEARS_EDUCATION	The number of years of education the patient has completed. Note: This is a	
SURGICAL_HX	LAST_UPDATE_DATE	The time this patient history record was pulled into enterprise reporting or	
SURGICAL_HX	LINE	The line number for the information associated with this contact. Multiple	
SURGICAL_HX	PATIENT_ID	Unique identifier for each patient; used	
SURGICAL_HX	PROC_CODE	Procedure code documented in the	
SURGICAL_HX	PROC_ID	The unique ID of the procedure record (EAP .1) associated with the surgical history contact. Note: This is NOT the	
SURGICAL_HX	PROC_NAME	Procedure name documented in the	
SURGICAL_HX	SHX_CONTACT_DATE	The contact date of the encounter associated with this surgical history contact. Note: There may be multiple	
SURGICAL_HX	SHX_LINK_VISIT_ID	The Contact Serial Number of the encounter in which the history was created/edited. If the history was	
SURGICAL_HX	SHX_SURGICAL_VISIT_ID	Stores the contact serial number of the surgery contact related to the current	
SURGICAL_HX	SHX_VISIT_ID	A unique serial number for this	
SURGICAL_HX	SURGICAL_HX_DATE	The free-text date entered in clinical system’s Surgical History window for the procedure. This field is free-text	

SURGICAL_HX	SURGICAL_HX_SRC	The category description for the surgical history's source for the patient	
SURGICAL_HX	SURGICAL_HX_SRC_CODE	The category code for the surgical history's source for the patient record.:	
VISIT	ACCOMMODATION_ICU	Indicator if the patient was in an ICU for the patient encounter: Y for yes,	
VISIT	ACCOUNT_NUM	Hospital accounting record for the	
VISIT	ADMIT_DATE	First contact date for the encounter - Clarity: PAT_ENC_HSP.ADT_ARRIVAL_TIME, HSP_ACCOUNT	
VISIT	ADMIT_PROV_ID	The admitting provider identifier for the	
VISIT	ADMIT_SOURCE	Category for hospital admission source: 1 (UB01 - SELF REFERRAL),	Y
VISIT	ADMIT_TYPE	Category for hospital admission source: 1 (EMERGENCY), 2	Y
VISIT	ADVANCED_DIRECTIVE	The advance directive category: Y for	
VISIT	AGE_DAYS	Calculated age in days (rounded) based on date of birth and admit date.	
VISIT	AGE_YEARS	Calculated age in years (rounded) based on date of birth and admit date.	Y
VISIT	APRDRG	The Diagnosis-Related Group (DRG) value uses the All Patient Refined	
VISIT	APR_DRG_ID	The DRG identifier links to the	
VISIT	ATTEND_PROV_ID	The attending provider identifier for the	
VISIT	CHIEF_COMPLAINT	Not populated for EPIC source, concsider VISIT_REASON for EPIC	
VISIT	DISCHARGE_DATE	Discharge date for the encounter - Clarity: PAT_ENC.DISCHARGE_DATE_DT,	
VISIT	DISCH_DISP	Category for disharge disposition: 1 (DIS HOME W/DME ONLY), 200 (DIS RESUME HOME HEALTH), 201	Y
VISIT	ENCOUNTER_TYPE	Category type for the patient encounter: 3 (HOSPITAL ENCOUNTER), 101 (OFFICE VISIT),	Y
VISIT	FINANCIAL_CLASS	Category for the financial class: 100 (BLUE CROSS BLUE SHIELD), 300	Y
VISIT	HOSPITAL_SERVICE	Category for the medical service: 225 (DRM-DERMATOLOGY),227 (MED-	Y
VISIT	INPATIENT_DATA_ID	Unique id to link related items to the	
VISIT	LAST_UPDATE_DATE	The last update timestamp for the	
VISIT	LENGTH_OF_STAY	Length of stay in days for the patient	
VISIT	LIVING_WILL	The living well category: Y for Yes, N	
VISIT	MSDRG	The Diagnosis-Related Group (DRG) value uses the CMS Medicare	Y
VISIT	MS_DRG_ID	The DRG identifier links to the	
VISIT	ORGAN_DONOR	The organ donor category: Y for Yes,	

VISIT	PATIENT_CLASS	Base classification of the patient visit: I (INPATIENT), O (OUTPAITIENT), E	Y
VISIT	PATIENT_ID	Unique identifier for each patient; used	
VISIT	PATIENT_TYPE	Further classification of the patient visit: 104 (OBSERVATION), 107	Y
VISIT	PCP_PROV_ID	The primary care provider identifier for	
VISIT	PRI_PROV_ID	The prinicipal provider identifier for the	
VISIT	READMIT_IND	Place holder, not populated in EPIC	
VISIT	REFER_PROV_ID	The referring provider identifier for the	
VISIT	SERVICING_DEPT	Category for the servicing department : 1700124 (MUSC ED 1 WEST	
VISIT	SERVICING_FACILITY	Category for the default servicing facility where the patient is regularly seen: 10001 (UNIVERSITY	
VISIT	SERVICING_LOCATION	The unique ID of the facility that was the place of service for this encounter.	
VISIT	VISIT_ID	Unique identifier for the patient	
VISIT	VISIT_STATUS	Status of the appointment or visit: 2	
VISIT_MEASURE	BMI	The Body Mass Index stored in the patient record, calculated by source	
VISIT_MEASURE	BP_DIASTOLIC	Blood pressure diastolic reading (bottom number when expressed as a	
VISIT_MEASURE	BP_SYSTOLIC	Blood pressure systolic reading (top number when expressed as a ratio).	
VISIT_MEASURE	BSA	The Body Surface Area, which is calculated based on the recorded	
VISIT_MEASURE	CONTACT_DATE	The date for the contact	
VISIT_MEASURE	ENCOUNTER_TYPE	Category type for the patient encounter: HOSPITAL ENCOUNTER,	
VISIT_MEASURE	HEIGHT	The patient’s height as recorded during this encounter. This field is a	
VISIT_MEASURE	INPATIENT_DATA_ID	Unique id to link related items to the	
VISIT_MEASURE	LAST_UPDATE_DATE	The last update timestamp for the	
VISIT_MEASURE	LMP_CATEGORY	The category value associated with alternative information entered in the LMP field of a clinical system encounter regarding the patient's	
VISIT_MEASURE	LMP_DATE	The date of the patient’s Last Menstrual Period. Only contains data	
VISIT_MEASURE	MEASURE_DATE	The best timestamp associated with the measure: VITAL_TAKEN_TM, HOSP_ADMSN_TIME,CHECKIN_TIM	
VISIT_MEASURE	PAIN_LOCATION	Contains information about regarding the body part where the patient is	
VISIT_MEASURE	PAIN_SCALE	The pain scale category under which	
VISIT_MEASURE	PAIN_SCORE	Indicates how much pain the patient is in at the time of the encounter/	
VISIT_MEASURE	PATENC_VISIT_ID	The contact serial number associated with the patient contact on this visit.	

VISIT_MEASURE	PATIENT_ID	The ID number of the patient for the encounter. Used to link to other tables.	
VISIT_MEASURE	PULSE	Patient pulse (heart rate) in beats per	
VISIT_MEASURE	RESPIRATIONS	Patient respirations per minute.	
VISIT_MEASURE	SPO2	The oxygen saturation	
VISIT_MEASURE	TEMPERATURE	The patient's temperature taken during this encounter in degrees Fahrenheit.	
VISIT_MEASURE	TEMPERATURE_SOURCE	The source of the patient's temperature: ORAL, RECTAL,	
VISIT_MEASURE	VISIT_CATEGORY	Category of appointment: RETURN PATIENT, NURSE VISIT,	
VISIT_MEASURE	VISIT_STATUS	Status of the appointment: Completed,	
VISIT_MEASURE	WEIGHT	Patient weight in ounces. Divide this number by 16 to report the patient's	
VISIT_REASON	ADMIT_DATE	Admit date for the encounter - Clarity: PAT_ENC.HOSP_ADMSN_TIME,	
VISIT_REASON	CONTACT_DATE	The contact date of the encounter associated with this reason for visit. Note: There may be multiple	
VISIT_REASON	DISCHARGE_DATE	Discharge date for the encounter - Clarity: PAT_ENC.HOSP_DISCHRG_TIME,DI	
VISIT_REASON	LAST_UPDATE_DATE		
VISIT_REASON	LINE	The line number of the reason for visit	
VISIT_REASON	PATIENT_ID	Unique identifier for each patient; used	
VISIT_REASON	REASON_CMT	The comments associated with the reason for visit entered in an clinical	
VISIT_REASON	REASON_ID	The ID of the record associated with the Reason for Visit entered in an	
VISIT_REASON	REASON_NAME	The reason for visit associated with this patient encounter, such as	
VISIT_REASON	REASON_OTHER	The custom reason for visit entered when the clinical system user chooses	
VISIT_REASON	VISIT_DATE_REAL	This is a numeric representation of the date of this encounter in your system. The integer portion of the number specifies the date of the encounter.	
VISIT_REASON	VISIT_ID	Unique identifier for the patient	
VISIT_REASON	VISIT_STATUS	Status descriptom of the appointment or visit: COMPLETED (2), ARRIVED	
VISIT_REASON	VISIT_STATUS_CODE	Status code of the appointment or visit: 2 (COMPLETED), 6 (ARRIVED),	
VITAL	AGGREGATE_GROUP	Statistical grouping for the observations. Examples: MIN, MAX,	
VITAL	BMI	The body mass index stored in the patient record, calculated by source	Y
VITAL	BP_DIASTOLIC	Blood pressure diastolic reading (bottom number when expressed as a	Y

VITAL	BP_METHOD	Method blood pressure was taken. Example: Manual, Machine, Doppler,	
VITAL	BP_SYSTOLIC	Blood pressure systolic reading (top number when expressed as a ratio).	Y
VITAL	HEART_RATE_SOURCE	The source for the pulse reading	
VITAL	HEIGHT	Height in inches.	Y
VITAL	OBSERVATION_DATE	The day the readings were measured.	
VITAL	PATIENT_ID	Unique identifier for each patient; used	
VITAL	PATIENT_POSITION	Patient orthostatic position when the set of readings were taken: Examples:	
VITAL	PULSE	Patient pulse (heart rate) in beats per	Y
VITAL	RESP_RATE	Patient respirations per minute	Y
VITAL	SPO2	Pulse oximetry	Y
VITAL	TEMPERATURE	Temperature in degrees F ??	Y
VITAL	TEMP_SOURCE	Source for the temperature reading: numeric values 1 (Oral), 2 (Tympanic),	
VITAL	VISIT_ID	Unique identifier for the patient billing encounter or the observation	
VITAL	WEIGHT	Weight in ounces	Y
VITAL	WEIGHT_METHOD	Method used for the weight reading.	

RDW - Hollings Cancer Center Registry Tables

TABLE_NAME	COMMENTS
CYCLE	The CYCLE table contains treatment details for patients from the MUSC Cancer Registry (HCC).
DRUG	The DRUG table contains medication treatment details for each cycle of treatment from the MUSC Cancer Registry (HCC).
PATIENT	The PATIENT table contains one record for each patient in the MUSC Cancer Center Registry.
RADIATION	The RADIATION table contains radiation treatment (RT) details for patients from the MUSC Cancer Registry (HCC).
TREATMENT	The TREATMENT table contains treatment details on tumors from the MUSC Cancer Registry (HCC).
TREATMENT_SMRY	The TREATMENT_SMRY table contains first course of treatment information on tumors from the MUSC Cancer Registry (HCC).
TUMOR	The TUMOR tables contains the cancer identification, stage/prognostic factors on tumors from the MUSC Cancer Registry (HCC).
TUMOR_2	The TUMOR_2 table contains the additional stage/prognostic factors on tumors from the MUSC Cancer Registry (HCC).

Hollings Cancer Center Registry/i2b2 Fields

TABLE_NAME	COLUMN_NAME	COMMENTS	IN_I2B2
CYCLE	BSA	BSA	
CYCLE	CYCLE_NUM	Cycle Number	
CYCLE	CYCLE_SEQ	Cycle Sequence Number	
CYCLE	CYCLE_STRT_DATE	Cycle Start Date	
CYCLE	CYCLE_HOSP_ID	Hospital identifier where treatment occurred	
CYCLE	MFAC_CYCLE_ID	Multi-Facility identifier	
CYCLE	MFAC_CYCLE_FAC_NUM	Multi-Facility, Facility Number for Cycle	
CYCLE	CYCLE_ID	Unique identifier assigned to each cycle –	
CYCLE	TREATMENT_ID		
DRUG	DAILY_DOSE	(CER) Daily Dosage	
DRUG	DAYS_GIVEN	(CER) Days Given/Number Doses Received	
DRUG	CER_DRUG_END_DATE	(CER) Drug End Date	
DRUG	CER_DRUG_END_DATE_FLAG	(CER) Drug End Date Flag	
DRUG	CER_DRUG_START_DATE	(CER) Drug Start Date	
DRUG	CER_DRUG_START_DATE_FLAG	(CER) Drug Start Date Flag	
DRUG	NSC_SUBCODE	(CER) NSC ID SubCode	
DRUG	NSC	(CER) NSC Number	
DRUG	TOT_DOSAGE	(CER) Received Total Dosage	
DRUG	DOSE_UNITS	Dose Units	
DRUG	DRUG_SEQ	Drug Sequence Number	
DRUG	DRUG_ROUTE	Drug route	
DRUG	DRUG_HOSP_ID	Hospital identifier where drug received	
DRUG	MFAC_DRUG_ID	Multi-Facility identifier	
DRUG	MFAC_DRUG_FAC_NUM	Multi-Facility, Facility Number for Drug	
DRUG	CYCLE_ID	Unique identifier assigned to each cycle	
DRUG	DRUG_ID	Unique identifier assigned to each drug	
PATIENT	HCC_ACCESSION_NUM	Accession Year 1st Primary plus Accession Number produces a unique sequence;	
PATIENT	AUTOPSY	Autopsy; NaaccrID 1930	
PATIENT	GENDER	Cancer registry gender codes: 1 Male, 2 Female, 3 Other, 4 Transexual, 9 Unknown;	Y
PATIENT	GENDER	Cancer registry gender codes: 1 Male, 2 Female, 3 Other, 4 Transexual, 9 Unknown;	Y
PATIENT	ICD_CODE	Cause of Death (Underlying Cause of Death (ICD Code)); NaaccrID 1910	
PATIENT	BIRTH_DATE	Date of Birth; NaaccrID 240	
PATIENT	LAST_CONTACT_DATE	Date of Last Contact or Death; NaaccrID	
PATIENT	ICD_REV	ICD Revision Number; NaaccrID 1920	
PATIENT	DEATH_MATCH	Indicates if Death Match was run	
PATIENT	HCC_PATIENT_MRN	Medical Record/Chart No.from HCC source;	
PATIENT	PAT_FIRST_NAME	Patient First Name; NaaccrID 2240	
PATIENT	PAT_LAST_NAME	Patient Last Name; NaaccrID 2230	

PATIENT	PAT_MIDDLE_NAME	Patient Middle Name; NaaccrID 2250	
PATIENT	SSN	Social Security Number; NaaccrID 2320	
PATIENT	HCC_PATIENT_SYSTEMID	Unique identifier for each patient from HCC source; appears as Pateint ID in the Metriq	
PATIENT	PATIENT_ID	Unique internal identifier for each patient from EPIC source; used to link to other RDM	
PATIENT	HCC_PATIENT_ID	Unique internal identifier for each patient from HCC source; used to link to other HCC	
PATIENT	VITAL_STATUS	Vital Status; NaaccrID 1760	
RADIATION	RT_BOOST_MODALITY	Boost RT Modality	
RADIATION	RADIATION_HOSPIID	Hospital ID	
RADIATION	RT_LOCATION	Location of Radiation Treatment	
RADIATION	MFAC_RAD_ID	Multi-Facility identifier	
RADIATION	MFAC_RAD_FAC_NUM	Multi-Facility, Facility Number for Radiation	
RADIATION	RT_TOT_FRACT	Number of Treatments to this Volume	
RADIATION	RT_BOOST_DOSE	RT Boost Dose: cGy	
RADIATION	RT_MODALITY	RT Regional Treatment Modality	
RADIATION	RT_DAYS	Radiation Elapsed Treatment Time (Days)	
RADIATION	RAD_SEQ	Radiation Sequence Number	
RADIATION	RT_STOP_DATE	Radiation treatment (RT) end date	
RADIATION	RT_SITE	Radiation treatment (RT) site	
RADIATION	RT_START_DATE	Radiation treatment (RT) start date	
RADIATION	RT_VOLUME	Radiation treatment (RT) volumne	
RADIATION	RT_REG_DOSE	Regional Dose: cGy	
RADIATION	RADIATION_ID	Unique identifer for the radiation treatment,	
RADIATION	TREATMENT_ID	Unique identifier assigned to each treatment	
TREATMENT	RX_CODE	(Rx) Code	
TREATMENT	RX_START_DATE	(Rx) Start Date – where Rx equals the	
TREATMENT	RX_SUBCODE	(Rx) Sub Code	
TREATMENT	ANCIL_RX_START_DATE	Ancillary Therapy Start Date	
TREATMENT	RX_COURSE	Course of treatment	
TREATMENT	TREATMENT_HOSP_ID	Hospital ID where therapy performed	
TREATMENT	RX_THIS_FAC	Indicates whether treatment performed at this	
TREATMENT	MFAC_RX_ID	Multi-Facility identifier	
TREATMENT	MFAC_RX_FAC_NUM	Multi-Facility, Facilty Number for Treatment	
TREATMENT	REG_LN_REMVD	Number of Regional Lymph Nodes Removed	
TREATMENT	PROT_ELIG	Protocol Eligibility Status	
TREATMENT	PROTOCOL	Protocol Participation	
TREATMENT	PROT_TYPE	Protocol type	
TREATMENT	RECON_SURG	Reconstruction/Restoration – First Course	
TREATMENT	RX_INPT_OUTPT	Record if treatment was done as an inpatient	
TREATMENT	RX_MD1	Rx Physician 1	
TREATMENT	RX_MD2	Rx Physician 2	
TREATMENT	SCP_LN_CODE	Scope Reg Lymph Nodes (LN) Surgery	
TREATMENT	OTHER_CODE	Surgery Other Site	
TREATMENT	APPROACH	Surgical Approach	
TREATMENT	SURG_MARG	Surgical Margins	
TREATMENT	RX_TYPE	Treatment Modality	

TREATMENT	TRX_SEQ	Treatment Sequence Number	
TREATMENT	TREATMENT_ID	Unique identifier assigned to each treatment;	
TREATMENT	TUMOR_ID	Unique identifier assigned to each tumor	
TREATMENT_SMRY	FIRST_SURG_DATE	Date of First Surgery; NaaccrID 1200	
TREATMENT_SMRY	MST_DEF_CHEMO_DATE	Most definitive 1st Course Chemotherapy date; NaaccrID 1220	Y
TREATMENT_SMRY	MST_DEF_CHEMO_SUMM	Most definitive 1st Course Chemotherapy summary; NaaccrID 1390	Y
TREATMENT_SMRY	MST_DEF_RT_DATE	Most definitive 1st Course Date Radiation	Y
TREATMENT_SMRY	MST_DEF_DX_STAGE_SUMM	Most definitive 1st Course Diagnostic/Staging Procedure summary; NaaccrID 1350	Y
TREATMENT_SMRY	MST_DEF_HORM_DATE	Most definitive 1st Course Hormone therapy	Y
TREATMENT_SMRY	MST_DEF_HORM_SUMM	Most definitive 1st Course Hormone therapy summary; NaaccrID 1400	Y
TREATMENT_SMRY	MST_DEF_IMMUNO_DATE	Most definitive 1st Course Immunotherapy date; NaaccrID 1240	Y
TREATMENT_SMRY	MST_DEF_IMMUNO_SUMM	Most definitive 1st Course Immunotherapy summary; NaaccrID 1410	Y
TREATMENT_SMRY	MST_DEF_OTH_RX_DATE	Most definitive 1st Course Other therapy date; NaaccrID 1250	Y
TREATMENT_SMRY	MST_DEF_OTH_RX_SUMM	Most definitive 1st Course Other therapy summary; NaaccrID 1420	Y
TREATMENT_SMRY	MST_DEF_PALL_SUMM	Most definitive 1st Course Palliative care	Y
TREATMENT_SMRY	MST_DEF_RT_SUMM	Most definitive 1st Course Radiation	Y
TREATMENT_SMRY	MST_DEF_SCOPE_LN_SUMM	Most definitive 1st Course Scope Regional Lymph Nodes summary; NaaccrID 1292	Y
TREATMENT_SMRY	MST_DEF_SURG_OTH_SUMM	Most definitive 1st Course Surg Other Reg Dist summary; NaaccrID 1294	Y
TREATMENT_SMRY	MST_DEF_SURG_PRIM_SUMM	Most definitive 1st Course Surgery this Primary Site summary; NaaccrID 1290	Y
TREATMENT_SMRY	MST_DEF_TRNSPLNT_SUMM	Most definitive 1st Course Transplant/Endocrine summary; NaaccrID	Y
TREATMENT_SMRY	MST_DEF_MARGINS_SUMM	Most definitive Final Surgical Margins summary; NaaccrID 1320	Y
TREATMENT_SMRY	RT_SRG_SEQ	RTSurgery Sequence; NaaccrID 1380	Y
TREATMENT_SMRY	RT_CNS	Radiation Therapy to Central Nervous	Y
TREATMENT_SMRY	TREATMENT_STATUS_SUMM	Rx Summ - Treatment Status; NaaccrID 1285	
TREATMENT_SMRY	SYS_SRG_SEQ	Systemic/Surg Sequence; NaaccrID 1639	Y
TREATMENT_SMRY	TUMOR_ID	Unique identifier assigned to each tumor;	
TREATMENT_SMRY	HCC_PATIENT_ID	Unique internal identifier for each patient from HCC source; used to link to other HCC	
TUMOR	CS_SSFACTOR1	CS Site - Specific Factor 1; NaaccrID 2880	Y
TUMOR	CS_SSFACTOR2	CS Site - Specific Factor 2; NaaccrID 2890	Y
TUMOR	CS_SSFACTOR3	CS Site - Specific Factor 3; NaaccrID 2900	Y
TUMOR	CS_SSFACTOR4	CS Site - Specific Factor 4; NaaccrID 2910	Y
TUMOR	CS_SSFACTOR5	CS Site - Specific Factor 5; NaaccrID 2920	Y
TUMOR	CS_SSFACTOR6	CS Site - Specific Factor 6; NaaccrID 2930	Y
TUMOR	CS_SSFACTOR10	CS Site – Specific Factor 10; NaaccrID 2864	Y

TUMOR	CS_SSFACTOR11	CS Site – Specific Factor 11; NaaccrID 2865	Y
TUMOR	CS_SSFACTOR12	CS Site – Specific Factor 12; NaaccrID 2866	Y
TUMOR	CS_SSFACTOR13	CS Site – Specific Factor 13; NaaccrID 2867	Y
TUMOR	CS_SSFACTOR14	CS Site – Specific Factor 14; NaaccrID 2868	Y
TUMOR	CS_SSFACTOR15	CS Site – Specific Factor 15; NaaccrID 2869	Y
TUMOR	CS_SSFACTOR16	CS Site – Specific Factor 16; NaaccrID 2870	Y
TUMOR	CS_SSFACTOR17	CS Site – Specific Factor 17; NaaccrID 2871	Y
TUMOR	CS_SSFACTOR18	CS Site – Specific Factor 18; NaaccrID 2872	Y
TUMOR	CS_SSFACTOR19	CS Site – Specific Factor 19; NaaccrID 2873	Y
TUMOR	CS_SSFACTOR20	CS Site – Specific Factor 20; NaaccrID 2874	Y
TUMOR	CS_SSFACTOR21	CS Site – Specific Factor 21; NaaccrID 2875	Y
TUMOR	CS_SSFACTOR22	CS Site – Specific Factor 22; NaaccrID 2876	Y
TUMOR	CS_SSFACTOR23	CS Site – Specific Factor 23; NaaccrID 2877	Y
TUMOR	CS_SSFACTOR24	CS Site – Specific Factor 24; NaaccrID 2878	Y
TUMOR	CS_SSFACTOR25	CS Site – Specific Factor 25; NaaccrID 2879	Y
TUMOR	CS_SSFACTOR7	CS Site – Specific Factor 7; NaaccrID 2861	Y
TUMOR	CS_SSFACTOR8	CS Site – Specific Factor 8; NaaccrID 2862	Y
TUMOR	CS_SSFACTOR9	CS Site – Specific Factor 9; NaaccrID 2863	Y
TUMOR	TUMOR_STATUS	Cancer Status; NaaccrID 1770	
TUMOR	AJCC_STAGE_GROUP_CLIN	Clinical Stage Group; NaaccrID 970	Y
TUMOR	CLIN_M_TNM	Clinical TNM M; NaaccrID 960	Y
TUMOR	CLIN_N_TNM	Clinical TNM N; NaaccrID 950	Y
TUMOR	CLIN_T_TNM	Clinical TNM T; NaaccrID 940	Y
TUMOR	RECURRENCE_DATE_FIRST	Date 1st Recurrence; NaaccrID 1860	
TUMOR	LAST_CHANGED_DATE	Date Case Last Changed; NaaccrID 2100	
TUMOR	DX_DATE	Date of Initial Diagnosis; NaaccrID 390	
TUMOR	DERIVED_AJCC7_M_DESC	Derived AJCC-7 M Descript; NaaccrID 3422	
TUMOR	DERIVED_AJCC7_M	Derived AJCC-7 M; NaaccrID 3420	Y
TUMOR	DERIVED_AJCC7_N_DESC	Derived AJCC-7 N Descript; NaaccrID 3412	
TUMOR	DERIVED_AJCC7_N	Derived AJCC-7 N; NaaccrID 3410	Y
TUMOR	DERIVED_AJCC7_STAGE_GRP	Derived AJCC-7 Stage Group; NaaccrID 3430	Y
TUMOR	DERIVED_AJCC7_T_DESC	Derived AJCC-7 T Descript; NaaccrID 3402	
TUMOR	DERIVED_AJCC7_T	Derived AJCC-7 T; NaaccrID 3400	Y
TUMOR	DSC_AJCC_STAGE7	Descriptive Derived AJCC Stage Group 7;	
TUMOR	RECURRENCE_DIST_SITE1	Distant Site 1 - 1st Recurrence; NaaccrID 1871	
TUMOR	GRADE	Grade/Differentiation; NaaccrID 440	Y
TUMOR	HISTOLOGY	Histology/Behavior ICDO3; NaaccrID 521	Y
TUMOR	LATERALITY	Laterality; NaaccrID 410	
TUMOR	AJCC_STAGE_GROUP_PATH	Pathologic Stage Group; NaaccrID 910	Y
TUMOR	PATH_M_TNM	Pathologic TNM M; NaaccrID 900	Y
TUMOR	PATH_N_TNM	Pathologic TNM N; NaaccrID 890	Y

TUMOR	PATH_T_TNM	Pathologic TNM T; NaaccrID 880	Y
TUMOR	PRIMARY_SITE	Primary Site; NaaccrID 400	Y
TUMOR	SEQ_PRIMARY	Sequence Primary; NaaccrID 560	
TUMOR	HISTOLOGY_SUBCODE	SubCode for Histology/ Behavior ICDO3;	Y
TUMOR	PRIMARY_SITE_SUBCODE	SubCode for Primary Site; NaaccrID -1	
TUMOR	TUMOR_SEQ	Tumor Sequence Number; NaaccrID 60	Y
TUMOR	RECURRENCE_TYPE_FIRST	Type 1st Recurrence; NaaccrID 1880	Y
TUMOR	TUMOR_ID	Unique identifier assigned to each tumor;	
TUMOR	HCC_PATIENT_ID	Unique internal identifier for each patient from HCC source; used to link to other HCC	
TUMOR_2	TX_SUMM_FIRST	1st Course Rx Summary	
TUMOR_2	DX_AGE	Age at Diagnosis (Calculated); NaaccrID 230	
TUMOR_2	ALCOHOL	Alcohol History	
TUMOR_2	BEST_STAGE	Best AJCC Stage (Calculated)	
TUMOR_2	BEST_CSTNM_STAGE	Best CS/AJCC Stage; Best stage that considers derived, pathologic and clinical	
TUMOR_2	BEST_CSSUMM_STAGE	Best CS/Summary Stage; Best SEER Summary stage that considers derived,	
TUMOR_2	BEST_SUMM_STAGE	Best SEER General Summary Stage	
TUMOR_2	CS_TUMOR_SIZE	CS Tumor Size; NaaccrID 2800	
TUMOR_2	CASE_STAT_FLAG	Case Status. I (Incomplete), C (Complete), R (Review - Report to State), etc.	
TUMOR_2	CLASS_CASE	Class of Case; NaaccrID 610	
TUMOR_2	COMORBIDITY1	Comorbid/Complication #1; NaaccrID 3110	
TUMOR_2	COMORBIDITY2	Comorbid/Complication #2; NaaccrID 3120	
TUMOR_2	COMORBIDITY3	Comorbid/Complication #3; NaaccrID 3130	
TUMOR_2	COMORBIDITY4	Comorbid/Complication #4; NaaccrID 3140	
TUMOR_2	COMORBIDITY5	Comorbid/Complication #5; NaaccrID 3150	
TUMOR_2	COMORBIDITY6	Comorbid/Complication #6; NaaccrID 3160	
TUMOR_2	D_AJCC_M_DESCR	Derived AJCC M Descriptor; NaaccrID 2990	
TUMOR_2	D_AJCC_M	Derived AJCC M; NaaccrID 2980	
TUMOR_2	D_AJCC_N_DESCR	Derived AJCC N Descriptor; NaaccrID 2970	
TUMOR_2	D_AJCC_N	Derived AJCC N; NaaccrID 2960	
TUMOR_2	D_AJCC_STAGE	Derived AJCC Stage Group ; NaaccrID 3000	
TUMOR_2	D_AJCC_T_DESCR	Derived AJCC T Descriptor; NaaccrID 2950	
TUMOR_2	D_AJCC_T	Derived AJCC T; NaaccrID 2940	
TUMOR_2	DIAGNOSTIC_CONFIRMATION	Diagnostic Confirmation; NaaccrID 490	
TUMOR_2	DSC_AJCC_STAGE	Display String Combination for Derived AJCC Stage Group; NaaccrID 3000	
TUMOR_2	DS_AJCC_STAGE	Display String for Derived AJCC Stage	
TUMOR_2	FAM_HX_CA	Family History of cancer	
TUMOR_2	GRADE_PATH_SYSTEM	Grade Path System; NaaccrID 449	
TUMOR_2	HISTOLOGY_ICDO2	Histology (9200) ICDO2; NaaccrID 420	
TUMOR_2	PCE_NCDS	PCE/NCDS ID	
TUMOR_2	PED_AGE	Pediatric Age	
TUMOR_2	PRIM_SURGEON	Primary Surgeon; NaaccrID 2480	

TUMOR_2	EOD_TUMOR_SIZE	Size of Tumor; NaaccrID 780	
TUMOR_2	HISTOLOGY_ICDO2_SUBCODE	Sub Code for Histology/Behavior ICD-O-2	
TUMOR_2	TX_SUMM_SUB	Subseq Course Rx Summary	
TUMOR_2	SURVIVAL	Survival	
TUMOR_2	TOBACCO	Tobacco History	
TUMOR_2	TUMOR_ID	Unique identifier assigned to each tumor;	
TUMOR_2	HCC_PATIENT_ID	Unique internal identifier for each patient from HCC source; used to link to other HCC	