DEMOGRAPHICS AND PATIENT INFORMATION

Use **black ink only** and **print legibly** or **type** when completing the Confidential Cancer Reporting Form. Some of the instructions in this section apply only to reporting facilities with a cancer registry program.

Some of the entry fields in SANDCRAB LITE (SCL) have Selection Pop-up Boxes that display all the valid inputs for the field. These Selection Pop-up Boxes are in an easy pull down menu format. Underlined fields will 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.

DATE OF FIRST CONTACT (NAACCR Item #580) (FORDS pg. 87)

Description
The date the patient was first admitted to your facility (outpatient or inpatient) with a diagnosis 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.

Coding Instructions

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

  EXAMPLE:

  Record the admit date of January 22, 2003 as 01222003.

- 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.

- 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 to your facility with active cancer.

- For autopsy-only or death certificate-only cases, use the date of death as the date of first contact.

- ACoS facilities should refer to page 87 of the FORDS for specific guidelines. ACoS does not require a date of admission on non-analytical cases, however, **non-analytical cases are reportable to the TCR and an admission date must be provided.**

EXAMPLES:

1. A patient has an outpatient mammography on February 12, 2003 at the reporting facility. The radiologist reads it as suspicious for malignancy. The patient then has an excisional biopsy on February 14, 2003 and a radical surgical procedure on February 16, 2003. Record the date of first contact as 02122003.

2. A patient has a biopsy in a staff physician's office on March 17, 2003 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, 2003 for a wide re-excision. Record the date of first contact as 03172003.

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

Description
A registry number is a unique number assigned to identify each patient.

Explanation
This data item protects the identity of the patient.

Coding Instructions
- To be completed only by SCL users or facilities with a **cancer registry** that maintains an accession register. The TCR will code this field for facilities using the paper reporting form.

- 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:

  200300001 would indicate the first 2003 case reported from a facility.

- SCL automatically assigns a registry number according to the year of admission. This field can be edited to assign the correct registry number.

  NOTE: If your facility begins using SCL after submitting cases on the paper form, contact the appropriate regional program for the correct registry number. This will alleviate duplicate registry numbers being assigned to different patients. The registry number for each individual patient remains the same regardless of the number of **reportable diagnoses** for that patient from your facility.

- **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 Manual for instructions on entering multiple primaries.

TUMOR RECORD NUMBER (NAACCR ITEM #60) (SEER pg. 64)

Description
This field refers to the number of primaries reported by your facility for the same patient.

Explanation
This data item identifies the order in which each primary tumor occurred and how many cases are reported for a particular patient.

Coding Instructions
- Only facilities with a cancer registry that maintain an accession register or SCL users must complete this item. The TCR will code this item for facilities using the paper reporting forms.

- For facilities completing this field, "01" must be used for the first primary reported from your facility. Each additional primary reported for the same patient must be assigned the next higher tumor record number.

  NOTE: Facilities approved (or seeking approval) by the American College of Surgeon's Commission on Cancer (ACoSCoC) are not required to complete this field for their accreditation status. However, the cancer registrar **must** ensure this field is coded as required by the TCR prior to data submission.

CODE	DEFINITION
01	First record
02	Second record
03	Third record
04	Fourth record
..	The actual number of this record

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

Description
Identifies the facility 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
- Enter the three-digit facility number assigned by the TCR.

- If you do not know your facility number, contact your regional program office or the central office in Austin.

REPORTING SOURCE (NAACCR ITEM #500) (SEER pgs. 66-67)

Description
This data item identifies the source documents used to abstract the case being reported.

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, or diagnosed by death certificate only.

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

CODE	DEFINITION OF REPORTING SOURCES
1	Facility Only (Inpatient, Outpatient, ER, or Clinic)
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

NOTE: Assign codes in the following priority: 1, 4, 5, or 3 if more than one source is used.

EXAMPLES:

1. 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.

2. A patient is admitted to your facility and is diagnosed with lung cancer. Code the reporting source to 1 (facility only). 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 primaries on the same patient.

Coding Instructions

- 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.

- 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.

- 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 that the facility plays 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 cancer analysis because those cases were referred to the facility for a cancer recurrence or subsequent therapy.

Coding Instructions

- *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.

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

- *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).

  NOTE: Per TCR reporting guidelines, non-analytical cases are reportable by all facilities if 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	
Class 0	**Diagnosed at the reporting facility and all of first course of treatment was performed elsewhere.** *Cases include:* • Patients who choose to be treated elsewhere. • 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.
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 refused any treatment. • 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.
Class 2	**First diagnosed elsewhere and treatment plan developed and/or 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 developed and documented a treatment plan or made the management decisions.

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 is treating or managing the recurrence, progression, or subsequent treatment of a previously diagnosed malignancy.
Class 4	**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.** *Cases include:* • Patients for whom the reporting facility manages or treats a recurrence or progression of disease after the reference date. • Patients for whom it is unknown whether the reporting facility delivered the first course of treatment prior to the reference date. ***Note*:** This class applies to ACoS facilities and/or facilities with a cancer program and reference date **only**.
Class 5	**First diagnosed at autopsy**. Prior to autopsy, there was no suspicion or diagnosis of cancer.
Class 6	**Diagnosed and the entire first course of treatment completed in a staff physician's office**. **Staff physician** refers to any physician with admitting privileges at the reporting facility.
Class 7	**Pathology report only**. Patient does not enter the reporting facility at any time for diagnosis or treatment. ***Note:*** This category excludes cases diagnosed at autopsy.
Class 8	**Diagnosis established only by death certificate**. ***Note:*** Used by central registries **only**.
Class 9	**Unknown**. Sufficient detail for determining Class of Case is not stated in medical record. • Unknown if previously diagnosed. • Unknown if previously treated. • Previously diagnosed, date unknown. ***Note:*** Used by central registries **only**

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.

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

  EXAMPLES:

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

- Do not leave blank. If the patient's last name is not known, enter UNKNOWN in this field.

  NOTE: Document in **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
- Enter the first name of the patient in **CAPITAL LETTERS**.

- Do not use punctuation.

- If the patient's first name is unknown, leave blank.

  NOTE: Document in **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
- Enter the middle initial if the complete middle name is not provided.
- Do not use punctuation.
- 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.

Coding Instructions
- 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.
- If the patient does not have a maiden name, or it is unknown, leave blank.

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

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

Explanation
It allows for the analysis of cancer clusters or environmental studies.

Coding Instructions
- Enter the number and street of the patient's residence at the time the cancer is diagnosed **in 25 characters or less**.
- Only use the post office box or the rural mailing address when the physical address is not available.

- Punctuation marks are **not** allowed in this field.
- If the address contains more than 25 characters, omit the least important elements, such as the apartment or space number.
- **Do not** omit elements needed to locate the address in a census tract, such as house number, street, direction or quadrant, and street type.

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).

- Abbreviations are limited to those recognized by the USPS standard abbreviations. These include but are not limited to:

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

EXAMPLE:

Patient's street address is 1232 Southwest Independence Apartment 400. Record: 1232 SW Independence Apt 400

- If the patient's address is not recorded in the medical record, record **NO ADDRESS** or **UNKNOWN. Do not** leave blank.

NOTE: Document in **OTHER PERTINENT INFORMATION:** patient address is unknown.

- **Do not** update this data item for the first primary if the patient's address changes with subsequent admissions or subsequent primaries.

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

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.

Explanation
It allows for the analysis of cancer clusters or environmental studies.

Coding Instructions
- Enter the city of residence at the time the cancer is diagnosed.
- 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.
- If the patient has multiple primaries, the address may be different for subsequent primaries.

NOTE: If the patient's address is not recorded in the medical record, enter the city in which your facility is located. Every effort should be made to record the patient's address from resources available in your facility.

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

Description
Identifies the patient's state of residence at the time of diagnosis/admission.

Explanation
It allows for the analysis of cancer clusters or environmental studies.

Coding Instructions
- Record the appropriate **two-letter abbreviation** for state of residence at the time of diagnosis.
- 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 next page for a list of Canadian Provinces/Territories.
- 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 on the next page for specific instructions.
- If the patient has multiple primaries, the state of residence may be different for subsequent cases.

NOTE: If the medical record has no patient address, enter the state in which your facility is

located. Every effort should be made to record the patient's address from resources available in your facility.

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.
CN	Resident of Canada, NOS
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 **known.**
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Mexico and Canada, and the country is **unknown.**
ZZ	Resident of U.S., NOS (including its territories, commonwealths, or possessions); residence unknown

EXAMPLES:

1. A patient's country of residence is documented as France; record XX in the **STATE** field.

2. 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.

3. 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 ZZ in the **STATE** field.

4. The patient's medical record gives no indication if the patient lives in the United States or a foreign country; record TX in the **STATE** field.

CANADIAN PROVINCES/TERRITORIES

PROVINCE/TERRITORY		PROVINCE/TERRITORY	
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	
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	
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.

Explanation
It allows for the analysis of cancer clusters or environmental studies.

Coding Instructions

- 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 the zip code is not available, refer to the *National Zip Code Directory* or to the USPS Web site, http://www.usps.gov.

- If the patient is a resident of foreign country at the time of diagnosis, record **88888** for the zip code.

NOTE: If the patient's address is not recorded in the medical chart, enter the zip code in which your facility is located. Every effort should be made to record the patient's address from resources available in your facility.

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 *National Zip Code Directory* of the USPS Web site.

EXAMPLES:

1. A patient's country of residence is documented as France; record 88888 in the **ZIP CODE** field.
2. A patient's address is in Canada and the zip code cannot be verified; record 99999 in the **ZIP CODE** field.
3. A patient's address is not documented in the medical record and remains unknown after researching all your facilities' resources; record your facilities' zip code 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.

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

Coding Instructions

- Enter the appropriate three-digit code for the county of residence.
- Refer to *Appendix E* for the list of Texas FIPS county codes.
- If the patient has multiple primaries, the FIPS county codes may be different for each primary.
- Enter the three-digit code 998 for an out-of-state or foreign country resident.
- For facilities using SCL, the FIPS code will automatically display when the city and zip is entered.
- Do not update this data item if the patient's county of residence changes.

NOTE: If the patient's address is not recorded in the medical chart, enter the FIPS county code where your facility is located. Every effort should be made to record the patient's address from resources available in your facility.

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 **AND** 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 to match and consolidate records.

Coding Instructions
- Every effort should be made to obtain the Social Security number.
- Enter the patient's nine-digit Social Security number in this field.
- If the Social Security number is unavailable or unknown, enter all 9's in this field.
- 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.

EXAMPLE:

A wife may be registered under her husband's Medicare account number e.g. 584-24-4457**B** or 584-24-4457**D**. In this case, record all "9's".

CODE	DEFINITION
123456789	Record the patient's Social Security number (SSN) without dashes.
999999999	Use when the patient does not have a Social Security number, or the information is not available. **Do not** code with "000000000" or "888888888" if Social Security number is unknown.

DATE OF BIRTH (NAACCR ITEM #240) (FORDS pg. 57; SEER pg. 77)

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

Explanation
This item is used by the TCR to match records.

Coding Instructions
- Punctuation marks (slashes, dashes, etc.) are not allowed.
- The patient's date of birth **must be entered.** Cases cannot be processed without the date of birth.
- If month and/or day of birth are not known, code 9's; the year **must** be entered in full.

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:

1. The patient's date of birth is June 30, 1899, record 06301899.
2. The patient is admitted on June 15, 2003 and states he is 60 years old. The medical record does not have a date of birth. Subtract 60 from 2003 to calculate the year of birth as 1943 and record 99991943 as the date of birth.
3. The medical record contains only the year of birth – 1927; record 99991927 as the date of birth.

PLACE OF BIRTH (NAACCR ITEM #250) (FORDS pg. 56; SEER pg. 76)

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
- Use the most specific code.
- Record the patient's place of birth (if available) using the SEER Geo-codes in *Appendix K*. If the

place of birth is unknown, code to "999".

> ***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. 79-80)

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.

Coding Instructions

- Record the two-digit code to identify the primary race of the patient.
- Race 1 is the field used to compare with race data on cases diagnosed prior to January 1, 2001.

  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.
- If the patient is multi-racial, then code all races using *Race 2* through *Race 5.*
- For cases diagnosed **prior to January 1, 2001,** Race 2 through Race 5 must be blank. For cases (including second primaries for the same patient) diagnosed **after January 1, 2001,** Race 2 through Race 5 must be coded.

CODE	RACE	CODE	RACE
01	White	20	Micronesian, NOS
02	Black	21	Chamorran
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

CODE	RACE	CODE	RACE
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean (Cambodian)	98	Other
14	Thai	99	Unknown

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

EXAMPLES:

RACE CODE	EXPLANATION
01	A patient was born in Mexico of Mexican parentage.
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 the person's primary race as Chinese and code the other race in *Race 2* as appropriate. In this case, Korean to *Race 2*.
05	A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded in *Race 2)*. If a person's race is recorded as a combination of white and any other race, code "05"(Japanese) in the *Race 1* field and the code Caucasian as "01" in the *Race 2* field.
05	When the race is recorded as "Oriental," "Mongolian," 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.
99	A patient's race is unknown. *Race 2* through *Race 5* must also be 99.

RACE 2 (NAACCR ITEM #161) (FORDS pg. 61; SEER pgs. 79-80)

Description
Identifies the patient's additional race.

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
- Record the two-digit code to identify a multi-racial patient.
- "Race" is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. All tumors for the same patient should have the same race code.

- For cases diagnosed **prior to January 1, 2001,** *Race 2* through *Race 5* must be blank. For cases, including second primaries for the same patient, diagnosed **after January 1, 2001,** *Race 2* through *Race 5* must be coded.

  ***NOTE*:** 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**.

  NOTE: Please refer to the table on page 46 for the appropriate Race codes.

RACE 3 (NAACCR ITEM #162)(FORDS pg. 62; SEER pgs. 79-80)

Description
Identifies the patient's additional race.

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
- Record the two-digit code to identify a multi-racial patient.

- "Race" is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. All tumors for the same patient should have the same race code.

- For cases diagnosed **prior to January 1, 2001,** *Race 2* through *Race 5* must be blank. For cases (including second primaries for the same patient) diagnosed **after January 1, 2001,** *Race 2* through *Race 5* must be coded.

  ***NOTE*:** 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**.

  NOTE: Please refer to the table on page 46 for the appropriate Race codes.

RACE 4 (NAACCR ITEM #163) (FORDS pg. 63; SEER pgs. 79-80)

Description
Identifies the patient's additional race.

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
- Record the two-digit code to identify a multi-racial patient.

- "Race" is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. All tumors for the same patient should have the same race code.

- For cases diagnosed **prior to January 1, 2001,** *Race 2* through *Race 5* must be blank. For cases (including second primaries for the same patient) diagnosed **after January 1, 2001,** *Race 2* through *Race 5* must be coded.

  ***NOTE*:** 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**.

  NOTE: Please refer to the table on page 46 for the appropriate Race codes.

RACE 5 (NAACCR ITEM #164) (FORDS pg. 64; SEER pgs. 79-80)

Description
Identifies the patient's additional race.

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
- Record the two-digit code to identify a multi-racial patient.

- "Race" is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. All tumors for the same patient should have the same race code.

- For cases diagnosed **prior to January 1, 2001,** *Race 2* through *Race 5* must be blank. For cases (including second primaries for the same patient) diagnosed **after January 1, 2001,** *Race 2* through *Race 5* must be coded.

  ***NOTE*:** 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**.

NOTE: Please refer to the table on page 46 for the appropriate Race codes.

SPANISH/HISPANIC ORIGIN (NAACCR ITEM #190) (FORDS pg. 65; SEER pg. 81)

Description
Identifies persons of Spanish or Hispanic origin.

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
- The information is coded from the medical record or is based on Spanish/Hispanic names.
- Review all sources available to determine the correct code, including stated ethnicity as Hispanic origin on the death certificate, birthplace and information about life history and language spoken.
- Refer to the list of Spanish/Hispanic surnames in *Appendix J*.

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.
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.

- Use **codes 1–5** if specific ethnicity is known.
- Use **code 6** when you know the patient is Hispanic but cannot classify him/her to **codes 1-5**.

- Use **code 7** if race in medical record is classified as White and he/she has a Spanish/Hispanic last name.

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

EXAMPLES:

1. Patient's last name is Gonzales and the medical record states the patient was born in Mexico, code to 1.

2. Patient's medical record states race as Hispanic, without mention of whether his/her origin was Mexico, Puerto Rico, Cuba, etc., code to 6.

3. 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. 83)

Description
Identifies the gender of the patient.

Explanation
The code must be gender-specific to the primary site e.g., prostate carcinoma – male; ovarian carcinoma – female.

Coding Instructions
- 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

OTHER PERTINENT INFORMATION (NAACCR ITEM #2680)

Document the patient's disease when there is not adequate or appropriate space on the reporting form. 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.

Document the name of the facility that referred the patient to your facility and the name of the facility that the patient was referred to for further care.

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.

Coding Instructions

- Document the name of the facility that referred the patient to **your** facility under **OTHER PERTINENT INFORMATION**.

- If the facility is unknown or the patient was not referred, also document this under **OTHER PERTINENT INFORMATION**.

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

EXAMPLE:

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.

***NOTE*:** 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 **OTHER PERTINENT INFORMATION.**

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 **OTHER PERTINENT INFORMATION** - Patient referred from Daytown Hospital, Daytown, Texas.

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.

Coding Instructions
- Document the name of the facility that the patient was referred to for further care after discharge from your facility under **OTHER PERTINENT INFORMATION**.

- If the facility is unknown or the patient was not referred, also document this under **OTHER PERTINENT INFORMATION**.

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

EXAMPLE:

CODE	DEFINITION
5220999999	Patient referred to Anywhere Hospital
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 **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 **OTHER PERTINENT INFORMATION** - Patient referred to Daytown Hospital, Daytown, Texas.

SEQUENCE NUMBER (NAACCR ITEM #560) (FORDS pgs. 34-35; SEER pgs. 89-90)

Description
Indicates the chronological sequence of all reportable neoplasms over the lifetime of the patient regardless of where the case was diagnosed.

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

- Codes 00-35 and 99 indicate reportable cases of malignant or in situ behavior.

- 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.

- 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.

- Codes 60-88 indicate non-malignant neoplasms (benign and borderline) and are reportable by agreement cases (e.g., those cases required by state registries). All benign and borderline neoplasms diagnosed/admitted to your facility in 2004 should be sequenced according to this guideline.

  NOTE: CDC and NAACCR edits will require benign CNS tumors diagnosed in 2004 to start with sequence number 60.

- 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.

- If two or more reportable non-malignant 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.

- Sequence numbers should be reassigned in the database if the facility learns later of an unaccessioned tumor that would affect the sequence.

MALIGNANT NEOPLASMS		
ONE PRIMARY	**MORE THAN ONE PRIMARY**	**SEQUENCE UNKNOWN**
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	
	Actual number of this primary	
NON-MALIGNANT NEOPLASMS		
ONE PRIMARY	**MORE THAN ONE PRIMARY**	**SEQUENCE UNKNOWN**
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	
	Actual number of this primary	

EXAMPLES:

1. A person is diagnosed with one primary. *Code the sequence number to 00.*

2. A person was diagnosed in 2001 with lung cancer. A colon cancer is diagnosed in 2003. *Code the sequence number of the colon cancer to 02 and change the sequence number of the lung cancer to 01.*

3. A person was diagnosed with breast cancer in April 2003 and metastasis to the lungs in November 2003. 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.*

4. A person was diagnosed with signet ring cell carcinoma of the bladder in 2002. In 2003, 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.*

5. A person was diagnosed with carcinoma of the stomach in 2001, squamous cell carcinoma of the left forearm (a non-reportable neoplasm) in 2002, and non-Hodgkin's lymphoma in 2003. *Code the sequence number of the stomach to 01.* The sequence number of the left forearm would be 02 and would not be abstracted or reported. *Code the sequence number of the lymphoma to 03.*

6. A person was diagnosed with a benign meningioma in June 2002 and comes to your facility for a MRI in 2003. *Code the sequence number to 60 for the benign meningioma.*

NOTE: Although squamous and/or basal cell carcinoma of the skin (except genital sites) is not reportable to the TCR, it **is** considered when assigning the appropriate sequence number. **However**, regardless of the number of squamous and/or basal cell carcinomas of the skin a person may have, it is only counted once when assigning sequence numbers.

- The **Tumor Record Number** refers to the number of primaries for that patient **at your facility**.

- The **Sequence Number** refers to the number of primaries **in the patient's lifetime**.

NOTE: Tumor Record Number and Sequence Number are two different data fields and are not always identical.

OTHER PRIMARY TUMORS (SITE, MORPHOLOGY, DATE)

Complete **only** if sequence number is anything other than 00 or 60 (one primary only). 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.

EXAMPLES:

1. The patient had a history of duct cell carcinoma of the left breast in 2002 and is admitted in 2003 for adenocarcinoma of the lung. Complete an abstract on the lung tumor, and record "duct cell carcinoma, left breast, 2002" in this area.

2. The patient has a history of prostate cancer, no date is given and no specific morphology is given. Patient is admitted in 2003 with a malignant melanoma of left leg. Document: history of prostate cancer, unknown date.