Data Dictionary

Case Administration

This section allows identifying the facility, this information is important for data quality follow up

Facility Name

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This identifier is needed to evaluate reporting per facility and for data quality purposes	This data item is automatically populated through the username and password of the user	Required	e-Notification	• Facility name as per HAAD facility licensing system • Upper cases only, left justified, space allowed, No other special characters	Alphabet	40

Facility License Number

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This identifier is needed to evaluate reporting per facility and for data quality purposes	This data item is automatically populated through the username and password of the user	Required	e-Notification	• Facility License number as per HAAD facility licensing system • Alphanumeric	Any combination,	10

Data Entered By

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This identifier is needed for communication purposes related to data cleaning and training	This data item is automatically populated through the username and password of the user	Required	e-Notification	• Facility License number as per HAAD facility licensing system • Upper cases only, left justified, space allowed, No other special characters	Alphabet	40

Facility From

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length

This data items enables the central registry to understand referral patterns in the catchment area, it is also helpful for data completeness.	Select the name of the facility from which the patient came to yours, if that patient was a referred one	Required	e-Notification	Select the name of one facility	Drop List	255

Facility To

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This data items enables the central registry to understand referral patterns in the catchment area, it is also helpful for data completeness.	Select the name of the facility to which the patient is referred.	Required	e-Notification	Select the name of one facility	Drop List	255

Patient Information

This section encompasses mainly demographic data necessary to identify the cases for data cleaning and linkage.

First Name

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Patient Identification tool	record the name as per patient file or identity card if available, if patient has two names as first name, put them both in this data field	Required	e-Notification	• Record the name as per patient file or identity card if available, if patient has two names as first name, put them both in this data field • Upper cases only, no embedded spaces, left justified, blank filled. No space, hyphen, coma or other special characters	Alphabet	Truncate if more than 40 characters

Middle Name

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length

Patient Identification tool	record the name as per patient file or identity card if available, if patient has two names as first name, put them both in this data field	Required	e-Notification	• Record the name as per patient file or identity card if available, if patient has two names as first name, put them both in this data field • Upper cases only, no embedded spaces, left justified, blank filled. No space, hyphen, coma or other special characters	Alphabet	Truncate if more than 40 characters

Last Name

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Patient Identification tool	record the name as per patient file or identity card if available, if patient has two names as first name, put them both in this data field	Required	e-Notification	• Record the name as per patient file or identity card if available, if patient has two names as first name, put them both in this data field • Upper cases only, no embedded spaces, left justified, blank filled. No space, hyphen, coma or other special characters	Alphabet	Truncate if more than 40 characters

Emirates ID Number

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This ID is unique for each patient; it helps all systems to identify the patient for data cleaning, linkage and analysis. It is vital in distinguishing patients of similar names	Put this number as per the Emirates ID card	Required	e-Notification	• 000-0000-0000000-0 National without card • 111-1111-1111111-1 Expatriate resident without a card • 222-2222-2222222-2 Non national, non-expat resident without a card • 999-9999-9999999-9 Unknown status, without a card • Any 15 digits	Numeric	15

Medical Record Number

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length

It helps identifying the patient within the facility. This is necessary for follow up, data quality and clinical research purposes	Put the medical record number as per your facility policies.	Required	e-Notification	Any Combination	Alphanumeric, uppercase and numbers	11

Address at Diagnosis - City

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
It allows for the analysis of cancer clusters or environmental studies. It also helps understanding referral patterns	• Name of the city in which the patient resides at the time the reportable tumor was diagnosed. • If the patient has multiple primaries, the address might be different for subsequent primaries. • Don't update the information if the patient's address changed after diagnosis. • Don't record the city of the facility where the diagnosis took place.	Required	e-Notification	Abu Dhabi Al Ain Al Ain Industrial Area Al Jemi Al Khabesi Al Khatim Al Mafraq Al Mirfa Al Rahba Al Ruwais Al Yahar Baniyas Delma Ghayathi Liwa Madinat Zayed Mussafah Shahama Sila	Description-dropdown menu	

Address at Diagnosis - Emirate

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length

It allows for the analysis of cancer clusters or environmental studies. It also helps understanding referral patterns	• Name of the Emirate in which the patient resides at the time the reportable tumor was diagnosed. • If the patient has multiple primaries, the address might be different for subsequent primaries. • Don't update the information if the patient's address changed after diagnosis.	Required	e-Notification	Abu Dhabi Ajman Dubai Fujairah Ras al Khaimah Sharjah Um Al Quwain Other	Description-dropdown menu	

Date of Birth

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
• Date of birth identifies the day, month and year when the patient was born. • Together with the date of diagnosis, it is used to calculate the age at diagnosis • This information helps identifying the patient • It is included in analysis based on age cohort	• If you have only the age and date of diagnosis, then calculate the year of birth. Month and day of birth are recorded as June 15th. • If you have the year of birth but not the month or day, then unknown month of birth shall be June, and unknown day of birth shall be 15.	Required	e-Notification	DDMMYYYY	Date	8

Date of Birth - Check If Date Is Incomplete

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Identify incomplete dates for statistical analysis	Check only if you don't have the exact information about day or month of birth	Required	e-Notification	Check box	Date	1

Gender

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length

To identify the sex of the patient. This item is necessary to compare cancer sites between genders	Record as provided in the patient medical file, or the identity card. This data item should have the same value in case of multiple primaries.	Required	e-Notification	Male Female	Description-dropdown menu	

Nationality

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Identify distribution of cancer among different nationalities	Record as per the patients identification card or passport	Required	e-Notification	Countries data set	Description-dropdown menu	

Marital status

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
• To identify the current marital status of the patient • Also helps identifying the patient once accompanied to other identifiers	• Record as provided in the patient medical file, or the identity card. This data item • Should have the same value in case of multiple primaries.	Required	e-Notification	1 =Single 2= Married 3= Divorced 4= Widowed 5= Not Known	Description-dropdown menu	

Occupation (longest)

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This data helps identifying environment related risk factor. An essential element in cancer prevention	Put the occupation that the patient had for most of his life, don't put the current employment, unless this is the longest occupation. If not listed, use "Other"	Required	e-Notification	HAAD occupation list	Description-dropdown menu	

Cancer Information

This section includes basic clinical data about the disease.

Date of Initial Contact / Admission

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This date helps measuring the period between the initial contact and the start of treatment for quality indicators	• Record the date when the patient had first contact with the facility, in or out patient, for diagnosis or treatment of reportable tumor. • In case of diagnosis by autopsy, then this date is the date of death	Required	e-Notification	DDMMYYYY	Date	8

Date of Initial Diagnosis

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This date is necessary in the survival calculations as start point	Date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed. Regardless of whether the diagnosis was made at the reporting facility or elsewhere.	Required	e-Notification	DDMMYYYY	Date	8

Date of Initial Diagnosis - Check If Date Is Incomplete

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Identify incomplete dates for statistical analysis	Check only if you don't have the exact information about day or month of diagnosis	Required	e-Notification	Check box	Date	1

Multiplicity Counter

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length

It is used to count the number of tumors (multiplicity) reported as a single primary.	• Use the IARC multiple primary rules for the specific site to determine whether the tumors are a single primary or multiple primaries
	• Code the number of tumors being abstracted as a single primary
	• Do not count metastasis.
	• When there is a tumor or tumors with separate single or multiple foci, ignore/do not count the foci.
	• Use code 01 when:
	  o There is a single tumor in the primary site being abstracted
	  o There is a single tumor with separate foci of tumor
	• Use codes 00-04 and code 99 for solid tumors including the following sites and histologies:
	  • Dendritic cell sarcoma (9757)
	  • Follicular dendritic cell sarcoma, extranodal (9758)
	  • Histiocytic sarcoma (9755)
	  • Ill-defined sites (C760-C768)
	  • Interdigitating dendritic cell sarcoma (9757)
	  • Kaposi sarcoma (9140)
	  • Langerhans cell histiocytosis (9751)
	  • Langerhans cell sarcoma (9756)
	  • Lymphoma, extranodal primary site (9590-9729, 9735-9738)
	  • Malignant histiocytosis (9750)
	  • Mast cell sarcoma (9740)
	  • Myeloid sarcoma (9930)
	  • Plasmacytoma, extramedullary (9734)
	  • Plasmacytoma, solitary (9731)
	• Use code 88 for:
	  • Leukemia (9800-9920, 9931-9948, 9963, 9964)
		Required	e-Notification	00 No primary tumor identified
				01 One tumor only
				02 Two tumors present
				03 Three tumors present
				04 Four tumors present
				88 Information on multiple tumors not collected/not applicable for this site
				89 Multicentric, multifocal, number unknown
				99 Unknown if multiple tumors; not documented
					Description-dropdown menu	

	• Lymphoma, lymph nodes or bone marrow primary site (9590-9729, 9735-9738) • Immunoproliferative diseases and other hematopoietic neoplasms (9732, 9733, 9741, 9742, 9759-9762, 9764, 9950, 9960-9962, 9965-9967, 997, 9975, 9980, 9982-9987, 9989, 9991. 9992) • Unknown primary (C809) • Use code 89 when: • The tumor is described as multifocal or multicentric and the number of tumors is not mentioned • Use code 99 when: • The original pathology report is not available and the documentation does not specify whether there was a single or multiple tumors in the primary site • The tumor is described as diffuse • The operative or pathology report describes multiple tumors but does not give an exact number • It is unknown if there is a single tumor or multiple tumors and the multiple primary rules instructed you to default to a single tumor.					

Primary Site / ICDO-3

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
• This information is the basis of staging and treatment • This information is the basis of cancer classification and stratification	• Refer to ICDO-3 Topography coding rules to code for the site of the origin • Consult the physician to identify the primary site if that information was not available for you.	Required	e-Notification	C000-C809, Refer to ICDO-3	Alphanumeric, C followed by 3 digits, no special characters, no embedded blanks	5

Primary Site - Text

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This information is needed for quality of coding and data cleaning	Put the exact wording used by the physician to describe the diagnosis	Required	e-Notification	Any text	Text Field	255

Histology / ICDO-3

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
• Identify the type of tissues of the primary site, • it is the basis for staging • Can affect disease prognosis. • This data item is necessary for the decision on multiple primaries	• Refer to ICDO-3 Morphology coding rules to code for the histology • Code using the final pathology report • The code for Cancer, NOS (8000) and Carcinoma (8010) are not interchangeable, if the physician writes Carcinoma, then code histology as 8010	Required	e-Notification	8000-9989, Refer to ICDO-3	Alphanumeric, C followed by 3 digits, no special characters, no embedded blanks	5

Histology - Text

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This information is needed for quality of coding and data cleaning	Put the exact wording used by the pathologist to describe the cell type	Required	e-Notification	Any text	Text Field	255

Behavior / ICDO-3

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Behavior identifies whether the tumor is benign or malignant	Code 3 for any malignancy present, even in metastatic nodes beyond the primary site	Required	e-Notification	2 = Carcinoma in situ 3 = Malignant, Primary site	Numeric	1

Grade / ICDO-3

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length

(Differentiation) It describes how far the tumor cells resemble the normal cells, important information for prognosis	• Code using the last pathology report prior to treatment. • In case of pathology report providing two grades, code for the highest. • If no pathology report available, use imaging reports. • If the primary site is unknown, code grade as 9. • Use codes 5-8 for leukemia and lymphoma, • don't use grades 1-4, and don't code for lymphoma using "high grade", or "low grade" as they don't refer to differentiation, use only codes 5-8	Required	e-Notification	1= Grade I: Well differentiated 2= Grade II: Moderately differentiated 3= Grade III: Poorly differentiated 4= Grade IV: Undifferentiated/ Anaplastic 5= T cell/T-precursor 6= B cell/ pre-B/ B-precursor 7= Null cell/ non T-non B 8= NK (natural killer) cell 9= Grade not determined/ not stated/ not applicable	Numeric	1

Laterality

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Code for the side of a paired organ, or the side of the body on which the reportable tumor originated. This applies to the primary site only.	• Record the side of the paired organ from which the primary was originated. • Don't record metastatic site as bilateral involvement.	Required	e-Notification	0= Not a paired site , Not Applicable 1= Right: origin of primary 2= Left: origin of primary 3= Only one side involved, right or left origin unspecified 4= Bilateral involvement 5= Paired site: midline tumor 9= Paired site, but lateral origin unknown	Description-dropdown menu	

Basis of Diagnosis

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
It gives information about the precision of diagnosis,	In case of multiple diagnostic methods, code for the most definitive method.	Required	e-Notification	• Positive Histology • Positive Cytology	Description-dropdown	

and case finding process				• Positive microscopic confirmation, method not specified • Positive laboratory test/marker study • Direct visualization without microscopic confirmation • Radiology and other imaging techniques without microscopic confirmation • Clinical diagnosis only • Unknown whether or not microscopically confirmed, death certificate only	menu	

Class of Case

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
To differentiate between analytical and non-analytical cases	Choose the case that corresponds exactly to your patient relationship with the facility	Required	e-Notification	• First Diagnosed at the reporting facility and all of the first line treatment was done elsewhere • First diagnosed and all or part of the first line treatment done at the reporting facility • First Diagnosed elsewhere, and a or part of the first line treatment was done at the reporting facility • First Diagnosed and all or part of the first line treatment was done elsewhere • First diagnosed by autopsy • Diagnosis by death certificate on • Unknown	Description-dropdown menu	

Staging and First Course of Treatment

TNM stage, basic information about first line treatment and few follow up data

Clinical T

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Site specific code that evaluates the primary tumor clinically (T) and reflects the tumor size and/or extension as recorded. Clinical stage is assigned prior to any cancer-directed treatment and should not be changed based on subsequent information	Code Clinical T as per treating physicians' notes. If the physician did not record that, then the registrar can code for Clinical T with the available clinical data. Use AJCC 7th edition. Use X for absent values	Required	e-Notification	X 0 IS A 1 1A 1B 1C 1D 1MI 2 2A 2B 2C 2D 3 3A 3B 3C 3D 4 4A 4B 4C 4D 4E	Description-dropdown menu	

				Not applicable Unknown		

Clinical N

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Site specific code that evaluates the involvement of lymph nodes. Clinical stage is assigned prior to any cancer-directed treatment and should not be changed based on subsequent information	Code Clinical N as per treating physicians' notes. If the physician did not record that, then the registrar can code for Clinical N with the available clinical data. Use AJCC 7th edition. Use X for absent values	Required	e-Notification	X 0 1 1A 1B 1C 1MI 2 2A 2B 2C 3 3A 3B 3C 4 Not applicable Unknown	Description-dropdown menu	

Clinical M

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Site specific code that evaluates the spread of cancer to other sites. Clinical	Code Clinical M as per treating physicians' notes. If the	Required	e-Notification	X 0	Description-dropdown	

stage is assigned prior to any cancer-directed treatment and should not be changed based on subsequent information	physician did not record that, then the registrar can code for Clinical M with the available clinical data. Use AJCC 7th edition. Use X for absent values			1 1A 1B 1C 1D 1E Not applicable Unknown	menu	

Clinical Stage Group

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Identify the extent of the disease based on T, N, and M values. it is used for treatment planning and evaluation of outcomes	Code Clinical Stage Group as per treating physicians' notes. If the physician did not record that, then the registrar can code for it with the available clinical data. Use AJCC 7th edition. Use X for absent values	Required	e-Notification	0 0A 0IS 1 1A 1B 1C 1S 2 2A 2B 2C 3 3A 3B 3C 4	Description-dropdown menu	

				4A 4B 4C Occult Not applicable Unknown		

Pathological T

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Site specific code that evaluates the primary tumor Pathologically (T) and reflects the tumor size and/or extension as recorded. Pathological stage is assigned prior to any cancer-directed treatment and should not be changed based on subsequent information	Code Pathological T as per Pathology report.	Required	e-Notification	X 0 IS A 1 1A 1B 1C 1D 1MI 2 2A 2B 2C 2D 3 3A 3B 3C 3D	Description-dropdown menu	

				4 4A 4B 4C 4D 4E Not applicable Unknown		

Pathological N

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Site specific code that evaluates the involvement of lymph nodes	Code Pathological N as per Pathology report.	Required	e-Notification	X 0 1 1A 1B 1C 1MI 2 2A 2B 2C 3 3A 3B 3C 4 Not applicable Unknown	Description-dropdown menu	

Pathological M

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Site specific code that evaluates the spread of cancer to other sites.	Code Pathological M as per Pathology report.	Required	e-Notification	X 0 1 1A 1B 1C 1D 1E Not applicable Unknown	Description-dropdown menu	

Pathological Stage Group

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Identify the extent of the disease based on T, N, and M values. it is used for treatment planning and evaluation of outcomes	Code pathological Stage Group as per pathology report.	Required	e-Notification	0 0A 0IS 1 1A 1B 1C 1S 2 2A 2B 2C	Description-dropdown menu	

				3 3A 3B 3C 4 4A 4B 4C Occult Not applicable Unknown		

Cancer Directed Surgery

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This information is used to evaluate and compare treatment options	• This data can be found in the surgery reports. • Document the most invasive surgery conducted on the primary site as first line (course) treatment. • Record here excisional biopsies that remove the whole site. • If a previous surgery was done to remove part of the primary site, followed by another final procedure, then record the final procedure. • Any procedures were provided to alleviate symptoms or prolong life should not be recorded here. • If the currently available information were not complete, then a follow up effort should be conducted to complete the information.	Required	e-Notification		Yes/No	

Start Date (Surgery)

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
It records the sequence of multiple treatment modalities	This data can be found in the surgical reports. Record the date of the most curative surgery conducted on	Required	e-Notification	DDMMYYYY	Date	8

	the primary site. If a previous surgery was done to remove part of the primary site, followed by another final procedure, then record the date of the final procedure					

Radiation Therapy

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This information is used to evaluate and compare treatment options	Only primary site directed radiation therapy provided as first line treatment should be recorded	Required	e-Notification		Yes/No	

Start Date (Radiation Therapy)

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
It records the sequence of multiple treatment modalities	This data can be found in the radiation oncologist summary or notes	Required	e-Notification	DDMMYYYY	Date	8

Chemotherapy

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This information is used to evaluate and compare treatment options	Only primary site directed chemotherapy provided as first line treatment should be recorded	Required	e-Notification		Yes/No	

Start Date (Chemotherapy)

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
It records the sequence of multiple treatment modalities	This data can be found in the physician notes and discharge summary	Required	e-Notification	DDMMYYYY	Date	8

Hormonal Therapy

Rational	Coding Instructions	Status	Source of	Permissible	Data Format	Item

			Standard	Values		Length
This information is used to evaluate and compare treatment options	Only primary site directed Hormonal therapy provided as first line treatment should be recorded	Required	e-Notification		Yes/No	

Start Date (Hormonal Therapy)

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
It records the sequence of multiple treatment modalities	This data can be found in the physician notes and discharge summary	Required	e-Notification	DDMMYYYY	Date	8

Immune Therapy

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This information is used to evaluate and compare treatment options	Only primary site directed immune therapy provided as first line treatment should be recorded	Required	e-Notification		Yes/No	

Start Date (Immune Therapy)

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
It records the sequence of multiple treatment modalities	This data can be found in the physician notes and discharge summary	Required	e-Notification	DDMMYYYY	Date	8

Hematologic Transplant and Endocrine Procedure

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This information is used to evaluate and compare treatment options	Only primary site directed procedures provided as first line treatment should be recorded	Required	e-Notification		Yes/No	

Start Date (Hematologic)

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
It records the sequence of multiple	This data can be found in the physician notes and	Required	e-	DDMMYYYY	Date	8

treatment modalities	discharge summary		Notification			

Other Treatment, Specify

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This information is used to evaluate and compare treatment options	Record first line treatment other than the regular upper mentioned treatment modalities, primary site oriented therapy	Required	e-Notification		Text	

No Treatment, Reason

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
This information helps understanding patient trends regarding conventional therapies	Record the reason behind the refusal of treatment	Required	e-Notification		Text	

Date at Discharge

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Helps identifying period calculation necessary for outcome evaluation and survival statistics	Put in the last date the patient was seen at your facility at the time of reporting the case.	Required	e-Notification	DDMMYYYY	Date	8

Status at Discharge

Rational	Coding Instructions	Status	Source of Standard	Permissible Values	Data Format	Item Length
Necessary for outcome evaluation and survival statistics	put in the last patient status at your facility at the time of reporting the case	Required	e-Notification		Drop List	