

**BCCA Data Access Request (DAR)**

**Field Extraction Checklist**

Revised: 09 September 2016

Use space bar to activate/deactivate check boxes in the ‘requested’ column

if you would like the data field included in your data output file.

*An asterisk (\*) indicates data fields that the BC Cancer Agency considers to be a potential personal identifier. Selection of any of these potentially identifiable variables requires a justification to be provided in the DAR for their release to be considered. Justifications for other selected data should be provided in the applicable sections within this checklist. Data fields requested without appropriate rationales will not be approved for release.*

*Note some fields include both a code and a description, the description will automatically be included on applicable fields.*

Section I: BC Cancer Registry/Cancer Diagnosis

These sections can be used to select data on cases of cancer diagnosed in BC residents. These data can also be linked to data from subsequent sections on cancer treatment and screening.

| **Column Name** | **Description** | **Requested** |
| --- | --- | --- |
| **1. DEMOGRAPHICS** |
| Please provide a justification as to why the data selected in this section are required for your project:       |
| \*agency\_id | A unique identifier for each patient system-generated by the BCCA Information System. | [ ]  |
| \*personal\_health\_num | The patient’s British Columbia (BC) personal health number. | [ ]  |
| sex | The patient’s gender: female (F) or male (M). | [ ]  |
| \*birth\_date | The patient’s date of birth. When the birth day is missing the system automatically sets it to 01. If the birth day and month are missing the system automatically sets the day and month to 0101. | [ ]  |
|  *Month and Year of birth only* | [ ]  |
|  *Year of birth only* | [ ]  |
| birth\_fuzz | An alphabetic flag is set when the day (D) of birth is system-generated to ‘01’ or when the day and month (M) of birth are system-generated to ‘0101’. | [ ]  |
| \*name | The patient’s surname, first name, second name, birth surname | [ ]  |
| \*address | The patient’s current home address, city, province. | [ ]  |
| \*phone\_num | The patient’s current home address phone number. | [ ]  |
| \*curr\_post\_code | The patient’s current home address postal code. | [ ]  |
|  *First 3 digits (forward sortation area or FSA) of this postal code only* | [ ]  |
| \*curr\_local\_health\_area | The numeric code for the local health area of the patient’s current BC home address postal code. | [ ]  |
| curr\_hsda | The numeric code for the health service delivery area of the patient’s current BC home address postal code. | [ ]  |
| curr\_hsda\_cc | The alphabetic code for the cancer centre whose catchment area the health service delivery area, of the patient’s current BC home address postal code is in | [ ]  |
| curr\_hlth\_auth | The numeric code for the health authority of the patient’s current BC home address postal code. | [ ]  |
| **2. CANCER DIAGNOSIS** |
| Please provide a justification as to why the data selected in this section are required for your project:      |
| age\_at\_diagnosis | The age of the patient at the time of diagnosis based on a mathematical calculation taking into account ‘fuzzy’ dates. System-generated ‘01’s (unknown values for birth and/or diagnosis day or month) are not included in the calculation. | [ ]  |
| age\_at\_diag\_estimated | A flag which indicates if the age\_at\_diagnosis is calculated using an unknown birth and/or diagnosis day or month. | [ ]  |
| age\_at\_diag\_range\_5 | Age at diagnosis is grouped into 5 year increments (0-4, 5-9… 90-94, 95+) | [ ]  |
| age\_at\_diag\_range\_20 | Age at diagnosis is grouped into 20 year increments (0-19, 20-39, 40-59, 60-79 80+). | [ ]  |
| diagnosis\_type | The level at which the patient’s disease information is entered into the system. | [ ]  |
| diagnosis\_date | The date the patient’s disease was diagnosed. When the day of diagnosis is missing the system automatically sets it to 01. If the day and month of diagnosis are missing the system automatically sets the day and month to 0101. | [ ]  |
|  *Month and Year of diagnosis only* | [ ]  |
|  *Year of diagnosis only* | [ ]  |
| diagnosis\_fuzz | A flag indicating the day of diagnosis (D) is system-generated to ‘01’ or the day and month of diagnosis (M) are system-generated to ‘0101’. | [ ]  |
| \*loc\_at\_diagnosis | The Canadian postal code or the BCCA geographic code of the patient’s residence at the time of diagnosis. | [ ]  |
|  *First 3 digits (forward sortation area or FSA) of this postal code only* | [ ]  |
| diagnosis\_ha | The numeric code for the health authority of the patient’s BC postal code at the time of diagnosis. | [ ]  |
| diagnosis \_hsda | The numeric code for the health service delivery area of the patient’s BC postal code at the time of diagnosis.  | [ ]  |
| diagnosis \_hsda\_cc | The alphabetic code for the cancer centre whose catchment area the health service delivery area, of the patient’s BC postal code at the time of diagnosis, is in. | [ ]  |
| \*diagnosis\_lha | The numeric code for the local health area of the patient’s BC postal code at the time of diagnosis.  | [ ]  |
| site\_admit\_date | The date the patient was admitted to a BC Cancer Centre or Community Oncology Network (CON) clinic for a particular site, where applicable. | [ ]  |
| loc\_at\_admit | The alphabetic code for the CON clinic or cancer centre where the patient was first admitted for a particular primary disease, where applicable. | [ ]  |
| cancer\_diagnosis | The International Classification of Diseases for Oncology 3rd edition (ICD-O-3) site and histology code plus laerality and behavior (5th digit of histology code) for the patient’s distinct primary disease. All diagnosis years are converted to an ICD-O-3 code. | [ ]  |
| method\_of confirmation | The numeric code assigned to the ‘method’ of confirmation of the patient’s distinct primary disease (calculated from the diagnostic\_confirm or the method\_of\_confirm fields, dependent on date of diagnosis). | [ ]  |
| total\_sites\_per\_pt | The total number of distinct disease records for the patient (not necessarily number of ‘cancer’ records as may also be ‘borderline’ or ‘in-situ’) | [ ]  |
| tumour\_group | The alphabetic code for the tumour group assigned to the patient’s primary disease based on site and histology.  | [ ]  |
| tumour\_subgroup | The alphabetic code for the subgroup of the tumour group assigned to the patient’s primary disease based on site and histology.  | [ ]  |
| performance\_status | The ECOG numeric code for the patient’s performance status. | [ ]  |
| \*clinic\_phys | The BCCA oncologist responsible for the patient’s care ie. most responsible physician. | [ ]  |
| status\_at\_referral | The numeric code for the status of the patient’s primary disease at referral to a cancer centre, where applicable.  | [ ]  |
| incid\_simple\_grp | The ICD-O-3 site and hist1 codes grouped according to the Canadian Cancer Statistics (CCS) tumour groupings. Includes malignant disease and insitu bladder. | [ ]  |
| Incid\_minor\_grp | The ICD-O-3 site and hist1 codes grouped into more detailed cancer groups used by both the BC Cancer Agency and CCS to compile cancer statistics. As of 2016 there were more than 45 groups for this variable.   | [ ]  |
| Incid\_major\_grp | The ICD-O-3 site and hist1 codes grouped into higher-level codes used by both the BC Cancer Agency and CCS to compile cancer statistics. As of 2016 there were 18 cancer groups for this variable.   | [ ]  |
| **3. CANCER STAGE** |
| Please provide a justification as to why the data selected in this section are required for your project:      |
| Cancer Staging System(s) | Check if you require staging information and the appropriate staging system(s) will be added to your request (eg. collaborative stage, tnm, other). | [ ]  |
| Collaborative Site Specific Prognostic Factors | If your request falls into the collaborative stage grouping (collaborative stage currently collected for nonreferred and referred breast, cervix, colorectal, lung and prostate cases diagnosed >=2010) check the box if you would like the collaborative stage [site specific prognostic factors](https://cancerstaging.org/cstage/schema/Pages/version0205.aspx) included.  | [ ]  |
| **4. MORTALITY** |
| Please provide a justification as to why the data selected in this section are required for your project:       |
| pat\_status | The patient’s status of ‘A’ (Alive) or ‘D’ (Deceased). | [ ]  |
| \*death\_date | The date of death. When the day of death is missing the system automatically sets it to 01. If the day and month of death are missing the system automatically sets the day and month to 0101. | [ ]  |
|  *Month and Year of death date only* | [ ]  |
|  *Year of death date only* | [ ]  |
| death\_fuzz | An alphabetic flag indicating the day of death (D) is system-generated to ‘01’ or the day and month of death (M) are system-generated to ‘0101’. | [ ]  |
| death\_cause | The ICD code (may be any ICD version, dependent on date of death) assigned by BC Vital Statistics.**Includes**: primary cause and secondary cause of death. | [ ]  |
| death\_place | The alphanumeric BCCA geographic code for the city/town in which the patient died. | [ ]  |
| death\_autopsy | An alphabetic code indicating if an autopsy was or was not done or if it is unknown if one was done. | [ ]  |
| mort\_simple\_grp | The ICDO cancer cause of death code grouped according to the Canadian Cancer Statistics (CCS) tumour groupings. | [ ]  |
| **5. FOLLOW-UP** |
| Please provide a justification as to why the data selected in this section are required for your project:      |
| last\_attended\_appt | The date of the patient’s last attended scheduling appointment.  | [ ]  |
|  *Month and Year of last attended appointment only* | [ ]  |
|  *Year of last attended appointment only* | [ ]  |
| last\_contact\_date | The date of last contact with the patient, usually as noted on the patient’s follow-up letter. It is NOT linked to the Scheduling system, so the patient may have a more recent BCCA appointment date they attended. When the day of last contact is missing the system automatically sets it to 01. If the day and month of last contact are missing the system automatically sets the day and month to 0101. | [ ]  |
|  *Month and Year of last contact only* | [ ]  |
|  *Year of last contact only* | [ ]  |
| last\_contact\_fuzz | An alphabetic flag indicating the day of last contact (D) is system-generated to ‘01’ or the day and month of last contact (M) are system-generated to ‘0101’. | [ ]  |
| last\_contact\_type | A numeric code for the source of the last\_contact\_date (i.e. outside physician, correspondence, etc). | [ ]  |
| **6. FAMILY PHYSICIAN** |
| Please provide a justification as to why the data selected in this section are required for your project:      |
| Family\_physician\_info | The Medical Services Commission (MSC) number of the physician entered in CAIS as the patient’s family physician.**Includes** - MSC\_id, last name, first name, second name, address, city, post\_code, phone num, phone local. | [ ]  |

Section II: Cancer Treatment Information

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| **7. TREATMENT FLAGS** |
| Please provide a justification as to why the data selected in this section are required for your project:      |
| fst\_treat\_date | The date of the patient’s first definitive treatment for a distinct primary disease. | [ ]  |
|  *Month and Year of first treatment only* | [ ]  |
|  *Year of first treatment only* | [ ]  |
| fst\_treat\_fuzz | A flag indicating the day of first treatment (D) is system-generated to ‘01’ or the day and month of first treatment (M) are system-generated to ‘0101’. | [ ]  |
| bcca\_chemo | A flag indicating the patient had chemotherapy up to 3 months post-BCCA admission, if the information is known. For non-referred cases hormone therapy is included. | [ ]  |
| bcca\_horm | A flag indicating the patient had hormone therapy up to 3 months post-BCCA admission, if the information is known. For non-referred cases see bcca\_chemo flag. | [ ]  |
| bcca\_rad | A flag indicating a radiation therapy record (radiotherapy and/or brachytherapy) is present and/or the patient had pre-admission radiation therapy outside of BCCA if the information is known. | [ ]  |
| bcca\_surg | A flag indicating a surgery record is present i.e. the patient had other than diagnostic surgery up to 3 months post-BCCA admission, if the information is known. | [ ]  |
| **8. RADIATION TREATMENT** |
| Please provide a justification as to why the data selected in this section are required for your project:      |
| treat\_type | Indicates whether the treatment is radiotherapy (R ) or brachytherapy (B). | [ ]  |
| start\_date | The date BCCA radiation therapy treatment started. | [ ]  |
|  *Month and Year of radiation start only* | [ ]  |
|  *Year of radiation start only* | [ ]  |
| stop\_date | The date BCCA radiation therapy treatment stopped. | [ ]  |
|  *Month and Year of radiation stop only* | [ ]  |
|  *Year of radiation stop only* | [ ]  |
| facility | The agency facility where radiotherapy treatment was administered. | [ ]  |
| rt\_treat\_intent | Indicates the expected result of the treatment course i.e. radical (R), palliative (P), adjuvant (A) or unknown (X). | [ ]  |
| treat\_plan | Indicates how the radiotherapy fits into the treatment protocol ie. initial (I), subsequent (S). | [ ]  |
| treat\_region | The anatomic site where the patient received radiotherapy treatment. | [ ]  |
| modality | The machine used to administer the radiation beam therapy. | [ ]  |
| technique | The method used to administer the radiotherapy. | [ ]  |
| fractions | The total number of individual exposures to radiation that the patient received for each treatment line. | [ ]  |
| dose\_cgy | The amount of radiation received by the patient. | [ ]  |
| complete | Indicates whether or not the patient completed initial planned radiotherapy. | [ ]  |
| **9. CANCER SURGERY** |
| Please provide a justification as to why the data selected in this section are required for your project:      |
| surg\_treat\_date | The date the surgery was performed. | [ ]  |
|  *Month and Year of surgery only* | [ ]  |
|  *Year of surgery only* | [ ]  |
| surg\_treat\_intent | Indicates the expected result of the surgical treatment. | [ ]  |
| surg\_treat\_plan | Indicates how the surgery fits into the treatment protocol | [ ]  |
| surg\_code | The Canadian Classification of Diagnostic, Therapeutic, and Surgical Procedure (CCP) code used to define the surgery performed. | [ ]  |
| **10. BCCA PHARMACY** |
| Please provide a justification as to why the data selected in this section are required for your project:      Note: please refer to list prices in Canada for oncology **drug costing** for research projects. |
| \*claim\_id | Prescription number or OSCAR , PANDA or BDM claim number generated by the system. | [ ]  |
| din | A Drug Identification Number (DIN) is a computer-generated (typically) eight digit number assigned by Health Canada to a drug product prior to being marketed in Canada. May also be generated by BCCA pharmacy to differentiate between various sources of supply, vial sizes and clinical trials. | [ ]  |
| prescription\_date | The date the drug was charged/billed. May be the date the drug was dispensed. May also reflect the date the prescription was reversed or credited. | [ ]  |
|  *Month and Year of prescription only* | [ ]  |
|  *Year of prescription only* | [ ]  |
| drug\_name | The name of the drug dispensed. | [ ]  |
| protocol\_code | The BCCA code specifying the name of the protocol for this prescription or predefined pneumonic for swift order entry purposes. May be blank if no code was specified or not applicable. | [ ]  |
| chemotherapy\_agent | Indicates if the drug is a treatment for cancer = Y; may also be a drug used in a clinical trial at BCCA. Derived from another table where the drug name, DIN, and route must be entered. If drug is blank, then chemotherapy\_agent = null. | [ ]  |
| route  | Sometimes it is the method of how the drug was administered (IV or PO). For non-PO routes it may default to IV or PO (for example, subcutaneous, topical, rectal, etc.). For some drugs dispensed but not administered, may be designated as PO even though they are given intravenously.  | [ ]  |
| source | The system from where the information originated (BDM, OSCAR, PANDA, VCP, WORX). | [ ]  |
| dose | The dose of drug dispensed or the unit size of a single unit of the drug. | [ ]  |
| disp\_unit\_qty | The quantity of drug dispensed if it is an oral or take-home drug; for intravenous drugs administered it may be the number of vials used in the preparation or it may be the dose. It may be a negative number to indicate that it is a credit. | [ ]  |
| bill\_status | Indicates the number of times the line item was filled on the prescription date. If source = OSCAR and the bill status is -1, ignore the line. If source = WORx and the bill status is a negative number, this indicates that this is a credit. Positive values are debits. | [ ]  |

Section III: Cancer Screening Information

These sections can be used to select information collected by the Screening Mammography Program of BC (SMPBC) and the Cervical Cancer Screening Program (CCSP) operated by the BCCA.

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| **11. SCREENING MAMMOGRAPHY (SMPBC)** |
| Please provide a justification as to why the data selected in this section are required for your project:      |
| \*birth\_date | The client’s birth\_date. | [ ]  |
|  *Month and Year of birth only* | [ ]  |
|  *Year of birth only* | [ ]  |
| \*name | The client’s first surname, first name, birth surname. | [ ]  |
| \*address | The client’s current home address, city, province. | [ ]  |
| \*adr\_postal\_code | The client’s current home address postal code. | [ ]  |
|  *First 3 digits (forward sortation area or FSA) of this postal code only* | [ ]  |
| \*home\_tel | The client’s current home address phone number. | [ ]  |
| birth\_country\_code | The client’s birth country. | [ ]  |
| ethnicity | The client’s ethnic/cultural heritage (british/irish/scottish/welsh, french, E european, N european, S european, W european, E/SE asian, S asian, first nations, black, other). | [ ]  |
| **Per Exam** |
| screen\_date | Date of screening mammogram. | [ ]  |
|  *Month and Year of mammogram only* | [ ]  |
|  *Year of mammogram only* | [ ]  |
| smp\_result | Result of screening mammogram. | [ ]  |
| \*fhist\_br\_ca | Family history of breast cancer in 1st degree female blood relatives. | [ ]  |
| \*fhist\_diag\_bf\_age50 | Family history of breast cancer diagnosed before age 50 in a 1st degree female relative. | [ ]  |
| \*fhist\_bilateral\_ca | Family history of bilateral breast cancer in a 1st degree female relative. | [ ]  |
| **Per Exam If Abnormal** |
| diagnosis\_date | The date the abnormality was diagnosed.  | [ ]  |
|  *Month and Year of diagnosis only* | [ ]  |
|  *Year of diagnosis only* | [ ]  |
| diagnosis\_cd | Code indicating final diagnosis at the end of the screening episode. Diagnostic workup must include a biopsy or field will be blank. | [ ]  |
| diag\_site | Site of diagnosed abnormality. | [ ]  |
| **12. CERVICAL CANCER SCREENING** |
| Please provide a justification as to why the data selected in this section are required for your project:      |
| \*birth\_date | The client’s birth\_date.  | [ ]  |
|  *Month and Year of birth only* | [ ]  |
|  *Year of birth only* | [ ]  |
| \*name | The client’s surname, first name, birth surname. | [ ]  |
| **Per Smear Site** |
| smear\_date | The date of the smear. | [ ]  |
|  *Month and Year of smear only* | [ ]  |
|  *Year of smear only* | [ ]  |
| smear\_site | The smear site: cervix, lateral vaginal wall and vaginal vault. Other sites available prior to 2011. | [ ]  |
| result\_cd | Most significant result reported per smear site | [ ]  |
| atypia\_type\_cd | Atypia cell type (s=squamous [default], g=glandular, e=epithelial) | [ ]  |
| **Per Colposcopy** |
| present\_exam\_date | Date of colposcopy procedure. | [ ]  |
|  *Month and Year of colposcopy only* | [ ]  |
|  *Year of colposcopy only* | [ ]  |
| site\_cd | Site of colposcopy procedure (cervix, vagina, or vulva). | [ ]  |
| evaluation\_cd\_1 | Final diagnosis of the colposcopy procedure as per colposcopist. | [ ]  |
| evaluation\_cell\_cd\_1 | Final result cell type as per colposcopist is squamous. | [ ]  |
| evaluation\_cell\_cd\_2 | Final result cell type as per colposcopist is glandular. | [ ]  |

Note: screening program’s client contact information will only be provided, if the client has indicated willingness to be contacted for research studies.

Section IV: Other Requested Data

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| **13. OTHER** |
| Please specify any additional data that are required for your project. If you know the name of the data repository that contains the information you require and any of the specific data field names, please provide these below. Otherwise provide as much detail as possible as to what is required.       |