State of Maryland

Department of Health and Mental Hygiene

Cancer Prevention, Education, Screening and Treatment (CPEST) Program
Client Database (CDB) User Guide

Prepared By:

Version 4.0 – CDC Project
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Version History

Version	Author(s)	Description of Version	Date Completed
4.0	DHMH	Revised to incorporate the changes to the **CDC portion** of the CPEST Client Database	07/31/2006
3.3	CIBER, Inc.	Updated per functionality included in 3.3 version of CPEST Client Database	02/24/2006
3.2	CIBER, Inc.	Updated per functionality included in 3.2 version of CPEST Client Database.	05/25/2005
3.1	CIBER, Inc.	Updated per functionality included in 3.1 version of the CPEST Client Database.	03/03/2005
3.0	CIBER, Inc. CIBER, Inc. and DHMH DHMH	Updated per functionality included in 3.0 version of the CPEST Client Database application. User Guide: Updated Cover, Table of Contents (Section 2) pages 2-13, 2-14; (Section 8) pages 8-3 thru 8-9: Appendices A, B, C, D, E, F, H, I and J User Guide: Updated Appendix F	10/20/2004, 11/19/2004 1/24/2005 02/17/2005
2.4	CIBER, Inc.	Updated pagination.	08/16/2004
2.3	CIBER, Inc.	Updated per functionality included in 2.2 version of CPEST Client Database application.	06/02/2004
2.2	DHMH	Updated sections for Phase II. Added information in Appendices F, G, H, I, J	04/14/2004
2.1	CIBER, Inc.	Updated sections for Phase II. Added Appendices H, I, J.	03/10/2004
2.0	CIBER, Inc.	Added sections for Phase II including Client Recall, Client Billing, Letters/Mail Merge, Download Client Data, and Notification Lists.	01/30/2004
1.4	CIBER, Inc.	Incorporated approved design changes for Save buttons, Clear options, and CRC Previous Screening History Date.	01/28/2004
1.3	CIBER, Inc. and DHMH	Changed the title CPEST used throughout to CDB. Changed “Screening Data” to “Data” where not talking about screening data. Added information regarding Login to the DHMH Family Health Administration Network. Changed Street to Street/PO Box in Mailing Address of Appendix A, and Provider description.	01/27/2004
1.2	CIBER, Inc.	Added Tip to Login description regarding responding No to browser prompt to remember password. Added Note to Mailing Address description that P.O. Boxes should be entered in Street Name field.	01/10/2004
1.1	CIBER, Inc.	UMB Feedback Included	12/29/2003
1.0	CIBER, Inc.	Initial version	12/12/2003

Chapter 1: General

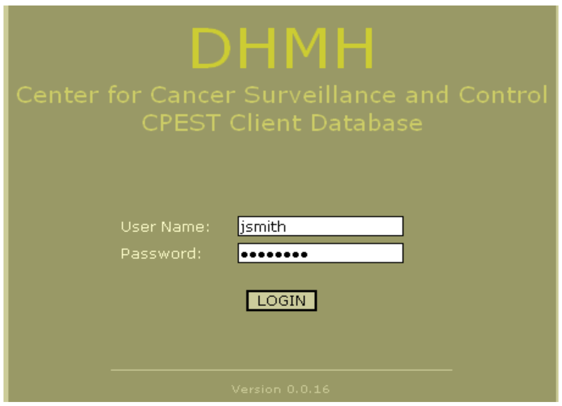
This chapter explains several important features of the CPEST CDB system such as logging in and the Main Menu.

Included in This Chapter

- Log in to CPEST CDB
- CPEST Client Database Main Menu
- Change Passwords
- Screening Form Navigation
- Help
- Log Off the System

Log in to CPEST Client Database (CDB)

Every user of the CPEST CDB system has a unique User Name and Password. Follow the steps below to log into the CPEST CDB system.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Open your web browser and navigate to the Login Page.</td></tr>
<tr><td>2</td><td>Enter your User Name and Password in the Login Page in the fields provided.


Click "Login" to enter the system.

Note:
If your password was reset or you are logging into the system for the first time, you will see the Change Password Page. Enter the system default password for the old password and a new password to continue to the Main Menu. To learn more about changing passwords, see the Change Passwords section later in this chapter.

Tip:
The first time you login to the system your browser may ask you if you want Windows to remember this password. If this happens, choose 'No'.

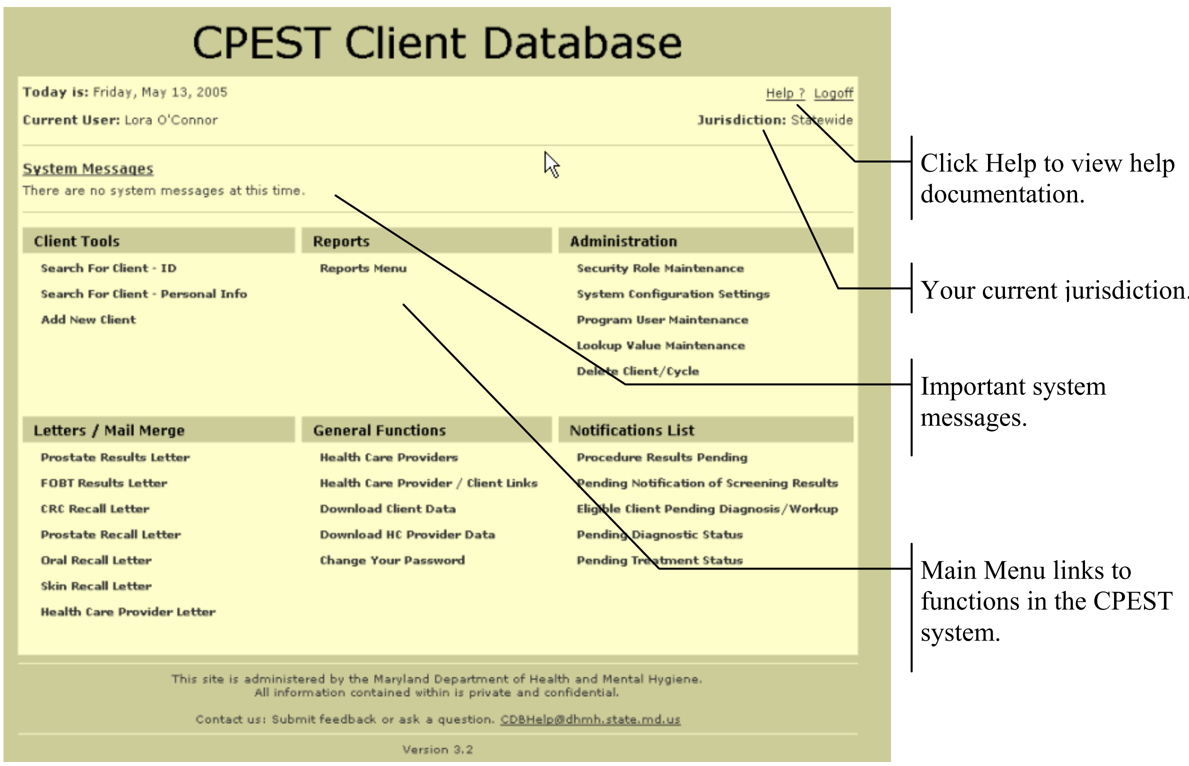
Tip:
If you are having problems with your password, make sure your Caps Lock is off. Passwords are case-sensitive in the CPEST CDB system.</td></tr>
</table>

3	If the User Name and Password entered are correct, you will see the Main Menu. Otherwise, the Login Page displays the message “Invalid Login Information Specified”. ***Note:*** If you have access to multiple programs, you will see a page which asks you to select the program you want to use. After you select a program, you will see the Main Menu.

CDB Client Database Main Menu

The Main Menu displays all of the available functions within the CDB system.

Main Menu



Note:
Some options may not appear on your Main Menu Page due to your security permissions.

System Messages:
The System Messages section of the Main Menu displays important information from the CDB system. For example, a message appears in this section when your password is about to expire.

Client Tools:

Search For Client – ID	Opens the search page for finding clients by identifiers. For more information, see the section titled "Search for an Existing Client" in Chapter 2.
Search For Client – Personal Info	Opens the search page for finding clients by personal information. For more information, see the section titled "Search for an Existing Client" in Chapter 2.
Add New Client	Adds a new client to the CDB database. For more information, see the section titled "Add a New Client" in Chapter 2.

Reports:
The Reports Menu link opens the Reports Page. This page shows all reports that are available to a person based on their security permissions. For more information on reports, see Chapter 9 - Reports.

Administration:

Security Role Maintenance	Click this link to define new security roles or update current roles in the CDB system. For more information on security roles, see the section titled "Maintaining Security Roles" in Chapter 13.
System Configuration Settings	This link opens the System Configuration Settings Page which contains the system-wide settings for CDB. For more information on system settings, see the section titled "Changing System Configuration Settings" in Chapter 13.
Program User Maintenance	Click this link to define a new user or update current users in the CDB system. For more information on users, see the section titled "Maintaining Users" in Chapter 13.
Lookup Value Maintenance	This link opens the Lookup Value Maintenance module that maintains lists used in the CDB system. For more information on lookup values, see the section titled "Maintaining Lookup Values" in Chapter 13.
Delete Client / Cycle	Click this link to delete a Client or Cycle in the CDB system. For more information on deleting, see Appendix E of the System Administration Manual.

Letters/Mail Merge:
The Letters and Mail Merge feature allows users of the CPEST system to download comma-separated data files which can be used in mail merges. For more information on letters and mail merge see Chapter 10 – Letters and Mail Merge.

General Functions:

Health Care Providers	Click this link to search for health care providers and maintain their information. For more information on health care providers, see Chapter 8 – Health Care Providers.
Health Care Provider / Client Links	Click this link to search for client records associated with a specific health care provider. For more information on health care providers, see Chapter 8 – Health Care Providers.
Download Client Data	The Download Client Data feature allows users to download CPEST data in comma-separated files.
Download HC Provider Data	The Download HC Provider Data allows users to download health care provider data in comma-separated files.
Change Your Password	Click this link to go to the Change Password Page and select a new password. For more information on changing passwords, see "Change Passwords" later in this chapter.

Notifications List:
Notifications List advises CPEST users that additional data needs to be entered to complete a client's cycle. For more information on notifications, see Chapter 12 – Notifications List.

Change Passwords

Follow these steps to change your password in the CDB system.

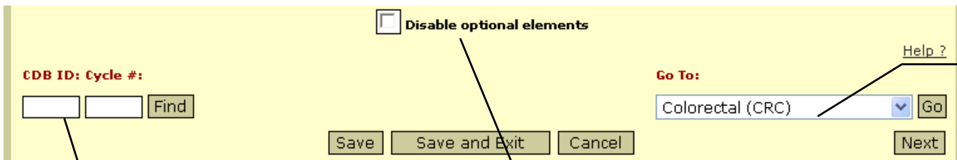
Step	*Action*
1	On the Main Menu Page, click "Change Password" under the General Functions section.

Step	*Action*
2	Enter your old password and your new password into the fields on the Change Password Page. You must enter your new password into both the "New Password" and "Confirm Password" fields.  Click "Change Password" to change your password. To cancel and return to the Main Menu, click "Cancel". ***Note:*** Your new password must be between eight and twelve characters and cannot match any of your last five passwords.

Screening Form Navigation

A common navigation bar appears at the top and bottom of each screening form in the CDB system. You will notice the navigation bars as you add clients and enroll clients in cancer modules. The navigation bars help a person quickly navigate through forms within the system.

Top Navigation



The “Go To” Menu navigates to a selected page.

Jumps to another client and cycle.

Disables fields that are not required.

Find Button

To quickly jump to another client, enter an ID and cycle number into the “CDB ID” and “Cycle #” fields on the left of the navigation bar and click “Find”. The system will then open the first screening form for the ID and cycle you entered. On the Core Demographic module, the “Cycle #” field is not displayed.

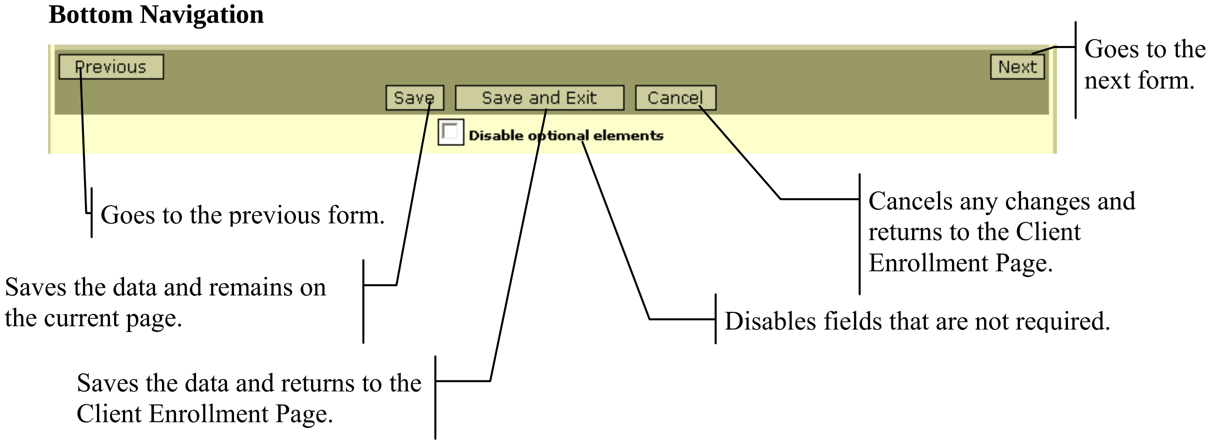
Go To Menu

To navigate to another page in the same screening process, select the form in the “Go To” menu on the right side of the header and click “Go”. Any data you changed will be saved before you go to the new page.

Disable Optional Elements

Important fields on the CDB screening forms must be entered. These required fields are highlighted in red. You can disable the fields that are not required so you can navigate through the screening forms more quickly. To do so, check the “Disable Optional Elements” box at the top of the form. You will notice that your cursor skips the optional fields as you tab through the screening forms.

Bottom Navigation



Previous and Next Buttons

The "Previous" and "Next" buttons navigate to other pages in the current screening cycle. The "Previous" button opens the prior page and the "Next" button opens the following page. Using the buttons to navigate to another page saves the changes for the current page.

Note:
As you navigate through the screening pages, the next button will skip certain pages based on your answers to previous screening questions.

Save and Cancel Buttons

The "Save and Exit" and "Cancel" buttons close the screening forms and return to the Client Enrollment Page. The "Save and Exit" button will save any changes to the information while the "Cancel" button will not save any changes. The "Save" button saves any changes to the information and remains on the current page.

Help

The "Help" link on the Main Menu opens the Help Menu Page. The Help Menu Page displays all available help documents. To open a document, click the document name.

Logoff the System

Every user should log off the CPEST System after he or she has finished using it. To log off the system, simply click the "Logoff" link in the upper right corner of the Main Menu Page. Logging off prevents other users from accessing the system on computers that are left unattended.

Chapter 2: Client Tools

This chapter explains how to find and manage client information within the CDB system. The Client Tools are available in the “Client Tools” section of the Main Menu. CDB provides two user-friendly interfaces to find clients within the system. The Client Tools module can also store a wealth of core client demographic information.

Search for an Existing Client

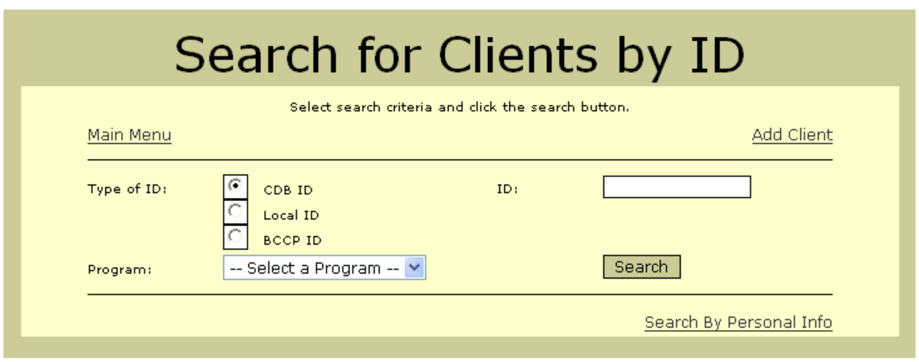
To search for clients in CDB, choose “Search for Client – ID” or “Search for Client – Personal Info” from the Main Menu. Search for the client by ID when you know one of the system identifiers for the client. Search by personal information if you do not know an identifier, but you do know the client’s name or other personal information.

Note:
In order to search for clients, you must have Access to Raw Data Statewide or Access to Raw Data Local security permissions.

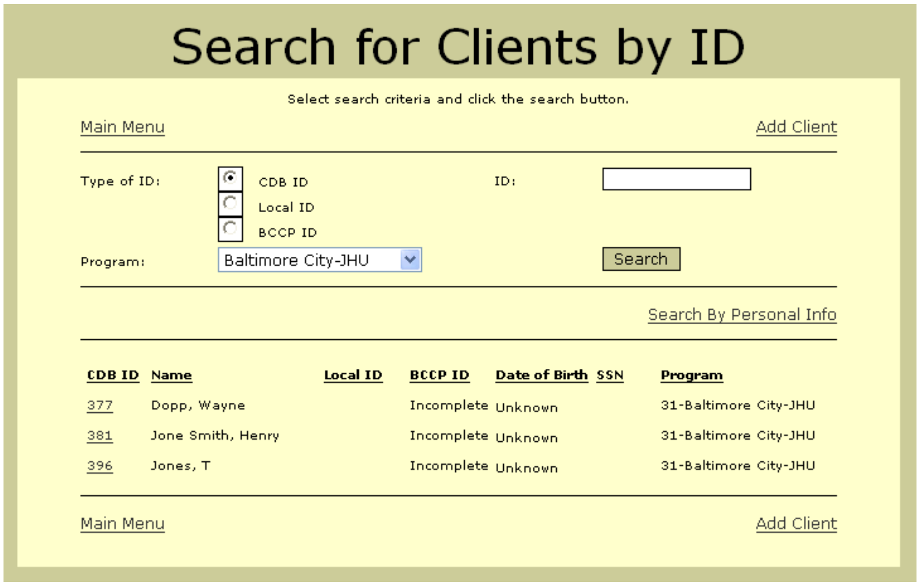
Search for Client by ID

Follow the steps below to search for a client by identifier.

Step	*Action*
1	Choose “Search for Client – ID” on the Main Menu Page.
2	On the Search Page, select the search criteria and click the “Search” button.



Type of ID:	Select the type of identifier to search, CDB ID, Local ID, or BCCP ID. The BCCP ID option will only appear for users who have Access to Identifiers security permissions.
ID:	Enter the ID to find or leave this blank to return all clients.
Program:	Select the program to search in this dropdown list. This list only appears for users who have Access to Raw Data Statewide security permissions.

Step	*Action*
3	The results of the search appear at the bottom of the page.  To continue to the Client Enrollment Page, click the CDB ID link for a client in the search results. If the search only finds one client, the Client Enrollment Page appears automatically. ***Note:*** Only the CDB ID and Local ID fields appear in the search results if you do not have Access to Identifiers security permissions.

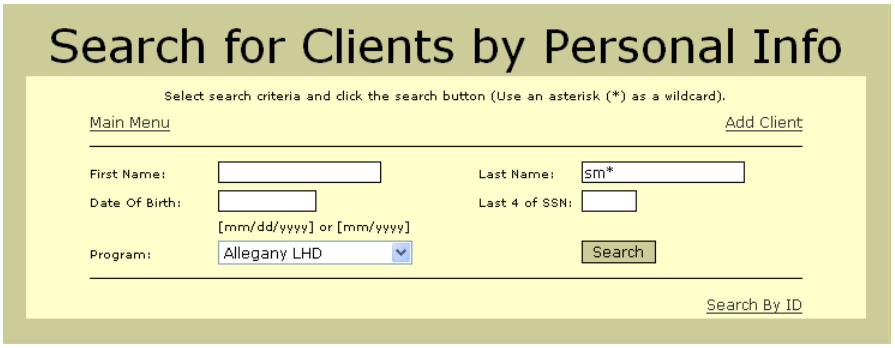
Search for Client by Personal Information

Note:
In order to search for clients by personal information, you must have Access to Identifiers security permissions.

Follow the steps below to search for a client by personal information.

Step	*Action*
1	Choose “Search for Client – Personal Info” on the Main Menu Page.

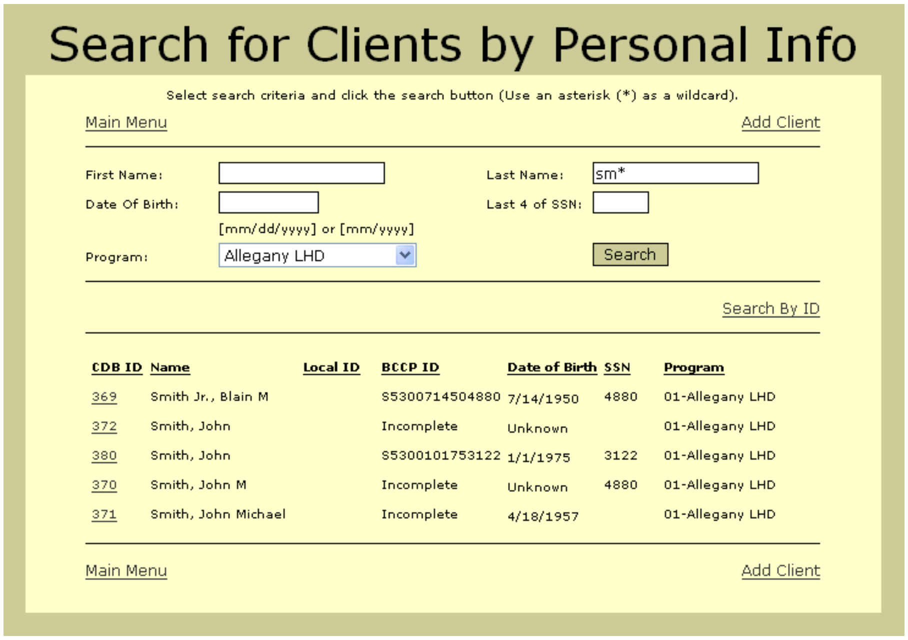
Step	*Action*
2	On the Search Page, select the search criteria and click the "Search" button. You must enter at least one criterion before clicking the "Search" button.



First Name:	Enter the first name of the client to find. This field accepts wildcards.
Last Name:	Enter the last name of the client to find. This field accepts wildcards.
Date Of Birth:	Enter the birth date of the client in mm/dd/yyyy or mm/yyyy format.
Last 4 of SSN:	Enter the last four digits of the client's Social Security Number.
Program:	Select the program to search in this dropdown list. This list only appears for users who have Access to Raw Data Statewide security permissions.

Tip:
Use asterisks (*) for wildcard searches in the First Name and Last Name fields. An asterisk will match any sequence of characters. For example:

ro* - Returns Rob but does not return Aaron.
ro - Returns Rob and Aaron.

Step	*Action*
3	The results of the search appear at the bottom of the page.  To continue to the Client Enrollment Page, click the CDB ID link in the search results. If the search only finds one client, the Client Enrollment Page appears automatically.

Add a New Client

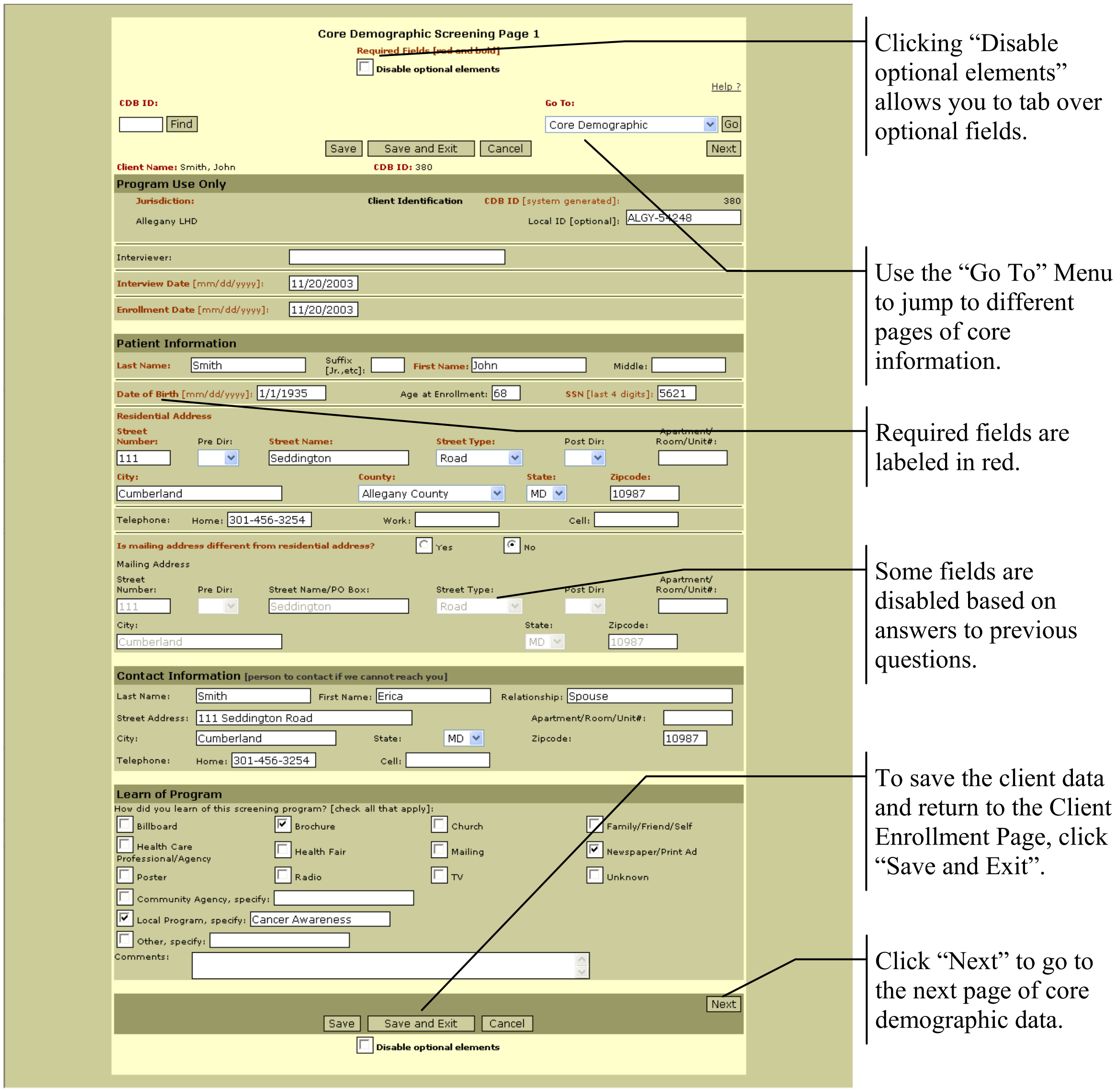
Adding a client to the CDB system entails entering their core demographic data. Follow the steps below to add a new client.

Note:
In order to add clients, you must have Update security permissions.

Tip:
Always search for a client before adding them to the system. The client may already exist in the CDB database.

Step	*Action*
1	Choose "Add New Client" on the Main Menu Page.
2	Enter the core demographics for the client on each of the three core demographic screening forms - the first form is shown below. The core demographic data is

Step	*Action*
	common to all cancer modules. Appendix A contains a description of all core demographic fields.



To continue to the next screening form, click the "Next" button at the bottom of the page.

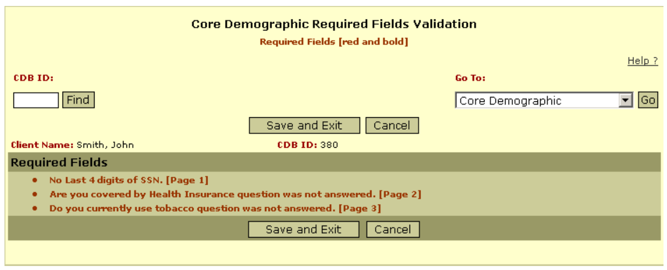
To save the core information and return to the Client Enrollment Page, click the "Save and Exit" button. To save the core information and remain on the current page, click the "Save" button. Clicking the "Save and Exit" button on the third Core Demographic Screening Page validates the required fields. If any required fields are missing, the Required Fields Validation Page opens as described in the next step.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td></td><td>

Tip:
You can save the data you have entered at any time and return when you want to finish. Simply click the “Save and Exit” button at the bottom of the page to save the data.

</td></tr>
<tr><td>3</td><td>

The Required Field Validations Page displays required core data that is missing for the client. The page displays each missing field as one bulleted item.

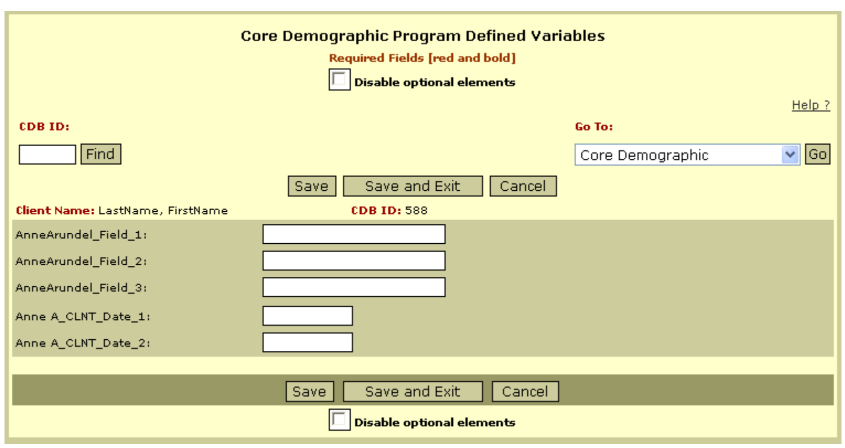


To correct the missing information, go to the appropriate core demographic screening form using the “Go To” Menu.

Tip:
You can view required field validations at any time by choosing “Required Field Validations” from the “Go To” Menu.

</td></tr>
<tr><td>4</td><td>

If applicable, enter the program defined data for the client. Program defined variables are specific to the enrolled program for the client. To get to the page, select “Program Defined Variables” on the “Go To” Menu at the top of the page.



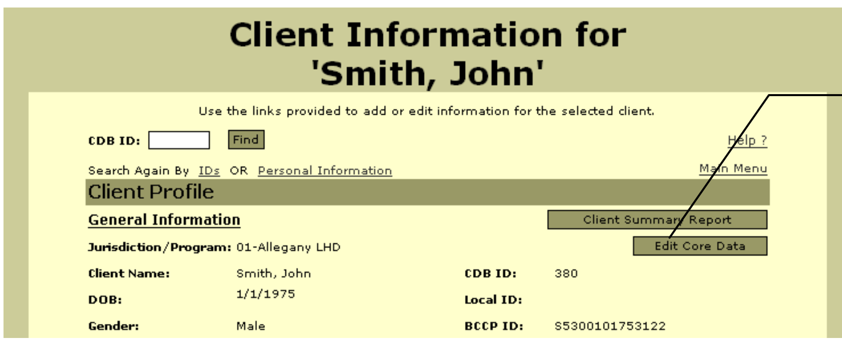
To save your changes and return to the Client Enrollment Page, click “Save and Exit”. To save your changes and remain on the page, click the “Save” button. To cancel without saving, click “Cancel”.

</td></tr>
</table>

Update Core Demographic Data

To return to the core demographic screening forms and update a client’s core data or program defined variables, follow the steps below.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Search for the client using the steps outlined in the “Search for an Existing Client” section earlier in this chapter. Open the Client Enrollment Page for the client by clicking their CDB ID in the search results.</td></tr>
<tr><td>2</td><td>Click the “Edit Core Data” button on the Client Enrollment Page to access the core demographic screening forms.



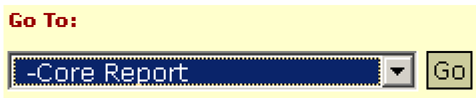
Click “Edit Core Data” to open the core screening forms.</td></tr>
<tr><td>3</td><td>Proceed to update the core demographic data using the same screening forms described in the “Add a New Client” section earlier in this chapter.</td></tr>
</table>

Note:
In order to view demographic data, you must have Access to Raw Data Statewide or Access to Raw Data Local security permissions. To view identifying data, you must have Access to Identifiers security permissions. Updating core demographics requires Update Data security permissions.

Viewing the Core Report

The core report displays information regarding all data elements within the core demographic forms. To view the report for an individual do the following.

Note:
In order to view the cycle report, you must have Access to Reports security permissions.

Step	*Action*
1	On the Core Demographic Screening Form, choose "Core Report" from the "Go To" Menu at the top right of the page and click "Go".  The core report opens in a new window and may be printed by using the tool bar at the top of the report window.

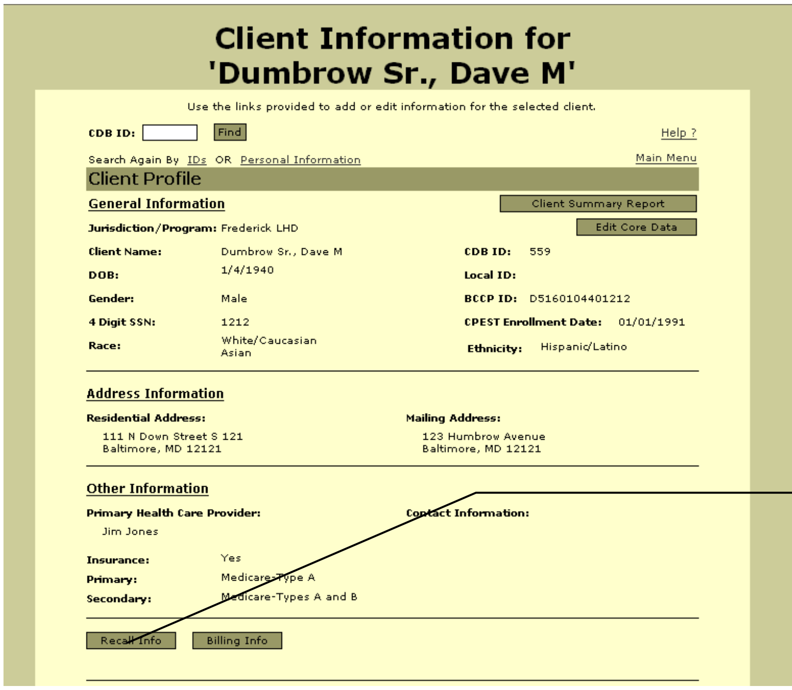
Manage Client Recalls

The Client Recall Page displays recall information for a client including the procedures from the cycle closure pages of all the modules on one page. To manage client recalls, follow the steps below.

Note:
In order to add/view recall information, you must have Access to Raw Data Local or Access to Raw Data Statewide security permissions. To update, edit, or delete recall information, you must have Update Data security permissions.

Step	*Action*
1	Search for the client using the steps outlined in the "Search for an Existing Client" section earlier in this chapter. Open the Client Enrollment Page for the client by clicking their CDB ID in the search results.

Step	*Action*
2	Click the “Recall Info” button on the Client Enrollment Page to access the Client Recall Page.



Client Information for
'Dumbrow Sr., Dave M'

Use the links provided to add or edit information for the selected client.

CDB ID: Find Help ?

Search Again By IDs OR Personal Information Main Menu

Client Profile

General Information Client Summary Report

Jurisdiction/Program: Frederick LHD Edit Core Data

Client Name:	Dumbrow Sr., Dave M	CDB ID:	559
DOB:	1/4/1940	Local ID:	
Gender:	Male	BCCP ID:	D5160104401212
4 Digit SSN:	1212	CPEST Enrollment Date:	01/01/1991
Race:	White/Caucasian Asian	Ethnicity:	Hispanic/Latino

Address Information

Residential Address:
111 N Down Street S 121
Baltimore, MD 12121

Mailing Address:
123 Humbrow Avenue
Baltimore, MD 12121

Other Information

Primary Health Care Provider:
Jim Jones

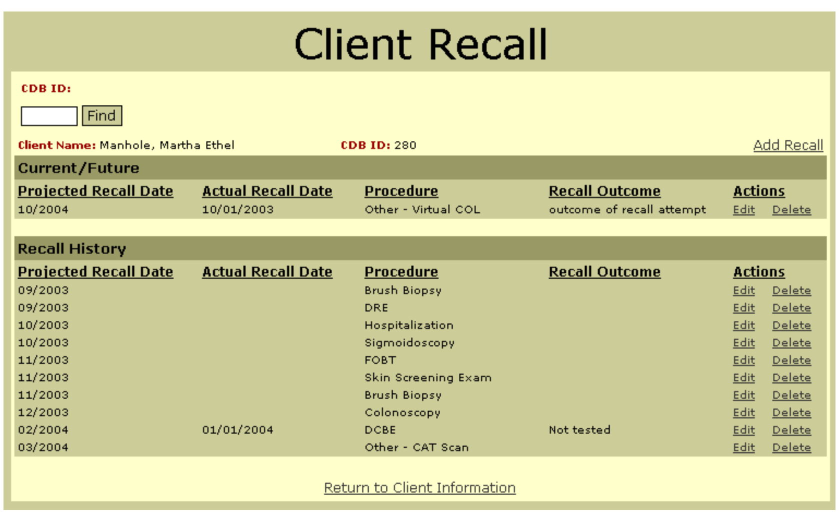
Contact Information:

Insurance:	Yes
Primary:	Medicare-Type A
Secondary:	Medicare-Types A and B

Recall Info Billing Info

Click “Recall Info” to open the Client Recall Page.

Step	*Action*
3	The Client Recall Page displays the recall procedures for the client. The Current/Future section of the page displays the recalls where the Projected Recall Date occurs in the current month or in a future month. The Recall History section displays where the Projected Recall Date is in the past.



Client Recall

CDB ID:

Find

Client Name: Manhole, Martha Ethel CDB ID: 280 Add Recall

Current/Future

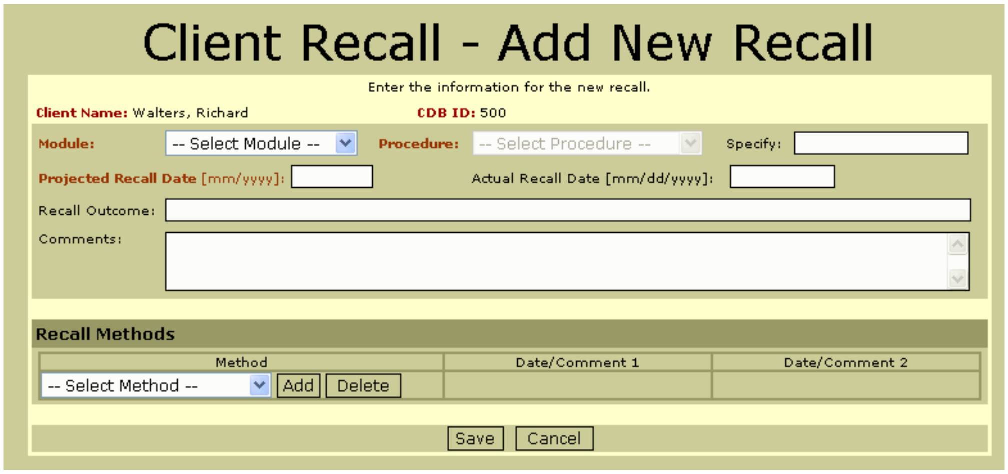
Projected Recall Date	Actual Recall Date	Procedure	Recall Outcome	Actions
10/2004	10/01/2003	Other - Virtual COL	outcome of recall attempt	Edit Delete

Recall History

Projected Recall Date	Actual Recall Date	Procedure	Recall Outcome	Actions
09/2003		Brush Biopsy		Edit Delete
09/2003		DRE		Edit Delete
10/2003		Hospitalization		Edit Delete
10/2003		Sigmoidoscopy		Edit Delete
11/2003		FOBT		Edit Delete
11/2003		Skin Screening Exam		Edit Delete
11/2003		Brush Biopsy		Edit Delete
12/2003		Colonoscopy		Edit Delete
02/2004	01/01/2004	DCBE	Not tested	Edit Delete
03/2004		Other - CAT Scan		Edit Delete

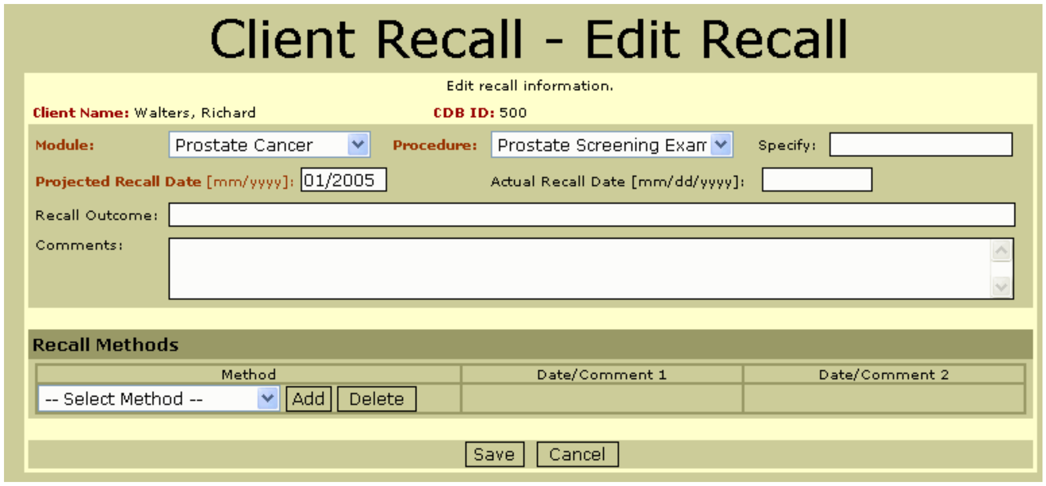
Return to Client Information

Step	*Action*
4	To add a new recall, click the "Add Recall" link in the upper right corner of the page. Enter the recall information into the Add New Recall Page.



Module	The cancer module associated with the recall entry. Note: to add a recall for Physical Exam, select Colorectal Module.
Procedure	The procedure that you are recalling the patient for in that cancer module.
Specify	A text description of an 'Other' procedure selected.
Projected Recall Date	The targeted recall month and year (mm/yyyy) when you want the client to appear in a Recall Report.
Actual Recall Date	Date client actually was recalled (mm/dd/yyyy); this can be completed also under Edit Recall.
Recall Outcome	The outcome of the recall attempt.
Comments	Any comments related to the recall effort.
Recall Methods	
Method	The recall method for the recall.
Date/Comment 1	Date or Comment for first attempt using this recall method. (mm/dd/yyyy)
Date/Comment 2	Date or Comment for second attempt using this recall method. (mm/dd/yyyy)

To save the recall procedure, click the "Save" button. To return to the Client Recall Page without saving, click the "Cancel" button.

Step	*Action*
5	To update a recall procedure, click the "Edit" link next to the procedure under Actions on the Client Recall page. Update the procedure on the Edit Recall Page and click "Save" to save the changes. 
6	To delete a recall procedure, click the "Delete" link next to the procedure under Actions on the Client Recall page. When prompted "Are you sure you want to delete the selected recall?", click "OK" to delete the procedure or "Cancel" to cancel.

Manage Client Billing

Users of the CPEST System can view and maintain client billing information in one table for all Modules using the Client Billing feature. This table can record either *projected* costs after a service is performed but bills are not yet received, or can record *actual amounts* paid by the program, or both. The Client Billing feature is available through the "Billing Info" button on the Client Enrollment Page. To manage client billing information, follow the steps below.

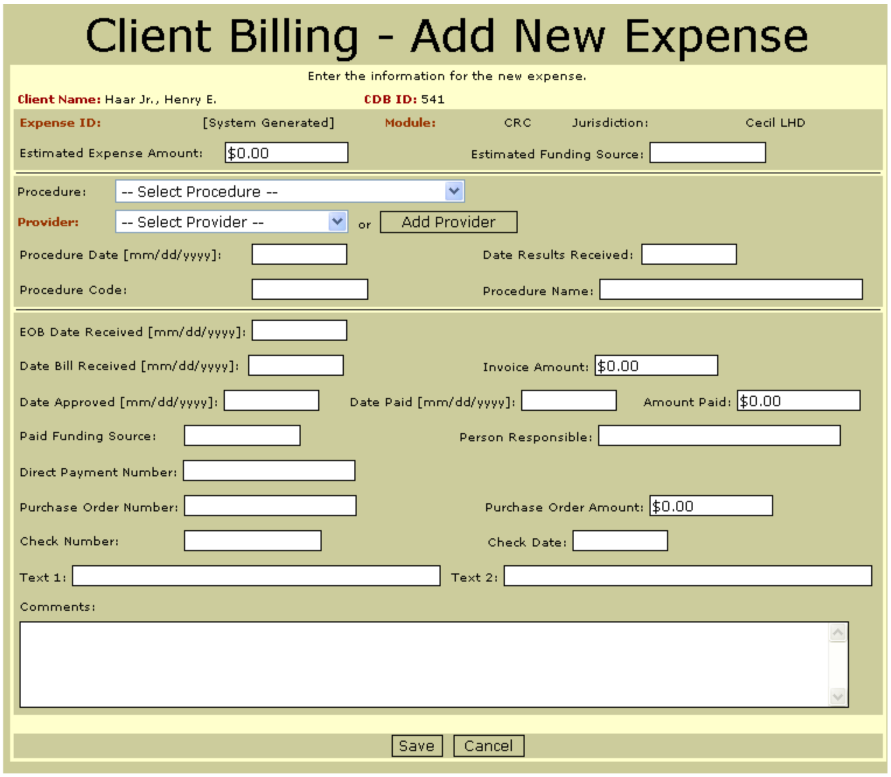
Note:
In order to add/view billing information, you must have Access to Raw Data Local or Access to Raw Data Statewide security permissions. To update, edit, or delete billing information, you must have Update Data security permissions.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Search for the client using the steps outlined in the “Search for an Existing Client” section earlier in this chapter. Open the Client Enrollment Page for the client by clicking their CDB ID in the search results.</td></tr>
<tr><td>2</td><td>Click the “Billing Info” button on the Client Enrollment Page to access the Client Billing Page.

Click “Billing Info” to open the Client Billing Page.</td></tr>
<tr><td>3</td><td>The Client Billing Page displays the Estimated Expenses and Amounts Paid for the client. Each recorded expense appears on the page.


</td></tr>
<tr><td>4</td><td>To add a new expense, select the module of the new expense then click the “Add Expense” link in the upper right corner of the page. Enter the expense information into the Add New Expense Page.</td></tr>
</table>

Step	*Action*



Client Billing - Add New Expense

Enter the information for the new expense.

Client Name: Haar Jr., Henry E. CDB ID: 541

Expense ID: [System Generated] Module: CRC Jurisdiction: Cecil LHD

Estimated Expense Amount: $0.00 Estimated Funding Source:

Procedure: -- Select Procedure --

Provider: -- Select Provider -- or Add Provider

Procedure Date [mm/dd/yyyy]: Date Results Received:

Procedure Code: Procedure Name:

EOB Date Received [mm/dd/yyyy]:

Date Bill Received [mm/dd/yyyy]: Invoice Amount: $0.00

Date Approved [mm/dd/yyyy]: Date Paid [mm/dd/yyyy]: Amount Paid: $0.00

Paid Funding Source: Person Responsible:

Direct Payment Number:

Purchase Order Number: Purchase Order Amount: $0.00

Check Number: Check Date:

Text 1: Text 2:

Comments:

Save Cancel

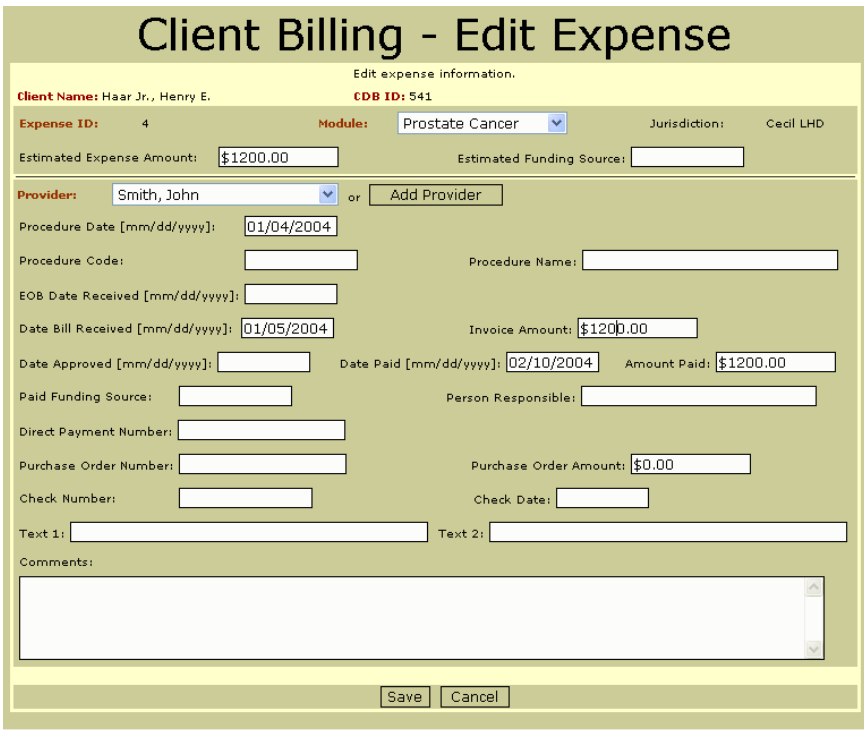
Expense ID	System-generated ID representing this billing record in the system.
Module	Type of cancer module for which money is being encumbered or paid.
Jurisdiction	Identifies the program in which this client is enrolled.
Estimated Expense Amount	Amount to be encumbered.
Estimated Funding Source	Text entry of expected funding source.
Procedure	Listing of all procedures entered within the CDB for the selected client and module. [The procedures are ordered by procedure name, date performed and cycle.]
Provider	Provider of service, or Add Provider here. If the selected billing record has a recorded provider it will be populated by the system.
Procedure Date	Date of the procedure from the HCFA-1500 or other billing form. If the selected billing record has a recorded date performed it will be populated by the system.
Date Results Received	If the selected billing record has a recorded date performed it will be populated by the system. (View only field)
Procedure Code	Common procedural terminology code (CPT code) for the procedure performed.
Procedure Name	Text entry for name of the procedure performed. The name associated with a selected billing procedure will be populated by the system.
EOB Date Received	Date the EOB was received.
Date Bill Received	Date the bill was received.

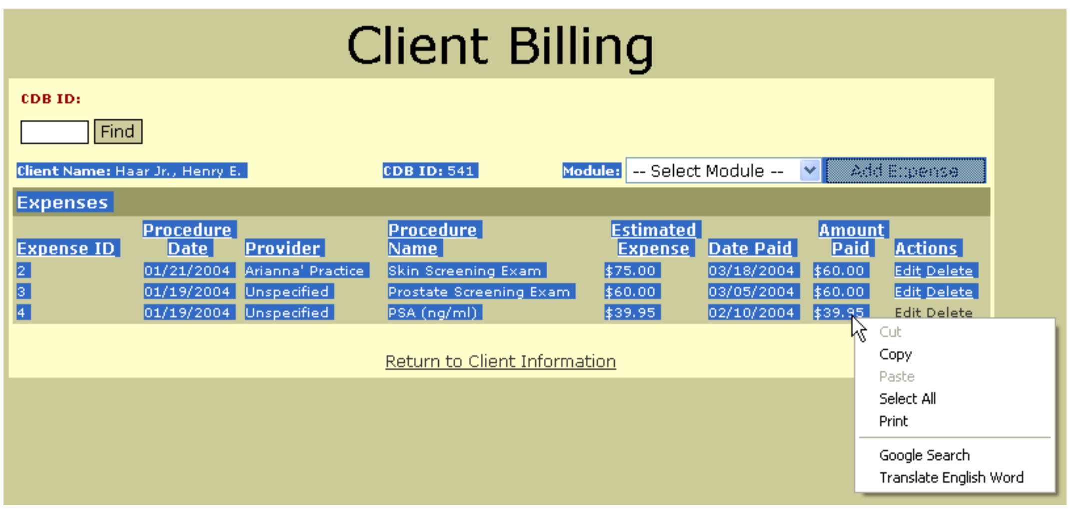
Step	Action

Invoice Amount	Amount provider charged for procedure on invoice
Date Approved	Date of invoice approval.
Date Paid	Date invoice paid.
Amount Paid	Amount paid to the provider for the procedure.
Paid Funding Source	Text entry of actual funding source.
Person Responsible	Name of person entering the information.
Direct Payment Number	Number of direct payment.
Purchase Order Number	Number of purchase order.
Purchase Order Amount	Amount of purchase order.
Check Number	Number of check associated with payment.
Check Date	Date of check associated with payment.
Text 1	Undesignated text area which allows for up to 50 characters.
Text 2	Undesignated text area which allows for up to 50 characters.
Comments	Comments about this billing entry. (such as amount billed by the provider of service, whether charge is HSCRC rate, etc.)

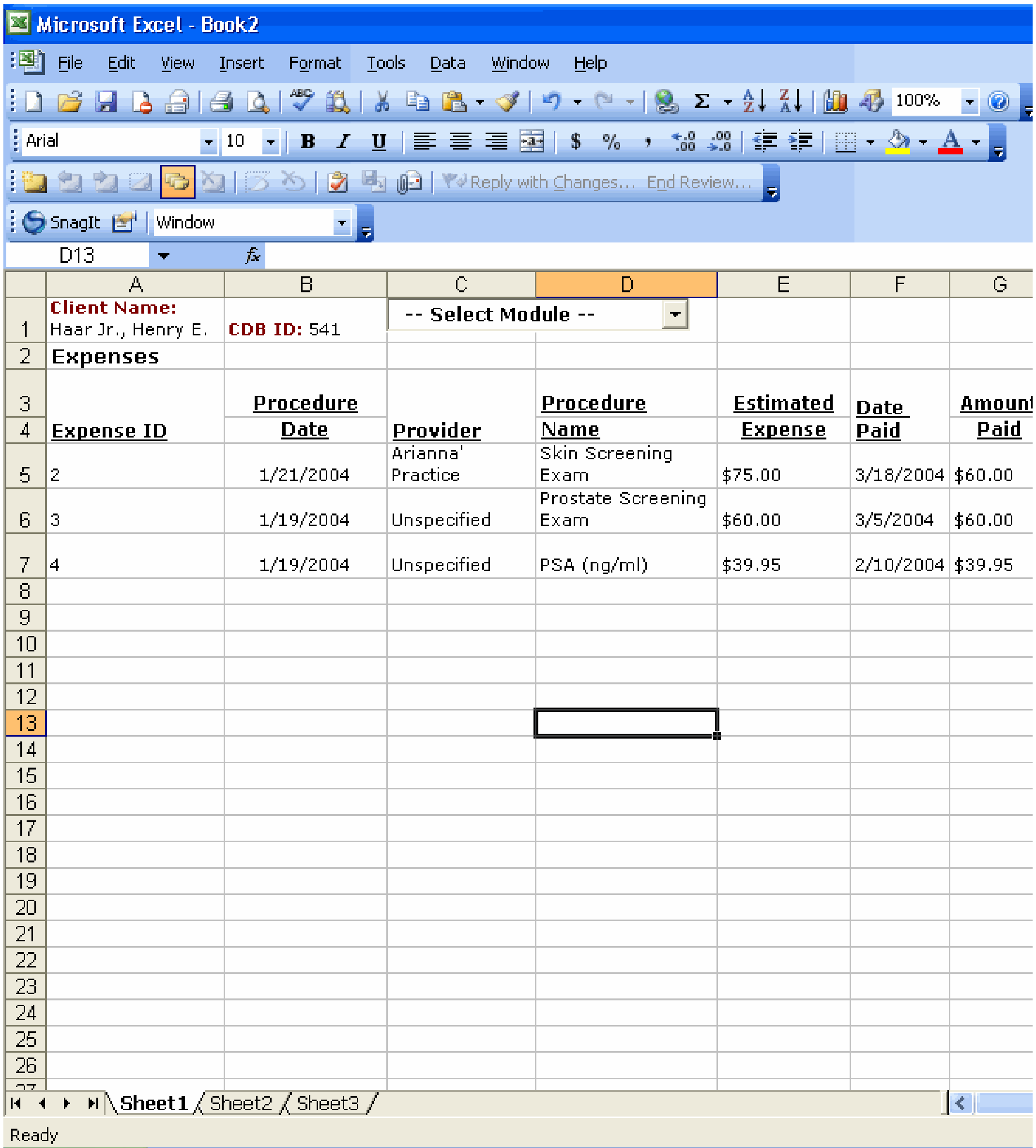
To save the expense information, click the “Save” button. To return to the Client Billing Page without saving, click the “Cancel” button.

5	To update an expense, click the “Edit” link next to the expense under Actions on the Client Billing page. Update the expense on the Edit Expense Page and click “Save” to save the changes.



Step	*Action*
6	To delete an expense, click the “Delete” link next to the expense record under Actions on the Client Billing page. When prompted “Are you sure you want to delete the selected expense?” click “OK” to delete or “Cancel” to cancel.
7	 ***Tip:*** **<u>Client Billing Expenses</u>** To import Client Billing Expenses into Excel in order to perform calculations: ❑ **Highlight** the table (Client name through last row of billing information) with the mouse. ❑ Select **Copy** with the right mouse button. ❑ Copy the Expenses, then going into Excel and **paste** the data into an **Excel** spreadsheet. 

Step	*Action*
8	The Expenses will then be imported to an **Excel** spreadsheet where calculations can be made.

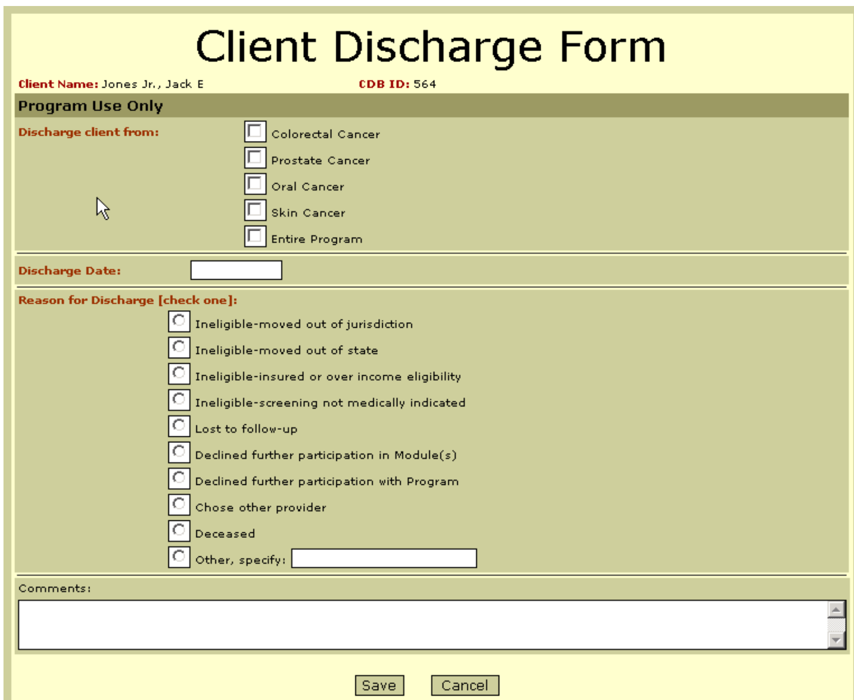


	A	B	C	D	E	F	G
1	Client Name: Haar Jr., Henry E.	CDB ID: 541					
2	Expenses						
3–4	Expense ID	Procedure Date	Provider	Procedure Name	Estimated Expense	Date Paid	Amount Paid
5	2	1/21/2004	Arianna' Practice	Skin Screening Exam	$75.00	3/18/2004	$60.00
6	3	1/19/2004	Unspecified	Prostate Screening Exam	$60.00	3/5/2004	$60.00
7	4	1/19/2004	Unspecified	PSA (ng/ml)	$39.95	2/10/2004	$39.95

Discharge a Client

To discharge a client from the CDB program or cancer module, follow the steps below.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Search for the client using the steps outlined in the “Search for an Existing Client” section earlier in this chapter. Open the Client Enrollment Page for the client by clicking their CDB ID in the search results.</td></tr>
<tr><td>2</td><td>Click the “Discharge Client” button at the lower left corner of the Client Enrollment Page to access the Client Discharge Form.


</td></tr>
<tr><td>3</td><td>Enter the information regarding the client discharge into the form.

<table>
<tr><td>Discharge client from</td><td>Selection list of active modules for the client from which the user may choose to discharge the client; from one module to the ‘Entire Program’. (Entire Program option will select all modules.)</td></tr>
<tr><td>Discharge Date</td><td>The date the client was discharged from the program.</td></tr>
<tr><td>Reason for Discharge</td><td>Indicates why the client was discharged.</td></tr>
<tr><td>Comments</td><td>Other comments pertaining to the discharge.</td></tr>
</table>

Click “Save” to discharge the client and save the information on the form, or “Cancel” to exit without discharging the client.</td></tr>
</table>

Chapter 3: Client Enrollment Page

The Client Enrollment Page is the hub of the CDB system. From this central page, a person can manage core client demographics and enroll clients in cancer screening programs.

Included in This Chapter

Accessing the Client Enrollment Page

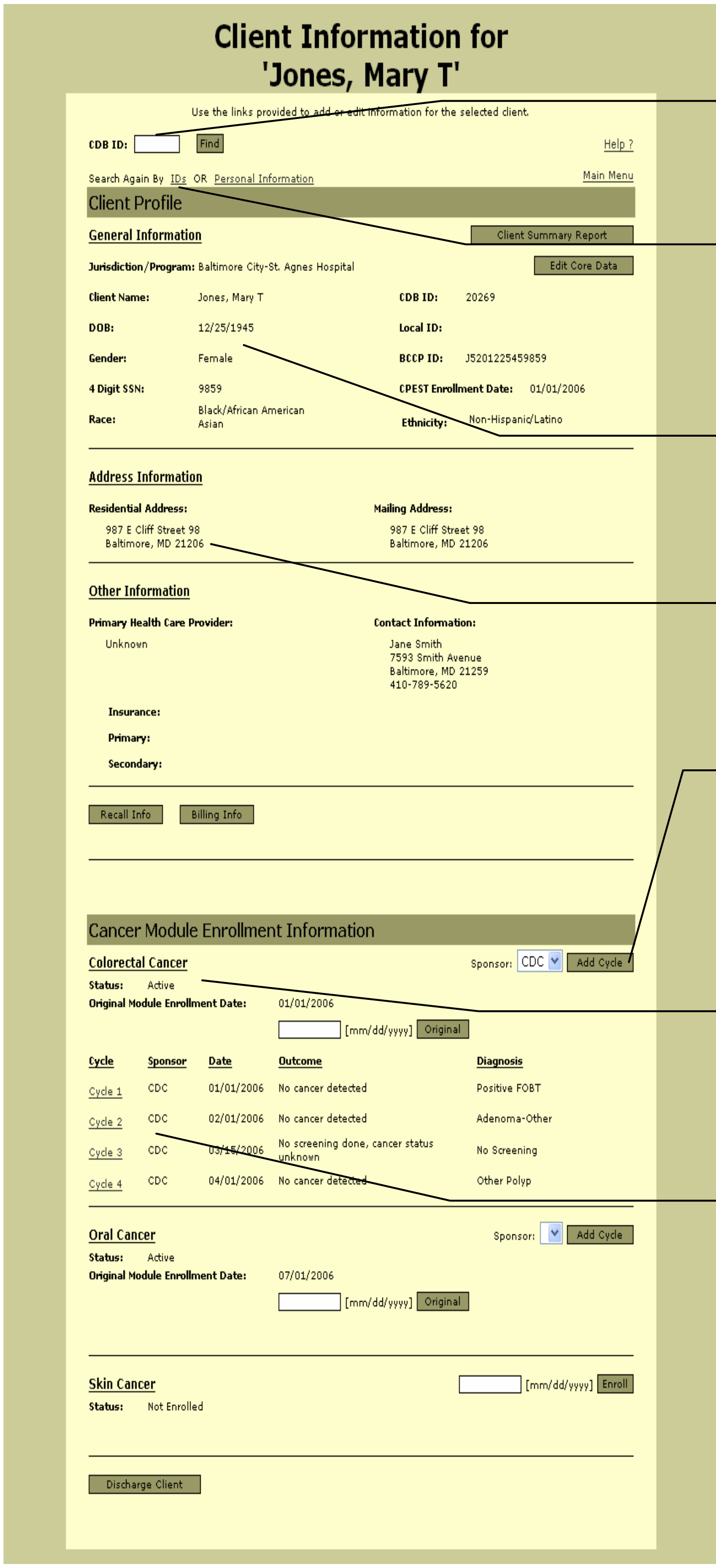
To access the Client Enrollment Page, use the search features detailed in the "Search for an Existing Client" section of Chapter 2.

Note:
Only users with Access to Raw Data Statewide or Access to Raw Data Local security permissions may access the Client Enrollment Page.

The Client Enrollment Page

The Client Enrollment Page is the central navigation point for the CDB system. From this page, a person can update the client's core demographic data or manage their cancer module enrollments. The page is divided into two sections. The top section displays the client's profile and the bottom section displays the client's cancer module enrollments.

Client Enrollment Page



To jump to another client, enter the CDB ID and click "Find".

To search for another client, click the search links.

This section displays the client's profile information.

If you do not have Access to Identifiers security permissions, the personal information for the client will not be displayed.

This section defaults to the Sponsor. If your program receives funding from different sponsors the option to choose it is available.

This section displays each cancer module and its status.

Each cancer module contains a list of cycles.

Note:
Users that do not have Update Data security permissions can only view the information provided on the Client Enrollment Page.

Client Profile

The Client Profile section of the page displays summary information for the client. The table below explains each field in the section.

Jurisdiction/Program	Program to which this client belongs.
Client Name	Name of the Client. (Last Suffix, First Middle)
CDB ID	Client ID for the Client.
DOB	Date of Birth.
Local ID	Local ID for the Client.
Gender	Client Gender.
BCCP ID	Derived ID.
4 Digit SSN	Last 4 digits of the Client SSN.
CPEST Enrollment Date	Date of Enrollment in CDB program.
Race	List of all Race values selected for the Client.
Ethnicity	Client Ethnicity.
Residential Address	Geographic Address of Client Residence.
Mailing Address	Mailing Address for Client. ***Note:*** Post Office Box information (i.e. P.O. Box 210) should be entered in the Street Name field.
Primary Health Care Provider	Name, Address and Phone of Primary Provider for Client.
Contact Information	Name, Address, Phone of Contact for Client.
Insurance	Yes if the Client has insurance, No if not.
Primary	Type of Insurance. (Primary)
Secondary	Type of Insurance. (Secondary)

The buttons on the Client Profile section perform actions for viewing and managing the client information. The table below describes each action in detail.

Client Summary Report	Click this button to open a report that displays the profile and enrollment data for the client. ***Note:*** Only users with Access to Reports can generate and view the Client Summary Report.
Edit Core Data *- or -* *View Core Data*	Click this button to edit or view the core demographic data for the client. More information on core demographic data is detailed in the "Add a New Client" section of Chapter 2.
Recall Info	Click this button to manage recall information for the client. For more information on managing recalls, see Chapter 2 – Manage Client Recalls.
Billing Info	Click this button to manage billing information for the client. For more information on managing billing data, see Chapter 2 – Manage Client Billing.
Delete Client	Deletes the Client record from the system. This button is only available if the client has never been enrolled in any Cancer Modules and you have Update Data security permissions.

Cancer Module Enrollment

The Cancer Module Enrollment section of the page displays enrollment information for each cancer module tracked within CDB. Furthermore, each module shows the client's cycles and their outcome. The table below explains each field in the section.

Status	Client's current status in cancer module.
Original Module Enrollment Date	Client's original enrollment date. This is only shown if the client is enrolled.
Module Re-Enroll Date	Client's re-enrollment date. This is only shown if client was re-enrolled.
Cycle Information	
Cycle	Incrementing number that identifies a cycle.
Sponsor	CRF or CDC sponsored program
Date	Cycle start date.
Outcome	Outcome of the cycle.
Diagnosis	Final Hierarchical Diagnosis. This only applies to Colorectal and Skin Cancer Modules. See Help for definitions.

The buttons in the Cancer Module Enrollment section perform actions for enrolling and discharging clients. The table below explains the functionality of each button in the section.

Note:
These buttons are only available if you have Update Data security permissions.

Enroll	This button is linked to the date field to its left. Enter an enrollment date in the date field and click this button to enroll the client in a cancer module. The button is only available if the client is not already enrolled in the specified cancer module.
Re-Enroll	This button is linked to the date field to its left. Enter an enrollment date in the date field and click this button to re-enroll a client in a cancer module. The button is only available if the client was discharged from the cancer module.
Add Cycle	Click this button to add a new cycle to a cancer module. This button is only available if the client is enrolled in the cancer module and has no open cycles.
Sponsor	Designates whether the cancer screening is being funded by CRF or CDC programs.
Original/Re-Enroll	This button is linked to the date field to its left. Enter an enrollment date in the date field and click this button to modify the original or re-enrollment date. The original button is only available if user is enrolled in the cancer module. The re-enroll button is only available if the user has been re-enrolled - and not discharged.
Discharge Client	Click this button to navigate to the discharge form to discharge the client. This button is only available if the client is enrolled in at least one cancer module and is not discharged from all of their enrolled cancer modules.

Chapter 4: Colorectal Cancer Screening

The Colorectal Cancer Screening Module comprises several pages that collect and maintain data within the context of a screening cycle. CDB stores the data for each cycle and provides reports for data validation.

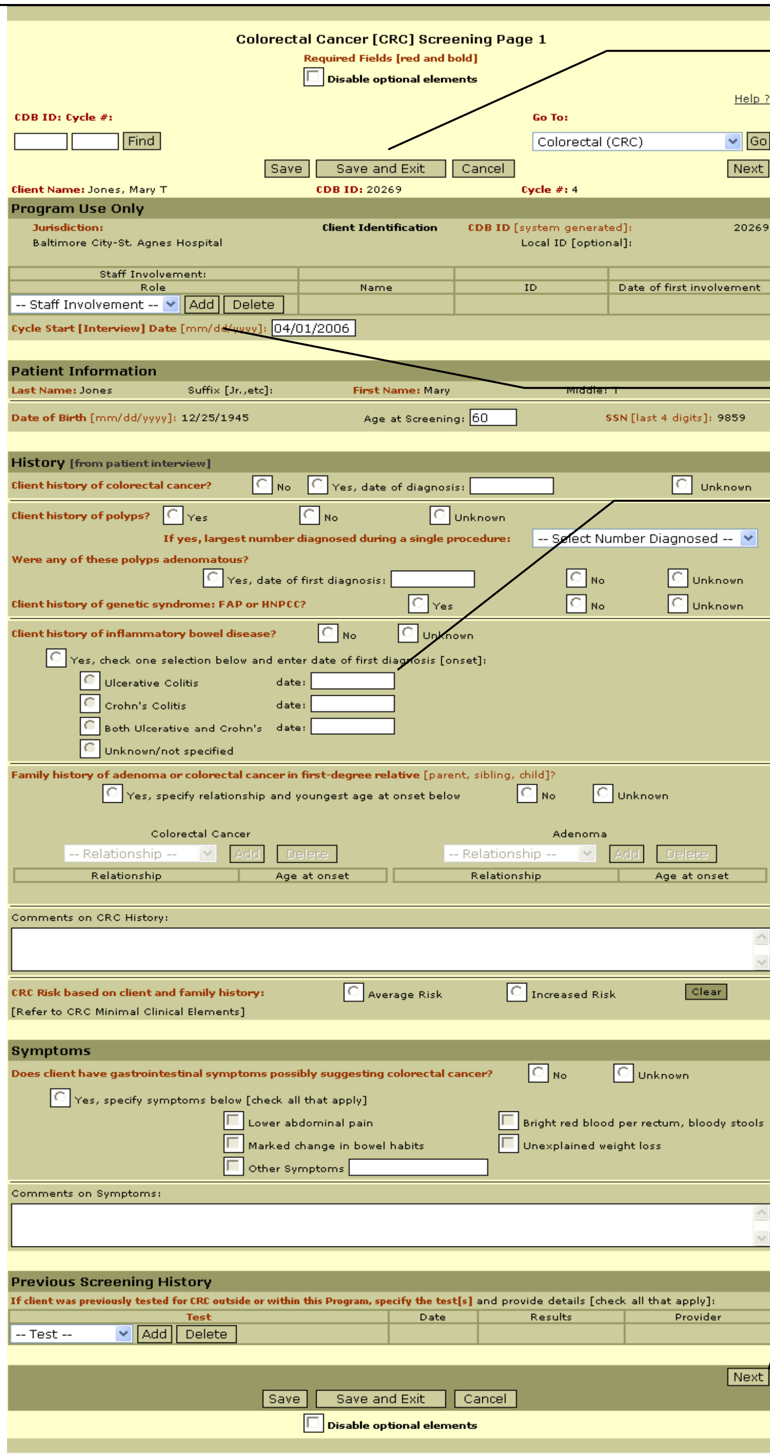
Note:
In order to access the Colorectal Module you must have Access to Raw Data Statewide or Access to Raw Data Local security permissions. Additionally, you must have Access to Identifiers security permissions in order to view fields designated as identifying data. You will be able to update data only if you have Update Data security permissions.

Adding a Cycle

A cycle represents an iteration of the screening process for a client. During the cycle, you perform all of the screening and any necessary post-screening actions. Follow the steps below to add a colorectal cancer screening cycle.

Step	*Action*
1	Enroll the client in the colorectal cancer module if they are not already enrolled. To enroll the client, click “Enroll” in the “Colorectal Cancer” section of the client’s enrollment page. For information on enrolling clients, see Chapter 3 – Client Enrollment Page.
2	On the Client Enrollment Page, click the “Add Cycle” button under the Colorectal Cancer screening section. ***Note:*** You must close all previous colorectal cycles before adding a new cycle. To close a previous cycle, go to the Cycle Closure Page and enter the closing information.
3	Enter the colorectal screening data on the four screening pages. The picture below shows the first screening form.

Step	*Action*
	See the form below.



This is the standard screening navigation header. To find out more about the header, see the "Screening Form Navigation" section of Chapter 1.

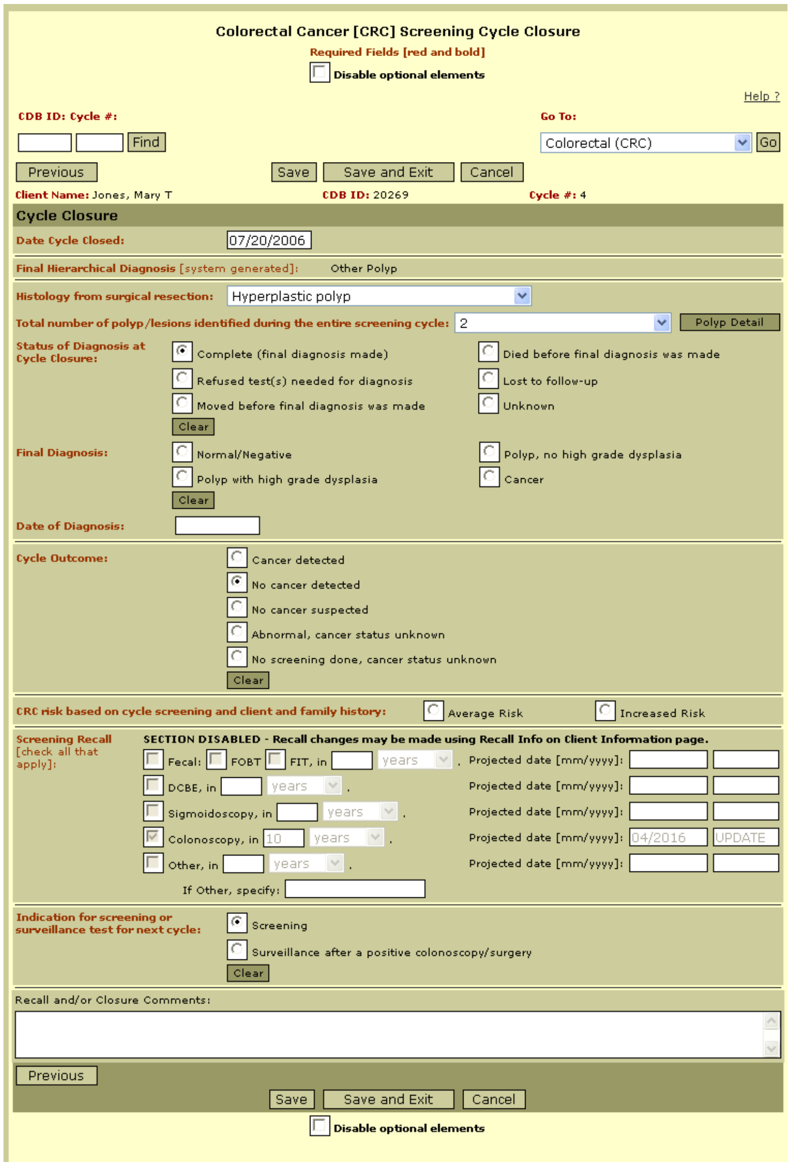
Required fields are displayed in red.

Some fields are enabled or disabled based on your answers in previous fields.

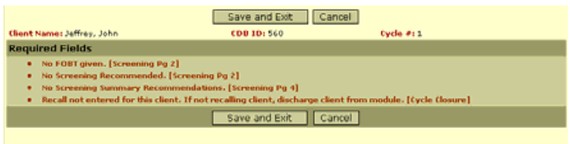
Click "Next" to go to the next screening page.

The field definitions for the screening forms are in Appendix B – Colorectal Cancer Screening Fields.

Step	*Action*
	Note: Fields on the screening forms are enabled or disabled based on your answers to previous questions. The “Previous” and “Next” buttons on the page navigate between forms. Some forms are skipped based on your responses to questions on previous forms.
4	To enter additional information pertaining to post-screening, proceed to the post-screening forms. ***Note:*** Fields on the post-screening forms will be enabled or disabled based on your answers to previous questions. The “Previous” and “Next” buttons on the page navigate between forms. Some forms are skipped based on your responses to questions on previous forms.

Step	Action
5	To close the cycle, enter the closing information on the Cycle Closure Page.  Click the "Save and Exit" button to save the data and return to the Client Enrollment Page or "Save" to save the data and remain on the current page. Click "Cancel" to exit without saving.

Step	*Action*
6	After saving the form, the Required Fields Validation Page shows any required fields that are missing. To correct the fields, navigate back to the individual pages using the “Go To” Menu and enter the missing information.

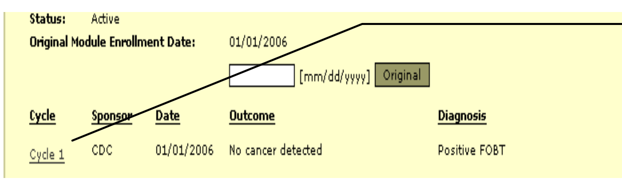


Note:
You can return to any page in the cycle at any time by opening the cycle from the Client Enrollment Page and using the “Go To” Menu at the top of the pages. The following section titled “Entering Additional Data” describes this process.

Closing a Cycle

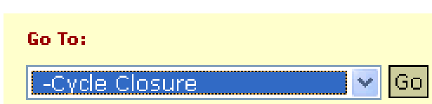
Closing a cycle is the method of ending a screening process and entering information about the outcome. To close a cycle, follow the steps below.

Step	*Action*
1	On the Client Enrollment Page, click the cycle link for the cycle you wish to close. For information on the Client Enrollment Page, see Chapter 3 – The Client Enrollment Page.



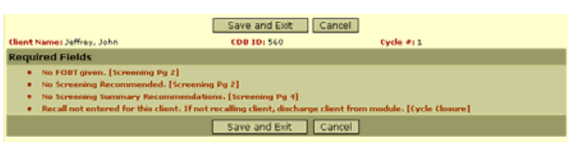
Click the cycle link to open the screening pages for the cycle.

Step	*Action*
2	On the Colorectal Cancer Screening Form, choose “Cycle Closure” from the “Go To” Menu at the top right of the page and click “Go”.



<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>3</td><td>
To close the cycle, enter the closing information on the Cycle Closure Page. A screening recall procedure and date are required. If the client is not being recalled, the client should be discharged from the module/program.

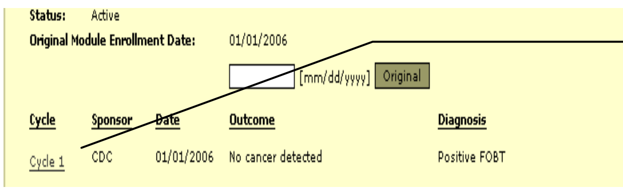
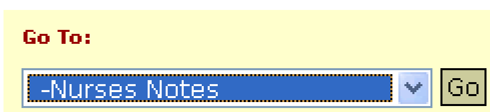
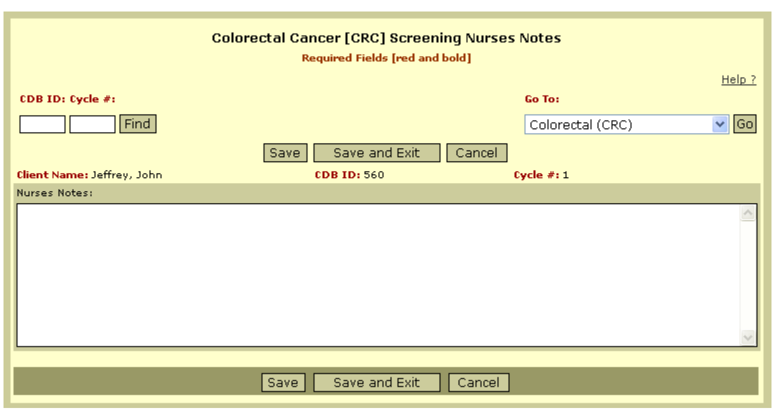
Click the "Save and Exit" button to save the closing data and return to the Client Enrollment Page or "Save" to save the data and remain on the current page. Click "Cancel" to exit without saving.
</td></tr>
<tr><td>4</td><td>
After saving the form, the Required Fields Validation Page shows any required fields that are missing. To correct the fields, navigate back to the individual pages using the "Go To" Menu and enter the missing information.



</td></tr>
</table>

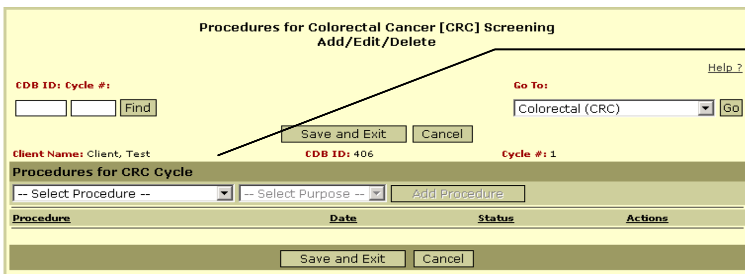
Entering Additional Data

At any time, a person can return to a cycle and enter additional information. This section explains how to return to a cycle and enter additional procedures, nurses' notes, and program defined variables. However, the procedure for opening a cycle and navigating to specific pages also applies to the screening forms, post-screening forms, and the cycle closure page.

Step	*Action*
1	On the Client Enrollment Page, click the cycle link for the cycle you wish to update. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.  Click the cycle link to open the screening pages for the cycle.
2	On the Colorectal Cancer Screening Form, choose the page you wish to view from the "Go To" Menu and click "Go". 
3	To enter nurses' notes, go to the Nurses Notes Page and enter the information.  Click "Save and Exit" to save the notes and return to the Client Enrollment Page or "Save" to save the notes and remain on the current page. Click "Cancel" to exit without saving.

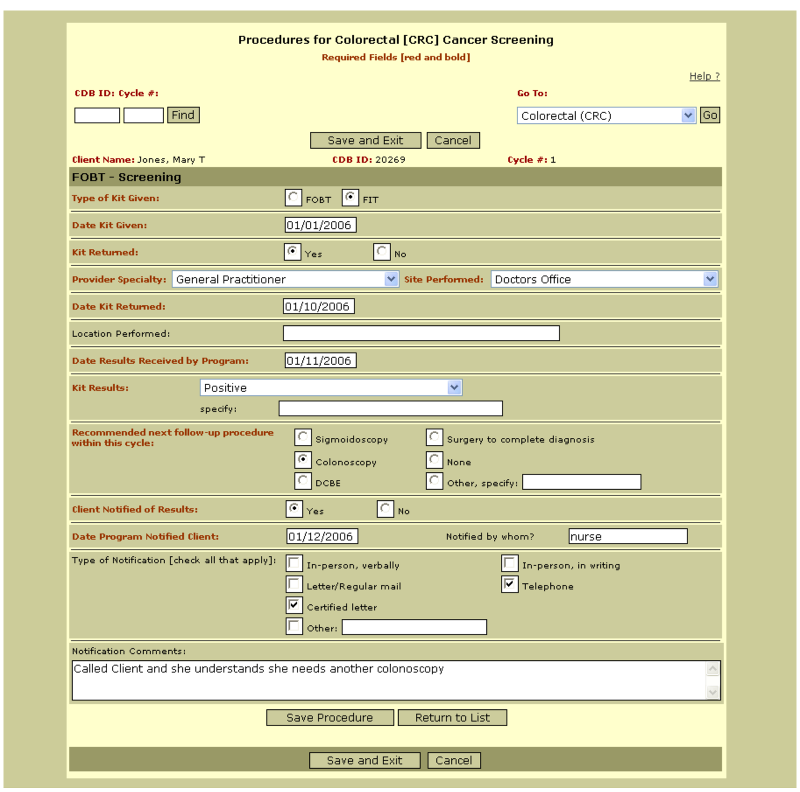
Step	*Action*
4	To enter additional procedures go to the Additional Procedures Page and enter the information on the page. Additional procedures are those completed by the program through the cycle for this client. Procedures entered via the Screening and Post Screening Evaluation Forms are also displayed on this page in order to provide access to additional, optional data elements not found on the forms.

To add a procedure, select the procedure and a purpose, and click the “Add Procedure” button. To change an existing procedure, click the “Edit” link next to the procedure. To delete a procedure, click the “Delete” link next to the procedure.

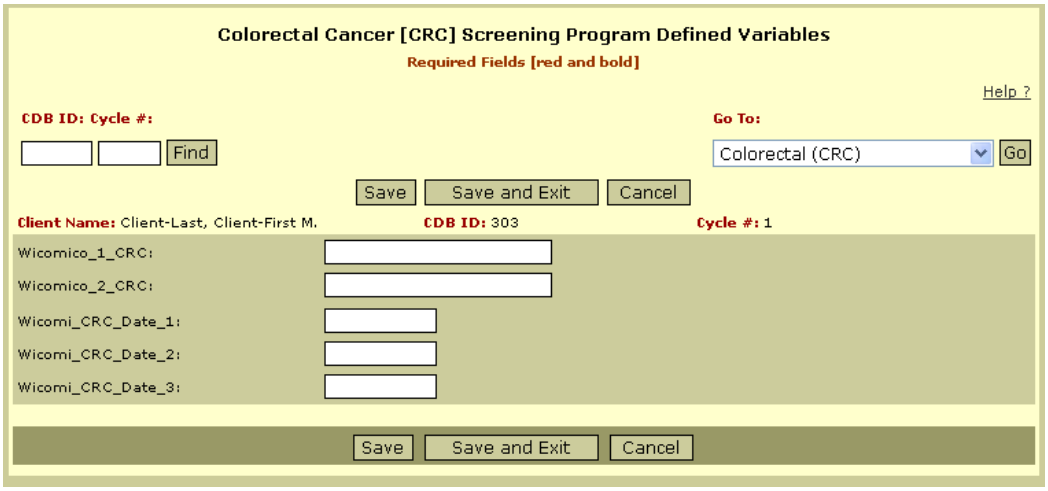


Enter a procedure and purpose and click “Add Procedure” to add the procedure.

Next, enter the procedure information for the procedure you selected.

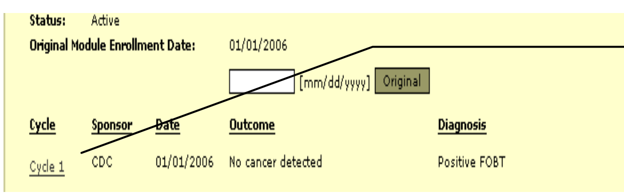


Click “Save and Exit” to save the procedure, or “Cancel” to exit without saving.

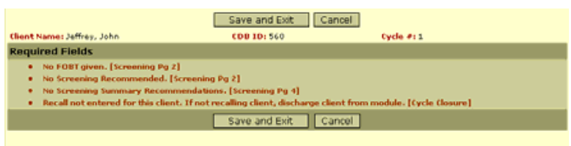
Step	*Action*
5	To enter program defined variables, go to the Program Defined Variables Page and enter the information for your program.  Click “Save and Exit” to save the variables and return to the Client Enrollment Page or “Save” to save the data and remain on the current page. Click “Cancel” to exit without saving.

Validating Required Fields

The Colorectal Cancer Screening module includes many pieces of required information. The CDB system provides a report to track any required fields that are not complete. Follow the steps below to validate required fields for the screening process.

Step	*Action*
1	On the Client Enrollment Page, click the cycle link for the cycle you wish to use. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.  Click the cycle link to open the screening pages for the cycle.

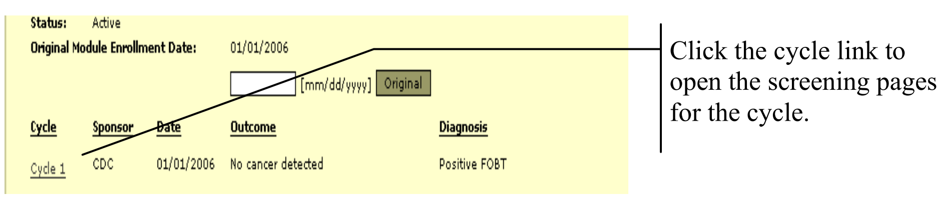
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>2</td><td>On the Colorectal Cancer Screening Form, choose “Required Fields Validation” from the “Go To” Menu at the top right of the page and click “Go”.

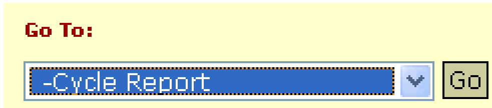
</td></tr>
<tr><td>3</td><td>The Required Fields Validation Page shows any required fields that are missing. To correct the fields, navigate back to the individual pages using the “Go To” Menu and enter the missing information.

</td></tr>
</table>

Viewing the Cycle Report

The cycle report displays information regarding a specific colorectal screening cycle. To view the report for an individual cycle, follow the steps below.

Note:
In order to view the cycle report, you must have Access to Reports security permissions.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>On the Client Enrollment Page, click the cycle link for the cycle you wish to view. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.

</td></tr>
</table>

Step	*Action*
2	On the Colorectal Cancer Screening Form, choose “Cycle Report” from the “Go To” Menu at the top right of the page and click “Go”.  The cycle report opens in a new window and may be printed by using the tool bar at the top of the report window.

Chapter 5: Prostate Cancer Screening

The Prostate Cancer Screening Module comprises several pages that collect and maintain data within the context of a screening cycle. CDB stores the Data for each cycle and provides reports for data validation.

Included in This Chapter

- Adding a Cycle
- Closing a Cycle
- Entering Additional Screening Data
- Validating Required Fields
- Viewing the Cycle Report

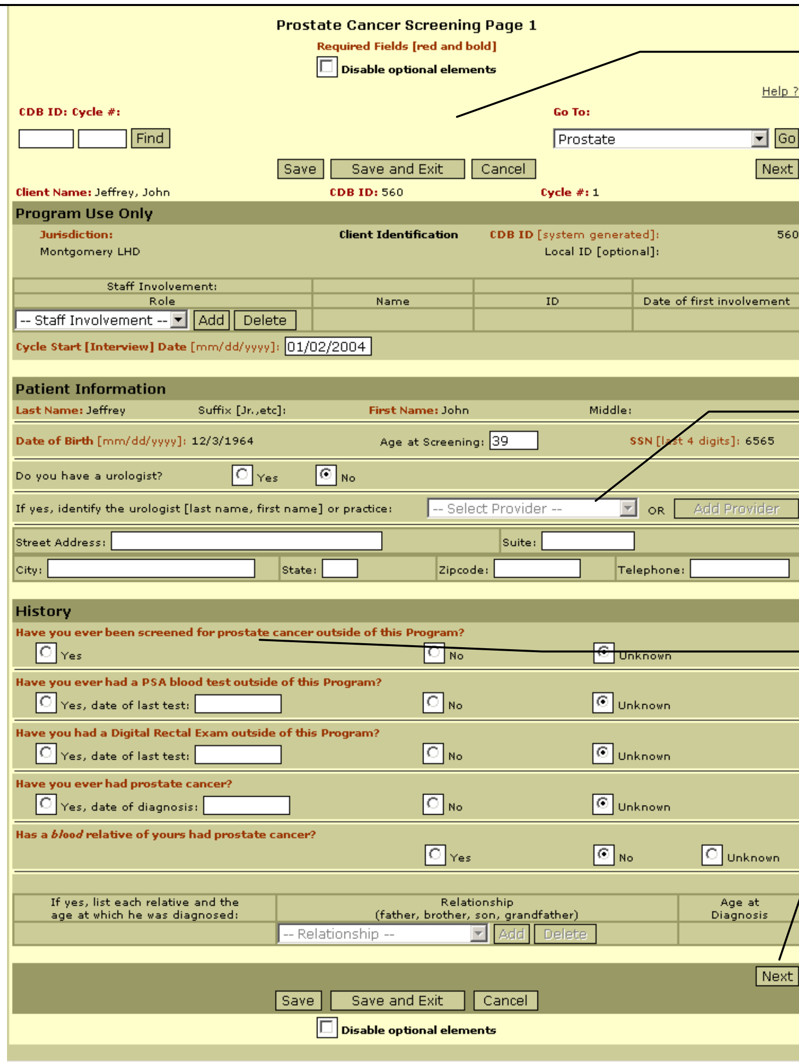
Note:
In order to access the Prostate Module you must have Access to Raw Data Statewide or Access to Raw Data Local security permissions. Additionally, you must have Access to Identifiers security permissions in order to view fields designated as identifying data. You will be able to update data only if you have Update Data security permissions.

Adding a Cycle

A cycle represents an iteration of the screening process for a client. During the cycle you perform all of the screening and any necessary post-screening actions. Follow the steps below to add a prostate cancer screening cycle.

Step	*Action*
1	Enroll the client in the prostate cancer module if they are not already enrolled. To enroll the client, click “Enroll” in the “Prostate Cancer” section of the client’s enrollment page. For information on enrolling clients, see Chapter 3 – Client Enrollment Page.
2	On the Client Enrollment Page, click the “Add Cycle” button under the Prostate Cancer screening section. ***Note:*** You must close all previous prostate cycles before adding a new cycle. To close a previous cycle, go to the Cycle Closure Page and enter the closing information.
3	Enter the prostate screening data on the three screening pages. The picture below shows the first screening form.

Step	*Action*


Prostate Cancer Screening Page 1
Required Fields [red and bold]
Disable optional elements
Help ?
CDB ID: Cycle #:
Find
Go To:
Prostate
Go
Save | Save and Exit | Cancel
Next
Client Name: Jeffrey, John
CDB ID: 560
Cycle #: 1
Program Use Only
Jurisdiction:
Montgomery LHD
Client Identification
CDB ID [system generated]: 560
Local ID [optional]:
Staff Involvement:
Role | Name | ID | Date of first involvement
-- Staff Involvement -- | Add | Delete
Cycle Start [Interview] Date [mm/dd/yyyy]: 01/02/2004
Patient Information
Last Name: Jeffrey
Suffix [Jr.,etc]:
First Name: John
Middle:
Date of Birth [mm/dd/yyyy]: 12/3/1964
Age at Screening: 39
SSN [last 4 digits]: 6565
Do you have a urologist? Yes No
If yes, identify the urologist [last name, first name] or practice: -- Select Provider -- OR Add Provider
Street Address:
Suite:
City:
State:
Zipcode:
Telephone:
History
Have you ever been screened for prostate cancer outside of this Program?
Yes No Unknown
Have you ever had a PSA blood test outside of this Program?
Yes, date of last test: No Unknown
Have you had a Digital Rectal Exam outside of this Program?
Yes, date of last test: No Unknown
Have you ever had prostate cancer?
Yes, date of diagnosis: No Unknown
Has a *blood* relative of yours had prostate cancer?
Yes No Unknown
If yes, list each relative and the age at which he was diagnosed:
Relationship (father, brother, son, grandfather)
Age at Diagnosis
-- Relationship -- | Add | Delete
Next
Save | Save and Exit | Cancel
Disable optional elements

This is the standard screening navigation header. To find out more about the header, see the "Screening Form Navigation" section of Chapter 1.

Some fields will be enabled or disabled based on your answers in previous fields.

Required fields are displayed in red.

Click "Next" to go to the next screening page.

The field definitions for the screening forms are in Appendix C – Prostate Cancer Screening Fields.

Note:

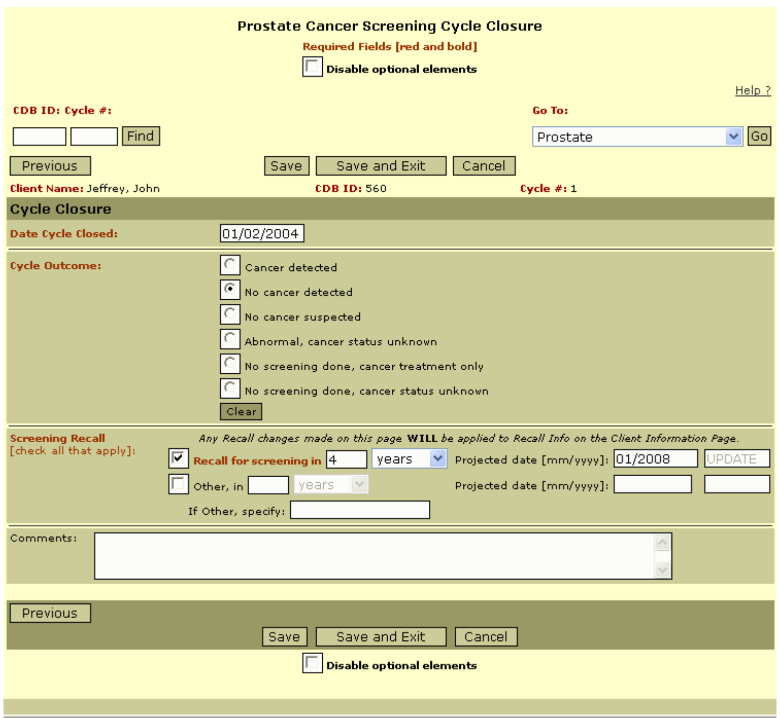
Fields on the screening forms are enabled or disabled based on your answers to previous questions.

The "Previous" and "Next" buttons on the page navigate between forms. Some forms are skipped based on your responses to questions on previous forms.

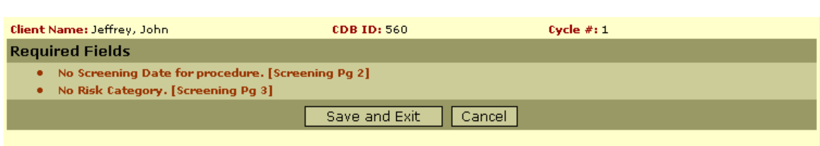
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>4</td><td>To enter additional information pertaining to post-screening, proceed to the post-screening forms.

Note:
Fields on the post-screening forms will be enabled or disabled based on your answers to previous questions.

The “Previous” and “Next” buttons on the page navigate between forms. Some forms are skipped based on your responses to questions on previous forms.</td></tr>
<tr><td>5</td><td>To close the cycle, enter the closing information on the Cycle Closure Page.



Clicking the “Save and Exit” button to save the closing data and return to the Client Enrollment Page or “Save” to save the data and remain on the current page. Click “Cancel” to exit without saving.</td></tr>
<tr><td>6</td><td>After saving the form, the Required Fields Validation Page shows any required fields that are missing. To correct the fields, navigate back to the individual pages using the “Go To” Menu and enter the missing information.

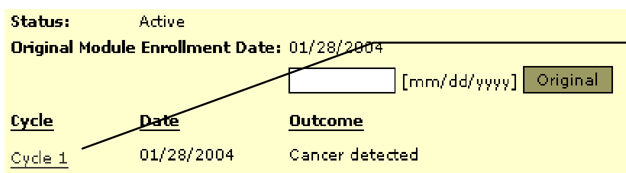

</td></tr>
</table>

Note:
You can return to any page in the cycle at any time by opening the cycle from the Client Enrollment Page and using the “Go To” Menu at the top of the pages. “Entering Additional Data” section later in this chapter describes this process.

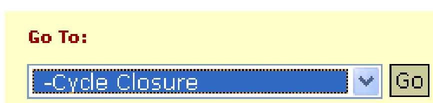
Closing a Cycle

Closing a cycle is the method of ending a screening process and entering information about the outcome. To close a cycle, follow the steps below.

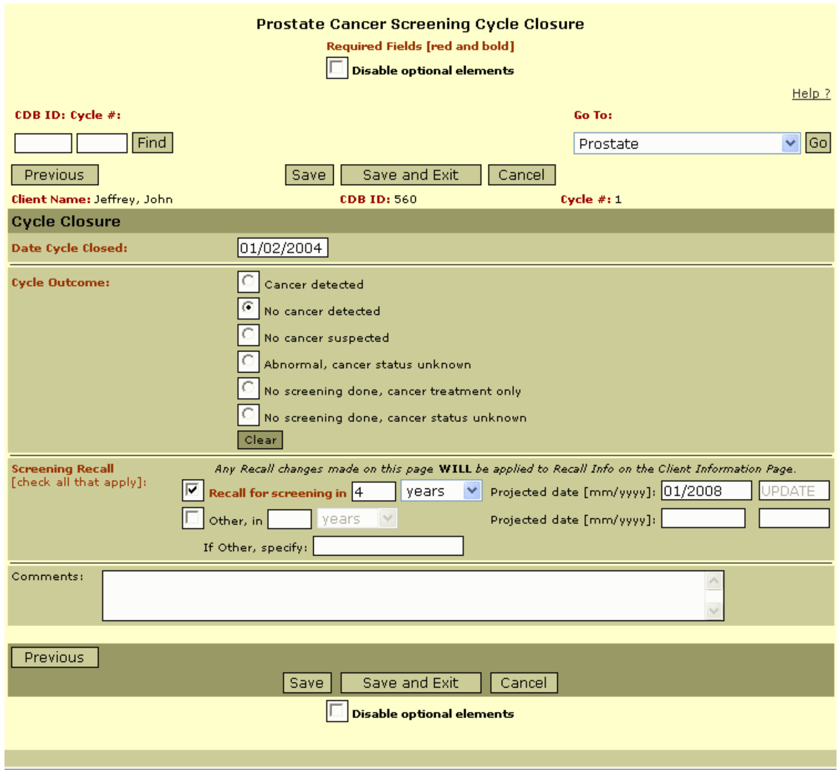
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>On the Client Enrollment Page, click the cycle link for the cycle you wish to close. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.



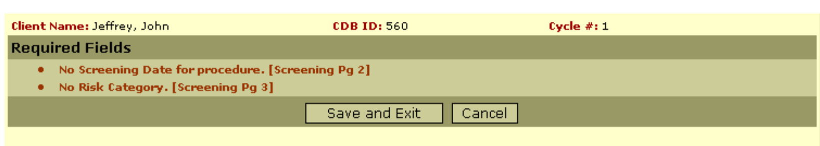
Click the cycle link to open the screening pages for the cycle.</td></tr>
<tr><td>2</td><td>On the Prostate Cancer Screening Form, choose “Cycle Closure” from the “Go To” Menu at the top right of the page and click “Go”.


</td></tr>
</table>

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>3</td><td>To close the cycle, enter the closing information on the Cycle Closure Page.



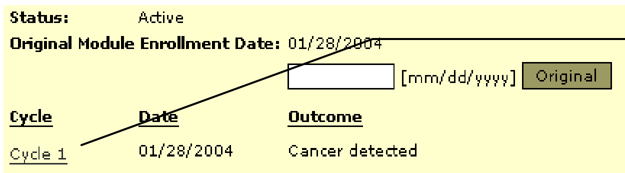
Click the “Save and Exit” button to save the closing data and return to the Client Enrollment Page or click "Save" to save the data and remain on the current page. Click “Cancel” to exit without saving.</td></tr>
<tr><td>4</td><td>After saving the form, the Required Fields Validation Page shows any required fields that are missing. To correct the fields, navigate back to the individual pages using the “Go To” menu and enter the missing information.


</td></tr>
</table>

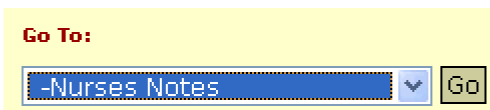
Entering Additional Data

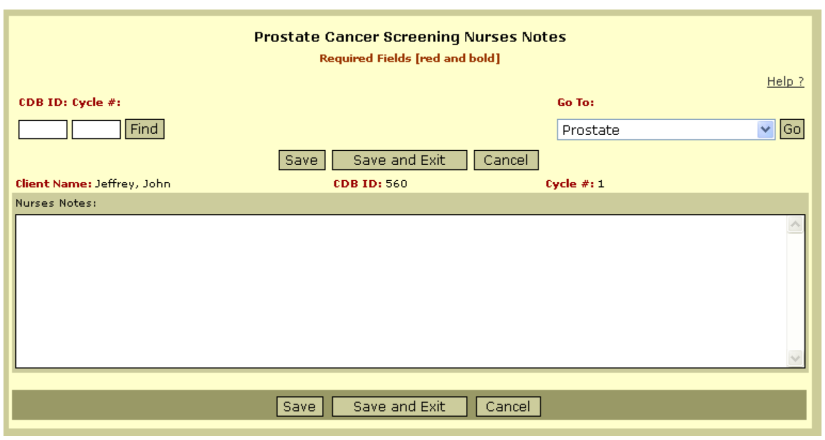
At any time, a person can return to a cycle and enter additional information. This section explains how to return to a cycle and enter additional procedures, nurses' notes, and program defined variables. However, the procedure for opening a cycle and navigating to specific pages also applies to the screening forms, post-screening forms, and cycle closure page.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>On the Client Enrollment Page, click the cycle link for the cycle you wish to use. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.



Click the cycle link to open the screening pages for the cycle.</td></tr>
<tr><td>2</td><td>On the Prostate Cancer Screening Form, choose the page you wish to view from the "Go To" Menu at the top right of the page and click "Go".

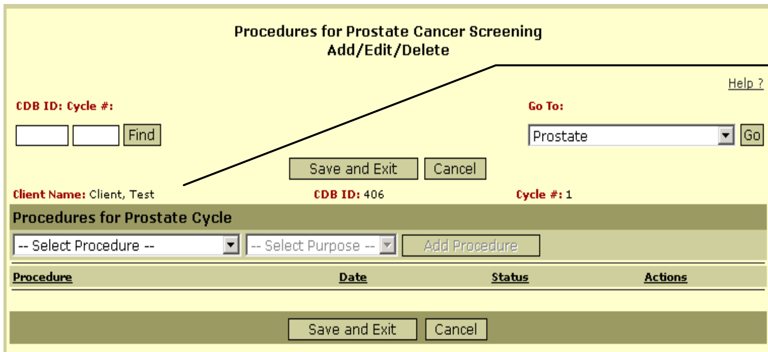

</td></tr>
<tr><td>3</td><td>To enter nurses' notes, go to the Nurses Notes Page and enter the notes.



Click the "Save and Exit" button to save the notes and return to the Client Enrollment Page or click "Save" to save the data and remain on the current page. Click "Cancel" to exit without saving.</td></tr>
<tr><td>4</td><td>To enter additional procedures go to the Additional Procedures Page and enter the information on the page. Additional procedures are those completed by the program through the cycle for this client. Procedures entered via the Screening and Post Screening Evaluation Forms are also displayed on this page in order to provide access to additional, optional data elements not found on the forms.</td></tr>
</table>

Step	*Action*

To add a procedure, select the procedure and a purpose, and click the "Add Procedure" button. To change an existing procedure, click the "Edit" link next to the procedure. To delete a procedure, click the "Delete" link next to the procedure.

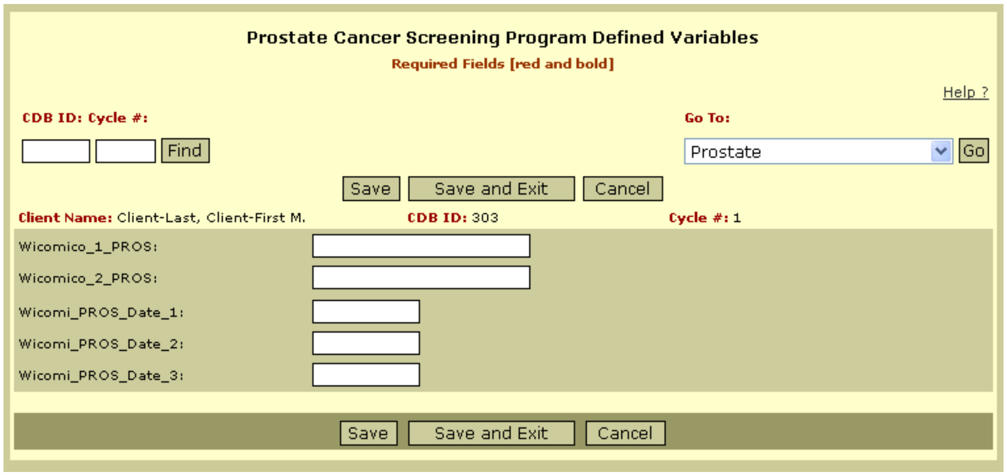


Enter a procedure and purpose and click "Add Procedure" to add the procedure.

Enter the procedure information for the procedure you selected.

Click "Save and Exit" to save the procedure, or "Cancel" to exit without saving.

Step	*Action*
5	To enter program defined variables, go to the Program Defined Variables Page and enter the information for your program.

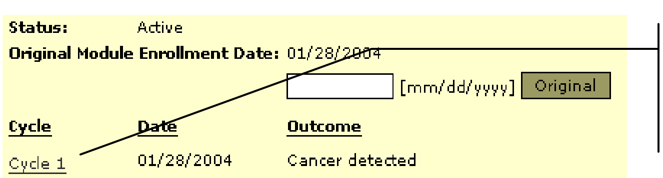


Click the “Save and Exit” button to save the variables and return to the Client Enrollment Page or click "Save" to save the data and remain on the current page. Click “Cancel” to exit without saving.

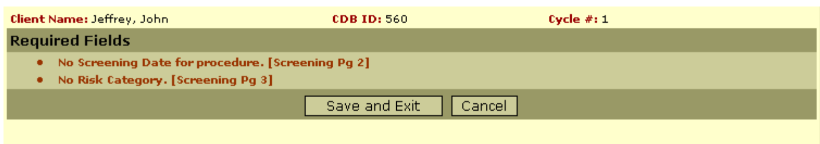
Validating Required Fields

The Prostate Cancer Screening module includes many pieces of required information. The CDB system provides a report to track any required fields that are not complete. Follow the steps below to validate required fields for the prostate screening process.

Step	*Action*
1	On the Client Enrollment Page, click the cycle link for the cycle you wish to use. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.



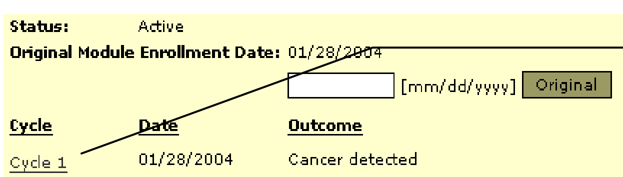
Click the cycle link to open the screening pages for the cycle.

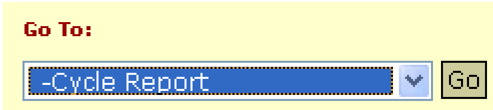
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>2</td><td>On the Prostate Cancer Screening Form, choose “Required Fields Validation” from the “Go To” Menu at the top right of the page and click “Go”.
</td></tr>
<tr><td>3</td><td>The Required Fields Validation Page shows any required fields that are missing. To correct the fields, navigate back to the individual pages using the “Go To” Menu and enter the missing information.
</td></tr>
</table>

Viewing the Cycle Report

The cycle report displays information regarding a specific prostate screening cycle. To view the report for an individual cycle, follow the steps below.

Note:
In order to view the cycle report, you must have Access to Reports security permissions.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>On the Client Enrollment Page, click the cycle link for the cycle you wish to view. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.

Click the cycle link to open the screening pages for the cycle.</td></tr>
</table>

Step	*Action*
2	On the Prostate Cancer Screening Form, choose "Cycle Report" from the "Go To" Menu at the top right of the page and click "Go".  The cycle report opens in a new window and may be printed by using the tool bar at the top of the report window.

Chapter 6: Oral Cancer Screening

The Oral Cancer Screening Module comprises several pages that collect and maintain data within the context of a screening cycle. CDB stores the Data for each cycle and provides reports for data validation.

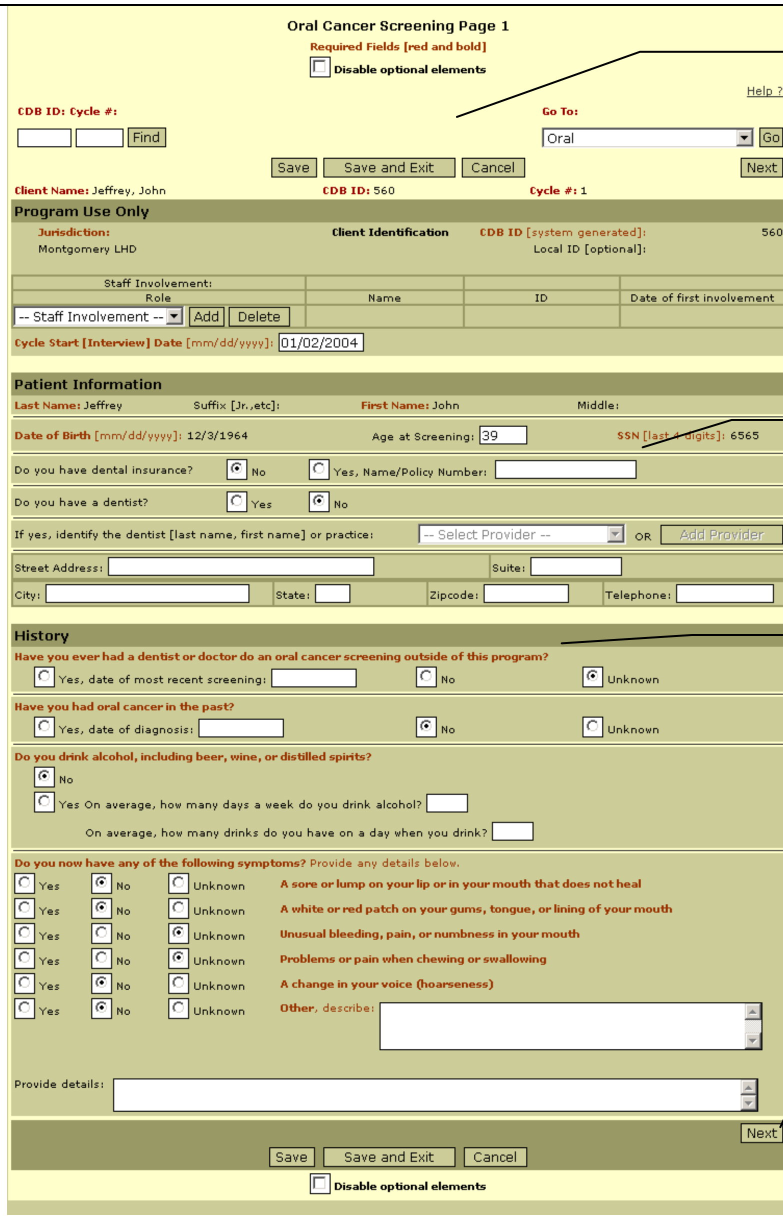
Included in This Chapter

Note:
In order to access the Oral Module you must have Access to Raw Data Statewide or Access to Raw Data Local security permissions. Additionally, you must have Access to Identifiers security permissions in order to view fields designated as identifying data. You will be able to update data only if you have Update Data security permissions.

Adding a Cycle

A cycle represents an iteration of the screening process for a client. During the cycle you perform all of the screening and any necessary post-screening actions. Follow the steps below to add an oral cancer screening cycle.

Step	*Action*
1	Enroll the client in the oral cancer module if they are not already enrolled. To enroll the client, click “Enroll” in the “Oral Cancer” section of the client’s information page. For information on enrolling clients, see Chapter 3 – Client Enrollment Page.
2	On the Client Enrollment Page, click the “Add Cycle” button under the Oral Cancer screening section. ***Note:*** You must close all previous oral cycles before adding a new cycle. To close a previous cycle, go to the Cycle Closure Page and enter the closing information.
3	Enter the oral screening data on the three screening pages. The picture below shows the first screening form.

Step	*Action*
	

This is the standard screening navigation header. To find out more about the header, see the “Screening Form Navigation” section of Chapter 1.

Some fields are enabled or disabled based on your answers in previous fields.

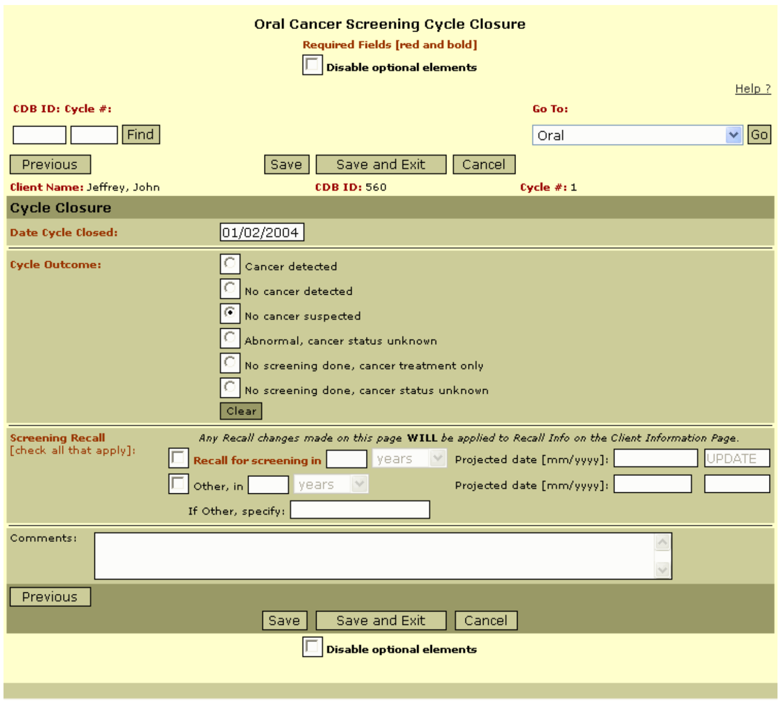
Required fields are displayed in red.

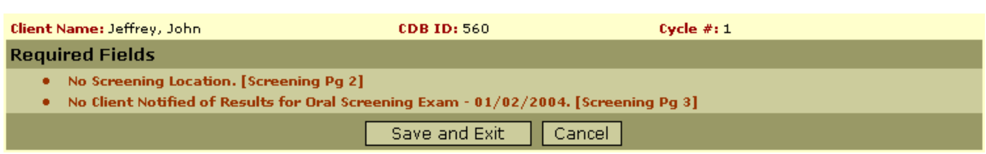
Click “Next” to go to the next screening page.

The field definitions for the screening forms are in Appendix D – Oral Cancer Screening Fields.

Note:
Fields on the screening forms are enabled or disabled based on your answers to previous questions.

The “Previous” and “Next” buttons on the page navigate between forms. Some forms are skipped based on your responses to questions on previous forms.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>4</td><td>
To enter additional information pertaining to post-screening, proceed to the post-screening forms.
Note:
Fields on the post-screening forms will be enabled or disabled based on your answers to previous questions.
The “Previous” and “Next” buttons on the page navigate between forms. Some forms are skipped based on your responses to questions on previous forms.
</td></tr>
<tr><td>5</td><td>
To close the cycle, enter the closing information on the Cycle Closure Page.


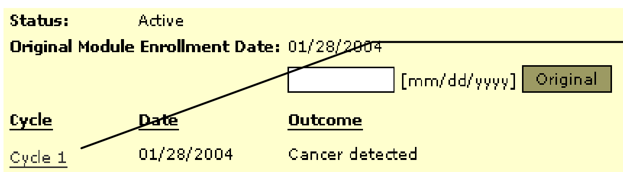
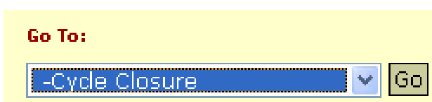
Click the “Save and Exit” button to save the closing data and return to the Client Enrollment Page or click "Save" to save the data and remain on the current page. Click “Cancel” to exit without saving.
</td></tr>
<tr><td>6</td><td>
After saving the form, the Required Fields Validation Page shows any required fields that are missing. To correct the fields, navigate back to the individual pages using the “Go To” Menu and enter the missing information.


</td></tr>
</table>

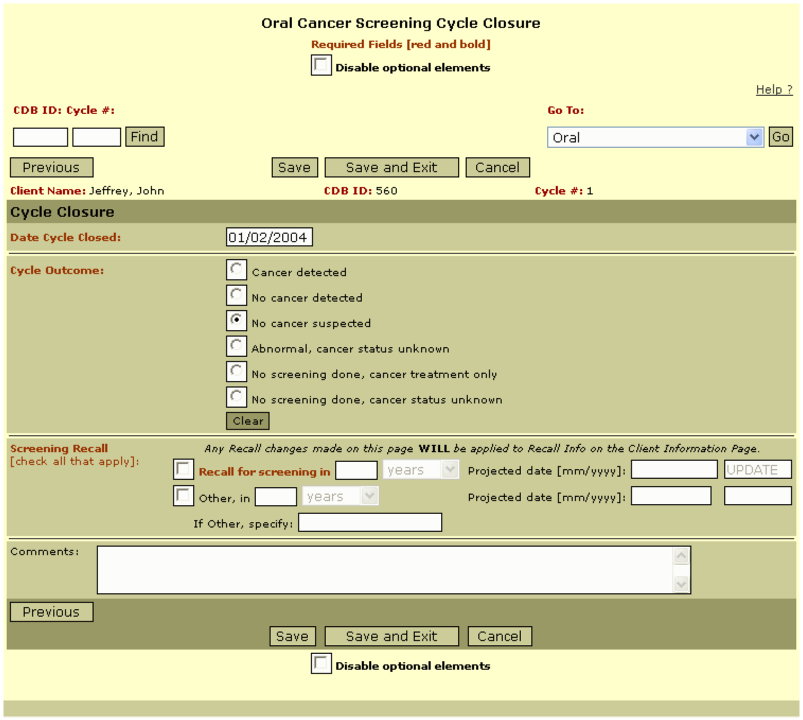
Note:
You can return to any page in the cycle at any time by opening the cycle from the Client Enrollment Page and using the "Go To" Menu at the top of the pages. The following section titled "Entering Additional Data" describes this process.

Closing a Cycle

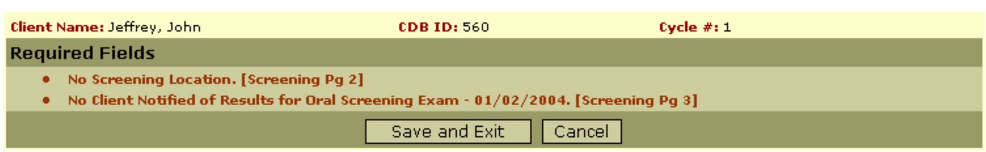
Closing a cycle is the method of ending a screening process and entering information about the outcome. To close a cycle, follow the steps below.

Step	*Action*
1	On the Client Enrollment Page, click the cycle link for the cycle you wish to close. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.  Click the cycle link to open the screening pages for the cycle.
2	On the Oral Cancer Screening Form, choose "Cycle Closure" from the "Go To" menu at the top right of the page and click "Go". 

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>3</td><td>To close the cycle, enter the closing information on the Cycle Closure Page.

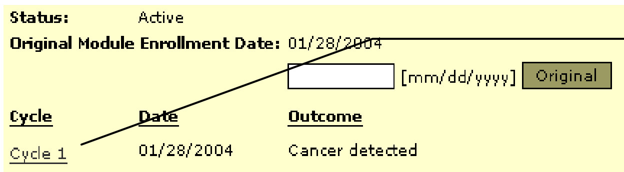
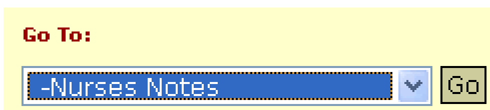
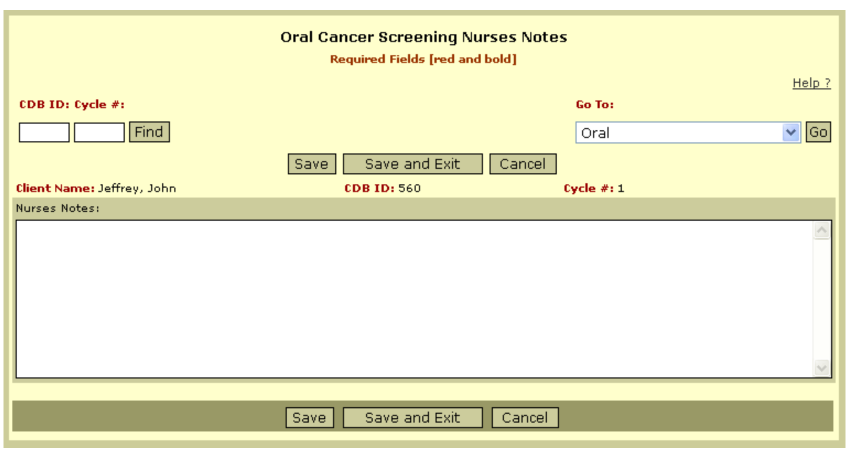


Click the “Save and Exit” button to save the closing data and return to the Client Enrollment Page or click "Save" to save the data and remain on the current page. Click “Cancel” to exit without saving.</td></tr>
<tr><td>4</td><td>After saving the form, the Required Fields Validation Page shows any required fields that are missing. To correct the fields, navigate back to the individual pages using the “Go To” Menu and enter the missing information.


</td></tr>
</table>

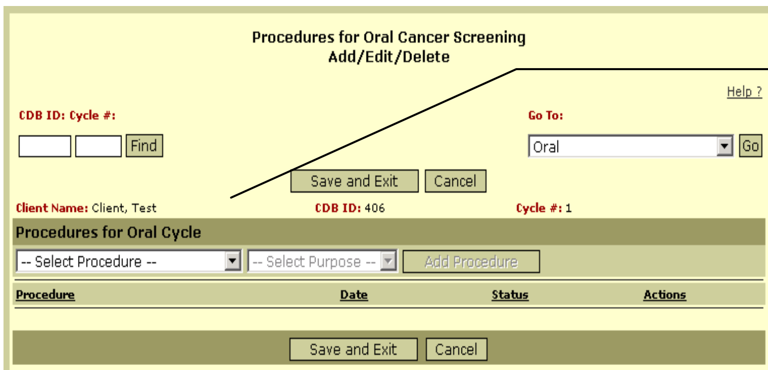
Entering Additional Data

At any time, a person can return to a cycle and enter additional information. This section explains how to return to a cycle and enter additional procedures, nurses’ notes, and program defined variables. However, the procedure for opening a cycle and navigating to specific pages also applies to the screening forms, post-screening forms, and cycle closure page.

Step	*Action*
1	On the Client Enrollment Page, click the cycle link for the cycle you wish to use. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.  Click the cycle link to open the screening pages for the cycle.
2	On the Oral Cancer Screening Form, choose the page you wish to view from the "Go To" menu at the top right of the page and click "Go". 
3	To enter nurses' notes, go to the Nurses Notes Page and enter the notes.  Click the "Save and Exit" button to save the notes and return to the Client Enrollment Page or click "Save" to save the data and remain on the current page. Click "Cancel" to exit without saving.

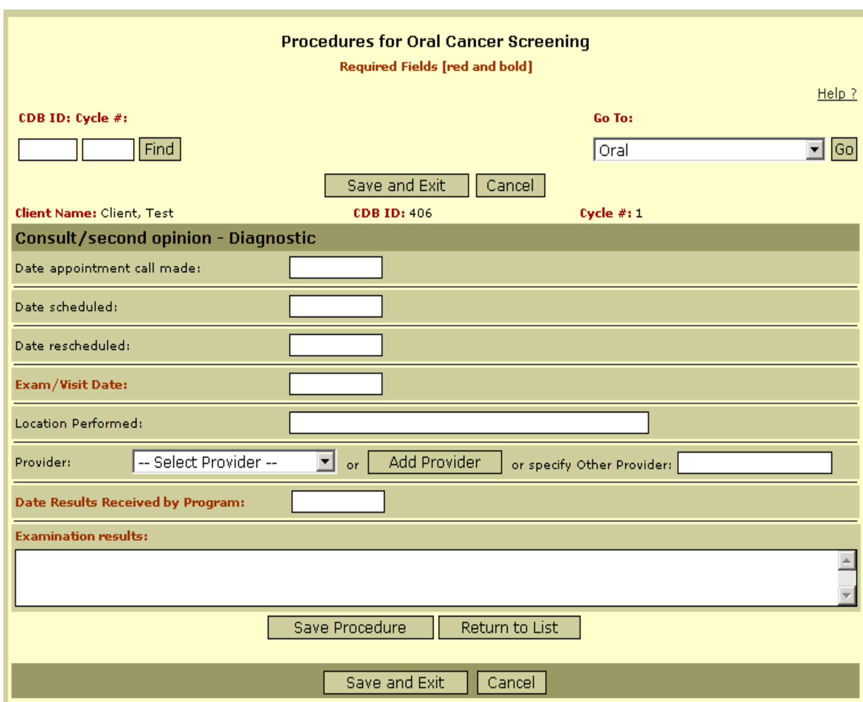
Step	*Action*
4	To enter additional procedures go to the Additional Procedures Page and enter the information on the page. Additional procedures are those completed by the program through the cycle for this client. Procedures entered via the Screening and Post Screening Evaluation Forms are also displayed on this page in order to provide access to additional, optional data elements not found on the forms.

To add a procedure, select the procedure, select a purpose, and click the “Add Procedure” button. To change an existing procedure, click the “Edit” link next to the procedure. To delete a procedure, click the “Delete” link next to the procedure.

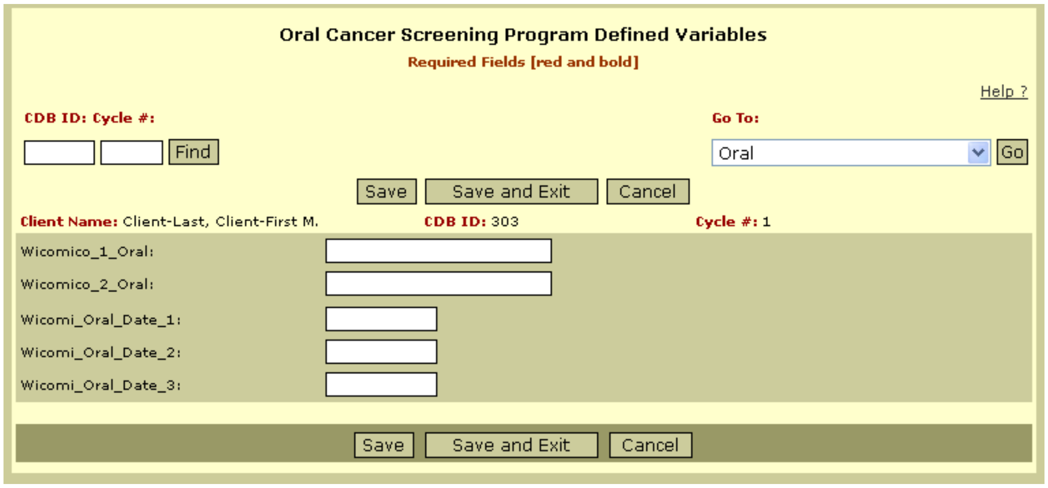


Enter a procedure and purpose and click “Add Procedure” to add the procedure.

Enter the procedure information for the procedure you selected.

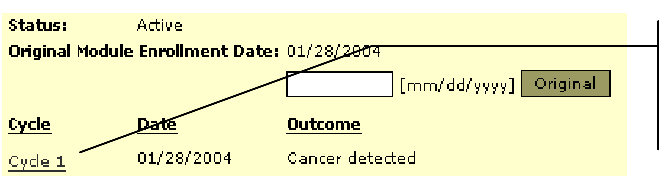


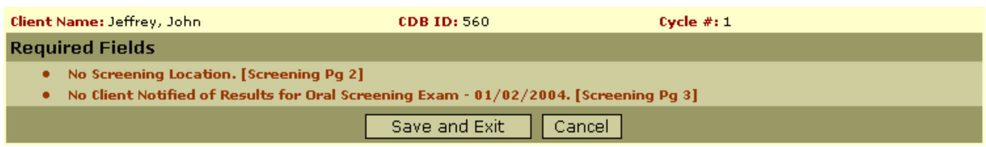
Click “Save and Exit” to save the procedure, or “Cancel” to exit without saving.

Step	*Action*
5	To enter program defined variables, go to the Program Defined Variables Page and enter the information for your program.  Click the “Save and Exit” button to save the variables and return to the Client Enrollment Page or click "Save" to save the data and remain on the current page. Click “Cancel” to exit without saving.

Validating Required Fields

The Oral Cancer Screening module includes many pieces of required information. The CDB system provides a report to track any required fields that are not complete. Follow the steps below to validate required fields for the oral screening process.

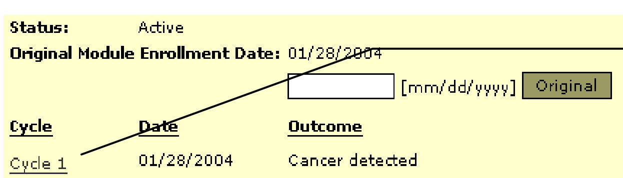
Step	*Action*
1	On the Client Enrollment Page, click the cycle link for the cycle you wish to close. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.  Click the cycle link to open the screening pages for the cycle.

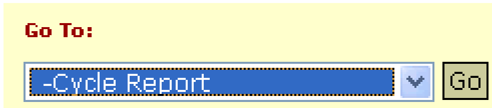
Step	*Action*
2	On the Oral Cancer Screening Form, choose "Required Fields Validation" from the "Go To" Menu at the top right of the page and click "Go". 
3	The Required Fields Validation Page shows any required fields that are missing. To correct the fields, navigate back to the individual pages using the "Go To" Menu and enter the missing information. 

Viewing the Cycle Report

The cycle report displays information regarding a specific oral screening cycle. To view the report for an individual cycle, follow the steps below.

Note:
In order to view the cycle report, you must have Access to Reports security permissions.

Step	*Action*
1	On the Client Enrollment Page, click the cycle link for the cycle you wish to view. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.  Click the cycle link to open the screening pages for the cycle.

Step	*Action*
2	On the Oral Cancer Screening Form, choose “Cycle Report” from the “Go To” Menu at the top right of the page and click “Go”.  The cycle report opens in a new window and may be printed by using the tool bar at the top of the report window.

Chapter 7: Skin Cancer Screening

The Skin Cancer Screening Module comprises several pages that collect and maintain data within the context of a screening cycle. CDB stores the Data for each cycle and provides reports for data validation.

Included in This Chapter

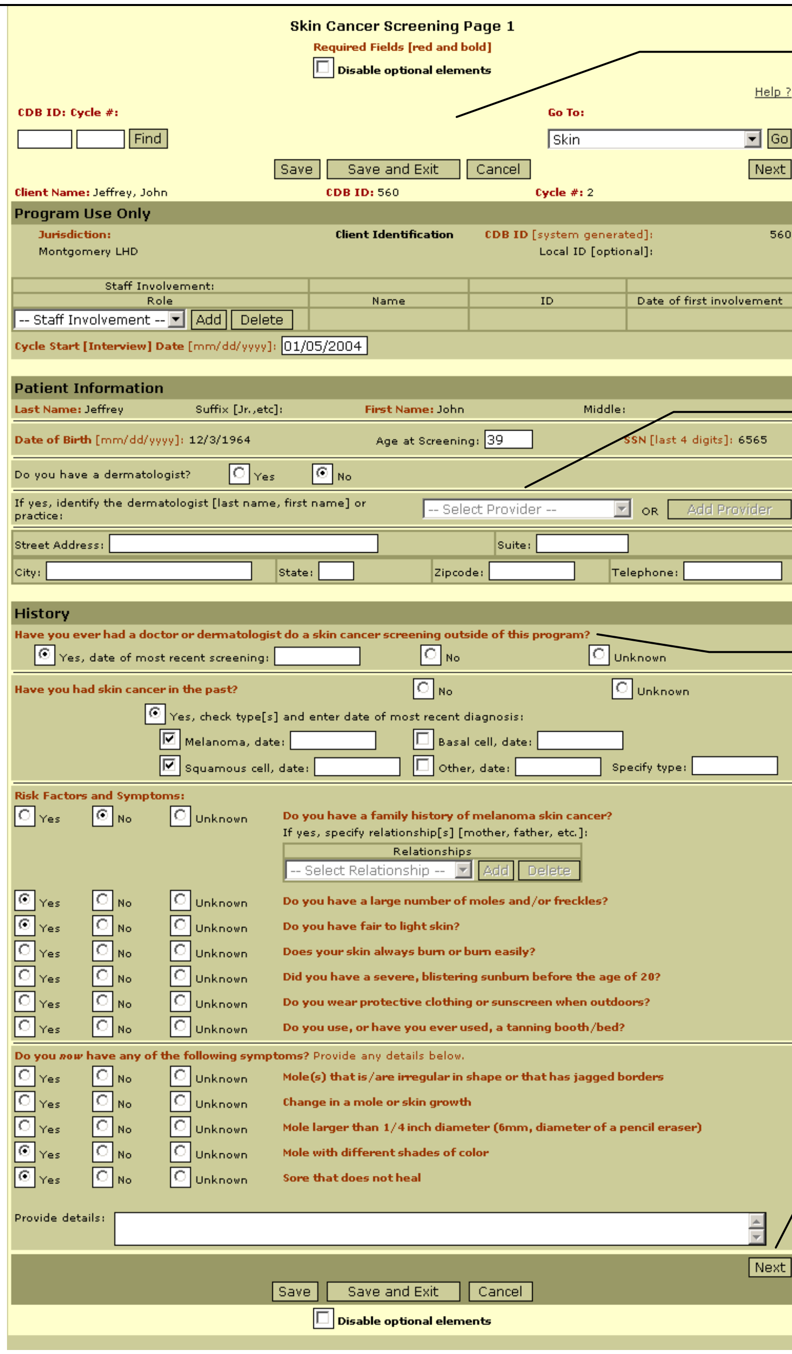
Note:
In order to access the Skin Module you must have Access to Raw Data Statewide or Access to Raw Data Local security permissions. Additionally, you must have Access to Identifiers security permissions in order to view fields designated as identifying data. You will be able to update data only if you have Update Data security permissions.

Adding a Cycle

A cycle represents an iteration of the screening process for a client. During the cycle you perform all of the screening and any necessary post-screening actions. Follow the steps below to add a skin cancer screening cycle.

Step	*Action*
1	Enroll the client in the skin cancer module if they are not already enrolled. To enroll the client, click “Enroll” in the Skin Cancer section of the client’s information page. For information on enrolling clients, see Chapter 3 – Client Enrollment Page.
2	On the Client Enrollment Page, click the “Add Cycle” button under the Skin Cancer screening section. ***Note:*** You must close all previous skin cycles before adding a new cycle. To close a previous cycle, go to the Cycle Closure Page and enter the closing information.
3	Enter the skin screening data on the three screening pages. The picture below shows the first screening form.

Step	*Action*



This is the standard screening navigation header. To find out more about the header, see the “Screening Form Navigation” section of Chapter 1.

Some fields are enabled or disabled based on your answers in previous fields.

Required fields are displayed in red.

Click “Next” to go to the next screening page.

The field definitions for the screening forms are in Appendix E – Skin Cancer Screening Fields.

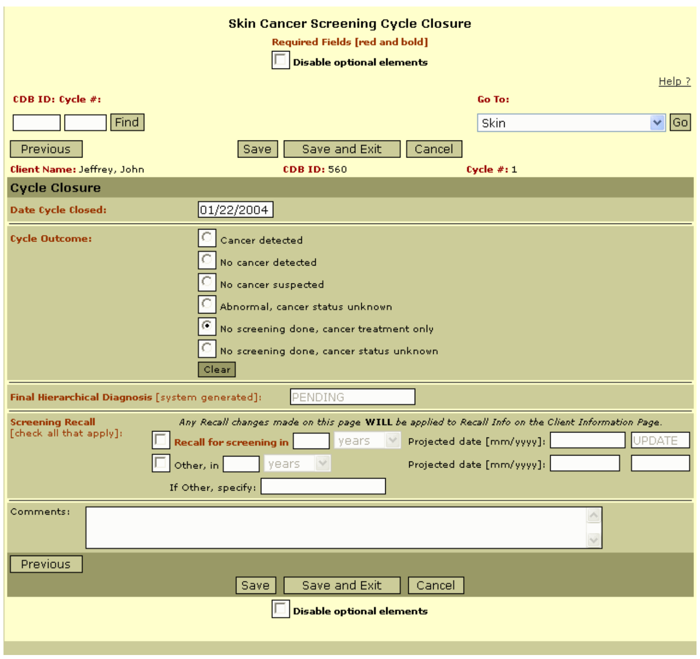
Note:
Fields on the screening forms are enabled or disabled based on your answers to previous questions.

The “Previous” and “Next” buttons on the page navigate between forms. Some

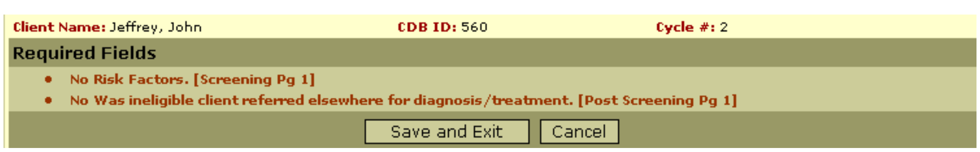
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td></td><td>forms are skipped based on your responses to questions on previous forms.</td></tr>
<tr><td>4</td><td>To enter additional information pertaining to post-screening, proceed to the post-screening forms.

Note:
Fields on the post-screening forms will be enabled or disabled based on your answers to previous questions.

The “Previous” and “Next” buttons on the page navigate between forms. Some forms are skipped based on your responses to questions on previous forms.</td></tr>
<tr><td>5</td><td>To close the cycle, enter the closing information on the Cycle Closure Page.



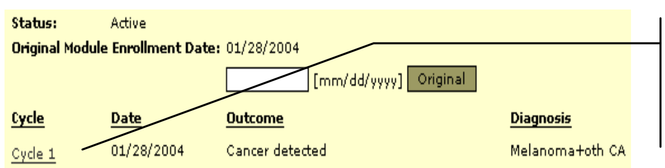
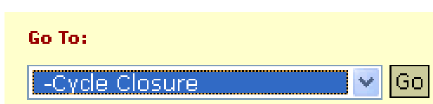
Click the “Save and Exit” button to save the closing data and return to the Client Enrollment Page or click "Save" to save the data and remain on the current page. Click “Cancel” to exit without saving.</td></tr>
<tr><td>6</td><td>After saving the form, the Required Fields Validation Page shows any required fields that are missing. To correct the fields, navigate back to the individual pages using the “Go To” Menu and enter the missing information.

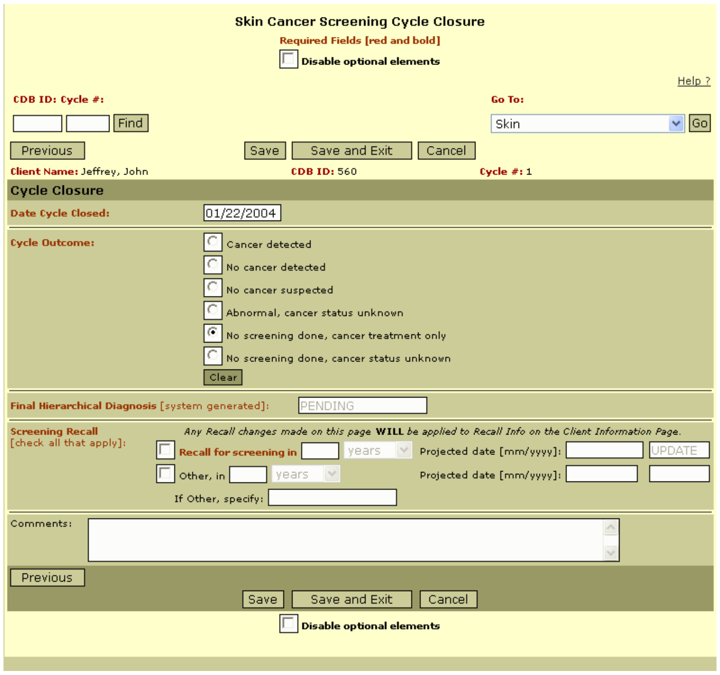
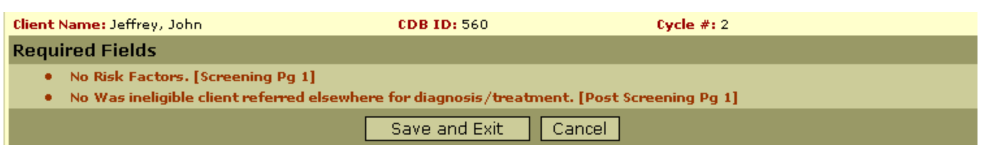

</td></tr>
</table>

Note:
You can return to any page in the cycle at any time by opening the cycle from the Client Enrollment Page and using the "Go To" Menu at the top of the pages. The following section titled "Entering Additional Data" describes this process.

Closing a Cycle

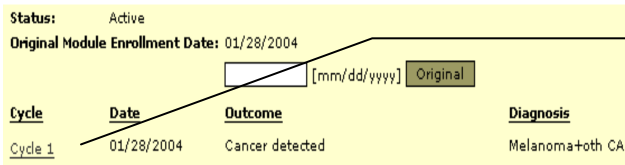
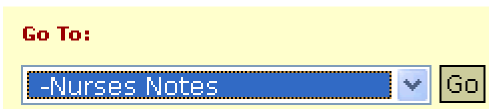
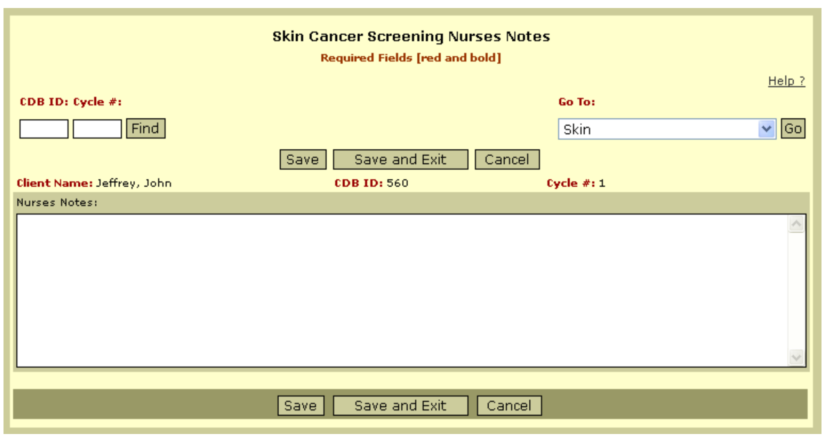
Closing a cycle is the method of ending a screening process and entering information about the outcome. To close a cycle, follow the steps below.

Step	*Action*
1	On the Client Enrollment Page, click the cycle link for the cycle you wish to close. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.  Click the cycle link to open the screening pages for the cycle.
2	On the Skin Cancer Screening Form, choose "Cycle Closure" from the "Go To" Menu at the top right of the page and click "Go". 

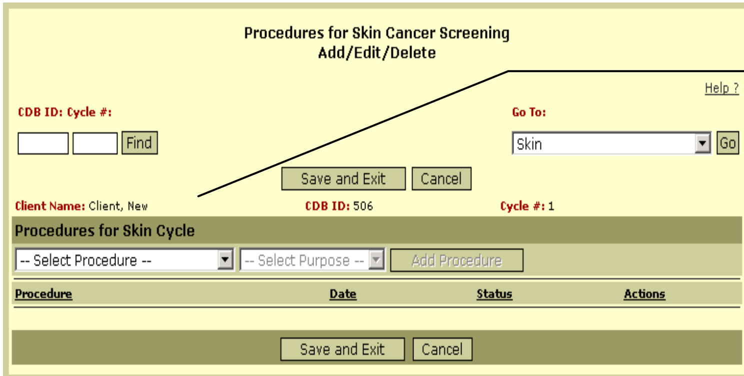
Step	Action
3	To close the cycle, enter the closing information on the Cycle Closure Page.  Click the "Save and Exit" button to save the closing data and return to the Client Enrollment Page or click "Save" to save the data and remain on the current page. Click "Cancel" to exit without saving.
4	After saving the form, the Required Fields Validation Page shows any required fields that are missing. To correct the fields, navigate back to the individual pages using the "Go To" Menu and enter the missing information. 

Entering Additional Data

At any time, a person can return to a cycle and enter additional information. This section explains how to return to a cycle and enter additional procedures, nurses' notes, and program defined variables. However, the procedure for opening a cycle and navigating to specific pages also applies to the screening forms, post-screening forms, and cycle closure page.

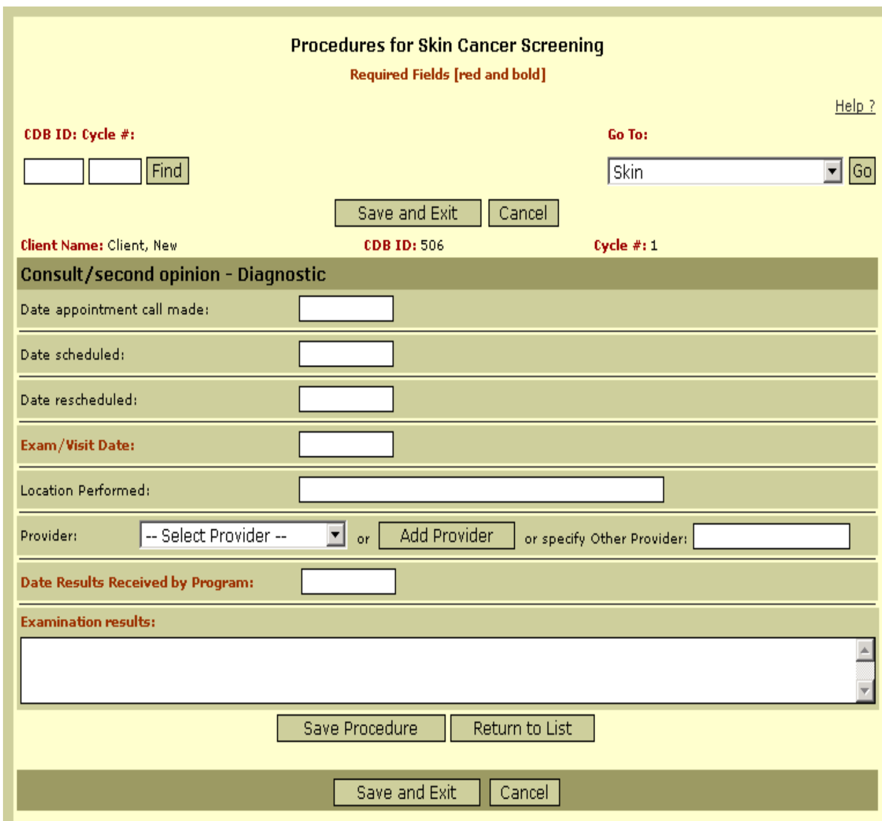
Step	*Action*
1	On the Client Enrollment Page, click the cycle link for the cycle you wish to use. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.  Click the cycle link to open the screening pages for the cycle.
2	On the Skin Cancer Screening Form, choose the page you wish to view from the “Go To” Menu at the top right of the page and click “Go”. 
3	To enter nurses’ notes, go to the Nurses Notes Page and enter the notes.  Click the “Save and Exit” button to save the notes and return to the Client Enrollment Page or click "Save" to save the data and remain on the current page. Click “Cancel” to exit without saving.
4	To enter additional procedures go to the Additional Procedures Page and enter the information on the page. Additional procedures are those completed by the program through the cycle for this client. Procedures entered via the Screening and Post Screening Evaluation Forms are also displayed on this page in order to provide access to additional, optional data elements not found on the forms. To add a procedure, select the procedure, select a purpose, and click the “Add Procedure” button. To change an existing procedure, click the “Edit” link next to the procedure. To delete a procedure, click the “Delete” link next to the procedure.

Step	*Action*

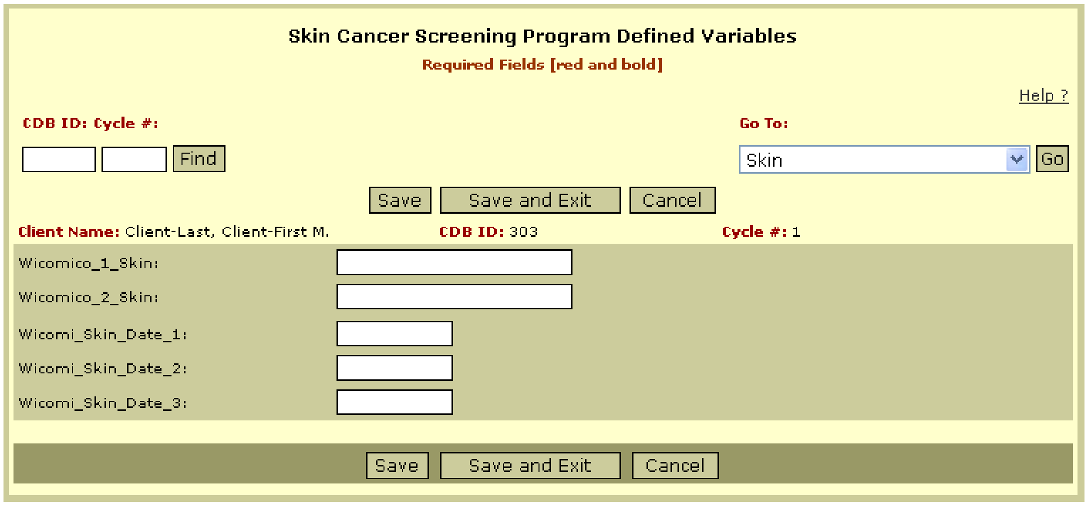


Enter a procedure and purpose and click "Add Procedure" to add the procedure.

Enter the procedure information for the procedure you selected.

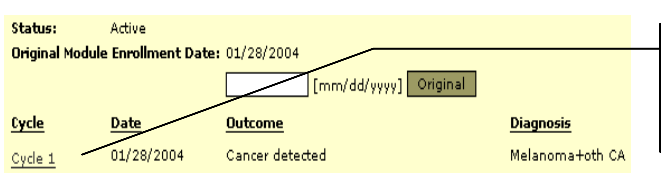


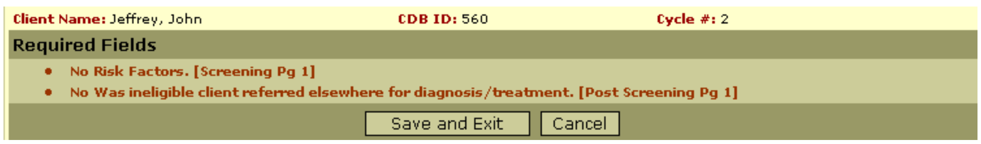
Click "Save and Exit" to save the procedure, or "Cancel" to exit without saving.

Step	*Action*
5	To enter program defined variables, go to the Program Defined Variables Page and enter the information for your program.  Click the "Save and Exit" button to save the variables and return to the Client Enrollment Page or click "Save" to save the data and remain on the current page. Click "Cancel" to exit without saving.

Validating Required Fields

The Skin Cancer Screening module includes many pieces of required information. The CDB system provides a report to track any required fields that are not complete. Follow the steps below to validate required fields for the prostate screening process.

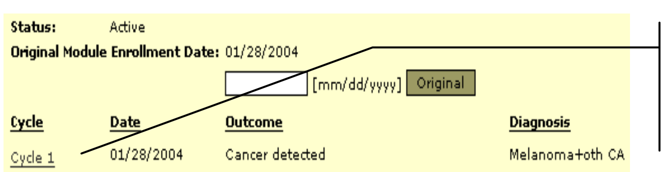
Step	*Action*
1	On the Client Enrollment Page, click the cycle link for the cycle you wish to close. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.  Click the cycle link to open the screening pages for the cycle.

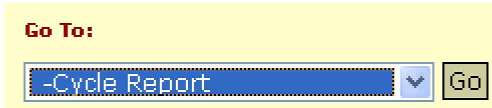
Step	*Action*
2	On the Skin Cancer Screening Form, choose “Required Fields Validation” from the “Go To” Menu at the top right of the page and click “Go”. 
3	The Required Fields Validation Page shows any required fields that are missing. To correct the fields, navigate back to the individual pages using the “Go To” Menu and enter the missing information. 

Viewing the Cycle Report

The cycle report displays information regarding a specific skin screening cycle. To view the report for an individual cycle, follow the steps below.

Note:
In order to view the cycle report, you must have Access to Reports security permissions.

Step	*Action*
1	On the Client Enrollment Page, click the cycle link for the cycle you wish to view. For information on the Client Enrollment Page, see Chapter 3 – Client Enrollment Page.  Click the cycle link to open the screening pages for the cycle.

Step	*Action*
2	On the Skin Cancer Screening Form, choose “Cycle Report” from the “Go To” Menu at the top right of the page and click “Go”.  The cycle report opens in a new window and may be printed by using the tool bar at the top of the report window.

Chapter 8: Health Care Providers

This chapter explains how to maintain health care providers in the CDB system.

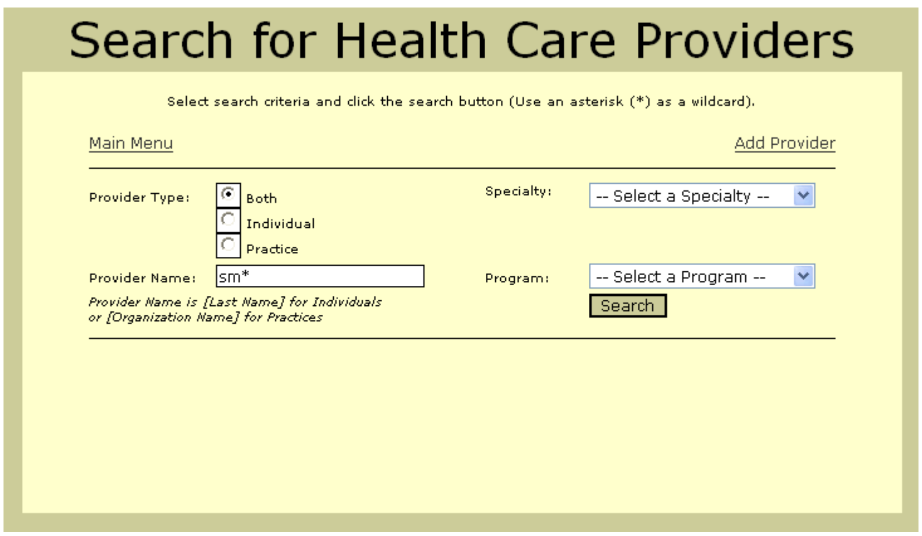
Included in This Chapter

Searching for Health Care Providers

Health Care Providers are of two types: Individuals and Practices. Follow the steps below to search for a health care provider in the CDB database.

Note:
In order to search for health care providers, you must have Access to Raw Data Statewide or Access to Raw Data Local security permissions.

Step	*Action*
1	Choose "Health Care Providers" on the Main Menu Page.
2	On the search page, select the search criteria and click the "Search" button. If you do not select any criteria, all providers appear in the results.



Provider Type	Select the type of provider to find.
Specialty	Select the specialty of the provider.
Provider Name	Enter the name of the provider to find. The provider name is the last name for individuals or the practice name for practices.
Program	Select the provider's program.

Tip:
Use asterisks (*) for wildcard searches in the Provider Name field. An asterisk will match any sequence of characters. For example:

ro* - Returns Rob and does not return Aaron.
ro - Returns Rob and Aaron.

Step	*Action*
3	After clicking "Search", the results of the search appear at the bottom of the page.  To continue to the Health Care Provider Maintenance Page, click the "Edit" link next to the provider.
4	To delete a health care provider, click the "Delete" link under Actions next to the desired health care provider's name. When prompted "Are you sure you want to delete the provider *{name of provider}?"* click "OK" to delete or "Cancel" to cancel.

Note:
In order to delete a health care provider, the health care provider can not be associated with any client records within the system. The Delete link will only be displayed when a health care provider may be deleted.

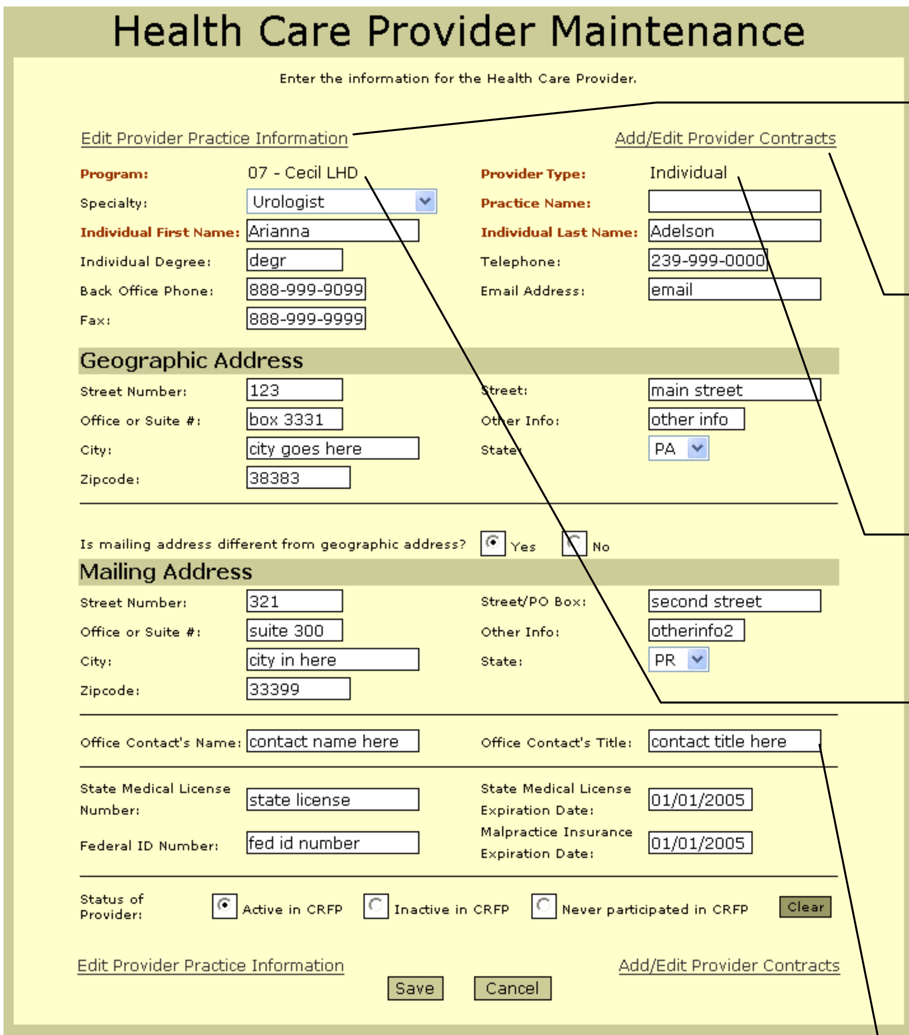
Maintaining Health Care Providers

To update or add a health care provider, enter the information about the provider on the Health Care Provider Page. You can access the maintenance page when adding a new provider or after searching for a provider and clicking the "Edit" link.

Note:
In order to maintain health care providers, you must have Update Data security permissions.

Entering Provider Information

Health Care Provider Page



Health Care Provider Maintenance

Enter the information for the Health Care Provider.

Edit Provider Practice Information | Add/Edit Provider Contracts

Program: 07 - Cecil LHD | Provider Type: Individual
Specialty: Urologist | Practice Name:
Individual First Name: Arianna | Individual Last Name: Adelson
Individual Degree: degr | Telephone: 239-999-0000
Back Office Phone: 888-999-9099 | Email Address: email
Fax: 888-999-9999

Geographic Address

Street Number: 123 | Street: main street
Office or Suite #: box 3331 | Other Info: other info
City: city goes here | State: PA
Zipcode: 38383

Is mailing address different from geographic address? Yes No

Mailing Address

Street Number: 321 | Street/PO Box: second street
Office or Suite #: suite 300 | Other Info: otherinfo2
City: city in here | State: PR
Zipcode: 33399

Office Contact's Name: contact name here | Office Contact's Title: contact title here

State Medical License Number: state license | State Medical License Expiration Date: 01/01/2005
Federal ID Number: fed id number | Malpractice Insurance Expiration Date: 01/01/2005

Status of Provider: Active in CRFP | Inactive in CRFP | Never participated in CRFP | Clear

Edit Provider Practice Information | Add/Edit Provider Contracts

Save | Cancel

Click this link to enter practice information for the provider

Click this link to enter contract information for the provider.

You cannot change the provider type if the provider has practices linked to the provider in the CPEST CDB.

You cannot change the program if the provider has practices in the CPEST CDB linked to the provider or if you are a user with only Access to Raw Data Local security permissions.

Note: This is CONTACT information. See below to link to Add/Edit Provider CONTRACTS

The following table describes the fields on the maintenance page.

Program	The program to which this provider belongs. You cannot change the program if the provider has practices established in CDB or if you are a user with only Access to Raw Data Local security permissions.
Provider Type	The type of provider. You cannot change the provider type if the provider has practices established in CDB.
Specialty	Defines the specialty of the provider.
Practice Name	Name of the practice if the provider type is practice.
Individual First Name	First Name of the provider if the provider type is individual.
Individual Last Name	Last Name of the provider if the provider type is individual
Individual Degree	The degree level that the provider holds if the provider type is individual.
Telephone	Telephone number.
Back Office Phone	Back office phone number.
Email Address	Email address.
Fax	Fax number.
Geographic Address	
Street Number	Geographic street number.
Street	Geographic street.
Office or Suite #	Geographic office or suite number.
Other Info	Geographic other info.
City	Geographic city.
State	Geographic state.
Zipcode	Geographic zipcode.
Is Mailing Address different from Geographic Address	Select No to automatically copy the Geographic Address information to the Mailing Address fields.
Mailing Address	
Street Number	Mailing street number.
Street/PO Box	Mailing street. Enter full PO Box address here.
Office or Suite #	Mailing office or suite number.
Other Info	Mailing other info.
City	Mailing city.
State	Mailing state.
Zipcode	Mailing zipcode.
Office Contact's Name	Name of contact person.
Office Contact's Title	Title of contact person.
State Medical License Number	Provider's state medical license number.
State Medical License Expiration Date	Expiration date for provider's state medical license.
Federal ID Number	Provider's federal ID number.
Malpractice Insurance Expiration Date	Date provider's malpractice insurance expires.
Status of Provider	Designation of provider's current status within CRFP.

To save the provider's information, click "Save" or click "Cancel" to exit without saving.

Adding a New Health Care Provider

Follow these steps to add a new health care provider in CDB.

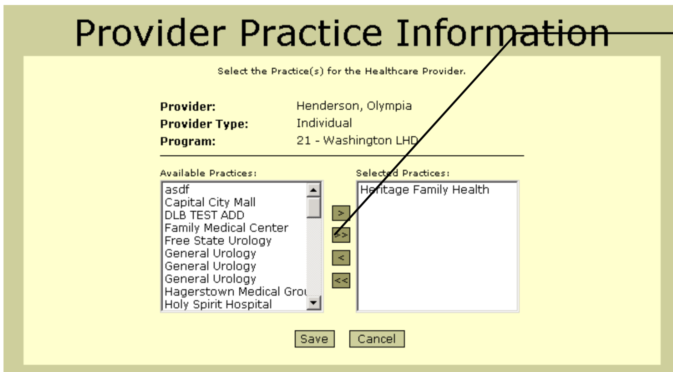
Step	*Action*
1	On the Main Menu Page, click "Health Care Providers" under the General Functions section.
2	Click the "Add Provider" link at the top of the search page.
3	CDB will open the Health Care Provider – Add New Provider Page. To enter the provider information, see the "Maintaining Health Care Providers" section earlier in this chapter.

Associating an Individual Provider with a Practice

A person enters Practices into the CDB system through the same process as entering an Individual health care provider. Then you can "associate" Individual providers with Practices. Follow the steps below to associate an Individual provider with a Practice.

Step	*Action*
1	If you have not already established the Individual provider and the Practice in CDB, follow the steps for "Adding a New Health Care Provider" earlier in this chapter. You may choose practices for a provider by clicking the "Edit Provider Practice Information" link on the "Add New Provider Page". Skip to Step 4.
2	Open the Health Care Provider Maintenance Page for the Individual provider. To find the Individual provider, use the Health Care Provider Search Page mentioned in the "Searching for a Health Care Providers" section of this chapter.
3	To choose Practices for an Individual provider, click the "Edit Provider Practice Information" link on the Health Care Provider Maintenance Page

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>4</td><td>On the Provider Practice Information Page, choose practices for the Individual provider by clicking the Practice name(s) in the list and moving them from the left list to the right list by clicking the arrow buttons. The “>>” and “<<” buttons move all practices between the lists while the “>” and “<” buttons move only the selected practice(s).



Choose the Practices that are related to this Individual provider by moving them into the list on the right of the page, “Selected Practices.”

Note:
Only practices within your program are available in the left list.

Tip:
You can select multiple Practices in the lists by using the Shift and Ctrl keys. Hold the Ctrl key while clicking Practices to select multiple entries. To select a range, click your first provider entry, hold the Shift key, and then click your last provider entry.

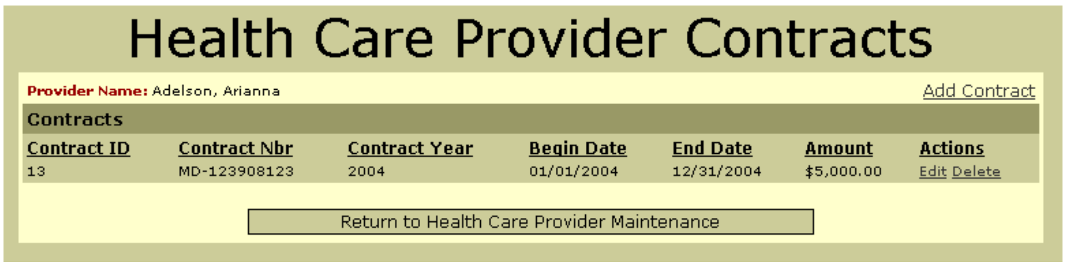
Click “Save” to save the information and return to the Health Care Provider Maintenance Page or “Cancel” to return without saving.</td></tr>
</table>

Maintaining Health Care Provider Contract Information

Contract data may be maintained for each provider within the system. Follow the steps below to access provider contract data.

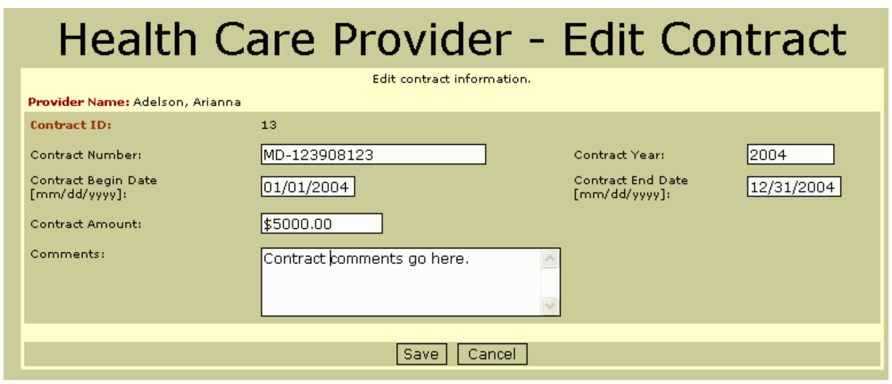
Step	*Action*
1	If you have not already established the Individual provider or Practice in CDB, follow the steps for “Adding a New Health Care Provider” earlier in this chapter. You may add contracts for the new provider by clicking the “Add Provider Contracts” link on the “Add New Provider” page. Skip to Step 4.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>2</td><td>Open the Health Care Provider Maintenance Page for the provider (Individual or Practice). To find the provider, use the Health Care Provider Search Page mentioned in the “Searching for a Health Care Providers” section of this chapter.</td></tr>
<tr><td>3</td><td>To work with contracts for a provider, click the “Add / Edit Provider Contracts” link on the Health Care Provider Maintenance Page.</td></tr>
<tr><td>4</td><td>The Health Care Provider Contracts Page displays the contracts entered for the provider.



</td></tr>
<tr><td>5</td><td>To add a new contract, click the “Add Contract” link in the upper right corner of the page. Enter the contract information on the Add New Contract page.

<table>
<tr><td>Contract ID:</td><td>System-generated ID representing this contract record to the system.</td></tr>
<tr><td>Contract Number</td><td>Number associated with this contract by your local program.</td></tr>
<tr><td>Contract Year</td><td>Designation for the year of contract.</td></tr>
</table>
</td></tr>
</table>

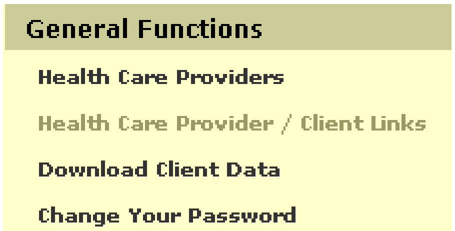
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td></td><td>
<table>
<tr><td>Contract Begin Date</td><td>Date the contract begins.</td></tr>
<tr><td>Contract End Date</td><td>Date the contract ends.</td></tr>
<tr><td>Contract Amount</td><td>Dollar amount of contract. Enter $0 if no limit is associated with contract.</td></tr>
<tr><td>Comments</td><td>Comments about this contract entry.</td></tr>
</table>
To save the contract information, click the “Save” button. To return to the Health Care Provider Contracts Page without saving, click the “Cancel” button.
</td></tr>
<tr><td>6</td><td>
To update a contract, click the “Edit” link next to the contract under Actions on the Health Care Provider Contracts page. Update the contract on the Edit Contract Page and click “Save” to save the changes.


</td></tr>
<tr><td>7</td><td>To delete a contract, click the “Delete” link next to the contract record under Actions on the Health Care Provider Contracts page. When prompted “Are you sure you want to delete the selected contract?” click “OK” to delete or “Cancel” to cancel.</td></tr>
</table>

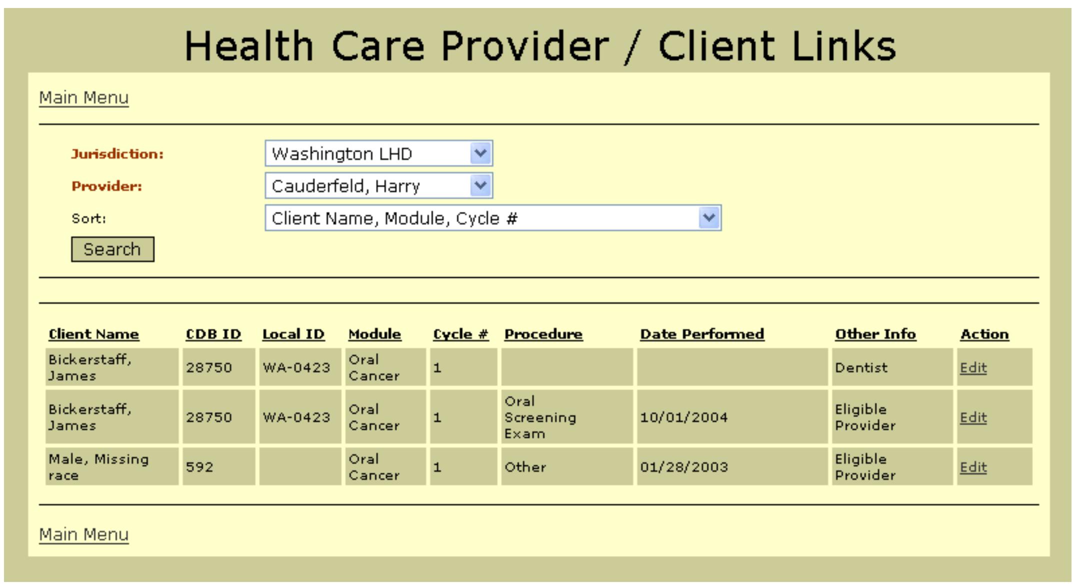
Determining Client Records Linked to a Health Care Provider

The system provides a function that displays all client records linked to a specific health care provider (Individual or Practice). NOTE: You may NOT delete a Health Care Provider who is linked to any client, so you must first follow the steps: Determining Client Records Linked to a Health Care Provider, link the client’s record to another provider (e.g., another correct spelling of the same provider’s name) and when no more clients are linked to that provider, then you may delete the provider (see below). Follow the steps below to view client records associated with (linked to) a health care provider.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Chose the Health Care Provider / Client Links link in the General Functions section of the Main Menu Page.



</td></tr>
<tr><td>2</td><td>Enter the Jurisdiction of the Provider. Select the Provider from the list. Choose the sort option you wish to be applied to the results and click “Search” to return a list of matching records.



</td></tr>
<tr><td>3</td><td>To navigate to a client record displayed within the list click the “Edit” (or “View”) link next to the client under Actions. The system provides one-way navigation to the selected record.</td></tr>
</table>

Deleting a Health Care Provider

Under certain circumstances you may wish to delete a Health Care Provider, for example if the provider has been entered with multiple spellings of the same and you wish to clean the CDB and have only one instance with the correct spelling.

Step	*Action*
1	Determine whether any clients are linked to the Health Care Provider you wish to delete (see above).
2	If any clients are linked to the Provider you wish to delete, go to each client record and Edit the record by entering the correct provider's name in the client record. Repeat this process until all clients linked to the provider have been removed/eliminated.
3	Delete provider by Searching for the Provider from the Main Menu—Health Care Providers page. In the right hand column next to Edit if the Provider is not linked to any clients, you will see Delete. If you press Delete, you will get a warning box stating that if you proceed, you may not undo this action. Press OK if you wish to proceed to delete the provider.

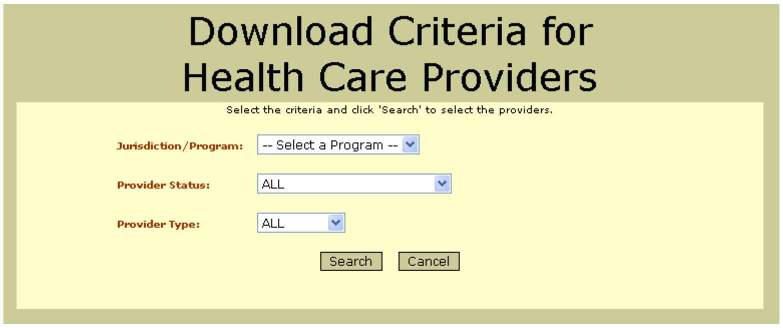
Downloading Health Care Provider Data

Follow the steps below to download health care provider data from the CPEST database. The health care provider download includes the data elements stored for a provider, including up to 15 associated individuals/practices and the most recent 15 contracts.

Note:
In order to download health care provider data, you must have Download Data security permissions.

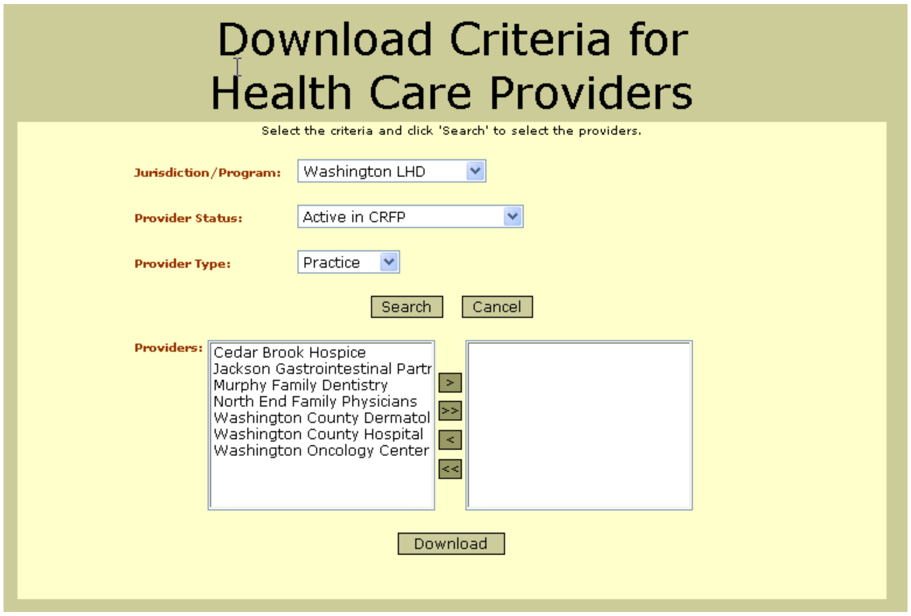
Step	*Action*

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Click the “Download HC Provider Data” link on the Main Menu to open the Download Criteria for Health Care Providers page.

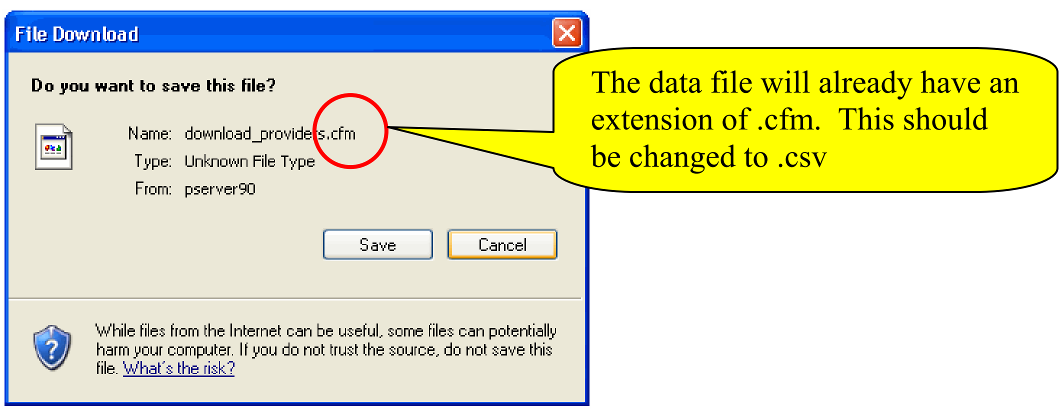

</td></tr>
<tr><td>2</td><td>Choose the Jurisdiction/Program for which you wish download providers. Select additional status and type criteria desired to filter the providers selected and then click the ‘Search’ button.

<table>
<tr><td>Jurisdiction / Program</td><td>The program of desired health care providers.</td></tr>
<tr><td>Provider Status</td><td>Status of providers to be selected (ALL, Active in CRFP, Inactive in CRFP, Never participated in CRFP).</td></tr>
<tr><td>Provider Type</td><td>Types of providers to be selected (ALL, Individual, Practice).</td></tr>
</table></td></tr>
</table>

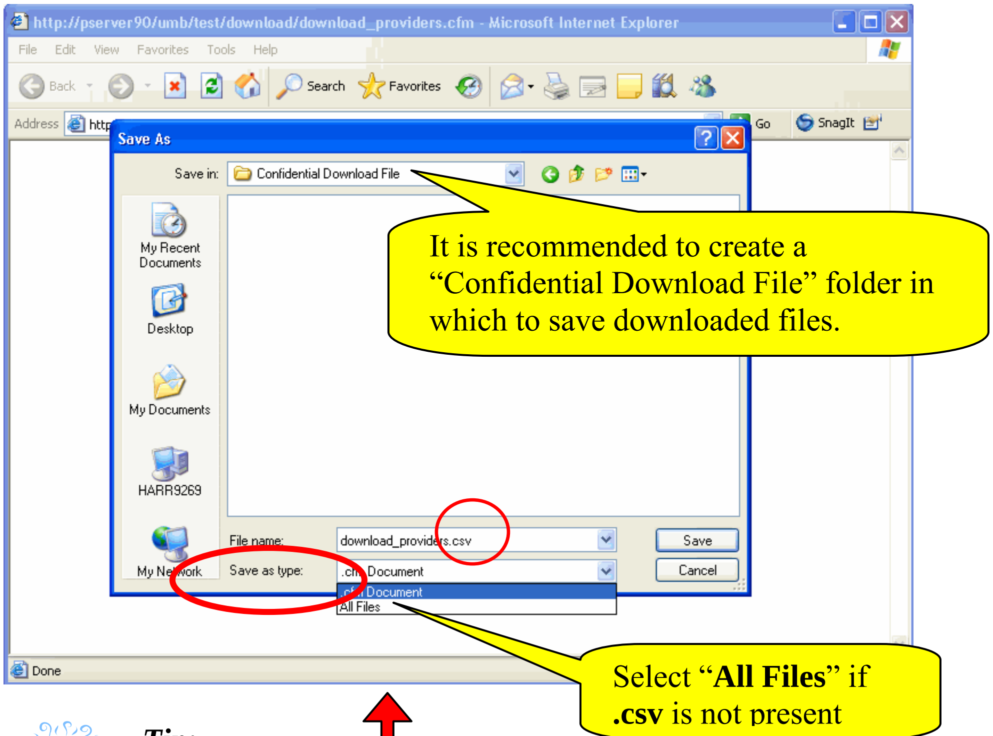
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>3</td><td>All providers which match the criteria entered will be displayed in the ‘Providers’ box. Use the “>>” button to select all matching providers for download or choose one provider at a time by clicking the providers name in the list and then clicking the “>” button. Click the “Download” button to download the data.



</td></tr>
<tr><td>4</td><td>The CPEST CDB system prompts to Save or Open the data file. To save the file, click the “Save” button and choose a file name and directory.



Tip:
To save the file so that it is easily opened with Microsoft Excel, rename the file from a .cfm to a **.csv** extension when downloading.
</td></tr>
</table>

Step	*Action*
5	  ***Tip:*** To save the file so that it is easily opened with Microsoft Excel and Microsoft Word, rename the file with a **.CSV** extension when downloading. Microsoft's "**Save As**" window prompt will appear. After changing the extension to **.CSV** in the "**File Name**" text box, in the text box below named "**Save As Type**" you want to choose "**All Files**" if **.CSV** is not present. This will allow you to save the file with the extension **.CSV**.
6	The list of the fields in the health care provider download data set is included in Appendix I.

Chapter 9: Reports

CDB provides a number of useful reports. This chapter explains how to view a report in the CDB system.

Available Reports

The screen below identifies the reports available in the CDB system.

CPEST Client Database Reports

Main Menu

CRFP Reports

- CoD (1A2) - Clients Screened in CRFP by Demographics and Jurisdiction of Screening
- MoD (2A2) - Monthly Statistics- Demographics of Persons Screened by Month of Earliest Procedure Within Cycle
- Comp-Re - Comprehensive Client Recall Report

Colorectal Cancer (CRC) Reports

- C-CoP (1B1b) - Results - Procedure-Based for Colorectal Cancer Screening by Jurisdiction
- C-CoPD (1B1a) - Summary of Colorectal Cancer Screening by Jurisdiction
- C-FL (2B5) - CRC Flow Sheet
- C-LLCD (3A1) - Colorectal Cancer Line List by Cycle
- C-LLPD - Colorectal Cancer Line List by Procedure Date
- C-Mo (2B1) - Monthly Report- Number of New People in CRC Module and Procedure Results by Month Procedure Performed
- C-QA (3B1) - Colorectal Cancer Notification Quality Assurance Report by Cycle
- C-Re - CRC Recall Report
- C-SP - CRC Scheduled Procedures

Prostate Cancer Reports

- P-CoP (1B3) - Results-Procedure-Based Report for Prostate Cancer Screening by Jurisdiction
- P-FL (2B7) - Prostate Cancer Flow Sheet
- P-LL (3A3) - Prostate Cancer Line List by Cycle
- P-Mo (2B3) - Monthly Report- Number of New People in Prostate Module and Screening Statistics
- P-QA (3B3) - Prostate Cancer Notification Quality Assurance Report by Cycle
- P-Re - Prostate Recall Report

Oral Cancer Reports

- O-CoP (1B2) - Results-Procedure-Based Report for Oral Cancer Screening by Jurisdiction
- O-FL (2B6) - Oral Cancer Flow Sheet
- O-LL (3A2) - Oral Cancer Line List by Cycle
- O-Mo (2B2) - Monthly Report- Number of New People in Oral Module and Screening Statistics
- O-QA (3B2) - Oral Cancer Notification Quality Assurance Report by Cycle
- O-Re - Oral Recall Report

Skin Cancer Reports

- S-CoP (1B4) - Results-Procedure-Based Report for Skin Cancer Screening by Jurisdiction
- S-FL (2B8) - Skin Cancer Flow Sheet
- S-LL (3A4) - Skin Cancer Line List by Cycle
- S-Mo (2B4) Monthly Report- Number of New People in Skin Module and Screening Statistics
- S-Re - Skin Recall Report

Billing Reports

- Bill-CP - Client Payments Report
- Bill-PP - Provider Payments Report

Main Menu

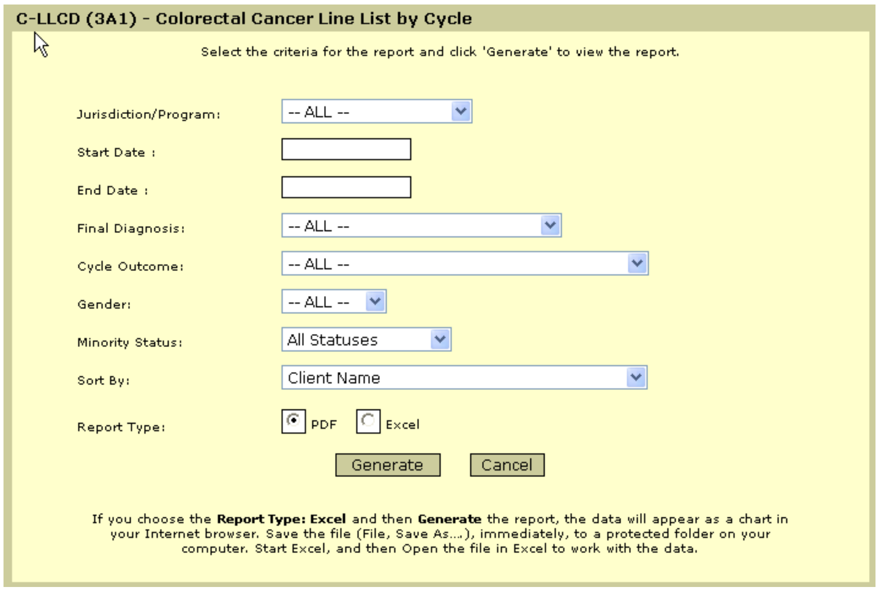
Viewing Reports

Follow the steps below to view a report in the CDB system.

Note:
In order to view reports, you must have Access to Reports security permissions.

Step	*Action*
1	Click the "Reports" link on the Main Menu to open the CPEST Client Database Reports page.

Step	*Action*
2	Click the report you wish to view from the list on the page.
3	Many reports include a criteria page that allows you to filter or select the information that appears on the report. The image below shows a sample criteria page.

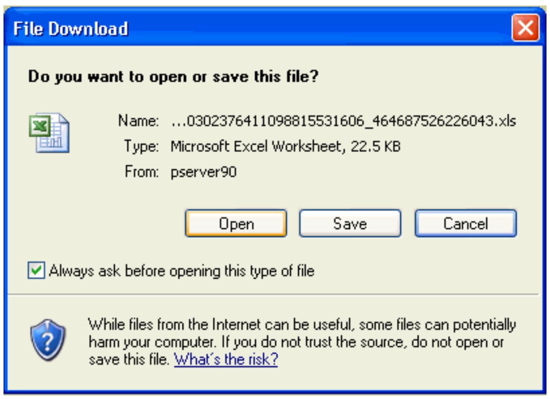


Tip:
Select "ALL" in a dropdown field to return all records for the criteria. Choosing "ALL" will not limit the results based on that field.

Step	*Action*
3	Click “Generate” to create the selected report.

If the report type selected is PDF, the report will open in a new window.. The report is generated as a PDF document that is viewed and printed from Adobe Acrobat Reader or can be saved to a location you wish (use caution if saving reports with *confidential information*!).

If the report type selected is Excel, when you press Generate, the CPEST CDB system will either open the report directly into your Internet browser, directly into Excel, or it may prompt you to Open or Save (or Cancel) the file (see File Download dialogue box, below). From here you may Open the file into Excel directly, or Save the file. If you Save the file, use an appropriate name for the file and select a directory and folder where you will save it. NOTE—Many reports contain **confidential** client information; please save to special folders that identify the files as containing *confidential information*.



The report you generated by clicking Excel may open directly to your Internet browser. If so, go to File, and select Save as... Rename the file with an appropriate name for the file and select a directory and folder to save it. NOTE—Many reports contain **confidential** client information; please save to special folders that identify the files as containing *confidential information*.

Tip:
Once saved in Excel, you may sort the data and perform other analyses in Excel or Microsoft Access. In Excel you may **delete names and dates of birth** so that you can work with a non-confidential file

Note: See Appendix J for additional information on the Reports

Chapter 10: Letters and Mail Merge

The Letters and Mail Merge feature allows users of the CPEST system to download comma-separated data files which can be used in mail merges. This chapter explains how to download the mail-merge data files from the CPEST system.

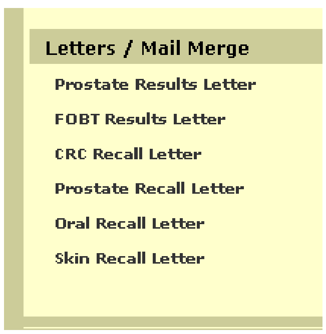
Downloading Mail Merge Data

Follow the steps below to download mail merge data from the CPEST database. Appendix H contains the layout for each data file and Mail Merge Instructions.

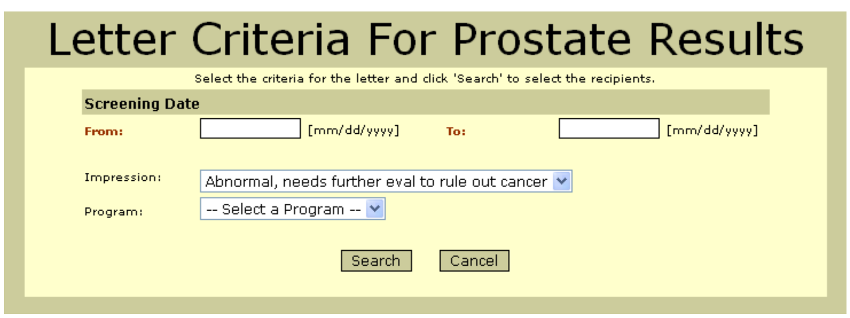
Letters / Mail Merge for a Group of Clients

Note:
In order to download mail merge data, you must have Access to Letters and Labels security permissions.

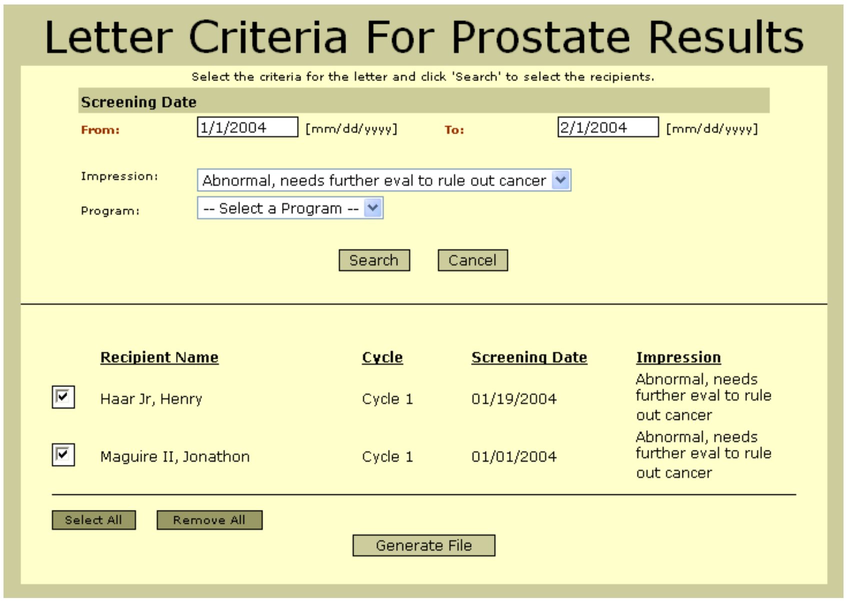
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Choose the type of data to download by clicking the appropriate link under “Letters / Mail Merge” on the Main Menu Page.



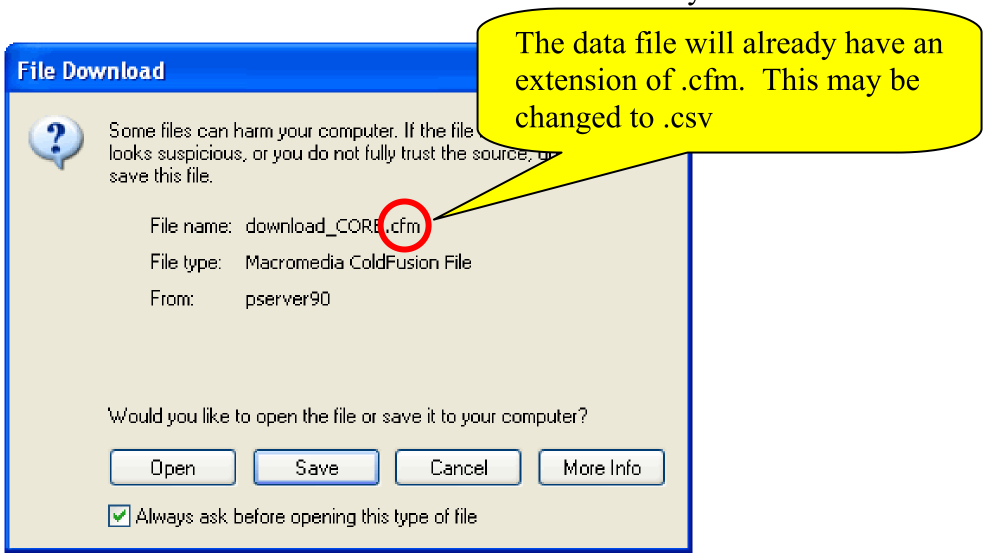
</td></tr>
<tr><td>2</td><td>Each mail merge download uses a Letter Criteria Page to “filter” or select the data that will appear in the download file. Enter the criteria for the mail merge and click “Search” to return a list of matching records.



Appendix H contains the fields for each Letter Criteria Page.</td></tr>
</table>

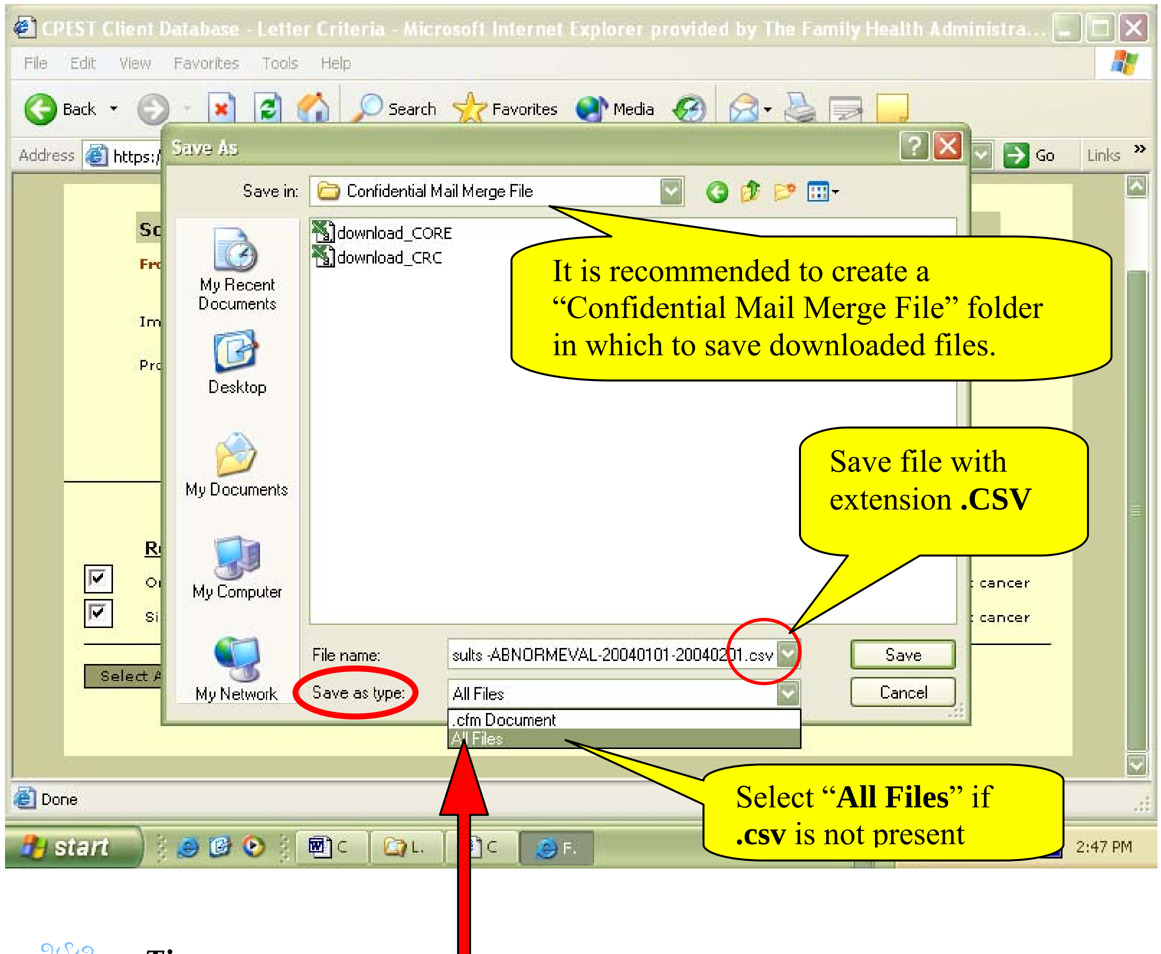
Step	*Action*
3	Select the records to include in the file that will be downloaded by checking the box next to each record. Initially, all records are selected. To remove all records, click the "Remove All" button at the bottom of the page. To include all records, click the "Select All" button.  To download the mail merge data file, click "Generate File" at the bottom of the page.

Step	*Action*
4	The CPEST CDB system prompts to Save or Open the data file. To save the file, click the "Save" button and choose a file name and directory.



Tip:
To save the file so that it is easily opened with Microsoft Excel and Microsoft Word, rename the file with a .CSV (i.e., Comma Separated Variables) extension when downloading. For Mail Merge, .cfm works fine

Step	*Action*
5	

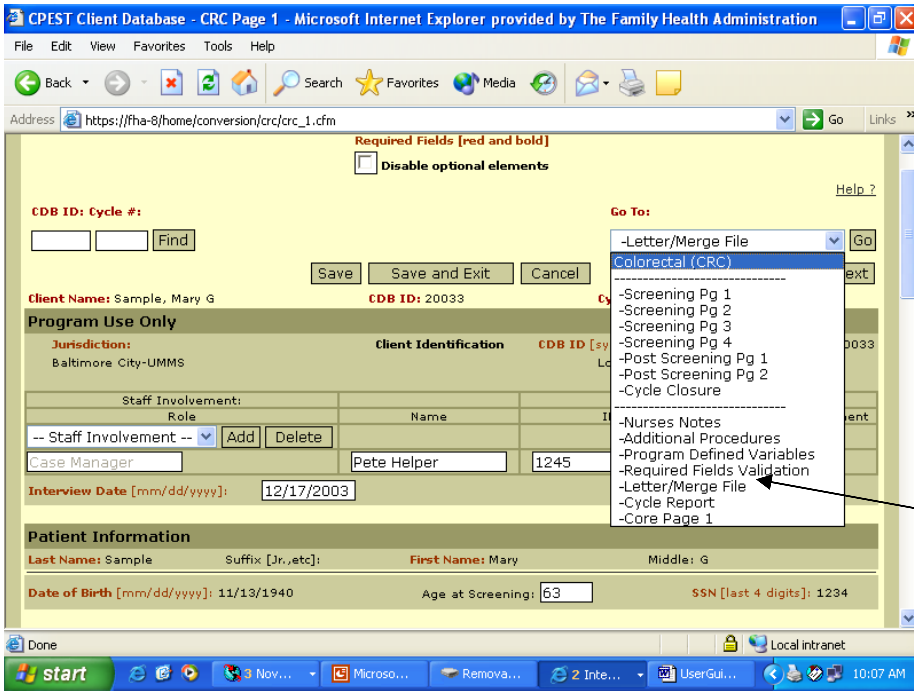


Tip:
To save the file so that it is easily opened with Microsoft Excel and Microsoft Word, rename the file with a .CSV extension when downloading. For Mail Merge it can be .csv or .cfm.

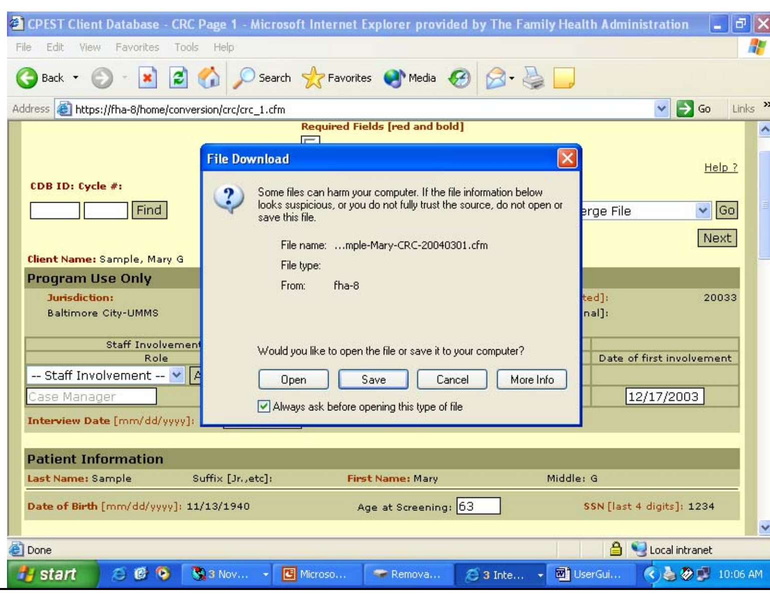
Tip:
To find out more about using the Mail Merge features of Microsoft Word, see Appendix H and review the Microsoft Word help topic "Mass Mailings."

Letters / Mail Merge for an Individual Client

1 When you are in the Client Record at the Module level, select Letters/Mail Merge from the Go To dropdown menu in the upper right corner.

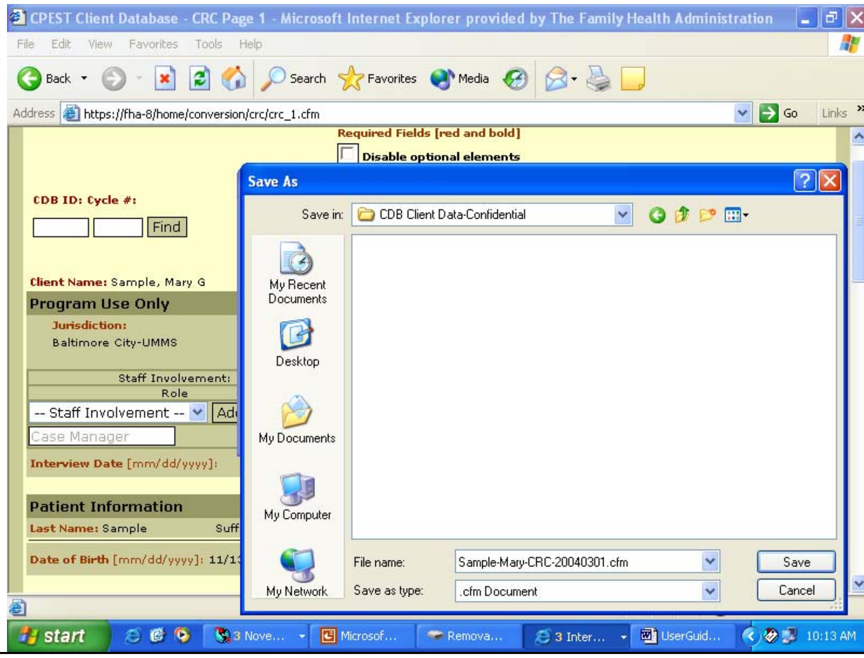


2 The File Download box appears and tells you the name of the file where the data will be stored. You should **Save** it to your computer file called *CDB Client Data-Confidential*



3

Tip:
To save the file so that it is easily opened with Microsoft Excel rename the file with a **.CSV** extension when downloading. For Mail Merge it can be .csv or .cfm.



4

You may close the file and you are now ready to open a template letter in Word and use the saved file of the client data to create a mail merge letter. See Appendix H for additional information on Mail Merge and the available fields for merging in letters.

Chapter 11: Download Client Data

The Download Client Data feature allows user of the CPEST system to download client and cancer module information to their personal computers. The download files are comma-separated and can be used in desktop programs such as Microsoft Excel or Access.

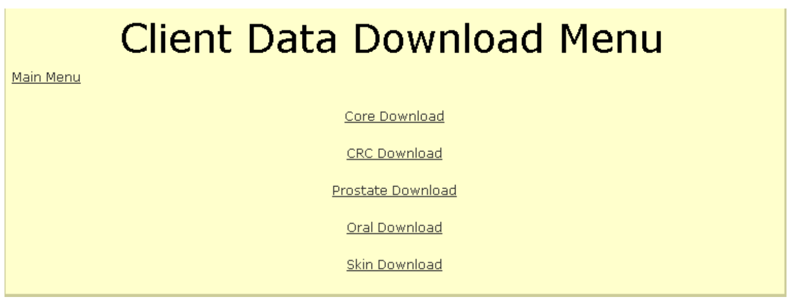
Included in This Chapter

- Downloading Data

Downloading Client Data

Follow the steps below to download data from the CPEST database. Core client data as well as CRC, Prostate, Oral, and Skin cancer data are available for download in the CPEST system. Appendix I contains the layout for each data file.

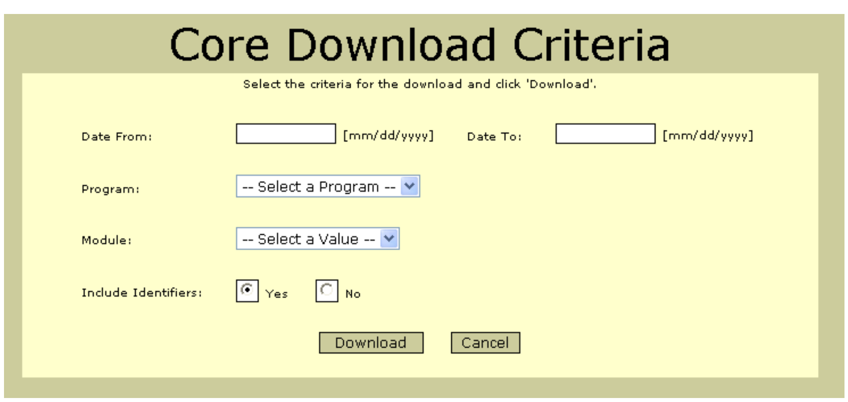
Note:
In order to download data, you must have Download Data security permissions. In order to view identifying data, you must have Access to Identifiers security permissions.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Click the “Download Client Data” link on the Main Menu to open the Client Data Download Menu.


</td></tr>
<tr><td>2</td><td>Choose the desired client data download option. The criteria entry page for the selected download will be displayed.</td></tr>
</table>

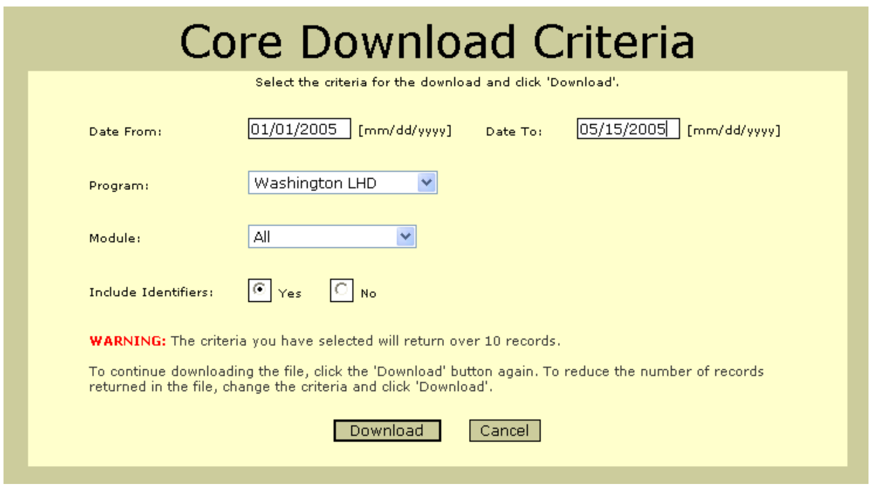
Downloading Core Data

Follow the steps below to download client core data from the CPEST database.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Enter the desired criteria for the clients to be included in the download.


</td></tr>
</table>

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td></td><td>
<table>
<tr><td>Date From</td><td>The start date of data to download. For core data, this is the client program enrollment date.</td></tr>
<tr><td>Date To</td><td>The end date of data to download. For core data, this is the client program enrollment date.</td></tr>
<tr><td>Program</td><td>The client's program. (Must select a singer program for download.)</td></tr>
<tr><td>Module</td><td>May select ALL or only clients enrolled in the selected module (CRC, Prostate, Oral, Skin).</td></tr>
<tr><td>Include Identifiers</td><td>Designates whether or not identifying data columns will be populated within the download.</td></tr>
</table>
</td></tr>
<tr><td>2</td><td>Click the "Download" button to download the data.</td></tr>
<tr><td>3</td><td>If the number of records in the file is greater than the Maximum Download Rows system setting, the page displays a warning message.

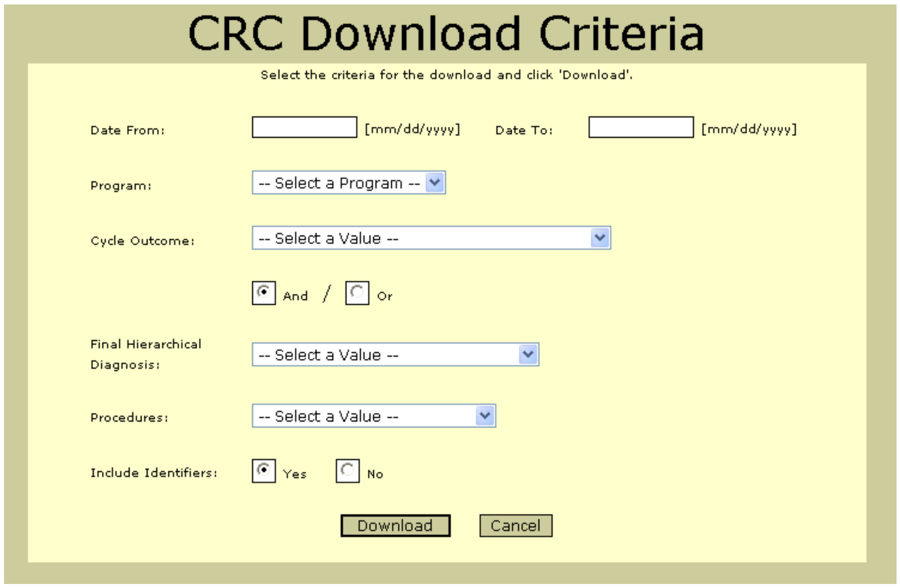


To ignore the warning and continue downloading the data, click the "Download" button again without changing any criteria. To reduce the size of the file, change the criteria and attempt to download the data again by clicking "Download".</td></tr>
<tr><td>4</td><td>Refer to 'Saving Downloaded Data' instructions later in this chapter.</td></tr>
</table>

Downloading CRC Data

Follow the steps below to download CRC client data from the CPEST database.

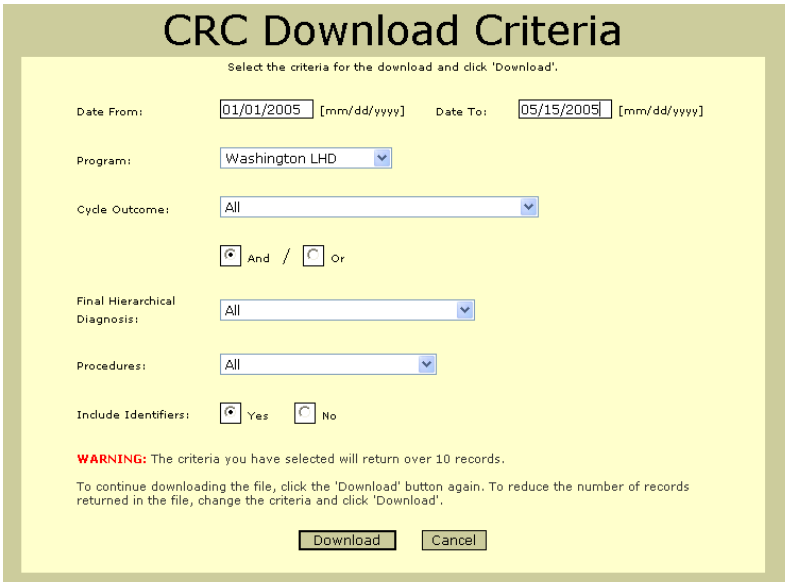
Step	*Action*
1	Enter the desired criteria for the clients to be included in the download.



Date From	The start date of data to download. For cancer module data, this is the cycle start date (Interview Date).
Date To	The end date of data to download. For cancer module data, this is the cycle start date (Interview Date).
Program	The client's program. (Must select a singer program for download.)
Cycle Outcome	Filters download record set based on selected Cycle Outcome.
And/Or	Designates how the Cycle Outcome and Final Hierarchical Diagnosis selections are to be related. (Cycle Outcome selection **AND** Final Hierarchical Diagnosis selection; Cycle Outcome selection **OR** Final Hierarchical Diagnosis selection)
Final Hierarchical Diagnosis	Filters download record set based on selected Final Hierarchical Diagnosis.
Procedures	Filters download record set based on procedures (All, FOBT, Sigmoidoscopy, Colonoscopy or None (No FOBT, SIG or COL)).
Include Identifiers	Designates whether or not identifying data columns will be populated within the download.

Step	*Action*
2	Click the "Download" button to download the data.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>3</td><td>If the number of records in the file is greater than the Maximum Download Rows system setting, the page displays a warning message.

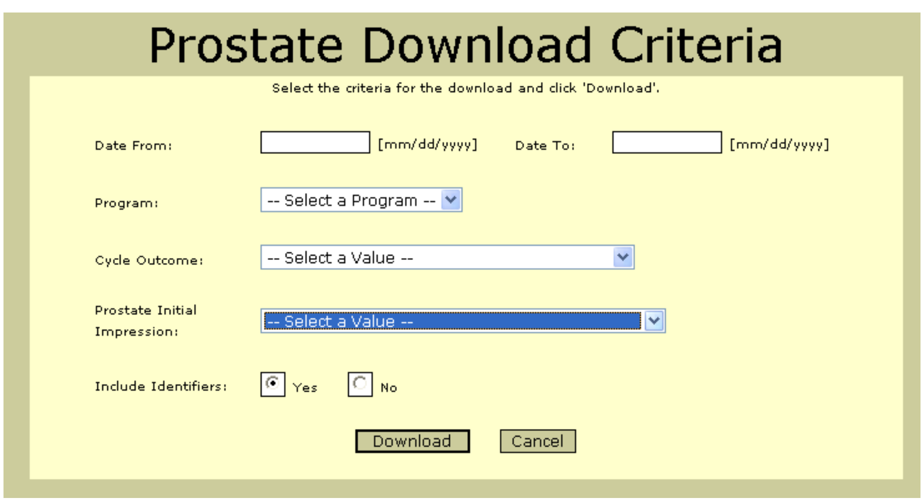


To ignore the warning and continue downloading the data, click the “Download” button again without changing any criteria. To reduce the size of the file, change the criteria and attempt to download the data again by clicking “Download”.</td></tr>
<tr><td>4</td><td>Refer to ‘Saving Downloaded Data’ instructions later in this chapter.</td></tr>
</table>

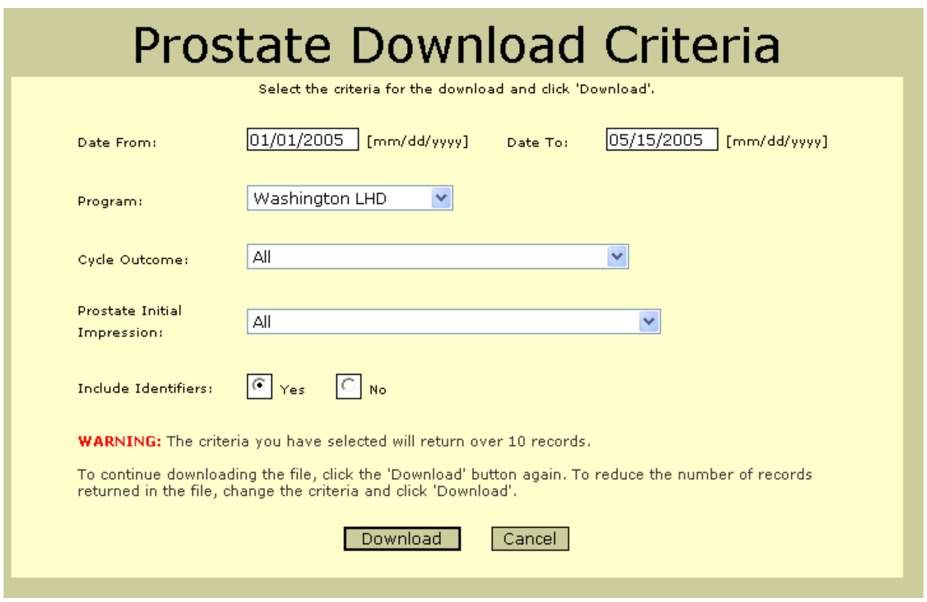
Downloading Prostate Data

Follow the steps below to download Prostate client data from the CPEST database.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Enter the desired criteria for the clients to be included in the download.


</td></tr>
</table>

Step	*Action*	
	Date From	The start date of data to download. For cancer module data, this is the cycle start date (Interview Date).
	Date To	The end date of data to download. For cancer module data, this is the cycle start date (Interview Date).
	Program	The client's program. (Must select a singer program for download.)
	Cycle Outcome	Filters download record set based on selected Cycle Outcome.
	Prostate Initial Impression	Filters download record set based on Prostate Initial Impression (All, Abnormal findings, not suggestive of cancer, Abnormal, needs further eval to rule out cancer, Normal findings).
	Include Identifiers	Designates whether or not identifying data columns will be populated within the download.
2	Click the "Download" button to download the data.	
3	If the number of records in the file is greater than the Maximum Download Rows system setting, the page displays a warning message.	



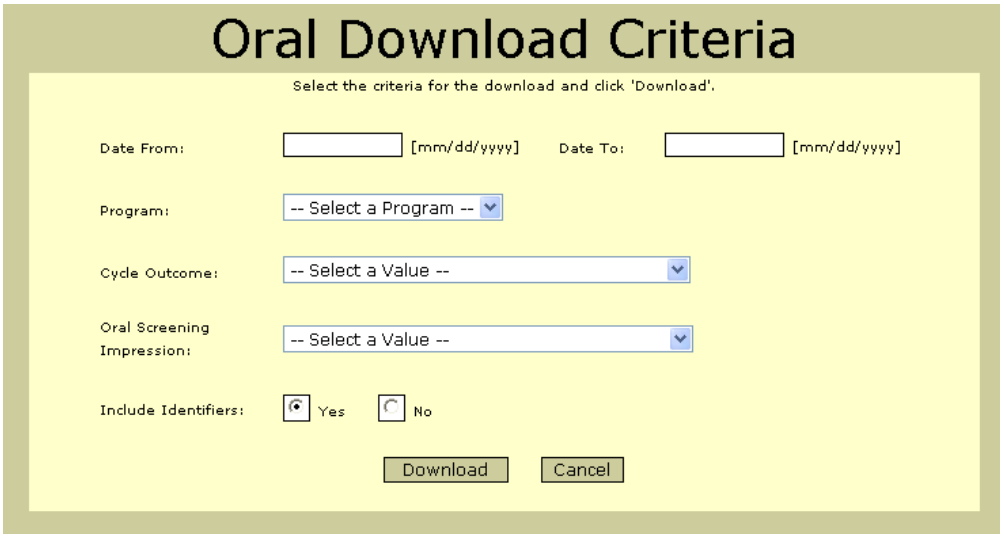
To ignore the warning and continue downloading the data, click the "Download" button again without changing any criteria. To reduce the size of the file, change the criteria and attempt to download the data again by clicking "Download".

4	Refer to 'Saving Downloaded Data' instructions later in this chapter.

Downloading Oral Data

Follow the steps below to download Oral client data from the CPEST database.

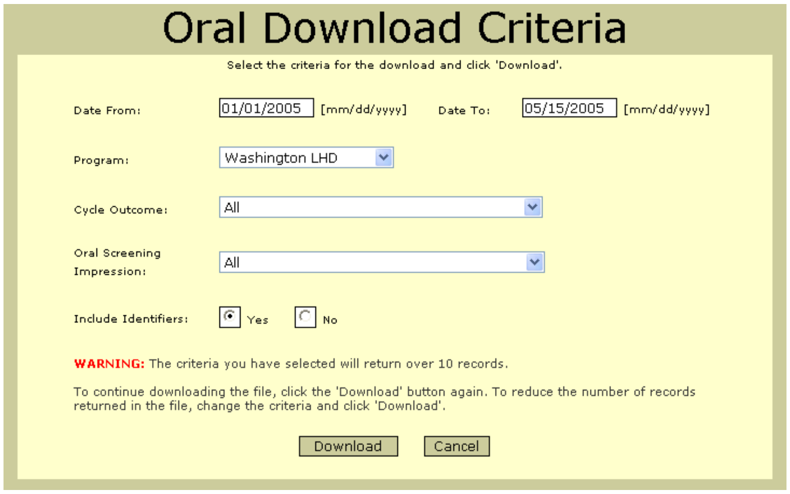
Step	*Action*
1	Enter the desired criteria for the clients to be included in the download.



Date From	The start date of data to download. For cancer module data, this is the cycle start date (Interview Date).
Date To	The end date of data to download. For cancer module data, this is the cycle start date (Interview Date).
Program	The client's program. (Must select a singer program for download.)
Cycle Outcome	Filters download record set based on selected Cycle Outcome.
Oral Screening Impression	Filters download record set based on selected Oral Screening Impression value (All, Abnormal findings, not suggestive of cancer, Cancer, Normal, Possible cancer).
Include Identifiers	Designates whether or not identifying data columns will be populated within the download.

Step	*Action*
2	Click the "Download" button to download the data.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>3</td><td>If the number of records in the file is greater than the Maximum Download Rows system setting, the page displays a warning message.

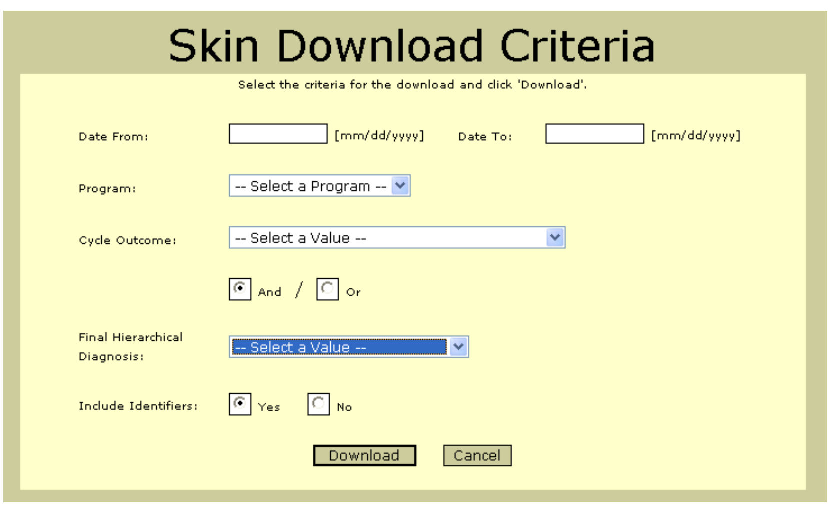


To ignore the warning and continue downloading the data, click the “Download” button again without changing any criteria. To reduce the size of the file, change the criteria and attempt to download the data again by clicking “Download”.</td></tr>
<tr><td>4</td><td>Refer to ‘Saving Downloaded Data’ instructions later in this chapter.</td></tr>
</table>

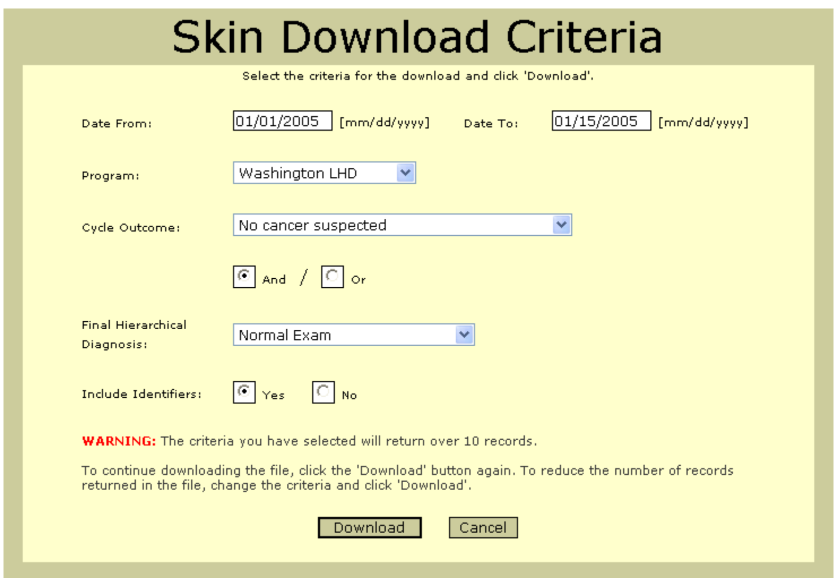
Downloading Skin Data

Follow the steps below to download Skin client data from the CPEST database.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Enter the desired criteria for the clients to be included in the download.


</td></tr>
</table>

Step	*Action*	
	Date From	The start date of data to download. For cancer module data, this is the cycle start date (Interview Date).
	Date To	The end date of data to download. For cancer module data, this is the cycle start date (Interview Date).
	Program	The client's program. (Must select a singer program for download.)
	Cycle Outcome	Filters download record set based on selected Cycle Outcome.
	And/Or	Designates how the Cycle Outcome and Final Hierarchical Diagnosis selections are to be related. (Cycle Outcome selection **AND** Final Hierarchical Diagnosis selection; Cycle Outcome selection **OR** Final Hierarchical Diagnosis selection)
	Final Hierarchical Diagnosis	Filters download record set based on selected Final Hierarchical Diagnosis.
	Include Identifiers	Designates whether or not identifying data columns will be populated within the download.
2	Click the "Download" button to download the data.	
3	If the number of records in the file is greater than the Maximum Download Rows system setting, the page displays a warning message.	



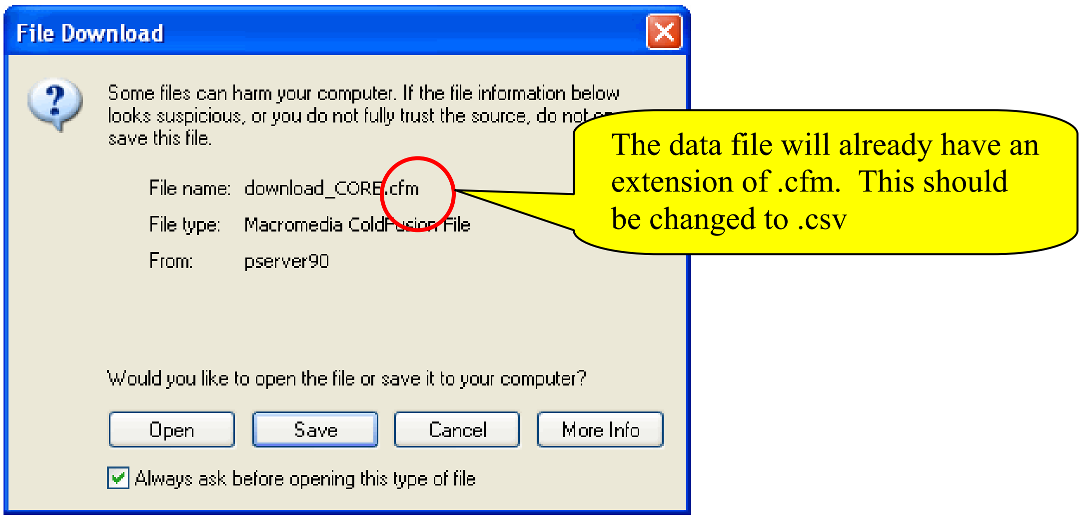
To ignore the warning and continue downloading the data, click the "Download" button again without changing any criteria. To reduce the size of the file, change the criteria and attempt to download the data again by clicking "Download".

4	Refer to 'Saving Downloaded Data' instructions later in this chapter.

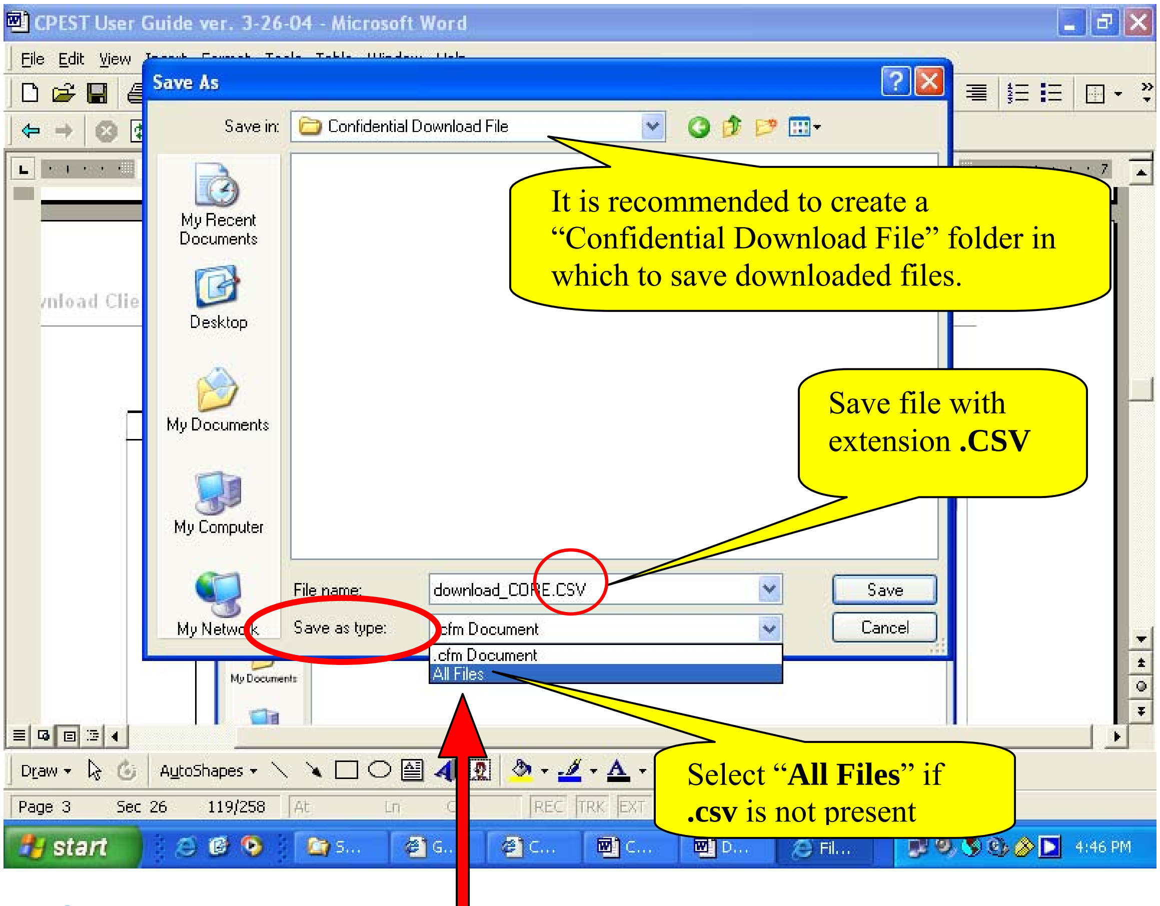
Saving Downloaded Data

Follow the steps to properly save data downloaded from the CPEST database.

Step	*Action*
1	The CPEST CDB system prompts to Save or Open the data file. To save the file, click the "Save" button and choose a file name and directory.



Tip:
To save the file so that it is easily opened with Microsoft Excel, rename the file from a .cfm to a **.CSV** extension when downloading.

Step	*Action*
5	 ***Tip:*** To save the file so that it is easily opened with Microsoft Excel and Microsoft Word, rename the file with a **.CSV** extension when downloading. Microsoft's "**Save As**" window prompt will appear. After changing the extension to **.CSV** in the "**File Name**" text box, in the text box below named "**Save As Type**" you want to choose "**All Files**" if **.CSV** is not present. This will allow you to save the file with the extension **.CSV**.
6	The lists of the fields in the five available download data sets are in Appendix I.

Chapter 12: Notifications List

Notifications List advises users that additional data needs to be entered to complete a client's cycle.

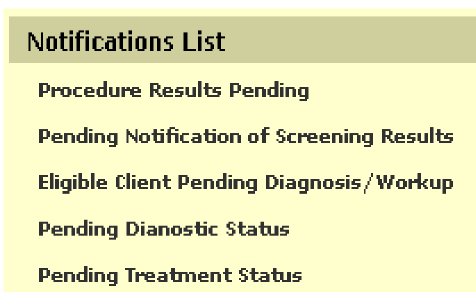
Included in This Chapter

Viewing Notifications

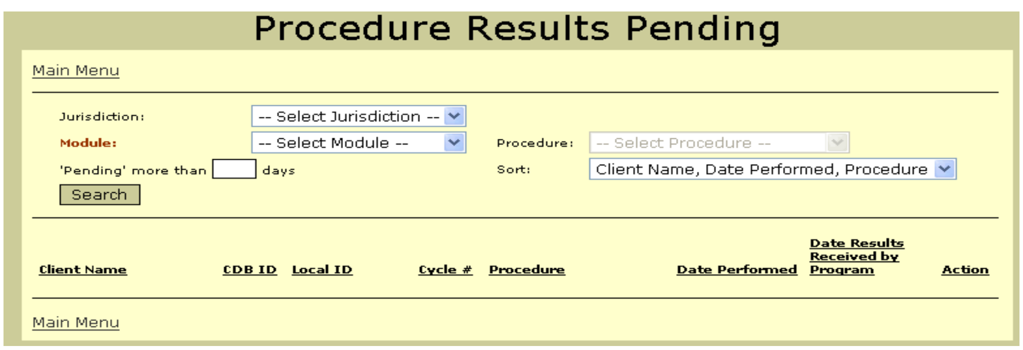
Follow the steps below to view notification lists in the CPEST System. Each list notifies CPEST System users when additional data are required to complete a cycle. Results criteria for each list can be found in Appendix G.

Note:
In order to download data, you must have Access to Data Statewide or Access to Raw Data Local security permissions. In order to view identifying data, you must have Access to Identifiers security permissions.

Step	*Action*
1	Choose the type of list to view by clicking the appropriate link under "Notifications List" on the Main Menu Page.



Step	*Action*
2	Each notification list uses a criteria page to filter and select the data displayed. Enter the criteria for the notification list you choose and click "Search" to return a list of matching records.



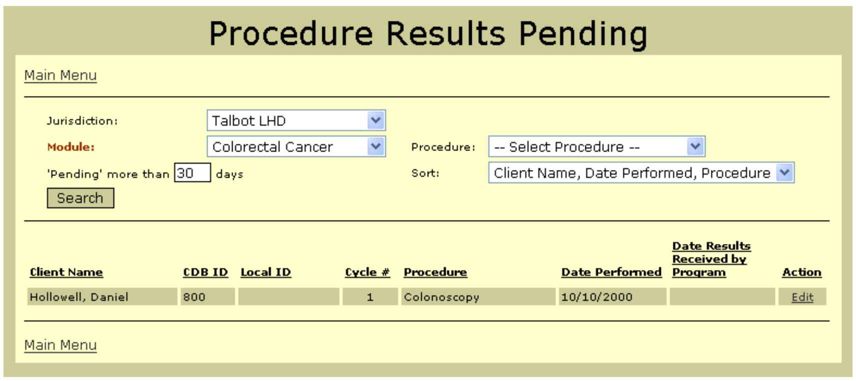
Jurisdiction	The client's jurisdiction.
Module	The client's cancer module.
Procedure	The specific procedure in the cancer module. This is available only for Pending Procedures and Pending Notification of Screening Results lists.
Results 'Pending' more than ___ days.	The number of days between the Today's Date and the Procedure Date that the Results or Findings are still

Step	Action

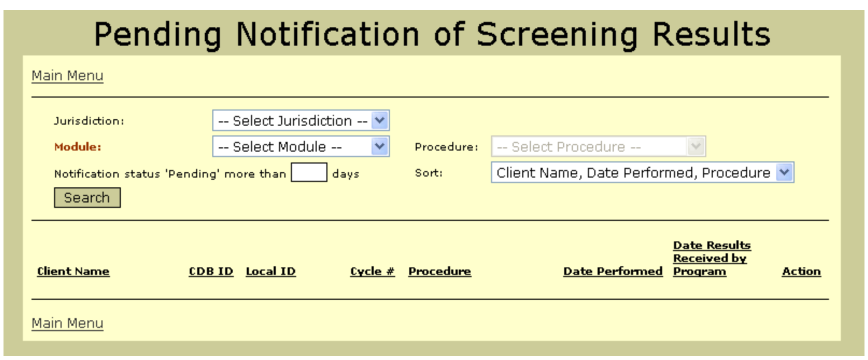
	pending.
Referrals 'Pending' for eligible clients, where last screening procedure was ___ or more days ago.	The number of days for the latest screening procedure. This is available only for Eligible Client Pending Diagnosis/Workup, Pending Diagnostic Status, and Pending Treatment Status lists.
Sort	The order in which the results are sorted on the page.

3

The matching records for the criteria appear at the bottom of the criteria page. The "Edit" (or "View") link provides one-way navigation to Screening Page 1 for the client / module / cycle to the left of the link.

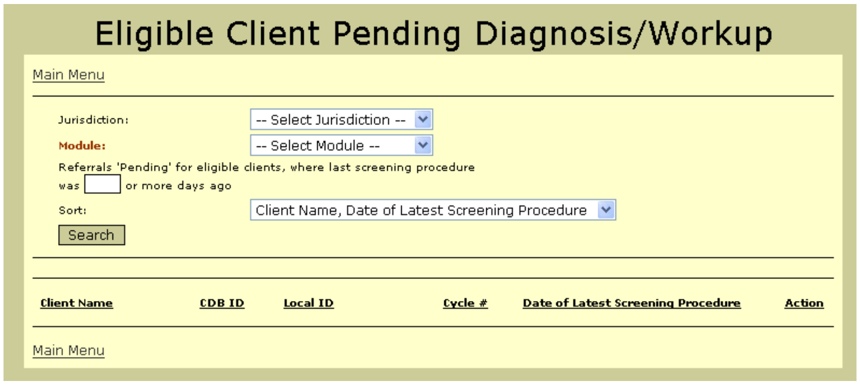


4



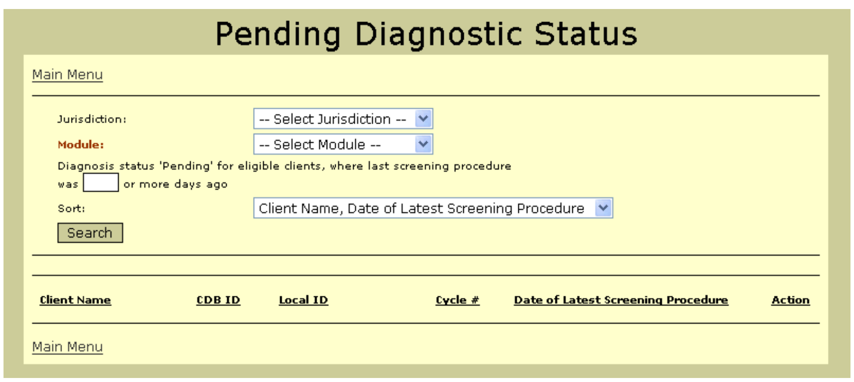
Jurisdiction	The client's jurisdiction.
Module	The client's cancer module.
Procedure	The specific procedure in the cancer module.
Notification status 'Pending' more than ___ days.	The number of days between Today's Date and the Procedure Date that the Client Notification is still 'pending.' Note: Client must have a valid date of procedure and date program notified of results for the client to appear in this list.
Sort	The order in which the results are sorted on the page.

Step	*Action*
5	



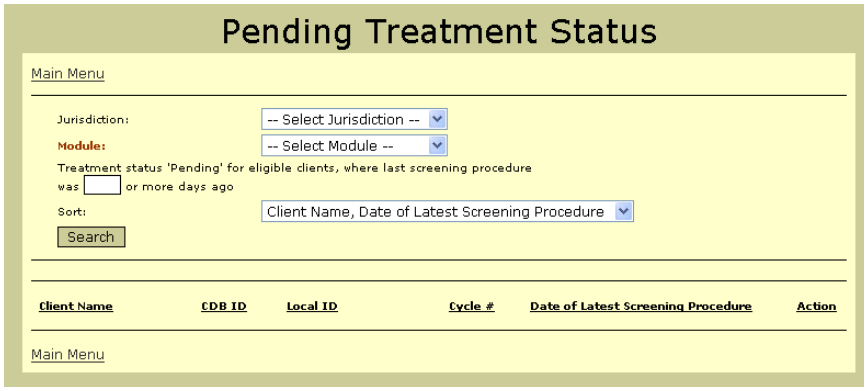
Jurisdiction	The client's jurisdiction.
Module	The client's cancer module.
Referrals 'Pending' for eligible clients, where last screening procedure was___ or more days ago.	Only for clients who are "eligible" on the top of Page 1 of the Post Screening Forms: The number of days between Today's Date and the last screening procedure date that you want to check whether the Referrals for Diagnosis/Workup are 'pending.'
Sort	The order in which the results are sorted on the page.

Step	*Action*
6	



Jurisdiction	The client's jurisdiction.
Module	The client's cancer module.
Diagnosis status 'Pending' for eligible clients, where last screening procedure was ___ or more days ago.	Only for clients who are "eligible" on the top of Page 1 of the Post Screening Forms: The number of days between Today's Date and the last screening procedure date that you want to check whether the Diagnosis Status is 'pending.' (Oral, Prostate, and Skin Modules only)
Sort	The order in which the results are sorted on the page.

Step	Action
7	



Jurisdiction	The client's jurisdiction.
Module	The client's cancer module.
Treatment status 'Pending' for eligible clients, where last screening procedure was ___ or more days ago.	Only for clients who are "eligible" on the top of Page 1 of the Post Screening Forms: The number of days between Today's Date and the last screening procedure date that you want to check whether the Treatment Status is 'pending."
Sort	The order in which the results are sorted on the page.

Appendix A: Core Demographic Screening Fields

Appendix A contains all of the fields that can be entered for a client's core demographic data. The chapter is divided into sections for each form used to maintain the data.

Note:
Fields highlighted in bold are required.

Core Demographic Screening Page 1

Program Use Only:

Jurisdiction	Identifies the program in which this client is enrolled.
Interviewer	The staff person who interviewed the client.
Cycle Start (Interview) Date	mm/dd/yyyy.
Enrollment Date	Date to be recorded as enrollment for each program specified on page three of Core form. (format is mm/dd/yyyy) (Not Editable after initial entry)
CDB ID	System generated ID representing client within system. This field will be blank for a new client until saved to the database. (Not Editable)
Local ID	Freeform ID for local health department use. (Optional)

Patient Information:

Last Name	Last name or Surname of client.
Suffix	Suffix of client. (Jr., III, etc)
First Name	First name of client.
Middle	Middle name or initial of client if they have one.
Date of Birth	Date of birth of client. This column is a character field to allow for partial data entry. Preferred format is mm/dd/yyyy.
Age at Enrollment	Age of client at time of enrollment.
SSN	Last four digits of patient's Social Security Number. (or NONE)
Residential Address	
(Street) Number	Housing number.
(Street) Pre Dir	Prefix directional of street. (N, NE, etc.)
(Street) Name	Name of street. (Main, Preston, etc.)
(Street) Type	Type of street. (AVE, BLVD, ST, etc.)
(Street) Post Dir	Post (Suffix) directional of street. (N, NE, etc.)
Apartment/ Room/Unit #	Apartment, Suite, Room or Unit Number.
City	City of residence.
County	County of residence.
State	State of residence.
Zipcode	Full zip code. (five or nine digits)
(Telephone) Home	Home telephone number of client.
(Telephone) Work	Work telephone number of client.
(Telephone) Cell	Cellular telephone of client.
Is mailing address different from residential address?	User must indicate 'Yes' in order to enable the Mailing Address fields for data entry; otherwise fields are populated with residential address data.
Mailing Address	
(Street) Number	Housing number.
(Street) Pre Dir	Prefix directional of street. (N, NE, etc.)
(Street) Name/PO Box	Name of street (Main, Preston, etc.) or Enter full PO Box address here.
(Street) Type	Type of street. (AVE, BLVD, ST, etc.)
(Street) Post Dir	Post (Suffix) directional of street. (N, NE, etc.)
Apartment/ Room/Unit #	Apartment, Suite, Room or Unit Number.
City	City of residence.

State	State of residence.
Zipcode	Full zip code. (five or nine digits)

Contact Information:

Last Name	Client contact's last name.
First Name	Client contact's first name.
Relationship	Contact's relationship to client.
Street Address	Client contact's street address. (e.g. 123 West Main Street)
Apartment/ Room/Unit #	Client contact's Apartment, Suite, Room or Unit Number.
City	Client contact's city of residence.
State	Client contact's state of residence.
Zipcode	Client contact's full zip code. (five digits)
(Telephone) Home	Contact person's home telephone number.
(Telephone) Cell	Contact person's cell phone number.

Learn of Program:

How did you learn of this screening program?	Indicates which method(s) influenced a client's participation within the program.
Community agency, specify	Captures detail of Community agency, when selected.
Other, specify	Captures detail of Other, when selected.
Comments	Captures additional comments regarding learn of program. (100)

Core Demographic Screening Page 2

Demographic Information:

Gender	Indicates gender (sex) of client.
Ethnicity (Hispanic or Latino)	Indicates Hispanic or Latino ethnicity of client.
Race	Indicates race of client.
Education	Indicates education level of client.
Marital Status	Indicates client's marital status.
Primary Language	Indicates client's primary language.
Other, specify	Identifies other primary language.
Is an interpreter needed?	Indicates client need of an interpreter.
Do you have any needs or disabilities of which we should be aware?	Indicates client's needs or disabilities.
Other, specify	Identifies other need or disability.
Annual Income	Client household's annual income.
Income Documentation	Indicates type of income documentation client provided.
Number of Persons in Household	Number of persons in client household, including the client.

Previous Enrollment:

Have you ever been screened or treated for colon, oral, skin, or prostate cancer by any Maryland health program?	Indicates client has participated in a Maryland health program for screening or treatment of these four cancers.

Yes, specify county(s)	Identifies Maryland County where screened or treated.
Have you ever been screened for breast or cervical cancer by the Breast and Cervical Cancer Program (BCCP)?	Indicates client participation in the BCCP program.

Health Care Provider and Insurance Information:

Do you have a primary health care provider?	
If yes, identify provider or practice	Health Care Provider must be selected from list provider. Information for the selected provider will be displayed on this page.
Add Provider	Button links to Health Care Provider screen so that user may enter a new provider.
Are you covered by health insurance?	Indicates existence of client health insurance.
If yes, type of *primary* health insurance	Identifies primary insurance source.
Name and policy number of *primary* health insurer	Identifies primary policy name and number.
Type of *secondary* health insurance, if any	Identifies secondary insurance source.
Name and policy number of *secondary* health insurer, if any	Identifies secondary policy name and number.

Core Demographic Screening Page 3

Health History:

Do you have a history of any kind of cancer?	Indicates client's cancer history.
Type of Cancer	Identifies type of cancer.
Add	Button to add a new row for a type of cancer selected from the list.
Delete	Button to delete last row of cancer within list.
Date of Diagnosis	Date of client's cancer diagnosis. Permits characters. Preferred format is mm/dd/yyyy.
Treatment Details	Text describing cancer treatment selected. (1000)
Have you had any of the following illnesses/conditions?	Indicates existence of each client condition.
Add	Button to add a new row for an illness/condition selected from the list.
Delete	Button to delete last row of illness/condition within list.
Details	Text describing illness/condition selected. (1000)
List any medications you are currently taking	Identifies client's current medications. (up to 1000 characters)
Have you *ever* used tobacco in any form?	Indicates whether client has ever used any form of tobacco.
Do you currently use tobacco?	Indicates whether client currently uses tobacco.
If yes, check all products used	Indicates tobacco products client has used.
Have you smoked 100 or more cigarettes over your lifetime?	Indicates whether client smoked 100 or more cigarettes over lifetime.
If yes, at what age did you first smoke?	Age client began to smoke.

If you quit smoking, at what age did you quit?	Age client quit smoking.
Average number of packs of cigarettes you smoke(d) each day (20 cigarettes per pack):	Average number of packs of cigarettes client smoked each day.

Program Use Only:

Provided literature to client on dangers of tobacco use	Indicates whether literature on dangers of smoking was provided to client.
Is client eligible for any cancer screening in the Program?	Indicates status of client's eligibility for screening.
Yes, enroll client in the following module (check all that apply, must select at least one)	Indicates client's module enrollment at the time client is entered into CDB.

Comments:

Comments	Text box for Program personnel comments or concerns. (1000)

Core Demographic Program Defined Variables

Screen Components:

Client_field_one	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Client_field_two	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Client_field_three	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Client_date_field_one	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Client_date_field_two	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Date of initial inquiry	Variable to be available for Allegany (program_ID=01) and Cecil (program_ID=07) users. (mm/dd/yyyy).
Birth Country	Variable to be available for Montgomery (program_ID=15) users.
State_date_field_one	Variable to defined and used by statewide users as desired. (mm/dd/yyyy)
State_field_one	Variable to defined and used by statewide users as desired. (50)
State_field_two	Variable to defined and used by statewide users as desired. (50)
State_field_three	Variable to defined and used by statewide users as desired. (50)

Appendix B: Colorectal Cancer Screening Fields

Appendix B contains all of the fields that can be entered for a client's colorectal cancer data. The chapter is divided into sections for each form used to maintain the data.

Note:
Fields highlighted in bold are required.

Colorectal Cancer Screening Page 1

Program Use Only:

Jurisdiction	Identifies the program in which this client is enrolled. (Not Editable)
CDB ID	System generated ID representing client within system. (Not Editable)
Local ID	Freeform ID for local health department use. (Optional) (Not Editable)
Staff Involvement	Collection of fields used to identify persons involved with the client during this cycle.
Role	Indicates the role of the staff member. (e.g. Interviewer, Outreach Worker, Educator, Case Manager)
Name	The full name of the staff member (or otherwise officially retained individual) involved in this capacity.
ID	Freeform text entry of staff member's local health department id.
Date of first involvement	Date of interaction or first involvement.
Add	Button to add an additional row to the staff involvement list.
Delete	Button to delete the last row of staff involvement list.
Cycle Start (Interview) Date	Represents the start date for this cycle of screening.

Patient Information:

Last Name	Last name of client. (Not Editable)
Suffix	Suffix of client. (Jr., III, etc) (Not Editable)
First Name	First name of client. (Not Editable)
Middle	Middle name or initial of client if they have one. (Not Editable)
Date of Birth	Date of birth of client. (Not Editable)
Age at Screening	Age of client at time of this screening cycle.
SSN	Last four digits of client's Social Security Number. (Not Editable)

History:

Client history of colorectal cancer?	
Yes, date of diagnosis:	Preferred entry format is mm/dd/yyyy, however character entry is permitted.
Client history of colon adenomatous polyps/ adenoma?	
Yes, date of first diagnosis:	Preferred entry format is mm/dd/yyyy, however character entry is permitted.
Client history of inflammatory bowel disease?	
Ulcerative Colitis, date:	Indicates client previous diagnosis of Ulcerative Colitis and date of diagnosis. (character entry permitted)
Crohn's Colitis, date:	Indicates client previous diagnosis of Crohn's Colitis and date of diagnosis. (character entry permitted)
Both Ulcerative and Crohn's, date:	Indicates client previous diagnosis of both Ulcerative and Crohn's Colitis and date of diagnosis. (character entry permitted)
Unknown/not specified	Indicates client previous unknown/not specified inflammatory bowel disease.

Family history of adenoma or colorectal cancer in first-degree relative (parent, sibling, child)?	
(Colorectal Cancer) Relationship	The relationship to the client of the first-degree relative diagnosed with colorectal Cancer.
(Colorectal Cancer) Age at onset	The age at onset for the client's relative diagnosed with colorectal cancer. (allows for character entry)
(Adenoma) Relationship	The relationship to the client of the first-degree relative diagnosed with Adenoma.
(Adenoma) Age at onset	The age at onset for the client's relative diagnosed with Adenoma. (allows for character entry)
Comments on CRC History	Comments about client's history of CRC. (1500)
CRC Risk based on client and family history	Client risk assessment based on guidelines within CRC Minimal Clinical Elements.
Clear	Clears current selection.

Symptoms:

Does client have gastrointestinal symptoms possibly suggesting colorectal cancer?	
Yes, specify symptoms below	Indication of which symptoms the client is experiencing.
Other Symptoms	Description of other gastrointestinal symptom indicated by client.
Comments on Symptoms	Captures overall comments about symptoms. (1500)

Previous Screening History:

If client was previously tested for CRC outside of this Program, specify the test(s) and provide details	
Test	Selection list for CRC screening completed outside of program. (each test may be selected only once)
Date	Date entered screening test was performed.
Results	Text description of results of entered screening test. (50)
Provider	Provider of entered screening test. (50)

Colorectal Cancer Screening Page 2

Other Medical History:

Does client have history of	
Prior abdominal surgery	
Pacemaker	
Replacement heart valve	
Internal defibrillator	
Joint replacement	
Bleeding tendency	
Regular use of aspirin, NSAIDS, coumadin, anticoagulants	

FOBT:

FOBT Kit Given	Indicates whether client was given an FOBT kit.
Date Given	Date the FOBT kit was given to the client.
Kit Returned	Identifies if FOBT kit was returned by the client.
Date FOBT Kit Returned	The date the client returned the FOBT kit.
Date Results Received by Program	The date the program received the results of the FOBT.
FOBT Kit Results	Results of FOBT.
(FOBT Kit Results) Other, specify	Description of Other FOBT Kit result.
Client Notified of Screening Results	Code value indicating the notification status.
Date Program Notified Client	Date successful notification was made. (mm/dd/yyyy)
Notified by whom	Staff person who notified client.
Type of notification	Code value indicating the notification type. Valid values: 'CERTMAIL', 'OTHER', 'REGMAIL', 'TELEPHONE', 'VERBAL', 'WRITING'.
(Type of Notification) Other, specify	Details of other notification.
Notification Comments	Comments regarding notification. (500)

Endoscopy Screening Eligibility:

Eligible for Screening Endoscopy by Program?	Indicates client eligibility for screening □igmoidos (□igmoidoscopy or colonoscopy) or other expensive screenings (DCBE, etc.), diagnosis or treatment.
If ineligible, reason for ineligibility	Indicates why a client was deemed ineligible.
Other, specify	Describes 'Other' ineligibility reason.
Screening/Diagnosis Payer	
Other, specify	Describes 'Other' Screening Payer selected.

Screening Recommended:

(Screening Recommended) Pre-Screening Physical Exam Sigmoidoscopy Colonoscopy DCBE	
Pre-Screening	Recommendation for Pre-Screening Physical Exam.
(Pre-Screening) Date Scheduled	The date the Pre-screening exam is scheduled. (mm/dd/yyyy)
(Pre-Screening) Date Rescheduled	If necessary, The date the Pre-screening exam is re-scheduled. (mm/dd/yyyy)
(Pre-Screening) Provider	Provider of the Pre-Screening Exam.
(Pre-Screening) Not Performed in CRF Program	If recommended Pre-Screening exam is not completed indicate why so that procedure group status will reflect CANCELLED.
(Screening Recommended) Pre-Screening Physical Exam Sigmoidoscopy Colonoscopy DCBE	

Physical Exam	Recommendation for Physical Exam.
(Physical Exam) Date Scheduled	The date the Physical Exam is scheduled. (mm/dd/yyyy)
(Physical Exam) Date Rescheduled	If necessary, The date the Physical Exam is re-scheduled. (mm/dd/yyyy)
(Physical Exam) Provider	Provider of the Physical Exam.
(Physical Exam) Not Performed in CRF Program	If recommended Physical Exam is not completed indicate why so that procedure group status will reflect CANCELLED.
Sigmoidoscopy	Recommendation for Sigmoidoscopy.
(Sigmoidoscopy) Date Scheduled	The date the Sigmoidoscopy is scheduled. (Format must be mm/dd/yyyy)
(Sigmoidoscopy) Date Rescheduled	If necessary, The date the Sigmoidoscopy is re-scheduled. (Format must be mm/dd/yyyy)
(Sigmoidoscopy) Provider	Provider of the Sigmoidoscopy.
(Sigmoidoscopy) Not Performed in CRF Program	If recommended Sigmoidoscopy is not completed indicate why so that procedure group status will reflect CANCELLED.
Colonoscopy	Recommendation for Colonoscopy.
(Colonoscopy) Date Scheduled	The date the Colonoscopy is scheduled. (mm/dd/yyyy)
(Colonoscopy) Date Rescheduled	If necessary, The date the Colonoscopy is re-scheduled. (mm/dd/yyyy)
(Colonoscopy) Provider	Provider of the Colonoscopy.
(Colonoscopy) Not Performed in CRF Program	If recommended Colonoscopy is not completed indicate why so that procedure group status will reflect CANCELLED.
DCBE	Recommendation for DCBE.
(DCBE) Date Scheduled	The date the DCBE is scheduled. (mm/dd/yyyy)
(DCBE) Date Rescheduled	If necessary, The date the DCBE is re-scheduled. (mm/dd/yyyy)
(DCBE) Provider	Provider of the DCBE.
(DCBE) Not Performed in CRF Program	If recommended DCBE is not completed indicate why so that procedure group status will reflect CANCELLED.
No screening recommended	Indicates that no screening is recommended for this client within this cycle.
(No screening recommended) specify details	The text description of why no screening was recommended. (100)
See own doctor	Recommendation for client to see his/her own physician.
(See own doctor) specify details	The text description of recommendation to see own doctor. (100)
Other screening recommended	Recommendation for screening procedure beyond those listed.
(Other screening recommended) specify details	The text description of other recommended screening. (100)

Colorectal Cancer Screening Page 3

Results from Exam:

Type of Exam	Designation of Physical Exam or Pre-Screening Visit.
Date of Exam	Date of Examination. (mm/dd/yyyy)
Date Results Received by Program	Date results were received by CDB program. (mm/dd/yyyy)
Provider	Designation of eligible provider of the exam.
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Designation of ineligible provider.
Significant Findings	The results of the examination as it pertains to CRC screening. (1000)
Client Notified of Exam Results	Code value indicating the notification status.
Date Client Notified	Date successful notification was made. (mm/dd/yyyy)
Notified by whom	Staff person who notified client.
Type of notification	Code value indicating the notification type. Valid values: ‘CERTMAIL’, ‘OTHER’, ‘REGMAIL’, ‘TELEPHONE’, ‘VERBAL’, ‘WRITING’.
(Type of Notification) Other, specify	Details of other notification.
Notification Comments	Comments regarding notification. (500)

Endoscopy and/or DCBE Results:

Procedure	Designation of Sigmoidoscopy, Colonoscopy or DCBE.
Date Performed	Date of procedure. (mm/dd/yyyy)
Provider	Designation of eligible provider of the procedure.
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Designation of other provider.
Biopsy Done	Indicates if a biopsy was completed as part of this procedure.
Clear	Clears the current selection.
Adequate Exam	Indicates if the exam was adequate.
Clear	Clears the current selection.
Date Results Received by Program	Date results were received by CDB program. (mm/dd/yyyy)
Findings	List of possible findings for this procedure, user may select as many as apply.
(Findings) Confirmed Cancer	Indicates if CRC was found.
(Confirmed Cancer) specify type	Indicates type of CRC found. (200)
(Confirmed Cancer) specify location	Indicates location of CRC found. (100)
(Findings) Presumed/ Suspect Cancer	Indicates if CRC was presumed but not confirmed.
(Findings) Adenoma	Indicates if adenomatous polyps found.
(Adenoma) Number	The number of adenomatous polyps found.
(Adenoma) Size of largest adenoma	The size, in mm, of the largest adenomatous polyp found.
(Adenoma) Histology of most advanced lesion	Histology of most advanced AP. Valid values: ‘TUBULAR’, ‘TUBULVIL’,’VILLOUS’.

(Adenoma) Were any of the adenomas called high-grade dysplasia on pathology, (high-grade dysplasia, severe dysplasia, carcinoma-in-situ, intramucosal carcinoma)?	
(Adenoma) Were any of the adenomas described as “serrated”?	
(Findings) Hyperplastic Polyps	Indicates Hyperplastic Polyps found.
(Hyperplastic Polyps) specify number	The number of hyperplastic polyps found.
(Findings) Other polyp/ polyp type not otherwise specified	Indicates other polyps found.
(Other polyp) number	The number of polyps found.
(Other polyp) Size of largest polyp	The size, in mm, of the largest polyp found.
(Other polyp) Type/reason ‘other’	Description of polyp that clarifies ‘other’ designation.
(Findings) Ulcerative colitis	Indicates ulcerative colitis was found.
(Findings) Crohn’s colitis	Indicates Crohn’s colitis was found.
(Findings) Diverticuli	Indicates Diverticuli was found.
(Findings) Hemorrhoids	Indicates Hemorrhoids were found.
(Findings) Other	Indicates findings other than those listed.
(Other) specify	Description of other findings. (500)
(Findings) Normal, none of the above findings	Indicates a normal exam, none of the listed findings detected.
Hierarchical Procedure Result	System derived hierarchical result for this procedure. (Not Editable)
Update Result	Button to refresh Hierarchical Procedure Result based on data entry changes made.
Converted Procedure Result	Field applies only to converted data for which a procedure result was carried to the new system. (Not Editable)
Comments on Findings	Further description of listed findings. (1000)
Complications of Procedure (if any)	Description of any complications encountered. (500)
Client Notified of Screening Results	Code value indicating the notification status.
Date Program Notified Client	Date successful notification was made. (mm/dd/yyyy)
Notified by whom	Staff person who notified client.
Type of notification	Code value indicating the notification type. Valid values: ‘CERTMAIL’, ‘OTHER’, ‘REGMAIL’, ‘TELEPHONE’, ‘VERBAL’, ‘WRITING’.
(Type of Notification) Other, specify	Details of other notification.
Notification Comments	Comments regarding notification. (500)

Colorectal Cancer Screening Page 4

Screening Summary Recommendations:

Recommendations	Recommendations at conclusion of screening.

No cancer detected, recall for routine screening.	This recommendation refers to colorectal cancer not being detected.
No cancer detected, refer for other findings	This recommendation refers to colorectal cancer not being detected.
Refer to	Text describing referral. (50)
No cancer detected, other recommendations	This recommendation refers to colorectal cancer not being detected.
Specify	Any other recommendation not previously listed. (50)
Cancer detected/suspected, refer for further evaluation/treatment for cancer.	
Cancer detected, no further evaluation/treatment needed. Recall for routine screening.	

Colorectal Cancer Post Screening Evaluation Page 1

Program Eligibility:

Is client eligible for additional CRF work-up, treatment or case management services	Specifies client eligibility for additional services.

Ineligible Client:

Reason for Ineligibility	Indicates why a client was deemed ineligible.
Other, specify	
Was ineligible client referred elsewhere for diagnosis/treatment?	
Yes, referred to	Text describing referral. (100)
Ineligible Client Outcome	
Final disposition of ineligible clients who contacted an HCP	
Other, specify	Describes Other disposition selected. (50)
If adenoma required surgery, specify treatment status	
(Adenoma, treatment status) Other, specify	Describes other treatment status selected. (100)
Cancer, specify type	Describes type of Cancer. (50)
If cancer required surgery, specify treatment status	
(Cancer, treatment status) Other, specify	Describes other treatment status selected. (100)
Comments	Comments related to ineligible client disposition. (500)

Colorectal Cancer Post Screening Evaluation Page 2

Eligible Client:

Diagnosis/ Treatment Payer	Designates those responsible for payment of diagnostic/ treatment services.
Other, specify	
Was eligible client referred for evaluation and/or treatment?	
Referred to	
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Date of referral appointment	Appointment date. (mm/dd/yyyy)
No, explain	Explanation for why client was not referred. (100)
Were additional procedures or surgeries completed?	If yes, user should enter this information via Additional Procedures page.
Final Hierarchical Diagnosis	System generated final diagnosis based on data for all procedures entered for this cycle. See Help for definitions.

Summary of Diagnostic Work-up and Treatment of Cancer:

Is cancer treatment recommended	
Treatment Type/Comments	Description of Cancer treatment. (500)
Date first treatment began	Date of first treatment. (mm/dd/yyyy)
Treatment Status	
Other, specify	Description of other treatment status. (100)
Clear	Clears the current selection.
Tumor	
Nodes	
Metastases	
Stage	
Hospitalized	
Yes, hospital	
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Capture text entry of provider when not selected from list.
Date of first admission	Date of first hospital admission. (mm/dd/yyyy)
Hospice	
Yes, facility	
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Capture text entry of provider when not selected from list.
Date of first service	Date of first hospice service. (mm/dd/yyyy)

Colorectal Cancer Cycle Closure Page

Cycle Closure:

Date Cycle Closed	Date the cycle was closed. (mm/dd/yyyy)
Final Hierarchical Diagnosis	System generated final diagnosis based on data for all procedures entered for this cycle. See Help for definitions.
Cycle Outcome	Code describing the cycle outcome. Valid values: ‘ CASTATUNK’, ‘CATREAT’, ‘CADETECTED’, ‘NOCASUSP’, ‘NOCADETECT’,’ABNORMAL’.

Clear	Clears the current selection.
CRC risk based on cycle screening and client and family history	Client risk evaluation at conclusion of the cycle.
Screening Recall	Captures recommendation of another CRC Screening Exam.
FOBT	
in _____	Captures number of months or years until the client should be recalled.
Month/years	Recall for screening interval. Valid values: 'MONTH', 'YEAR'.
Projected date	Projected date of recall exam. (mm/yyyy)
DCBE	
in _____	Captures number of months or years until the client should be recalled.
Month/years	Recall for screening interval. Valid values: 'MONTH', 'YEAR'.
Projected date	Projected date of recall exam. (mm/yyyy)
Sigmoidoscopy	
in _____	Captures number of months or years until the client should be recalled.
Month/years	Recall for screening interval. Valid values: 'MONTH', 'YEAR'.
Projected date	Projected date of recall exam. (mm/yyyy)
Colonoscopy	
in _____	Captures number of months or years until the client should be recalled.
Month/years	Recall for screening interval. Valid values: 'MONTH', 'YEAR'.
Projected date	Projected date of recall exam. (mm/yyyy)
Other	
in _____	Captures number of months or years until the client should be recalled.
Month/years	Recall for screening interval. Valid values: 'MONTH', 'YEAR'.
Projected date	Projected date of recall exam. (mm/yyyy)
If other, specify	Captures the description of the other procedure for recall.
Comments	Comments pertaining to cycle closure. (500)

Nurses Notes Page

Nurses Notes:

Nurses Notes	Text field for capturing information about the cycle. (6000)

Colorectal Cancer Additional Procedures Page

Additional Procedures:

Select Procedure	List of procedures in CRC module. May be used to select a procedure to add to this cycle.
Select Purpose	List of valid purposes for the selected procedure. Purpose must be chosen in order to add the procedure.
Add Procedure	Button to add the selected procedure/purpose to this cycle. *Note: Purpose may not be changed after procedure is added.*
Procedure	Column heading, procedure name.
Date	Column heading, date procedure was performed.
Status	Column heading, current status of procedure.
Actions	Column heading, available actions the user may take with regard to this procedure. (Edit, Delete)

Colorectal Cancer Program Defined Variables Page

Program Defined Variables:

Crc_field_one	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Crc_field_two	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
CRC_date_field_one	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
CRC_date_field_two	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
CRC_date_field_three	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Admit CRF Date	Variable to be available for Carroll County (program_ID=6) clients. (mm/dd/yyyy)
Sponsor	Variable to be available for Montgomery (program_ID=15) clients.
(Sponsor) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of 'Other' sponsor. (50)
Date of education/intake	Variable to be available for Montgomery (program_ID=15) clients. (mm/dd/yyyy)
Group Education Session ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text to 10 characters.
Referral Date	Variable to be available for Montgomery (program_ID=15) clients. (mm/dd/yyyy)
Referral Location	Variable to be available for Montgomery (program_ID=15) clients.
(Referral Location) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of 'Other' referral location. (50)
Telephone log ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text of 10 characters.
Call Date/Time	Variable to be available for Montgomery (program_ID=15) clients. Datetime format. (MM/DD/YYYY HH:MM:SS AM/PM)
Medical History Incomplete due to:	Variable to be available for Montgomery (program_ID=15) clients. Freeform text up to 250 characters.
Polyp: Num <1 cm	Variable to be available for Montgomery (program_ID=15) clients.
Polyp: Num=1<2 cm	Variable to be available for Montgomery (program_ID=15) clients.
Polyp: Num >=2 cm	Variable to be available for Montgomery (program_ID=15) clients.
Polyp: NumLoc < 60 cm	Variable to be available for Montgomery (program_ID=15) clients.
Polyp: NumLoc >= 60 cm	Variable to be available for Montgomery (program_ID=15) clients.
State_CRC_date_field_one	Variable to defined and used by statewide users as desired. (mm/dd/yyyy)
State_CRC_field_one	Variable to defined and used by statewide users as desired. (50)
State_CRC_field_two	Variable to defined and used by statewide users as desired. (50)
State_CRC_field_three	Variable to defined and used by statewide users as desired. (50)
State_CRC_comment	Variable to defined and used by statewide users as desired. (150)

Appendix C: Prostate Cancer Screening Fields

Appendix C contains all of the fields that can be entered for a client's prostate cancer data. The chapter is divided into sections for each form used to maintain the data.

Note:
Fields highlighted in bold are required.

Prostate Cancer Screening Page 1

Program Use Only:

Jurisdiction	Identifies the program in which this client is enrolled. (Not Editable)
CDB ID	System generated ID representing client within system. (Not Editable)
Local ID	Freeform ID for local health department use. (Optional) (Not Editable)
Staff Involvement	Collection of fields used to identify persons involved with the client during this cycle.
Role	Indicates the role of the staff member. (e.g. Interviewer, Outreach Worker, Educator, Case Manager)
Name	The full name of the staff member (or otherwise officially retained individual) involved in this capacity.
ID	Freeform text entry of staff member's local health department id.
Date of first involvement	Date of interaction or first involvement.
Add	Button to add an additional row to the staff involvement list.
Delete	Button to delete the last row of staff involvement list.
Cycle Start (Interview) Date	Represents the start date for this cycle of screening.

Patient Information:

Last Name	Last name of client. (Not Editable)
Suffix	Suffix of client. (Jr., III, etc) (Not Editable)
First Name	First name of client. (Not Editable)
Middle	Middle name or initial of client if they have one. (Not Editable)
Date of Birth	Date of birth of client. (Not Editable)
Age at Screening	Age of client at time of this screening cycle.
SSN	Last four digits of patient's Social Security Number. (Not Editable)
Do you have a urologist	Identifies the urologist of the client.
If yes, identify the urologist (last name, first name) or practice	Health Care Provider must be selected from the provider list. Information for the selected provider will be displayed on this page.
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.

History:

Have you ever been screened for prostate cancer outside of this Program?	
Have you ever had a PSA blood test outside of this Program?	
Date of last test:	Date of last out-of-program PSA.
Have you had a Digital Rectal Exam outside of this Program?	
Date of last test:	Date of last out-of-program DRE.
Have you ever had prostate cancer?	
Date of diagnosis:	

Has a *blood* relative of yours had prostate cancer?	
If yes, list each relative and the age at which he was diagnosed	
Relationship	
Age at Diagnosis	
Add	Button to create a new row in the list of relative's history of prostate cancer.
Delete	Button to delete the last row in the list of relative's history of prostate cancer.

Prostate Cancer Screening Page 2

Program Use Only:

Eligible for Prostate Screening Program?	Indicates client eligibility for screening.
Screening Payer	
Other, specify	Describes Other Screening Payer selected.

Screening Findings:

Screening Date	Date of prostate screening exam. (mm/dd/yyyy)
Screening Location	Location of Prostate Exam.
Screening Provider	Name of person who completed the screening exam.
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Specify Other provider	Name of provider if not recorded as a CDB provider.
PSA	Indicates whether PSA was drawn during the screening exam.
Drawn, specify date	Date of PSA. (mm/dd/yyyy) (Not Editable)
PSA Comments	Comments related to the PSA. (100)
DRE	Indicates results of DRE.
Not Evaluated, Reason	Description of why DRE was not performed.
DRE Findings	Text description of DRE findings. (1000)
Client Refused DRE	Notation client refusal of procedure.
Client Refused PSA	Notation client refusal of procedure.

Prostate Cancer Screening Page 3

Program Use Only:

(PSA Test #1) Date Drawn	Required only if test was performed. (mm/dd/yyyy)
(PSA Test #1) Lab	
Specify Other provider	Captures text entry of a provider name. (100)
(PSA Test #1) Date Results Received by Program	Required only if test was performed. Date results were received by CRF program. (mm/dd/yyyy)
(PSA Test #1) Results in ng/ml	Required only if test was performed.
(PSA Test #1) Comments	Any comments about PSA #1.

(PSA Test #2) Date Drawn	Required only if test was performed. (mm/dd/yyyy)
(PSA Test #2) Lab	
Specify Other provider	Captures text entry of a provider name. (100)
(PSA Test #2) Date Results Received by Program	Required only if test was performed. (mm/dd/yyyy)
(PSA Test #2) Results in ng/ml	Required only if test was performed.
(PSA Test #2) Comments	Any comments about PSA #2.

Initial Results and Recommendations:

Risk Category	Code value indicating the initial risk assessment. Valid values: 'AVERAGE', 'INCREASED'.
PSA Result (based on guidelines)	Code value indicating PSA result. Valid values: 'NOTELEVATE', 'ELEVATED' ,'OTHER'.
Other, specify	Detail when Other listed as PSA Result.
Initial Impression	Code value indicating initial impression. Valid values: 'NORMAL', 'ABNORMAL', 'ABNORMEVAL'.
Comments	Comments pertaining to initial assessment.
Recommendations	Recommendations based on screening.
Recall for routine screening	
Repeat PSA within this cycle	
Date	Date to repeat PSA within this cycle. (mm/dd/yyyy)
Refer for further evaluation to rule out cancer	
Refer for other findings	
Refer to	Text describing referral. (250)
Other, specify	Any other recommendation not previously listed. (100)

Notification Status:

Client notified of screening results	Code value indicating the notification status.
Date Program notified client	Date successful notification was made. (mm/dd/yyyy)
Notified by whom	Staff person who notified client.
Type of notification	Code value indicating the notification type. Valid values: 'CERTMAIL', 'OTHER', 'REGMAIL', 'TELEPHONE', 'VERBAL', 'WRITING'.
Other, specify	Description of other method of notification. (50)
Comments	Comments regarding notification. (500)

Prostate Cancer Post Screening Evaluation Page 1

Program Eligibility:

Is client eligible for additional CRF diagnosis, treatment or case management services	Specifies client eligibility for additional services.

Ineligible Client:

Reason for Ineligibility	Indicates why a client was deemed ineligible.
Other, specify	
Was ineligible client referred elsewhere for	

diagnosis/treatment?	
Yes, referred to	Text describing referral. (100)
Ineligible Client Outcome	
Final disposition of ineligible clients who contacted an HCP	
Other, specify	Describes Other disposition selected. (50)
Cancer, specify type	Describes other Cancer selected. (50)
Specify treatment status	
Other, specify	Describes other treatment status selected. (100)
Comments	Comments related to ineligible client disposition. (500)

Eligible Client:

Diagnosis Payer	Designates those responsible for payment of diagnostic services.
Other, specify	
Treatment Payer	Designates those responsible for payment of treatment services.
Other, specify	
Was eligible client referred for consultation and/or biopsy?	
Referred to	
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Date of referral appointment	Appointment date. (mm/dd/yyyy)
No, explain	Explanation for why client was not referred. (100)

Prostate Cancer Post Screening Evaluation Page 2

Consultation, Laboratory, and/or Biopsy Results:

Test # 1- Date	Date test was performed. (mm/dd/yyyy)
Test # 1- Test	Selection list of diagnostic laboratory tests; current values. (PSA, Free PSA, PSA Velocity, Other)
Test #1 – Other, specify	Designation of what Other test was completed.
Test #1 – Lab/Provider	Designation of eligible provider who provided test results.
Add Provider	Button links to Health Care Provider so that user may enter a new provider.
Other Provider	Designation of provider not in the provider list.
Test #1 – Date Results Received by Program	Date program received results of the test. (mm/dd/yyyy)
Test #1 - Results	Results of entered test.
Test #1 – Comments	Comments related to the test.
Test # 2- Date	Date test was performed. (mm/dd/yyyy)
Test # 2- Test	Selection list of diagnostic laboratory tests; current values. (PSA, Free PSA, PSA Velocity, Other)
Test #2– Other, specify	Designation of what Other test was completed.
Test #2 – Lab/Provider	Designation of eligible provider who provided test results.
Add Provider	Button links to Health Care Provider so that user may enter a new provider.
Other Provider	Designation of provider not in the provider list.
Test #2 – Date Results Received by Program	Date program received results of the test. (mm/dd/yyyy)

Test #2 – Results	Results of entered test.
Test #2 – Comments	Comments related to the test.
Test # 3- Date	Date test was performed. (mm/dd/yyyy)
Test # 3- Test	Selection list of diagnostic laboratory tests; current values. (PSA, Free PSA, PSA Velocity, Other)
Test #3 – Other, specify	Designation of what Other test was completed.
Test #3– Lab/Provider	Designation of eligible provider who provided test results.
Add Provider	Button links to Health Care Provider so that user may enter a new provider.
Other Provider	Designation of provider not in the provider list.
Test #3 – Date Results Received by Program	Date program received results of the test. (mm/dd/yyyy)
Test #3 – Results	Results of entered test.
Test #3 – Comments	Comments related to the test.
Date of Exam	Date exam was performed. (mm/dd/yyyy)
Date Results Received by Program	Date program received results of the test. (mm/dd/yyyy)
Provider	Designation of eligible provider who provided test results.
Add Provider	Button links to Health Care Provider so that user may enter a new provider.
Other Provider	Designation of provider not in the provider list.
Examination Results	Description of examination results. (1000)
Procedure, None	
TRUS only **Date**	Date TRUS was performed. (mm/dd/yyyy)
Date Results Received by Program	Date program received results of the test. (mm/dd/yyyy)
Results	Description of TRUS results. (1000)
TRUS-Guided biopsy **Date**	Date TRUS was performed. (mm/dd/yyyy)
Pathology lab	Designation of eligible provider who provided test results.
Add Provider	Button links to Health Care Provider so that user may enter a new provider.
Other Provider	Designation of provider not in the provider list.
Date Results Received by Program	Date program received results of the test. (mm/dd/yyyy)
Results	Possible result categories of TRUS-Guided Biopsy.
(TRUS- Guided Biopsy Result) Other, specify	Clarification of Other result entered for TRUS-Guided Biopsy.
Gleason score on prostate biopsy	If cancer, Gleason Score at time of biopsy.
Clinical stage	If cancer, clinical stage at time of biopsy.
(Procedure) Other, specify procedure	Indication of procedure performed but not listed on the form.
(Other procedure) Results	Description of other procedure results. (1000)
Impression	Impression based on diagnostic procedures performed. (250)

Prostate Cancer Post Screening Evaluation Page 3

Summary of Diagnostic Work-up and Treatment:

Recommendations at Completion of Diagnostic Work-up	
Recall for routine screening	
Exam in __ months	
_____ months	Indicates number of months until re-examination.
Date of re-exam	Captures text describing date of re-exam.
Refer for consultation, further evaluation, treatment, etc.	
Refer to	Selection list from which to designate Eligible provider to whom client is being referred.
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Date	Date of referral. (mm/dd/yyyy)
Other, specify	Freeform text for other recommendation. (100)
Diagnosis Status	
Other, specify	Description when Other diagnosis status is selected.
Comments	Comments related to diagnosis status. (100)
Final Diagnosis	
Other diagnosis, not cancer, specify	Description for non-cancer findings.
Cancer, check type	Specifies type of prostate cancer diagnosed.
Other type, specify	Description of other cancer type diagnosed.
Cancer Treatment Plan	
Surgery	
Radiation	
Hormonal Treatment	
Chemotherapy	
Watchful Waiting	
Unknown	
Other, specify	Description of Other Cancer Treatment plan. (100)
Date first treatment began	Date of first treatment. (mm/dd/yyyy)
Comments	Comments related to treatment. (500)
Gleason Score on Prostatectomy	
Stage Tumor	
Stage Nodes	
Stage Metastases	
Stage	
Treatment Status	
Other, specify	Description of other treatment status. (100)
Clear	Clears the current selection.
Hospitalized	
Yes, hospital	
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Capture text entry of provider when not selected from list.
Date of first admission	Entered as mm/dd/yyyy.
Hospice	

Yes, facility	
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Capture text entry of provider when not selected from list.
Date of first service	Entered as mm/dd/yyyy.

Prostate Cancer Cycle Closure

Cycle Closure:

Date Cycle Closed	Date the cycle was closed. (mm/dd/yyyy)
Cycle Outcome	Code describing the cycle outcome. Valid values: ' CASTATUNK', 'CATREAT', 'CADETECTED', 'NOCASUSP', ‘NOCADETECT’,'ABNORMAL'.
Clear	Clears the current selection.
Recall for screening	Captures recommendation of another Prostate Screening Exam.
in ______	Captures number of months or years until the client should be recalled.
month/years	Recall for screening interval. Valid values: 'MONTH', 'YEAR'
Projected date	Projected date of recall exam. (mm/yyyy)
Comments	Comments pertaining to cycle closure (500)

Nurses Notes Page

Nurses Notes:

Nurses Notes	Text field for capturing information about the cycle. (6000)

Prostate Cancer Additional Procedures

Additional Procedures:

Select Procedure	List of procedures in Prostate module. May be used to select a procedure to add to this cycle.
Select Purpose	List of valid purposes for the selected procedure. Purpose must be chosen in order to add the procedure.
Add Procedure	Button to add the selected procedure/purpose to this cycle. *Note: Purpose may not be changed after procedure is added.*
Procedure	Column heading, procedure name.
Date	Column heading, date procedure was performed.
Status	Column heading, current status of procedure
Actions	Column heading, available actions the user may take with regard to this procedure (Edit, Delete).

Prostate Cancer Program Defined Variables

Program Defined Variables:

Prostate_field_one	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.

Prostate_field_two	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Prostate_date_field_one	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Prostate_date_field_two	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Prostate_date_field_three	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Sponsor	Variable to be available for Montgomery (program_ID=15) clients.
(Sponsor) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of 'Other' sponsor. (50)
Date of education/intake	Variable to be available for Montgomery (program_ID=15) clients. Date field.
Group Education Session ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text to 10 characters.
Referral Date	Variable to be available for Montgomery (program_ID=15) clients. Date field.
Referral Location	Variable to be available for Montgomery (program_ID=15) clients.
(Referral Location) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of 'Other' referral location. (50)
Telephone log ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text of 10 characters.
Call Date/Time	Variable to be available for Montgomery (program_ID=15) clients. Date/time field format of mm/dd/yyyy HH:MM:SS AM/PM.
Medical History Incomplete due to:	Variable to be available for Montgomery (program_ID=15) clients. Freeform text up to 250 characters.
State_PROSTATE_date_field_one	Variable to defined and used by statewide users as desired. (mm/dd/yyyy)
State_PROSTATE_field_one	Variable to defined and used by statewide users as desired. (50)
State_PROSTATE_field_two	Variable to defined and used by statewide users as desired. (50)
State_PROSTATE_field_three	Variable to defined and used by statewide users as desired. (50)
State_PROSTATE_comment	Variable to defined and used by statewide users as desired. (150)

Appendix D: Oral Cancer Screening Fields

Appendix D contains all of the fields that can be entered for a client's oral cancer data. The chapter is divided into sections for each form used to maintain the data.

Note:
Fields highlighted in bold are required.

Oral Cancer Screening Page 1

Program Use Only:

Jurisdiction	Identifies the program in which this client is enrolled. (Not Editable)
CDB ID	System generated ID representing client within system. (Not Editable)
Local ID	Freeform ID for local health department use. (Optional) (Not Editable)
Staff Involvement	Collection of fields used to identify persons involved with the client during this cycle.
Role	Indicates the role of the staff member. (e.g. Interviewer, Outreach Worker, Educator, Case Manager)
Name	The full name of the staff member (or otherwise officially retained individual) involved in this capacity.
ID	Freeform text entry of staff member's local health department id.
Date of first involvement	Date of interaction or first involvement.
Add	Button to add an additional row to the staff involvement list.
Delete	Button to delete the last row of staff involvement list.
Cycle Start (Interview) Date	Represents the start date for this cycle of screening.

Patient Information:

Last Name	Last name of client. (Not Editable)
Suffix	Suffix of client. (Jr., III, etc) (Not Editable)
First Name	First name of client. (Not Editable)
Middle	Middle name or initial of client if they have one. (Not Editable)
Date of Birth	Date of birth of client. (Not Editable)
Age at Screening	Age of client at time of this screening cycle.
SSN	Last four digits of client's Social Security Number. (Not Editable)
Do you have dental insurance?	Indicates if client currently has dental insurance.
Yes, Name/Policy Number	Captures Name/Policy Number of client's dental insurance. (50)
Do you have a dentist	Identifies the dentist of the client.
If yes, identify the dentist (last name, first name) or practice	Health Care Provider must be selected from the provider list. Information for the selected provider will be displayed on this page.
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.

History:

Have you ever had a dentist or doctor do an oral cancer outside of this program?	
Yes, date of most recent screening	Preferred entry format is mm/dd/yyyy, however character entry is permitted.
Have you ever had oral cancer in the past?	
Yes, date of diagnosis:	Preferred entry format is mm/dd/yyyy, however character entry is permitted.
Do you drink alcohol, including beer, wine, or distilled spirits?	

Yes, On average, how many days a week do you drink alcohol?	
Yes, On average, how many drinks do you have on a day when you drink?	
Do you now have any of the following symptoms?	
Other, describe	
Provide details	Captures overall comments about symptoms. (100)

Oral Cancer Screening Page 2

Program Use Only:

Eligible for Oral Screening Program?	Indicates client eligibility for screening.
Screening Payer	
Other, specify	Describes Other Screening Payer selected.

Screening Findings:

Screening Date	Date of Oral screening exam. (mm/dd/yyyy)
Screening Location	Location of Oral Exam..
Screening Provider	Name of person who completed the screening exam
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Specify Other provider	Name of provider if not recorded as a CDB provider.
Neck	Outcome of neck evaluation. (Not Evaluated, Negative, Positive)
(Neck) Description of Findings	Text description of findings. (150)
Lips	Outcome of neck evaluation. (Not Evaluated, Negative, Positive)
(Lips) Description of Findings	Text description of findings. (150)
Oral Cavity	Outcome of oral cavity evaluation. (Not Evaluated, Negative, Positive)
(Oral Cavity) Description of Findings	Text description of findings. (150)
Other,	Outcome of other site evaluation. (Not Evaluated, Negative, Positive)
Specify (thyroid, etc.)	Description of what other site was evaluated.
(Other) Description of Findings	Text description of findings. (150)
Other findings	If any of the listed items are identified during the screening exam each item found is to be checked.
(Other findings) Other, specify	Description of other finding identified. (150)
Were any brush biopsies taken?	Designates if brush biopsies were taken at oral screening exam.
Add	Button to enable addition of a biopsy location.
Delete	Button to delete a biopsy location that has been entered for this client. Rows are deleted from the bottom.
Locations	Anatomic location of brush biopsy.

Initial Results and Recommendations:

Initial Impression	Code value indicating initial impression. Valid values: 'NORMAL', 'ABNORMNOCA', 'ABNORMEVAL'.
Recommendations	Recommendations based on screening.
Recall for routine screening	
Refer for other findings	
Refer to	Text describing referral. (50)
Refer for further evaluation to rule out cancer	
Other, specify	Any other recommendation not previously listed. (100)
If lesion does not resolve in 2-4 weeks, see dentist or call	
(If lesion does not resolve in 2-4 weeks, see dentist or call) _______	Description of contact to be made if lesion does not resolve.
Await results of brush biopsy (biopsies)	

Oral Cancer Screening Page 3

Brush Biopsy Results:

Date of Brush Biopsy	Required only if test was performed. (mm/dd/yyyy)
Date Results Received by Program	Required only if test was performed. Date results were received by CDB program. (mm/dd/yyyy)
Screening Biopsy Results	
Add	Button to enable addition of a biopsy location.
Delete	Button to delete biopsy row. Rows deleted from the bottom.
Anatomic Location of Brush Biopsy	
Result	Required only if test was performed.
Comments	Any comments about Brush Biopsies. (500)

Call-Back:

Contact made with client	Based on recommendation, indicates client contact.
Date	If client was contacted, indicates date.
Result	Outcome of client contact. Only required if Contact made with client was Yes.
Specify	Describes other result. (50)

Screening Results and Recommendations:

Screening Impression	Impression based on all screening findings.
Comments	Comments related to screening impression. (50)
Recommendations based on Impression	Recommendations based on Screening Impression.
Recall for routine screening	
Repeat exam in ___ months	
(Repeat exam in) ___ months	Number of months to wait until exam is repeated.
Date	Date at which exam should be repeated. (Preferred as mm/dd/yyyy; character entry accepted.)

Refer for other findings	
Refer to	Text describing referral. (50)
Refer for further evaluation to rule out cancer	
Other, specify	Any other recommendation not previously listed. (100)

Notification Status:

Client notified of Screening /Results	Code value indicating the notification status.
Date Program Notified Client	Date successful notification was made. (mm/dd/yyyy)
Notified by whom	Staff person who notified client.
Type of notification	Code value indicating the notification type. Valid values: 'CERTMAIL', 'OTHER', 'REGMAIL', 'TELEPHONE', 'VERBAL', 'WRITING'.
Other, specify	Description of other method of notification. (50)
Risk reduction discussed with client	Yes/No.
Specify type	Designates if Smoking Cessation and/or Alcohol reduction/cessation was discussed.
Comments	Comments regarding notification. (500)

Oral Cancer Post Screening Evaluation Page 1

Program Eligibility:

Is client eligible for additional CRF diagnosis, treatment or case management services	Specifies client eligibility for additional services.

Ineligible Client:

Reason for Ineligibility	Indicates why a client was deemed ineligible.
Other, specify	
Was ineligible client referred elsewhere for diagnosis/treatment?	
Yes, referred to	Text describing referral. (100)
Ineligible Client Outcome	
Final Disposition of ineligible clients who contacted an HCP	
Other, specify	Describes Other disposition selected. (50)
Cancer, specify type	Describes type of Cancer. (50)
Specify treatment status	
Other, specify	Describes other treatment status selected. (100)
Comments	Comments related to ineligible client disposition. (500)

Eligible Client:

Diagnosis Payer:	Designates those responsible for payment of diagnostic services.
Other, specify	
Treatment Payer:	Designates those responsible for payment of treatment services.
Other, specify	
Was eligible client referred for consultation and/or biopsy?	
Referred to	
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Date of referral appointment	Appointment date. (mm/dd/yyyy)
No, explain	Explanation for why client was not referred. (100)

Oral Cancer Post Screening Evaluation Page 2

Consultation, Laboratory, and/or Biopsy Results:

Date of Exam/Visit	Date exam was performed. (mm/dd/yyyy)
Date Results Received by Program	Date program received results of the exam. (mm/dd/yyyy)
Provider	Designation of eligible provider who provided test results.
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Designation of other provider who provided test results.
Examination Results	Description of examination results. (1000)
Date of Brush Biopsy	Date Brush Biopsy was performed. (mm/dd/yyyy)
Date Results Received by Program	Date program received results of the test. (mm/dd/yyyy)
Add	Button to enable addition of a biopsy location.
Delete	Button to delete a biopsy location. Rows deleted from the bottom.
Anatomic Location of Brush Biopsy	
Result	Possible result categories of Brush Biopsy.
Comments	Captures comments about Brush Biopsies. (500)
Date of Incisional Biopsy	Date procedure was performed. (mm/dd/yyyy)
Date Results Received by Program	Date program received results of the test. (mm/dd/yyyy)
Provider	Designation of eligible provider who provided test results.
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Designation of other provider who provided test results.
Anatomic Location of Incisional Biopsy	
Results	Possible result categories of Incisional Biopsy.
Diagnostic Impression	Impression based on diagnostic procedures performed. (250)

Summary of Diagnostic Work-up and Treatment:

Recommendations at Completion of Diagnostic Work-up	
Recall for routine screening	
Exam in __ months	
_____ months	Indicates number of months until re-examination.
Date of re-exam	Captures text describing date of re-exam.
Refer for consultation, further evaluation, treatment, etc.	
Refer to	Selection list from which to designate Eligible provider to whom client is being referred.
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Date	Date of referral. (mm/dd/yyyy)
Other, specify	Freeform text for other recommendation. (100)
Diagnosis Status	
Other, specify	Description when Other diagnosis status is selected.
Comments	Comments related to diagnosis status. (100)

Oral Cancer Post Screening Evaluation Page 3

Summary of Diagnostic Work-up and Treatment:

Final Diagnosis	
Other diagnosis, not cancer, specify	Description for non-cancer findings.
Cancer, or Carcinoma in situ, specify type	Specifies type of Oral cancer diagnosed.
Other, specify	Description of other cancer diagnosed.
Cancer location(s)	
Floor of mouth	
Tongue	
Hard Palate	
Base of tongue	
Salivary gland	
(Salivary gland, specify) Parotid	
(Salivary gland, specify) Submandibular	
(Salivary gland, specify) Sublingual	
(Salivary gland, specify) Minor	
Other	
(Other,) specify	Description of Other Cancer location. (50)
Is cancer treatment recommended	
Cancer Treatment Type/Comments	Description of Cancer treatment. (500)
Date first treatment began	Date of first treatment as mm/dd/yyyy.
Stage Tumor	

Stage Nodes	
Stage Metastases	
Stage	
Treatment Status	
Other, specify	Description of other treatment status. (100)
Clear	Clears the current selection.
Hospitalized	
Yes, hospital	
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Capture text entry of provider when not selected from list.
Date of first admission	Entered as mm/dd/yyyy.
Rehab	
Yes, facility	
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Capture text entry of provider when not selected from list.
Date of first service	Entered as mm/dd/yyyy.
Hospice	
Yes, facility	
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Capture text entry of provider when not selected from list.
Date of first service	Entered as mm/dd/yyyy.

Oral Cancer Cycle Closure

Cycle Closure:

Date Cycle Closed	Date the cycle was closed. (mm/dd/yyyy)
Cycle Outcome	Code describing the cycle outcome. Valid values: ‘ CASTATUNK’, ‘CATREAT’, ‘CADETECTED’, ‘NOCASUSP’, ‘NOCADETECT’,’ABNORMAL’.
Clear	Clears the current selection.
Recall for screening	Captures recommendation of another Oral Screening Exam.
In _____	Captures number of months or years until the client should be recalled.
Month/years	Recall for screening interval. Valid values: ‘MONTH’, ‘YEAR’.
Projected date	Projected date of recall exam. (mm/yyyy)
Comments	Comments pertaining to cycle closure. (500)

Nurses Notes Page

Nurses Notes:

Nurses Notes	Text field for capturing information about the cycle. (6000)

Oral Cancer Additional Procedures

Additional Procedures:

Select Procedure	List of procedures in Oral module. May be used to select a procedure to add to this cycle.

Select Purpose	List of valid purposes for the selected procedure. Purpose must be chosen in order to add the procedure.
Add Procedure	Button to add the selected procedure/purpose to this cycle. *Note: Purpose may not be changed after procedure is added.*
Procedure	Column heading, procedure name.
Date	Column heading, date procedure was performed.
Status	Column heading, current status of procedure.
Actions	Column heading, available actions the user may take with regard to this procedure. (Edit, Delete)

Oral Cancer Program Defined Variables

Program Defined Variables:

Oral_field_one	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Oral_field_two	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Oral_date_field_one	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Oral_date_field_two	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Oral_date_field_three	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Sponsor	Variable to be available for Montgomery (program_ID=15) clients.
(Sponsor) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of ‘Other’ sponsor. (50)
Date of education/intake	Variable to be available for Montgomery (program_ID=15) clients. (mm/dd/yyyy)
Group Education Session ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text to 10 characters.
Referral Date	Variable to be available for Montgomery (program_ID=15) clients. (mm/dd/yyyy)
Referral Location	Variable to be available for Montgomery (program_ID=15) clients.
(Referral Location) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of ‘Other’ referral location. (50)
Telephone log ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text of 10 characters.
Call Date/Time	Variable to be available for Montgomery (program_ID=15) clients. Datetime format = mm/dd/yyyy HH:MM:SS AM/PM.
Medical History Incomplete due to:	Variable to be available for Montgomery (program_ID=15) clients. Freeform text up to 250 characters.
State_ORAL_date_field_one	Variable to defined and used by statewide users as desired. (mm/dd/yyyy)
State_ORAL_field_one	Variable to defined and used by statewide users as desired. (50)
State_ORAL_field_two	Variable to defined and used by statewide users as desired. (50)
State_ORAL_field_three	Variable to defined and used by statewide users as desired. (50)
State_ORAL_comment	Variable to defined and used by statewide users as desired. (150)

Appendix E: Skin Cancer Screening Fields

Appendix E contains all of the fields that can be entered for a client's skin cancer data. The chapter is divided into sections for each form used to maintain the data.

Note:
Fields highlighted in bold are required.

Skin Cancer Screening Page 1

Program Use Only:

Jurisdiction	Identifies the program in which this client is enrolled. (Not Editable)
CDB ID	System generated ID representing client within system. (Not Editable)
Local ID	Freeform ID for local health department use. (Optional) (Not Editable)
Staff Involvement	Collection of fields used to identify persons involved with the client during this cycle.
Role	Indicates the role of the staff member. (e.g. Interviewer, Outreach Worker, Educator, Case Manager)
Name	The full name of the staff member (or otherwise officially retained individual) involved in this capacity.
ID	Freeform text entry of staff member's local health department id.
Date of first involvement	Date of interaction or first involvement.
Add	Button to add an additional row to the staff involvement list.
Delete	Button to delete the last row of staff involvement list.
Cycle Start (Interview) Date	Represents the start date for this cycle of screening.

Patient Information:

Last Name	Last name of client. (Not Editable)
Suffix	Suffix of client. (Jr., III, etc) (Not Editable)
First Name	First name of client. (Not Editable)
Middle	Middle name or initial of client if they have one. (Not Editable)
Date of Birth	Date of birth of client. (Not Editable)
Age at Screening	Age of client at time of this screening cycle.
SSN	Last four digits of client's Social Security Number. (Not Editable)
Do you have a dermatologist?	Identifies the dermatologist of the client.
If yes, identify the dermatologist (last name, first name) or practice	Health Care Provider must be selected from the provider list. Information for the selected provider will be displayed on this page.
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.

History:

Have you ever had a doctor or dermatologist do a skin cancer screening outside of this program?	
Yes, date of most recent screening	Preferred entry format is mm/dd/yyyy, however character entry is permitted.
Have you ever had skin cancer in the past?	
Melanoma, date	Indicates client history of melanoma and date of most recent diagnosis. Format is mm/dd/yyyy, however character entry is permitted.
Basal cell, date	Indicates client history of Basal cell and date of most recent diagnosis. Format is mm/dd/yyyy, however character entry is permitted.
Squamous cell, date	Indicates client history of Squamous cell and date of most recent diagnosis. Format is mm/dd/yyyy, however character entry is permitted.

Other, date	Indicates client history of Other skin cancer and date of most recent diagnosis. Format is mm/dd/yyyy, however character entry is permitted.
Specify type	Description of other skin cancer indicated. (100)
Do you have a family history of melanoma skin cancer?	Indicates a client family member was diagnosed with melanoma.
Relationship	Indicates which family member(s) diagnosed with melanoma.
Add	Button to create a new row in the list of relative's history of melanoma.
Delete	Button to delete the last row in the list of relative's history of melanoma.
(Risk Factors)	
Do you now have any of the following symptoms?	
Provide details	Captures overall comments about symptoms. (250)

Skin Cancer Screening Page 2

Program Use Only:

Eligible for Skin Screening Program?	Indicates client eligibility for screening.
Screening Payer	
Other, specify	Describes Other Screening Payer selected.

Screening Findings:

Screening Date	Date of skin screening exam. (mm/dd/yyyy)
Screening Location	Location of Skin Exam.
Screening Provider	Name of person who completed the screening exam.
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Specify Other provider	Name of provider if not recorded as a CDB provider.
Head, face, neck (inc.: lips, ears, scalp, nose, mouth, eyes)	Outcome of Head, face, neck evaluation. (Not Evaluated, Negative, Positive)
(Head, face, neck) Description of Findings	Text description of findings. (150)
Trunk (front and back)	Outcome of trunk evaluation. (Not Evaluated, Negative, Positive)
(Trunk) Description of Findings	Text description of findings. (150)
Limbs (inc.: nails, calves, hands, palms, soles)	Outcome of limbs evaluation. (Not Evaluated, Negative, Positive)
(Limbs) Description of Findings	Text description of findings. (150)
Other,	Outcome of other site evaluation. (Not Evaluated, Negative, Positive)
(Other) Specify	Description of what other site was evaluated.
(Other) Description of Findings	Text description of findings. (150)

Initial Results and Recommendations:

Initial Impression	Code value indicating initial impression. Valid values: 'NORMAL', 'ABNOTSUG, 'ABFURTHEV'.
Differential Diagnosis	Description of diagnosis for abnormal findings. (150)
Recommendations	Recommendations based on screening.
Recall for routine screening	

Refer for other findings	
Refer to	Text describing referral. (50)
Refer for further evaluation to rule out cancer	
Other, specify	Any other recommendation not previously listed. (100)
Repeat exam in ___ week(s).	
___ week(s).	Number of week(s) until repeat exam.
Date	Date of repeat exam. (mm/dd/yyyy)

Skin Cancer Screening Page 3

Exam Call-Back:

If initial recommendation at screening was "Repeat exam", was client seen?	Based on recommendation, indicates client was seen.
Date	If client was re-examined, indicates date.
Findings	Describes findings of repeat exam.
Screening Impression	Impression based on all screening findings.
Differential Diagnosis	Description of diagnosis for abnormal findings. (150)
Recommendations based on Impression	Recommendations based on Screening Impression.
Recall for routine screening	
Refer for other findings	
Refer to	Text describing referral. (150)
Refer for further evaluation to rule out cancer	
Other, specify	Any other recommendation not previously listed. (100)

Notification Status:

Client notified of screening results	Code value indicating the notification status.
Date Program notified client	Date successful notification was made. (mm/dd/yyyy)
Notified by whom	Staff person who notified client.
Type of notification	Code value indicating the notification type. Valid values: 'CERTMAIL', 'OTHER', 'REGMAIL', 'TELEPHONE', 'VERBAL', 'WRITING'.
Other, specify	Description of other method of notification. (50)
Risk reduction discussed with client	Yes/No.
Comments	Comments regarding notification. (500)

Skin Cancer Post Screening Evaluation Page 1

Program Eligibility:

Is client eligible for additional CRF diagnosis, treatment or case management services	Specifies client eligibility for additional services.

Ineligible Client:

Reason for Ineligibility	Indicates why a client was deemed ineligible.
Other, specify	
Was ineligible client referred elsewhere for diagnosis/treatment?	
Yes, referred to	Text describing referral. (100)
Ineligible Client Outcome	
Final disposition of ineligible clients who contacted an HCP	
Other, specify	Describes Other disposition selected. (50)
(Cancer) Squamous Cell	
(Cancer) Basal Cell	
(Cancer) Melanoma	
(Cancer) Other	
(Cancer Other) specify	Describes type of Cancer. (50)
Specify treatment status	
Other, specify	Describes other treatment status selected. (100)
Comments	Comments related to ineligible client disposition. (500)

Eligible Client:

Diagnosis Payer:	Designates those responsible for payment of diagnostic services.
Other, specify	
Treatment Payer:	Designates those responsible for payment of treatment services.
Other, specify	
Was eligible client referred for consultation and/or biopsy?	
Referred to	
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Date of referral appointment	Appointment date. (mm/dd/yyyy)
No, explain	Explanation for why client was not referred. (100)

Skin Cancer Post Screening Evaluation Page 2-3

Consultation and/or Biopsy Results:

Date of Exam/Visit	Date exam was performed. (mm/dd/yyyy)
Date Results Received by Program	Date program received results of the exam. (mm/dd/yyyy)
Provider	Designation of eligible provider who provided test results.
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Designation of other provider. who provided test results.
Examination Results	Description of examination results. (1000)
Date of Biopsy	Date Biopsy was performed. (mm/dd/yyyy)
Date Results Received by Program	Date program received results of the test. (mm/dd/yyyy)
Add	Button to enable addition of a biopsy location.
Delete	Button to delete a biopsy location. Rows deleted from the bottom.

Anatomic Location of Biopsy	
Result	Possible result categories of Skin Biopsy.
(Result) Other, specify	Description of 'other' result.
Comments	Captures comments about Skin Biopsies. (500)
Impression	Impression based on diagnostic procedures performed. (250)

Summary of Diagnostic Work-up and Treatment:

Recommendations at Completion of Diagnostic Work-up	
Recall for routine screening	
Exam in __ months	
_____ months	Indicates number of months until re-examination.
Date of re-exam	Captures text describing date of re-exam.
Refer for consultation, further evaluation, treatment, etc.	
Refer to	Selection list from which to designate Eligible provider to whom client is being referred.
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Date	Date of referral. (mm/dd/yyyy)
Other, specify	Freeform text for other recommendation. (100)
Diagnosis Status	
Other, specify	Description when Other diagnosis status is selected.
Comments	Comments related to diagnosis status. (100)
Final Diagnosis	
Other diagnosis, not cancer, specify	Description for non-cancer findings.
Cancer, or Carcinoma in situ, **specify type**	Specifies type of Skin Cancer diagnosed.
Melanoma	Diagnosis of melanoma.
Squamous Cell	Diagnosis of Squamous Cell.
Basal Cell	Diagnosis of Basal Cell.
Other	Diagnosis of Other skin cancer.
(Other) specify	Description of other cancer diagnosed. (50)
(Melanoma Staging) Clark's Level	
(Melanoma Staging) Breslow thickness (in mm)	
Is cancer treatment recommended	
Cancer Treatment Type/Comments	Description of Cancer treatment (500)
Date first treatment began	Date of first treatment as mm/dd/yyyy.
Treatment Status	
Other, specify	Description of other treatment status. (100)
Clear	Clears the current selection.
Hospitalized	
Yes, hospital	
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Capture text entry of provider when not selected from list.
Date of first admission	Entered as mm/dd/yyyy.
Hospice	

Yes, facility	
Add Provider	Button links to Health Care Provider page so that user may enter a new provider.
Or specify Other provider	Capture text entry of provider when not selected from list.
Date of first service	Entered as mm/dd/yyyy

Skin Cancer Cycle Closure

Cycle Closure:

Date Cycle Closed	Date the cycle was closed. (mm/dd/yyyy)
Cycle Outcome	Code describing the cycle outcome. Valid values: ' CASTATUNK', 'CATREAT', 'CADETECTED', 'NOCASUSP', 'NOCADETECT','ABNORMAL'.
Clear	Clears the current selection.
Final Hierarchical Diagnosis [system generated]	System generated final diagnosis based on data entered. See Help for definitions.
Recall for screening	Captures recommendation of another Skin Screening Exam.
in _____	Captures number of months or years until the client should be recalled.
month/years	Recall for screening interval. Valid values: 'MONTH', 'YEAR'.
Projected date	Projected date of recall exam. (mm/yyyy)
Comments	Comments pertaining to cycle closure. (500)

Nurses Notes Page

Nurses Notes:

Nurses Notes	Text field for capturing information about the cycle. (6000)

Skin Cancer Additional Procedures

Additional Procedures:

Select Procedure	List of procedures in Skin module. May be used to select a procedure to add to this cycle.
Select Purpose	List of valid purposes for the selected procedure. Purpose must be chosen in order to add the procedure.
Add Procedure	Button to add the selected procedure/purpose to this cycle. *Note: Purpose may not be changed after procedure is added.*
Procedure	Column heading, procedure name.
Date	Column heading, date procedure was performed.
Status	Column heading, current status of procedure
Actions	Column heading, available actions the user may take with regard to this procedure (Edit, Delete).

Skin Cancer Program Defined Variables

Program Defined Variables:

skin_field_one	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
skin_field_two	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
skin_date_field_one	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
skin_date_field_two	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
skin_date_field_three	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.
Sponsor	Variable to be available for Montgomery (program_ID=15) clients.
(Sponsor) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of 'Other' sponsor. (50)
Date of education/intake	Variable to be available for Montgomery (program_ID=15) clients. (mm/dd/yyyy)
Group Education Session ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text to 10 characters.
Referral Date	Variable to be available for Montgomery (program_ID=15) clients. (mm/dd/yyyy)
Referral Location	Variable to be available for Montgomery (program_ID=15) clients.
(Referral Location) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of 'Other' referral location. (50)
Telephone log ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text of 10 characters.
Call Date/Time	Variable to be available for Montgomery (program_ID=15) clients. Datetime format = mm/dd/yyyy HH:MM:SS AM/PM
Medical History Incomplete due to:	Variable to be available for Montgomery (program_ID=15) clients. Freeform text up to 250 characters.
State_SKIN_date_field_one	Variable to defined and used by statewide users as desired. (mm/dd/yyyy)
State_SKIN_field_one	Variable to defined and used by statewide users as desired. (50)
State_SKIN_field_two	Variable to defined and used by statewide users as desired. (50)
State_SKIN_field_three	Variable to defined and used by statewide users as desired. (50)
State_SKIN_comment	Variable to defined and used by statewide users as desired. (150)

Appendix F: Program Information

Appendix F contains additional definitions for certain fields in the CDB.

Appendix F—Table of Contents

Eligibility Definitions for Colorectal Cancer Module

Variable and Choices	Description
Eligible for screening □igmoidos by program? CRC Screening form, page 2	Eligible for colonoscopy or □igmoidoscopy or other **expensive** screening (DCBE, etc.), diagnosis, or treatment in the Program.
Yes	Client meets age, residence, income, and health insurance requirements to qualify for colonoscopy or □igmoidoscopy, or other *expensive* screening, diagnosis, or treatment in the CRF Program (*beyond* FOBT). Answer "Yes" for clients coming into the Program for Diagnosis and/or Treatment Only.
No	Client has need for further screening (e.g., is FOBT positive or has increased risk or symptoms), but does **not** meet requirements and is ineligible for □igmoidos screening (or other expensive screening procedures) in the CRF Program.
Not applicable/Unknown	Program does not ask client for eligibility information (e.g., average risk client with negative FOBT for whom program will **not** pay for colonoscopy unless the client calls back and goes through Program eligibility process for more screening/diagnosis/treatment in the Program).
	Client does not give Program the information needed to determine eligibility.
Is client eligible for additional CRF work-up, treatment, or case management services? CRC Post Screening form, page 1	Eligible for diagnostic, treatment, or case management services, when indicated (e.g., surgery, chemotherapy, additional procedures such as □igmoidoscopy or colonoscopy for someone with a positive FOBT who is known to *not* be eligible for additional expensive screening, etc.).
Yes, funds available	Client needs more care and: 1) Client meets income, insurance, and residence eligibility of Program, 2) Client has signed "long form" consent, and 3) **CRF funds are available and being used** to pay part or all of the medical care. (This may include clients who have no coverage, or those, for example, who get Medical Assistance but on whom you are **spending CRF funds for services** not covered by MA or other insurance).
Yes, but funds are **not** available	Client needs more care and: 1) Client meets income, insurance, and residence eligibility of Program, 2) Client has signed "long form" consent, and 3) Program will continue to do case management and obtain tumor and treatment information, **but** 4) **CRF funds are NOT available** to pay for any part of their medical care, including: a. Clients whom you are "linking" to care (not paying their bills) or b. Clients screened under your Program who get Medical Assistance or have private insurance for biopsy/treatment, etc. OR Client is **NOT financially eligible** for the Program but is **eligible for case management services**

Eligibility Definitions for Colorectal Cancer Module (Continued)

No	Program **not** case managing the client; and 1) Client needs more care and client does **not** meet income, insurance, or residence eligibility of Program; 2) Client is referred for medical care paid for by private insurance, Medicare, self pay, Medical Assistance, etc., and is **not** linked to treatment through your Program. For example, client had a positive FOBT but has private medical insurance and is referred for colonoscopy.
Unknown	Client does not give the Program the information to determine eligibility.
	Client is lost to follow-up before eligibility is determined.

Eligibility Definitions for Prostate, Oral, and Skin Cancer Modules

<table>
<tr><th>Variable and Choices</th><th>Description</th></tr>
<tr><td>Eligible for (prostate, oral, skin) screening program?
Prostate, Oral, Skin Screening forms, page 2</td><td>Eligible for prostate, oral, or skin cancer screening, diagnosis, and/or treatment in the Program.</td></tr>
<tr><td>Yes</td><td>Client meets age, residence, income, and insurance requirements to qualify for screening, diagnosis, or treatment (prostate, oral, skin). Answer “Yes” for clients coming into the Program for Diagnosis and/or Treatment Only.</td></tr>
<tr><td>No</td><td>Client does not meet requirements and is not eligible for screening, diagnosis, or treatment in the CRF Program.</td></tr>
<tr><td>Not applicable/Site not determining eligibility</td><td>Program does not determine eligibility prior to screening. A Program might select this choice for clients in mass screenings, screenings at health fairs, etc, or in any situation where income and health insurance eligibility are not determined before screening.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Is client eligible for additional CRF diagnosis, treatment, or case management services?
Prostate, Oral, Skin Post Screening form, page 1</td><td></td></tr>
<tr><td>Yes, funds available</td><td>Client needs more care and:
1) Client meets income, insurance, and residence eligibility of Program;
2) Client has signed “long form” consent; and
CRF funds are available and being used to pay part or all of the medical care. (This may include clients who have no coverage or those, for example, who get Medical Assistance but on whom you are spending CRF funds for services not covered by MA, Medicare, or other insurance.</td></tr>
<tr><td>Yes, but funds not available</td><td>Client needs more care and:
1) Client meets income, insurance, and residence eligibility of Program;
2) Client has signed “long form” consent; and
3) Program will continue to do case management and obtain tumor and treatment information;
but
4) CRF funds are NOT available to pay for any part of their medical care, including:
b. Clients whom you are “linking” to care (not paying their bills); or
c. Clients screened under your Program who get Medical Assistance or have private insurance for biopsy/treatment, etc.
OR
Client is NOT financially eligible for the Program but is eligible for case management services</td></tr>
</table>

Eligibility Definitions for Prostate, Oral, and Skin Cancer Modules (Continued)

No	Program **not** case managing the client; and 1) Client needs more care and client does **not** meet income, insurance, or residence eligibility of Program; 2) Client is referred for medical care paid for by private insurance, Medicare, self pay, Medical Assistance, etc., and is **not** linked to treatment through your Program. For example, client had positive prostate, oral, or skin screening test but has private medical insurance and is referred for further diagnostic tests or treatment.
Unknown	Client does not give the Program the information to determine eligibility.
	Client is lost to follow-up before eligibility is determined.

Final (Hierarchical) Diagnosis for CRC Screening Results at the Cycle Level

Text	Description
No Screening	No Diagnosis, that is, no results exist for the cycle (no screening this cycle). This result will also appear when a client has an FOBT with ‘Other’ results and no other procedures were done.
Negative FOBT	This will appear if the client has a negative FOBT and no other procedures were done.
Positive FOBT	This will appear if the client has a positive FOBT (indicates at least one window on the FOBT slide was positive) and no other procedures were done.
CRC-Confirmed	Cancer was confirmed with a biopsy or during surgery, by pathology. Most advanced lesion during colonoscopy was Cancer (adenocarcinoma, carcinoid, lymphoma, other), with or without another finding (such as adenomatous polyp(s), hyperplastic polyp(s), hemorrhoids, etc.).
CRC-Suspected	This diagnosis is made when cancer is strongly suspected but there is no definite diagnosis by pathology. It can occur when a mass is seen during a barium enema or □igmoidoscopy (without biopsy) or when a biopsy is done but the diagnosis is not definitive.
Ad Polyp/Adenoma	Most advanced lesion was “Adenomatous polyp(s)/Adenoma,” either alone or with another finding(s). Other findings would include “other polyps,” “hyperplastic polyps,” “other finding” (e.g., diverticuli, colitis, inflammatory bowel disease, hemorrhoids).
Hyperplastic Polyp	Most advanced lesion was “Hyperplastic polyp(s),” either alone or with another finding(s). Other findings would include “other polyps,” “hyperplastic polyps,” “other finding” (e.g., diverticuli, colitis, inflammatory bowel disease, hemorrhoids).
Other Polyp	Most advanced lesion was a polyp(s) other than adenomatous or hyperplastic polyp. May include “non-adenomatous polyp”; those for which there is **no pathology** and just a description such as sessile, pedunculated, or unspecified polyp(s); those that have been biopsied but the pathology does not confirm a polyp, shows normal mucosa, shows artifact; those that were lost and didn’t make it to the pathology laboratory. “Other findings” during colonoscopy (e.g., diverticuli, colitis, hemorrhoids) may or may not be present.

Final (Hierarchical) Diagnosis for CRC Screening Results at the Cycle Level (Continued)

Text	Description
Other; No or Neg FOBT	OTHER means "other findings" on colonoscopy, igmoidoscopy, or DCBE. No cancer or polyps found on colonoscopy. "Other findings" means those findings noted in the clinical report or pathology report, such as diverticuli, diverticulosis, colitis, hemorrhoids, anal fissure, inflammatory bowel disease, collagenous colitis, etc. No or Neg FOBT indicates **either** an FOBT was done and is **negative or** an FOBT was **not done**.
Other; Positive FOBT	OTHER means "other findings" on colonoscopy, sig, or DCBE. No cancer or polyps found on colonoscopy. "Other findings" means those findings noted in the clinical report or pathology report, such as diverticuli, diverticulosis, colitis, hemorrhoids, anal fissure, inflammatory bowel disease, collagenous colitis, etc. POS FOBT indicates at least one window on the FOBT slide was positive.
Normal; No or Neg FOBT	No findings listed on colonoscopy or sig or DCBE. Often reported as a "normal" or "negative" colonoscopy. Note: "Negative for cancer or adenomatous polyps" or "negative for neoplasia" means neither cancer nor adenomatous polyps were found on colonoscopy; however, **if other findings were present,** classify the results into one of the above categories **other than** normal based on the findings. No or Neg FOBT indicates either an FOBT was done and is negative or an FOBT was not done.
Normal; Positive FOBT	No findings listed on colonoscopy or sig or DCBE. Often reported as a "normal" or "negative" colonoscopy. Note: "Negative for cancer or adenomatous polyps" or "negative for neoplasia" means neither cancer nor adenomatous polyps were found on colonoscopy; however, **if other findings were present,** classify the results into one of the above categories **other than** normal based on the findings. POS FOBT indicates at least one window on the FOBT slide was positive.
Normal-Inadeq; No or Neg FOBT	No findings are listed on colonoscopy, sig, or DCBE, **but** the examination was reported as being **not adequate**. ('No" to the "adequate exam" question.) No or Neg FOBT indicates **either** an FOBT was done and is negative **or** an FOBT was not done.
Normal-Inadeq; Pos FOBT	No findings are listed on colonoscopy, sig, or DCBE, but the examination was reported as being not adequate. ('No" to the "adequate exam" question.) POS FOBT indicates at least one window on the FOBT slide was positive.

Hierarchical Diagnosis for Colonoscopy Results at the Procedure Level

Text	**Description**
Col-CRC	Most advanced lesion during colonoscopy was Cancer (adenocarcinoma, carcinoid, lymphoma, other), *with or without* another finding (such as adenomatous polyp(s), hyperplastic polyp(s), hemorrhoids, etc.)
Col-Susp CRC	This diagnosis is made when cancer is strongly suspected but there is no definite diagnosis by pathology. It can occur when a mass is seen during a colonoscopy (without biopsy) or when a biopsy is done but the diagnosis is not definitive.
Col-Ad Polyp	Most advanced lesion was “Adenomatous polyp(s)/Adenoma(s),” either alone or with another finding(s). Other findings would include “other polyps,” “hyperplastic polyps,” or “other finding” (e.g., diverticuli, colitis, inflammatory bowel disease, hemorrhoids).
Col-Oth Polyp	Most advanced lesion was a polyp(s) other than adenomatous polyps/adenomas; may include those with pathology showing “hyperplastic polyp” or “non-adenomatous polyp”; those for which there is **no pathology** and just a description such as sessile, pedunculated, or unspecified polyp(s); those that have been biopsied but the pathology does not confirm a polyp, shows normal mucosa, shows artifact; those that were lost and didn’t make it to the pathology laboratory. “Other findings” during colonoscopy (e.g., diverticuli, colitis, hemorrhoids) may or may not be present.
Col-Other	No cancer or polyps found on colonoscopy. “Other” means those findings noted in the clinical report or pathology report, such as diverticuli, diverticulosis, colitis, hemorrhoids, anal fissure, inflammatory bowel disease, collagenous colitis, etc.
Col-Inadeq	This diagnosis will appear if “no” is selected for the adequate exam question and no other diagnoses are checked (i.e., the exam was “normal”).
Col-Norm	No findings listed above. Often reported as a “normal” or “negative” colonoscopy. Note: “Negative for cancer or adenomatous polyps” or “negative for neoplasia” means neither cancer nor adenomatous polyps were found on colonoscopy; however, **if other findings were present,** classify the results into one of the above categories **other than** normal based on the findings.
Col-Error	

Hierarchical Diagnosis for Double Contrast Barium Enema Results at the Procedure Level

Text	Description
BE-Susp CRC	Most advanced lesion identified by double contrast barium enema (DCBE) is suspected cancer
BE-Polyp	This diagnosis will be used when polyps are seen on DCBE.
BE-Other	No cancer or polyps identified on DCBE. “Other findings” means those findings noted in the report such as diverticuli, diverticulosis, colitis, hemorrhoids, anal fissure, inflammatory bowel disease, etc.
BE-Inadeq	This diagnosis will appear if “no” is selected for the adequate exam question and no other diagnoses are checked (i.e., the exam was “normal’).
BE-Norm	No findings listed above. Often reported as a “normal” or “negative” DCBE. Note: “Negative for cancer or polyps” or “negative for neoplasia” means neither cancer nor polyps were found on DCBE; however, **if other findings were present,** classify the results into one of the above categories **other than** normal based on the findings.
BE-Error	

Hierarchical Diagnosis for Sigmoidoscopy Results at the Procedure Level

Text	Description
Sig-CRC	Most advanced lesion during □igmoidoscopy. Must be confirmed with biopsy.
Sig-Susp CRC	Most advanced lesion identified by □igmoidoscopy is suspected cancer
Sig-Ad Polyp	Most advanced lesion was “Adenomatous polyp(s)/Adenoma(s),” either alone or with another finding(s). Other findings would include “other polyps,” “hyperplastic polyps”, “other finding” (e.g., diverticuli, colitis, inflammatory bowel disease, hemorrhoids).
Sig-Oth Polyp	This diagnosis will be used in the event that no biopsy is done during the □igmoidoscopy and polyps are seen or if a biopsy is done and the polyp is not adenomatous.
Sig-Other	No cancer or polyps grossly seen on □igmoidoscopy. “Other” means those findings noted in the clinical report or pathology report, such as diverticuli, diverticulosis, colitis, hemorrhoids, anal fissure, inflammatory bowel disease, collagenous colitis, etc.
Sig-Inadeq	This diagnosis will appear if “no” is selected for the adequate exam question and no other diagnoses are checked (i.e., the exam was “normal’).
Sig-Norm	No findings listed above. Often reported as a “normal” or “negative” □igmoidoscopy. Note: “Negative for cancer or polyps” or “negative for neoplasia” means neither cancer nor adenomatous polyps were found on □igmoidoscopy; however, **if other findings were present,** classify the results into one of the above categories **other than** normal based on the findings.
Sig-Error	

Cycle Outcome for Colorectal Cancer Screening

Cycle Outcome Text and Short Name	**Findings on Colorectal Cancer Screening Cycle (including all procedures performed in that cycle)**
Cancer detected **CADETECTED**	Cancer confirmed by biopsy performed during a □igmoidoscopy or colonoscopy
	Cancer confirmed by pathology during surgery
	Ineligible clients on whom you get a **verbal report from the client or verbal or written documentation from a provider or laboratory** of “colorectal cancer” based on the results of colonoscopy, □igmoidoscopy, or surgery, etc.
No cancer detected **NOCADETECT**	Adequate colonoscopy, no cancer found (however client may have other findings such as adenoma, hyperplastic polyp, inflammatory bowel disease, etc.)
	Ineligible client on whom you get **verbal or written documentation from a provider or laboratory** of “no cancer” based on the results of colonoscopy, surgery.
No cancer suspected **NOCASUSP**	FOBT negative, no increased risk, no symptoms
	FOBT negative with □igmoidoscopy negative for cancer
	Adequate □igmoidoscopy negative for cancer; FOBT not done
	Inadequate examination (□igmoidoscopy, colonoscopy, or DCBE) but no cancer was found on the inadequate exam and FOBT negative or not done
	Adequate DCBE with no significant lesions seen on DCBE that need further work-up
	Ineligible client on whom you get a **verbal** report from the client of “no cancer” based on results of colonoscopy, sig, surgery, etc.
Abnormal, cancer status unknown **ABNORMAL**	Abnormal findings suggestive of cancer without further work-up (e.g., DBCE that looked like cancer but client had no further testing; large polyp with dysplasia and person refuses surgery to rule out or confirm cancer)
	FOBT positive, no further work-up
	FOBT positive, inadequate colonoscopy (unless cancer found, then see above)
	FOBT positive, inadequate DCBE
	FOBT positive, □igmoidoscopy negative or inadequate (unless cancer found)
	FOBT negative, **BUT** client has either increased risk or symptoms and no colonoscopy done

Cycle Outcome for Colorectal Cancer Screening (Continued)

Cycle Outcome Text and Short Name	**Findings on Colorectal Cancer Screening Cycle (including all procedures performed in that cycle)**
Abnormal, cancer status unknown **ABNORMAL (continued)**	Inadequate exam on □igmoidoscopy, colonoscopy, or DCBE (unless cancer found) in a client with increased risk or with symptoms, but no further work-up was performed this cycle.
	Ineligible clients with an abnormal finding on initial screening (positive FOBT, increased risk, symptoms suggesting CRC) who were referred for further evaluation and for whom **no final diagnosis is known**. This would include clients whose **Ineligible Client Outcome** is “client plans to see HCP,” “client declined to see HCP,” and “client lost to follow-up.” It would also include clients whose **Final Disposition** (after contacting an HCP) is “refused” or “unknown.”
No screening done, cancer treatment only **CATREAT**	Clients who came into the Program **after** screening to have **diagnosis and/or treatment** paid for by the Program
No screening done, cancer status unknown **NOSCRNING**	FOBT distributed but not returned
	No screening test (FOBT, □igmoidoscopy, colonoscopy, or DCBE) performed

Cycle Outcome Prostate Cancer Screening

Cycle Outcome Text and SHORT NAME	**Findings on Prostate Screening Cycle (including all procedures performed in that cycle)**
Cancer detected **CADETECTED**	Cancer detected and confirmed through a biopsy or during surgery
No cancer detected **NOCADETECT**	A biopsy was done for abnormal screening results and no cancer was found
No cancer suspected **NOCASUSP**	DRE exam normal or abnormal but not suggestive of cancer and PSA not elevated
	PSA not elevated and DRE not performed
	DRE exam normal or abnormal but not suggestive of cancer and PSA not done
Abnormal, cancer status unknown **ABNORMAL**	The Program was **unable to notify** the client of abnormal result following the initial screening. Client had an elevated PSA or DRE that was suggestive of cancer and the Program has no more information on diagnosis/treatment.
	Ineligible clients with an abnormal finding suggestive of cancer on initial screening and who need further evaluation to rule out cancer, for whom no final diagnosis is known. This would include clients whose **Ineligible Client Outcome** is “client plans to see HCP,” “client declined to see HCP,” and “client lost to follow-up.” It would also includes clients whose **Final Disposition** (after contacting an HCP) is “refused,” “unknown,” or “other.”
	Among eligible clients, those who had abnormal screening suggestive of cancer who need further evaluation to rule out cancer, and **further testing is incomplete** or **has not been conducted** because client is lost to follow-up, refused biopsy/work-up, moved, chose other provider, or other reason.
No screening done, cancer treatment only **CATREAT**	Client came into the Program **after** screening to have treatment paid for by the Program
No screening done, cancer status unknown **NOSCRNING**	No screening test (PSA or DRE) performed

Cycle Outcome for Oral Cancer Screening

Cycle Outcome Text and SHORT NAME	**Findings on Oral Screening Cycle (including all procedures performed in that cycle)**
Cancer detected **CADETECTED**	Cancer has been detected and confirmed through a biopsy or during surgery
No cancer detected **NOCADETECT**	Client had a brush biopsy or tissue biopsy for abnormal screening results and no cancer was found
No cancer suspected **NOCASUSP**	Oral screening exam was normal or abnormal but not suggestive of cancer
Abnormal, cancer status unknown **ABNORMAL**	The Program was **unable to notify** the client of an abnormal result following the initial oral screening and the client was lost to follow-up. This would include clients who need to be contacted in 2-4 weeks for an abnormal finding, but are lost to follow-up.
	Ineligible clients with an abnormal finding suggestive of cancer on initial oral screening and who need further evaluation to rule out cancer, for whom no final diagnosis is known. This would include clients whose **Ineligible Client Outcome** is “client plans to see HCP,” “client declined to see HCP,” and “client lost to follow-up.” It would also includes clients whose **Final Disposition** (after contacting an HCP) is “refused,” “unknown,” or “other.”
	Among eligible clients, those who had abnormal screening suggestive of cancer and who need further evaluation to rule out cancer, and **further testing is incomplete** or **has not been conducted** because client is lost to follow-up, refused biopsy/work-up, moved, chose other provider, or other reason.
No screening done, cancer treatment only **CATREAT**	Client came into the Program **after** screening to have treatment paid for by the Program
No screening done, cancer status unknown **NOSCRNING**	Client refused the oral screening exam

Cycle Outcome for Skin Cancer Screening

Cycle Outcome Text and SHORT NAME	**Findings on Skin Screening Cycle (including all procedures performed in that cycle)**
Cancer detected **CADETECTED**	Cancer has been detected and confirmed through a biopsy or during surgery
No cancer detected **NOCADETECT**	Client had a tissue biopsy for abnormal screening results and no cancer was found
No cancer suspected **NOCASUSP**	Skin screening exam normal or abnormal but not suggestive of cancer
Abnormal, cancer status unknown **ABNORMAL**	The Program was **unable to notify** the client of an abnormal result following the initial skin screening and the client was lost to follow-up. (This would include clients who **need to have a repeat screening exam in X weeks** for an abnormal finding, but are lost to follow-up.)
	Ineligible clients with an abnormal finding suggestive of cancer on initial skin screening and who need further evaluation to rule out cancer, for whom no final diagnosis is known. This would include clients whose **Ineligible Client Outcome** is “client plans to see HCP,” “client declined to see HCP,” and “client lost to follow-up.” It would also includes clients whose **Final Disposition** (after contacting an HCP) is “refused,” “unknown,” or “other.”
	Among eligible clients, those who had abnormal screening suggestive of cancer and who need further evaluation to rule out cancer, and **further testing is incomplete** or **has not been conducted** because client is lost to follow-up, refused biopsy/work-up, moved, chose other provider, or other reason.
No screening done, cancer treatment only **CATREAT**	Client came into the Program **after** screening to have treatment paid for by the Program.
No screening done, cancer status unknown **NOSCRNING**	Client refused the skin screening exam

Final (Hierarchical) Diagnosis for Skin Cancer Screening Results at the Cycle Level

Text	Description
Melanoma + oth CA	The client has been diagnosed with **both** a malignant melanoma **and** a second non-melanoma skin cancer. The second cancer will usually be squamous cell and/or basal cell carcinoma, but may be another type of non-melanoma skin cancer. These are diagnoses that are made by pathologic examination of a tissue biopsy or surgical specimen.
Melanoma Only	The client has been diagnosed with a malignant melanoma and **not** with another skin cancer. This is a diagnosis that is made by pathologic examination of a tissue biopsy or surgical specimen.
Other skin CA	The client has been diagnosed with a non-melanoma skin cancer. This cancer will usually be squamous cell and/or basal cell carcinoma, but may be another type of non-melanoma skin cancer. This is a diagnosis that is made by pathologic examination of a tissue biopsy or surgical specimen.
Possible CA	The client is suspected of having skin cancer but the work-up is incomplete, and a final diagnosis was not made or is not known to the Program.
Other (Other Dx)	The client has a skin diagnosis that is not cancer. This diagnosis can be made on screening examination (that is, "abnormal findings, not suggestive of cancer") or on follow-up clinical examination or following a skin biopsy where the diagnosis is **not** cancer. Examples would include keratosis, actinic keratosis, psoriasis, seborrhea, acne, impetigo, cyst, nevus, etc.
Normal Exam	Either the client has no findings on screening exam suggestive of either malignant or benign skin disease; OR Client had an abnormality and proceeds to a post-screening exam/diagnostic testing, but the final diagnosis is "Normal/Negative."
Unk/Not Eligible	The client has an abnormal screening exam that is suggestive is cancer (Screening Impression, Page 3 of Skin Screening form is "Abnormal findings, needs further evaluation to rule out cancer," but is not eligible for diagnosis or treatment under the CRF Program. (This is the Skin Hierarchical Final Diagnosis even if cancer or other findings are found in ineligible clients outside of the Program.)
Pending	No diagnosis has been made; results of exam have not been entered in CDB.

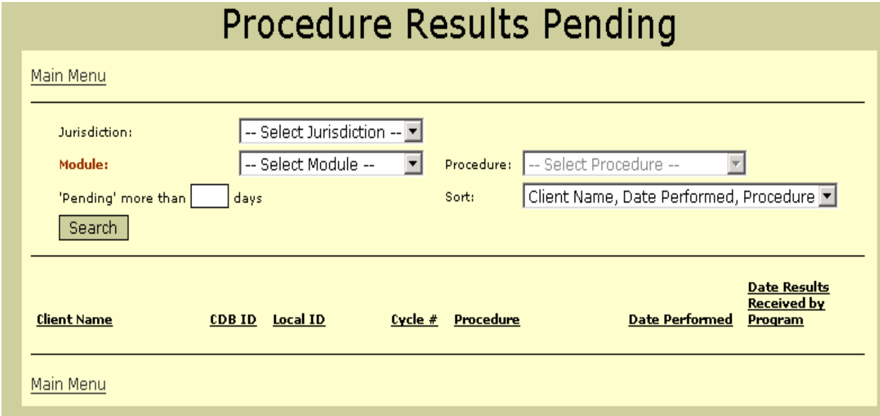
Colorectal Cancer (CRC) Risk Definitions

Risk Category	Definition
Increased Risk for CRC	Client has one or more of the following risk factors: • Personal history of Prior CRC Prior adenomas/adenomatous poly(s) or polyp of unknown pathologic type in the past Inflammatory bowel disease (ulcerative colitis, Crohn's colitis) Endometrial cancer Ovarian cancer • Family history of CRC, adenomatous polyp, or polyp of unknown pathologic type in parent, sibling, or child (first degree relative) of any age • Family or personal history of genetic syndrome that increases a person's risk, for example, familial adenomatous polyposis (FAP); hereditary nonpolyposis colorectal cancer (HNPCC) also known as Lynch syndrome Note: Symptoms are *not* taken into account when defining "Increased Risk of CRC" and "Average Risk for CRC." Base the definition of Risk for CRC on personal and family history only, and record symptoms as a separate item. Note: A person who is at "increased risk" and who then has a normal colonoscopy is *still* at "increased risk."
Average Risk for CRC	Client who does **not** have any factors of increased risk listed above Note: Symptoms are *not* taken into account when defining "Increased Risk of CRC" and "Average Risk for CRC." Base the definition of Risk for CRC on personal and family history only, and record symptoms as a separate item.

Appendix G: Notifications List Results Criteria

Appendix G contains additional definitions for Notifications List criteria.

Procedure Results Pending

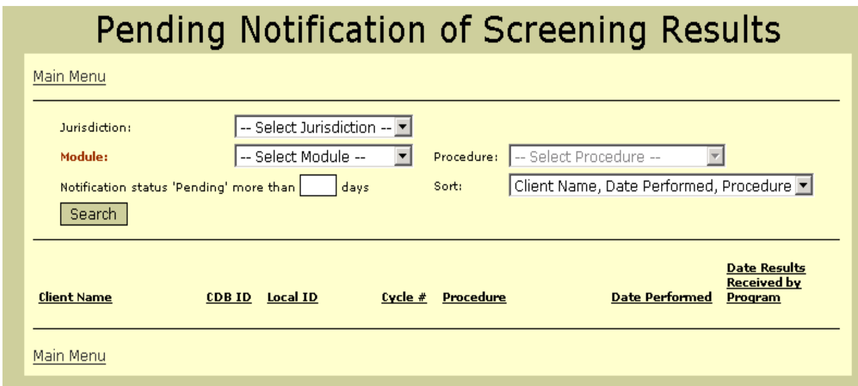


Results Criteria

Module	Page	Field Name/Required Value
CRC	Screening Page 2 **OR** Screening Page 3	Date FOBT Kit Returned = Valid Date Date of Exam = Valid Date Significant Findings = NULL **OR** Date Performed = Valid Date Findings = NULL
Prostate	Screening Page 2 **OR** Screening Page 3 **OR** Post Page 2	Screening Date = Valid Date PSA = Drawn Date Drawn = Valid Date Results in ng/ml = NULL (Test #1, #2 or #3) Date = Valid Date Results = NULL **OR** Date of Exam = Valid Date Examination Results = NULL **OR** TRUS only Date = Valid Date Results = NULL **OR** TRUS-Guided biopsy Date = Valid Date Results = NULL
Oral	Screening Page 2 **OR** Screening Page 3 **OR** Post Page 2	Screening Date = Valid Date Were any brush biopsies taken? = NULL or Yes Date of Brush Biopsy = Valid Date Anatomic Location of Brush Biopsy = Anatomic Location Result – NULL Date of Exam/Visit = Valid Date Examination Results = NULL **OR** Date of Brush Biopsy = Valid Date

		Anatomic Location of Brush Biopsy = Anatomic Location Result = NULL **OR** Date of Incisional Biopsy = Valid Date Results = NULL
Skin	Post Page 2-3	Date of Exam/Visit = Valid Date Examination Results = NULL **OR** Date of Biopsy = Valid Date Anatomic Location of Biopsy = Anatomic Location Result = NULL

Pending Notification of Screening Results

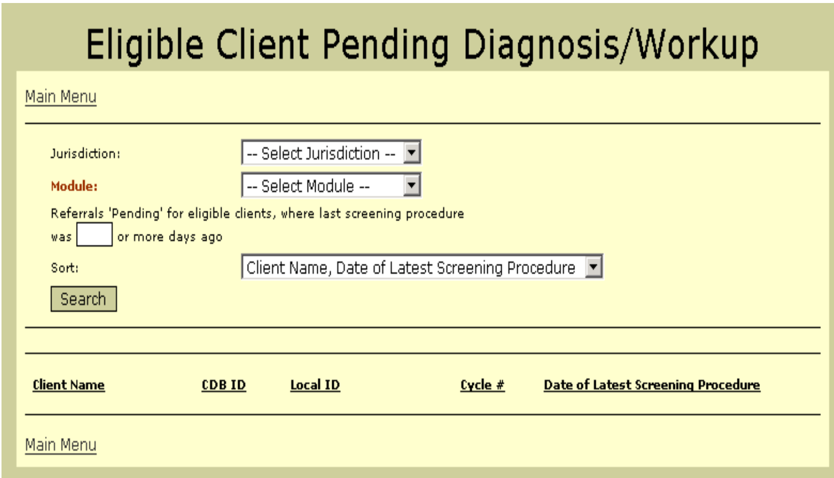


Results Criteria

Module	Page	Field Name/Required Value
CRC	Screening Page 2 **OR** Screening Page 3	Date FOBT Kit Returned = Valid Date Date Results Received by Program = Valid Date Client Notified = NULL Date of Exam = Valid Date Date Results Received by Program = Valid Date Client Notified = NULL **OR** Date Performed = Valid Date Date Results Received by Program = Valid Date Client Notified = NULL
Prostate	Screening Page 2 Screening Page 3 **OR** Screening Page 3	Screening Date = Valid Date Client Notified = NULL PSA Test #1- Date Drawn = Valid Date Date Results Received by Program = Valid Date Client Notified = NULL **OR** PSA Test #2- Date Drawn = Valid Date Date Results Received by Program = Valid Date Client Notified = NULL
Oral	Screening Page 2 Screening Page 3 **OR**	Screening Date = Valid Date Client Notified = NULL

	Screening Page 3	Date of Brush Biopsy = Valid Date Date Results Received by Program = Valid Date Anatomic Location of Brush Biopsy = Anatomic Location Client Notified = NULL
Skin	Screening Page 2 Screening Page 3	Screening Date = Valid Date Client Notified = NULL

Eligible Client Pending Diagnosis/Workup

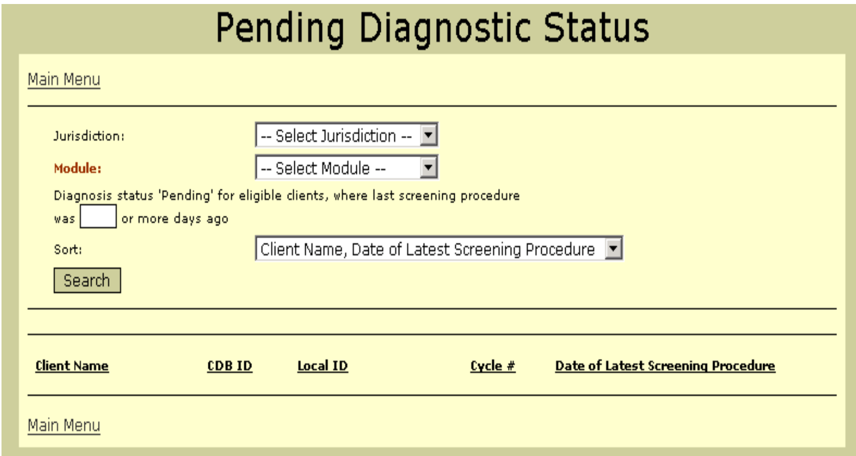


Results Criteria

Module	Page	Field Name/Required Value
CRC	Screening Page 3 Post Page 1 Post Page 2 Screening Page 3 Post Page 1 Post Page 2	Date of Exam = Valid Date Client eligibility = Yes or Yes, no funds Eligible client referred = NULL **OR** Date Performed = Valid Date Client eligibility = Yes or Yes, no funds Eligible client referred = NULL
Prostate	Screening Page 2 Post Page 1 **OR** Screening Page 3 Post Page 1 Screening Page 3 Post Page 1	Screening Date = Valid Date Client eligibility = Yes or Yes, no funds Eligible client referred = NULL PSA Test #1- Date Drawn = Valid Date Client eligibility = Yes or Yes, no funds Eligible client referred = NULL **OR** PSA Test #2- Date Drawn = Valid Date Client eligibility – Yes or Yes, no funds Eligible client referred = NULL
Oral	Screening Page 2 Post Page 1 **OR** Screening Page 3 Post Page 1	Screening Date = Valid Date Client eligibility = Yes or Yes, no funds Eligible client referred = NULL Date of Brush Biopsy = Valid Date Client eligibility = Yes or Yes, no funds

		Eligible client referred = NULL
Skin	Screening Page 2 Post Page 1	Screening Date = Valid Date Client eligibility = Yes or Yes, no funds Eligible client referred = NULL

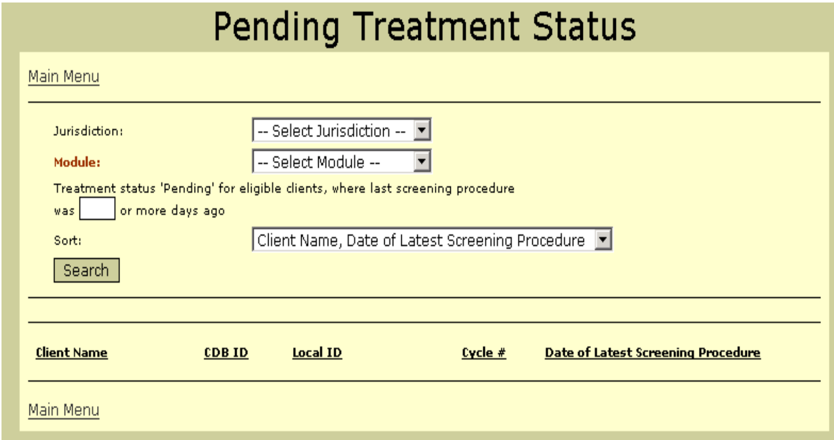
Pending Diagnostic Status



Results Criteria

Module	Page	Field Name/Required Value
Prostate	Screening Page 2 Post Page 1 Post Page 3 **OR** Screening Page 3 Post Page 1 Post Page 3	Screening Date = Valid Date Client eligibility = Yes or Yes, no funds Summary Diagnosis Status = NULL PSA Test #1- Date Drawn = Valid Date Client eligibility = Yes or Yes, no funds Summary Diagnosis Status = NULL **OR** PSA Test #2- Date Drawn = Valid Date Client eligibility = Yes or Yes no funds Summary Diagnosis Status = NULL
Oral	Screening Page 2 Post Page 1 Post Page 2 **OR** Screening Page 3 Post Page 1 Post Page 2	Screening Date = Valid Date Client eligibility = Yes or Yes, no funds Summary Diagnosis Status = NULL Date of Brush Biopsy = Valid Date Client eligibility = Yes or Yes, no funds Summary Diagnosis Status = NULL
Skin	Screening Page 2 Post Page 1 Post Page 2-3	Screening Date = Valid Date Client eligibility = Yes or Yes, no funds Summary Diagnosis Status = NULL

Pending Treatment Status



Results Criteria

Module	Page	Field Name/Required Value
CRC	Screening Page 2 Post Page 1 Post Page 2 **OR** Screening Page 3 Post Page 1 Post Page 2	Date FOBT Kit Returned = Valid Date Client eligibility = Yes or Yes, no funds Summary Treatment Status = NULL Date of Exam = Valid Date Client eligibility = Yes or Yes, no funds Summary Treatment Status = NULL **OR** Date Performed = Valid Date Client eligibility = Yes or Yes, no funds Summary Treatment Status = NULL
Prostate	Screening Page 2 Post Page 1 Post Page 3 **OR** Screening Page 3 Post Page 1 Post Page 3	Screening Date = Valid Date Client eligibility = Yes or Yes, no funds Summary Treatment Status = NULL PSA Test #1- Date Drawn = Valid Date Client eligibility = Yes or Yes, no funds Summary Treatment Status = NULL **OR** PSA Test #2- Date Drawn = Valid Date Client eligibility = Yes or Yes, no funds Summary Treatment Status = NULL
Oral	Screening Page 2 Post Page 1 Post Page 2 **OR** Screening Page 3 Post Page 1 Post Page 2	Screening Date = Valid Date Client eligibility = Yes or Yes, no funds Summary Treatment Status = NULL Date of Brush Biopsy = Valid Date Client eligibility = Yes or Yes, no funds Summary Treatment Status = NULL
Skin	Screening Page 2 Post Page 1 Post Page 2-3	Screening Date = Valid Date Client eligibility = Yes or Yes, no funds Summary Treatment Status = NULL

Appendix H: Mail Merge Information

Appendix H contains additional definitions for the Mail Merge function.

Health Care Provider Mail Merge Fields

PROVIDER TYPE: «provider_type»
PROVIDER NAME: «provider_name»
PROVIDER FIRST NAME: «provider_first_name»
INDIVIDUAL DEGREE: «individual_degree»
SPECIALTY: «specialty»
PROVIDER ADDRESS 1: «addr_line1»
PROVIDER ADDRESS 2: «addr_line2»
PROVIDER ADDRESS 3: «addr_line3»
CONTRACT: «contract»
CONTRACT BEGIN DATE: «contract_begin»
CONTRACT END DATE: «contract_end»

Colorectal Recall Letters

CLIENT ID: «client_id»
LAST NAME: «last_name»
SUFFIX: «suffix»
FIRST NAME: «first_name»
MIDDLE INIT: «middle_initial»
ADDRESS 1: «addr_line1»
ADDRESS 2: «addr_line2»
ADDRESS 3: «addr_line3»
DATE OF BIRTH: «date_of_birth»
LOCAL ID: «local_id»
MOST RECENT CYCLE: «cycle_id»
CYCLE START DATE: «cycle_start_date»
CYCLE STOP DATE: «cycle_stop_date»
CYCLE OUTCOME: «cycle_outcome»
FINAL HIERARCHICAL DX: «hierarchical_dx»
CRC RISK: «crc_risk»
RECALL DATE 1: «recall_date_1»
PROCEDURE (1): «recall_proc_1»

RECALL DATE 2: «recall_date_2»
PROCEDURE (2): «recall_proc_2»
RECALL DATE 3: «recall_date_3»
PROCEDURE (3): «recall_proc_3»

Prostate and Oral Recall Letters

CLIENT ID: «client_id»
LAST NAME: «last_name»
SUFFIX: «suffix»
FIRST NAME: «first_name»
MIDDLE INIT: «middle_initial»
ADDRESS 1: «addr_line1»
ADDRESS 2: «addr_line2»
ADDRESS 3: «addr_line3»
DATE OF BIRTH: «date_of_birth»
LOCAL ID: «local_id»
MOST RECENT CYCLE: «cycle_id»
CYCLE START DATE: «cycle_start_date»
CYCLE STOP DATE: «cycle_stop_date»
CYCLE OUTCOME: «cycle_outcome»
RECALL DATE: «recall_date»

Skin Recall Letters

CLIENT ID: «client_id»
LAST NAME: «last_name»
SUFFIX: «suffix»
FIRST NAME: «first_name»
MIDDLE INIT: «middle_initial»
ADDRESS 1: «addr_line1»
ADDRESS 2: «addr_line2»
ADDRESS 3: «addr_line3»
DATE OF BIRTH: «date_of_birth»
LOCAL ID: «local_id»
MOST RECENT CYCLE: «cycle_id»
CYCLE START DATE: «cycle_start_date»
CYCLE STOP DATE: «cycle_stop_date»
CYCLE OUTCOME: «cycle_outcome»
FINAL HIERARCHICAL DX: «hierarchical_dx»
RECALL DATE: «recall_date»

CRC Results–Single Client

CLIENT ID: «client_id»
LAST NAME: «last_name»
SUFFIX: «suffix»
FIRST NAME: «first_name»
MIDDLE INIT: «middle_initial»
ADDRESS 1: «addr_line1»
ADDRESS 2: «addr_line2»
ADDRESS 3: «addr_line3»
DATE OF BIRTH: «date_of_birth»
LOCAL ID: «local_id»
PROVIDER NAME: «provider_name»
PROVIDER FIRST NAME: «provider_first_name»
INDIVIDUAL DEGREE: «individual_degree»
PROVIDER ADDRESS 1: «prv_addr_line1»
PROVIDER ADDRESS 2: «prv_addr_line2»
PROVIDER ADDRESS 3: «prv_addr_line3»
CYCLE: «cycle_id»
FAMILY HISTORY CANCER: «family_history_cancer»
FAMILY HISTORY ADENOMA: «family_history_adenoma»
PERSONAL HISTORY CANCER: «personal_history_cancer»
PERSONAL HISTORY ADENOMA: «personal_history_adenoma»
PERSONAL HISTORY IBD: «personal_history_ibd»
CRC INITIAL RISK: «crc_initial_risk»
SYMPTOMS: «symptoms»
CYCLE OUTCOME: «cycle_outcome»
FINAL HIERARCHICAL DX: «hierarchical_dx»
CRC SCREENING RISK: «crc_screening_risk»
CRC STATUS: «crc_status»
FOBT DATE GIVEN: «fobt_date_given»
FOBT DATE RETURNED: «fobt_date_returned»
FOBT RESULT: «fobt_result»
FOBT NOTIFICATION STATUS: «fobt_client_notif»
COLONOSCOPY DATE: «col_date»
COLONOSCOPY PROVIDER: «col_provider»
COLONOSCOPY RESULT: «col_result»
ADENOMA: «adenoma»
HYPERPLASTIC POLYPS: «hp_polyp»
OTHER POLYP: «other_polyp»
ULCERATIVE COLITIS: «ulcer_colitis»
CROHN’S COLITIS: «crohn_colitis»
DIVERTICULI: «diverticuli»
HEMORRHOIDS: «hemorrhoids»
SIGMOIDOSCOPY DATE: «sig_date»
SIGMOIDOSCOPY PROVIDER: «sig_provider»
SIGMOIDOSCOPY RESULT: «sig_result»
DCBE DATE: «dcbe_date»
DCBE PROVIDER: «dcbe_provider»
DCBE RESULT: «dcbe_result»
RECALL DATE 1: «recall_1_date»
PROCEDURE (1): «recall_1_proc»
RECALL DATE 2: «recall_2_date»
PROCEDURE (2): «recall_2_proc»
RECALL DATE 3: «recall_3_date»
PROCEDURE (3): «recall_3_proc»

Prostate Results-Single Client

CLIENT ID: «client_id»
LAST NAME: «last_name»
SUFFIX: «suffix»
FIRST NAME: «first_name»
MIDDLE INIT: «middle_initial»
ADDRESS 1: «addr_line1»
ADDRESS 2: «addr_line2»
ADDRESS 3: «addr_line3»
DATE OF BIRTH: «date_of_birth»
LOCAL ID: «local_id»
RACE BLACK?: «race_black»
FAMILY HISTORY OF PROSTATE CANCER: «family_hx_prostate_ca»
PROVIDER NAME: «provider_name»
PROVIDER FIRST NAME: «provider_first_name»
INDIVIDUAL DEGREE: «individual_degree»
PROVIDER ADDRESS 1: «prv_addr_line1»
PROVIDER ADDRESS 2: «prv_addr_line2»
PROVIDER ADDRESS 3: «prv_addr_line3»
CYCLE: «cycle_id»
CYCLE OUTCOME: «cycle_outcome»
SCREENING LOCATION: «screening_location»
PSA 1 DATE: «psa_1_date»
PSA 1 RESULT: «psa_1_result»
PSA 2 DATE: «psa_2_date»
PSA 2 RESULT: «psa_2_result»
DRE DATE: «dre_date»
DRE RESULT: «dre_result»
INITIAL IMPRESSION: «init_impression»
RECOMMENDATION(S): «recommendation»
RECALL DATE: «recall_date»

Oral Results–Single Client

CLIENT ID: «client_id»
LAST NAME: «last_name»
SUFFIX: «suffix»
FIRST NAME: «first_name»
MIDDLE INIT: «middle_initial»
ADDR LINE 1: «addr_line1»
ADDR LINE 2: «addr_line2»
ADDR LINE 3: «addr_line3»
DOB: «date_of_birth»
LOCAL ID: «local_id»
CURRENT TOBACCO USE: «current_tobacco_use»
PROVIDER NAME: «provider_name»
PROVIDER FIRST NAME: «provider_first_name»
INDIVIDUAL DEGREE: «individual_degree»
PROVIDER ADDRESS 1: «prv_addr_line1»
PROVIDER ADDRESS 2: «prv_addr_line2»
PROVIDER ADDRESS 3: «prv_addr_line3»
CYCLE: «cycle_id»
CYCLE OUTCOME: «cycle_outcome»
SCREENING LOCATION: «screening_location»
SCREENING DATE: «screening_date»
INITIAL IMPRESSION: «init_impression»
RECOMMENDATIONS: «recommendation»
RECALL DATE: «recall_date»

Skin Results–Single Client

CLIENT ID: «client_id»
LAST NAME: «last_name»
SUFFIX: «suffix»
FIRST NAME: «first_name»
MIDDLE INIT: «middle_initial»
ADDR LINE 1: «addr_line1»
ADDR LINE 2: «addr_line2»
ADDR LINE 3: «addr_line3»
DOB: «date_of_birth»
LOCAL ID: «local_id»
PROVIDER NAME: «provider_name»
PROVIDER FIRST NAME: «provider_first_name»
INDIVIDUAL DEGREE: «individual_degree»
PROVIDER ADDRESS 1: «prv_addr_line1»
PROVIDER ADDRESS 2: «prv_addr_line2»
PROVIDER ADDRESS 3: «prv_addr_line3»
CYCLE: «cycle_id»
SKIN CANCER IN PAST: «past_skin_cancer»
PREVIOUS CANCER TYPES: «past_skin_cancer_type»
CYCLE OUTCOME: «cycle_outcome»
SCREENING LOCATION: «screening_location»
SCREENING DATE: «screening_date»
INITIAL IMPRESSION: «init_impression»
RECOMMENDATIONS: «recommendation»
RECALL DATE: «recall_date»
SCREENING IMPRESSION: «screening_impression»
SCREENING RECOMMENDATIONS: «screening_recommendations»

FOBT Results Letter—Group of Clients

CLIENT ID: «client_id»
LAST NAME: «last_name»
SUFFIX: «suffix»
FIRST NAME: «first_name»
MIDDLE INIT: «middle_initial»
ADDRESS 1: «addr_line1»
ADDRESS 2: «addr_line2»
ADDRESS 3: «addr_line3»
DATE OF BIRTH: «date_of_birth»
LOCAL ID: «local_id»
PROVIDER NAME: «provider_name»
PROVIDER FIRST NAME: «provider_first_name»
INDIVIDUAL DEGREE: «individual_degree»
PROVIDER ADDRESS 1: «prv_addr_line1»
PROVIDER ADDRESS 2: «prv_addr_line2»
PROVIDER ADDRESS 3: «prv_addr_line3»
CYCLE: «cycle_id»
FAMILY HISTORY CANCER: «family_history_cancer»
FAMILY HISTORY ADENOMA: «family_history_adenoma»
PERSONAL HISTORY CANCER: «personal_history_cancer»
PERSONAL HISTORY ADENOMA: «personal_history_adenoma»
PERSONAL HISTORY IBD: «personal_history_ibd»
CRC INITIAL RISK: «crc_initial_risk»
SYMPTOMS: «symptoms»
CYCLE OUTCOME: «cycle_outcome»
FINAL HIERARCHICAL DX: «hierarchical_dx»
CRC SCREENING RISK: «crc_screening_risk»
CRC STATUS: «crc_status»

FOBT DATE GIVEN: «fobt_date_given»
FOBT DATE RETURNED: «fobt_date_returned»
FOBT RESULT: «fobt_result»
FOBT NOTIFICATION STATUS: «fobt_client_notif»
COLONOSCOPY DATE: «col_date»
COLONOSCOPY PROVIDER: «col_provider»
COLONOSCOPY RESULT: «col_result»
SIGMOIDOSCOPY DATE: «sig_date»
SIGMOIDOSCOPY PROVIDER: «sig_provider»
SIGMOIDOSCOPY RESULT: «sig_result»
DCBE DATE: «dcbe_date»
DCBE PROVIDER: «dcbe_provider»
DCBE RESULT: «dcbe_result»
RECALL DATE 1: «recall_1_date»
PROCEDURE (1): «recall_1_proc»
RECALL DATE 2: «recall_2_date»
PROCEDURE (2): «recall_2_proc»
RECALL DATE 3: «recall_3_date»
PROCEDURE (3): «recall_3_proc»

Prostate Results Letter—Group of Clients

CLIENT ID: «client_id»
LAST NAME: «last_name»
SUFFIX: «suffix»
FIRST NAME: «first_name»
MIDDLE INIT: «middle_initial»
ADDRESS 1: «addr_line1»
ADDRESS 2: «addr_line2»
ADDRESS 3: «addr_line3»
DATE OF BIRTH: «date_of_birth»
LOCAL ID: «local_id»
PROVIDER NAME: «provider_name»
PROVIDER FIRST NAME: «provider_first_name»
INDIVIDUAL DEGREE: «individual_degree»
PROVIDER ADDRESS 1: «prv_addr_line1»
PROVIDER ADDRESS 2: «prv_addr_line2»
PROVIDER ADDRESS 3: «prv_addr_line3»
CYCLE: «cycle_id»
CYCLE OUTCOME: «cycle_outcome»
SCREENING LOCATION: «screening_location»
PSA 1 DATE: «psa_1_date»
PSA 1 RESULT: «psa_1_result»
PSA 2 DATE: «psa_2_date»
PSA 2 RESULT: «psa_2_result»
DRE DATE: «dre_date»
DRE RESULT: «dre_result»
INITIAL IMPRESSION: «init_impression»
RECOMMENDATION(S): «recommendation»
RECALL DATE: «recall_date»

Mail Merge Instructions

Create folders in which to put your Mail Merge files

Please follow these steps prior to beginning your mail merge. They will help you organize the files that you will need to create letters, envelope addresses, or labels.

1. **Go to** Windows Explorer **or** My Computer **to create 3 folders.**
   - **You can get to** Windows Explorer **by doing the following:**
     - **On your task bar, go to** Start→Programs→Accessories→Windows Explorer
   - You can get to **My Computer** by going to your desktop and looking for a small computer icon or go to **Start → My Computer**

2. Identify a location for your new folders, for example in My Documents or in your own user area.

3. Create 3 new folders on your hard drive:

   - **CDB Letter Templates**
     Keep your standard letter templates in this folder

   - **CDB Client Letter Data-Confidential**
     Have the CDB write the client data to a file in this folder

   - **CDB Client Letters-Confidential**
     After you merge the files, keep your finished letter files in this folder

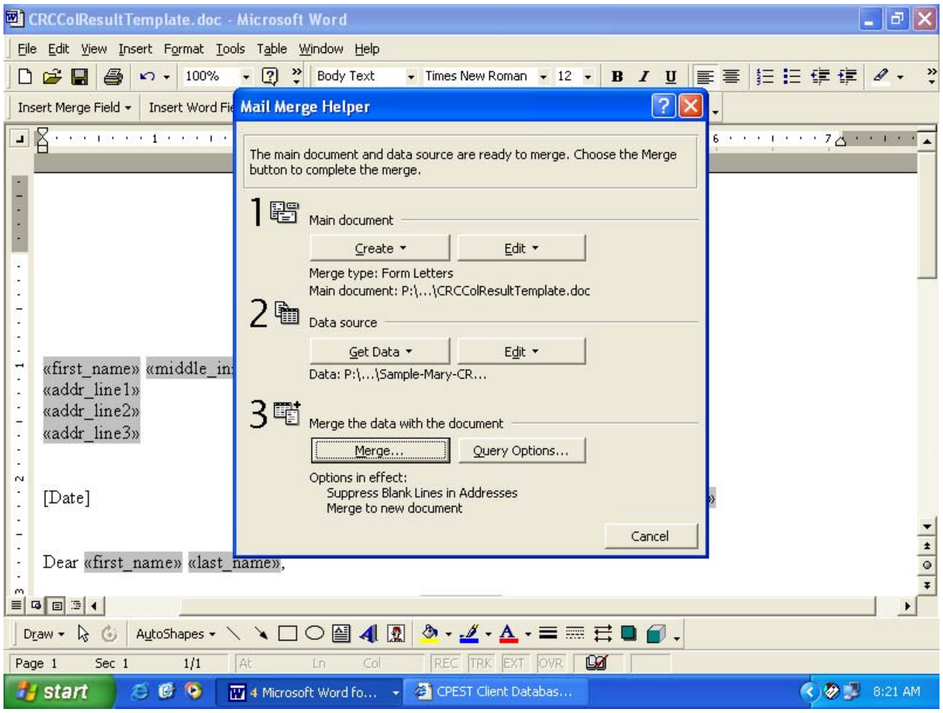
Create Mail Merge Documents

Method I: Use an Existing Mail Merge Template Letter

- Open Microsoft Word

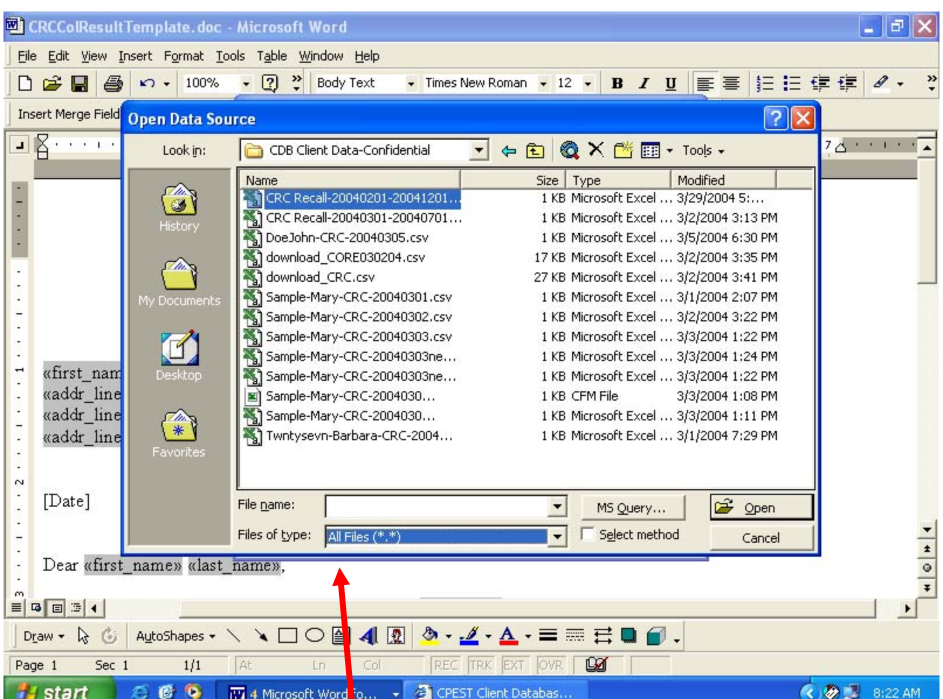
- Open the template letter stored in your **CDB Letter Template** file (e.g.CRCColResultTemplate)

- Click on Tools→Mail Merge. Because you already have the document open, it may already say Form Letters and have the Main Document listed as your template letter. If not, under Main Document, select Create→ Form Letters and at this point choose Active Window.

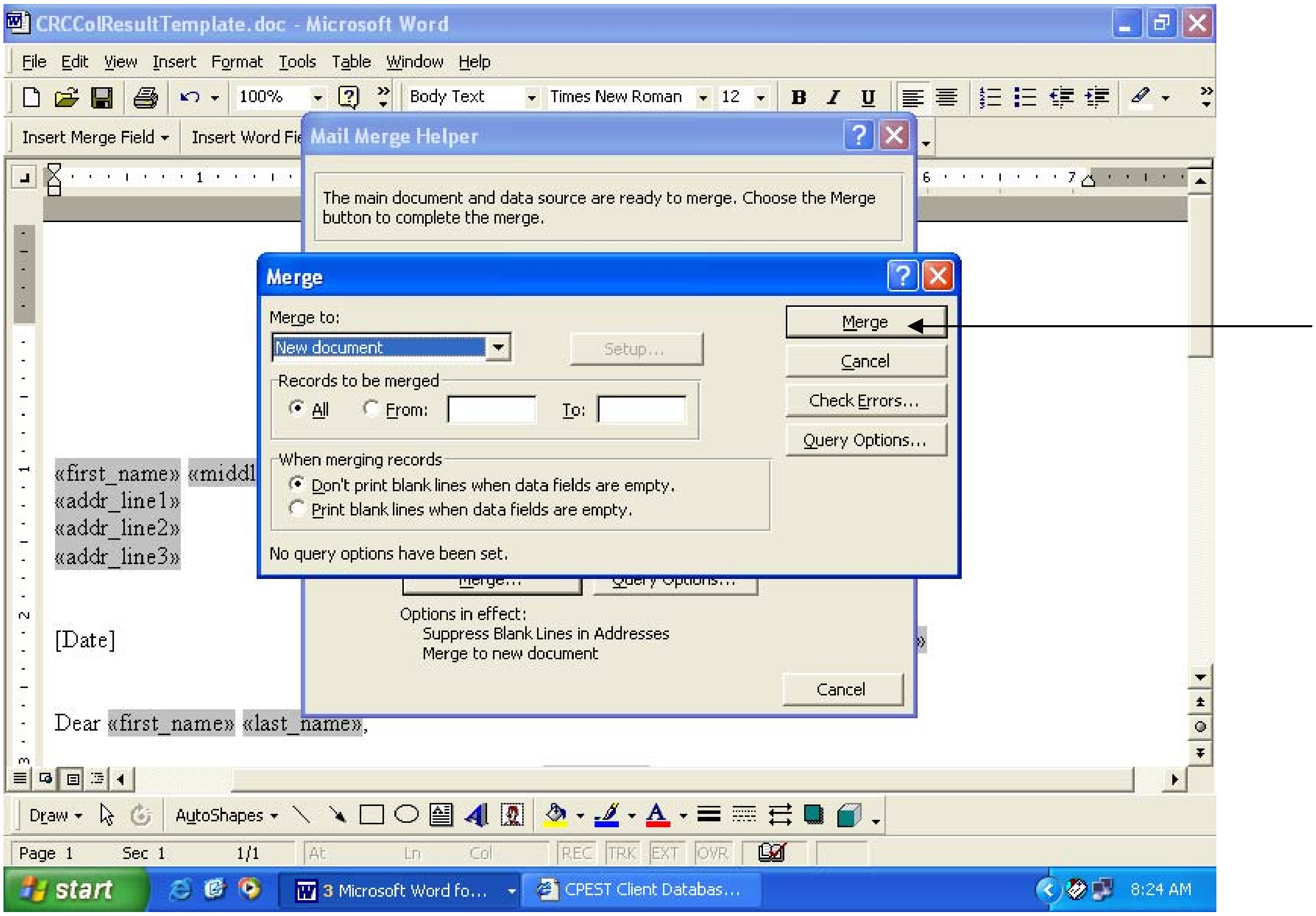


- Go to Data Source→ Get Data→Open Data Source.

- Go to the **CDB Client Data-Confidential** file to find the data file you wish to merge with the letter—remember to change to "File types" **All Files** at the bottom so that you can see the **.cvs** or **.cfm** files. This is the information that you created from the CDB (see Chapter 10).



- To merge the letter with the data, pick Merge→ Merge→ and you will have your merged letter(s).



- The merged letter will pop up. Review **and edit** the merged letter(s) before printing. You may refer back to the client data to enter more of the findings or customize your letter to the individual receiving it.

- Save the merged letter(s) to the file **CDB Letters Confidential** with a name identifying the letter (e.g. last name and date of the letter).

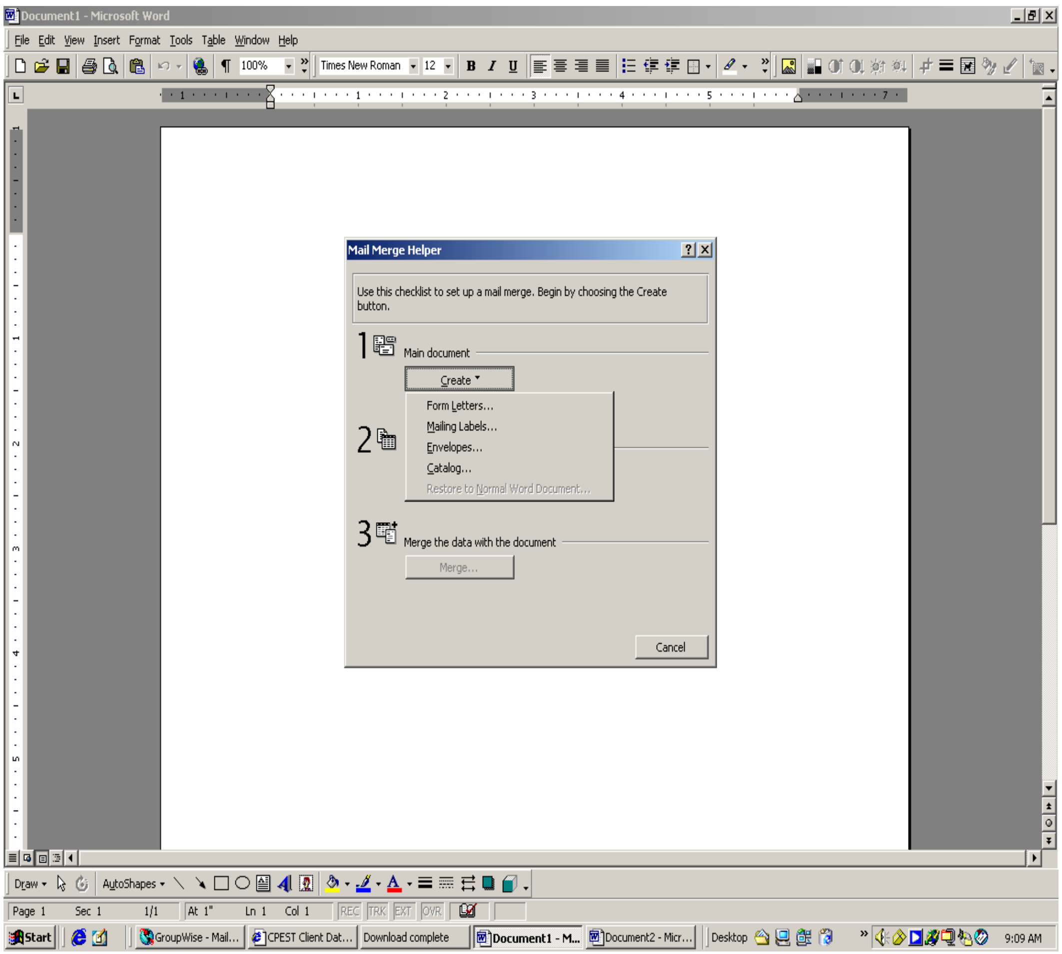
Method II: Creating your Mail Merge Letter in Mail Merge

Step 1: Choose a Document Type and Main Document

Open Microsoft Word with a blank document to start the mail merge.

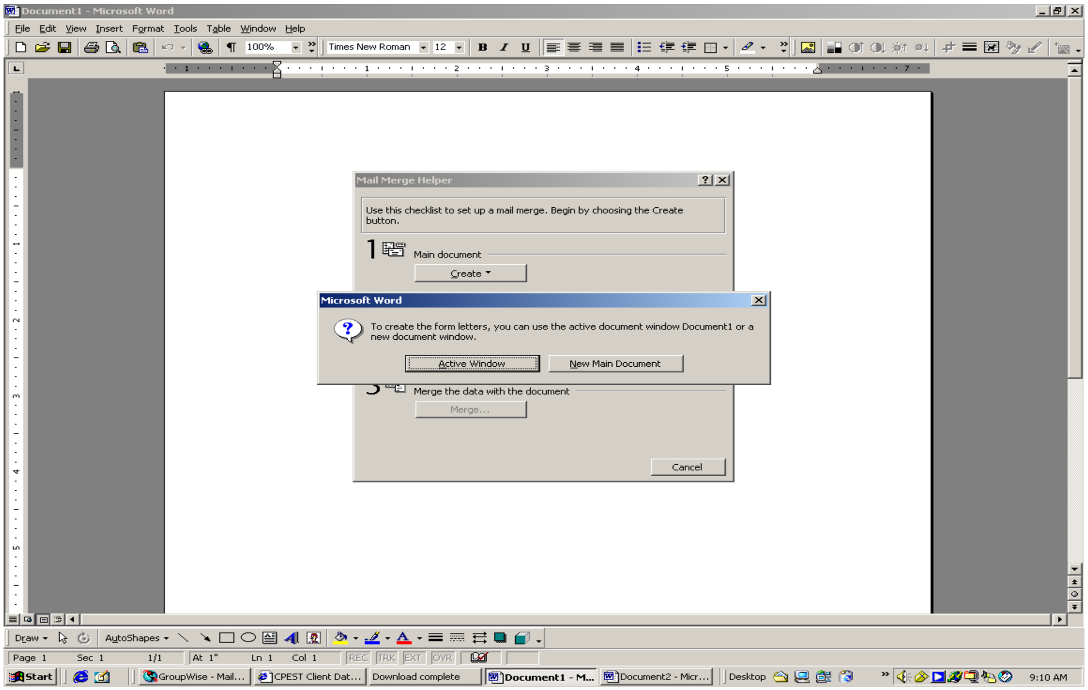
To create the form letter, choose the type of document into which you want to merge information.
On the toolbar select **Tools**→Letters and Mailing**→Mail Merge→Main Document→Create (drop down box).**

Select: **Form Letters**



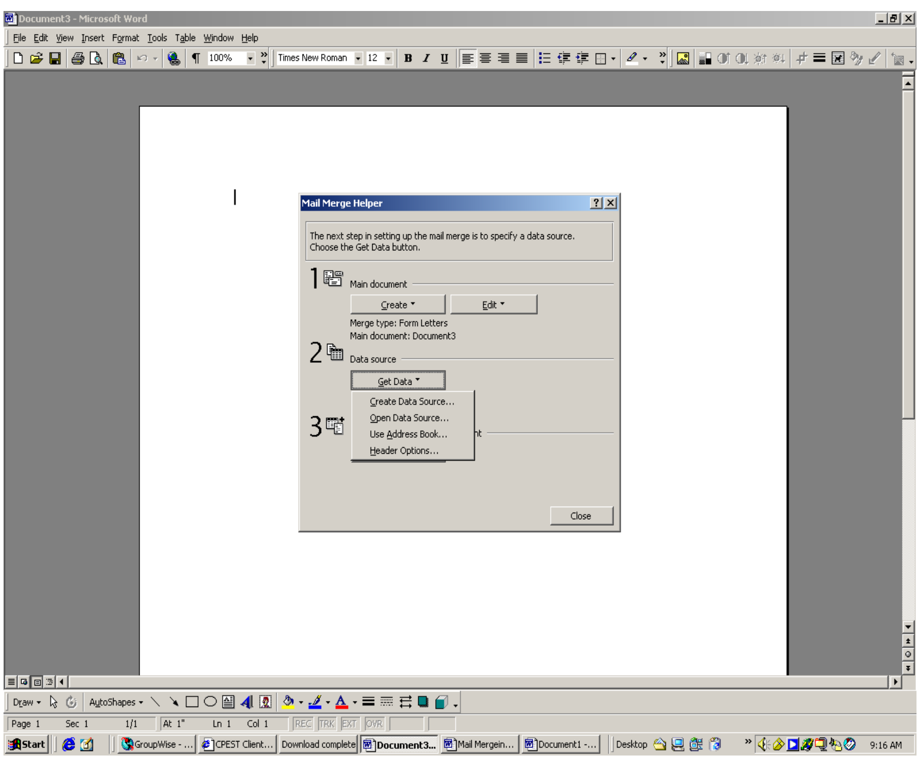
Choose the Main Document you want to use.

Select **New Main Document**.

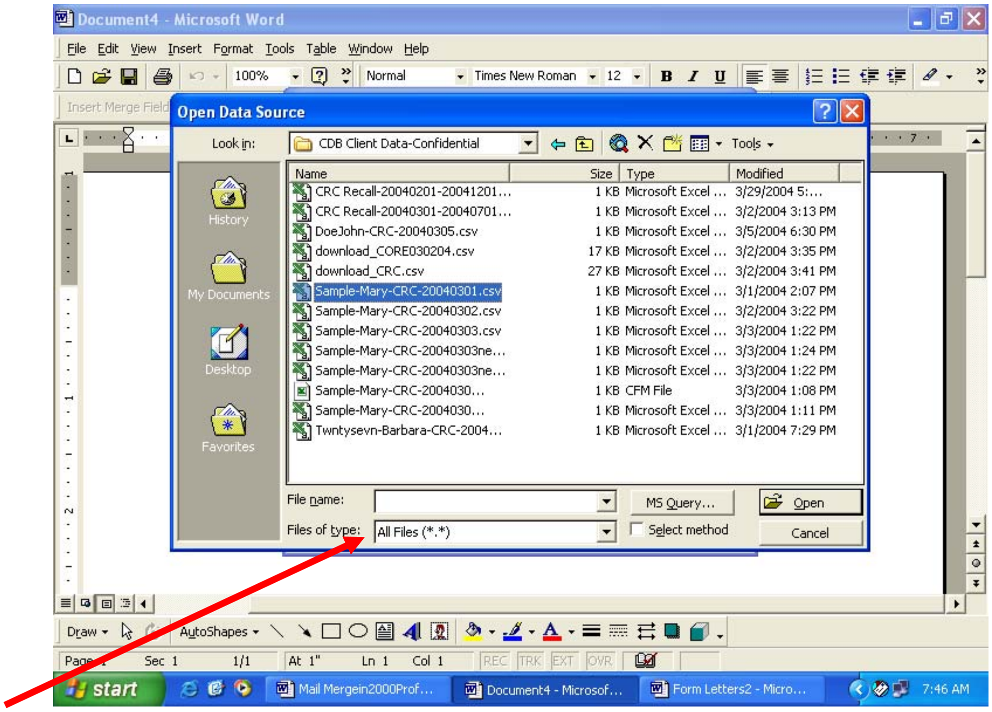


Step 2: Connect to a data file with confidential client data
In this step in the mail-merge process, you connect your Word document to the data file that contains the information that you want to merge into your Word document.

Select **Get Data→Open Data Source**

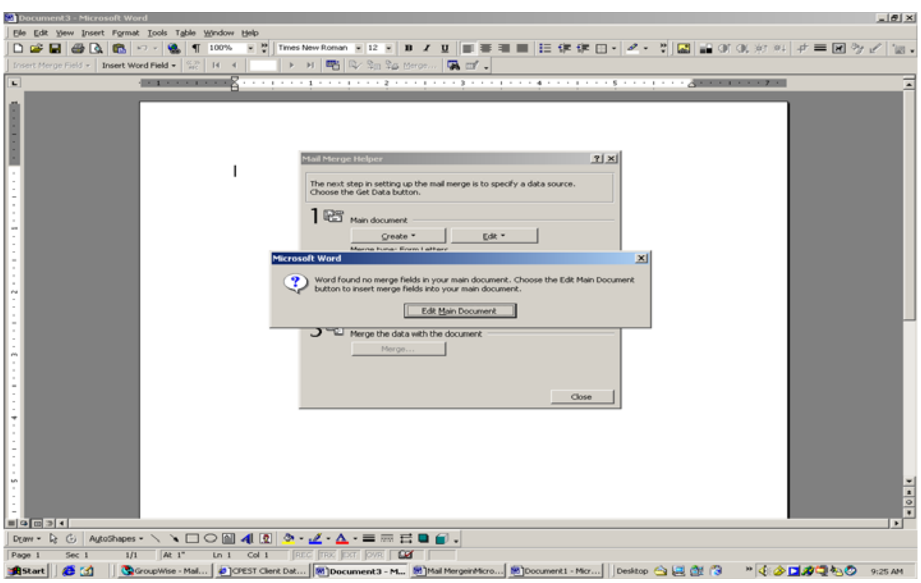


Under “**Files of type” at the bottom of the screen,** select **All Files (*.*)** to pull up all of the client data files you created in the CDB and saved to the CDB Client Data-Confidential Folder with the .csv or .cfm extension.

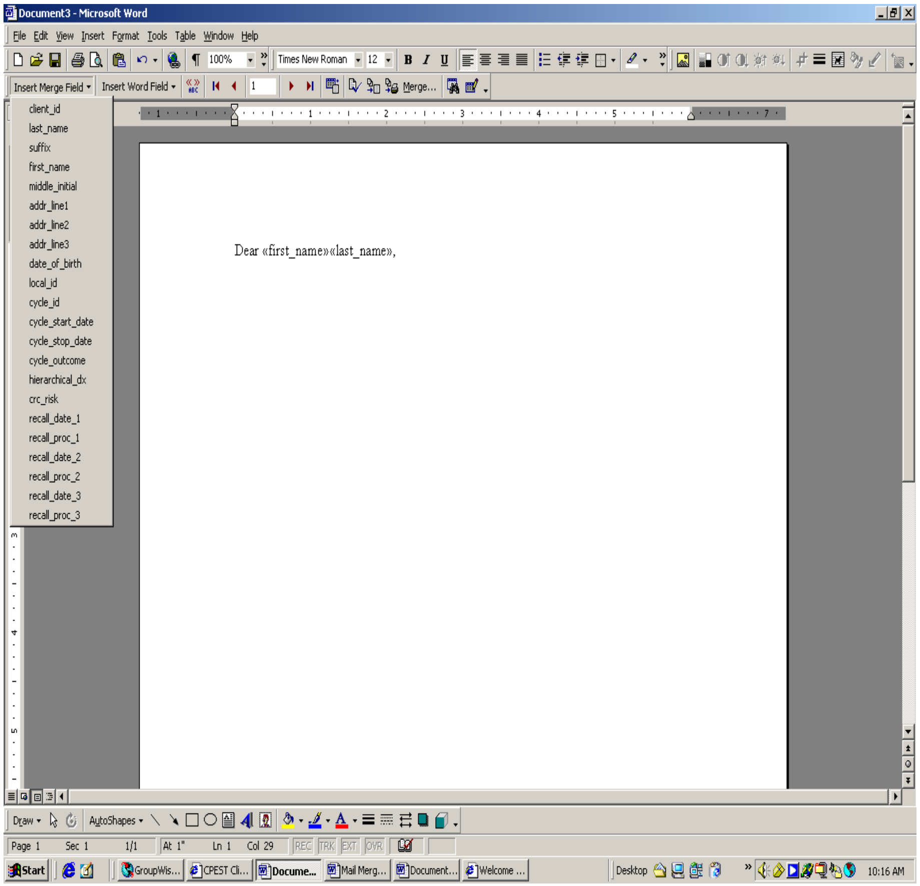


Click on the name of the file that has the client data you wish to use and select **Open.**

The dialogue box (below) will appear. Select **Edit Main Document** and begin typing your document.



Step 3: Add Mail Merge fields to the Main Document as you create the document



As you create a new document, type the information that will appear in each letter. As you go, add merge fields by clicking on **Insert Merge Field** (a button on the left hand side of the toolbar) and a drop down box will show all available fields for use in your letter. Fields are placeholders that you insert into the main document at locations where you want unique information to appear. Once you click on the field, it will be inserted and appear in the following manner: **<<field name>>**. For example, to add a greeting line, type the word "Dear" and insert the fields <<first_name>> <<last_name>> and then type your punctuation. The information on your screen should look like the screen to the left.

Step 4: Preview the merged letter and then complete it

Preview the Merged Letter

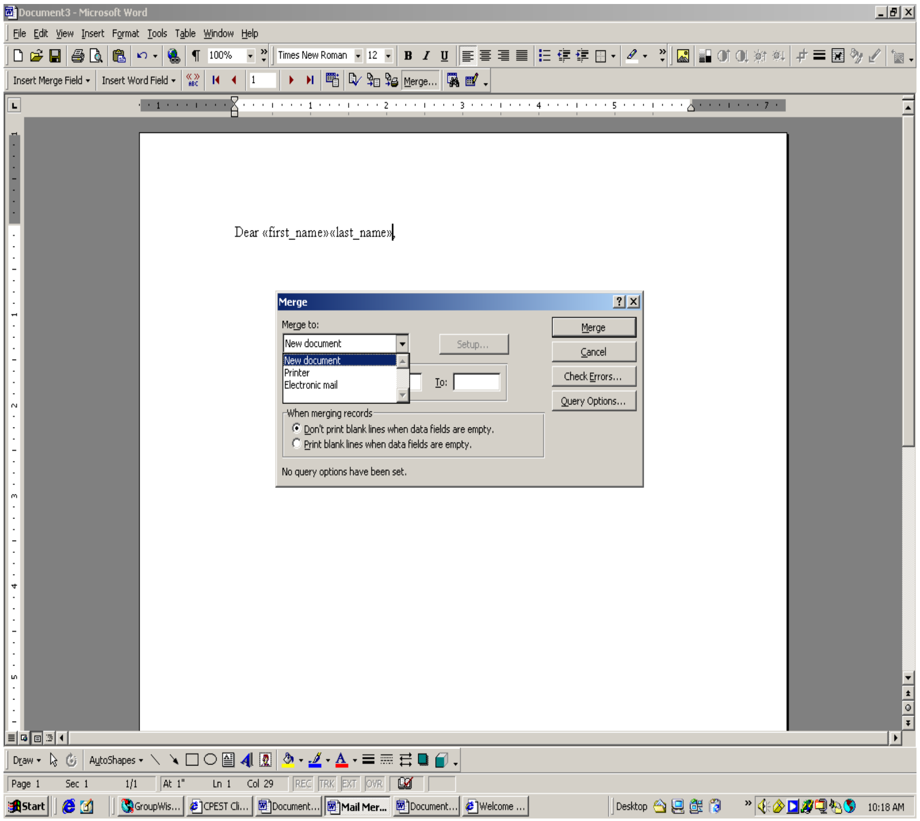
To preview your document prior to merging with data printing it, click anywhere in the document, and then click the **View Merged Data** button (it has the characters: << >> above "ABC") on the Mail Merge toolbar (it is the button to the right of the **Insert Word Field** button). Word will display information from the <u>first</u> data record in place of the merge field.

Save the Main Document

Save the main document as a template letter so that you can use it for future mail merges. Save it in the file you created **CDB Letter Templates**.

View the Letters

To view information from other data records, click the arrow buttons on the mail merge toolbar, or type a record number in the **Go to Record** box and press Enter.



Complete the Merge

To complete the merge, go to the middle of the toolbar and click on the **Merge** button. A dialog box will appear and then click on **Merge to**, then in the drop down menu select **New Document**, and then click **Merge** in the top right hand corner of the box. Word will populate the template letter with data from the data source file.

Edit the Merged Letters

Once the merge is complete, scroll through each letter to make sure it is correct and to check for correct formatting. Save the merged, confidential letters in the folder: **CDB Client Letters Confidential** with a name and date that will help you identify them.

Print the Letters

Appendix I: Data Download Information

Appendix I contains additional definitions for the Data Download functions.

Core Demographic Data Download

Core Demographic Screening Form, Page 1

Screen Components – Program use only		
UI Label	Description	Download Field Name
CDB ID	System generated ID representing client within system. This field will be blank for a new client until saved to the database.	Client_id
Local ID		Local_id
Jurisdiction	Identifies the program in which this client is enrolled	Program
Interview Date	mm/dd/yyyy	interview_date
Enrollment Date	Date to be recorded as enrollment for each program specified on page three of Core form. (format is mm/dd/yyyy)	program_enrollment_date

Screen Components – Patient Information		
UI Label	Description	Download Field Name
Last Name (Access to Identifiers)	Last name or Sur name of client.	last_name
First Name (Access to Identifiers)	First name of client.	first_name
Suffix (Access to Identifiers)	Suffix of client (Jr., III, etc)	suffix
Date of Birth (Access to Identifiers)	Date of birth of client. This column is a character field to allow for partial data entry. Preferred format is mm/dd/yyyy	date_of_birth
SSN (Access to Identifiers)	Last four digits of patient's Social Security Number (or NONE).	Last_four_of_SSN
Residential Address		
(Street) Number (Access to Identifiers)	Housing number	geographic_addr_number
(Street) Pre Dir (Access to Identifiers)	Prefix directional of street (N, NE, etc.)	geographic_addr_prefix_dir
(Street) Name (Access to Identifiers)	Name of street (Main, Preston, etc.)	geographic_addr_name
(Street) Type (Access to Identifiers)	Type of street (AVE, BLVD, ST, etc.)	geographic_addr_street_type
(Street) Post Dir (Access to Identifiers)	Post (Suffix) directional of street (N, NE, etc.)	geographic_addr_suffix_dir

Screen Components – Patient Information

UI Label	Description	Download Field Name
Apartment/ Room/Unit # (Access to Identifiers)	Apartment, Suite, Room or Unit Number	geographic_addr_apt
City (Access to Identifiers)	City of residence	geographic_addr_city
State (Access to Identifiers)	State of residence	geographic_addr_state
Zipcode (Access to Identifiers)	Full zip code (five or nine digits)	geographic_addr_zip
County (Access to Identifiers)	County of residence	geographic_addr_county
(Telephone) Home (Access to Identifiers)	Home telephone number of client.	home_phone
(Telephone) Work (Access to Identifiers)	Work telephone number of client.	work_phone
(Telephone) Cell (Access to Identifiers)	Cellular telephone of client.	cell_phone
Is mailing address different from residential address? (Access to Identifiers)	User must indicate 'Yes' in order to enable the Mailing Address fields for data entry; otherwise fields are populated with residential address data.	Mailing_addr_diff
Mailing Address		
(Street) Number (Access to Identifiers)	Housing number	mailing_addr_number
(Street) Pre Dir (Access to Identifiers)	Prefix directional of street (N, NE, etc.)	mailing_addr_prefix_dir
(Street) Name (Access to Identifiers)	Name of street (Main, Preston, etc.)	mailing_addr_name
(Street) Type (Access to Identifiers)	Type of street (AVE, BLVD, ST, etc.)	mailing_addr_street_type
(Street) Post Dir (Access to Identifiers)	Post (Suffix) directional of street (N, NE, etc.)	mailing_addr_suffix_dir

Screen Components – Patient Information		
UI Label	**Description**	**Download Field Name**
Apartment/ Room/Unit # (Access to Identifiers)	Apartment, Suite, Room or Unit Number	mailing_addr_apt
City (Access to Identifiers)	City of residence	mailing_addr_city
State (Access to Identifiers)	State of residence	mailing_addr_state
Zipcode (Access to Identifiers)	Full zip code (five or nine digits)	mailing_addr_zip

Screening Components – Learn of Program		
UI Label	Description	Download Field Name
How did you learn of this screening program?	List of semi-colon-separated method(s) influenced a client's participation within the program	client_learn_of_program

Core Demographic Screening Form, Page 2

Screening Components – Demographic Information		
UI Label	Description	Download Field Name
Gender	Indicates gender (sex) of client.	gender
Ethnicity (Hispanic or Latino)	Indicates Hispanic or Latino ethnicity of client.	ethnicity
Race	Semi-colon-separated list of races of client.	race
N/A	Indicates if the client is a minority.	Minority
N/A	Indicates if the client is multi-race.	Multi_race
Education	Indicates education level of client.	education
Marital Status	Indicates client's marital status.	Marital_status
Primary Language	Indicates client's primary language.	Primary_language
Other, specify	Identifies other primary language.	Primary_language_other
Annual Income	Client household's annual income.	Household_income
Number of Persons in Household	Number of persons in client household, including the client.	number_in_household

Screening Components – Previous Enrollment		
UI Label	Description	Download Field Name
Have you ever been screened or treated for colon, oral, skin, or prostate cancer by any Maryland health program?	Indicates client has participated in a Maryland health program for screening or treatment of these four cancers.	Prior_cpest_enrollment
Have you ever been screened for breast or cervical cancer by the Breast and Cervical Cancer Program (BCCP)?	Indicates client participation in the BCCP program.	BCCP_enrollment

Screening Components – Health Care Provider and Insurance Information		
UI Label	Description	Download Field Name
Do you have a primary health care provider?		Has_Primary_care_provider
If yes, identify provider or practice	Health Care Provider must be selected from list provider. Information for the selected provider will be displayed on this page.	Primary_care_provider

Screening Components – Health Care Provider and Insurance Information		
UI Label	Description	Download Field Name
Are you covered by health insurance?	Indicates existence of client health insurance.	Insurance
If yes, type of *primary* health insurance	Identifies primary insurance source.	Primary_insurance_type
Type of *secondary* health insurance, if any	Identifies secondary insurance source	second_insurance_type

Core Demographic Screening Form, Page 3

Screening Components – Health History		
UI Label	Description	Download Field Name
Do you have a history of any kind of cancer?	Indicates client's cancer history.	Cancer_history
Type of Cancer	Semi-colon-separated list of types of cancer for client.	Cancer_types
Have you had any of the following illnesses/conditions?	Semi-colon-separated list of client conditions	Conditions
Have you *ever* used tobacco in any form?	Indicates whether client has ever used any form of tobacco.	Tobacco_use_ever
Do you currently use tobacco?	Indicates whether client currently uses tobacco.	Tobacco_use_current
Used cigarette tobacco	Indicates tobacco product client has used.	Tobacco_use_cigarette
Used pipe tobacco	Indicates tobacco product client has used.	Tobacco_use_pipe
Used cigar tobacco	Indicates tobacco product client has used.	Tobacco_use_cigar
Used spit tobacco (snuff, chewing, etc.)	Indicates tobacco product client has used.	Tobacco_use_spit
Have you smoked 100 or more cigarettes over your lifetime?	Indicates whether client smoked 100 or more cigarettes over lifetime.	Cigarette_100
If yes, at what age did you first smoke?	Age client began to smoke.	Cigarette_100_start
If you quit smoking, at what age did you quit?	Age client quit smoking.	Cigarette_100_quit
Average number of packs of cigarettes you smoke(d) each day (20 cigarettes per pack):	Average number of packs of cigarettes client smoked each day.	Tobacco_use_ppd

Screen Components – Program Use Only		
UI Label	Description	Download Field Name
Provided literature to client on dangers of tobacco use	Indicates whether literature on dangers of smoking was provided to client.	tobacco_use_literature
Is client eligible for any cancer screening in the Program?	Indicates status of client's eligibility for screening.	Cancer_screening_eligible
(Is client eligible for any cancer screening in the Program?) Colorectal	Indicates client's module enrollment at the time client is entered into CDB.	Enrolled_crc
(Is client eligible for any cancer screening in the Program?) Prostate	Indicates client's module enrollment at the time client is entered into CDB.	Enrolled_prostate
(Is client eligible for any cancer screening in the Program?) Oral	Indicates client's module enrollment at the time client is entered into CDB.	Enrolled_oral
(Is client eligible for any cancer screening in the Program?) Skin	Indicates client's module enrollment at the time client is entered into CDB.	Enrolled_skin

Discharge Client

Screen Components – Discharge Client		
UI Label	Description	Download Field Name
Discharge Date (CRC)	The date the client was discharged from the program.	Crc_discharge_date
Reason for Discharge (CRC)	Indicates why the client was discharged.	Crc_discharge_reason
Discharge Date (PROSTATE)	The date the client was discharged from the program.	Prostate_discharge_date
Reason for Discharge (PROSTATE)	Indicates why the client was discharged.	Prostate_discharge_reason
Discharge Date (ORAL)	The date the client was discharged from the program.	Oral_discharge_date
Reason for Discharge (ORAL)	Indicates why the client was discharged.	Oral_discharge_reason
Discharge Date (SKIN)	The date the client was discharged from the program.	skin_discharge_date
Reason for Discharge (SKIN)	Indicates why the client was discharged.	Skin_discharge_reason

Core Program Defined Variables

Screen Component – Program Defined Variables		
Label	Description	Download Field Name
Client_field_one	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Client_field_one

Screen Component – Program Defined Variables		
Label	Description	Download Field Name
Client_field_two	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Client_field_two
Client_field_three	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Client_field_three
Client_date_field_one	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Client_date_field_one
Client_date_field_two	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Client_date_field_two
Date of initial inquiry	Variable to be available for Allegany (program_ID=01) and Cecil (program_ID=07) users. (mm/dd/yyyy)	date_of_initial_inquiry
Birth Country	Variable to be available for Montgomery (program_ID=15) users.	birth_country
State_date_field_one	Variable to defined and used by statewide users as desired. (mm/dd/yyyy)	client_state_date_field_one
State_field_one	Variable to defined and used by statewide users as desired. (50)	client_state_field_one
State_field_two	Variable to defined and used by statewide users as desired. (50)	client_state_field_two
State_field_three	Variable to defined and used by statewide users as desired. (50)	client_state_field_three
State_comment	Variable to defined and used by statewide users as desired. (150)	client_state_comment

CRC Data Download

CRC Screening Form, Page 1

Screen Components— Program Use Only Section		
UI Label	Description	Download Field Name
CDB ID	System generated ID representing client within system.	client_ID
Local ID	Local program id for this client.	Local_id
Cycle Number	Internal sequence number for the cycle.	cycle_id
Cycle Start (Interview) Date	Represents the start date for this cycle of screening	cycle_start_date
Jurisdiction	Identifies the program in which this client is enrolled.	Program

Screen Components— Patient Information		
UI Label	Description	Download Field Name
Last Name (Access to Identifiers)	Last name or Sur name of client.	last_name
First Name (Access to Identifiers)	First name of client.	first_name
Date of Birth (Access to Identifiers)	Date of birth of client. This column is a character field to allow for partial data entry. Preferred format is mm/dd/yyyy	date_of_birth
SSN (Access to Identifiers)	Last four digits of patient's Social Security Number (or NONE).	Last_four_of_SSN
Gender	Indicates gender (sex) of client.	gender
Ethnicity (Hispanic or Latino)	Indicates Hispanic or Latino ethnicity of client.	ethnicity
Race	Semi-colon-separated list of races of client.	race
N/A	Indicates if the client is a minority.	Minority
N/A	Indicates if the client is multi-racial	Multi_race

Screen Components— History		
UI Label	Description	Download Field Name
Client history of colorectal cancer?		Crc_Self_history
Yes, date of diagnosis:		Crc_diagnosis_date
Client history of colon adenomatous polyps/ adenoma?		Crc_self_history_adenoma
Yes, date of first diagnosis:		Crc_adenoma_diagnosis_date

Screen Components— History		
UI Label	Description	Download Field Name
Client history of inflammatory bowel disease?		Crc_Self_history_ibd
Ulcerative Colitis, date:	Indicates client previous diagnosis of Ulcerative Colitis and date of diagnosis.	Crc_Self_ulcerative_colitis_diagnosis_date
Crohn's Colitis, date:	Indicates client previous diagnosis of Crohn's Colitis and date of diagnosis. (character entry ipermitted)	Crc_Self_crohns_colitis_diagnosis_date
Ulcerative and Crohn's Colitis, date:	Indicates client previous diagnosis of both Ulcerative and Crohn's Colitis and date of diagnosis.	Crc_Self_ulcerative_crohns_colitis_diagnosis_date
Unknown/not specified	Indicates client previous unknown/not specified inflammatory bowel disease	Crc_Self_history_unkown
Family history of adenoma or colorectal cancer in first-degree relative (parent, sibling, child)?		Crc_family_history
(Colorectal Cancer) Relationship	Semi-colon-separated list of relationships to the client.	Crc_family_members
(Adenoma) Relationship	The relationship to the client of the first-degree relative diagnosed with Adenoma.	Crc_Adenoma_family_members
CRC Risk based on client and family history	Client risk assessment based on guidelines within CRC Minimal Clinical Elements.	Crc_initial_risk_assessment

Screen Components— Symptoms		
UI Label	Description	Download Field Name
Does client have gastrointestinal symptoms possibly suggesting colorectal cancer?	"YES" if client has symptoms selected	Crc_Has_gi_symptoms

Screen Components— Symptoms		
UI Label	Description	Download Field Name
Lower abdominal pain		crc_abd_pain
Bright red blood per rectum, bloody stools		crc_blood_per_rectum_or_stools
Marked change in bowel habits		crc_changed_bowel_habits
Unexplained weight loss		crc_weight_loss
Other Symptoms		crc_other_symptom
Other, specify	Description of other gastrointestinal symptom indicated by client.	Crc_other_ symptom_descr

Screen Components— Previous Screening History		
UI Label	Description	Download Field Name
If client was previously tested for CRC outside of this Program, specify the test(s) and provide details	Selection list for CRC screening completed outside of program	Crc_screening_tests

CRC Screening Form, Page 2

Screen Components— FOBT
FOBT procedures are detailed in the CRC Procedures section below (page 7).

Screen Components— Endoscopy Screening Eligibility		
UI Label	Description	Download Field Name
Eligible for Screening Endoscopy by Program?	Indicates client eligibility for screening ndoscopy.	Crc_eligibility_initial_screening
If ineligible, reason for ineligibility	Semi-colon-seperates list of reasons why a client was deemed ineligible.	Crc_ineligibility_reasons

Screen Components— Screening Recommended
Screening procedures are detailed in the CRC Procedures section below (page 7).

CRC Screening Form, Page 3

Screen Components— Results from Exam
Screening procedures are detailed in the CRC Procedures section below (page7).

Screen Components— Endoscopy and/or DCBE Results
Screening procedures are detailed in the CRC Procedures section below (page 7).

CRC Screening Form, Page 4

Screen Components— Screening Summary Recommendations		
UI Label	Description	Download Field Name
No cancer detected, recall for routine screening.	This recommendation refers to colorectal cancer not being detected.	Crc_screening_rec_non_ca_recall
No cancer detected, refer for	This recommendation	Crc_screening_rec_non_ca_refer

Screen Components— Screening Summary Recommendations		
UI Label	Description	Download Field Name
other findings	refers to colorectal cancer not being detected.	
Refer to	Text describing referral. (50)	Crc_screening_rec_non_ca_refer_detail
No cancer detected, other recommendations	This recommendation refers to colorectal cancer not being detected.	Crc_screening_rec_other
Other, specify	Any other recommendation not previously listed. (50)	Crc_screening_rec_other_detail
Cancer detected/suspected, refer for further evaluation/treatment for cancer.		Crc_screening_rec_ca_refer
Cancer detected, no further evaluation/treatment needed. Recall for routine screening.		Crc_screening_rec_ca_recall

CRC Post Screening Form, Page 1

Screen Components— Program Eligibility		
UI Label	Description	Download Field Name
Is client eligible for additional CRF work-up, treatment or case management services	Specifies client eligibility for additional services.	Crc_eligibility_further_procedures

Screen Components— Ineligible Client		
UI Label	Description	Download Field Name
Reason for Ineligibility	Semi-colon-separated list of reasons why a client was deemed ineligible	Crc_ineligibility_reasons
Was ineligible client referred elsewhere for diagnosis/treatment?		Crc_ineligible_referral_status
Yes, referred to	Text describing referral. (100)	Crc_ineligible_referred_to
Ineligible Client Outcome		Crc_ineligible_client_outcome
Final disposition of ineligible clients who contacted an HCP		Crc_ineligible_referral_dx
Other, specify	Describes Other disposition selected. (50)	Crc_ineligible_referral_dx_other
If adenoma required surgery, specify treatment status		Crc_ineligible_adenoma_treatment_ status

Screen Components— Ineligible Client		
UI Label	**Description**	**Download Field Name**
(Adenoma, treatment status) Other, specify	Describes other treatment status selected. (100)	Crc_ineligible_adenoma_treatmen t_ status_other
Cancer, specify type	Describes type of Cancer. (50)	Crc_ineligible_referral_dx_ cancer_type
If cancer required surgery, specify treatment status		Crc_ineligible_cancer_treatment_ status
(Cancer, treatment status) Other, specify	Describes other treatment status selected. (100)	Crc_ineligible_cancer_treatment_ status_other

CRC Post Screening Form, Page 2

Screen Components— Eligible Client		
UI Label	**Description**	**Download Field Name**
Diagnosis/ Treatment Payer	Designates those responsible for payment of diagnostic/ treatment services.	Crc_diagnosis_payer
Was eligible client referred for evaluation and/or treatment?		Crc_eligible_client_referral
Referred to		Crc_eligible_client_referred_to
Were additional procedures or surgeries completed?	If yes, user should enter this information via Additional Procedures page.	Crc_additional_procedures

Screen Components— Summary of Diagnostic Work-up and Treatment of Cancer		
UI Label	**Description**	**Download Field Name**
Is cancer treatment recommended		Crc_ca_treatment_rec
Treatment Type/Comments	Description of Cancer treatment. (250)	Crc_treatment_comments
Date first treatment began	Date of first treatment. (mm/dd/yyyy)	Crc_treatment_date
Treatment Status		Crc_treatment_status
Tumor		Crc_treatment_tumor_stage
Nodes		Crc_treatment_nodes
Metastases		Crc_treatment_metastases
Stage		Crc_treatment_ca_stage
Hospitalized		Crc_treatment_hospitalized
Hospitalization procedures are detailed in the CRC Procedures section below (page 7).		
Hospice		Crc_treatment_hospice
Hospice procedures are detailed in the CRC Procedures section below (page 7).		

CRC Cycle Closure

Screen Components— Cycle Closure		
UI Label	Description	Download Field Name
Date cycle closed	Date the cycle was closed. (mm/dd/yyyy)	Crc_ cycle_close_date
Cycle Outcome	Code describing the cycle outcome. Valid values: ‘ CASTATUNK’, ‘CATREAT’, ‘CADETECTED’, ‘NOCASUSP’, ‘NOCADETECT’,’ABNORMAL’.	Crc_ cycle_closed_reason
Final Hierarchical Diagnosis	System generated final diagnosis based on data for all procedures entered for this cycle.	Crc_final_hier_dx
CRC risk based on cycle screening and client and family history	Client risk evaluation at conclusion of the cycle.	Crc_ screening_risk_assessment
(Screening Recall, FOBT) Projected date	Projected date of recall exam. (mm/yyyy)	Crc_recall_fobt_ projected_date
(Screening Recall, DCBE) Projected date	Projected date of recall exam. (mm/yyyy)	Crc_recall_dcbe_ projected_date
(Screening Recall, Sigmoidoscopy) Projected date	Projected date of recall exam. (mm/yyyy)	Crc_recall_ Sigmoidoscopy_ projected_date
(Screening Recall, Colonoscopy) Projected date	Projected date of recall exam. (mm/yyyy)	Crc_recall_Colonoscopy_ projected_date
(Screening Recall, Other) Projected date	Projected date of recall exam. (mm/yyyy)	Crc_recall_other_projected_date
(Screening Recall, Other) If other, specify	Captures the description of the other procedure for recall.	Crc_recall_other_descr

Discharge Client

Screen Components— Discharge Client		
UI Label	Description	Download Field Name
Discharge Date	The date the client was discharged from the program.	Crc_discharge_date
Reason for Discharge	Indicates why the client was discharged.	Crc_discharge_reason

CRC Program Defined Variables

Screen Components— Program Defined Variables		
Label	Description	Download Field Name
Crc_field_one	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Crc_field_one
Crc_field_two	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Crc_field_two
Crc_date_field_ one	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Crc_date_field_one
Crc_date_field_t wo	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Crc_date_field_two
Crc_date_field_t hree	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Crc_date_field_three
Admit CRF Date	Variable to be available for Carroll County (program_ID=6) clients. (mm/dd/yyy)	Crc_ admin_crf_date
Sponsor	Variable to be available for Montgomery (program_ID=15) clients.	Crc sponsor
(Sponsor) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of 'Other' sponsor. (50)	Crc_sponsor_other
Date of education/intake	Variable to be available for Montgomery (program_ID=15) clients. (mm/dd/yyy)	Crc_ date_of_education_intake
Group Education Session ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text to 10 characters.	Crc_group_education_session_ID
Referral Date	Variable to be available for Montgomery (program_ID=15) clients. (mm/dd/yyy)	Crc_ referral_date
Referral Location	Variable to be available for Montgomery (program_ID=15) clients.	Crc_ referral_location
(Referral Location) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of 'Other' referral location. (50)	Crc_ referral_location_other
Telephone log ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text of 10 characters.	Crc_ telephone_log_ID
Call Date/Time	Variable to be available for Montgomery (program_ID=15) clients. Datetime format (MM/DD/YYYY)	Crc_ call_date_time
Medical History Incomplete due to:	Variable to be available for Montgomery (program_ID=15) clients. Freeform text up to 250 characters.	Crc_medical_history_incomplete_detail
Polyp: Num <1 cm	Variable to be available for Montgomery (program_ID=15) clients.	Crc_ num_polyp_lessthan_one
Polyp: Num=1<2 cm	Variable to be available for Montgomery (program_ID=15) clients.	Crc_num_polyp_between_one_two

Screen Components— Program Defined Variables		
Label	Description	Download Field Name
Polyp: Num >=2 cm	Variable to be available for Montgomery (program_ID=15) clients.	Crc_ num_polyp_greaterthan_two
Polyp: NumLoc < 60 cm	Variable to be available for Montgomery (program_ID=15) clients.	Crc_ num_loc_lessthan_sixty
Polyp: NumLoc >= 60 cm	Variable to be available for Montgomery (program_ID=15) clients.	Crc_ num_loc_greatherthan_sixty
State_CRC_date _field_one	Variable to defined and used by statewide users as desired. (mm/dd/yyyy)	state_CRC_date_field_one
State_CRC_field _one	Variable to defined and used by statewide users as desired. (50)	state_CRC_field_one
State_CRC_field _two	Variable to defined and used by statewide users as desired. (50)	state_CRC_field_two
State_CRC_field _three	Variable to defined and used by statewide users as desired. (50)	state_CRC_field_three
State_CRC_ comment	Variable to defined and used by statewide users as desired. (150)	state_CRC_comment

CRC Procedures

Colorectal procedures are the last fields in the download set. Each procedure may appear multiple times and the column names are designated with a sequence number (denoted with an 'x' in the table below). The table below shows the download fields for CRC procedures. The table also shows the number of occurrences for each group will appear in the download set.

Procedure Type	UI Label	Download Field Name
FOBT procedures 2 occurrences	FOBT Kit Given	Crc_fobt_x_kit_given
	Date Given	Crc_fobt_x_kit_given_date
	Kit Returned	Crc_fobt_x_kit_returned
	Date FOBT Kit Returned	Crc_fobt_x_kit_returned_date
	Date Results Received by Program	Crc_fobt_x_results_date
	FOBT Kit Results	Crc_fobt_x_results
	Client Notified of Screening Results	Crc_fobt_x_client_notified
	Date Program Notified Client	Crc_fobt_x_client_notified_date
Procedures with CRC detail 5 occurrences	N/A	Crc_proc_x_name
	Date Scheduled	Crc_proc_x_sched_date
	Provider	Crc_proc_x_provider
	Not Performed in CRF Program	Crc_proc_x_not_perform_reason
	Date Performed or Date of first admission (for Hospitalization)	Crc_proc_x_perform_date
	Biopsy Done	Crc_proc_x_biopsy_done
	Adequate Exam	Crc_proc_x_adequate_exam
	Date Results Received by Program	Crc_proc_x_results_date
	Findings	Crc_proc_x_findings
	Hierarchical Procedure Result	Crc_proc_x_hier_result
	Complications of Procedure (if any)	Crc_proc_x_complications
	Client Notified of Screening Results	Crc_proc_x_client_notified
	Date Program Notified Client	Crc_proc_x_client_notified_date

Procedures w/o CRC detail 5 occurrences	N/A	Crc_proc_x_name
	Date Performed or Date of first service (for Hospice)	Crc_proc_x_perform_date
	Results	Crc_proc_x_results

Prostate Data Download

Prostate Screening Form, Page 1

Screen Components— Program Use Only		
UI Label	Description	Download Field Name
CDB ID	System generated ID representing client within system.	Client_ID
Local ID	The local program's id for this client.	Local_id
Cycle ID	Internal sequence number for the cycle.	Cycle_ID
Cycle Start (Interview) Date	Represents the start date for this cycle of screening.	cycle_start_date
Jurisdiction	Identifies the program in which this client is enrolled.	Program

Screen Components— Patient Information		
UI Label	Description	Download Field Name
Last Name (Access to Identifiers)	Last name or Sur name of client.	last_name
First Name (Access to Identifiers)	First name of client.	first_name
Date of Birth (Access to Identifiers)	Date of birth of client. This column is a character field to allow for partial data entry. Preferred format is mm/dd/yyyy	date_of_birth
SSN (Access to Identifiers)	Last four digits of patient's Social Security Number (or NONE).	last_four_of_SSN
Gender	Indicates gender (sex) of client.	gender
Ethnicity (Hispanic or Latino)	Indicates Hispanic or Latino ethnicity of client.	ethnicity
Race	Semi-colon-separated list of races of client.	race
N/A	Indicates if the client is a minority.	minority
N/A	Indicates if the client is multi-race.	Multi_race

Screen Components— History		
UI Label	Description	Download Field Name
Have you ever been screened for prostate cancer outside of this Program?		Prostate_oop_screening
Have you ever had a PSA blood test outside of this Program?		Prostate_oop_psa
Have you had a Digital Rectal Exam outside of this		Prostate_oop_dre

Screen Components— History		
UI Label	Description	Download Field Name
Program?		
Have you ever had prostate cancer?		Prostate_Self_history
Date of diagnosis:		Prostate_diagnosis_date
Has a *blood* relative of yours had prostate cancer?		prostate _Family_history
If yes, list each relative and the age at which he was diagnosed	Semi-colon-separated list of relationships	Prostate_ family_members

Prostate Screening Form, Page 2

Screen Components— Screening Findings
Prostate exam procedures are detailed in the Prostate Procedures section below (page 6).

Prostate Screening Form, Page 3

Screen Components—Program Use Only
Prostate exam procedures are detailed in the Prostate Procedures section below (page 6)

Screen Components— Initial Results and Recommendations		
UI Label	Description	Download Field Name
Risk Category	Code value indicating the initial risk assessment. Valid values: 'AVERAGE', 'INCREASED'.	Prostate_ initial_risk_assessment
PSA Result (based on guidelines)	Code value indicating PSA result. Valid values: 'NOTELEVATE', 'ELEVATED' ,'OTHER'.	Prostate_ initial_psa_assessment
Other, specify	Detail when Other listed as PSA Result.	Prostate_initial_ psa_assessment_other
Initial Impression	Code value indicating initial impression. Valid values: 'NORMAL', 'ABNORMAL', 'ABNORMEVAL'.	Prostate_ initial_impression
Recall for routine screening		Prostate_initial_rec_recall
Repeat PSA within this cycle		Prostate_ initial_rec_repeat
Date	Date to repeat PSA within this cycle (mm/dd/yyyy)	Prostate_ initial_rec_repeat_date
Refer for further evaluation to rule out cancer		Prostate_ initial_rec_further_eval
Refer for other		Prostate_initial_ rec_non_ca_referral

Screen Components— Initial Results and Recommendations		
UI Label	Description	Download Field Name
findings		

Screen Components— Notification Status
Notification status for procedures are detailed in the Prostate Procedures section below (page 6).

Prostate Post Screening Form, Page 1

Screen Components— Program Eligibility		
UI Label	Description	Download Field Name
Is client eligible for additional CRF diagnosis, treatment or case management services	Specifies client eligibility for additional services.	Prostate_eligibility_further_procedures

Screen Components— Ineligible Client		
UI Label	Description	Download Field Name
Reason for Ineligibility	Semi-colon-separated list of reasons why a client was deemed ineligible	Prostate_ineligibility_reasons
Was ineligible client referred elsewhere for diagnosis/treatment ?		Prostate_ ineligible_referral_status
Yes, referred to	Text describing referral. (100)	Prostate_ ineligible_referral_to
Ineligible Client Outcome		Prostate_ineligible_client_outcome
Final disposition of ineligible clients who contacted an HCP		Prostate_ineligible_referral_dx
Other, specify	Describes Other disposition selected. (50)	Prostate_ineligible_referral_dx_other
Cancer, specify type	Describes other Cancer selected. (50)	Prostate_ineligible_referral_cancer
Specify treatment status		Prostate_ ineligible_treatment_status
Other, specify	Describes other treatment status selected. (100)	Prostate_ineligible_treatment_status_other

Screen Components— Eligible Client

UI Label	Description	Download Field Name
Was eligible client referred for consultation and/or biopsy?		Prostate_eligible_client_referral
Referred to		Prostate_eligible_client_referred_to
Date of referral appointment	Appointment date. (mm/dd/yyyy)	Prostate_eligible_client_referred_date
No, explain	Explanation for why client was not referred. (100)	Prostate_eligible_client_not_referred

Prostate Post Screening Form, Page 2

Screen Components— Consultation, Laboratory, and/or Biopsy Results
Prostate exam procedures are detailed in the Prostate Procedures section below (page 6)

Prostate Post Screening Form, Page 3

Screen Components— Summary of Diagnostic Work-up and Treatment		
UI Label	Description	Download Field Name
Recall for routine screening		Prostate_ summary_rec_recall
Exam in __ months		Prostate_ summary_rec_repeat
_____ months	Indicates number of months until re-examination	Prostate_summary_rec_repeat_months
Date of re-exam	Captures text describing date of re-exam.	Prostate_summary_rec_repeat_date

Screen Components— Summary of Diagnostic Work-up and Treatment		
UI Label	Description	Download Field Name
Refer for consultation, further evaluation, treatment, etc.		Prostate_summary_rec_further_eval
Refer to	Selection list from which to designate Eligible provider to whom client is being referred.	Prostate_summary_rec_further_eval_provider
Date	Date of referral. (mm/dd/yyyy)	Prostate_summary_rec_further_eval_date
Other, specify	Freeform text for other recommendation. (100)	Prostate_summary_rec_other
Diagnosis Status		Prostate_summary_dx_status
Other, specify	Description when Other diagnosis status is selected.	Prostate_summary_dx_other
Other findings, not cancer, specify	Description for non-cancer findings.	Prostate_summary_dx_other_descr

Cancer, check type	Specifies type of prostate cancer diagnosed.	Prostate_final_dx_ca_type
Other type, specify	Description of other cancer type diagnosed.	Prostate_final_dx_ca_type_other
Surgery		Prostate_treatment_plan_surgery
Radiation		Prostate_treatment_plan_radiation
Hormonal Treatment		Prostate_treatment_plan_HT
Chemotherapy		Prostate_treatment_plan_chemo
Watchful Waiting		Prostate_treatment_plan_watchful
Unknown		Prostate_treatment_plan_unknown
Other, specify	Description of Other Cancer Treatment plan. (100)	Prostate_treatment_plan_other
Date first treatment began	Date of first treatment. (mm/dd/yyyy)	Prostate_treatment_date
Gleason Score on Prostatectomy		Prostate_final_gleason_score
Stage Tumor		Prostate_final_stage_tumor
Stage Nodes		Prostate_final_stage_nodes
Stage Metastases		Prostate_final_stage_metastases
Stage		Prostate_final_AJCC_stage
Treatment Status		Prostate_treatment_status
Other, specify	Description of other treatment status. (100)	Prostate_treatment_status_other
Hospitalized		Prostate_hospitalized
Hospice		Prostate_hospice

Prostate Cycle Closure

Screen Components— Cycle Closure		
UI Label	Description	Download Field Name
Date cycle closed	Date the cycle was closed. (mm/dd/yyyy)	Prostate_ cycle_close_date
Cycle Outcome	Code describing the cycle outcome. Valid values: ' CASTATUNK', 'CATREAT', 'CADETECTED', 'NOCASUSP', 'NOCADETECT','ABNORMAL'.	Prostate_cycle_closed_reason
Projected date	Projected date of recall exam. (mm/yyyy)	Prostate_recall_projected_date

Discharge Client

Screen Components— Discharge Client		
UI Label	Description	Download Field Name
Discharge Date	The date the client was discharged from the program.	Prostate_discharge_date
Reason for	Indicates why the client was discharged.	prostate_discharge_reason

Screen Components— Discharge Client		
UI Label	Description	Download Field Name
Discharge		

Prostate Program Defined Variables

Screen Components— Program Variables		
Label	Description	Lookup
Prostate_field_one	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	prostate_field_one
Prostate_field_two	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	prostate_field_two
Prostate_date_field_one	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	prostate_date_field_one
Prostate_date_field_two	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	prostate_date_field_two
Prostate_date_field_three	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	prostate_date_field_three
Sponsor	Variable to be available for Montgomery (program_ID=15) clients.	Prostate_sponsor
(Sponsor) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of 'Other' sponsor. (50)	Prostate_ sponsor_other
Date of education/intake	Variable to be available for Montgomery (program_ID=15) clients. Date field.	Prostate_date_of_education_intake
Group Education Session ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text to 10 characters.	Prostate_group_education_session_ID
Referral Date	Variable to be available for Montgomery (program_ID=15) clients. Date field.	Prostate_ referral_date

Screen Components— Program Variables		
Label	Description	Lookup
Referral Location	Variable to be available for Montgomery (program_ID=15) clients.	Prostate_ referral_location
(Referral Location) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of 'Other' referral location. (50)	Prostate_ referral_location_other
Telephone log ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text of 10 characters.	Prostate_ telephone_log_ID
Call Date/Time	Variable to be available for Montgomery (program_ID=15) clients. Date/time field format of mm/dd/yyyy	Prostate_ call_date_time
Medical History Incomplete due to:	Variable to be available for Montgomery (program_ID=15) clients. Freeform text up to 250 characters.	Prostate_medical_history_incomplete_detail
State_PROSTATE_ date_field_one	Variable to defined and used by statewide users as desired. (mm/dd/yyyy)	state_PROSTATE_date_field_one
State_PROSTATE_ field_one	Variable to defined and used by statewide users as desired. (50)	state_PROSTATE_field_one
State_PROSTATE_ field_two	Variable to defined and used by statewide users as desired. (50)	state_PROSTATE_field_two
State_PROSTATE_ field_three	Variable to defined and used by statewide users as desired. (50)	state_PROSTATE_field_three
State_PROSTATE_ comment	Variable to defined and used by statewide users as desired. (150)	state_PROSTATE_comment

Prostate Procedures

Prostate procedures are the last fields in the download set. Each procedure may appear multiple times and the column names are designated with a sequence number (denoted with an 'x' in the table below). The table below shows the download fields for Prostate procedures. The table also shows the number of occurrences for each group will appear in the download set.

Procedure Type	UI Label	Download Field Name
Prostate screening exams 1 occurrences	N/A	Prostate_exam_x_name
	Date Drawn	Prostate_exam_x_perform_date
	Screening Location	Prostate_exam_x_location
	PSA	Prostate_exam_x_psa_drawn
	Date Results Received by Program	Prostate_exam_x_psa_results_date
	PSA Results	Prostate_exam_x_psa_results
	DRE Results	Prostate_exam_x_dre_results
	DRE Findings	Prostate_exam_x_dre_findings
	Client Notified of Screening Results	Prostate_exam_x_client_notified
	Date Program Notified Client	Prostate_exam_x_ client_notified_date
Prostate procedures 10 occurrences	N/A	Prostate_proc_x_name
	Date or Date of first admission (Hospitalization) or Date of first service (Hospice)	Prostate_proc_x_perform_date

	Date Results Received by Program	Prostate_proc_x_results_date
	Results	Prostate_proc_x_results
TRUS-Guided Biopsy 2 occurrences	TRUS-Guided biopsy Date	Prostate_trus_guided_ x_perform_date
	Date program received results of the test.	Prostate_trus_guided_ x_results_date
	Possible result categories of TRUS-Guided Biopsy	Prostate_trus_guided_x_results
	If cancer, Gleason Score at time of biopsy	Prostate_trus_guided_x_gleason
	If cancer, clinical stage at time of biopsy	Prostate_trus_guided_x_stage

Oral Data Download

Oral Screening Form, Page 1

Screen Components— Program Use Only Section		
UI Label	Description	Download Field Name
CDB ID	System generated ID representing client within system.	client_ID
Local ID	The local program's id for this client.	Local_id
Cycle ID	Internal sequence number for the cycle.	cycle_id
Cycle Start (Interview) Date	Represents the start date for this cycle of screening.	cycle_start_date
Jurisdiction	Identifies the program in which this client is enrolled.	Program

Screen Components— Patient Information		
UI Label	Description	Download Field Name
Last Name (Access to Identifiers)	Last name or Sur name of client.	last_name
First Name (Access to Identifiers)	First name of client.	first_name
Date of Birth (Access to Identifiers)	Date of birth of client. This column is a character field to allow for partial data entry. Preferred format is mm/dd/yyyy	date_of_birth
SSN (Access to Identifiers)	Last four digits of patient's Social Security Number (or NONE).	Last_four_of_SSN
Gender	Indicates gender (sex) of client.	gender
Ethnicity (Hispanic or Latino)	Indicates Hispanic or Latino ethnicity of client.	ethnicity
Race	Semi-colon-separated list of races of client.	race
N/A	Indicates if the client is a minority.	Minority
N/A	Indicates if the client is multi-racial.	Multi_race

Screen Components— History		
UI Label	Description	Download Field Name
Have you ever had a dentist or doctor do an oral cancer outside of this program?		Oral_ oop_screening
Yes, date of most recent screening	Preferred entry format is mm/dd/yyyy, however character entry is permitted.	Oral_oop_screening_date
Have you ever had oral cancer in the past?		Oral_Self_history
Yes, date of diagnosis:	Preferred entry format is mm/dd/yyyy, however character entry is permitted.	Oral_Self_history_date
Do you drink alcohol, including beer, wine, or distilled spirits?		Oral_ drink_alcohol
Yes, On average, how many days a week do you drink		Oral_ alcohol_per_week

Screen Components— History		
UI Label	Description	Download Field Name
alcohol?		
Yes, On average, how many drinks do you have on a day when you drink?		Oral_alcohol_each_time
A sore or lump or your lip or in your mouth that does not heal		Oral_symptom_sore
A white or red patch on your gums, tongue, or lining of your mouth		Oral_symptom_patch
Unusual bleeding, pain, or numbness in your mouth		Oral_symptom_pain
Problems or pain when chewing or swallowing		Oral_symptom_chew
A change in your voice (hoarseness)		Oral_symptom_voice
Other, describe		Oral_symptom_other

Oral Screening Form, Page 2

Screen Components— Screen Findings		
UI Label	Description	Download Name
Were any brush biopsies taken?	Designates if brush biopsies were taken at oral screening exam.	Oral_brush_biopsy
Brush biopsy procedures are detailed in the Oral Procedures section below (page 6).		

Screen Components— Initial Results and Recommendations		
UI Label	Description	Download Field Name
Initial Impression	Code value indicating initial impression. Valid values: 'NORMAL', 'ABNORMNOCA', 'ABNORMEVAL'.	Oral_initial_screen_impression
Recall for routine screening		Oral_ initial_rec_recall
Refer for other findings		Oral_ initial_rec_non_ca_referral
Refer for further evaluation to rule out cancer		Oral_ initial_rec_further_eval
If lesion does not resolve in 2-4 weeks, see dentist or call		Oral_ initial_rec_4week_dent
Await results of brush biopsy (biopsies)		Oral_initial_rec_bx_wait

Oral Screening Form, Page 3

Screen Components— Brush Biopsy Results
Brush biopsy procedures are detailed in the Oral Procedures section below (page 6).

Screen Components— Screening Results and Recommendations		
UI Label	Description	Download Field Name
Screening	Impression based on all screening findings.	Oral_ screening_impression

Screen Components— Screening Results and Recommendations		
UI Label	Description	Download Field Name
Impression		

Screen Components— Screening Results and Recommendations		
UI Label	Description	Download Field Name
Recall for routine screening		Oral_screening_rec_recall
Repeat exam in ___ months		Oral_screening_rec_repeat
(Repeat exam in) ___ months	Number of months to wait until exam is repeated.	Oral_screening_rec_repeat_months
Refer for other findings		Oral_screening_rec_non_ca_referral
Refer for further evaluation to rule out cancer		Oral_screening_rec_further_eval

Screen Components— Notification Status		
UI Label	Description	Download Field Name
Notification status for biopsy procedures are detailed in the Oral Procedures section below (page 6).		

Oral Post Screening Form, Page 1

Screen Components— Program Eligibility		
UI Label	Description	Download Field Name
Is client eligible for additional CRF diagnosis, treatment or case management services	Specifies client eligibility for additional services.	Oral_ eligibility_further_procedures

Screen Components— Ineligible Client		
UI Label	Description	Download Field Name
Reason for Ineligibility	Semi-colon-separates list of reasons why a client was deemed ineligible.	Oral_ ineligibility_reasons
Was ineligible client referred elsewhere for diagnosis/treatment?		Oral_ ineligible_referral_status
Yes, referred to	Text describing referral. (100)	Oral_ ineligible_refer_to
Ineligible Client Outcome		Oral_ ineligible_client_outcome
Final disposition of ineligible clients who contacted an HCP		Oral_ ineligible_final_disposition
Other, specify	Describes Other disposition selected. (50)	Oral_ ineligible_final_disposition_other

Screen Components— Ineligible Client		
UI Label	Description	Download Field Name
Cancer, specify type	Describes type of Cancer. (50)	Oral_ineligible_final_disposition_cancer_type
Specify treatment status		Oral_ ineligible_treatment_status

Screen Components—Eligible Client		
UI Label	Description	Download Field Name
Was eligible client referred for consultation and/or biopsy?		Oral_ eligible_client_referral

Oral Post Screening Form, Page 2

Screen Components— Consultation, Laboratory, and/or Biopsy Results		
UI Label	Description	Download Field Name
Brush biopsy and consultation procedures are detailed in the Oral Procedures section below (page 6).		
Diagnostic Impression	Impression based on diagnostic procedures performed. (250)	Oral_incisional_biopsy_diagnostic_impression

Screen Components— Summary of Diagnostic Work-up and Treatment		
UI Label	Description	Download Field Name
Recall for routine screening		Oral_ summary_rec_recall
Exam in __ months		Oral_. Summary_rec_repeat
_____ months	Indicates number of months until re-examination.	Oral_ summary_rec_repeat_months
Refer for consultation, further evaluation, treatment, etc.		Oral_ summary_rec_further_eval
Refer to	Selection list from which to designate Eligible provider to whom client is being referred.	Oral_ summary_rec_ further_eval_refer
Other, specify	Freeform text for other recommendation. (100)	Oral_ summary_rec_other
Diagnosis Status		Oral_ summary_dx_status
Other, specify	Description when Other diagnosis status is selected.	Oral_ summary_dx_other

Oral Post Screening Form, Page 3

Screen Components— Summary of Diagnostic Work-up and Treatment		
UI Label	Description	Download Field Name
Final Diagnosis		Oral_ final_dx
Other diagnosis, not cancer, specify	Description for non-cancer findings	Oral_ final_dx_other
Cancer, or Carcinoma in situ, specify type	Specifies type of Oral cancer diagnosed.	Oral_ final_dx_ca_type
Other, specify	Description of other cancer diagnosed.	Oral_ final_dx_ca_other

Screen Components— Summary of Diagnostic Work-up and Treatment		
UI Label	Description	Download Field Name
Floor of mouth		Oral_ ca_loc_floor
Tongue		Oral_ ca_loc_tongue
Hard Palate		Oral_ ca_loc_palate
Base of tongue		Oral_ ca_loc_base
Salivary gland		Oral_ ca_loc_salivary
(Salivary gland, specify) Parotid		Oral_ ca_loc_parotid
(Salivary gland, specify) Submandibular		Oral_ ca_loc_submandibular
(Salivary gland, specify) Sublingual		Oral_ ca_loc_sublingual
(Salivary gland, specify) Minor		Oral_ ca_loc_minor
Other		Oral_ ca_loc_other
(Other,) specify	Description of Other Cancer location (50)	Oral_ ca_loc_other_descr
Is cancer treatment recommended		Oral_ ca_tx_rec
Cancer Treatement Type/Comments	Description of Cancer treatment (250)	Oral_ treatment_comments
Date first treatment began	Date of first treatment as mm/dd/yyyy	Oral_ treatment_date
Stage Tumor		Oral_ post_dx_tumor_stage
Stage Nodes		Oral_ post_dx_nodes
Stage Metastases		Oral_ post_dx_metastases
Stage		Oral_ post_dx_ca_stage
Treatment Status		Oral_ treatment_status
Other, specify	Description of other treatment status (100)	Oral_ treatment_status_other
Hospitalized		Oral_ hospitalized
Rehab		Oral_rehab
Hospice		Oral_hospice

Oral Cycle Closure

Screen Components— Cycle Closure		
UI Label	Description	Download Field Name
Date cycle closed	Date the cycle was closed. (mm/dd/yyyy)	Oral_ cycle_close_date
Cycle Outcome	Code describing the cycle outcome. Valid values: ‘ CASTATUNK’, ‘CATREAT’, ‘CADETECTED’, ‘NOCASUSP’, ‘NOCADETECT’,’ABNORMAL’.	Oral_ cycle_closed_reason
Projected date	Projected date of recall exam. (mm/yyyy)	Oral_recall_projected_date

Discharge Client

Screen Components— Discharge Client		
UI Label	Description	Download Field Name
Discharge Date	The date the client was discharged from the program.	Oral_discharge_date
Reason for Discharge	Indicates why the client was discharged.	Oral_discharge_reason

Oral Program Defined Variables

Screen Components— Program Defined Variables		
Label	Description	Lookup
Oral_field_one	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Oral_field_one
Oral_field_two	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Oral_ field_two
Oral_date_field_one	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Oral_date_field_one
Oral_date_field_two	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Oral_date_field_two
Oral_date_field_three	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Oral_date_field_three
Sponsor	Variable to be available for Montgomery (program_ID=15) clients.	Oral_ sponsor
(Sponsor) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of ‘Other’ sponsor. (50)	Oral_ sponsor_other
Date of education/intake	Variable to be available for Montgomery (program_ID=15) clients. (mm/dd/yyy)	Oral_date_of_education_intake
Group Education Session ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text to 10 characters.	Oral_group_education_session_ID
Referral Date	Variable to be available for Montgomery (program_ID=15) clients. (mm/dd/yyy)	Oral_ referral_date
Referral Location	Variable to be available for Montgomery (program_ID=15) clients.	Oral_ referral_location
(Referral Location) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of ‘Other’ referral location. (50)	Oral_ referral_location_other
Telephone log ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text of 10 characters.	Oral_ telephone_log_ID
Call Date/Time	Variable to be available for Montgomery (program_ID=15) clients. Datetime format =	Oral_ call_date_time

Screen Components— Program Defined Variables		
Label	Description	Lookup
	mm/dd/yyyy	
Medical History Incomplete due to:	Variable to be available for Montgomery (program_ID=15) clients. Freeform text up to 250 characters.	Oral_medical_history_incomplete_detail
State_ORAL_date_field_one	Variable to defined and used by statewide users as desired. (mm/dd/yyyy)	state_ORAL_date_field_one
State_ORAL_field_one	Variable to defined and used by statewide users as desired. (50)	state_ORAL_field_one
State_ORAL_field_two	Variable to defined and used by statewide users as desired. (50)	state_ORAL_field_two
State_ORAL_field_three	Variable to defined and used by statewide users as desired. (50)	state_ORAL_field_three
State_ORAL_ comment	Variable to defined and used by statewide users as desired. (150)	state_ORAL_comment

Oral Procedures

Oral procedures are the last fields in the download set. Each procedure may appear multiple times and the column names are designated with a sequence number (denoted with an ‘x’ in the table below). The table below shows the download fields for Oral procedures. The table also shows the number of occurrences for each group will appear in the download set.

Procedure Type	UI Label	Download Field Name
Biopsies 10 occurrences	N/A	Oral_biopsy_x_type
	Date	Oral_biopsy_x_perform_date
	Date Results Received	Oral_biopsy_x_results_date
	Anatomic Location	Oral_biopsy_x_location
	Result	Oral_biopsy_x_result
	Client Notified of Screening Results	Oral_ biopsy _x_client_notified
	Date Client Notified of Screening Results	Oral_biopsy_x_client_notified_date
Oral Procedures 5 occurrences	N/A	Oral_proc_x_name
	Date Performed or Date of first admission (for Hospitalization) Date of first service (for Hospice, Rehab)	Oral_proc_x_perform_date
	Date Results Received by Program	Oral_proc_x_results_date
	Results	Oral_proc_x_results

Skin Data Download

Skin Screening Form, Page 1

Screen Components— Program Use Only Section		
UI Label	Description	Download Field Name
CDB ID	System generated ID representing client within system.	Client_ID
Local ID	The local program's id for this client.	Local_id
Cycle ID	The internal sequence number for the cycle.	Cycle_id
Cycle Start (Interview) Date	Represents the start date for this cycle of screening.	cycle_start_date
Jurisdiction	Identifies the program in which this client is enrolled.	program

Screen Components— Patient Information		
UI Label	Description	Download Field Name
Last Name (Access to Identifiers)	Last name or Sur name of client.	last_name
First Name (Access to Identifiers)	First name of client.	first_name
Date of Birth (Access to Identifiers)	Date of birth of client. This column is a character field to allow for partial data entry. Preferred format is mm/dd/yyyy	date_of_birth
SSN (Access to Identifiers)	Last four digits of patient's Social Security Number (or NONE).	last_four_of_SSN
Gender	Indicates gender (sex) of client.	gender
Ethnicity (Hispanic or Latino)	Indicates Hispanic or Latino ethnicity of client.	ethnicity
Race	Semi-colon-separated list of races of client.	race
N/A	Indicates if the client is a minority.	minority
N/A	Indicates if the client is multi-race.	Multi_race

Screen Components— History		
UI Label	Description	Download Field Name
Have you ever had a doctor or dermatologist do a skin cancer screening outside of this program?		Skin_ oop_screening
Have you ever had skin cancer in the past?		Skin_self_history
Specify type	Description of other skin cancer indicated. (100)	Skin_self_history_type
Do you have a family history of melanoma skin cancer?	Indicates a client family member was diagnosed with melanoma.	Skin_family_history
Relationship	Semi-colon-separated list of family member(s) diagnosed with melanoma	Skin_family_members
Symptoms: Mole(s) that is/are irregular in		skin_irreg_mole

Screen Components— History		
UI Label	Description	Download Field Name
shape or that has jagged borders		
Symptoms: Change in a mole or skin growth		skin_mole_change
Symptoms: Mole larger than 1/4 inch diameter (6mm, diameter of a pencil eraser)		skin_large_mole
Symptoms: Mole with different shades of color		skin_shaded_mole
Symptoms: Sore that does not heal		skin_sore_not_healing
Risk Factors: Do you have a large number of moles and/or freckles?		skin_many_moles
Risk Factors: Do you have fair to light skin?		skin_fair_skin
Risk Factors: Does your skin always burn or burn easily?		skin_sunburn_easily
Risk Factors: Did you have a severe, blistering sunburn before the age of 20?		skin_sunburn_early_age
Risk Factors: Do you wear protective clothing or sunscreen when outdoors?		skin_use_sunscreen
Risk Factors: Do you use, or have you ever used, a tanning booth/bed?		skin_use_tanning_booth

Skin Screening Form, Page 2

Screen Components— Initial Results and Recommendations		
UI Label	Description	Download Field Name
Initial Impression	Code value indicating initial impression. Valid values: 'NORMAL', 'ABNOTSUG', 'ABFURTHEV'.	Skin_ initial_exam_impression
Differential Diagnosis	Description of diagnosis for abnormal findings. (150)	Skin_ initial_exam_diff_diag
Recall for routine screening		Skin_ initial_rec_recall
Refer for other findings		Skin_ initial_rec_non_ca_referral
Refer to	Text describing referral (50)	Skin_initial_rec_non_ca_refer_to
Refer for further evaluation to rule out cancer		Skin_ initial_rec_further_eval
Other, specify	Any other recommendation not previously listed. (100)	Skin_ initial_rec_other
Date	Date of repeat exam. (mm/dd/yyyy)	Skin_ initial_rec_repeat_date

Skin Screening Form, Page 3

Screen Components— Exam Call-back		
UI Label	Description	Download Field Name
If initial recommendation at screening was "Repeat exam", was client seen?	Based on recommendation, indicates client was seen.	Skin_ interim_contact
Date	If client was re-examined, indicates date	Skin_ interim_contact_date
Findings	Describes findings of repeat exam.	Skin_ interim_contact_findings
Screening Impression	Impression based on all screening findings.	Skin_ screening_impression
Recall for routine screening		Skin_ screening_rec_recall
Refer for other findings		Skin_screening_rec_non_ca_referral
Refer to	Text describing referral (150)	Skin_screening_rec_non_ca_referral_descr
Refer for further evaluation to rule out cancer		Skin_ screening_rec_further_eval
Other, specify	Any other recommendation not previously listed. (100)	Skin_ screening_rec_other

Screen Components— Notification Status		
UI Label	Description	Download Field Name
Notification status for skin procedures are detailed in the Skin Procedures section below (page 6).		

Skin Post Screening Form, Page 1

Screen Components— Program Eligibility		
UI Label	Description	Download Field Name
Is client eligible for additional CRF diagnosis, treatment or case management services	Specifies client eligibility for additional services.	Skin_ eligibility_further_procedures

Screen Components— Ineligible Client		
UI Label	Description	Download Field Name
Reason for Ineligibility	Semi-colon-separates list of reasons why a client was deemed ineligible.	Skin_ ineligibility_reasons
Was ineligible client referred elsewhere for diagnosis/treatment?		Skin_ ineligible_referral_status

Screen Components— Ineligible Client		
UI Label	Description	Download Field Name
Yes, referred to	Text describing referral. (100)	Skin_ ineligible_refer_to
Ineligible Client Outcome		Skin_ ineligible_client_outcome
Final disposition of ineligible clients who contacted an HCP		Skin_ ineligible_referral_dx
Other, specify	Describes Other disposition selected. (50)	Skin_ ineligible_referral_dx_other
(Cancer) Squamous Cell		Skin_ ineligible_dx_ca_squamous
(Cancer) Basal Cell		Skin_ ineligible_dx_ca_basal
(Cancer) Melanoma		Skin_ ineligible_dx_ca_melanoma
(Cancer) Other		Skin_ ineligible_dx_ca_other
(Cancer Other) specify	Describes type of Cancer. (50)	Skin_ ineligible_dx_ca_other_descr
Specify treatment status		Skin_ ineligible_treatment_status
Other, specify	Describes other treatment status selected. (100)	Skin_ineligible_treatment_status_other

Screen Components— Eligible Client		
UI Label	Description	Download Field Name
Was eligible client referred for consultation and/or biopsy?		Skin_ eligible_client_referral
Referred to		Skin_ eligible_client_referred_to

Skin Post Screening Form, Page 2-3

Screen Components— Consultation and/or Biopsy Results		
UI Label	Description	Download Field Name
Biopsy and other skin procedures are detailed in the Skin Procedures section below (page 6).		

Screen Components— Summary of Diagnostic Work-up and Treatment		
UI Label	Description	Download Field Name
Recall for routine screening		Skin_ summary_rec_recall
Exam in __ months		Skin_ summary_rec_repeat
Refer for consultation, further evaluation, treatment, etc.		Skin_ summary_rec_further_eval
Refer to	Selection list from which to designate Eligible provider to whom client is being referred.	Skin_ summary_rec_ further_eval_refer
Other, specify	Freeform text for other recommendation. (100)	Skin_ summary_rec_other
Diagnosis Status		Skin_ final_diagnosis_status
Other, specify	Description when Other diagnosis status is selected.	Skin_ final_diagnosis_ status_other
Final Diagnosis		Skin_ final_dx
Other diagnosis, not cancer, specify	Description for non-cancer findings	Skin_ final_dx_other_descr
Melanoma	Diagnosis of melanoma.	Skin_ final_dx_ca_melanoma
Squamous Cell	Diagnosis of Squamous Cell.	Skin_ final_dx_ca_squamous

Screen Components— Summary of Diagnostic Work-up and Treatment		
UI Label	Description	Download Field Name
Basal Cell	Diagnosis of Basal Cell.	Skin_ final_dx_ca_basal
Other	Diagnosis of Other skin cancer.	Skin_ final_dx_ca_other
(Other) specify	Description of other cancer diagnosed. (50)	Skin_ final_dx_ca_other_descr
(Melanoma Staging) Clark's Level		Skin_ final_dx_clarks_level
(Melanoma Staging) Breslow thickness (in mm)		Skin_ final_dx_breslow
Is cancer treatment recommended		Skin_ ca_tx_rec
Cancer Treatment Type/Comments	Description of Cancer treatment (250)	Skin_ treatment_comments
Date first treatment began	Date of first treatment as mm/dd/yyyy	Skin_ treatment_date
Treatment Status		Skin_ treatment_status
Other, specify	Description of other treatment status (100)	Skin_ treatment_status_other
Hospitalized		Skin_ hospitalized
Hospice		Skin_ hospice

Cycle Closure

Screen Components— Cycle Closure		
UI Label	Description	Download Field Name
Date cycle closed	Date the cycle was closed. (mm/dd/yyyy)	Skin_ cycle_close_date
Cycle Outcome	Code describing the cycle outcome. Valid values: ' CASTATUNK', 'CATREAT', 'CADETECTED', 'NOCASUSP', 'NOCADETECT','ABNORMAL'.	Skin_ cycle_closed_reason
Final Hierarchical Diagnosis	System generated final diagnosis based on data entered.	Skin_final_hier_dx
Projected date	Projected date of recall exam. (mm/yyyy)	Skin_recall_projected_date

Discharge Client

Screen Components— Discharge Client		
UI Label	Description	Download Field Name
Discharge Date	The date the client was discharged from the program.	Skin_discharge_date
Reason for Discharge	Indicates why the client was discharged.	skin_discharge_reason

Skin Program Defined Variables

Screen Components— Program Defined Variables		
Label	Description	Lookup
skin_field_one	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Skin_field_one
skin_field_two	Variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Skin_field_two
skin_date_field_ one	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Skin_date_field_one
skin_date_field_t wo	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Skin_date_field_two
skin_date_field_t hree	Date variable to be defined and used by each program as desired. Description of the field (label) can be changed for each program by the System Administrator.	Skin_date_field_three
Sponsor	Variable to be available for Montgomery (program_ID=15) clients.	Skin_ sponsor
(Sponsor) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of 'Other' sponsor. (50)	Skin_sponsor_other
Date of education/intake	Variable to be available for Montgomery (program_ID=15) clients. (mm/dd/yyy)	Skin_date_of_education_intake
Group Education Session ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text to 10 characters.	Skin_group_education_session_ID
Referral Date	Variable to be available for Montgomery (program_ID=15) clients. (mm/dd/yyy)	Skin_referral_date
Referral Location	Variable to be available for Montgomery (program_ID=15) clients.	Skin_referral_location
(Referral Location) Other, specify	Variable to be available for Montgomery (program_ID=15) clients. Description of 'Other' referral location. (50)	Skin_referral_location_other
Telephone log ID	Variable to be available for Montgomery (program_ID=15) clients. Freeform text of 10 characters.	Skin_telephone_log_ID
Call Date/Time	Variable to be available for Montgomery (program_ID=15) clients. Datetime format = mm/dd/yyyy	Skin_call_date_time
Medical History Incomplete due to:	Variable to be available for Montgomery (program_ID=15) clients. Freeform text up to 250 characters.	Skin_medical_history_incomplete_detai l
State_SKIN_date _field_one	Variable to defined and used by statewide users as desired. (mm/dd/yyyy)	state_SKIN_date_field_one
State_SKIN_field _one	Variable to defined and used by statewide users as desired. (50)	state_SKIN_field_one
State_SKIN_field _two	Variable to defined and used by statewide users as desired. (50)	state_SKIN_field_two

Screen Components— Program Defined Variables		
Label	Description	Lookup
State_SKIN_field _three	Variable to defined and used by statewide users as desired. (50)	state_SKIN_field_three
State_SKIN_ comment	Variable to defined and used by statewide users as desired. (150)	state_SKIN_comment

Skin Procedures

Skin procedures are the last fields in the download set. Each procedure may appear multiple times and the column names are designated with a sequence number (denoted with an 'x' in the table below). The table below shows the download fields for Skin procedures. The table also shows the number of occurrences for each group will appear in the download set.

Procedure Type	UI Label	Download Field Name
Biopsies 10 occurrences	Date	Skin_biopsy_x_perform_date
	Date Results Received	Skin _biopsy_x_results_date
	Anatomic Location	Skin _biopsy_x_location
	Result	Skin _biopsy_x_result
	Client Notified of Screening Results	Skin _boipsy_x _client_notified
	Client Notified of Screening Results	Skin _biopsy_x_ client_notified_date
Skin Procedures 5 occurrences	N/A	Skin_proc_x_name
	Date Performed or Date of first admission (for Hospitalization) Date of first service (for Hospice, Rehab)	Skin_proc_x_perform_date
	Date Results Received by Program	Skin_proc_x_results_date
	Results	Skin_proc_x_results

HC Provider Download

Health Care Providers			
UI Label	Description	Download Field Name	Source
Program	Program to which this provider belongs.	program	Health_care_provider.progra m_id
Provider_ID	System-generated unique key for provider.	provider_id	
Provider Type	Type of Provider.	provider_type	Health_care_provider.provid er_type
Specialty	Defines the Specialty of the Provider.	specialty	Health_care_provider.special ty
Practice Name	Name of the Practice. (if the Provider Type is Practice)	practice_name	Health_care_provider.organi zation_name
Individual First Name	First Name of the Provider. (if Provider Type is Individual)	provider_first_name	Health_care_provider.individ ual_first_name
Individual Last Name	Last Name of the Provider. (if Provider Type is Individual)	provider_last_name	Health_care_provider.individ ual_last_name

Health Care Providers			
UI Label	Description	Download Field Name	Source
Individual Degree	Degree level that the Provider Holds. (if the Provider Type is Individual)	provider_degree	Health_care_provider.individual_degree
Telephone	Phone Number.	phone_nbr	Health_care_provider.phone
Back Office Phone	Back Office Phone Number.	back_office_phone	Health_care_provider.back_office_phone
Email Address	Email Address.	email_address	Health_care_provider.e_mail_address
Fax	Fax Number.	fax_phone	Health_care_provider.fax_phone
Geographic Address			
Street Number	Geographic Street Number.	geo_addr_street_nbr	Health_care_provider.geographic_street_number
Street	Geographic Street.	geo_addr_street	Health_care_provider.geographic_street
Office or Suite #	Geographic Office or Suite Number.	geo_addr_office_or_suite_nbr	Health_care_provider.geographic_office_or_suite_number
Other Info	Geographic Other Info.	geo_addr_other_info	Health_care_provider.geographic_address_other_info
City	Geographic City.	geo_addr_city	Health_care_provider.geographic_city
State	Geographic State.	geo_addr_state	Health_care_provider.geographic_state
Zipcode	Geographic Zip Code. (Postal Code)	geo_addr_zip	Health_care_provider.geographic_zip
Mailing Address			
Street Number	Mailing Street Number.	mailing_addr_street_nbr	Health_care_provider.mailing_street_number
Street/PO Box	Mailing Street.	mailing_addr_street	Health_care_provider.mailing_street
Office or Suite #	Mailing Office or Suite Number.	mailing_addr_office_or_suite_nbr	Health_care_provider.mailing_office_or_suite_number
Other Info	Mailing Other Info.	mailing_addr_other_info	Health_care_provider.mailing_address_other_info
City	Mailing City.	mailing_addr_city	Health_care_provider.mailing_city
State	Mailing State.	mailing_addr_state	Health_care_provider.mailing_state
Zipcode	Mailing Zip Code. (Postal Code)	mailing_addr_zip	Health_care_provider.mailing_zip
Office Contact's Name	Name of Contact Person.	office_contact_name	Health_care_provider.contact_name
Office Contact's Title	Title of Contact Person.	office_contact_title	Health_care_provider.contact_title
State Medical License Number	(15)	state_med_license_nbr	Health_care_provider.state_license_number
State Medical License	(MM/DD/YYYY)	state_med_license_expiration_date	Health_care_provider.license_expiration_date

Health Care Providers			
UI Label	Description	Download Field Name	Source
Expiration Date			
Federal ID Number	(15)	federal_id_nbr	Health_care_provider.federal_id_number
Malpractice Insurance Expiration Date	(MM/DD/YYYY)	malpractice_expiration_date	Health_care_provider.malpractice_expiration_date
Status of Provider	Status of this Provider within the CRFP.	provider_status	Health_care_provider.provider_status

Associated Health Care Providers (Individuals/Practices)

An individual provider may be associated with one or more practices and a practice may be associated with one or more individual providers. The table below shows the download fields for each HCP associated with the provider in the download record. The table also shows the number of associated HCP occurrences which can be included in a download record.

Associated Health Care Providers			
	UI Label	Download Field Name	Source
Associated Provider or Practice 15 occurrences	ID of Individual or Practice associated to the Provider specified.	Assoc__HCP_X	Provider_practice.individual_id OR Provider_practice.practice_id
	Provider Type	Assoc__HCP_X_provider_type	Health_care_provider.provider_type
	Specialty	Assoc__HCP_X_specialty	Health_care_provider.specialty
	Practice Name	Assoc__HCP_X_practice_name	Health_care_provider.organization_name
	Individual First Name	Assoc__HCP_X_first_name	Health_care_provider.individual_first_name
	Individual Last Name	Assoc__HCP_X_last_name	Health_care_provider.individual_last_name

Health Care Provider Contracts

An individual provider may be associated with one or more contracts. The table below shows the download fields for each contract associated with the provider in the download record. The table also shows the number of contract occurrences which can be included in a download record. When more than 15 contracts exist for the HCP the most recent (highest contract end date) contracts will be included. The contracts will be descending by contract end date.

Provider Contracts			
	UI Label	Download Field Name	Source
HCP Contracts	**Contract ID**	contract_ID_x	health_care_provider_contracts.contract_id

Provider Contracts			
	UI Label	Download Field Name	Source
15 occurrences	Contract Number	contract_nbr_x	health_care_provider_contracts. contract_number
	Contract Year	contract_year_x	health_care_provider_contracts. contract_year
	Contract Begin Date	contract_begin_date_x	health_care_provider_contracts. contract_begin_date
	Contract End Date	contract_end_date_x	health_care_provider_contracts. contract_end_date
	Contract Amount	contract_amount_x	health_care_provider_contracts. contract_amount
	Comments	contract_comments_x	health_care_provider_contracts. contract_comment

Appendix J: Report Information

Appendix J contains additional descriptions of the CPEST CDB Reports.

Appendix J is kept as a series of separate files and is **not** part of the User Guide Document.

See "Help?" within the CDB for copies of Appendix J files.

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