Research Data Warehouse (RDW) Data Dictionary

TABLE_NAME	COLUMN_NAME
ALLERGY	The RCR_CONDITION table contains the procedure and diagnosis codes provide by the SAS RCR Query as of June 14, 2018
ALLERGY_REACTION	The ALLERGY_REACTION table contains the reactions to allergies noted for patients.
CPT_PROCEDURE	The Current Procedural Terminology procedure table contains one row for each CPT™ procedure associatd with the hospital account.
DHEC_DATA	Result of matching patient from HSSC that contain the DHEC death date for MUSC patients
DIAGNOSIS	The diagnosis table contains one row for each billing diagnosis associatd with the hospital account.
DIAGNOSIS_INFO	The DIAGNOSIS_INFO table lists all diagnoses for all patients. It looks at encounters, the problem list, professional and hospital claims, the hospital account, the hospital admission diagnosis list, surgical cases, medical history, and referrals to collect the diagnoses. It stores how many times a diagnosis was recorded for a particular patient from a particular source and also the first and the last date it was recorded from any source.
ED_DETAIL	The ED_DETAIL table contains commonly used information for ED encounters. Each emergency department encounter has a single row in this table. Encounters that are pending or cancelled are not included in this table. Source is Clarity F_ED_ENCOUNTERS table. Use this table to track ED visits that become inpatient or observation visits.
FAMILY_HX	The FAMILY_HX table contains data recorded in the family history contacts entered in the patient's chart during an clinical system encounter. Note: This table is designed to hold a patient's history over time; however, it is most typically implemented to only extract the latest patient history contact.
HNO_NOTE	This table contains the Clinical notes as a single large text field. Join to HNO_NOTE_INFO for the metadata about the notes.
HNO_NOTE_INFO	This table contains the metatdata regarding a note. Join to HNO_NOTE for the actual note.
HOSPITAL_BILLING	Hospital Billing by hospital account based on HSP_TRANSACTIONS and V_ARHB_COLLECTION_RATIO. Amount values can be different that in RDM.ACCOUNT
HSP_TRANSACTION	HSP_TRANSACTION contains hospital account transaction charge details from the HTR master file. Includes CPT, HCPCS and/or custom procedure codes.

ICU_LOCATION	The ICU_LOCATION table stores information about when a patient was physically in the ICU using both the standard and Apache ICU stay definitions. Each row represents a period of time that a patient was physically in a department identified as an ICU.
IMMUNIZATION	The IMMUNIZATION table contains contains immunizations administered through clinical system, imported, or reported by patient, but not ordered/administered via clinical system.
LAB_RESULT	This table contains information on orders and results for Labs, Micro, and Point of Care
MEDICAL_HX	The MEDICAL_HX table contains data from medical history contacts entered in clinical system patient encounters. Since one patient encounter may contain multiple medical history contacts, each contact is uniquely identified by a patient encounter serial number and a line number.
MED_ADMIN	This table contains information on medication administration.
MED_AVS	The MED_AVS table contains the list of medications in the after visit summary (AVS) where the ordering date coincides with the encounter date range for RDW
MED_CURRENT	The MED_CURRENT table is a list of a patient's current medications from the last time a user reviewed the patient's medications. Refreshed monthly.
MED_DISPENSE	This table contains information about the dispensed medications for orders.
MED_ORDER	This table contains information on medication orders.
NOTE	This table contains the impression or narrative as a single large text field. Join to ORDERS for the metadata about the notes.
NOTE_RSLT	This table contains the extended result comments or full report as a single large text field. Join to ORDERS or LAB_RESULT for the metadata about the notes.
OBSERVATION	The observations table contains the measured values for specific groups of observations including vitals and smoking details.
OB_DELIVERY_RECORD	The OB_DELIVERY_RECORD table contains information relevant to a baby's delivery record on one row.
ORDERS	This table contains information on orders excluding Labs, Micro, and Point of Care
ORDER_RESULT	This table contains information on results from clinical system orders excluding Labs, Micro, and Point of Care.
ORDER_SUMMARY	The ORDER_SUMMARY contains the summary for a dialysis order that has been signed
PATIENT	The PATIENT table contains one record for each patient and consists of demographics,registration information, and other information.

PHENOTYPE	The PHENOTYPE table is updated monthly and contains indicators if chronic conditions exist for a patient. Secondly, the table contains the calculated Charlson Index
PNEG_MEDICAL_HX	The PNEG_MEDICAL_HX table contains data from pertinent negative medical history contacts entered in clinical system patient encounters. Since one patient encounter may contain multiple medical history contacts, each contact is uniquely identified by a patient encounter serial number and a line number.
PNEG_SURGICAL_HX	The PNEG_SURG_HX table contains pertinent negative surgical history data from history contacts entered in clinical system patient encounters. Since one patient encounter may contain multiple surgical history contacts, each contact is uniquely identified by a patient encounter serial number and a line number.
PROBLEM_LIST	The PROBLEM_LIST table contains data from patients problem lists in the clinical system.
PROCEDURE	The procedure table contains one row for each procedure associatd with the hospital account.
PROFESSIONAL_BILLING	Professional Billing from Transactionsl Detail Summary information for the cases where there are payments matched to charges
QSTN_ANS	The QSTN_ANS table contains the questions and answers for questionnaire answer records. Table is update monthly with answered questions. Test patient and erroneous encounter answers are not excluded. Join to the metadata table QSTN_INFO to exclude test patient and erroneous encounter answers.
QSTN_INFO	The QST_INFO table contains the metadata for questionaires. This table contains rows for completed forms. Forms for test patients and erroneous visits are excluded. Refreshed monthly.
RESEARCH_PERMISSION	The Research Permission table contains the contact and biobank permission preferences.
RSCH_ENROLLMENT	The table contains patient enrollments in research studies, including status, alias, start and end dates, and last modified user and instant.
RSCH_ENROLL_HX	The RSCH_ENROLL_HX table contains a history of changes to information pertaining to a patient's enrollment in a research study.
RSCH_STUDY	The table contains information on research studies at MUSC.
RSCH_VISIT	This table contains the visits that are linked to a research study.
SMOKE_HX	The smoking history contains the most recent smoking history for patients
SOCIAL_HX	The SOCIAL_HX table contains one row per history encounter in your system, regardless of history encounter type (e.g. surgical, social, family etc).

SURGICAL_HX	The SURGICAL_HX table contains data from medical history contacts entered in clinical system patient encounters. Since one patient encounter may contain multiple medical history contacts, each contact is uniquely identified by a combination of the patient encounter serial number , and a line number.
VENT_EPISODE	The VENT_EPISODE table contains a listing of all the mechanical ventilation episodes documented in Flowsheets. A ventilation episode begins when a ventilator start row is documented upon. That ventilation episode ends when a ventilator end row is documented upon, the patient is discharged, or the patient goes on a leave of absence. The inpatient data store ID, flowsheet data ID, and episode times are provided so you can look up more specific flowsheet information and link back to the patient's hospital records.
VISIT	The visit table contains one row for each patient encounter where the visit status is complete or null. The table does not include cancelled visits, documentaion visits, etc.
VISIT_MEASURE	This table contains the vitals and measurements stored on the encounter table.
VISIT_REASON	The VISIT_REASON table contains the data entered as the Reason for Visit for a clinical system encounter.One patient encounter may have multiple reasons for visit; the LINE is used to identify each reason for visit within an encounter.
VITAL	The vitals table contains the minimum, maximum and median vitals per day for encounters. Three rows per encounter.

Research Data Warehouse (RDW) Data Dictionary

TABLE_NAME	COLUMN_NAME	COMMENTS	IN_I2B2
ACCOUNT	ADMIT_DATE	The admission date and time associated with the hospital account.	
ACCOUNT	COVERAGE_ID	The unique ID assigned to the coverage record. Use to join to REF_COVERAGE_PAYOR_PLAN.	
ACCOUNT	DISCH_DATE	The discharge date and time associated with the hospital account	
ACCOUNT	LAST_UPDATE_DATE	The last update timestamp for the record	
ACCOUNT	PATIENT_CLASS	Base classification of the patient visit: I (INPATIENT), O (OUTPAITIENT), E (EMERGENCY)	
ACCOUNT	PATIENT_ID	The ID number of the patient for the hospital account.	
ACCOUNT	PATIENT_TYPE	Further classification of the patient visit: 104 (OBSERVATION), 107 (NEWBORN), etc.	
ACCOUNT	PRIMARY_BENEFIT_PLAN_ID	The code of the benefit plan associated with the dates effective for this row. Get the name from REF_COVERAGE_PAYOR_PLAN joining on COVERAGE_ID.	
ACCOUNT	PRIMARY_PAYOR_ID	The unique ID of the payor, join to REF_COVERAGE_PAYOR_PLAN using COVERAGE_ID to get the name.	
ACCOUNT	PRIMARY_SERVICE	Category for the primary medical service: 225 (DRM-DERMATOLOGY),227 (MED-EMERGENCY MEDICINE), 233 (PED-NEONATOLOGY), etc.	
ACCOUNT	PRIMARY_VISIT_ID	The contact serial number associated with the primary patient contact on the hospital account.	

ACCOUNT	SECONDARY_SERVICE	Category for the secondary medical service: 225 (DRM-DERMATOLOGY),227 (MED-EMERGENCY MEDICINE), 233 (PED-NEONATOLOGY), etc.	
ACCOUNT	TOTAL_ACCOUNT_BALANCE	The current balance on the hospital account.	
ACCOUNT	TOTAL_ADJUSTMENTS	The total of all adjustments on the hospital account.	
ACCOUNT	TOTAL_CHARGES	The total of all charges on the hospital account.	
ACCOUNT	TOTAL_PAYMENTS	The total of all payments on the hospital account.	
ALLERGY	ALLERGEN_ID	The unique ID assigned to the allergen (Agent) record.	
ALLERGY	ALLERGEN_NAME	The name of the allergen.	Y
ALLERGY	ALLERGEN_TYPE	The type of allergen (DRUG, DRUG INGREDIENT, DRUG CLASS).	
ALLERGY	ALLERGY_DELETE_CMT	Stores the free text comment why an allergy was deleted from a patient's chart.	
ALLERGY	ALLERGY_DELETE_RSN	Stores the category reason for deleting an allergy. Example: ENTRY DETERMINED TO BE CLINICALLY INSIGNIFICANT, ENTRY MISCATEGORIZED AS AN ALLERGY, ERRONEUS ENTRY, WRONG ALLERGY SELECTED,WRONG PATIENT SELECTED	
ALLERGY	ALLERGY_ID	The unique ID used to identify the allergy record	
ALLERGY	ALLERGY_SEVERITY	This item stores the severity of an allergy.	
ALLERGY	ALLERGY_STATUS	The status category number for this allergy record. The status can be ACTIVE or DELETED.	
ALLERGY	ALLERGY_TYPE	The allergy type category value, describing the nature or character of the allergy. Example: ALLERGY, CONTRAINDICATION,INTOLERANCE	

ALLERGY	ENTERED_DATE	The date and time the allergy was entered into the patient's record. NOTE: If an allergy record is edited/updated, this will show the most recent change date.	
ALLERGY	ENTRY_USER_ID	The unique ID of the clinical system user who entered this allergy into the patient's record.	
ALLERGY	LAST_UPDATE_DATE	The last update timestamp for the allergy record	
ALLERGY	NOTED_DATE	The date the patient made it known that they had experienced an allergic reaction	
ALLERGY	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
ALLERGY	REACTION_CMT	Contains the free text reaction comments. The actual reaction category value responses are stored in the ALLERGY_REACTION table which is linked via the ALLERGY_ID columns in both tables.	
ALLERGY_REACTION	ALLERGY_ID	The unique ID used to identify the allergy record. Join to ALLERGY on ALLERGY_ID.	
ALLERGY_REACTION	LAST_UPDATE_DATE	The last update timestamp for the allergy reaction record	
ALLERGY_REACTION	LINE	The line number for the reaction with this record. Multiple reactions can be associated with the same allergy.	
ALLERGY_REACTION	REACTION	The category value corresponding to the type of reaction.Example: ANAPHYLAXIS, HIVES, NAUSEA AND VOMITING, etc.	
CPT_PROCEDURE	ACCOUNT_NUM	Hospital accounting record for the patient encounter	
CPT_PROCEDURE	CPT_CODE	A CPT™ code stored in the hospital account.	Y
CPT_PROCEDURE	CPT_DATE	A date associated with a CPT™ code stored in the hospital account.	

CPT_PROCEDURE	CPT_MODIFIERS	A modifier or modifiers associated with a CPT™ code stored in the hospital account.	
CPT_PROCEDURE	CPT_PERF_PROV_ID	The ID number of a performing provider associated with a CPT™ code stored in the hospital account.	
CPT_PROCEDURE	CPT_QUANTITY	Quantity of the CPT™ code.	
CPT_PROCEDURE	CPT_VISIT_ID	Unique identifier for the patient encounter when the CPT™ procedure was performed.	
CPT_PROCEDURE	LAST_UPDATE_DATE	The last update timestamp for the record	
CPT_PROCEDURE	LINE	Since multiple CPT™ codes can be stored in one hospital account, each CPT™ code will have a unique line number.	
CPT_PROCEDURE	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
CPT_PROCEDURE	PRIMARY_DX_ID	The primary diagnosis id associated with the procedure. Join to REF_DX_ID for description.	
CPT_PROCEDURE	PROC_NAME	The name of each procedure from the Clarity EAP table, the CPT_CODE_DESC is not always populated.	Y
CPT_PROCEDURE	VISIT_ID	Unique identifier for the patient encounter.	
CPT_PROCEDURE	VOID_DATE	The date the transaction was voided	
DHEC_DATA	DHEC_DEATH_DATE	DHEC death date in the YYYY-MM-DD format. Uncertainty in month or day is represented with 00. For example, 2012-00-00 means that the precision of the known death date is only to the year of death	
DHEC_DATA	LAST_UPDATE_DATE	The time when the row was inserted or last updated.	
DHEC_DATA	PATIENT_ID	Unique identifier for each patient; used to link to other tables	

DHEC_DATA	PATIENT_MRN	Patient Medical Record Number sourced from Clarity	
DIAGNOSIS	ACCOUNT_NUM	Hospital accounting record for the patient encounter	
DIAGNOSIS	COMORBIDITY_TYPE	Specifies if the diagnosis is a non-complication/comorbidity ("NO")), complication/comorbidity ("CC"), or major complication/comorbidity ("MCC")	
DIAGNOSIS	COMORBIDITY_YN	Specifies if the diagnosis is a non-complication/comorbidity ("N"), complication/comorbidity ("Y"), or major complication/comorbidity ("Y")	
DIAGNOSIS	DX_CODE	The billing code for the diagnosis	Y
DIAGNOSIS	DX_CODE_SET	The billing coding set for the diagnosis	
DIAGNOSIS	DX_DATE	The date the diagnosis was observed	
DIAGNOSIS	DX_ID	Unique Identifier for diagnosis and links to the referecne table: REF_ICD_DX	
DIAGNOSIS	DX_NAME	The name or description of the diagnosis	Y
DIAGNOSIS	DX_POA	Indicator if the diagnosis was present on admission	
DIAGNOSIS	DX_SOURCE	Values set to : 1 (Primary Billing), 2 (Injury) after 7/1/2014 or 0 prior to 7/1/2014	
DIAGNOSIS	LAST_UPDATE_DATE	The last update timestamp for the diagnosis	
DIAGNOSIS	LINE	Since multiple final ICD diagnoses can be stored in one hospital account, each diagnosis will have a unique line number. The record associated with line 1 represents the principal final coded diagnosis.	Y
DIAGNOSIS	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
DIAGNOSIS	ROM	Risk of Mortality: 1 (MINOR), 2 (MODERATE), 3 (MAJOR), etc.	Y
DIAGNOSIS	SOI	Severity of illness: 1 (MINOR), 2 (MODERATE), 3 (MAJOR), etc.	Y

DIAGNOSIS	VISIT_ID	Unique identifier for the patient encounter.	
DIAGNOSIS_INFO	DX_ID	The unique ID of the diagnosis record; join to REF_DX for ICD codes.	
DIAGNOSIS_INFO	FIRST_DATE	The first date on which this diagnosis was recorded, from any source.	
DIAGNOSIS_INFO	FIRST_DATE_CLM_DX	The first date on which this diagnosis appeared on the patient's hospital claim.	
DIAGNOSIS_INFO	FIRST_DATE_ENC_DX	The first date on which this diagnosis appeared on the patient's encounter diagnosis list.	
DIAGNOSIS_INFO	FIRST_DATE_INV_DX	The first date on which this diagnosis appeared on a professional claim for the patient.	
DIAGNOSIS_INFO	FIRST_DATE_PROB_LIST	The first date on which this diagnosis appeared on the patient's problem list.	
DIAGNOSIS_INFO	FIRST_DATE_REF_DX	The first date on which this diagnosis appeared on a referral related to the patient. This comes from the entry date of the referral.	
DIAGNOSIS_INFO	FIRST_DT_HSP_ACT_DX	The first date on which this diagnosis appeared on the patient's hospital account.	
DIAGNOSIS_INFO	FIRST_DT_HSP_ACT_EXTINJ	The first date on which this diagnosis appeared on the patient's hospital account as an external injury.	
DIAGNOSIS_INFO	FIRST_DT_HSP_ADM_DX	The first date on which this diagnosis appeared on the patient's hospital admission list.	
DIAGNOSIS_INFO	FIRST_DT_MED_HIST_DX	The first date on which this diagnosis appeared on the patient's medical history .	
DIAGNOSIS_INFO	FIRST_DT_OR_CASE_DX	The first date on which this diagnosis appeared on the patient's surgical case.	
DIAGNOSIS_INFO	LAST_DATE	The last date on which this diagnosis was recorded, from any source.	

DIAGNOSIS_INFO	LAST_DATE_CLM_DX	The last date on which this diagnosis appeared on the patient's hospital claim.	
DIAGNOSIS_INFO	LAST_DATE_ENC_DX	The last date on which this diagnosis appeared on the patient's encounter diagnosis list.	
DIAGNOSIS_INFO	LAST_DATE_INV_DX	The last date on which this diagnosis appeared on a professional claim for the patient.	
DIAGNOSIS_INFO	LAST_DATE_PROB_LIST	The last date on which this diagnosis appeared on the patient's problem list.	
DIAGNOSIS_INFO	LAST_DATE_REF_DX	The last date on which this diagnosis appeared on a referral related to the patient. This comes from the entry date of the referral.	
DIAGNOSIS_INFO	LAST_DT_HSP_ACT_DX	The last date on which this diagnosis appeared on the patient's hospital account.	
DIAGNOSIS_INFO	LAST_DT_HSP_ACT_EXTINJ	The last date on which this diagnosis appeared on the patient's hospital account as an external injury.	
DIAGNOSIS_INFO	LAST_DT_HSP_ADM_DX	The last date on which this diagnosis appeared on the patient's hospital admission list.	
DIAGNOSIS_INFO	LAST_DT_MED_HIST_DX	The last date on which this diagnosis appeared on the patient's medical history .	
DIAGNOSIS_INFO	LAST_DT_OR_CASE_DX	The last date on which this diagnosis appeared on the patient's surgical case.	
DIAGNOSIS_INFO	NUM_CLM_DX	The number of times this diagnosis appeared on the patient's hospital claim.	
DIAGNOSIS_INFO	NUM_ENC_DX	The number of times this diagnosis appeared on the patient's encounter diagnosis list.	
DIAGNOSIS_INFO	NUM_HSP_ACT_DX	The number of times this diagnosis appeared on the patient's hospital account.	

DIAGNOSIS_INFO	NUM_HSP_ACT_EXTINJ	The number of times this diagnosis appeared on the patient's hospital account as an external injury.	
DIAGNOSIS_INFO	NUM_HSP_ADM_DX	The number of times this diagnosis appeared on the patient's hospital admission diagnosis list.	
DIAGNOSIS_INFO	NUM_INV_DX	The number of times this diagnosis appeared on a professional claim for the patient.	
DIAGNOSIS_INFO	NUM_MED_HIST_DX	The number of times this diagnosis appeared on the patient's medical history.	
DIAGNOSIS_INFO	NUM_OR_CASE_DX	The number of times this diagnosis appeared on the patient's surgical case.	
DIAGNOSIS_INFO	NUM_PROBLEM_LIST	The number of times this diagnosis appeared on the patient's problem list.	
DIAGNOSIS_INFO	NUM_REF_DX	The number of times this diagnosis appeared on referrals related to the patient.	
DIAGNOSIS_INFO	PATIENT_ID	The unique ID assigned to the patient; used to join to other tables.	
ED_DETAIL	ACUITY_LEVEL	The description for the category value corresponding to the acuity level for this patient contact. Examples: Immediate (1), Emergent (2), Urgent (3), Less Urgent (4) Non-Urgent (5)	
ED_DETAIL	ACUITY_LEVEL_CODE	The category value corresponding to the acuity level for this patient contact. Examples: 1,2,3,4,5 or null	
ED_DETAIL	ADT_ARRIVAL_DATE	The date and time of arrival for this patient contact	
ED_DETAIL	AGE_AT_ARRIVAL_MONTHS	The patient's calculated age in months upon arrival.	
ED_DETAIL	AGE_AT_ARRIVAL_YEARS	The patient's calculated age in years upon arrival.	

ED_DETAIL	ED_ACCOUNT_NUM	Hospital accounting record for the patient encounter sourced from the Clarity.F_ED_ENCOUNTERS table	
ED_DETAIL	ED_ADMIT_DATE	The date and time during the hospital encounter when the patient first received a base patient class of emergency.	
ED_DETAIL	ED_DEPARTURE_DATE	Date and time the patient left the ED.	
ED_DETAIL	ED_DISPOSITION	The description for the disposition of the patient when discharged from the ED. Exmaple: Discharge Home(69), Admit (3), Admitted CH-07AC (53), etc	
ED_DETAIL	ED_DISPOSITION_CODE	The category value of the disposition of the patient when discharged from the ED. Exmaple: 1,2,3, etc	
ED_DETAIL	ED_PRIMARY_CARE_AREA_CODE	The unique ID for the primary area of care for the patient during their stay in the ED. Values are numeri.	
ED_DETAIL	ED_PRIMARY_CARE_AREA_NAME	The description for the primary area of care id for the patient during their stay in the ED. Examples: MUSC ED ADULT POD A (1700005), MUSC ED PEDS ZONE A (1710005), MUSC ED CPC GENERAL CARE (1720004), etc.	
ED_DETAIL	ED_VISIT_ID	The unique identifier for this Emergency Department contact	
ED_DETAIL	FIRST_CHIEF_COMPLAINT	The description of the first chief complaint	
ED_DETAIL	FIRST_CHIEF_COMPLAINT_ID	The first chief complaint (line 1)	
ED_DETAIL	FIRST_CHIEF_COMPLAINT_OTHER	The custom reason for visit entered when the clinical system user chooses “Other” as a reason for visit on line 1.	

ED_DETAIL	FIRST_ED_ATTEND_PROV_ID	The unique ID of the attending provider for the patient who was first assigned to the patient as an ED attending. Used to join the REF_PROVIDER table.	
ED_DETAIL	FIRST_EMERGENCY_DEPARTMENT_ID	The unique ID of the first emergency department the patient was roomed in. Used to join to the REF_DEPT table.	
ED_DETAIL	HOSPITAL_ADMIT_DATE	The date and time that the patient was first admitted to the facility, bedded in the ED, or confirmed for an HOV for this contact, regardless of patient's base patient class.	
ED_DETAIL	HOSPITAL_DISCH_DATE	The hospital discharge date and time for this patient contact.	
ED_DETAIL	INPATIENT_ADMIT_DATE	The date and time of inpatient admission. This is the date and time during the hospital encounter when the patient first received a base patient class of inpatient. This data will come from the encounter with CSN stored in INPATIENT_PAT_ENC_CSN_ID. This could be the same encounter as the ED encounter, or it could be an inpatient encounter within 1 hour of hospital discharge if this encounter was never inpatient.	
ED_DETAIL	INPATIENT_VISIT_ID	The encounter visit id for an inpatient encounter within 1 hour of hospital discharge if this encounter was never inpatient. This corresponds to the inpatient portion of a stay in discharge/readmit workflows. If this encounter was a combined ED/IP encounter, then this will be the same as the encounter visit id.	

ED_DETAIL	LAST_DEPARTMENT_ID	The unique ID of the last emergency department the patient was roomed in. Used to join to the REF_DEPT table.	
ED_DETAIL	LAST_ED_ATTEND_PROV_ID	The unique ID of the attending provider for the patient who was last unassigned to the patient as an ED attending.Used to join the REF_PROVIDER table.	
ED_DETAIL	LAST_UPDATE_DATE	The last update timestamp for the record	
ED_DETAIL	LONGEST_ED_ATTEND_PROV_ID	The unique ID of the attending provider for the patient who had the most time assigned to the patient as an ED attending.Used to join the REF_PROVIDER table.	
ED_DETAIL	MEANS_OF_ARRIVAL	The description for the category value corresponding to the means of arrival of the patient for this patient contact. Example: Assist From Vehicle (10), Public Transportion (260), Meducare - Helicopter (313), etc.	
ED_DETAIL	MEANS_OF_ARRIVAL_CODE	The category value corresponding to the means of arrival of the patient for this patient contact. Examples, 1,2,3, etc.	
ED_DETAIL	OBSERVATION_END_DATE	The maximum time associated with ED visits that become Observation visits	
ED_DETAIL	OBSERVATION_START_DATE	The minimum time associated with ED visits that become Observation visits	
ED_DETAIL	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
ED_DETAIL	PREV_VISIT_DIFF_DAYS	The time difference in days between the arrival time of this encounter and the discharge time of the PREV_VISIT_ID	
ED_DETAIL	PREV_VISIT_DIFF_HOURS	The time difference in hours between the arrival time of this encounter and the discharge time of the PREV_VISIT_ID	

ED_DETAIL	PREV_VISIT_ED_YN	Yes (Y) / No (N) Flag to indicate if prior encounter in PREV_VISIT_ID is an emergency department visit	
ED_DETAIL	PREV_VISIT_ID	The visit identifier for the previous hospital encounter if that encounter was discharged less than 60 days ago.	
ED_DETAIL	PREV_VISIT_INPATIENT_YN	Yes (Y) / No (N) Flag to indicate if prior encounter in PREV_VISIT_ID is an inpatient visit	
ED_DETAIL	PRIMARY_DX_ID	The primary diagnosis ID for the encounter. Used to join to the REF_ICD_DX table.	
ED_DETAIL	PRIMARY_DX_NAME	The description for the primary diagnosis ID for the encounter.	
ED_DETAIL	VISIT_ID	The unique identifier for the primary visit associated with this ED encounter	
FAMILY_HX	AGE_OF_ONSET	This is the age of onset of the family member documented with a history of a medical problem.	
FAMILY_HX	FAM_HX_SRC	Family Medical History Source Category Description: Provider (1), Patient (2), Parent (3), etc.	
FAMILY_HX	FAM_HX_SRC_CODE	Family Medical History Source Category Code: 1 (Provider), 2 (Patient), 3 (Parent), etc.	
FAMILY_HX	FAM_RELATION_NAME	This is the first and/or last name of the patient's family member.This column is free-text and is meant to be used together with the RELATION_C category to form a unique key for the family member. If no name is entered this column will display an abbreviation of the family relation type beginnning with ##.	
FAMILY_HX	FHX_CONTACT_DATE	The date of this contact in calendar format.	

FAMILY_HX	FHX_LNK_VISIT_ID	The Contact Serial Number of the encounter in which the history was created/edited. If the history was created/edited outside of the context of an encounter, then this column will be blank	
FAMILY_HX	FHX_VISIT_ID	A unique serial number for this encounter.	
FAMILY_HX	LAST_UPDATE_DATE	The time this patient family history record was pulled into enterprise reporting or date of last update.	
FAMILY_HX	LINE	The line number to identify the family history contact within the patient's record. NOTE: A given patient may have multiple records (identified by line number) that reflect multiple lines of history.	
FAMILY_HX	MEDICAL_HX	The category description associated with the Problem documented in the patient's family history: Cancer(600), Diabetes(700), etc.	
FAMILY_HX	MEDICAL_HX_CODE	The category code associated with the Problem documented in the patient's family history: 600 (Cancer), 700 (Diabetes), etc.	
FAMILY_HX	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
FAMILY_HX	RELATION	The category value description associated with the family member who has or had this problem: Father (2), Brother (4), or Paternal Grandfather (8), etc.	
FAMILY_HX	RELATION_CODE	The category value code associated with the family member who has or had this problem: 2 (Father), 4 (Brother), or 8 (Paternal Grandfather), etc.	

HIV_REGISTRY	FIRST_INCLUDE_DTTM	The instant at which the registry data record was included in the registry. This is cleared each time the registry data record is removed from the registry. This gives the beginning of the most recent contiguous enrollment.	
HIV_REGISTRY	LAST_UPDATE_DATE	The instant at which the registry was last updated for this registry data record.	
HIV_REGISTRY	PATIENT_ID	The ID number of the patient in the registry.	
HIV_REGISTRY	PATIENT_REGISTRY_STATUS	The status category (Active, Inactive) for the patient in the HIV registry.	
HIV_REGISTRY	REGISTRY_ID	The unique ID of the registry record	
HIV_REGISTRY	REGISTRY_NAME	Name of the Registry Configuration record.	
HNO_NOTE	CONTACT_DATE	The date of this contact in calendar format.	
HNO_NOTE	FULL_TEXT	The full plain text of the note. All formatting has been removed.	
HNO_NOTE	NOTE_CSN_ID	The unique contact serial number for this contact.	
HNO_NOTE	NOTE_ID	The unique ID of the note record	
HNO_NOTE_INFO	AMB_NOTE_YN	Indicates whether the note is an ambulatory note. Y indicates that the note's encounter context is ambulatory. N or a null value indicates that the context is not ambulatory.	
HNO_NOTE_INFO	AUTHOR_TYPE	The author type	
HNO_NOTE_INFO	CREATE_INSTANT_DTTM	The instant when the note is created	
HNO_NOTE_INFO	CURRENT_AUTHOR_ID	The current author of the note.	
HNO_NOTE_INFO	DATE_OF_SERVICE	The date of service associated with the note.	
HNO_NOTE_INFO	DELETE_INSTANT_DTTM	The instant when the note is deleted.	

HNO_NOTE_INFO	ENC_VISIT_ID	The unique contact serial number for the patient encounter to which the note is attached.	
HNO_NOTE_INFO	EXT_INTERF_ID	Numeric indentifer for the external interface. Can be null.	
HNO_NOTE_INFO	INPATIENT_DATA_ID	The ID of the INP record associated with this note.	
HNO_NOTE_INFO	IP_NOTE_TYPE	The note type description associated with this note. Applies mostly to inpatient notes.	
HNO_NOTE_INFO	IP_NOTE_TYPE_CODE	The note type code associated with this note. Applies mostly to inpatient notes.	
HNO_NOTE_INFO	LAST_UPDATE_DATE	The date and time when this row was created or last updated in Clarity.	
HNO_NOTE_INFO	LST_FILED_INST_DTTM	The instant the note was last edited	
HNO_NOTE_INFO	NOTE_AUTHOR	The name of the author of the note	
HNO_NOTE_INFO	NOTE_ID	The unique ID of the note record	
HNO_NOTE_INFO	NOTE_PURPOSE	The description for the note purpose: Normal (1), Cosign (2), Appendum (3)...	
HNO_NOTE_INFO	NOTE_PURPOSE_CODE	The numeric code for the note purpose: 1 (Normal), 2 (Cosign), 3 (Appendum)...	
HNO_NOTE_INFO	NOTE_TYPE	The note type description associated with this note. Applies to ambulatory.	
HNO_NOTE_INFO	NOTE_TYPE_CODE	The note type code associated with this note. Applies to ambulatory.	
HNO_NOTE_INFO	PATIENT_ID	The unique ID of the patient who is associated to this note.	
HNO_NOTE_INFO	PROFILE_NAME	The profile name for the external interface id. Source Clarity table INTERFACE_PROFILE. Some interface ids are not in the profile table.	
HOSPITAL_BILLING	ACCOUNT_NUM	The unique ID of the hospital account.	

HOSPITAL_BILLING	ACCT_CLOSE_DATE	The date the hospital account was closed.	
HOSPITAL_BILLING	ADMIT_DATE	The admission date and time associated with the hospital account.	
HOSPITAL_BILLING	CHARGE_AMOUNT	Total charges for the hospital account from the view (same as HSP_ACCOUNT)	
HOSPITAL_BILLING	DISCHARGE_DATE	The discharge date and time associated with the hospital account	
HOSPITAL_BILLING	DISCHARGE_DEPARTMENT_ID	The discharge department ID stored in the hospital account. Join to REF_DEPT for details.	
HOSPITAL_BILLING	FINANCIAL_CLASS	The hospital account's financial class name.	
HOSPITAL_BILLING	GUARANTOR_ID	The ID of the guarantor for the hospital account.	
HOSPITAL_BILLING	GUARANTOR_NAME	The name of the guarantor for the hospital account at time of discharge.	
HOSPITAL_BILLING	GUARANTOR_TYPE	The category value of the guarantor account type. Ex: Personal/Family, Other, etc.	
HOSPITAL_BILLING	GUARANTOR_TYPE_CODE	The category value of the guarantor account type. Values are numeric.	
HOSPITAL_BILLING	PATIENT_ID	The ID number of the patient for the hospital account.	
HOSPITAL_BILLING	PAYMENT_AMOUNT	Calculated: Insurance payments + Self-pay payments - Refunds from HSP_TRANSACTIONS for the hospital account.	
HOSPITAL_BILLING	RESEARCH_ID	The unique ID number(s) of research study; use to join to RSCH_STUDY. Sometimes patients have multiple research studies for the same hospital account.	
HOSPITAL_BILLING	VISIT_ID	The contact serial number associated with the primary patient contact on the hospital account. Can be null.	

HSP_TRANSACTION	ACCOUNT_BASE_CLASS	The hospital account's account base class. Values are Inpatient, Outpatient, Emergency	
HSP_TRANSACTION	ACCOUNT_CLASS	The class associated with the transaction. Values are Inpatient, Outpatient, Emergency	
HSP_TRANSACTION	ACCOUNT_NUM	The hospital account number associated with the transaction.	
HSP_TRANSACTION	ALLOWED_AMOUNT	An allowed amount stored in a payment transaction.	
HSP_TRANSACTION	BILLED_AMOUNT	A billed amount stored in a payment transaction.	
HSP_TRANSACTION	BILLING_PROV_ID	The ID number of a billing provider stored in the transaction.	
HSP_TRANSACTION	CHARGES	The monetary amount of a charge transaction.	
HSP_TRANSACTION	CHARGE_CODE_DISPLAY	The charged procedure name and code. Can be A/R or clinical procedures	
HSP_TRANSACTION	CLM_PROC_TYPE	The classification for the procedure charge. Values can be Technical, Professional or null	
HSP_TRANSACTION	COST	The cost for a procedure.	
HSP_TRANSACTION	COST_CENTER	The name of the cost center associated with a charge transaction	
HSP_TRANSACTION	CPT_CODE	The CPT™ code stored in a charge transaction. If the value is the same as PROC_ID, it's not a CPT code	
HSP_TRANSACTION	CPT_MODIFIERS	A comma-delimited list of one or more modifiers associated with a charge transaction.	
HSP_TRANSACTION	CREDIT_ADJUSTMENT	The monetary amount of a credit adjustment transaction.	
HSP_TRANSACTION	DEBIT_ADJUSTMENT	The monetary amount of a debit adjustment transaction.	
HSP_TRANSACTION	DEPARTMENT_ID	Department identifier, join to REF_DEPT for details	

HSP_TRANSACTION	DFLT_PROC_DESC	The description of the procedure stored in the procedure master file. This is I EAP 6, which appears in the procedure master file as Proc Name. This item is only populated if the description for the procedure was overridden in charge entry.	
HSP_TRANSACTION	GUARANTOR_ID	A unique id for the guarantor of this account.	
HSP_TRANSACTION	GUARANTOR_NAME	The name of the guarantor of the account	
HSP_TRANSACTION	HCPCS_CODE	HCPCS Code for this transaction. Can be null.	
HSP_TRANSACTION	HSPTX_VISIT_ID	For a charge dropped via ADT's bed charge billing function or a payment collected at the point-of-service, the contact serial number of the patient contact that triggered the bed charge or led to the collection of the payment.	
HSP_TRANSACTION	IP_OP	IN (Inpatient) or OP (Outpatient) category	
HSP_TRANSACTION	LAST_UPDATE_DATE	Last updated date for the row	
HSP_TRANSACTION	NDC_CODE	NDC (National Drug Code). Sample values are: 63739-486-10, 68084-154-01, 0904-5306-61, etc.	
HSP_TRANSACTION	NDC_ID	The ID for the current NDC code information, NDC_CODE_RG_ID column in the HSP_TX_NDC_CODES table where Line = 1	
HSP_TRANSACTION	ORDER_ID	The ID number of an clinical system order that triggered a transaction.	
HSP_TRANSACTION	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
HSP_TRANSACTION	PAYMENTS	The monetary amount of a payment transaction.	

HSP_TRANSACTION	PLACE_OF_SERVICE	The place of service. Values can be: MUSC HOSPITAL, MUSC ASHLEY RIVER TOWER, MUSC CHILDRENS HOSPITAL, MUSC RUTLEDGE TOWER, etc.	
HSP_TRANSACTION	PROCEDURE_DESC	The value manually entered for the procedure description at the time of charge entry. If no value was manually entered, then the default description from the procedure(I EAP 6) is populated here.	
HSP_TRANSACTION	PROC_ID	An internal system ID for the procedure associated with the transaction.	
HSP_TRANSACTION	RESEARCH_ID	The unique ID of the research study that is associated with this transaction.	
HSP_TRANSACTION	REVENUE_CODE_NAME	The Revenue Grouping. Values include: PHARMACY - EXTENSION OF 025X - SELF-ADMINISTRABLE DRUGS (B), LABORATORY - CHEMISTRY,CLINIC - GENERAL CLASSIFICATION, etc.	
HSP_TRANSACTION	REVENUE_LOCATION	The revenue location. Only set when hospital account IDs are assigned by location instead of service area. Values can be: MUSC PARENT HOSPITAL LOCATION, MUSC WOMENS CARE NORTH, MUSCP CARNES CROSSROADS, etc.	
HSP_TRANSACTION	RSCH_ORIG_ACCOUNT_NUM	The unique ID of the original hospital account for a research charge.	
HSP_TRANSACTION	SERVICE_DATE	The service date of a charge or the creation date of an adjustment.	
HSP_TRANSACTION	SERVICE_PROV_ID	The performing provider associated with a charge transaction.	

HSP_TRANSACTION	TOTAL_CHARGES_ACT	For adjustment transactions that move liability from one bucket to another, the total monetary amount of charges on the latter bucket.	
HSP_TRANSACTION	TX_AMOUNT	The monetary amount of a transaction.	
HSP_TRANSACTION	TX_FILED_DATE	The date and time when a transaction was filed on a hospital account.	
HSP_TRANSACTION	TX_ID	The ID and primary key of the transaction	
HSP_TRANSACTION	TX_QUANTITY	The quantity (number) associated with a transaction	
HSP_TRANSACTION	TX_SOURCE	The source of the transaction, i.e. unit charge entry, payment posting, electronic remittance, etc.	
HSP_TRANSACTION	TX_TYPE	The transaction type: Charge, Payment, Debit Adjustment, Credit Adjustment	
HSP_TRANSACTION	VISIT_ID	The primary visit associated with the hospital account	
ICU_LOCATION	DEPARTMENT_ID	The unique ID number assigned to the ICU department record corresponding to where the patient stayed during the indicated period of time.	
ICU_LOCATION	DEPARTMENT_NAME	The name of the ICU department corresponding to where the patient stayed during the indicated period of time.	
ICU_LOCATION	DEPT_STAY_END_DTTM	The instant that the patient stopped being considered bedded in an ICU during the current standard ICU stay. Standard ICU stays can only include admissions in the same ICU department.	
ICU_LOCATION	DEPT_STAY_START_DTTM	The instant that the patient was first considered bedded in an ICU during the current standard ICU stay. Standard ICU stays can only include admissions in the same ICU department.	

ICU_LOCATION	ICU_IN_DTTM	The instant that the patient physically entered the ICU.	
ICU_LOCATION	ICU_OUT_DTTM	The instant that the patient physically exited the ICU.	
ICU_LOCATION	ICU_VISIT_ID	The unique contact serial number for this contact.	
ICU_LOCATION	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
ICU_LOCATION	STAY_END_DTTM	The instant that the patient stopped being considered bedded in an ICU during the current Apache ICU stay. Apache ICU stays can include admissions in different ICU departments.	
ICU_LOCATION	STAY_START_DTTM	The instant that the patient was first considered bedded in an ICU during the current Apache ICU stay. Apache ICU stays can include admissions in different ICU departments.	
IMMUNIZATION	BODY_SITE	Code for the body site: 17 (ORAL), 14 (LEFT ARM), etc.	
IMMUNIZATION	DEFER_REASON	Category value indicating the reason for deferring the immunization, e.g. PATIENT REFUSED, CONTRAINDICATION, etc.	
IMMUNIZATION	DOSE	The immunization dosage (amount and unit).	
IMMUNIZATION	DOSE_AMOUNT	Immunization dose amount.	
IMMUNIZATION	DOSE_UNIT	Immunization dose unit.	
IMMUNIZATION	ENTRY_DATE	The date the immunization was recorded in the patient's chart. NOTE: If an immunization record is edited/updated, this will show the most recent change date.	
IMMUNIZATION	EXPIRATION_DATE	Date upon which this immunization expires	
IMMUNIZATION	EXTERNAL_ADMIN	Category value indicating the source of verification of external administration of immunization, e.g. PATIENT REPORTED, CONFIRMED, etc	

IMMUNIZATION	GIVEN_BY_USER_ID	The unique ID of the system user who administered the immunization.	
IMMUNIZATION	IMMUNE_ID	The unique ID of the immunization entry.	
IMMUNIZATION	IMM_ABBR	The abbreviation of the immunization	Y
IMMUNIZATION	IMM_DATE	The date and time the immunization was administered	
IMMUNIZATION	IMM_HISTORIC_ADM_YN	Indicates whether the immunization administration is a historical administration	
IMMUNIZATION	IMM_ID	The unique ID of the immunization record.	
IMMUNIZATION	IMM_NAME	The name of the immunization	
IMMUNIZATION	IMM_STATUS	The category value associated with immunization: GIVEN, DELETED, DEFERRED, REFUSED, PARTIALLY ADMINISTERED, INCOMPLETE if the item has been ordered but not administered	
IMMUNIZATION	IMM_TYPE	The type of immunization (i.e. ADULT or PEDIATRIC) that defines the general group of people to whom this immunization is given	
IMMUNIZATION	IMM_VISIT_ID	The unique contact serial number of the most recent patient encounter where this problem list was documented.	
IMMUNIZATION	LAST_UPDATE_DATE	The last update timestamp for the immunization	
IMMUNIZATION	MED_ADMIN_COMMENT	Free text comment regarding the administration of this immunization	
IMMUNIZATION	NDC_CODE	NDC number code associated with the administration	
IMMUNIZATION	NDC_NUM_ID	NDC number ID associated with the administration	
IMMUNIZATION	ORDER_DATE	The date the order was placed, if null the order is outside the clinical order system	
IMMUNIZATION	ORDER_ID	Order ID for immunization ordered. Null for patient reported, imported	

IMMUNIZATION	ORDER_SOURCE	Category (PROC or MED) for the source of the order	
IMMUNIZATION	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
IMMUNIZATION	ROUTE	The immunization route (IM,SQ,etc.)	
IMMUNIZATION	VISIT_ID	The unique contact serial number for the primary visit associated with the immunization	
LAB_RESULT	ACCESSION_NUMBER	The accession number associated with an order.	
LAB_RESULT	AUTHRZING_PROV_ID	The unique ID of the provider prescribing or authorizing the order.	
LAB_RESULT	DEPARTMENT_ID	The ID of the department for the encounter. If there are multiple departments for the encounter, this is the ID of the first department in the list.	
LAB_RESULT	FACILITY	Referring facility name	
LAB_RESULT	FACILITY_ID	Referring facility numeric identifier	
LAB_RESULT	LAB_CODE	A numeric identifer associated with this lab component	
LAB_RESULT	LAB_NAME	The description for the numeric identifer associated with this lab component	
LAB_RESULT	LAB_STATUS	The status category number of the result: 1 (In Progress), 2 (Preliminary result) , 3 (Final result), 4 (Edited), 5 (Edited Result - FINAL)	
LAB_RESULT	LAB_VISIT_ID	Unique identifier for the patient encounter for the lab results	
LAB_RESULT	LAST_UPDATE_DATE	The last update timestamp for the record	
LAB_RESULT	LINE	The line number of each result component for the order	
LAB_RESULT	LOINC	Free text LOINC code associated with a component.	Y
LAB_RESULT	ORDERING_PROV_ID	The ID of the lab order's ordering provider.	

LAB_RESULT	ORDER_CLASS	The order class category number of the procedure order: 1 (Normal), 2 (Point of care), 11 (Unit Collect), etc.	
LAB_RESULT	ORDER_CPT_CODE	The procedure code associated with this order, as of the ordering date. This is not a true CPT code, but the value is in the Clarity_EAP table for EPIC souce.	
LAB_RESULT	ORDER_DATE	The date when the order was placed	
LAB_RESULT	ORDER_ID	The unique ID of the order	
LAB_RESULT	ORDER_PROC	The description of the procedure code associated with this order	
LAB_RESULT	ORDER_PROC_CODE	The procedure code associated with this order.	
LAB_RESULT	ORDER_STATUS	The status category number of the order: 2 (Sent), 3 (Resulted), 5 (Completed), etc.	
LAB_RESULT	ORDER_TYPE	The order type category description for the order.	
LAB_RESULT	ORDER_TYPE_CODE	The order type category number for the order.	
LAB_RESULT	ORD_DATE_REAL	Numeric version of the date with decimal values to handle mulitple orders on the same day.	
LAB_RESULT	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
LAB_RESULT	PRIORITY	The overall priority category number for the procedure order: 1 (ASAP), 2 (STAT), 6 (ROUTINE), etc.	
LAB_RESULT	REFERENCE_HIGH	The highest acceptable value for each result component.	
LAB_RESULT	REFERENCE_LOW	The lowest acceptable value for each result component.	

LAB_RESULT	REFERENCE_NORMAL	This is a free-text item which allows you to enter a reference range without tying it to a "low" or "high" value. For example, it could be a string ("negative"), a list of choices ("Yellow, orange"), or a descriptive range ("Less than 20"). The values entered in this range should always represent the "normal" values.	
LAB_RESULT	REFERENCE_UNIT	The units for each result component value	Y
LAB_RESULT	REFERRING_PROV_ID	The unique ID of the provider who has referred this lab order, i.e. the referring provider	
LAB_RESULT	RESULT_DATA_TYPE	The data-type category number for the result component type. Supported result component types are 0 (string), 1 (titer), 2 (category), 3 (structured numeric), 12 (numeric), etc.	
LAB_RESULT	RESULT_DATE	The date the technician ran the tests for each order.	
LAB_RESULT	RESULT_FLAG	The category value associated with a flag code corresponding to a standard HL7 code to mark each component result as abnormal: 2 (Abnormal), 3 (Panic), 4 (Low), 5 (High), etc.	
LAB_RESULT	RESULT_IN_RANGE_YN	A Yes/No category value to indicate whether a result has been verified to be within its reference range. This item is set by the interface when the result is sent. A null value is equivalent to a "no" value.	
LAB_RESULT	RESULT_NUMERIC	A numeric representation of the value returned for each component where applicable.	Y
LAB_RESULT	RESULT_STATUS	The status category number of the result: 2 (Preliminary), 3 (Final), 4 (Corrected), 5 (Incomplete)	
LAB_RESULT	RESULT_TEXT	The value returned for each result component, in short free text format	

LAB_RESULT	SERVICE_AREA	The service area description of the department in which the appointment associated with this order took place.	
LAB_RESULT	SERVICE_AREA_CODE	The service area code of the department in which the appointment associated with this order took place.	
LAB_RESULT	SPECIMEN_DATE	The date the specimen was collected.	
LAB_RESULT	SPECIMEN_SOURCE	The source category number for the procedure order: 135 (Nasopharynx, Swab), 219 (Urine), 236 (Whole Blood-Venous), etc.	
LAB_RESULT	SPECIMEN_TYPE	The specimen type category number for the procedure order: 4567 (Blood), 4568 (Urine), etc.	
LAB_RESULT	VISIT_ID	Unique identifier for the patient primary billing encounter	
MEDICAL_HX	DX_ID	The unique ID of the diagnosis record (EDG .1) associated with the medical history contact. Note: This is NOT the ICD9 diagnosis code. It is an internal identifier that is typically not visible to a user.	
MEDICAL_HX	DX_NAME	The name for the diagnois.	
MEDICAL_HX	LAST_UPDATE_DATE	The time this patient history record was pulled into enterprise reporting or date of last update.	
MEDICAL_HX	LINE	The line number of the medical history contact within the encounter. Note: A given patient may have multiple records (identified by line number) that reflect multiple lines of history	
MEDICAL_HX	MEDICAL_HX_DATE	The free-text date entered in clinical system's Medical History window for the diagnosis. This field is free-text due to the imprecise nature of patient-provided historical information.	

MEDICAL_HX	MED_HX_SOURCE	The category description for the medical history's source for the patient record.: Provider (1), Patient (2), Parent (3), etc.	
MEDICAL_HX	MED_HX_SOURCE_CODE	The category code for the medical history's source for the patient record.: 1 (Provider), 2 (Patient), 3 (Parent), etc.	
MEDICAL_HX	MHX_CONTACT_DATE	The date of this contact in calendar format.	
MEDICAL_HX	MHX_LINK_VISIT_ID	The Contact Serial Number of the encounter in which the history was created/edited. If the history was created/edited outside of the context of an encounter, then this column will be blank	
MEDICAL_HX	MHX_VISIT_ID	A unique serial number for this encounter.	
MEDICAL_HX	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
MED_ADMIN	ACCOUNT_NUM	Hospital accounting record for the primary patient encounter	
MED_ADMIN	ADMIN_SITE	The site category number used for the administration. Example: 1 (Left Arm), 2 (Right Arm), etc.	
MED_ADMIN	ADMIN_STATUS	The medication action category number associated with this administration. Examples: 1 (Given), 2 (Missed), etc.	
MED_ADMIN	DOSE	The dose value of the administration.	
MED_ADMIN	DOSE_UNIT	The category number for the dose unit of a medication that corresponds with the DOSE column. Example: 3 (MG), 4 (G), 5002 (TABLET), etc,	
MED_ADMIN	INFUSION_RATE	The rate at which the medication was infused.	
MED_ADMIN	INFUSION_RATE_UNIT	The unit category number associated with the infusion rate of the administration Example: 1 (mL), 2 (L), 3 (mg), etc.	

MED_ADMIN	INPATIENT_DATA_ID	The unique ID of the inpatient data store record - applies to EPIC inpatient only	
MED_ADMIN	LAST_UPDATE_DATE	The day and time the order record was last updated.	
MED_ADMIN	LINE	The sequential line count for the administration. There can be multiple lines per order	
MED_ADMIN	MEDADMIN_VISIT_ID	Unique identifier for the patient encounter for the medication administration	
MED_ADMIN	MEDORDER_VISIT_ID	Unique identifier for the patient encounter for the medication order	
MED_ADMIN	MED_ADMIN_DATE	The user-specified time that the action took place.	
MED_ADMIN	MED_ADMIN_DEPT	The unique ID of the login department of the documenting user of the administration.	
MED_ADMIN	MED_CODE	The unique ID of the medication record that is associated with this administration.	
MED_ADMIN	MED_DESC	The description of the ordered medication.	
MED_ADMIN	MED_DURATION	The length of time the administration took to complete or infuse.	
MED_ADMIN	MED_DURATION_UNIT	The length of time the administration took to complete or infuse. Example: 1 (Minutes), 2(Hours), 3(Days).	
MED_ADMIN	MED_ORDER_ID	The unique ID of the order record associated with the medication order for the administration.	
MED_ADMIN	NOT_GIVEN_REASON	The reason category number associated with the use of a specific action.	
MED_ADMIN	PROVIDER_ID	The "billing provider" for a given administration.	
MED_ADMIN	ROUTE	The route category number associated with this administration.	
MED_ADMIN	VISIT_ID	Unique identifier for the patient primary billing encounter	

MED_AVS	AVS_ALL_REVIEWED_YN	This stores whether or not the last printed AVS included orders that were not reviewed.	
MED_AVS	AVS_HAS_CHANGES_YN	This stores whether or not there were any relevant discharge reconciliation changes since the AVS was last printed.	
MED_AVS	AVS_PRINTED_YN	This stores whether or not the AVS was printed.	
MED_AVS	DEPARTMENT	The ID number of the unit of the event record at the effective time. Join to REF_DEPT for name.	
MED_AVS	DISCHARGE_DATE	The hospital discharge date and time for this patient contact.	
MED_AVS	DISCH_ATTEND_PROV_ID	The provider id for the attending at time of discharge. Join to REF_PROVIDER for name.	
MED_AVS	EVENT_DATE	The instant when the event occurred.	
MED_AVS	GROUP_NAME	The name of the category value for the medication. Resume, CHanged, New, Stop Taking, No Group, Expired Long Term	
MED_AVS	LAST_UPDATE_DATE	The day and time the order record was last updated.	
MED_AVS	LINE	The sequential line for the after visit summary. There can be multiple lines per order; lines are not always sequential	
MED_AVS	LOCATION	The unique ID of the location that serves as the parent in your facility's ADT organizational structure. Join to REF_POS for name.	
MED_AVS	MEDICATION_ID	The unique ID of the medication record that is associated with this order.	
MED_AVS	MED_NAME	The name of the medication as it appears in the order record.	
MED_AVS	MED_ORDER_ID	The unique medication order id of the order record associated with this after visit summary	
MED_AVS	MED_VISIT_ID	Unique identifier for the patient encounter for the medication order	

MED_AVS	ORDER_CHANGED_YN	This stores whether or not the order changed after this snapshot.	
MED_AVS	ORDER_REVIEWED_YN	This stores if the order was reviewed for this snapshot.	
MED_AVS	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
MED_AVS	SNP_ACCOUNT_NUM	Hospital accounting record for the primary patient encounter; may be different than the VISIT account number	
MED_AVS	SNP_VISIT_ID	Unique identifier for the patient encounter for the after visit summary	
MED_CURRENT	LINE	The line number for the information associated with this record. Multiple pieces of information can be associated with this record.	
MED_CURRENT	MEDS_LAST_REV_DATE	The date the medication list was last reviewed	
MED_CURRENT	MED_DESC	The description of the reviewed medication	
MED_CURRENT	MED_ORDER_DATE	The date and time the order was placed.	
MED_CURRENT	MED_ORDER_ID	The medication order associated with the reviewed medication	
MED_CURRENT	MED_REVIEWER_NAME	The medication reviewer name	
MED_CURRENT	MED_REVIEW_VISIT_ID	The visit associated with the medication.	
MED_CURRENT	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
MED_CURRENT	PROV_ID	The provider id for the medication list reviewer	
MED_CURRENT	TAKING_YN	Indicates whether the associated medication order was marked as taking at the most recent time of review. Values are Y (yes) or N (no).	
MED_DISPENSE	ACCOUNT_NUM	Hospital accounting record for the primary patient encounter	

MED_DISPENSE	CONTACT_DATE_REAL	A unique, internal contact date in decimal format. The integer portion of the number indicates the date of the contact. The digits after the decimal distinguish different contacts on the same date and are unique for each contact on that date. For example, .00 is the first/only contact, .01 is the second contact, etc.	
MED_DISPENSE	DISPENSE_DATE	The instant of the pharmacy action.	
MED_DISPENSE	DISPENSE_QTY	The quantity of the dispensed medication.	
MED_DISPENSE	DISPENSE_QTY_UNIT	The category number for the medication unit of this verify/dispense/return. Example: 3 (MG), 4 (G), 5002 (TABLET), etc,	
MED_DISPENSE	DISPENSE_TYPE	The category number for the type of this component. Example: 1 (Base), 2 (Additives), 3 (Medications), 4 (Electrolytes), etc.	
MED_DISPENSE	DISP_MED_CODE	The unique ID of the medication that is related to this component action (the medication that was dispensed, verified or returned)	
MED_DISPENSE	DISP_MED_DESC	The description of the dispensed medication	
MED_DISPENSE	DISP_NDC_CSN	The NDC CSN of the dispensed medication.	
MED_DISPENSE	LAST_UPDATE_DATE	The day and time the order record was last updated.	
MED_DISPENSE	LINE	The sequential line count for the dispensing. There can be multiple lines per order	
MED_DISPENSE	MEDORDER_VISIT_ID	Unique identifier for the patient encounter for the medication order	
MED_DISPENSE	MED_ORDER_ID	The unique ID of the order record associated with the medication order for the dispensing.	

MED_DISPENSE	ORDERING_MODE	The category number for the ordering mode of the order (i.e. Outpatient, Inpatient). Note that Outpatient orders can be placed from an Inpatient encounter as discharge orders / take-home prescriptions.	
MED_DISPENSE	SUPPLY_DAYS	When a prescription is filled in an integrated pharmacy, a fill contact is created in the order and all fill information is saved to this fill contact. A prescription can have multiple fills. This is the number of days this fill will supply. For example, this fill dispensed enough to cover a 30-day supply.	
MED_DISPENSE	VISIT_ID	Unique identifier for the patient primary billing encounter	
MED_ORDER	ACCOUNT_NUM	Hospital accounting record for the primary patient encounter	
MED_ORDER	AUTH_PROV_ID	The id of the authorizing provider	
MED_ORDER	AUTH_PROV_NAME	The name of the authorizing provider	
MED_ORDER	DISPENSE_QUANTITY	This item stores the discrete quantity to dispense. Use with DISPENSE_UNIT.	
MED_ORDER	DISPENSE_UNIT	This item stores the category for the discrete dispense unit. Use with DISPENSE_QUANTITY. Example: 3 (MG), 4 (G), 5002 (TABLET), etc,	
MED_ORDER	DOSE	The discrete dose for a medication as entered by the user in the orders activity.	Y
MED_ORDER	DOSE_UNIT	The category number for the dose unit of a medication that corresponds with the DOSE column. Example: 3 (MG), 4 (G), 5002 (TABLET), etc,	
MED_ORDER	END_DATE	The date when the medication order is scheduled to end.	
MED_ORDER	FREQUENCY	The unique ID of the discrete frequency record associated with this medication order.	

MED_ORDER	INSTRUCTIONS	Patient instructions for the prescription as entered by the user in the orders activity.	
MED_ORDER	LASTDOSE	Comments for the last administered dose : Not taking, Taking or null	
MED_ORDER	LAST_UPDATE_DATE	The day and time the order record was last updated.	
MED_ORDER	MED_CODE	The unique ID of the medication record that is associated with this order.	
MED_ORDER	MED_DESC	The description of the order.	Y
MED_ORDER	MED_ORDER_ID	The unique ID of the order record associated with this medication order.	
MED_ORDER	MED_VISIT_ID	Unique identifier for the patient encounter for the medication order	
MED_ORDER	ORDERING_MODE	The category number for the ordering mode of the order (i.e. Outpatient, Inpatient). Note that Outpatient orders can be placed from an Inpatient encounter as discharge orders / take-home prescriptions. This column might be blank for Outpatient order	
MED_ORDER	ORDER_CLASS	The category number for the order class. Example: 1 (NORMAL), 3 (HISTORICAL MED), 9 (PHONE IN), 12 (PRINT), etc.	
MED_ORDER	ORDER_DATE	The date and time the order was placed.	
MED_ORDER	ORDER_REASON	The diagnosis associated with medication ordered	
MED_ORDER	ORDER_STATUS	The category number for the current status of an order. Example: (1) Pending, (2) Sent, 5 (Completed), etc.	
MED_ORDER	PATIENT_ID	Unique identifier for each patient; used to link to other tables	

MED_ORDER	PHARMACY_ID	The unique ID of the pharmacy record that is associated with this medication order. This column is frequently used to link to the RX_PHR table. This field is only populated if the clinical system user selects a specific pharmacy from the list, otherwise the field is null. This field is only populated by the ambulatory clinical system, not the pharmacy system.	
MED_ORDER	PHARMACY_NAME	The name of the pharmacy associated with the PHARMACY_ID	
MED_ORDER	PRIORITY	The category number for the priority assigned to an order. Example: 1 (ASAP), 2 (STAT)... 6 (ROUTINE)	
MED_ORDER	QUANTITY	The quantity of the prescription being dispensed as entered by the user in the orders activity. Relates to DISPENSE_QUANTITY and DISPENSE_UNIT	
MED_ORDER	REFILLS	The number of refills allowed for this prescription as entered by the user in the orders activity.	
MED_ORDER	ROUTE	The category number for the route of administration of a medication. Example: 4 (INJECTION), 7 (INHALATION), 15 (ORAL), etc.	
MED_ORDER	START_DATE	The date when the medication order is to start.	
MED_ORDER	VISIT_ID	Unique identifier for the patient primary billing encounter	
NOTE	CONTACT_DATE	The date of this contact in calendar format.	
NOTE	FULL_TEXT	The full plain text of the note. All formatting has been removed.	
NOTE	NOTE_TYPE	The type of note: IMP for impression, NAR for narrative.	
NOTE	ORDER_DATE_REAL	An internal value used to maintain the most recent current version of the note.	

NOTE	ORDER_ID	The order number associated with the note.	
NOTE_RSLT	COMPONENT_ID	A numeric identifer associated with this resultcomponent.	
NOTE_RSLT	FULL_TEXT	The full plain text of the note. All formatting has been removed.	
NOTE_RSLT	LINE	The line number of each result component for the order	
NOTE_RSLT	NOTE_SOURCE	An internal value to indicate if the source of the comment is ORDER_RES_CMT (CMT) or ORDER_RES_COMMENT (COMMENT)	
NOTE_RSLT	NOTE_TYPE	The tyoe of note: PATHOLOGY AND CYTOLOGY, ECG, MICROBIOLOGY, LAB, BLOOD BANK, PFT	
NOTE_RSLT	ORDER_DATE_REAL	The order date in a manner to handle muliple orders on the same day for the order. The integer portion of the number specifies the date of the encounter. The digits after the decimal point indicate multiple visits on one day.	
NOTE_RSLT	ORDER_ID	The order number associated with the note.	
NOTE_RSLT	RESULT_DATA_TYPE	The data-type category number for the result component type. Supported result component types are 0 (string), 1 (titer), 2 (category), 3 (structured numeric), 12 (numeric), etc.	
NOTE_RSLT	RESULT_DATE	The date the technician ran the tests for each order.	
NOTE_RSLT	RESULT_NUMERIC	A numeric representation of the value returned for each component where applicable.	
NOTE_RSLT	RESULT_TEXT	The value returned for each result component, in short free text format	
OBSERVATION	ABNORMAL	Stores whether or not the value is abnormal. Values are 1 (Yes) or null	
OBSERVATION	ACCOUNT_NUM	Hospital accounting record for the patient encounter	

OBSERVATION	FLOWSHEETID	The unique ID of the for the measurements recorded on the flowsheet template.	
OBSERVATION	INPATIENT_DATA_ID	Unique id to link related items to the visit.	
OBSERVATION	LAST_UPDATE_DATE	The last update timestamp for the observation	
OBSERVATION	LINE	The line count for the item. It is unique for the instance of the flowsheet	
OBSERVATION	OBSERVATION_DATE	The instant the reading was taken.	
OBSERVATION	OBSERVATION_DISPLAY_NAME	The display name fiven to the measured item	
OBSERVATION	OBSERVATION_GROUP	Logical grouping for the observations. Examples: VITAL, SMOKE, etc.	
OBSERVATION	OBSERVATION_ID	The unique ID for the flowsheet data record. Example: 11 is height, 14 is weight	
OBSERVATION	OBSERVATION_NAME	The name given to the measured item	Y
OBSERVATION	OBSERVATION_VALUE	The actual value of the flowsheet reading.	Y
OBSERVATION	OBS_VISIT_ID	Unique identifier for the patient encounter associated with the observation.	
OBSERVATION	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
OBSERVATION	TEMPLATE_ID	The unique ID of the flowsheet template which was used to record the measured data	
OBSERVATION	UNITS	This determines the units that will display with the value in the additional information window	
OBSERVATION	VALUE_TYPE	This determines the type of data in the record (i.e. numeric, string, temperature, etc.)	
OBSERVATION	VISIT_ID	Unique identifier for the patient encounter.	
OB_DELIVERY_RECORD	ANESTH_CONC	A comma delimited list of all anesthesia methods for the baby. Ex. Epidural, Spinal, General	

OB_DELIVERY_RECORD	APGAR1	The Apgar score (0-10) at 1 minute	
OB_DELIVERY_RECORD	APGAR10	The Apgar score (0-10) at 10 minutes	
OB_DELIVERY_RECORD	APGAR5	The Apgar score (0-10) at 5 minutes	
OB_DELIVERY_RECORD	AUGMENT_CONC		
OB_DELIVERY_RECORD	BABY_ID	The patient ID of the baby; used to link to other tables on PATIENT_ID	
OB_DELIVERY_RECORD	BABY_VISIT_ID	The visit id associated with the baby's birth	
OB_DELIVERY_RECORD	BIRTHWT	The baby's birth weight in grams (converted from ounces).	
OB_DELIVERY_RECORD	CERVRIPE_CONC	A comma delimited list of all cervical ripening methods for the baby. Ex. Gel, Misoprostol	
OB_DELIVERY_RECORD	CORD_CLAMP_DTTM	The instant the umbilical cord was clamped.	
OB_DELIVERY_RECORD	DELIVERYPRES_CONC	A comma delimited list of all delivery presentations. Ex. Vertex, Compound, Breech, etc.	
OB_DELIVERY_RECORD	DELMETHOD_CODE	The code of the delivery method used	
OB_DELIVERY_RECORD	DELMETHOD_NAME	The name of delivery method used	
OB_DELIVERY_RECORD	DELPLCTARM_CONC	A comma delimited list of the placenta removal information. Ex. Gel, Misoprostol	
OB_DELIVERY_RECORD	DELREC_ID	The baby's delivery record ID	
OB_DELIVERY_RECORD	DELRUPTCLR_CONC	A comma delimited list of the color of the vaginal fluid resulting from membrane rupture for this pregnancy. Ex. Clear, Bloody, Meconium, etc.	
OB_DELIVERY_RECORD	DELRUPTTYPE_CONC	A comma delimited list of how membranes ruptured for this pregnancy. Ex. Spontaneous, Aritical, etc.	
OB_DELIVERY_RECORD	DEL_DTTM	The delivery time of the baby.	
OB_DELIVERY_RECORD	DEPT_ID	The ID of the department where the birth occurred	

OB_DELIVERY_RECORD	EPISIO_CONC	A comma delimited list of all episiotomy methods for the baby. Ex. Median, Left Mediolateral	
OB_DELIVERY_RECORD	FORCEPS_DEL_ATT_YN	This column displays Y or N depending on whether or not a forceps delivery was attempted during this labor.	
OB_DELIVERY_RECORD	GA	The gestational age at birth in weeks and days. Ex. 39w 3d	
OB_DELIVERY_RECORD	INDUCT_CONC	A comma delimited list of all induction methods for the baby. Ex. Cervidil, Foley/EASI	
OB_DELIVERY_RECORD	LACER_CONC	A comma delimited list of all laceration methods for the baby. Ex. 1st, Vaginal	
OB_DELIVERY_RECORD	LAST_INSUPD_DATE	The timestamp associated with an insert or the last update of the row	
OB_DELIVERY_RECORD	LDCOMPLICATION_CONC	A comma delimited list of all labor and delivery complications. Ex. None, Fetal Intolerance, Failure to Progress to Second Stage, etc.	
OB_DELIVERY_RECORD	LIVING	The living status of the baby. Example: null, Yes, Neonatal Demise, Fetal Demise	
OB_DELIVERY_RECORD	MOM_ID	The patient ID of the mom; used to link to other tables on PATIENT_ID	
OB_DELIVERY_RECORD	MOM_VISIT_ID	The visit id associated with the mom's delivery	
OB_DELIVERY_RECORD	OB_DELIV_MD_NAME	The name of the provider who was responsible for delivering this infant	
OB_DELIVERY_RECORD	OB_DEL_DELIV_MD_ID	The unique ID of the provider who was responsible for delivering this infant	

OB_DELIVERY_RECORD	OB_DEL_RUP_DTTM	The amount of time (in seconds) from rupture of membranes until the patient delivers. For pregnancy episodes, if there are multiples, it will calculate the length of time from the earliest rupture instant documented on a delivery record through to the latest delivery instant. If no time value was recorded, the default is midnight (use RUPT_TM_PRESENT_YN to determine if a midnight value is entered by the user or defaulted).	
OB_DELIVERY_RECORD	PREG_EPISODE_ID	The mother's pregnancy episode ID	
OB_DELIVERY_RECORD	ROM_TO_DELIVER		
OB_DELIVERY_RECORD	RUPT_TM_PRESENT_YN	VALUES ARE Y, N, or NULL and denotes whether a rupture time was present in HSB 35151. If there was no rupture time present, OB_DEL_RUP_DTTM stores midnight as a default time.	
OB_DELIVERY_RECORD	VACUUM_DEL_ATT_YN	This column displays Y or N depending on whether or not a vacuum delivery was attempted during this labor.	
ORDERS	ACCESSION_NUMBER	The accession number associated with an order.	
ORDERS	AUTHRZING_PROV_ID	The unique ID of the provider prescribing or authorizing the order.	
ORDERS	DEPARTMENT	The name of the department for the encounter. If there are multiple departments for the encounter, this is the first department in the list.	
ORDERS	DEPARTMENT_ID	The ID of the department for the encounter. If there are multiple departments for the encounter, this is the ID of the first department in the list.	

ORDERS	ENCOUNTER_TYPE	Category type for the patient encounter associated with the ORDER_VISIT_ID: 3 (HOSPITAL ENCOUNTER), 101 (OFFICE VISIT), 1003 (PROCEDURE VISIT), etc.	
ORDERS	IMPRESSION_YN	Y for Yes or N for No indicating if there is are impression notes associated with the order.	
ORDERS	INPATIENT_DATA_ID	Unique id to link related items to the visit.	
ORDERS	LAST_UPDATE_DATE	The last update timestamp for the record	
ORDERS	NARRATIVE_YN	Y for Yes or N for No indicating if there is a narrative associated with the order.	
ORDERS	ORDERING_PROV_ID	The ID of the order's ordering provider.	
ORDERS	ORDER_CLASS	The order class category of the procedure order: HOSPITAL PERFORMED,ANCILLARY PERFORMED, CLINIC PERFORMED, NORMAL, etc.	
ORDERS	ORDER_DATE	The date when the order was placed	
ORDERS	ORDER_ID	The unique ID of the order	
ORDERS	ORDER_PROC	The description of the procedure code associated with this order	
ORDERS	ORDER_PROC_CODE	The procedure code associated with this order.	
ORDERS	ORDER_STATUS	The status category of the order: CANCELED, COMPLETED, SENT, RESULT, etc.	
ORDERS	ORDER_TYPE	The order type category description for the order.	
ORDERS	ORDER_TYPE_CODE	The order type category number for the order.	
ORDERS	ORDER_VISIT_ID	Unique identifier for the patient encounter associated with the order	
ORDERS	PATIENT_ID	Unique identifier for each patient; used to link to other tables	

ORDERS	PRIORITY	The priority of the order: ROUTINE, STAT, ASAP, TIMED, TODAY, ADD-ON, etc.	
ORDERS	PROC_ID	The unique internal identifier of the procedure record corresponding to this order.	
ORDERS	PROC_START_DATE	The date and time when the procedure order is to start.	
ORDERS	RADIOLOGY_STATUS	The status category of the imaging orders: FINAL, EXAM ENDED, SCHEDULED, PRELIMINARY, etc.	
ORDERS	REFERRING_PROV_ID	The unique ID of the provider who has referred this order, i.e. the referring provider.	
ORDERS	RESULT_DATE	The most recent date and time when the procedure order was resulted.	
ORDERS	SPECIALTY_DEPARTMENT	The category number for the requested medical specialty of the department to which the patient is referred.	
ORDERS	SPECIMEN_DATE	The date the specimen was collected.	
ORDERS	SPECIMEN_SOURCE	The specimen source category number for the procedure order: BLOOD, COLON/POLYP, CERVIX, etc.	
ORDERS	SPECIMEN_TYPE	The specimen type category for the procedure order: TISSUE, BLOOD, FLUID, etc.	
ORDERS	VISIT_ID	Unique identifier for the patient primary billing encounter. Can be null for order only encounters.	
ORDER_RESULT	COMPONENT_COMMENT	Contains the comments associated with an order COMPONENT_ID, i.e. this is the comments associated with a specific order component's results. If comment data is too long to fit in this item, then the comments will be found in the NOTE_RSLT table.	
ORDER_RESULT	COMPONENT_ID	A numeric identifer associated with this result component	

ORDER_RESULT	COMPONENT_NAME	The description for the numeric identifer associated with this component	
ORDER_RESULT	LAB_STATUS	The status category number of the result: 1 (In Progress), 2 (Preliminary result) , 3 (Final result), 4 (Edited), 5 (Edited Result - FINAL)	
ORDER_RESULT	LAST_UPDATE_DATE	The last update timestamp for the record	
ORDER_RESULT	LINE	The line number of each result component for the order	
ORDER_RESULT	LOINC	Free text LOINC code associated with a component.	
ORDER_RESULT	ORDER_ID	The unique ID of the order,	
ORDER_RESULT	ORD_DATE_REAL	Numeric version of the date with decimal values to handle mulitple orders on the same day.	
ORDER_RESULT	REFERENCE_HIGH	The highest acceptable value for each result component.	
ORDER_RESULT	REFERENCE_LOW	The lowest acceptable value for each result component.	
ORDER_RESULT	REFERENCE_NORMAL	This is a free-text item which allows you to enter a reference range without tying it to a "low" or "high" value. For example, it could be a string ("negative"), a list of choices ("Yellow, orange"), or a descriptive range ("Less than 20"). The values entered in this range should always represent the "normal" values.	
ORDER_RESULT	REFERENCE_UNIT	The units for each result component value	
ORDER_RESULT	RESULT_DATA_TYPE	The data-type category number for the result component type. Supported result component types are 0 (string), 1 (titer), 2 (category), 3 (structured numeric), 12 (numeric), etc.	
ORDER_RESULT	RESULT_DATE	The date the technician ran the tests for each order.	

ORDER_RESULT	RESULT_FLAG	The category value associated with a flag code corresponding to a standard HL7 code to mark each component result as abnormal: 2 (Abnormal), 3 (Panic), 4 (Low), 5 (High), etc.	
ORDER_RESULT	RESULT_IN_RANGE_YN	A Yes/No category value to indicate whether a result has been verified to be within its reference range. This item is set by the interface when the result is sent. A null value is equivalent to a "no" value.	
ORDER_RESULT	RESULT_NUMERIC	A numeric representation of the value returned for each component where applicable.	Y
ORDER_RESULT	RESULT_STATUS	The status category number of the result: 2 (Preliminary), 3 (Final), 4 (Corrected), 5 (Incomplete)	
ORDER_RESULT	RESULT_TEXT	The value returned for each result component, in short free text format	
ORDER_RESULT	RSLT_VISIT_ID	Unique identifier for the patient encounter for the order results	
ORDER_RESULT	SERVICE_AREA	The service area description of the department in which the appointment associated with this order took place.	
ORDER_RESULT	SERVICE_AREA_CODE	The service area code of the department in which the appointment associated with this order took place.	
ORDER_RESULT	VISIT_ID	Unique identifier for the patient primary billing encounter	
ORDER_SUMMARY	ORDER_ID	The unique ID of the order record, used to link to the ORDERS table.	
ORDER_SUMMARY	ORDER_VISIT_ID	The unique contact serial number for this contact.	
ORDER_SUMMARY	ORD_SUMMARY	The order summary narrative.	
ORDER_SUMMARY	PATIENT_ID	The unique ID of the patient record associated with this dialysis order; used to link to other tables	

PATIENT	ADD_LINE_1	First line of patient address	
PATIENT	ADD_LINE_2	Second line of patient address	
PATIENT	BIRTH_DATE	Patient date of birth	
PATIENT	CITY	City where the patient lives	
PATIENT	COUNTRY	Code corresponding to the country where the patient lives	
PATIENT	COUNTY	Code corresponding to the county where the patient lives	
PATIENT	CREATE_USER_ID	The unique ID of the system user who entered this patient's record. This ID may be encrypted.	
PATIENT	DEATH_DATE	Patient date of death	
PATIENT	EMAIL_ADDRESS	The patient's e-mail address.	
PATIENT	GENDER	Code for gender; values are F, M, U, O, I	Y
PATIENT	GENDER	Code for gender; values are F, M, U, O, I	Y
PATIENT	HISPANIC	Code for hispanic ethnicity; valid codes are 1,2,3,4	Y
PATIENT	HOME_PHONE	The patient's home phone number.	
PATIENT	LANGUAGE	Code for language; valid codes are null or numeric	
PATIENT	LAST_UPDATE_DATE	The time this patient record was pulled into enterprise reporting or date of last update.	
PATIENT	MARITAL_STATUS	Code for marital status; valid codes are mull, 1 - 7,100	Y
PATIENT	MILITARY_STATUS	Code for marital status; valid codes are null, 1 - 7	Y
PATIENT	MOBILE_PHONE	The patient's mobile phone number.	
PATIENT	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
PATIENT	PATIENT_MRN	Patient Medical Record Number	
PATIENT	PATIENT_STATUS	The category value of the patient status. Possible statuses include alive and deceased.	Y
PATIENT	PAT_FIRST_NAME	Patient first name	
PATIENT	PAT_LAST_NAME	Patient last name	
PATIENT	PAT_MIDDLE_NAME	Patient middle name	
PATIENT	PAT_NAME	Patient full name: Last name, First name, Middle name	

PATIENT	PAT_NAME_SUFFIX	The suffix to the patient name, e.g. Jr., Sr., III, etc	
PATIENT	PRELIM_COD_DX_ID	The preliminary cause of death diagnosis id, join to REF_ICD_DX for details	
PATIENT	RACE	Code for race: Codes are numeric 1- 10	Y
PATIENT	REC_CREATE_DATE	The date the patient record was created in the system.	
PATIENT	REC_CREATE_DEPT_ID	The unique ID of the department in which the patient record was created.	
PATIENT	REG_DATE	The date on which the last patient verification occurred. If a patient was verified and then re-verifed at a later date, this column will show the re-verified date. This column will be null for patients that have never been verified.	
PATIENT	RELIGION	Code for religion; valid codes are null or numeric	Y
PATIENT	RESEARCH_ID	The research id is populated for dummy records for billing purposes Used to link to CLARITY_RSH. It will be null for actual patient records.	
PATIENT	SSN	The patient's Social Security Number. This number is formatted as 999-99-9999	
PATIENT	STATE	State abbreviation where the patient lives	
PATIENT	WORK_PHONE	The patient's work phone number.	
PATIENT	ZIP	The ZIP Code area in which the patient lives	
PHENOTYPE	ACQ_HYPOTHR	Y (yes) or NULL (no) indicator if the chronic condition Acquired Hypothyroidism exists for a patient.	Y
PHENOTYPE	ACUTE_MI	Y (yes) or NULL (no) indicator if the chronic condition Acute Myocardial Infarction exists for a patient.	Y

PHENOTYPE	AFIB	Y (yes) or NULL (no) indicator if the chronic condition Atrial Fibrillation exists for a patient.	Y
PHENOTYPE	ALZHEIMER	Y (yes) or NULL (no) indicator if the chronic condition Alzheimer's Disease exists for a patient.	Y
PHENOTYPE	ALZHEIMER_DEMENTIA	Y (yes) or NULL (no) indicator if the chronic condition Alzheimer's Disease and Related Disorders or Senile Dementia exists for a patient.	Y
PHENOTYPE	ANEMIA	Y (yes) or NULL (no) indicator if the chronic condition Anemia exists for a patient.	Y
PHENOTYPE	ASTHMA	Y (yes) or NULL (no) indicator if the chronic condition Asthma exists for a patient.	Y
PHENOTYPE	BPH	Y (yes) or NULL (no) indicator if the chronic condition Benign Prostatic Hyperplasia exists for a patient.	Y
PHENOTYPE	BREAST_CANCER	Y (yes) or NULL (no) indicator if the chronic condition Female / Male Breast Cancer exists for a patient.	Y
PHENOTYPE	CATARACT	Y (yes) or NULL (no) indicator if the chronic condition Cataract exists for a patient.	Y
PHENOTYPE	CHARLSON_INDEX	Calculated Charlson Index score with weights applied to comobordity groups and age adjustment.	Y
PHENOTYPE	CHARLSON_INDEX_NOAGE ADJ	Calculated Charlson Index score with weights applied to comobordity groups with no age adjustment.	Y
PHENOTYPE	CKD	Y (yes) or NULL (no) indicator if the chronic condition Chronic Kidney Disease exists for a patient.	Y
PHENOTYPE	COLORECTAL_CANCER	Y (yes) or NULL (no) indicator if the chronic condition Colorectal Cancer exists for a patient.	Y

PHENOTYPE	COPD	Y (yes) or NULL (no) indicator if the chronic condition Chronic Obstructive Pulmonary Disease and Bronchiectasis exists for a patient.	Y
PHENOTYPE	DEPRESSION	Y (yes) or NULL (no) indicator if the chronic condition Depression exists for a patient.	Y
PHENOTYPE	DIABETES	Y (yes) or NULL (no) indicator if the chronic condition Diabetes exists for a patient.	Y
PHENOTYPE	ENDOMETRIAL_CANCER	Y (yes) or NULL (no) indicator if the chronic condition Endometrial Cancer exists for a patient.	Y
PHENOTYPE	GLAUCOMA	Y (yes) or NULL (no) indicator if the chronic condition Glaucoma exists for a patient.	Y
PHENOTYPE	HEART_FAILURE	Y (yes) or NULL (no) indicator if the chronic condition Heart Failure exists for a patient.	Y
PHENOTYPE	HIP_PELVIC_FRACTURE	Y (yes) or NULL (no) indicator if the chronic condition Hip/Pelvic Fracture exists for a patient.	Y
PHENOTYPE	HYPERLIPIDEMIA	Y (yes) or NULL (no) indicator if the chronic condition Hyperlipidemia exists for a patient.	Y
PHENOTYPE	HYPERTENSION	Y (yes) or NULL (no) indicator if the chronic condition Hypertension exists for a patient.	Y
PHENOTYPE	ISCHEMIC_HEART_DISEASE	Y (yes) or NULL (no) indicator if the chronic condition Ischemic Heart Disease exists for a patient.	Y
PHENOTYPE	LUNG_CANCER	Y (yes) or NULL (no) indicator if the chronic condition Lung Cancer exists for a patient.	Y
PHENOTYPE	OSTEOPOROSIS	Y (yes) or NULL (no) indicator if the chronic condition Osteoporosis exists for a patient.	Y
PHENOTYPE	PATIENT_ID	Unique identifier for the patient. Used to link to other tables.	

PHENOTYPE	PROSTATE_CANCER	Y (yes) or NULL (no) indicator if the chronic condition Prostate Cancer exists for a patient.	Y
PHENOTYPE	RA_OA	Y (yes) or NULL (no) indicator if the chronic condition RA/OA (Rheumatoid Arthritis/ Osteoarthritis) exists for a patient.	Y
PHENOTYPE	STROKE	Y (yes) or NULL (no) indicator if the chronic condition Stroke / Transient Ischemic Attack exists for a patient.	Y
PNEG_MEDICAL_HX	DX_NAME	The name for the diagnois.	
PNEG_MEDICAL_HX	LAST_UPDATE_DATE	The time this patient history record was pulled into enterprise reporting or date of last update.	
PNEG_MEDICAL_HX	LINE	The line number for the information associated with this contact. Multiple pieces of information can be associated with this contact.	
PNEG_MEDICAL_HX	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
PNEG_MEDICAL_HX	PNEG_MED_HX_SRC	The category description for the pertinent negative medical history's source for the patient record.: Provider (1), Patient (2), Parent (3), etc.	
PNEG_MEDICAL_HX	PNEG_MED_HX_SRC_CODE	The category code for the pertinent negative medical history's source for the patient record.: 1 (Provider), 2 (Patient), 3 (Parent), etc.	
PNEG_MEDICAL_HX	PNEG_MHX_CONTACT_DATE	The date of this contact in calendar format.	
PNEG_MEDICAL_HX	PNEG_MHX_DX_ID	The unique ID of the diagnosis record associated with the pertinent negatives medical history contact. Note: This is NOT the ICD9/10 diagnosis code. It is an internal identifier that is typically not visible to a user.	

PNEG_MEDICAL_HX	PNEG_MHX_LNK_VISIT_ID	The Contact Serial Number of the encounter in which the history was created/edited. If the history was created/edited outside of the context of an encounter, then this column will be blank.	
PNEG_MEDICAL_HX	PNEG_MHX_VISIT_ID	A unique serial number for this encounter.	
PNEG_SURGICAL_HX	LAST_UPDATE_DATE	The time this patient history record was pulled into enterprise reporting or date of last update.	
PNEG_SURGICAL_HX	LINE	The line number for the information associated with this contact. Multiple pieces of information can be associated with this contact.	
PNEG_SURGICAL_HX	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
PNEG_SURGICAL_HX	PNEG_SURG_HX_ID	The unique ID of the procedure record associated with the pertinent negatives surgical history data for the history contact.	
PNEG_SURGICAL_HX	PNEG_SURG_HX_SRC	The category description for the pertinent negative surgical history's source for the patient record.: Provider (1), Patient (2), Parent (3), etc.	
PNEG_SURGICAL_HX	PNEG_SURG_HX_SRC_CODE	The category code for the pertinent negative surgical history's source for the patient record.: 1 (Provider), 2 (Patient), 3 (Parent), etc.	
PNEG_SURGICAL_HX	PROC_CODE	Procedure code documented in the patient's pertinent negative surgical history	
PNEG_SURGICAL_HX	PROC_NAME	Procedure namw documented in the patient's pertinent negative surgical history	

PNEG_SURGICAL_HX	PSHX_CONTACT_DATE	The contact date of the encounter associated with this pertinent surgical surgical history contact. Note: There may be multiple encounters on the same calendar date.	
PNEG_SURGICAL_HX	PSHX_VISIT_ID	The unique contact serial number for this contact. This number is unique across all patient encounters in your system	
PROBLEM_LIST	CHRONIC_YN	Yes/No indicates whether or not this problem is flagged as chronic.	
PROBLEM_LIST	DX_CODE	The code for the problem diagnosis	Y
PROBLEM_LIST	DX_CODE_SET	The coding set for the problem diagnosis	
PROBLEM_LIST	DX_ID	Unique Identifier for diagnosis and links to the referecne table: REF_ICD_DX	
PROBLEM_LIST	DX_NAME	The name or description of the problem diagnosis	Y
PROBLEM_LIST	DX_POA	Indicator if the diagnosis was present on admission	
PROBLEM_LIST	ENTRY_DATE	The date the problem was entered into the patient's medical record. or was last edited (i.e., a change was made, either in status, priority, etc.	
PROBLEM_LIST	HOSPITAL_PL_YN	Yes/No Is this problem a hospital problem?	
PROBLEM_LIST	LAST_UPDATE_DATE	The last update timestamp for the probelm diagnosis	
PROBLEM_LIST	NOTED_DATE	The date the problem was first diagnosed. By default, this is the date of the encounter during which the problem was added to the problem list. The intent of this field is to allow users to change this date to the date the problem was first diagnosed if that is different than the encounter date.	

PROBLEM_LIST	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
PROBLEM_LIST	PL_VISIT_ID	The unique contact serial number of the most recent patient encounter where this problem list was documented.	
PROBLEM_LIST	PRINCIPAL_PL_YN	Yes/No Is this problem the principal problem?	
PROBLEM_LIST	PRIORITY	The category value associated with the relative severity of the problem. Example: 1 (high), 2 (medium), or 3 (low)). This field shows the category value associated with the current priority level assigned to a problem	
PROBLEM_LIST	PROBLEM_CLASS	The category value associated with additional information for the problem, such as Acute, chronic, minor, and so on.	
PROBLEM_LIST	PROBLEM_LIST_ID	The unique ID of this Problem List entry.	
PROBLEM_LIST	PROBLEM_STATUS	The category value associated with the problem's current state: 1 (Active), 2 (Resolved), or 3 (Deleted).	Y
PROBLEM_LIST	RESOLVED_DATE	The date the problem was resolved	
PROBLEM_LIST	STAGE_DESC	Description of the cancer for the associated stage in the STAGE_ID column	
PROBLEM_LIST	STAGE_ID	The unique ID of the cancer stage record (STG .1) associated with the entry in the patient's Problem	
PROBLEM_LIST	VISIT_ID	The main encounter closest to or the same as the problem encounter.	
PROCEDURE	ACCOUNT_NUM	Hospital accounting record for the patient encounter	
PROCEDURE	LAST_UPDATE_DATE	The last update timestamp for the record	

PROCEDURE	LINE	Since multiple final ICD procedures can be stored in one hospital account, each procedure will have a unique line number.	
PROCEDURE	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
PROCEDURE	PROC_CODE	The billing code for the procedure	Y
PROCEDURE	PROC_CODE_SET	The billing coding set for the procedure	Y
PROCEDURE	PROC_DATE	The date the procedure was performed	
PROCEDURE	PROC_ID	Unique Identifier for ICD procedures and links to the reference table: REF_ICD_PX	
PROCEDURE	PROC_NAME	The name or description of the procedure	Y
PROCEDURE	PROC_PERF_PROV_ID	The identifier for the performing provider	
PROCEDURE	PROC_VISIT_ID	Unique identifier for the patient encounter when the procedure was performed.	
PROCEDURE	VISIT_ID	Unique identifier for the patient encounter.	
PROFESSIONAL_BILLING	ACCOUNT_NUM	The unique ID of the hospital account that is associated with this transaction.	
PROFESSIONAL_BILLING	ACCT_CLOSE_DATE	The date the hospital account was closed	
PROFESSIONAL_BILLING	BILL_VISIT_ID	The contact serial number associated with this transaction.	
PROFESSIONAL_BILLING	CHARGE_AMOUNT	The sum of any charges (detail type 1) and voids (detail type 10) for the transaction	
PROFESSIONAL_BILLING	DEPARTMENT_ID	The unique ID of the department of the transaction; join to REF_DEPT for details	
PROFESSIONAL_BILLING	DX_FIVE	The fifth diagnosis that is associated with the charge transaction. Join to REF_ICD_DX for dx code information.	

PROFESSIONAL_BILLING	DX_FOUR	The fourth diagnosis that is associated with the charge transaction. Join to REF_ICD_DX for dx code information.	
PROFESSIONAL_BILLING	DX_ONE	The first diagnosis that is associated with the charge transaction. This is the primary diagnosis for the charge transaction. Join to REF_ICD_DX for dx code information.	
PROFESSIONAL_BILLING	DX_SIX	The sixth diagnosis that is associated with the charge transaction. Join to REF_ICD_DX for dx code information.	
PROFESSIONAL_BILLING	DX_THREE	The third diagnosis that is associated with the charge transaction. Join to REF_ICD_DX for dx code information.	
PROFESSIONAL_BILLING	DX_TWO	The second diagnosis that is associated with the charge transaction. Join to REF_ICD_DX for dx code information.	
PROFESSIONAL_BILLING	FINANCIAL_CLASS	The name of the financial class: Self-Pay, Medicare, Blue Cross Blue Shield, Commercial, etc.	
PROFESSIONAL_BILLING	GUARANTOR_ID	A unique id for the guarantor of this account.	
PROFESSIONAL_BILLING	GUARANTOR_NAME	The name of the guarantor of the account	
PROFESSIONAL_BILLING	GUARANTOR_TYPE	Name for the category value associated with the type of account, such as Personal/Family, Worker's Comp, etc.	
PROFESSIONAL_BILLING	GUARANTOR_TYPE_CODE	Category value associated with the type of account, such as 1 (Personal/Family), 5 (Worker's Comp), etc.	

PROFESSIONAL_BILLING	MTCH_TX_HX_DATE	The date that a charge and a payment were matched based on a transaction id. This column is populated for the research rows (RSCH_BILLING_YN=Y).	
PROFESSIONAL_BILLING	PATIENT_ID	The internal patient id used to link to other tables.	
PROFESSIONAL_BILLING	PAYMENT_AMOUNT	The sum of any matched payments (detail type 20) for the transaction	
PROFESSIONAL_BILLING	POST_DATE	The date the transaction was posted to Resolute. Detail type of 1 with matched payments	
PROFESSIONAL_BILLING	RESEARCH_ID	The unique ID number of research study; use to join to RSCH_STUDY	
PROFESSIONAL_BILLING	RESEARCH_STUDY_CODE	External ID for research study. MUSC source is Sparc. Same as value in RSCH_STUDY.STUDY_CODE	
PROFESSIONAL_BILLING	SERVICE_DATE	The service date of the transaction (TX_ID). For payment transactions (DETAIL_TYPE is 2, 11, 32, or 33), this is the deposit date of the payment.	
PROFESSIONAL_BILLING	VISIT_ID	The primary contact serial number associated with the hospital account number; use to join to VISIT	
QSTN_ANS	ANSWER_ID	The unique ID of the questionnaire answer record. Used to join to the meta data in QSTN_INFO.	
QSTN_ANS	FORM_ID	The id of the form (questionnaire).	
QSTN_ANS	QUESTION_DISPLAY	The question that the user sees	
QSTN_ANS	QUESTION_LINE	Line count of the answers in the questionnaire record.	
QSTN_ANS	QUESTION_NAME	The name of the question record.	
QSTN_ANS	QUEST_ANSWER	The answer to the question for this record	
QSTN_ANS	QUEST_ID	The unique ID of the question for this record.	

QSTN_INFO	ANSWER_ID	The unique ID of the questionnaire answer record. Used to join to the answers in QSTN_ANS.	
QSTN_INFO	CONTACT_DATE	The contact date for the visit associated with the questionnaire	
QSTN_INFO	ENCOUNTER_TYPE	The description for the encounter type associated with the questionnaire	
QSTN_INFO	FORM_NAME	The name of the form (questionnaire).	
QSTN_INFO	LOS_PROC_CODE	The procedure code for the primary LOS (level of service).	
QSTN_INFO	LOS_PROC_NAME	The description of the procedure code for the primary LOS (level of service).	
QSTN_INFO	PARENT_MSG_CREATED_DATE		
QSTN_INFO	PATIENT_ID	The unique patient identifier used to join to related tables.	
QSTN_INFO	QSTN_VISIT_ID	The visit id associated with the questionnaire.	
QSTN_INFO	QUESTION_INSTANT	The instant a question was answered.	
RESEARCH_PERMISSION	BIO_BANK_PREF	The patient's preference that their left over tissue may be used in de-idenified research: 1 (Yes), 2 (No), 3 (Not ready to make a decision)	Y
RESEARCH_PERMISSION	CONTACT_PREF	The patient's preference to be contacted for research: 1 (Yes), 2 (No), 3 (Not ready to make a decision)	Y
RESEARCH_PERMISSION	LAST_UPDATE_DATE	The date the row was inserted into this table. This table is refreshed periodically.	
RESEARCH_PERMISSION	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
RESEARCH_PERMISSION	PREFERENCE_DATE	The date the preferences were submitted	
RESEARCH_PERMISSION	RECORD_ID	Unique identifier for research permission registry	
RSCH_ENROLLMENT	ENROLL_COMMENT	Comment associated with the enrollment	

RSCH_ENROLLMENT	ENROLL_END_DATE	End date of the patient's enrollment in the study.	
RSCH_ENROLLMENT	ENROLL_ID	The unique ID of the patient enrollment record for this row.	
RSCH_ENROLLMENT	ENROLL_START_DATE	Start date of the patient's enrollment in the study.	
RSCH_ENROLLMENT	ENROLL_STATUS	Enrollment status category. Values include: IDENTIFIED, SCREEN FAILURE, CONSENTED - IN SCREENING, ENROLLED- RECEIVING TREATMENT AND/OR INTERVENTION, etc.	Y
RSCH_ENROLLMENT	LAST_UPDATE_DATE	The last update timestamp for the record	
RSCH_ENROLLMENT	PATIENT_ID	Unique ID of the associated patient record.	
RSCH_ENROLLMENT	REC_CREATE_DATE	Research record create date	
RSCH_ENROLLMENT	RESEARCH_ID	Unique ID of the associated Research Study record. Use to join to RSCH_STUDY.	
RSCH_ENROLLMENT	STUDY_ALIAS	Patient's alias for the study enrollment.	
RSCH_ENROLL_HX	ENROLL_ID	The unique ID of the patient enrollment record for this row. Use to link to RSCH_ENROLLMENT.	
RSCH_ENROLL_HX	HX_ENROLL_STATUS	The status catagory. This value can change over time.	
RSCH_ENROLL_HX	HX_MOD_DTTM	Instant that the enrollment information was modified.	
RSCH_ENROLL_HX	HX_MOD_END_DT	A history of end date changes for the enrollment.	
RSCH_ENROLL_HX	HX_MOD_START_DT	A history of start date changes for the enrollment.	
RSCH_ENROLL_HX	HX_MOD_VISIT_ID	A history of the changes to the comments note record associated with the enrollment.	
RSCH_ENROLL_HX	LINE	The line number for the information associated with this record. Multiple pieces of information can be associated with this record.	

RSCH_ENROLL_HX	NOTE_ID	The note identfier associated with history of comments. Can be null.	
RSCH_ENROLL_HX	NOTE_TEXT	Comment associated with the enrollment history.	
RSCH_STUDY	BILLING_CONTACT	The billing contact person associated with the research study.	
RSCH_STUDY	IRB_APPROVAL_NUM	The IRB approval identifier.	
RSCH_STUDY	LAST_UPDATE_DATE	The last update timestamp for the record	
RSCH_STUDY	NCT_NUM	The National Clinical Trials Number is a registry number specified for all studies registered with ClinicalTrials.gov	Y
RSCH_STUDY	PI_ID	The internal id for the prinicipal investigator, use to join to the REF_PROVIDER for more information.	
RSCH_STUDY	PI_NAME	The principal investigator's full name	
RSCH_STUDY	RECORD_STATUS	The record status category. Values include: INACTIVE, DELETED, HIDDEN, INACTIVE AND HIDDEN, DELETED AND HIDDEN	
RSCH_STUDY	REC_CREATE_DATE	Research record create date	
RSCH_STUDY	RESEARCH_ID	The unique ID number of research study record	
RSCH_STUDY	RESEARCH_NAME	The name of the research study record	Y
RSCH_STUDY	RMID	Research Mater ID (RMID); used to link across software systems.	
RSCH_STUDY	STUDY_CODE	External ID for research study. MUSC source is Sparc. This code will appear on research-related charges.	
RSCH_STUDY	STUDY_STATUS	The research study status category. Values include: ACTIVE, COMPLETED, INACTIVE	
RSCH_STUDY	STUDY_TYPE	The category of study type derived from Sparc questions. Values include: T00, T01, T02, etc.	

RSCH_VISIT	CONTACT_DATE	The date of this contact in calendar format	
RSCH_VISIT	ENROLL_ID	The unique ID of the patient enrollment record; link to RSRHC_ENROLLMENT	
RSCH_VISIT	LAST_UPDATE_DATE	The last update timestamp for the record	
RSCH_VISIT	LINE	The line number for the information associated with this contact. Multiple pieces of information can be associated with this contact for the same visit.	
RSCH_VISIT	MANUAL_LINK_YN	Indicates whether the non-inferred columns of this table are based on manual user linkage. Y indicates that a user manually linked the encounter to the patient timeline. N indicat	
RSCH_VISIT	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
RSCH_VISIT	PAT_ENC_DATE_REAL	A unique contact date in decimal format. The integer portion of the number indicates the date of contact. The digits after the decimal distinguish different contacts on the same date and are unique for each contact on that date. For example, .00 is the first/only contact, .01 is the second contact, etc.	
RSCH_VISIT	RESEARCH_ID	The unique ID of the research study linked to this patient encounter. This column is frequently used to link to the RSCH_STUDY table	
RSCH_VISIT	RSCH_VISIT_ID	Unique identifier for the research visit. Join to VISIT for more information.	
SMOKE_HX	CHEW_YN	Y if the patient uses chewing tobacco. N if the patient does not.	
SMOKE_HX	CIGARETTES_YN	Y if the patient uses cigarettes. N if the patient does not.	

SMOKE_HX	CIGARS_YN	Y if the patient smokes cigars. N if the patient does not.	
SMOKE_HX	CONTACT_DATE	The date of this contact in calendar format.	
SMOKE_HX	LAST_UPDATE_DATE	The time this patient social history record was pulled into enterprise reporting or date of last update.	
SMOKE_HX	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
SMOKE_HX	PIPES_YN	Y if the patient smokes a pipe. N if the patient does not.	
SMOKE_HX	SMOKELESS_QUIT_DATE	The date on which the patient quit using smokeless tobacco	
SMOKE_HX	SMOKELESS_TOB_USE	Stores the patient's usage of smokeless tobacco. Data may include, 1 (Current User), 2 (Former User), 3 (Never Used) or 4 (Unknown)	Y
SMOKE_HX	SMOKELESS_TOB_USE_NAME	Stores the patient's usage of smokeless tobacco. Data may include, Current User (1), Former User (2), Never Used (3) or Unknown (4)	
SMOKE_HX	SMOKING_QUIT_DATE	The date on which the patient quit smoking in calendar format.	
SMOKE_HX	SMOKING_START_DATE	The date on which the patient started smoking in calender format.	
SMOKE_HX	SMOKING_TOB_USE	Stores the patient's usage of smoking tobacco. Data may include, 1 (Current Everyday Smoker), 2 (Current Some Day Smoker), 3 (Smoker, Current Status Unknown), 4 (Former Smoker).	Y
SMOKE_HX	SMOKING_TOB_USE_NAME	Stores the patient's usage of smoking tobacco. Data may include, Current Everyday Smoker (1), Current Some Day Smoker (2), Smoker, Current Status Unknown (3), Former Smoker (4).	
SMOKE_HX	SNUFF_YN	Y if the patient uses snuff. N if the patient does not	

SMOKE_HX	SOCIAL_HX_LINK_VISIT_ID	The Contact Serial Number of the encounter in which the history was created/edited. If the history was created/edited outside of the context of an encounter, then this column will be blank.	
SMOKE_HX	SOCIAL_HX_VISIT_ID	A unique serial number for this encounter.	
SMOKE_HX	TOBACCO_COMMENT	Free-text comments regarding the patient's use of tobacco.	
SMOKE_HX	TOBACCO_PAK_PER_DY	The number of packs of cigarettes the patient smokes per day, or null if the patient does not smoke.	
SMOKE_HX	TOBACCO_SRC	Source for Tobacco History. Values include: 1 (Provider), 2 (Patient), 3 (Parent), 4 (Legal guardian)	
SMOKE_HX	TOBACCO_SRC_NAME	Source for Tobacco History. Values include: Provider (1), Patient (2), Parent (3), (Legal guardian (4)	
SMOKE_HX	TOBACCO_USED_YEARS	The number of years a patient has smoked.	Y
SMOKE_HX	TOBACCO_USER	The category value associated with the patient's tobacco use. Data may include, 1 (Yes), 2 (Never), 3 (Not Asked), 4 (Quit), or (5) Passive.	Y
SMOKE_HX	TOBACCO_USER_NAME	The category description associated with the patient's tobacco use. Data may include, Yes (1), Never (2), Not Asked (3), Quit (4), or Passive (5).	
SOCIAL_HX	ABSTINENCE_YN	Y if the patient practices abstinence. N if the patient does not.	
SOCIAL_HX	ALCOHOL_OZ_PER_WK	The fluid ounces of alcohol the patient consumes per week.	
SOCIAL_HX	ALCOHOL_SRC	Source description or alcohol history. Values include: 1 (Provider), 2 (Patient), 3 (Parent), 4 (Legal guardian)	

SOCIAL_HX	ALCOHOL_SRC_CODE	Source code for alcohol history. Values include: 1 (Provider), 2 (Patient), 3 (Parent), 4 (Legal guardian)	
SOCIAL_HX	ALCOHOL_USE	The category value associated with the patient's alcohol use. Data may include, Yes, No or Not Asked	
SOCIAL_HX	ALCOHOL_USE_CODE	The category value associated with the patient's alcohol use. Data may include, 1 (Yes), 2 (No) or 3 (Not Asked)	
SOCIAL_HX	CONDOM_YN	Y if the patient uses a condom during sexual activity. N if the patient does not.	
SOCIAL_HX	CONTACT_DATE	The contact date of the encounter associated with this pertinent surgical surgical history contact. Note: There may be multiple encounters on the same calendar date.	
SOCIAL_HX	DIAPHRAGM_YN	Y if the patient uses a diaphragm. N if the patient does not.	
SOCIAL_HX	DRUG_SRC	Source description or drug history. Values include: 1 (Provider), 2 (Patient), 3 (Parent), 4 (Legal guardian)	
SOCIAL_HX	DRUG_SRC_CODE	Source code for drug history. Values include: 1 (Provider), 2 (Patient), 3 (Parent), 4 (Legal guardian)	
SOCIAL_HX	FEMALE_PARTNER_YN	Y if the patient has a female sexual partner. N if the patient does not.	
SOCIAL_HX	ILLICIT_DRUG_FREQ	The times per week the patient uses or used illicit drugs.	
SOCIAL_HX	ILL_DRUG_USER	The category description associated with the patient's use of illicit drugs. Data may include, Yes(1), No (2), or Not Asked (3).	
SOCIAL_HX	ILL_DRUG_USER_CODE	The category value associated with the patient's use of illicit drugs. Data may include, 1 (Yes), 2 (No), or 3 (Not Asked).	

SOCIAL_HX	IMPLANT_YN	Y if the patient uses an implant as a form of birth control. N if the patient does not.	
SOCIAL_HX	INJECTION_YN	Y if the patient uses an injection as a form of birth control. N if the patient does not.	
SOCIAL_HX	INSERTS_YN	Y if the patient uses inserts as a form of birth control. N if the patient does not.	
SOCIAL_HX	IUD_YN	Y if the patient uses an IUD. N if the patient does not.	
SOCIAL_HX	IV_DRUG_USER_YN	Y if the patient is an IV drug user. N if the patient is not.	
SOCIAL_HX	LAST_UPDATE_DATE	The time this patient history record was pulled into enterprise reporting or date of last update.	
SOCIAL_HX	MALE_PARTNER_YN	Y if the patient has a male sexual partner. N if the patient does not.	
SOCIAL_HX	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
SOCIAL_HX	PILL_YN	Y if the patient uses birth control pills. N if the patient does not	
SOCIAL_HX	RHYTHM_YN	Y if the patient uses the rhythm method as a form of birth control. N if the patient does not.	
SOCIAL_HX	SEXUALLY_ACTIVE		
SOCIAL_HX	SEXUALLY_ACTIVE_CODE		
SOCIAL_HX	SEX_SRC	This columns stores the person (e.g. provider, patient, legal guardian) who provided sexual activity information for this encounter.	
SOCIAL_HX	SEX_SRC_CODE		
SOCIAL_HX	SOCIAL_HX_LINK_VISIT_ID	The Contact Serial Number of the encounter in which the history was created/edited. If the history was created/edited outside of the context of an encounter, then this column will be blank.	
SOCIAL_HX	SOCIAL_HX_VISIT_ID	A unique serial number for this encounter.	

SOCIAL_HX	SPERMICIDE_YN	Y if the patient uses spermicide. N if the patient does not.	
SOCIAL_HX	SPONGE_YN	Y if the patient uses a sponge as a form of birth control. N if the patient does not.	
SOCIAL_HX	SURGICAL_YN	Y if the patient uses a surgical method of birth control such as hysterectomy, vasectomy, or tubal-ligation. N if the patient does not.	
SOCIAL_HX	UNKNOWN_FAM_HX_YN	Y if the patient's family history is unknown by the patient. N otherwise.	
SOCIAL_HX	YEARS_EDUCATION	The number of years of education the patient has completed. Note: This is a free text field.	
SURGICAL_HX	LAST_UPDATE_DATE	The time this patient history record was pulled into enterprise reporting or date of last update.	
SURGICAL_HX	LINE	The line number for the information associated with this contact. Multiple pieces of information can be associated with this contact.	
SURGICAL_HX	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
SURGICAL_HX	PROC_CODE	Procedure code documented in the patient's surgical history	
SURGICAL_HX	PROC_ID	The unique ID of the procedure record (EAP .1) associated with the surgical history contact. Note: This is NOT the CPT™ code. It is an internal identifier that is typically not visible to a user	
SURGICAL_HX	PROC_NAME	Procedure name documented in the patient's surgical history	
SURGICAL_HX	SHX_CONTACT_DATE	The contact date of the encounter associated with this surgical history contact. Note: There may be multiple encounters on the same calendar date.	

SURGICAL_HX	SHX_LINK_VISIT_ID	The Contact Serial Number of the encounter in which the history was created/edited. If the history was created/edited outside of the context of an encounter, then this column will be blank.	
SURGICAL_HX	SHX_SURGICAL_VISIT_ID	Stores the contact serial number of the surgery contact related to the current procedure.	
SURGICAL_HX	SHX_VISIT_ID	A unique serial number for this encounter.	
SURGICAL_HX	SURGICAL_HX_DATE	The free-text date entered in clinical system's Surgical History window for the procedure. This field is free-text due to the imprecise nature of patient-provided historical information.	
SURGICAL_HX	SURGICAL_HX_SRC	The category description for the surgical history's source for the patient record.: Provider (1), Patient (2), Parent (3), etc.	
SURGICAL_HX	SURGICAL_HX_SRC_CODE	The category code for the surgical history's source for the patient record.: 1 (Provider), 2 (Patient), 3 (Parent), etc.	
VENT_EPISODE	ASSUMED_VENT_END_DATE	This column will store the first instant after a ventilator start row was documented upon that a ventilator end row was documented upon. This column may differ from VENT_END_DATE in the event that the patient left for a leave of absence or was discharged without the ventilator end row being documented upon. This column may not be populated if a ventilator start was documented during a leave of absence. This column can be used in conjunction with ASSUMED_VENT_START_DATE to find overlapping ventilator documentation.	

VENT_EPISODE	ASSUMED_VENT_START_DATE	If the ventilator start row was documented upon without corresponding documentation in the ventilator end row prior to VENT_START_DATE, then the earliest such documentation instant is stored in this column. Otherwise, this column stores the same instant as VENT_START_DATE. This column can be used in conjunction with ASSUMED_VENT_END_DATE to find overlapping ventilator documentation	
VENT_EPISODE	END_OBSERVATION_ID	The unique ID for the flowsheet row in which the ventilation end instant was documented.	
VENT_EPISODE	INPATIENT_DATA_ID	The unique ID of the inpatient data record associated with the ventilation start documentation for this ventilation episode.	
VENT_EPISODE	LAST_UPDATE_DATE	The instant this ventilation episode was last updated.	
VENT_EPISODE	PATIENT_ID	The unique ID of the patient record associated with this ventilation episode; used to link to other tables	
VENT_EPISODE	START_OBSERVATION_ID	The unique ID for the flowsheet row in which the ventilation start instant was documented.	
VENT_EPISODE	VENT_END_DATE	The instant the stop row for this ventilation episode was documented upon. If the stop row was not documented after an episode began and before a leave of absence out or discharge event, then this instant will be updated to the leave of absence out time or discharge time, respectively. Note that even if the row is a date or time row, the data mart uses the recorded time of the documentation to determine the vent stop time.	

VENT_EPISODE	VENT_END_FLOWSHEETID	The unique ID for the flowsheet data record that contains the ventilation end cell for this ventilation episode. Combine this with VENT_END_FLOWSHEETID_LINE to get the cell that documents the end of this episode.	
VENT_EPISODE	VENT_END_FLOWSHEETID_LINE	The line count for the row in OBSERVATION that stores the ventilation end time for this ventilation episode. Combine this with VENT_END_FLOWSHEETID to get the cell that documents the end of this episode.	
VENT_EPISODE	VENT_START_DATE	The instant the ventilation start row was documented upon for this ventilation episode. Note that even if the row is a date or time row, the data mart will use the recorded time of the entry to signal the vent start time.	
VENT_EPISODE	VENT_START_FLOWSHEETID	The unique ID for the flowsheet data record that contains the ventilation start cell for this ventilation episode. Combine this with VENT_START_FLOWSHEETID_LINE to get the cell that documents the start of this episode.	
VENT_EPISODE	VENT_START_FLOWSHEETID_LINE	The line count for the row in OBSERVATION that stores the ventilation start time for this ventilation episode. Combine this with VENT_START_FLOWSHEETID to get the cell that documents the start of this episode.	
VISIT	ACCOMMODATION_ICU	Indicator if the patient was in an ICU for the patient encounter: Y for yes, otherwise null	
VISIT	ACCOUNT_NUM	Hospital accounting record for the patient encounter	

VISIT	ADMIT_DATE	First contact date for the encounter - Clarity: PAT_ENC_HSP.ADT_ARRIVAL_TIME, HSP_ACCOUNT .ADM_DATE_TIME, PAT_ENC.CONTACT_DATE; Oacis: Admission date	
VISIT	ADMIT_PROV_ID	The admitting provider identifier for the encounter	
VISIT	ADMIT_SOURCE	Category for hospital admission source: 1 (UB01 - SELF REFERRAL), 2 (PHYSICIAN REFERRAL), etc.	Y
VISIT	ADMIT_TYPE	Category for hospital admission source: 1 (EMERGENCY), 2 (URGENT), 3 (ELECTIVE), 4 (NEWBORN), etc.	Y
VISIT	ADVANCED_DIRECTIVE	The advance directive category: Y for Yes, N for No or null	
VISIT	AGE_DAYS	Calculated age in days (rounded) based on date of birth and admit date.	
VISIT	AGE_YEARS	Calculated age in years (rounded) based on date of birth and admit date.	Y
VISIT	APRDRG	The Diagnosis-Related Group (DRG) value uses the All Patient Refined (APR) Grouper. Values are 3-digit numbers.	
VISIT	APR_DRG_ID	The DRG identifier links to the reference table: REF_DRG table.	
VISIT	ATTEND_PROV_ID	The attending provider identifier for the encounter	
VISIT	CHIEF_COMPLAINT	Not populated for EPIC source, concsider VISIT_REASON for EPIC source.	
VISIT	DISCHARGE_DATE	Discharge date for the encounter - Clarity: PAT_ENC.DISCHARGE_DATE_DT, PAT_ENC.HOSP_DISCHRG_TIME; OacisL Discharge date	

VISIT	DISCH_DISP	Category for disharge disposition: 1 (DIS HOME W/DME ONLY), 200 (DIS RESUME HOME HEALTH), 201 (HOSPITAL/ACUTE CARE FACILITY), etc.	Y
VISIT	ENCOUNTER_TYPE	Category type for the patient encounter: 3 (HOSPITAL ENCOUNTER), 101 (OFFICE VISIT), 1003 (PROCEDURE VISIT), etc.	Y
VISIT	FINANCIAL_CLASS	Category for the financial class: 100 (BLUE CROSS BLUE SHIELD), 300 (MANAGED CARE), ETC.	Y
VISIT	HOSPITAL_SERVICE	Category for the medical service: 225 (DRM-DERMATOLOGY),227 (MED-EMERGENCY MEDICINE), 233 (PED-NEONATOLOGY), etc.	Y
VISIT	INPATIENT_DATA_ID	Unique id to link related items to the visit.	
VISIT	LAST_UPDATE_DATE	The last update timestamp for the record	
VISIT	LENGTH_OF_STAY	Length of stay in days for the patient encounter	
VISIT	LIVING_WILL	The living well category: Y for Yes, N for No or null	
VISIT	MSDRG	The Diagnosis-Related Group (DRG) value uses the CMS Medicare Severity (MS) Grouper. Values are 3-digit numbers.	Y
VISIT	MS_DRG_ID	The DRG identifier links to the reference table: REF_DRG table.	
VISIT	ORGAN_DONOR	The organ donor category: Y for Yes, N for No or null	
VISIT	PATIENT_CLASS	Base classification of the patient visit: I (INPATIENT), O (OUTPAITIENT), E (EMERGENCY)	Y
VISIT	PATIENT_ID	Unique identifier for each patient; used to link to other tables	

VISIT	PATIENT_TYPE	Further classification of the patient visit: 104 (OBSERVATION), 107 (NEWBORN), etc.	Y
VISIT	PCP_PROV_ID	The primary care provider identifier for the encounter	
VISIT	PRI_PROV_ID	The prinicipal provider identifier for the encounter	
VISIT	READMIT_IND	Place holder, not populated in EPIC source	
VISIT	REFER_PROV_ID	The referring provider identifier for the encounter	
VISIT	SERVICING_DEPT	Category for the servicing department : 1700124 (MUSC ED 1 WEST (ADULT ED)), 1710124 (MUSC ED PEDS), etc.	
VISIT	SERVICING_FACILITY	Category for the default servicing facility where the patient is regularly seen: 10001 (UNIVERSITY HOSPITAL), 10212 (MUSC ASHLEY RIVER TOWER), etc.	
VISIT	SERVICING_LOCATION	The unique ID of the facility that was the place of service for this encounter.	
VISIT	VISIT_ID	Unique identifier for the patient encounter.	
VISIT	VISIT_STATUS	Status of the appointment or visit: 2 (COMPLETED) or null	
VISIT_MEASURE	BMI	The Body Mass Index stored in the patient record, calculated by source system.	
VISIT_MEASURE	BP_DIASTOLIC	Blood pressure diastolic reading (bottom number when expressed as a ratio).	
VISIT_MEASURE	BP_SYSTOLIC	Blood pressure systolic reading (top number when expressed as a ratio).	
VISIT_MEASURE	BSA	The Body Surface Area, which is calculated based on the recorded height and weight.	
VISIT_MEASURE	CONTACT_DATE	The date for the contact	
VISIT_MEASURE	ENCOUNTER_TYPE	Category type for the patient encounter: HOSPITAL ENCOUNTER, OFFICE VISIT,PROCEDURE VISIT, etc.	

VISIT_MEASURE	HEIGHT	The patient's height as recorded during this encounter. This field is a string and contains indicators for feet and/or inches	
VISIT_MEASURE	INPATIENT_DATA_ID	Unique id to link related items to the visit.	
VISIT_MEASURE	LAST_UPDATE_DATE	The last update timestamp for the record	
VISIT_MEASURE	LMP_CATEGORY	The category value associated with alternative information entered in the LMP field of a clinical system encounter regarding the patient's OB/GYN Status. Ex: Postmenopausal, Hysterectomy, Pregnant, etc.	
VISIT_MEASURE	LMP_DATE	The date of the patient's Last Menstrual Period. Only contains data for encounters with female patients.	
VISIT_MEASURE	MEASURE_DATE	The best timestamp associated with the measure: VITAL_TAKEN_TM, HOSP_ADMSN_TIME,CHECKIN_TIME, EFFECTIVE_DATE_DTTM,ENTRY_TIME,CONTACT_DATE	
VISIT_MEASURE	PAIN_LOCATION	Contains information about regarding the body part where the patient is experiencing discomfort.	
VISIT_MEASURE	PAIN_SCALE	The pain scale category under which the pain score is collected	
VISIT_MEASURE	PAIN_SCORE	Indicates how much pain the patient is in at the time of the encounter/	
VISIT_MEASURE	PATENC_VISIT_ID	The contact serial number associated with the patient contact on this visit.	
VISIT_MEASURE	PATIENT_ID	The ID number of the patient for the encounter. Used to link to other tables.	
VISIT_MEASURE	PULSE	Patient pulse (heart rate) in beats per minute.	
VISIT_MEASURE	RESPIRATIONS	Patient respirations per minute.	
VISIT_MEASURE	SPO2	The oxygen saturation	

VISIT_MEASURE	TEMPERATURE	The patient's temperature taken during this encounter in degrees Fahrenheit.	
VISIT_MEASURE	TEMPERATURE_SOURCE	The source of the patient's temperature: ORAL, RECTAL, ANCILLARY,...	
VISIT_MEASURE	VISIT_CATEGORY	Category of appointment: RETURN PATIENT, NURSE VISIT, PROCEDURE, etc.	
VISIT_MEASURE	VISIT_STATUS	Status of the appointment: Completed, Arrived, etc. Can be null	
VISIT_MEASURE	WEIGHT	Patient weight in ounces. Divide this number by 16 to report the patient's weight in pounds.	
VISIT_REASON	ADMIT_DATE	Admit date for the encounter - Clarity: PAT_ENC.HOSP_ADMSN_TIME, PE.CHECKIN_TIME	
VISIT_REASON	CONTACT_DATE	The contact date of the encounter associated with this reason for visit. Note: There may be multiple encounters on the same calendar date.	
VISIT_REASON	DISCHARGE_DATE	Discharge date for the encounter - Clarity: PAT_ENC.HOSP_DISCHRG_TIME,DISCHARGE_DATE_DT,CHECKOUT_TIME	
VISIT_REASON	LAST_UPDATE_DATE		
VISIT_REASON	LINE	The line number of the reason for visit within the encounter.	
VISIT_REASON	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
VISIT_REASON	REASON_CMT	The comments associated with the reason for visit entered in an clinical system exam encounter.	
VISIT_REASON	REASON_ID	The ID of the record associated with the Reason for Visit entered in an clinical system exam encounter.	
VISIT_REASON	REASON_NAME	The reason for visit associated with this patient encounter, such as "HEADACHE" or "ANNUAL PHYSICAL."	

VISIT_REASON	REASON_OTHER	The custom reason for visit entered when the clinical system user chooses “Other” as a reason for visit.	
VISIT_REASON	VISIT_DATE_REAL	This is a numeric representation of the date of this encounter in your system. The integer portion of the number specifies the date of the encounter. The digits after the decimal point indicate multiple visits on one day.	
VISIT_REASON	VISIT_ID	Unique identifier for the patient encounter.	
VISIT_REASON	VISIT_STATUS	Status descriptom of the appointment or visit: COMPLETED (2), ARRIVED (6), or null	
VISIT_REASON	VISIT_STATUS_CODE	Status code of the appointment or visit: 2 (COMPLETED), 6 (ARRIVED), or null	
VITAL	AGGREGATE_GROUP	Statistical grouping for the observations. Examples: MIN, MAX, MEDIAN	
VITAL	BMI	The body mass index stored in the patient record, calculated by source system	Y
VITAL	BP_DIASTOLIC	Blood pressure diastolic reading (bottom number when expressed as a ratio).	Y
VITAL	BP_METHOD	Method blood pressure was taken. Example: Manual, Machine, Doppler, etc.	
VITAL	BP_SYSTOLIC	Blood pressure systolic reading (top number when expressed as a ratio).	Y
VITAL	HEART_RATE_SOURCE	The source for the pulse reading (Brachial, Monitor, etc.)	
VITAL	HEIGHT	Height in inches.	Y
VITAL	OBSERVATION_DATE	The day the readings were measured.	
VITAL	PATIENT_ID	Unique identifier for each patient; used to link to other tables	
VITAL	PATIENT_POSITION	Patient orthostatic position when the set of readings were taken: Examples: Sitting, Lying down	

VITAL	PULSE	Patient pulse (heart rate) in beats per minute	Y
VITAL	RESP_RATE	Patient respirations per minute	Y
VITAL	SPO2	Pulse oximetry	Y
VITAL	TEMPERATURE	Temperature in degrees F ??	Y
VITAL	TEMP_SOURCE	Source for the temperature reading: numeric values 1 (Oral), 2 (Tympanic), 3 (Rectal),4 (Axillary),etc.	
VITAL	VISIT_ID	Unique identifier for the patient billing encounter or the observation encounter. Billing VISIT_ID when ACCOUNT_NUM is populated.	
VITAL	WEIGHT	Weight in ounces	Y
VITAL	WEIGHT_METHOD	Method used for the weight reading. Examples: measured, stated	

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

Hollings Cancer Center Registry/i2b2 Fields

TABLE_NAME	COLUMN_NAME	COMMENTS	IN_I2B2
CYCLE	CYCLE_NUM	Cycle Number	
CYCLE	CYCLE_SEQ	Cycle Sequence Number	
CYCLE	CYCLE_STRT_DATE	Cycle Start Date	
CYCLE	CYCLE_HOSP_ID	Hospital identifier where treatment occurred	
CYCLE	MFAC_CYCLE_ID	Multi-Facility identifier	
CYCLE	MFAC_CYCLE_FAC_NUM	Multi-Facility, Facility Number for Cycle	
CYCLE	CYCLE_ID	Unique identifier assigned to each cycle – Primary Key	
CYCLE	TREATMENT_ID		
DRUG	DAILY_DOSE	(CER) Daily Dosage	
DRUG	DAYS_GIVEN	(CER) Days Given/Number Doses Received	
DRUG	CER_DRUG_END_DATE	(CER) Drug End Date	
DRUG	CER_DRUG_END_DATE_FLAG	(CER) Drug End Date Flag	
DRUG	CER_DRUG_START_DATE	(CER) Drug Start Date	
DRUG	CER_DRUG_START_DATE_FLAG	(CER) Drug Start Date Flag	
DRUG	NSC_SUBCODE	(CER) NSC ID SubCode	
DRUG	NSC	(CER) NSC Number	
DRUG	TOT_DOSAGE	(CER) Received Total Dosage	
DRUG	DOSE_UNITS	Dose Units	
DRUG	DRUG_SEQ	Drug Sequence Number	
DRUG	DRUG_ROUTE	Drug route	
DRUG	DRUG_HOSP_ID	Hospital identifier where drug received	
DRUG	MFAC_DRUG_ID	Multi-Facility identifier	
DRUG	MFAC_DRUG_FAC_NUM	Multi-Facility, Facility Number for Drug	
DRUG	CYCLE_ID	Unique identifier assigned to each cycle	
DRUG	DRUG_ID	Unique identifier assigned to each drug	
PATIENT	HCC_ACCESSION_NUM	Accession Year 1st Primary plus Accession Number produces a unique sequence; NaaccrID 550	
PATIENT	AUTOPSY	Autopsy; NaaccrID 1930	
PATIENT	GENDER	Cancer registry gender codes: 1 Male, 2 Female, 3 Other, 4 Transexual, 9 Unknown; NaaccrID 220)	Y

PATIENT	GENDER	Cancer registry gender codes: 1 Male, 2 Female, 3 Other, 4 Transexual, 9 Unknown; NaaccrID 220)	Y
PATIENT	ICD_CODE	Cause of Death (Underlying Cause of Death (ICD Code)); NaaccrID 1910	
PATIENT	BIRTH_DATE	Date of Birth; NaaccrID 240	
PATIENT	LAST_CONTACT_DATE	Date of Last Contact or Death; NaaccrID 1750	
PATIENT	ICD_REV	ICD Revision Number; NaaccrID 1920	
PATIENT	DEATH_MATCH	Indicates if Death Match was run	
PATIENT	HCC_PATIENT_MRN	Medical Record/Chart No.from HCC source; NaaccrID 2300.	
PATIENT	PAT_FIRST_NAME	Patient First Name; NaaccrID 2240	
PATIENT	PAT_LAST_NAME	Patient Last Name; NaaccrID 2230	
PATIENT	PAT_MIDDLE_NAME	Patient Middle Name; NaaccrID 2250	
PATIENT	SSN	Social Security Number; NaaccrID 2320	
PATIENT	HCC_PATIENT_SYSTEMID	Unique identifier for each patient from HCC source; appears as Pateint ID in the Metriq interface	
PATIENT	PATIENT_ID	Unique internal identifier for each patient from EPIC source; used to link to other RDM tables. Will be null if we can't match the patient.	
PATIENT	HCC_PATIENT_ID	Unique internal identifier for each patient from HCC source; used to link to other HCC tables. Primary key.	
PATIENT	VITAL_STATUS	Vital Status; NaaccrID 1760	
RADIATION	RT_BOOST_MODALITY	Boost RT Modality	
RADIATION	RADIATION_HOSPIID	Hospital ID	
RADIATION	RT_LOCATION	Location of Radiation Treatment	
RADIATION	MFAC_RAD_ID	Multi-Facility identifier	
RADIATION	MFAC_RAD_FAC_NUM	Multi-Facility, Facility Number for Radiation	
RADIATION	RT_TOT_FRACT	Number of Treatments to this Volume	
RADIATION	RT_BOOST_DOSE	RT Boost Dose: cGy	
RADIATION	RT_MODALITY	RT Regional Treatment Modality	
RADIATION	RT_DAYS	Radiation Elapsed Treatment Time (Days)	
RADIATION	RAD_SEQ	Radiation Sequence Number	

RADIATION	RT_STOP_DATE	Radiation treatment (RT) end date	
RADIATION	RT_SITE	Radiation treatment (RT) site	
RADIATION	RT_START_DATE	Radiation treatment (RT) start date	
RADIATION	RT_VOLUME	Radiation treatment (RT) volumne	
RADIATION	RT_REG_DOSE	Regional Dose: cGy	
RADIATION	RADIATION_ID	Unique identifer for the radiation treatment, Primary Key	
RADIATION	TREATMENT_ID	Unique identifier assigned to each treatment	
TREATMENT	RX_CODE	(Rx) Code	
TREATMENT	RX_START_DATE	(Rx) Start Date – where Rx equals the modality therapy	
TREATMENT	RX_SUBCODE	(Rx) Sub Code	
TREATMENT	ANCIL_RX_START_DATE	Ancillary Therapy Start Date	
TREATMENT	RX_COURSE	Course of treatment	
TREATMENT	TREATMENT_HOSP_ID	Hospital ID where therapy performed	
TREATMENT	RX_THIS_FAC	Indicates whether treatment performed at this facility	
TREATMENT	MFAC_RX_ID	Multi-Facility identifier	
TREATMENT	MFAC_RX_FAC_NUM	Multi-Facility, Facilty Number for Treatment	
TREATMENT	REG_LN_REMVD	Number of Regional Lymph Nodes Removed	
TREATMENT	PROT_ELIG	Protocol Eligibility Status	
TREATMENT	PROTOCOL	Protocol Participation	
TREATMENT	PROT_TYPE	Protocol type	
TREATMENT	RECON_SURG	Reconstruction/Restoration – First Course	
TREATMENT	RX_INPT_OUTPT	Record if treatment was done as an inpatient or outpatient	
TREATMENT	RX_MD1	Rx Physician 1	
TREATMENT	RX_MD2	Rx Physician 2	
TREATMENT	SCP_LN_CODE	Scope Reg Lymph Nodes (LN) Surgery	
TREATMENT	OTHER_CODE	Surgery Other Site	
TREATMENT	APPROACH	Surgical Approach	
TREATMENT	SURG_MARG	Surgical Margins	
TREATMENT	RX_TYPE	Treatment Modality	
TREATMENT	TRX_SEQ	Treatment Sequence Number	
TREATMENT	TREATMENT_ID	Unique identifier assigned to each treatment; Primary Key	
TREATMENT	TUMOR_ID	Unique identifier assigned to each tumor	
TREATMENT_SMRY	FIRST_SURG_DATE	Date of First Surgery; NaaccrID 1200	

TREATMENT_SMRY	MST_DEF_CHEMO_DATE	Most definitive 1st Course Chemotherapy date; NaaccrID 1220	Y
TREATMENT_SMRY	MST_DEF_CHEMO_SUMM	Most definitive 1st Course Chemotherapy summary; NaaccrID 1390	Y
TREATMENT_SMRY	MST_DEF_RT_DATE	Most definitive 1st Course Date Radiation Started; NaaccrID 1210	Y
TREATMENT_SMRY	MST_DEF_DX_STAGE_SUMM	Most definitive 1st Course Diagnostic/Staging Procedure summary; NaaccrID 1350	Y
TREATMENT_SMRY	MST_DEF_HORM_DATE	Most definitive 1st Course Hormone therapy date; NaaccrID 1230	Y
TREATMENT_SMRY	MST_DEF_HORM_SUMM	Most definitive 1st Course Hormone therapy summary; NaaccrID 1400	Y
TREATMENT_SMRY	MST_DEF_IMMUNO_DATE	Most definitive 1st Course Immunotherapy date; NaaccrID 1240	Y
TREATMENT_SMRY	MST_DEF_IMMUNO_SUMM	Most definitive 1st Course Immunotherapy summary; NaaccrID 1410	Y
TREATMENT_SMRY	MST_DEF_OTH_RX_DATE	Most definitive 1st Course Other therapy date; NaaccrID 1250	Y
TREATMENT_SMRY	MST_DEF_OTH_RX_SUMM	Most definitive 1st Course Other therapy summary; NaaccrID 1420	Y
TREATMENT_SMRY	MST_DEF_PALL_SUMM	Most definitive 1st Course Palliative care summary; NaaccrID 3270	Y
TREATMENT_SMRY	MST_DEF_RT_SUMM	Most definitive 1st Course Radiation summary; NaaccrID 1360	Y
TREATMENT_SMRY	MST_DEF_SCOPE_LN_SUMM	Most definitive 1st Course Scope Regional Lymph Nodes summary; NaaccrID 1292	Y
TREATMENT_SMRY	MST_DEF_SURG_OTH_SUMM	Most definitive 1st Course Surg Other Reg Dist summary; NaaccrID 1294	Y
TREATMENT_SMRY	MST_DEF_SURG_PRIM_SUMM	Most definitive 1st Course Surgery this Primary Site summary; NaaccrID 1290	Y
TREATMENT_SMRY	MST_DEF_TRNSPLNT_SUMM	Most definitive 1st Course Transplant/Endocrine summary; NaaccrID 3250	Y
TREATMENT_SMRY	MST_DEF_MARGINS_SUMM	Most definitive Final Surgical Margins summary; NaaccrID 1320	Y
TREATMENT_SMRY	RT_SRG_SEQ	RTSurgery Sequence; NaaccrID 1380	Y
TREATMENT_SMRY	RT_CNS	Radiation Therapy to Central Nervous System; NaaccrID 1370	Y

TREATMENT_SMRY	TREATMENT_STATUS_SUMM	Rx Summ - Treatment Status; NaaccrID 1285	
TREATMENT_SMRY	SYS_SRG_SEQ	Systemic/Surg Sequence; NaaccrID 1639	Y
TREATMENT_SMRY	TUMOR_ID	Unique identifier assigned to each tumor; Primary Key	
TREATMENT_SMRY	HCC_PATIENT_ID	Unique internal identifier for each patient from HCC source; used to link to other HCC tables.	
TUMOR	CS_SSFACTOR1	CS Site - Specific Factor 1; NaaccrID 2880	Y
TUMOR	CS_SSFACTOR2	CS Site - Specific Factor 2; NaaccrID 2890	Y
TUMOR	CS_SSFACTOR3	CS Site - Specific Factor 3; NaaccrID 2900	Y
TUMOR	CS_SSFACTOR4	CS Site - Specific Factor 4; NaaccrID 2910	Y
TUMOR	CS_SSFACTOR5	CS Site - Specific Factor 5; NaaccrID 2920	Y
TUMOR	CS_SSFACTOR6	CS Site - Specific Factor 6; NaaccrID 2930	Y
TUMOR	CS_SSFACTOR10	CS Site – Specific Factor 10; NaaccrID 2864	Y
TUMOR	CS_SSFACTOR11	CS Site – Specific Factor 11; NaaccrID 2865	Y
TUMOR	CS_SSFACTOR12	CS Site – Specific Factor 12; NaaccrID 2866	Y
TUMOR	CS_SSFACTOR13	CS Site – Specific Factor 13; NaaccrID 2867	Y
TUMOR	CS_SSFACTOR14	CS Site – Specific Factor 14; NaaccrID 2868	Y
TUMOR	CS_SSFACTOR15	CS Site – Specific Factor 15; NaaccrID 2869	Y
TUMOR	CS_SSFACTOR16	CS Site – Specific Factor 16; NaaccrID 2870	Y
TUMOR	CS_SSFACTOR17	CS Site – Specific Factor 17; NaaccrID 2871	Y
TUMOR	CS_SSFACTOR18	CS Site – Specific Factor 18; NaaccrID 2872	Y
TUMOR	CS_SSFACTOR19	CS Site – Specific Factor 19; NaaccrID 2873	Y
TUMOR	CS_SSFACTOR20	CS Site – Specific Factor 20; NaaccrID 2874	Y
TUMOR	CS_SSFACTOR21	CS Site – Specific Factor 21; NaaccrID 2875	Y

TUMOR	CS_SSFACTOR22	CS Site – Specific Factor 22; NaaccrID 2876	Y
TUMOR	CS_SSFACTOR23	CS Site – Specific Factor 23; NaaccrID 2877	Y
TUMOR	CS_SSFACTOR24	CS Site – Specific Factor 24; NaaccrID 2878	Y
TUMOR	CS_SSFACTOR25	CS Site – Specific Factor 25; NaaccrID 2879	Y
TUMOR	CS_SSFACTOR7	CS Site – Specific Factor 7; NaaccrID 2861	Y
TUMOR	CS_SSFACTOR8	CS Site – Specific Factor 8; NaaccrID 2862	Y
TUMOR	CS_SSFACTOR9	CS Site – Specific Factor 9; NaaccrID 2863	Y
TUMOR	TUMOR_STATUS	Cancer Status; NaaccrID 1770	
TUMOR	AJCC_STAGE_GROUP_CLIN	Clinical Stage Group; NaaccrID 970	Y
TUMOR	CLIN_M_TNM	Clinical TNM M; NaaccrID 960	Y
TUMOR	CLIN_N_TNM	Clinical TNM N; NaaccrID 950	Y
TUMOR	CLIN_T_TNM	Clinical TNM T; NaaccrID 940	Y
TUMOR	RECURRENCE_DATE_FIRST	Date 1st Recurrence; NaaccrID 1860	
TUMOR	LAST_CHANGED_DATE	Date Case Last Changed; NaaccrID 2100	
TUMOR	DX_DATE	Date of Initial Diagnosis; NaaccrID 390	
TUMOR	DERIVED_AJCC7_M_DESC	Derived AJCC-7 M Descript; NaaccrID 3422	
TUMOR	DERIVED_AJCC7_M	Derived AJCC-7 M; NaaccrID 3420	Y
TUMOR	DERIVED_AJCC7_N_DESC	Derived AJCC-7 N Descript; NaaccrID 3412	
TUMOR	DERIVED_AJCC7_N	Derived AJCC-7 N; NaaccrID 3410	Y
TUMOR	DERIVED_AJCC7_STAGE_GRP	Derived AJCC-7 Stage Group; NaaccrID 3430	Y
TUMOR	DERIVED_AJCC7_T_DESC	Derived AJCC-7 T Descript; NaaccrID 3402	
TUMOR	DERIVED_AJCC7_T	Derived AJCC-7 T; NaaccrID 3400	Y
TUMOR	DSC_AJCC_STAGE7	Descriptive Derived AJCC Stage Group 7; NaaccrID 3430	
TUMOR	RECURRENCE_DIST_SITE1	Distant Site 1 - 1st Recurrence; NaaccrID 1871	
TUMOR	GRADE	Grade/Differentiation; NaaccrID 440	Y
TUMOR	HISTOLOGY	Histology/Behavior ICDO3; NaaccrID 521	Y
TUMOR	LATERALITY	Laterality; NaaccrID 410	
TUMOR	AJCC_STAGE_GROUP_PATH	Pathologic Stage Group; NaaccrID 910	Y
TUMOR	PATH_M_TNM	Pathologic TNM M; NaaccrID 900	Y

TUMOR	PATH_N_TNM	Pathologic TNM N; NaaccrID 890	Y
TUMOR	PATH_T_TNM	Pathologic TNM T; NaaccrID 880	Y
TUMOR	PRIMARY_SITE	Primary Site; NaaccrID 400	Y
TUMOR	SEQ_PRIMARY	Sequence Primary; NaaccrID 560	
TUMOR	HISTOLOGY_SUBCODE	SubCode for Histology/ Behavior ICDO3; NaaccrID -1	Y
TUMOR	PRIMARY_SITE_SUBCODE	SubCode for Primary Site; NaaccrID -1	
TUMOR	TUMOR_SEQ	Tumor Sequence Number; NaaccrID 60	Y
TUMOR	RECURRENCE_TYPE_FIRST	Type 1st Recurrence; NaaccrID 1880	Y
TUMOR	TUMOR_ID	Unique identifier assigned to each tumor; Primary Key	
TUMOR	HCC_PATIENT_ID	Unique internal identifier for each patient from HCC source; used to link to other HCC tables.	
TUMOR_2	TX_SUMM_FIRST	1st Course Rx Summary	
TUMOR_2	DX_AGE	Age at Diagnosis (Calculated); NaaccrID 230	
TUMOR_2	ALCOHOL	Alcohol History	
TUMOR_2	BEST_STAGE	Best AJCC Stage (Calculated)	
TUMOR_2	BEST_CSTNM_STAGE	Best CS/AJCC Stage; Best stage that considers derived, pathologic and clinical AJCC stage groups	
TUMOR_2	BEST_CSSUMM_STAGE	Best CS/Summary Stage; Best SEER Summary stage that considers derived, SS2000 and SS1977 stage groups	
TUMOR_2	BEST_SUMM_STAGE	Best SEER General Summary Stage	
TUMOR_2	CS_TUMOR_SIZE	CS Tumor Size; NaaccrID 2800	
TUMOR_2	CASE_STAT_FLAG	Case Status. I (Incomplete), C (Complete), R (Review - Report to State), etc.	
TUMOR_2	CLASS_CASE	Class of Case; NaaccrID 610	
TUMOR_2	COMORBIDITY1	Comorbid/Complication #1; NaaccrID 3110	
TUMOR_2	COMORBIDITY2	Comorbid/Complication #2; NaaccrID 3120	
TUMOR_2	COMORBIDITY3	Comorbid/Complication #3; NaaccrID 3130	
TUMOR_2	COMORBIDITY4	Comorbid/Complication #4; NaaccrID 3140	
TUMOR_2	COMORBIDITY5	Comorbid/Complication #5; NaaccrID 3150	

TUMOR_2	COMORBIDITY6	Comorbid/Complication #6; NaaccrID 3160	
TUMOR_2	D_AJCC_M_DESCR	Derived AJCC M Descriptor; NaaccrID 2990	
TUMOR_2	D_AJCC_M	Derived AJCC M; NaaccrID 2980	
TUMOR_2	D_AJCC_N_DESCR	Derived AJCC N Descriptor; NaaccrID 2970	
TUMOR_2	D_AJCC_N	Derived AJCC N; NaaccrID 2960	
TUMOR_2	D_AJCC_STAGE	Derived AJCC Stage Group ; NaaccrID 3000	
TUMOR_2	D_AJCC_T_DESCR	Derived AJCC T Descriptor; NaaccrID 2950	
TUMOR_2	D_AJCC_T	Derived AJCC T; NaaccrID 2940	
TUMOR_2	DIAGNOSTIC_CONFIRMATION	Diagnostic Confirmation; NaaccrID 490	
TUMOR_2	DSC_AJCC_STAGE	Display String Combination for Derived AJCC Stage Group; NaaccrID 3000	
TUMOR_2	DS_AJCC_STAGE	Display String for Derived AJCC Stage Group; NaaccrID 0	
TUMOR_2	FAM_HX_CA	Family History of cancer	
TUMOR_2	GRADE_PATH_SYSTEM	Grade Path System; NaaccrID 449	
TUMOR_2	HISTOLOGY_ICDO2	Histology (9200) ICDO2; NaaccrID 420	
TUMOR_2	PCE_NCDS	PCE/NCDS ID	
TUMOR_2	PED_AGE	Pediatric Age	
TUMOR_2	PRIM_SURGEON	Primary Surgeon; NaaccrID 2480	
TUMOR_2	EOD_TUMOR_SIZE	Size of Tumor; NaaccrID 780	
TUMOR_2	HISTOLOGY_ICDO2_SUBCODE	Sub Code for Histology/Behavior ICD-O-2	
TUMOR_2	TX_SUMM_SUB	Subseq Course Rx Summary	
TUMOR_2	SURVIVAL	Survival	
TUMOR_2	TOBACCO	Tobacco History	
TUMOR_2	TUMOR_ID	Unique identifier assigned to each tumor; Primary Key	
TUMOR_2	HCC_PATIENT_ID	Unique internal identifier for each patient from HCC source; used to link to other HCC tables.	