CPCSSN Data Dictionary

2022-Q2

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Table: Network

- A master list of all the practice-based research networks within CPCSSN whose data has been sent to the central repository
- Linking table that contains the names and locations of each practice-based research network within CPCSSN

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	
GeographicArea	Categorical		Geographical area of the Network.	'Southern Alberta', 'Northern Alberta', 'Greater Toronto Area', 'Eastern Ontario', 'Quebec', 'Newfoundland & Labrador', 'Manitoba', 'Maritime Provinces', 'British Columbia', 'Southern Ontario', 'National Capital Region', 'Northern Ontario'	

Table: Provider

- Contains limited demographic information on providers (physicians and nurse practitioners) who are currently participating in CPCSSN

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
Provider_ID	Provider table key	4 digits	Unique integer identifying each CPCSSN provider.	Positive Integers	● Unique number assigned by each network to the providers in its sites
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
BirthYear	Date	yyyy	Provider's year of birth.	BirthYear + 25 <= extraction year <= BirthYear + 85	
Sex	Categorical		Provider's sex.	Male, Female	● Contains provider-reported sex
ProviderType	Categorical		The type of health care practitioner that the provider is.		● Not currently standardised
StartDate	Date	yyyy-mm-dd	Date that the provider joined CPCSSN at their current practice site.		● If a provider changes sites but remains part of CPCSSN, StartDate will be the date they started at the new site

Table: Patient

- List of EMR patients whose primary provider is a consenting physician in the CPCSSN project (has an entry in the Provider table)
- Contains limited demographic information on each patient

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
Patient_ID	Patient Table Key	15 or 16-digits	Unique integer randomly assigned to each patient within CPCSSN.	Positive integers	● The Patient_ID can be used to link records for each patient that are stored in other tables
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Provider_ID	Provider Table Key	15-16 digits	Unique integer identifying each CPCSSN provider.	Positive Integers	● Only a Provider_ID that exists in the Provider table can be referenced here
StartDate	Date	yyyy-mm-dd	Date that the provider starts providing care to the patient at this site.	1980-01-01 to CutOffDate (see the Cycle table)	● If this information is not recorded in the EMR, the date on the earliest record in the EMR may be used
Sex_calc	Categorical		Standardised sex (not gender) of the patient.	'Male' or 'Female'	
Age	Integer	1-2 digits	The age of the patient as of the cycle cut-off date.	0 - 125	● Must pick one of the following options: ● **Option 1**: Age (to nearest year) and Location = 'Urban' or 'Rural' ● **Option 2**: Age (to nearest 5 years) and Location = full postal code (if available)
Location	Categorical		Urban/rural or postal code.	'Urban', 'Rural',	● Must pick one of the following options: ● **Option 1**: Age (to nearest year) and Location = 'Urban' or 'Rural' ● **Option 2**: Age (to nearest 5 years) and Location = full postal code (if available)
DateCreated	Date	yyyy-mm-dd	The date on which the record was input into the EMR.	1980-01-01 to CutOffDate (see the Cycle table)	● If the date of record creation cannot be found within the EMR, the date on which the record was last modified may be used

Table: AllergyIntolerance

- All allergy and intolerance data for the patient

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
AllergyIntolerance_ID	AllergyIntolerance Table Key	15-16 digits	Unique integer identifying an allergy/intolerance record.	Positive Integers	
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Patient_ID	Patient Table Key	15 or 16-digits	Unique and randomly assigned integer CPCSSN patient ID.	See Patient table	● Allows this table to be linked to the patient table and all tables that contain the patient table key ● Only a Patient_ID that exists in the Patient table can be referenced here
Encounter_ID	Encounter Table Key	15 or 16-digits	Unique integer ID that links a record in this table to a specific Encounter record (i.e., to a single interaction with a primary care provider).	See Encounter table	● Allows this table to be linked to the Encounter table and all other tables that include the Encounter_ID ● Only an Encounter_ID that exists in the Encounter table can be referenced here ● Multiple records in this table may be linked to a single Encounter record ● May be empty if the record cannot be linked to a specific encounter
StartDate	Date	yyyy-mm-dd	Date on which the allergy was first identified.	1902-01-01 to CutOffDate (see the Cycle table)	
StopDate	Date	yyyy-mm-dd	Date on which the allergy noted as inactive.	1902-01-01 to CutOffDate (see the Cycle table)	● If an allergy is inactive and StopDate cannot be found, Status field must still be set to 'Inactive'
DIN_calc	Categorical	8 digits	Drug Identification Number for the medication.	00000000 - 99999999	● DIN look-up and downloadable files can be found on Health Canada's Drug Product Database website
Name_calc	Categorical		Standardised text description that accompanies the specific ATC code recorded in Code_calc.	Descriptions from Health Canada's Drug Product Database	● Populated by the CPCSSN ATC coding algorithm, which uses the medication descriptions from Health Canada's Drug Product Database

CodeType_calc	Categorical		Code set from which the code in Code_calc was drawn. Currently, can only be 'ATC'.	ATC	● Must be 'ATC' or empty
Code_calc	Categorical		An ATC code.	Valid ATC code only	● Populated by the CPCSSN ATC coding algorithm, which uses the ATC codes from Health Canada's Drug Product Database
Severity_calc	Categorical		Standardised severity of the allergy or intolerance reaction.	'Mild', 'Moderate', 'Severe'	
AllergyStatus_calc	Categorical		Current status of the allergy or intolerance.	'Active', 'Inactive'	
DateCreated	Date	yyyy-mm-dd	EMR date stamp of the record.	1980-01-01 to CutOffDate (see the Cycle table)	● If the date of record creation cannot be found within the EMR, the date on which the record was last modified may be used

Table: Billing

- Contains patient-level EMR billing records that have been processed by CPCSSN text processing algorithms
- Each record is for a single patient, labelled by Patient_ID
- Each patient may have more than one record for a single encounter (i.e., physician billed for multiple services). Linking to other records corresponding to single encounters is accomplished through the Encounter_ID variable

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
Billing_ID	Billing Table Key	15 or 16-digits	Unique integer identifying a Billing record.	Positive Integers	
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Patient_ID	Patient Table Key	15 or 16-digits	Unique and randomly assigned integer CPCSSN patient ID.	See Patient table	● Allows this table to be linked to the the patient table and all tables that contain the patient table key ● Only a Patient_ID that exists in the Patient table can be referenced here
Encounter_ID	Encounter Table Key	15 or 16-digits	Unique integer ID that links a Billing record to a specific Encounter record (i.e., to a single interaction with a primary care provider).	See Encounter table	● Allows this table to be linked to the Encounter table and all other tables that include the Encounter_ID ● Only an Encounter_ID that exists in the Encounter table can be referenced here ● Multiple records in this table may be linked to a single Encounter record ● May be empty if the record cannot be linked to a specific encounter
ServiceDate	Date	yyyy-mm-dd	Date on which the service was provided.	1980-01-01 to CutOffDate (see the Cycle table)	
ServiceCode_calc	Categorical	Varies by province	Province-specific code for the service being billed for.	Varies by province	● Allowed service code sets vary by province and may change with time. ● We currently have data for five provinces. Links to documentation are below: BC: MSC Payment Schedule AB: Health Service Codes MB: Manitoba Physician's Manual ON: OHIP Schedule of Benefits & Fees NS: MSI Billing

DiagnosisText_calc	Categorical		Standardised text description that accompanies the specific ICD-9-CM code recorded in DiagnosisCode_calc.	Descriptions from ICD-9-CM only	● Populated by the CPCSSN ICD-9-CM coding algorithm, which uses the descriptions of disease entities from ICD-9-CM ● Text terms can be found through an ICD-9 look-up website
DiagnosisCodeType_calc	Categorical		The diagnosis code set from which the code in DiagnosisCode_calc was drawn. Currently, can only be 'ICD9'.	'ICD9'	● Must be 'ICD9' or empty
DiagnosisCode_calc	Categorical		An ICD-9-CM code.	Valid ICD-9-CM code	● Populated by the CPCSSN ICD-9-CM coding algorithm, which uses the descriptions of disease entities from ICD-9-CM ● ICD-9 codes can be found through an ICD-9 look-up website
DateCreated	Date	yyyy-mm-dd	EMR date stamp of the record.	1980-01-01 to CutOffDate (see the Cycle table)	● If the date of record creation cannot be found within the EMR, the date on which the record was last modified may be used

Table: Encounter

- Encounters (i.e., interactions) between patient and provider
- Not all interactions are captured in this table
- The interaction provider does not need to be participating in CPCSSN, although if they are not, the provider's information is suppressed

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
Encounter_ID	Encounter Table Key	15-16 digits	Unique integer identifying an Encounter record.	Positive Integers	● Encounter_IDs can be used to link records that are located in separate CPCSSN tables, but are from a single encounter between patient and provider ● Not all Encounter_IDs link to records in other CPCSSN tables ● The majority of records in other CPCSSN tables have no Encounter_ID
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 13	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Patient_ID	Patient Table Key	15 or 16-digits	Unique and randomly assigned integer CPCSSN patient ID.	See Patient Table	● Allows this table to be linked to the patient table and all tables that contain the patient table key ● Only a Patient_ID that exists in the Patient table can be referenced here
Provider_ID	Provider Table Key	15-16 digits	Unique integer identifying each CPCSSN provider.	See Provider Table	● Only a Provider_ID that exists in the Provider table can be referenced here ● If the provider for the visit is not part of CPCSSN, the Provider_ID will be empty
EncounterDate	Date	yyyy-mm-dd	Date on which the encounter occurred.	1980-01-01 to cut-off date	
EncounterType_calc	Categorical		Standard coding of the Encounter_orig text.	'Email', 'Office Visit' 'Out of Office Visit', 'Phone Call'	

DateCreated	Date	yyyy-mm-dd	EMR date stamp of the record.	1980-01-01 to CutOffDate (see the Cycle table)	● If the date of record creation cannot be found within the EMR, the date on which the record was last modified may be used

Table: EncounterDiagnosis

- Diagnoses resulting from each encounter between patient and provider

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
EncounterDiagnosis_ID	EncounterDiagnosis Table Key	15 or 16-digits	Unique integer identifying an EncounterDiagnosis record.	Positive Integers	
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Patient_ID	Patient Table Key	15 or 16-digits	Unique and randomly assigned integer CPCSSN patient ID.	See Patient table	● Allows this table to be linked to the the patient table and all tables that contain the patient table key ● Only a Patient_ID that exists in the Patient table can be referenced here
Encounter_ID	Encounter Table Key	15 or 16-digits	Unique integer ID that links an EncounterDiagnosis record to a specific Encounter record (i.e., to a single interaction with a primary care provider).	See Encounter table	● Allows this table to be linked to the Encounter table and all other tables that include the Encounter_ID ● Only an Encounter_ID that exists in the Encounter table can be referenced here ● Multiple records in this table may be linked to a single Encounter record ● May be empty if the record cannot be linked to a specific encounter
DiagnosisText_calc	Categorical		Standardised text description that accompanies the specific ICD-9-CM code recorded in DiagnosisCode_calc.	Descriptions from ICD-9-CM only	● Populated by the CPCSSN ICD-9-CM coding algorithm, which uses the descriptions of disease entities from ICD-9-CM ● Text terms can be found through an ICD-9 look-up website
DiagnosisCodeType_calc	Categorical		The diagnosis code set from which the code in DiagnosisCode_calc was drawn. Currently, can only be 'ICD9'.	'ICD9'	● Must be 'ICD9' or empty
DiagnosisCode_calc	Categorical		An ICD-9-CM code.	Valid ICD-9-CM code	● Populated by the CPCSSN ICD-9-CM coding algorithm, which uses the descriptions of disease entities from ICD-9-CM ● ICD-9 codes can be found through an ICD-9 look-up website
DateCreated	Date	yyyy-mm-dd	EMR date stamp of the record.	1980-01-01 to CutOffDate (see the Cycle table)	● If the date of record creation cannot be found within the EMR, the date on which the record was last modified may be used

Table: Exam

- Results of physical exams performed on the patient
- Eight exams are currently extracted by CPCSSN (allowed ranges and units in brackets)
    - Body mass index (BMI) [10-100 kg/m^2]
    - Diabetic foot exam
    - Height [adult (19+) height: 85-230 cm, child height (<19) 30-230 cm]
    - Peak expiratory flow rate (PEFR) [0.1-200 L/min]
    - Systolic and diastolic blood pressure (sBP and dBP) [sBP: 50-300 mmHg; dBP: 30-230 mmHg]
    - Waist circumference [30-300 cm]
    - Waist-to-hip ratio [0.3-3]
    - Weight [1-500 kg]

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
Exam_ID	Exam Table Key	15 or 16-digits	Unique integer identifying an Exam record.	Positive Integers	
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Patient_ID	Patient Table Key	15 or 16-digits	Unique and randomly assigned integer CPCSSN patient ID.	See Patient table	● Allows this table to be linked to the the patient table and all tables that contain the patient table key ● Only a Patient_ID that exists in the Patient table can be referenced here
Encounter_ID	Encounter Table Key	15 or 16-digits	Unique integer ID that links an exam record to a specific Encounter record (i.e., to a single interaction with a primary care provider).	See Encounter table	● Allows this table to be linked to the Encounter table and all other tables that include the Encounter_ID ● Only an Encounter_ID that exists in the Encounter table can be referenced here ● Multiple records in this table may be linked to a single Encounter record ● May be empty if the record cannot be linked to a specific encounter
Exam1_calc	Categorical		Standardised name of the physical exam.	BMI, Foot Exam, Height, Joint Pain, PEFR,	

				sBP, Waist Circumference, Waist Hip Ratio, Weight	
Result1_calc	Numeric		Result1_orig converted to CPCSSN standard units.		● Only populated if Result1_orig (and Result2_orig, if applicable) can be converted from the UnitOfMeasure_orig to the CPCSSN standard units, and the converted value is within allowed bounds ● CPCSSN does not yet code 'Foot Exam results to standard text, so all Result1_calc entries for this exam type will be blank
Exam2_calc	Categorical		Standardised name of the physical exam that is paired with Exam1	'dBP' or empty	● Currently the only paired exam is blood pressure ● When Exam 1 is 'sBP' then Exam2 must be 'dBP'
Result2_calc	Integer		Result2_orig converted to CPCSSN standard units.		● Only populated if Result1_orig (and Result2_orig, if applicable) can be converted from the UnitOfMeasure_orig to the CPCSSN standard units, and the converted value is within allowed bounds
UnitOfMeasure_calc	Categorical		The CPCSSN standard units for each exam.	cm, kg, kg/m^2, L/min, mmHg	● Only populated if Result1_orig (and Result2_orig, if applicable) can be converted from the UnitOfMeasure_orig to the CPCSSN standard units, and the converted value is within allowed bounds
DateCreated	Date	yyyy-mm-dd	EMR date stamp of the record.	1980-01-01 to CutOffDate (see the Cycle table)	● If the date of record creation cannot be found within the EMR, the date on which the record was last modified may be used

Table: FamilyHistory

- Family history of the patient

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
FamilyHistory_ID	FamilyHistory Table Key	15 or 16-digits	Unique integer identifying a FamilyHistory record.	Positive Integers	
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Patient_ID	Patient Table Key	15 or 16-digits	Unique and randomly assigned integer CPCSSN patient ID.	See Patient table	● Allows this table to be linked to the the patient table and all tables that contain the patient table key ● Only a Patient_ID that exists in the Patient table can be referenced here
Encounter_ID	Encounter Table Key	15 or 16-digits	Unique integer ID that links an family history record to a specific Encounter record (i.e., to a single interaction with a primary care provider).	See Encounter table	● Allows this table to be linked to the Encounter table and all other tables that include the Encounter_ID ● Only an Encounter_ID that exists in the Encounter table can be referenced here ● Multiple records in this table may be linked to a single Encounter record ● May be empty if the record cannot be linked to a specific encounter
DiagnosisText_calc	Categorical		Standardised text description that accompanies the specific ICD-9-CM code recorded in DiagnosisCode_calc.	Descriptions from ICD-9-CM only	● Populated by the CPCSSN ICD-9-CM coding algorithm, which uses the descriptions of disease entities from ICD-9-CM ● Text terms can be found through an ICD-9 look-up website
DiagnosisCodeType_calc	Categorical		The diagnosis code set from which the code in DiagnosisCode_calc was drawn. Currently, can only be 'ICD9'.	'ICD9'	● Must be 'ICD9' or empty
DiagnosisCode_calc	Categorical		An ICD-9-CM code.	Valid ICD-9-CM code	● Populated by the CPCSSN ICD-9-CM coding algorithm, which uses the descriptions of disease entities from ICD-9-CM ● ICD-9 codes can be found through an ICD-9 look-up website
Relationship_calc	Categorical		Standardised relationship type, determined from the CPCSSN relationship coding algorithm.	'Aunt' 'Brother' 'Cousin' 'Daughter' 'Father' 'Granddaughter' 'Grandfather' 'Grandmother' 'Grandson'	● Both Relationship_orig and DiagnosisText_orig entries factor into the coding; however, only when the Relationship_calcs determined from both fields are consistent (or only one of the field is empty), will this variable be populated ● The allowed values may have different capitalisation or hyphenation than indicated

				'Great Aunt' 'Great Granddaughter' 'Great Grandfather' 'Great Grandmother' 'Great Grandson' 'Great Uncle' 'Half Brother' 'Half Sister' 'Mother' 'Nephew' 'Niece' 'Sister' 'Son' 'Uncle'	
RelationshipSide_calc	Categorical		Was the relationship on the mother's or father's side?	'Maternal', 'Paternal'	
RelationshipDegree_calc	Categorical		Network degree of the relationship.	1, 2	● Relationship degree defined here: http://www.cdc.gov/genomics/resources/diseases/breast_ovarian_cancer/risk_categories.htm
AgeAtOnset	Integer	1-3 digits	Age of onset for the condition.	0-125	
VitalStatus_calc	Categorical		Standardised text indicating if the relative was alive or deceased at the time when the family history was recorded.	'Alive', 'Deceased'	
WasCauseOfDeath	Integer	1 digit	Was this condition the cause of death?	0, 1	● 0 = not the cause of death ● 1 = was the cause of death
AgeAtDeath	Integer	1-3 digits	Relation's age at death.	0-125	
DateCreated	Date	yyyy-mm-dd	EMR date stamp of the record.	1980-01-01 to CutOffDate (see the Cycle table)	● If the date of record creation cannot be found within the EMR, the date on which the record was last modified may be used

Table: HealthCondition

- The problem list and past medical history of the patient.

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
HealthCondition_ID	HealthCondition Table Key	15 or 16-digits	Unique integer identifying a HealthCondition record.	Positive Integers	
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Patient_ID	Patient Table Key	15 or 16-digits	Unique and randomly assigned integer CPCSSN patient ID.	See Patient table	● Allows this table to be linked to the the patient table and all tables that contain the patient table key ● Only a Patient_ID that exists in the Patient table can be referenced here
Encounter_ID	Encounter Table Key	15 or 16-digits	Unique integer ID that links an family history record to a specific Encounter record (i.e., to a single interaction with a primary care provider).	See Encounter table	● Allows this table to be linked to the Encounter table and all other tables that include the Encounter_ID ● Only an Encounter_ID that exists in the Encounter table can be referenced here ● Multiple records in this table may be linked to a single Encounter record ● May be empty if the record cannot be linked to a specific encounter
DiagnosisText_calc	Categorical		Standardised text description that accompanies the specific ICD-9-CM code recorded in DiagnosisCode_calc.	Descriptions from ICD-9-CM only	● Populated by the CPCSSN ICD-9-CM coding algorithm, which uses the descriptions of disease entities from ICD-9-CM ● Text terms can be found through an ICD-9 look-up website
DiagnosisCodeType_calc	Categorical		The diagnosis code set from which the code in DiagnosisCode_calc was drawn. Currently, can only be 'ICD9'.	'ICD9'	● Must be 'ICD9' or empty
DiagnosisCode_calc	Categorical		An ICD-9-CM code.	Valid ICD-9-CM code	● Populated by the CPCSSN ICD-9-CM coding algorithm, which uses the descriptions of disease entities from ICD-9-CM ● ICD-9 codes can be found through an ICD-9 look-up website

DateOfOnset	Date	yyyy-mm-dd	Date on which the health condition began.	1902-01-01 to CutOffDate (see the Cycle table)	
Status_calc	Categorical		A standardised indicator that the condition is active at the time of data extraction.	'Active', 'Inactive'	
DateCreated	Date	yyyy-mm-dd	EMR date stamp of the record.	1980-01-01 to CutOffDate (see the Cycle table)	● If the date of record creation cannot be found within the EMR, the date on which the record was last modified may be used

Table: Lab

- Results of lab tests

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
Lab_ID	Lab Table Key	15-16 digits	Unique integer identifying a lab record.	Positive Integers	
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Patient_ID	Patient Table Key	15 or 16-digits	Unique and randomly assigned integer CPCSSN patient ID.	See Patient table	● Allows this table to be linked to the patient table and all tables that contain the patient table key ● Only a Patient_ID that exists in the Patient table can be referenced here
Encounter_ID	Encounter Table Key	15 or 16-digits	Unique integer ID that links a record in this table to a specific Encounter record (i.e., to a single interaction with a primary care provider).	See Encounter table	● Allows this table to be linked to the Encounter table and all other tables that include the Encounter_ID ● Only an Encounter_ID that exists in the Encounter table can be referenced here ● Multiple records in this table may be linked to a single Encounter record ● May be empty if the record cannot be linked to a specific encounter
PerformedDate	Date	yyyy-mm-dd	Date on which the lab test was performed.	1902-01-01 to CutOffDate (see the Cycle table)	
Name_calc	Categorical		CPCSSN or LOINC standardised text description for the LOINC code recorded in Code_calc.		● Populated by the CPCSSN lab coding algorithm ● There are standardised CPCSSN names for 53 lab tests, with remaining labs named as per the LOINC standard
CodeType_calc	Categorical		Code set from which the code in Code_calc was drawn. Currently, can only be 'LOINC'.	'LOINC'	● Must be 'LOINC' or empty
Code_calc	Categorical		A LOINC code.	Valid LOINC code only	● Populated by the CPCSSN lab coding algorithm ● All LOINCs, including for the 53 CPCSSN lab tests, are drawn from the LOINC data set
TestResult_calc	Open text		TestResult_orig converted into the standard units used for the 50 CPCSSN lab tests or standardised text.		● Populated by the CPCSSN lab test cleaning algorithm, and only applied to the 53 CPCSSN lab tests

					● There are both numeric and text lab results ● Numeric lab results may include comparison operators (<, <=, >, >=)
NormalRange_calc	Text		A standardised form of the range of values that constitute 'normal' for a given lab test.	Can be ● a range, ● a comparison operation, or ● standardised text. Allowed values for the standardised text are: ● Negative ● Positive ● Clear/Yellow ● Clear ● Yellow ● Straw or Amber ● Non-reactive	● Examples ● Range: 1-20 ● Comparison: >60, <=90 ● Standard text: 'Clear', 'Yellow'
UnitOfMeasure_calc	Categorical		The standardised unit of measure for the 53 CPCSSN lab tests.		● Populated by the CPCSSN lab test cleaning algorithm, and only applied to the 53 CPCSSN lab tests
DateCreated	Date	yyyy-mm-dd	EMR date stamp of the record.	1980-01-01 to CutOffDate (see the Cycle table)	● If the date of record creation cannot be found within the EMR, the date on which the record was last modified may be used

Table: Medication

- Medications prescribed for the patient

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
Medication_ID	Medication Table Key	15-16 digits	Unique integer identifying a medication record.	Positive Integers	
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Patient_ID	Patient Table Key	15 or 16-digits	Unique and randomly assigned integer CPCSSN patient ID.	See Patient table	● Allows this table to be linked to the patient table and all tables that contain the patient table key ● Only a Patient_ID that exists in the Patient table can be referenced here
Encounter_ID	Encounter Table Key	15 or 16-digits	Unique integer ID that links a record in this table to a specific Encounter record (i.e., to a single interaction with a primary care provider).	See Encounter table	● Allows this table to be linked to the Encounter table and all other tables that include the Encounter_ID ● Only an Encounter_ID that exists in the Encounter table can be referenced here ● Multiple records in this table may be linked to a single Encounter record ● May be empty if the record cannot be linked to a specific encounter
StartDate	Date	yyyy-mm-dd	Date on which the medication was first prescribed.	1902-01-01 to CutOffDate (see the Cycle table)	
StopDate	Date	yyyy-mm-dd	Date on which the patient stopped taking the medication.	1902-01-01 to CutOffDate (see the Cycle table)	● If an allergy is inactive and StopDate cannot be found, Status field must still be set to 'Inactive'
DIN_calc	Categorical	8 digits	Drug Identification Number for the medication.	00000000 - 99999999	● DIN look-up and downloadable files can be found on Health Canada's Drug Product Database website
Name_calc	Categorical		Standardised text description that accompanies the specific ATC code recorded in Code_calc.	Descriptions from Health Canada's Drug Product Database	● Populated by the CPCSSN ATC coding algorithm, which uses the medication descriptions from Health Canada's Drug Product Database

CodeType_calc	Categorical		Code set from which the code in Code_calc was drawn. Currently, can only be 'ATC'.	ATC	● Must be 'ATC' or empty
Code_calc	Categorical		An ATC code.	Valid ATC code only	● Populated by the CPCSSN ATC coding algorithm, which uses the ATC codes from Health Canada's Drug Product Database
DurationCount_calc	Integer		The length of time for which the medication is to be given.		● All duration count data are converted to days.
DurationUnit_calc	Categorical		The CPCSSN standard unit of measure for how long the medication is to be given.	'Day'	● Must be 'Day' or empty.
DispensedCount_calc	Integer		The number of units of the medication that are dispensed.		
DispensedForm_calc	Categorical		The form of the medication that is dispensed converted to standardised text.	'Bottle', 'Capsule', 'Container', 'Cream', 'Disk', 'Drops', 'Gel', 'Inhaler', 'Kit', 'Lotion', 'MDI', 'Ointment', 'Powder', 'Spray', 'Stick', 'Syringe', 'Tablet', 'Vial'	
RefillCount_calc	Integer		The number of allowed refills for the given medication.		● Must be in the range 0 < RefillCount <= 100
DateCreated	Date	yyyy-mm-dd	EMR date stamp of the record.	1980-01-01 to CutOffDate (see the Cycle table)	● If the date of record creation cannot be found within the EMR, the date on which the record was last modified may be used

Table: Referral

- All referrals (to specialists, physiotherapy, etc.) made by their assigned provider or clinic
- Excludes referrals made by specialists

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
Referral_ID	Referral Table Key	15-16 digits	Unique integer identifying a referral record.	Positive Integers	
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	• Allows this table to be linked to the Network table and all other tables that include the Network table key • Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Patient_ID	Patient Table Key	15 or 16-digits	Unique and randomly assigned integer CPCSSN patient ID.	See Patient table	• Allows this table to be linked to the patient table and all tables that contain the patient table key • Only a Patient_ID that exists in the Patient table can be referenced here
Encounter_ID	Encounter Table Key	15 or 16-digits	Unique integer ID that links a record in this table to a specific Encounter record (i.e., to a single interaction with a primary care provider).	See Encounter table	• Allows this table to be linked to the Encounter table and all other tables that include the Encounter_ID • Only an Encounter_ID that exists in the Encounter table can be referenced here • Multiple records in this table may be linked to a single Encounter record • May be empty if the record cannot be linked to a specific encounter
CompletedDate	Date	yyyy-mm-dd	Date of the patient's visit to the referred to provider's clinic.	1980-01-01 to CutOffDate (see the Cycle table)	• Is **not** the date on which the patient's provider created the referral or the referral letter was written
Name_calc	Categorical		Standardised text description that accompanies the specific SNOMED-CT code recorded in ConceptCode_calc.	Name of a alid SNOMED-CT codes	• Populated by the CPCSSN Referral Cleaning algorithm, which is based on SNOMED-CT coding
ConceptCode_calc	Integer		SNOMED concept code.	Valid SNOMED-CT codes	• Populated by the CPCSSN Referral Cleaning algorithm, which is based on SNOMED-CT coding
DateCreated	Date	yyyy-mm-dd	EMR date stamp of the record.	1980-01-01 to CutOffDate (see the Cycle table)	• If the date of record creation cannot be found within the EMR, the date on which the record was last modified may be used

Table: RiskFactor

- Risk factors recorded for the patient
- CPCSSN currently codes for six risk factors

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
RiskFactor_ID	RiskFactor Table Key	15-16 digits	Unique integer identifying a risk factor record.	Positive Integers	
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Patient_ID	Patient Table Key	15 or 16-digits	Unique and randomly assigned integer CPCSSN patient ID.	See Patient table	● Allows this table to be linked to the patient table and all tables that contain the patient table key ● Only a Patient_ID that exists in the Patient table can be referenced here
Encounter_ID	Encounter Table Key	15 or 16-digits	Unique integer ID that links a record in this table to a specific Encounter record (i.e., to a single interaction with a primary care provider).	See Encounter table	● Allows this table to be linked to the Encounter table and all other tables that include the Encounter_ID ● Only an Encounter_ID that exists in the Encounter table can be referenced here ● Multiple records in this table may be linked to a single Encounter record ● May be empty if the record cannot be linked to a specific encounter
StartDate	Date	yyyy-mm-dd	Date on which the risk factor began.	1902-01-01 to CutOffDate (see the Cycle table)	
EndDate	Date	yyyy-mm-dd	Date on which the risk factor ended.	1902-01-01 to CutOffDate (see the Cycle table)	
Name_calc	Categorical		Standardised risk factor name coded from the text in Name_orig.	'Alcohol', 'Diet', 'Exercise', 'Obesity', 'Psychosocial Stress', 'Smoking'	● Populated by the CPCSSN RiskFactor name coding algorithm
Status_calc	Categorical		Standardised risk factor status coded from the text in Name_orig.	'Current', 'Never',	● Populated by the CPCSSN RiskFactor status coding algorithm

				'Not Current', 'Past'	● 'Not Current' indicates that it is unclear whether the patient never had or does not currently have the risk factor (e.g., 'non-smoker' could indicate has stopped smoking or has never smoked)
DateCreated	Date	yyyy-mm-dd	EMR date stamp of the record.	1980-01-01 to CutOffDate (see the Cycle table)	● If the date of record creation cannot be found within the EMR, the date on which the record was last modified may be used

Table: Vaccine

- Vaccinations given (or attempted to be given) to the patient

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
Vaccine_ID	Vaccine Table Key	15-16 digits	Unique integer identifying a vaccine record.	Positive Integers	
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Patient_ID	Patient Table Key	15 or 16-digits	Unique and randomly assigned integer CPCSSN patient ID.	See Patient table	● Allows this table to be linked to the patient table and all tables that contain the patient table key ● Only a Patient_ID that exists in the Patient table can be referenced here
Encounter_ID	Encounter Table Key	15 or 16-digits	Unique integer ID that links a record in this table to a specific Encounter record (i.e., to a single interaction with a primary care provider).	See Encounter table	● Allows this table to be linked to the Encounter table and all other tables that include the Encounter_ID ● Only an Encounter_ID that exists in the Encounter table can be referenced here ● Multiple records in this table may be linked to a single Encounter record ● May be empty if the record cannot be linked to a specific encounter
GivenDate	Date	yyyy-mm-dd	Date of vaccine administration.	1902-01-01 to CutOffDate (see the Cycle table)	
ExpiryDate	Date	yyyy-mm-dd	Vaccine expiry date.	1902-01-01 to CutOffDate (see the Cycle table)	● The vaccine-batch expiry date, **not** the end-date of vaccine efficacy
Name_calc	Categorical		Standardised text description that accompanies the specific ATC code recorded in Code_calc.	Descriptions from Health Canada's Drug Product Database	● Populated by the CPCSSN ATC coding algorithm, which uses the medication descriptions from Health Canada's Drug Product Database
CodeType_calc	Categorical		Code set from which the code in Code_calc was drawn. Currently, can only be 'ATC'.	ATC	● Must be 'ATC' or empty
Code_calc	Categorical		An ATC code.	Valid ATC code only	● Populated by the CPCSSN ATC coding algorithm, which uses the ATC codes from Health Canada's Drug Product Database

DIN_calc	Categorical	8 digits	Drug Identification Number for the medication.	00000000 - 99999999	● DIN look-up and downloadable files can be found on Health Canada's Drug Product Database website
NotGiven	Integer		Whether or not the vaccine was administered.	0 or 1	● 'No' = 0 (vaccine administered) ● 'Yes' = 1 (vaccine NOT administered)
DateCreated	Date	yyyy-mm-dd	EMR date stamp of the record.	1980-01-01 to CutOffDate (see the Cycle table)	● If the date of record creation cannot be found within the EMR, the date on which the record was last modified may be used

Table: DiseaseCase

- Patients who have been identified by the CPCSSN disease case detection algorithms as having one or more diseases

Variable Name	Variable Type	Format	Definition	Allowed Values	Notes
Disease_ID	Disease Table Key	15-16 digits	Unique integer identifying a disease record.	Positive Integers	
Network_ID	Network Table Key	1 or 2-digits	Unique integer assigned to each regional practice-based research network within CPCSSN.	1 - 14	● Allows this table to be linked to the Network table and all other tables that include the Network table key ● Refer to the Network table for the specific regional practice-based research network covered by a given Network_ID
Patient_ID	Patient Table Key	15 or 16-digits	Unique and randomly assigned integer CPCSSN patient ID.	See Patient table	● Allows this table to be linked to the patient table and all tables that contain the patient table key ● Only a Patient_ID that exists in the Patient table can be referenced here
Disease	Categorical		The disease name.	See the CPCSSN disease case documentation	
Version	Integer		The version number for the disease case definition.	See the CPCSSN disease case documentation	
IsDefaultDefinition	Integer		Whether the disease is the most current or is the CPCSSN standard definition, OR is an older or less accurate definition.	0 or 1	● 'No' = 0 ● 'Yes' = 1
DateCaseDetected	Date	yyyy-mm-dd	The date on which the first indication of disease, for a given case definition, appears in the CPCSSN record.	1980-01-01 to CutOffDate (see the Cycle table)	