

Module: family-history

Module Contents

family

1. [CENTER_NO](#)
2. [FAMILY_ID \(PK*\)](#)
3. [CTR_SUB](#)
4. [FSRC](#)
5. [FRSTDATE](#)
6. [FRSTEST](#)
7. [BASELINE_CUTOFF](#)
8. [ASHKENAZI](#)

1	CENTER_NO	number (2,0)	Required: true
Center Identification Number			

Allowable Values

11	Sinai Health Systems (formerly Cancer Care Ontario)
12	Cedars-Sinai & Cleveland Clinic (formerly USC Consortium)
13	University of Melbourne
14	University of Hawaii Cancer Center
15	Mayo Clinic
16	Fred Hutch, Seattle
17	UCSF: University of California at San Francisco (formerly CPIC, originally Northern California (NCCC))

2	FAMILY_ID (PK*)	string (9)	Required: true
Family identification number uniquely identifying a family. Consists of concatenated CENTER_NO (2 digits; digits 1-2) + local family number (7 digits; digits 3-9). The last portion of the number (7 digit part) should be right justified, zero filled. Ex: Family Id 12345 from Philadelphia Breast Center should be: 010012345 or 10012345 Ex: Family Id 12345 from Australia Colon Center should be: 130012345. *This field is a Primary Key for the table.			

3	CTR_SUB	string (2)	Required: false
Center subsite location (determined by institution).			

Allowable Values

01	Dartmouth
02	USC
03	Uni of Colorado
04	Uni of Arizona
05	Cleveland Clinic
06	UNC
07	Uni of Minnesota
13	Cases 18-44
14	Cases 45-49
15	Cases 18-44 2003+
16	Cases 45-49 2003+
17	Cases 18-44 preNIH Ph II

18	Cases 45-49 preNIH Ph II
23	Controls 18-44
24	Controls 45-49
31	Clinic Ph I
32	Clinic Ph II
33	Clinic Ph III
32	Clinic Cases with Frozen Tissue
34	Community Recruitment PhIV
55	Ph I Clinic-Based (Mayo Clinic)
56	Ph I Clinic-Based (Nth Central Ca Tx Center)
57	Ph I Pop-Based (Minnesota Ca Surveillance System)
58	Ph I Other Clinic-Based
65	Ph II Clinic-Based (Mayo Clinic)
67	Ph II Pop-Based (Minnesota Ca Surveillance System)
68	Ph II Other Clinic-Based
75	Ph III Clinic-Based (Mayo Clinic)
78	Ph III Other Clinic-Based

Error Description
If CENTER_NO = 12 then CTR_SUB must be in (01,02,03,04,05,06,07)
If CENTER_NO = 13 then CTR_SUB must be in(13,14,15,16,17,18,23,24,31,32,33)
If CENTER_NO = 15 then CTR_SUB must be in (32,55,56,57,58,65,67,68,75,78)

4	FSRC	number (1,0)	Required: true
Source of family/proband.			

- | Allowable Values | |
|------------------|------------------------------------|
| 1 | Population-based (cancer registry) |
| 2 | Clinic (non-population based) |

5	FRSTDATE	string (8)	Required: true
Date proband first identified. E.g. date of diagnosis of incident case in cancer registry or date of first visit to clinic or date first identified to study.			

6	FRSTEST	number (1,0)	Required: false
Accuracy of date identified/recruited.			

- | Allowable Values | |
|------------------|----------------------|
| 1 | Exact |
| 2 | Within 1 year |
| 3 | Within 1+ to 5 years |

- 4 Within 5+ to 10 years
- 5 10 or more years
- 9 Unknown

7	BASELINE_CUTOFF	string (8)	Required: false
Date when the complete initial family history interview/information was received.			

Date Value Check	
<p>The date must follow to the following format:</p> <p>Format YYYYMMDD. Must consist of valid date. Components of date should be right justified and zero filled. MM = 01 - 12, 88, 99 DD = 01 - 31, 88, 99 YYYY = Minimum year - system date year, 8888, 9999 Use 88, 8888 for not currently known, in progress to obtain information. Use 99, 9999 for not known. If century is known, but year is unknown then give an estimate of year or code YYYY = 9999. If MM = 99 then DD must = 99. If century is known, but year is unknown then give an estimate of year or code YYYY = 9999. If YYYY = 9999 then MM and DD must = 99.</p> <p>The following special parameters are used:</p>	
Format YYYYMMDD	
YYYY	1997 (Minimum year) - system date year, 8888, 9999
MM	01 - 12, 88, 99
DD	01 - 31, 88, 99

8	ASHKENAZI	number (1,0)	Required: true
Flag to indicate whether proband is of Ashkenazi Jewish descent			

- | | |
|------------------|---------|
| Allowable Values | |
| 1 | Yes |
| 2 | No |
| 9 | Unknown |

Module: family-history

Module Contents

family-membership

1. [CENTER_NO](#)
2. [FAMILY_ID \(PK*\)](#)
3. [PERSON_ID \(PK*\)](#)
4. [PROBAND_FLG](#)
5. [PROBAND_TYPE](#)
6. [SPOUSE_CONTROL_ID](#)
7. [FUNDING_PHASE](#)
8. [PROB_WGT](#)
9. [P_FRACTION](#)
10. [P_POP_TYPE](#)
11. [LINEAGE](#)
12. [RELATION_CODE](#)

1	CENTER_NO	number (2,0)	Required: true
	Center Identification Number		

Allowable Values	
11	Sinai Health Systems (formerly Cancer Care Ontario)
12	Cedars-Sinai & Cleveland Clinic (formerly USC Consortium)
13	University of Melbourne
14	University of Hawaii Cancer Center
15	Mayo Clinic
16	Fred Hutch, Seattle
17	UCSF: University of California at San Francisco (formerly CPIC, originally Northern California (NCCC))

2	FAMILY_ID (PK*)	string (9)	Required: true
	Family identification number uniquely identifying a family. Consists of concatenated CENTER_NO (2 digits; digits 1-2) + local family number (7 digits; digits 3-9). The last portion of the number (7 digit part) should be right justified, zero filled. Ex: Family Id 12345 from Australia Colon Center should be: 130012345. *FAMILY_ID + PERSON_ID are the primary key for the table.		

3	PERSON_ID (PK*)	string (12)	Required: true
	Number that uniquely identifies an individual. Consists of concatenation of CENTER_NO (2 digit; digits 1-2) + (10 digit local unique individual id; digits 3-12). The 10 digit individual number component should be right justified, zero filled. Ex: Individual Id 98765 from Australia Colon Center should be: 130000098765. *FAMILY_ID + PERSON_ID are the primary key for the table.		

4	PROBAND_FLG	number (1,0)	Required: false
	Flag indicated that individual is the proband. Note: multiple records within a family may be flagged as a proband for families sampled with population-based criteria.		

Allowable Values	
1	First identified or only proband
2	Second identified proband
3	Third identified proband
4	Forth identified proband
5	Fifth identified proband

5	PROBAND_TYPE	number (1,0)	Required:false																		
	Type of proband.																				
	<table border="1"> <tr> <td colspan="2">Allowable Values</td> </tr> <tr> <td>1</td> <td>Affected proband (Affected with a CRC)</td> </tr> <tr> <td>2</td> <td>Unaffected proband (Do not have colorectal cancer)</td> </tr> <tr> <td>3</td> <td>Population-based control</td> </tr> <tr> <td>4</td> <td>Recruited as population-based control , later developed colorectal cancer and ascertained as an affected proband</td> </tr> </table>			Allowable Values		1	Affected proband (Affected with a CRC)	2	Unaffected proband (Do not have colorectal cancer)	3	Population-based control	4	Recruited as population-based control , later developed colorectal cancer and ascertained as an affected proband								
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1	Affected proband (Affected with a CRC)																				
2	Unaffected proband (Do not have colorectal cancer)																				
3	Population-based control																				
4	Recruited as population-based control , later developed colorectal cancer and ascertained as an affected proband																				
6	SPOUSE_CONTROL_ID	string (12)	Required:false																		
	Person _id of corresponding individuals that are linked together as proband/individual and spouse control. For example, the proband/individual record would have the spouse_control_id set to the person_id of their spouse. A proband or a family member may have a spouse control but the spouse may not have the proband as a spouse control. Note: this field should only be used in the situation that spouses are recruited specifically for serving as a control.																				
7	FUNDING_PHASE	number (1,0)	Required:false																		
	Funding phase/source for recruitment of proband/family.																				
	<table border="1"> <tr> <td colspan="2">Allowable Values</td> </tr> <tr> <td>1</td> <td>Phase 1, initial funding (first 5 years of funding, colon centers 4 years of funding)</td> </tr> <tr> <td>2</td> <td>Phase 2, renewal funding</td> </tr> <tr> <td>3</td> <td>Ashkenazi supplement (only applicable for Breast centers)</td> </tr> <tr> <td>4</td> <td>Interim one year funding</td> </tr> <tr> <td>5</td> <td>Non-NIH Funding Source</td> </tr> <tr> <td>6</td> <td>Non-participation for Phase 1, Participating in Phase 2</td> </tr> <tr> <td>7</td> <td>Minority RO1 Funding</td> </tr> <tr> <td>8</td> <td>Phase III, second renewal funding (third 5 years of funding)</td> </tr> </table>			Allowable Values		1	Phase 1, initial funding (first 5 years of funding, colon centers 4 years of funding)	2	Phase 2, renewal funding	3	Ashkenazi supplement (only applicable for Breast centers)	4	Interim one year funding	5	Non-NIH Funding Source	6	Non-participation for Phase 1, Participating in Phase 2	7	Minority RO1 Funding	8	Phase III, second renewal funding (third 5 years of funding)
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6	Non-participation for Phase 1, Participating in Phase 2																				
7	Minority RO1 Funding																				
8	Phase III, second renewal funding (third 5 years of funding)																				
8	PROB_WGT	number (9,6)	Required:false																		
	Weight for population-based probands that does NOT take response/participation rates into account.																				
9	P_FRACTION	number (4,3)	Required:false																		
	The sampling fraction, based on ascertainment criteria such as family history, ethnicity, age of diagnosis etc. The probability of being sampled. It does not take response/participation rates into account. Applicable to population-based probands.																				
10	P_POP_TYPE	number (1,0)	Required:false																		
	Type of recruitment for population-based probands.																				

	Allowable Values	
1	Incident: The CRC is the subjects first CRC diagnosis, and it was made during the CFR recruitment period	
2	Previous Incident: The qualifying tumor is an incident or 'first CRC', but the diagnosis date is prior to the CFR recruitment period. In other words, the proband had one CRC diagnosis up to enrollment in the CFR, prior to the 'CFR recruitment period'.	
3	Second primary (previously referred to as 'prevalent'). The qualifying tumor is not the first CRC. In other words, the participant had one or more CRC diagnoses prior to a CRC diagnosis during the CFR recruitment period. The new (or subsequent) CRC is flagged as the 'qualifying tumor'.	
9	Unknown	

11	LINEAGE	number (1,0)	Required:FALSE
An indication of which line down the pedigree a relative descends from. Maternal or Paternal or Both to be used in conjunction with the RELATION_CODE to denote lineage.			

Allowable Values	
1	PATERNAL
2	MATERNAL
3	BOTH
8	NON BLOOD
9	UNKNOWN

12	RELATION_CODE	string (3)	Required:true
An internal code to describe the individuals relationship to the primary proband (proband_flag ; 1 First identified or only proband) in a family. Will serve as a foreign key to a new relationship meta-table that contains the code, degree of relationship, English description of the relationship and potentially other attributes.			

Code1	Degree	Description	Common Name
OS0	0	Self	Proband
OS1	1	Child	Daughter/son
OS2	2	Grandchild	Granddaughter/son
OS3	3	Great grandchild	Great granddaughter/son
OTO	0	Twin sibling (identical)	Sister/brother
OFO	1	Full sibling	Sister/brother
OHO	2	Half sibling	Sister/brother
OOU	2	Unkn sibling (one parent is unknown)	Sister/brother
OT1	1	Twin siblings child	Niece/nephew
OT2	2	Twin siblings grandchild	Grandniece/nephew
OT3	3	Twin siblings great grandchild	Great grandniece/nephew
OF1	2	Full siblings child	Niece/nephew
OF2	3	Full siblings grandchild	Grandniece/nephew
OF3	4	Full siblings great grandchild	Great grandniece/nephew
OH1	3	Half siblings child	Niece/nephew
OH2	4	Half siblings grandchild	Grandniece/nephew
OH3	5	Half siblings great grandchild	Great grandniece/nephew
OOU1	3	Unkn siblings child	Niece/nephew
OOU2	4	Unkn siblings grandchild	Grandniece/nephew
OOU3	5	Unkn siblings great grandchild	Great grandniece/nephew
1S0	1	Parent	Mother/father
2S0	2	Grandparent	Grandmother/father

3SO	3	Great grandparent	Great grandmother/father
4SO	4	Great-great grandparent	Great-great grandmother/father
1TO	1	Parents twin sibling	Aunt/uncle
1FO	2	Parents full sibling	Aunt/uncle
1HO	3	Parents half sibling	Aunt/uncle
1UO	3	Parents unkn sibling	Aunt/uncle
1T1	2	Parents twin siblings child	1st cousin
1T2	3	Parents twin siblings grandchild	1st cousin 1x rem
1T3	4	Parents twin siblings great grandchild	1st cousin 2x rem
1T4	5	Parents twin siblings great-great grandchild	1st cousin 3x rem
1F1	3	Parents full siblings child	1st cousin
1F2	4	Parents full siblings grandchild	1st cousin 1x rem
1F3	5	Parents full siblings great grandchild	1st cousin 2x rem
1F4	6	Parents full siblings great-great grandchild	1st cousin 3x rem
1H1	4	Parents half siblings child	1st cousin
1H2	5	Parents half siblings grandchild	1st cousin 1x rem
1H3	6	Parents half siblings great grandchild	1st cousin 2x rem
1H4	7	Parents half siblings great-great grandchild	1st cousin 3x rem
1U1	4	Parents unkn siblings child	1st cousin
1U2	5	Parents unkn siblings grandchild	1st cousin 1x rem
1U3	6	Parents unkn siblings great grandchild	1st cousin 2x rem
1U4	7	Parents unkn siblings great-great grandchild	1st cousin 3x rem
2TO	2	Grandparents twin sibling	Grandaunt/uncle
2FO	3	Grandparents full sibling	Grandaunt/uncle
2HO	4	Grandparents half sibling	Grandaunt/uncle
2UO	4	Grandparents unkn sibling	Grandaunt/uncle
2T1	3	Grandparents twin siblings child	1st cousin 1x rem
2T2	4	Grandparents twin siblings grandchild	2nd cousin
2T3	5	Grandparents twin siblings great grandchild	2nd cousin 1x rem
2T4	6	Grandparents twin siblings great-great grandchild	2nd cousin 2x rem
2T5	7	Grandparents twin siblings great-great-great grandchild	2nd cousin 3x rem
2F1	4	Grandparents full siblings child	1st cousin 1x rem
2F2	5	Grandparents full siblings grandchild	2nd cousin
2F3	6	Grandparents full siblings great grandchild	2nd cousin 1x rem
2F4	7	Grandparents full siblings great-great grandchild	2nd cousin 2x rem
2F5	8	Grandparents full siblings great-great-great grandchild	2nd cousin 3x rem
2H1	5	Grandparents half siblings child	1st cousin 1x rem

2H2	6	Grandparents half siblings grandchild	2nd cousin
2H3	7	Grandparents half siblings great grandchild	2nd cousin 1x rem
2H4	8	Grandparents half siblings great-great grandchild	2nd cousin 2x rem
2H5	9	Grandparents half siblings great-great-great grandchild	2nd cousin 3x rem
2U1	5	Grandparents unkn siblings child	1st cousin 1x rem
2U2	6	Grandparents unkn siblings grandchild	2nd cousin
2U3	7	Grandparents unkn siblings great grandchild	2nd cousin 1x rem
2U4	8	Grandparents unkn siblings great-great grandchild	2nd cousin 2x rem
2U5	9	Grandparents unkn siblings great-great-great grandchild	2nd cousin 3x rem
3T0	3	Great grandparents twin sibling	Great grandaunt/uncle
3F0	4	Great grandparents full sibling	Great grandaunt/uncle
3H0	5	Great grandparents half sibling	Great grandaunt/uncle
3U0	5	Great grandparents unkn sibling	Great grandaunt/uncle
3T1	4	Great grandparents twin siblings child	2nd cousin 2x rem
3T2	5	Great grandparents twin siblings grandchild	2nd cousin 1x rem
3T3	6	Great grandparents twin siblings great grandchild	3rd cousin
3T4	7	Great grandparents twin siblings great-great grandchild	3rd cousin 1x rem
3T5	8	Great grandparents twin siblings great-great-great grandchild	3rd cousin 2x rem
3T6	9	Great grandparents twin siblings great-great-great-great grandchild	3rd cousin 3x rem
3F1	5	Great grandparents full siblings child	2nd cousin 2x rem
3F2	6	Great grandparents full siblings grandchild	2nd cousin 1x rem
3F3	7	Great grandparents full siblings great grandchild	3rd cousin
3F4	8	Great grandparents full siblings great-great grandchild	3rd cousin 1x rem
3F5	9	Great grandparents full siblings great-great-great grandchild	3rd cousin 2x rem
3F6	10	Great grandparents full siblings great-great-great-great grandchild	3rd cousin 3x rem
3H1	6	Great grandparents half siblings child	2nd cousin 2x rem
3H2	7	Great grandparents half siblings grandchild	2nd cousin 1x rem
3H3	8	Great grandparents half siblings great grandchild	3rd cousin
3H4	9	Great grandparents half siblings great-great grandchild	3rd cousin 1x rem
3H5	10	Great grandparents half siblings great-great-great grandchild	3rd cousin 2x rem
3H6	11	Great grandparents half siblings great-great-great-great grandchild	3rd cousin 3x rem
3U1	6	Great grandparents unkn siblings child	2nd cousin 2x rem
3U2	7	Great grandparents unkn siblings grandchild	2nd cousin 1xrem
3U3	8	Great grandparents unkn siblings great grandchild	3rd cousin
3U4	9	Great grandparents unkn siblings great-great grandchild	3rd cousin 1x rem
3U5	10	Great grandparents unkn siblings great-great-great grandchild	3rd cousin 2x rem
3U6	11	Great grandparents unkn siblings great-great-great-great grandchild	3rd cousin 3x rem

BLO	3	Blood relation - other	Blood relation - other
NBS	1	Non-blood relation - proband spouse	Non-blood relation - proband spouse
NBO	1	Non-blood relation - other	Non-blood relation - other
XXX	9	Relationship is completely unknown	Unknown

Module: family-history

Module Contents

individual

1. [CENTER_NO](#)
2. [PERSON_ID \(*PK\)](#)
3. [PERSON_CID](#)
4. [MOTHER_ID](#)
5. [FATHER_ID](#)
6. [TWIN_ID](#)
7. [TWIN_TYPE](#)
8. [SEX](#)
9. [VS](#)
10. [LIVEDATE](#)
11. [LIVEDATESRC](#)
12. [DTHDATE](#)
13. [DTHDATESRC](#)
14. [AGE_DEATH](#)
15. [AGE_DEATH_EST](#)
16. [DOB](#)
17. [BIREST](#)
18. [INDIVSRC](#)
19. [BLOOD](#)
20. [BUCCAL_SALIVA](#)
21. [EPI_Q_COLON](#)
22. [COLON_1ST_FU](#)
23. [COLON_2ND_FU](#)
24. [COLON_3RD_FU](#)
25. [COLON_4TH_FU](#)
26. [DIET_Q_HI](#)
27. [DIET_Q_AUS](#)
28. [CLINICAL_COLON](#)
29. [RACE_SOURCE](#)
30. [ADDITIONAL_RACE_COLON](#)

1	CENTER_NO	number (2,0)	Required: true
	Center Identification Number		
	Allowable Values		
	11	Sinai Health Systems (formerly Cancer Care Ontario)	
	12	Cedars-Sinai & Cleveland Clinic (formerly USC Consortium)	
	13	University of Melbourne	
	14	University of Hawaii Cancer Center	
	15	Mayo Clinic	
	16	Fred Hutch, Seattle	
	17	UCSF: University of California at San Francisco (formerly CPIC, originally Northern California (NCCC))	
2	PERSON_ID (*PK)	string (12)	Required: true
	Number that uniquely identifies an individual. Consists of concatenation of CENTER_NO (2 digit; digits 1-2) + (10 digit local unique individual id; digits 3-12). The 10 digit individual number component should be right justified, zero filled. Ex: Individual Id 98765 from Australia Colon Center should be: 130000098765. *This field is the primary key for the table.		
3	PERSON_CID	string (30)	Required: false
	The external person ID (or concatenated set of IDs) that is local to the submitting center.		
4	MOTHER_ID	string (12)	Required: false
	Person identification number (PERSON_ID) of mother. Consists of concatenation of CENTER_NO (2 digit) + (10 digit local unique individual id). The 10 digit individual number component should be right justified, zero filled.		

5	FATHER_ID	string (12)	Required: false										
Identification number (PERSON_ID) of father.													
6	TWIN_ID	string (12)	Required: false										
Identification number (PERSON_ID) of the corresponding twin. Example: Persons 3 and 4 are twins. Person 3 = 02000008763 Person 4 = 02000008764 Example: Persons 3, 4, and 5 are triplets. Code as follows: Person 3 = 02000008763 Person 4 = 02000008764 Person 5 = 02000008765													
7	TWIN_TYPE	number (1,0)	Required: false										
Type of twin.													
<table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th colspan="2">Allowable Values</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td>Monozygous</td> </tr> <tr> <td style="text-align: center;">2</td> <td>Dizygous</td> </tr> <tr> <td style="text-align: center;">9</td> <td>Twin, type unknown</td> </tr> </tbody> </table>				Allowable Values		1	Monozygous	2	Dizygous	9	Twin, type unknown		
Allowable Values													
1	Monozygous												
2	Dizygous												
9	Twin, type unknown												
8	SEX	number (1,0)	Required: true										
Sex of the individual.													
<table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th colspan="2">Allowable Values</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td>Male</td> </tr> <tr> <td style="text-align: center;">2</td> <td>Female</td> </tr> <tr> <td style="text-align: center;">3</td> <td>Other</td> </tr> <tr> <td style="text-align: center;">9</td> <td>Unknown</td> </tr> </tbody> </table>				Allowable Values		1	Male	2	Female	3	Other	9	Unknown
Allowable Values													
1	Male												
2	Female												
3	Other												
9	Unknown												
9	VS	number (1,0)	Required: true										
Vital Status of individual.													
<table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th colspan="2">Allowable Values</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td>Alive</td> </tr> <tr> <td style="text-align: center;">2</td> <td>Dead</td> </tr> <tr> <td style="text-align: center;">9</td> <td>Unknown</td> </tr> </tbody> </table>				Allowable Values		1	Alive	2	Dead	9	Unknown		
Allowable Values													
1	Alive												
2	Dead												
9	Unknown												
10	LIVEDATE	string (8)	Required: true										
The most recent date a subject is known to be living. This is the last date the subject is known to be alive. There are multiple sources of information that can be used to obtain this date. Acceptable sources are listed in LIVEDATESRC. Upon notification of the death of the subject, the LIVEDATE should remain unchanged and VS should be updated to 2-dead and DTHDATE and DTHDATESRC, AGE_DEATH and AGE_DEATH_EST populated.													

Date Value Check
<p>The date must follow to the following format:</p> <p>Format YYYYMMDD. Must consist of valid date. Components of date should be right justified and zero filled. MM = 01 - 12, 88, 99 DD = 01 - 31, 88, 99 YYYY = Minimum year - system date year, 8888, 9999 Use 88, 8888 for not currently known, in progress to obtain information.</p>

Use 99, 9999 for not known.
 If century is known, but year is unknown then give an estimate of year or code YYYY = 9999.
 If MM = 99 then DD must = 99.
 If century is known, but year is unknown then give an estimate of year or code YYYY = 9999.
 If YYYY = 9999 then MM and DD must = 99.

The following special parameters are used:

Format YYYYMMDD	
YYYY	1700 (Minimum year) - system date year, 8888, 9999
MM	01 - 12, 88, 99
DD	01 - 31, 88, 99

11	LIVEDATESRC	number (2,0)	Required:true
Source of information for LIVEDATE			

Allowable Values

1	Self representation either by conducting a study activity in person, by telephone, or by mail. These could include completing a survey, signing a study document, providing a blood sample, etc
2	Relative (or Respondent) report that a subject is living
3	Linkage with national death indices, such as the NDI and NDI+, where the OMISSION of a subject presumes he/she is living (consensus advised).
4	Linkage with state death indices, such as through the health department where the OMISSION of a subject presumes he/she is living (consensus advised)
5	Linkage with another information source that reports an activity that indicates the subject is living, such as current use of social security benefits, credit report
6	Hospital record, medical file that reports contact with or a procedure performed on subject.
7	SEER, which reports the last date they know the subject is known to be alive.
8	State Cancer registry, which reports the last date they know the subject to be alive.
9	Other, for example specialized genealogy
99	Unknown

12	DTHDATE	string (8)	Required:false
The date of death. There are multiple sources of information that can be used to obtain this date. Acceptable sources are listed in DTHDATESRC.			

Date Value Check
<p>The date must follow to the following format:</p> <p>Format YYYYMMDD. Must consist of valid date. Components of date should be right justified and zero filled. MM = 01 - 12, 88, 99 DD = 01 - 31, 88, 99 YYYY = Minimum year - system date year, 8888, 9999 Use 88, 8888 for not currently known, in progress to obtain information. Use 99, 9999 for not known. If century is known, but year is unknown then give an estimate of year or code YYYY = 9999. If MM = 99 then DD must = 99. If century is known, but year is unknown then give an estimate of year or code YYYY = 9999. If YYYY = 9999 then MM and DD must = 99.</p> <p>The following special parameters are used:</p>

Format YYYYMMDD	
YYYY	1700 (Minimum year) - system date year, 8888, 9999
MM	01 - 12, 88, 99
DD	01 - 31, 88, 99

Error Description
If VS is 2 then DTHDATE must not be null
If VS is not 2 then DTHDATE must be null
Date of death must be equal to or after date of birth
LIVEDATE must be less DTHDATE

13	DTHDATESRC	number (2,0)	Required:false
Source of information reporting subject is deceased			

Allowable Values	
1	Relative (or Respondent) report of subject death
2	Linkage with national death indices (e.g., NDI, NDI+)
3	Linkage with another information source that reports termination of services due to death (e.g., social security benefits, medicare, medicaid).
4	Hospital record, medical file that reports
5	SEER
6	State Cancer registry
7	State Death Indices (e.g., through the health department)
8	Death certificate
9	Obituary
10	Other (e.g., specialized genealogy research)
99	Unknown

Error Description
If VS is not 2 then DTHDATESRC must be null
If VS is 2 then DTHDATESRC must not be null

14	AGE_DEATH	number (3,0)	Required:false
Age at death. Coding for this field is based on SEER, NAACCR and ACoS guidelines.			

Allowable Values	
998	Less than 1 year
999	Unknown

15	AGE_DEATH_EST	number (1,0)	Required:false
Accuracy of age of death.			

Allowable Values	
1	Exact
2	Within 1 year
3	Within 1+ to 5 years
4	Within 5+ to 10 years
5	10 or more years
9	Unknown

16	DOB	string (8)	Required: true
	Date of birth.		

Date Value Check

The date must follow to the following format:

Format YYYYMMDD. Must consist of valid date.
 Components of date should be right justified and zero filled.
 MM = 01 - 12, 88, 99
 DD = 01 - 31, 88, 99
 YYYY = **Minimum year** - system date year, 8888, 9999
 Use 88, 8888 for not currently known, in progress to obtain information.
 Use 99, 9999 for not known.
 If century is known, but year is unknown then give an estimate of year or code YYYY = 9999.
 If MM = 99 then DD must = 99.
 If century is known, but year is unknown then give an estimate of year or code YYYY = 9999.
 If YYYY = 9999 then MM and DD must = 99.

The following special parameters are used:

Format YYYYMMDD	
YYYY	1700 (Minimum year) - system date year, 8888, 9999
MM	01 - 12, 88, 99
DD	01 - 31, 88, 99

Error Description
 must be a valid date of format YYYYMMDD

17	BIREST	number (1,0)	Required: true
	Accuracy of date of birth.		

Allowable Values	
1	Exact
2	Within 1 year
3	Within 1+ to 5 years
4	Within 5+ to 10 years
5	10 or more years
9	Unknown

18	INDIVSRC	number (1,0)	Required: true
Source of information for individual family member.			

Allowable Values	
0	Self
1	1st degree relative
2	2nd degree relative
3	Other relative
4	Other
5	Dummy record (i.e. dummy spouse or parent)
9	Unknown

19	BLOOD	number (1,0)	Required: true
Status of blood specimen.			

Allowable Values	
0	Not needed / not applicable
1	Needed, but can't get (e.g. deceased, overseas, etc.)
2	Needed, Pending
3	Blood received
4	Refusal from patient
6	Sample lost or destroyed

20	BUCCAL_SALIVA	number (1,0)	Required: false

Allowable Values	
0	Not needed, not applicable
1	Needed, but cannot get (e.g. deceased, overseas, etc.)
2	Needed, pending
3	Buccal_Saliva received
4	Refusal from patient
6	Sample lost or destroyed

21	EPI_Q_COLON	number (1,0)	Required: false
Status of colon epidemiology questionnaire.			

Allowable Values	
0	Not needed / not applicable
1	Needed, not requested yet
2	Questionnaire requested, pending

3	Questionnaire received, completed personally
4	Questionnaire completed by proxy
5	Refused
6	Needed but can't get (i.e. language, disability, etc.)
7	Deceased

22	COLON_1ST_FU	number (1,0)	Required:false
Status of the First Colon Follow Up questionnaire administered after the Baseline questionnaire.			

Allowable Values	
0	Not needed / not applicable
1	Needed, not requested yet
2	Questionnaire requested, pending
3	Questionnaire received
5	Refused (unable to complete/contact but will re-attempt next phase)
6	Permanently Lost (i.e. Withdrew, medically incapable etc)
7	Deceased

23	COLON_2ND_FU	number (1,0)	Required:false
Status of the Second Colon Follow Up questionnaire administered after the Baseline questionnaire.			

Allowable Values	
0	Not needed / not applicable
1	Needed, not requested yet
2	Questionnaire requested, pending
3	Questionnaire received
5	Refused (unable to complete/contact but will re-attempt next phase)
6	Permanently Lost (i.e. Withdrew, medically incapable etc)
7	Deceased

24	COLON_3RD_FU	number (1,0)	Required:false
Status of the Third Colon Follow Up questionnaire administered after the Baseline questionnaire.			

Allowable Values	
0	Not needed / not applicable
1	Needed, not requested yet
2	Questionnaire requested, pending
3	Questionnaire received
5	Refused (unable to complete/contact but will re-attempt next phase)
6	Permanently Lost (i.e. Withdrew, medically incapable etc)

7	Deceased

25	COLON_4TH_FU	number (1,0)	Required:false
Status of the Fourth Colon Follow Up questionnaire administered after the Baseline questionnaire.			

Allowable Values	
0	Not needed / not applicable
1	Needed, not requested yet
2	Questionnaire requested, pending
3	Questionnaire received
5	Refused (unable to complete/contact but will re-attempt next phase)
6	Permanently Lost (i.e. Withdrew, medically incapable etc)
7	Deceased

26	DIET_Q_HI	number (1,0)	Required:false
Status of Hawaiian Diet Questionnaire.			

Allowable Values	
0	Not needed / not applicable
1	Needed, not requested yet
2	Questionnaire requested, pending
3	Questionnaire received
5	Refused
6	Needed but can't get (i.e. language, disability, etc.)
7	Deceased

27	DIET_Q_AUS	number (1,0)	Required:false
Status of Australian diet questionnaire.			

Allowable Values	
0	Not needed / not applicable
1	Needed, not requested yet
2	Questionnaire requested, pending
3	Questionnaire received
5	Refused
6	Needed but can't get (i.e. language, disability, etc.)
7	Deceased

28	CLINICAL_COLON	number (1,0)	Required:false
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Consent for clinical data collected in clinical treatment module.

Allowable Values

- | | |
|---|------------------------------------------------------------------------------------|
| 0 | Not needed / not applicable |
| 1 | Needed, can't get (hospital has no records/ correct hospital cannot be identified) |
| 2 | Needed, pending consent |
| 3 | Records received |
| 4 | Consent received records pending |
| 5 | Refused- consent |
| 6 | Needed- but can't consent (lost contact/deceased, no proxy etc.) |

Error Description

If CENTER_NO=17 then CLINICAL_COLON must be null

If CENTER_NO does not equal 17 then must not be null

29

RACE_SOURCE

number (1,0)

Required:false

Source of race/ethnicity information.

Allowable Values

- | | |
|---|----------------------------------------|
| 1 | Epidemiology questionnaire self report |
| 2 | Other questionnaire self report |
| 3 | Epidemiology questionnaire proxy |
| 4 | Other questionnaire proxy |
| 5 | Cancer registry |
| 6 | Other external source |

30

ADDITIONAL_RACE_COLON

number (2,0)

Required:false

Self reported Race/ethnicity from source(s) other than Epi or FUP Epi questionnaire. This includes race reported via other questionnaires such as family history questionnaire, information provided during blood/saliva collection, verbal information, etc. For consistency and comparability with the EPI or EPIFU RACE variables, only self reported information will be provided and only for those individuals who did not provide RACE information or did not complete Epi questionnaire.

Allowable Values

- | | |
|---|--------------------------------------------------------------------------------------|
| 1 | CAUCASIAN/WHITE |
| 2 | BLACK OR AFRICAN AMERICAN (does not include Africans or persons of Caribbean origin) |
| 3 | Latino, Hispanic, Mexican American, Mexican, Cuban, Puerto Rican |
| 4 | JAPANESE (includes Okinawan) |
| 5 | CHINESE |
| 6 | FILIPINO, MALAY, INDONESIAN |
| 7 | KOREAN |
| 8 | SOUTHEAST ASIAN (such as Vietnamese, Laotian, Thai, Hmong, Kampuchean) |
| 9 | SOUTH ASIAN (such as Indian, Pakistani, Sri Lankan) |

10	NATIVE AMERICAN (such as Inuit, Aleutuan, First Nations Person)
11	POLYNESIAN (such as Hawiian, Maori, Samoan, Tongan, Tahitian, Cook Islander)
12	MICRONESIAN (such as Chmorro)
13	AUSTRALIAN ABORIGINAL (such as Chmorro)
14	MELANESIAN (such as Fijian, New Guinean)
15	CARIBBEAN BLACK (such as Jamaican, Trinidadian, Tobagonian)
16	CENTRAL/SOUTH AMERICAN (such as Costa Rican, Salvadorian, Colombian, Brazilian)
17	BLACK AFRICAN
18	NORTH AFRICAN (such as Egyptian, Algerian, Moroccan)
19	MIDDLE EASTERN (such as Iranian, Lebanese, Kuwaiti, Saudi)
98	OTHER
99	DONT KNOW/REFUSED

Module: family-history

Module Contents

cancer

1. [CENTER_NO](#)
2. [PERSON_ID \(*PK\)](#)
3. [TUMOR_NO \(*PK\)](#)
4. [SITE](#)
5. [LATERAL](#)
6. [HISTO](#)
7. [BEHAV](#)
8. [AGEDX](#)
9. [DXDATE](#)
10. [DXEST](#)
11. [DXSRC](#)
12. [TISSUE](#)
13. [QUALIFY_TUMOR](#)

1	CENTER_NO	number (2,0)	Required: true
	Center Identification Number		
	Allowable Values		
	11	Sinai Health Systems (formerly Cancer Care Ontario)	
	12	Cedars-Sinai & Cleveland Clinic (formerly USC Consortium)	
	13	University of Melbourne	
	14	University of Hawaii Cancer Center	
	15	Mayo Clinic	
	16	Fred Hutch, Seattle	
	17	UCSF: University of California at San Francisco (formerly CPIC, originally Northern California (NCCC))	
2	PERSON_ID (*PK)	number (12,0)	Required: true
	Number that uniquely identifies an individual. *PERSON_ID + TUMOR_NO are the primary key for this table.		
3	TUMOR_NO (*PK)	number (2,0)	Required: true
	Computer generated sequential number, starting with "1", assigned to each tumor for a given individual when entered into local system. No adjustment is made when a tumor is deleted from the system. Tumor numbers are never reused. Tumor_no is a machine-generated value that has no implied meaning such as sequence of diagnosis. The first tumor that is entered into the system is assigned 1, the second tumor entered into the system assigned 2, etc. For example, if a person has two tumors and tumor_no 2 is deleted, that number should never be reused for that individual. Should that person develop a second primary, that tumor should have tumor_no set to 3. *PERSON_ID + TUMOR_NO are the primary key for this table. This tumor is also mapped throughout the Registry to all block samples and molecular testing for that PERSON_ID.		
4	SITE	string (4)	Required: true
	Location where this tumor originated in as much detail as is known and for which a code is provided in ICD-O-3.		
	Error Description		
	SITE must be C000-C809		
5	LATERAL	number (1,0)	Required: true
	Laterality of tumor. Side of the body in which the tumor originated. Note: laterality of left and right is not applicable for all sites. Coding for this field is based on SEER, NAACCR and AcoS guidelines.		

Allowable Values	
0	Not a paired site
1	Right
2	Left
3	Unilateral, NOS
4	Bilateral
5	Midline
9	Paired site, no information

6	HISTO	number (5,0)	Required: true
	First four digits of the ICD-O-3 morphology code which designates the histologic type of this tumor. Coding for this field is based on SEER, NAACCR and AcoS guidelines.		

Allowable Values	
8000 to 9990	Range
8000	No specific histologic type information
72860	Keratoacanthoma

7	BEHAV	number (1,0)	Required: false
	ICD-O-3 5th digit behavior code. Coding for this field is based on SEER, NAACCR and AcoS guidelines.		

Allowable Values	
0	Benign
1	Uncertain whether benign or malignant; borderline; low malignant potential
2	Carcinoma in situ
3	Malignant (Invasive)

8	AGEDX	number (3,0)	Required: true
	Age at diagnosis.		

Allowable Values	
0 to 130 or 998, 999	Range
998	Less than 1 year
999	Unknown

9	DXDATE	string (8)	Required: true
	Date of diagnosis.		

Date Value Check

The date must follow to the following format:
Format YYYYMMDD. Must consist of valid date.

Components of date should be right justified and zero filled.
MM = 01 - 12, 88, 99
DD = 01 - 31, 88, 99
YYYY = **Minimum year** - system date year, 8888, 9999
Use 88, 8888 for not currently known, in progress to obtain information.
Use 99, 9999 for not known.
If century is known, but year is unknown then give an estimate of year or code YYYY = 9999.
If MM = 99 then DD must = 99.
If century is known, but year is unknown then give an estimate of year or code YYYY = 9999.
If YYYY = 9999 then MM and DD must = 99.

The following special parameters are used:

Format YYYYMMDD	
YYYY	1700 (Minimum year) - system date year, 8888, 9999
MM	01 - 12, 88, 99
DD	01 - 31, 88, 99

10	DXEST	number (1,0)	Required: true
Accuracy of diagnosis date.			

Allowable Values	
1	Exact
2	Within 1 year
3	Within 1+ to 5 years
4	Within 5+ to 10 years
5	10 or more years
9	Unknown

11	DXSRC	number (2,0)	Required: true
Source of diagnosis information (site, histology, behavior, laterality).			

Allowable Values	
1	Pathology review (means your center's pathologist examined the tissue and may have also completed an internal review sheet;)
2	Pathology report (means the documents from the hospital's medical records or pathologist. It often comes with the Biospecimens (block, tissue...))
3	Other hospital record or clinic record
4	Death certificate
5	Self
6	Relative
7	SEER
8	Other cancer registry (e.g. state)
9	Unknown
10	NDI, NDI+, site-specific state death indices (health department)
11	Spouse

12 Other source, for example specialized genealogy

TISSUE

number (1,0)

Required:true

12

Status of tissue procurement.

Allowable Values

0 Not needed / not applicable

1 Permission granted by patient, pending request to hospital/clinic

2 Specimen requested from hospital/clinic, awaiting receipt

3 Specimen received

4 Refusal from patient

5 Lost or destroyed

6 Refusal from hospital/clinic

7 Unable to request tissue (tissue location overseas or location is unknown)

8 Pending permission from patient

QUALIFY_TUMOR

number (1,0)

Required:false

13

Flag indicating that the tumor qualifies a population sampled affected proband as eligible for inclusion in the study. The tumor must meet all site-specific eligibility criteria. Synchronous qualifying tumours should be sequentially ordered beginning with the largest in size.

Allowable Values

1 to 4 Range

Error Description

If FAMILY-MEMBERSHIP.PROBAND_FLG=1 And FAMILY.FSRC=1, then CANCER.QUALIFY_TUMOR must be 1 (at least one cancer record)

Module: family-history

Module Contents

cause-of-death

1. [CENTER_NO](#)
2. [PERSON_ID \(*PK\)](#)
3. [CRC_COD](#)
4. [COD_IMM_ICD](#)
5. [COD_IMM_TXT](#)
6. [COD_UND1_ICD](#)
7. [COD_UND1_TXT](#)
8. [COD_UND2_ICD](#)
9. [COD_UND2_TXT](#)
10. [COD_UND3_ICD](#)
11. [COD_UND3_TXT](#)
12. [COD_UND4_ICD](#)
13. [COD_UND4_TXT](#)
14. [COD_UND5_ICD](#)
15. [COD_UND5_TXT](#)
16. [COD_UND6_ICD](#)
17. [COD_UND6_TXT](#)
18. [COD_UND7_ICD](#)
19. [COD_UND7_TXT](#)
20. [COD_UND8_ICD](#)
21. [COD_UND8_TXT](#)
22. [COD_UND9_ICD](#)
23. [COD_UND9_TXT](#)
24. [COD_UND10_ICD](#)
25. [COD_UND10_TXT](#)
26. [COD_SOURCE](#)
27. [COD_ICD_VERSION](#)

1	CENTER_NO	number (2,0)	Required: true
	Unique identifier for a CFR center		
	Allowable Values		
	11	Sinai Health Systems (formerly Cancer Care Ontario)	
	12	Cedars-Sinai & Cleveland Clinic (formerly USC Consortium)	
	13	University of Melbourne	
	14	University of Hawaii Cancer Center	
	15	Mayo Clinic	
	16	Fred Hutch, Seattle	
	17	UCSF: University of California at San Francisco (formerly CPIC, originally Northern California (NCCC))	
2	PERSON_ID (*PK)	number (12,0)	Required: true
	Identifier for person that is globally unique within the BC-CFR central database. *This field is the primary key for the table.		
3	CRC_COD	number (1,0)	Required: true
	Flag indicating the immediate or underlying cause of death was due to colorectal cancer. ICD-O: C18[0-9]*, C199, C209, C218, C260 ICD-9: 153.[0-9]*, 154.[0-3]* Text: includes colon, colorectal, bowel, large intestine		
	Allowable Values		
	1	Cause of death involved CRC	

	COD_IMM_ICD	string (6)	Required: true
4	First, primary or immediate cause of death in ICD. NOTE: Some sources, like SEER, do not give a primary/immediate Cause of Death but only a derived underlying cause of death. In these cases this element should be marked '999999=unknown' and the derived value go into COD_UND1_ICD.		
	COD_IMM_TXT	string (250)	Required: false
5	First, primary or immediate cause of death in text if ICD not available		
	COD_UND1_ICD	string (6)	Required: false
6	First underlying cause of death in ICD. Note for some sources, like SEER, this maybe a derived COD.		
	COD_UND1_TXT	string (250)	Required: false
7	First underlying cause of death in text if no ICD		
	COD_UND2_ICD	string (6)	Required: false
8	2nd underlying cause of death in ICD		
	COD_UND2_TXT	string (250)	Required: false
9	2nd underlying cause of death in text if no ICD		
	COD_UND3_ICD	string (6)	Required: false
10	3rd underlying cause of death in ICD		
	COD_UND3_TXT	string (250)	Required: false
11	3rd underlying cause of death in text if no ICD		
	COD_UND4_ICD	string (6)	Required: false
12	4th underlying cause of death in ICD		
	COD_UND4_TXT	string (250)	Required: false
13	4th underlying cause of death in text if no ICD		
	COD_UND5_ICD	string (6)	Required: false
14	5th underlying cause of death in ICD		
	COD_UND5_TXT	string (250)	Required: false
15	5th underlying cause of death in text if no ICD		
	COD_UND6_ICD	string (6)	Required: false
16	6th underlying cause of death in ICD		
	COD_UND6_TXT	string (250)	Required: false
17	6th underlying cause of death in text if no ICD		
	COD_UND7_ICD	string (6)	Required: false
18	7th underlying cause of death in ICD		
	COD_UND7_TXT	string (250)	Required: false
19	7th underlying cause of death in text if no ICD		
	COD_UND8_ICD	string (6)	Required: false
20	8th underlying cause of death in ICD		

21	COD_UND8_TXT	string (250)	Required:false
	8th underlying cause of death in text if no ICD		
22	COD_UND9_ICD	string (6)	Required:false
	9th underlying cause of death in ICD		
23	COD_UND9_TXT	string (250)	Required:false
	9th underlying cause of death in text if no ICD		
24	COD_UND10_ICD	string (6)	Required:false
	10th underlying cause of death in ICD		
25	COD_UND10_TXT	string (250)	Required:false
	10th underlying cause of death in text if no ICD		
26	COD_SOURCE	number (1,0)	Required:false
	Source of Cause of Death for all causes primary to 10 underlying. This should be from the single best source the site has for that individual. General rule of the thumb for priority should be NDI > SEER > Med Record > dept of health > death certificate. Though this might vary some at particular sites. NOTE: The source of the ICD code is derived as follows. For COD_SOURCE options 1,2,3,4,5 & 9 the source of the ICD code is the same as COD_SOURCE. For COD options 6,7,8 the ICD code source is "Assigned by Site".		

Allowable Values	
1	SEER
2	Cancer registry
3	NDI US
4	NDI AUS
5	Linkage_Other database
6	Death certificate
7	Other medical record
8	Other family member
9	Unknown

27	COD_ICD_VERSION	number (2,0)	Required:false
	Version of ICD for all cause of deaths from COD source. NOTE: this value is sometimes determined by the ICD version in use at time of death which is usually accurate but not perfect especially if the death occurred in early January when a code change might have been in progress.		

Allowable Values	
2	ICD-2
3	ICD-3
4	ICD-4
5	ICD-5
6	ICD-6
7	ICD-7
8	ICD-8

9	ICD-9
10	ICD-10
88	Not Applicable
99	unknown