

# **Standardised cervical screening data dictionary**

**April 2007**

## Contents

1. Person – family name, text X[X(39)] (mandatory).....	4
2. Person – given names, text [X(40)] (mandatory) .....	8
3. Person – other family name, text X[X(39)] (mandatory).....	11
4. Person (address) – address line, text [X(180)] (mandatory) .....	14
5. Person (address) – suburb/town/locality name, text [A(50)] (mandatory).....	17
6. Person – alternative or other names for suburb/town/locality, text [A(50)] (mandatory) .....	19
7. Person (address) – Australian state/territory identifier, code (ASGC 2004) N (mandatory) .....	20
8. Person (address) – Australian postcode, {NNNN} (mandatory) .....	22
9. Person – government funding identifier, Medicare card number identifier N(11) (conditional).....	23
10. Person – date of birth, date DDMMYYYY (mandatory).....	25
11. Person – Indigenous status, code N (conditional).....	27
12. Person – date of cervical cytology screening specimen, date DDMMYYYY (mandatory) .....	32
13. Person – hysterectomy status, code N (mandatory) .....	33
14. Person – date of hysterectomy, date DDMMYYYY (conditional).....	34
15. Provider taking specimen – provider identifier, Identifier N[N(11)]A (mandatory) .....	35
16. Provider taking specimen – family name, text X[X(39)] (mandatory).....	36
17. Provider taking specimen – given names, text [X(40)] (mandatory) .....	40
18. Provider taking specimen – name of practice or medical centre, text [X(200)] (mandatory) .....	44

19. Provider taking specimen (practice address) – address line, text [X(180)] (mandatory)	
20. Provider taking specimen (practice address) – practice suburb/town/locality name, text [A(50)] (mandatory)	48
21. Provider taking specimen (practice address) – alternative or other names for suburb/town/locality, text [A(50)] (conditional)	49
22. Provider taking specimen (practice address) – postcode, code {NNNN} (mandatory)	50
23. Provider taking specimen – occupation of person taking specimen, code A (mandatory)	51
24. Pathology laboratory – laboratory, identifier X(3) (mandatory)	52
25. Pathology laboratory – cervical cytology accession number, number X(20) (mandatory)	53
26. Pathology laboratory – test type, code AN (mandatory)	54
27. Person – HPV DNA result, code N (conditional)	55
28. Person – HPV DNA test type, code AAN (conditional)	57
29. Person – cervical cytology specimen type, cervical cytology screening code AN (mandatory)	60
30. Person – cervical cytology specimen site, cervical cytology screening code AN (mandatory)	62
31. Person – squamous cell analysis, cervical cytology screening code XX (mandatory)	64
32. Person – endocervical cell analysis, cervical cytology screening code XX (mandatory)	67
33. Person – other/non-cervical cell analysis, cervical cytology screening code XX (mandatory)	69
34. Person – follow-up recommendation, cervical cytology screening code XX (mandatory)	72
35. Person – registry contact suspension flag, code A (conditional)	74
36. Person – vital status, code N (conditional)	75
37. Person – date of death, DDMMYYYY (conditional)	76

### **Draft Histology data elements**

Person – procedure used for obtaining gynaecological specimen, code ANN

Person – cervical specimen analysis, histology code ANN

Person – endocervical specimen analysis, histology code ANN

Person – endometrial specimen analysis, histology code ANN

Person – vaginal specimen analysis, histology code ANN

Person – vulval specimen analysis, histology code ANN

Person – other gynaecological specimen analysis, histology code ANN

---

# 1. Person—family name, text X[X(39)]

---

## Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	311593
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The text that represents the part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names.

## Value domain representational attributes

---

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	X[X(39)]
<i>Maximum character length:</i>	40

## Data element attributes

---

### Collection and usage attributes

<i>Guide for use:</i>	The agency or establishment should record the person's full family name on their information systems.
<i>Collection methods:</i>	<p>This metadata item should be recorded for all persons.</p> <p>Mixed case should be used.</p> <p>Family name should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.</p> <p>It is acknowledged that some people use more than one family name (e.g. formal name, birth name, married/maiden name, tribal name) depending on the circumstances. Each name should be recorded against the appropriate Name type (see Comments).</p> <p>A person is able to change his/her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may only change his/her name under the Change of Name Act. Care should be taken when recording a change of name for a minor. Ideally, the name recorded for the minor should be known to both of his/her parents, so the minor's records can be retrieved and continuity of care maintained, regardless of which parent accompanies the minor to the agency or establishment.</p> <p>A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be the name on their Medicare card.</p>

The Name type metadata item can be used to distinguish between the different types of names that may be used by the person. The following format may assist with data collection:

What is your family name?

---

Are you known by any other family names that you would like recorded? If so, what are they

---

Please indicate, for each name above, the 'type' of family name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by). Whenever a person informs the agency or establishment of a change of family name (e.g. following marriage or divorce), the former name should be recorded as an alias name. A full history of names should be retained. e.g. 'Mary Georgina Smith' informs the hospital that she has been married and changed her family name to 'Jones'. Record 'Jones' as her preferred family name and record 'Smith' as an alias name.

Hyphenated family names:

Sometimes people with hyphenated family names use only one of the two hyphenated names. It is useful to record each of the hyphenated names as an alias. If the person has a hyphenated family name, e.g. 'Wilson-Phillips' record 'Wilson-Phillips' in the preferred family name field and record 'Wilson' and 'Phillips' separately as alias family names.

Punctuation:

If special characters form part of the family name they should be included, e.g. hyphenated names should be entered with a hyphen.

Examples:

- hyphen, e.g. Wilson-Phillips

Do not leave a space before or after a hyphen, i.e. between the last letter of 'Wilson' and the hyphen, nor a space between the hyphen and the first letter of 'Phillips'.

- apostrophe, e.g. O'Brien, D'Agostino

Do not leave a space before or after the apostrophe, i.e. between the 'O' and the apostrophe, nor a space between the apostrophe and 'Brien'.

- full stop, e.g. St. John, St. George

Do not leave a space before a full stop, i.e. between 'St' and the full stop. Do leave a space between the full stop and 'John'.

- space, e.g. van der Humm, Le Brun, Mc Donald

If the health care client has recorded their family name as more than one word, displaying spaces in between the words, record their family name in the same way leaving one space between each word.

People with only one name:

Some people do not have a family name and a given name, they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' field blank.

Registering an unidentified health care client:

The default for unknown family name, should be unknown in all instances and the name recorded as an alias name. Don't create a 'fictitious' family name such as 'Doe' as this is an actual family name. When the person's name becomes known, record it as the preferred family name and do not overwrite the alias name of unknown.

Registering health care clients from disaster sites:

People treated from disaster sites should be recorded under the alias Name Type. Local business rules should be developed for consistent recording of disaster site person details.

Care should be taken not to use identical dummy data (family name, given name, date of birth, sex) for two or more people from a disaster site.

If the family name needs to be shortened:

If the length of the family name exceeds the length of the field, truncate the family name from the right (that is, dropping the final letters). Also, the last character of the name should be a hash (#) to identify that the name has been truncated.

Use of incomplete names or fictitious names:

Some health care facilities permit females to use a pseudonym (fictitious or partial name) in lieu of their full or actual name. It is recommended that the person be asked to record both the pseudonym (Alias name) in addition to the person's Medicare card name.

Prefixes:

Where a family name contains a prefix, such as one to indicate that the person is a widower/widow, this must be entered as part of the 'Family name' field. When widowed, some Hungarian women add 'Ozvegy' (abbreviation is 'Ozy') before their married family name, e.g. 'Mrs Szabo' would become 'Mrs Ozy Szabo'. That is, 'Mrs Szabo' becomes an alias name and 'Mrs Ozy Szabo' becomes the preferred name.

Ethnic Names:

The Centrelink publication, Naming Systems for Ethnic Groups, provides the correct coding for ethnic names.

Misspelled family name:

If the person's family name has been misspelled in error, update the family name with the correct spelling and record the misspelled family name as an alias name. Recording misspelled names is important for filing documents that may be issued with

previous versions of the person's name. Discretion should be used regarding the degree of recording that is maintained.

Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between MacIntosh and McIntosh - can make record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) 'Given name' and 'Family name'. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred names that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family name or surname separately. These should then be recorded as 'Given name' and 'Family name' as appropriate, regardless of the order in which they may be traditionally given.

**Comments:**

National Community Services Data Dictionary specific:

Selected letters of the family name in combination with selected letters of the given name, date of birth and sex, may be used for record linkage for statistical purposes only.

Name type is a metadata item in Australian Standard AS5017 – 2002 Health care client identification (Standards Australia 2002) and in the National Health Data Dictionary, Version 12 (NHDC 2003). In both cases the Data domain refers to Code A Alias name; Code M Medicare card name; Code N Newborn name; and Code P Preferred name. A name type data element is being considered for inclusion in a future version of the National Community Services Data Dictionary.

**Source and reference attributes**

*Submitting organisation:*

Australian Institute of Health and Welfare

*Origin:*

Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

*Reference documents:*

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

**Relational attributes**

*Related metadata references:*

Supersedes Family name, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005

*Data Set Specifications which include this Data Element:*

Cervical Screening Standardised Data Set V3 *No registration status*

---

## 2. Person—given names, text [X(40)]

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier</i>	311599
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The person's identifying name(s) within the family group or by which the person is socially identified.

### Value domain representational attributes

---

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(40)]
<i>Maximum character length:</i>	40

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	<p>The agency or establishment should record the full given name(s) of the person on their information systems.</p> <p>National Health Data Dictionary specific:</p> <p>Health care establishments may record given names (first and other given names) in one field or several fields. This metadata item definition applies regardless of the format of data recording. A full history of names is to be retained.</p>
<i>Collection methods:</i>	<p>This metadata item should be recorded for all people.</p> <p>Given name(s) should be recorded in the format preferred by the person. The format should be the same as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.</p> <p>It is acknowledged that some people use more than one given name (e.g. formal name, birth name, nick name or shortened name, or tribal name) depending on the circumstances.</p> <p>A person is able to change their name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may only change their name under the Change of Name Act.</p> <p>The person should generally be registered using their preferred name as it is more likely to be used in common usage. The preferred name of the person may in fact be their legal (or Medicare card) name.</p> <p>Use of first initial:</p> <p>If the given name of the person is not known, but the first letter (initial) of the given name is known, record the first letter in the preferred 'Given name' field. Do not record a full stop following the initial.</p>

The person with only one name:

Some people do not have a family name and a given name: they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' blank.

Multiple given names (middle, second, third etc. names):

All of the given names of the person should be recorded in the 'Given name' field, leaving a space between each name.

Record complete information:

If the person has many given names and all of them cannot fit in the field, record as many names in full as possible, in preference to recording initials.

Shortened or alternate first given name:

If the person uses a shortened version or an alternate version of their first given name, record their preferred name, the actual name as their Medicare card name and any alternative versions as alias names as appropriate.

e.g. The given name of the person is Jennifer but she prefers to be called Jenny. Record 'Jenny' as the preferred 'Given name' and 'Jennifer' as her Medicare card name.

Punctuation:

If special characters form part of the given names they shall be included, e.g. hyphenated names shall be entered with the hyphen.

· Hyphen, e.g. Anne-Maree, Mary-Jane

Do not leave a space before or after the hyphen, i.e. between last letter of 'Anne' and the hyphen, nor a space between the hyphen and the first letter of 'Maree'.

If the person has recorded their given name as more than one word, displaying spaces in between the words, record their given names in data collection systems in the same way.

e.g. Wendy Hilda

Leave a single space between the person's first name and each of their middle names.

Aboriginal/Torres Strait Islander names not for continued use:

For cultural reasons, an Aboriginal or Torres Strait Islander may advise an agency or establishment that they are no longer using the given name that they had previously registered and are now using an alternative current name.

Record their current name as the preferred 'Given name' and record their previous used given name as an alias name.

Ethnic Names:

The Centrelink Naming Systems for Ethnic Groups publication provides the correct coding for ethnic names. Refer to Ethnic Names Condensed Guide for summary information.

Misspelled given names:

If the given name of the person has been misspelled in error, update the Given name field with the correct spelling and record the misspelled given name as an Alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the person's name. Discretion should be used regarding the degree of recording that is maintained.

People should provide their full (formal) Given name and Family name. These may be different from the name that the person may prefer the agency or establishment to use in personal dealings. Agencies or establishments may choose to separately record the preferred name that the person wishes to be used by agency or establishment.

**Comments:**

National Community Services Data Dictionary specific:

Selected letters of the given name in combination with selected letters of the family name, date of birth and sex may be used for record linkage for statistical purposes only (see metadata item Record linkage).

Name type is a metadata item in Australian Standard AS5017-2002 Health care client identification (Standards Australia 2002) and in the NHDD, Version 12. In both cases the Value domain refers to Code A Alias name; Code M Medicare card name; Code N Newborn name; and Code P Preferred name.

**Source and reference attributes**

*Submitting organisation:*

Australian Institute of Health and Welfare

*Origin*

Cervical Cytology Registries

**Relational attributes**

*Related metadata references:*

Australian Institute of Health and Welfare

*Data Set Specifications which include this Data Element:*

Cervical Screening Standardised Data Set V3 No registration status

---

### 3. Person—other family name, text X[X(39)]

---

#### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Synonymous names:</i>	Previous family name
<i>METeOR identifier:</i>	311605
<i>Registration status:</i>	No registration status
<i>Definition:</i>	That part of a name a person has or had in common with some other members of their other or previous family(s), as distinguished from their other or previous given names.

---

#### Value domain representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	X[X(39)]
<i>Maximum character length:</i>	40

---

#### Data element attributes

##### Collection and usage attributes

<i>Guide for use:</i>	The agency or establishment should record the person's full other or previous family name on their information systems.
<i>Collection methods:</i>	<p>If a person who receives services from or is of interest to an organisation has one or more other family names, this metadata item should be recorded. For the purposes of positive identification, it may also be recorded for providers of those services who are individuals.</p> <p>Mixed case should be used.</p> <p>Other or previous family names should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre) registration form.</p> <p>Sometimes people with hyphenated other or previous family names use only one of the two hyphenated names. It is useful to record each of the hyphenated names as an alias. If the person has a hyphenated family name, e.g. 'Wilson-Phillips' record 'Wilson-Phillips' in the preferred family name field and record 'Wilson' and 'Phillips' separately as alias family names.</p> <p>Punctuation:</p> <p>If special characters form part of the other or previous family names they should be included, e.g. hyphenated names should be entered with a hyphen.</p> <p>Examples:</p> <p>- hyphen, e.g. Wilson-Phillips</p> <p>Do not leave a space before or after a hyphen, i.e. between the last letter of 'Wilson' and the hyphen, nor a space between the hyphen</p>

and the first letter of 'Phillips'.

- apostrophe, e.g. O'Brien, D'Agostino

Do not leave a space before or after the apostrophe, i.e. between the 'O' and the apostrophe, nor a space between the apostrophe and 'Brien'.

- full stop, e.g. St. John, St. George

Do not leave a space before a full stop, i.e. between 'St' and the full stop. Do leave a space between the full stop and 'John'.

- space, e.g. van der Humm, Le Brun, Mc Donald

If the health care client has recorded their other or previous family names as more than one word, displaying spaces in between the words, record their family name in the same way leaving one space between each word.

People with only one name:

Some people do not have an other or previous family name and a previous given name, they have only one previous name by which they are known. If the person has only one other or previous name, record it in the 'Family name' field and leave the 'Given name' field blank.

Registering health care clients from disaster sites:

People treated from disaster sites should be recorded under the alias Name Type. Local business rules should be developed for consistent recording of disaster site person details.

Care should be taken not to use identical dummy data (family name, given name, date of birth, sex) for two or more persons from a disaster site.

If the other or previous family name needs to be shortened:

If the length of the family name exceeds the length of the field, truncate the family name from the right (that is, dropping the final letters). Also, the last character of the name should be a hash (#) to identify that the name has been truncated.

Prefixes:

Where an other or previous family name contains a prefix, such as one to indicate that the person is a widower/widow, this must be entered as part of the 'Family name' field. When widowed, some Hungarian women add 'Ozvegy' (abbreviation is 'Ozy') before their married family name, e.g. 'Mrs Szabo' would become 'Mrs Ozy Szabo'. That is, 'Mrs Szabo' becomes an alias name and 'Mrs Ozy Szabo' becomes the preferred name.

Ethnic Names:

The Centrelink publication, Naming Systems for Ethnic Groups, provides the correct coding for ethnic names.

Misspelled previous family name:

If the person's previous family name has been misspelled in error, update the other or previous family name with the correct spelling and record the misspelled previous family name as an

alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the person's name. Discretion should be used regarding the degree of recording that is maintained.

*Comments:*

**Source and reference attributes**

*Submitting organisation:* Australian Institute of Health and Welfare

*Origin:* Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

*Reference documents:* AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

**Relational attributes**

*Related metadata references:* Supersedes Person (name) – family name, text X[X(39)] NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005

*Data Set Specifications which include this Data Element:* Cervical Screening Standardised Data Set V3 *No registration status*

---

## 4. Person (address)—address line, text [X(180)]

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Synonymous names:</i>	Address line (Person)
<i>METeOR identifier:</i>	286620
<i>Registration status:</i>	NHIG, Standard 04/05/2005 NCSIMG, Standard 30/09/2005
<i>Definition:</i>	A composite of one or more standard address components that describes a low level of geographical/physical description of a location, as represented by text. Used in conjunction with the other high-level address components i.e. Suburb/town/locality, Postcode - Australian, Australian state/territory, and Country, forms a complete geographical/physical address of a person.

---

### Value domain representational attributes

---

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(180)]
<i>Maximum character length:</i>	180

---

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	<p>A high-level address component is defined as a broad geographical area that is capable of containing more than one specific physical location. Some examples of a broad geographical area are:</p> <ul style="list-style-type: none"><li>- Suburb, town or locality</li><li>- Postcode - Australian or international</li><li>- State, Territory, local government area, electorate, statistical local area</li><li>- Postal delivery point identifier</li><li>- Countries, provinces, etc other than in Australia</li></ul> <p>These components of a complete address do not form part of the Address line.</p> <p>When addressing an Australian location, following are the standard address data elements that may be concatenated in the Address line:</p> <ul style="list-style-type: none"><li>- Building/complex sub-unit type</li><li>- Building/complex sub-unit number</li><li>- Building/property name</li><li>- Floor/level number</li></ul>
-----------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

- Floor/level type
- House/property number
- Lot/section number
- Street name
- Street type code
- Street suffix code

One complete identification/description of a location/site of an address can comprise one or more than one instance of address line.

Instances of address lines are commonly identified in electronic information systems as Address-line 1, Address-line 2, etc.

The format of data collection is less important than consistent use of conventions in the recording of address data. Hence, address may be collected in an unstructured manner but should ideally be stored in a structured format.

Where Address line is collected as a stand-alone item, software may be used to parse the Address line details to separate the sub-components.

Multiple Address lines may be recorded as required.

***Collection methods:***

The following concatenation rules should be observed when collecting address lines addressing an Australian location.

- Building/complex sub-unit type is to be collected in conjunction with Building/complex sub-unit number and vice versa.
- Floor/level type is to be collected in conjunction with Floor/level number and vice versa.
- Street name is to be used in conjunction with Street type code and Street suffix code.
- Street type code is to be used in conjunction with Street name and Street suffix code.
- Street suffix code is to be used in conjunction with Street name and Street type code.
- House/property number is to be used in conjunction with Street name.

**Source and reference attributes**

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	Health Data Standards Committee AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia.
<i>Reference documents:</i>	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

**Relational attributes**

<i>Related metadata references:</i>	Is formed using Person (address) – street suffix, code A[A] NHIG, Standard 01/03/2005
-------------------------------------	---------------------------------------------------------------------------------------

Is formed using Person (address) – street type, code A[AAA]  
NHIG, Standard 01/03/2005

Is formed using Person (address) – street name, text [A(30)]  
NHIG, Standard 01/03/2005

Is formed using Person (address) – lot/section identifier, N[X(14)]  
NHIG, Standard 01/03/2005

Is formed using Person (address) – house/property identifier,  
text [X(12)] NHIG, Standard 01/03/2005

Is formed using Person (address) – floor/level type, code A[A]  
NHIG, Standard 01/03/2005

Is formed using Person (address) – floor/level identifier,  
[NNNA] NHIG, Standard 01/03/2005

Is formed using Person (address) – building/complex sub-unit  
type, code A[AAA] NHIG, Standard 01/03/2005

Is formed using Person (address) – building/complex sub-unit  
identifier, [X(7)] NHIG, Standard 01/03/2005

Is formed using Person (address) – building/property name, text  
[X(30)] NHIG, Standard 01/03/2005

Supersedes Person (address) – health address line, text [X(180)]  
NHIG, Superseded 04/05/2005

Cancer (clinical) DSS NHIG, Standard 04/06/2004

Cervical Screening Standardised Data Set V3 *No registration status*

Health care client identification DSS NHIG, Standard 04/05/2005

Health care provider identification DSS NHIG, Standard  
04/05/2005

***Data Set Specifications which  
include this Data Element:***

---

## 5. Person (address)—suburb/town/locality name, text [A(50)]

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Synonymous names:</i>	Suburb/town/locality name
<i>METeOR identifier:</i>	311579
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The text that represents the full name of the locality contained within the specific address of a person.

### Value domain representational attributes

---

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[A(50)]
<i>Maximum character length:</i>	50

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	<p>The suburb/ town/locality name, may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community. The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names. This metadata item may be used to describe the location of person, organisation or event. It can be a component of a street or postal address.</p> <p>If there is no data for this item please refer to 'Person – alternative or other names for suburb/ town/locality' as this may contain an alternative name the locality can be known by.</p>
<i>Collection methods:</i>	Enter 'Unknown' when the locality name or geographic area for a person or event is not known. Enter 'No fixed address' when a person has no fixed address or is homeless.

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare.
<i>Origin:</i>	Australia Post 2005. Australia Postcode File. Viewed 12 April, <a href="http://www.auspost.com.au/postcodes">www.auspost.com.au/postcodes</a>
<i>Reference documents:</i>	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

## **Relational attributes**

### *Related metadata references:*

Supersedes Person (address) – suburb/town/locality name, text [A(50)] NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005

### *Data Set Specifications which include this Data Element:*

Cervical Screening Standardised Data Set V3 *No registration status*

---

## 6. Person—alternative or other names for suburb/town/locality, text [A(50)]

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	324661
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The alternative name or other name of the suburb/town/locality (for example an Indigenous name or a colloquial name for a locality that is different to the official or commonly used name) that is contained within the specific address of a person, as represented by text.

### Value domain representational attributes

---

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[A(50)]
<i>Maximum character length:</i>	50

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	The alternative or other name for a suburb/town/locality, may be used instead of, or in addition to, the official or commonly used name of the locality.
<i>Collection methods:</i>	If there is not an alternative or other name for a locality other than the official or commonly used name, then do not enter any data for this item.

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------

---

## 7. Person (address)—Australian state/territory identifier, code (ASGC 2004) N

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	311489
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The code that represents the Australian state or territory in which a person usually lives.

### Value domain representational attributes

---

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>New South Wales</td></tr><tr><td>2</td><td>Victoria</td></tr><tr><td>3</td><td>Queensland</td></tr><tr><td>4</td><td>South Australia</td></tr><tr><td>5</td><td>Western Australia</td></tr><tr><td>6</td><td>Tasmania</td></tr><tr><td>7</td><td>Northern Territory</td></tr><tr><td>8</td><td>Australian Capital Territory</td></tr><tr><td>9</td><td>Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)</td></tr></tbody></table>	Value	Meaning	1	New South Wales	2	Victoria	3	Queensland	4	South Australia	5	Western Australia	6	Tasmania	7	Northern Territory	8	Australian Capital Territory	9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)
Value	Meaning																				
1	New South Wales																				
2	Victoria																				
3	Queensland																				
4	South Australia																				
5	Western Australia																				
6	Tasmania																				
7	Northern Territory																				
8	Australian Capital Territory																				
9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)																				

### Collection and usage attributes

<i>Guide for use:</i>	The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).
-----------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

### Source and reference attributes

<i>Reference documents:</i>	Australian Bureau of Statistics 2005. Australian Standard Geographical Classification (ASGC). Cat. no. 1216.0. Canberra: ABS. Viewed on 30/09/2005
-----------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------

### Data element attributes

---

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare.
---------------------------------	---------------------------------------------

## **Relational attributes**

*Data Set Specifications which include this Data Element:*

Cervical Screening Standardised Data Set V3 *No registration status*  
National Bowel Screening Program NMDS *No registration status*

---

## 8. Person (address)—Australian postcode, {NNNN}

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	311484
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The code that represents a postal delivery area, aligned with locality, suburb or place for the address of a person.

### Value domain representational attributes

---

<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	{NNNN}
<i>Maximum character length:</i>	4

### Collection and usage attributes

<i>Comments:</i>	<p>Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible.</p> <p>When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs) using the ABS National Localities Index (NLI).</p>
------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

### Data element attributes

---

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------

---

## 9. Person—government funding identifier, Medicare card number identifier N(11)

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Synonymous names:</i>	Medicare card number
<i>METeOR identifier:</i>	311633
<i>Registration status:</i>	No registration status
<i>Definition:</i>	A numeric number on a medical card allocated by Medicare Australia for the purpose of identifying those people eligible for specific services. (NB: This is not currently collected but is included here for future use)
<i>Context:</i>	Medicare utilisation statistics. Persons eligible for Medicare services.

### Value domain representational attributes

---

<i>Representation class:</i>	Identifier
<i>Data type:</i>	Number
<i>Format:</i>	N(11)
<i>Maximum character length:</i>	11

### Collection and usage attributes

<i>Guide for use:</i>	This is not currently collected by the Cervical Cytology Registries but is included in this data set for future use. Full Medicare number for an individual (i.e. family number plus person (individual reference) number).
<i>Comments:</i>	The Medicare card number is printed on a Medicare card and is used to access Medicare records for an eligible person. Up to 9 persons can be included under the one Medicare card number with up to five persons appearing on one physical card. Persons grouped under one Medicare card number are often a family, however, there is no requirement for persons under the same Medicare card number to be related. A person may be shown under separate Medicare card numbers where, for example, a child needs to be included on separate Medicare cards held by their parents. As a person can be identified on more than one Medicare card this is not a unique identifier for a person.

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	The Medicare card number should only be collected from persons eligible to receive health services that are to be funded by the Commonwealth government. The number should be reported to the appropriate government agency to reconcile payment for the
-----------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

service provided. The data should not be used by private sector organisations for any other purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.

**Comments:**

Note: Veterans may have a Medicare card number and a Department of Veterans' Affairs (DVA) number or only a DVA number.

**Source and reference attributes**

*Submitting organisation:*

Australian Institute of health and Welfare

*Origin:*

AS5017 Health care client identification

**Relational attributes**

*Related metadata references:*

Supersedes Medicare card number, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005

*Data Set Specifications which include this Data Element:*

Cervical Screening Standardised Data Set V3 *No registration status*

---

## 10. Person—date of birth, date DDMMYYYY

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Synonymous names:</i>	Date of birth
<i>METeOR identifier:</i>	311613
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The date on which a person was born.

### Value domain representational attributes

---

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYY
<i>Maximum character length:</i>	8

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age. Collected or estimated age would usually be in years.
<i>Collection methods:</i>	Information on date of birth can be collected using the one question: What is your/(the person's) date of birth? In self-reported data collections, it is recommended that the following response format is used: Date of birth: __ / __ / ____ This enables easy conversion to the preferred representational layout (DDMMYYYY).
<i>Comments:</i>	Privacy issues need to be taken into account in asking persons their date of birth. Wherever possible and wherever appropriate, date of birth should be used rather than age because the actual date of birth allows a more precise calculation of age. When date of birth is an estimated or default value, national health and community services collections typically use 0101 or 0107 or 3006 as the estimate or default for DDMM.

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin</i>	Cervical Cytology Registries

#### Relational attributes

<i>Related metadata references:</i>	Supersedes Date of birth, version 5, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005
-------------------------------------	---------------------------------------------------------------------------------------------------

*Data Set Specifications which include this Data Element:*

Cervical Screening Standardised Data Set V3 *No registration status*

---

## 11. Person—Indigenous status, code N

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Short name:</i>	Indigenous status
<i>METeOR identifier:</i>	291036
<i>Registration status:</i>	NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005
<i>Definition:</i>	Whether a person identifies as being of Aboriginal or Torres Strait Islander descent, as represented by a code. This is in accord with the first two of three components of the Commonwealth definition.

### Value domain representational attributes

---

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Aboriginal but not Torres Strait Islander descent</td></tr><tr><td>2</td><td>Torres Strait Islander but not Aboriginal descent</td></tr><tr><td>3</td><td>Both Aboriginal and Torres Strait Islander descent</td></tr><tr><td>4</td><td>Neither Aboriginal nor Torres Strait Islander descent</td></tr></tbody></table>	Value	Meaning	1	Aboriginal but not Torres Strait Islander descent	2	Torres Strait Islander but not Aboriginal descent	3	Both Aboriginal and Torres Strait Islander descent	4	Neither Aboriginal nor Torres Strait Islander descent
Value	Meaning										
1	Aboriginal but not Torres Strait Islander descent										
2	Torres Strait Islander but not Aboriginal descent										
3	Both Aboriginal and Torres Strait Islander descent										
4	Neither Aboriginal nor Torres Strait Islander descent										
<i>Supplementary codes:</i>	9 Not stated/inadequately described										

### Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item is based on the Australian Bureau of Statistics (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS Website as indicated in the Reference documents.</p> <p>The classification for Indigenous status has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'not stated' responses. The classification is as follows:</p> <p>Indigenous:</p> <ul style="list-style-type: none"><li>• Aboriginal but not Torres Strait Islander descent.</li><li>• Torres Strait Islander but not Aboriginal descent.</li><li>• Both Aboriginal and Torres Strait Islander descent.</li></ul> <p>Non-indigenous:</p>
-----------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

- Neither Aboriginal nor Torres Strait Islander descent.

Not stated/ inadequately described:

This category is not to be available as a valid answer to the questions but is intended for use:

- Primarily when importing data from other data collections that do not contain mappable data.
- Where an answer was refused.
- Where the question was not able to be asked prior to completion of assistance because the client was unable to communicate or a person who knows the client was not available.

Only in the last two situations may the tick boxes on the questionnaire be left blank.

## **Data Element attributes**

---

### **Collection and usage attributes**

*Collection methods:*

The standard question for Indigenous Status is as follows:

[Are you] [Is the person] [Is (name)] of Aboriginal or Torres Strait Islander descent?

(For persons of both Aboriginal and Torres Strait Islander descent, mark both 'Yes' boxes.)

No.....

Yes, Aboriginal.....

Yes, Torres Strait Islander.....

This question is recommended for self-enumerated or interview-based collections. It can also be used in circumstances where a close relative, friend, or another member of the household is answering on behalf of the subject. It is strongly recommended that this question be asked directly wherever possible.

When someone is not present, the person answering for them should be in a position to do so, i.e. this person must know well the person about whom the question is being asked and feel confident to provide accurate information about them.

This question must always be asked regardless of data collectors' perceptions based on appearance or other factors.

The Indigenous status question allows for more than one response. The procedure for coding multiple responses is as follows:

If the respondent marks 'No' and either 'Aboriginal' or 'Torres Strait Islander', then the response should be coded

to either Aboriginal or Torres Strait Islander as indicated (i.e. disregard the 'No' response).

If the respondent marks both the 'Aboriginal' and 'Torres Strait Islander' boxes, then their response should be coded to 'Both Aboriginal and Torres Strait Islander descent'.

If the respondent marks all three boxes ('No', 'Aboriginal' and 'Torres Strait Islander'), then the response should be coded to 'Both Aboriginal and Torres Strait Islander Descent' (i.e. disregard the 'No' response).

This approach may be problematical in some data collections, for example when data are collected by interview or using screen based data capture systems. An additional response category

Yes, both Aboriginal and Torres Strait Islander...

may be included if this better suits the data collection practices of the agency or establishment concerned.

*Comments:*

The following definition, commonly known as 'The Commonwealth Definition', was given in a High Court judgement in the case of *Commonwealth v Tasmania* (1983) 46 ALR 625.

'An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives'.

There are three components to the Commonwealth definition:

- descent;
- self-identification; and
- community acceptance.

In practice, it is not feasible to collect information on the community acceptance part of this definition in general purpose statistical and administrative collections and therefore standard questions on Indigenous status relate to descent and self-identification only.

## **Source and reference attributes**

*Origin:*

National Health Data Committee

National Community Services Data Committee

*Reference documents:*

Australian Bureau of Statistics 1999. Standards for Social, Labour and Demographic Variables. Cultural Diversity Variables, Canberra. Viewed 3 August 2005.

## **Relational attributes**

*Related metadata references:*

Supersedes Person—Indigenous status, code N NHIG, Superseded 04/05/2005

*Implementation in Data Set Specifications:*

Acute coronary syndrome (clinical) DSS NHIG, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS NHIG, Superseded 07/12/2005

Admitted patient care NMDS NHIG, Standard 07/12/2005

Admitted patient care NMDS NHIG, Superseded 07/12/2005

Admitted patient mental health care NMDS NHIG, Standard 07/12/2005

Admitted patient mental health care NMDS NHIG, Superseded 07/12/2005

Admitted patient palliative care NMDS NHIG, Standard 07/12/2005

Admitted patient palliative care NMDS NHIG, Superseded 07/12/2005

Alcohol and other drug treatment services NMDS NHIG, Standard 21/03/2006

Alcohol and other drug treatment services NMDS NHIG, Superseded 21/03/2006

Cardiovascular disease (clinical) DSS NHIG, Standard 01/03/2005

Community mental health care 2004-2005 NHIG, Superseded 08/12/2004

Community mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005

Community mental health care NMDS 2006-2007 NHIG, Standard 07/12/2005

Computer Assisted Telephone Interview demographic module DSS NHIG, Standard 04/05/2005

***Information specific to this data set***

For data collection using Computer Assisted Telephone Interviewing (CATI) the suggested questions are:

Q.1 Are you of Aboriginal or Torres Strait Islander origin?

Yes - go to Q.2

No - no more questions

Q.2 Are you of Aboriginal origin, Torres Strait Islander origin, or both?

Aboriginal

Torres Strait Islander

Both Aboriginal and Torres Strait Islander

Diabetes (clinical) DSS NHIG, Superseded 21/09/2005

Diabetes (clinical) DSS NHIG, Standard 21/09/2005

Health care client identification DSS NHIG, Standard  
04/05/2005

National Bowel Screening Program NMDS *No registration  
status*

Non-admitted patient emergency department care NMDS  
NHIG, Superseded 24/03/2006

Non-admitted patient emergency department care NMDS  
NHIG, Standard 24/03/2006

Non-admitted patient emergency department care NMDS  
NHIG, Superseded 07/12/2005

Perinatal NMDS NHIG, Standard 07/12/2005

Perinatal NMDS NHIG, Superseded 07/12/2005

Residential mental health care NMDS 2005-2006 NHIG,  
Superseded 07/12/2005

Residential mental health care NMDS 2006-2007 NHIG,  
Standard 07/12/2005

---

## 12. Person—date of cervical cytology screening specimen, date DDMMYYYY

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	302555
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The date that represents when a cytology specimen was taken from a person to screen for cancer or pre-cancerous changes to the cervix.

### Value domain representational attributes

---

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYY
<i>Maximum character length:</i>	8

### Data element attributes

---

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin</i>	Cervical Cytology Registries
<i>Reference documents:</i>	

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------

---

## 13. Person—hysterectomy status, code N

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	325613
<i>Registration status:</i>	No registration status
<i>Definition:</i>	An indication as to whether a person has had a total hysterectomy (removal of uterus and cervix), as represented by a code.

### Value domain representational attributes

---

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>No hysterectomy reported</td></tr><tr><td>1</td><td>Hysterectomy reported</td></tr></tbody></table>	Value	Meaning	0	No hysterectomy reported	1	Hysterectomy reported
Value	Meaning						
0	No hysterectomy reported						
1	Hysterectomy reported						

### Data element attributes

---

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------

---

## 14. Person—date of hysterectomy, date DDMMYYYY

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	303539
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The date a person underwent a total hysterectomy (removal of uterus and cervix) as represented by text.

### Value domain representational attributes

---

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYY
<i>Maximum character length:</i>	8

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	This data should only be collected if it is an accurate date of a reported hysterectomy. If this date is not known, or if part of the date is estimated, then 'Person – hysterectomy flag' is more appropriate and the date not collected.
<i>Collection methods:</i>	The collection of data for this data element is conditional on a person having had a total hysterectomy.

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------

---

## 15. Provider taking specimen—provider identifier, Identifier N[N(11)]A

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	312422
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The Medicare provider identifier of the provider taking the specimen to be sent to a laboratory for further analysis as represented by a number.

### Value domain representational attributes

---

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	N[N(11)]A
<i>Maximum character length:</i>	12

### Collection and usage attributes

<i>Guide for use:</i>	<p>For the Cervical Screening Program, a service provider can be a general practitioner (GP) or a specialist who takes a specimen from a client. Even if a specimen is taken by a person (e.g. a nurse) other than a GP or a specialist, the service provider is still the GP or a specialist for whom the person works.</p> <p>However, in Western Australia there are registered Nurse Pap Smear providers with their own provider numbers.</p>
-----------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

### Data element attributes

---

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------

---

## 16. Provider taking specimen—family name, text X[X(39)]

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Synonymous names:</i>	Family name
<i>METeOR identifier:</i>	301478
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The part of a name a provider taking a specimen(s) usually had in common with some other members of his/her family(s), as distinguished from his/her given names.
<i>Context:</i>	Administrative purposes and individual identification.

### Value domain representational attributes

---

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	X[X(39)]
<i>Maximum character length:</i>	40

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	<p>The agency or establishment should record the full family name of a person taking a specimen(s) on their information systems.</p> <p>National Community Services Data Dictionary specific:</p> <p>In instances where there is uncertainty about which name to record for a person taking specimen living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the name of an indigenous person taking specimen as it is first provided to Centrelink. Or, where proof of identity is required, as the name is recorded on a majority of the higher point scoring documents that are produced as proof of identity.</p>
<i>Collection methods:</i>	<p>This metadata item should be recorded for all persons who take specimens.</p> <p>Mixed case should be used.</p> <p>Family name should be recorded in the format preferred by the person taking specimen. The format should be the same as that written by the person taking specimen on a (pre) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.</p> <p>It is acknowledged that some people use more than one family name (e.g. formal name, birth name, married/maiden name, tribal name) depending on the circumstances. Each name should be recorded against the appropriate Name type (see Comments).</p> <p>A person taking specimen is able to change his or her name by</p>

usage in all States and Territories of Australia with the exception of Western Australia, where a person taking specimen may only change his or her name under the Change of Name Act. Care should be taken when recording a change of name for a minor. Ideally, the name recorded for the minor should be known to both of his/her parents, so the minor's records can be retrieved and continuity of care maintained, regardless of which parent accompanies the minor to the agency or establishment.

A person taking specimen should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The preferred name of a person taking specimen may in fact be the name on their Medicare card.

Hyphenated family names:

Sometimes persons taking specimen with hyphenated family names use only one of the two hyphenated names. It is useful to record each of the hyphenated names as an alias. If the person taking specimen has a hyphenated family name, e.g. 'Wilson-Phillips' record 'Wilson-Phillips' in the preferred family name field and record 'Wilson' and 'Phillips' separately as alias family names.

Punctuation:

If special characters form part of the family name they should be included, e.g. hyphenated names should be entered with a hyphen.

Examples:

- hyphen, e.g. Wilson-Phillips

Do not leave a space before or after a hyphen, i.e. between the last letter of 'Wilson' and the hyphen, nor a space between the hyphen and the first letter of 'Phillips'.

- apostrophe, e.g. O'Brien, D'Agostino

Do not leave a space before or after the apostrophe, i.e. between the 'O' and the apostrophe, nor a space between the apostrophe and 'Brien'.

- full stop, e.g. St. John, St. George

Do not leave a space before a full stop, i.e. between 'St' and the full stop. Do leave a space between the full stop and 'John'.

- space, e.g. van der Humm, Le Brun, Mc Donald

If the person taking specimen has recorded their family name as more than one word, displaying spaces in between the words, record their family name in the same way leaving one space between each word.

Person taking specimen with only one name:

Some persons taking specimen do not have a family name and a given name, they have only one name by which they are known. If the person taking specimen has only one name, record it in the 'Family name' field and leave the 'Given name' field blank.

#### Prefixes:

Where a family name contains a prefix, such as one to indicate that the person taking specimen is a widow, this must be entered as part of the 'Family name' field. When widowed, some Hungarian women add 'Ozvegy' (abbreviation is 'Ozy') before their married family name, e.g. 'Mrs Szabo' would become 'Mrs Ozy Szabo'. That is, 'Mrs Szabo' becomes an alias name and 'Mrs Ozy Szabo' becomes the preferred name.

#### Ethnic Names:

The Centrelink publication, Naming Systems for Ethnic Groups, provides the correct coding for ethnic names.

#### Misspelled family name:

If the family name of a person taking specimen has been misspelled in error, update the family name with the correct spelling and record the misspelled family name as an alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the name of the person taking specimen. Discretion should be used regarding the degree of recording that is maintained.

#### *Comments:*

Some persons taking specimen use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between MacIntosh and McIntosh - can make record linkage impossible. To minimise discrepancies in the recording and reporting of name information, person taking specimen should be asked for their full (formal) 'Given name' and 'Family name'. These may be different from the name that the person taking specimen may prefer the agency or establishment to use in personal dealings. Agencies or establishments may choose to separately record the preferred names that the person taking specimen wishes to be used by agency or establishment. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person taking specimen to specify their first given name and their family name or surname separately. These should then be recorded as 'Given name' and 'Family name' as appropriate, regardless of the order in which they may be traditionally given.

#### National Community Services Data Dictionary specific:

Selected letters of the family name in combination with selected letters of the given name, date of birth and sex, may be used for record linkage for statistical purposes only.

### **Source and reference attributes**

#### *Submitting organisation:*

Australian Institute of Health and Welfare

	Standards Australia
	National Health Data Committee
	National Community Services Data Committee
<i>Origin:</i>	Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia
<i>Reference documents:</i>	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
<b>Relational attributes</b>	
<i>Related metadata references:</i>	Supersedes Person (name) – family name, text X[X(39)] NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005
<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 <i>No registration status</i>

---

## 17. Provider taking specimen—given names, text [X(40)]

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Synonymous names:</i>	Given name(s)
<i>METeOR identifier:</i>	301470
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The given names or initial(s) of a provider taking the specimen, as represented by text.
<i>Context:</i>	Administrative purposes and individual identification.

### Value domain representational attributes

---

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(40)]
<i>Maximum character length:</i>	40

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	<p>The agency or establishment should record the full given name(s) of a person taking specimen on their information systems.</p> <p>National Health Data Dictionary specific:</p> <p>Health care establishments may record given names (first and other given names) in one field or several fields. This metadata item definition applies regardless of the format of data recording.</p> <p>A full history of names is to be retained.</p>
<i>Collection methods:</i>	<p>This metadata item should be recorded for all persons taking specimen.</p> <p>Given name(s) should be recorded in the format preferred by the person taking specimen. The format should be the same as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.</p> <p>It is acknowledged that some people use more than one given name (e.g. formal name, birth name, nick name or shortened name, or tribal name) depending on the circumstances. A smear taker is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person taking specimen may only change his or her name under the Change of Name Act.</p> <p>A person taking specimen should generally be registered using their preferred name as it is more likely to be used in common usage. The preferred name of a person taking specimen may in fact be their legal (or Medicare card) name.</p> <p>Use of first initial:</p>

If the given name of a person taking specimen is not known, but the first letter (initial) of the given name is known, record the first letter in the preferred 'Given name' field. Do not record a full stop following the initial.

Person taking specimen with only one name:

Some people do not have a family name and a given name: they have only one name by which they are known. If the person taking specimen has only one name, record it in the 'Family name' field and leave the 'Given name' blank.

Multiple given names (middle, second, third etc. names):

All of the given names of a person taking specimen should be recorded in the 'Given name' field, leaving a space between each name.

Record complete information:

If the person taking specimen has many given names and all of them cannot fit in the field, record as many names in full as possible, in preference to recording initials.

Shortened or alternate first given name:

If the person taking specimen uses a shortened version or an alternate version of their first given name, record their preferred name, the actual name as their Medicare card name and any alternative versions as alias names as appropriate.

e.g. The given name of a person taking specimen is Jennifer but she prefers to be called Jenny. Record 'Jenny' as the preferred 'Given name' and 'Jennifer' as her Medicare card name.

e.g. The given name of a person taking specimen is 'Giovanni' but he prefers to be called 'John'.

Record 'John' as the preferred 'Given name' and 'Giovanni' as the Medicare card name.

Punctuation:

If special characters form part of the given names they shall be included, e.g. hyphenated names shall be entered with the hyphen.

- Hyphen, e.g. Anne-Maree, Mary-Jane

Do not leave a space before or after the hyphen, i.e. between last letter of 'Anne' and the hyphen, nor a space between the hyphen and the first letter of 'Maree'.

- spaces, e.g. Jean Claude

If the person taking specimen has recorded their given name as more than one word, displaying spaces in between the words, record their given names in data collection systems in the same way.

e.g. Oscar Peter, Wendy Hilda

Leave a single space between the person's first name and each of their middle names.

Aboriginal/Torres Strait Islander names not for continued use:

For cultural reasons, an Aboriginal or Torres Strait Islander may advise an agency or establishment that they are no longer using the given name that they had previously registered and are now using an alternative current name.

Record their current name as the preferred 'Given name' and record their previous used given name as an alias name.

Ethnic Names:

The Centrelink Naming Systems for Ethnic Groups publication provides the correct coding for ethnic names. Refer to Ethnic Names Condensed Guide for summary information.

Misspelled given names:

If the given name of a person taking specimen has been misspelled in error, update the Given name field with the correct spelling and record the misspelled given name as an Alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the person taking specimens name. Discretion should be used regarding the degree of recording that is maintained.

People taking specimen should provide their full (formal) Given name and Family name. These may be different from the name that the person taking a specimen may prefer the agency or establishment to use in personal dealings. Agencies or establishments may choose to separately record the preferred name that the person wishes to be used by agency or establishment.

*Guide for use:*

The agency or establishment should record the full given name(s) of a person taking specimen on their information systems.

National Health Data Dictionary specific:

Health care establishments may record given names (first and other given names) in one field or several fields. This metadata item definition applies regardless of the format of data recording.

A full history of names is to be retained.

## **Source and reference attributes**

*Submitting organisation:*

Australian Institute of Health and Welfare  
Standards Australia  
National Health Data Committee  
National Community Services Data Committee

*Origin:*

Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

*Reference documents:*

Centrelink Australia 2000. Naming Systems of Ethnic Groups: A Guide (4th ed.). Centrelink, AusInfo: Canberra, Australia

## **Relational attributes**

*Related metadata references:*

Supersedes Given name(s), version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005

*Data Set Specifications which include this Data Element:*

Cervical Screening Standardised Data Set V3 *No registration status*

---

## 18. Provider taking specimen—name of practice or medical centre, text [X(200)]

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	301443
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The name of the practice or medical centre where the provider taking the specimen performed the screening procedure as represented by text.

### Value domain representational attributes

---

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(200)]
<i>Maximum character length:</i>	200

### Data element attributes

---

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------

---

## 19. Provider taking specimen (practice address)—address line, text [X(180)]

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	322882
<i>Registration status:</i>	No registration status
<i>Definition:</i>	A composite of one or more standard address components that describes a low level of geographical/physical description of a location, as represented by a text. Used in conjunction with the other high-level address components i.e. Suburb/town/locality, Postcode - Australian, Australian state/territory, and Country, forms a complete geographical/physical address of a provider's practice address.

### Value domain representational attributes

---

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(180)]
<i>Maximum character length:</i>	180

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	<p>A high-level address component is defined as a broad geographical area that is capable of containing more than one specific physical location. Some examples of a broad geographical area are:</p> <ul style="list-style-type: none"><li>- Suburb, town or locality</li><li>- Postcode - Australian or international</li><li>- State, Territory, local government area, electorate, statistical local area</li><li>- Postal delivery point identifier</li><li>- Countries, provinces, etc other than in Australia</li></ul> <p>These components of a complete address do not form part of the Address line.</p> <p>When addressing an Australian location, following are the standard address data elements that may be concatenated in the Address line:</p> <ul style="list-style-type: none"><li>- Building/complex sub-unit type</li><li>- Building/complex sub-unit number</li><li>- Building/property name</li><li>- Floor/level number</li><li>- Floor/level type</li></ul>
-----------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

- House/property number
- Lot/section number
- Street name
- Street type code
- Street suffix code

One complete identification/description of a location/site of an address can comprise one or more than one instance of address line.

Instances of address lines are commonly identified in electronic information systems as Address-line 1, Address-line 2, etc.

The format of data collection is less important than consistent use of conventions in the recording of address data. Hence, address may be collected in an unstructured manner but should ideally be stored in a structured format.

Where Address line is collected as a stand-alone item, software may be used to parse the Address line details to separate the sub-components.

Multiple Address lines may be recorded as required.

***Collection methods:***

The following concatenation rules should be observed when collecting address lines addressing an Australian location.

- Building/complex sub-unit type is to be collected in conjunction with Building/complex sub-unit number and vice versa.
- Floor/level type is to be collected in conjunction with Floor/level number and vice versa.
- Street name is to be used in conjunction with Street type code and Street suffix code.
- Street type code is to be used in conjunction with Street name and Street suffix code.
- Street suffix code is to be used in conjunction with Street name and Street type code.
- House/property number is to be used in conjunction with Street name.

**Source and reference attributes**

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	Health Data Standards Committee AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia.
<i>Reference documents:</i>	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

**Relational attributes**

<i>Related metadata references:</i>	Supersedes Person (address) – health address line, text [X(180)] NHIG, Superseded 04/05/2005
	Is formed using Person (address) – building/property name, text [X(30)] NHIG, Standard 01/03/2005

Is formed using Person (address) – building/ complex sub-unit identifier, [X(7)] NHIG, Standard 01/03/2005

Is formed using Person (address) – building/ complex sub-unit type, code A[AAA] NHIG, Standard 01/03/2005

Is formed using Person (address) – floor/level identifier, [NNNA] NHIG, Standard 01/03/2005

Is formed using Person (address) – floor/level type, code A[A] NHIG, Standard 01/03/2005

Is formed using Person (address) – house/property identifier, text [X(12)] NHIG, Standard 01/03/2005

Is formed using Person (address) – lot/section identifier, N[X(14)] NHIG, Standard 01/03/2005

Is formed using Person (address) – street name, text [A(30)] NHIG, Standard 01/03/2005

Is formed using Person (address) – street type, code A[AAA] NHIG, Standard 01/03/2005

Is formed using Person (address) – street suffix, code A[A] NHIG, Standard 01/03/2005

***Data Set Specifications which include this Data Element:***

Cervical Screening Standardised Data Set V3 *No registration status*

---

## 20. Provider taking specimen (practice address)—practice suburb/town/locality name, text [A(50)]

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	312409
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The suburb/town/locality name of the practice of the provider taking a specimen as represented by text.

### Value domain representational attributes

---

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[A(50)]
<i>Maximum character length:</i>	50

### Data element attributes

---

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries
<i>Reference documents:</i>	

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------

---

## 21. Provider taking specimen (practice address)— alternative or other names for suburb/town/locality, text [A(50)]

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	324643
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The alternative name or other name of the suburb/town/locality (for example an Indigenous name or a colloquial name for a locality that is different to the official or commonly used name) where the practice of the provider taking a specimen is located, as represented by text.

### Value domain representational attributes

---

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[A(50)]
<i>Maximum character length:</i>	50

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	The alternative or other name for a suburb/town/locality, may be used instead of, or in addition to, the official or commonly used name of the locality.
<i>Collection methods:</i>	If there is not an alternative or other name for a locality other than the official or commonly used name, then do not enter any data for this item.

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------

---

## 22. Provider taking specimen (practice address)— postcode, code {NNNN}

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	312416
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The postcode of the practice where a provider taking a specimen for further analysis is located as represented by a code.

### Value domain representational attributes

---

<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	{NNNN}
<i>Maximum character length:</i>	4

### Collection and usage attributes

<i>Comments:</i>	<p>Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible.</p> <p>When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs) using the ABS National Localities Index (NLI).</p>
------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

### Data element attributes

---

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries
<i>Reference documents:</i>	

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------

---

## 23. Provider taking specimen—occupation of person taking specimen, code A

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	303600
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The occupation of the person who takes a specimen(s) as represented by a code.
<i>Context:</i>	Administrative purposes.

### Value domain representational attributes

---

<i>Representation class:</i>	Code														
<i>Data type:</i>	String														
<i>Format:</i>	A														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>G</td><td>General practitioner</td></tr><tr><td>N</td><td>Nurse</td></tr><tr><td>S</td><td>Specialists (Obstetricians and gynaecologists)</td></tr><tr><td>A</td><td>Aboriginal and Torres Strait Islander health care worker</td></tr><tr><td>O</td><td>Other</td></tr><tr><td>U</td><td>Unassigned</td></tr></tbody></table>	Value	Meaning	G	General practitioner	N	Nurse	S	Specialists (Obstetricians and gynaecologists)	A	Aboriginal and Torres Strait Islander health care worker	O	Other	U	Unassigned
Value	Meaning														
G	General practitioner														
N	Nurse														
S	Specialists (Obstetricians and gynaecologists)														
A	Aboriginal and Torres Strait Islander health care worker														
O	Other														
U	Unassigned														

### Data element attributes

---

#### Collection and usage attributes

*Guide for use:* As provided by Cervical Cytology Registries

#### Source and reference attributes

*Submitting organisation:* Australian Institute of Health and Welfare

*Origin:* Cervical Cytology Registries

#### Relational attributes

*Data Set Specifications which include this Data Element:* Cervical Screening Standardised Data Set V3 No registration status

---

## 24. Pathology laboratory—laboratory, identifier X(3)

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	324491
<i>Registration status:</i>	No registration status
<i>Definition:</i>	A unique identification that Cervical Cytology Registries allocate to the laboratories that perform analyses on cervical screening tests as represented by a code.

### Value domain representational attributes

---

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	XXX
<i>Maximum character length:</i>	3

### Data element attributes

---

#### Collection and usage attributes

<i>Collection methods:</i>	As provided by Cervical Cytology Registries
----------------------------	---------------------------------------------

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries
<i>Reference documents:</i>	

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------

---

## 25. Pathology laboratory—cervical cytology accession number, number X(20)

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	302560
<i>Registration status:</i>	No registration status
<i>Definition:</i>	A unique record identifier allocated by the cervical screening laboratory to a cervical specimen to distinguish it from all other specimens analysed by the laboratory as represented by a number.

### Value domain representational attributes

---

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	X
<i>Maximum character length:</i>	20

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	As provided by Pathology Laboratories
-----------------------	---------------------------------------

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------

---

## 26. Pathology laboratory—test type, code AN

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	302551
<i>Registration status:</i>	No registration status
<i>Definition:</i>	Whether a laboratory test is cytological, histological or Human Papilloma Virus (HPV) for the purpose of screening for cancer or pre-cancerous changes to a person's cervix, as represented by a code.

### Value domain representational attributes

---

<i>Representation class:</i>	Code								
<i>Data type:</i>	String								
<i>Format:</i>	AN								
<i>Maximum character length:</i>	2								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>T1</td><td>Cytological specimen</td></tr><tr><td>T2</td><td>Histological specimen</td></tr><tr><td>T3</td><td>HPV</td></tr></tbody></table>	Value	Meaning	T1	Cytological specimen	T2	Histological specimen	T3	HPV
Value	Meaning								
T1	Cytological specimen								
T2	Histological specimen								
T3	HPV								

### Data element attributes

---

#### Collection and usage attributes

*Collection methods:* As provided by pathology laboratories

#### Source and reference attributes

*Submitting organisation:* Australian Institute of Health and Welfare

*Origin:* Cervical Cytology Registries

#### Relational attributes

*Data Set Specifications which include this Data Element:* Cervical Screening Standardised Data Set V3 No registration status

---

## 27. Person—HPV DNA result, code N

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – HPV DNA result, code N
<i>METeOR identifier:</i>	339245
<i>Registration status:</i>	No registration status
<i>Definition:</i>	An indication as to whether a high risk HPV DNA strain is detected in a specimen from a person for the purpose of predicting people at greatest risk of recurrent cervical abnormality following diagnosis of a confirmed high-grade lesion by biopsy, as represented by a code.

### Value domain representational attributes

---

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>No high risk types of HPV DNA detected</td></tr><tr><td>1</td><td>High risk types of HPV DNA detected</td></tr><tr><td>2</td><td>Unsatisfactory sample</td></tr></tbody></table>	Value	Meaning	0	No high risk types of HPV DNA detected	1	High risk types of HPV DNA detected	2	Unsatisfactory sample
Value	Meaning								
0	No high risk types of HPV DNA detected								
1	High risk types of HPV DNA detected								
2	Unsatisfactory sample								

### Collection and usage attributes

<i>Guide for use:</i>	<p>HPV DNA testing is used to test the efficacy of treatment following the detection of a histologically verified high-grade intraepithelial abnormality during screening for cervical cancer. Studies have confirmed a 98-100% negative predictive value for HPV testing.</p> <p>The strains of HPV DNA considered high risk (as at June 2006) are viral types: 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68, 73 and 82. An additional three types (23, 53 and 66) are considered probable high-risk.</p> <p>Those strains of HPV DNA that are understood to be relatively low risk for the development cervical cancer are 6, 11, 40, 42, 43 44, 54, 61, 70, 72, 81 and CP108).</p> <p>See guide for use for 'Person – HPV DNA test type, code AAN' for information on specific strains identified by each test.</p>
-----------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

### Data Element attributes

---

### Source and reference attributes

*Origin:*

Australian Institute of Health and Welfare

*Reference documents:*

Lab Tests Online 2006. Cited 9 June 2006,  
[www.labtestsonline.org](http://www.labtestsonline.org).

Malloy, C, Sherris J and Herdman C (2000). HPV DNA Testing: Technical and Programmatic Issues for Cervical Cancer Prevention in Low-Resource Settings, cited 25 May 2006, <http://www.path.org/files/HPV-DNA-Testing-Issues.pdf>

NHMRC Screening to Prevent Cervical Cancer: Guidelines for the Management of Asymptomatic Women with Screen Detected Abnormalities, 2005, cited 9 June 2006  
[www.nhmrc.gov.au/publications](http://www.nhmrc.gov.au/publications).

MSAC Report: The use of human papilloma virus testing to monitor effectiveness of treatment of high-grade intraepithelial abnormalities of the cervix, cited 9 June 2006  
[www.msac.gov.au/pdfs/reports/msacref12e.pdf](http://www.msac.gov.au/pdfs/reports/msacref12e.pdf).

---

## 28. Person—HPV DNA test type, code AAN

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person—HPV DNA test type, code AAN
<i>METeOR identifier:</i>	339236
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The type of test used to determine whether a specimen from a person contains HPV DNA for the purpose of predicting people at greatest risk of recurrent cervical abnormality following diagnosis of a confirmed high-grade lesion by biopsy, as represented by a code.

### Value domain representational attributes

---

<i>Representation class:</i>	Code										
<i>Data type:</i>	String										
<i>Format:</i>	AAN										
<i>Maximum character length:</i>	3										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>HP1</td><td>Signal-amplified techniques (Hybrid Capture Test and Hybrid Capture II test)</td></tr><tr><td>HP2</td><td>Target-amplified techniques (Polymerase Chain Reaction (PCR))</td></tr><tr><td>HP3</td><td>Non-amplified techniques (Southern blot hybridization, dot blot hybridization and in situ hybridization)</td></tr><tr><td>HP9</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	HP1	Signal-amplified techniques (Hybrid Capture Test and Hybrid Capture II test)	HP2	Target-amplified techniques (Polymerase Chain Reaction (PCR))	HP3	Non-amplified techniques (Southern blot hybridization, dot blot hybridization and in situ hybridization)	HP9	Not stated
Value	Meaning										
HP1	Signal-amplified techniques (Hybrid Capture Test and Hybrid Capture II test)										
HP2	Target-amplified techniques (Polymerase Chain Reaction (PCR))										
HP3	Non-amplified techniques (Southern blot hybridization, dot blot hybridization and in situ hybridization)										
HP9	Not stated										

### Data Element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	<p><b>HP1: Signal-amplified techniques (HCT and HCII)</b></p> <p>A manufacturer of the HC-II test (Digene) claims it can detect 13 strains of HPV DNA, they are listed as 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, and 68. The University of Washington, Department of Pathology reports the HC-II test can differentiate between two HPV DNA groups: low risk HPV types 6/11/42/43/44; and high/intermediate-risk HPV types 16/18/31/33/35/39/45/51/56/58/59/68, but cannot determine the specific HPV type present. The format of HC-II used in Australia is currently the high-risk oncogenic type assay that detects at least 13 high-risk types.</p> <p>Cervical specimens which may be tested with the Hybrid</p>
-----------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Capture 2 HPV DNA Test include: Specimens collected with the Digene Cervical Sampler; Biopsies collected in Digene Specimen Transport Medium, Specimens collected using a broom-type collection device and placed in Cytoc PreservCyt Solution. (University of Washington, Department of Pathology)

HC-II is approved to be used as a test method by MSAC following a histologically confirmed high-grade cervical lesion.

### **HP2: Target-amplified techniques (Polymerase Chain Reaction (PCR))**

PCR based detection of HPV is both extremely sensitive and specific. PCR techniques identify individual HPV types and require only small amounts of DNA. A consensus PCR is generally performed which identifies several HPV types in one assay. The most common test assays can detect more than 25 of the different HPV types.

Standard cell collection devices used for Pap smears can be used to collect samples for PCR.

PCR is approved to be used as a test method by MSAC following a histologically confirmed high-grade cervical lesion.

### **HP3: Non-amplified techniques (Southern blot hybridization, dot blot hybridization and in situ hybridization)**

Non-amplified methods can be used but are laborious, require large amounts of DNA and are not reproducible. For these reasons these methods are not routinely used for HPV DNA testing.

These methods have not been approved as a test method by MSAC.

## **Source and reference attributes**

*Submitting organisation:*

Australian Institute of Health and Welfare

*Reference documents:*

Malloy, C, Sherris J and Herdman C (2000). HPV DNA Testing: Technical and Programmatic Issues for Cervical Cancer Prevention in Low-Resource Settings, cited 25 May 2006, <http://www.path.org/files/HPV-DNA-Testing-Issues.pdf>  
University of Washington, Department of Pathology. Cited 9 June 2006, [www.pathology.washington.edu/clinical/HPV/clinical/index.php?location=hpvc&file=detection](http://www.pathology.washington.edu/clinical/HPV/clinical/index.php?location=hpvc&file=detection).

MSAC Report: The use of human papilloma virus testing to

monitor effectiveness of treatment of high-grade  
intraepithelial abnormalities of the cervix, cited 9 June 2006  
[www.msac.gov.au/pdfs/reports/msacref12e.pdf](http://www.msac.gov.au/pdfs/reports/msacref12e.pdf).

---

## 29. Person—cervical cytology specimen type, cervical cytology screening code AN

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	308229
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The type of cervical cytology screening specimen used to obtain cells for the purpose of screening for cancer or pre-cancerous changes to the cervix of a person as represented by a code.

### Value domain representational attributes

---

<i>Representation class:</i>	Code										
<i>Data type:</i>	String										
<i>Format:</i>	AN										
<i>Maximum character length:</i>	2										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>A1</td><td>Conventional smear</td></tr><tr><td>A2</td><td>Liquid based specimen</td></tr><tr><td>A3</td><td>Conventional and liquid based specimen</td></tr><tr><td>A0</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	A1	Conventional smear	A2	Liquid based specimen	A3	Conventional and liquid based specimen	A0	Not stated
Value	Meaning										
A1	Conventional smear										
A2	Liquid based specimen										
A3	Conventional and liquid based specimen										
A0	Not stated										

### Collection and usage attributes

<i>Guide for use:</i>	<p>CODE A1 Conventional smear</p> <p>The Pap smear test uses an instrument (e.g. spatula or cytobrush) to extract exfoliated cells from the transformation zone of the cervix. These cells are transferred and fixed to a slide for staining and microscopic evaluation by a pathologist, cytologist or specially trained technician.</p> <p>CODE A2 Liquid based specimen</p> <p>This process is commonly known as ThinPrep or CytoRich. The sampling instrument is rinsed in a vial of fluid fixative; a 'monolayer' of cells is then spread on the slide. This facilitates reading of the slide either by cytotechnologist or by machine.</p> <p>CODE A3 Conventional <i>and</i> liquid based specimen</p> <p>This is when a liquid based specimen is examined in addition to the conventional (Pap) smear.</p> <p>CODE A0 Not stated</p> <p>This code should be used when there is no information on the type of screening test provided.</p>
-----------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

## Data element attributes

---

### Collection and usage attributes

*Guide for use:* As provided by laboratories.

### Source and reference attributes

*Submitting organisation:* Australian Institute of Health and Welfare

*Origin:* Cervical Cytology Registries

*Reference documents:* Cytology Codes for use by the Cervical Cytology Registries,  
Edition Date: 6 October 2004.

### Relational attributes

*Data Set Specifications which include this Data Element:* Cervical Screening Standardised Data Set V3 No registration status

---

## 30. Person—cervical cytology specimen site, cervical cytology screening code AN

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	308252
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The site from where a specimen of cells has been taken from a person for the purpose of screening for cancer or pre-cancerous changes as represented by a code.

### Value domain representational attributes

---

<i>Representation class:</i>	Code										
<i>Data type:</i>	String										
<i>Format:</i>	AN										
<i>Maximum character length:</i>	2										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>B1</td><td>Cervical</td></tr><tr><td>B2</td><td>Vaginal (<i>with or without an intact cervix</i>)</td></tr><tr><td>B3</td><td>Other gynaecological site</td></tr><tr><td>B0</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	B1	Cervical	B2	Vaginal ( <i>with or without an intact cervix</i> )	B3	Other gynaecological site	B0	Not stated
Value	Meaning										
B1	Cervical										
B2	Vaginal ( <i>with or without an intact cervix</i> )										
B3	Other gynaecological site										
B0	Not stated										

### Collection and usage attributes

<i>Guide for use:</i>	<p>CODE B2</p> <p>A vaginal sample can be taken whether or not a person has an intact cervix; this item is meant to represent only an anatomical description of the origin of the specimen. It is the supplementary use of CODE E- in item '29. <i>Person – endocervical cell analysis, cervical cytology screening code XX</i>' that indicates a vault smear, not the anatomical site sampled.</p> <p>To code a vault smear: record CODE B2 for item '27. <i>Person – cervical cytology specimen site, code AN</i>' <b>and</b> CODE E- for item '29. <i>Person – endocervical cell analysis, cervical cytology screening code XX</i>'.</p> <p>(NOTE: The use of CODE B2 will be almost exclusively indicative of vault samples because 'vaginal only' smears in people with intact cervixes are uncommon; however it is important to be able to distinguish whether a specimen is a vault smear or not for accurate reporting purposes.)</p>
-----------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

## **Data element attributes**

---

### **Collection and usage attributes**

*Collection methods:* Provided by pathology laboratories.

### **Source and reference attributes**

*Submitting organisation:* Australian Institute of Health and Welfare

*Origin:* Cervical Cytology Registries

*Reference documents:* Cytology Codes for use by the Cervical Cytology Registries,  
Edition Date: 6 October 2004.

### **Relational attributes**

*Data Set Specifications which include this Data Element:* Cervical Screening Standardised Data Set V3 *No registration status*

---

## 31. Person—squamous cell analysis, cervical cytology screening code XX

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Synonymous names:</i>	Squamous cells cytology
<i>METeOR identifier:</i>	307899
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The cytological analysis of squamous cells obtained from a specimen for the purpose of screening for cancer or pre-cancerous changes to the cervix of a person as represented by a code.

### Value domain representational attributes

---

<i>Representation class:</i>	Code																		
<i>Data type:</i>	String																		
<i>Format:</i>	XX																		
<i>Maximum character length:</i>	2																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>S1</td><td>Cell numbers and preservation satisfactory. No abnormality or only reactive changes</td></tr><tr><td>S2</td><td>Possible low-grade squamous intraepithelial lesion (LSIL)</td></tr><tr><td>S3</td><td>Low-grade LSIL (HPV and/or CIN I)</td></tr><tr><td>S4</td><td>Possible high-grade squamous intraepithelial lesion (HSIL)</td></tr><tr><td>S5</td><td>High-grade squamous intraepithelial lesion (HSIL) (CIN II/CIN III)</td></tr><tr><td>S6</td><td>High-grade squamous intraepithelial lesion (HSIL) with possible microinvasion/ invasion</td></tr><tr><td>S7</td><td>Squamous carcinoma</td></tr><tr><td>SU</td><td>Unsatisfactory for evaluation</td></tr></tbody></table>	Value	Meaning	S1	Cell numbers and preservation satisfactory. No abnormality or only reactive changes	S2	Possible low-grade squamous intraepithelial lesion (LSIL)	S3	Low-grade LSIL (HPV and/or CIN I)	S4	Possible high-grade squamous intraepithelial lesion (HSIL)	S5	High-grade squamous intraepithelial lesion (HSIL) (CIN II/CIN III)	S6	High-grade squamous intraepithelial lesion (HSIL) with possible microinvasion/ invasion	S7	Squamous carcinoma	SU	Unsatisfactory for evaluation
Value	Meaning																		
S1	Cell numbers and preservation satisfactory. No abnormality or only reactive changes																		
S2	Possible low-grade squamous intraepithelial lesion (LSIL)																		
S3	Low-grade LSIL (HPV and/or CIN I)																		
S4	Possible high-grade squamous intraepithelial lesion (HSIL)																		
S5	High-grade squamous intraepithelial lesion (HSIL) (CIN II/CIN III)																		
S6	High-grade squamous intraepithelial lesion (HSIL) with possible microinvasion/ invasion																		
S7	Squamous carcinoma																		
SU	Unsatisfactory for evaluation																		

### Collection and usage attributes

<i>Guide for use:</i>	<p>CODE S1</p> <p>Cell numbers and preservation satisfactory. No abnormality or only reactive changes</p> <p>Record this code where there no abnormality is detected and cell numbers and preservation is satisfactory.</p> <p>CODE S2</p> <p>This code encompasses changes in squamous cells where the reporting cytologist/pathologist believes the changes may represent a low grade squamous intraepithelial lesion but no definitive changes are present.</p>
-----------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

CODE S3 Low grade squamous intraepithelial lesion (LSIL)

Record this code where the cytologist/pathologist observes changes which would have been described as HPV effect or CIN I (i.e. incorporates HPV effect and/or CIN I).

CODE S4 Possible high grade squamous intraepithelial lesion (HSIL)

Record this code when the presence of a high grade squamous abnormality such as CIN 2, CIN 3 or SCC is suspected but the changes are insufficient to justify a confident cytological prediction of a high grade lesion.

CODE S5 High grade squamous intraepithelial lesion (HSIL)

Record this code where the changes observed would have previously been described as CIN 2 or CIN 3 (i.e. code S5 incorporates CIN 2 & CIN 3.)

CODE S6 High grade squamous intraepithelial lesion (HSIL) with possible invasion

Record this code when a definite HSIL is present, but the possibility of invasion cannot be excluded.

CODE S7 Squamous carcinoma

Record this when squamous carcinoma is present.

CODE SU Unsatisfactory for evaluation

Record this code if the specimen is unable to be assessed due to poor cellularity, poor preservation, cell detail obscured by inflammation/blood/degenerate cells.

## **Data element attributes**

---

### **Collection and usage attributes**

*Collection methods:* As provided by pathology laboratories

### **Source and reference attributes**

*Submitting organisation:* Australian Institute of Health and Welfare

*Origin:* Cervical Cytology Registries

*Reference documents:* Cytology Codes for use by the Cervical Cytology Registries, Edition Date: 6 October 2004.

## **Relational attributes**

*Data Set Specifications which include this Data Element:*

Cervical Screening Standardised Data Set V3 *No registration status*

---

## 32. Person—endocervical cell analysis, cervical cytology screening code XX

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	307602
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The cytological analysis of endocervical cells obtained from a specimen for the purpose of screening for cancer or pre-cancerous changes to the cervix of a person as represented by a code.

### Value domain representational attributes

---

<i>Representation class:</i>	Code																				
<i>Data type:</i>	String																				
<i>Format:</i>	XX																				
<i>Maximum character length:</i>	2																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>E1</td><td>Endocervical component present. No abnormality or only reactive changes</td></tr><tr><td>E2</td><td>Atypical endocervical cells of uncertain significance</td></tr><tr><td>E3</td><td>Possible high-grade endocervical glandular lesion</td></tr><tr><td>E4</td><td>Adenocarcinoma-in-situ</td></tr><tr><td>E5</td><td>Adenocarcinoma-in-situ with possible microinvasion/invasion</td></tr><tr><td>E6</td><td>Adenocarcinoma</td></tr><tr><td>EU</td><td>Due to unsatisfactory nature of the smear, no assessment has been made</td></tr><tr><td>E-</td><td>Not applicable: vault smear/previous hysterectomy</td></tr><tr><td>E0</td><td>No endocervical component</td></tr></tbody></table>	Value	Meaning	E1	Endocervical component present. No abnormality or only reactive changes	E2	Atypical endocervical cells of uncertain significance	E3	Possible high-grade endocervical glandular lesion	E4	Adenocarcinoma-in-situ	E5	Adenocarcinoma-in-situ with possible microinvasion/invasion	E6	Adenocarcinoma	EU	Due to unsatisfactory nature of the smear, no assessment has been made	E-	Not applicable: vault smear/previous hysterectomy	E0	No endocervical component
Value	Meaning																				
E1	Endocervical component present. No abnormality or only reactive changes																				
E2	Atypical endocervical cells of uncertain significance																				
E3	Possible high-grade endocervical glandular lesion																				
E4	Adenocarcinoma-in-situ																				
E5	Adenocarcinoma-in-situ with possible microinvasion/invasion																				
E6	Adenocarcinoma																				
EU	Due to unsatisfactory nature of the smear, no assessment has been made																				
E-	Not applicable: vault smear/previous hysterectomy																				
E0	No endocervical component																				

### Collection and usage attributes

<i>Guide for use:</i>	<p>CODE E1 Endocervical component present. No abnormality or only reactive changes</p> <p>Record if where no abnormality is detected &amp; cell numbers &amp; preservation is satisfactory.</p> <p>CODE E2 Atypical endocervical cells of uncertain significance</p> <p>Record where changes are insufficient to raise the possibility of a lesion such as AIS but are beyond a reactive process.</p> <p>CODE E3 Possible high grade endocervical glandular lesion</p> <p>Record If AIS is suspected but a confident prediction is not possible.</p>
-----------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

CODE E4 Endocervical adenocarcinoma-in-situ (AIS)

This record is self explanatory i.e. the diagnosis is to be used when the reporting cytologist / pathologist is confident of the presence of an adenocarcinoma-in situ.

CODE E5 Endocervical adenocarcinoma-in-situ with possible invasion

Record this when a definite AIS is present, but the possibility of invasion cannot be excluded.

CODE E6 Endocervical adenocarcinoma

This category is self explanatory.

CODE EU Due to the unsatisfactory nature of the smear, no assessment has been made.

Unable to be assessed due to poor cellularity, poor preservation, cell detail obscured by blood/inflammation/degenerate cells. The reasoning for this is a smear can't be "partly" unsatisfactory & would need to be repeated for a satisfactory evaluation & result. Of course, if for example a smear is sub optimal but atypical/abnormal cells are detected, the abnormality overrides the UNSATISFACTORY coding & should be coded to reflect the abnormality detected.

CODE E- Not applicable: vault smear/previous hysterectomy

This category is self explanatory.

CODE E0 No endocervical component

This category is self explanatory.

*Collection methods:* Provided by pathology laboratories

## **Data element attributes**

---

### **Collection and usage attributes**

*Collection methods:* As provided by pathology laboratories

### **Source and reference attributes**

*Submitting organisation:* Australian Institute of Health and Welfare

*Origin:* Cervical Cytology Registries

*Reference documents:* Cytology Codes for use by the Cervical Cytology Registries, Edition Date: 9 September 2005.

### **Relational attributes**

*Data Set Specifications which include this Data Element:* Cervical Screening Standardised Data Set V3 *No registration status*

---

## 33. Person—other/non-cervical cell analysis, cervical cytology screening code XX

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	302521
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The cytological analysis of other/non-cervical cells (cells from areas of the person's genital tract other than the cervix) obtained from a specimen for the purpose of screening for cancer or pre-cancerous changes in a person as represented by a code.

### Value domain representational attributes

---

<i>Representation class:</i>	Code																						
<i>Data type:</i>	String																						
<i>Format:</i>	XX																						
<i>Maximum character length:</i>	2																						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>O1</td><td>No other abnormal cells.</td></tr><tr><td>O2</td><td>Atypical endometrial cells of uncertain significance</td></tr><tr><td>O3</td><td>Atypical glandular cells of uncertain significance – site unknown</td></tr><tr><td>O4</td><td>Possible endometrial adenocarcinoma</td></tr><tr><td>O5</td><td>Possible high-grade lesion – non-cervical</td></tr><tr><td>O6</td><td>Malignant cells – uterine body</td></tr><tr><td>O7</td><td>Malignant cells – vagina</td></tr><tr><td>O8</td><td>Malignant cells – ovary</td></tr><tr><td>O9</td><td>Malignant cells – other</td></tr><tr><td>OU</td><td>Due to the unsatisfactory nature of the smear, no assessment has been made</td></tr></tbody></table>	Value	Meaning	O1	No other abnormal cells.	O2	Atypical endometrial cells of uncertain significance	O3	Atypical glandular cells of uncertain significance – site unknown	O4	Possible endometrial adenocarcinoma	O5	Possible high-grade lesion – non-cervical	O6	Malignant cells – uterine body	O7	Malignant cells – vagina	O8	Malignant cells – ovary	O9	Malignant cells – other	OU	Due to the unsatisfactory nature of the smear, no assessment has been made
Value	Meaning																						
O1	No other abnormal cells.																						
O2	Atypical endometrial cells of uncertain significance																						
O3	Atypical glandular cells of uncertain significance – site unknown																						
O4	Possible endometrial adenocarcinoma																						
O5	Possible high-grade lesion – non-cervical																						
O6	Malignant cells – uterine body																						
O7	Malignant cells – vagina																						
O8	Malignant cells – ovary																						
O9	Malignant cells – other																						
OU	Due to the unsatisfactory nature of the smear, no assessment has been made																						

### Collection and usage attributes

<i>Guide for use:</i>	<p>CODE O1 No other abnormal cells Record this where there is no abnormality detected &amp; cell numbers &amp; preservation is satisfactory.</p> <p>CODE O2 Atypical endometrial cells of uncertain significance Record this where there are changes in endometrial cells, but insufficient to raise the possibility of an endometrial carcinoma.</p> <p>CODE O3 Atypical glandular cells of uncertain significance – site unknown This category would be used where there was uncertainty about</p>
-----------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

whether the abnormal cells were endocervical or endometrial in origin. Use where changes are insufficient to raise the possibility of a neoplasm but are beyond a reactive process.

CODE O4 Possible endometrial adenocarcinoma

Record this if endometrial adenocarcinoma is suspected, but a confident prediction is not possible, the code O4 would be used.

CODE O5 Possible high grade lesion – non cervical

Record if abnormal cells are present but do not appear to be cervical, endometrial or vaginal in origin, the code O5 would be used.

CODE O6 Malignant cells – uterine body (Endometrial adenocarcinoma, all types)

Record when malignant endometrial cells are present.

CODE O7 Malignant cells – vagina

Record if malignant cells are present in a vaginal or vault smear.

CODE O8 Malignant cells – ovary

Record if malignant cells – ovarian are present.

CODE O9 Malignant cells – other (09)

Record if malignant cells are present which are none of the above.

CODE OU Due to the unsatisfactory nature of the smear, no assessment has been made

Record this code when smear is unable to be assessed due to poor cellularity, poor preservation, cell detail obscured by blood/inflammation/degenerate cells. The reasoning for this is a smear can't be "partly" unsatisfactory & would need to be repeated for a satisfactory evaluation & result. Of course, if for example a smear is sub optimal but atypical/abnormal cells are detected, the abnormality overrides the UNSATISFACTORY coding & should be coded to reflect the abnormality detected.

*Collection methods:* Provided by pathology laboratories

## **Data element attributes**

---

### **Collection and usage attributes**

*Collection methods:* As provided by pathology laboratories

## **Source and reference attributes**

*Submitting organisation:* Australian Institute of Health and Welfare  
*Origin:* Cervical Cytology Registries  
*Reference documents:* Cytology Codes for use by the Cervical Cytology Registries,  
Edition Date: 9 September 2005.

## **Relational attributes**

*Data Set Specifications which include this Data Element:* Cervical Screening Standardised Data Set V3 *No registration status*

---

## 34. Person—follow-up recommendation, cervical cytology screening code XX

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	309539
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The recommended assessment action (as per NHMRC guidelines) based on the cytological analysis of cells for the purpose of screening for cancer or pre-cancerous changes to the cervix of a person as represented by a code.

### Value domain representational attributes

---

<i>Representation class:</i>	Code																								
<i>Data type:</i>	String																								
<i>Format:</i>	XX																								
<i>Maximum character length:</i>	2																								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>R1</td><td>Repeat smear 3 years</td></tr><tr><td>R2</td><td>Repeat smear 2 years</td></tr><tr><td>R3</td><td>Repeat smear 12 months</td></tr><tr><td>R4</td><td>Repeat smear 6 months</td></tr><tr><td>R5</td><td>Repeat smear 6-12 months</td></tr><tr><td>R6</td><td>Colposcopy/biopsy recommended</td></tr><tr><td>R7</td><td>Already under gynaecological management</td></tr><tr><td>R8</td><td>Referral to specialist</td></tr><tr><td>R9</td><td>Other management recommended</td></tr><tr><td>R0</td><td>No recommendation</td></tr><tr><td>RS</td><td>Symptomatic-Clinical management required</td></tr></tbody></table>	Value	Meaning	R1	Repeat smear 3 years	R2	Repeat smear 2 years	R3	Repeat smear 12 months	R4	Repeat smear 6 months	R5	Repeat smear 6-12 months	R6	Colposcopy/biopsy recommended	R7	Already under gynaecological management	R8	Referral to specialist	R9	Other management recommended	R0	No recommendation	RS	Symptomatic-Clinical management required
Value	Meaning																								
R1	Repeat smear 3 years																								
R2	Repeat smear 2 years																								
R3	Repeat smear 12 months																								
R4	Repeat smear 6 months																								
R5	Repeat smear 6-12 months																								
R6	Colposcopy/biopsy recommended																								
R7	Already under gynaecological management																								
R8	Referral to specialist																								
R9	Other management recommended																								
R0	No recommendation																								
RS	Symptomatic-Clinical management required																								

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	Definition of symptoms of cervical cancer is forthcoming and will be included in Version 2.
<i>Collection methods:</i>	As provided by pathology laboratories

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries
<i>Reference documents:</i>	Cytology Codes for use by the Cervical Cytology Registries, Edition Date: 9 September 2005.

## **Relational attributes**

*Data Set Specifications which include this Data Element:*

Cervical Screening Standardised Data Set V3 *No registration status*

---

## 35. Person—registry contact suspension flag, code A

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	309639
<i>Registration status:</i>	No registration status
<i>Definition:</i>	An indication as to whether a person wishes to remain on the register or has requested the register not correspond with them nor contact them, as represented by a code.

### Value domain representational attributes

---

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	X						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Person remains an active entry on the Cervical Cytology Registry</td></tr><tr><td>1</td><td>Person has requested not to be contacted by the Cervical Cytology Registry</td></tr></tbody></table>	Value	Meaning	0	Person remains an active entry on the Cervical Cytology Registry	1	Person has requested not to be contacted by the Cervical Cytology Registry
Value	Meaning						
0	Person remains an active entry on the Cervical Cytology Registry						
1	Person has requested not to be contacted by the Cervical Cytology Registry						

### Data element attributes

---

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------

---

## 36. Person—vital status, code N

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	325609
<i>Registration status:</i>	<i>No registration status</i>
<i>Definition:</i>	An indication as to whether a person is alive or deceased, as represented by a code.
<i>Context:</i>	This data is essential to ensure that correspondence is not sent to deceased people to avoid potential distress for the person's family or friends.

### Value domain representational attributes

---

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Alive</td></tr><tr><td>1</td><td>Deceased</td></tr></tbody></table>	Value	Meaning	0	Alive	1	Deceased
Value	Meaning						
0	Alive						
1	Deceased						

### Data element attributes

---

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 <i>No registration status</i>
-----------------------------------------------------------------	---------------------------------------------------------------------------

---

## 37. Person—date of death, DDMMYYYY

---

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>METeOR identifier:</i>	309630
<i>Registration status:</i>	No registration status
<i>Definition:</i>	The date of death of the person.
<i>Context:</i>	Required to prevent screening reminder letters or other correspondence being sent to people.

### Value domain representational attributes

---

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYY
<i>Maximum character length:</i>	8

### Collection and usage attributes

<i>Guide for use:</i>	Record the date of death.  This data element should always be recorded as an 8 digit valid date comprising day, month and year. Year should always be recorded in its full 4 digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example if the person dies on 1 July 2005 the Date of death should be recorded as 01072005 as specified in the representational layout.
<i>Collection methods:</i>	If an accurate date of death can not be recorded then do not enter any data, the completion of 'Person – vital status' will be sufficient.

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	This item should only be recorded if notification of a death is received by the Cervical Cytology Registries.
-----------------------	---------------------------------------------------------------------------------------------------------------

#### Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Cervical Cytology Registries

#### Relational attributes

<i>Data Set Specifications which include this Data Element:</i>	Cervical Screening Standardised Data Set V3 No registration status
-----------------------------------------------------------------	--------------------------------------------------------------------