2012 Researcher’s Guide
Preface
The Researcher’s Guide is intended for investigators within and outside of the USRDS Coordinating Center who wish to undertake research projects using data from the USRDS database. This guide places particular emphasis on the USRDS Standard Analysis Files (SAFs), the primary means by which USRDS data are available for use. The Researcher’s Guide includes the information needed to select and use the appropriate SAFs for the intended project.

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Introduction

History of the USRDS
The first USRDS contract was awarded in 1988 to the Urban Institute in Washington, DC, which worked in conjunction with investigators at the University of Michigan at Ann Arbor. Under a new contract created in 1999, the USRDS was divided into a Coordinating Center (CC) and four Special Studies Centers (SSCs), each of which continues to operate under the direction of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) at the National Institutes of Health (NIH).

The CC and Cardiovascular ssc contracts were awarded in 1999 to the Minneapolis Medical Research Foundation, and are directed by Allan Collins MD and Charles Herzog MD, respectively. The Economic ssc was awarded to the University of Iowa under the direction of Lawrence Hunsicker MD. In 2000, the Nutrition ssc was awarded to the University of California at San Francisco, directed by Glenn Chertow MD, and the Rehabilitation ssc to Emory University, directed by Nancy Kutner PhD.

In early 2007, the CC and the SSCs entered a new seven-year contract period. The Cardiovascular, Nutrition, and Quality of Life/Rehabilitation SSCs remain as before, and the activities of the Economic ssc are included with those of the CC.

USRDS website: www.usrds.org
The USRDS website provides users with access to PDF files of the printed Annual Data Report (ADR), Excel files of the Reference Tables and the data underlying the graphs and state maps, and PowerPoint slides of USRDS presentations and ADR figures. Because of the size and complexity of the ADR files, downloading time for large portions of the book may be substantial.

RenDER
The USRDS Renal Data Extraction and Referencing (Render) System is an online data querying application accessible through the USRDS website, allowing access to a wealth of information regarding esrd in the United States. It quickly returns an accurate table of data or an interactive map based on the user’s query specifications. Tables can be copied into a spreadsheet application on the user’s computer for further manipulation and investigation, and map images can be copied or saved to local applications. A database file download of the mapped data, which can be opened or imported by most spreadsheet applications, is also available.

The Render System allows easy access to some of the most frequently requested data. While the ADR thoroughly covers many esrd statistics, it cannot reasonably contain the more detailed tables often requested by researchers. Render allows users to “drill down” into the data behind many of the tables published in
the ADR, allowing cross interactions among various demographic fields. For more information, visit http://usrds.org/render/xrender_home.asp to access the Render tutorial.

**What's New in 2012**

**preop_bill**

A new variable was added this year. *PREOP_BILL* is found in the Transplant CD-1 and CD-2 section of Data Descriptions.

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**Structure of the USRDS Database**

CMS PMMIS/REBUS/REMIS  
CMS ESRD Part A SAF claims: OP, IP, SNE, HH, Hospice  
CMS ESRD Part B SAF claims: Physician / Supplier, DME  
CMS ESRD Part D SAF claims: OP, IP, SNE, HH, Hospice, Physician / Supplier, DME  
UNOS tx data  
Ingenix cd & MarketScan enrollment & claims data  
CMS ESRD & 5% SAF data  
CMS ESRD facility data  
CDC survey data  
NHANES  
Network SIMS  
Common Standard Re-usable Working Set Library  
ESRD cohort finder files  
Patient profile  
Modality / payor sequence  
Comorbidity profile  
Tx profile  
CMS ESRD & 5% general Medicare Claims data: EPO & Parts A, B, & D  
UNOS transplant data  
USRDS Special Studies data  
Disease-specific cohort finder files (CKD, CHF, DM)  
EGHP claims data: Parts A & B  
USRDS database (2.38 million patients)  
USRDS Annual Data Report  
USRDS researcher SAF CDs  
Data analyses  
USRDS custom data files  
USRDS web-based applications

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**Year-to-Year Comparison of Number of Records in USRDS Standard Analysis Files (SAF)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENTS</td>
<td>1,516,251</td>
<td>1,600,693</td>
<td>1,698,706</td>
<td>1,801,298</td>
<td>1,910,161</td>
<td>2,024,425</td>
<td>2,138,876</td>
<td>2,260,986</td>
<td>2,377,166</td>
</tr>
<tr>
<td>MEDEVID</td>
<td>786,297</td>
<td>896,447</td>
<td>1,164,686</td>
<td>1,147,657</td>
<td>1,265,566</td>
<td>1,385,589</td>
<td>1,505,285</td>
<td>1,630,270</td>
<td>1,753,496</td>
</tr>
<tr>
<td>RXHIST</td>
<td>10,630,350</td>
<td>10,733,455</td>
<td>11,658,208</td>
<td>12,533,612</td>
<td>13,532,743</td>
<td>11,626,297</td>
<td>11,741,390</td>
<td>12,392,072</td>
<td>13,038,727</td>
</tr>
<tr>
<td>FACILITY</td>
<td>55,547</td>
<td>60,138</td>
<td>64,870</td>
<td>69,764</td>
<td>74,831</td>
<td>80,071</td>
<td>85,572</td>
<td>91,332</td>
<td>97,201</td>
</tr>
<tr>
<td>TX</td>
<td>256,315</td>
<td>272,277</td>
<td>289,533</td>
<td>308,002</td>
<td>324,476</td>
<td>343,051</td>
<td>360,297</td>
<td>378,536</td>
<td>395,347</td>
</tr>
<tr>
<td>TXWAIT</td>
<td>313,446*</td>
<td>347,564*</td>
<td>378,262*</td>
<td>405,165*</td>
<td>437,256</td>
<td>474,348</td>
<td>513,028</td>
<td>546,239</td>
<td>579,225</td>
</tr>
</tbody>
</table>

'TXWAIT is the total number of observations between Waitlist_ki and Waitlist_kp.  
'MEDEVID is the total number of observations between Medevid95 and Medevid05.
Getting Started

Work on a typical study consists of determining the study variables, selecting the variables from the datasets in which they are stored, merging the selected variables into one or more datasets for analysis, and finally performing the statistical analyses of the data. This section offers dataset examples of this process to first-time users of the USRDS SAF.

All USRDS data are stored in SAS datasets that were created in the Windows environment and can be used only on the Windows operating system. Using the datasets on another computer platform requires moving and converting the data to SAS datasets for that platform. Using another data analysis system requires a conversion to a format compatible with that system.

The examples use basic SAS code. New SAS users should take classes, consult colleagues, or otherwise become familiar with the SAS system. Regardless of SAS experience, all users must know:

- The location of the SAS dataset.
- The location of the SAS catalog of formats.

In the examples, the datasets and the format catalog are assumed to be in the same directory, namely, C:\SAF. Two SAS statements are needed to point to this information:

LIBNAME saf 'c:\saf'; * Directory location of the data;
LIBNAME LIBRARY 'c:\saf'; * Directory location of format catalog;

Always assume that these two statements are required in all code. See Data Formatting for additional information. The datasets and the format catalog may be in different directories.

**Basic SAS Use**

The SAS CONTENTS procedure generates a list of all variables in the dataset and a label associated with each. The information in this label is usually an adequate indication of whether the variable will be of use; however, PROC CONTENTS is always the best method for obtaining the latest variable list, as last minute updates may not be reflected in the printed documentation. (See Data Descriptions.)

Note: In the following program examples, SAS keywords are in uppercase text. Datasets, comments, and variables in which SAS will perform operations, are in lowercase text.

To determine the contents of the PATIENTS dataset, or any dataset, use the following code: (Remember the requirement of the two LIBNAMES.)
PROC CONTENTS DATA=saf.patients;
TITLE1 'DATASET: saf.patients';
RUN;

To see what the data look like, use the SAS procedure PRINT to list all observations of the dataset.

PROC PRINT data=saf.patients;
TITLE1 'DATASET: saf.patients';
RUN;

A dataset can have thousands of observations. To print the first 500, use the following code:

PROC PRINT DATA=saf.patients (OBS=500);
TITLE1 'DATASET: saf.patients';
RUN;

To print a group of observations other than the first N observations, use the following code; this example prints observations 1500-2000, inclusive.

PROC PRINT DATA=saf.patients (FIRSTOBS=1500 OBS=2000);
TITLE1 'DATASET: saf.patients';
RUN;

A dataset can contain hundreds of variables. Print selected variables using the 'VAR' statement:

PROC PRINT DATA=saf.patients (OBS=500);
VAR usrds_id sex race incyear;
TITLE1 'DATASET: saf.patients';
RUN;

There are two parts to the 'data=' expression. The first is the directory location, defined by the LIBNAME, and the second is the dataset name. The first part (directory location) implies that the dataset is permanent. Later examples do not include this part, and the datasets you create will disappear when you leave SAS. To permanently save a dataset, the first part of the expression must be included.

**SAS Formats for USRDS Data**

Information in a dataset may be coded. Thus, the variable GENDER may have the values F, M, or U, where F is the coded value for female, M is the value for male, and U is the value for unknown. Using one character instead of several saves disk storage, but because the coded values are not always easy for users to understand, a format is assigned to translate them. Many variables have been assigned formats by the USRDS.

In each program, SAS must be told where these formats are. Assume that the format catalog is in the directory C:\saf. Then the following SAS LIBNAME makes the formats accessible to your SAS programs.

LIBNAME LIBRARY 'c:\saf';  * Directory location of format catalog;

The SAS keyword LIBRARY must be used because it tells SAS to look for formats in the directory, C:\saf. Other methods can accomplish this, but not as easily. To bypass the use of formats, use the following two SAS statements before running any SAS procedures:

LIBNAME LIBRARY;
OPTIONS NOFMTERR
Bypassing the use of formats allows you to see raw data instead of the formatted values, which may be useful when you need to write SAS IF statements to control the flow of your program in a SAS data step. See Data Formatting for a tabular list of the formats with their coded values.

**Comment Lines**
Comment lines in the SAS code look like this:

```sas
/* Comment line */
* Comment line;
```

These refer to any descriptive comment. The use of comments is optional but strongly recommended.

**The SAF Directory**
Throughout this section SAF has been used as the permanent SAS LIBNAME. It is assumed that all of the USRDS SAF datasets and catalogs have been placed in this directory. If the datasets have been placed in the WINDOWS directory C:\SAF, then the following SAS LIBNAME would point to the SAF datasets.

```sas
LIBNAME saf 'c:\saf';
Note: The datasets may be loaded into any directory, with the directory in the LIBNAME changed accordingly.
```

```sas
LIBNAME core_cd 'C:\USRDS\CORE_CD\SAF';
LIBNAME hosp_cd 'C:\USRDS\HOSP_CD\SAF';
LIBNAME in_cd 'C:\USRDS\IN\SAF';
LIBNAME cpm_cd 'C:\USRDS\CPM\SAF';
LIBNAME library 'C:\USRDS\CORE_CD\SAF';
```

**Examples**

**Example 1: Incident Cohort**

Create a patient cohort of incident patients from 2000 to 2010 to use in the examples that follow.

```sas
DATA inc2000_2010 (KEEP=usrds_id esrddate inc_year rxgroup);
  SET core_cd.rxhist60;
  BY usrds_id begdate;
  FORMAT esrddate MMDDYY10.;
  IF (FIRST.usrds_id) AND
    (MDY(1,1,2000) <= begdate <= MDY(12,31,2010));
  esrddate = begdate;
  inc_year = YEAR(esrddate);
RUN;

PROC FREQ DATA=inc2000_2010;
  TABLE inc_year;
  TITLE 'Frequency Distribution of Incident Patients 2000 – 2010 by Incident Year';
RUN;

PROC FREQ DATA=inc2000_2010;
  TABLE inc_year * rxgroup;
  TITLE 'Frequency Distribution of Incident Patients 2000 - 2010 by Incident Year and Modality';
RUN;
```
Example 2: Incident Patients Distribution by Demographic Data

PROC FREQ DATA=core_cd.patients;
  TABLE incagec sex race disgrpc;
  WHERE (incyear = 2010);
  TITLE 'Frequency Distribution of 2010 Incident Patients by Demographic Data';
RUN;

Example 3: Point Prevalent Cohort

CREATE A PATIENT COHORT OF POINT PREVALENT DIALYSIS PATIENTS WHO WERE ALIVE ON JANUARY 1, 2010.

DATA pre_2010 (KEEP=usrds_id rxgroup);
  SET core_cd.rxhist60;
  BY usrds_id begdate;
  IF (begdate <= MDY(1,1,2010)) AND
    ((enddate = .) OR (enddate >= MDY(1,1,2010))) AND
    (rxgroup NOT IN ('D' 'X' 'Z')) THEN
    OUTPUT;
RUN;

PROC FREQ DATA=pre_2010;
  TABLE rxgroup;
  TITLE 'Frequency Distribution of 1-1-2010 Point Prevalent Patients by Modality';
RUN;

Example 4: 1995 Incident Patient Survival Rates (Kaplan Meier)

CALCULATE 5-YEAR SURVIVAL RATES OF 2005 INCIDENT DIALYSIS PATIENTS USING KAPLAN MEIER METHOD.

DATA inc_2005_s;
  MERGE inc2000_2010 (IN = x1)
    core_cd.patients (IN = x2 KEEP=usrds_id died tx1date);
    BY usrds_id;
  IF x1 AND x2;
  * Extract only 2005 incident dialysis patients.;
  IF (inc_year = 2005) AND (rxgroup ^= 'T');
  * Calculate the survival time (in month) of each incident patient.;
  t = (MIN(died, tx1date, MDY(12,31,2010)) - esrddate + 1) / 30.4375;
  IF (t < 0) THEN t = 0;
  * Determine whether the patient is censored.;
  c = (MIN(died, tx1date, MDY(12,31,2010)) = died);
RUN;

PROC LIFETEST DATA=inc_2005_s METHOD=KM NOTABLE PLOTS=(s) OUTSURV=surv2005;
  TIME t*c(0);
  TITLE '2005 Incident Dialysis Patients 5-Year Survival Rates';
RUN;
Example 5: Merge with Medical Evidence file (CMS 2728)

Demonstrate a way to extract comorbid conditions for a pre-defined study cohort from the Medical Evidence file.

DATA medevid;
   SET core_cd.medev (KEEP=usrds_id cancer cararr carfail cva diabins diabprim
dyrsyrt hyper lhd mi pulmon pvasc);
   BY usrds_id;
   IF (FIRST.usrds_id);
RUN;

DATA me_2728;
   MERGE medevid                (IN=x1)
core_cd.patients (IN=x2 KEEP=usrds_id died tx1date);
   BY usrds_id;
   IF x1 AND x2;
RUN;

DATA inc2008_me;
   MERGE inc2000_2010 (IN=x1 WHERE=(inc_year = 2008))
me_2728           (IN=x2);
   BY usrds_id;
   IF x1 AND x2;
RUN;

Example 6: 2008 Incident Patient Survival Rates (Kaplan Meier)

Show a survival rate calculation stratified by patient comorbid condition.

DATA inc_2008_s;
   SET inc2008_me;
   BY usrds_id;
   IF (UPCASE(cancer) IN ('1' '2' 'Y' 'N'));
      IF (UPCASE(cancer) IN ('1' 'Y')) THEN
         can = 1;
      ELSE
         can = 0;

      * Calculate the survival time (in month) of each incident patient.;
      t = (MIN(died, MDY(12,31,2010)) - esrdate + 1) / 30.4375;
      IF (t < 0) THEN t = 0;

      * Determine whether the patient is censored.;
      c = (MIN(died, MDY(12,31,2010)) = died);
RUN;

PROC LIFETEST DATA=inc_2008_s METHOD=KM NOTABLE PLOTS=(s) OUTSURV=surv2008;
TIME t*c(0);
STRATA can;
TITLE '2008 Incident Dialysis Patients 2-Year Survival Rates by Co-Morbidity';

RUN;

Example 7: Waitlist Access Rate
Determine waitlist access rate to December 31, 2010, of 2008 incident dialysis patients who were registered in the transplant waitlist.

DATA txwait;
  set core_cd.waitseq_ki core_cd.waitseq_kp;
Run;
  PROC SORT data=txwait;
  by usrds_id;
RUN;
DATA inc_2008_w;
  MERGE inc2008_me (IN=x1)
    txwait (IN=x2 KEEP=usrds_id begin);
  BY usrds_id;
  IF x1;
    * Extract only 2008 incident dialysis patients.;
    IF (rxgroup ^= 'T');
    * Make sure all dialysis patients who were not put on the waitlist;
    * get to be censored at the end of follow-up period.;
    IF x1 AND ^x2 THEN begin = MDY(1,1,2011);
    * Calculate the waitlist access time (in month) of each incident patient.;
    t = (MIN(begin, died, MDY(12,31,2010)) - esrddate + 1) / 30.4375;
    IF (t < 0) THEN t = 0;
    * Determine whether the patient is censored.;
    c = (MIN(begin, died, MDY(12,31,2010)) = begin);
RUN;

  PROC LIFETEST DATA=inc_2008_w METHOD=KM NOTABLE PLOTS=(s) OUTSURV=wait2008;
  TIME t*c(0);
  TITLE '2008 Incident Dialysis Patients Waitlist Access Rates';
RUN;

Example 8: Total Admission Rate
Create the patient driver for hospitalization rates, or use previously created file.

DATA driver;
  SET core_cd.patients (WHERE=(incyear=2008));
  sfu = first_se + 91;
  efu = MIN(died, first_se+455);
  IF (died NE .) AND (died < sfu) THEN DELETE;
  FORMAT sfu efu MMDDYY10.;
RUN;
  PROC SORT DATA=driver;
BY usrds_id;
RUN;

LINK TO HOSPITALIZATION FILE; GATHER HOSPITALIZATIONS WITHIN PERIOD
OF INTEREST (INCLUDES ONLY PATIENTS WITH HOSPITALIZATIONS).
PROC SQL;
   CREATE TABLE hospdat AS
   SELECT * FROM driver a, hosp_cd.hosp (KEEP=usrds_id clm_from clm_thru) b
   WHERE a.usrds_id=b.usrds_id AND a.sfu<=clm_thru AND a.efu>=b.clm_from;
QUIT;
PROC SORT DATA=hospdat;
   BY usrds_id clm_from clm_thru;
RUN;

DATA rate;
   SET hospdat;
   BY usrds_id;
   RETAIN n_hos n_adm exptime rt_adm;
   IF FIRST.usrds_id THEN
      DO; /* INITIALIZE RETAIN VARIABLES FOR EACH USRDS_ID */
         n_hos=0;
         n_adm=0;
         exptime=0;
         rt_adm=0;
      END;

   * FOR HOSPITALIZATIONS OVERLAPPING STUDY START ONLY COUNT;
   * HOSPITAL DAYS, NOT AS ADMISSION;
      IF (clm_from<sfu<=clm_thru) THEN n_hos=n_hos+(MIN(clm_thru,efu)-sfu+1);

   * IF WITHIN STUDY PERIOD COUNT DAYS (UP TO STUDY END) AND
   * ADMISSIONS;
      ELSE IF (sfu<=clm_from<=efu) THEN
         DO;
            n_hos=n_hos+(MIN(clm_thru,efu)-clm_from);
            n_adm=n_adm+1;
         END;

   IF LAST.usrds_id THEN /* OUTPUT ONE RECORD PER USRDS_ID */
      DO;
         exptime=(efu-sfu-n_hos)/365;
         IF exptime>0 then rt_adm=n_adm*1000/exptime;
         ELSE IF (exptime<0) THEN exptime=0;
         OUTPUT;
      END;
RUN;

Combine result with original incident sample to include patients without hospitalizations.

DATA rateall;
   MERGE driver (IN=x1)
      rate    (IN=x2);
BY usrsds_id;

IF x2=0 THEN
DO;
   n_hos=0;
   n_adm=0;
   rt_adm=0;
   exptime=(efu-sfu+1)/365;
END;
IF x1 THEN OUTPUT;
RUN;

Calculate mean admissions per 1000 patient-years by gender.
PROC TABULATE DATA=rateall;
VAR rt_adm;
CLASS sex;
WEIGHT exptime;
TABLE sex="*"rt_adm="*"mean*f=8.1;
KEYLABEL mean="";
TITLE1 'Total Admission rates per 1,000 patient years';
RUN;

Example 9: First Admission Rate
USING HOSPITALIZATION DATA FROM ABOVE, CALCULATE FIRST HOSPITALIZATION RATES.
DATA frate;
SET hospdat;
BY usrsds_id;

RETAIN n_adm exptime rt_adm fl ag;

IF FIRST.usrsds_id THEN
DO; /* INITIALIZE RETAIN VARIABLES FOR EACH USRDS_ID */
   n_adm=0;
   exptime=0;
   rt_adm=0;
   fl ag=0;
END;

* FOR HOSPITALIZATIONS OVERLAPPING STUDY START SET EXPOSURE
* TIME TO ZERO TO EXCLUDE FROM RATE;
  IF (clm_from<=sfu<=clm_thru) THEN
  DO;
     exptime=0;
     fl ag=1;
  END;

* IF WITHIN STUDY PERIOD COUNT ADMISSION AND CALCULATE
* EXPOSURE TIME;
  ELSE IF (sfu<clm_from<=efu) AND fl ag=0 THEN
  DO;
     exptime=(clm_from-sfu+1)/365;
     n_adm=n_adm+1;
     fl ag=1;
IF LAST.usrds_id THEN /* OUTPUT ONE RECORD PER USRDS_ID */
DO;
   IF exptime>0 then rt_fadm=n_adm*1000/exptime;
   OUTPUT;
END;
RUN;

COMBINE RESULT WITH ORIGINAL INCIDENT SAMPLE TO INCLUDE PATIENTS WITHOUT HOSPITALIZATIONS.
DATA frateall;
MERGE driver (IN=x1) frate (IN=x2);
   BY usrds_id;
IF x2=0 THEN
   DO;
      n_adm=0;
      rt_fadm=0;
      exptime=(efu-sfu+1)/365;
   END;
IF x1 THEN OUTPUT;
RUN;

CALCULATE MEAN ADMISSIONS PER 1000 PATIENT-YEARS BY GENDER.
PROC TABULATE DATA=frateall;
VAR rt_fadm;
CLASS sex;
WEIGHT exptime;
TABLE sex="'*rt_fadm="'*mean"*f=8.1;
KEYLABEL mean="';
TITLE1 'First Admission rates per 1,000 patient years';
RUN;

Example 10: Create a patient cohort of 2008 Medicare Incident patients
CREATE THE 2008 INCIDENT PATIENT FILE.
DATA inc_2008;
   SET core_cd.patients (WHERE=(incyear=2008));
RUN;

FIND MEDICARE PAYER STATUS AT FIRST SERVICE DATE.
DATA first_payer;
   SET core_cd.payhist;
   BY usrds_id begdate;
   IF first.usrds_id;
RUN;

COMBINE PAYER INFORMATION WITH ORIGINAL INCIDENT COHORT AND LIMIT TO PATIENTS WITH MEDICARE PAYERS AT FIRST SERVICE DATE.
PROC SORT DATA=inc_2008;
   BY usrds_id;
RUN;
DATA medicare_inc_2008;
MERGE inc_2008       (IN=x1)
first_payer (IN=x2 KEEP=usrds_id mcare payer dualelig);
   BY usrds_id;
   IF x1 AND mcare = 'Y';
RUN;
Section 1: ESRD Data and the USRDS Database System

The main objective of the USRDS CC is to use all relevant ESRD data to create an integrated and consistent database system for outcomes research. The CC database includes ESRD patient demographic and diagnosis data, biochemical values, dialysis claims, and information on treatment history, hospitalization events, and physician/supplier services.

Data Sources

The data used by the USRDS CC originates from CMS, UNOS, the CDC, the ESRD Networks, and the USRDS Special Studies.

PMMIS/REBUS/REMIS Database System

The major source of ESRD patient information for the USRDS is the CMS Renal Beneficiary and Utilization System (REBUS), which was adopted in 1995 as the On-Line Transaction Processing (OLTP) system from its predecessor, the Program Management and Medical Information System (PMMIS) database. The PMMIS/REBUS database contains demographic, diagnosis, and treatment history information for all Medicare beneficiaries with ESRD. The database has been expanded to include non-Medicare patients, as discussed below.

Having advanced its database technology, CMS transformed the REBUS database into an Oracle relational database system, called the Renal Management Information System (REMIS), in the fall of 2003. This database included all patients who were alive and had ESRD as of January 1, 1995, or were incident after this date. This approach was adopted from the procedure used to create the Networks’ Standard Information Management System (SIMS) database. However, because the REMIS system as it existed did not include legacy patients for longitudinal studies, CMS expanded it in the fall of 2004 to include all ESRD patients.

CMS regularly updates the PMMIS/REBUS/REMIS database, using the Medicare Enrollment Database (EDB), Medicare inpatient and outpatient claims, the UNOS transplant database, the ESRD Medical Evidence Report (CMS-2728) provided by the ESRD Networks, the ESRD Death Notification (CMS-2746) obtained from renal providers, and the ESRD Networks’ SIMS database. CMS has established data integrity rules to ensure accurate identification of patients in the SIMS and CMS databases. Each ESRD patient (new and old) is identified with a unique patient identification number common to both databases, guaranteeing that data for all patients are consistently managed over time.
The USRDS CC continues to collaborate with CMS and the ESRD Networks to address data-tracking issues related to non-Medicare ESRD patients. Working solely with data from the Medical Evidence Report, the CC could establish the first ESRD service data for these patients, but could not consistently generate a detailed treatment history. The integration of the SIMS event data into the CC database, however, allows for the examination of issues that arise in the non-Medicare ESRD population, such as the large and growing number of lost-to-follow-up patients, and for the gathering of data on patients for whom no data were previously available on initial modality or death.

CMS Medical Evidence Report (Form CMS-2728)
The CMS Medical Evidence Report is completed by the renal provider for each new ESRD patient, and is sent to CMS through the ESRD Networks. It establishes Medicare eligibility for individuals who previously were not Medicare beneficiaries, reclassifies previously eligible Medicare beneficiaries as ESRD patients, and provides demographic and diagnostic information for all new ESRD patients regardless of Medicare entitlement.

Before 1995, dialysis units and transplant centers were required to file the Medical Evidence Report only for Medicare-eligible patients. The form was revised in 1995, and providers were subsequently required to complete it for all new ESRD patients regardless of Medicare eligibility status. The 1995 revised form also included new fields for comorbid conditions, employment status, expanded race categories, ethnicity, and biochemical data at ESRD onset.

Only one Medical Evidence Report is expected for each ESRD patient for the entire ESRD treatment period; however, multiple forms may be filed for patients whose insurance eligibility changes due to therapy changes. For example, transplant patients with functioning grafts after 3 years lose Medicare benefits if ESRD was the sole qualification for Medicare eligibility. If such a patient experiences graft failure and returns to dialysis, a second Medical Evidence Report must be filed to reestablish Medicare eligibility. Dialysis patients who discontinue dialysis for more than 12 months also lose Medicare ESRD benefits. If such a patient returns to dialysis or undergoes kidney transplant, a second Medical Evidence Report must be filed to reestablish Medicare eligibility.

Revised Medical Evidence Report (Form CMS-2728)
Another revision of the Medical Evidence Report was introduced in May 2005. It includes new data collection methods and new variables. It allows users to specify whether the Medicare registration is initial (new ESRD patient), re-entitlement (reinstating Medicare entitlement after a lapse due to no claims being filed for 12 or more months or a functioning graft for 36 or more months), or supplemental (updating missing or incorrect information). This clarifies the intended use of the form without recourse to the “First Regular Dialysis Start Date,” and helps chronicle the historical sequence of multiple forms for the same patient.

Multiple races can be specified. CMS provides a single variable containing a concatenated string representing all selected race codes with binary digits (0s and 1s). This string must be decoded to determine patient race (or races). Similar formatting requirements apply to information on comorbid conditions, medical coverage, and reasons for not informing patients of transplant options. Because the required programming is substantial, we include, for each of these 4 data categories, the original variable with the concatenated string and a new variable with the decoded values (i.e., information noted on form CMS-2728). However, the decoded multiple race values must be presented as “Other” or “Multiple race” to maintain consistency with the legacy race information.

Data fields for nephrologist care, dietitian care, and access type were also added, with their respective time intervals relative to ESRD onset. Data on the laboratory values hematocrit, creatinine clearance, BUN, and urea clearance are no longer collected. Added laboratory values are HbA1c and lipid profiles (TC, LDL, and HDL cholesterol, and TG). Additional fields relate to whether patients were informed of transplant options and if not why not, and donor type. Comorbid conditions and primary diagnoses were also added. Please see the What’s New section for the addition of new variables (page 6). Both the 2005 and 1995 versions of
the form are provided in the USRDS Core SAF data set and are available for download in PDF format from the USRDS website: http://wwwUSRDS.org/reference.htm.

**CMS ESRD Death Notification (Form CMS-2746)**

Like the Medical Evidence Report, the Death Notification form is data rich, and CMS requires renal providers to complete it. Providers usually have 45 days to report ESRD death events to their respective ESRD Networks, including information about place, time, and cause of death. Data are thus available to the USRDS CC for research on cause-specific mortality outcomes.

**CMS Medicare Enrollment Database (EDB)**

The CMS Enrollment Database is the designated repository of all Medicare beneficiary enrollment and entitlement data, including current and historical information on beneficiary residence, Medicare as Secondary Payer (MSP) status, and Health Insurance Claim/Beneficiary Identification Code (HIC/BIC) cross-referencing.

**CMS Paid Claims Records**

Inpatient transplant and outpatient dialysis claims records are sometimes used to identify new ESRD patients for whom no Medical Evidence Report has been filed. These patients are most likely to be non-Medicare patients or beneficiaries already receiving Medicare because of age or disability. They will eventually be entered into the PMMIS/REBUS database, and hence the USRDS database, through the claims records. For patients without Medical Evidence reports, these claims are the only reliable information from which to determine first ESRD service dates. These paid claims records, however, only supplement and do not replace other sources of information on incidence and prevalence. Bills for some Medicare-eligible patients may not be submitted to or paid by Medicare. These patients are MSP patients covered by private insurance, HMOs, Medicaid, or the Department of Veterans Affairs (DVA).

**UNOS Transplant Database**

CMS began collecting data on all Medicare kidney transplants in the early 1980s. In 1988, UNOS was created to provide a national system for allocating donor organs and to maintain a centralized data depository for organ transplants. UNOS also began collecting data on all transplants. These two collection efforts were consolidated in 1994, and UNOS became the sole source of data on transplant donors and recipients.

The CMS and UNOS transplant data files overlap for 1988–1993, and some patients with Medical Evidence Reports indicating transplant as the initial modality are not included in either file. To resolve the conflicts among these three sources, the USRDS has adopted the following procedure:

Before 1988, all transplant events found in CMS PMMIS/REBUS Transplant files are used.
- After 1994, all transplant events found in UNOS files are used.
- Between 1988 and 1993, all transplant events found in UNOS files are used, and additional transplant events from the CMS PMMIS/REBUS Transplant file are used only if they occur at least 30 days on either side of a previously accepted transplant event.
- Additionally, transplant events associated with reported incident transplant patients from the Medical Evidence Report are used if they occur at least 30 days on either side of a previously accepted transplant event.
- Each transplant event found in the Transplant file of the USRDS SAF Core CD is thus a unique event derived from the UNOS, CMS PMMIS/REBUS Transplant, and Medical Evidence record files.

**CMS ESRD Standard Analytical Files (SAFs)**

The CMS SAFs contain data from final action claims, submitted by Medicare beneficiaries, in which all adjustments have been resolved. For Part A institutional claims, the USRDS uses the following 100% SAF claims:
- Inpatient
- Outpatient
- Skilled nursing facility (SNF)
• Home health agency (HHA)
• Hospice

For Part-B physician/supplier 100% SAF claims:
• Physician/supplier
• Durable medical equipment (DME)

CMS SAFs are updated each quarter through June of the next year, when the annual files are finalized. Datasets for the current year are created six months into the year and updated quarterly until finalized at 18 months, after which files are frozen and will not include late arriving claims. Annual files are thus approximately 98% complete. The USRDS 2012 ADR includes all claims up to December 31, 2010. Patient-specific demographic and diagnosis information, however, includes data as recent as October 2011.

CMS 5% General Medicare SAFs
The 5% general Medicare SAFs have the same structure and data elements as the ESRD 100% SAFs, but they were extracted from the general Medicare billing database as a random sample of 5% of the entire Medicare population. Because the sample is selected using the last two digits of patient Social Security Numbers, one should expect to see the same group of Medicare beneficiaries represented in the 5% SAFs each year, with exceptions for death, disenrollment, and new Medicare entitlements.

The USRDS CC uses these files to conduct studies on Healthy People 2020 objectives, comparing preventive care and other non-ESRD disease treatments in general Medicare and ESRD patients. In addition, these files are used to create CKD cohort finder files.

CLINICAL PERFORMANCE MEASURES PROJECT (CPM)
CMS developed the ESRD CPM (formerly the ESRD Core Indicators Project) to collect information on the quality of care provided to dialysis patients. The data originate from surveys completed by primary care facilities, and focus on dialysis adequacy measures, anemia management, and vascular access use. Additional clinical parameters such as albumin are also available. These data have been collected annually since 1994, using a random sample of patients aged 18 years and older, alive and on dialysis at the end of each calendar year; on average, about 8500 in-center hemodialysis patients and 1500 peritoneal dialysis patients are surveyed each year. Data collection for all pediatric patients aged 12 to 17 years began in 2000, and in 2002 was expanded to all in-center hemodialysis patients aged younger than 18 years. Starting in 2005, all PD patients in the US have been sampled for the pediatric PD data collection. The USRDS CC, in collaboration with CMS, provides CPM/USRDS merged data to the general research community.

CMS DIALYSIS FACILITY COMPARE DATA
The USRDS uses the CMS Dialysis Facility Compare data to define chain and ownership information for each renal facility; before the 2003 ADR, similar data were extracted from the Independent Renal Facility Cost Report (CMS 265-94).

CMS ANNUAL FACILITY SURVEY (AFS)
In addition to the CMS ESRD databases, independent ESRD patient counts are available from the CMS Annual Facility Survey, which all Medicare-approved dialysis units and transplant centers are required to complete at the end of each calendar year. The AFS reports counts of patients being treated at the end of the year, new ESRD patients starting during the year, and patients who died during the year. Counts of Medicare and non-Medicare end-of-year patients are included. While AFS files do not carry patient-specific demographic and diagnosis information, they do provide independent patient counts used to complement the CMS patient-specific records.
CDC NATIONAL SURVEILLANCE DATA
From 1993-2002, the CDC used its National Surveillance of Dialysis-Associated Diseases in the United States to collect information from dialysis facilities on patient and staff counts, membrane types, reuse practices, water treatment methods, therapy types, vascular access use, antibiotic use, hepatitis vaccination and conversion rates (for both staff and patients), and the incidence of HIV, AIDS, and tuberculosis. None of the information is patient-specific. Because the CDC terminated this program in 2003, the last surveillance report is for 2002 data. The CDC did not conduct a survey in 1998.

DIALYSIS MORBIDITY AND MORTALITY STUDY (DMMS)
The DMMS was an observational study that collected data on demographics, comorbidity, laboratory values, treatment, socioeconomic factors, and insurance for a random sample of US dialysis patients, using dialysis records. Data were collected on 6,000 eSRD patients in each of Waves I, III, and IV, and 4,500 patients in Wave II, a total of 22,500 patients over three years. Waves I, III, and IV are each historical prospective studies in which data were collected for patients receiving in-center hemodialysis on December 31, 1993. Data were abstracted from patient medical records, and each patient was followed from December 31, 1993, through the earliest of data abstraction, death, transplant, change in modality, or transfer to another facility. Wave II is a true prospective study of incident hemodialysis and peritoneal dialysis patients for 1996 and some incident patients entering the eSRD program in the first part of the 1997 calendar year.

CASE MIX ADEQUACY STUDY
The objectives of the USRDS Case Mix Adequacy Study of Dialysis were to:
- establish the relationship between the dose of delivered dialysis therapy and mortality.
- determine the strength of this relationship when data are adjusted for comorbidity.
- assess how this relationship changes at different dialysis doses
- assess how this relationship is affected by dialyzer reuse.
- assess the impact of different dialysis membranes on patient morbidity and mortality.

The study consisted of two groups of patients: an incident sample of eSRD patients who began hemodialysis during 1990, and a prevalent sample of hemodialysis patients with eSRD onset before 1990. A total of 7,096 patients from 523 dialysis units were included, the pre- and post-BUN values needed to calculate delivered dialysis dose were present for approximately 3,300 patients. Ninety-four percent of these cases were matched to the USRDS database. The eSRD Networks collected these data in conjunction with their Medical Case Review data abstraction.

CASE MIX SEVERITY STUDY
The objectives of this study were to:
- estimate the correlation of comorbidity and other factors present at eSRD onset with subsequent mortality and hospitalization rates, adjusting for age, gender, race, and primary diagnosis
- evaluate possible associations of these factors with reported causes of death.
- assess the distribution of comorbidity and other factors among patients using different treatment modalities.
- compare relative mortality rates by treatment modality, adjusting for selected comorbid conditions and other factors.

Data were collected for 5,255 incident patients in 1986 and 1987 at 328 dialysis units nationwide.

PEDIATRIC GROWTH AND DEVELOPMENT
The objectives of the USRDS Pediatric eSRD Growth and Development Study were to:
- establish a baseline for assessing the relation of pediatric eSRD patient growth and sexual maturation to modality
- establish a prototype for the ongoing collection of pediatric data.

All patients prevalent in 1990 and born after December 31, 1970, were included in the study, a total of 3,067 patients at 548 dialysis units.
CAPD AND PERITONITIS STUDY
The USRDS CAPD and Peritonitis Rates Study examined the relation of peritonitis episodes in CAPD patients to connection device technology and other factors. The study population included all patients newly starting CAPD in the first six months of 1989, up to a maximum of 14 patients per dialysis unit. All units providing CAPD training participated in the study. The sample includes 3385 patients from 706 units.

USRDS Database System
The USRDS CC has developed a centralized ESRD patient database by integrating data from the above data sources and establishing methods to identify patients with ESRD. We use this database to update and maintain data on demographics, clinical measurements, biochemical lab test results, renal replacement therapy, treatment history, and all medical service events reported in the Medicare claims database. Through this patient-oriented database we attempt to define each individual ESRD patient through multiple stages of data cleaning, conversion, validation, and consolidation. Establishment of a universal patient identification system was critical to ensure that unique patient identification numbers are assigned to each ESRD patient at the time of ESRD initiation, to accurately track counts and rates of incident and prevalent cohorts over time.

In 1994, the USRDS CC introduced the Standard Analysis Files (SAFs)—not to be confused with the CMS Standard Analytical Files for Part A and Part B claims data—to help meet the ESRD data needs of a wide variety of research studies. These SAFs were subsequently enhanced to include not only ESRD clinical and claims data from CMS, but also transplant and wait list data from UNOS. All SAFs are sorted by the unique USRDS-specified patient identification number, and patient identifiers (name, address, SSN, HIC/BIC, etc.) are removed to protect patient confidentiality.

The CC also uses the USRDS ESRD database to generate data sets for the tables, graphs, and maps in the USRDS ADR.

The USRDS ESRD database is updated regularly with data obtained from the various data sources. The CC generally receives CMS SAF claims data, Facility Survey data, CDC Survey data, and UNOS transplant and wait list data once a year, and REBUS and EDB data more frequently. These multiple updates allow the CC to assess growth of the ESRD population, the demographic distribution of ESRD patients, and changes in the percent of patients diagnosed with major diseases secondary to ESRD.

Section 2: ESRD Patients
ESRD is defined as chronic renal failure requiring renal replacement treatment—dialysis or transplant—to sustain life. It is not the same as acute renal failure, from which patients are expected to recover within weeks or months. A Medical Evidence Report must be completed immediately by renal providers for all ESRD patients to register them in the CMS ESRD database and to apply for Medicare eligibility if they were not previously eligible.

Data Sources
To establish the incident and prevalent cohorts by year, modality, primary cause of renal failure, and other factors, patient demographic and clinical information are required as well as treatment history data. This information can be obtained from the USRDS Core CD with files “PATIENTS,” “MEDEVID,” “RXHIST,” “RXHIST60,” and “PAYHIST.”

First ESRD Service Date
The first ESRD service date (FSD) is the single most important data element in the USRDS database, and each patient must, at a minimum, have a valid FSD. This date is used to determine each new patient’s incident year and the first year in which the patient is counted as prevalent. The date 90 days after the FSD is used as the starting point for most patient survival outcomes analyses. This rule allows each new ESRD patient to generate Medicare services despite potential delays in completing the Medicare eligibility application process, and it provides an adequate time period for patients to arrive at a stable and suitable dialytic treatment modality.
The FSD is derived by taking the earliest of:

- the date of the start of dialysis for chronic renal failure, as reported on the Medical Evidence report,
- the date of a kidney transplant, as reported on a CMS or UNOS transplant form, a Medical Evidence report, or a hospital inpatient claim, or
- the date of the first Medicare dialysis claim.

Most FSDs are derived from the Medical Evidence Report. In the absence of this form, the date of the first Medicare dialysis claim or transplantation usually supplies the FSD. In the few cases in which the date of the earliest dialysis claim is earlier than the first dialysis date reported on the Medical Evidence Report, the earliest claim date is used as the FSD.

**Identifying ESRD Patients**

A person is identified as having ESRD when a physician certifies the disease on the Medical Evidence (ME) Report (form CMS-2728), or when other evidence of chronic dialysis or kidney transplant exists. Patients with acute kidney failure who are on dialysis for days or weeks, but who then recover kidney function, are excluded from the database if their ME forms have not been submitted. Patients who die soon after kidney failure without receiving dialysis are sometimes missed.

The ESRD First Service Date (FSD) is the single most important data element in the USRDS database, and each patient must, at a minimum, have a valid FSD. This date is used to determine the incident year for each new patient and the first year in which the patient is counted as prevalent. The date 90 days after the FSD is used as the starting point for most survival analyses.

The FSD is derived by taking the earliest of dialysis start date, as reported on the ME form, for chronic kidney failure; the date of kidney transplant, as reported on a CMS or OPTN transplant form, an ME form, or a hospital inpatient claim; or the date of the first Medicare dialysis claim. Most FSDs are obtained from the ME form. In the absence of this form, the FSD usually comes from the date of the first Medicare dialysis claim or transplant. In the few cases in which the date of the earliest dialysis claim precedes the first dialysis date reported on the ME form, the earliest claim date is used as the FSD. However, starting with the 2007 ADR, FSDs for patients entering the ESRD program after December 31, 1994, are defined solely by the regular dialysis start date or the preemptive transplant date, whichever is earliest, on the ME form. This new method of determining FSD has been introduced in this ADR to align more closely to methods used by CMS. After years of careful monitoring and repeated comparative analyses of the traditional USRDS method to the new ME method, the USRDS believes it is appropriate to apply the ME method to incident patients entering the ESRD program on or after January 1, 1995.

**Incidence and Prevalence**

Incidence is defined as the number of people in a population who are newly diagnosed with a disease in a given time period, typically a year. Prevalence is the number of people in a population who have the disease at a given point in time (point prevalence) or during a given time period (period prevalence). The USRDS generally reports point prevalence, used primarily throughout the ADR, as of December 31, and period prevalence for a calendar year. Annual period prevalent data thus include people who have the disease at the end of the year and those who had the disease during the year and died before the year's end. Please refer to Getting Started for further details about defining incident and prevalent patient cohorts using the USRDS SAFS.

The USRDS treats successful transplant as a therapy, not as recovery from ESRD. Patients who undergo transplant at the time of ESRD initiation are counted as incident patients, and those with functioning grafts as prevalent.

Because data are available only for patients whose ESRD therapy is reported to CMS, patients who die of ESRD before receiving treatment or whose therapy is not reported to CMS are not included in the database. The terms incidence and prevalence are thus qualified as incidence and prevalence of reported ESRD. Some ESRD registries, such as the European Dialysis and Transplantation Association, use the term "acceptance
into ESRD therapy.” The USRDS, however, believes that “incidence of reported ESRD therapy” is more precise, because “acceptance” implies that remaining patients are rejected, when in fact they may simply not be identified as ESRD cases or may not be reported to CMS.

Point prevalence is useful in public health research because it measures the current burden of the disease on the health care delivery system. Period prevalence is appropriate for cost analysis because it indicates the total disease burden over the course of the year. The USRDS CC focuses primarily on ESRD incidence as the most useful measure for medical and epidemiological research that examines disease causality and its effect on various subpopulations.

Medicare and Non-Medicare (‘ZZ’) Patients

Beneficiaries are enrolled in Medicare based on criteria defined in Title xviii of the Social Security Act of 1965 and in subsequent amendments to the Act. A person in one of these four categories is eligible to apply for Medicare entitlement:

- Aged 65 years and older
- Disabled
- Enrolled in the ESRD program
- Railroad Retirement Board (RRB)

Most ESRD patients are eligible to apply for Medicare as their primary insurance payer. However, some patients are not immediately eligible for Medicare primary payer coverage because of their employment status and pre-existing primary insurance payers such as Employer Group Health Plans (EGHPs), the Department of Veteran Affairs, and private insurers. Typically, these patients wait 30-33 months before becoming eligible for Medicare as primary payer, and are not included in the EDB database during the waiting period. Some of these patients, particularly those who are new since 1995, have FSDs established by Medical Evidence Reports, but have no dialysis claims or hospitalization events in the CMS claims database to establish treatment history events. In the PMMIS/REBUS database, these patients are designated ZZ, or non-Medicare (the PMMIS/REBUS group assigns ZZ in the 2-character Beneficiary Identification Code field to identify all non-Medicare ESRD patients). CMS does not generally include these patients in the datasets released to researchers.

The USRDS recognizes that ZZ patients are ESRD patients and should therefore be included in patient counts for incidence, prevalence, and treatment modality. However, calculations of standardized mortality ratios (SMRs), standardized hospitalization ratios (SHRs), and standardized transplantation ratios (STRs) should not include these patients because of the small number of claims available in the first 30 to 33 months after first ESRD service. Furthermore, linking ZZ patients to their ESRD Death Notification (CMS 2746) or to the UNOS transplant data may be impossible; determining comorbid conditions or Part A and Part B services may also be impossible. Due to the limited availability of event data, event rates that include these patients must be assessed with caution.

Section 3: Treatment History

The USRDS CC uses billing information from the CMS ESRD database to create a longitudinal history of ESRD treatment for each patient in the database. This history defines incident and prevalent cohorts and determines censoring points and outcomes for observational studies.

Data Sources

The FSD is established by evaluating information from several sources. REBUS includes first ESRD service date from the Medical Evidence Report. The REBUS Quarterly Dialysis record summarizes dialysis billing information, and can also establish FSD if data are missing from other files. The UNOS transplant dataset provides FSD information for incident transplant patients. Data combined from these sources establish the first ESRD service date. Section 2 describes the decision algorithm used.
**Treatment Modality Categories**

Table 3.1 lists modality categories used by the USRDS. They can be described as detailed or general. For most analyses, the general categories, which combine detailed modality categories, are sufficient. A new modality/event (recovered renal function; RRF) was introduced in the 2007 ADR. RRF can be established only if it occurs within the first 180 days of FSD, and the RRF period persists for at least 90 days. The RRF modality (i.e., event) is similar to the lost-to-follow-up event in that patients with an RRF event will not be included in the prevalent populations for outcomes analyses. However, as with lost-to-follow-up events, these patients remain in the modality sequence so subsequent renal failure episodes can be closely tracked in a timely manner.

<table>
<thead>
<tr>
<th>Type</th>
<th>Detailed</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Center HD</td>
<td>HD</td>
</tr>
<tr>
<td>2</td>
<td>Center Self HD</td>
<td>HD</td>
</tr>
<tr>
<td>3</td>
<td>Home HD</td>
<td>HD</td>
</tr>
<tr>
<td>4</td>
<td>HD Training</td>
<td>HD</td>
</tr>
<tr>
<td>5</td>
<td>CAPD</td>
<td>CAPD</td>
</tr>
<tr>
<td>6</td>
<td>CAPD Training</td>
<td>CAPD</td>
</tr>
<tr>
<td>7</td>
<td>CCPD</td>
<td>CCPD</td>
</tr>
<tr>
<td>8</td>
<td>CCPD Training</td>
<td>CCPD</td>
</tr>
<tr>
<td>9</td>
<td>Other PD</td>
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<tr>
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<td>Uncertain Dialysis</td>
<td>Unknown Dialysis</td>
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<tr>
<td>T</td>
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<td>Transplant</td>
</tr>
<tr>
<td>X</td>
<td>Lost to follow-up</td>
<td>Lost to follow-up</td>
</tr>
<tr>
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<tr>
<td>Z</td>
<td>Recovered Function</td>
<td>Recovered Function</td>
</tr>
</tbody>
</table>

**How Treatment Modality is Determined**

The treatment history files in the USRDS Core CD record the sequence of modalities for each patient. The variables included in these files are presented in Table 3.2. Each record in the file indicates a period of therapy with a given modality, and any change in provider or detailed modality results in a new record. Several data sources are used to determine the treatment history, including the Medical Evidence file, the Quarterly Dialysis file, the UNOS Transplant events file, and Medicare claims files.

<table>
<thead>
<tr>
<th>RXHIST</th>
<th>Detailed Treatment History</th>
</tr>
</thead>
<tbody>
<tr>
<td>USRDS_ID</td>
<td>USRDS Patient Identification</td>
</tr>
<tr>
<td>BEGDATE</td>
<td>Beginning date of a modality period</td>
</tr>
<tr>
<td>ENDDATE</td>
<td>Ending date of a modality period</td>
</tr>
<tr>
<td>BEGDAY</td>
<td>Start day of modality period (First Service Date = 1)</td>
</tr>
<tr>
<td>ENDDAY</td>
<td>End day of modality period (First Service Date = 1)</td>
</tr>
<tr>
<td>RXDETAIL</td>
<td>Detailed treatment modality for period</td>
</tr>
<tr>
<td>RXGROUP</td>
<td>Grouped treatment modality for period</td>
</tr>
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<td>PROVUSRDS</td>
<td>USRDS assigned facility identification</td>
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<tr>
<td>RXHIST60</td>
<td>Condensed Treatment History</td>
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<tr>
<td>USRDS_ID</td>
<td>USRDS Patient Identification</td>
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<td>Beginning date of a modality period</td>
</tr>
<tr>
<td>ENDDATE</td>
<td>Ending date of a modality period</td>
</tr>
<tr>
<td>BEGDAY</td>
<td>Start day of modality period (First Service Date = 1)</td>
</tr>
<tr>
<td>ENDDAY</td>
<td>End day of modality period (First Service Date = 1)</td>
</tr>
<tr>
<td>RXGROUP</td>
<td>Grouped treatment modality for period</td>
</tr>
</tbody>
</table>

In constructing this treatment history file (RXHIST), these conventions are followed:
• The sequence always begins with the first ESRD service date and ends with the earliest of date of death or end of the period for which the data are complete. For the categories death, loss to follow-up, and functioning graft, the end date may be missing from a patient's last record. Dialysis categories always have an end date.
• Death is treated as the last event of the day, and is the absolute end point of the treatment history.
• If 2 dialysis billing periods overlap, the earlier is terminated at the start of the later. If a dialysis billing period is entirely contained within another billing period, the contained period is ignored.
• A functioning transplant is considered treatment, not recovery from ESRD.
• If a dialysis billing period overlaps a transplant date, the dialysis period is closed at the transplant date.
• If a graft failure is recorded in the database, but there are no subsequent records of dialysis or another transplant, a period of “unknown dialysis” is inserted. If no dialysis billing records or re-transplant appears within 1 year, the patient is designated lost to follow-up at the end of that year, and this status continues until dialysis or new transplant records appear.
• Once established, a modality is assumed to continue until a change in provider or detailed modality occurs. For dialysis patients, if no new dialysis billing data appear for 1 year, the patient is reclassified as lost to follow-up at the end of that 1-year period.
• A functioning graft is assumed to continue until an indication of graft failure or death appears, or evidence of regular or maintenance dialysis.

**Graft Failure**
The CC assumes that a graft failure date reported in the UNOS transplant follow-up file or the REBUS identification file is correct unless death or a new transplant occurs before this date. However, a graft failure date may be unrecorded in both files. In this case, the CC derives the graft failure date from the following sources:

- Date of death
- Date of subsequent transplant
- Date of return to regular dialysis, indicated by a continuous period of dialysis billing records covering a minimum of 60 days with at least 22 reported dialysis treatments
- Date of return to dialysis reported on the Medical Evidence Report, or the date of graft nephrectomy from the UNOS transplant follow-up record or a Medicare claim.
- If no failure date is available, then the earliest of the above dates is used as the graft failure date.

**The 60-Day Collapsing Rule**
The CC uses the convention that a dialysis modality must continue for at least 60 days to be considered stable. A transplant is considered a stable modality regardless of duration.

Because the dialysis treatment history is derived from the Medical Evidence Report, UNOS transplant events, and Medicare billing records, it includes intermixed and overlapping details that are not required or are unsuitable for most analyses. A long period of CAPD, for example, may be interrupted by a short period of inpatient hemodialysis treatment, or a patient may go on vacation and receive dialysis from a different provider. By applying the 60-day rule, we collapse modality periods of less than 60 days, and periods that differ only by provider, giving a less complex treatment history for analyses that require less detail than is available in the detailed treatment history. For maximum flexibility, we provide two treatment history files, one with full detail (RXHIST), and one applying the 60-day collapsing rule (RXHIST60). Table 3.3 shows an example of how these two files differ. The 60-day file is constructed from the detailed file as follows:

- Consecutive records with the same modality group are collapsed into a single record. This removes changes of provider only and changes between detailed modalities within the same general modality group.
- Remaining modality periods, except functioning transplant, < 60 days are recoded as uncertain dialysis, and consecutive dialysis records labeled uncertain are combined.
- If a modality is interrupted by a different modality that lasts < 60 days (e.g., a period of peritoneal dialysis between two longer periods of hemodialysis), the short modality period is ignored and the longer modality extends over the entire period.
Table 3.3 - Detailed vs. Condensed Treatment History RXHIST

<table>
<thead>
<tr>
<th>USRDS ID</th>
<th>BEGDATE</th>
<th>ENDDATE</th>
<th>RXDETAIL</th>
<th>PROVUSRDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>900000001</td>
<td>1/1/91</td>
<td>1/31/91</td>
<td>Center HD</td>
<td>5</td>
</tr>
<tr>
<td>900000001</td>
<td>2/1/91</td>
<td>5/31/91</td>
<td>Center HD</td>
<td>7</td>
</tr>
<tr>
<td>900000001</td>
<td>6/1/91</td>
<td>6/31/91</td>
<td>CAPD training</td>
<td>14</td>
</tr>
<tr>
<td>900000001</td>
<td>7/1/91</td>
<td>1/31/92</td>
<td>CAPD</td>
<td>14</td>
</tr>
<tr>
<td>900000001</td>
<td>2/2/92</td>
<td>9/30/92</td>
<td>Center HD</td>
<td>5</td>
</tr>
<tr>
<td>900000001</td>
<td>10/1/92</td>
<td>10/15/92</td>
<td>CAPD</td>
<td>14</td>
</tr>
<tr>
<td>900000001</td>
<td>10/17/92</td>
<td>5/31/93</td>
<td>Center HD</td>
<td>5</td>
</tr>
<tr>
<td>900000001</td>
<td>6/1/93</td>
<td>7/15/93</td>
<td>Transplant</td>
<td>23</td>
</tr>
<tr>
<td>900000001</td>
<td>7/16/93</td>
<td>2/12/95</td>
<td>Center HD</td>
<td>5</td>
</tr>
<tr>
<td>900000001</td>
<td>2/13/95</td>
<td>1/31/96</td>
<td>Center self HD</td>
<td>5</td>
</tr>
<tr>
<td>900000001</td>
<td>2/1/96</td>
<td>2/29/96</td>
<td>HD training</td>
<td>5</td>
</tr>
<tr>
<td>900000001</td>
<td>3/1/96</td>
<td>2/12/97</td>
<td>Home HD</td>
<td>5</td>
</tr>
<tr>
<td>900000001</td>
<td>2/13/97</td>
<td></td>
<td>Death</td>
<td></td>
</tr>
</tbody>
</table>

RXHIST60

<table>
<thead>
<tr>
<th>USRDS ID</th>
<th>BEGDATE</th>
<th>ENDDATE</th>
<th>RXGROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>900000001</td>
<td>1/1/91</td>
<td>5/31/91</td>
<td>Hemodialysis^a</td>
</tr>
<tr>
<td>900000001</td>
<td>6/1/91</td>
<td>1/31/92</td>
<td>CAPD^b</td>
</tr>
<tr>
<td>900000001</td>
<td>2/2/92</td>
<td>5/31/93</td>
<td>Hemodialysis^c</td>
</tr>
<tr>
<td>900000001</td>
<td>6/1/93</td>
<td>7/15/93</td>
<td>Transplant^d</td>
</tr>
<tr>
<td>900000001</td>
<td>7/16/93</td>
<td>2/12/97</td>
<td>Hemodialysis^c</td>
</tr>
<tr>
<td>900000001</td>
<td>2/13/97</td>
<td></td>
<td>Death</td>
</tr>
</tbody>
</table>

^a Provider change only.
^b Same modality category.
^c CAPD record only 15 days.
^d The 60-day rule does not apply to transplants.
^e Same modality category.

Determining Lost-to-Follow-up Periods

The functioning transplant modality is assumed to continue until a graft failure occurs. A dialysis modality is assumed to continue for a maximum of 1 year in the absence of dialysis billing data or other confirmation of dialysis therapy. After 1 year with no dialysis billing data, the patient is classified as lost to follow-up until evidence of a new modality appears. Patients cannot be classified as lost to follow-up during the first 3 years of ESRD because Medicare may be secondary payer for up to 33 months. The dialysis billing data frequently contain gaps, as listed below.

- The first service date may be known from the Medical Evidence Report, but many ESRD patients are not Medicare eligible for 90 days, delaying billing data for modality determination.
- For patients who have medical insurance other than Medicare, Medicare is the secondary payer for up to 33 months. The first ESRD service date may be known from the Medical Evidence Report, but dialysis billing data are unavailable until Medicare becomes the primary payer.
- Some patients may recover enough renal function to discontinue dialysis, and the USRDS database contains no data for non-dialysis time periods.
- A patient may leave the country and become lost to follow up.
- A patient may die and the death data may not reach the USRDS.
- Self-dialysis treatments are billed by 2 methods, 1 of which may not be available in the CMS PMMIS/REBUS system, causing some home dialysis billing to be missed.
- Some dialysis bills for patients enrolled in Managed Care Organizations may be missed by the CMS billing system.
- Reporting, data entry, and clerical errors may obscure the first service date; for example, first-ever dialysis, not the start of maintenance dialysis, may be reported on the Medical Evidence Report.
• Errors in beneficiary identification may cause data for a single patient to be split between two patients or to be associated with the wrong patient.

**Defining Home Hemodialysis Patients**
The 2006 ADR instituted an improved method for defining home hemodialysis patients. Previously, modality event data were taken from the SIMS event file only in the case of a gap or missing data in the USRDS Modality Sequence (i.e., Treatment History), which was constructed primarily from Medicare billing data and the REMIS database. However, after applying a series of systematic validation rounds to the SIMS database and examining the root causes of persistent under-counting of home hemodialysis patients, the CC concluded that SIMS event data should play a more prominent role. Thus, for the 2006 ADR, the CC incorporated all home hemodialysis events from SIMS data, with the billing data and the REMIS database, into the standard process of creating the final USRDS Modality Sequence. Subsequently, counts of incident and prevalent home hemodialysis patients rose substantially for all years reported in the 2006 ADR. In the event of data discrepancies, researchers should use home hemodialysis counts from the 2006 or later ADR.

**Section 4: Payer History**
The payer history file is similar to the treatment history file. CMS payer information is used to create a continuous sequential history of payers for each patient in the ESRD database, beginning with the first ESRD service date. Each patient's FSD in the payer history file is the same date reported in the treatment history file.

**Data Sources**
The payer for any given time period is determined by evaluating several data sources. The CMS Enrollment DataBase (EDB) is used to determine Part A, Part B, Group Health Organization, MSP Primary Payer, Third Party Part A, and Third Party Part B payers. The CMS claims billing files provide dates of regular maintenance dialysis, used as an indicator of Medicare as primary payer. The “patients” file in the USRDS Core CD contains dates of death, used to help establish the end point of the payer sequence.

**Payer Categories**
Table 4.1 shows the payer categories used by the USRDS and indicates whether a patient is considered a Medicare patient (yes or no), and whether the patient has dual Medicare/Medicaid eligibility for that payer time period (yes or no).

<table>
<thead>
<tr>
<th>Medicare Code</th>
<th>Medicare/Medicaid Description</th>
<th>Medicare Patient</th>
<th>Medicare/Medicaid Dual Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPAB</td>
<td>Medicare Primary, Part A and Part B</td>
<td>Y</td>
<td>Y or N</td>
</tr>
<tr>
<td>MPO</td>
<td>Medicare Primary, Other</td>
<td>Y</td>
<td>Y or N</td>
</tr>
<tr>
<td>MSP-EGHP</td>
<td>Medicare as Secondary Payer with EGHP</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>MSP</td>
<td>Medicare as Secondary Payer</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>HMO</td>
<td>Group Health Org.</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>WAIT</td>
<td>90 Day Waiting Period</td>
<td>Y or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>OTH</td>
<td>Other/Unknown</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

**How the Payer Category is Determined**
The payer history SAF in the USRDS Core CD records the sequence of payers for each patient. Table 4.2 shows the variables included in this file. Each record in the file represents a time period covered by a particular payer. Any change in payer, Medicare status, or dual eligibility status results in a new record.

Note that the “WAIT” status can be either Medicare or non-Medicare, depending on the Medicare status of the sequence following the “WAIT” period. This is a change from the payer history files for prior years, where each payer code corresponded to only one possible Medicare status.
Table 4.2 - Payer History SAF Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>USRDS_ID</td>
<td>USRDS Patient Identification</td>
</tr>
<tr>
<td>BEGDATE</td>
<td>Beginning date of a payer period</td>
</tr>
<tr>
<td>ENDDATE</td>
<td>Ending date of a payer period</td>
</tr>
<tr>
<td>PAYER</td>
<td>Payer for the period</td>
</tr>
<tr>
<td>MCARE</td>
<td>Payer includes Medicare (Y/N)</td>
</tr>
<tr>
<td>DUALELIG</td>
<td>Payer includes Medicare and Medicaid (Y/N)</td>
</tr>
</tbody>
</table>

Because several data sources are used to determine payer history, more than one payer may be reported for any given time period. In constructing the history, the following conventions are followed:

- The sequence begins with the first ESRD service date. If the patient has died, the end date for the last patient record is the date of death. If the patient has not died, the end date is missing from the patient's last record.
- The expected ESRD entitlement date is defined as the remainder of the month of incidence, plus two full calendar months. If the payer on the first service date is unknown, the patient is assumed to be in the waiting period prior to entitlement, and the first payer is assigned to the value "WAIT". The "WAIT" period lasts until the expected entitlement date, or until another payer is identified. The Medicare status of the "WAIT" period is assumed to be the same as the Medicare status of the following period.
- If the reported end date for a payer is missing in the data source, the payer is assumed to continue sharing responsibility through the date of death or through the period of available payer information, whichever comes first.
- If more than one payer is identified for a time period, precedence for assigning the payer for the sequence is as follows: HMO, Medicare Primary if indicated by the claims billing file, MSP, then Medicare Primary if indicated by the Enrollment Database. Note this is a change from prior years, where MSP was given precedence over other payers.
- If payer and dual eligibility status are the same in consecutive payer sequences, the sequences are collapsed into 1 time period, starting with the beginning date of the first and ending with the end date of the last.
- Unlike the treatment history file, the payer history file does not require a payer to continue for any specific time period to be considered stable, and all changes in payer are reported. At their discretion, users may apply additional rules to manage the payer history sequence.

Gaps in the Payer History

Some patient payer histories include gaps with Other/Unknown as payer between sequences with identified payers. This might occur for several reasons, similar to the explanations for gaps in the treatment history:

- Payer information for successful transplant patients may not be reported in the data sources because Medicare eligibility terminated after 3 years with a functioning graft.
- A patient may leave the country and become lost to follow-up.
- A patient may die and the death data may not reach the USRDS.
- CMS may not collect payer information.
- Reporting, data entry, and clerical errors may obscure the record of ESRD and the corresponding payer.
- Errors in patient identification may cause data for a single patient to be split between two patients or to be associated with the wrong patient.

If a patient is alive but the last reported payer in the data sources ends on a date before the reported data extraction date, an additional payer sequence is created with Other/Unknown payer to extend the patient's payer history. Thus, only patients who have died have end dates in their last payer sequences, and the last end date is the date of death.
Some patients have no identified payers. Their payer histories are represented in the file as one payer sequence, starting at first ESRD service date, with missing end date and Other/Unknown payer.

**Section 5: Transplant Process and Outcomes**

Transplant patients constitute a unique subset of the ESRD population and are often studied separately from dialysis patients. Researchers may wish to simply count the number of transplant events that meet certain criteria, or calculate transplant event rates and survival probabilities. Using the USRDS transplant data, researchers can obtain information on transplant events, such as donor and recipient characteristics, and on patient- and graft-related outcomes.

**Data Sources**

Basic transplant variables are contained in the Transplant file (TX) on the Core CD. Transplant event data are combined from various sources including CMS (PMMIS/REBUS files) and UNOS. Before 1988, CMS was the primary source for all transplant event data. Between 1988 and 1993, both CMS and UNOS collected information regarding transplant events. Since 1994, UNOS has been the primary source for all transplant event data. (See figure 5.1.)

**Figure 5.1 - Source of Transplant Events in the USRDS Population**

- CMS is primary source of transplant event
- CMS and UNOS collect transplant event data
- UNOS is primary source of transplant event

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1976</td>
<td>All transplants from CMS data are accepted.</td>
</tr>
<tr>
<td>1988</td>
<td>All transplants from UNOS data are accepted. Transplant events from CMS data are accepted if they occur at least 30 days on either side of a previously accepted transplant event.</td>
</tr>
<tr>
<td>1994</td>
<td>All transplants from UNOS data are accepted.</td>
</tr>
</tbody>
</table>

**Reconciliation of CMS and UNOS Events**

The USRDS has implemented a decision algorithm that reconciles identical transplant events when multiple sources contain conflicting information.

- Before 1988, all transplant events found in CMS PMMIS/REBUS transplant files are used.
- After 1994, all transplant events found in the UNOS files are used.
- Between 1988 and 1993, all transplant events found in the UNOS files are used and additional transplant events from the CMS PMMIS/REBUS transplant file are used only if they occur at least 30 days on either side of a previously accepted transplant event.
- Additionally, transplant events associated with the reported incident transplant patients in the Medical Evidence Report are used if they occur at least 30 days on either side of a previously accepted transplant event.
- Each transplant event found in the Transplant file of the Core CD is thus a unique event that the USRDS believes occurred after reviewing both UNOS and CMS PMMIS/REBUS Transplant and Medical Evidence record files.
Table 5.2 details the various USRDS SAFs related to transplant. The Transplant file (TX) on the Core SAF contains transplant dates, basic descriptive data, and causes of graft failure, when known.

**Figure 5.2 - USRDS Transplant Files**

<table>
<thead>
<tr>
<th>File</th>
<th>Data Source</th>
<th>Contents</th>
<th>Years</th>
<th>SAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>Constructed by USRDS CC from UNOS, CMS PMMIS/REBUS Transplant, Medical Evidence files</td>
<td>Identifying data on all known transplants</td>
<td>All</td>
<td>Core</td>
</tr>
<tr>
<td>WAITSEQ_KI</td>
<td>UNOS Transplant Waiting List</td>
<td>Waitlist periods on all patients from UNOS</td>
<td>Core</td>
<td></td>
</tr>
<tr>
<td>WAITLIST_KP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TXHCFA</td>
<td>CMS PMMIS/REBUS Transplant file</td>
<td>Details from CMS</td>
<td>1976-93</td>
<td>TX</td>
</tr>
<tr>
<td>TXUNOS</td>
<td>UNOS Transplant file</td>
<td>Details from UNOS</td>
<td>1988+</td>
<td></td>
</tr>
<tr>
<td>TXFUHCFA</td>
<td>CMS PMMIS/REBUS Transplant Follow-up file</td>
<td>Follow-up details, CMS</td>
<td>1988+</td>
<td>TX</td>
</tr>
<tr>
<td>TXFUUNOS</td>
<td>UNOS Transplant Follow-up file</td>
<td>Follow-up details, UNOS</td>
<td>1988+</td>
<td>TX</td>
</tr>
</tbody>
</table>

**Kidney and Pancreas Waiting list**

The Core CD also contains four files with information on the kidney and simultaneous kidney-pancreas waiting list files from UNOS.

Most investigators are simply interested in the dates of listing at specific transplant centers. The WAITSEQ_KI and WAITSEQ_KP files contain entry and removal date sequences per patient per transplant center for the kidney alone and simultaneous kidney-pancreas waiting lists, respectively. These records are collapsed from the raw UNOS waiting list files WAITLIST_KI and WAITLIST_KP. Both the raw UNOS waiting list files and the sequence files contain two patient identifiers, PID and USRDS_ID. ESRD patients included in the USRDS patient profile have a USRDS_ID. PID is the UNOS patient identifier and can be used to link the sequence files to the raw waiting list files.

Because the sequence files are collapsed versions of the waiting list files, investigators should use caution when linking back to the raw waiting list files to obtain information such as PRA values. Investigators will need to obtain all raw waiting list records and then make decisions as to which record contains the information most relevant to their needs. Some specific assumptions the CC used to collapse waiting list records are as follows:

- Candidates listed in error were removed (REMCODE=10).
- Patients with missing listing dates (EDATE=) were removed.
- Patients with listing and removal dates on the same date were removed.
- Transplant dates were taken from the USRDS Transplant file and not from the UNOS waiting list file. The transplant dates on the USRDS Transplant file are cleaned and reconciled with other sources of data, so these dates were used to ensure consistency. In the event that a patient not known to the USRDS received a transplant, the UNOS transplant date found in the raw waiting list file was used.
- Known transplant dates are used to truncate waiting periods at all centers at which a patient is currently listed. For example, if a patient underwent transplant but was not removed from a center’s waiting list, a removal date would be imputed on the transplant date. This is true for all centers at which a patient is listed.
- Patients with inactive waiting periods were removed; the waiting list sequence lists only active periods.
- Overlapping waiting periods at the same center were collapsed.
Transplant SAF

To obtain additional data regarding transplant events, users need the Transplant SAF, which contains detailed information, in separate files, from CMS and UNOS. The Transplant file (TX) on the Core SAF contains reconciled transplant event data from all available sources; as some researchers may find it beneficial to see the transplant data obtained from each source, data from each source are included.

Two transplant files contain data collected by CMS and UNOS on transplant follow-up visits. The follow-up records in TXFUHCFA and TXFUUNOS overlap in time, especially 1988 to 1993, and contain information collected during patient follow-up visits, which typically occur at 6 months, 1 year, and yearly thereafter. Before 2003, UNOS used 1 file to store kidney and kidney/pancreas recipient registration worksheet data and 1 file to store kidney and kidney/pancreas recipient follow-up worksheet data. Starting in 2003, UNOS separated these 2 recipient data groups. However, UNOS did not move the legacy kidney/pancreas recipient data into the respective new files. Users who need kidney/pancreas recipient longitudinal data should use TRR_ID and merge records from TXFUUNOS_KP with TXUNOS_KI and TXFUUNOS_KI to obtain all legacy kidney/pancreas records.

The TXIRUNOS and TXIFUNOS files contain information on immunosuppression treatment. Data in these files are from the Immunosuppression Treatment (TXIRUNOS) and Immunosuppression Treatment Follow-up (TXIFUNOS) forms. TXIRUNOS contains data on treatments at the time of transplant, and TXIFUNOS contains data on treatments updated at each follow-up visit if available.

Each file on the Transplant CD should be considered a separate analytical file. Attempting to combine information from various files involves reconciling information across files.

Starting in 2003, UNOS began to use the bitmask technique to maintain multiple values (i.e. selections/choices) within 1 variable. This method applies to all multiple selection questions. Previously, UNOS used as many variables as needed to collect all possible answers for such questions. For example, for the question “Treatment: Other therapies,” UNOS used 3 variables, "PHOTOPH," "PLASMA," and "LYMPHOID" with answer "Yes/No." After 2003, UNOS combined these variables into a single variable, "THERAPIES," for the same question, using bitmask technique. The basic code values are value 1 = Photopheresis, value 2 = Plasmapheresis, value 4 = Total Lymphoid Irradiation (TLI). Value 3 represents the sum of values 1 and 2; similarly value 5 implies that 1 and 4 are selected. To assist researchers in decrypting these multiple-selection/value variables, USRDS has identified all possible additive combinations of these bitmask-value variables and made them available as formats for researcher convenience.

Appendix F, Data Forms, lists the CMS and UNOS data collection forms, which are available at www.usrds.org. As a cross reference between the data file and the form, the SAS variable labels (shown in Appendix D, Data File Descriptions) indicate, whenever possible, the question number from the form. The label PM7694, for example, indicates that the variable can be found on the PMMIS from 1976 to 1994. If the question number on the form did not change over time, this number is also indicated in the label. PM819421b indicates question 21b on the PMMIS form collected between 1981 and 1994. Variables from the UNOS follow-up forms are labeled using section A-M, letters assigned by the CC because the form does not include question numbers. Table 5.3 gives details regarding these labels.
Most descriptive data on transplant events can be found in the Core SAF’s Tx Transplant file, which can be used to construct counts of various transplant-related events. Transplant rates can be constructed by combining transplant data with a patient treatment history file, RXHIST or RXHIST60; rates in the ADR are typically calculated using RXHIST60, the treatment history file with the 60-day rule built in. Transplant survival, both graft and patient, can be calculated using the transplant failure date found in the Transplant file and the date of death found in the PATIENT file.

**Section 6: Morbidity and Hospitalization**

Morbidity associated with ESRD can be determined from information on hospitalizations and acute events, documented in Medicare claims files through ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) and CPT (Current Procedural Terminology) codes. The USRDS provides data on inpatient admissions, discharges, and diagnosis and procedure codes, which may be used to produce different types of hospitalization rates, such as first hospitalization, total admission, and hospital day rates.

**Data Sources**

Inpatient hospitalization data, a subset of the data in the Institutional Claims file, are included in the HOSP data file. These data originate from the Part A institutional inpatient claims data and are supplemented by the REBUS inpatient data, as hospitalizations may appear in both sources or in one but not the other. The patient treatment history file (RXHIST or RXHIST60) provides the patient modality treatment history, which may be used to construct hospitalization rate data, while demographic data are obtained from the PATIENTS file.

**Contents of the Hospital File**

A complete list of variables in the HOSP file can be found in Appendix D of the Data File Descriptions. The following list outlines some of the key variables:

- HCFA SAF: indicates the data source of the claim.
- CLM_FROM: provides the from date of service, indicating the admission date.
- CLM_THRU: provides the through date of service, indicating the date of discharge.
- HSDIAG1-HSDIAG10: provide up to 10 ICD-9-CM diagnosis codes.
- HSSURG1-HSSURG10: provide up to 10 ICD-9-CM procedure codes.

<table>
<thead>
<tr>
<th>File</th>
<th>Variable Label Prefix</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>TXHCF6A</td>
<td>TXPM7681</td>
<td>From CMS form, 1976-1981</td>
</tr>
<tr>
<td>TXPM8194</td>
<td>From CMS form, 1981-1994</td>
<td></td>
</tr>
<tr>
<td>TXPM7694</td>
<td>Appears on all CMS forms, 1976-1994</td>
<td></td>
</tr>
<tr>
<td>TXPM819421b</td>
<td>CMS form, 1981-1994, question 21b</td>
<td></td>
</tr>
<tr>
<td>TXUNOS</td>
<td>TCR</td>
<td>Transplant Candidate Registration form</td>
</tr>
<tr>
<td>CDR</td>
<td>Cadaveric Donor Registration form</td>
<td></td>
</tr>
<tr>
<td>LDR</td>
<td>Living Donor Registration form</td>
<td></td>
</tr>
<tr>
<td>DH</td>
<td>Donor Histocompatibility form</td>
<td></td>
</tr>
<tr>
<td>RH</td>
<td>Recipient Histocompatibility form</td>
<td></td>
</tr>
<tr>
<td>KIR</td>
<td>Kidney Transplant Recipient Registration form</td>
<td></td>
</tr>
<tr>
<td>TCR55</td>
<td>Transplant Candidate Registration form, question 55</td>
<td></td>
</tr>
<tr>
<td>TXFUHCFA</td>
<td>TFU</td>
<td>From CMS form before 1994</td>
</tr>
<tr>
<td>TXFUUNOS</td>
<td>UNOS A-M</td>
<td>UNOS form, sections A-M indicated by the USRDS CC</td>
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</table>
• **DRG_CD**: provides diagnostic-related group (DRG) codes, which categorize inpatient stays by ICD-9-CM diagnosis and procedure codes.
• **PRIMDIAG**: equals “YES” when HSDIAG1 provides the principal diagnosis code.

**Preparing Inpatient Claims Data for Use**

Preparing data for analyses requires that they be cleaned, with overlapping hospitalizations for the same patient combined. The principal diagnosis and procedure codes from the first of 2 overlapping hospitalizations should be retained, with the combined hospitalization extending from the first admission date to the last discharge date.

To create a dataset to calculate rates for period prevalent patient cohorts, attach data for hospitalizations occurring during the selected year by patient UID to a period prevalent cohort file for the year. In this way, all patients in the file, including those with multiple hospitalizations and those with none, are included in the rate calculation. Use data in which the 90-day rule defines patient start dates. The 90-day rule defines each patient start date as day 91 of ESRD. This avoids incomplete hospitalization data from center hemodialysis patients aged younger than 65 years and not disabled, who cannot bill Medicare until 90 days after first ESRD service date. To calculate rates by patient characteristics, demographic data may be attached to the dataset by patient UID from the PATIENTS file.

Because hospitalization data are incomplete for non-Medicare patients and for patients classified as Medicare secondary payer (MSP), these patients should be excluded, thereby limiting their contribution to patient-years at risk. One method of MSP patient exclusion used in the ADR hospitalization rate calculation involves excluding dialysis patients who do not reach a certain level of Medicare paid dialysis bills. Dialysis patient start dates (January 1 of the year for prevalent patients and day 91 of ESRD for incident patients) must fall between start and end dates based on Medicare paid dialysis claims as follows:

• Claims start date: the first day of the first month in which there is at least $675 of Medicare paid dialysis claims.
• Claims end date: the end of a three-month period in which there is less than $675 of paid claims in each month.

If a patient's start date does not fall between the claims start and end dates, that patient is excluded from the analysis for that year.

**Hospitalization Rates**

When we refer the hospitalization rate of a cohort, we usually mean the underlying hospitalization rate, which is not observable. But hospitalization rates can be estimated by observed rates or model-based rates. The calculation of the observed hospitalization rate is straightforward. It is the number of hospitalization admissions observed divided by the follow-up time. For the ESRD population or large groups, the observed hospitalization rate works well for estimating the underlying hospitalization rate. But for small groups, the observed hospitalization may not be a good estimator. It may be unstable. Model-based rate may be more appropriate.

Statistical modeling is used to produce stabilized rates for small groups. Current USRDS methodology for computing total admission and hospital day rates uses a generalized linear model with log link and Poisson distribution, details for model-based event rate calculations can be found in Appendix C, Statistical Methods.

Notice that the calculation of follow-up time may be affected by which patient group you are looking at. For example, when you calculate the hospitalization rate for the January 1 point prevalent dialysis patients in 2010, you will follow patients from January 1, 2010 to the earliest date of death, 3 days before kidney transplant, loss-to-follow-up, or December 31, 2010. If calculating hospitalization rates for hemodialysis patients, you also stop follow-up when patients are changed to PD. Also, the days that a patient was in-hospital should be excluded from the follow-up time of that patient because he or she was not at risk for another...
hospitalization in those days. When a patient is discharged from one hospital to another, we usually consider that as one hospitalization.

When hospitalization was used as an outcome, length of stay, or number of hospital days is also used as a measurement. Number of hospital days per patient year can be calculated the same way as the hospitalization rate. But, for hospital days per patient year calculation, the days that patient was in-hospital is counted for the follow-up time.

**Unadjusted vs. Stabilized Hospitalization Rates**

Hospitalization rates may be computed as raw unadjusted rates or as model-based rates. Calculation of raw rates is fairly straightforward, but caution is needed when interpreting raw rates because they may be unstable for small patient groups. In the case of unstable raw rates, a pooled rate (comprising data from several combined years) or a model-based rate may be more appropriate.

Statistical modeling is used to produce stabilized rates, preventing instability of raw rates in groups with small sample sizes and few patient years at risk. Current USRDS methodology for computing total admission and hospital day rates uses a generalized linear model with log link and Poisson distribution. Calculation of raw rates is described below, and methods of calculating raw and model-based rates are described in further detail in Appendix C, Statistical Methods.

**Computation of Unadjusted Rates per Patient-Year**

Unadjusted first admission, total admission, and hospital day rates can be computed for period prevalent patients for selected years. For each year, the unadjusted rates can be calculated as total events divided by total time at risk. These rates can also be pooled to increase stability, but follow-up is for single calendar year periods using cohorts of patients alive at the beginning of each year. The number of events and the number of years at risk for each event are computed separately for each year and summed over the pooled years; rates are then computed by dividing the total admissions or days by the total time at risk. Rates may be expressed per patient-year or per 1000 patient-years at risk.

For patients in the all-dialysis, hemodialysis, and peritoneal dialysis categories, the period at risk for all hospitalization analyses is from January 1 or day 91 of ESRD until the earliest of death, 3 days before transplant, or December 31. The only modality change considered a censoring event is from dialysis to transplant. For dialysis patients in the all-ESRD category, in contrast, the analysis period for hospitalization is censored only at death or December 31; modality change is not a censoring event. For transplant patients in the all-ESRD and transplant categories, the analysis period is censored at the earliest of death, 3 years after the transplant date, or December 31. Censoring transplant patients at 3 years after the date of transplant is necessary because Medicare eligibility may cease and hospitalization data may be incomplete.

If a hospitalization begins before January 1 or day 91 of ESRD and continues into the analysis year, the time at risk for first admission begins the day of discharge from this bridge hospitalization. Patients with bridge hospitalizations that span the entire analysis period are excluded from the first admission rates.

Time at risk is calculated differently for length of stay and for total admissions. Because hospitalized patients remain at risk for additional hospital days, rates for hospital days include hospital days in the time at risk. But because currently hospitalized patients are not at risk for additional admissions, hospital days for each year are subtracted from the time at risk for total admissions. For hospitalizations in which admission occurs the same day as discharge, zero days are subtracted from the time at risk for total admissions. When bridge hospitalizations span the start of the analysis period, only the days within the period are subtracted from the time at risk for total admissions.

All admissions and hospital days that occur during the analysis period are included, respectively, in the total admissions and length of stay for each year. Admission for a hospitalization that occurs before and spans the start of the analysis period is excluded from the total admissions for that analysis period, and only the hospitalization days within the period are counted in the total days for length of stay rates. The minimum
length of stay is 1 day; hospitalizations with admission and discharge on the same day or with discharge the day after admission are counted as 1 day.

**Cause-specific Unadjusted Rates per Patient-Year**

Cause-specific hospitalization rates may be computed by counting only hospitalizations with selected principal ICD-9-CM diagnosis codes. In the denominator of the rate, computation of time at risk is similar to computation described above for total admission rates. However, in the numerator, only hospitalizations with specified principal diagnosis codes are counted in total cause-specific admissions. For example, principal ICD-9-CM diagnosis codes of 480-486 and 487.0 can be used for pneumonia.

**Unadjusted Rates per Patient**

Rates of hospital days and total admissions may also be calculated per patient. For a selected year, the numerator remains the total number of events, and the denominator is the total number of period prevalent patients for the year. Rates per patient are susceptible to bias because they do not consider the actual length of time that a patient is at risk during the year. For example, a greater number of patients at risk for only a fraction of the year may produce smaller rates.

**Section 7: Survival and Mortality**

Survival and mortality analyses are often used to compare outcomes among treatment modalities, age groups, or races, or to evaluate outcome trends over time. Results can be reported for both incident and prevalent cohorts for the following groups: all-ESRD patients, all dialysis patients, all hemodialysis patients, all peritoneal dialysis patients, all transplant patients, or all ESRD patients aged 65 years and over, etc. Primary analyses include unadjusted survival probabilities using the Kaplan-Meier method, adjusted survival probabilities using the Cox regression model, unadjusted death rates, and adjusted death rates, etc.

**Data Sources**

These survival and mortality analyses require patient demographic information such as age, gender, race, primary cause of ESRD, death date, and cause of death, and treatment modality history data, which can be obtained from the USRDS Core CD files PATIENTS and RXHIST or RXHIST60.

**Unadjusted First-year Survival Probabilities: Incident Patients**

First-year survival probability was estimated from the Kaplan-Meier method. Patients were followed from the date of ESRD onset to the earliest date of death, lost-to-follow-up, or 1 year. For dialysis patients, we also stop follow-up at transplant date, and also stop at modality change date for PD and HD patients. Same as hospitalization rates, the first-year survival probability from Kaplan-Meier may not be stable when the group is small. A Cox proportional hazard regression model might be used for subgroup first-year survival probability estimation. At times, the first-year survival probability was also calculated for those who survived the first 90 days after onset of ESRD. For this first-year survival calculation, patients were followed from day 91 to the earliest date of death, lost-to-follow-up, or 1 year plus 90 days. This is usually done for Medicare patients.

**Adjusted First-year Survival Probabilities: Incident Patients**

The adjusted first-year survival probability can be estimated for a specific cohort with a reference population based on a Cox proportional regression model with only variables adjusting for the model. The Cox model was fit for the specific cohort and the estimates of the baseline survival and coefficients were applied to the preference population to calculate expected first-year survival probability for each patient in the reference population. The average of the expected first-year survival probability over the reference population would be the estimate of the adjusted first-year survival probability.

**Adjusted First-year Death Rates: Incident Hemodialysis Cohorts**

Adjusted first-year death rates for incident cohorts can be estimated using a Cox model. These death rates are presented using aggregate categories for age, gender, race, and primary cause of ESRD (diabetes,
hypertension, glomerulonephritis, and other). A death rate estimated for one of these variables is adjusted for the remaining three; overall death rates for all patients are adjusted for each of the four variables. The method for calculating these death rates is also described in Appendix C, Statistical Methods.

Unadjusted Death Rates: Period Prevalent Cohorts
Period prevalent cohorts include patients who are prevalent at the beginning of the period and those who become incident during the time period (e.g., 2010). For the 2010 period prevalent dialysis patients, follow-up starts on January 1, 2010, for prevalent patients and day 1 of dialysis for incident dialysis patients, and stops at transplant, death, or December 31. The observed death rate was calculated by dividing the number of deaths by total of follow-up time. For subgroup death rate calculation, a Poisson model might be used.

Adjusted Death Rates: Period Prevalent Cohorts
The adjusted death rate for a period prevalent cohort was calculated similarly to the adjusted first year survival probability, with the exception of the Poisson model and the follow-up time of patients in the reference groups.

Section 8: Providers
The Facility SAF file is constructed from data supplied by the CMS Annual Facility Survey, the CDC National Surveillance of Dialysis-Associated Diseases, and the CMS Dialysis Facility Compare database. Information is for dialysis facilities only and data are at the facility level; there are no individual patient-level data.

Construction of the Facility SAF is accomplished by merging the CMS Annual Survey data with the CMS Dialysis Facility Compare database by provider number and year. All provider numbers in the Facility SAF file are assigned by the USRDS in an effort to ensure dialysis facility confidentiality; they are not the original provider numbers assigned by CMS.

Over time, dialysis facilities may be purchased and sold. Thus, a facility may have the same provider number for several years, then be purchased by a different owner and receive a new provider number. The physical facility and location may be the same, and most staff may remain, but the provider number has changed. Linking the 2 numbers is not possible.

Researchers who wish to conduct patient-level studies incorporating the Facility SAF can link patient information from the Detailed Treatment History SAF (RXHIST), the Condensed Treatment History SAF (RXHIST60), or other SAFs with associated dialysis providers, to the Facility SAF via the USRDS provider number and year.

The Facility SAF file contains over 100 provider characteristics, including:
- Transplant counts
- Self-dialysis information
- HD, IPD, CAPD, and CCPD patient counts
- Number of in-center new dialysis patients at a facility
- Profit status, and hospital-based or freestanding status
- Chain affiliation
- Reuse practices

Data Sources
The CMS Annual Facility Survey is obtained as part of the CROWN data that the USRDS receives. CMS Dialysis Facility Compare data are sent quarterly from CMS. The CDC National Surveillance of Dialysis-Associated Diseases survey was requested from the CDC annually through 2002. A list of the CMS and CDC Surveys can be found in Appendix F, Data Forms. The forms are available at www.usrds.org. As the last CDC National Surveillance survey occurred in 2002, all data for CDC variables are missing after this date.
Provider Numbers Assigned by the USRDS
Each provider has been assigned an identification number by CMS. To conceal provider identity, the USRDS converts this number to an anonymous number.

Profit Status
The profit variable, NU_P_NP, has the values 'For-profit', 'Non-profit', and 'Unknown' (case sensitive).

The for-profit group consists of the facilities categorized on the CMS survey. They include individual-profit, partnership-profit, corporation-profit, or other-profit. Non-profit facilities are listed as individual-non-profit, partnership-nonprofit, corporate-nonprofit, state-government non-federal, county-government non-federal, city government non-federal, city/county-government non-federal, hospital district/authority government non-federal, other-government non-federal, Veterans Administration Government Federal, Public Health Service Government Federal, military-government federal, or other-government federal. These 18 categories are designated by the variable TYPOWNER. The 2002 CMS Survey (2004 ADR SAF) dropped this variable and it is missing in subsequent survey periods. Profit status is now determined solely from CMS Dialysis Facility Compare data.

Chain Affiliation
Originally, the USRDS definition of a chain was 20 or more facilities in 2 or more states owned by the same corporation. The number of chains can vary from year to year depending on changes of facility ownership and the opening of new facilities. Because of the many changes occurring with regard to facility ownership, the original chain definition was modified. Starting with the 2005 facility survey, chains were further classified into Large Dialysis Organizations (LDO) and Small Dialysis Organizations (SDO). SDOs are defined as those dialysis organizations that operate at least 20 but not more than 199 facilities. LDOs are those organizations with 200 or more facilities. The chain variable, CHAIN_ID, contains a text string identifying the chain ownership of the facility. A blank value for CHAIN_ID indicates that the facility has no chain affiliation. The grouping variable, NU_TYPE, combines all of the small Small Dialysis Organizations into a single group labeled SDO. LDOs are not grouped. Facilities with no chain affiliation are divided into Hospital-based facilities and Independent facilities.

Freestanding vs. Hospital-based Facility
A hospital-based dialysis facility is associated with a hospital; it can be located in the hospital or at a remote location. Freestanding dialysis facilities operate independently of a hospital.

A study analyzing freestanding vs. hospital-based units will include 3 groups: freestanding, hospital-based, and unknown. The variable NU_HBFS designates this status. The number 1 represents hospital-based and 2 represents free-standing. The unknown category will consist of any provider in the researcher’s study not found in the Facility database.

Section 9: CKD Cohort (5% CKD Cohort Finder Files)
Due to growing CKD concern that affects ESRD patients, the USRDS has constructed a set of CKD cohort finder files to help researchers gain a better understanding of causes and effects of this illness and their associations to morbidity and mortality in patients with ESRD.

Data Sources
To create the CKD cohort finder files by year, the CC uses 5% General Medicare Claims data (1992-2010) and patient demographic information.

The CKD finder file data set contains three basic data components, Patient Master File, Payer Sequence File, and a series of Co-Morbid Files. To illustrate the methodology used to ascertain patients with the CKD and the underlying data structure and file organization, below is a description of how the CKD Cohort Finder File data set was created using the 5% General Medicare Claims data.
**Patient Master File**

For patients in this file, at least 1 CKD ICD-9 diagnosis code (Table 9.1) was identified in the 5% IP, OP, HH, HS, SNF, and PB SAFs, with 1 record per patient. Definitions of the two key variables CKD_xx (1-year entry period CKD indicator) and CKD_xxyy (2-year entry period CKD indicator) are defined below.

\[
\text{CKD_xx} = \begin{cases} 
Y & \text{if a patient in year } xx \text{ (e.g., CKD_95 or CKD_02):} \\
N & \text{otherwise}
\end{cases}
\]

- was Part A and Part B entitled and not enrolled in an HMO for the entire year (i.e., Payer_Seq_File)
- had any one CKD ICD-9 diagnosis code from IP or HH or SNF, or any two CKD ICD-9 diagnosis code combinations from PB or OP with different claim dates

\[
\text{CKD_xx} = N \text{ otherwise}
\]

\[
\text{CKD_xxyy} = \begin{cases} 
Y & \text{if a patient in a two-year entry period (e.g., CKD_9596, CKD_9900, or CKD_0102):} \\
N & \text{otherwise}
\end{cases}
\]

- was Part A and Part B entitled and not enrolled in an HMO for the entire two-year entry period (i.e., Payer_Seq_File)
- was alive and did not develop ESRD as of December 31 of the two-year entry period
- had any one CKD ICD-9 diagnosis code from IP or HH or SNF, or any two CKD ICD-9 diagnosis code combinations from PB or OP with different claim dates identified at any time during the two year entry period (either in one of the two years or across the two years)

\[
\text{CKD_xxyy} = N \text{ otherwise}
\]

Patients with CKD_95 = Y are a subset of patients in the 1995 Co-Morbid file (Co_Morbid_95) in the 'Co-Morbid Files' data set; patients with CKD_9900 = Y are a subset of the patients from the 1999 and 2000 comorbid files (Co_Morbid_99 and Co_Morbid_00) in the 'Co-Morbid Files' data set respectively.

Some patients in the Patient Master File may have all CKD_xx = N and all CKD_xxyy = N. This implies that these patients had at least 1 CKD ICD-9 diagnosis code identified in the 1992 to 2010 5% IP, OP, HH, HS, SNF, and PB SAFs but did not meet the 1-year entry period and 2-year entry period CKD eligibility criteria described above.

Each patient is identified by 2 patient identification numbers. One is FIVEP_ID, a unique patient ID in the 5% sample population and the primary linking key within the USRDS CKD Cohort Finder data set. Each year, new FIVEP_ID numbers are generated only for new patients added to the 5% sample. All existing patients (repeated patients) are referenced with their previously assigned numbers. A second patient identification number, USRDS_ID, is the unique ID in the USRDS database system for identifying ESRD patients. Only patients with ESRD are assigned a valid USRDS_ID number. FIVEP_ID and USRDS_ID are not related.

**Payer Sequence File**

This file was created from the 5% Medicare denominator files and the IP, OP, HH, HS, SNF and PB SAFs. It contains Medicare coverage information for 5% patients with at least 1 CKD ICD-9 diagnosis code identified through the 5% IP, OP, HH, HS, SNF, and PB SAFS. A patient might have one or many sequence records in which each record indicates different insurance coverage within a well-defined time period. There are five unique insurance types:

- A - Entitled with Part A only
- B - Entitled with Part B only
- AB - Entitled with Part A and Part B
- H - Enrolled in a Medicare HMO health plan
- N - Non-Medicare

The first record contains the earliest available date for coverage information in the 5% Medicare denominator files. The last record contains the last known available date (i.e., the most recent) for coverage information in the 5% Medicare denominator files. FIVEP_ID is the primary patient identification number.

Co-Morbid Files
The Co-Morbid files are constructed from the 5% Medicare IP, OP, HH, HS, SNF, and PB SAFs and named individually by the respective calendar years. Each file contains all patients whose CKD diagnosis was identified from the 5% Medicare IP, OP, HH, HS, SNF, and PB SAFs within that year (i.e., Co_Morbid_95 contains all patients whose CKD disease events were identified from the 1995 5% Medicare Claims SAFs). However, patients were not necessarily required to be entitled to Parts A and B and not enrolled in an HMO for that entire year. A patient might have one or many records within a calendar year in which each record depicts one unique CKD disease event. Records are considered duplicates if they are extracted from the same type of claim file with the same ICD-9 diagnosis code on the same date. These files do not include duplications. For example, each record in Co-Morbid_95 consists of 1 CKD code per claim file per service date per unique patient in 1995. The combination of claim type, CKD code, and service date for a patient establishes uniqueness in each Co-Morbid file. FIVEP_ID is the primary patient identification number.

CKD ICD-9 Diagnosis Codes
016.0, 095.4, 189.0, 189.9, 223.0, 236.91, 250.4, 271.4, 274.1, 283.11, 403.x0, 403.x1, 404.x0, 404.x1, 404.x2, 404.x3, 440.1, 442.1, 447.3, 572.4, 580-588, 591, 642.1, 646.2, 753.12-753.17, 753.19, 753.2, 794.4

Section 10: Comprehensive Dialysis Study SAF Files
The Comprehensive Dialysis Study (CDS) collected data on patient demographics, contact information, treatment, laboratory values, quality of life (QOL) survey interviews, and nutrition survey interviews for US dialysis patients who started treatment 2005-2007 at 335 randomly selected dialysis facilities. Patients were selected via a monthly remis/sims database custom extract process using the following criteria:
- Incident dialysis patients (age ≥ 18) who had survived for at least two months,
- No prior transplant,
- Dialyzed at one of the pre-determine 335 facilities

Over a period of 2 years, 11,292 patients were selected. Of these, 1,677 consented and participated in the surveys or lab assays. The CDS SAF files contain the data for these patients. Of the 1,677 patients, 1,279 participated only in the QOL survey; 364 participated in the QOL and nutrition surveys (231 with and 133 without lab data); 34 did not participate in either survey but provided lab data.

SAF files for the CDS dataset consist of:
- CDS Patient file. Contains 1 record for each of the 1,677 patients. A patient record includes a unique identifier USRDS_ID (unique identifier used to cross reference to other USRDS SAF files), demographic data, and a patient category indicator (PAT_CAT_BL), which indicates baseline survey and lab participation status (QOL-only, QOL and nutrition w/lab data, QOL and nutrition w/o lab data, Lab data w/o survey).
- CDS QOL Baseline file. This file contains the Baseline QOL survey answer data and some derivative score data from QOL only and QOL/Nutrition participants.
- CDS Food Baseline file. This file contains the Baseline Nutrition survey answer data and data generated by “Block Dietary Data System” on QOL/Nutrition participants.
- CDS Lab file. This file contains up to 5 sets of lab data from a subset of QOL/Nutrition participants.
- CDS Dictionary. This file contains each CDS SAF file contents, variable’s format.
Section 11: Medicare Prescription Drug

Section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 amended Title XVIII of the Social Security Act by establishing the Voluntary Prescription Drug Benefit Program (Part D). Effective January 1, 2006, Part D is an optional prescription drug benefit for individuals who are entitled to Medicare benefits under Part A or enrolled in Medicare benefits under Part B. The data from the first few months of 2006, while the benefit was very new, may not be complete, and should be interpreted with caution.

Data Sources

The Part D data is obtained from CMS annually with USRDS provided Finder Files. The Part D data is divided into two separate files: an annual enrollment file containing monthly indicators of enrollment in Part D, and a prescription drug event file (PDE) containing details of prescriptions filled by Part D beneficiaries.

PART D ENROLLMENT SAF

Since the Part D benefit is voluntary, not all Medicare beneficiaries are enrolled in Part D. The annual enrollment file contains 12 monthly indicators that detail whether the beneficiary is enrolled in Part D, and if so, what type of plan the beneficiary is enrolled in. There are also monthly indicators for dual eligibility (Medicare and Medicaid), monthly indicators for Retiree Drug Subsidy, and low income subsidy (LIS). The variables included in the annual enrollment file are shown in table 11.1.

The variables PTD_CNTRCTID_01-PTD_CNTRCTID_12 indicate Part D enrollment as follows:

- H = Managed care organizations other than Regional Preferred Provider Organization
- R = Regional Preferred Provider Organization
- S = Stand-alone Prescription Drug Plan (PDP)
- E = Employer sponsored
- O = Not Medicare enrolled
- X = Medicare enrolled, but no Part D enrollment record
- N = Not Part D enrolled

Values of H, R, S, and E for these variables are generally considered to indicate Part D enrollment.

Low income subsidy status can be determined from the variables CST_SHR_GRP_CD_01-CST_SHR_GRP_CD_12.

If beneficiary is Medicare enrolled and Part D enrolled:

- 01 = 100% premium subsidy and no copayment
- 02 = 100% premium subsidy and low copayment
- 03 = 100% premium subsidy and high copayment
- 04 = LIS, 100% premium-subsidy and high copayment
- 05 = LIS, 100% premium-subsidy and 15% copayment
- 06 = LIS, 75% premium-subsidy and 15% copayment
- 07 = LIS, 50% premium-subsidy and 15% copayment
- 08 = LIS, 25% premium-subsidy and 15% copayment
- 09 = No premium subsidy or cost sharing

If beneficiary is Medicare enrolled and not Part D enrolled:

- 10 = Not enrolled in Part D, but employer is entitled for RDS subsidy
### 11.1 Variables in the Part D Enrollment SAF (continued)

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### Variables in the Part D Event SAF

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</table>
• 11 = Creditable coverage but no RDS
• 12 = Not Part D enrolled, no creditable coverage, no RDS
• 13 = None of the above conditions have been met

PRESCRIPTION DRUG EVENT SAF
This SAF contains details on prescription drug utilization, including brand name, generic name, dosage form, drug strength, quantity dispensed, date of service, and total prescription cost. The variables in this SAF are listed in Table 11.2. More detailed information on the Part D benefit can be found at http://www.cms.gov/PrescriptionDrugCovGenIn/.

11.1 Variables in the Part D Enrollment SAF

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Appendix A: Products & Services

Products and services provided by the USRDS to support the work of the renal community are detailed in table A.1. The entire ADR is available at www.usrds.org, with PowerPoint slides of all figures and Excel files of the data behind the graphs; included as well are PDF files of the researcher's guide. The site's rendering system allows users to create customized data tables and regional maps. Data on website use are presented in figure A.1.

Data Requests
Making information on ESRD available to the renal community is a primary objective of the USRDS, and we are committed to the timely fulfillment of data requests. In many cases requests can be answered through data published in the ADR or elsewhere. Requests for data not available in material published by the USRDS, but that require two hours or less of staff time, are fulfilled by the Coordinating Center without charge, usually within one week. More complex requests — requiring more than two hours of staff time — as well as requests for Standard Analysis Files and custom files, must be accompanied by a written proposal (see details below), and will be completed only upon written approval by the NIDDK Project Officer.

Research Files
The Coordinating Center maintains a set of Standard Analysis Files (SAFs) to meet diverse research needs and provide easy access to data used in the ADR. The SAFs were introduced in 1994, as the NIDDK began awarding new grants focusing on research using the USRDS data. The result has been an annual increase in the number of files provided by the USRDS.

Prior to 1994, all researcher files were created for specific projects. Since the introduction of the SAFs, however, custom files are generally limited to cases in which a researcher provides a patient finder file to be matched with the USRDS database. For more information on merged data requests, please contact the Coordinating Center at usrds@usrds.org.

The Core SAF dataset contains basic patient data, and is needed to use any of the other SAFs. Included are each patient's demographic information, payer and treatment history, limited transplant data, provider data, and data from many of the USRDS Special Studies. Approximately half of the researchers using the USRDS SAFs need only this data set. The Transplant data set contains detailed transplant and transplant follow-up data collected by CMS and UNOS. Data on hospital inpatient stays are found on the Hospital data set. All Medicare billing data are available by individual year (see Table A.3).
Standard Analysis Files
SAF use is governed by the USRDS policy on data release for investigator-initiated research, found later in these appendices. Research proposals must be approved by a USRDS Project Officer, and researchers must sign the USRDS “Agreement for Release of Data,” on the same page. File prices are listed in Table A.3.

Most SAFs provide patient-specific data. All patient identifiers are removed or encrypted, but data confidentiality remains a serious concern. The USRDS “Agreement for Release of Data” describes restrictions on SAF use and disposition. SAFs include an encrypted ID number to allow patient data from multiple SAFs to be merged.

Core SAF Dataset
The Core SAFs contain the most frequently used data and are needed for use of the Transplant and Hospital datasets, or any data based on Medicare claims. Included files are as follows (also listed in Table B.1).

- **Patient** Contains one record per patient in the USRDS database, and gives basic demographic and ESRD-related data.
- **Residence** A longitudinal record, to ZIP code, of residence.
- **Payor History** Contains a new record for each patient at each change in insurance payor.
- **Treatment History/Modality Sequence** Contains a new record for each patient at each change in modality or dialysis provider.
- **Medical Evidence** Contains full data from the 1995 and 2005 versions of the CMS Medical Evidence form. In April 1995 a new version of the form went into use, with data on comorbidity, employment status, lab values at initiation, and Hispanic ethnicity.
- **Transplant** Contains basic data for all transplants (reported by CMS and UNOS), including the date of graft failure (detailed transplant data are contained on a separate transplant data set).
- **Transplant Wait List** Beginning with 2001 data (used in the 2002 ADR), this file has been updated to include basic patient demographic data and, from UNOS, all unique wait-list periods for each dialysis patient.
- **Facility** Conducted annually, the CMS End-Stage Renal Disease Facility Survey is the source of data for the Facility SAF. Geographic variables that could identify facilities are deleted. The survey period is January 1 through December 31.
- **Facility Cost Reports** CMS hospital and independent facility cost reports for 1989–1995 and 1989–1993, respectively, are available as SAFs. All geographic variables are deleted to ensure confidentiality. The files may be linked to the Facility SAF using the USRDS provider ID, though analyses at less than a regional or network level are not possible. Because these files are rarely used, additional data will be added only if there is sufficient demand.
- **Dialyzers** The Case Mix Severity, Case Mix Adequacy, and DMMS Special Studies collected information on patient dialyzers. SAFs for these studies describe the dialyzer through a code, which must be matched to information in the Dialyzer file to find the manufacturer and model along with characteristics such as membrane type and clearance. We believe that these data, from published sources available at the time of the study, accurately represent the dialyzer characteristics, but they should be used with caution.

Data from Special Studies
Topics for USRDS Special Studies are approved by the NIDDK, with recommendations from CMS, the Scientific Advisory Committee, the ESRD networks, and the Renal Community Council. Design and sampling plans are developed, samples are selected, and data collection forms and instructions are drafted, tested, and finalized. The main studies to date are summarized below, and are detailed in the Researcher’s Guide.

Dialysis Morbidity & Mortality Study (DMMS) The DMMS was a USRDS Special Study in which data on demographics, comorbidity, laboratory values, treatment, socioeconomic factors, and insurance were collected, using dialysis records, for a random sample of U.S. patients. Waves 1, 3, and 4 are historical prospective studies on a total of 16,812 participants in which data were collected for patients on in-center hemodialysis on December 31, 1993. Data were abstracted from medical records, and patients were followed to the earliest of data abstraction, death, transplant, change in modality, or transfer to another facility. Wave 2 is
a prospective study of incident hemodialysis and peritoneal dialysis patients for 1996 and early 1997 and included 4,024 participants. Case Mix Adequacy Study of Dialysis: The objectives of this USRDS Special Study were to establish the relationship between the dose of delivered dialysis therapy and mortality, determine the strength of this relationship when data are adjusted for comorbidity, assess how this relationship changes with dialysis dose, assess how this relationship is affected by dialyzer reuse, and examine the impact of different dialysis membranes on patient morbidity and mortality.

The study consisted of two groups: an incident sample of ESRD patients who began hemodialysis in 1990, and a prevalent sample of hemodialysis patients whose ESRD began prior to 1990. A total of 7,096 patients from 523 dialysis units were included, with approximately 3,300 patients having both the pre- and post-BUN values needed to calculate delivered dialysis dose. Ninety-four percent of these cases were matched to the USRDS database. The ESRD networks collected these data in conjunction with their Medical Case Review data abstraction.

Case Mix Severity Study For this USRDS Special Study, data were collected on 5,255 patients incident in 1986–87 at 328 dialysis units nationwide. Objectives were to estimate the correlation of comorbidity and other factors existing at the onset of ESRD to mortality and hospitalization rates, while adjusting for age, gender, race, and primary diagnosis; evaluate possible associations of these factors with reported causes of death; assess the distribution of comorbidity and other factors among patients on different modalities; and compare relative mortality rates by treatment modality, adjusting for comorbid conditions and other factors.

Pediatric Growth & Development The objectives of the USRDS Pediatric Growth and Development Study were to establish a baseline for assessing the relation of patient growth and sexual maturation to modality, and establish a prototype for the ongoing collection of pediatric data. All patients prevalent in 1990 and born after December 31, 1970, were included in the study, a total of 3,067 patients at 548 units.

CAPD & Peritonitis Study The USRDS CAPD and Peritonitis Study examined the relation of peritonitis episodes in CAPD patients to connection device technology and other factors. The study population included all patients newly starting CAPD in the first six months of 1989, a maximum of 14 patients per dialysis unit. All units providing CAPD training participated in the study. The sample contains data on 3,385 patients from 706 units.

Transplant SAF Dataset
Due to changes in data collection sources over the years, data related to transplants are now presented in eight separate SAFs. The first two are included on the Core SAF, and the remaining six are included in the Transplant data set.

TX includes minimum details on all transplants from all sources

- TXWAIT contains one record for each patient in the USRDS database per wait list event
- TXHCFA includes transplant information collected by CMS’s PMMIS system prior to 1994
- TXUNOS includes transplant information collected since 1987 by UNOS, currently the main source of transplant data for the USRDS
- TXIRUNOS includes information on immunosuppressive drugs collected by UNOS at the time of transplantation events
- TXFUHCFA includes transplant follow-up reports collected by CMS prior to 1994; reports are completed at discharge, six months, each year post-transplant, and at graft failure
- TXFUFUNOS includes transplant follow-up reports collected by UNOS since 1988
- TXIFUNOS includes information on immunosuppressive drugs, collected by UNOS at follow-up visits

Reference tables in Transplant Sections E and F are produced primarily from the CMS and UNOS transplant files.
In July of 1994, CMS and the Health Resources Services Administration (HRSA) consolidated transplant data into a single collection by UNOS under its HRSA contract. Expanded transplant data are shared among HRSA, CMS, and the NIH, and are thus available to the USRDS. This has resulted in the addition of data on a substantial number of non-Medicare transplant patients, including children.

CMS and UNOS transplant files overlap for 1988–1993, and some Medical Evidence (ME) forms and institutional claims records indicate transplants not included in either file. To resolve conflicts among the sources and create the transplant SAF, all UNOS transplants are first accepted into the file, with all pre-1988 CMS transplants accepted next. CMS transplants from 1988–1993 are then accepted if there is no transplant in the file for that patient within 30 days of the CMS transplant (it is common for dates between sources to differ by one day). Finally, transplants indicated on the ME form are accepted if no transplant is listed for the patient within 30 days of the Medical Evidence transplant date.

**Hospital SAF Dataset**
Hospitalization inpatient data are a subset of the data in the Institutional Claims file. No payment or cost variables are included on this dataset, which is for researchers who need data on hospital inpatient stays and on diagnoses and procedures for those stays, but who do not need payment data.

**Comprehensive Dialysis Study Dataset**
This dataset contains information from the Comprehensive Dialysis Study (CDS), a USRDS special data collection study to assess rehabilitation/quality of life and nutrition issues in incident dialysis patients. The study was conducted between 2005 and 2008. All 1,677 participants answered questions on physical activity level, health-related quality of life, and work/disability status during the first six months of after the initiation of ESRD therapy. In a subset of 400 participants, dietary intake and nutritional status were also assessed.

**Dialysis Morbidity & Mortality Claims Dataset**
This dataset contains Medicare claims for participants in the Dialysis Morbidity and Mortality Studies. Data are followed to the currently reported claims year.

**Case Mix Adequacy Claims Dataset**
This dataset contains Medicare claims for participants in the Case Mix Adequacy Special Study. Medicare payment data for these patients are followed to the currently reported claims year.

**Medicare Payment Data**
Medicare payment data on institutional claims are available for pre-1989 through 2007, while data on physician/supplier claims are available for 1991–2007. The 2008 claims will be available, along with other updated USRDS SAFs, by the end of 2010.

Institutional claims consist of all inpatient/outpatient claims (inpatient, outpatient, skilled nursing facility, home health agency, and hospice), including outpatient dialysis claims. Physician/supplier claims account for 80 percent of claims but only 20 percent of dollars. The structure and content of the two types of claims differ, as do the files derived from them. Institutional claims are provided in two types of files: the Institutional Claims file, indicating claim type, dollar amounts, DRG code, type of dialysis involved (if any), and dates of service; and the Institutional Claims Detail file, containing details such as diagnosis and procedure codes. Many analyses require only the Institutional Claims files. Physician/supplier claims are contained in one type of file with one record for each claim line-item. The file includes dollar amounts, dates of service, diagnosis and procedure codes, and type and place of service.

**Clinical Performance Measures Survey**
The Clinical Performance Measures (CPM) data is a CMS project developed to collect information on the quality of care provided to the dialysis population. The data originates from yearly surveys of approximately 10,000 dialysis patients completed by the primary care facilities, and was formerly known as the ESRD Core Indicators Project. This project results in a rich source of detailed information, useful in analyses of healthcare delivery in a sample of the dialysis population.
To further expand the value and use of the CPM data, we have linked patient data from the USRDS SAFs, enabling complete claims extraction from the SAFs for all identified patients. The resulting claims history has been combined with the CPM data to form a complete mini-set of the USRDS data products with supporting files. This enables researchers to add patient-level laboratory and dialysis prescription detail to a broad range of healthcare service event data over many years.

The USRDS Coordinating Center has made the CPM data available as SAFs. The dataset contains CPM data collected in surveys from 1994–2008. A listing of available files and the corresponding costs can be found in Table a.e, or you may contact the USRDS Coordinating Center for further information. For a detailed explanation of why there are no 2009 CPM form data available, please view the CPM 2010 Researcher’s Guide on the USRDS website.

**CKD 5 Percent General Medicare Payment Data**
The CKD cohort datasets are built from the 5 percent general Medicare Claims SAFs, and contain a patient master file, a payor sequence file, and a set of comorbidity files. We no longer produce datasets for diabetes and CHF based on the 5 percent Medicare claims.

Separately, a 5 percent general Medicare Hospital SAF (inpatient, outpatient, skilled nursing facility, home health, hospice, Part B, and durable medical equipment) for the CKD cohort is also available for 1992–2008; 2009 claims will be available by the end of 2011. Data are derived from the IP claims SAF files. No payment or cost variables are included, so these data are for researchers who need data on hospital inpatient stays and on diagnoses and procedures for those stays, but do not need payment data.

**Pre-ESRD Medicare claims**
The pre-ESRD claims (also known as the back-casted claims) are a collection of Medicare institutional and physician/supplier billing records incurred prior to the onset of ESRD. Included in these claims are any and all claims available from Medicare for incident patients during their incident year and the two prior calendar years.

The USRDS has made the pre-ESRD data available as SAFs. This dataset includes Medicare claims of ESRD patients from incident years 1995–2008 with 2009 data available by the end of 2010. The structure of the claims file is identical to the ESRD claims files and organized by calendar year. In addition, a pre-ESRD payor sequence is provided so researchers can determine Medicare enrollment for the periods prior to first ESRD service date. A listing of available files and the corresponding costs can be found in Table a.e.

**Part D Data**
Section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 amended Title XVIII of the Social Security Act by establishing the Voluntary Prescription Drug Benefit Program (Part D). Effective January 1, 2006, Part D is an optional prescription drug benefit for individuals who are entitled to Medicare benefits under Part A or enrolled in Medicare benefits under Part B. The data from the first few months of 2006, when the benefit was very new, may be incomplete, and should be interpreted with caution.

The Part D data is obtained from CMS annually, with finder files provided by the USRDS. The Part D data are divided into two separate files: an annual enrollment file containing monthly indicators of enrollment in Part D, and a prescription drug event file (PDE) containing details of prescriptions filled by Part D beneficiaries.

Since the Part D benefit is voluntary, not all Medicare beneficiaries are enrolled. The annual enrollment file contains 12 monthly indicators that detail whether the beneficiary is enrolled in Part D, and if so, the type of plan. There are also monthly indicators for dual eligibility (Medicare and Medicaid), the retiree drug Subsidy, and the low income subsidy (LIS).
Linkages to the USRDS Database
The USRDS does provide the service of linking population cohorts to the USRDS dataset to determine ESRD status and outcomes for epidemiological research. Please contact the USRDS Coordinating Center for more information on the application process and the costs for this service.

File Media & Formats
SAFs are provided on DVDs as SAS files, and can be used by SAS on any 486 or Pentium PC with a DVD reader. The SAS format is widely used, easily transported, and largely self-documenting. SAS is a commercially available data management and statistical analysis software system that runs on most computers, and is almost universally available on university computer systems. The SAFs take full advantage of the program's ability to incorporate detailed documentation into the file. Researchers needing another format or medium must arrange for the conversion.

Costs
File prices cover file reproduction, documentation, administrative costs, and costs of technical support. Prices are subject to change.

Documentation
The Researcher's Guide to the USRDS database provides most of the SAF documentation. It includes a codebook of variables and a chapter on using the SAFs in SAS. Copies of data collection forms used by CMS, UNOS, and the USRDS Special Studies as well as the entire guide may be downloaded from the USRDS website (PDF copy included on Core SAF).

Data Use Acknowledgement
Publications using USRDS data should include an acknowledgment and this notice: The data reported here have been supplied by the United States Renal Data System (USRDS). The interpretation and reporting of these data are the responsibility of the author(s) and in no way should be seen as an official policy or interpretation of the U.S. government.

Data Release Policy
Since the SAFs and custom data files contain confidential, patient-specific data, their release requires the approval process described here. Investigators may contact the USRDS Project Officer (PO) at the NIDDK to discuss requests before preparing a proposal. To request and use USRDS data files, investigators must provide the PO with a detailed description of the proposed investigation (see Table b.d). The summary must include goals, background data, an in-depth description of study design and methodology, and resources available for completing the project, and may be the description from a grant proposal or other application. The project must comply with the Privacy Act of 1974, and the summary should provide enough information to enable assessment of compliance. Guidelines for Privacy Act adherence are found in the “Agreement for Release of Data,” later in the appendices. With your completed research proposal, please include a signed agreement for release of information from each investigator and analyst who will use the data files.

Investigators must also indicate needed USRDS SAFs by name. If these files cannot meet requirements of the proposed research, investigators must specify precisely which data elements are needed, and budget for a substantially higher cost.

The investigator and the Coordinating Center (CC) will resolve any technical questions. The investigator will arrange payment with the CC, and payment must be received before the files will be released. Checks must be made payable to the Minneapolis Medical Research Foundation.

The NIH will review the project for technical merit and for conformity with the Privacy Act. The PO will notify the investigator(s) in writing of the outcome, and if the project is not approved will discuss reasons for the decision. The PO will send a copy of the approval letters to the CC. When payment for the files has been received by the CC, the CC will prepare the files and documentation and send them to the investigator.
Any reports or articles resulting from use of USRDS data must be submitted to the PO prior to submission for publication to assure adherence to the Privacy Act. The PO must respond within 30 days. If a report or article is determined not to adhere to the Act, it shall not be published until compliance is achieved. Assessment of compliance will not depend on the opinions and conclusions expressed by the investigators, nor will the PO’s approval indicate government endorsement of the investigator’s opinions and conclusions.

All publications using released data must contain the standard acknowledgement and disclaimer presented above. Investigators are requested to send copies of all final publications resulting from this research to both the PO and the CC.

Caveats
This policy establishes conditions and procedures for the release of data from the USRDS, and is intended to ensure that data are made available to investigators in the pursuit of legitimate biomedical, cost-effectiveness, or other economic research.

The USRDS will not release data that identify individual patients, providers, or facilities. Since it might be possible, however, to infer identity from SAF data, these data are considered confidential. The USRDS “Agreement for Release of Data” contains a number of general and specific restrictions on the use of USRDS data, and investigators are expected to abide by these restrictions. If individually identifiable data are needed, the request should be submitted directly to CMS. Use of these data to identify and/or contact patients, facilities, or providers is prohibited by USRDS policy and by the Privacy Act of 1974.

The USRDS CC will provide data in one DVD. Analytical services other than review of the proposal and preparation of the data file will not be provided under the USRDS contract, though CC personnel may participate in analyses funded by other sources.
A.1  USRDS Products & Services

Reports & guides
Annual Data Reports Available from the National Kidney and Urologic Disease Information Clearinghouse, 3 Information Way, Bethesda, MD 20892-3560; 301.654.4415, nkudic@info.niddk.nih.gov. ADR material is also published in the American Journal of Kidney Diseases.

Annual Data Report CD Contains the text and graphics of the ADR, data tables, PowerPoint slides, and the Researcher’s Guide.

Researcher’s Guide to the USRDS database Provides a detailed description of the USRDS database and of the USRDS Standard Analysis Files; the basic reference for researchers who use USRDS data files.

www.usrds.org Contains PDF files of the chapters, reference tables, and the Researcher’s Guide; PowerPoint slides of atlas figures and USRDS conference presentations; Excel files of the data tables; notices regarding current news and analyses; links to related Internet sites; and email addresses for contacting the USRDS.

RenDER The USRDS Renal Data Extraction and Referencing (RenDER) System is a querying application that allows users to create data tables and interactive maps. It can be accessed at www.usrds.org/odr/render_home.asp following a short registration; a tutorial is also available on this site to help new users.

Requests for data
Data requests: two-hour Questions and data requests that are not answered directly by the ADR can be addressed to the Coordinating Center; those that require less than two hours of staff time to fulfill will be processed without charge.

Data requests: more than two hours Questions and data requests that require over two hours of staff time must be submitted in writing and approved by the NIDDK Project Officer. Fulfillment of these requests is subject to staff availability, and costs are assessed on a case-by-case basis.

Standard Analysis Files SAFs provide patient-specific data from the USRDS to support ESRD research. A standard price list has been established for the files (Table A.3), and users must sign a Data Release Agreement with the NIDDK.

Merged data files Merged files can be created by the Coordinating Center for approved research projects. An hourly rate of $119.57 will be assessed for time spent on the request, and users must sign a data release agreement with the NIDDK. Contact the USRDS Coordinating Center for more information.

Publications & presentations
Most USRDS research studies result in published papers or presentations at national meetings. Figures from abstracts and presentations can be found on the website, while published abstracts and papers can be found in the relevant journals.

Contact information
USRDS Coordinating Center 914 South 8th Street, Suite 52.100 Minneapolis, MN 55404 612.347.7776 or 1.888.99USRDS Fax 612.347.5878 usrds@usrds.org

Data file contacts Shu-Cheng Chen, MS; schen@usrds.org Beth Forrest, BBA; bforrest@usrds.org

A.2  Contents of the USRDS Core Standard Analysis Files

Patient (PATIENTS) one record for each ESRD patient. This is the patient master file and it contains patient demographic information, ESRD first service date, cause of renal failure, and more. Most other files will need to be linked to this file using the encrypted patient ID.

Residence (RESIDENC) for each patient, one record for each period in a different residence. This file is suitable for geographic variation analyses.

Treatment History (RXHIST) one record for each period a patient is on one modality. This file is suitable for analyses pertaining to treatment modalities and patterns.

Payor History (PAYHIST) one record for each period a patient is covered by one payor; each patient can have many records. This file would be used in analyses with respect to the impact of insurance payors on clinical outcomes.

Medical Evidence (MEDEVID05) one record for each 2728 form filed (1995 version). ESRD first service date, initial treatment modality, comorbid conditions, patient status at start of ESRD.

Medical Evidence (MEDEVID05s) one record for each 2728 form filed (2005 version). ESRD first service date, initial treatment modality, comorbid conditions, patient status at start of ESRD, pre-ESRD care, and vascular access information.

Transplant (TX) one record for each transplant event; patients can have multiple events. This file would be used in transplant and transplant outcome analyses.

Transplant Waiting List (WAITLIST_KI, WAITLIST_KP) one or more records for each patient ever on list. This file would be used in analyses involving the comparison of transplanted patients to dialysis patients who are transplant candidates. Patient selection to wait list.

Transplant Waiting Sequence (WAITSEQ_KI, WAITSEQ_KP) one or more records for each patient ever on list. Comparison of transplanted patients to dialysis patients who are transplant candidates. Patient selection to wait list.

Dialysis Morbidity and Mortality Special Study (DMMS) Wave 1: 5,670 patients; Wave 2: 4,024 patients; Wave 3–4: 11,142 patients. Comorbid conditions, adequacy of dialysis, dialysis prescription and other treatment parameters, laboratory test values, nutrition, vascular access.

Case Mix Adequacy Special Study (ADEQUACY) 7,096 patients. Comorbid conditions, adequacy of dialysis, dialysis prescription and other treatment parameters, laboratory values.

Case Mix Severity Special Study (CASEMIXS) 3,355 patients. Comorbid conditions, adequacy of dialysis, dialysis prescription and other treatment parameters, laboratory values.

Pediatric Growth and Development Special Study (PEDGROW) 3,067 patients. Growth, development, and other issues relating to pediatric ESRD patients.

CAPD Peritonitis Special Study (CAPD) 3,185 patients. CAPD and peritonitis.

Facility (FACILITY) one record for each year facility has operated. This data would be used to merge with the treatment history, transplant, or annual summary SAFs for analyses involving provider characteristics by encrypted ID.

Facility Cost Reports (FCOSHOS) one record per facility per year (1989–1995). This file contains the costs of staffing and dialysis facilities.

Dialyzers (DIALYZER) information on dialyzer characteristics; to be matched to patient dialyzer information in other SAFs. This file would be used in analyses involving the relation of dialyzer characteristics to patient outcomes.

Claim Codes (CLMCODES) one record for each diagnosis, procedure, or HCPCS code appearing in claims files. A starting point for analyses that will use diagnosis and procedure codes.

Formats all USRDS-defined SAS formats used by SAFs. Format library used to format values of categorical variables.
Appendix A: USRDS Products & Services

A.3 Prices for the USRDS Standard Analysis Files

<table>
<thead>
<tr>
<th>Standard Analysis Files</th>
<th>Institutional</th>
<th>Physician/supplier</th>
<th>Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core dataset</td>
<td>$1,275</td>
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<td></td>
</tr>
<tr>
<td>Transplant dataset</td>
<td>$500</td>
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<td></td>
</tr>
<tr>
<td>Hospital dataset</td>
<td>$500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDS survey dataset</td>
<td>$750</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DMMS claims</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Case Mix Adequacy claims</td>
<td>$125</td>
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</tbody>
</table>

Pre-ESRD claims available for 1993 to 2010; price ranges from $200 to $800 per year and claim type. Prices subject to change.

A.4 Prices for the CKD 5 Percent Medicare Sample Standard Analysis Files

<table>
<thead>
<tr>
<th>Patient cohort finder $750 / Hospital file $250</th>
<th>Institutional</th>
<th>Physician/supplier</th>
<th>Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>$375</td>
<td>$375</td>
<td></td>
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<tr>
<td>1993</td>
<td>$375</td>
<td>$375</td>
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<td>1994</td>
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<tr>
<td>2001</td>
<td>$500</td>
<td>$500</td>
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</tbody>
</table>

A.5 Prices for the ESRD CPM/USRDS Files

<table>
<thead>
<tr>
<th>ESRD CPM Survey data</th>
<th>Institutional</th>
<th>Physician/supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,250</td>
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</table>

<table>
<thead>
<tr>
<th>ESRD CPM/SAF linked files</th>
<th>Institutional</th>
<th>Physician/supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core files</td>
<td>$500</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>Transplant</td>
<td>$200</td>
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</tbody>
</table>

ESRD CPM Medicare participant institutional & physician/supplier claims are available for the years pre-1989 through 2011; $100–300 per year.

A.6 Outline for Research Proposals Using USRDS Data

A data request applies only to the project stated in the proposal; a new proposal must be submitted for each additional use of the data.

I. Research topic title and submission date.

II. Background information.

III. Study design: objectives, hypothesis(es), analytical methods.

IV. Data being requested: 1) List of Standard Analysis Files needed (if multiple years, please specify), or data fields needed in custom data file. 2) Description of data security: responsible party, computer access, etc. 3) Time frame for the project. 4) Statement that data will be returned to the USRDS or destroyed at the end of the project.

V. To address patient privacy issues, to be consistent with HIPAA policies, and to ensure that researchers are adhering to local privacy standards as well as to USRDS and CMS privacy policies, the USRDS now requires IRB approval for all research proposals. IRB approval is not required from those requesting aggregate data.

VI. Outline of estimated costs of requested data; source of funding.

VII. Agreement for Release of Data, signed by all researchers.

VIII. For Principal Investigator and co-authors, required:

- Name
- Affiliation
- Business address
- Business phone & fax
- Email address

Submit to
Paul Eggers, PhD
NIDDK
6707 Democracy Blvd, Room 615
Bethesda, MD 20892-5458
Phone 301-594.8305
Fax 301.480.3510
eggersp@extra.niddk.nih.gov
United States Renal Data System (USRDS) Agreement for Release of Data

Project title _________________________________________________________________________________________________

In this agreement, “Requestor Organization” means _________________________________________________________________

A. The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), through the United States Renal Data System (USRDS) Coordinating Center (CC), will provide the Requestor with CDs, DVDs, or other media type containing the data extracted from the USRDS research database (the “Data”), which constitutes a Limited Data Set within the meaning of the HIPAA privacy regulations.

B. The sole purpose of providing the Data is the conduct of legitimate and approved biomedical, cost-effectiveness, and/or other economic research by the Requestor.

C. The Requestor shall not use the Data to identify individuals on the file.

D. The Requestor shall not combine or link the Data provided with any other collection or source of information that may contain information specific to individuals on the file, except where written authorization has been obtained through the approval process.

E. The Requestor shall not use the Data for purposes that are not related to biomedical research, cost-effectiveness, economic and/or other epidemiological research. Purposes for which the Data may not be used include, but are not limited to,
   • the identification and targeting of under- or over-served health service markets primarily for commercial benefit
   • the obtaining of information about providers or facilities for commercial benefit
   • insurance purposes such as redlining areas deemed to offer bad health insurance risks
   • adverse selection (e.g., identifying patients with high risk diagnoses)

Any use of the Data for research not in the original proposal must be approved by the USRDS Project Officer (PO).

F. The Requestor shall not publish or otherwise disclose the Data in the file to any person or organization unless the Data have been aggregated (that is, combined into groupings of Data such that the Data are no longer specific to any individuals within each grouping), and no cells (aggregates of Data) contain information on fewer than ten individuals or fewer than five providers or facilities. The Requestor shall not publish or otherwise disclose Data that identify individual providers or facilities, or from which such identities could be inferred. However, the Requestor may release Data to a contractor for purposes of data processing or storage if (1) the Requestor specified in the research plan submitted to the USRDS Project Officer that Data would be released to the particular contractor, or the Requestor has obtained written authorization from the PO to release the Data to such contractor, and (2) the contractor has signed a data release agreement with the PO.

G. A copy of any aggregation of Data intended for publication shall be submitted to the PO for review for compliance with the confidentiality provisions of this agreement prior to submission for publication and, if not approved, shall not be published until compliance is achieved. The PO must respond within 30 days.

H. Appropriate administrative, technical, procedural, and physical safeguards shall be established by the Requestor to protect the confidentiality of the data and to prevent unauthorized access to it. The safeguards shall provide a level of security outlined in OMB Circular No. A-130, Appendix III — Security of Federal Automated Information System, which sets forth guidelines for security plans for automated information systems in Federal agencies.

I. No copies or derivatives shall be made of the data in this file except as necessary for the purpose authorized in this agreement. The Requestor shall keep an accurate written account of all such copies and derivative files, which will be furnished upon request to the PO. The USRDS data files covered in this data use agreement may be retained by the Requestor until the date specified by the PO in the approval letter, at which time Requestor may request renewal of this data use agreement to extend the retention period to comply with legal or institutional recordkeeping requirements or to maintain the integrity of the research or research publications. If at any time during the data retention period the DUA between USRDS and CMS is canceled, the Requestor will be contacted to destroy the files in their possession. At the completion of the activities in the research plan, the file(s) and any derivative files and copies shall be destroyed. At that time the Requestor will inform the USRDS and the PO in writing that the files have been destroyed.

J. For the purpose of inspecting security procedures and arrangements, authorized representatives of the NIDDK and/or of CMS will, upon request, be granted access to premises where the Data are kept.
K. The following USRDS data file(s) is/are covered under this Agreement.

<table>
<thead>
<tr>
<th>Name of Data file(s) requested (e.g. Core, Institutional claims, etc)</th>
<th>Year(s) if applicable</th>
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REQUESTOR SIGNATURE: __________________________________________________________

Authorized signatory (name, title & date)

Requestor address

Requestor telephone number

READ AND ACKNOWLEDGED:

Investigator/Analyst signature

Print Investigator/Analyst name & date

Investigator/Analyst signature

Print Investigator/Analyst name & date

Investigator/Analyst signature

Print Investigator/Analyst name & date

USRDS Project Officer - Lawrence Y. C. Agodoa, MD, NIDDK, NIH or Paul W. Eggers, PhD, NIDDK, NIH

USRDS Project Officer signature & date

June 2012
United States Renal Data System (USRDS)  
Merged Dataset Agreement for Release of Data

Project title  _________________________________________________________________________________________________

In this agreement, "Requestor Organization" means  _________________________________________________________________

A. The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), through the United States Renal Data System (USRDS) Coordinating Center (CC), will provide the Requestor CDs, DVDs or other media type containing data extracted from the USRDS research database. Prior to receiving USRDS data, the Requestor will provide USRDS with a list of personally identifiable information (PII) so USRDS can report which of the Requestor's subjects are in the USRDS end-stage renal disease (ESRD) data.

B. The sole purpose of providing the Data is the conduct of legitimate and approved biomedical, cost-effectiveness, and/or other economic research by the Requestor.

C. USRDS shall not use or disclose the Requestor's data for any purpose other than to create the data extracted from the USRDS database. In the event that the Requestor's data is used or disclosed for any purpose other than that covered by this agreement, USRDS will notify the Requestor immediately and agree to work with Requestor to address the use or disclosure. The USRDS will destroy the Requestor's data set one year after the linkage is complete unless otherwise specified by the Requestor in the research proposal.

D. The Requestor shall not combine or link the data provided with any other collection or source of information that may contain information specific to individuals on the file, except where a waiver of authorization has been approved by the Requestor's IRB/Privacy Board.

E. The Requestor shall not use the Data for purposes that are not related to biomedical research, cost-effectiveness, economic and/or other epidemiological research. Purposes for which the Data may not be used include, but are not limited to,

- the identification and targeting of under- or over-served health service markets primarily for commercial benefit
- insurance purposes such as redlining areas deemed to offer bad health insurance risks
- adverse selection (e.g., identifying patients with high risk diagnoses)

Any use of the Data for research not in the original proposal must be approved by the USRDS Project Officer (PO).

F. The Requestor shall not publish or otherwise disclose the data in the file to any person or organization unless the data have been aggregated (that is, combined into groupings of data such that the data are no longer specific to any individuals within each grouping), and no cells (aggregates of data) contain information on fewer than ten individuals or fewer than five providers or facilities. The Requestor shall not publish or otherwise disclose data that identify individual providers or facilities, or from which such identities could be inferred. However, the Requestor may release data to a contractor for purposes of data processing or storage if (1) the Requestor specified in the research plan submitted to the USRDS Project Officer that data would be released to the particular contractor, or the Requestor has obtained written authorization from the PO to release the data to such contractor, and (2) the contractor has signed a data release agreement with the PO.

G. A copy of any aggregation of data intended for publication shall be submitted to the PO for review for compliance with the confidentiality provisions of this agreement prior to submission for publication and, if not approved, shall not be published until compliance is achieved. The PO must respond within 30 days.

H. Appropriate administrative, technical, procedural, and physical safeguards shall be established by the Requestor to protect the confidentiality of the data and to prevent unauthorized access to it. The safeguards shall provide a level of security outlined in OMB Circular No. A-130, Appendix III — Security of Federal Automated Information System, which sets forth guidelines for security plans for automated information systems in Federal agencies.

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</tbody>
</table>

REQUESTOR SIGNATURE: ________________________________________________

Authorized signatory (name, title & date)

Requestor address

Requestor telephone number

READ AND ACKNOWLEDGED:

Requestor/investigator signature   Print name & date

Requestor/investigator signature   Print name & date

Requestor/investigator signature   Print name & date

USRDS Project Officer - Lawrence Y. C. Agodoa, MD, NIDDK, NIH or Paul W. Eggers, PhD, NIDDK, NIH

USRDS Project Officer signature & date

June 2012
Appendix B: Medicare Claims

Introduction
The USRDS Coordinating Center created files from CMS billing data to incorporate into the USRDS database. These files include claims for some patients who are not included in the SAF.PATIENTS file and claims for some patients before the start of ESRD. These cases can be identified and handled by merging the claims files with SAF.PATIENTS, as discussed under the heading “Patients and Time Periods Included.”

CMS Data Sources
Medicare claims are of two types: physician/supplier claims for all of Medicare Part B, and institutional claims primarily for Part A. Some Part B claims, however, are institutional claims, notably those for outpatient dialysis. The structure and content of the two types of claims are different, as are the files derived from them.

The institutional claims files are obtained from the CMS SAFs, and the physician/supplier data from the 100% National Claims History nearline file. Information on outpatient dialysis and hospital inpatient stays not included in the CMS SAFs is obtained from PMMIS/REBUS. Together, these sources provide data on all types of Medicare bills. The following CMS SAFs are used:

- Inpatient
- Outpatient
- Skilled Nursing Facility
- Home Health Agency
- Hospice

For institutional and physician/supplier claims files, data for a year is frozen at the end of the following June, so claims submitted after June of the year following the year of service are not included. All data are resolved to final bills, with duplicates and correction transactions resolved into a single final bill for the service in question.

For 1977 through 1990 the PMMIS/REBUS system provides an alternate source of data on hospital inpatient stays and outpatient dialysis, but it includes no charge or payment data. The inpatient data include diagnosis and procedure codes, and outpatient data include summaries of dialysis claims by calendar quarter and provider. This is the only source for data from before 1989, the year in which the CMS SAFs start. Starting with 1991, data from PMMIS/REBUS is used only when a matching hospital stay or dialysis record is not in the CMS SAFs. SAF data are given preference because of their greater detail. However, because these files contain no data for claims processed by CMS after the June following the year of service, some claims are missed. PMMIS/REBUS data are included in the Institutional Claims and Institutional Claim Details Files and can
be distinguished by the value of the HCPASAF variable (M or Q). CMS SAFs and Part B physician/supplier data both begin in 1991, and extend through the last date shown in Table A.3. Data for a given year usually become available in August or September of the following year, and are based on claims processed through June.

Bills submitted or finalized after the cutoff date are included in the SAF for the following year. When analyzing claims, it is important to realize that all claims contained in the SAFs for a given year may not have been incurred in that year, while some claims incurred in a given year may appear in the SAFs for the following year. Because the service dates of the claim correspond to the actual dates of service, they should be used to determine inclusion in analyses, not the calendar year of the SAFs. As the reporting window is 18 months for January claims and only six months for December claims, data are likely to be less complete as a year progresses.

Patients and Time Periods Included
The Medicare claims files contain data for some patients not included in the SAF.PATIENTS file. When the USRDS database is updated, all claims for all patients who show an indication of having ESRD are retrieved from the CMS database. Some patients are then filtered out, and not included in SAF.PATIENTS or the USRDS analyses. This procedure allows the USRDS Coordinating Center itself to exclude data, rather than request them anew from CMS should they be needed later. Patients may be filtered out because of problems with the data, as when two patients have the same Medicare ID or Social Security number, or a patient’s listed birth date comes after the death date. In other cases, too little information is available to establish the presence of ESRD or a date of first ESRD service. Sometimes a person filtered out one year passes the filters the next year because data problems are resolved or new data confirm that the patient has ESRD.

Researchers need to decide whether to include the claims for these patients in their analyses. The claims can be excluded by merging the claims file with SAF.PATIENTS by USRDS_ID and selecting only patients who appear in SAF.PATIENTS.

The USRDS database also includes pre-ESRD claims for patients who were entitled to Medicare due to age or disability before they developed ESRD. Because these data are not available for all patients, and because it is likely that patients entitled to Medicare before ESRD are systematically different from those not entitled, analyses of these data must be designed with care.

To obtain claims from the ESRD period only, merge the claims file with PATIENTS to identify the first service date, and select only those claims occurring on or after this date. It is up to researchers to determine how or whether to include claims that straddle the first service date.

Basic File Structure
Institutional claims are for hospital inpatient stays, hospital outpatient services, most dialysis, skilled nursing facilities, home health agencies, and hospices. Dollar amounts are available in the Institutional Claims file. The Institutional Claims Details file contains diagnostic and procedural codes that can occur a number of times for each claim. For many analyses this file is not needed.

Physician/supplier claims are bills covering physician services and medical supplies. They account for approximately 80% of the claims but only 20% of the dollars. One diagnostic and one procedural code can occur on each physician/supplier claim, which is essentially a line-item record. One visit to a physician can generate multiple claims records.

While there are only minor differences in the structure of the data included in the five institutional claim types (hospital inpatient, hospital and freestanding outpatient, hospice, home health agency, skilled nursing facility), the structure of the physician/supplier claims is substantially different from that of the institutional claims.
Institutional claims are submitted on Part A claim forms, which have a large header portion followed by variable length trailers. Possible trailer fields include diagnoses, procedures, and revenue centers. Physician/supplier claims have a simpler header portion and fewer trailer fields, including the revenue center with a CMS Common Procedure Code Standard (HCPCS) procedural code. Unlike the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) procedural codes on the institutional claims, which primarily record invasive surgical procedures, HCPCS codes record all procedures performed by physicians (e.g., patient histories) and all supplies, ranging from Band-Aids to dialysis machines.

Institutional Claims

Effective on January 1, 2008, CMS required an important change in billing requirements for ESRD facilities. This change in turn had a substantial effect on the content of the institutional claims files that the USRDS receives from CMS for ESRD patients. The USRDS Institutional files for years prior to 2008 will not change, but USRDS Institutional files for calendar year 2008 and later will undergo some changes in order to accommodate the changes in the Institutional files obtained from CMS. In this guide, descriptions of Institutional files for calendar years before 2008 will be followed by a description of any differences in the 2008 files compared to prior years.

The CMS mandated changes in billing requirements for ESRD facilities for 2008 essentially require ESRD facilities to report each separately billable service (e.g., dialysis, ESA administration) as a separate revenue center line item with a date of service for each service. In the past, ESRD facilities were able to bill an entire month of each separately billable service as a single line item (i.e., 1 line item for dialysis, 1 for EPO, 1 for IV Iron, etc.). Since January 1, 2008 ESRD facilities are required to report each service separately, so a typical month of dialysis would require 13 separate line items (as opposed to 1 line item in previous years), 13 separate line items for EPO administrations (instead of 1), and so forth. The practical result of this change (which was actually phased in over the entire 2007 calendar year) is an enormous increase in Revenue Center Detail records, from 76 million in 2006 to over 175 million in 2008. Meanwhile, the number of other detail records showed the usual yearly increases (from 39 million to 43 million over the same time period). The increased detail in ESRD billing may be useful for studying patterns of utilization, so the USRDS will make these additional Revenue Line Items available to researchers. The Revenue Center details will no longer be included in the Institutional details file, but rather in a separate Revenue Center detail SAF. CMS also altered the method for ESRD facilities reporting of EPO administration and dosage. These changes will be described in the section on EPO variables.

A “claim” file and a “claim detail” file, and starting with calendar year 2008, a “revenue detail” file, are created from the institutional files. The details can be linked back to the claims. The Institutional Claims File has one record per claim, with a claim generally representing a single instance of service, such as a hospital inpatient stay, an outpatient surgery, or a month of dialysis. Dollar values for total charges and payment amounts are stored in the claim file, which also shows the type and number of dialysis sessions included in the claim. Data in the Institutional Claims File allow researchers to determine dialysis treatment modality over time, compute hospitalization rates, and determine aggregate costs by time period and type of cost. These data are sufficient for many research studies and most USRDS products. Analyses of particular diagnoses, procedures, or revenue centers require the claims detail files. Tables B.1 and B.2 show the variables in the Institutional Claims, Claims Detail, and Revenue Detail files. The claims are uniquely identified by a compound key consisting of four variables: USRDS_ID, CLM_FROM, HCFASAF, and SEQ_KEYC; which are used to uniquely link claim records among the Institutional Claims, Claims Detail, and Revenue Detail files. The records in all institutional files are sorted by this compound key. The derivation of the dialysis and EPO variables on the Institutional Claims record is described below under Revenue Center Details.

Medicare Payment Variables

CLM_TOT is the total amount billed for the claim, while CLM_AMT is the amount actually paid by Medicare. For inpatient and skilled nursing facility claims, the cost also includes an amount for the CMS pass-through payments for items such as indirect medical education, capital, and kidney acquisition for transplants. To obtain this pass-through payment amount, multiply the per diem amount (PER_DIEM) by the count of
covered days (cvr_dcnt). In addition to these overall amounts, the billed amount for dialysis and for EPO are provided by the variables dialcash and epocash.

**Dialysis Variables**
The variable rxcat indicates the type of dialysis, if any, included in a claim. rxcat is derived from dialrevc and dialcrc, which come from the Revenue Center and Claim Related Condition details, as described below. dialsess is the units value from the Revenue Center detail which indicates dialysis. For in-center hemodialysis, this generally indicates a plausible value for the number of dialysis sessions. For other types of dialysis, particularly CAPD and CCPD, this may indicate the number of days. dialcash is rev_ch from the Revenue Center detail and is the provider’s billed charge rather than the Medicare payment. The Revenue Center and Claim Related Condition details, which indicate dialysis, are not included in the Institutional Claim Details file prior to 2001, unless the claim has multiple details which indicate dialysis. All dialysis revenue line items are included in the revenue center details file starting with calendar year 2001.

**EPO Variables**
Summary variables are provided for EPO treatments covered by a claim. EPO treatments are identified by Revenue Center codes 0634 and 0635 on a Revenue Center detail. For claims prior to 2008, the variable for number of EPO administrations (epoadmin) is the units variable from the Revenue Center detail, while the variable for EPO payments (epocash) is the rev_ch variable. If the claim has multiple Revenue Center details indicating EPO, the epoadmin and epocash are summed over these details. The Revenue Center details from which these variables come are retained in the Institutional Claim Details SAF starting with CY2001. The variables for the dose of EPO (epodose) come from a Claim Related Value detail with code ‘68’, and the variable for hematocrit (hcrit) comes from a Claim Related Value detail with code ‘48’. The Claim Related Value details from which these variables come are not retained in the Institutional Claim Details SAF. CMS mandated line-item billing for ESRD facilities effective January 1, 2008. Facilities are required to report each EPO administration as a separate line item, and to report the EPO dose administered in the units field as a multiple of 100 (e.g., a dose of 5,000 units would be reported as 50 in the units field. Value code 68, the total EPO dose, is no longer required. Also starting with the 2008 claims, a summarization of darbepoeitin (DPO) claims, identified by HCPCS codes, is also included on the claim.

**Institutional Claim Details**
The Institutional Claim Details file includes a variety of details about each claim. The records in this file can be linked back to the corresponding claim in the claims file. There may be none, one, or many records for each type of detail for a particular claim.

- ICD-9-CM diagnosis codes
- ICD-9-CM procedure codes
- CMS revenue center codes (line item, for years prior to 2008)
- HCPCS procedure codes (with line item)
- CMS claim related condition codes
- CMS claim related value codes

Table B.2 shows the variables appearing in the Institutional Claim Details and Revenue Center Detail files. There can be any number of Institutional Details records for each Institutional Claims record. The claim detail files are sorted by the same four-part compound key as the Claims file, so that this key can be used to link the files. The multi-file structure is a solution to the problem of a number of important data items that appear none, one, or many times on a given claim. Hospital inpatient stay claims, for example, always have DRG codes, but other types of institutional claims never have this code. All claims should have at least one ICD-9-CM diagnosis code, but they may have up to ten. A hospital inpatient claim probably uses one or more ICD-9-CM surgical procedure codes if the stay involved surgery, but may also have revenue center details which specify procedures using HCPCS and/or revenue center codes, and an outpatient claim is more likely to specify procedures using revenue center codes with HCPCS codes. Using a master and detail files creates a simple structure easily manipulated in SAS. Examples of useful value code details (cdtype=V) are height and weight, which are required elements for ESA and dialysis claims beginning with the 2007 claim.
Code A8 indicates that the value of the UNITS variable is patient post-dialysis weight (in kilograms), while code A9 indicates that the UNITS variable holds the patient height (in centimeters).

**Revenue Center Details**

The Revenue Center details are the source of a number of important variables. The Revenue Center details correspond to the Revenue Center “trailers” on the CMS SAF records. A record “trailer” is a section of the file record that can appear a variable number of times; the number of occurrences is indicated by an additional variable resulting in records that vary in length depending upon the amount of data present. The CMS SAF records have nine types of trailers, making the record structure quite complex. The Revenue Center details (or record trailers) provide data about the breakdown of the total charges into charges from “each cost center for which a separate charge is billed (type of accommodation or ancillary).” A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). Each Revenue Center detail contains a variable for the amount charged (REV_Ch in the Institutional Claims Detail file), and one detail, while Revenue Center code '0001,' is the sum of all of the REV_Ch for all other Revenue Center details for that claim. To test the consistency of the Revenue Center Details and the CLM_TOT variable, The Coordinating Center examined the original CMS SAF records for 10,000 inpatient and 10,000 outpatient claims. In all cases the '0001' Revenue Center amount was the sum of the other Revenue Center amounts. In about 3% of the inpatient records, however, CLM_TOT was greater than this sum. Beginning in late 2000, CMS began providing a field in the revenue trailers called revenue center payment amount, which corresponds to the payment amount for each revenue center trailer for all outpatient claims. This field is included as an additional variable (REVPMT) in the Institutional Detail SAF, starting with calendar year 2001. This value allows researchers to more accurately determine the payment amount for individual types of Revenue Center services (such as Laboratory service, EPO, and dialysis) billed on outpatient claims. One caveat for using this variable is that the REVPMT summed overall Revenue Center Details for a given claim will not always agree with the CLM_AMT variable contained in the Institutional Claim SAF for that claim. Our analysis showed that the sum of REVPMT over all outpatient claims exceeded the CLM_AMT for all outpatient claims by approximately 3%. The SAS format $REVCEN gives labels for the Revenue Center codes (the CODE variable on records with CDTYPE = ‘R’). The Revenue Center details are the source for the dialysis and EPO variables on the Institutional Claims file. Codes 0800-0809 and 0820-0889 indicate the type of dialysis (DIALREVC). UNITS provides the number of dialysis sessions (DIALSESS), and REV_Ch provides the dialysis charges (DIALCASH).

DIALCASH should be treated with caution because its use may be inconsistently defined; it is not clear if the value is the charged amount or the CMS allowed charge, and definition of the value may vary from institution to institution. When a claim has only one dialysis Revenue Center code, as is usually the case for years prior to 2001, a Revenue Center detail record is not produced because the relevant data items are recorded on the Institutional Claim record. If a claim has multiple Revenue Center details indicating dialysis, the dialysis variables are derived from the first Revenue Center code encountered, giving precedence to the more specific codes. In this case, a detail record is created for each Revenue Center detail on the claim so users have the opportunity to interpret the multiple details. Other Institutional Revenue Center details are of lesser interest unless a HCPCS code is included indicating a more specific service. A code showing that a claim is for laboratory services, for example, frequently includes a HCPCS code indicating the specific test performed. Revenue Center Detail records are included regardless of the presence or absence of a HCPCS code. Before calendar year 2008, Revenue Center Detail records are included with other Claim Detail records, and after 2008 are placed in a separate file. For many analyses, the Revenue Center Detail records may not be required.

**Institutional Claims Detail File Variables**

**CDTYPE, Code**

CDTYPE indicates the type of code contained in the CODE variable. Both variables are present on every record, while the remaining variables are not present for some CDTYPEs.

The SAS format $CDTYPEI indicates the meaning of each CDTYPE.
**UNITS**

Use of the UNITS variable varies with CDTYPE. When CDTYPE = "P" (ICD-9-CM Surgical Procedures), UNITS is a value created by the USRDS to indicate when the surgical procedure was performed, and time is expressed as the number of days from the date given by CLM_FROM, with CLM_FROM counted as 1. A value of 1 for UNITS indicates that the procedure was performed on the date given by CLM_FROM, and 2 indicates the day after CLM_FROM. When CDTYPE = "R," UNITS is described in the CMS file documentation as "a quantitative measure (unit) of services provided to a beneficiary associated with accommodation and ancillary revenue centers" described on an institutional claim. Depending on the type of service, units are measured by number of covered days in a particular accommodation, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests. The revenue center code or the HCPCS code indicates the type of service. Because the meaning of UNITS varies greatly, the variable must be used with caution. When using this variable, tabulate the distribution of values over the records being analyzed to ensure that the values look correct. When CDTYPE = "I," UNITS has a value of 1 or 0, where 1 indicates that this was the primary diagnosis for this claim and 0 indicates that it was a secondary diagnosis. The claim details are not necessarily sorted with the primary diagnosis first.

**REV_CH**

REV_CH occurs only on Revenue Center details (CDTYPE= "R") and indicates "the total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided." REV_CH corresponds in concept to the CLM_TOT variable on the Institutional Claims file, as discussed above under Revenue Center Details.

**HCPCS**

The CMS Common Procedure Coding Standard (HCPCS) "is a collection of codes that represent procedures, supplies, products, and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs." The HCPCS code occurs only on Revenue Center (CDTYPE = R) details but may not be present on all such records. HCPCS are an extension of the American Medical Association CPT-4 codes. Codes for certain pharmaceuticals, laboratory procedures, durable medical equipment, and radiology procedures are added to the CPT-4 codes to form HCPCS.

**URR_CD**

Starting in 1998, CMS began requiring the reporting of Urea Reduction Ratios (URRs) on outpatient hemodialysis claims. The URR is reported as a range that reflects the results for the month being billed. This information appears as a formatted value in the Revenue Center Details for hemodialysis claims.

**Physician/Supplier File**

In the physician/supplier file, a claim does not necessarily correspond to a logical instance of service, but is more likely to represent all services provided to a patient during the provider’s billing period. Because procedures and costs are specified at the claim line item level, the file is constructed as a line item file, with one record per claim line item. For physician claims, the from/through dates can be used to identify a series of line items associated with a single visit. For supplier claims, however, the instance of service is more difficult to define. Bills for home dialysis dialysate, for example, specify the quantity and delivery date of the dialysate but not the time period over which it is to be dispensed.

Table B.3 shows the variables in the Physician/Supplier Claims files. It contains two file types, identified by the value of the CDTYPE variables. CDTYPE = B indicates a physician/supplier line item, which has data for all the other variables. The DIAG variable indicates the diagnosis code associated with this line item. CDTYPE = I indicates that this record contains only a diagnosis code (DIAG); in this case the diagnosis code is associated with all line items on the claim. Payment variables for these records should be missing.
Variables MOD1-MOD4 are included to further identify the type of service billed on the line item. They are used in conjunction with the HCPCS/CPT code on the line item, and their meaning can be found in the Current Procedural Terminology codebook and the HCPCS Level II codebook.

The physician/supplier specialty code (SPCLTY) can be useful for untangling the bills for a specific surgical procedure. The principal surgeon, physician surgical assistants, and anesthesiologist use the HCPCS referring to the major invasive surgery to bill for that surgery. The code for nephrologists is 39.

The place of service variable (PLCSRV) indicates where the service was rendered. It can be used to distinguish between inpatient and outpatient services and between home dialysis and in-unit dialysis supplies. The value 6 refers to an ESRD treatment center.

The CMS service code variable (HCSRVC) can be used to distinguish between the principal surgeon and assistants. The value for immunosuppressive drugs is G, for renal supplier in the home L, for monthly capitation payment (dialysis) M, and for kidney donor N.

Three cost fields appear on each physician/supplier line item: submitted charges (SMTCH); allowed charges (ALOWCH), which are the lower of prevailing, customary, or actual as determined by CMS; and the payment amount (PMTAMT), the amount paid to the provider and/or beneficiary after deductible and co-insurance amounts have been paid for the services included as a line item on a physician/supplier claim.
<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Length</th>
<th>Format</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLM_AMT</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>Medicare payments</td>
</tr>
<tr>
<td>CLM_FROM</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>From date of service</td>
</tr>
<tr>
<td>CLM_THRU</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>Service through date</td>
</tr>
<tr>
<td>CLM_TOT</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>Total charges</td>
</tr>
<tr>
<td>CVR_DCNT</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>For Inpatient and SNF claims, the Medicare covered day count. See PER_DIEM.</td>
</tr>
<tr>
<td>DIALCASH</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>Claim amounts for dialysis</td>
</tr>
<tr>
<td>DIALCRC</td>
<td>Char</td>
<td>5</td>
<td>$DIALCRC</td>
<td>Claim related condition for dialysis. Right digit of the primary claim related condition code indicates dialysis. See text for determining dialysis modality</td>
</tr>
<tr>
<td>DIALREVC</td>
<td>Char</td>
<td>5</td>
<td>$DIALRVC</td>
<td>Revenue center code for dialysis. Right two characters of the primary Revenue Center code indicate dialysis. See text for determining dialysis modality</td>
</tr>
<tr>
<td>DIALSESS</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>Dialysis treatments based on the UNITS variable for the Revenue Center code indicated by DIALREVC. If multiple occurrences of Revenue Center code, UNITS are summed across occurrences</td>
</tr>
<tr>
<td>DISCSTAT</td>
<td>Char</td>
<td>2</td>
<td>$DRC_DES</td>
<td>Discharge status</td>
</tr>
<tr>
<td>DPOADMIN*</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>Number of DPO administrations</td>
</tr>
<tr>
<td>DPOCASH*</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>Total Charge for DPO on this claim</td>
</tr>
<tr>
<td>DPDOSE*</td>
<td>Num</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRG_CD</td>
<td>Char</td>
<td>3</td>
<td></td>
<td>Diagnosis Related Group Code. Inpatient and SNF claims only. DRG 302 indicates kidney transplant</td>
</tr>
<tr>
<td>EPOADMIN</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>Number of EPO administrations</td>
</tr>
<tr>
<td>EPOCASH</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>Total Charge for EPO on this claim</td>
</tr>
<tr>
<td>EPODOSE</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>Total EPO dosage (units) for this claim</td>
</tr>
<tr>
<td>HCFASAF</td>
<td>Char</td>
<td>1</td>
<td>$HCFASAF</td>
<td>CMS SAF source of this bill. Format: D Dialysis, H-Home health, I Inpatient, N Skilled nursing facility, O Outpatient, P Physician/supplier, S Hospice</td>
</tr>
<tr>
<td>HCRIT</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>Hematocrit reported on ESA claim</td>
</tr>
<tr>
<td>HGB*</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>Hemoglobin reported on ESA claim</td>
</tr>
<tr>
<td>PER_DIEM</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>For inpatient and SNF claims, the HCFA pass-through payments. Hospital is reimbursed separately for PER_DIEM times CVR_DCNT.</td>
</tr>
<tr>
<td>PRM_PYR</td>
<td>Char</td>
<td>1</td>
<td>$PRPAYR</td>
<td>Primary payer for this bill</td>
</tr>
<tr>
<td>PROVUSRD</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>USRDS provider ID number for dialysis providers (HCFA SAF = D), blank for others</td>
</tr>
<tr>
<td>RXCAT</td>
<td>Char</td>
<td>1</td>
<td>$RXCATIC</td>
<td>Dialysis treatment modality</td>
</tr>
<tr>
<td>SEQ_KEYC</td>
<td>Char</td>
<td>2</td>
<td></td>
<td>Sequence # to ensure unique key</td>
</tr>
<tr>
<td>USRDS_ID</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>Patient: Patient ID Used To Cross Reference To Other USRDS SAF Files</td>
</tr>
</tbody>
</table>

*For calendar years greater than 2007 only.
### B.2 Variables in the Institutional Claims Detail SAF File

<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Length</th>
<th>Format</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>USRDS_ID</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>USRDS_ID</td>
</tr>
<tr>
<td>CLM_FROM</td>
<td>Num</td>
<td>8</td>
<td>Date7.</td>
<td>Claim from date</td>
</tr>
<tr>
<td>HCFA SAF</td>
<td>Char</td>
<td>1</td>
<td>$HCFA SAF</td>
<td>SAF source of bill</td>
</tr>
<tr>
<td>SEQ_KEYC</td>
<td>Char</td>
<td>2</td>
<td></td>
<td>Sequence number to ensure unique key</td>
</tr>
<tr>
<td>CODE</td>
<td>Char</td>
<td>5</td>
<td></td>
<td>Diagnosis, procedure, or revenue code</td>
</tr>
<tr>
<td>CDTYPE</td>
<td>Char</td>
<td>1</td>
<td>$CDTYPE</td>
<td>Defines type for variable ‘CODE’</td>
</tr>
<tr>
<td>HCPCS*</td>
<td>Char</td>
<td>5</td>
<td></td>
<td>HCPCS code</td>
</tr>
<tr>
<td>REV.CH*</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>Revenue center total charge</td>
</tr>
<tr>
<td>UNITS</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>Varies by detail type. See documentation</td>
</tr>
<tr>
<td>URR_CD*</td>
<td>Char</td>
<td>8</td>
<td>$URRFMT</td>
<td>Urea reduction ratio for reported hemo bills</td>
</tr>
<tr>
<td>REVMT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>Line item payment amount</td>
</tr>
<tr>
<td>REV_DT**</td>
<td>Num</td>
<td>8</td>
<td>Date7.</td>
<td>Date of service for line item</td>
</tr>
</tbody>
</table>

*For Revenue Center Detail file only, starting with calendar year 2008; prior to 2008 these variables are included in the details files, but are always missing values for all details except Revenue Centers.

**Revenue Center Detail file, new starting with calendar year 2008.

### B.3 Variables in the Physician/Supplier File

<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Length</th>
<th>Format</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALOWCH</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>Allowed charges</td>
</tr>
<tr>
<td>CDTYPE</td>
<td>Char</td>
<td>1</td>
<td>$HCCDTYP</td>
<td>Line Item Type</td>
</tr>
<tr>
<td>CLM_FROM</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>From Date of Service</td>
</tr>
<tr>
<td>CLM_THRU</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>Thru Date of Service</td>
</tr>
<tr>
<td>DIAG</td>
<td>Char</td>
<td>5</td>
<td></td>
<td>ICD-9-cm Diagnostic Code</td>
</tr>
<tr>
<td>HCFA SAF</td>
<td>Char</td>
<td>1</td>
<td>$HCFA SAF</td>
<td>HCFA SAF Source of this Bill</td>
</tr>
<tr>
<td>HCPCS*</td>
<td>Char</td>
<td>5</td>
<td></td>
<td>HCPCS code</td>
</tr>
<tr>
<td>HCSRVC</td>
<td>Char</td>
<td>1</td>
<td>HCFASVC</td>
<td>HCFA Service Code</td>
</tr>
<tr>
<td>MOD1</td>
<td>Char</td>
<td>2</td>
<td></td>
<td>HCPCS/CPT 1st Modifier</td>
</tr>
<tr>
<td>MOD2</td>
<td>Char</td>
<td>2</td>
<td></td>
<td>HCPCS/CPT 2nd Modifier</td>
</tr>
<tr>
<td>MOD3</td>
<td>Char</td>
<td>2</td>
<td></td>
<td>HCPCS/CPT 3rd Modifier</td>
</tr>
<tr>
<td>MOD4</td>
<td>Char</td>
<td>2</td>
<td></td>
<td>HCPCS/CPT 4th Modifier</td>
</tr>
<tr>
<td>PLCSRV</td>
<td>Char</td>
<td>2</td>
<td>$PLACESV</td>
<td>Place of Service</td>
</tr>
<tr>
<td>PMTAMT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>Claim Payment Amount</td>
</tr>
<tr>
<td>PYRCOD</td>
<td>Char</td>
<td>1</td>
<td>$PRPAYR</td>
<td>Primary Payer Code</td>
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<td>USRDS_ID</td>
<td>Num</td>
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<td>BEST</td>
<td>USRDS_ID</td>
</tr>
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</table>
Appendix C: Statistical Methods

Methods for Event Rate Calculation
Transplant rates and rates of \textit{esrd} incidence, prevalence, and mortality are often estimated overall or by groups. Some are based on population size (incidence and prevalence) or follow-up time (mortality). Rates can be direct estimates based on the data observed (observed rate), they can be estimated based on statistical models, or they can be adjusted for patient case-mix.

Observed Event Rate
The observed event rate calculation is straightforward. It is the number of events divided by the population size or the total follow-up time and sometime it need to multiple a number based the size of the rate or the unit people are used to use. For example, if state A had 1600 incident \textit{esrd} patients in 2004 and the state population size was 6,400,000 people, the incidence rate of state A in 2004 is:

\[ r = \frac{1600}{6,400,000} \times 1,000,000 = 250 \text{ per million people} \]

The rate is multiplied by 1,000,000 because otherwise the rate is a very small number. If the total follow-up time of these \textit{esrd} patients in 2004 is 1100 patient-years, and 150 patient die in the incident year, the 2004 death rate of the incident patients in state A is:

\[ r = \frac{150}{1100} \times 1000 = 136.4 \text{ per thousand patient-years} \]

The standard error of the rate is usually estimated by \( \sqrt{r/d} \), where \( r \) is the rate and \( d \) is the denominator in the rate calculation.

Model-Based Event Rate
Using the observed rate as the estimate of the real rate usually works well for the population level or for big groups. When it is necessary to calculate event rate for subgroups and some subgroups are small, the observed rate may not be an accurate estimate of the real rate, and a statistical model will be necessary. As an example, we can calculate the death rate of each age (every 5 years), race (white, black, Asian, Native American, and other), and gender combination group. We usually do not have enough data to calculate the death rate of the (age<5, female, Native American) group. If the Poisson model is the right model to fit the number of deaths, we can fit a Poisson model with the number of deaths as the response variable, age, race, and gender as independent variables, and the natural logarithm of follow-up time as the offset, i.e. \( y \sim \text{Poisson}(t \cdot \exp(x\beta)) \), where \( y \) is the number of deaths, \( x \) is the corresponding values of age, race, gender, and maybe some interactions, as well as 1, which corresponds to the intercept, and \( \beta \) is the corresponding coefficients. Then the death rate of a combination group will be \( \exp(x\beta) \), where the \( x \) corresponds to the combination group. For a rate calculation, a logistic regression model, a Poisson regression model, and a Cox proportional hazard regression model can be used. The closer the model is to the saturated model, the better the rate estimate conditional on overfitting. In the \textit{esrd} Annual Data Report, both a Poisson model and a Cox model were used with/without random effects.
Adjusted Event Rates

When comparing the event rate of two groups with different patients, the event rate comparison may not be meaningful. For example, we can compare the death rates of Groups A and B, with Group A having far older patients than Group B. Group A has a higher death rate than Group B, perhaps because Group A made patients have a higher risk, or simply because the older patients have a higher risk than the younger patients. To figure out if Group A made people have a higher risk we need to adjust the patient age when calculating the rates. When comparing rates adjusted for a particular factor, any remaining observed differences between groups cannot be attributed to confounding by that factor. The two main adjustment techniques are the direct method and the indirect method; only the direct method allows the rates to be compared (Fleiss 1981).

Direct Adjustment

If each group has many categories (for example, combination groups defined by age, race, and gender), the direct adjusted rate is derived by applying the observed category-specific rates in the group to a single standard, or reference, population. This weighted average of the observed category-specific rates, with the weights taken from a standard reference population, provides for each group a single summary rate that reflects the numbers of events that would be expected if the group had identical distribution of the characteristic of interest as the reference. This makes the comparison valid, but the values of the adjusted rates are not meaningful. Adjusted rates and their explanation are reference dependent. Because the reference population must have the same categories as all of the groups, it must be chosen with caution.

The disadvantages of this method are:

- If one category in a group is small the corresponding category-specific rate will be unstable; this may make the adjusted rate for this group unstable as well.
- If one category is empty, the adjusted rate cannot be calculated for that group.

Model-Based Adjustment

Because of the disadvantages of the direct adjustment method, a model-based adjustment method is necessary. Using an appropriate model to calculate category-specific event rates as described in the Model-Based Estimates above, we can apply the direct adjustment method based on the model-based category-specific rates, instead of observed category-specific rate [Liu, 2006].

Survival Analysis

The most commonly used methods for survival analyses are the Kaplan-Meier method, log-rank test, and the Cox proportional regression model.

The Kaplan-Meier method is used to estimate the survival probability over time. The plots of the survival estimates are used to intuitively compare groups on patient survival. The log-rank test is a method for testing the hypothesis that there is no difference in survival probabilities over a time among groups. The Cox regression model is the most widely used method for survival analysis. It can be used to compare risk of mortality or other events among groups and to find risk factors. Details for these methods can be found in Kalbfleisch and Prentice 1980. More advanced methods can be found in Therneau and Grambsch 2000.

Bibliography


Appendix D: Data File Descriptions

**Core CD-1**
Patient Profile PATIENTS
Condensed Treatment History RXHIST60
Death File DEATH
Transplant TX
Payer History PAYHIST
Census Population (1) CPST3R
Census Population (2) CPST4R
Census Population (3) CPUS3R
Census Population (4) CPUS4R

**Core CD-2**
Medical Evidence Form MEDEVID95
Medical Evidence Form MEDEVID05
Residence RESIDENC
CMS/CDC ESRD Annual Facility FACILITY
Transplant Wait List (Kidney) WAITLIST_KI
Transplant Wait List (Kidney/Pancreas) WAITLIST_KP
Transplant Wait List Sequence (Kidney) WAITSEQ_KI
Transplant Wait List Sequence (Kidney Pancreas) WAITSEQ_KP

**Core CD-3**
Detailed Treatment History RXHIST
Case Mix Adequacy Special Study ADEQUACY
Case Mix Adequacy Spec. Study Facility ADQFACS
CAPD Peritonitis Special Study CAPD
Case Mix Severity Special Study CASEMIXS
Claim Codes CLMCODES
Case Mix Severity Special Study Facility CMFSFACS
Dialyzer DIALYZER
DMMS Wave 1 Special Study DMMSWAV1
DMMS Wave 2 Special Study DMMSWAV2
DMMS Wave 3 & 4 Special Study DMMSWAV34
Dialysis Facility DMMSFACS1
Dialysis Facility DMMSFACS2
Dialysis Facility `DMMSFACS34`
Facility Cost Reports for Hospital Facility `FCOSHOS`
Facility Cost Reports for Independ. Facility `FCOSIND`
Pediatric Growth `PEDGROW`
Updated DMMS Wave 2 Data `WAV2UPDT`

### Core CD-4
- Medical Evidence Form `MEDEVID`

### Transplant CD-1
- Kidney Transplant-UNOS (Kidney) `TXUNOS_KI_PRE_JUL04`

### Transplant CD-2
- Kidney Transplant-UNOS (Kidney) `TXUNOS_KI_POST_JUL04`
- Kidney Tx -UNOS (Kidney Pancreas) `TXUNOS_KP`

### Transplant CD-3
- Immunosuppression at Follow-up-UNOS `TXIFUNOS`
- Immunosuppression at Registration-UNOS `TXIRUNOS`
- Kidney Transplant Follow-ups-cms `TXFUHCFA`
- Kidney Transplant-cms `TXHCFA`

### Transplant CD-4
- Kidney Tx Follow-ups-UNOS (Kidney) `TXFUUNOS_KI`
- Kidney Tx Follow-ups-UNOS (Kidney Pancreas) `TXFUUNOS_KP`

### Hospital CD-1
- Hospitalization 1 `HOSP1`

### Hospital CD-2
- Hospitalization 2 `HOSP2`

### Hospital CD-3
- Hospitalization 3 `HOSP3`

### DMMS Claims CD-1
- Hospitalization `HOSP`
- Institutional Claims `INCLAIM`

### DMMS Claims CD-2
- Institutional Claims Details `INDETAIL`

### DMMS Claims CD-3
- Physician/Supplier Claims `PSCLAIM1`

### DMMS Claims CD-4
- Physician/Supplier Claims `PSCLAIM2`

### Case Mix Adequacy CD
- Hospitalization `HOSP`
- Institutional Claims `INCLAIM`
- Institutional Detail `INDETAIL1`
- Institutional Detail `INDETAIL2`
- Physician/Supplier Claims `PSCLAIM`
Appendix D: Data File Descriptions

Comprehensive Dialysis Study CDS
Patient file CDS_SAF_PATIENT
Lab file CDS_SAF_LAB
Food Baseline file CDS_SAF_FOOD_BASELINE
QOL Baseline file CDS_SAF_QOL_BASELINE

Institutional Detail Claims CD*
Institutional Claims
Institutional Claims Details

Physician/Supplier Claims CD*
Physician/Supplier

Medicare 5% Sample CKD-Based Cohort CD
Medicare 5% Sample CKD Patient Master File CKD_PATIENTS_MASTER_FILE
Medicare 5% Sample CKD Payer Sequence File CKD_PAYER_SEQ_FILE
Medicare 5% Sample CKD Patient Co-morbid File CKD_CO_MORBID_YY

Medicare 5% Sample CKD Patient Institutional Detail Claims CD*
Medicare 5% Sample CKD Patient Institutional Claims
Medicare 5% Sample CKD Patient Institutional Claims Details

Medicare 5% Sample CKD Patient Physician/Supplier Detail Claims CD*
Medicare 5% Sample CKD Patient Physician/Supplier Claims Details

Medicare 5% Sample CKD Patient Hospital Stay Summary CD
Medicare 5% Sample CKD Patient Hospital Stay Summary File CKD_92_to_YR_hosp_clm

Medicare Prescription Drug - Part D
Medicare Prescription Drug PDENROLSY
Medicare Prescription Drug PDEYFL

*Institutional and Physician/Supplier CD claims files are based on the same file structures year to year. Only file descriptions for the most recent year are shown.
### CORE CD-1

**PATIENTS: Patient Profile**

Contains one record per patient in the USRDS database, and gives basic demographic and ESRD-related data.

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<th>Format</th>
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<td>This patient is included in the ADR cohort</td>
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<td>$DEATHFM</td>
<td>Primary cause of death</td>
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<tr>
<td>CDEATH2</td>
<td>Char</td>
<td>3</td>
<td>$DEATHFM</td>
<td>Secondary cause of death1</td>
</tr>
<tr>
<td>CDEATH3</td>
<td>Char</td>
<td>3</td>
<td>$DEATHFM</td>
<td>Secondary cause of death2</td>
</tr>
<tr>
<td>CDEATH4</td>
<td>Char</td>
<td>3</td>
<td>$DEATHFM</td>
<td>Secondary cause of death3</td>
</tr>
<tr>
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<td>3</td>
<td>$DEATHFM</td>
<td>Secondary cause of death4</td>
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<td>8</td>
<td>MMDDYY</td>
<td>Date of Death</td>
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### RXHIST60: Condensed Treatment History

A condensed version of the RXHIST file. All modality periods less than 60 days are subjected to a collapse with adjacent cells of longer durations.

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<td>MMDDYY</td>
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</tr>
<tr>
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<td>BEST</td>
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DEATH: Death Form
Contains full data from the death notification form (CMS-2746).

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<td>$STATE</td>
<td>6. - Patient State at Death</td>
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<td>BEST</td>
<td>USRDS_ID</td>
</tr>
<tr>
<td>YEAR</td>
<td>Num</td>
<td>8</td>
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<td>Y ear of Transplant</td>
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</table>

TX: Transplant
Includes minimum details about all transplants from all sources.

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<td>USRDS Assigned Facility ID</td>
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### CPST3R: Census Population
Census data, by state, and three races, white, black, or other.

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### CPUS3R: Census Population
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### CPUS4R: Census Population
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### Appendix D: Data File Descriptions

**CORE CD-2 MEDEVID95: Medical Evidence form 1995**

Contains full data from the 1995 version of the CMS Medical Evidence Report (CMS-2728), implemented in April, 1995. This is the source of data regarding primary cause of renal disease and start date of chronic renal dialysis. The 1995 version includes data on comorbidity, employment status, lab values at start of ESRD, and Hispanic ethnicity.

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<tr>
<td>UREADT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>Urea date (Q18h)</td>
</tr>
<tr>
<td>USRDS_ID</td>
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<tr>
<td>WEIGHT</td>
<td>Num</td>
<td>8</td>
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<td>Patient weight (Q14)</td>
</tr>
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</table>
Appendix D: Data File Descriptions

**MEDEVID05: Medical Evidence form 2005**

Contains full data from the 2005 version of the CMS Medical Evidence Report (CMS-2728), implemented in May, 2005. This is the source of data regarding primary cause of renal disease and start date of chronic renal dialysis. The 2005 version includes purpose of the form (initial, re-entitlement, supplemental), multiple patient race data, and data on nephrologist care, diet care, and access type.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Type</th>
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<tbody>
<tr>
<td>ALBUM</td>
<td>Num</td>
<td>8</td>
<td>(19.a.1)</td>
<td>Serum Albumin Value (g/dl).</td>
</tr>
<tr>
<td>ALBUMDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>(19.a.1.1) Serum Albumin Date</td>
</tr>
<tr>
<td>ALBUMLM</td>
<td>Num</td>
<td>8</td>
<td>(19.a.2)</td>
<td>Serum Albumin Lower Limit Value</td>
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<tr>
<td>AVFMATURING</td>
<td>Num</td>
<td>8</td>
<td>(18.d.1)</td>
<td>If not AVF, then: Is maturing AVF present?</td>
</tr>
<tr>
<td>AVGMATURING</td>
<td>Num</td>
<td>8</td>
<td>(18.d.2)</td>
<td>If not AVF, then: Is maturing graft present?</td>
</tr>
<tr>
<td>BMI</td>
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<td>8</td>
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<td>Body Mass Index - Calculated</td>
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<tr>
<td>COMO_ALCHO</td>
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<td>1</td>
<td>(17.p)</td>
<td>Co-Morbid P: Alcohol dependence.</td>
</tr>
<tr>
<td>COMO_AAMP</td>
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<td>Co-Morbid G: Amputation.</td>
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<tr>
<td>COMO_ASHD</td>
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<tr>
<td>COMO_COPD</td>
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<tr>
<td>COMO_DRUG</td>
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<tr>
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<td>Co-Morbid R: Inability to ambulate.</td>
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<tr>
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<td>Char</td>
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<tr>
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<tr>
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<td>(17.) Concatenates the patients comorbidity factors</td>
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<td>COUNTRY (9.)</td>
<td>Country</td>
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<tr>
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<tr>
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<td>8</td>
<td>MMDDYY</td>
<td>(50) Supervising Physician Signature Date.</td>
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<tr>
<td>CURSTSIT</td>
<td>Char</td>
<td>1</td>
<td>SMSET</td>
<td>(37) Current Dialysis Treatment Site.</td>
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<tr>
<td>CURTXS</td>
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<td>1</td>
<td>SMETXST (34.)</td>
<td>Transplant Status.</td>
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<tr>
<td>DECBAS</td>
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<td>(CMS) Decision regarding how the patient was confirmed as ESRD.</td>
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<tr>
<td>DIALDAT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>(24.) Date Regular Dialysis Began.</td>
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<td>(CMS) Date patient stopped dialysis therapy.</td>
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<tr>
<td>DIALRDT</td>
<td>Num</td>
<td>8</td>
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<td>(36.) Dialysis Return date after a transplant rejection.</td>
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<td>(CMS) Date of patients death.</td>
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<td>(18.c) Was patient under care of kidney dietitian?</td>
</tr>
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<td>RANGE (18.c.1)</td>
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<td>RANGE</td>
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<td>ETHN</td>
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<td>SMETH (8.)</td>
<td>Patients ethnicity.</td>
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<td>(25.) Date Patient Started at 2728 Provider.</td>
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<td>GFR calculated (Ab. Levey or Schwartz)</td>
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<td>Hemoglobin Value (g/dl).</td>
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<td>(19.c.1) Hemoglobin Date.</td>
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<td>HEIGHT</td>
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<td>(13.) Patient Height. (cm)</td>
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<tr>
<td>HEMOHOURS</td>
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<td>(23.2) Primary Type of Dialysis: Hemodialysis-(Hours per session)</td>
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<tr>
<td>HEMOSESSIONS</td>
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<td>(23.1) Primary Type of Dialysis: Hemodialysis-(Sessions per week)</td>
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<td>Age at incidence (ESRD date from profile)</td>
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<td>INHOSP</td>
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<td>(CMS) Was patient admitted prior to the transplant.</td>
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<td>LABMETHOD</td>
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<td>(19.a.3) Serum Albumin Lower Limit: Lab Method Used (BCG or BCP)</td>
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<td>LIPIDPROFILEHDLDATE</td>
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<td>8</td>
<td>MMDDYY</td>
<td>(19.e.3.1) Lipid Profile HDL Date</td>
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<tr>
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<td>MMDDYY</td>
<td>(19.e.2.1) Lipid Profile LDL Date</td>
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<td>MMDDYY</td>
<td>(19.e.1.1) Lipid Profile TC Date</td>
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<td>(55. - 1995 Form) Network Number.</td>
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<tr>
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<td>(27.) Patient NOT informed of TX options: Patient declines information</td>
</tr>
<tr>
<td>PATTXOP_MEDUNFIT</td>
<td>Char</td>
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<td></td>
<td>(27.) Patient NOT informed of TX options: Medically unfit</td>
</tr>
<tr>
<td>PATTXOP_OTHER</td>
<td>Char</td>
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<td>(27.) Patient NOT informed of TX options: Other</td>
</tr>
<tr>
<td>PATTXOP_PHYSUNFIT</td>
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<tr>
<td>PATTXOP_UNSASSESSED</td>
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<td></td>
<td>(27.) Patient NOT informed of TX options: Patient has not been assessed</td>
</tr>
<tr>
<td>PATTXOP_UNSUITEGE</td>
<td>Char</td>
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<td></td>
<td>(27.) Patient NOT informed of TX options: Unsuitable due to age</td>
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<tr>
<td>SERCR</td>
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<td>8</td>
<td>MMDDYY</td>
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<tr>
<td>TDATE</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>(28.) Date of most recent transplant.</td>
</tr>
<tr>
<td>TRAINSET</td>
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<td>TRAINSET</td>
<td>(41.ab) Hemodialysis Training Setting: Home or Center</td>
</tr>
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<td>TRNEND</td>
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<td>(42.) Patient has/will complete training.</td>
</tr>
<tr>
<td>TSTDAT</td>
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<td>(40.) Dialysis Training Begin Date.</td>
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<td>USRDS_ID</td>
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<tr>
<td>WEIGHT</td>
<td>Num</td>
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<td>(14.) Patient Weight. (kg)</td>
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**RESIDENC: Residence**  
*Provides a longitudinal record to ZIP code level of each patient's place of residence.*

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<td>County (FIPS code)</td>
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<td>ENDRES</td>
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<td>8</td>
<td>DATE</td>
<td>Ending date for this period</td>
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<td>FSD</td>
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<td>In USA? (Y/N)</td>
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<td>ZIP_ZIPCODE</td>
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The CMS ESRD Annual Facility Survey and the CDC Dialysis Surveillance Survey are the sources of survey data for the Facility SAF, which can be linked to the Facility Cost Report files using the USRDS provider ID. Because of this link, geographic variables that could be used to identify facilities have been deleted. The survey period is January 1 through December 31.

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</tr>
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<td>CATRAIND</td>
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<td>BEST</td>
<td>32 CAPD</td>
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<td>DATE</td>
<td>Date of Cert. to provide renal serv.</td>
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<tr>
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<td>54 Sent to Another U.S. facility</td>
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<td>53 Transplanted at this facility</td>
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### FACILITY: CMS/CDC ESRD Annual Facility (continued)

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<td>BEST</td>
<td>08B Home - Deaths</td>
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### Format  |
### Comment |
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| OPATXPLT | Num  | 8 | BEST | 58 Transplanted at this facility |
| OTH_WAIT | Num  | 8 | BEST | 52 Non-Dialysis |
| PCRTCODE | Char  | 1 | $FSCERT | Prior certification type |
| PCRTDATE | Num  | 8 | BEST | Prior certification date |
| PERHOME | Num  | 8 | BEST | 22 Home Dialysis - IPD |
| PERI | Char  | 1 | $YNYNFMT | Staff Assisted Peri. Indicator |
| PERNTRTG | Num  | 8 | BEST | 17 Self Dialysis Training - IPD |
| PERISC | Char  | 1 | $YNYNFMT | In-Unit Self-Care Peri. Indicator |
| PERITRNG | Char  | 1 | $YNYNFMT | Peri. Training Indicator |
| PERSLSTF | Num  | 8 | BEST | 15 Outpatient Dialysis - IPD |
| PROVST | Char  | 2 | $ | State Abbreviation |
| PROVUSRD | Num  | 8 | BEST | USRDS Assigned Facility ID |
| PTRGTRT | Num  | 8 | BEST | 39 IPD |
| PTRMCODE | Char  | 1 | $TERMCOD | Prior Termination reason |
| PTRMDATE | Num  | 8 | BEST | Prior Termination Date |
| RLIVDONR | Num  | 8 | BEST | 47 Living Related |
| SHTRAIND | Num  | 8 | BEST | 30 Hemodialysis |
| SPTRAIND | Num  | 8 | BEST | 31 IPD |
| SURVCERT | Char  | 1 | $FSCERT | Cert. Type for Fac. Survey Purposes |
| T1SCRD | Num  | 8 | BEST | 78 Discarded Kidneys |
| TERMDATE | Num  | 8 | BEST | 78 Discarded Kidneys |
| TOT_LOSS | Num  | 8 | BEST | 76 Non-Viable Kidneys |
| TOT TXPL | Num  | 8 | BEST | 75 Sent Outside the U.S. |
| TOT_US | Num  | 8 | BEST | 74 Sent to Another U.S. facility |
| TOTTXPLT | Num  | 8 | BEST | 73 Transplanted at this facility |
| TRSRTCCH | Num  | 8 | BEST | 77 Used for research |
| TRSI_PAT | Num  | 8 | BEST | 34 Treated during Survey Period |
| TRSI_TRT | Num  | 8 | BEST | 35 Number of outpatient treatments |
| TNONMED | Num  | 8 | BEST | 46 Non-Medicare - Other |
| TXPL_PAT | Num  | 8 | BEST | 42 Patients transplanted at this facil. |
| TYPOWNER | Char  | 2 | $FSOWN | Type of Ownership |
| ULIVDONR | Num  | 8 | BEST | 48 Living Unrelated |
| ZIPCODE | Char  | 5 | | Zip Code of Facility |
## WAITLIST_KI: Transplant Waiting List (Kidney)
Contains one record for each patient per waiting list event in the USRDS database who can also be identified on the kidney transplant waiting list maintained by UNOS.

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<td>Most Updated Current PRA in the UNet System</td>
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**WAITLIST_KI: Transplant Waiting List (Kidney) (continued)**

Contains one record for each patient per waiting list event in the USRDS database who can also be identified on the kidney transplant waiting list maintained by UNOS.

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### WAITLIST_KP: Transplant Waiting List (Kidney/Pancreas)

Contains one record for each patient per waiting list event in the USRDS database who can also be identified on the kidney transplant waiting list maintained by UNOS.

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Appendix D: Data File Descriptions 87
### WAITLIST_KP: Transplant Waiting List (Kidney/Pancreas) (continued)
Contains one record for each patient per waiting list event in the USRDS database who can also be identified on the kidney transplant waiting list maintained by UNOS.

<table>
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<tr>
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### WAITSEQ_KI: Transplant Waiting List Sequence (Kidney)
A condensed kidney transplant waiting list date sequence file, center-specific and containing beginning and ending dates for each patient at each transplant center where patients are registered on the waiting list. Investigators who wish to investigate the raw UNOS kidney waiting list file should refer to WAITLIST_KI. Also refer to Transplant Process and Outcomes, for a more detailed description of these files.

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### WAITSEQ_KP: Transplant Waiting List Sequence (Kidney/Pancreas)
A condensed kidney/pancreas transplant waiting list date sequence file, center-specific and containing beginning and ending dates for each patient at each transplant center where patients are registered on the waiting list. Investigators who wish to investigate the raw UNOS kidney/pancreas waiting list file should refer to WAITLIST_KP. Also refer to Transplant Process and Outcomes, for a more detailed description of these files.

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**CORE CD-3**

**RXHIST: Detailed Treatment History**
Also called the Modality Sequence file; contains a new record for each patient at each change in treatment modality or dialysis provider.

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<td>End date of this period</td>
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### ADEQUACY: Case Mix Adequacy Special Study
Contains the Case Mix Adequacy Special Study file and extracts data from all other SAFs for the patients in this study. All data on Medicare and payments for these patients are followed to the currently reported claims year. Along with analyses related to the study itself, this file is useful for developing analyses that will alter and be run on the full Medicare payment files.

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<td>AQP C.2: Dry weight - pounds</td>
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<td>HHemo</td>
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<td>8</td>
<td>DATE</td>
<td>AQP E3: Date of switch to home hemo</td>
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### ADEQUACY: Case Mix Adequacy Special Study (continued)

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<td>AQP C1: Height - cm.</td>
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<td>HT_FT</td>
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<td>AQP A11: SSD per instructions</td>
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<td>AQP B 9c: Known metastases</td>
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<td>AQP B 9b: Date of first neoplasm Dx</td>
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### ADEQUACY: Case Mix Adequacy Special Study (continued)

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**ADQFACS: Case Mix Adequacy Special Study Facility**

Contains the Case Mix Adequacy Special Study file and extracts data from all other SAFs for the patients in this study. All data on Medicare and payments for these patients are followed to the currently reported claims year. Along with analyses related to the study itself, this file is useful for developing analyses that will alter and be run on the full Medicare payment files.

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The USRDS CAPD and Peritonitis Rates Study examined the relationship of peritonitis episodes in CAPD patients to the connection device technology and other factors.

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**CAPD: CAPD Peritonitis Special Study (continued)**
## CAPD: CAPD Peritonitis Special Study (continued)

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**CASEMIXS: Case Mix Severity Special Study**

The study consists of two groups of patients: an incident sample of ESRD patients who began hemodialysis during 1990, and a prevalent sample of hemodialysis patients with onset of ESRD prior to 1990.

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### CASEMIXS: Case Mix Serverity Special Study  (continued)

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CLMCODES: Claim Codes
Frequency of occurrence of each code. A starting point for analyses using diagnosis and procedure codes.

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CMSEFACS: Case Mix Severity Special Study Patient Form
Facility Questionnaire for Case Mix Severity Special Study

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DIALYZER: Dialyzers
The Case Mix Serverity, Case Mix Adequacy, and DMMS Special Studies all collected information on the manufacturer and model of the dialyzer used for a patient at a specific time.

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### DMMSWA V1: DMMS Wave 1 Patients

Each wave includes a data collection instrument for collecting core data that allows collection of a consistent set of fundamental data for research questions that require a large sample size. Wave 1 includes a non-core component designed to address additional research questions that require smaller sample sizes.

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**DMMSWAV1: DMMS Wave 1 Patients (continued)**

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### DMMSWA V1: DMMS Wave 1 Patients (continued)

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## DMMSWA V1: DMMS Wave 1 Patients (continued)

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**DMMSWAV2: DMMS Wave 2 Patients**

Each wave includes a data collection instrument for collecting core data that allows collection of a consistent set of fundamental data for research questions that require a large sample size. Wave 2 includes a non-core component designed to address additional research questions that require smaller sample sizes.

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### DMMSAV2: DMMS Wave 2 Patients (continued)

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### DMMSWAV2: DMMS Wave 2 Patients (continued)

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### DMMSWAV2: DMMS Wave 2 Patients (continued)

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### DMMSWAV2: DMMS Wave 2 Patients (continued)

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### DMMSWAV2: DMMS Wave 2 Patients (continued)

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### DMMSWAV2: DMMS Wave 2 Patients (continued)

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DMMSWV34: DMMS Wave 3 & 4 Patients
Each wave includes a data collection instrument for collecting core data allowing collection of a consistent set of fundamental data for research questions that require a large sample size. Waves 3 and 4 are historical prospective studies in which data were collected for patients receiving in-center hemodialysis on December 31, 1993, and each planned to include 6,000 patients.

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## DMMSWA V34: DMMS Wave 3 & 4 Patients (continued)

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## DMMSWAV34: DMMS Wave 3 & 4 Patients (continued)

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Appendix D: Data File Descriptions 117
## DMMSAV34: DMMS Wave 3 & 4 Patients (continued)

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### DMMSFACS1: DMMS Special Studies Facility

*Facility Questionnaire for Wave I Special Study*

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### Facility Questionnaire for Wave 2 Special Study

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### DMMSFACS34: DMMS Special Studies Facility (continued)

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**FCOSHOS: Facility Cost Reports for Hospital Facilities**

*The CMS hospital and independent facility cost reports for the years 1989-1995 and 1989-1993 are available as Standard Analysis Files.*

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### FCOSIND: Facility Cost Reports for Independent Facilities

**Cost and staffing of dialysis facilities**

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PEDGROW: Pediatric Growth

All patients prevalent in 1990 who were born after December 31, 1970 are included in the study, with a study population of more than 3000 cases. The ESRD Networks began receiving data from units and centers with eligible patients in April, 1991. Data collection was completed by the Networks in the early fall of 1991.

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### PEDGROW: Pediatric Growth (continued)

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## Appendix D: Data File Descriptions

**WA V2UPDT: Wave 2 Special Study Updated with USRDS Established ESRD Dates**

Wave 2 Study with updated variables.

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### WAV2UPDT: Wave 2 Special Study Updated with USRDS Established ESRD Dates (continued)

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### Appendix D: Data File Descriptions

#### WAV2UPDT: Wave 2 Special Study Updated with USRDS Established ESRD Dates (continued)

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<td>MODACT</td>
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<td>D2Q A4: Moderate acts: vacuuming, bowel</td>
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<td>MODACT2</td>
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<td>MORSTRS</td>
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<td>$AGREE6A</td>
<td>D2Q C 8g: PD more stressful than HD</td>
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<td>MOSTIMP</td>
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<td>D2Q C 9: Most imp reason for txt choice</td>
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<td>D2Q A47: Muscle soreness</td>
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<td>MYSELF</td>
<td>Char</td>
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<td>D2Q D5: Who pays: Myself/family</td>
</tr>
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<td>NAP</td>
<td>Char</td>
<td>1</td>
<td>$YESNO</td>
<td>D2Q A69: Sleep/nap during day</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
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<td>Char</td>
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<td>D2Q A57: Nausea/upset stomach</td>
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<td>$NOYES</td>
<td>D2Q D3: Requires help walking/climbing</td>
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<td>NEEDLES</td>
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<td>DW2.M B 9b: Year of first neoplasm Dx</td>
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<td>NEPHVST</td>
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<td>$VISITS</td>
<td>D2Q B4: Visits to nephrologist prior to</td>
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<td>NERPVER</td>
<td>Char</td>
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<td>$TIME6A</td>
<td>D2Q A24: Nervous person</td>
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<td>NERPVER2</td>
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<td>DW2.PFUP A24: Nervous Person</td>
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<td>$NETFMT</td>
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<td>NOCAR</td>
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<td>$NOYES</td>
<td>D2Q D3: No access to a car</td>
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<tr>
<td>NO&gt;Nama</td>
<td>Char</td>
<td>1</td>
<td>$NOYES</td>
<td>D2Q D3: Does not know how to drive</td>
</tr>
<tr>
<td>NOIN51</td>
<td>Char</td>
<td>1</td>
<td>$YESNO</td>
<td>DW2.M A 9g: No Insurance Mth bfore A6</td>
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<tr>
<td>NOIN52</td>
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<td>$YESNO</td>
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<tr>
<td>NOTABLE</td>
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<td>$NOYES</td>
<td>D2Q D3: No longer able to drive a car</td>
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<tr>
<td>NOTDRIV2</td>
<td>Char</td>
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<td>$NOYES</td>
<td>D2Q E1a: Not currently employed</td>
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<td>NOTSTRCT</td>
<td>Char</td>
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<td>D2Q C 8d: Diet less strict with HD</td>
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<td>DW2.PFUP A56: Numbness in hands/feet</td>
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<td>D2Q B9a: # months prior to start of HD</td>
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<td>DW2.M D 6d: Number of Transfusions recd</td>
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<tr>
<td>NWLSBNFT</td>
<td>Char</td>
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<td>$NOYES</td>
<td>D2Q F3: Not working: Lose benefits, cl</td>
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<tr>
<td>NWLSBNT2</td>
<td>Char</td>
<td>1</td>
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<td>DW2.PFUP E3: S.Work: Would lose Benefits</td>
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<tr>
<td>NWNOFLX</td>
<td>Char</td>
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<td>D2Q F3: Not working: No other job avai</td>
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<td>NWNOND</td>
<td>Char</td>
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<td>$NOYES</td>
<td>D2Q F3: Not working: Did not want/need</td>
</tr>
<tr>
<td>NWNOND2</td>
<td>Char</td>
<td>1</td>
<td>$NOYES</td>
<td>DW2.PFUP E3: S.Work: No Need/Want to wrk</td>
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<tr>
<td>NWOTHDT</td>
<td>Char</td>
<td>1</td>
<td>$NOYES</td>
<td>D2Q F3: Not working: Needed for other</td>
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<tr>
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<tr>
<td>NWTRRD</td>
<td>Char</td>
<td>1</td>
<td>$NOYES</td>
<td>D2Q F3: Not working: I am retired</td>
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<tr>
<td>NWTRRD2</td>
<td>Char</td>
<td>1</td>
<td>$NOYES</td>
<td>DW2.PFUP E3: Stopped Work: I am retired</td>
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<tr>
<td>NWTOSK</td>
<td>Char</td>
<td>1</td>
<td>$NOYES</td>
<td>D2Q F3: Not working: Too sick, too muc</td>
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<tr>
<td>NWTOSK2</td>
<td>Char</td>
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<td>DW2.PFUP E3: Stopped Work: Too sick</td>
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<tr>
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<td>D2Q F3: Not working: Job is too tiring</td>
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<tr>
<td>NWTTRD3M</td>
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<tr>
<td>NWTTRD3M2</td>
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<tr>
<td>OCCUPAT</td>
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<td>D2Q C 1: Treat opt disc: CAPD at home</td>
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<tr>
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<td>D2Q C 1: Treat opt disc: HD in dial unit</td>
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<td>ODPERCEN</td>
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<td>D2Q C 1: Treat opt disc: PD at center</td>
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<td>ODPERCYC</td>
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<td>D2Q A22: Amt of pain interference w/ wo</td>
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<td>DW2.PFUP A22: Amt of pain interfer, w/work</td>
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<td>PCDIS</td>
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<td>DW2.M B 1: Primary Cause of ESRD</td>
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<td>PCATHDAY</td>
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<td>DW2.M C 5o: day PD catheter</td>
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<td>PCATHMTH</td>
<td>Char</td>
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<td>DW2.M C 5o: mth PD catheter</td>
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<td>DW2.M C 4a: DBP at SSD / predialysis</td>
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<td>DW2.MFUP B3a: Pre Weight in KG or LB</td>
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<td>DW2.M C 4a: SBP at SSD / predialysis</td>
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<td>DW2.M C 4a: SBP at SSD / predial 3rd</td>
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<td>DW2.M A 9b: Private at/near A7</td>
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<td>DW2.MFUP B3b: Post Weight in KG or LB</td>
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### WAV2UPDT: Wave 2 Special Study Updated with USRDS Established ESRD Dates (continued)

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### WAV2UPDT: Wave 2 Special Study Updated with USRDS Established ESRD Dates (continued)

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**CORE CD-4**

**MEDEVID: Medical Evidence form**

Contains full data from the 1995 and 2005 versions of the CMS Medical Evidence Report (CMS-2728). This is the source of data regarding primary cause of renal disease and start date of chronic renal dialysis.

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<td>COMO_PVD</td>
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<td>1</td>
<td>(17.e) Co-Morbid E: Peripheral vascular disease*.</td>
<td></td>
</tr>
<tr>
<td>COMO_TOBAC</td>
<td>Char</td>
<td>1</td>
<td>(17.m) Co-Morbid M: Tobacco use (current smoker).</td>
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<tr>
<td>COMO_TOXNEPH</td>
<td>Char</td>
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<td>(17.o) Co-Morbid O: Toxic nephropathy.</td>
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<tr>
<td>COMORBID</td>
<td>Char</td>
<td>49</td>
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<td>(17.) Concatenates the patients comorbidty factors</td>
</tr>
<tr>
<td>COUNTRY</td>
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<td>8</td>
<td>COUNTRY</td>
<td>(9.) Country</td>
</tr>
<tr>
<td>CRDATE</td>
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<td>(CMS) Date this form was entered into the system.</td>
</tr>
<tr>
<td>CREADATE</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>Creatinine clearance (Q18f)</td>
</tr>
<tr>
<td>CREA</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>(Q18f)</td>
</tr>
<tr>
<td>CREADAT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>Creatinine clearance date (Q18f)</td>
</tr>
<tr>
<td>CTDATE</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>(50.) Supervising Physician Signature Date.</td>
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<tr>
<td>CURSTST</td>
<td>Char</td>
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<td>SMSET</td>
<td>(37) Current Dialysis Treatment Site.</td>
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<tr>
<td>CURTXS</td>
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<td>(34.) Transplant Status.</td>
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<tr>
<td>CVA</td>
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<td>SYNFMT</td>
<td>Cerebrovascular disease, CVA TIA (Q16g)</td>
</tr>
<tr>
<td>DECRA</td>
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<td>(CMS) Decision regarding how the patient was confirmed as ESRD.</td>
</tr>
<tr>
<td>DIABINS</td>
<td>Char</td>
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<td>Diabetes, currently on insulin (Q16k)</td>
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<tr>
<td>DIABPRIM</td>
<td>Char</td>
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<td>SYNFMT</td>
<td>Diabetes, (primary or contrib.) (Q16k)</td>
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<td>(24.) Date Regular Dialysis Began.</td>
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<tr>
<td>DIALEDT</td>
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<td>(CMS) Date patient stopped dialysis therapy.</td>
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<tr>
<td>DIALRAT</td>
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<td>(36.) Dialysis Return date after a transplant rejection.</td>
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<td>(22.) Dialysis Setting.</td>
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<td>(CMS) Date of patients death.</td>
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Appendix D: Data File Descriptions 145
### MEDEVID: Medical Evidence form (continued)

<table>
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<tr>
<th>Variable</th>
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<td>DIETCARE</td>
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<td>(18.c) Was patient under care of kidney dietitian?</td>
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<tr>
<td>DONORTYPERANGE</td>
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<td>(25.) Date Patient Started at 2728 Provider.</td>
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<td>GFR calculated (Ab. Levey or Schwartz)</td>
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<td>HBA1C</td>
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<td>(19.d) HbA1c (%).</td>
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<td>(19.d.1) HbA1c Date</td>
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<td>Hematocrit date (Q18a)</td>
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<td>Hematocrit (Q18a)</td>
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<td>(19.c) Hemoglobin Value (g/dL).</td>
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<td>(13.) Patient Height. (cm)</td>
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<td>(23.2) Primary Type of Dialysis: Hemodialysis-(Hours per session)</td>
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<td>HEMOSESSIONS</td>
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<td>(16.2) Ischemic heart disease (Q16b)</td>
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<td>Age at incidence (ESRD date from profile)</td>
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<td>(CMS) Was patient admitted prior to the transplant.</td>
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<td>(19.a.3) Serum Albumin Lower Limit: Lab Method Used (BCG or BCP)</td>
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<td>LIPIDPROFILEHDLDATE</td>
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<td>(19.e.3.1) Lipid Profile HDL Date</td>
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<td>Medicare coverage (Q10c)</td>
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<tr>
<td>MDCRCOD</td>
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<td>(11.) Patient is applying for ESRD Medicare.</td>
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<tr>
<td>MEDCOW_ADVANTAGE</td>
<td>Char</td>
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<td>(12.) Patient is currently entitled to Federal Medicare Advantage benefits.</td>
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<tr>
<td>MEDCOW_GROUP</td>
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<td>(12.) Patient receives medical benefits through an employer group health plan.</td>
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<tr>
<td>MEDCOW_MEDDVA</td>
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<td>(12.) Patient is receiving medical care from a Department of Veterans Affairs facility.</td>
</tr>
<tr>
<td>MEDCOW_MEDICAID</td>
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<td>(12.) Patient is receiving state Medicaid benefits.</td>
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<tr>
<td>MEDCOW_MEDICARE</td>
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<td>(12.) Patient is currently entitled to Federal Medicare benefits.</td>
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<td>MEDCOW_NONE</td>
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<td>(12.) Patient has no medical insurance plan.</td>
</tr>
<tr>
<td>MEDCOW_OTHER</td>
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<td></td>
<td>(12.) Patient is receiving other medical benefits.</td>
</tr>
<tr>
<td>MEDICALCOVERAGE</td>
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<td>(12.) Concatenates the patients Medical Coverage</td>
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<td>MESEQ</td>
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<tr>
<td>MI</td>
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<td>(18.b) Was patient under care of a nephrologist?</td>
</tr>
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<td>NEPHCARE</td>
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<td>RANGE</td>
<td>(18.b.1) Was patient under care of a nephrologist? If Yes,6-12 or &gt;12 mths</td>
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<td>NETADT</td>
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### MEDEVID: Medical Evidence form (continued)

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<td>PATINFORMED</td>
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<td>Has patient been informed of kidney transplant options?</td>
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<td>PATNOTINFORMEDREASON</td>
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<td>PATTXOPDECLINE</td>
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<tr>
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<td>TRAINSET</td>
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<td>(42.) Patient has/will complete training.</td>
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<td>(40.) Dialysis Training Begin Date.</td>
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<td>ACAPRG</td>
<td>KIR: Recipient Academic Progress</td>
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<td>8</td>
<td>ACAPRG</td>
<td>TCR_KI: Patient Academic Progress at Listing Time</td>
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<td>ACREJEPI</td>
<td>KIR: Did patient have any acute rejection episodes between tx and disch</td>
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<td>KIR: Recipient Age at Transplant Time</td>
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<td>ANTI_VIRAL</td>
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<td>BACK_TBL_FLUSH_DBL_ENBKI</td>
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<td>CDR: Donor Double Enbloc Kidney Back Table Flash Solution</td>
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**TRANSPORT CD-1 AND CD-2**

**TXUNOS_KI_PRE_JUL04 and TXUNOS_KI_POST_JUL04: Kidney Transplants UNOS**

Includes transplant details collected by UNOS for years since 1988.
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<td>BACK_TBL_FLUSH_PA</td>
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<td>BIOP_ARTER_SCLERO_LT</td>
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<td>KIR: Multiple Organ Recipient: Bone Marrow (T/F)</td>
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<td>LDR: Preoperative Blood Pressure Diastolic</td>
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<td>COGDEVLP</td>
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<td>COGDEVLP</td>
<td>TCR_KI: Cognitive Development(Pediatric Only) at Listing Time</td>
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<td>COLD_ISCH_PUMP_KI_LT</td>
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<td>KIR: Total Cold ischemia Time Left KI(OR EN-BLOC): (if pumped, include pump time)</td>
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<tr>
<td>COLD_ISCH_TM_RT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KIR: Total Cold Ischemic Time KI Right. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>COLD_ISCH_TM_RT_I</td>
<td>Char</td>
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<td>$TRIND</td>
<td>KIR: Total Cold Ischemic Time/Status KI Right. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>CONSENT_ATTORNEY</td>
<td>Char</td>
<td>1</td>
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</tr>
<tr>
<td>CONSENT_DOC_Mech_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Other Consent Mechanism intent to be a donor, Specify</td>
</tr>
<tr>
<td>CONSENT_DON_CARD</td>
<td>Char</td>
<td>1</td>
<td></td>
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<td>CONSENT_DON_REGIS</td>
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<td>CONSENT_DRIVE_LIC</td>
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<tr>
<td>CONSENT_LIV_WILL</td>
<td>Char</td>
<td>5</td>
<td>$YNUNK</td>
<td>CDR: Consent based solely on written documentation: mechanisms/ Living will. Stop Collect From 2004</td>
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<tr>
<td>CONSENT_PX_WRIT_DOC</td>
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<td>CDR: Was the consent based solely on this documentation</td>
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<td>CONSENT_TIME</td>
<td>Char</td>
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<td>CDR: Date and time consent obtained for first organ</td>
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<td>CONSENT_WRIT_DOC_INTENT</td>
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<td>CDR: Did the patient have written documentation of their intent to be a donor</td>
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<td>CONTIN_ALCOHOL</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>CDR: Continued alcohol in last six months. Stop Collect From 2004</td>
</tr>
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<td>CONTIN_COCAIN</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Lifestyle Factors: Cocaine Use AND continued in last six months</td>
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<td>CONTIN_IV_DRUG</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>CDR: Continued IV Drug Use in last six months. Stop Collect From 2004</td>
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<td>CONTROLLED</td>
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<td>$YNUNK</td>
<td>CDR: If Was a DCD donor, controlled(Y/N/U)</td>
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<td>CONVERT_OPEN_KI</td>
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<td>$YNUNK</td>
<td>LDR: Kidney Surgical Information: Conversion from Laparoscopic to Open</td>
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<tr>
<td>CREAT_CLEAR</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KIR: Pretransplant Creatinine Clearance. Stop Collect from 6/30/2004</td>
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<td>CREAT_CLEAR_I</td>
<td>Char</td>
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<td>KIR: Pretransplant Creatinine Clearance/Status. Stop Collect from 6/30/2004</td>
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<td>CREAT_CLEAR_I_L</td>
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<td>TCR_KI: Creatinine Clearance/Status at Listing Time. Stop Collect from 6/30/2004</td>
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<tr>
<td>CREAT_CLEAR_L</td>
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<td>TCR_KI: Creatinine Clearance at Listing Time. Stop Collect from 6/30/2004</td>
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<td>CREAT_CLEAR_METH</td>
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<td>CREATMET</td>
<td>KIR: Pretransplant Creatinine Clearance Method. Stop Collect from 6/30/2004</td>
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<td>CREAT_CLEAR_METH_L</td>
<td>Num</td>
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<td>CREATMET</td>
<td>TCR_KI: Creatinine Clearance/Method at Listing Time. Stop Collect from 6/30/2004</td>
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<td>CREATDEC</td>
<td>Char</td>
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<td>KIR: Creatinine decline by 25% or more in first 24 hours on 2 separate samples(Y/N)</td>
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<td>CRSMATCH_DONE_PERIOD</td>
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<td>RHS: If Crossmatch Done yes, was the crossmatch prospective to transplant</td>
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<td>CTR_TY</td>
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<td>CVASCER</td>
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<td>LDR: DONOR WORKUP FACILITY</td>
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<td>DA1</td>
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<td>USRDS: DONOR HLA TYPING A(1)</td>
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<td>Char</td>
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<td>USRDS: DONOR HLA TYPING A(2)</td>
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<td>DABO</td>
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<td>CDR: ABO Blood Group</td>
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<td>DANCONV</td>
<td>Char</td>
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<td>CDR: Medications administered within 24 hr prior to crossclamp:</td>
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<td>Anticonvulsants(Y/N/U)</td>
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<td>Antihypertensives(Y/N/U)</td>
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<td>Char</td>
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<td>CDR: Serology: Anti-HBC</td>
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<td>CDR: Serology: Anti-HCV</td>
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<td>DB1</td>
<td>Char</td>
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<td></td>
<td>USRDS: DONOR HLA TYPING B(1)</td>
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<tr>
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<tr>
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<td>DHS: Typing Method Class I: B(1)</td>
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<td>DISCD_CD</td>
<td>CDR: Reason organ not transplanted - Double Enbloc Kidney</td>
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<td>DBLDINF</td>
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<td>CDR: Terminal Lab Data: BUN</td>
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<tr>
<td>DBUN ST</td>
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<td>CDR: Terminal Lab Data: BUN, Status</td>
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<td>DBW4D</td>
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<td>DCANCER</td>
<td>Char</td>
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<td>CDR / LDR: History of Cancer, Specify</td>
</tr>
<tr>
<td>DCDATE</td>
<td>Num</td>
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<td>MMDDYY</td>
<td>KIR: Date of Discharge from Tx Center</td>
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<tr>
<td>DCITY</td>
<td>Char</td>
<td>20</td>
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<td>CDR / LDR: Home City</td>
</tr>
<tr>
<td>DCITYZ</td>
<td>Num</td>
<td>8</td>
<td>CITIZEN</td>
<td>CDR / LDR: Donor Citizenship</td>
</tr>
<tr>
<td>DCMV</td>
<td>Char</td>
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<td>$SCREEN</td>
<td>CDR / LDR: Serology: Anti-CMV</td>
</tr>
<tr>
<td>DCMV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>$YNUNK</td>
<td>LDR: Viral Detection: DCMV_YN / If Yes, Was there clinical disease</td>
</tr>
<tr>
<td>DCMV_CULTURE</td>
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<td>2</td>
<td>$SCREEN</td>
<td>LDR: Viral Detection: DCMV_YN / If Yes, Culture</td>
</tr>
<tr>
<td>DCMV DNA</td>
<td>Char</td>
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<td>$SCREEN</td>
<td>LDR: Donor CMV DNA. Stop Collect From 2004</td>
</tr>
<tr>
<td>DCMV IGG</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>LDR: Viral Detection: CMV IGG</td>
</tr>
<tr>
<td>DCMV IGM</td>
<td>Char</td>
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<td>$SCREEN</td>
<td>LDR: Viral Detection: CMV IGM</td>
</tr>
<tr>
<td>DCMV NUCLEIC</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>LDR: Viral Detection: DCMV_YN / If Yes, Nucleic Acid Testing</td>
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<td>DCMV YN</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>LDR: Viral Detection: CMV tested</td>
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<td>DCNFREE</td>
<td>Num</td>
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<td>CDR / LDR: History of Cancer: Cancer Free Interval(years)</td>
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<td>DCNFREEST</td>
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<td>CDR / LDR: History of Cancer: Cancer Free Interval, Status</td>
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<tr>
<td>DCNTRY</td>
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<td>$CTRY</td>
<td>CDR: Home Country</td>
</tr>
<tr>
<td>DCOD</td>
<td>Num</td>
<td>8</td>
<td>DON_COD</td>
<td>CDR: Deceased Donor Cause of Death</td>
</tr>
<tr>
<td>DCOD1TXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR / LDR: Cause of Death, Specify</td>
</tr>
<tr>
<td>DCONCIG</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Lifestyle Factors: Cigarette Use AND continued in last six months</td>
</tr>
<tr>
<td>DCON OR COOL</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>CDR: If was a DCD donor Yes, Core Cooling Used</td>
</tr>
<tr>
<td>DCON OR DRUG</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>CDR: Lifestyle Factors: Other Drug Use AND continued in last six months</td>
</tr>
<tr>
<td>DCREAT</td>
<td>Num</td>
<td>8</td>
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<td>CDR / LDR: Donor Pre-Donation Serum Creatinine</td>
</tr>
<tr>
<td>DCREST</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR / LDR: Donor Pre-Donation Serum Creatinine, Status</td>
</tr>
<tr>
<td>DCW1D</td>
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<td>CWHLA</td>
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<td>CWHLA</td>
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<td>CWHLA</td>
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<tr>
<td>DDAVP</td>
<td>Char</td>
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<td>CDR: Medications administered within 24 hr prior to crossclamp: DDAVP(Y/N/U)</td>
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<tr>
<td>DDCLMPDT</td>
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<tr>
<td>DDIET</td>
<td>Char</td>
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<td>CDR: If History of Hypertension, Method of control: Diet(Y/N/U)</td>
</tr>
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<td>Char</td>
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<td>$YNUNK</td>
<td>CDR: If History of Hypertension, Method of control: Diuretics(Y/N/U)</td>
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<td>DDDOBUT</td>
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<td>CDR: Medications given to donor (24 hours prior to cross clamp): Dobutamine. Stop Separately Collect From 2003</td>
</tr>
<tr>
<td>DDOD</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Date of Death</td>
</tr>
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<td>Char</td>
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<td>$YNUNK</td>
<td>CDR: Medications given to donor (24 hours prior to cross clamp): Dopamine. Stop Separately Collect From 2003</td>
</tr>
<tr>
<td>DDP1D</td>
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<td>USRDS: DONOR HLA TYPING DR(1)</td>
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<td>Char</td>
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<td>USRDS: DONOR HLA TYPING DR(2)</td>
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<td>RHS: Donor HLA Retyping DR(1)</td>
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</tr>
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<td>DEEDUC</td>
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<td>KIR: If Pretransplant Dialysis Yes, Date First Dialedyzed</td>
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<tr>
<td>DISP_PA_SEG1</td>
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<td>CDR: Donor Right Kidney Disposition Code</td>
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<td>TCR_KI</td>
<td>Previous Transplant Organ at Listing Time</td>
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<td>TCR_KI</td>
<td>Previous Transplant Organ at Listing Time</td>
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<td>CDR: Inotropic Medications at Time of Cross Clamp: Final Dosage Duration(hours)</td>
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<td>CDR: Inotropic Medications at Time of Cross Clamp: Final Dosage Units</td>
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<td>CDR: Other Medications administered within 24 hr prior to crossclamp: Specify</td>
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<td>CDR: Donor Received Prerecovery Medication(Y/N/U). Stop Collect From 2003</td>
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<td>Char</td>
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<td>CDR / LDR: Donor Race</td>
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<td>MMDDYY</td>
<td>CDR / LDR: Orang Recovery Date</td>
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<td>HLA_TYMT</td>
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<td>HLA_TYMT</td>
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<td>CDR / LDR: Gender</td>
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<td>CDR: Cancer at time of procurement: Skin(Y/N/U)</td>
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<td>Char</td>
<td>2</td>
<td>$STATE</td>
<td>CDR / LDR: Home State</td>
</tr>
<tr>
<td>DUSPND_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR:</td>
</tr>
<tr>
<td>DTHRII</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Terminal Lab Data: Total Bilirubin</td>
</tr>
<tr>
<td>DTHRILST</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Terminal Lab Data: Total Bilirubin, Status</td>
</tr>
<tr>
<td>DTCELL1</td>
<td>Num</td>
<td>8</td>
<td>TGCELSRC</td>
<td>DHS: Target Source for Class I. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32</td>
</tr>
<tr>
<td>DTCELL2</td>
<td>Num</td>
<td>8</td>
<td>TGCELSRC</td>
<td>DHS: Target Source for Class II. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32</td>
</tr>
<tr>
<td>DTHCIRC</td>
<td>Num</td>
<td>8</td>
<td>D_CIRCUM</td>
<td>CDR: Circumstances of Death</td>
</tr>
<tr>
<td>DTHMECH</td>
<td>Num</td>
<td>8</td>
<td>D_MECH</td>
<td>CDR: Mechanism of Death</td>
</tr>
<tr>
<td>DTYMETHC1</td>
<td>Num</td>
<td>8</td>
<td>HLA_TYMT</td>
<td>DHS: Donor Typing Method Class I. Multiple selections. The value is comb of value(s) 1, 2, 4</td>
</tr>
<tr>
<td>DTYMETHC2</td>
<td>Num</td>
<td>8</td>
<td>HLA_TYMT</td>
<td>DHS: Donor Typing Method Class II. Multiple selections. The value is comb of value(s) 1, 2, 4</td>
</tr>
<tr>
<td>DTYPE</td>
<td>Char</td>
<td>3</td>
<td>$DONOR</td>
<td>KIR: Donor Type</td>
</tr>
<tr>
<td>DUR_ABSTINENCE</td>
<td>Num</td>
<td>8</td>
<td>DUR_ABS</td>
<td>LDR: History of Cigarette Use: Duration of Abstinence</td>
</tr>
<tr>
<td>DURINF</td>
<td>Char</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DVASOD</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp: Vasodilators(Y/N/U)</td>
</tr>
<tr>
<td>DVDRL</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>CDR: Serology: RPR-VDRL</td>
</tr>
<tr>
<td>DVIROUSES_TESTED</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Have HIV, CMV, HBV, HCV, EBV ever been tested for</td>
</tr>
<tr>
<td>DWGTT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR / LDR: Weight(for LDR: Post-Op(Within 6 weeks post-donation))</td>
</tr>
<tr>
<td>DWGTST</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR / LDR: Weight in kg Status</td>
</tr>
<tr>
<td>DWORK_INCOME</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Working for income(Y/N/U)</td>
</tr>
<tr>
<td>DWORK_NO_STATUS</td>
<td>Num</td>
<td>8</td>
<td>NOTWORK</td>
<td>LDR: Not Working Due To</td>
</tr>
<tr>
<td>DWORK_YES_STATUS</td>
<td>Num</td>
<td>8</td>
<td>WORKINC</td>
<td>LDR: Yes Working Status</td>
</tr>
<tr>
<td>DTIME</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: If a DCD donor, Estimated Warm Ischemic Time</td>
</tr>
<tr>
<td>DWTIMEST</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: If a DCD donor, Estimated Warm Ischemic Time, Status</td>
</tr>
<tr>
<td>Dyr_ENTRY_US</td>
<td>Char</td>
<td>29</td>
<td>$</td>
<td>LDR: If a Non-Resident Alien, Year of Entry to the U.S</td>
</tr>
<tr>
<td>DZIP</td>
<td>Char</td>
<td>10</td>
<td>$</td>
<td>CDR / LDR: Donor Home Zip</td>
</tr>
<tr>
<td>EBV</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Pretransplant EBV Detection(Y/N/U). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>EBV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>$YNUNK</td>
<td>KIR: Pretransplant EBV Detection: Was there clinical disease(Y/N/U). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>EBV_SEROSTATUS</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Viral Detection at Tx time // EBV Serology status. Converted from EBV IgG, EBV IgM and EBV DNA</td>
</tr>
<tr>
<td>EDUC</td>
<td>Num</td>
<td>8</td>
<td>ED_LEVEL</td>
<td>TCR_KI: Patient Highest Education Level at Listing Time</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
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<tr>
<td>EN_SHARE</td>
<td>Num</td>
<td>8</td>
<td>SHARETYC</td>
<td>CDR: Share Type - En-bloc Kidney. Stop Collect From 2003</td>
</tr>
<tr>
<td>EPSTDNA</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant EBV Detection: DNA(P/N/U/ND). Stop Separately Collect from 2/7/2007</td>
</tr>
<tr>
<td>EPSTIGG</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant EBV Detection: IgG(P/N/U/ND). Stop Separately Collect from 2/7/2007</td>
</tr>
<tr>
<td>EPSTIGM</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant EBV Detection: IgM(P/N/U/ND). Stop Separately Collect from 2/7/2007</td>
</tr>
<tr>
<td>EXP_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR:</td>
</tr>
<tr>
<td>EXPERACC</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>TCR_KI: Exhausted Peritoneal Access at Listing Time</td>
</tr>
<tr>
<td>EXPRESS_FAMILY</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Did the patient express to family or others the intent to be a donor</td>
</tr>
<tr>
<td>EXVASACC</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>TCR_KI: Exhausted Vascular Access at Listing Time</td>
</tr>
<tr>
<td>FFP_UNITS</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Non-Autologous Blood Administration /If Yes, Number of FFP Units</td>
</tr>
<tr>
<td>FIN_FLOW_RATE_TX</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KIR: If put on pump or stayed on pump, final flow rate at transplant</td>
</tr>
<tr>
<td>FIN_FLOW_RATE_TX_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KIR: If Kidney(s) put on pump or stayed on pump, Final flow rate at transplant, status</td>
</tr>
<tr>
<td>FIN_RESIST_TX</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KIR: If put on pump or stayed on pump, final resistance at transplant</td>
</tr>
<tr>
<td>FIN_RESIST_TX_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KIR: If Kidney(s) put on pump or stayed on pump, Final resistance at transplant, status</td>
</tr>
<tr>
<td>FINAL_FLUSH_DBL_ENBKI</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Double Enbloc Kidney Final/Storage Flush Solution</td>
</tr>
<tr>
<td>FINAL_FLUSH_DBL_ENBKI_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Double Enbloc Kidney Final/Storage Flush Solution, Specify</td>
</tr>
<tr>
<td>FINAL_FLUSH_KIL</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Left Kidney Final/Storage Flush Solution</td>
</tr>
<tr>
<td>FINAL_FLUSH_KIL_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Left Kidney Final/Storage Flush Solution, Specify</td>
</tr>
<tr>
<td>FINAL_FLUSH_KIR</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Right Kidney Final/Storage Flush Solution</td>
</tr>
<tr>
<td>FINAL_FLUSH_KIR_OSTXT</td>
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<td>50</td>
<td>$</td>
<td>CDR: Donor Right Kidney Final/Storage Flush Solution, Specify</td>
</tr>
<tr>
<td>FINAL_FLUSH_PA</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Final/Storage Flush Solution</td>
</tr>
<tr>
<td>FINAL_FLUSH_PA_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Final/Storage Flush Solution, Specify</td>
</tr>
<tr>
<td>FINAL_FLUSH_PA_SEG1</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Segment 1 Final/Storage Flush Solution</td>
</tr>
<tr>
<td>FINAL_FLUSH_PA_SEG2</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Segment 2 Final/Storage Flush Solution</td>
</tr>
<tr>
<td>FINAL_FLUSH_PA_SEG1_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Segment 1 Final/Storage Flush Solution, Specify</td>
</tr>
<tr>
<td>FINAL_FLUSH_PA_SEG2_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Segment 2 Final/Storage Flush Solution, Specify</td>
</tr>
<tr>
<td>FLUSH_DBL_ENBKI</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Double Enbloc Kidney Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_DBL_ENBKI_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Donor Double Enbloc Kidney Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_KIL</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Left Kidney Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_KIL_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Donor Left Kidney Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_KIR</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Right Kidney Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_KIR_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Donor Right Kidney Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_PA</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_PA_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Donor Pancreas Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_PA_SEG1</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Segment 1 Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_PA_SEG2</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Segment 2 Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_PA_SEG1_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Donor Pancreas Segment 1 Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
</tr>
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</tr>
<tr>
<td>FLUSH_PA_SEG2_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>CDR</td>
<td>Donor Pancreas Segment 2 Flush Solution, Specify Stop Collect From 2004</td>
</tr>
<tr>
<td>FORGOV</td>
<td>Char</td>
<td>3</td>
<td>$CTRY</td>
<td>KIR: If Primary Source of Payment is “FOREIGN GOVT”, Specify Foreign Government</td>
</tr>
<tr>
<td>FORGOV_D</td>
<td>Char</td>
<td>3</td>
<td>$CTRY</td>
<td>LDR: Primary Source of Payment: Foreign Govt Stop Collect From 2004</td>
</tr>
<tr>
<td>FORGOV_L</td>
<td>Char</td>
<td>3</td>
<td>$CTRY</td>
<td>TCR_KI: If Primary Source of Payment at Listing Time is “FOREIGN GOVT”, Specify Foreign Government</td>
</tr>
<tr>
<td>FORMAL_REQ</td>
<td>Num</td>
<td>8</td>
<td>DONATION</td>
<td>CDR: Was a formal organ donation request made Stop Collect From 2004</td>
</tr>
<tr>
<td>FORMAL_REQ_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>CDR</td>
<td>Was a formal organ donation request made, Specify Stop Collect From 2004</td>
</tr>
<tr>
<td>FREE</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Secondary Source of Payment: Free Care Stop Collect From 2004</td>
</tr>
<tr>
<td>FUNCSTAT</td>
<td>Num</td>
<td>8</td>
<td>FUNCSTAT</td>
<td>KIR: Patient Status pertaining to activities of daily living</td>
</tr>
<tr>
<td>FUNCSTL</td>
<td>Num</td>
<td>8</td>
<td>FUNCSTAT</td>
<td>TCR_KI: Patient Status pertaining to activities of daily living at Listing Time</td>
</tr>
<tr>
<td>FWDIAL</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Patient Need Dialysis within First Week(Y/N)</td>
</tr>
<tr>
<td>GFREAS1</td>
<td>Num</td>
<td>8</td>
<td>KI_C_GRF</td>
<td>KIR: Primary Cause of Graft Failure</td>
</tr>
<tr>
<td>GFRESOTH</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KIR: Primary Cause of Graft Failure, Specify</td>
</tr>
<tr>
<td>GRF_FAIL_DT1</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant Graft Fail Date</td>
</tr>
<tr>
<td>GRF_FAIL_DT2</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant Graft Fail Date</td>
</tr>
<tr>
<td>GRF_FAIL_DT3</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant Graft Fail Date</td>
</tr>
<tr>
<td>GFRFAIL</td>
<td>Char</td>
<td>1</td>
<td>$PA_STAT</td>
<td>KIR: Post Tx: Graft Status: Functioning Failed (Y/N)</td>
</tr>
<tr>
<td>GRTFRHM</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Contributory causes of graft failure: Graft Thrombosis</td>
</tr>
<tr>
<td>HAPLMAT</td>
<td>Num</td>
<td>8</td>
<td>HAPLOTY</td>
<td>DHS: Recipient of a Living Donor Information: Haplotype Match</td>
</tr>
<tr>
<td>HBCORE</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant HBV Detection: Core Antibody(P/N/U/ND)</td>
</tr>
<tr>
<td>HBSAG</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant HBV Detection: Surface Antigen(P/N/U/ND)</td>
</tr>
<tr>
<td>HBSAGC</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant HBV Detection: Serology: HBsAg</td>
</tr>
<tr>
<td>HBV</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Pretransplant HBV Detection(Y/N/U) Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HBV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>$YNUNK</td>
<td>KIR: Pretransplant HBV Detection: Was there clinical disease(Y/N/U) Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HBV_LI_HIST</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant HBV Detection: Liver Histology(P/N/U/ND) Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HBVDNA</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant HBV Detection: DNA(P/N/U/ND) Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HCRIBA</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant HCV Detection: RIBA(P/N/U/ND) Stop Separately Collect from 2/7/2007</td>
</tr>
<tr>
<td>HCSRNR</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant HCV Detection: Antibody(P/N/U/ND) Stop Separately Collect from 2/7/2007</td>
</tr>
<tr>
<td>HCV</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Pretransplant HCV Detection(Y/N/U) Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HCV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>$YNUNK</td>
<td>KIR: Pretransplant HCV Detection: Was there clinical disease(Y/N/U) Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HCV_LI_HIST</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant HCV Detection: Liver Histology(P/N/U/ND) Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HCV_SEROSTATUS</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Viral Detection at Tx time HCV Serology status Converted from HCV_ANTIBODY and HCV_RIBA</td>
</tr>
<tr>
<td>HCVRrna</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant HCV Detection: RNA(P/N/U/ND) Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HEALTH_INS</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Did the donor have health insurance</td>
</tr>
<tr>
<td>HEMATOCRIT</td>
<td>Num</td>
<td>8</td>
<td>CDR</td>
<td>Terminal Lab Data: Hematocrit</td>
</tr>
<tr>
<td>HEMATOCRIT_1</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Terminal Lab Data: Hematocrit, Status</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
</tr>
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<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>HGT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KIR: Height in Centimeters</td>
</tr>
<tr>
<td>HGT_L</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: Height in Centimeters at Listing Time</td>
</tr>
<tr>
<td>HGTST</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KIR: Height in Centimeters, Status</td>
</tr>
<tr>
<td>HGTST_L</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>TCR_KI: Height in Centimeters at Listing Time, Status</td>
</tr>
<tr>
<td>HIST_ALCOHOL</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Alcohol Dependency - Ever. Stop Collect From 2004</td>
</tr>
<tr>
<td>HIST_CANCER</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR / LDR: History of Cancer</td>
</tr>
<tr>
<td>HIST_COCAIN</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Lifestyle Factors: Cocaine Use - Ever</td>
</tr>
<tr>
<td>HIST_IV_DRUG</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: IV Drug - Ever. Stop Collect From 2004</td>
</tr>
<tr>
<td>HIST_PRISON</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: History of Prison. Stop Collect From 2004</td>
</tr>
<tr>
<td>HIV</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Pretransplant HIV Detection(Y/N/U). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HIV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>$YNUNK</td>
<td>KIR: Pretransplant HIV Detection: Was there clinical disease(Y/N/U). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HIV_SEROSTATUS</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Viral Detection at Tx time // HIV Serology status. Converted from HIV_ANTIBODY, HIV_CONF_READONLY, HIV_RNA and HIV_SCRN_READONLY from 2007</td>
</tr>
<tr>
<td>HIVCNF</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant HIV Detection: Confirmation(P/N/U/ND). Stop Separately Collect from 2/7/2007</td>
</tr>
<tr>
<td>HIVSCRN</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KIR: Pretransplant HIV Detection: Screening(P/N/U/ND). Stop Separately Collect from 2/7/2007</td>
</tr>
<tr>
<td>HLA1DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Date Typing Completed Class I</td>
</tr>
<tr>
<td>HLA2DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Date Typing Completed Class II</td>
</tr>
<tr>
<td>HLA_INTERPRET1</td>
<td>Num</td>
<td>8</td>
<td>ANTIHLAA</td>
<td>RHS: Anti-HLA Interpretation - Most Recent Class I</td>
</tr>
<tr>
<td>HLA_INTERPRET2</td>
<td>Num</td>
<td>8</td>
<td>ANTIHLAB</td>
<td>RHS: Anti-HLA Interpretation - Most Recent Class II</td>
</tr>
<tr>
<td>Hladone</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>RHS: Test Information - HLA typing Done</td>
</tr>
<tr>
<td>HMO_PPO</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Secondary Source of Payment: HMO/PPO. Stop Collect</td>
</tr>
<tr>
<td>HOSP_90_DAYS</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Was patient hospitalized during the last 90 days prior to the transplant admission</td>
</tr>
<tr>
<td>HRTX</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>KIR: Multiple Organ Recipient: Heart(T/F)</td>
</tr>
<tr>
<td>HTLV</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>CDR: Serology: Anti-HTLV 1/II</td>
</tr>
<tr>
<td>HYPER_Diet</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: History of Hypertension / If Yes, MethodCtl: Diet</td>
</tr>
<tr>
<td>HYPER_Diur</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: History of Hypertension / If Yes, MethodCtl: Diuretics</td>
</tr>
<tr>
<td>HYPER_Meds</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: History of Hypertension / If Yes, MethodCtl: Other Hypertensive Med</td>
</tr>
<tr>
<td>HYPERTENSION</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Post-Op(Within 6 weeks post-donation): Donor Developed HTN Requiring Med</td>
</tr>
<tr>
<td>INFECT</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Contributory causes of graft failure: Infection</td>
</tr>
<tr>
<td>INFECT_HOSP</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Infections During Hosp. Stop Collect From 2004</td>
</tr>
<tr>
<td>INIT_DISCHARGE_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Date of Initial Discharge</td>
</tr>
<tr>
<td>INITIAL_FLUSH_KBL</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Double Enbloc Kidney Initial Flush Solution</td>
</tr>
<tr>
<td>INITIAL_FLUSH_KIL</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Left Kidney Initial Flush Solution, Specify</td>
</tr>
<tr>
<td>INITIAL_FLUSH_KIL_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Left Kidney Initial Flush Solution, Specify</td>
</tr>
<tr>
<td>INITIAL_FLUSH_KIR</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Right Kidney Initial Flush Solution</td>
</tr>
<tr>
<td>INITIAL_FLUSH_KIR_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Right Kidney Initial Flush Solution, Specify</td>
</tr>
<tr>
<td>INITIAL_FLUSH_PA</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Initial Flush Solution</td>
</tr>
<tr>
<td>INITIAL_FLUSH_PA_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Initial Flush Solution, Specify</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
</tr>
<tr>
<td>--------------------------------</td>
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<td>--------</td>
<td>--------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>INITIAL_FLUSH_PA_SEG1</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Segment 1 Initial Flush Solution</td>
</tr>
<tr>
<td>INITIAL_FLUSH_PA_SEG2</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Segment 2 Initial Flush Solution</td>
</tr>
<tr>
<td>INITIAL_FLUSH_PA_SEG1_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Segment 1 Initial Flush Solution, Specify</td>
</tr>
<tr>
<td>INITIAL_FLUSH_PA_SEG2_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Segment 2 Initial Flush Solution, Specify</td>
</tr>
<tr>
<td>INOTROP_AGENTS</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Three or more inotropic agents at time of incision</td>
</tr>
<tr>
<td>INOTROP_SUP</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Inotropic Medications at Time of Cross Clamp</td>
</tr>
<tr>
<td>INR</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Terminal Lab Data: INR</td>
</tr>
<tr>
<td>INR_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Terminal Lab Data: INR, Status</td>
</tr>
<tr>
<td>INSULIN</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp: Insulin(Y/N/U)</td>
</tr>
<tr>
<td>INTX</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Multiple Organ Recipient: Intestine(T/F)</td>
</tr>
<tr>
<td>KI_CREAT_DISCH</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Kidney Creatinine At Discharge. Stop Collect From 2004</td>
</tr>
<tr>
<td>KI_CREAT_DISCH_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>LDR: Kidney Creatinine At Discharge/Status. Stop Collect From 2004</td>
</tr>
<tr>
<td>KI_CREAT_POSTOP</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Post-Op(Within 6 weeks post-donation) Kidney Serum Creatinine</td>
</tr>
<tr>
<td>KI_CREAT_POSTOP_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>LDR: Post-Op(Within 6 weeks post-donation) Kidney Serum Creatinine, Status</td>
</tr>
<tr>
<td>KI_GLOMERUL</td>
<td>Num</td>
<td>8</td>
<td>KI_GLUMR</td>
<td>LDR: Kidney Biopsy / If Yes, Glomerulosclerosis</td>
</tr>
<tr>
<td>KILDISC</td>
<td>Num</td>
<td>8</td>
<td>DISCD_CD</td>
<td>CDR: Reason organ not transplanted - Left Kidney</td>
</tr>
<tr>
<td>KLTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Organ Dispositions: Reason Code Left Kidney, Specify</td>
</tr>
<tr>
<td>KIPROC</td>
<td>Num</td>
<td>8</td>
<td>KP_PROC</td>
<td>KIR: Procedure Type</td>
</tr>
<tr>
<td>LABCTRTYD</td>
<td>Char</td>
<td>3</td>
<td>$</td>
<td>DHS: Lab Center Type</td>
</tr>
<tr>
<td>LABCTRTYR</td>
<td>Char</td>
<td>3</td>
<td>$</td>
<td>RHS: Lab Center Type</td>
</tr>
<tr>
<td>LDCOD</td>
<td>Num</td>
<td>8</td>
<td>LDON_COD</td>
<td>LDR: Living Donor Cause of Death</td>
</tr>
<tr>
<td>LDISCTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Reason organ not transplanted Left Kidney, Specify</td>
</tr>
<tr>
<td>LDON_ORG2</td>
<td>Char</td>
<td>4</td>
<td></td>
<td>LDR: Donor 2nd Recovered Organ</td>
</tr>
<tr>
<td>LDTYPEI</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>LDR: Donor Type, Status</td>
</tr>
<tr>
<td>LEN_HOSP_STAY</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Length of Hospital Stay (days). Stop Collect From 2004</td>
</tr>
<tr>
<td>LEN_HOSP_STAY_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>LDR: Length of Hospital Stay/Status. Stop Collect From 2004</td>
</tr>
<tr>
<td>LIFE_SUP</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Patient on Life Support at Tx Time. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>LIFE_SUP_ECMO_L</td>
<td>Char</td>
<td>5</td>
<td></td>
<td>TCR_KI: Patient on Life Support at Listing Time / ECMO. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>LIFE_SUP_IABP_L</td>
<td>Char</td>
<td>5</td>
<td></td>
<td>TCR_KI: Patient on Life Support at Listing Time / IABP. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>LIFE_SUP_INOTROPES_L</td>
<td>Char</td>
<td>5</td>
<td></td>
<td>TCR_KI: Patient on Life Support at Listing Time / IV Inotropes. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>LIFE_SUP_L</td>
<td>Char</td>
<td>5</td>
<td></td>
<td>TCR_KI: Patient on Life Support at Listing Time. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>LIFE_SUP_PGE_L</td>
<td>Char</td>
<td>5</td>
<td></td>
<td>TCR_KI: Patient on Life Support at Listing Time / PGE. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>LIFE_SUP_VENTILATOR_L</td>
<td>Char</td>
<td>5</td>
<td></td>
<td>TCR_KI: Patient on Life Support at Listing Time / Ventilator. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>LIPASE</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Terminal Lab Data: Serum Lipase</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
</tr>
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<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LIPASE_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Terminal Lab Data: Serum Lipase, Status</td>
</tr>
<tr>
<td>LISTDATE</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Date of Listing or Add</td>
</tr>
<tr>
<td>LITX</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>KIR: Multiple Organ Recipient: Liver(T/F)</td>
</tr>
<tr>
<td>LK_SHARE</td>
<td>Num</td>
<td>8</td>
<td>SHARETYC</td>
<td>CDR: Share Type - L-Kidney. Stop Collect From 2003</td>
</tr>
<tr>
<td>LKPUMP</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Pump (Left Kidney)</td>
</tr>
<tr>
<td>LT_KI_BIOPSY</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Left Kidney Biopsy</td>
</tr>
<tr>
<td>LT_KI_FLOW</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Flow Rate(cc's/min) (Left Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>LT_KI_FLOW_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Flow Rate/Status (Left Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>LT_KI_GLOMERUL</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: % Glomerulosclerosis (Left Kidney)</td>
</tr>
<tr>
<td>LT_KI_PERFUS_DIAST</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Perfusion Pressure Diastolic(mm/Hg) (Left Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>LT_KI_PERFUS_DIAST_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Perfusion Pressure/Status Diastolic (Left Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>LT_KI_PERFUS_SYST</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Perfusion Pressure Systolic (mm/Hg)(Left Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>LT_KI_PERFUS_SYST_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Perfusion Pressure/Status Systolic (Left Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>LUTX</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>KIR: Multiple Organ Recipient: Lung(T/F)</td>
</tr>
<tr>
<td>MAINTMED</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Are any medications given currently for maintenance or anti-rejection(Y/N)</td>
</tr>
<tr>
<td>MALIG</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Malignancies between listing and transplant(Y/N/U)</td>
</tr>
<tr>
<td>MALIG_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KIR: Malignancy type. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32, 64, 128, 256, 512, 1024, 2048.</td>
</tr>
<tr>
<td>MARITAL_STAT</td>
<td>Num</td>
<td>8</td>
<td>MRTLSTAT</td>
<td>LDR: Marital Status</td>
</tr>
<tr>
<td>MATC</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>USRDS: CNT HLA A, B, DR MATCH(0 - 6)</td>
</tr>
<tr>
<td>MDCOND</td>
<td>Num</td>
<td>8</td>
<td>MED_COND</td>
<td>KIR: Medical Condition at time of transplant</td>
</tr>
<tr>
<td>MDCONDL</td>
<td>Num</td>
<td>8</td>
<td>MED_COND</td>
<td>TCR_KI: Medical Condition at Listing Time</td>
</tr>
<tr>
<td>MEASURE1</td>
<td>Num</td>
<td>8</td>
<td>PRAMEAS</td>
<td>RHS: Technique Measures - Most Recent Class I</td>
</tr>
<tr>
<td>MEASURE2</td>
<td>Num</td>
<td>8</td>
<td>PRAMEAS</td>
<td>RHS: Technique Measures - Most Recent Class II</td>
</tr>
<tr>
<td>MEASURE_POS_XMAT1</td>
<td>Num</td>
<td>8</td>
<td>PRAMEAS</td>
<td>RHS: Positive Xmatch row 1//Measures:</td>
</tr>
<tr>
<td>MEASURE_POS_XMAT2</td>
<td>Num</td>
<td>8</td>
<td>PRAMEAS</td>
<td>RHS: Positive Xmatch row 2//Measures:</td>
</tr>
<tr>
<td>MEASURE_POS_XMAT3</td>
<td>Num</td>
<td>8</td>
<td>PRAMEAS</td>
<td>RHS: Positive Xmatch row 3//Measures:</td>
</tr>
<tr>
<td>MEASURE_POS_XMAT4</td>
<td>Num</td>
<td>8</td>
<td>PRAMEAS</td>
<td>RHS: Positive Xmatch row 4//Measures:</td>
</tr>
<tr>
<td>MEASURE_POS_XMAT5</td>
<td>Num</td>
<td>8</td>
<td>PRAMEAS</td>
<td>RHS: Positive Xmatch row 5//Measures:</td>
</tr>
<tr>
<td>MEASURE_XMAT1</td>
<td>Num</td>
<td>8</td>
<td>PRAMEAS</td>
<td>RHS: Most Recent row 1//Measures:</td>
</tr>
<tr>
<td>MEASURE_XMAT2</td>
<td>Num</td>
<td>8</td>
<td>PRAMEAS</td>
<td>RHS: Most Recent row 2//Measures:</td>
</tr>
<tr>
<td>MEASURE_XMAT3</td>
<td>Num</td>
<td>8</td>
<td>PRAMEAS</td>
<td>RHS: Most Recent row 3//Measures:</td>
</tr>
<tr>
<td>MEASURE_XMAT4</td>
<td>Num</td>
<td>8</td>
<td>PRAMEAS</td>
<td>RHS: Most Recent row 4//Measures:</td>
</tr>
<tr>
<td>MEASURE_XMAT5</td>
<td>Num</td>
<td>8</td>
<td>PRAMEAS</td>
<td>RHS: Most Recent row 5//Measures:</td>
</tr>
<tr>
<td>MEASUREMENT_DT</td>
<td>Char</td>
<td>29</td>
<td>$</td>
<td>KIR: Date of Measurement(Pediatric Only)</td>
</tr>
<tr>
<td>MEASUREMENT_DT_L</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Date of Measurement(Pediatric Only) at Listing Time</td>
</tr>
<tr>
<td>MED_EXAM</td>
<td>Num</td>
<td>8</td>
<td>MEXAMRPT</td>
<td>CDR: Procurement and Consent: Medical Examiner/Coroner</td>
</tr>
<tr>
<td>MEDICAID</td>
<td>Char</td>
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<td>MNTDDT</td>
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<td>MMDDYY</td>
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<td>MMDDYY</td>
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<td>MRKTXDT</td>
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<td>MMDDYY</td>
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<td>TCR_KI: Previous Transplant: Lung / Latest Tx Date. Stop</td>
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<td>NUM_TXFUS</td>
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<td>of value(s) 1, 2, 4, 8, 16, 32, 64, 128</td>
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<td>LDR: KI Other Complic, Other Specify</td>
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<td>KIR: Contributory causes of graft failure: Other, Specify</td>
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<td>DISCD_CD</td>
<td>CDR: Reason organ not transplanted - Pancreas Segment 1</td>
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<td>LDR: History of Cigarette Use / If Yes, # pack years</td>
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<td>ANTIHLAA</td>
<td>RHS: Anti-HLA Interpretation - Peak Serum Class I</td>
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<td>RHS: Anti-HLA Interpretation - Peak Serum Class II</td>
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<td>RHS: Measures - Peak Serum Class I</td>
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<td>TCR_KI: Patient State of Permanent Residence</td>
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<td>PHYSCAP</td>
<td>KIR: Physical Capacity</td>
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<td>PHYSCAP</td>
<td>TCR_KI: Patient Physical Capacity at Listing Time</td>
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<td>RHS: USRDS PRA(%) - Peak</td>
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<td>PLACED_BY_KIL</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Placed By - Left Kidney. Stop Collect From 2004</td>
</tr>
<tr>
<td>PLACED_BY_KIR</td>
<td>Num</td>
<td>8</td>
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<td>CDR: Placed By - Right Kidney. Stop Collect From 2004</td>
</tr>
<tr>
<td>PLACED_BY_PA</td>
<td>Num</td>
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<td>CDR: Placed By - PA. Stop Collect From 2004</td>
</tr>
<tr>
<td>PLACED_BY_PA_SEG1</td>
<td>Num</td>
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<td>CDR: Placed By - PA_SEG1. Stop Collect From 2004</td>
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<td>Num</td>
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<td>CDR: Placed By - PA_SEG2. Stop Collect From 2004</td>
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<tr>
<td>PLATELETS_UNITS</td>
<td>Num</td>
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<td>LDR: Non-Autologous Blood Administration /If Yes, Number of Platelets Units</td>
</tr>
<tr>
<td>POS_AUTOXM</td>
<td>Char</td>
<td>2</td>
<td>$AUTOXM</td>
<td>RHS: Autocrossmatch results: Has autocrossmatch ever been positive</td>
</tr>
<tr>
<td>POSTOP_URINE_PROTEIN</td>
<td>Num</td>
<td>8</td>
<td>URINEPRO</td>
<td>LDR: Post-Operative Urinalysis/Urine Protein</td>
</tr>
<tr>
<td>POSTOP_URINE_RATIO</td>
<td>Num</td>
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<td>LDR: Post-Operative Urinalysis/Protein-Creatinine Ratio</td>
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<td>POSXMDT1</td>
<td>Num</td>
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<td>MMDDYY</td>
<td>RHS: Positive Xmatch row 1/Serum Date</td>
</tr>
<tr>
<td>POSXMDT2</td>
<td>Num</td>
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<td>MMDDYY</td>
<td>RHS: Positive Xmatch row 2/Serum Date</td>
</tr>
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<td>MMDDYY</td>
<td>RHS: Positive Xmatch row 3/Serum Date</td>
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<td>MMDDYY</td>
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</tr>
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<td>PRAA</td>
<td>Num</td>
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<td>RHS: Most Recent PRA. Stop Collect From 2004</td>
</tr>
<tr>
<td>PRAA_DT</td>
<td>Num</td>
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<td>MMDDYY</td>
<td>RHS: Date of Most Recent PRA. Stop Collect From 2004</td>
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<td>PRAA_DT_I</td>
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<td>$TRIND</td>
<td>RHS: Date of Most Recent PRA/Status. Stop Collect From 2004</td>
</tr>
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<td>PRAA_I</td>
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<td>RHS: Most Recent PRA/Status. Stop Collect From 2004</td>
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<tr>
<td>PRAB</td>
<td>Num</td>
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<td>RHS: Peak PRA. Stop Collect From 2004</td>
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<tr>
<td>PRAB_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Date of Peak PRA. Stop Collect From 2004</td>
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<td>Char</td>
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<td>RHS: Date of Peak PRA/Status. Stop Collect From 2004</td>
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<td>PRAB_I</td>
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<td>RHS: Peak PRA/Status. Stop Collect From 2004</td>
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<tr>
<td>PRADONE</td>
<td>Char</td>
<td>1</td>
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<td>RHS: Test Information - HLA Antibody Screening Done</td>
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<tr>
<td>PRBC_UNITS</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Non-Autologous Blood Administration /If Yes, Number of PRBC Units</td>
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<tr>
<td>PRE_AVG_INSULIN_USED</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KIR: Pretransplant Average Daily Insulin Units. Stop Collect from 6/30/2004</td>
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<td>PRE_AVG_INSULIN_USED_I</td>
<td>Char</td>
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<td>KIR: Pretransplant Average Daily Insulin Units/Status. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRE_DON_BIOPSY_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Pre-Donation Kidney Clinical Information: Kidney Biopsy(Y/N)</td>
</tr>
<tr>
<td>PRE_TX_BIOP</td>
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<td>$YNUNK</td>
<td>KIR: Was preimplantation kidney biopsy performed at the transplant center</td>
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<tr>
<td>PRE_TX_DIAL</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>KIR: Pretransplant Dialysis(Y/N/U)</td>
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<tr>
<td>PRE_TX_DIAL_TY</td>
<td>Num</td>
<td>8</td>
<td>DIAL_TY</td>
<td>KIR: Pretransplant Dialysis Type. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRE_TX_TXFUS</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>KIR: Did Patient receive pretransplant blood transfusions(Y/N/U).</td>
</tr>
<tr>
<td>PRE_TX_TXFUS_L</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>TCR_KI: Any Previous Transfusions. Stop Collect from 6/30/2004</td>
</tr>
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<td>PRE_TX_TXFUS_NUM</td>
<td>Num</td>
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<td>TRANSFUS</td>
<td>KIR: Number of Pre-Tx Blood Transfusions. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PREDON_HGT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Pre-Donation Height</td>
</tr>
<tr>
<td>PREDON_HGT_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>LDR: Pre-Donation Height, Status</td>
</tr>
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<td>PREDON_WGT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Pre-Donation Weight</td>
</tr>
<tr>
<td>PREDON_WGT_I</td>
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<td>$TRIND</td>
<td>LDR: Pre-Donation Weight, Status</td>
</tr>
<tr>
<td>PREOP_BILI</td>
<td>Num</td>
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<td>LDR: Donor TOTAL BILIRUBIN</td>
</tr>
<tr>
<td>PREOP_UNIRE PROTEIN</td>
<td>Char</td>
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<td>LDR: Preoperative Urinalysis/Urine Protein</td>
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<tr>
<td>PREOP_UNIRE RATIO</td>
<td>Num</td>
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<td>LDR: Preoperative Urinalysis/Protein-Creatinine Ratio</td>
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<tr>
<td>PREV_MALIG_TY</td>
<td>Num</td>
<td>8</td>
<td>MALIGMUL</td>
<td>TCR_KI: Previous Malignancy Type at Listing Time. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32, 64, 128, 256, 512, 1024, 2048.</td>
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<tr>
<td>PREV_MALIG_TY_OSTXT</td>
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<td>$</td>
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<td>PREV_PI_TX</td>
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<td>TCR_KI: Previous Pancreas Islet Infusion at Listing Time(Y/N/U)</td>
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<tr>
<td>PREVKI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Received Previous Kidney Tx. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PREVPG</td>
<td>Num</td>
<td>8</td>
<td>PRV_PREG</td>
<td>KIR: Previous Pregnancies</td>
</tr>
<tr>
<td>PRIPAY</td>
<td>Num</td>
<td>8</td>
<td>P_S_PAY</td>
<td>KIR: Primary Source of Payment</td>
</tr>
<tr>
<td>PRIPAY_D</td>
<td>Num</td>
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<td>P_S_PAY</td>
<td>LDR: Primary Source of Payment. Stop Collect From 2004</td>
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<tr>
<td>PRIPAY_L</td>
<td>Num</td>
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<td>P_S_PAY</td>
<td>TCR_KI: Primary Source of Payment at Listing Time</td>
</tr>
<tr>
<td>PRIV_INS</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Secondary Source of Payment: Private Ins. Stop Collect From 2004</td>
</tr>
<tr>
<td>PRMALR</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>TCR_KI: Any previous Malignancy at Listing Time</td>
</tr>
<tr>
<td>PROTEIN URINE</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Protein in Urine</td>
</tr>
<tr>
<td>PROVUSRD_LIST</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>TCR_KI: USRDS Assigned Listing Center ID</td>
</tr>
<tr>
<td>PROVUSRD_MNTDPROV</td>
<td>Num</td>
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<td>BEST</td>
<td>KIR: USRDS Assigned Post-Tx Resumed Maint. Dialysis Provider ID</td>
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<td>PROVUSRD_ORIG_LIST</td>
<td>Num</td>
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<td>BEST</td>
<td>TCR_KI: USRDS Assigned Original Listing Center ID</td>
</tr>
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<td>PROVUSRD_TX</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>KIR: USRDS Assigned Transplant Center ID</td>
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<tr>
<td>PRVBTX</td>
<td>Num</td>
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<td>TCR_KI: Previous Transplant: # of Bone Marrow Transplant. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVBTXI</td>
<td>Char</td>
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<td>$TRIND</td>
<td>TCR_KI: Previous Transplant: Bone Marrow / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
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<td>Format</td>
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<tr>
<td>PRVHTEX</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: Previous Transplant: # of Heart Transplant. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVHTEXI</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>TCR_KI: Previous Transplant: Heart / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVICTEX</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: Previous Transplant: # of Pancreas (Islet Cells) Transplant. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVICTEXI</td>
<td>Char</td>
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<td>TCR_KI: Previous Transplant: Pancreas (Islet Cells) / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVINTX</td>
<td>Num</td>
<td>8</td>
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<td>TCR_KI: Previous Transplant: # of Intestine Transplant. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVINTXI</td>
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<td>TCR_KI: Previous Transplant: Intestine / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVKITX</td>
<td>Num</td>
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<td>KIR: Number of Previous Kidney Tx. Stop Collect from 6/30/2004</td>
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<tr>
<td>PRVKITX_L</td>
<td>Num</td>
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<td>TCR_KI: Previous Transplant: # of Kidney Transplant at Listing Time. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVKITXI</td>
<td>Char</td>
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<td>$TRIND</td>
<td>KIR: Number of Previous Kidney Tx/Status. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVKITXI_L</td>
<td>Char</td>
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<td>$TRIND</td>
<td>TCR_KI: Previous Transplant: Kidney at Listing Time / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVLITX</td>
<td>Num</td>
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<td>TCR_KI: Previous Transplant: # of Liver Transplant. Stop Separately Collect from 6/30/2004</td>
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<td>PRVLITXI</td>
<td>Char</td>
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<td>TCR_KI: Previous Transplant: Liver / Status. Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>PRVLUTX</td>
<td>Num</td>
<td>8</td>
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<td>TCR_KI: Previous Transplant: # of Lung Transplant. Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>PRVLUTXI</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>TCR_KI: Previous Transplant: Lung / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVPTX</td>
<td>Num</td>
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<td></td>
<td>TCR_KI: Previous Transplant: # of Pancreas Transplant. Stop Separately Collect from 6/30/2004</td>
</tr>
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<td>PRVPTXI</td>
<td>Char</td>
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<td>$TRIND</td>
<td>TCR_KI: Previous Transplant: Pancreas (Islet Cells) / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVTX</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>TCR_KI: Previous Transplant (Y/N). Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PT_OTH2_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Management: Other (two) // Other/Specify</td>
</tr>
<tr>
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<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Management: Other (three) // Other/Specify</td>
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<td>$</td>
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<tr>
<td>PT_T3</td>
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<td>1</td>
<td>$YNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp: T3(Y/N/U)</td>
</tr>
<tr>
<td>PT_T4</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp: T4(Y/N/U)</td>
</tr>
<tr>
<td>PTSTAT</td>
<td>Char</td>
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<td>$PSTAT</td>
<td>KIR: Patient Status: Living/Dead/Retransplanted</td>
</tr>
<tr>
<td>PTSTDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>KIR: Patient Status//Date: Last Seen, Retransplanted or Death</td>
</tr>
<tr>
<td>PULCERR</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: Peptic Ulcerat Listing Time</td>
</tr>
<tr>
<td>PULM_EMBOL</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>TCR_KI: Pulmonary Embolism (within last 6 months). Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PULM_EMBOL_HOSP</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Pulmonary Embolism During Hosp. Stop Collect From 2004</td>
</tr>
<tr>
<td>PULM_INF_CONF</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Clinical Infection: Lung // Confirmed by Culture</td>
</tr>
<tr>
<td>PUMP_TM_HRS_LT</td>
<td>Num</td>
<td>8</td>
<td>$YNUNK</td>
<td>KIR: Preservation Info: Total Pump Time (Hrs) KI Left. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PUMP_TM_HRS_RT</td>
<td>Num</td>
<td>8</td>
<td>$YNUNK</td>
<td>KIR: Preservation Info: Total Pump Time (Hrs) KI Right. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PUMP_TM_HRSMINS_LT_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KIR: Preservation Info: Total Pump Time/Status KI Left. Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>PUMP_TM_HRSMINS_RT_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KIR: Preservation Info: Total Pump Time/Status KI Right. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PUMP_TM_MINS_LT</td>
<td>Num</td>
<td>8</td>
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<td>KIR: Preservation Info: Total Pump Time (Min) KI Left. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PUMP_TM_MINS_RT</td>
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<td>8</td>
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<td>KIR: Preservation Info: Total Pump Time (Min) KI Right. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PVASCSCR</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>TCR_KI: Symptomatic Peripheral Vascular Disease at Listing Time</td>
</tr>
<tr>
<td>PX_STAT</td>
<td>Char</td>
<td>1</td>
<td>$PSTAT</td>
<td>LDR: Donor Status</td>
</tr>
<tr>
<td>PX_TXFER_PRIOR_TX</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Transferred from Another Hosp Prio to Tx. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PX_TXFER_PRIOR_TX_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>KIR: Date of Admi to Transferring From Another Hosp. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PXRESRH</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Did patient participate any clinical research protocol for immune</td>
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<tr>
<td>PXRESTXT</td>
<td>Char</td>
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<td>$</td>
<td>KIR: Did patient participate any clinical research protocol for immune, specify</td>
</tr>
<tr>
<td>RA1</td>
<td>Char</td>
<td>8</td>
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<td>RHS: Recipient HLA Typing A(1)</td>
</tr>
<tr>
<td>RA2</td>
<td>Char</td>
<td>8</td>
<td></td>
<td>RHS: Recipient HLA Typing A(2)</td>
</tr>
<tr>
<td>RABO</td>
<td>Char</td>
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<td>$</td>
<td>TCR_KI: Patient ABO Blood Group</td>
</tr>
<tr>
<td>RB1</td>
<td>Char</td>
<td>8</td>
<td></td>
<td>RHS: Recipient HLA Typing B(1)</td>
</tr>
<tr>
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<td>Char</td>
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<td>RHS: Recipient HLA Typing B(2)</td>
</tr>
<tr>
<td>RBW4</td>
<td>Num</td>
<td>8</td>
<td>WKGRPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class I: Bw4</td>
</tr>
<tr>
<td>RBW6</td>
<td>Num</td>
<td>8</td>
<td>WKGRPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class I: Bw6</td>
</tr>
<tr>
<td>RCITZ</td>
<td>Num</td>
<td>8</td>
<td>CITIZEN</td>
<td>TCR_KI: Patient Citizenship at Listing Time</td>
</tr>
<tr>
<td>RCNT_POS_XMAT</td>
<td>Char</td>
<td>1</td>
<td>$YNDU</td>
<td>RHS: Most Recent Auto Xmatch Positive. Stop Collect From 2004</td>
</tr>
<tr>
<td>RCOD</td>
<td>Num</td>
<td>8</td>
<td>KI_COD</td>
<td>KIR: Primary Cause of Death</td>
</tr>
<tr>
<td>RCOD2</td>
<td>Num</td>
<td>8</td>
<td>KI_COD</td>
<td>KIR: Contributory Cause of Death</td>
</tr>
<tr>
<td>RCOD3</td>
<td>Num</td>
<td>8</td>
<td>KI_COD</td>
<td>KIR: Contributory Cause of Death</td>
</tr>
<tr>
<td>RCOD2TXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KIR: Contributory Cause of Death, Specify</td>
</tr>
<tr>
<td>RCOD3TXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KIR: Contributory Cause of Death, Specify</td>
</tr>
<tr>
<td>RCOD7TXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KIR: Primary Cause of Death, Specify</td>
</tr>
<tr>
<td>RCW1</td>
<td>Num</td>
<td>8</td>
<td>CWHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class I: Cw1</td>
</tr>
<tr>
<td>RCW2</td>
<td>Num</td>
<td>8</td>
<td>CWHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class I: Cw2</td>
</tr>
<tr>
<td>RDISCTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Reason organ not transplanted: Right Kidney, Specify</td>
</tr>
<tr>
<td>RDPW1</td>
<td>Num</td>
<td>8</td>
<td>DPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DPw1</td>
</tr>
<tr>
<td>RDPW2</td>
<td>Num</td>
<td>8</td>
<td>DPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DPw2</td>
</tr>
<tr>
<td>RDQW1</td>
<td>Num</td>
<td>8</td>
<td>DQHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DQ1</td>
</tr>
<tr>
<td>RDQW2</td>
<td>Num</td>
<td>8</td>
<td>DQHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DQ2</td>
</tr>
<tr>
<td>RDR1</td>
<td>Char</td>
<td>8</td>
<td></td>
<td>RHS: Recipient HLA Typing DR(1)</td>
</tr>
<tr>
<td>RDR2</td>
<td>Char</td>
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<td>RHS: Recipient HLA Typing DR(2)</td>
</tr>
<tr>
<td>RDRW51</td>
<td>Num</td>
<td>8</td>
<td>WKGRPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DR51</td>
</tr>
<tr>
<td>RDRW52</td>
<td>Num</td>
<td>8</td>
<td>WKGRPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DR52</td>
</tr>
<tr>
<td>RDRW53</td>
<td>Num</td>
<td>8</td>
<td>WKGRPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DR53</td>
</tr>
<tr>
<td>REA_CD_DBL_ENBKI</td>
<td>Num</td>
<td>8</td>
<td>DISP_REA</td>
<td>CDR: Donor Double Enbloc Kidney Disposition Reason Code</td>
</tr>
<tr>
<td>REA_CD_L</td>
<td>Num</td>
<td>8</td>
<td>DISP_REA</td>
<td>CDR: Donor Left Kidney Disposition Reason Code</td>
</tr>
<tr>
<td>REA_CD_PA</td>
<td>Num</td>
<td>8</td>
<td>DISP_REA</td>
<td>CDR: Donor Pancreas Disposition Reason Code</td>
</tr>
<tr>
<td>REA_CD_PA_SEG1</td>
<td>Num</td>
<td>8</td>
<td>DISP_REA</td>
<td>CDR: Donor Pancreas Segment 1 Disposition Reason Code</td>
</tr>
<tr>
<td>REA_CD_PA_SEG2</td>
<td>Num</td>
<td>8</td>
<td>DISP_REA</td>
<td>CDR: Donor Pancreas Segment 2 Disposition Reason Code</td>
</tr>
<tr>
<td>REA_CD_R</td>
<td>Num</td>
<td>8</td>
<td>DISP_REA</td>
<td>CDR: Donor Right Kidney Disposition Reason Code</td>
</tr>
<tr>
<td>READMISSION_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Any Readmission After Initial Discharge</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------</td>
<td>--------</td>
<td>----------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>READMISSION_KI_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Any Readmission After Initial Discharge / If Yes, Date of First Readmission</td>
</tr>
<tr>
<td>READMISSION_KI_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>LDR: Any Readmission After Initial Discharge, Specify</td>
</tr>
<tr>
<td>READMISSION_KI_REASON</td>
<td>Num</td>
<td>8</td>
<td>READMIT</td>
<td>LDR: Reason for readmission (during first six weeks), Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32</td>
</tr>
<tr>
<td>REC_F_TY</td>
<td>Char</td>
<td>3</td>
<td>$</td>
<td>LDR: Donor Recovery Facility Center Type</td>
</tr>
<tr>
<td>REC_HLA_CELL</td>
<td>Num</td>
<td>8</td>
<td>TGTCSRC</td>
<td>RHS: Recipient HLA Typing Cell Source. Stop Collect From 2004</td>
</tr>
<tr>
<td>REC_HLA_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Recipient HLA Typed Date. Stop Collect From 2004</td>
</tr>
<tr>
<td>REC_ON_IC</td>
<td>Char</td>
<td>1</td>
<td>$RECONIC</td>
<td>KIR: Kidney(s) Received on ice</td>
</tr>
<tr>
<td>REC_ON_PUMP</td>
<td>Char</td>
<td>1</td>
<td>$RECONPM</td>
<td>KIR: Kidney(s) Received on pump</td>
</tr>
<tr>
<td>RECDS</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Contributory causes of graft failure: Recurrent Disease</td>
</tr>
<tr>
<td>RECOV_COUNTRY</td>
<td>Char</td>
<td>3</td>
<td>$CTRY</td>
<td>CDR: If Recovered Outside the U.S.: Recovered Country</td>
</tr>
<tr>
<td>RECOV_OUT_US</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Recovered Outside the U.S.</td>
</tr>
<tr>
<td>REFCLDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>CDR: Referral Date</td>
</tr>
<tr>
<td>REFERRAL_FLG</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Referral Flag</td>
</tr>
<tr>
<td>REJ_ACUTE</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Contributory causes of graft failure: Acute Rejection(Y/N/U)</td>
</tr>
<tr>
<td>REJ_TREATED_TY</td>
<td>Num</td>
<td>8</td>
<td>REJ_TRET</td>
<td>KIR: Patient Treated for Rejection. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>REOP_BLEED_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Reason for reoperation (during first six weeks): Bleeding</td>
</tr>
<tr>
<td>REOP_BOWEL_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Reason for reoperation (during first six weeks): Bowel Obstruction</td>
</tr>
<tr>
<td>REOP_BOWEL_KI_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Kidney Reoperation Bowel Obstruction Date</td>
</tr>
<tr>
<td>REOP_HERNIA_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Reason for reoperation (during first six weeks): Hernia Repair</td>
</tr>
<tr>
<td>REOP_HERNIA_KI_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Kidney Reoperation Hernia Repair Date</td>
</tr>
<tr>
<td>REOP_OTH_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Reason for reoperation (during first six weeks): Other</td>
</tr>
<tr>
<td>REOP_OTH_KI_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Kidney Reoperation Other Date</td>
</tr>
<tr>
<td>REOP_OTH_KI_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>LDR: Kidney Reoperation Other Specify</td>
</tr>
<tr>
<td>REOP_VASC_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Reason for reoperation (during first six weeks): Vascular</td>
</tr>
<tr>
<td>REOP_VASC_KI_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Kidney Reoperation Vascular Date</td>
</tr>
<tr>
<td>REOPERATION_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Kidney Reoperation</td>
</tr>
<tr>
<td>RESIST_SHIP_LT_KI</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Final Resistance Prior to Shipping (left)</td>
</tr>
<tr>
<td>RESIST_SHIP_LT_KI_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Final Resistance Prior to Shipping (left), Status</td>
</tr>
<tr>
<td>RESIST_SHIP_RT_KI</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Final Resistance Prior to Shipping (right)</td>
</tr>
<tr>
<td>RESIST_SHIP_RT_KI_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Final Resistance Prior to Shipping (right), Status</td>
</tr>
<tr>
<td>RESULT_AUTOXM1</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Most Recent row 1//AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_AUTOXM2</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Most Recent row 2//AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_AUTOXM3</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Most Recent row 3//AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_AUTOXM4</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Most Recent row 4//AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_AUTOXM5</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Most Recent row 5//AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_POS_AUTOXM1</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Positive Xmarch row 1//AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_POS_AUTOXM2</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Positive Xmarch row 2//AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_POS_AUTOXM3</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Positive Xmarch row 3//AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
</tr>
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<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>RESULT_POS_AUTOXM4</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Positive Xmatch row 4/ AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_POS_AUTOXM5</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Positive Xmatch row 5/ AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_POS_XM1</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Result - Positive Xmatch row 1. Stop Collect From 2004</td>
</tr>
<tr>
<td>RESULT_POS_XM2</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Result - Positive Xmatch row 2. Stop Collect From 2004</td>
</tr>
<tr>
<td>RESULT_POS_XM3</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Result - Positive Xmatch row 3. Stop Collect From 2004</td>
</tr>
<tr>
<td>RESULT_POS_XM4</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Result - Positive Xmatch row 4. Stop Collect From 2004</td>
</tr>
<tr>
<td>RESULT_POS_XM5</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Result - Positive Xmatch row 5. Stop Collect From 2004</td>
</tr>
<tr>
<td>RESULT_XMAT1</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Most Recent row 1/ Result:</td>
</tr>
<tr>
<td>RESULT_XMAT2</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Most Recent row 2/ Result:</td>
</tr>
<tr>
<td>RESULT_XMAT3</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Most Recent row 3/ Result:</td>
</tr>
<tr>
<td>RESULT_XMAT4</td>
<td>Num</td>
<td>8</td>
<td>X.Match</td>
<td>RHS: Most Recent row 4/ Result:</td>
</tr>
<tr>
<td>RESULT_XMAT5</td>
<td>Num</td>
<td>8</td>
<td>X.Match</td>
<td>RHS: Most Recent row 5/ Result:</td>
</tr>
<tr>
<td>RESUSCIT_DUR</td>
<td>Num</td>
<td>8</td>
<td>$TRIND</td>
<td>CDR: If cardiac arrest since neurological event that led to declaration of brain death: Duration of Resuscitation(min)</td>
</tr>
<tr>
<td>RESUSCIT_DUR_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Duration of Resuscitation, Status</td>
</tr>
<tr>
<td>RETURN_OR</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Return to OR After Recov of Donor Organ. Stop Collect From 2004</td>
</tr>
<tr>
<td>RH</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>TCR_KI: ABO Blood/Rh. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>RHISP</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>TCR_KI: Patient Hispanic Ethnicity</td>
</tr>
<tr>
<td>RK_SHARE</td>
<td>Num</td>
<td>8</td>
<td>SHARETYC</td>
<td>CDR: Share Type - R-Kidney. Stop Collect From 2003</td>
</tr>
<tr>
<td>RKPUMP</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Pump (Right Kidney)(Y/N)</td>
</tr>
<tr>
<td>RRACE</td>
<td>Char</td>
<td>3</td>
<td>$RACEFMT</td>
<td>TCR_KI: Patient Race</td>
</tr>
<tr>
<td>RSEX</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KIR: Recipient Gender</td>
</tr>
<tr>
<td>RT_KI_BIOPSY</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Kidney Biopsy (right)(Y/N)</td>
</tr>
<tr>
<td>RT_KI_FLOW</td>
<td>Num</td>
<td>8</td>
<td>$TRIND</td>
<td>CDR: Flow Rate (cc’s/min) (Right Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>RT_KI_FLOW_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Flow Rate/Status (Right Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>RT_KI_GLOMERUL</td>
<td>Num</td>
<td>8</td>
<td>$TRIND</td>
<td>CDR: % Glomerulosclerosis (Right Kidney)</td>
</tr>
<tr>
<td>RT_KI_PERFUS_DIAST</td>
<td>Num</td>
<td>8</td>
<td>$TRIND</td>
<td>CDR: Perfusion Presseure Diastolic (mm/Hg) (Right Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>RT_KI_PERFUS_DIAST_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Perfusion Presseure/Status Diastolic (Right Kidney). Stop Collect 2004</td>
</tr>
<tr>
<td>RT_KI_PERFUS_SYST</td>
<td>Num</td>
<td>8</td>
<td>$TRIND</td>
<td>CDR: Perfusion Presseure (mm/Hg) Systolic (Right Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>RT_KI_PERFUS_SYST_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Perfusion Pressure/Status Systolic (Right Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>RTYMETHC1</td>
<td>Num</td>
<td>8</td>
<td>HLA_TYMT</td>
<td>RHS: Typing Method Class I. Multiple selections. The value is comb of value(s) 1, 2, 4</td>
</tr>
<tr>
<td>RTYMETHC2</td>
<td>Num</td>
<td>8</td>
<td>HLA_TYMT</td>
<td>RHS: Typing Method Class II. Multiple selections. The value is comb of value(s) 1, 2, 4</td>
</tr>
<tr>
<td>RWT_ZIP</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>TCR_KI: Is Patient waiting in permanent ZIP code(Y/N/U)</td>
</tr>
<tr>
<td>SECONDARY_PAY</td>
<td>Num</td>
<td>8</td>
<td>SECNDPAY</td>
<td>KIR: Secondary Source of Payment</td>
</tr>
<tr>
<td>SECONDARY_PAY_L</td>
<td>Num</td>
<td>8</td>
<td>SECNDPAY</td>
<td>TCR_KI: Secondary Source of Payment at Listing Time</td>
</tr>
<tr>
<td>SELF</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Secondary Source of Payment: SELF Stop Collect From 2004</td>
</tr>
<tr>
<td>SERA_TEST_CLASS1</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>RHS: Were any sera tested pre-transplant that contain anti-HLA Class I antibody</td>
</tr>
<tr>
<td>SERA_TEST_CLASS2</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>RHS: Were any sera tested pre-transplant that contain anti-HLA Class II antibody</td>
</tr>
<tr>
<td>SERCREAT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KIR: Serum Creatinie at Time of Tx(mg/dl)</td>
</tr>
<tr>
<td>SERCREATI</td>
<td>Char</td>
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<td>$TRIND</td>
<td>KIR: Serum Creatinie at Time of Tx / Status</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
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<tr>
<td>SERMALB</td>
<td>Num</td>
<td>8</td>
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<td>TCR_KI: Total Serum Albumin at Listing Time</td>
</tr>
<tr>
<td>SERMALBI</td>
<td>Char</td>
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<td>TCR_KI: Total Serum Albumin at Listing Time, Status</td>
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<tr>
<td>SERUM_DTORIGINAL</td>
<td>Num</td>
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<td>MMDDYY</td>
<td>RHS: Date of crossmatch serum - Least Recent</td>
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<tr>
<td>SERUM_DRECENT</td>
<td>Num</td>
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<td>MMDDYY</td>
<td>RHS: Date of crossmatch serum</td>
</tr>
<tr>
<td>SERUM_SCREEN</td>
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<td>RHS: Was serum screened for anti-HLA Class II antibody</td>
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<td>SEX_PROMISC</td>
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<td>CDR: Lifestyle Factors: Sexual Promiscuity. Stop Collect From 2004</td>
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<td>SODIUM170</td>
<td>Char</td>
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<td>SODIUM170_VAL</td>
<td>Num</td>
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<td>SRGCMP</td>
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<td>KIR: Post-Tx - Contributory causes of graft failure: Surgical Complications</td>
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<td>STORAGE_DBGL_ENBKI</td>
<td>Num</td>
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<td>CDR: Storage Solution - Enbloc Kidney. Stop Separately Collect From 2004</td>
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<tr>
<td>STORAGE_LKI</td>
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<td>Char</td>
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</tr>
<tr>
<td>STORAGE_PA</td>
<td>Num</td>
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<td>CDR: Storage Solution - Pancreas. Stop Separately Collect From 2004</td>
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<tr>
<td>STORAGE_PA_OSTXT</td>
<td>Char</td>
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<td>STORAGE_PA_SEG2</td>
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<td>CDR: Storage Solution - Pancreas Segment 2. Stop Separately Collect From 2004</td>
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<td>STORAGE_RKI</td>
<td>Num</td>
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<td>CDR: Storage Solution - Right Kidney. Stop Separately Collect From 2004</td>
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<td>SUITABLE</td>
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<td>SUSPND_DT</td>
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<td>PRATARGT</td>
<td>RHS: Target- Most Recent Class I</td>
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<td>PRATARGT</td>
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<td>CDR: Lifestyle Factors: Tattoos</td>
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<td>Num</td>
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<td>MMDDYY</td>
<td>KIR: Tx Date</td>
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<tr>
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<tr>
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<tr>
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<td>RHS: Positive Xmatch row 5 Technique//Specify:</td>
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<td>HISTTCHX</td>
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<td>HISTTCHX</td>
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<td>HISTTCHX</td>
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<td>HISTTCHX</td>
<td>RHS: Most Recent row 4//Technique:</td>
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<td>8</td>
<td>HISTTCHX</td>
<td>RHS: Most Recent row 5//Technique:</td>
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<td>$</td>
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<td>$</td>
<td>RHS: Most Recent row 4 Technique//Specify:</td>
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<tr>
<td>TECHNIQUE_XMAT_OSTXT5</td>
<td>Char</td>
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<td>$</td>
<td>RHS: Most Recent row 5 Technique//Specify:</td>
</tr>
<tr>
<td>TECHNIQUEA</td>
<td>Num</td>
<td>8</td>
<td>HISTOTEC</td>
<td>RHS: Most Recent PRA Technique. Stop Collect From 2004</td>
</tr>
<tr>
<td>TECHNIQUEB</td>
<td>Num</td>
<td>8</td>
<td>HISTOTEC</td>
<td>RHS: Peak PRA Technique. Stop Collect From 2004</td>
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<tr>
<td>THERAPIES</td>
<td>Char</td>
<td>1</td>
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<td>KIR: Treatment: other therapies(Y/N)</td>
</tr>
<tr>
<td>THERAPIES_TREATMENT</td>
<td>Num</td>
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<td>OTOTHER</td>
<td>KIR: If other therapies, all that apply. Multiple selections. The value is comb of value(s) 1, 2, 4</td>
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<tr>
<td>TISS</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>CDR: Was Donor Tissue Removed for Purposes of Transplantation? (Y/N/U). Stop Collect From 2003</td>
</tr>
<tr>
<td>TISSUE_CONSENT</td>
<td>Char</td>
<td>5</td>
<td>$YNUNK</td>
<td>CDR: Consent Information: Tissue Consented (Y/N). Stop Collect From 2004</td>
</tr>
<tr>
<td>TISSUE_CONSENT_REA</td>
<td>Num</td>
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<td>CONS_NOT</td>
<td>CDR: Consent Information: Tissue Not Consented Reason. Stop Collect From 2004</td>
</tr>
<tr>
<td>TISSUE_CONSENT_REA_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Consent Information: Tissue Not Consented Reason/Other Specify. Stop Collect From 2004</td>
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<tr>
<td>TISSUE_REQ</td>
<td>Char</td>
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<td>CDR: Consent Information: Tissue Requested (Y/N). Stop Collect From 2004</td>
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<tr>
<td>TISSUE_REQ_REASON</td>
<td>Num</td>
<td>8</td>
<td>CONSNOTR</td>
<td>CDR: Consent Information: Reason Tissue Not Requested. Stop Collect From 2004</td>
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<tr>
<td>TISSUE_REQ_REASON_OSTXT</td>
<td>Char</td>
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<td>CDR: Consent Information: Reason Tissue Not Requested/Other Specify. Stop Collect From 2004</td>
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<tr>
<td>TOBACCO_USE</td>
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<td>1</td>
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<td>LDR: Other Tobacco Used</td>
</tr>
<tr>
<td>TOLER_IND_TECH</td>
<td>Char</td>
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<td>KIR: Any tolerance induction technique used</td>
</tr>
<tr>
<td>TRANS_PUMP_LT_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Transferred on pump (left)</td>
</tr>
<tr>
<td>TRANS_PUMP_RT_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Transferred on pump (right)</td>
</tr>
<tr>
<td>TRANSFUS_INTRAOOP_NUM</td>
<td>Num</td>
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<td>TRANSFUS</td>
<td>CDR: Transfusion Units Intraoperatively. Stop Collect From 2004</td>
</tr>
<tr>
<td>TRANSFUS_PRIOR_NUM</td>
<td>Num</td>
<td>8</td>
<td>TRANSFUS</td>
<td>CDR: Transfusion Units Prior to Surgery. Stop Collect From 2004</td>
</tr>
<tr>
<td>TRANSFUS_TERM</td>
<td>Num</td>
<td>8</td>
<td>TRANSFUS</td>
<td>CDR: Number of transfusions during this (terminal) hospitalization</td>
</tr>
<tr>
<td>TRCOPDR</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>TCR_KI: Drug Treated COPD at Listing Time</td>
</tr>
<tr>
<td>TRDG</td>
<td>Num</td>
<td>8</td>
<td>KI_DGN</td>
<td>KIR: Primary Diagnosis</td>
</tr>
<tr>
<td>TRDG_L</td>
<td>Num</td>
<td>8</td>
<td>KI_DGN</td>
<td>TCR_KI: Primary Diagnosis at Listing Time</td>
</tr>
<tr>
<td>TRDG_PA_L</td>
<td>Num</td>
<td>8</td>
<td>PA_DGN</td>
<td>TCR_KP: Primary Pancreas Diagnosis at Listing Time</td>
</tr>
<tr>
<td>TRDGNTX</td>
<td>Char</td>
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<td>$</td>
<td>KIR: Primary Diagnosis, Specify</td>
</tr>
<tr>
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<td>Char</td>
<td>50</td>
<td>$</td>
<td>TCR_KI: Primary Diagnosis at Listing Time, Specify</td>
</tr>
<tr>
<td>TRDGNTX_PA_L</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>TCR_KP: Primary Pancreas Diagnosis at Listing Time, Specify</td>
</tr>
<tr>
<td>TRHYPR</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>TCR_KI: Drug Treated Systemic Hypertension at Listing Time</td>
</tr>
<tr>
<td>TRR_ID</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KIR: Transplant Recipient Registration ID</td>
</tr>
<tr>
<td>TUMOR_TX</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Incidental Tumor found at time of Transplant</td>
</tr>
<tr>
<td>TUMOR_TY</td>
<td>Num</td>
<td>8</td>
<td>TUMOR_KI</td>
<td>KIR: Type of Incidental Tumor found at time of Transplant</td>
</tr>
<tr>
<td>TUMOR_TY_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KIR: Incidental Tumor found at time of Transplant, Specify</td>
</tr>
<tr>
<td>TX_DT1</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant Date</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
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<tr>
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<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant Date</td>
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<tr>
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<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant Date</td>
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<td>TXFER_DT</td>
<td>Num</td>
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<td>MMDDYY</td>
<td>KIR: Transfer Date</td>
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<tr>
<td>TXFUS_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>KIR: Pretransplant Date of Last Tranfusion. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>TXFUS_DT_I</td>
<td>Char</td>
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<td>$TRIND</td>
<td>KIR: Pretransplant Date of Last Tranfusion/Status. Stop Collect from 6/30/2004</td>
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<td>UNSOSGFDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>KIR: Date of Graft Failure</td>
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<tr>
<td>UNSUITABLE_REAS_OSTXT</td>
<td>Char</td>
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<td>$</td>
<td>CDR: Donor unsuitable for procurement reason/Specify. Stop Collect From 2004</td>
</tr>
<tr>
<td>URINE24</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>KIR: Kidney Produced &gt; 40ml of Urine in First 24 Hours</td>
</tr>
<tr>
<td>URINE_INF_CONF</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>CDR: Clinical Infection: Urine // Confirmed by Culture</td>
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<tr>
<td>URLCMP</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Contributory causes of graft failure: Urological Complications</td>
</tr>
<tr>
<td>USRDS_ID</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>USRDS_ID</td>
</tr>
<tr>
<td>VASC_COMP_KI</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>LDR: Kidney Vascular Complications Requiring Intervention</td>
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<td>Num</td>
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<td>VASCCOMP</td>
<td>LDR: Kidney Vascular Complications, Specify. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32, 64</td>
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<tr>
<td>VASC_COMP_KI_INTER_OSTXT</td>
<td>Char</td>
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<td>$</td>
<td>LDR: Kidney Vascular Complications Other, Specify</td>
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<tr>
<td>VIRUSES_TESTED</td>
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<td>1</td>
<td>$YNUNK</td>
<td>KIR: Have any of HIV, CMV, HBV, HCV, EBV ever been tested for. Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>WARM_ISCH_ANAS_KI_LT</td>
<td>Num</td>
<td>8</td>
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<td>KIR: Total Warm Ischemia Time Left KI (OR EN-BLOC): (Include Anastomotic time)</td>
</tr>
<tr>
<td>WARM_ISCH_ANAS_KI_LT_I</td>
<td>Char</td>
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<td>$TRIND</td>
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<td>8</td>
<td></td>
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<tr>
<td>WARM_ISCH_ANAS_KI_RT_I</td>
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<tr>
<td>WARM_ISCH_TM_LT</td>
<td>Num</td>
<td>8</td>
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<td>KIR: Total Warm Ischemic Time KI Left. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>WARM_ISCH_TM_LT_I</td>
<td>Char</td>
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<td>$TRIND</td>
<td>KIR: Total Warm Ischemic Time/Status KI Left. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>WARM_ISCH_TM_RT</td>
<td>Num</td>
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<td>KIR: Total Warm Ischemic Time KI Right. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>WARM_ISCH_TM_RT_I</td>
<td>Char</td>
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<td>KIR: Total Warm Ischemic Time/Status KI Right. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>WGT_KG_POST_TX</td>
<td>Num</td>
<td>8</td>
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<td>KIR: Post-tx Weight In Kg</td>
</tr>
<tr>
<td>WGT_KG_POST_TX_I</td>
<td>Char</td>
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<td>$TRIND</td>
<td>KIR: Post-tx Weight In Kg</td>
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<tr>
<td>WGT_L</td>
<td>Num</td>
<td>8</td>
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<td>TCR_KI: Weight in Kilograms at Listing Time</td>
</tr>
<tr>
<td>WGTST_L</td>
<td>Char</td>
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<td>TCR_KI: Weight in Kilograms at Listing Time, Status</td>
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<td>WORK_INCOME</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KIR: Working for income(Y/N/U)</td>
</tr>
<tr>
<td>WORK_INCOME_L</td>
<td>Char</td>
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<td>TCR_KI: Working for income at Listing Time(Y/N/U)</td>
</tr>
<tr>
<td>WORK_NO_STATUS</td>
<td>Num</td>
<td>8</td>
<td>NOTWORK</td>
<td>KIR: Not Working Due To</td>
</tr>
<tr>
<td>WORK_NO STATUS</td>
<td>Num</td>
<td>8</td>
<td>NOTWORK</td>
<td>TCR_KI: Not Working Due To at Listing Time</td>
</tr>
<tr>
<td>WORK_YES_STATUS</td>
<td>Num</td>
<td>8</td>
<td>WORKINC</td>
<td>KIR: Yes Working Status</td>
</tr>
<tr>
<td>WORK_YES_STATUS_L</td>
<td>Num</td>
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<td>WORKINC</td>
<td>TCR_KI: Yes Working Status</td>
</tr>
<tr>
<td>WRIT_CONSENT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Written Consent Obtained By. Stop Collect From 2004</td>
</tr>
<tr>
<td>WRIT_CONSENT_OSTXT</td>
<td>Char</td>
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<td>$</td>
<td>CDR: Written Consent Specified. Stop Collect From 2004</td>
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<tr>
<td>XMAT_OTH_SER</td>
<td>Char</td>
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<td>RHS: C. Positive crossmatch with sera other than the most recent by any method</td>
</tr>
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<td>XMDONE</td>
<td>Char</td>
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<td>RHS: Test Information - Crossmatch Done</td>
</tr>
<tr>
<td>YR_ENTRY_US</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: If Patient is Non-Resident Alien, Year of Entry to the U.S</td>
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<td>Variable</td>
<td>Type</td>
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<td>ACADEMIC_LEVEL</td>
<td>Num</td>
<td>8</td>
<td>ACAACT</td>
<td>KPR: Recipient Academic Activity Level</td>
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<tr>
<td>ACADEMIC_LEVEL_L</td>
<td>Num</td>
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<td>ACAACT</td>
<td>TCR_KI: Patient Academic Activity Level at Listing Time</td>
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<td>ACADEMIC_PRG</td>
<td>Num</td>
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<td>ACAPRG</td>
<td>KPR: Recipient Academic Progress</td>
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<td>ACADEMIC_PRG_L</td>
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<td>ACAPRG</td>
<td>TCR_KI: Patient Academic Progress at Listing Time</td>
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<td>ACUTE_REJ_EPI_KI</td>
<td>Num</td>
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<td>ACREJEPI</td>
<td>KPR: Did patient have any acute kidney rejection episodes between tx and disch</td>
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<tr>
<td>ACUTE_REJ_EPI_PA</td>
<td>Num</td>
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<td>ACREJEPI</td>
<td>KPR: Did patient have any acute pancreas rejection episodes between tx and disch</td>
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<td>ADMDATE</td>
<td>Num</td>
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<td>MMDDYY</td>
<td>KPR: Date of Admission to Tx Center</td>
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<td>AGE</td>
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<td>KPR: Recipient Age at Transplant Time</td>
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<td>AGE_UNIT</td>
<td>Char</td>
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<td>$AGEUNIT</td>
<td>CDR: Age Unit</td>
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<tr>
<td>AGEDIAB</td>
<td>Num</td>
<td>8</td>
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<td>TCR_KI: Patient Age of Diabetes Onset</td>
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<td>AGEDIABI</td>
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<td>TCR_KI: Patient Age of Diabetes Onset, Status</td>
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<tr>
<td>AGNT1</td>
<td>Num</td>
<td>8</td>
<td>INTROMED</td>
<td>CDR: Inotropic Medications at Time of Cross Clamp: Medication</td>
</tr>
<tr>
<td>AGNT2</td>
<td>Num</td>
<td>8</td>
<td>INTROMED</td>
<td>CDR: Inotropic Medications at Time of Cross Clamp: Medication</td>
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<tr>
<td>AGNT3</td>
<td>Num</td>
<td>8</td>
<td>INTROMED</td>
<td>CDR: Inotropic Medications at Time of Cross Clamp: Medication</td>
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<td>AGNT_DOSE1</td>
<td>Num</td>
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<td>CDR: Inotropic Medications at Time of Cross Clamp: Dosage At Time</td>
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<td>CDR: Inotropic Medications at Time of Cross Clamp: Dosage At Time</td>
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<td>CDR: Inotropic Medications at Time of Cross Clamp: Dosage At Time</td>
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<td>ALCOHOL_HEAVY</td>
<td>Char</td>
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<td>CDR: Lifestyle Factors: Heavy Alcohol Use (heavy= 2+ drinks/day)</td>
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<tr>
<td>AMYLASE</td>
<td>Num</td>
<td>8</td>
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<td>CDR: Terminal Lab Data: Serum Amylase</td>
</tr>
<tr>
<td>AMYLASE_I</td>
<td>Char</td>
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<td>$TRIND</td>
<td>CDR: Terminal Lab Data: Serum Amylase, Status</td>
</tr>
<tr>
<td>ANAST_LK</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Contributory Cause of Pancreas Failure: Anastomatic Leak</td>
</tr>
<tr>
<td>ANASTOM_TM_KI_LT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Anastomatic Time KI Left. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>ANASTOM_TM_KI_LT_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KPR: Anastomatic Time/Status KI Left. Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>ANASTOM_TM_KI_RT</td>
<td>Num</td>
<td>8</td>
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<td>KPR: Anastomatic Time KI Right. Stop Separately Collect from 6/30/2004</td>
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<td>$TRIND</td>
<td>KPR: Anastomatic Time/Status KI Right. Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>ANASTOM_TM_PA</td>
<td>Num</td>
<td>8</td>
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<td>KPR: Anastomatic Time Pancreas. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>ANASTOM_TM_PA_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KPR: Anastomatic Time/Status Pancreas. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>ANGINA</td>
<td>Num</td>
<td>8</td>
<td>ANGINAA</td>
<td>TCR_KI: Angina/Coronary Artery Disease. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>ANGINA_CAD</td>
<td>Num</td>
<td>8</td>
<td>ANGINACA</td>
<td>TCR_KI: Angina / CAD at Listing Time</td>
</tr>
<tr>
<td>ANTI_VIRAL</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Treatment: Biological or Anti-viral Therapy(Y/N/U)</td>
</tr>
<tr>
<td>ANTI_VIRAL_TREATMENTS</td>
<td>Num</td>
<td>8</td>
<td>ANTVIRL</td>
<td>KPR: If Anti-viral, check all that apply. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32, 64, 128, 256, 512, 1024.</td>
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<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
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<tr>
<td>ARGinine</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp:</td>
</tr>
<tr>
<td>ART_RECON</td>
<td>Num</td>
<td>8</td>
<td>ARTILREK</td>
<td>KPR: Arterial Reconstruction</td>
</tr>
<tr>
<td>ART_RECON_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KPR: Arterial Reconstruction, Specify</td>
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<tr>
<td>BACK_TBL_FLUSH_DBL_ENBKI</td>
<td>Num</td>
<td>8</td>
<td>BTFLUSH</td>
<td>CDR: Donor Double Enbloc Kidney Back Table Flush Solution</td>
</tr>
<tr>
<td>BACK_TBL_FLUSH_DBL_ENBKI_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Double Enbloc Kidney Back Table Flush Solution, Specify</td>
</tr>
<tr>
<td>BACK_TBL_FLUSH_KIL</td>
<td>Num</td>
<td>8</td>
<td>BTFLUSH</td>
<td>CDR: Donor Left Kidney Back Table Flush Solution</td>
</tr>
<tr>
<td>BACK_TBL_FLUSH_KIL_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Left Kidney Back Table Flush Solution, Specify</td>
</tr>
<tr>
<td>BACK_TBL_FLUSH_KIR</td>
<td>Num</td>
<td>8</td>
<td>BTFLUSH</td>
<td>CDR: Donor Right Kidney Back Table Flush Solution</td>
</tr>
<tr>
<td>BACK_TBL_FLUSH_KIR_OSTXT</td>
<td>Char</td>
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<td>$</td>
<td>CDR: Donor Right Kidney Back Table Flush Solution, Specify</td>
</tr>
<tr>
<td>BACK_TBL_FLUSH_PA</td>
<td>Num</td>
<td>8</td>
<td>BTFLUSH</td>
<td>CDR: Donor Pancreas Back Table Flush Solution</td>
</tr>
<tr>
<td>BACK_TBL_FLUSH_PA_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Back Table Flush Solution, Specify</td>
</tr>
<tr>
<td>BACK_TBL_FLUSH_PA_SEG1</td>
<td>Num</td>
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<td>BTFLUSH</td>
<td>CDR: Donor Pancreas Segment 1 Back Table Flush Solution</td>
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<td>BACK_TBL_FLUSH_PA_SEG1_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Segment 1 Back Table Flush Solution, Specify</td>
</tr>
<tr>
<td>BACK_TBL_FLUSH_PA_SEG2</td>
<td>Num</td>
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<td>BTFLUSH</td>
<td>CDR: Donor Pancreas Segment 2 Back Table Flush Solution</td>
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<tr>
<td>BACK_TBL_FLUSH_PA_SEG2_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Segment 2 Back Table Flush Solution, Specify</td>
</tr>
<tr>
<td>BANFF</td>
<td>Num</td>
<td>8</td>
<td>BANFFLEV</td>
<td>KPR: BANFF Level (Stages). Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>BIOP_ARTER_SCLERO_LT</td>
<td>Num</td>
<td>8</td>
<td>KIBIOPVA</td>
<td>KPR: Biopsy of Donor Kidney Arteriosclerosis Left KI. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>BIOP_ARTER_SCLERO_RT</td>
<td>Num</td>
<td>8</td>
<td>KIBIOPVA</td>
<td>KPR: Biopsy of Donor Kidney Arteriosclerosis Right KI. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>BIOP_FIBROSIS_LT</td>
<td>Num</td>
<td>8</td>
<td>KIBIOPVA</td>
<td>KPR: Biopsy of Donor Kidney Fibrosis Left KI. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>BIOP_FIBROSIS_RT</td>
<td>Num</td>
<td>8</td>
<td>KIBIOPVA</td>
<td>KPR: Biopsy of Donor Kidney Fibrosis Right KI. Stop Collect from 6/30/2004</td>
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<td>BIOP_GLUMEROS_LT</td>
<td>Num</td>
<td>8</td>
<td>KI_GLUMR</td>
<td>KPR: Biopsy of Donor Kidney Glomerulosclerosis Left KI. Stop Collect from 6/30/2004</td>
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<tr>
<td>BIOP_GLUMEROS_RT</td>
<td>Num</td>
<td>8</td>
<td>KI_GLUMR</td>
<td>KPR: Biopsy of Donor Kidney Glomerulosclerosis Right KI. Stop Collect from 6/30/2004</td>
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<tr>
<td>BIOP_ISLET</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>KPR: Contributory Cause of Pancreas Failure: Biopsy Proven Isletitis(Y/N/U)</td>
</tr>
<tr>
<td>BIOP_SECTION</td>
<td>Num</td>
<td>8</td>
<td>BIOPSEC</td>
<td>KPR: Biopsy of Donor Kidney Performed at Tx Center. Stop Collect from 6/30/2004</td>
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<tr>
<td>BIOPSY_CONFIRMED_KI</td>
<td>Num</td>
<td>8</td>
<td>BIOPCONF</td>
<td>KPR: Was biopsy done to confirm kidney acute rejection</td>
</tr>
<tr>
<td>BIOPSY_CONFIRMED_PA</td>
<td>Num</td>
<td>8</td>
<td>BIOPCONF</td>
<td>KPR: Was biopsy done to confirm pancreas acute rejection</td>
</tr>
<tr>
<td>BIOPSY_DONE_KI</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>KPR: Patient Treated for Rejection. If yes, biopsy done Kidney. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>BIOPSY_DONE_PA</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>KPR: Patient Treated for Rejection. If yes, biopsy done Pancreas. Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>BIOPSY_KI</td>
<td>Char</td>
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<td>SYNUNK</td>
<td>KPR: Biopsy Confirmed Kidney Rejection. Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>BIOPSY_PA</td>
<td>Char</td>
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<td>SYNUNK</td>
<td>KPR: Biopsy Confirmed Pancreas Rejection. Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>BLEED</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>KPR: Contributory Cause of Pancreas Failure: Bleeding(Y/N/U)</td>
</tr>
<tr>
<td>BLEED_REQ_TRANSFUS</td>
<td>Num</td>
<td>8</td>
<td>TRANSFUS</td>
<td>LDR: Bleeding Requiring Transfusion. Stop Collect From 2004</td>
</tr>
<tr>
<td>BLOOD_INF_CONF</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>CDR: Clinical Infection: Blood // Confirmed by Culture</td>
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<td>BMI</td>
<td>Num</td>
<td>8</td>
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<td>KPR: BMI</td>
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<tr>
<td>BMI_L</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: bmi at Listing Time</td>
</tr>
<tr>
<td>MTX</td>
<td>Char</td>
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<td>KPR: Multiple Organ Recipient: Bone Marrow(T/F)</td>
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<td>Char</td>
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<td>KPR: Biological or Anti-viral Therapy2//Specify</td>
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<tr>
<td>BP_DIAS</td>
<td>Num</td>
<td>8</td>
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<td>LDR: Preoperative Blood Pressure Diastolic</td>
</tr>
<tr>
<td>BP_DIASI</td>
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<td>LDR: Preoperative Blood Pressure Diastolic, Status</td>
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<td>BP_DISCH_DIAST</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: At Discharge Diastolic. Stopped from Oct. 2004 file</td>
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<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>LDR: At Discharge Diastolic/Status. Stop Collect From 2004</td>
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<tr>
<td>BP_DISCH_SYSYST</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: At Discharge Systolic. Stop Collect From 2004</td>
</tr>
<tr>
<td>BP_DISCH_SYSYST_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>LDR: At Discharge Systolic/Status. Stop Collect From 2004</td>
</tr>
<tr>
<td>BP_POSTOP_DIAST</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Post-Op(Within 6 weeks post-donation) Blood Pressure Diastolic</td>
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<tr>
<td>BP_POSTOP_DIAST_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>LDR: Post-Op (Within 6 weeks post-donation) Blood Pressure Diastolic, Status</td>
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<td></td>
<td>LDR: Post-Op (Within 6 weeks post-donation) Blood Pressure Systolic</td>
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<td>Char</td>
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<td>$TRIND</td>
<td>LDR: Post-Op (Within 6 weeks post-donation) Blood Pressure Systolic, Status</td>
</tr>
<tr>
<td>BP_PRE</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Preoperative Blood Pressure Systolic</td>
</tr>
<tr>
<td>BP_PREI</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>LDR: Preoperative Blood Pressure Systolic, Status</td>
</tr>
<tr>
<td>BRAIN_DTH_TIME</td>
<td>Char</td>
<td>29</td>
<td></td>
<td>CDR: Date and time of pronouncement of death: (Complete for brain dead and DCD donors)</td>
</tr>
<tr>
<td>CARDARREST_NEURO</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Cardiac arrest since neurological event that led to declaration of brain death</td>
</tr>
<tr>
<td>CDC_GROWTH_BMI</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: BMI://%ile</td>
</tr>
<tr>
<td>CDC_GROWTH_BMI_L</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: cdc growth bmi at Listing Time</td>
</tr>
<tr>
<td>CDC_GROWTH_HGT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Height Percentile//Growth Percentiles/%ile</td>
</tr>
<tr>
<td>CDC_GROWTH_HGT_L</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: cdc growth hgt at Listing Time</td>
</tr>
<tr>
<td>CDC_GROWTH_WGT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Weight Percentile//Growth Percentiles/%ile</td>
</tr>
<tr>
<td>CDC_GROWTH_WGT_L</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: cdc growth wgt at Listing Time</td>
</tr>
<tr>
<td>CDC_RISK_HIV</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Does the Donor meet CDC guidelines for 'High Risk' for an organ donor</td>
</tr>
<tr>
<td>CELL_SRC_POS_XMAT1</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TGCELSRC RHS: Positive Xmatch row 1//Target</td>
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<tr>
<td>CELL_SRC_POS_XMAT2</td>
<td>Num</td>
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<td>TGCELSRC RHS: Positive Xmatch row 2//Target</td>
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<td>Num</td>
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<td>TGCELSRC RHS: Positive Xmatch row 3//Target</td>
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<td>CELL_SRC_POS_XMAT4</td>
<td>Num</td>
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<td>TGCELSRC RHS: Positive Xmatch row 4//Target</td>
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<tr>
<td>CELL_SRC_POS_XMAT5</td>
<td>Num</td>
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<td>TGCELSRC RHS: Positive Xmatch row 5//Target</td>
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<tr>
<td>CELL_SRCA</td>
<td>Num</td>
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<td>TGTCSRC RHS: Cell Source - Most Recent PRA. Stop Collect From 2004</td>
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<tr>
<td>CELL_SRCA</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TGTCSRC RHS: Cell Source - Peak PRA. Stop Collect From 2004</td>
</tr>
<tr>
<td>CELL_TY_POS_XMAT1</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CELL_TY RHS: Positive Xmatch row 1//Cell Type</td>
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<td>CELL_TY_POS_XMAT2</td>
<td>Num</td>
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<td>CELL_TY RHS: Positive Xmatch row 2//Cell Type</td>
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<tr>
<td>CELL_TY_POS_XMAT3</td>
<td>Num</td>
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<tr>
<td>CELL_TY_POS_XMAT4</td>
<td>Num</td>
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<td></td>
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<tr>
<td>CELL_TY_POS_XMAT5</td>
<td>Num</td>
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<td>CELL_TY RHS: Positive Xmatch row 5//Cell Type</td>
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<td>CELL_TYA</td>
<td>Num</td>
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<td></td>
<td>CELL_TY RHS: Cell Type - Most Recent PRA. Stop Collect From 2004</td>
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<td>CELL_TYB</td>
<td>Num</td>
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<td></td>
<td>CELL_TY RHS: Cell Type - Peak PRA. Stop Collect From 2004</td>
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<tr>
<td>CLAMP_TM_I</td>
<td>Char</td>
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<td>$TRIND</td>
<td>CDR: Clamp Time Status</td>
</tr>
<tr>
<td>CLAMP_TM_ZONE</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TIMEZONE CDR: Clamp Time Zone</td>
</tr>
<tr>
<td>CMV</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KPR: Pretransplant CMV Detection. Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>CMV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>$YNUNK</td>
<td>KPR: Pretx: Was there clinical disease(Y/N/U). Stop Collect from 2/7/2007</td>
</tr>
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<td>CMV_CULTURE</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KPR: Pretransplant CMV Detection: Culture(P/N/U/ND). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>CMV_DNA</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KPR: Pretransplant Serology: CMV DNA. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
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<tr>
<td>CMV_YN</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>KPR: Pretx CMV(Y/N/U). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>CMVIGG</td>
<td>Char</td>
<td>2</td>
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<td>KPR: Pretransplant CMV Detection: IGG(P/N/U/ND)</td>
</tr>
<tr>
<td>CMVIGM</td>
<td>Char</td>
<td>2</td>
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<td>KPR: Pretransplant CMV Detection: IGM(P/N/U/ND)</td>
</tr>
<tr>
<td>COGNITIVE_DEV</td>
<td>Num</td>
<td>8</td>
<td>COGDEVLP</td>
<td>KPR: Cognitive Development(Pediatric Only)</td>
</tr>
<tr>
<td>COGNITIVE_DEV_L</td>
<td>Num</td>
<td>8</td>
<td>COGDEVLP</td>
<td>TCR_KI: Cognitive Development(Pediatric Only) at Listing Time</td>
</tr>
<tr>
<td>COLD_ISCH_PUMP_KI_LT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Total Cold ischemia Time Left KI(OR EN-BLOC): (if pumped, include pump time)</td>
</tr>
<tr>
<td>COLD_ISCH_PUMP_KI_LT_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KPR: Total Cold ischemia Time Left KI(OR EN-BLOC): (if pumped, include pump time), Status</td>
</tr>
<tr>
<td>COLD_ISCH_PUMP_KI_RT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Total Cold ischemia Time Right KI(OR EN-BLOC): (if pumped, include pump time)</td>
</tr>
<tr>
<td>COLD_ISCH_PUMP_KI_RT_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KPR: Total Cold ischemia Time Right KI(OR EN-BLOC): (if pumped, include pump time), Status</td>
</tr>
<tr>
<td>COLD_ISCH_TM_KI_LT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Total Cold Ischemic TimeKI Left. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>COLD_ISCH_TM_KI_LT_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KPR: Total Cold Ischemic Time/Status KI Left. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>COLD_ISCH_TM_KI_RT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Total Cold Ischemic Time KI Right. Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>COLD_ISCH_TM_KI_RT_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KPR: Total Cold Ischemic Time/Status KI Right. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>COMPL_ABSC</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Pancreas Transplant Complications(Not leading to graft failure): Abcess or Local Infection(Y/N/U)</td>
</tr>
<tr>
<td>COMPL_ANASLK</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Pancreas Transplant Complications(Not leading to graft failure): Anastomotic Leak(Y/N/U)</td>
</tr>
<tr>
<td>COMPL_PANCREA</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Pancreas Transplant Complications(Not leading to graft failure): Pancreatitis(Y/N/U)</td>
</tr>
<tr>
<td>CONSENT_ATTORNEY</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>CDR: Consent based solely on written documentation: mechanisms/ Living will. Stop Collect From 2004</td>
</tr>
<tr>
<td>CONSENT_DON_REGIS</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>CDR: Other Consent Mechanism intent to be a donor, Specify</td>
</tr>
<tr>
<td>CONSENT_DRIVE_LIC</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>CDR: Consent based solely on written documentation: mechanisms/ Living will. Stop Collect From 2004</td>
</tr>
<tr>
<td>CONSENT_LIV_WILL</td>
<td>Char</td>
<td>5</td>
<td>$YNUNK</td>
<td>CDR: Consent based solely on written documentation: mechanisms/ Living will. Stop Collect From 2004</td>
</tr>
<tr>
<td>CONSENT_PX_WRIT_DOC</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Was the consent based solely on this documentation</td>
</tr>
<tr>
<td>CONSENT_TIME</td>
<td>Char</td>
<td>29</td>
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<td>CDR: Date and time consent obtained for first organ</td>
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<tr>
<td>CONSENT_WRIT_DOC_INTENT</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>CDR: Did the patient have written documentation of their intent to be a donor</td>
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<tr>
<td>CONTIN_ALCOHOL</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Continued alcohol in last six months. Stop Collect From 2004</td>
</tr>
<tr>
<td>CONTIN_COCAIN</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Lifestyle Factors: Cocaine Use AND continued in last six months</td>
</tr>
<tr>
<td>CONTIN_IV_DRUG</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Continued IV Drug Use in last six months. Stop Collect From 2004</td>
</tr>
<tr>
<td>CONTROLLED</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: If Was a DCD donor, controlled(Y/N/U)</td>
</tr>
<tr>
<td>CONVERT_OPEN_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Kidney Surgical Information: Conversion from Laparoscopic to Open</td>
</tr>
<tr>
<td>CREAT_CLEAR</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Pretransplant Creatinine Clearance. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>CREAT_CLEAR_I</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Pretransplant Creatinine Clearance/Status. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>CREAT_CLEAR_I_L</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>TCR_KI: Creatinine Clearance/Status at Listing Time. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
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<tr>
<td>CREAT_CLEAR_L</td>
<td>Num</td>
<td>8</td>
<td>TCR_KI:</td>
<td>Creatinine Clearance at Listing Time. Stop Collect from 6/30/2004</td>
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<tr>
<td>CREAT_CLEAR_METH</td>
<td>Num</td>
<td>8</td>
<td>CREATMET</td>
<td>Pretransplant Creatinine Clearance Method. Stop Collect from 6/30/2004</td>
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<tr>
<td>CREAT_CLEAR_METH_L</td>
<td>Num</td>
<td>8</td>
<td>CREATMET</td>
<td>Creatinine Clearance/Method at Listing Time. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>CREATDEC</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Creatinine Decline by 25% or More in First 24 Hours on 2 separate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>samples (Y/N)</td>
</tr>
<tr>
<td>CRSMATCH_DONE_PERIOD</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>RHS: If Crossmatch Done yes, was the crossmatch prospective to</td>
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<tr>
<td></td>
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<td></td>
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<td>transplant</td>
</tr>
<tr>
<td>CTR_TY</td>
<td>Char</td>
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<td>KPR: Transplant Center Type</td>
</tr>
<tr>
<td>CTR_TY_LISTING</td>
<td>Char</td>
<td>3</td>
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<td>TCR_KI: Listing Center Type</td>
</tr>
<tr>
<td>CVASCR</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>TCR_KI: Symptomatic Cerebrovascular Disease at Listing Time</td>
</tr>
<tr>
<td>D_F_TY</td>
<td>Char</td>
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<td>LDR: DONOR WORKUP FACILITY</td>
</tr>
<tr>
<td>DA1</td>
<td>Char</td>
<td>5</td>
<td>USRDS:</td>
<td>DONOR HLA TYPING A(1)</td>
</tr>
<tr>
<td>DA2</td>
<td>Char</td>
<td>5</td>
<td>USRDS:</td>
<td>DONOR HLA TYPING A(2)</td>
</tr>
<tr>
<td>DA1D</td>
<td>Char</td>
<td>8</td>
<td>DHS:</td>
<td>Typing Method Class I: A(1)</td>
</tr>
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<td>RHS:</td>
<td>Donor HLA Retyping A(1)</td>
</tr>
<tr>
<td>DA2D</td>
<td>Char</td>
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<td>DHS:</td>
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</tr>
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<td>Char</td>
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<td>RHS:</td>
<td>Donor HLA Retyping A(2)</td>
</tr>
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<td>DABO</td>
<td>Char</td>
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<td>CDR: ABO Blood Group</td>
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<tr>
<td>DAGE</td>
<td>Num</td>
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<td>CDR / LDR: Donor Age in Months</td>
</tr>
<tr>
<td>DANCONV</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp:</td>
</tr>
<tr>
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<td></td>
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<td>Anticonvulsants (Y/N/U)</td>
</tr>
<tr>
<td>DANHYP</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp:</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>Antihypertensives (Y/N/U)</td>
</tr>
<tr>
<td>DANTHBC</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>CDR: Serology: Anti-HBC</td>
</tr>
<tr>
<td>DANTHCV</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>CDR: Serology: Anti-HCV</td>
</tr>
<tr>
<td>DB1</td>
<td>Char</td>
<td>5</td>
<td>USRDS:</td>
<td>DONOR HLA TYPING B(1)</td>
</tr>
<tr>
<td>DB2</td>
<td>Char</td>
<td>5</td>
<td>USRDS:</td>
<td>DONOR HLA TYPING B(2)</td>
</tr>
<tr>
<td>DB1D</td>
<td>Char</td>
<td>8</td>
<td>DHS:</td>
<td>Typing Method Class I: B(1)</td>
</tr>
<tr>
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<td>Char</td>
<td>8</td>
<td>RHS:</td>
<td>Donor HLA Retyping B(1)</td>
</tr>
<tr>
<td>DB2D</td>
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<td>Typing Method Class I: B(2)</td>
</tr>
<tr>
<td>DB2R</td>
<td>Char</td>
<td>8</td>
<td>RHS:</td>
<td>Donor HLA Retyping B(2)</td>
</tr>
<tr>
<td>DBL_ENB_KIDISCD</td>
<td>Num</td>
<td>8</td>
<td>DISCD_CD</td>
<td>CDR: Reason organ not transplanted - Double Enbloc Kidney</td>
</tr>
<tr>
<td>DBL_ENB_KIDISCDTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Reason organ not transplanted - Double Enbloc Kidney, Specify</td>
</tr>
<tr>
<td>DBL_ENB_KITXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Organ Dispositions: Reason Code - Double/En-bloc Kidney, Specify</td>
</tr>
<tr>
<td>DLBLINF</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>CDR: Terminal Lab Data: BUN</td>
</tr>
<tr>
<td>DBUN</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Terminal Lab Data: BUN</td>
</tr>
<tr>
<td>DBUNST</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Terminal Lab Data: BUN, Status</td>
</tr>
<tr>
<td>DW4D</td>
<td>Num</td>
<td>8</td>
<td>WKGRPHLA</td>
<td>DHS: Typing Method Class I: Bw4</td>
</tr>
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<td>DBW4R</td>
<td>Num</td>
<td>8</td>
<td>WKGRPHLA</td>
<td>RHS: Donor Retyping - Typing Method Class I: Bw4</td>
</tr>
<tr>
<td>DW6D</td>
<td>Num</td>
<td>8</td>
<td>WKGRPHLA</td>
<td>DHS: Typing Method Class I: Bw6</td>
</tr>
<tr>
<td>DW6R</td>
<td>Num</td>
<td>8</td>
<td>WKGRPHLA</td>
<td>RHS: Donor Retyping - Typing Method Class I: Bw6</td>
</tr>
<tr>
<td>DCANCER</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR / LDR: History of Cancer, Specify</td>
</tr>
<tr>
<td>DCDATE</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>KPR: Date of Discharge from Tx Center</td>
</tr>
<tr>
<td>DCITY</td>
<td>Char</td>
<td>20</td>
<td>$</td>
<td>CDR / LDR: Home City</td>
</tr>
<tr>
<td>DCITZ</td>
<td>Num</td>
<td>8</td>
<td>CITIZEN</td>
<td>CDR / LDR: Donor Citizenship</td>
</tr>
<tr>
<td>DCMV</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>CDR / LDR: Serology: Anti-CMV</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
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<tr>
<td>DCMV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>SYNUNK</td>
<td>LDR: Viral Detection: DCMV_YN / If Yes, Was there clinical disease</td>
</tr>
<tr>
<td>DCMV_CULTURE</td>
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<td>LDR: Viral Detection: DCMV_YN / If Yes, Culture</td>
</tr>
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<td>DCMV_DNA</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>LDR: Donor CMV DNA. Stop Collect From 2004</td>
</tr>
<tr>
<td>DCMV_IGG</td>
<td>Char</td>
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<td>LDR: Viral Detection: CMV IGG</td>
</tr>
<tr>
<td>DCMV_IGM</td>
<td>Char</td>
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<td>LDR: Viral Detection: CMV IGM</td>
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<td>DCMV_NUCLEIC</td>
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<td>LDR: Viral Detection: DCMV_YN / If Yes, Nucleic Acid Testing</td>
</tr>
<tr>
<td>DCMV_YN</td>
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<td>LDR: Viral Detection: CMV tested</td>
</tr>
<tr>
<td>DCFREE</td>
<td>Num</td>
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<td></td>
<td>CDR / LDR: History of Cancer: Cancer Free Interval(years)</td>
</tr>
<tr>
<td>DCNFreeest</td>
<td>Char</td>
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<td>TRIND</td>
<td>CDR / LDR: History of Cancer: Cancer Free Interval, Status</td>
</tr>
<tr>
<td>DCNTRY</td>
<td>Char</td>
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<td>CTRY</td>
<td>CDR: Home Country</td>
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<tr>
<td>DCOD</td>
<td>Num</td>
<td>8</td>
<td>DON_COD</td>
<td>CDR: Deceased Donor Cause of Death</td>
</tr>
<tr>
<td>DOCDTXT</td>
<td>Char</td>
<td>50</td>
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<td>CDR / LDR: Cause of Death, Specify</td>
</tr>
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<td>DCONCIG</td>
<td>Char</td>
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<td>SYNUNK</td>
<td>CDR: Lifestyle Factors: Cigarette Use AND continued in last six months</td>
</tr>
<tr>
<td>DCOORCOOL</td>
<td>Char</td>
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<td>SYNUNK</td>
<td>CDR: If Was this a DCD donor Yes, Core Cooling Used</td>
</tr>
<tr>
<td>DCOOTDRUG</td>
<td>Char</td>
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<td>SYNUNK</td>
<td>CDR: Lifestyle Factors: Other Drug USE AND continued in last six months</td>
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<tr>
<td>DCREAT</td>
<td>Num</td>
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<td>CDR / LDR: Donor Pre-Donation Serum Creatinine</td>
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<tr>
<td>DCREST</td>
<td>Char</td>
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<td>CDR / LDR: Donor Pre-Donation Serum Creatinine, Status</td>
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<td>DCW2D</td>
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<tr>
<td>DDAVP</td>
<td>Char</td>
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<td>CDR: Medications administered within 24 hr prior to crossclamp:</td>
</tr>
<tr>
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<td></td>
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<td></td>
<td>DAVP(Y/N/U)</td>
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<td>DDCLPDPDT</td>
<td>Num</td>
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<td>MMDDYY</td>
<td>CDR: Clamp Date</td>
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<td>DDCLMPTM</td>
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<td>10</td>
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<td>CDR: Clamp Time</td>
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<tr>
<td>DDIEET</td>
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<td>CDR: If History of Hypertension, Method of control: Diet(Y/N/U)</td>
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<td>DDUR</td>
<td>Char</td>
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<td>SYNUNK</td>
<td>CDR: If History of Hypertension, Method of control: Diuretics(Y/N/U)</td>
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<td>DDOBUT</td>
<td>Char</td>
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<td>CDR: Medications given to donor (24 hours prior to cross clamp):</td>
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<td></td>
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<td></td>
<td></td>
<td>Dobutamine. Stop Separately Collect From 2003</td>
</tr>
<tr>
<td>DDOD</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Date of Death</td>
</tr>
<tr>
<td>DDOPA</td>
<td>Char</td>
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<td>CDR: Medications given to donor (24 hours prior to cross clamp):</td>
</tr>
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<td></td>
<td></td>
<td>Dopamine. Stop Separately Collect From 2003</td>
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<td>DHS: Typing Method Class II: DQ(1)</td>
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<td>DDR1</td>
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<td>USRDS: DONOR HLA TYPING DR(1)</td>
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<td>Char</td>
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<td>USRDS: DONOR HLA TYPING DR(2)</td>
</tr>
<tr>
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<td>Char</td>
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<td>DHS: Typing Method Class II: DR(1)</td>
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<td>Char</td>
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<td>SDRLOCUS</td>
<td>RHS: Donor HLA Retyping DR(1)</td>
</tr>
<tr>
<td>DDR2D</td>
<td>Char</td>
<td>8</td>
<td>SDRLOCUS</td>
<td>DHS: Typing Method Class II: DR(2)</td>
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<td>Char</td>
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<td>SDRLOCUS</td>
<td>RHS: Donor HLA Retyping DR(2)</td>
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<td>WKRPHLA</td>
<td>DHS: Typing Method Class II: DR51</td>
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<td>Num</td>
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<td>WKRPHLA</td>
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<td>Format</td>
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<td>WKGRPHLA</td>
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<tr>
<td>DEBNA</td>
<td>Char</td>
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<td>$SCREEN</td>
<td>CDR: Serology: EBNA</td>
</tr>
<tr>
<td>DEBV</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Viral Detection: EBV tested</td>
</tr>
<tr>
<td>DEBV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>$YNUNK</td>
<td>LDR: Viral Detection: DEBV / If Yes, Was there clinical disease</td>
</tr>
<tr>
<td>DEBV_Igg</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>CDR: Serology: EBV(VCA)(IgG)</td>
</tr>
<tr>
<td>DEBV_Igm</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>CDR: Serology: EBV(VCA)(IgM)</td>
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<tr>
<td>DEDUC</td>
<td>Num</td>
<td>8</td>
<td>ED_LEVEL</td>
<td>LDR: Living Donor Highest Education Level</td>
</tr>
<tr>
<td>DEPSTDNA</td>
<td>Char</td>
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<td>$SCREEN</td>
<td>LDR: Viral Detection: EBV DNA</td>
</tr>
<tr>
<td>DEPSTIgg</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>LDR: Viral Detection: EBV IgG</td>
</tr>
<tr>
<td>DEPSTIgm</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>LDR: Viral Detection: EBV IgM</td>
</tr>
<tr>
<td>DEXNCR</td>
<td>Char</td>
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<td>CDR: Cancer at time of procurement: Extracranial(Y/N/U)</td>
</tr>
<tr>
<td>DFUNCSTAT</td>
<td>Num</td>
<td>8</td>
<td>FUNCSTAT</td>
<td>LDR: Donor Functional Status</td>
</tr>
<tr>
<td>DHDUC</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>LDR: Viral Detection: HBV Core Antibody</td>
</tr>
<tr>
<td>DHB5AB</td>
<td>Char</td>
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<td>CDR: Serology: HBsAb</td>
</tr>
<tr>
<td>DHB5AG</td>
<td>Char</td>
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<td>$SCREEN</td>
<td>LDR: Viral Detection: HBV Surface Antigen</td>
</tr>
<tr>
<td>DHB5V</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Viral Detection: HBV tested</td>
</tr>
<tr>
<td>DHBV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>$YNUNK</td>
<td>LDR: Viral Detection: HBV / If Yes, Was there clinical disease</td>
</tr>
<tr>
<td>DHBV_HDV</td>
<td>Char</td>
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<td>LDR: Viral Detection: HBV HDV (Delta Virus)</td>
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<tr>
<td>DHBV_LI_HIST</td>
<td>Char</td>
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<td>LDR: Viral Detection: HBV Liver Histology</td>
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<tr>
<td>DHBVDNA</td>
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<td>LDR: Viral Detection: HBV DNA</td>
</tr>
<tr>
<td>DHCRCRA</td>
<td>Char</td>
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<td>LDR: Viral Detection: HCV RIBA</td>
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<td>DHCSCCRN</td>
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<td>LDR: Viral Detection: HCV Antibody</td>
</tr>
<tr>
<td>DHCV</td>
<td>Char</td>
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<td>LDR: Viral Detection: HCV tested</td>
</tr>
<tr>
<td>DHCV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>$YNUNK</td>
<td>LDR: Viral Detection: HCV / If Yes, Was there clinical disease</td>
</tr>
<tr>
<td>DHCV_LI_HIST</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>LDR: Viral Detection: HCV Liver Histology</td>
</tr>
<tr>
<td>DHCVRNA</td>
<td>Char</td>
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<td>$SCREEN</td>
<td>LDR: Viral Detection: HCV RNA</td>
</tr>
<tr>
<td>DHDIAB</td>
<td>Num</td>
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<td>HISTDIAB</td>
<td>CDR: History of Diabetes</td>
</tr>
<tr>
<td>DHRGT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR / LDR: Height(for LDR: Post-Op(Within 6 weeks post-donation))</td>
</tr>
<tr>
<td>DHGTST</td>
<td>Char</td>
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<td>$TRIND</td>
<td>CDR / LDR: Height in cm Status</td>
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<tr>
<td>DHHYP</td>
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<td>CDR / LDR: Donor History of Hypertension</td>
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<td>Char</td>
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<td>CDR / LDR: Donor Hispanic Ethnicity</td>
</tr>
<tr>
<td>DHISTCIG</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>CDR / LDR: Lifestyle Factors: Cigarette Use - Ever</td>
</tr>
<tr>
<td>DHIHV</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>CDR: Serology: Anti-HIV I/II</td>
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<tr>
<td>DHIHV_ANTIBODY</td>
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<td>$SCREEN</td>
<td>LDR: Viral Detection: HIV Antibody</td>
</tr>
<tr>
<td>DHIHV_CLINICAL</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>LDR: Viral Detection: HIV / If Yes, Was there clinical disease</td>
</tr>
<tr>
<td>DHIHV_RNA</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>LDR: Viral Detection: HIV RNA</td>
</tr>
<tr>
<td>DHIHV_YN</td>
<td>Char</td>
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<td>LDR: Viral Detection: HIV tested</td>
</tr>
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<td>DHIHCVNF</td>
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<td>LDR: Serology: HIV Confirmation(pre 2004 data)</td>
</tr>
<tr>
<td>DHIHVSCRN</td>
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<td>LDR: Serology: HIV Screening(pre 2004 data)</td>
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<td>DHLATYP</td>
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<td>DHS: Donor HLA Typed(Y/N/U)</td>
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<td>DIAB_TREAT</td>
<td>Num</td>
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<td>DIABTRET</td>
<td>LDR: Diabetes Treatment. Multiple selections. The value is comb of value(s) 1, 2, 4</td>
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<tr>
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<td>Char</td>
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<td>DIABR</td>
<td>Num</td>
<td>8</td>
<td>DIAB_TY</td>
<td>TCR_KI: Diabetes / Type at Listing Time</td>
</tr>
<tr>
<td>DIALDRT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>KPR: If Pretransplant Dialysis Yes, Date First Dialed</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
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<td>STRING</td>
<td>KPR: If Pretransplant Dialysis Yes, Date First Dialyzed, Status</td>
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<td>DIAL_TY</td>
<td>TCR_KI: Dialysis Type at Listing Time</td>
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<td>SYNUNK</td>
<td>CDR: Cancer at time of procurement: Intracranial(Y/N/U)</td>
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<td>DINFCT</td>
<td>Char</td>
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<td>SYNUNK</td>
<td>CDR: Clinical Infection</td>
</tr>
<tr>
<td>DINSDEP</td>
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<td>INSDEP</td>
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<tr>
<td>DISP_DBLEB_KI</td>
<td>Num</td>
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<td>DISPOS</td>
<td>CDR: Donor Double Enbloc Kidney Disposition Code</td>
</tr>
<tr>
<td>DISP_LKI</td>
<td>Num</td>
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<td>DISPOS</td>
<td>CDR: Donor Left Kidney Disposition Code</td>
</tr>
<tr>
<td>DISP_PA</td>
<td>Num</td>
<td>8</td>
<td>DISPOS</td>
<td>CDR: Donor Pancreas Disposition Code</td>
</tr>
<tr>
<td>DISP_PA_SEG1</td>
<td>Num</td>
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<td>DISPOS</td>
<td>CDR: Donor Pancreas Segment 1 Disposition Code</td>
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<tr>
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<td>Num</td>
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<td>DISPOS</td>
<td>CDR: Donor Pancreas Segment 2 Disposition Code</td>
</tr>
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<td>Num</td>
<td>8</td>
<td>DISPOS</td>
<td>CDR: Donor Right Kidney Disposition Code</td>
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<td>SYNUNK</td>
<td>CDR: IV Drug Use - Ever. Stop Collect From 2003</td>
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<td>Char</td>
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<td>SYNUNK</td>
<td>CDR: Was this a DCD donor (non-heartbeating)</td>
</tr>
<tr>
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<td>Char</td>
<td>4</td>
<td>$</td>
<td>KPR: Previous Transplant Organ</td>
</tr>
<tr>
<td>DON_ORG1</td>
<td>Char</td>
<td>8</td>
<td>TCR_KI</td>
<td>Previous Transplant Organ at Listing Time</td>
</tr>
<tr>
<td>DON_ORG2</td>
<td>Char</td>
<td>8</td>
<td>TCR_KI</td>
<td>Previous Transplant Organ at Listing Time</td>
</tr>
<tr>
<td>DON_SPEC_TXFUS</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>KPR: Pretransplant: Any Donor Specific Transfusions. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>DONATION</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>LDR: Secondary Source of Payment: Donation. Stop Collect From 2004</td>
</tr>
<tr>
<td>DONID</td>
<td>Char</td>
<td>7</td>
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<td>KPR: UNOS Donor ID #</td>
</tr>
<tr>
<td>DONREL_U</td>
<td>Num</td>
<td>8</td>
<td>DON_REL</td>
<td>LDR: Donor Type</td>
</tr>
<tr>
<td>DOSE_DUR1</td>
<td>Num</td>
<td>8</td>
<td>INTROUNT</td>
<td>CDR: Inotropic Medications at Time of Cross Clamp: Final Dosage Duration(hours)</td>
</tr>
<tr>
<td>DOSE_DUR2</td>
<td>Num</td>
<td>8</td>
<td>INTROUNT</td>
<td>CDR: Inotropic Medications at Time of Cross Clamp: Final Dosage Duration(hours)</td>
</tr>
<tr>
<td>DOSE_DUR3</td>
<td>Num</td>
<td>8</td>
<td>INTROUNT</td>
<td>CDR: Inotropic Medications at Time of Cross Clamp: Final Dosage Duration(hours)</td>
</tr>
<tr>
<td>DOSE_UNITS1</td>
<td>Num</td>
<td>8</td>
<td>INTROUNT</td>
<td>CDR: Inotropic Medications at Time of Cross Clamp: Final Dosage Units</td>
</tr>
<tr>
<td>DOSE_UNITS2</td>
<td>Num</td>
<td>8</td>
<td>INTROUNT</td>
<td>CDR: Inotropic Medications at Time of Cross Clamp: Final Dosage Units</td>
</tr>
<tr>
<td>DOSE_UNITS3</td>
<td>Num</td>
<td>8</td>
<td>INTROUNT</td>
<td>CDR: Inotropic Medications at Time of Cross Clamp: Final Dosage Units</td>
</tr>
<tr>
<td>DOTHRUG</td>
<td>Char</td>
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<td>SYNUNK</td>
<td>CDR: Lifestyle Factors: Other Drug Use (non - IV) - Ever</td>
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<tr>
<td>DOTHINF</td>
<td>Char</td>
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</tr>
<tr>
<td>DOTHITX3</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Clinical Infection - other, specify</td>
</tr>
<tr>
<td>DOTHMED1</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Medications administered within 24 hr prior to crossclamp: Other /Specify</td>
</tr>
<tr>
<td>DOTHMED2</td>
<td>Char</td>
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<td>CDR: Medications administered within 24 hr prior to crossclamp: Other /Specify</td>
</tr>
<tr>
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<td>CDR: Medications administered within 24 hr prior to crossclamp: Other /Specify</td>
</tr>
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<td>DOTHYMED</td>
<td>Char</td>
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<td>SYNUNK</td>
<td>CDR: If History of Hypertension, Method of control: Other Hypertensive Med(Y/N/U)</td>
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<tr>
<td>DPHYSICAL_CAPACITY</td>
<td>Num</td>
<td>8</td>
<td>PHYSCAP</td>
<td>LDR: Donor Physical Capacity</td>
</tr>
<tr>
<td>DPINF</td>
<td>Char</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPTDIUR</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp: Diuretics(Y/N/U)</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
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<tr>
<td>DPTHEP</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp: Heparin(Y/N/U)</td>
</tr>
<tr>
<td>DPTOTH1</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Other Medications administered within 24 hr prior to crossclamp: Specify</td>
</tr>
<tr>
<td>DPTOTH2</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Other Medications administered within 24 hr prior to crossclamp: Specify</td>
</tr>
<tr>
<td>DPTOTH3</td>
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<td>CDR: Other Medications administered within 24 hr prior to crossclamp: Specify</td>
</tr>
<tr>
<td>DPTOTH4</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Received Prerecovery Medication, Other specify. Stop Collect From 2003</td>
</tr>
<tr>
<td>DPTREAT</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Donor Received Prerecovery Medication(Y/N/U). Stop Collect From 2003</td>
</tr>
<tr>
<td>DPTSTER</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp: Steroids(Y/N/U)</td>
</tr>
<tr>
<td>DRACE</td>
<td>Char</td>
<td>3</td>
<td>$RACEFMT</td>
<td>CDR / LDR: Donor Race</td>
</tr>
<tr>
<td>DRECVDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>CDR / LDR: Orang Recovery Date</td>
</tr>
<tr>
<td>DRETYMD1</td>
<td>Num</td>
<td>8</td>
<td>HLA_TYMT</td>
<td>RHS: Donor Typing Method Class I:</td>
</tr>
<tr>
<td>DRETYMD2</td>
<td>Num</td>
<td>8</td>
<td>HLA_TYMT</td>
<td>RHS: Donor Typing Method Class II:</td>
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<td>DRETYP</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>RHS: Donor Retyped at Your Center:</td>
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<td>DRETYP1DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Date Typing Completed Class I</td>
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<tr>
<td>DRETYP2DT</td>
<td>Num</td>
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<td>MMDDYY</td>
<td>RHS: Date Typing Completed Class II</td>
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<td>DRETYPTGT1</td>
<td>Num</td>
<td>8</td>
<td>TGCELSRC</td>
<td>RHS: Donor Retyping - Target Cell Source Class I. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32</td>
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<tr>
<td>DRETYPTGT2</td>
<td>Num</td>
<td>8</td>
<td>TGCELSRC</td>
<td>RHS: Donor Retyping - Target Cell Source Class II. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32</td>
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<tr>
<td>DRH</td>
<td>Char</td>
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<td>CDR: Donor ABO Blood RH. Stop Collect From 2004</td>
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<tr>
<td>DSEX</td>
<td>Char</td>
<td>1</td>
<td>$</td>
<td>CDR / LDR: Gender</td>
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<tr>
<td>DSGOT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Terminal Lab Data: SGOT/AST</td>
</tr>
<tr>
<td>DSGOTST</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Terminal Lab Data: SGOT/AST, Status</td>
</tr>
<tr>
<td>DSGPT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Terminal Lab Data: SGPT/ALT</td>
</tr>
<tr>
<td>DSGPTST</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Terminal Lab Data: SGPT/ALT, Status</td>
</tr>
<tr>
<td>DSKCNCNCR</td>
<td>Char</td>
<td>1</td>
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<td>CDR: Cancer at time of procurement: Skin(Y/N/U)</td>
</tr>
<tr>
<td>DSTATE</td>
<td>Char</td>
<td>2</td>
<td>$STATE</td>
<td>CDR / LDR: Home State</td>
</tr>
<tr>
<td>DSUSPND_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR:</td>
</tr>
<tr>
<td>DTBILI</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Terminal Lab Data: Total Bilirubin</td>
</tr>
<tr>
<td>DTBILST</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Terminal Lab Data: Total Bilirubin, Status</td>
</tr>
<tr>
<td>DTCELL1</td>
<td>Num</td>
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<td>TGCELSRC</td>
<td>DHS: Target Source for Class I. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32</td>
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<tr>
<td>DTCELL2</td>
<td>Num</td>
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<td>TGCELSRC</td>
<td>DHS: Target Source for Class II. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32</td>
</tr>
<tr>
<td>DTHCIRC</td>
<td>Num</td>
<td>8</td>
<td>D_CIRCUM</td>
<td>CDR: Circumstances of Death</td>
</tr>
<tr>
<td>DTHMECH</td>
<td>Num</td>
<td>8</td>
<td>D_MECH</td>
<td>CDR: Mechanism of Death</td>
</tr>
<tr>
<td>DTYMETHC1</td>
<td>Num</td>
<td>8</td>
<td>HLA_TYMT</td>
<td>DHS: Donor Typing Method Class I. Multiple selections. The value is comb of value(s) 1, 2, 4</td>
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<tr>
<td>DTYMETHC2</td>
<td>Num</td>
<td>8</td>
<td>HLA_TYMT</td>
<td>DHS: Donor Typing Method Class II. Multiple selections. The value is comb of value(s) 1, 2, 4</td>
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<tr>
<td>DTYPE</td>
<td>Char</td>
<td>3</td>
<td>$DONOR</td>
<td>KPR: Donor Type</td>
</tr>
<tr>
<td>DUCT_MGMT</td>
<td>Num</td>
<td>8</td>
<td>PADUCTMG</td>
<td>KPR: Surgical Information: Duct Management</td>
</tr>
<tr>
<td>DUCT_MGMT_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KPR: Surgical Information: Duct Management/Specify</td>
</tr>
<tr>
<td>DUR_ABSTINENCE</td>
<td>Num</td>
<td>8</td>
<td>DUR_ABS</td>
<td>LDR: History of Cigarette Use: Duration of Abstinence</td>
</tr>
<tr>
<td>DURINF</td>
<td>Char</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
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</tr>
<tr>
<td>DVASOD</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp: Vasodilators(Y/N/U)</td>
</tr>
<tr>
<td>DVDRIL</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>CDR: Serology: RPR-VDRL</td>
</tr>
<tr>
<td>DVIRUSES_TESTED</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Have HIV, CMV, HBV, HCV, EBV ever been tested for</td>
</tr>
<tr>
<td>DWGT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR / LDR: Weight(for LDR: Post-Op(Within 6 weeks post-donation))</td>
</tr>
<tr>
<td>DWGTST</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>CDR / LDR: Weight in kg Status</td>
</tr>
<tr>
<td>DWORK_INCOME</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Working for income(Y/N/U)</td>
</tr>
<tr>
<td>DWORK_NO_STATUS</td>
<td>Num</td>
<td>8</td>
<td>NOTWORK</td>
<td>LDR: Not Working Due To</td>
</tr>
<tr>
<td>DWORK_YES_STATUS</td>
<td>Num</td>
<td>8</td>
<td>WORKINC</td>
<td>LDR: Yes Working Status</td>
</tr>
<tr>
<td>DWTIME</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: If Was a DCD donor, Estimated Warm Ischemic Time</td>
</tr>
<tr>
<td>DWTIMEST</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>CDR: If Was a DCD donor, Estimated Warm Ischemic Time, Status</td>
</tr>
<tr>
<td>DYR_ENTRY_US</td>
<td>Char</td>
<td>29</td>
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<td>LDR: If Donor is Non-Resident Alien, Year of Entry to the U.S</td>
</tr>
<tr>
<td>DZIP</td>
<td>Char</td>
<td>10</td>
<td>$</td>
<td>CDR / LDR: Donor Home Zip</td>
</tr>
<tr>
<td>EBV</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Pretransplant EBV Detection(Y/N/U). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>EBV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>$YNUNK</td>
<td>KPR: Pretransplant EBV Detection: Was there clinical disease(Y/N/U). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>EBV_SEROSTATUS</td>
<td>Char</td>
<td>2</td>
<td>SCREEN</td>
<td>KPR: Viral Detection at Tx time // EBV Serology status. Converted from EBV IgG, EBV IgM and EBV DNA</td>
</tr>
<tr>
<td>EDUC</td>
<td>Num</td>
<td>8</td>
<td>ED_LEVEL</td>
<td>TCR_KI: Patient Highest Education Level at Listing Time</td>
</tr>
<tr>
<td>EN_SHARE</td>
<td>Num</td>
<td>8</td>
<td>SHARETYC</td>
<td>CDR: Share Type - En-bloc Kidney. Stop Collect From 2003</td>
</tr>
<tr>
<td>EPSTDNA</td>
<td>Char</td>
<td>2</td>
<td>SCREEN</td>
<td>KPR: Pretransplant EBV Detection: DNA(P/N/U/ND). Stop Separately Collect from 2/7/2007</td>
</tr>
<tr>
<td>EPSTIGG</td>
<td>Char</td>
<td>2</td>
<td>SCREEN</td>
<td>KPR: Pretransplant EBV Detection: IgG(P/N/U/ND). Stop Separately Collect from 2/7/2007</td>
</tr>
<tr>
<td>EPSTIGM</td>
<td>Char</td>
<td>2</td>
<td>SCREEN</td>
<td>KPR: Pretransplant EBV Detection: IgM(P/N/U/ND). Stop Separately Collect from 2/7/2007</td>
</tr>
<tr>
<td>EXP_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR:</td>
</tr>
<tr>
<td>EXPERACC</td>
<td>Char</td>
<td>1</td>
<td>SYUNK</td>
<td>TCR_KI: Exhausted Peritoneal Access at Listing Time</td>
</tr>
<tr>
<td>EXPRESS_FAMILY</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Did the patient express to family or others the intent to be a donor</td>
</tr>
<tr>
<td>EXVASACC</td>
<td>Char</td>
<td>1</td>
<td>SYUNK</td>
<td>TCR_KI: Exhausted Vascular Access at Listing Time</td>
</tr>
<tr>
<td>FPP_UNITS</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Non-Autologous Blood Administration /If Yes, Number of FFP Units</td>
</tr>
<tr>
<td>FIN_FLOW_RATE_TX</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: If put on pump or stayed on pump, Final flow rate at transplant</td>
</tr>
<tr>
<td>FIN_FLOW_RATE_TX_I</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>KPR: Final flow rate at tx, Status</td>
</tr>
<tr>
<td>FIN_RESIST_TX</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: If put on pump or stayed on pump, Final resistance at transplant</td>
</tr>
<tr>
<td>FIN_RESIST_TX_I</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>KPR: Final resistance at tx, Status</td>
</tr>
<tr>
<td>FINAL_FLUSH_DBL_ENBKI</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Double Enbloc Kidney Final/Storage Flush Solution</td>
</tr>
<tr>
<td>FINAL_FLUSH_DBL_ENBKI_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Double Enbloc Kidney Final/Storage Flush Solution, Specify</td>
</tr>
<tr>
<td>FINAL_FLUSH_KIL</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Left Kidney Final/Storage Flush Solution</td>
</tr>
<tr>
<td>FINAL_FLUSH_KIL_OSTXT</td>
<td>Char</td>
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<td>$</td>
<td>CDR: Donor Left Kidney Final/Storage Flush Solution, Specify</td>
</tr>
<tr>
<td>FINAL_FLUSH_KIR</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Right Kidney Final/Storage Flush Solution</td>
</tr>
<tr>
<td>FINAL_FLUSH_KIR_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Right Kidney Final/Storage Flush Solution, Specify</td>
</tr>
<tr>
<td>FINAL_FLUSH_PA</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Final/Storage Flush Solution</td>
</tr>
<tr>
<td>FINAL_FLUSH_PA_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Final/Storage Flush Solution, Specify</td>
</tr>
<tr>
<td>FINAL_FLUSH_PA_SEG1</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Segment 1 Final/Storage Flush Solution</td>
</tr>
<tr>
<td>FINAL_FLUSH_PA_SEG2</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Segment 2 Final/Storage Flush Solution</td>
</tr>
<tr>
<td>Variable</td>
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<td>Length</td>
<td>Format</td>
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</tr>
<tr>
<td>FINAL_FLUSH_PA_SEG1_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Segment 1 Final/Storage Flush Solution, Specify. Stop Collect From 2004</td>
</tr>
<tr>
<td>FINAL_FLUSH_PA_SEG2_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Segment 2 Final/Storage Flush Solution, Specify. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_DLK_ENBKI</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Double Enbloc Kidney Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_DLK_ENBKI_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Donor Double Enbloc Kidney Flush Solution, Specify. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_KIL</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Left Kidney Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_KIL_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Donor Left Kidney Flush Solution, Specify. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_KIR</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Right Kidney Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_KIR_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Donor Right Kidney Flush Solution, Specify. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_PA</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_PA_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Donor Pancreas Flush Solution, Specify. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_PA_SEG1</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Segment 1 Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_PA_SEG1_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Donor Pancreas Segment 1 Flush Solution, Specify. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_PA_SEG2</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Segment 2 Flush Solution. Stop Collect From 2004</td>
</tr>
<tr>
<td>FLUSH_PA_SEG2_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Donor Pancreas Segment 2 Flush Solution, Specify. Stop Collect From 2004</td>
</tr>
<tr>
<td>FORGOV_D</td>
<td>Char</td>
<td>3</td>
<td>$CTRY</td>
<td>LDR: Primary Source of Payment: Foreign Govt. Stop Collect From 2004</td>
</tr>
<tr>
<td>FORGOV_KI</td>
<td>Char</td>
<td>3</td>
<td>$CTRY</td>
<td>KPR: If Kidney Primary Source of Payment is &quot;FOREIGN GOVT&quot;, Specify Foreign Government</td>
</tr>
<tr>
<td>FORGOV_L</td>
<td>Char</td>
<td>3</td>
<td>$CTRY</td>
<td>TCR_KI: If Primary Source of Payment at Listing Time is &quot;FOREIGN GOVT&quot;, Specify Foreign Government</td>
</tr>
<tr>
<td>FORGOV_PA</td>
<td>Char</td>
<td>3</td>
<td>$CTRY</td>
<td>KPR: If Pancreas Primary Source of Payment is &quot;FOREIGN GOVT&quot;, Specify Foreign Government</td>
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<td>FORMAL_REQ</td>
<td>Num</td>
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<td>DONATIOR</td>
<td>CDR: Was a formal organ donation request made. Stop Collect From 2004</td>
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<tr>
<td>FORMAL_REQ_OSTXT</td>
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<td>CDR: Was a formal organ donation request made, Specify. Stop Collect From 2004</td>
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<tr>
<td>FREE</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Secondary Source of Payment: Free Care. Stop Collect From 2004</td>
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<tr>
<td>FUNCSTAT</td>
<td>Num</td>
<td>8</td>
<td>FUNCSTAT</td>
<td>KPR: Patient Status: pertaining to activities of daily living</td>
</tr>
<tr>
<td>FUNCSTL</td>
<td>Num</td>
<td>8</td>
<td>FUNCSTAT</td>
<td>TCR_KI: Patient Status: pertaining to activities of daily living at Listing Time</td>
</tr>
<tr>
<td>FW_DIAL</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Patient Need Dialysis within First Week(Y/N)</td>
</tr>
<tr>
<td>GFREAS1_KI</td>
<td>Num</td>
<td>8</td>
<td>KI_C_GRF</td>
<td>KPR: Primary Cause of Kidney Failure</td>
</tr>
<tr>
<td>GFREAS1_PA</td>
<td>Num</td>
<td>8</td>
<td>PACGFT</td>
<td>KPR: Primary Cause of Pancreas Failure</td>
</tr>
<tr>
<td>GFRESOTH_KI</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KPR: Kidney Primary Cause of Graft Failure, Specify</td>
</tr>
<tr>
<td>GFRESOTH_PA</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KPR: Pancreas Primary Cause of Graft Failure, Specify</td>
</tr>
<tr>
<td>GFR_FAIL_DT1</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant Graft Fail Date</td>
</tr>
<tr>
<td>GFR_FAIL_DT2</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant Graft Fail Date</td>
</tr>
<tr>
<td>GFR_FAIL_DT3</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant Graft Fail Date</td>
</tr>
<tr>
<td>GFR_PLMC_PAI</td>
<td>Num</td>
<td>8</td>
<td>PAGFPTPL</td>
<td>KPR: Surgical Information: Graft Placement</td>
</tr>
<tr>
<td>GFR_REMOV_DT_PAI</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>KPR: Pancreas Graft Removed: If Yes, Date Pancreas Graft Removed</td>
</tr>
<tr>
<td>GFR_REMOV_PAI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Pancreas Graft Removed(Y/N/U)</td>
</tr>
<tr>
<td>GFRFAIL_KI</td>
<td>Char</td>
<td>1</td>
<td>$PA_STAT</td>
<td>KPR: Post Tx: Kidney Status: Functioning / Failed (Y/N)</td>
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<tr>
<td>GFRFAIL_PA</td>
<td>Char</td>
<td>1</td>
<td>$PA_STAT</td>
<td>KPR: Post Tx: Pancreas Status: Functioning / Partial Function / Failed (Y/P/N)</td>
</tr>
<tr>
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<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
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<tr>
<td>GRFTHRM_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Contributory Cause of KI Failure: Kidney Graft Thrombosis</td>
</tr>
<tr>
<td>GRFTHRM_PA</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Contributory Cause of PA Failure: Pancreas Graft/Vascular Thrombosis</td>
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<tr>
<td>HAPLMAT</td>
<td>Num</td>
<td>8</td>
<td>HAPLOTY</td>
<td>DHS: Recipient of a Living Donor Information: Haplotype Match</td>
</tr>
<tr>
<td>HBCORE</td>
<td>Char</td>
<td>2</td>
<td>SCREEN</td>
<td>KPR: Pretransplant HBV Detection: Core Antibody(P/N/U/ND)</td>
</tr>
<tr>
<td>HBSAG</td>
<td>Char</td>
<td>2</td>
<td>SCREEN</td>
<td>KPR: Pretransplant HBV Detection: Surface Antigen(P/N/U/ND)</td>
</tr>
<tr>
<td>HBSAGC</td>
<td>Char</td>
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<td>SCREEN</td>
<td>CDR: Serology: HBsAg</td>
</tr>
<tr>
<td>HBV</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Pretransplant HBV Detection (Y/N/U). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HBV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>$YNUNK</td>
<td>KPR: Pretransplant HBV Detection: Was there clinical disease(Y/N/U). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HBV_LI_HIST</td>
<td>Char</td>
<td>2</td>
<td>SCREEN</td>
<td>KPR: Pretransplant HBV Detection: Liver Histology(P/N/U/ND). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HBVDNA</td>
<td>Char</td>
<td>2</td>
<td>SCREEN</td>
<td>KPR: Pretransplant HBV Detection: DNA(P/N/U/ND). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HCV</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>KPR: Pretransplant HCV Detection(Y/N/U). Stop Collect from 2/7/2007</td>
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<tr>
<td>HCV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>$YNUNK</td>
<td>KPR: Pretransplant HCV Detection: Was there clinical disease(Y/N/U). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HCV_SEROSTATUS</td>
<td>Char</td>
<td>2</td>
<td>SCREEN</td>
<td>KPR: Viral Detection at Tx time // HCV Serology status. Converted from HCV_ANTIBODY and HCV_RIBA</td>
</tr>
<tr>
<td>HEALTH_INS</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Did the donor have health insurance</td>
</tr>
<tr>
<td>HEMATOCRIT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Terminal Lab Data: Hematocrit</td>
</tr>
<tr>
<td>HEMATOCRIT_I</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>CDR: Terminal Lab Data: Hematocrit, Status</td>
</tr>
<tr>
<td>HGT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Height in Centimeters</td>
</tr>
<tr>
<td>HGT_L</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: Height in Centimeters at Listing Time</td>
</tr>
<tr>
<td>HGTST</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>KPR: Height in Centimeters, Status</td>
</tr>
<tr>
<td>HIST_ALCOHOL</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Alcohol Dependency - Ever. Stop Collect From 2004</td>
</tr>
<tr>
<td>HIST_CANCER</td>
<td>Num</td>
<td>8</td>
<td>CCRSITE</td>
<td>CDR / LDR: History of Cancer</td>
</tr>
<tr>
<td>HIST_COCAINE</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Lifestyle Factors: Cocaine Use - Ever</td>
</tr>
<tr>
<td>HIST_IV_DRUG</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: IV Drug - Ever. Stop Collect From 2004</td>
</tr>
<tr>
<td>HIST_PRISON</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: History of Prison. Stop Collect From 2004</td>
</tr>
<tr>
<td>HIV</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Pretransplant HIV Detection(Y/N/U). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HIV_CLINICAL</td>
<td>Char</td>
<td>2</td>
<td>$YNUNK</td>
<td>KPR: Pretransplant HIV Detection: Was there clinical disease(Y/N/U). Stop Collect from 2/7/2007</td>
</tr>
<tr>
<td>HIV_SEROSTATUS</td>
<td>Char</td>
<td>2</td>
<td>SCREEN</td>
<td>KPR: Viral Detection at Tx time // HIV Serology status. Converted from HIV_ANTIBODY, HIV_CONF_READONLY, HIV_RNA and HIV_SCRN_READONLY from 2007</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
</tr>
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</tr>
<tr>
<td>HIVCNF</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KPR: Pretransplant HIV Detection: Confirmation(P/N/U/ND). Stop Separately Collect from 2/7/2007</td>
</tr>
<tr>
<td>HIVSCRN</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>KPR: Pretransplant HIV Detection: Screening(P/N/U/ND). Stop Separately Collect from 2/7/2007</td>
</tr>
<tr>
<td>HLA1DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Date Typing Completed Class I</td>
</tr>
<tr>
<td>HLA2DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Date Typing Completed Class II</td>
</tr>
<tr>
<td>HLA_INTERPRET1</td>
<td>Num</td>
<td>8</td>
<td>ANTIHLAA</td>
<td>RHS: Anti-HLA Interpretation - Most Recent Class I</td>
</tr>
<tr>
<td>HLA_INTERPRET2</td>
<td>Num</td>
<td>8</td>
<td>ANTIHLAB</td>
<td>RHS: Anti-HLA Interpretation - Most Recent Class II</td>
</tr>
<tr>
<td>HLADONE</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>RHS: Test Information - HLA typing Done</td>
</tr>
<tr>
<td>HMO_PPO</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Secondary Source of Payment: HMO/PPO. Stop Collect</td>
</tr>
<tr>
<td>HOSP_90_DAYS</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Was patient hospitalized during the last 90 days prior to the tx admission</td>
</tr>
<tr>
<td>HRTX</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>KPR: Multiple Organ Recipient: Heart(T/F)</td>
</tr>
<tr>
<td>HTLV</td>
<td>Char</td>
<td>2</td>
<td>$SCREEN</td>
<td>CDR: Serology: Anti-HTLV I/II</td>
</tr>
<tr>
<td>HYPER_DIET</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: History of Hypertension / If Yes, Method Ctl: Diet</td>
</tr>
<tr>
<td>HYPER_DIAG</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: History of Hypertension / If Yes, Method Ctl: Diuretics</td>
</tr>
<tr>
<td>HYPER_MEDS</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: History of Hypertension / If Yes, Method Ctl: Other Hypertensive Med</td>
</tr>
<tr>
<td>HYPERTENSION</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Post-Op(Within 6 weeks post-donation): Donor Developed HTN Requiring Med</td>
</tr>
<tr>
<td>INFECT_HOSP</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Infections During Hosp. Stop Collect From 2004</td>
</tr>
<tr>
<td>INFECT_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Contributory Cause of Kidney Graft Failure: Kidney Infection</td>
</tr>
<tr>
<td>INFECT_PA</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Contributory Cause of Pancreas Graft Failure: Pancreas Infection</td>
</tr>
<tr>
<td>INIT_DISCHARGE_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Date of Initial Discharge</td>
</tr>
<tr>
<td>INITIAL_FLUSH_DBK</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Double Enbloc Kidney Initial Flush Solution</td>
</tr>
<tr>
<td>INITIAL_FLUSH_DBK_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Double Enbloc Kidney Initial Flush Solution, Specify</td>
</tr>
<tr>
<td>INITIAL_FLUSH_KIL</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Left Kidney Initial Flush Solution</td>
</tr>
<tr>
<td>INITIAL_FLUSH_KIL_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Left Kidney Initial Flush Solution, Specify</td>
</tr>
<tr>
<td>INITIAL_FLUSH_KIR</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Right Kidney Initial Flush Solution</td>
</tr>
<tr>
<td>INITIAL_FLUSH_KIR_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Right Kidney Initial Flush Solution, Specify</td>
</tr>
<tr>
<td>INITIAL_FLUSH_PA</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Initial Flush Solution</td>
</tr>
<tr>
<td>INITIAL_FLUSH_PA_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Initial Flush Solution, Specify</td>
</tr>
<tr>
<td>INITIAL_FLUSH_PA_SEG1</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Segment 1 Initial Flush Solution</td>
</tr>
<tr>
<td>INITIAL_FLUSH_PA_SEG2</td>
<td>Num</td>
<td>8</td>
<td>FLUSH</td>
<td>CDR: Donor Pancreas Segment 2 Initial Flush Solution</td>
</tr>
<tr>
<td>INITIAL_FLUSH_PA_SEG1_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Segment 1 Initial Flush Solution, Specifyorest</td>
</tr>
<tr>
<td>INITIAL_FLUSH_PA_SEG2_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Pancreas Segment 2 Initial Flush Solution, Specify</td>
</tr>
<tr>
<td>INOTROP_AGENTS</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Three or more inotropic agents at time of incision</td>
</tr>
<tr>
<td>INOTROP_SUP</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Inotropic Medications at Time of Cross Clamp</td>
</tr>
<tr>
<td>INR</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Terminal Lab Data: INR</td>
</tr>
<tr>
<td>INR_1</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Terminal Lab Data: INR, Status</td>
</tr>
<tr>
<td>INSULIN</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp: Insulin(Y/N/U)</td>
</tr>
<tr>
<td>INSULIN_RES_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>KPR: Date Insulin/Medication Resumed</td>
</tr>
<tr>
<td>INTX</td>
<td>Char</td>
<td>1</td>
<td>MMDDYY</td>
<td>KPR: Multiple Organ Recipient: Intestine(T/F)</td>
</tr>
<tr>
<td>KI_CREAT_DISCH</td>
<td>Num</td>
<td>8</td>
<td>$YNUNK</td>
<td>LDR: Kidney Creatinine At Discharge. Stop Collect From 2004</td>
</tr>
<tr>
<td>KI_CREAT_DISCH_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>LDR: Kidney Creatinine At Discharge/Status. Stop Collect From 2004</td>
</tr>
<tr>
<td>KI_CREAT_POSTOP</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Post-Op(Within 6 weeks post-donation) Kidney Serum Creatinine</td>
</tr>
<tr>
<td>KI_CREAT_POSTOP_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>LDR: Post-Op(Within 6 weeks post-donation) Kidney Serum Creatinine, Status</td>
</tr>
<tr>
<td>KI_GLOMERUL</td>
<td>Num</td>
<td>8</td>
<td>KI_GLUMR</td>
<td>LDR: Kidney Biopsy / If Yes, Glomerulosclerosis</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
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<td>KILDISCD</td>
<td>Num</td>
<td>8</td>
<td>DISCD_CD</td>
<td>CDR: Reason organ not transplanted - Left Kidney</td>
</tr>
<tr>
<td>KILTXT</td>
<td>Char</td>
<td>50</td>
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<td>CDR: Organ Dispositions: Reason Code Left Kidney. Specify</td>
</tr>
<tr>
<td>KIPROC</td>
<td>Num</td>
<td>8</td>
<td>KI_PR_TY</td>
<td>LDR: Kidney//Intended Procedure Type</td>
</tr>
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<td>DISCD_CD</td>
<td>CDR: Reason organ not transplanted - Right Kidney</td>
</tr>
<tr>
<td>KIRTXT</td>
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<td>CDR: Organ Dispositions: Reason Code Right Kidney, Specify</td>
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<tr>
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<td>KPR: Multiple Organ Recipient: Kidney(T/F)</td>
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<tr>
<td>KPPROC</td>
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<td>KP_PROC</td>
<td>KPR: Procedure Type</td>
</tr>
<tr>
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<td>DHS: Lab Center Type</td>
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<tr>
<td>LABCTRTYR</td>
<td>Char</td>
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<td>RHS: Lab Center Type</td>
</tr>
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<td>LDCOD</td>
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<td>LDON_COD</td>
<td>LDR: Living Donor Cause of Death</td>
</tr>
<tr>
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<tr>
<td>LDON_ORG2</td>
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</tr>
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<td>LDTYPEI</td>
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<td>Num</td>
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<td>LDR: Length of Hospital Stay (days). Stop Collect From 2004</td>
</tr>
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<td>LDR: Length of Hospital Stay/Status, Stop Collect From 2004</td>
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<td>KPR: Patient on Life Support atTx Time, Stop Collect from 6/30/2004</td>
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<td>TCR_KI: Patient on Life Support at Listing Time / ECMO, Stop Collect from 6/30/2004</td>
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<tr>
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<td>TCR_KI: Patient on Life Support at Listing Time / Ventilator, Stop Collect from 6/30/2004</td>
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<td>LIPASE</td>
<td>Num</td>
<td>8</td>
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<td>CDR: Terminal Lab Data: Serum Lipase</td>
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<tr>
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<td>Char</td>
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<td>STRING</td>
<td>CDR: Terminal Lab Data: Serum Lipase, Status</td>
</tr>
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<td>LISTDAT</td>
<td>Num</td>
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<td>MMDDYY</td>
<td>TCR_KI: Date of Listing or Add</td>
</tr>
<tr>
<td>LITX</td>
<td>Char</td>
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<td>KPR: Multiple Organ Recipient: Liver(T/F)</td>
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<tr>
<td>LK_SHARE</td>
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<td>SHARETYC</td>
<td>CDR: Share Type - L-Kidney. Stop Collect From 2003</td>
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<td>Char</td>
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<td>CDR: Pump (Left Kidney)</td>
</tr>
<tr>
<td>LT_KI_BIOPSY</td>
<td>Char</td>
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<tr>
<td>LT_KI_FLOW</td>
<td>Num</td>
<td>8</td>
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<td>CDR: FlowRate(ccs/min) (Left Kidney). Stop Collect From 2004</td>
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<tr>
<td>LT_KI_FLOW_I</td>
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<td>STRING</td>
<td>CDR: FlowRate/Status (Left Kidney). Stop Collect From 2004</td>
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<tr>
<td>LT_KI_GLOMERUL</td>
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<td>8</td>
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<td>CDR: % Glomerulosclerosis (Left Kidney)</td>
</tr>
<tr>
<td>LT_KI_PERFUS_DIAST</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Perfusion Pressure Diastolic(mm/Hg) (Left Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>LT_KI_PERFUS_DIAST_I</td>
<td>Char</td>
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<td>STRING</td>
<td>CDR: Perfusion Pressure/Status Diastolic (Left Kidney). Stop Collect From 2004</td>
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<tr>
<td>LT_KI_PERFUS_SYST</td>
<td>Num</td>
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<td></td>
<td>CDR: Perfusion Pressure Systolic (mm/Hg)(Left Kidney). Stop Collect From 2004</td>
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<td>CDR: Perfusion Pressure/Status Systolic (Left Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>LUTX</td>
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<td>KPR: Multiple Organ Recipient: Lung(T/F)</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
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<tr>
<td>MAINTMED</td>
<td>Char</td>
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<td>KPR: Are any medications given currently for maintenance or anti-rejection(Y/N)</td>
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<tr>
<td>MALIG</td>
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<td>KPR: Malignancies between listing and transplant(Y/N/U)</td>
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<tr>
<td>MALIG_OSTXT</td>
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<td>KPR: Malignancies between listing and transplant, Specify</td>
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<td>MALIG_TY</td>
<td>Num</td>
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<td>MALIGMUL</td>
<td>KPR: Malignancy type. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32, 64, 128, 256, 512, 1024, 2048.</td>
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<td>MARITAL_STAT</td>
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<td>LDR: Marital Status</td>
</tr>
<tr>
<td>MATC</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>USRDS: CNT HLA A, B, DR MATCH(0 - 6)</td>
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<tr>
<td>MDCOND</td>
<td>Num</td>
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<td>MED_COND</td>
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<td>Num</td>
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<td>MED_COND</td>
<td>TCR_KI: Medical Condition at Listing Time</td>
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<tr>
<td>MEASURE1</td>
<td>Num</td>
<td>8</td>
<td>PRA MEAS</td>
<td>RHS: Technique Measures - Most Recent Class I</td>
</tr>
<tr>
<td>MEASURE2</td>
<td>Num</td>
<td>8</td>
<td>PRA MEAS</td>
<td>RHS: Technique Measures - Most Recent Class II</td>
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<tr>
<td>MEASURE_POS_XMAT1</td>
<td>Num</td>
<td>8</td>
<td>PRA MEAS</td>
<td>RHS: Positive Xmatch row 1//Measures:</td>
</tr>
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<td>MEASURE_POS_XMAT2</td>
<td>Num</td>
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<td>Num</td>
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<td>PRA MEAS</td>
<td>RHS: Positive Xmatch row 3//Measures:</td>
</tr>
<tr>
<td>MEASURE_XMAT1</td>
<td>Num</td>
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<td>PRA MEAS</td>
<td>RHS: Most Recent row 1//Measures:</td>
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<tr>
<td>MEASURE_XMAT2</td>
<td>Num</td>
<td>8</td>
<td>PRA MEAS</td>
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<td>PRA MEAS</td>
<td>RHS: Most Recent row 3//Measures:</td>
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<td>Num</td>
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<td>PRA MEAS</td>
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<tr>
<td>MEASURE_XMAT5</td>
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<td>8</td>
<td>PRA MEAS</td>
<td>RHS: Most Recent row 5//Measures:</td>
</tr>
<tr>
<td>MEASUREMENT_DT</td>
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<td>KPR: Date of Measurement(Pediatric Only)</td>
</tr>
<tr>
<td>MEASUREMENT_DT_L</td>
<td>Num</td>
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<td>TCR_KI: Date of Measurement(Pediatric Only) at Listing Time</td>
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<tr>
<td>MED_EXAM</td>
<td>Num</td>
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<td>MEXAMRPT</td>
<td>CDR: Procurement and Consent: Medical Examiner/Coroner</td>
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<tr>
<td>MEDICARE</td>
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<td>LDR: Secondary Source of Payment: MEDICARE. Stop Collect From 2004</td>
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<td>METH_BLOOD_SUG_CTL</td>
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<td>METHBLD</td>
<td>KPR: Method of blood sugar control. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16</td>
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<td>METH_CLS1_TYP_DT</td>
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<td>DHS: Date Typing Complete Class II</td>
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<td>USRDS: CNT HLA A, B, DR MIS_MATCH(0 - 6)</td>
</tr>
<tr>
<td>MNTDDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>KPR: Date Maintenance Dialysis Resumed</td>
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<tr>
<td>MNTDIAL</td>
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<td>KPR: Resumed Maintenance Dialysis(Y/N)</td>
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<td>MOTOR_DEV</td>
<td>Num</td>
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<td>MOTDEVLP</td>
<td>KPR: Motor Development(Pediatric Only)</td>
</tr>
<tr>
<td>MOTOR_DEV_L</td>
<td>Num</td>
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<td>MOTDEVLP</td>
<td>TCR_KI: Motor Development(Pediatric Only) at Listing Time</td>
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<tr>
<td>MRBTXDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant: Bone Marrow / Latest Tx Date. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>MRCELL1</td>
<td>Num</td>
<td>8</td>
<td>CELL_TY</td>
<td>RHS: Most Recent row 1//Cell Type:</td>
</tr>
<tr>
<td>MRCELL2</td>
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<td>CELL_TY</td>
<td>RHS: Most Recent row 2//Cell Type:</td>
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<td>Num</td>
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<td>CELL_TY</td>
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<td>RHS: Most Recent row 4//Cell Type:</td>
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<td>Num</td>
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<td>CELL_TY</td>
<td>RHS: Most Recent row 5//Cell Type:</td>
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<td>MRCREAT</td>
<td>Num</td>
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<td>KPR: Most Recent Serum Creatinine Prior to Discharge</td>
</tr>
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<td>MRCREATI</td>
<td>Char</td>
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<td>TCR_KI: Most Recent Serum Creatinine at Listing Time, Status</td>
</tr>
<tr>
<td>MRCREATL</td>
<td>Num</td>
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<td>TCR_KI: Most Recent Serum Creatinine at Listing Time</td>
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</tr>
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<td>KPR: Most Recent Serum Creatinine Prior to Discharge, Status</td>
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<td>Comment</td>
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<tr>
<td>MRCTXDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant: Pancreas (Islet Cells) / Latest Tx Date. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>MRHTXDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant: Heart / Latest Tx Date. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>MRITXDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant: Intestine / Latest Tx Date. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>MRKTXDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant: Kidney / Latest Tx Date. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>MRLTXDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant: Liver / Latest Tx Date. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>MRKTXDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant: Pancreas (whole) / Latest Tx Date. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>MRTGT1</td>
<td>Num</td>
<td>8</td>
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<td>RHS: Most Recent row 1//Target:</td>
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<tr>
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<td>Num</td>
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<td>RHS: Most Recent row 3//Target:</td>
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<td>Num</td>
<td>8</td>
<td>TGCELSRC</td>
<td>RHS: Most Recent row 4//Target:</td>
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<td>MRTGT5</td>
<td>Num</td>
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<td>TGCELSRC</td>
<td>RHS: Most Recent row 5//Target:</td>
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<td>MRTXDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant: Lung / Latest Tx Date. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>MRXMDT1</td>
<td>Num</td>
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<td>MMDDYY</td>
<td>RHS: Xmatch Serum Date - Mst Rec Row 1. Stop Collect From 2004</td>
</tr>
<tr>
<td>MRXMDT2</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Xmatch Serum Date - Mst Rec Row 2. Stop Collect From 2004</td>
</tr>
<tr>
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<td>MRXMDT4</td>
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<td>8</td>
<td>MMDDYY</td>
<td>RHS: Xmatch Serum Date - Mst Rec Row 4. Stop Collect From 2004</td>
</tr>
<tr>
<td>MRXMDT5</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Xmatch Serum Date - Mst Rec Row 5. Stop Collect From 2004</td>
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<tr>
<td>NEG_XM1</td>
<td>Char</td>
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<td>RHS: Positive Xmatch row 1//NEG XM by any other technique with this serum:</td>
</tr>
<tr>
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<tr>
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</tr>
<tr>
<td>NON_AUTO_BLOOD</td>
<td>Char</td>
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<td>LDR: Post-Op: Non-Autologous Blood Administration</td>
</tr>
<tr>
<td>NUM_TXFUS</td>
<td>Num</td>
<td>8</td>
<td>$YNUNK</td>
<td>KPR: Pretransplant # of Bld Transfusionss at Tx Time. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>NUM_TXFUS_I</td>
<td>Char</td>
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<td>$TRIND</td>
<td>KPR: Pretransplant # of Bld Transfusionss/Status</td>
</tr>
<tr>
<td>OPER_TECH</td>
<td>Num</td>
<td>8</td>
<td>KPTXTYP</td>
<td>KPR: Surgical Information: Operative Technique</td>
</tr>
<tr>
<td>ORG_REC_ON</td>
<td>Char</td>
<td>1</td>
<td>SORGRECO</td>
<td>KPR: Kidney(s) received on</td>
</tr>
<tr>
<td>ORG_REC_TXCSAME</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Did organ recovery and transplant occur at the same center</td>
</tr>
<tr>
<td>ORG_TYP</td>
<td>Char</td>
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<td>SORC_TYP</td>
<td>KPR: Organ(s)</td>
</tr>
<tr>
<td>OTH_COMP_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Kidney Other Complications Requiring Intervention(Y/N/U)</td>
</tr>
<tr>
<td>OTH_COMP_KI_INTER</td>
<td>Num</td>
<td>8</td>
<td>OTHCOMP</td>
<td>LDR: KI Other Complic, Specify. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32, 64, 128</td>
</tr>
<tr>
<td>OTH_COMP_KI_INTER_OSTXT</td>
<td>Char</td>
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<td>$</td>
<td>LDR: KI Other Complic, Other Specify</td>
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<td>OTH_COMP_OSTXT</td>
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</tr>
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<td>OTH_INTER_PROC_KI</td>
<td>Char</td>
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<td>LDR: Kidney Other Interventional Procedures</td>
</tr>
<tr>
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<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Kidney Other Interventional Procedures Date</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
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<td>Char</td>
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<td>$</td>
<td>LDR: Kidney Other Interventional Procedures//If Yes, Specify Procedure</td>
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<td>OTH_LIFE_SUP</td>
<td>Char</td>
<td>5</td>
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<td>TCR_KI: Other Life Support Mechanism. Stop Collect from 6/30/2004</td>
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<td>OTH_LIFE_SUP_OSTXT</td>
<td>Char</td>
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<td>TCR_KI: Other Life Support Mechanism/Specify. Stop Collect from 6/30/2004</td>
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<td>OTH_LIFESTYLE1_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Lifestyle Factors: Other/Specify. Stop Collect From 2004</td>
</tr>
<tr>
<td>OTH_LIFESTYLE2_OSTXT</td>
<td>Char</td>
<td>50</td>
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<td>CDR: Lifestyle Factors: Other/Specify. Stop Collect From 2004</td>
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<tr>
<td>OTH_LIFESTYLE3_OSTXT</td>
<td>Char</td>
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<td>CDR: Lifestyle Factors: Other/Specify. Stop Collect From 2004</td>
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<td>OTH_POS_XMAT</td>
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<td>$YNDU</td>
<td>RHS: Positive Crossmatch Auto Xmatch Positive. Stop Collect From 2004</td>
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<tr>
<td>OTHER_INF_CONF</td>
<td>Char</td>
<td>1</td>
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<td>CDR: Clinical Infection: Other // Confirmed by Culture</td>
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<tr>
<td>OTHGF_KI</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KPR: Contributory causes of KI failure: Other, Specify</td>
</tr>
<tr>
<td>OTHGF_PA</td>
<td>Char</td>
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<td>KPR: Contributory causes of PA failure: Other, Specify</td>
</tr>
<tr>
<td>OTIS_REGID</td>
<td>Char</td>
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<td>TCR_KI: Otis Regid</td>
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<td>PA_PRESERV_TM</td>
<td>Num</td>
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<td>KPR: Total Pancreas Preservation Time (include Cold, Warm, Anastomotic time)</td>
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<tr>
<td>PA_PRESERV_TM_I</td>
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<td>KPR: Total Pancreas Preservation Time (include Cold, Warm, Anastomotic time), Status</td>
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<td>PA_REVASC</td>
<td>Num</td>
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<td>PAREVASC</td>
<td>KPR: Surgical Information: Was the Pancreas revascularized before or after other organs</td>
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<tr>
<td>PA_SEG1DISCD</td>
<td>Num</td>
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<td>DISCD_CD</td>
<td>CDR: Reason organ not transplanted - Pancreas Segment 1</td>
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<td>PA_SEG1DISCDTXT</td>
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<td>$</td>
<td>CDR: Reason organ not transplanted - Pancreas Segment 1, Specify</td>
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<td>PA_SEG1TXT</td>
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<td>50</td>
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<td>PA_SEG2DISCD</td>
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<td>DISCD_CD</td>
<td>CDR: Reason organ not transplanted - Pancreas Segment 2</td>
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<td>$</td>
<td>CDR: Reason organ not transplanted - Pancreas Segment 2, Specify</td>
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<td>PA_SEG2TXT</td>
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<td>50</td>
<td>$</td>
<td>CDR: Organ Dispositions: Pancreas Segment 2, Specify</td>
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<tr>
<td>PACK_YRS</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: History of Cigarette Use / If Yes, # pack years</td>
</tr>
<tr>
<td>PADISCD</td>
<td>Num</td>
<td>8</td>
<td>DISCD_CD</td>
<td>CDR: Reason organ not transplanted - Pancreas</td>
</tr>
<tr>
<td>PADISCDTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Reason organ not transplanted - Pancreas, Specify</td>
</tr>
<tr>
<td>PANCREATIT</td>
<td>Char</td>
<td>1</td>
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<td>KPR: Contributory Cause of Pancreas Failure: Pancreatitis</td>
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<td>PATX</td>
<td>Char</td>
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<td>KPR: Multiple Organ Recipient: Pancreas(T/F)</td>
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<tr>
<td>PATXT</td>
<td>Char</td>
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<td>$</td>
<td>CDR: Organ Dispositions: Reason Code Pancreas, Specify</td>
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<tr>
<td>PEAK_HLA_INTERPRET1</td>
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<td>ANTIHLAA</td>
<td>RHS: Anti-HLA Interpretation - Peak Serum Class I</td>
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<tr>
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<td>8</td>
<td>ANTIHLAB</td>
<td>RHS: Anti-HLA Interpretation - Peak Serum Class II</td>
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<td>PEAK_MEASURE1</td>
<td>Num</td>
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<td>PRAMEAS</td>
<td>RHS: Measures - Peak Serum Class I</td>
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<td>RHS: Measures - Peak Serum Class II</td>
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<td>PEAK_PRA1</td>
<td>Num</td>
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<td>RHS: PRA (%) - Peak Serum Class I</td>
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<td>RHS: PRA (%) - Peak Serum Class II</td>
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<td>Num</td>
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<td>MMDDYY</td>
<td>RHS: Serum Date - Peak Serum Class I</td>
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<td>Char</td>
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<td>RHS: Serum Date - Peak Serum Class I, status</td>
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<td>RHS: PRA (%) - Peak Serum Class I, status</td>
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<td>RHS: PRA (%) - Peak Serum Class II, status</td>
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<td>PEAK_TARGET1</td>
<td>Num</td>
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<td>PRATARGT</td>
<td>RHS: Target - Peak Serum Class I</td>
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<td>Num</td>
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<td>PRATARGT</td>
<td>RHS: Target - Peak Serum Class II</td>
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<td>PRATECH</td>
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</tr>
<tr>
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<td>Format</td>
<td>Comment</td>
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<td>PEAK_TECHNIQUE2_OSTXT</td>
<td>Char</td>
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<td>$</td>
<td>RHS: Technique - Peak Serum Class II, Specify</td>
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<tr>
<td>PERM_STATE</td>
<td>Char</td>
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<td>SSTATE</td>
<td>KPR: Recipient State of Permanent Residence</td>
</tr>
<tr>
<td>PERM_STATE_L</td>
<td>Char</td>
<td>2</td>
<td>SSTATE</td>
<td>TCR_KI: Patient State of Permanent Residence at Listing Time</td>
</tr>
<tr>
<td>PERM_ZIP</td>
<td>Char</td>
<td>10</td>
<td>$</td>
<td>KPR: Recipient Permanent Zip</td>
</tr>
<tr>
<td>PERM_ZIP_L</td>
<td>Char</td>
<td>10</td>
<td>$</td>
<td>TCR_KI: Patient Permanent Zip at Listing Time</td>
</tr>
<tr>
<td>PH</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Blood PH</td>
</tr>
<tr>
<td>PH_I</td>
<td>Char</td>
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<td>STRIND</td>
<td>CDR: Blood PH, Status</td>
</tr>
<tr>
<td>PHYSICAL_CAPACITY</td>
<td>Num</td>
<td>8</td>
<td>PHYSCP</td>
<td>KPR: Physical Capacity</td>
</tr>
<tr>
<td>PHYSICAL_CAPACITY_L</td>
<td>Num</td>
<td>8</td>
<td>PHYSCP</td>
<td>TCR_KI: Patient Physical Capacity at Listing Time</td>
</tr>
<tr>
<td>PITX</td>
<td>Char</td>
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<td>KPR: Multiple Organ Recipient: Pancreas Islets(T/F)</td>
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<tr>
<td>PKPRA</td>
<td>Num</td>
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<td>RHS: USRDS PRA(%) - Peak</td>
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<tr>
<td>PLACED_BY_DBL_ENBKI</td>
<td>Num</td>
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<td>CDR: Placed By - DBL_ENBKI Stop Collect From 2004</td>
</tr>
<tr>
<td>PLACED_BY_KIL</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Placed By - Left Kidney. Stop Collect From 2004</td>
</tr>
<tr>
<td>PLACED_BY_KIR</td>
<td>Num</td>
<td>8</td>
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<td>CDR: Placed By - Right Kidney. Stop Collect From 2004</td>
</tr>
<tr>
<td>PLACED_BY_PA</td>
<td>Num</td>
<td>8</td>
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<td>CDR: Placed By - PA. Stop Collect From 2004</td>
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<td>CDR: Placed By - PA_SEG1. Stop Collect From 2004</td>
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<tr>
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<tr>
<td>PLATELETS_UNITS</td>
<td>Num</td>
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<td>LDR: Non-Autologous Blood Administration /If Yes, Number of Platelets Units</td>
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<tr>
<td>POS_AUTOXM</td>
<td>Char</td>
<td>2</td>
<td>AUTOXM</td>
<td>RHS: Autocrossmatch results: Has autocrossmatch ever been positive</td>
</tr>
<tr>
<td>POS_AUTOXM_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: AutoXM Date - Positive AutoXM</td>
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<tr>
<td>POST_AVG_INSULIN_USED</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: If Pancreas Partial or Non Function, Average Daily Insulin Units. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>POST_AVG_INSULIN_USED_I</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>KPR: If Pancreas Partial or Non Function, Average Daily Insulin Units/ Status. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>POSTOP_TEST_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Post-Op Clinical Information (Within 6 weeks post-donation): Most Recent Date of Tests</td>
</tr>
<tr>
<td>POSTOP_Urine_protein</td>
<td>Num</td>
<td>8</td>
<td>URINEPRO</td>
<td>LDR: Post-Operative Urinalysis//Urine Protein</td>
</tr>
<tr>
<td>POSTOP_Urine_ratio</td>
<td>Num</td>
<td>8</td>
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<td>LDR: Post-Operative Urinalysis//Protein-Creatinine Ratio</td>
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<tr>
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<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Positive Xmatch row 1/Serum Date</td>
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<td>Num</td>
<td>8</td>
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<td>RHS: Positive Xmatch row 2/Serum Date</td>
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<tr>
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<td>Num</td>
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<td>MMDDYY</td>
<td>RHS: Positive Xmatch row 3/Serum Date</td>
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<td>Num</td>
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<td>MMDDYY</td>
<td>RHS: Positive Xmatch row 4/Serum Date</td>
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<td>Num</td>
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<td>MMDDYY</td>
<td>RHS: Positive Xmatch row 5/Serum Date</td>
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<tr>
<td>PRA1</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>RHS: PRA (%) - Most Recent Class I</td>
</tr>
<tr>
<td>PRA2</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>RHS: PRA (%) - Most Recent Class II</td>
</tr>
<tr>
<td>PRA1_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Serum Date - Most Recent Class I</td>
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<tr>
<td>PRA1_DT_I</td>
<td>Char</td>
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<td>STRIND</td>
<td>RHS: Serum Date - Most Recent Class I, status</td>
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<td>PRA1_I</td>
<td>Char</td>
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<td>STRIND</td>
<td>RHS: PRA (%) - Most Recent Class I, status</td>
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<td>8</td>
<td>MMDDYY</td>
<td>RHS: Serum Date - Most Recent Class II</td>
</tr>
<tr>
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<td>STRIND</td>
<td>RHS: Serum Date - Most Recent Class II, status</td>
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<td>PRA_GT10</td>
<td>Char</td>
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<td>SYNNUNK</td>
<td>TCR_KI: PRA &gt; 10% (with DTT or DTE testing). Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRAA</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>RHS: Most Recent PRA. Stop Collect From 2004</td>
</tr>
<tr>
<td>PRAA_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Date of Most Recent PRA. Stop Collect From 2004</td>
</tr>
<tr>
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<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>RHS: Date of Most Recent PRA/Status. Stop Collect From 2004</td>
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<td>PRAA_I</td>
<td>Char</td>
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<td>STRIND</td>
<td>RHS: Most Recent PRA/Status. Stop Collect From 2004</td>
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<tr>
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<td>8</td>
<td></td>
<td>RHS: Peak PRA. Stop Collect From 2004</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
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<tr>
<td>PRAB_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Date of Peak PRA. Stop Collect From 2004</td>
</tr>
<tr>
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<td>1</td>
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<td>RHS: Date of Peak PRA/Status. Stop Collect From 2004</td>
</tr>
<tr>
<td>PRAB_I</td>
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<td>$TRIND</td>
<td>RHS: Peak PRA/Status. Stop Collect From 2004</td>
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<tr>
<td>PRADONE</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>RHS: Test Information - HLA Antibody Screening Done</td>
</tr>
<tr>
<td>PRBC_UNITS</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Non-Autologous Blood Administration /If Yes, Number of PRBC Units</td>
</tr>
<tr>
<td>PRE_AVG_INSULIN_USED</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Pretransplant - Average Daily Insulin Units</td>
</tr>
<tr>
<td>PRE_AVG_INSULIN_USED_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KPR: Pretransplant - Average Daily Insulin Units, status</td>
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<tr>
<td>PRE_DON_BIOP_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Pre-Donation Kidney Clinical Information: Kidney Biopsy(Y/N)</td>
</tr>
<tr>
<td>PRE_TX_BIOP</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Was preimplantation kidney biopsy performed at the transplant center(Y/N)</td>
</tr>
<tr>
<td>PRE_TX_DIAL</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Pretransplant Dialysis(Y/N/U)</td>
</tr>
<tr>
<td>PRE_TX_DIAL_TY</td>
<td>Num</td>
<td>8</td>
<td>DIAL_TY</td>
<td>KPR: Pretransplant Dialysis Type. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRE_TX_TXFUS</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Did Pt receive pretransplant blood transfusions(Y/N/U).</td>
</tr>
<tr>
<td>PRE_TX_TXFUS_L</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>TCR_KI: Any Previous Transfusions. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRE_TX_TXFUS_NUM</td>
<td>Num</td>
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<td>TRANSFUS</td>
<td>KPR: Number of Pre-Tx Blood Transfusions. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PREDON_HGT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Pre-Donation Height</td>
</tr>
<tr>
<td>PREDON_HGT_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>LDR: Pre-Donation Height, Status</td>
</tr>
<tr>
<td>PREDON_WGT</td>
<td>Num</td>
<td>8</td>
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<td>LDR: Pre-Donation Weight</td>
</tr>
<tr>
<td>PREDON_WGT_I</td>
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<td>LDR: Pre-Donation Weight, Status</td>
</tr>
<tr>
<td>PREOP_URINE_PROTEIN</td>
<td>Char</td>
<td>5</td>
<td>$URINEPR</td>
<td>LDR: Preoperative Urinalysis//Urine Protein</td>
</tr>
<tr>
<td>PREOP_URINE_RATIO</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>LDR: Preoperative Urinalysis//Protein-Creatinine Ratio</td>
</tr>
<tr>
<td>PREV_MALIG_TY</td>
<td>Num</td>
<td>8</td>
<td>MALIGMUL</td>
<td>TCR_KI: Previous Malignancy Type at Listing Time. Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32, 64, 128, 256, 512, 1024, 2048.</td>
</tr>
<tr>
<td>PREV_MALIG_TY_OSTXT</td>
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<td>TCR_KI: Previous Pancreas Islet Infusion at Listing Time(Y/N/U)</td>
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<td>PREVPG</td>
<td>Num</td>
<td>8</td>
<td>PRV_PREG</td>
<td>KIR: Recipient Previous Preganancies</td>
</tr>
<tr>
<td>PRIPAY_D</td>
<td>Num</td>
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<td>P_S_PAY</td>
<td>LDR: Primary Source of Payment. Stop Collect From 2004</td>
</tr>
<tr>
<td>PRIPAY_KI</td>
<td>Num</td>
<td>8</td>
<td>P_S_PAY</td>
<td>KPR: Kidney Primary Source of Payment</td>
</tr>
<tr>
<td>PRIPAY_L</td>
<td>Num</td>
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<td>P_S_PAY</td>
<td>TCR_KI: Primary Source of Payment at Listing Time</td>
</tr>
<tr>
<td>PRIPAY_PA</td>
<td>Num</td>
<td>8</td>
<td>P_S_PAY</td>
<td>KPR: Pancreas Primary Source of Payment</td>
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<tr>
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<td>LDR: Secondary Source of Payment: Private Ins. Stop Collect From 2004</td>
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<td>Char</td>
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<td>$YNUNK</td>
<td>TCR_KI: Any previous Malignancy at Listing Time</td>
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<tr>
<td>PROTEIN URINE</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Protein in Urine</td>
</tr>
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<td>PROVUSRD_LIST</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>TCR_KI: USRDS Assigned Listing Center ID</td>
</tr>
<tr>
<td>PROVUSRD_MNTDPROV</td>
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<td>BEST</td>
<td>KPR: USRDS Assigned Post-Tx Resumed Maint. Dialysis Provider ID</td>
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<td>PROVUSRD_ORIG_LIST</td>
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<td>BEST</td>
<td>TCR_KI: USRDS Assigned Original Listing Center ID</td>
</tr>
<tr>
<td>PROVUSRD_TX</td>
<td>Num</td>
<td>8</td>
<td>BEST</td>
<td>KPR: USRDS Assigned Transplant Center ID</td>
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<td>PRVBTX</td>
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<td>TCR_KI: Previous Transplant: # of Bone Marrow Transplant. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVBTXI</td>
<td>Char</td>
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<td>TCR_KI: Previous Transplant: Bone Marrow / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVHTX</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: Previous Transplant: # of Heart Transplant. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVHTXI</td>
<td>Char</td>
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<td>$TRIND</td>
<td>TCR_KI: Previous Transplant: Heart / Status. Stop Separately Collect from 6/30/2004</td>
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<td>PRVICTX</td>
<td>Num</td>
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<td>TCR_KI: Previous Transplant: # of Pancreas (Islet Cells) Transplant. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
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<td>Format</td>
<td>Comment</td>
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<td>PRVICTXI</td>
<td>Char</td>
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<td>STRIND</td>
<td>TCR_KI: Previous Transplant: Pancreas (Islet Cells) / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVINTX</td>
<td>Num</td>
<td>8</td>
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<td>TCR_KI: Previous Transplant: # of Intestine Transplant. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVINTXI</td>
<td>Char</td>
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<td>STRIND</td>
<td>TCR_KI: Previous Transplant: Intestine / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVKITX_L</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: Previous Transplant: # of Kidney Transplant at Listing Time. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVKITXI_L</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>TCR_KI: Previous Transplant: Kidney at Listing Time / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVLITX</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: Previous Transplant: # of Liver Transplant. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVLITXI</td>
<td>Char</td>
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<td>STRIND</td>
<td>TCR_KI: Previous Transplant: Liver / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVLUTX</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: Previous Transplant: # of Lung Transplant. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVLUTXI</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>TCR_KI: Previous Transplant: Lung / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVPTX</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: Previous Transplant: # of Pancreas Transplant. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVPTXI</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>TCR_KI: Previous Transplant: Pancreas (Islet Cells) / Status. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PRVTX</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>TCR_KI: Previous Transplant (Y/N). Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PT_OTH2_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Donor Management: Other (two) //Other/Specify</td>
</tr>
<tr>
<td>PT_OTH3_OSTXT</td>
<td>Char</td>
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<td>$</td>
<td>CDR: Donor Management: Other (three) //Other/Specify</td>
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<tr>
<td>PT_OTH_OSTXT</td>
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<td>50</td>
<td>$</td>
<td>CDR: Donor Management: Other (one) //Other/Specify</td>
</tr>
<tr>
<td>PT_T3</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp: T3(Y/N/U)</td>
</tr>
<tr>
<td>PT_T4</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>CDR: Medications administered within 24 hr prior to crossclamp: T4(Y/N/U)</td>
</tr>
<tr>
<td>PTSTAT</td>
<td>Char</td>
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<td>SPSTAT</td>
<td>KPR: Patient Status: Living/Dead/Retransplanted</td>
</tr>
<tr>
<td>PTSTDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>KPR: Patient Status//Date: Last Seen, Retransplanted or Death</td>
</tr>
<tr>
<td>PULCERR</td>
<td>Num</td>
<td>8</td>
<td>PEPULCER</td>
<td>TCR_KI: Peptic Ulcerat Listing Time</td>
</tr>
<tr>
<td>PULM_EMBOL</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>TCR_KI: Pulmonary Embolism (within last 6 months). Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PULM_EMBOL_HOSP</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>LDR: Pulmonary Embolism During Hosp. Stop Collect From 2004</td>
</tr>
<tr>
<td>PULM_INF_CONF</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>CDR: Clinical Infection: Lung // Confirmed by Culture</td>
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<tr>
<td>PUMP_TM_HRS_KI_LT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Preservation Info: Total Pump Time (Hrs) KI Left. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PUMP_TM_HRS_KI_RT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Preservation Info: Total Pump Time (Hrs) KI Right. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PUMP_TM_HRSMINS_KI_LT_I</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>KPR: Preservation Info: Total Pump Time/Status KI Left. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PUMP_TM_HRSMINS_KI_RT_I</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>KPR: Preservation Info: Total Pump Time/Status KI Right. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PUMP_TM_MINS_KI_LT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Preservation Info: Total Pump Time (Min) KI Left. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PUMP_TM_MINS_KI_RT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Preservation Info: Total Pump Time (Min) KI Right. Stop Separately Collect from 6/30/2004</td>
</tr>
<tr>
<td>PVASCRC</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>TCR_KI: Symptomatic Peripheral Vascular Disease at Listing Time</td>
</tr>
<tr>
<td>PX_STAT</td>
<td>Char</td>
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<td>$PSTAT</td>
<td>LDR: Donor Status</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
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</tr>
<tr>
<td>PX_TXFER_PRIOR_TX</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>KPR: Transferred from Another Hosp Prio to Tx. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PX_TXFER_PRIOR_TX_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>KPR: Date of Adm to Transferring From Another Hosp. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>PXRESTRH</td>
<td>Char</td>
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<td>KPR: Did patient participate any clinical research protocol for immuno med</td>
</tr>
<tr>
<td>PXRESTXT</td>
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<td>$</td>
<td>KPR: Did patient participate any clinical research protocol for immuno med, specify</td>
</tr>
<tr>
<td>RA1</td>
<td>Char</td>
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<td>RHS: Recipient HLA Typing A(1)</td>
</tr>
<tr>
<td>RA2</td>
<td>Char</td>
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<td>RHS: Recipient HLA Typing A(2)</td>
</tr>
<tr>
<td>RABO</td>
<td>Char</td>
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<td>TCR_KI: Patient ABO Blood Group</td>
</tr>
<tr>
<td>RB1</td>
<td>Char</td>
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<td>RHS: Recipient HLA Typing B(1)</td>
</tr>
<tr>
<td>RB2</td>
<td>Char</td>
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<td>RHS: Recipient HLA Typing B(2)</td>
</tr>
<tr>
<td>RBW4</td>
<td>Num</td>
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<td>WKGRPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class I: Bw4</td>
</tr>
<tr>
<td>RBW6</td>
<td>Num</td>
<td>8</td>
<td>WKGRPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class I: Bw6</td>
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<tr>
<td>RCITZ</td>
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<td>CITIZEN</td>
<td>TCR_KI: Patient Citizenship at Listing Time</td>
</tr>
<tr>
<td>RCNT_POS_XMAT</td>
<td>Char</td>
<td>1</td>
<td>SYNDU</td>
<td>RHS: Most Recent Auto Xmatch Positive. Stop Collect From 2004</td>
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<tr>
<td>RCOD</td>
<td>Num</td>
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<td>KI_COD</td>
<td>KPR: Primary Cause of Death</td>
</tr>
<tr>
<td>RCOD2</td>
<td>Num</td>
<td>8</td>
<td>KI_COD</td>
<td>KPR: Contributory Cause of Death</td>
</tr>
<tr>
<td>RCOD3</td>
<td>Num</td>
<td>8</td>
<td>KI_COD</td>
<td>KPR: Contributory Cause of Death</td>
</tr>
<tr>
<td>RCO2TXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KPR: Contributory Cause of Death, Specify</td>
</tr>
<tr>
<td>RCO2TXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KPR: Contributory Cause of Death, Specify</td>
</tr>
<tr>
<td>RCO2TXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KPR: Primary Cause of Death, Specify</td>
</tr>
<tr>
<td>RCO2TXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KPR: Contributory Cause of Death, Specify</td>
</tr>
<tr>
<td>RCW1</td>
<td>Num</td>
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<td>CWHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class I: Cw1</td>
</tr>
<tr>
<td>RCW2</td>
<td>Num</td>
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<td>CWHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class I: Cw2</td>
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<td>RDISCTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>CDR: Reason organ not transplanted: Right Kidney, Specify</td>
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<tr>
<td>RDPW1</td>
<td>Num</td>
<td>8</td>
<td>DPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DPw1</td>
</tr>
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<td>RDPW2</td>
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<td>DPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DPw2</td>
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<tr>
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<td>DQHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DQ1</td>
</tr>
<tr>
<td>RDQW2</td>
<td>Num</td>
<td>8</td>
<td>DQHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DQ2</td>
</tr>
<tr>
<td>RDR1</td>
<td>Char</td>
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<td>RHS: Recipient HLA Typing DR(1)</td>
</tr>
<tr>
<td>RDR2</td>
<td>Char</td>
<td>8</td>
<td></td>
<td>RHS: Recipient HLA Typing DR(2)</td>
</tr>
<tr>
<td>RDRW51</td>
<td>Num</td>
<td>8</td>
<td>WKGRPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DR51</td>
</tr>
<tr>
<td>RDRW52</td>
<td>Num</td>
<td>8</td>
<td>WKGRPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DR52</td>
</tr>
<tr>
<td>RDRW53</td>
<td>Num</td>
<td>8</td>
<td>WKGRPHLA</td>
<td>RHS: Recipient HLA Typing - Typing Method Class II: DR53</td>
</tr>
<tr>
<td>REA_CD_DBL_ENBKI</td>
<td>Num</td>
<td>8</td>
<td>DISP_REA</td>
<td>CDR: Donor Double Enbloc Kidney Disposition Reason Code</td>
</tr>
<tr>
<td>REA_CD_L</td>
<td>Num</td>
<td>8</td>
<td>DISP_REA</td>
<td>CDR: Donor Left Kidney Disposition Reason Code</td>
</tr>
<tr>
<td>REA_CD_PA</td>
<td>Num</td>
<td>8</td>
<td>DISP_REA</td>
<td>CDR: Donor Pancreas Disposition Reason Code</td>
</tr>
<tr>
<td>REA_CD_PA_SEG1</td>
<td>Num</td>
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<td>DISP_REA</td>
<td>CDR: Donor Pancreas Segment 1 Disposition Reason Code</td>
</tr>
<tr>
<td>REA_CD_PA_SEG2</td>
<td>Num</td>
<td>8</td>
<td>DISP_REA</td>
<td>CDR: Donor Pancreas Segment 2 Disposition Reason Code</td>
</tr>
<tr>
<td>REA_CD_R</td>
<td>Num</td>
<td>8</td>
<td>DISP_REA</td>
<td>CDR: Donor Right Kidney Disposition Reason Code</td>
</tr>
<tr>
<td>READEMISSION_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Any Readmission After Initial Discharge</td>
</tr>
<tr>
<td>READEMISSION_KI_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Any Readmission After Initial Discharge / If Yes, Date of First Readmission</td>
</tr>
<tr>
<td>READEMISSION_KI_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>LDR: Any Readmission After Initial Discharge, Specify</td>
</tr>
<tr>
<td>READEMISSION_KI_REASON</td>
<td>Num</td>
<td>8</td>
<td>READMIT</td>
<td>LDR: Reason for readmission (during first six weeks). Multiple selections. The value is comb of value(s) 1, 2, 4, 8, 16, 32</td>
</tr>
<tr>
<td>REC_F_TY</td>
<td>Char</td>
<td>3</td>
<td>$</td>
<td>LDR: Donor Recovery Facility Center Type</td>
</tr>
<tr>
<td>REC_HLA_CELL</td>
<td>Num</td>
<td>8</td>
<td>TGTCSRC</td>
<td>RHS: Recipient HLA Typing Cell Source. Stop Collect From 2004</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
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<tr>
<td>REC_HLA_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Recipient HLA Typed Date. Stop Collect From 2004</td>
</tr>
<tr>
<td>REC_ON_ICE</td>
<td>Char</td>
<td>1</td>
<td>$RECONIC</td>
<td>KPR: Kidney(s) Received on ice</td>
</tr>
<tr>
<td>REC_ON_PUMP</td>
<td>Char</td>
<td>1</td>
<td>$RECONPM</td>
<td>KPR: Kidney(s) Received on pump</td>
</tr>
<tr>
<td>RECDS</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Contributory Cause of Kidney Failure: Recurrent Disease</td>
</tr>
<tr>
<td>RECOV_COUNTRY</td>
<td>Char</td>
<td>3</td>
<td>$CTRY</td>
<td>CDR: If Recovered Outside the U.S.: Recovered Country</td>
</tr>
<tr>
<td>RECOV_OUT_US</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Recovered Outside the U.S.</td>
</tr>
<tr>
<td>REFCLDT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>CDR: Referral Date</td>
</tr>
<tr>
<td>REFERRAL_FLG</td>
<td>Char</td>
<td>1</td>
<td>$</td>
<td>CDR: Referral Flag</td>
</tr>
<tr>
<td>REJ_ACUTE_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Contributory causes of KI failure: Acute Rejection(Y/N/U)</td>
</tr>
<tr>
<td>REJ_ACUTE_PA</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Contributory causes of PA failure: Acute Rejection(Y/N/U)</td>
</tr>
<tr>
<td>REJ_HYPER_PA</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Contributory causes of PA failure: Hyperacute Rejection(Y/N/U)</td>
</tr>
<tr>
<td>REOP_BLEED_KI</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>LDR: Reason for reoperation (during first six weeks): Bleeding</td>
</tr>
<tr>
<td>REOP_BLEED_KI_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Kidney Reoperation Bleeding Date</td>
</tr>
<tr>
<td>REOP_BOWEL_KI</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>LDR: Reason for reoperation (during first six weeks): Bowel Obstruction</td>
</tr>
<tr>
<td>REOP_BOWEL_KI_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Kidney Reoperation Bowel Obstruction Date</td>
</tr>
<tr>
<td>REOP_HERNIA_KI</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>LDR: Reason for reoperation (during first six weeks): Hernia Repair</td>
</tr>
<tr>
<td>REOP_HERNIA_KI_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Kidney Reoperation Hernia Repair Date</td>
</tr>
<tr>
<td>REOP_OTH_KI</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>LDR: Reason for reoperation (during first six weeks): Other</td>
</tr>
<tr>
<td>REOP_OTH_KI_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Kidney Reoperation Other Date</td>
</tr>
<tr>
<td>REOP_OTH_KI_OSTXT</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>LDR: Kidney Reoperation Other Specify</td>
</tr>
<tr>
<td>REOP_VASC_KI</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>LDR: Reason for reoperation (during first six weeks): Vascular</td>
</tr>
<tr>
<td>REOP_VASC_KI_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>LDR: Kidney Reoperation Vascular Date</td>
</tr>
<tr>
<td>REOPERATION_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Kidney Reoperation</td>
</tr>
<tr>
<td>RESIST_SHIP_LT_KI</td>
<td>Num</td>
<td>8</td>
<td>$YNUNK</td>
<td>CDR: Final Resistance Prior to Shipping (left)</td>
</tr>
<tr>
<td>RESIST_SHIP_LT_KI_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Final Resistance Prior to Shipping (left), Status</td>
</tr>
<tr>
<td>RESIST_SHIP_RT_KI</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Final Resistance Prior to Shipping (right)</td>
</tr>
<tr>
<td>RESIST_SHIP_RT_KI_I</td>
<td>Char</td>
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<td>$TRIND</td>
<td>CDR: Final Resistance Prior to Shipping (right), Status</td>
</tr>
<tr>
<td>RESULT_AUTOXM1</td>
<td>Num</td>
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<td>AUTOXMR</td>
<td>RHS: Most Recent row 1/AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_AUTOXM2</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Most Recent row 2/AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_AUTOXM3</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Most Recent row 3/AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_AUTOXM4</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Most Recent row 4/AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_AUTOXM5</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Most Recent row 5/AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_POS_AUTOXM1</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Positive Xmatch row 1/AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_POS_AUTOXM2</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Positive Xmatch row 2/AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_POS_AUTOXM3</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Positive Xmatch row 3/AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_POS_AUTOXM4</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Positive Xmatch row 4/AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_POS_AUTOXM5</td>
<td>Num</td>
<td>8</td>
<td>AUTOXMR</td>
<td>RHS: Positive Xmatch row 5/AutoXM Result Using This Target and Technique:</td>
</tr>
<tr>
<td>RESULT_POS_XM1</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Result - Positive Xmatch row 1. Stop Collect From 2004</td>
</tr>
<tr>
<td>RESULT_POS_XM2</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Result - Positive Xmatch row 2. Stop Collect From 2004</td>
</tr>
<tr>
<td>RESULT_POS_XM3</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Result - Positive Xmatch row 3. Stop Collect From 2004</td>
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<td>Variable</td>
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<td>Length</td>
<td>Format</td>
<td>Comment</td>
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<tr>
<td>RESULT_POS_XM4</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Result - Positive Xmatch row 4. Stop Collect From 2004</td>
</tr>
<tr>
<td>RESULT_POS_XM5</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Result - Positive Xmatch row 5. Stop Collect From 2004</td>
</tr>
<tr>
<td>RESULT_XMAT1</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Most Recent row 1/Result:</td>
</tr>
<tr>
<td>RESULT_XMAT2</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Most Recent row 2/Result:</td>
</tr>
<tr>
<td>RESULT_XMAT3</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Most Recent row 3/Result:</td>
</tr>
<tr>
<td>RESULT_XMAT4</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Most Recent row 4/Result:</td>
</tr>
<tr>
<td>RESULT_XMAT5</td>
<td>Num</td>
<td>8</td>
<td>X_MATCH</td>
<td>RHS: Most Recent row 5/Result:</td>
</tr>
<tr>
<td>RESUSCIT_DUR</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: If cardiac arrest since neurological event that led to declaration of brain death: Duration of Resuscitation(min)</td>
</tr>
<tr>
<td>RESUSCIT_DUR_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Duration of Resuscitation, Status</td>
</tr>
<tr>
<td>RETURN_OR</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Return to OR After Recov of Donor Organ. Stop Collect From 2004</td>
</tr>
<tr>
<td>RETX_ORG</td>
<td>Char</td>
<td>2</td>
<td>$</td>
<td>KPR: Retransplanted Organ</td>
</tr>
<tr>
<td>RH</td>
<td>Char</td>
<td>1</td>
<td></td>
<td>TCR_KI: ABO Blood/Rh. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>RHISP</td>
<td>Char</td>
<td>1</td>
<td>$ETHFMT</td>
<td>TCR_KP: Patient Hispanic Ethnicity</td>
</tr>
<tr>
<td>RK_SHARE</td>
<td>Num</td>
<td>8</td>
<td>SHARETYC</td>
<td>CDR: Share Type - R-Kidney. Stop Collect From 2003</td>
</tr>
<tr>
<td>RKPUMP</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Pump (Right Kidney)(Y/N)</td>
</tr>
<tr>
<td>RRACE</td>
<td>Char</td>
<td>3</td>
<td>$RACEFMT</td>
<td>TCR_KP: Patient Race</td>
</tr>
<tr>
<td>RSEX</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Recipient Gender</td>
</tr>
<tr>
<td>RT_KI_BIOPSY</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Kidney Biopsy (right)(Y/N)</td>
</tr>
<tr>
<td>RT_KI_FLOW</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Flow Rate (cc's/min) (Right Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>RT_KI_FLOW_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Flow Rate/Status (Right Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>RT_KI_GLOMERUL</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: % Glomerulosclerosis (Right Kidney)</td>
</tr>
<tr>
<td>RT_KI_PERFUS_DIAST</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Perfusion Pressuer Diastolic (mm/Hg) (Right Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>RT_KI_PERFUS_DIAST_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Perfusion Pressuer/Status Diastolic (Right Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>RT_KI_PERFUS_SYST</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Perfusion Pressuer (mm/Hg) Systolic (Right Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>RT_KI_PERFUS_SYST_I</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>CDR: Perfusion Pressuer/Status Systolic (Right Kidney). Stop Collect From 2004</td>
</tr>
<tr>
<td>RTYMETHC1</td>
<td>Num</td>
<td>8</td>
<td>HLA_TYMT</td>
<td>RHS: Typing Method Class I. Multiple selections. The value is comb of value(s) 1, 2, 4</td>
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<tr>
<td>RTYMETHC2</td>
<td>Num</td>
<td>8</td>
<td>HLA_TYMT</td>
<td>RHS: Typing Method Class II. Multiple selections. The value is comb of value(s) 1, 2, 4</td>
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<tr>
<td>RWT_ZIP</td>
<td>Char</td>
<td>1</td>
<td>$</td>
<td>TCR_KI: Is Patient waiting in permanent ZIP code(Y/N/U)</td>
</tr>
<tr>
<td>SECONDARY_PAY_KI</td>
<td>Num</td>
<td>8</td>
<td>SECNDPAY</td>
<td>KPR: Kidney Secondary Source of Payment</td>
</tr>
<tr>
<td>SECONDARY_PAY_L</td>
<td>Num</td>
<td>8</td>
<td>SECNDPAY</td>
<td>TCR_KI: Secondary Source of Payment at Listing Time</td>
</tr>
<tr>
<td>SECONDARY_PAY_PA</td>
<td>Num</td>
<td>8</td>
<td>SECNDPAY</td>
<td>KPR: Pancreas Secondary Source of Payment</td>
</tr>
<tr>
<td>SELF</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>LDR: Secondary Source of Payment: SELF Stop Collect From 2004</td>
</tr>
<tr>
<td>SERA_TEST_CLASS1</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>RHS: Were any sera tested pre-transplant that contain anti-HLA Class I antibody:</td>
</tr>
<tr>
<td>SERA_TEST_CLASS2</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>RHS: Were any sera tested pre-transplant that contain anti-HLA Class II antibody:</td>
</tr>
<tr>
<td>SERCREAT</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Serum Creatinine at Time ofTx(mg/dl)</td>
</tr>
<tr>
<td>SERCREATI</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>KPR: Serum Creatinine at Time of Tx, Status</td>
</tr>
<tr>
<td>SERMALB</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: Total Serum Albumin at Listing Time</td>
</tr>
<tr>
<td>SERMALBI</td>
<td>Char</td>
<td>1</td>
<td>$TRIND</td>
<td>TCR_KI: Total Serum Albumin at Listing Time, Status</td>
</tr>
<tr>
<td>SERUM_DT_ORIGINAL</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Date of crossmatch serum - Least Recent</td>
</tr>
<tr>
<td>SERUM_DT_RECENT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>RHS: Date of crossmatch serum</td>
</tr>
<tr>
<td>Variable</td>
<td>Type</td>
<td>Length</td>
<td>Format</td>
<td>Comment</td>
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</tr>
<tr>
<td>SERUM_SCREEN</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>RHS: Was serum screened for anti-HLA Class II antibody</td>
</tr>
<tr>
<td>SEX_PROMISC</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>CDR: Lifestyle Factors: Sexual Promiscuity. Stop Collect From 2004</td>
</tr>
<tr>
<td>SODIUM170</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>CDR: Last Serum Sodium Prior to Procurement &gt; 170 mEq/l. Stop Collect From 2004</td>
</tr>
<tr>
<td>SODIUM170_VAL</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>CDR: Last Serum Sodium Prior to Procurement(mEq/L)</td>
</tr>
<tr>
<td>SODIUM170_VAL_I</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>CDR: Last Serum Sodium Prior to Procurement, Status</td>
</tr>
<tr>
<td>SRGCMP</td>
<td>Char</td>
<td>1</td>
<td>SYNUNK</td>
<td>KPR: Contributory Cause of Kidney Failure: Surgical Complications</td>
</tr>
<tr>
<td>STORAGE_DBL_ENBKI</td>
<td>Num</td>
<td>8</td>
<td>STORSOLN</td>
<td>CDR: Storage Solution - Enbloc Kidney. Stop Separately Collect From 2004</td>
</tr>
<tr>
<td>STORAGE_LKI</td>
<td>Num</td>
<td>8</td>
<td>STORSOLN</td>
<td>CDR: Storage Solution - Left Kidney. Stop Separately Collect From 2004</td>
</tr>
<tr>
<td>STORAGE_PAI</td>
<td>Num</td>
<td>8</td>
<td>STORSOLN</td>
<td>CDR: Storage Solution - Pancreas. Stop Separately Collect From 2004</td>
</tr>
<tr>
<td>STORAGE_PAI_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Storage Solution/Specify - Pancreas. Stop Collect From 2004</td>
</tr>
<tr>
<td>STORAGE_PA_SEG1</td>
<td>Num</td>
<td>8</td>
<td>STORSOLN</td>
<td>CDR: Storage Solution - Pancreas Segment 1. Stop Separately Collect From 2004</td>
</tr>
<tr>
<td>STORAGE_PA_SEG2</td>
<td>Num</td>
<td>8</td>
<td>STORSOLN</td>
<td>CDR: Storage Solution - Pancreas Segment 2. Stop Separately Collect From 2004</td>
</tr>
<tr>
<td>STORAGE_PAI_SEG1_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Storage Solution/Specify - Pancreas Segment 1. Stop Collect From 2004</td>
</tr>
<tr>
<td>STORAGE_PAI_SEG2_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Storage Solution/Specify - Pancreas Segment 2. Stop Collect From 2004</td>
</tr>
<tr>
<td>STORAGE_RKI</td>
<td>Num</td>
<td>8</td>
<td>STORSOLN</td>
<td>CDR: Storage Solution - Right Kidney. Stop Separately Collect From 2004</td>
</tr>
<tr>
<td>STORAGE_RKI_OSTXT</td>
<td>Char</td>
<td>50</td>
<td></td>
<td>CDR: Storage Solution/Specify - Right Kidney. Stop Collect From 2004</td>
</tr>
<tr>
<td>SUITABLE</td>
<td>Num</td>
<td>8</td>
<td>DNRSUIT</td>
<td>CDR: Donor suitable for procurement of organs. Stop Collect From 2004</td>
</tr>
<tr>
<td>SURG_INCIS</td>
<td>Num</td>
<td>8</td>
<td>SURGINCI</td>
<td>KPR: Surgical Information: Surgical Incision</td>
</tr>
<tr>
<td>SUSPND_DT</td>
<td>Num</td>
<td>8</td>
<td>MMDDYY</td>
<td>KPR:</td>
</tr>
<tr>
<td>TARGET1</td>
<td>Num</td>
<td>8</td>
<td>PRATARGT</td>
<td>RHS: Target- Most Recent Class I</td>
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<td>TATTOOS</td>
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<td>SYNUNK</td>
<td>CDR: Lifestyle Factors: Tattoos</td>
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<td>TDATE</td>
<td>Num</td>
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<td>KPR: Tx Date</td>
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<td>HISTOTEC</td>
<td>RHS: Most Recent PRA Technique. Stop Collect From 2004</td>
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<td>TECHNIQUEB</td>
<td>Num</td>
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<td>HISTOTEC</td>
<td>RHS: Peak PRA Technique. Stop Collect From 2004</td>
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<td>THERAPIES</td>
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<td>KPR: Treatment: other therapies(Y/N)</td>
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<td>THERAPIES_TREATMENT</td>
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<td>8</td>
<td>OTHTHER</td>
<td>KPR: If other therapies, all that apply. Multiple selections. The value is comb of value(s) 1, 2, 4</td>
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<td>TISS</td>
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<td>CDR: Was Donor Tissue Removed for Purposes of Transplantation? (Y/N/U). Stop Collect From 2003</td>
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<td>TISSUE_CONSENT</td>
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<td>CDR: Consent Information: Tissue Consented (Y/N). Stop Collect From 2004</td>
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<td>Num</td>
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<td>CONS_NOT</td>
<td>CDR: Consent Information: Tissue Not Consented Reason. Stop Collect From 2004</td>
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<tr>
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<td>Char</td>
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<td>$YNUNK</td>
<td>CDR: Consent Information: Tissue Not Consented Reason/Other Specify. Stop Collect From 2004</td>
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<td>TISSUE_REQ</td>
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<td>Num</td>
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<td>CONSNOTR</td>
<td>CDR: Consent Information: Reason Tissue Not Requested. Stop Collect From 2004</td>
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<td>$YNUNK</td>
<td>CDR: Consent Information: Reason Tissue Not Requested/Other Specify. Stop Collect From 2004</td>
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<tr>
<td>TOBACCO_USE</td>
<td>Char</td>
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<td>LDR: Other Tobacco Used</td>
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<td>TOLER_IND_TECH</td>
<td>Char</td>
<td>1</td>
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<td>KPR: Any tolerance induction technique used</td>
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<tr>
<td>TOT_PRESERV_TM_COLD_PA</td>
<td>Num</td>
<td>8</td>
<td>TRANSFUS</td>
<td>KPR: Total Pancreas Preservation Time (Cold) (Hrs). Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>TOT_PRESERV_TM_COLD_PA_I</td>
<td>Char</td>
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<td>KPR: Total Pancreas Preservation Time (Cold)/Status. Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>TRANS_PUMP_LT_KI</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>CDR: Transferred on pump (left)</td>
</tr>
<tr>
<td>TRANS_PUMP_RT_KI</td>
<td>Char</td>
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<td>$YNUNK</td>
<td>CDR: Transferred on pump (right)</td>
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<tr>
<td>TRANSFUS_INTRAOP_NUM</td>
<td>Num</td>
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<td>TRANSFUS</td>
<td>CDR: Transfusion Units Intraoperatively. Stop Collect From 2004</td>
</tr>
<tr>
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<td>Num</td>
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<td>TRANSFUS</td>
<td>CDR: Transfusion Units Prior to Surgery. Stop Collect From 2004</td>
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<tr>
<td>TRANSFUS_TERM</td>
<td>Num</td>
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<td>TRANSFUS</td>
<td>CDR: Number of transfusions during this (terminal) hospitalization</td>
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<tr>
<td>TRCOPDR</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>TCR_KI: Drug Treated COPD at Listing Time</td>
</tr>
<tr>
<td>TRDGN_KI</td>
<td>Num</td>
<td>8</td>
<td>KI_DGN</td>
<td>KPR: Kidney Primary Diagnosis</td>
</tr>
<tr>
<td>TRDGN_L</td>
<td>Num</td>
<td>8</td>
<td>KI_DGN</td>
<td>TCR_KI: Primary Diagnosis at Listing Time</td>
</tr>
<tr>
<td>TRDGN_PA</td>
<td>Num</td>
<td>8</td>
<td>PA_DGN</td>
<td>KPR: Pancreas Primary Diagnosis</td>
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<tr>
<td>TRDGN_PA_L</td>
<td>Num</td>
<td>8</td>
<td>PA_DGN</td>
<td>TCR_KP: Primary Pancreas Diagnosis at Listing Time</td>
</tr>
<tr>
<td>TRDGNTX_KI</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KPR: Kidney Primary Diagnosis, Specify</td>
</tr>
<tr>
<td>TRDGNTX_L</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>TCR_KI: Primary Diagnosis at Listing Time, Specify</td>
</tr>
<tr>
<td>TRDGNTX_PA</td>
<td>Char</td>
<td>50</td>
<td>$</td>
<td>KPR: Pancreas Primary Diagnosis, Specify</td>
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<td>TRDGNTX_PA_L</td>
<td>Char</td>
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<td>TCR_KP: Primary Pancreas Diagnosis at Listing Time, Specify</td>
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<td>TRHYPR</td>
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<td>TCR_KI: Drug Treated Systemic Hypertension at Listing Time</td>
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<td>TRR_ID</td>
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<td>KPR: Transplant Recipient Registration ID</td>
</tr>
<tr>
<td>TRT_REJ</td>
<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Patient Treated for Rejection. Stop Collect from 6/30/2004</td>
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<tr>
<td>TRT_REJ_KI_NUM</td>
<td>Num</td>
<td>8</td>
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<td>KPR: Number of Kidney Rejection Events. Stop Collect from 6/30/2004</td>
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<td>Format</td>
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<td>TRT_REJ_KI_NUM_I</td>
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<td>KPR: Number of Kidney Rejection Events/Status. Stop Separately Collect from 6/30/2004</td>
</tr>
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<td>TRT_REJ_PA_NUM</td>
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<td>KPR: Number of Pancreas Rejection Events. Stop Collect from 6/30/2004</td>
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<td>KPR: Number of Pancreas Rejection Events/Status. Stop Collect from 6/30/2004</td>
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<tr>
<td>TUMOR_TX</td>
<td>Char</td>
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<td>SYNUNK</td>
<td>KPR: Incidental Tumor found at time of Transplant</td>
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<tr>
<td>TUMOR_TY</td>
<td>Num</td>
<td>8</td>
<td>TUMOR_KI</td>
<td>KPR: Incidental Tumor found at time of Transplant: tumor type</td>
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<td>TUMOR_TY_OSTXT</td>
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<td>KPR: Incidental Tumor found at time of Transplant, Specify</td>
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<td>TX_DT1</td>
<td>Num</td>
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<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant Date</td>
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<td>MMDDYY</td>
<td>TCR_KI: Previous Transplant Date</td>
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<td>TCR_KI: Previous Transplant Date</td>
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<td>Num</td>
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<td>MMDDYY</td>
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<td>TXFUS_DT</td>
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<td>MMDDYY</td>
<td>KPR: Pretransplant Date of Last Transfusion. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>TXFUS_DT_I</td>
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<td>STRIND</td>
<td>KPR: Pretransplant Date of Last Transfusion. Stop Collect from 6/30/2004</td>
</tr>
<tr>
<td>UNOSGF_PA_DT</td>
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<td>8</td>
<td>MMDDYY</td>
<td>KPR: Date of Pancreas Failure</td>
</tr>
<tr>
<td>UNOSGFDT</td>
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<td>8</td>
<td>MMDDYY</td>
<td>KPR: Date of Kidney Failure</td>
</tr>
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<td>SYNUNK</td>
<td>KPR: Kidney Produced &gt; 40ml of Urine in First 24 Hours</td>
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<td>URINE_INF_CONF</td>
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<td>SYNUNK</td>
<td>CDR: Clinical Infection: Urine // Confirmed by Culture</td>
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<td>URCMP</td>
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<td>SYNUNK</td>
<td>KPR: Contributory Cause of Graft Failure: Urological Complications</td>
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<td>VASC_COMP_KI</td>
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<td>SYNUNK</td>
<td>LDR: Kidney Vascular Complications Requiring Intervention</td>
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<td>VASCCOMP</td>
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<td>VASC_COMP_KI_INTER_OSTXT</td>
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<td>$</td>
<td>LDR: Kidney Vascular Complications Other, Specify</td>
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<td>VASC_MGMT</td>
<td>Num</td>
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<td>SYNUNK</td>
<td>KPR: Surgical Information: Venous Extension Graft</td>
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<td>Char</td>
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<td>SYNUNK</td>
<td>KPR: Have any of HIV, CMV, HBV, HCV, EBV ever been tested for. Stop Collect from 6/30/2004</td>
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<tr>
<td>WARM_ISCH_ANAS_KI_LT</td>
<td>Num</td>
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<td>KPR: Total Warm ischemia Time Left KI (Include Anastomotic time)</td>
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<tr>
<td>WARM_ISCH_ANAS_KI_LT_I</td>
<td>Char</td>
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<td>STRIND</td>
<td>KPR: Total Warm ischemia Time Left KI, status</td>
</tr>
<tr>
<td>WARM_ISCH_ANAS_KI_RT</td>
<td>Num</td>
<td>8</td>
<td></td>
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<tr>
<td>WARM_ISCH_ANAS_KI_RT_I</td>
<td>Char</td>
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<td>STRIND</td>
<td>KPR: Total Warm ischemia Time Right KI, status</td>
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<tr>
<td>WARM_ISCH_TM_KI_LT</td>
<td>Num</td>
<td>8</td>
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<td>KPR: Total Warm Ischemic Time KI Left. Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>WARM_ISCH_TM_KI_LT_I</td>
<td>Char</td>
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<td>STRIND</td>
<td>KPR: Total Warm Ischemic Time/Status KI Left. Stop Separately Collect from 6/30/2004</td>
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<tr>
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<td>8</td>
<td></td>
<td>KPR: Total Warm Ischemic Time KI Right. Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>WARM_ISCH_TM_KI_RT_I</td>
<td>Char</td>
<td>1</td>
<td>STRIND</td>
<td>KPR: Total Warm Ischemic Time/Status KI Right. Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>WARM_ISCH_TM_PA</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Total Warm Ischemic Time/Status Pancreas. Stop Separately Collect from 6/30/2004</td>
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<tr>
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<td>Char</td>
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<td>STRIND</td>
<td>KPR: Total Warm Ischemic Time Pancreas (Min). Stop Separately Collect from 6/30/2004</td>
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<tr>
<td>WGT_KG_POST_TX</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Post-Tx - Weight In Kg</td>
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<td>STRIND</td>
<td>KPR: Post-Tx - Weight In Kg, status</td>
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<td>Variable</td>
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<td>Length</td>
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<tr>
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<td>Num</td>
<td>8</td>
<td></td>
<td>KPR: Pre-tx Weight In Kg</td>
</tr>
<tr>
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<td>$TRIND</td>
<td>KPR: Pre-tx Weight In Kg, Status</td>
</tr>
<tr>
<td>WGT_L</td>
<td>Num</td>
<td>8</td>
<td></td>
<td>TCR_KI: Weight in Kilograms at Listing Time</td>
</tr>
<tr>
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<td>Char</td>
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<td>$TRIND</td>
<td>TCR_KI: Weight in Kilograms at Listing Time, Status</td>
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<td>Char</td>
<td>1</td>
<td>$YNUNK</td>
<td>KPR: Working for income(Y/N/U)</td>
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<td>TCR_KI: Not Working Due To at Listing Time</td>
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<td>WORKINC</td>
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| YR_ENTRY_US            | Num   | 8      | MMDDYY | TCR_KI: If Patient is Non-Resident Alien, Year of Entry to the U.S }
### TXIFUNOS: Transplant Followup with Immunosuppression-UNOS

Includes post-transplant time (i.e., followup time) and the recipients' immunosuppression drug using information collected by UNOS. A transplant followup patient may have multiple records in a followup event. Includes transplant followup reports collected by UNOS.

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<td>IMF: DRUG MAINT PREV</td>
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### TXIRUNOS: Transplant with Immunosuppression at Registration-UNOS

Includes transplant recipients and immunosuppression drug(s) using information collected by UNOS. Transplant recipients may have multiple records for a transplant event.

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<td>T,F</td>
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### TXFUHCFA: Kidney Transplant Follow-ups

Includes transplant follow-up reports collected by CMS before 1994. Reports are completed at discharge, six months, each year post-transplant, and graft failure.

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<td>DATE</td>
<td>TFU 11 Death date</td>
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<td>TFU/UNOS Follow-up date USRDS computed</td>
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### TXHCFA: Kidney Transplant-HCFA

Includes transplant followup reports collected by CMS prior to 1994. Reports are completed at discharge, six months, each year post-transplant, and graft failure.

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### TXHCFA: Kidney Transplant-HCFA (continued)

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### TXFUUNOS_KI: Kidney Transplant Followup-UNOS
Includes transplant followup reports collected by UNOS since 1988.

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**TTXFUUNOS_KP: Kidney Pancreas Transplant Followup-UNOS**  
Includes transplant followup reports collected by UNOS since 2003.

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HOSPITAL CD-1
HOSPITALIZATION 1
Hospitalization inpatient data from the USRDS database are a subset of the data in the Institutional Claims file. No payment or cost variables are included on this CD. This CD is for researchers who need data on hospital inpatient stays and on diagnoses and procedures for those stays but who do not need payment data.

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HOSPITAL CD-2

HOSP2: Hospitalization 2

Hospitalization inpatient data from the USRDS database are a subset of the data in the Institutional Claims file. No payment or cost variables are included on this CD. This CD is for researchers who need data on hospital inpatient stays and on diagnoses and procedures for those stays but who do not need payment data.

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HOSPITAL CD-3

HOSP3: Hospitalization 3

Hospitalization inpatient data from the USRDS database are a subset of the data in the Institutional Claims file. No payment or cost variables are included on this CD. This CD is for researchers who need data on hospital inpatient stays and on diagnoses and procedures for those stays but who do not need payment data. Starting with the 2010 Institutional Claims file, CMS altered the Institutional Claims file format by allowing up to 25 ICD9 diagnosis codes and up to 25 ICD9 procedure codes. This required that USRDS change the HOSP file structure for 2010 and beyond.

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**DMMS CLAIMS CD-1**

**HOSP: Hospitalization**

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## INCLAIM: Institutional Claims

*Consists of all Part A Claims*

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DMMS CLAIMS CD-2

**INDETAIL1: Institutional Claim Details**
Contains details like DRG, diagnoses, and procedures. For many analyses, the Claims Details file will not be needed.

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**INDETAIL2: Institutional Claim Details**
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**DMMS CLAIMS CD-3**

**PSCLAIM1: Physician/Supplier claims**

All the physician/supplier claims are Medicare Part B. There is one type of file with one record for each claim line-item. The files include dollar amount, dates of service, diagnosis and procedure codes, type, and place of service.

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DMMS CLAIMS CD-4

All the physician/supplier claims are Medicare Part B. There is one type of file with one record for each claim line-item. The files includes dollar amount, dates of service, diagnosis and procedure codes, type, and place of service.

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**CASE MIX ADEQUACY CD**  
**HOSP: Hospitalization**  
Hospitalization inpatient data from the USRDS database are a subset of the data in the Institutional Claims file. No payment or cost variables are included on this CD. This CD is for researchers who need data on hospital inpatient stays and on diagnoses and procedures for those stays but who do not need payment data.

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### INCLAIM: Institutional Claims

**Consists of all Part A Claims**

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### INDETAIL: Institutional Claim Details

**Contains details like DRG, diagnoses, and procedures. For many analyses, the Claims Details file will not be needed.**

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**PSCLAIM: Physician/Supplier claims**

Contains all the physician/supplier claims of the Case Mix patients. There is one type of file with one record for each claim line-item. The files include dollar amounts, dates of service, diagnosis and procedure codes, type, and place of service.

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COMPREHENSIVE DIALYSIS STUDY (CDS)

**CDS_SAF_PATIENT: CDS Patient file**

This file contains one record for each of the 1677 patients.

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**CDS_SAF_LAB: CDS Lab file**

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## CDS_SAF_QOL_BASELINE: CDS QOL Baseline file

This file contains the Baseline QOL survey answer data and some derivative score data from QOL only and QOL/Nutrition participants.

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## MEDICARE INSTITUTIONAL DETAIL CLAIMS CD

**Institutional Claims**
Consists of all Part A Claims of all ESRD patients.

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### Institutional Claims Details
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Appendix D: Data File Descriptions 239
**PHYSICIAN/SUPPLIER CLAIMS CD**

*Physician/Supplier Claims*

Contains all the physician/supplier claims of all ESRD patients. There is one type of file with one record for each claim line-item. The files include dollar amounts, dates of service, diagnosis and procedure codes, types, and places of service.

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**MEDICARE 5% SAMPLE CKD-BASED COHORT CD**

*Medicare 5% Sample CKD Patient Master File: CKD_PATIENTS_MASTER_FILE*

The patients in this file are those who had at least one CKD ICD-9 diagnosis code identified in the 5% IP, OP, HH, HS, SNF and PB SAFs. There is one record per patient.

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**MEDICARE 5% SAMPLE CKD PATIENT INSTITUTIONAL DETAIL CLAIMS CD**

*Medicare 5% Sample CKD Patient Institutional Claims*

Consists of all Part A Claims of all patients from Medicare 5% claim files who had at least one CKD ICD-9 diagnosis code.

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**Medicare 5% Sample CKD Patient Institutional Claims Details**

Contains details like diagnoses and procedures of all patients from Medicare 5% claim files who had at least one CKD ICD-9 diagnosis code.

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### MEDICARE 5% SAMPLE CKD PATIENT PHYSICIAN/SUPPLIER DETAIL CLAIMS CD

**Medicare 5% Sample CKD Patient Physician/Supplier Claims Details**
Contains all the physician/supplier claims of all patients from Medicare 5% claim files who had at least one CKD ICD-9 diagnosis code. The files include dollar amounts, dates of service, diagnosis and procedure codes, types, and places of service.

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### MEDICARE 5% SAMPLE CKD PATIENT HOSPITAL STAY SUMMARY CD

**Medicare 5% Sample CKD Patient Hospital Stay Summary File: CKD_92_to_YR_hosp_clm**
Contains diagnosis codes, procedure codes, days in intensive care unit (ICU), and days in coronary unit (CCU), of patients who had at least one CKD ICD-9 diagnosis code identified in the 5% IP, OP, HH, HS, SNF, and PB SAFs.

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MEDICARE PRESCRIPTION DRUG - PART D

Contains 12 monthly indicators that detail whether the beneficiary is enrolled in Part D, and if so, what type of plan. There are also monthly indicators for dual eligibility (Medicare and Medicaid), monthly indicators for Retiree Drug Subsidy, and low income subsidy (LIS).

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MEDICARE PRESCRIPTION DRUG - PART D

**PDEyrA: Medicare Prescription Drug - Part D**

Contains details on prescription drug utilization, including brand name, generic name, dosage form, drug strength, quantity dispensed, date of service, and total prescription cost.

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## Appendix E: Data Formatting

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| COGDEVLP               | Numeric | 1 | Definite Cognitive delay/impairment |
|                       |        | 2 | Probable Cognitive delay/impairment |
|                       |        | 3 | Questionable Cognitive delay/impairment |
|                       |        | 4 | No Cognitive delay/impairment |
|                       |        | 998 | Not Assessed |

| COMPFMT                | Character | 1 | Much better now than one year ago |
|                       |          | 2 | Somewhat better now than one year ago |
|                       |          | 3 | About the same |
|                       |          | 4 | Somewhat worse now than a year ago |
|                       |          | 5 | Much worse now than one year ago |

| CONSNOTR               | Numeric | 10 | DONOR AGE                  |
|                       |        | 11 | NON-HEART BEATING DONOR    |
|                       |        | 12 | HISTORY OF PREVIOUS CARDIAC SURGERY (valid only for HR) |
|                       |        | 13 | HISTORY OF SEVERE CARDIAC DISEASE (valid only for HR) |
|                       |        | 14 | HISTORY OF LUNG DISEASE (valid only for LU) |
|                       |        | 15 | HISTORY OF GASTRO-INTESTINAL DISEASE (valid only for IN) |
|                       |        | 16 | HISTORY OF DIABETES MELLITUS (valid only for PA) |
|                       |        | 17 | PANCREATITIS (valid only for PA) |
|                       |        | 18 | ACUTE/CHRONIC RENAL FAILURE |
|                       |        | 21 | Donor Quality |
|                       |        | 22 | Donor ABO |
|                       |        | 99 | OTHER SPECIFY |

<p>| CONS_NOT               | Numeric | 100 | EMOTIONAL |
|                       |        | 101 | CULTURAL BELIEFS |</p>
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**CYCLER**

Character 1
- four times or more
- three times
- twice
- once
- not at all
- I am not on a cycler

**C_GRF_FU**

Numeric 1
- Hyperacute Rejection
- Acute Rejection
- Primary Failure
- Graft Thrombosis
- Infection
- Surgical Complications
- Urological Complications
- Recurrent Disease
- Chronic Rejection
- BK (Polyoma) Virus
- Other, Specify

**DCANC**

Character 1
- Intracranial
- Extracranial
- None

**DCRFMT**

Character
- Missing
- Gram pos
- Gram neg, single
- Gram neg, multiple
- Gram pos and neg
- Fungal
- Fungal and bacterial
- No growth
- Other
- Unknown

**DEATHFM**

Character
- Pericarditis(incl. Cardiac Tamponade) *Discontinued, as of Aug. 1990
- Myocardial Infarction, Acute
- Cardiac (Other Than 01 Or 02) *Discontinued, as of Aug. 1990
- Cerebrovascular *Discontinued, as of Aug. 1990
- Embolism, Air *Discontinued, as of Aug. 1990
- Embolism, Pulmonary *Discontinued, as of Aug. 1990
- GI Hemorrhage *Discontinued, as of Aug. 1990
- Vascular Access *Discontinued, as of Aug. 1990
- Hemorrhage (Other Than 04, 07, Or 08) *Discontinued, as of Aug. 1990
- Pericarditis(incl. Cardiac Tamponade) *Discontinued, as of Aug. 1990
- Pulmonary Infection *Discontinued, as of Aug. 1990
- Hypoglycemia
- Hyperglycemia
- Diabetic coma
- Hyperthyroidism
- Withdrawal from dialysis/uremia
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<td>Septicemia *Discontinued, as of Aug. 1990</td>
<td>Septicemia *Discontinued, as of Aug. 1990</td>
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<td>12</td>
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<td>Viral Hepatitis *Discontinued, as of Aug. 1990</td>
<td>Viral Hepatitis *Discontinued, as of Aug. 1990</td>
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<td>Infection (Other Than 10, 11, Or 12) *Discontinued, as of Aug. 1990</td>
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<td>Pancreatitis</td>
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<td>Malignancy *Discontinued, as of Aug. 1990</td>
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<td>Withdraw From Dialysis *Discontinued, as of Aug. 1990</td>
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<td>18</td>
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<td>Hyperkalemia</td>
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<td>Pericarditis, Incl. Cardiac Tamponade</td>
<td>Pericarditis, Incl. Cardiac Tamponade</td>
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<td>27</td>
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<td>Atherosclerotic Heart Disease</td>
<td>Atherosclerotic Heart Disease</td>
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<td>28</td>
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<td>Cardiomyopathy</td>
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<td>Cardiac Arrhythmia</td>
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<td>Cardiac Arrest, Cause Unknown</td>
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<td>Cardiac (Other Than 01 Or 02) *Discontinued, as of Aug. 1990</td>
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<td>Valvular Heart Disease</td>
<td>Valvular Heart Disease</td>
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<td>Pulmonary Edema Due To Exogenous Fluid</td>
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<td>Congestive heart failure</td>
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<td>Septicemia due to internal vascular access</td>
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<td>Septicemia due to vascular access catheter</td>
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<td>Cerebro-Vascular Accident Including Intracranial Hemorrhage</td>
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<td>Ischemic Brain Damage/Anoxic Encephalopathy</td>
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<td>Hemorrhage From Transplant Site</td>
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<td>Hemorrhage From Vascular Access</td>
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<td>Hemorrhage From Dialysis Circuit</td>
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<td>Hemorrhage From Ruptured Vascular Aneurysm</td>
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<td>Peritoneal access infectious complication, bacterial</td>
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<td>Peritoneal access infectious complication, fungal</td>
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<td>Peritonitis (complication of peritoneal dialysis)</td>
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<td>Central nervous system infection (brain abscess, meningitis, encephalitis, etc.)</td>
<td>Central nervous system infection (brain abscess, meningitis, encephalitis, etc.)</td>
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<td>Cardiac infection (endocarditis)</td>
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<td>Pulmonary infection (pneumonia, influenza)</td>
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<td>Abdominal infection (peritonitis-not complication of PD, perforated bowel, diverticular disease, gallbladder)</td>
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<td>Liver Failure, Cause Unknown Other</td>
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<td>Gi Hemorrhage *Discontinued, as of Aug. 1990</td>
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<td>Genito-urinary infection (urinary tract infection, pyelonephritis, renal abscess)</td>
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<td>Gastro-Intestinal Hemorrhage</td>
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<td>Pancreatitis</td>
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<td>Fungal Peritonitis *Discontinued, as of Oct 2004</td>
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<td>Perforation Of Peptic Ulcer</td>
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<td>Perforation Of Bowel (Not 75)</td>
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<td>Vascular Access *Discontinued, as of Aug. 1990</td>
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<td>Bone Marrow Depression</td>
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<td>Cachexia</td>
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<td>Malignant Disease, Patient Ever On Immunosuppressive Therapy</td>
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<td>Malignant Disease (Not 82)</td>
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<td>Seizures</td>
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<td>Diabetic Coma, Hyperglycemia, Hypoglycemia *Discontinued, as of Oct 2004</td>
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<td>Chronic Obstructive Lung Disease (Copd)</td>
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<td></td>
<td>Complications Of Surgery</td>
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<td>89</td>
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<td>Air Embolism</td>
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<td>Hemorrhage (Other Than 04, 07, Or 08) *Discontinued, as of Aug. 1990</td>
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<td>90</td>
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<td>Accident Related To Treatment</td>
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<td>Accident Unrelated To Treatment</td>
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<td>92</td>
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<td>Suicide</td>
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<td>Drug Overdose (Street Drugs)</td>
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<td>Drug Overdose (Not 92 Or 93)</td>
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<td>Acidosis</td>
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<td>Adrenal insufficiency</td>
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<td>Hypothyroidism</td>
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<td>Other Identified Cause Of Death, Please Specify</td>
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**DESCFMT**  Character 1  RENAL RECOVERY
          2  DIED
          3  CURRENT (12/90)
          4  LOST TO FOLLOWUP

**DIABFMT**  Character  Missing
          1  IDDM (Juv. Type I)
          2  NIDDM (Adult Type II)

**DIABTRET**  Numeric 0  N/A
            1  INSUL
            2  ORAL HYPOGLYCEMIC AGENT
            3  INSUL;ORAL HYPOGLYCEMIC AGENT
            4  DIET
            5  INSUL;DIET
            6  ORAL HYPOGLYCEMIC AGENT;DIET
            7  INSUL;ORAL HYPOGLYCEMIC AGENT;DIET

**DIAB_TY**  Numeric 1  No
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<td>Type II</td>
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<tr>
<td>998</td>
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**DIAG** Character | 042 | AIDS nephropathy |
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<td>Urinary tract tumor (malignant)</td>
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<td>20280</td>
<td>Lymphoma of kidneys</td>
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<td>20300</td>
<td>Multiple myeloma</td>
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<td>20308</td>
<td>Other immuno proliferative neoplasms (including light chain nephropathy)</td>
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<td>Renal tumor (benign)</td>
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<td>Diabetes with renal manifestations Type 2</td>
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**DIAGFMT** Character 1 DIABETES
2 HYPERTENSION
3 GLOMERULONEPH
4 CYSTIC KIDNEY
5 OTHER UROLOGIC
6 OTHER CAUSE

**DIALCRC** Character 1 FULL CARE UNIT
2 SELF CARE UNIT
3 SELF CARE TRAINING
4 HOME
5 HOME 100 PERCENT
6 BACK-UP FACILITY

**DIALRVC** Character 00 INPATIENT
01 INP HEMO
02 INP PERI NONCAPD
03 INP CAPD
04 INP CCPD
0800 INPATIENT
0801 INP HEMO
0802 INP PERI NONCAPD
0803 INP CAPD
0804 INP CCPD
0809 INP OTHER
0810 Organ Acquis.
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- **FUCHGTY Character: 01** no change in status or modality
- **FUCHGTY Character: 02** changed to PD (for at least 2 weeks)
- **FUCHGTY Character: 03** changed to hemodialysis (for at least 2 weeks)
- **FUCHGTY Character: 04** changed to home hemodialysis (for at least 2 weeks)
- **FUCHGTY Character: 05** return of renal function
- **FUCHGTY Character: 06** transferred to another facility
- **FUCHGTY Character: 07** kidney transplant
- **FUCHGTY Character: 08** died
- **FUCHGTY Character: 09** lost to followup
- **FUCHGTY Character: 10** withdrew from dialysis

- **FUMODAL Character: 1** hemo
- **FUMODAL Character: 2** PD

- **FUNCSTAT Numeric: 1** No Activity Limitations. NYHA Cls I or Cls II
- **FUNCSTAT Numeric: 2** Performs Activities of Daily Living w/ some assistance. NYHA Cls III
- **FUNCSTAT Numeric: 3** Performs Activities of Daily Living w/ total assistance. NYHA Cls IV
- **FUNCSTAT Numeric: 996** Not Applicable (patient < 1 year old)
- **FUNCSTAT Numeric: 998** Unknown

- **FUNUM Numeric: 0** At Discharge
- **FUNUM Numeric: 1** Disch-6 mths post tx
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<td>Following acute medical complication</td>
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**RXSTOP**

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<td>Yes, following chronic failure to thrive</td>
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<td>D</td>
<td>Yes, following acute medical complication</td>
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**WKGRPHLA** Numeric . Not Reported
- 0: 0
- 95: Positive
- 96: Negative
- 98: Confirmed Blank
- 99: Not Tested
- 998: Unknown
- **OTHER**: Unknown

**WORK8A** Character 1
- Working full-time
- Working part-time
- Unemployed, laid off, or looking for work
- Retired
- Disabled
- In school
- Keeping house
- None of the above

**WORKINC** Numeric . Not Reported
- 1: Working Full Time
- 2: Working Part Time due to Demands of Treatment
- 3: Working Part Time due to Disability
- 4: Working Part Time due to Insurance Conflict
- 5: Working Part Time due to Inability to Find Full Time Work
- 6: Working Part Time due to Patient Choice
- 7: Working Part Time Reason Unknown
- 998: Working, Part Time vs. Full Time Unknown
- **OTHER**: Unknown

**WRITCONS** Numeric 1
- 2: YES, CONSENT OBTAINED BY PHYSICIAN
- 3: YES, CONSENT OBTAINED BY NURSE
- 4: YES, CONSENT OBTAINED BY CLERGY
- 5: YES, CONSENT OBTAINED BY OPO COORDINATOR
- 6: YES, CONSENT OBTAINED BY SOCIAL WORKER
- 999: YES, CONSENT OBTAINED BY OTHER, SPECIFY

**WRKSTAT** Character 1
- Yes, full-time
- Yes, part-time
- No
- Don't know
- REFUSED
- 998: Missing

**X_MATCH** Numeric 0
- 0: Indeterminate
- 1: Negative
- 2: Positive
- 3: Weak Positive

**YESNO** Character 1
- Yes
- No

**YESNON** Character 1
- Yes
- No
- Not sure

**YN12FMT** Character Missing
- 1: Yes
- 2: No

**YNCDS1_** Character 1
- Yes
- 10: N/A
- 2: No
- 8: Don't know
- 9: REFUSED
- 998: Missing

**YNCDS2_** Character 1
- Yes, 12 months or more before I started regular dialysis
- Yes, less than 12 months before I started regular dialysis
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Appendix F: Data Forms

CMS ESRD Forms
- Previous CMS 2728-Chronic Renal Disease Medical Evidence Report
- CMS 2728-ESRD Medical Evidence Report Medicare Entitlement &/or Patient Registration v. 1995
- CMS 2728-ESRD Medical Evidence Report Medicare Entitlement &/or Patient Registration v. 2005
- CMS 2746-ESRD Death Notification (1996)
- CMS 2744-ESRD Facility Survey
- UB92-CMS 1450-Uniform Bill
- CMS 1500-Health Insurance Claim Form

CDC National Surveillance of Dialysis-Associated Diseases Form
- 1993–2002

Note: The 1996 CDC form is not available. The CDC did not conduct a study in 1998 and the last study was in 2002. Data for the CDC variables are missing after this date.

UNOS Transplant Forms
Transplant Candidate Registration Form
Includes waitlist data as well as other clinical and organ-specific information collected prior to the transplant.
- Adult Kidney Transplant Candidate Registration Worksheet
- Adult Kidney/Pancreas Transplant Candidate Registration Worksheet
- Adult Pancreas Transplant Candidate Registration Worksheet
- Adult Liver Transplant Candidate Registration Worksheet
- Adult Intestine Transplant Candidate Registration Worksheet
- Adult Heart Transplant Candidate Registration Worksheet
- Adult Lung Transplant Candidate Registration Worksheet
- Adult Heart/Lung Transplant Candidate Registration Worksheet
- Pediatric Kidney Transplant Candidate Registration Worksheet
- Pediatric Kidney/Pancreas Transplant Candidate Registration Worksheet
- Pediatric Pancreas Transplant Candidate Registration Worksheet
- Pediatric Liver Transplant Candidate Registration Worksheet
- Pediatric Intestine Transplant Candidate Registration Worksheet
- Pediatric Heart Transplant Candidate Registration Worksheet
• Pediatric Lung Transplant Candidate Registration Worksheet
• Pediatric Heart/Lung Transplant Candidate Registration Worksheet

**Transplant Recipient Registration Form**
Includes the patient status at discharge, pre- and post-transplant clinical information, as well as treatment data. The form is generated when the patient receives a transplant and is removed from the waitlist.

- Adult Kidney Transplant Recipient Registration Worksheet
- Adult Kidney-Pancreas Transplant Recipient Registration Worksheet
- Adult Pancreas Transplant Recipient Registration Worksheet
- Adult Liver Transplant Recipient Registration Worksheet
- Adult Intestine Transplant Recipient Registration Worksheet
- Adult Thoracic-Lung Transplant Recipient Registration Worksheet
- Adult Thoracic-Heart Transplant Recipient Registration Worksheet
- Adult Thoracic-Heart/Lung Transplant Recipient Registration Worksheet
- Pediatric Kidney Transplant Recipient Registration Worksheet
- Pediatric Kidney-Pancreas Transplant Recipient Registration Worksheet
- Pediatric Pancreas Transplant Recipient Registration Worksheet
- Pediatric Liver Transplant Recipient Registration Worksheet
- Pediatric Intestine Transplant Recipient Registration Worksheet
- Pediatric Thoracic-Lung Transplant Recipient Registration Worksheet
- Pediatric Thoracic-Heart Transplant Recipient Registration Worksheet
- Pediatric Thoracic-Heart/Lung Transplant Recipient Registration Worksheet

**Transplant Recipient Follow-up Form**
This form is generated at six months post-transplant and on the transplant anniversary for every living organ recipient with a functioning graft. It includes patient status as well as clinical and treatment information. A reduced set of data is collected after 5 years. Shown here are the adult and pediatric forms for collecting follow-up through 5 years post-transplant.

- Adult Kidney Transplant Recipient Follow-Up Worksheet
- Adult Kidney-Pancreas Transplant Recipient Follow-Up Worksheet
- Adult Liver Transplant Recipient Follow-Up Worksheet
- Adult Intestine Transplant Recipient Follow-Up Worksheet
- Adult Thoracic Lung Transplant Recipient Follow-Up Worksheet
- Adult Thoracic Heart Transplant Recipient Follow-Up Worksheet
- Adult Thoracic Heart Lung Transplant Recipient Follow-Up Worksheet
- Pediatric Kidney Transplant Recipient Follow-Up Worksheet
- Pediatric Kidney-Pancreas Transplant Recipient Follow-Up Worksheet
- Pediatric Liver Transplant Recipient Follow-Up Worksheet
- Pediatric Intestine Transplant Recipient Follow-Up Worksheet
- Pediatric Thoracic Lung Transplant Recipient Follow-Up Worksheet
- Pediatric Thoracic Heart Transplant Recipient Follow-Up Worksheet
- Pediatric Thoracic Heart Lung Transplant Recipient Follow-Up Worksheet
- Adult Post-Transplant Malignancy Worksheet
- Pediatric Post-Transplant Malignancy Worksheet
- Adult Post-Transplant Malignancy Worksheet
- Pediatric Post-Transplant Malignancy Worksheet
- Liver Recipient Explant Pathology Worksheet
- Recipient Histocompatibility Worksheet
- Deceased Donor Registration Worksheet
- Living Donor Registration Worksheet
- Living Donor Follow-Up Worksheet
- Donor Histocompatibility Worksheet
Special Study Data Forms

Case Mix/Adequacy Study
- Confidential Report

CAPD Peritonitis Study
- Confidential Report

Data Validation Study
- Transplant Information
- Patient History
- Dialysis Treatments
- Hospital Stay Information

EPO & Quality of Life Study
- Health Status Measurement
- Social Worker Questionnaire
- Physician Questionnaire
- Six-month Follow-up

Pediatric ESRD Growth & Development Study
- Patient History

Renal Biopsy Study
- Prognosis After ESRD

USRDS Dialysis Morbidity and Mortality Study Forms

DMMS Wave I Special Study Data Forms
- Instructions: USRDS Dialysis Morbidity & Mortality Study
- Dialysis Facility/Unit Questionnaire
- Vascular Access Questionnaire
- Vascular Access in Incident Patients
- USRDS DMMS-Core Confidential Report
- Anemia Questionnaire
- USRDS DMMS-Anemia Confidential Report
- Nutrition Questionnaire
- USRDS DMMS-Nutrition Confidential Report
- Patient Tracking form

DMMS Wave II Special Study Data Forms
- Cover Sheet & Patient Consent form
- Instruction Manual
- Dialysis Facility/Unit Questionnaire Instructions
- Dialysis Patient Questionnaire
- Medical Questionnaire Confidential Report
- USRDS DMMS Prospective Follow-up Study-Instructions
- Cover Sheet for Medical Update Questionnaire
- Medical Update & Questionnaire
- Cover Sheet & Patient Consent form
- Dialysis Patient Questionnaire
- Patient Tracking & Identification form

DMMS Wave III-IV Special Study Data Forms
- Instruction Manual for Clinical Questionnaire
- Clinical Questionnaire
• Confidential Report: Clinical Questionnaire
• Patient Tracking

DMMS FACS Special Study Data Forms
• Dialysis Facility/Unit Questionnaire
**Glossary**

Definitions are taken from *Dorland’s Illustrated Medical Dictionary* or *On-line Medical Dictionary*.

**ARF Acute Renal Failure**
Sudden decrease in glomerular filtration rate accompanied by azotemia. ARF may or may not require renal replacement therapy; ARF patients who require dialysis may or may not recover renal function with short-term dialysis.

**CAPD Continuous Ambulatory Peritoneal Dialysis**
A method of dialysis in which dialysate is always present in the abdomen and is usually exchanged every two hours. Normal treatment length is 48 to 72 hours.

**CCPD Continuous Cycler-assisted Peritoneal Dialysis**
A method of dialysis in which the patient is connected to a cycler machine, usually at bedtime, and dialysate in the patient’s abdomen is replaced with fresh dialysate 3 to 5 times during the night.

**CDC Centers for Disease Control & Prevention**
Recognized as the lead federal agency for protecting the health and safety of people at home and abroad, the CDC serves as the national focus for disease prevention by developing and applying programs designed to improve the health of the people of the United States.

**CKD Chronic Kidney Disease**
A condition of deteriorating kidney function classified by five stages that define increasing evidence of kidney damage shown by microalbuminuria and estimated glomerular filtration rate.

**CMS Centers for Medicare & Medicaid Services**
Created in 1977 as the Health Care Financing Administration (HCFA) and renamed in June 2001, this federal agency is responsible for the administration of the nation’s largest healthcare programs, Medicare and Medicaid.

**CMS-2728 Medical Evidence Report**
Provides source data about ESRD patients, including information on patient demographics, primary cause of renal disease, comorbidity, laboratory values, dialysis treatment, transplant, dialysis training, employment status, and initial insurance coverage.

**CMS-2744 ESRD Facility Survey**
Data collected annually by CMS from all facilities certified to provide Medicare-covered renal dialysis and transplantation. The survey includes the entire United States and encompasses the full calendar year, with geographical data to the facility’s zip code level. Each record contains facility information and information on the number of patients served, dialysis treatments provided, and kidney transplants performed, for Medicare and non-Medicare patients.

**CMS-2746 Death Notification**
A form used to report ESRD patient demographic information and information on the primary cause of death.

**Chain Provider**
A Chain, as applied to the usrds Annual Data Report, is defined as follows: from 2001 to 2007 inclusive, a Chain is defined as a business entity that owns 20 or more dialysis units located in more than one state. After 2007 a USRDS Chain is defined as a business entity that owns 20 or more dialysis units (there is no state restriction). In addition, the USRDS defines a small Dialysis Operation (SDO) as a Chain with less than 100 dialysis units. A Large Dialysis Operation (LDO) is a chain with 100 or more dialysis units. The Annual Data Report will compare the data of each LDO and the sum of all SDOs in the numerous graphical displays. There may be graphical displays between just the SDOs.

**CHF Congestive Heart Failure**
A risk factor for and complication of kidney disease.

**CWF Common Working File System**
The Medicare Part A and Part B benefit coordination and claims validation system, through which CMS maintains institutional and physician/supplier claims-level data. CWF claims records are the data sources for most claims and utilization files used by the USRDS.

**DM Diabetes Mellitus**
A condition of impaired ability to metabolize carbohydrates, protein, and fat, both a complication of kidney disease and a risk factor for ESRD and heart disease.

**EGHP Employer Group Health Plan**
A source of data on CKD patients aged less than 65 years and continuously enrolled in a fee-for-service plan for two consecutive years.

**ESRD End-stage Renal Disease**
A condition in which kidney function is not adequate to support life.

**ESRD Networks**
Eighteen geographically defined organizations under contract to CMS serving as liaisons between the federal government and providers of ESRD services. The Network Organizations oversee the quality of patient care, collect data to administer the national Medicare ESRD program, and provide technical assistance to ESRD providers and patients.

**EPO Erythropoietin**
A hormone secreted chiefly by the adult kidney; it acts on the bone marrow to stimulate red cell production. Erythropoetin is available as a therapeutic agent used to treat anemia resulting from chronic renal failure and other conditions.
FOR-PROFIT FACILITY A dialysis facility owned, leased, or by any other means, controlled by a single business entity.

FREESTANDING FACILITY; INDEPENDENT UNIT A dialysis facility licensed to provide only outpatient and home maintenance dialysis.

HCFA HEALTH CARE FINANCING ADMINISTRATION See cms, Centers for Medicare & Medicaid Services.

HD HEMODIALYSIS Removal of uremic toxins from the blood by virtue of the difference in rates of their diffusion through a semipermeable membrane while being circulated outside the body.

HOSPITAL-BASED FACILITY A dialysis facility attached to or located in a hospital and licensed to provide outpatient dialysis services.

INCIDENT PATIENT A patient starting renal replacement therapy for ESRD during a given calendar year. Excludes patients with acute renal failure, patients with chronic renal failure who die before receiving treatment for ESRD, and patients whose ESRD treatment is not reported through cms.

NCH NATIONAL CLAIMS HISTORY 100% NEARLINE FILE Contains all Common Working File (cwf) Part A (provider) and Part B (physician/supplier) Medicare claims and adjusted claims information.

NIDDK NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES A part of the NIH that conducts and supports research on internal medicine diseases, including kidney, urologic, and hemalogic diseases.

NIH NATIONAL INSTITUTES OF HEALTH The federal focal point for medical research in the United States and one of eight health agencies of the Public Health Services, part of the Department of Health and Human Services.

PD PERITONEAL DIALYSIS A type of dialysis in which fluid (dialysate) is introduced into the abdominal cavity and uremic toxins are removed across the peritoneum.

PERIOD PREVALENT PATIENT A patient receiving treatment for ESRD at some point during a given time period, usually six or twelve months. Patients may die during the period or be point prevalent at the end of the period.

POINT PREVALENT PATIENT A patient reported as receiving treatment for ESRD on a particular day, such as December 31 of a given year.

PMMIS/REBUS/REMI PROGRAM MEDICAL MANAGEMENT AND INFORMATION SYSTEM FOR ESRD/RENAL BENEFICIARY AND UTILIZATION SYSTEM/RENAL MANAGEMENT INFORMATION SYSTEM The major source of data for the USRDS. This cms file incorporates data from the Medical Evidence Report (cms-2728), the Death Notification (cms-2746), the Medicare Enrollment Database, Medicare inpatient and outpatient claims, the sims database, and the usnos Transplant Database.

PREVALENT PATIENT A patient receiving renal replacement therapy or having a functioning kidney transplant (regardless of when the transplant was performed). Excludes patients with acute renal failure, patients with chronic renal failure who die before receiving treatment for ESRD, and patients whose ESRD treatments are not reported through cms.

REUSE A process by which a hemodialyzer is cleaned and disinfected, allowing multiple uses on the same patient.

SAF STANDARD ANALYSIS FILES CMS files containing final action Medicare Part A claims data, including Inpatient, Outpatient, Home Health Agency, Hospice, Skilled Nursing Facility, Clinical Laboratory, Durable Medical Equipment, and 3% Sample Beneficiary.

SAS® STATISTICAL ANALYSIS SYSTEM Format chosen for the USRDS SAFs because it is widely used, easily transported, and largely self-documenting. Sas is a commercially available data management and statistical analysis software system that runs on most computers, from mainframes to pcs, and it is almost universally available on university computer systems. The USRDS SAFs take full advantage of the program’s ability to incorporate a large amount of documentation into the file.

SHR STANDARDIZED HOSPITALIZATION RATIO Used to compare hospitalization rates for a selected group of patients by computing the ratio of the group’s observed hospitalization rate to the expected hospitalization rate for the national ESRD population.

SIMS STANDARD INFORMATION MANAGEMENT SYSTEM A database generated by the ESRD Networks used by the USRDS to provide detailed treatment history and to follow non-Medicare patients more closely.

SMR STANDARDIZED MORTALITY RATIO Used to compare dialysis patient mortality rates from year to year. Mortality rates for a subgroup of patients are compared to a set of reference rates, with adjustments for age, race, gender, and diabetes as a cause of ESRD.

STR STANDARDIZED TRANSPLANTATION RATIO Used to compare the transplant rate of a sub-group of patients to the national transplant rate.

TRANSPLANT CENTER A hospital unit licensed to provide transplantation and other medical and surgical specialty services for the care of kidney transplant patients, including inpatient dialysis furnished directly or under arrangement.

UNOS UNITED NETWORK FOR ORGAN SHARING A private, non-profit organization that maintains the organ transplant list for the nation and coordinates the matching and distribution of organs to patients awaiting transplant.

WAIT-LIST A list maintained byunos of patients awaiting an organ transplant.