

**CASEFINDING SOURCE**

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**Description:** *This variable codes the earliest source of identifying information. For cases identified by a source other than reporting facilities (such as through death clearance or as a result of an audit), this variable codes the type of source through which the tumor was first identified.*

**Instructions for Coding (See current version of NAACCR Volume II, Data Standards and Data Dictionary):**

This variable is intended to code the source that first identified the tumor. Determine where the case was first identified and enter the appropriate code. If the case was first identified at a reporting facility (codes 10-29), code the earliest source (based on patient or specimen contact at the facility) of identifying information.

If a death certificate, independent pathology laboratory report, consultation-only report from a hospital, or other report was used to identify a case that was then abstracted from a different source, enter the code for the source that first identified the case, not the source from which it was subsequently abstracted.

**Codes:**

Case first identified at a reporting facility:

- 10 Reporting Hospital, NOS
- 20 Pathology Department Review (surgical pathology reports, autopsies, or cytology reports)
- 21 Daily Discharge Review (daily screening of charts of discharged patients in the medical records department)
- 22 Disease Index Review (review of disease index in the medical records department)
- 23 Radiation Therapy Department/Center
- 24 Laboratory Reports (other than pathology reports, code 20)
- 25 Outpatient Chemotherapy
- 26 Diagnostic Imaging/Radiology (other than radiation therapy, codes 23; includes nuclear medicine)
- 27 Tumor Board
- 28 Hospital Rehabilitation Service or Clinic
- 29 Other Hospital Source (including clinic, NOS or outpatient department, NOS)

Case first identified by source other than a reporting facility covered in the codes above:

- 30 Physician-Initiated Case
- 40 Consultation-only or Pathology-only Report (not abstracted by reporting hospital)
- 50 Independent (non-hospital) Pathology-Laboratory Report
- 60 Nursing Home-Initiated Case
- 70 Coroner's Office Records Review
- 75 Managed Care Organization (MCO) or Insurance Records
- 80 Death Certificate (case identified through death clearance)
- 85 Out-of-State Case Sharing
- 90 Other Non-Reporting Hospital Source
- 95 Quality Control Review (case initially identified through quality control activities such as casefinding audit of a regional or central registry)
- 99 Unknown