BioSense 2.0 Variables Received

State, Local, Territorial Public Health Jurisdictions

Variable Name	Variable Description
	Unique facility identifier of facility where the patient originally presented
Facility Identifier (Treating)	(original provider of the data)
	Name of facility where the patient originally presented (original provider
Facility Name (Treating)	of the data)
Facility Location (Treating) – Street	
Address	Street address of treating facility location
Facility Location (Treating) – City	City of treating facility location
Facility Location (Treating) – County	County of treating facility location
Facility Location (Treating) – State	State of treating facility location
Facility / Visit Type	Type of facility that the patient visited for treatment
	Date and time of report transmission from original source (from treating
Report Date/Time	facility)
Unique Patient Identifier	Unique identifier for the patient
Medical Record #	Patient medical record number
Age	Numeric value of patient age
	Unit corresponding to numeric value of patient age (e.g. Days, Month or
Age units	Years)
Gender	Gender of patient
City/Town	City/Town of patient residence
ZIP Code	Zip code of patient residence
State	State of patient residence
Country	Country of patient residence
Race	Race of patient
Ethnicity	Ethnicity of patient
Unique Visiting ID	Unique identifier for a patient visit
Visit Date / Time	Date/Time of patient presentation
Date of onset	Date that patient began having symptoms of condition being reported
Patient Class	Patient classification within facility
	Short description of the chief complaint or reason of patient's visit,
Chief Complaint / Reason for visit	recorded when seeking care
Triage Notes	Triage notes for the patient visit
	Diagnosis or injury code of patient condition (i.e., ICD-9-CM, ICD-10-CM,
Diagnosis / Injury Code	or SNOMED)
Clinical Impression	Clinical impression (free text) of the diagnosis
·	Qualifier for Diagnosis / Injury Code specifying type of diagnosis (i.e.,
Diagnosis Type	admitting, final, or working)
Discharge Disposition	Patient's anticipated location or status following ED/UC visit
Disposition Date / Time	Date and time of disposition
Initial Temperature	1st recorded temperature, including units
Initial Pulse Oximetry	1st recorded pulse oximetry value
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Department of Defense

Variable Name	Variable Description
	The postal zip code for the city located. For outside contiguous United
	States (OCONUS) location an APO/FPO (Military Post Office Zip Code) or
Patient ZIP Code	country zip code
	The Postal zip code for the city clinic is located. For OCONUS code is used
	to correspond to obtained from CHCS (Composite Health Care System). Zip
Clinic ZIP Code	code are indicative of OCONUS loc.
	Designates whether the appointment is CHCS, Ambulatory Data System
Appointment Prefix	(ADS), Clinical Integrated Workstation (CIW), CHCSII
	The appointment identifier number is a system generated unique app that
Appointment Identifier Number	system. The appointment combine to create a unique identifier
Appointment Standard Ambulatory	
Data Record (SADR) Status	Status of appointment record SADR extract. (Ready or Updated)
Appointment SADR Extract Date	Date the SADR was extracted
	Coded: appointment scheduled, walk-in, sick call, cancelled by provider,
Appointment Status Type	telephone consult, no-show, cancelled by facility, or canceled by patient
	Indicates the year of the most Current Procedural Terminology in ADM
CPT4 Version Year	(Ambulatory Data Module)
E&M code with Level "E"	Evaluation and Management appointment
CPT4 Codes with Diagnosis Flag	Field correlates CPT4 to diagnosis
Patient Age at Appointment	Age of patient at the day of the appointment. Age given in years
	Code that indicates circumstance under which patient leaves the facility.
	(Code: released without limitations, released with work/duty restrictions,
	sick at home/quarters, immediate referral, transferred to another facility,
	left without being seen, left against medical advice, admitted, continued
Disposition Code	stay, discharged home, or expired)
	Codes: Consultation requested, Referred to another provider,
Administrative Disposition Code	Convalescent leave, Medical Board, or Medical hold
	The Defense Medical Information identification number that identifies
Treatment DMIS ID	patient was treated
Gender	Code: Male or Female
Appointment (Encounter) Date	Date of the appointment
ICD-9 Version Year	Indicates the year of the most current ICD Code Table in ADM
ICD-9 Codes, Including Extenders	Four ICD-9 codes, 9 character level
Treatment MEPRS Code	Describes each work center
Patient Status	Code: inpatient or outpatient
Provider Specialty Code	Code that identifies the health providers medical specialty
End of Record Flag	End of record marker

Veterans Affairs

Variable Name	Variable Description
	Created by BioSense to provide a consistent definition of a visit regardless of
	how a visit is defined by a given hospital. Combines patient visits, if they occur
AnalysisVisitID	within 24 hours of each other.
	Uniquely distinguishes a patient across all visits to a single facility or across all
	visits to a healthcare system when a common patient identification system is
PatientID	used.
5 . 00.0	Date of Visit based on the visit date associated with this specific clinical data, for
DateofVisit	this specific AnalysisVisitID, in DATE format (mm/dd/yyyy).
Analysis Visit Data	Date and time of Visit based on the visit date associated with this specific
AnalysisVisitDate	clinical data, for this specific AnalysisVisitID
FacID	Unique facility identifier of the facility where the patient originally presented (original provider of the data)
ServicingFacility	Primary VA Local Facility ID
PatientCounty	Patient county
PatientZip	Patient Zip code
Patientzip	Indicates how quickly care is required. 30="Time to evaluation or treatment"
	not critical "; 20="Request Prompt Evaluation or Treatment" "10=Request
Acuity	Immediate Evaluation or Treatment"
Age	Numeric value for patient age
AgeUnit	Unit for numeric value (years, days, months)
BirthDate	Year and Month of patient birth
DeathDate	Date of death (mm/dd/yyyy)
Ethnicity	Patient ethnicity
Gender	Patient gender
Race	Patient race
	Numeric 1/0 indicator. Set to 1 if there is evidence of a hospital admission
Admit (1=Yes 0=No)	having taken place
AdmitDate	Date of admission of patient into hospital (mm/dd/yyyy)
DeathCode	Hospital death disposition code that was reported
DischargeDate	Date patient was discharged from hospital
	Most recent non-Admit/Death Hospital Discharge Disposition Code (admit,
Disposition	discharge, transfer, left, expiration)
BP	Max Blood Pressure associated with an AnalysisVisitID
MinBp	Min Blood Pressure associated with an AnalysisVisitID
Pulse	Max pulse oximetry associated with an AnalysisVisitID
MinPulse	Min pulse oximetry associated with an AnalysisVisitID
Temperature	Max temperature among recorded temperatures assoc w/ an AnalysisVisitID
MinTemperature	Min temperature among recorded temperatures assoc w/ an AnalysisVisitID
OnsetDate	Date the patient began having symptoms of condition
PatientClass	Emergency, outpatient, inpatient
ActivityCode	ICD-9-CM, ICD-19-CM, or SNOMED
Diagnosis / Injury Description OR	Text: description of activity code OR description of the reason the patient has
Chief Complaint/Reason for Visit	presented to the healthcare facility
Activity Status	Diagnosis type – admitting, working, final
Activity Type	Diagnosis/Injury Description, Chief Complaint, or Procedure

Laboratory

Variable Name	Variable Description
BioSense Patient ID	Uniquely distinguishes a patient across all visits to a single facility or across
	all visits to a healthcare system when a common patient identification
	system is used.
BioSense Visit ID	Used to uniquely distinguish a patient visit based on the healthcare facility
	account identifier. Created to reflect the visit as defined by the healthcare
5.1.1	facility.
Date of Birth	Patient date of birth (month/year)
Sex	Patient gender
Zip code	Patient or provider Zip code
State	Patient or provider state
Ethnic group	Patient ethnicity
Race	Patient race
Date into Point of Care/location	Date patient arrived at healthcare facility
Test Code/Name	Local codes or local text names used to describe a laboratory test
Reason for Test	ICD-9CM code
Specimen Type	Type of sample taken for testing
Order Date/time	Date and time test was ordered
Ordering Facility Name	Name of facility that ordered test
Ordering facility address	Address of facility that ordered test
Ordering Facility Phone Number	Phone number of facility that ordered test
Ordering provider address	Address of healthcare provider that ordered test
Diagnostic Service	Type of diagnostic Service (immunology, microbiology)
Performing laboratory	Lab within performing the service
Result Status	Final or pending
Report date/time Collection date	Date lab reports the result of the test
	Date sample was collected for test
Collection method	Method used to collect sample
Specimen site Accession date	From where on patient's body the sample came
	Date the sample was received
Accession ID	Unique ID number assigned to sample when it is received by the laboratory
Sequence number Ordered Test Code/Name	Number assigned to each lab order LOINC codes and Descriptive text
Resulted Test Code/Name	LOINC codes and Descriptive text LOINC or SNOMED codes and Descriptive text
Organism identified	Name of organism identified by a specific test
Method type	Ordered method for testing the specimen
Result other than organism	Result of a lab test that does not give the name of an organism
Result unit	Unit of measure for a lab test
Test interpretation	Interpretation of the lab test result
Susceptibility test interpretation	Antimicrobials to which a microorganism is susceptible
Result notes	Important issues regarding the results
References Range	Range of what is normal or range of results that can be seen with that test
Last Update Date	Most recently updated date
Analysis Visit ID	Unique ID assigned for each visit
Lab Result Key ID	Unique ID for each patient
Coding Sys	Order or Result coding system (LOINC, SNOMED, NULL flavor)
County Jys	Oracl of Result County System (Londo, SNOTVIED, NOLL Havor)

Pharmacy

Variable Name	Variable Description
RXNUMBER	Prescription number
QUANTITYDISPENSED	Total amount of medication dispensed
DAYSSUPPLY	Number of days worth of medication dispensed
PRODUCTNAME	Name of medication dispensed
GPICODE	Generic Product Identifier number for medication
GPITEXT	Generic Product Identifier name for medication
RXNORMCODE	RXNORM number for medication
Pharmacy UID	Unique ID for Retail Pharmacy
Pharmacy 5 digit zip	Pharmacy Zip code (5 digits)
AGE	Patient age
PATZIP3	Patient Zip code (3 digits)
PATSTATE	Patient State
PATCOUNTY	Patient County
RECORD UID	Record number
DATEOFSERVICE	Date RX Transaction at Pharmacy
PRESCRIBERIDQUALIFIER	Prescriber type
PRESCRIBERID	Unique ID number of prescribing healthcare provider
Insurance Type	Indicates Client type