Data Field	Section Name	Definition	Value Choices
Medical Record Number	Patient Demographics	Indicate institution's medical record number of the patient	n/a
Date of Birth	Patient Demographics	Indicate the patient's date of birth	n/a
Zip Code	Patient Demographics	Indicate the zip code where the patient resided at time of hospitalization	n/a
Race (select all applicable)	Patient Demographics	Indicate the race of the patient as determined by the patient	1. White/Caucasian 2. African American 3. Asian 4. American Indian/ Alaskan Native 5. Native Hawaiian / Pacific Islander 6. Hispanic/Latino/Spanish 7. Unknown 8. Chose not to disclose
Date patient first seen by gynecologic oncology site collecting this data	Cervical Cancer Screening	Indicate the date when the site first saw patient.	n/a
Is patient U.S. born?	Cervical Cancer Screening	Indicate whether the patient was born in the United States.	1. Yes 2. No 3. Unknown
Has patient seen a healthcare provider in the past 5 years?	Cervical Cancer Screening	Indicate whether the patient was seen by a healthcare provider. This can include an MD, NP or PA.	1. Yes 2. No
How many pregnancies has the patient had altogether?	Cervical Cancer Screening	Indicate the total number of pregnancies the patient has had. This includes all pregnancies including those ending in live birth, miscarriage, abortion, still birth, and ectopic pregnancies. If there were none, enter zero.	n/a
Date of most recent pregnancy	Cervical Cancer Screening	If patient has had pregnancy(ies), indicate the date of the most recent pregnancy.	n/a
Did a pregnancy delay disease management?	Cervical Cancer Screening	Indicate if a pregnancy delayed disease management.	1. Yes 2. No
Has patient had a PAP in the past 5 years?	Cervical Cancer Screening	Indicate if the patient has had a PAP in the past 5 years	1. Yes 2. No
Date of PAP Ten options will be A-J	Cervical Cancer Screening	Indicate the date(s) of the PAP test	n/a
Type of PAP Ten options will be A-J	Cervical Cancer Screening	Indicate the type of PAP; conventional or liquid-based.	1. STM/Glass slide 2. ThinPrep 3. SurePath
Name of Lab where test run	Cervical Cancer Screening	Provide the name of the lab where the test was processed	Free text

Data Field	Section Name	Definition	Value Choices
Image-based evaluation?	Cervical Cancer Screening	Using the Pap test results, indicate whether there was an image-based evaluation.	1. Yes 2. No 3. Not Indicated
Test Performed by	Cervical Cancer Screening	Indicate the specialty of the physician who performed the procedure.	1. Family Practice 2. Primary Care Physician 3. Gynecologist 4. Gyn/onc 5. Advanced Practice (APN, PA, NP) 6. Other (specify) _____
Satisfactory test result?	Cervical Cancer Screening	Using the Pap test results, indicate whether there was a satisfactory result.	1. Yes 2. No 3. Not Indicated
Endocervical/TZ component present?	Cervical Cancer Screening	Using the Pap test results, indicate whether there was a Endocervical/TZ component present.	1. Yes 2. No 3. Not Indicated
PAP result	Cervical Cancer Screening	Indicate the result of the PAP test	1. Normal (NILM) 2. ASC-US 3. LSIL 4. HSIL 5. AGC 6. AIS
Was patient referred to colposcopy?	Cervical Cancer Screening	Indicate if patient was referred for a colposcopy.	1. Yes 2. No 3. Not Indicated
Has patient had a colposcopy for an abnormal PAP test?	Cervical Cancer Screening	Indicate if the patient had a colposcopy for an abnormal PAP test.	1. Yes 2. No
Date of Colposcopy	Cervical Cancer Screening	Provide date of colposcopy	n/a
Date of PAP test to which it correlates	Cervical Cancer Screening	Indicate the date of abnomal PAP test to which the colposcopy applies.	n/a
Was colposcopy satisfactory?	Cervical Cancer Screening	Indicate if the colposcopy was satisfactory.	1. Yes 2. No 3. Not reported
Has patient had a HPV test in the past 5 years?	Cervical Cancer Screening	Indicate if the patient has had a HPV test in the past 5 years	1. Yes 2. No
Date of HPV	Cervical Cancer Screening	Indicate the date(s) of the HPV test	n/a
Type of HPV test	Cervical Cancer Screening	Indicate the type of HPV test	1. Qiagen 2. Cervista 3. Roche Cobas 4. Aptima 5. Laboratory Developed Test (LDT) 6. Not Specified
Name of Lab where test run	Cervical Cancer Screening	Provide the name of the lab where the test was processed	NOTE: this will be free text.

Data Field	Section Name	Definition	Value Choices
HPV test result	Cervical Cancer Screening	Indicate the result of the HPV test	1. Positive HR 2. Negative HR 3. Indeterminate 4. Not reported
HPV genotyping performed?	Cervical Cancer Screening	Indicate whether an HPV genotyping was done. Check all that apply.	1. HPV 16 2. HPV 18 3. HPV 45
Results of genotyping?	Cervical Cancer Screening	Indicate the results of the genotyping performed	1. Positive 2. Negative 3. Not Reported
Test Performed by	Cervical Cancer Screening	Indicate the specialty of the physician who performed the procedure.	1. Family Practice 2. Primary Care Physician 3. Gynecologist 4. Gyn/onc 5. Advanced Practice (APN, PA, NP) 6. Other (specify) _____
Was patient referred to colposcopy?	Cervical Cancer Screening	Indicate if patient was referred for a colposcopy.	1. Yes 2. No 3. Not Indicated
Has patient had a colposcopy for an abnormal HPV test?	Cervical Cancer Screening	Indicate if the patient had a colposcopy for an abnormal HPV test.	1. Yes 2. No
Date of Colposcopy	Cervical Cancer Screening	Provide date of colposcopy	n/a
Date of HPV test to which it correlates	Cervical Cancer Screening	Indicate the date of abnomal HPV test to which the colposcopy applies.	n/a
Was colposcopy satisfactory?	Cervical Cancer Screening	Indicate if the colposcopy was satisfactory.	1. Yes 2. No 3. Not reported
Has patient had other anogenital biopsies?	Cervical Cancer Screening	Indicate if patient has had other anogenital biopsies. Include all tests in past 5 years.	1. Yes 2. No
Select type of anogenital biopsy(ies) performed.	Cervical Cancer Screening	If yes selected to other anogenital biopsies, select all types that apply.	1. Endometrial 2. Anus 3. Vulva 4. Vagina
Endometrial: Biopsy results	Cervical Cancer Screening	Indicate the biopsy results if Endometrial Biopsy was selected.	1. Normal 2. AGUS 3. Hyperplasia without atypia 4. Hyperplasia with atypia 5. Cancer
Date of Endometrial Biopsy test	Cervical Cancer Screening	Indicate the date of test of the Endometrial Biopsy	n/a
Type of Physician	Cervical Cancer Screening	Indicate the specialty of the physician who performed the procedure.	1. Family Practice 2. Primary Care Physician 3. Gynecologist 4. Gyn/onc 5. Advanced Practice (APN, PA, NP) 6. Other (specify) _____

Data Field	Section Name	Definition	Value Choices
Type of Physician-other	Cervical Cancer Screening	Indicate the specialty of the physician who performed the biopsy, if other was selected.	n/a
Anus: Biopsy results	Cervical Cancer Screening	Indicate the biopsy results if Anus Biopsy was selected.	1. Normal 2. Dysplasia (mild, moderate, severe) 3. Cancer
Date of Anus Biopsy test	Cervical Cancer Screening	Indicate the date of test of the Anus Biopsy	n/a
Type of Physician	Cervical Cancer Screening	Indicate the specialty of the physician who performed the procedure.	1. Family Practice 2. Primary Care Physician 3. Gynecologist 4. Gyn/onc 5. Advanced Practice (APN, PA, NP) 6. Other (specify) _____
Type of Physician-other	Cervical Cancer Screening	Indicate the specialty of the physician who performed the biopsy, if other was selected.	n/a
Vulva: Biopsy results	Cervical Cancer Screening	Indicate the biopsy results if Vulva was selected.	1. Normal 2. VIN-1 3. VIN-2 4. VIN-3 5. Cancer
Date of Vulva Biopsy test	Cervical Cancer Screening	Indicate the date of test of the Vulva Biopsy	n/a
Type of Physician	Cervical Cancer Screening	Indicate the specialty of the physician who performed the procedure.	1. Family Practice 2. Primary Care Physician 3. Gynecologist 4. Gyn/onc 5. Advanced Practice (APN, PA, NP) 6. Other (specify) _____
Type of Physician-other	Cervical Cancer Screening	Indicate the specialty of the physician who performed the biopsy, if other was selected.	n/a
Vagina: Biopsy results	Cervical Cancer Screening	Indicate the biopsy results if Vagina Biopsy was selected.	1. Normal 2. AGUS 3. VAIN-1 4. VAIN-2 5. VAIN-3 6. Cancer
Date of Vagina Biopsy test	Cervical Cancer Screening	Indicate the date of test of the vagina biopsy	n/a
Type of Physician	Cervical Cancer Screening	Indicate the specialty of the physician who performed the procedure.	1. Family Practice 2. Primary Care Physician 3. Gynecologist 4. Gyn/onc 5. Advanced Practice (APN, PA, NP) 6. Other (specify) _____
Type of Physician-other	Cervical Cancer Screening	Indicate the specialty of the physician who performed the biopsy, if other was selected.	n/a
Has patient had a Cervical Biopsy(ies) in the past 5 years?	Cervical Cancer Screening	Indicate whether patient had a Cervical Biopsy in the past 5 years.	1. Yes 2. No

Data Field	Section Name	Definition	Value Choices
Date of Cervical Biopsy	Cervical Cancer Screening	Indicate date of Cervical Biopsy	n/a
Results of Cervical Biopsy	Cervical Cancer Screening	Provide results of Cervical Biopsy	1. CIN1 2. CIN2 3. CIN3 4. CGIN/Atypical glandular cells 5. LSIL 6. HSIL
Type of Physician	Cervical Cancer Screening	Indicate the specialty of the physician who performed the procedure.	1. Family Practice 2. Primary Care Physician 3. Gynecologist 4. Gyn/onc 5. Advanced Practice (APN, PA, NP) 6. Other (specify) _____
Type of Physician-other	Cervical Cancer Screening	Indicate the specialty of the physician who performed the biopsy, if other was selected.	n/a
Has patient had a Endocervical Curettage (ECC) in the past 5 years?	Cervical Cancer Screening	Indicate whether patient had a Endocervical Curettage (ECC) in the past 5 years.	1. Yes 2. No
Date of Endocervical Curettage (ECC)	Cervical Cancer Screening	Indicate date of Endocervical Curettage (ECC)	n/a
Results of Endocervical Curettage (ECC)	Cervical Cancer Screening	Provide results of Endocervical Curettage (ECC)	1. Normal 2. Inadequate 3. AIS 4. CGIN/Atypical glandular cells 5. Cancer
Type of Physician	Cervical Cancer Screening	Indicate the specialty of the physician who performed the procedure.	1. Family Practice 2. Primary Care Physician 3. Gynecologist 4. Gyn/onc 5. Advanced Practice (APN, PA, NP) 6. Other (specify) _____
Type of Physician-other	Cervical Cancer Screening	Indicate the specialty of the physician who performed the biopsy, if other was selected.	n/a
Has patient been treated for an abnormal PAP or cervical biopsy in the past 5 years?	Cervical Cancer Screening	Indicate if the patient has been treated for an abnormal PAP or cervical biopsy in the past 5 years.	1. Yes 2. No
Date of treatment for an abnormal PAP or cervical biopsy?	Cervical Cancer Screening	Indicate the date of each treatment for the past 5 years.	n/a
Type of treatment received	Cervical Cancer Screening	Indicate the type of treatment received for the abnormal PAP or cervical biopsy. This will include laser & cryo for ablation.	1. LEEP 2. Cold knife cone 3. CO2 Laser therapy 4. Cryo

Data Field	Section Name	Definition	Value Choices
Type of Physician	Cervical Cancer Screening	Indicate the specialty of the physician who performed the procedure.	1. Family Practice 2. Primary Care Physician 3. Gynecologist 4. Gyn/onc 5. Advanced Practice (APN, PA, NP) 6. Other (specify) _____
Type of Physician-other	Cervical Cancer Screening	Indicate the specialty of the physician who performed the biopsy, if other was selected.	n/a
Was the patient treated for an abnormal PAP or cervical biopsy greater than 5 years ago?	Cervical Cancer Screening	Indicate whether the patient treated for an abnormal PAP or cervical biopsy greater than 5 years ago?	1. Yes 2. No
Has patient taken any immunosuppressant medications within the past 5 years?	Cervical Cancer Screening	Indicate whether the patient took any immunosuppressant medications, for any reason, in the past 5 years. This can include steroids, SLE, RA, transplant medications, etc.	1. Yes 2. No
Has patient taken any anti-retovirals medications within the past 5 years?	Cervical Cancer Screening	Indicate whether patient has taken anti-retrovirals in the past 5 years.	1. Yes 2. No
Has patient experienced symptoms of cervical disease within the past 5 years?	Cervical Cancer Screening	Indicate if patient has had symptoms of cervical disease.	1. Yes 2. No
If yes to symptoms, please select all that apply.	Cervical Cancer Screening	Select all symtoms patient has had within past 5 years.	1. Abnormal bleeding 2. Bleeding after intercourse 3. Discharge 4. Pain 5. Urinary symptoms 6. Other
Hospital Admit Date	Hospitalization	Indicate the patient's initial date of admission	n/a
Hospital Discharge Date	Hospitalization	Indicate the patient's date of discharge	n/a
Height (cm)/(in)	Preoperative Risk Factors	Indicate the patient's height in centimeters or inches at time of admission	n/a
Weight (kg)/(lb)	Preoperative Risk Factors	Indicate the patient's weight in kilograms or pounds at time of admission	n/a
Body Mass Index (calculated field)	Preoperative Risk Factors	Indicate the patient's Body Mass Index (BMI) as calculated from the patient's weight and height. BMI is system generated based on the following calculation (Weight)/((Height/100)^2)	n/a
ASA Class	Preoperative Risk Factors	Indicate the ASA Class (time of surgery). Adopted by the American Society of Anesthesiologists in 1963, the ASA physical status classification system is a system for assessing the fitness of cases before surgery. Class 1 - healthy person Class 2 - mild systemic disease Class 3 - severe systemic disease Class 4 - severe systemic disease that is a constant threat to life.	1. Class 1 2. Class 2 3. Class 3 4. Class 4

Data Field	Section Name	Definition	Value Choices
Diabetes	Preoperative Risk Factors	Indicate whether the patient has a history of diabetes as defined by the American Diabetes Association: 1. A1c >=6.5%; or 2. Fasting plasma glucose >=126 mg/dl (7.0 mmol/l); or 3. Two-hour plasma glucose >=200 mg/dl (11.1 mmol/l) during an oral glucose tolerance test; or 4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose >=200 mg/dl (11.1 mmol/l)	1. Yes 2. No
Diabetes Medication	Preoperative Risk Factors	Indicate type of diabetes medication used prior to admission.None: diabetes controlled by diet alone. Insulin: a diagnosis of diabetes requiring daily insulin therapy.Oral Hypoglycemic: a diagnosis of diabetes requiring therapy with an oral hypoglycemic agent.	1. None 2. Insulin 3. Oral Hypoglycemic
Current Smoker	Preoperative Risk Factors	Indicate whether patient has smoked cigarettes within the past year prior to admission. Patients who smoke cigars or pipes or use chewing tobacco are not included.	1. Yes 2. No
Prior Abdominal Surgery	Preoperative Risk Factors	Has patient had any prior abdominal surgery?	1. Yes 2. No
If Yes to Prior Abdominal Surgery, Year?			n/a

Data Field	Section Name	Definition	Value Choices
History of Conditions/Previous Interventions (Select all applicable)	Preoperative Risk Factors	Indicate all disorders or conditions that apply based on the patient's history	1. Cardiac Surgery (includes stent,CABG,Valve,Pacemaker,Other Cardiac Surgery (hover over definition) 2. Creatinine level >1.5 (hover over definition) 3. Steroid Use (Use of oral/perenteral steroids for >10 days in prior 30 days) (hover over definition) 4. Pulmonary (drop down) a. COPD, b. Pulmonary HTN, c. Other 5. Heme (drop down) a. DVT/PE (within 90 days) b. Transfusion c. Other 6. Neuro (drop down) a. Stroke b. Other 7. Endocrine (drop down) a. Thyroid - Hyper b. Thyroid - Hypo 8. Cardiac Conditions (drop down) a. Afib/Arrhythmia b. Angina (within 30 days) c. CHF (within 30 days) d. HTN e. MI (within 6 months) f. Other
Presurgical Radiotherapy			
Neoadjuvant Therapy	Preoperative Laboratory Data and Medications	Indicate whether the patient received neoadjuvant therapy prior to this procedure	1. Yes 2. No
Neoadjuvant Therapy Start Date	Preoperative Laboratory Data and Medications	Indicate the start date of neoadjuvant therapy	n/a
Which neoadjuvant chemotherapy drugs were used?	Preoperative Laboratory Data and Medications	List which drugs were used for the neoadjuvant therapy.	Free text
Neoadjuvant Therapy Cycles	Preoperative Laboratory Data and Medications	Indicate the number of cycles of neoadjuvant therapy	
Did Patient ultimately undergo surgery?		Indicate if patient had surgery following neoadjuvant therapy.	

Data Field	Section Name	Definition	Value Choices
Histology (*select all that apply*)	Histology	Indicate the type of histology performed during surgical pathology. 1. Squamous Cell Carcinoma 2. Adenocarcinoma 3. Adenosquamos 4. Glassy Cell 5. Neuroendocrine 6. Clear Cell 7. Other	1. Squamous Cell Carcinoma 2. Adenocarcinoma 3. Adenosquamos 4. Glassy Cell 5. Neuroendocrine 6. Clear Cell 7. Other
Histology - Other	Histology	Indicate the type of histology performed during surgical pathology if Other was selected	n/a
Largest Primary Tumor Diameter (cm)	Histology	Indicate the diameter in centimeters of the largest primary tumor. A primary tumor is a tumor growing at the anatomical site where tumor progression began and proceeded to yield a cancerous mass.	n/a
Lymphovascular Space Invasion	Histology	Lymphovascular space invasion (LVSI) is defined as the presence of tumor cells inside the capillary lumens of either the lymphatic or the microvascular drainage system within the primary tumor.	1. Yes 2. No 3. Unknown
FIGO Stage (select one)	Surgical Pathology	Indicate FIGO staging: **Stage I**: Cancer confined to the cervix IA Microscopic cancer depth ≤5 mm and extension ≤7 mm IA1 Stromal invasion ≤3 mm and extension ≤7 mm IA2 Stromal invasion >3 mm and ≤5 mm with extension ≤7 mm IB Cancer confined to the cervix clinically visible or exceeds the dimensions for IA IB1 ≤4 cm in greatest diameter IB2 >4 cm in greatest diameter **Stage II:** Cancer extends beyond cervix but not to pelvic wall or lower third of vagina IIA Without parametrial invasion IIA1 ≤4 cm in greatest diameter IIA2 >4 cm in greatest diameter IIB With parametrial invasion **Stage III:** Cancer extends to pelvic wall and/or involves lower third of vagina and/or causes hydronephrosis or non-functioning kidney IIIA Tumor involves lower third of vagina, no extension to pelvic wall IIIB Extension to pelvic wall and/or hydronephrosis or non-functioning kidney **Stage IV:** Cancer extends beyond true pelvis or has involved (biopsy proven) mucosa of bladder or rectum IVA Cancer spread to adjacent organs IVB Cancer spread to distant organs Note: Lymph vascular space invasion (LVSI) is not part of the staging, but should be reported.	1. IA 2. IA1 3. IA2 4. IB 5. IB1 6. IB2 7. IIA 8. IIA1 9. IIA2 10. IIB 11. IIIA 12. IIIB 13. IVA 14. IVB 15. Recurrent

Data Field	Section Name	Definition	Value Choices
Pelvic Lymphadenectomy	Surgical Pathology	Indicate if a pelvic lymphadenectomy was performed on the patient to remove lymph nodes in the pelvis for microscopic examination.	1. Yes 2. No
Number of Right Nodes Removed	Surgical Pathology	Indicate the number of right nodes removed during the pelvic lymphadenectomy	n/a
Number of Right Nodes Positive	Surgical Pathology	Indicate the number of right nodes which tested positive during the pelvic lymphadenectomy	n/a
Number of Left Nodes Removed	Surgical Pathology	Indicate the number of left nodes removed during the pelvic lymphadenectomy	n/a
Number of Left Nodes Positive	Surgical Pathology	Indicate the number of left nodes which tested positive during the pelvic lymphadenectomy	n/a
Total Removed	Surgical Pathology	calculated field= Number of Right Nodes + Number of Left Nodes Removed	
Total Positive	Surgical Pathology	calculated field Number of Right Nodes + Number of Left Nodes Positive	
Paraaortic Lymphadenectomy	Surgical Pathology	Indicate if a Paraaortic Lymphadenectomy was performed on the patient	1. Yes 2. No
Total Removed	Surgical Pathology	Indicate the total number of nodes removed during the paraaortic lymphadenectomy	n/a
Total Positive	Surgical Pathology	Indicate the total number of nodes which tested positive during the paraaortic lymphadenectomy	n/a
Sentinel Lymph Node	Surgical Pathology		1. Yes 2. No
Sentinel Lymph Node - Positive	Surgical Pathology	If yes to Sentinel Lymph Node, is it positive?	1. Yes 2. No
If SLN positive, was Ultra Staging Performed	Surgical Pathology	needs definition	1. Yes 2. No
If yes to Ultra Staging Performed, was H & E positive	Surgical Pathology	needs definition	1. Yes 2. No
If yes to Ultra Staging Performed, was Microstaged positive	Surgical Pathology	needs definition	1. Yes 2. No
If yes to Ultra Staging Performed, was Isolated (ITC) positive	Surgical Pathology	needs definition	1. Yes 2. No
If yes to Ultra Staging Performed, Micromets positive	Surgical Pathology	needs definition	1. Yes 2. No
If yes to Ultra Staging Performed, was Macromets positive	Surgical Pathology	needs definition	1. Yes 2. No
Was chemosensitivity assay ordered?	Surgical Pathology	Indicate whether or not a chemosensitivity assay was ordered.	1. Yes 2. No
National Provider Identifier	Surgery	Indicate the unique 10-digit identification number (NPI) issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS) for the surgeon performing the procedure	n/a

Data Field	Section Name	Definition	Value Choices
Date of Surgery	Surgery	Indicate the date the surgery begins	
Surgeon Specialty			1. Gynecologic Oncology 2. Obstetrics and Gynecology 3. General Surgery 4. Other
Surgeon Specialty - Other	Surgery	Indicate the specialty of the physician who performed the procedure, if other was selected.	n/a
Surgical Approach	Surgery	Indicate the surgical approach used for the procedure	1. Laparotomy 2. Conventional Laparoscopy 3. Robotic assisted
Did patient convert to Laparotomy	Surgery	needs definition	1. Yes 2. No
If yes to patient convert to Laparotomy	Surgery	definitions/explanation	1. Large BMI 2. Large Uterus 3. Extension adhesion 4. Anesthsia or insufflation related problems 5. Other, _____(free text?)
Extent of Cancer (if Stage IV) (select all applicable)	Surgery	Indicate the location(s) of cancer found during surgery if Stage IV. Check all that apply.	1. N/A 2. Diaphragm 3. Below Pelvic Brim 4. Spleen 5. Liver 6. Lung 7. Small Bowel Serosa/Mensentery 8. Carcinomatosis (>50% of all peritoneal surfaces involved by tumor) 9. Other
Previous hysterectomy	Surgery	needs definition	1. Yes 2. No
If yes, date	surgery	Indicate year of hysterectomy if known.	
Operation (user selects one)	Surgery	Indicate the operation performed by the surgeon	1. Hysterectomy Type I (extrafascial) 2.Hysterectomy Type II (modified radical) 3. Hysterectomy Type III (radical) 4. Extenteration (Total/Anterior/Posterior) 5. Cold Knife Cone/LEEP 6. Radical Trachelectomy 7. Biopsy only 8. Other _____
Uterine weight	Surgery	Indicate uterine weight, in grams, if Hysterectomy Types I, II, or III were selected.	
Operative Note Completed/Present (within 48 hours of operation)	Surgery	Indicate if an operative note was completed or present in the patient's record	1. Yes 2. No
Operative Note Completed/Present (within 48 hours of operation) - Radical Surgery Details (select all that apply)	Surgery	If patient undergoes radical surgery, Select: Positive Lymph Nodes Positive Parametria Positive Vaginal Margin	1. Positive lymph nodes 2. Positive parametria 3. Positive vaginal margin
Estimated Blood Loss	Surgery	Indicate estimated blood loss (ml)	

Data Field	Section Name	Definition	Value Choices
OR Entry Time	Surgery	Indicate the time, to the nearest minute (using 24-hour clock), that the patient entered the operating room.	
Skin Incision Start Time	Surgery	Indicate the time, to the nearest minute (using 24-hour clock), that the first skin incision was made.	
Skin Incision Stop Time	Surgery	Indicate the time, to the nearest minute (using 24-hour clock), that the first skin incision, was closed.	
OR Exit Time	Surgery	Indicate the time, to the nearest minute (using 24-hour clock), that the patient exited the operating room.	
Total OR Time	Surgery	Calculated field of the total time patient was in the OR: OR entry to exit time.	
Total Skin Incision time	surgery	Calculated field of the total skin incision time: skin incision start time to skin incision stop time.	
Patient Medical Record Number	Postoperative Complications Within 30 days	Provide the institutional medical record number for the patient	
Patient Date of Birth	Postoperative Complications Within 30 days	Enter patient date of birth	
Patient Zip Code	Postoperative Complications Within 30 days	Indicate the zip code where the patient resided at time of operation	
Postoperative Complication	Postoperative Complications Within 30 Days	Indicate whether the patient had any postoperative complications within 30 days that fall into Grade 2, Grade 3 or Grade 4 categories listed below. Classifications based on the Accordian classification published by Strasberg in Annals of Surgery. Check all that apply in each Grade.	1. Yes 2. No
Date of Occurrence	Postoperative Complications Within 30 Days	Indicate the date of occurrence of the postoperative complication	n/a
Unplanned ICU transfer or admission	Postoperative Complications Within 30 Days	Indicate whether there was an ICU transfer or admission within 30 days of surgery date.	1. Yes 2. No
Grade 2 Complication	Postoperative Complications Within 30 Days	Indicate if the patient had a grade 2 complication	1. Yes 2. No
Grade 2 Complication - Details (select all applicable)	Postoperative Complications Within 30 Days	Indicate which grade 2complications occurred if yes was selected . Check all that apply.	1. Wound Infection requiring antibiotics 2. UTI 3. Pneumonia 4. Other condition requiring antibiotics 5. Blood transfusion 6. Total Parenteral Nutrition 7. DVT 8. PE 9. Lymphatic
Grade 3 Complication	Postoperative Complications Within 30 Days	Indicate if the patient had a grade 3 complication	1. Yes 2. No

Data Field	Section Name	Definition	Value Choices
Grade 3 Complication - Categories	Postoperative Complications Within 30 Days	Indicate which grade 3 complications occurred if yes was selected.	1. Return to OR 2. Endoscopic Procedures 3. Interventional Radiology 4. Organ Failure
Return to OR - Details (select all applicable)	Postoperative Complications Within 30 Days	Indicate OR details if return to OR was selected	1. Bowel Perforation or Obstruction 2. Abdominal Abscess 4. Wound Disruption 5. Bleeding 6. Fistula 7. Cuff Dehiscence 8. Other _____
Return to OR - Details - Other	Postoperative Complications Within 30 Days	Indicate OR details if other was selected	n/a
Endoscopic - Details (select all applicable)	Postoperative Complications Within 30 Days	Indicate Endoscopic details if Endoscopic was selected	1. PEG 2. Colonoscopy 3. Laparoscopy 4. Upper Endoscopy 5. Other _____
Endoscopic - Details - Other	Postoperative Complications Within 30 Days	Indicate Endoscopic details if other was selected	n/a
Interventional Radiology- Details (select all applicable)	Postoperative Complications Within 30 Days	Indicate Interventional Radiology details if Interventional Radiology was selected	1. Ureteral Stent Placement 2. Colonic Stent Placement 3. Other _____
Interventional Radiology - Details - Other	Postoperative Complications Within 30 Days	Indicate Interventional Radiology details if other was selected	n/a
Organ Failure - Details (select all applicable)	Postoperative Complications Within 30 Days	Indicate Organ Failure details if Organ Failure was selected	1. Cardiac 2. GI/Hepatic 3. CNS 4. Renal 5. Hematologic 6. Respiratory
Grade 4 Complication Postoperative Complication-Related Death	Postoperative Complications Within 30 Days	Indicate whether or not the patient died from a postop complication	1. Yes 2. No
Grade 4 Complication Postoperative Complication-Related Death - Date	Postoperative Complications Within 30 Days	If yes to Postop Death, enter date	

Data Field	Section Name	Definition	Value Choices
Medical Record Number	Follow Up Care and Surveillance	Indicate the institutional medical record number of the patient	Provide the institutional medical record number for the patient
Date of Birth	Follow Up Care and Surveillance	Indicate the patient's date of birth	n/a
Zip Code	Follow Up Care and Surveillance	Indicate the patient's zip code	n/a
Race (select all applicable)	Follow Up Care and Surveillance	Indicate the race of the patient as determined by the patient	1. White/Caucasian 2. African American 3. Asian 4. American Indian/ Alaskan Native 5. Native Hawaiian / Pacific Islander 6. Hispanic/Latino/Spanish 7. Unknown 8. Chose not to disclose
National Provider Identifier	Follow Up Care and Surveillance	Indicate the unique 10-digit identification number (NPI) issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS) for the provider who performed the procedure	n/a
Date of Service	Follow Up Care and Surveillance	Indicate the date the service was performed	n/a
Provider Specialty	Follow Up Care and Surveillance	Indicate the provider's specialty	1. Gynecologic Oncology 2. Obstetrics and Gynecology 3. Other _____
Provider Specialty - Other	Follow Up Care and Surveillance	Indicate the specialty of the provider who performed the procedure, if other was selected.	n/a
Patient follow-up care provided elsewhere	Follow Up Care and Surveillance	Indicate whether follow-up care was provided elsewhere & whether the information on therapy is known. If therapy data is known, complete that information.	1. Data unavailable 2. Data provided (complete below)
Patient declined follow up care	Follow Up Care & Surveillance		check if Yes
Not part of care plan	Follow Up Care & Surveillance		check if Yes
Follow Up Visit Only	Follow Up Care & Surveillance	Indicate if this is for a follow up visit only. Patient will not have any type of thereapy, just surveillance.	1. Yes 2. No
Clinical Trial Offered	Follow Up Care & Surveillance		1. Yes 2. No 3. unavailable
Primary Therapy	Follow Up Care & Surveillance	Indicate if this is primary therapy for the patient	1. Yes 2. No
Recurrence/Progression Therapy	Follow Up Care & Surveillance	Indicate if this is therapy for recurrence	1. Yes 2. No

Data Field	Section Name	Definition	Value Choices
Recurrence Date	Follow Up Care & Surveillance	Date of diagnosed recurrence	
Number of days since recurrence Calculated field	Follow Up Care & Surveillance	This is a caluculated field for the number of days from the date of surgery until the recurrence was diagnosed.	calculated
Recurrence Site	Follow Up Care & Surveillance	Indicate site of recurrence	1. Vaginal 2. Pelvic 3. Abdominal 4. Distant (outside abdomen)
Chemotherapy Given	Follow Up Care & Surveillance	Indicate if chemotherapy was provided	1. Yes 2. No
Cisplatin	Follow Up Care & Surveillance	Agent given	
Cisplatin # Cycles	Follow Up Care & Surveillance	# Cycles	
Carboplatin	Follow Up Care & Surveillance	Agent given	n/a
Carboplatin # Cycles	Follow Up Care & Surveillance	# Cycles	n/a
Docetaxel (taxotere)	Follow Up Care & Surveillance	Agent given	n/a
Docetaxel (taxotere) # Cycles	Follow Up Care & Surveillance	# Cycles	n/a
Paclitaxel	Follow Up Care & Surveillance	Agent given	n/a
Paclitaxel # Cycles	Follow Up Care & Surveillance	# Cycles	n/a
Topotecan	Follow Up Care & Surveillance	Agent given	n/a
Topotecan # Cycles	Follow Up Care & Surveillance	# Cycles	n/a
Bevacizumab	Follow Up Care & Surveillance	Agent given	n/a

Data Field	Section Name	Definition	Value Choices
Bevacizumab # Cycles	Follow Up Care & Surveillance	# Cycles	n/a
Gemcitabine	Follow Up Care & Surveillance	Agent given	n/a
Gemcitabine # Cycles	Follow Up Care & Surveillance	# Cycles	n/a
Ifosfamide	Follow Up Care & Surveillance	Agent given	n/a
Ifosfamide # Cycles	Follow Up Care & Surveillance	# Cycles	n/a
Other Agent	Follow Up Care & Surveillance	Agent given	Specify Agent _____
Other Agent # Cycles	Follow Up Care & Surveillance	# Cycles	
Was a chemosensitivity assay consulted during treatment?	Follow Up Care & Surveillance	Indicate if a chemosensitivity assay was consulted during treatment.	1. Yes 2. No
Chemosensitivity Patient Report Accession Number	Follow Up Care & Surveillance	If yes to chemsensitivity assay consulted (line 76), enter the chemosensitivity patient report accession number.	
Vaginal Brachytherapy	Follow Up Care & Surveillance	Indicate if vaginal brachytherapy was given	1. Yes 2. No
Number of Treatments	Follow Up Care & Surveillance	Indicate number of treatments if yes was selected	n/a
Total Dose	Follow Up Care & Surveillance	Indicate total dose if yes was selected	n/a
External Beam Radiation Pelvis	Follow Up Care & Surveillance	Indicate if External Beam Radiation was given	1. Yes 2. No
Total Treatment Time (number of days)	Follow Up Care & Surveillance	Indicate the total treatment time in number of days	n/a
Total Dose	Follow Up Care & Surveillance	Indicate total dose if yes was selected	n/a
Para-aortic Radiation	Follow Up Care & Surveillance	Indicate if Para-aortic Radiation was given	1. Yes 2. No
Number of Treatments	Follow Up Care & Surveillance	Indicate number of treatments if yes was selected	n/a
Total Dose	Follow Up Care & Surveillance	Indicate total dose if yes was selected	n/a
Follow Up Care-Related Death	Follow Up Care & Surveillance	Indicate whether the patient had a follow up care-related death	1. Yes 2. No
Date of Death	Follow Up Care & Surveillance	Indicate the patient's date of death	n/a