UK Childhood Cancer Study

Study ID

Region		Case No.				
D	I	2	0	0	0	0

Person ID

0	0	0

GP Abstractions : Instructions

All information contained in the GP notes must be noted including details from medical correspondence relating to hospital attendances.

Complete for mother/father/index child -   record of events
                                             validation sheet
                                             hospital details
Complete vaccination sheet for index child only.

EXCLUSIONS **Apply to mother/father only.**

Do not record the following.

Oct 93   - antenatal visits for pregnancies other than the index. Do not record these attendances if only vitamin and iron have
                  been prescribed. **All visits for the index pregnancy should be recorded.**
                - **normal** smears/cervical smears
                - date recorded and nil written
                - hearing and eye tests
                - medicals - insurance, occupation
                - chiropody visits
                - verruccas
                - cancellations/DNA
                - routine postnatal visits
                - minor injuries (eg scalds, sprains) with no treatment. (strapping/ bandage = no treatment)
                - back/limb pain with no treatment
                - return visit for 'sick notes' (Cf)

DATE OF EVENT

Enter the first date noted within the specified time period. Then continue to record each GP/hospital visit with drug details in the appropriate headed column, aggregating repeat visits for the same condition and aggregating repeated drug prescriptions.

EVENT CODE

For the specified time period record all dated events with appropriate 'Event Code' as detailed at the foot of the Record of Events page. If the reason for the visit to the GP is not covered by the range of codes please code as 'other' and describe in the column headed 'event'.

AGGREGATED EVENTS

This enables the recording of multiple attendances for the same condition or repeated prescriptions of the same drug.In any single horizontal section information coded into the 'Type Code' box is related to the information in the 'Event/drug' box. For example - a single visit to the GP with a chest infection where an antibiotic was prescribed will be recorded with the date and coded in a single section.

In any situation where the 'Type codes' do not correspond to the dates in the aggregated events box, additional sections will have to be completed. For example: repeated visits for chest infections can be aggregated with first and last dates in a single section but if different antibiotics are prescribed additional sections will have to be completed with the appropriate drug code and date prescribed.

NB Date of event = 1st date for aggregated events.

CODING

X-RAYS   - code with numbers used in the interview questionnaire for x-ray exposures, these differ for parents and child

ICD   - code from ICD10

BNF   - use BNF as described in the coding manual

ABBREVIATIONS

A list of common abbreviations is found in **Appendix 5 of the Procedures Manual.**