

**Nova Scotia Atlee  
Perinatal Database  
Coding Manual  
7th Edition**

**(REVISED)**

**Reprinted  
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“LEFT BLANK INTENTIONALLY”

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LISTING OF HOSPITALS

*Hospitals appearing in bold are currently providing maternity services.*

<b>Aberdeen Hospital</b> .....	11	...	New Glasgow
All Saints Hospital .....	12	...	Springhill
Annapolis Community Health Centre .....	13	...	Annapolis Royal
Bayview Memorial Health Centre .....	58	...	Advocate Harbour
Buchanan Memorial Hospital .....	15	...	Neil's Harbour
<b>Cape Breton Healthcare Complex:</b>			
<b>Glace Bay Site</b> .....	75	...	Glace Bay
<b>Northside (North Sydney Site)</b> .....	41	...	North Sydney
<b>Sydney Site</b> .....	73	...	Sydney
CFB Cornwallis .....	79	...	Cornwallis
CFB Stadacona .....	78	...	Halifax
Chaleur Regional Hospital .....	-10	..	New Brunswick
<b>Colchester Regional Hospital</b> .....	18	...	Truro
Dartmouth General Hospital .....	65	...	Dartmouth
Digby General Hospital .....	20	...	Digby
Eastern Memorial Hospital .....	22	...	Canso
Eastern Shore Memorial Hospital .....	23	...	Sheet Harbour
Fishermen's Memorial Hospital .....	24	...	Lunenburg
George Dumont Hospital .....	-11	..	New Brunswick
<b>Glace Bay Health Care Corporation</b> .....	<b>( See Cape Breton Healthcare Complex)</b>		
Guysborough Memorial Hospital .....	27	...	Guysborough
Hants Community Hospital .....	37	...	Windsor
<b>Health Services Assoc. of the South Shore</b> .....	14	...	Bridgewater
<b>Highland View Regional Hospital</b> .....	30	...	Amherst
Home of the Guardian Angel .....	88	...	Halifax
(Use for discharged to only if Mom and Babe both go to the Home)			
<b>Inverness Consolidated Memorial Hospital.</b> .....	34	...	Inverness
<b>IWK Grace Health Centre</b> .....	86	...	Halifax
Lillian Fraser Memorial Hospital .....	32	...	Tatamagouche
MABLE .....	90	...	Mable Discharge
Moncton Hospital(The) .....	-12	..	New Brunswick
Musquodoboit Valley Memorial Hospital .....	33	...	Middle Musquodoboit



**LISTING OF HOSPITALS**

New Waterford Consolidated Hospital .....	63	..	New Waterford
North Cumberland Memorial Hospital .....	35	..	Pugwash
<b>Northside Harbour View Hospital .....</b>	<b>(See Cape Breton Healthcare Complex)</b>		
Nova Scotia Hospital .....	77	..	Dartmouth
Point Pleasant Lodge .....	64	..	Halifax
Prince County Hospital .....	-13	..	Prince Edward Island
Queen Elizabeth Hospital .....	-14	..	Prince Edward Island
Queen Elizabeth II Health Sciences Centre .....	85	..	Halifax
<b>Queens General Hospital .....</b>	<b>38</b>	..	<b>Liverpool</b>
Roseway Hospital .....	39	..	Shelburne
Sacred Heart Hospital .....	47	..	Cheticamp
Sackville Memorial Hospital .....	-15	..	New Brunswick
<b>Soldiers Memorial Hospital .....</b>	<b>48</b>	..	<b>Middleton</b>
South Cumberland Community Care Centre .....	49	..	Parrsboro
St. Anne's Hospital .....	40	..	Arichat
<b>St. Martha's Regional Hospital .....</b>	<b>43</b>	..	<b>Antigonish</b>
St. Mary's Memorial Hospital .....	45	..	Sherbrooke
Strait Richmond Hospital .....	68	..	Cleveland
Sutherland-Harris Memorial Hospital .....	50	..	Pictou
Twin Oaks Memorial Hospital .....	52	..	Musquodoboit Harbour
<b>Valley Regional Hospital .....</b>	<b>67</b>	..	<b>Kentville</b>
Victoria County Memorial Hospital .....	53	..	Baddeck
Western Kings Memorial Health Centre .....	55	..	Berwick
<b>Western Regional Health Centre .....</b>	<b>56</b>	..	<b>Yarmouth</b>
Hospitals in Alberta .....	-16	..	Alberta
Hospitals in British Columbia .....	-17	..	British Columbia
Hospitals in Manitoba .....	-18	..	Manitoba
Hospitals in Newfoundland .....	-19	..	Newfoundland
Hospitals in New Brunswick (other than those above) .....	-20	..	New Brunswick
Hospitals in Northwest Territories .....	-21	..	Northwest Territories
Hospitals in Ontario .....	-22	..	Ontario
Hospitals in PEI (other than those above) .....	-23	..	Prince Edward Island
Hospitals in Quebec .....	-24	..	Quebec
Hospitals in Saskatchewan .....	-25	..	Saskatchewan
Hospitals in United States .....	-26	..	United States

**ROUTINE INFORMATION - DELIVERED ADMISSIONS**

**DELIVERED ADMISSIONS:**

Any admission of a pregnant women resulting in the delivery of a fetus greater than or equal to 20 completed weeks gestation or a birth weight greater than or equal to 500 grams, or both.

**MOTHER'S UNIT NUMBER** . . . . . Mother's hospital unit number.

Found on the health record folder or the  
'*HOSPITAL ADMISSION FORM*'.

**CONTACT HOSPITAL** . . . . . Hospital in which the chart is being coded.  
*When the hospital number is associated with a  
coder user name, this field will be auto-filled.*

Found on the '*HOSPITAL ADMISSION FORM*'

Code using one of the standard 2 digit provincial  
codes for hospitals found on pages 1-2.

**MOTHER'S ADMISSION DATE** . . . . . Mother's admission date to hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'

**MOTHER'S ADMISSION TIME** . . . . . Mother's admission time to hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'

"HH" is in range 0-23, "MM" is in range 0-59

**GIVEN NAME(S)** . . . . . Mother's given name(s).

Found on the '*HOSPITAL ADMISSION FORM*'.

**SURNAME** . . . . . Mother's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

**PREVIOUS SURNAME** . . . . . Mother's maiden name or other previous surname.

Found on the '*HOSPITAL ADMISSION FORM*'

Mother's maiden name or other previous surname.  
*This field can be left blank if not documented.*

**MOTHER'S A/S/D NUMBER** . . . . . Hospital number referring to the mother's present admission.

Found on the mother's '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'XXYYYYYY'  
where "XX" denotes the year (April 1 to March 31),  
changing on April 1st of each year, and "YYYYYY"  
is an ascension number related to the number of  
admissions of the year.

*Zeroes before the ascension number must be  
entered if number does not have 5 digits, e.g.  
00123.*

Code '9999999' for other provincial account  
numbers, or when unknown.

**MATERNAL HEALTH** ..... Mother's health card number.  
**CARD NUMBER**

Found on the '*HOSPITAL ADMISSION FORM*'.

*Record Nova Scotia Health Card Numbers only.*

Code using one of the following if HCN is unavailable:

- 0 ..... N.S. patient, lost card
- 0 ..... Armed Forces
- 0 ..... RCMP
- 0 ..... First Nations
- 0 ..... Self-paying
- 1 ..... Patient from outside N.S.

**MOTHER'S BIRTH DATE** ..... Mother's date of birth.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'

**MUNICIPAL CODE FOR** ..... Mother's municipal code.  
**MOTHER'S RESIDENCE**

Found on the '*HOSPITAL ADMISSION FORM*'.  
Code using one of the following:

**ANNAPOLIS COUNTY**

- 12 ..... Annapolis Municipality
- 13 ..... Annapolis Royal
- 19 ..... Bridgetown
- 49 ..... Middleton

**ANTIGONISH COUNTY**

- 14 ..... Antigonish Municipality
- 15 ..... Town of Antigonish

**CAPE BRETON COUNTY**

- 22 ..... Cape Breton Municipality
- 31 ..... Dominion
- 32 ..... Glace Bay
- 45 ..... Louisbourg
- 52 ..... New Waterford
- 53 ..... North Sydney
- 67 ..... Sydney
- 68 ..... Sydney Mines

**COLCHESTER COUNTY**

- 26 ..... Colchester Municipality
- 65 ..... Stewiacke
- 70 ..... Truro

**CUMBERLAND COUNTY**

- 11 ..... Amherst
- 27 ..... Cumberland Municipality
- 54 ..... Oxford
- 55 ..... Parrsboro
- 63 ..... Springhill

**DIGBY COUNTY**

- 24 ..... Clare Municipality
- 29 ..... Digby Municipality
- 30 ..... Town of Digby

**MUNICIPAL CODE FOR  
MOTHER'S RESIDENCE**

GUYSBOROUGH COUNTY

- 21 ..... Canso
- 33 ..... Guysborough Municipality
- 50 ..... Mulgrave
- 66 ..... St. Mary's Municipality

HALIFAX COUNTY

- 77 ..... Bedford
- 28 ..... Dartmouth City
- 34 ..... Halifax City
- 35 ..... Halifax Municipality

HANTS COUNTY

- 38 ..... Hantsport
- 36 ..... East Hants Municipality
- 37 ..... West Hants Municipality
- 73 ..... Windsor

INVERNESS COUNTY

- 39 ..... Inverness Municipality
- 58 ..... Port Hawkesbury

KINGS COUNTY

- 18 ..... Berwick
- 41 ..... Kentville
- 42 ..... Kings Municipality
- 74 ..... Wolfville

LUNENBURG COUNTY

- 20 ..... Bridgewater
- 23 ..... Chester Municipality
- 46 ..... Lunenburg Municipality
- 47 ..... Lunenburg Town
- 48 ..... Mahone Bay

PICTOU COUNTY

- 51 ..... New Glasgow
- 56 ..... Pictou Municipality
- 57 ..... Pictou Town
- 64 ..... Stellarton
- 69 ..... Trenton
- 72 ..... Westville

MUNICIPAL CODE FOR  
MOTHER'S RESIDENCE

QUEENS COUNTY

- 43 . . . . . Liverpool
- 59 . . . . . Queens Municipality

RICHMOND COUNTY

- 60 . . . . . Richmond Municipality

SHELBURNE COUNTY

- 17 . . . . . Barrington Municipality
- 25 . . . . . Clark's Harbour
- 44 . . . . . Lockeport
- 61 . . . . . Shelburne Municipality
- 62 . . . . . Shelburne Town

VICTORIA COUNTY

- 71 . . . . . Victoria Municipality

YARMOUTH COUNTY

- 16 . . . . . Argyle Municipality
- 75 . . . . . Yarmouth Municipality
- 76 . . . . . Yarmouth Town

OUT OF PROVINCE RESIDENTS

- 81 . . . . . Alberta
- 82 . . . . . British Columbia
- 83 . . . . . Manitoba
- 84 . . . . . New Brunswick
- 85 . . . . . Newfoundland
- 86 . . . . . Ontario
- 87 . . . . . Prince Edward Island
- 88 . . . . . Quebec
- 89 . . . . . Saskatchewan
- 90 . . . . . Yukon
- 92 . . . . . Nunavut
- 93 . . . . . Western Territory
- 97 . . . . . USA
- 99 . . . . . Other countries

**MARITAL STATUS** ..... Mother's marital status.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using one of the following:

- 1 ..... Single
- 2 ..... Married
- 3 ..... Widowed
- 4 ..... Divorced
- 5 ..... Separated
- 6 ..... Common Law

Code '7' for unknown.

**STREET ADDRESS** ..... Mother's street address.

Found on the '*HOSPITAL ADMISSION FORM*'.

Example: 4 King Street

**MAIL ADDRESS** ..... Mother's mail address.

*This field can be left blank if mail address is not documented or same as street address.*

Found on the '*HOSPITAL ADMISSION FORM*'.

Example: P.O. Box 40 or RR#2

**POSTAL CODE** ..... Mother's postal code.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'A1A1A1'  
where "A" is an alphabetic character and "1" is a number.

*Code '888888' when the postal code is known and outside of country, e.g. U.S.A., Britain, St. Pierre-Miquelon.*

Code '999999' for unknown.



**CITY/ TOWN** ..... Mother's city, town or village of residence.

Found on the '*HOSPITAL ADMISSION FORM*'.

**PROVINCE** ..... Mother's province of residence.

Found on the '*HOSPITAL ADMISSION FORM*'.

- AB ..... Alberta
- BC ..... British Columbia
- MB ..... Manitoba
- NS ..... Nova Scotia
- NB ..... New Brunswick
- NF ..... Newfoundland
- ON ..... Ontario
- PE ..... Prince Edward Island
- QC ..... Quebec
- SK ..... Saskatchewan
- YT ..... Yukon
- NU ..... Nunavut
- NT ..... Western Territory
- US ..... USA
- XX ..... Other countries

**MOTHER'S ATTENDING** ..... Physician most responsible for the patient's  
**PHYSICIAN** ..... care *while in hospital*.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board  
Registration Number.

*Code '88888' when physician is not registered in  
Nova Scotia.*

Code '99999' for unknown.

**DISCHARGE DATE** ..... Mother's discharge date from hospital.

Found on the 'NURSES NOTES'.

Use the following format: 'DDMMYYYY'.

**DISCHARGE TIME** ..... Mother's discharge time from hospital.

Found on the 'NURSES NOTES'.

Use the following format: 'HHMM'.

If Discharge Time is not documented enter 1200.

"HH" is in range 0-23, "MM" is in range 0-59

**DISCHARGE DISPOSITION** ..... (Not Applicable)

**CONTACT TYPE** ..... The contact type will automatically fill.

**SEX** ..... The sex will automatically fill as **F** for female.

**MOTHER PROCESS STATUS** ..... Indicates the coding status of the admission information.

Code using one of the following:

- 1 . . . . Patient discharged, chart to be coded
- 2 . . . . Coding of chart in process'  
*The case is set to 2 automatically when it is accessed by the coder for the first time.*
- 3 . . . . Coding of admission information completed  
*The data can be viewed, but not changed. '4' actually indicates that data is ready to be transferred to the Data Mart*

The information which has been entered into the **Admit Screen** will automatically be transferred to the **Delivered Screen**. The next variable which your cursor will land on will be **Hospital of Delivery**. If the **Contact Hospital** and **Hospital of Delivery** are the same, hit enter and begin abstracting with the **Admitted From** variable. If the **Hospital of Delivery** is different from the **Contact Hospital** enter the appropriate number

**HOSPITAL OF DELIVERY** . . . . . Hospital which the delivery of the infant took place.

Found on the 'HOSPITAL ADMISSION FORM' or 'MATERNAL ADMISSION ASSESSMENT'.

Code using one of the standard 2 digit provincial codes for hospitals found on pages 1-2.

*If an emergency birth occurs in a hospital not providing maternity services, and the mother and baby are transferred to another facility, the hospital receiving the transfer is responsible for coding the case. In these situations, the 'Delivery Hospital' should be coded with the hospital number of the facility where the birth actually occurred, while 'Reason for admission' should be coded as '33', indicating a postpartum admission.*

Code the following for the unusual situations:

- 1 . . . Unplanned out of hospital, e.g. delivery en route to hospital, unplanned birth at home.
- 2 . . . Planned birth at home.

**ADMITTED FROM** . . . . . Mother's location immediately prior to admission.

Found on the '*HOSPITAL ADMISSION FORM*'.

If patient is transferred from another hospital, record the standard 2 digit provincial code number for that facility found on pages 1-2.

*If patient comes from home, code '0'.*

**DATE OF LAST NORMAL MENSTRUAL PERIOD** . . . . . Date of patient's last normal menstrual period.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Use the following format: 'DDMMYYYY'.

If the date of the last normal menstrual period is unknown, leave 'LMP date' blank and code '9' in the field immediately following.

**PRE-CONCEPTUAL FOLATE INTAKE** . . . . . Maternal pre-conceptual folate intake.

Found on the '*PRENATAL RECORD*'.

Code using one of the following:

Y . . . . . Yes

N . . . . . No

Code '9' unknown.

**GRAVIDA** . . . . . The number of pregnancies, including the present pregnancy, which the mother has had.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '99' for unknown.

**PARA** . . . . . The number of pregnancies, excluding the present pregnancy, which resulted in one or more infants weighing 500 grams or more at birth (regardless of whether such infants were stillborn, died after birth or lived).

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '99' for unknown.

**ABORTIONS** ..... The number of pregnancies, excluding the present pregnancy, which resulted in a fetus weighing less than 500 grams or, when weight not known, less than 20 weeks gestation, regardless of whether the fetus was born alive.

Found on the '*PRENATAL RECORD*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Code '99' for unknown.

**NUMBER OF PREVIOUS FETAL DEATHS** ..... Number of previous fetal deaths specifically recorded as weighing 500 grams or more, and/or equal to or greater than 20 weeks gestation, or when documented as a fetal death by the physician.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '9' for unknown.

**NUMBER OF PREVIOUS NEONATAL DEATHS** ..... Number of previous neonatal deaths specifically recorded as weighing 500 grams or more *or* when documented as a neonatal death by the physician.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '9' for unknown.

**NUMBER OF PREVIOUS C-SECTIONS** ..... Number of previous C-sections.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '0' if no previous C-sections.

Code '9' for unknown.

**POSTPARTUM HEMORRHAGE IN A PREVIOUS PREGNANCY** . . . . . Postpartum hemorrhage in a previous pregnancy as stated *and/or* there has been blood loss > 500 ml.

Found on the '*PRENATAL RECORD*', or the '*PHYSICIANS' ASSESSMENT*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Code using one of the following:

Y . . . . . Yes

N . . . . . No

Code '9' for unknown.

**NUMBER OF PREVIOUS LOW BIRTH WEIGHT INFANTS** . . . . . Number of previous infants with birth weight less than or equal to 2499 grams (5lbs.8 oz.).

Found on the '*PRENATAL RECORD*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '9' for unknown.

**NUMBER OF PREVIOUS OVERWEIGHT INFANTS** . . . . . Number of previous infants with birth weight greater than 4080 grams (9 lbs.).

Found on the '*PRENATAL RECORD*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '9' for unknown.

**PRE-PREGNANCY SMOKING** . . . . . Number of cigarettes smoked per day before the mother became pregnant.

Found on the '*PRENATAL RECORD*'.

Code the number of cigarettes smoked per day pre-pregnancy, with the following exceptions:

- 0 . . . . patient did not smoke pre-pregnancy
- 75 . . . patient smoked  $\geq 75$  cigarettes per day pre-pregnancy
- 88 . . . patient known to be a smoker pre-pregnancy, but number of cigarettes smoked per day is unknown

*NOTE: 1/2 PACK=13 CIGS, 1 PACK=25 CIGS*

If the number is recorded in a range, code the highest number, e.g. 10-15 would be coded as 15.

*If the number is contradicted on different forms, use the highest number recorded.*

Code '99' if not indicated whether or not patient smoked pre-pregnancy.

**SMOKING AT FIRST PRENATAL VISIT** . . . . . Number of cigarettes smoked per day at the time of the first prenatal visit.

Found on the '*PRENATAL RECORD*'.

Code the number of cigarettes smoked per day at the time of the first prenatal visit, with the following exceptions:

- 0 . . . . patient did not smoke at the time of the first prenatal visit
- 75 . . . patient smoked  $\geq 75$  cigarettes per day at the time of the first prenatal visit
- 88 . . . patient known to be a smoker at the time of the first prenatal visit, but number of cigarettes smoked per day is unknown

*NOTE: 1/2 PACK=13 CIGS, 1 PACK=25 CIGS*

*If the number is recorded in a range, code the highest number, e.g. 10-15 would be coded as 15.*

*If the number is contradicted on different forms, use the highest number recorded.*

Code '99' if not indicated whether or not patient smoked at the time of the first prenatal visit.

**PRESENT PREGNANCY** . . . . . Maternal bleeding in present pregnancy greater than or equal to 20 weeks gestation.  
**ANTEPARTUM BLEEDING**  
**≥ 20 WEEKS**

Found on the '*PRENATAL RECORD*', or the '*PHYSICIANS' ASSESSMENT*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Code using one of the following:

Y . . . . . Yes

N . . . . . No

Code '9' for unknown.

**INTENT TO BREASTFEED** . . . . . Maternal intention to breastfeed.

Found on the '*PRENATAL RECORD*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Code using one of the following:

Y . . . . . Yes

N . . . . . No

U . . . . . Unsure

Code '9' for unknown.

**PREVIOUS BREASTFEEDING EXPERIENCE** . . . . . Mother's previous breastfeeding experience.

Found on the '*PRENATAL RECORD*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Code using one of the following:

Y . . . . . Yes

N . . . . . No

Code '9' for unknown.



**PREVIOUS GYN SURGERY** . . . . . Any uterine, tubal, vaginal or pelvic surgery, e.g. removal of: ovarian cysts, fibroids, surgery for endometriosis, anterior and posterior repair (bladder and bowel surgery), LEEP(Loop, electro, exisional procedure), repair of prolapses, suspension, and conizations, including laser and cryotherapy to cervix.

Found on the '*PRENATAL RECORD*', or the '*PHYSICIANS' ASSESSMENT*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Code using one of the following:

Y . . . . . Yes  
N . . . . . No

*DO NOT INCLUDE diagnostic laparoscopies, (e.g. if done to investigate infertility, unless surgery is done at the same time), cervical punch biopsies, D and C, wart removal of any kind (even if the warts are on the cervix), or therapeutic abortions.*

Code '9' for unknown.

**PRE-PREGNANCY WEIGHT** . . . . . Maternal pre-pregnancy weight.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*'.

This field has been designed to allow either pounds (lbs.) or kilograms (kgs.) to be coded. If the weight is recorded in kilograms, it should be entered in kgs., and 'K' should be coded in the field immediately following, e.g. 60 K.

If the weight is recorded in pounds (lbs.), it should be entered in pounds, and 'P' should be coded in the field immediately following, e.g. 121 P.

*If weight not documented as a whole number, round to the nearest whole number.*

e.g. 60.2 kgs.=60 kgs.  
60.7 kgs.=61 kgs.

*If weight is recorded in a range, code the highest weight.*

e.g. 130-135 lbs.=135lbs.

*If pre-pregnancy weight is unknown, subtract weight gain from pre-delivery weight.*

Code '999' for unknown.

**MATERNAL Rh FACTOR** . . . . . Maternal Rh Status.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*', or the '*RED CROSS SHEET*' or the '*LAB REPORTS*'.

Code using one of the following:

POS . . . . . Rh positive  
NEG . . . . . Rh negative

Code '999' for unknown.

**MATERNAL ANTEPARTUM ANTI-D Rh IMMUNE GLOBULIN** . . . . . Maternal antepartum anti-D Rh immune globulin administration.

Found on the '*PRENATAL RECORD*' or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*RED CROSS SHEET*'.

Code using one of the following:

- Y . . . . . Yes
- N . . . . . No

Code '9' for unknown.

**REASON FOR MOTHER'S ADMISSION** . . . . . The reason, *as stated*, for admission, regardless if this reason is later ruled out.

Found on the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*' or the '*NURSES' NOTES*'.

Code using one of the following:

- 1 . . . . . Pregnancy in labour
- 2 . . . . . Elective C-section
- 3 . . . . . Fetal growth assessment
- 4 . . . . . Post dates
- 5 . . . . . Multiple pregnancy
  
- 8 . . . . . Hypertensive disease of pregnancy
- 9 . . . . . Diabetes
- 10 . . . . . Iso-immunization
- 11 . . . . . Possible fetal distress (includes induction for low Planning Score)
  
- 12 . . . . . Spontaneous rupture of membranes
- 13 . . . . . Intrauterine death
- 14 . . . . . Antepartum hemorrhage
- 15 . . . . . Pyelonephritis
- 16 . . . . . Premature labour
  
- 17 . . . . . Eclampsia
- 18 . . . . . Hydramnios or polyhydramnios
- 19 . . . . . Hyperemesis, nausea or vomiting of pregnancy

<b><u>REASON FOR MOTHER'S</u></b> .....	20 .....	Respiratory infection
<b><u>ADMISSION CON'T</u></b>	21 .....	Asthma
	22 .....	Low back pain
	23 .....	Abdominal pain
	24 .....	Anemia
	25 .....	Thrombo-embolic disease
	26 .....	Cholecystitis
	27 .....	Pancreatitis
	28 .....	Renal colic
	29 .....	Suspected fetal anomaly
	30 .....	Excessive weight gain and/or edema
	31 .....	Liver disease, e.g. hepatitis
	32 .....	Proteinuria
	33 .....	Postpartum admission
	34 .....	Incompetent cervix
	35 .....	Colitis, e.g. Crohn's disease
	36 .....	Elective induction
	37 .....	Mom accompanying sick baby, e.g. breastfeeding
	38 .....	Oligohydramnios
	40 .....	Other

*If an emergency birth occurs in a hospital not providing maternity services, and the mother and baby are transferred to another facility, the hospital receiving the transfer is responsible for coding the case. In these situations, the 'Delivery Hospital' should be coded with the hospital number of the facility where the birth actually occurred, while 'Reason for Admission' should be coded as '33', indicating a postpartum admission.*

**ATTENDANCE AT** .....

**PRENATAL CLASSES** ..... Maternal attendance at any prenatal classes.

Found on the 'MATERNAL ADMISSION ASSESSMENT' or the 'PRENATAL RECORD'.

Code using one of the following:

Y ..... Yes  
N ..... No

*Code for current pregnancy only.*

Code '9' for unknown.

**SMOKING AT TIME OF DELIVERY** . . . . . Number of cigarettes smoked per day at time of the delivery.

Found on the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIAN'S ASSESSMENT*' .

Code the number of cigarettes smoked per day at the time of the delivery, with the following exceptions:

- 0 . . . . patient did not smoke at the time of the delivery
- 75 . . . patient smoked  $\geq 75$  cigarettes per day at the time of the delivery
- 88 . . . patient known to be a smoker at the time of the delivery, but number of cigarettes smoked per day is unknown

*NOTE: 1/2 PACK=13 CIGS, 1 PACK=25 CIGS  
If the number is recorded in a range, code the highest number, e.g. 10-15 would be coded as 15.*

*If the number is contradicted on different forms, use the highest number recorded.*

Code '99' if not indicated whether or not patient smoked at the time of the delivery.

**PRESENT WEIGHT** ..... Patient's weight just before delivery.

Found on the '*MATERNAL ADMISSION ASSESSMENT*', or the '*NURSES' NOTES*' or the '*PROGRESS NOTES*' **OR** patient's last weight (if within a week of delivery) on the '*PRENATAL RECORD*'.

This field has been designed to allow either pounds (lbs.) or kilograms (kgs.) to be coded. If the weight is recorded in kilograms, it should be entered in kgs., and 'K' should be coded in the field immediately following, e.g. 60 K.

If the weight is recorded in pounds (lbs.), it should be entered in pounds, and 'P' should be coded in the field immediately following, e.g. 121 P.

*If weight not documented as a whole number, round to the nearest whole number.*

e.g. 60.2 kgs.=60 kgs.  
60.7 kgs.=61 kgs.

*If weight is recorded in a range, code the highest weight.*

e.g. 130-135 lbs.=135 lbs.

*If present weight is unknown, add pre-pregnancy and weight gain.*

Code '999' for unknown value.

**PROCESS STATUS** ..... Indicates the coding status of **delivered** routine information.

Code using one of the following:

- 1 . . . . Patient discharged, chart to be coded.
- 2 . . . . Coding of chart in process'.  
*The case is set to 2 automatically when it is accessed by the coder for the first time.*
- 3 . . . . Coding of **delivered** information completed.
- 4 . . . . Frozen.  
*The data can be viewed, but not changed.  
Indicates data are ready to be transferred to DataMart.*
- 5 . . . . Frozen.  
*The data can be viewed, but not changed.  
Indicates data have been transferred to DataMart.*

Once data has been 'frozen', any necessary changes or corrections must be forward to the Health Record Coordinator at RCP.

**ROUTINE INFORMATION - LABOUR AND INFANT**

**BIRTH ORDER** ..... Infant's order of birth during delivery of present pregnancy.

Found on the '*BIRTH RECORD*' or the '*OPERATIVE REPORT*'.

Use one of the following codes:

- 1 ..... Singleton, or first born of multiples,
- 2 ..... Second born of multiples,
- 3 ..... Third born of multiples,
- 4 ..... Fourth born of multiples,
- etc-

**INFANT'S UNIT NUMBER** ..... Infant's hospital unit number.

Found on the health record folder or the '*HOSPITAL ADMISSION FORM*'.

Enter '7777777777' (10 in total) for fetal deaths.

**GIVEN NAME(S)** ..... Infant's given name(s).

Found on the '*HOSPITAL ADMISSION FORM*'.

**SURNAME** ..... Infant's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.



**NUMBER OF FETUSES** ..... Code the number of fetuses which the mother carried to delivery during the present pregnancy.

Found on the '*BIRTH RECORD*' or the '*PRENATAL RECORD*', or the '*PHYSICIANS' ASSESSMENT*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Use one of the following codes:

- 1 ..... Singleton
- 2 ..... Twins
- 3 ..... Triplets
- 4 ..... Quadruplets
- etc-

**DATE OF RUPTURE OF MEMBRANES** ..... Date of rupture of membranes (ROM).

Found on the '*BIRTH RECORD*'.

Use the following format: 'DDMMYYYY'.

*If there is more than one rupture of membranes, code the earliest date.*

*If the patient has an elective C-section and there is no history of prior rupture of membranes, use the date of birth as the date of rupture of membranes, since membranes would have been ruptured on the day of delivery.*

If the date of rupture of membranes is unknown, leave 'Rupt Date' blank, and code '9' in the field immediately following.

**TIME OF RUPTURE OF MEMBRANES** ..... Time of rupture of membranes (ROM).

Found on the '*BIRTH RECORD*'.

Use the following format: 'HHMM'.

"HH" is in range 0-23, "MM" is in range 0-59

*If there is more than one rupture of membranes, record the earliest time. If the patient has an elective C-section and there is no history of prior rupture of membranes, use the time of birth as the time of rupture of membranes, since membranes would have been ruptured at the time of delivery.*

*When membranes are known to have ruptured within 5 minutes of delivery and the exact time not specified, then the time of birth should be coded as the time of rupture of membranes.*

*If more than 5 minutes and exact time not specified, then leave 'Rupt Time' blank, and code '9' in the field immediately following.*

*In situations of long rupture and when the date is known but the time not specified, code the appropriate date, leave "Rupt Time" blank, and code '9' in the field immediately following.*

If the time of rupture of membranes is unknown, leave 'Rupt Time' blank, and code '9' in the field immediately following.

**TYPE OF RUPTURE OF MEMBRANES** . . . . . Type of rupture of membranes.

Found on the '*BIRTH RECORD*'.

Code using one of the following:

- S . . . . . Spontaneous
- A . . . . . Artificial

*If there is more than one rupture of membranes, code the type based on the first rupture of membranes. If the patient has an elective C-section, and there is no history of prior rupture of membranes, code the type of rupture as "artificial."*

Code '9' for unknown.

**MECONIUM STAINING** . . . . . Meconium staining of the amniotic fluid.

Found on the '*BIRTH RECORD*' or the '*NURSES NOTES*'. *Do Not code Y if documentation states "as noted at time of birth or delivery."*

Code using one of the following:

- Y . . . . . Yes
- N . . . . . No

Code '9' for unknown.

**LABOUR** ..... Initiation of labour.

Found on the '*BIRTH RECORD*' or the '*PARTOGRAM*'.

Code using one of the following:

- S ..... Spontaneous onset of labour (include augmentation of spontaneous labour)
- I ..... Artificial induction of labour (does not include augmentation of labour)
- N ..... No labour prior to delivery (e.g. elective repeat C-section)

*If the cervical dilatation is  $\geq 3$ cm **and** regular contractions are present when the oxytocin is initiated, code labour as augmented (S).*

*If the cervical dilatation is  $< 3$ cm **or** there are no regular contractions when the oxytocin or prostaglandin is initiated, code labour as induced (I).*

**INDICATION FOR INDUCTION** . . . . . Reason for induction of labour.  
**OF LABOUR**

Found on the '*BIRTH RECORD*', the '*PHYSICIANS' ASSESSMENT*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Code using one of the following:

- 0 . . . . . Not Induced
- 1 . . . . . Elective
- 2 . . . . . Fetal growth retardation
- 3 . . . . . Diabetes
- 4 . . . . . Post dates
- 5 . . . . . Premature rupture of membranes  
without Chorioamnionitis
- 6 . . . . . Premature rupture of membranes  
with clinical Chorioamnionitis
- 7 . . . . . Isoimmunization
- 8 . . . . . History of precipitate labour
- 9 . . . . . (Possible) fetal distress; low  
planning score
- 10 . . . . . Intrauterine death
- 11 . . . . . Geographic
- 12 . . . . . Hypertension
- 13 . . . . . Other
- 14 . . . . . Oligohydramnios (decreased  
amniotic fluid)
- 15 . . . . . Fetal anomaly
- 16 . . . . . Polyhydramnios

**DATE OF ADMISSION TO LABOUR/DELIVERY ROOM** . . . . . Date of admission to the Labour and Delivery Room in apparent labour and delivered before discharged from the unit.

Found on the 'PARTOGRAM' or the 'PROGRESS NOTES' or 'MATERNAL ADMISSION ASSESSMENT'.

Use the following format: 'DDMMYYYY'.

*In the case of an in-patient induction with oxytocin or prostaglandin, record the date that the drug was initiated.*

*In the case of an out-patient induction with prostaglandin, record the date of admission to the LDR in apparent labour and delivered before discharged from the unit.*

If date of admission to LDR is unknown, leave 'LDR Date' blank, and code '9' in the field immediately following.

**TIME OF ADMISSION TO LABOUR/DELIVERY ROOM** . . . . . Time of admission to the Labour and Delivery Room in apparent labour and delivered before discharged from the unit.

Found on the 'PARTOGRAM' or the 'PROGRESS NOTES' or the 'MATERNAL ADMISSION ASSESSMENT'.

Use the following format: 'HHMM'.  
"HH" is in range 0-23, "MM" is in range 0-59

*In the case of an in-patient induction with oxytocin record the time the drug was initiated.*

*In the case of an inpatient induction with prostaglandin, record the time of the last administration which initiated labour.*

*In the case of an out-patient induction with prostaglandin, record the time of admission to the LDR in apparent labour and delivered before discharged from the unit.*

If time of admission to LDR is unknown, leave 'LDR Time' blank, and code '9' in the field immediately following.

**DILATATION AT TIME OF ADMISSION TO LABOUR/DELIVERY ROOM** . . . . . Cervical dilatation at admission to the Labour and Delivery Room in apparent labour and delivered before discharged from the unit.

Found on the 'PARTOGRAM'.

Code using the following format: 'XX'  
where "XX" represents the dilatation in centimetres.

*Code the first dilatation recorded within 2 hours of admission to the LDR. Round the dilatation down to the nearest centimetre, e.g.3.5 would be coded as 3.*

*In the case of an in-patient induction with oxytocin or prostaglandin, record the dilatation when the drug was initiated.*

*In the case of an out-patient induction with prostaglandin, record the dilatation at the time of admission to the LDR in apparent labour and delivered before discharged from the unit.*

Code '99' for unknown.

**MEDICAL AUGMENTATION** . . . . . Use of oxytocin to improve contractions after labour has started spontaneously.

Found on the 'PARTOGRAM or BIRTH RECORD.'

Code using one of the following:

Y . . . . . Yes  
N . . . . . No

Code '9' for unknown.

**DATE OF INITIATION OF MEDICAL AUGMENTATION** . . . . . Date of initiation of oxytocin administration for medical augmentation.

Found on the '*PARTOGRAM*'.

Use the following format: 'DDMMYYYY'

If date of medical augmentation is unknown, leave 'Aug Date' blank, and code '9' in the field immediately following.

**TIME OF INITIATION OF MEDICAL AUGMENTATION** . . . . . Time of initiation of oxytocin administration for medical augmentation.

Found on the '*PARTOGRAM*'.

Use the following format: 'HHMM'

"HH is in the range 0-23, "MM" is in range 0-59

*If the time of initiation of oxytocin is the same as the time of admission to LDR, code the augmentation time as one minute after the admission time.*

If time of medical augmentation is unknown, leave 'Aug Time' blank, and code '9' in the field immediately following.



**CERVICAL DILATATION** . . . . . Cervical dilatation at time of augmentation.

**TIME OF MEDICAL  
AUGMENTATION**

Found on the 'PARTOGRAM'.

Code using the following format: 'XX'  
where 'XX' represents the dilatation in centimetres.

*Round the dilatation down to the nearest  
centimetre, e.g.3.5 would be coded as 3.*

*If the dilatation is not documented, code the last  
dilatation recorded during the two hours prior to  
the initiation of the oxytocin.*

*If the dilatation is not recorded during this time  
frame, code 99.*

*If the dilatation is noted to be less than the  
dilatation on admission to LDR, code the dilatation  
at time of augmentation as noted, and change the  
dilatation on admission to LDR to the same lower  
dilatation.*

Code '99' for unknown.

**DATE WHEN CERVICAL DILATATION AT 4 CENTIMETRES** . . . . . Date when cervical dilatation at 4cm.

Found on the 'PARTOGRAM' or the 'PROGRESS NOTES'.

Use the following format: 'DDMMYYYY'.

*Code when first indicated by physician or nurse.*

If the patient goes into labour, but has a c-section AND dilation at c-section is < 4 cms, leave '4 cms Date' blank, and code '7' in the field immediately following.

If date cervical dilatation at 4cm is unknown, leave '4 cms Date' blank, and code '9' in the field immediately following.

**TIME WHEN CERVICAL DILATATION AT 4 CENTIMETRES** . . . . . Time when cervical dilatation at 4cm.

Found on the 'PARTOGRAM' or the 'PROGRESS NOTES'.

Use the following format: 'HHMM'.

"HH" is in the range 0-23,"MM" is in range 0-59

*Code when first indicated by physician or nurse.*

*If 4cm dilation is not documented on the Partogram, however, a dilatation is recorded both before and after 4cm dilation, draw a line between the two points, and code the time where the line crosses 4cm.*

If the patient goes into labour, but has a c-section AND dilation at c-section is < 4 cms, leave '4 cms Time' blank, and code '7' in the field immediately following.

If time cervical dilatation at 4cm is unknown, leave '4cms Time' blank, and code '9' in the field immediately following.

**DATE OF ONSET OF SECOND** . . . . . Defined as full cervical dilatation (10 cms).

**STAGE OF LABOUR**

Found on the '*BIRTH RECORD*'.

Use the following format: 'DDMMYYYY'.

If the patient goes into labour, but does not get to second stage prior to having a c-section, leave 'Stg2 Date' blank, and code '7' in the field immediately following.

If date of stage 2 is unknown, leave 'Stg2 Date' blank, and code '9' in the field immediately following.

**TIME OF ONSET OF SECOND** . . . . . Defined as full cervical dilatation (10 cms).

**STAGE OF LABOUR**

Found on the '*BIRTH RECORD*'.

Use the following format: 'HHMM'

"HH" is in the range 0-23, "MM" is in range 0-59

If the patient goes into labour, but does not get to second stage prior to having a c-section, leave 'Stg2 Time' blank, and code '7' in the field immediately following.

If time of stage 2 is unknown, leave 'Stg2 Time' blank, and code '9' in the field immediately following.

**DATE OF INFANT'S BIRTH** . . . . . Date of infant's birth.

Found on the '*BIRTH RECORD*'.

Use the following format: 'DDMMYYYY'

If the date of infant's birth is unknown, leave 'birth date' blank, and code '9' in the field immediately following.

**TIME OF INFANT'S BIRTH** . . . . . Time of infant's birth.

Found on the '*BIRTH RECORD*'.

Use the following format: 'HHMM'

"HH" is in the range 0-23,"MM" is in range 0-59

If the time of infant's birth is unknown, leave 'birth time' blank, and code '9' in the field immediately following.

**MODE OF DELIVERY** . . . . . Mode of delivery.

Found on the '*OPERATIVE REPORT*' or the '*BIRTH RECORD*'.

Code using one of the following:

- ABD . . . . . Abdominal
- CSC . . . . . C-section, combined transverse and vertical incision - Inverted Lower T
- CSH . . . . . C-section/hysterectomy
- CST . . . . . C-section, transverse incision
- CSV . . . . . C-section, classical incision (vertical incision in the body of uterus)
- CSU . . . . . C-section, type unknown
- LVS . . . . . C-section, low vertical incision
- VAG . . . . . Vaginal

**METHOD OF DELIVERY** . . . . . Method of delivery.

Found on the ‘*OPERATIVE REPORT*’ or the ‘*BIRTH RECORD*’.

Code using one of the following:

- ABR . . . . . Assisted breech
- ACH . . . . . Forceps to after-coming head  
(*Breech - vaginal delivery only*)
- BRE . . . . . Breech extraction  
(*Vaginal delivery only*)
  
- CSF . . . . . C-section with forceps
- CSN . . . . . C-section
- FAF . . . . . Failed forceps or failed trial of  
forceps followed by C-section
- FCF . . . . . Failed forceps followed by C-section  
with forceps
  
- HIF . . . . . High forceps
- LMF . . . . . Low-mid forceps
- LOF . . . . . Low or outlet forceps
- MIF . . . . . Mid-forceps
  
- PVE . . . . . Podalic version and extraction  
(*Do not use for C-section*)
  
- SPT . . . . . Spontaneous vaginal
  
- VAC . . . . . Vacuum followed by C-section
- VAF . . . . . Vacuum followed by forceps
- VEX . . . . . Vacuum extraction, malstrum  
extraction
- VFC . . . . . Vacuum followed by forceps and  
then C-section

**TRIAL OF LABOUR** . . . . . Attempted vaginal delivery after previous C-section

Found on the 'BIRTH RECORD', or the 'PHYSICIANS' ASSESSMENT', or the 'OPERATIVE REPORT'.

Code using one of the following:

- Y . . . . . Yes, had trial
- N . . . . . No, did not have trial

*This is a planned attempt for vaginal delivery after a previous C-section delivery, whether or not it is successful. The previous C-section delivery does not have to be the most recent delivery.*

*DO NOT INCLUDE patients who are booked for a planned C-section but unexpectedly go into labour and there is no attempt to deliver vaginally. The patient may labour while waiting to under go a planned repeat C-section but this in not a trial of labour in an attempt to deliver vaginally. These patients should be entered as N- No, did not have trial.*

*DO INCLUDE patients who have planned to have repeat C-section, but unexpectedly go into labour, change their mind and clearly undergo a trial of labour. The end result may be a vaginal delivery, or a repeat C-section for another reason (e.g. Fetal Distress, Failure to Progress).*

*If trial of labour is 'Y', the Maternal Diagnosis screen will pop up with code 1490. Enter appropriate modifier.*

Code '9' for unknown.

**CERVICAL DILATATION** . . . . . Cervical dilatation during last exam prior to  
**DURING LAST EXAM**  
**PRIOR TO C-SECTION** C-Section.

Found on the '*PARTOGRAM*' or the '*PROGRESS NOTES*'.

Code using the following format: 'XX' where 'XX' represents the dilatation in centimetres.

*Round the dilatation down to the nearest centimetre, e.g .3.5 would be coded as 3.*

Code '99' for unknown.

**POSITION AT DELIVERY** . . . . . Position of infant at delivery.

Found on the '*OPERATIVE REPORT*', or the '*BIRTH RECORD*'.

Code using one of the following:

BCH . . . . . Breech, other or unspecified

BOW . . . . . Brow

CPD . . . . . Compound presentation

FAC . . . . . Face

FRB . . . . . Frank breech

FTB . . . . . Footling breech

POP . . . . . Occiput posterior (OP)

SHL . . . . . Shoulder presentation

TLI . . . . . Transverse lie

VTX . . . . . Vertex (includes LOA, ROA, OT)

*If the position at delivery is not noted on any of the above forms, and the fetal position recorded on the '*PRENATAL RECORD*' throughout the pregnancy is VTX, and the fetal position recorded on the '*PHYSICIANS' ASSESSMENT*' when the patient is admitted for delivery is vertex, code VTX.*

Code '999' for unknown.

**ROTATION** ..... Rotation of presenting part to facilitate delivery.

Found on the '*BIRTH RECORD*' or the '*OPERATIVE REPORT*'.

Code using one of the following:

- F ..... Forceps rotation
- M ..... Manual rotation
- S ..... Spontaneous, including vacuum extraction (*no other manoeuvres used to rotate the infant's head*)

**EPISIOTOMY** ..... Episiotomy.

Found on the '*BIRTH RECORD*' or the '*OPERATIVE REPORT*'.

Code using one of the following:

- 0 ..... Not done
- 4 ..... Medio-lateral
- 6 ..... Midline

Code '9' for unknown.

**SEX** ..... The legal phenotypic sex of the infant, regardless of karyotype.

Found on the '*BIRTH RECORD*'.

Code using one of the following:

- F ..... Female
- M ..... Male
- A ..... Ambiguous



**BIRTH WEIGHT** ..... Infant's birth weight.

Found on the '*BIRTH RECORD*' or the '*NEWBORN WEIGHT GRAPH*' in grams.

First weight noted after birth

If birth weight is  $\leq 40$  gms., code '40'.

If birth weights of abortions are unknown, code '40'.

If a viable infant ( $\geq 500$  gms or gest.  $\geq 20$  weeks) was born dead or died after birth and was not weighed, code '2501'.

*For Siamese twins, split weight between babies.*

*If a baby has a tumour or growth at time of birth and the tumour or growth is removed shortly after, record actual weight at birth, including tumour or growth.*

**DO NOT** take from Pathology Report.

Code '9999' for unknown.

**APGAR SCORE** ..... Apgar score at 1 minute.  
**AT 1 MINUTE**

Found on the '*BIRTH RECORD*'.

Code between 0 and 10 for Apgar score.

Code '99' for unknown.

Code '77' for fetal deaths (Auto fill).

**APGAR SCORE** ..... Apgar score at 5 minutes.  
**AT 5 MINUTES**

Found on the '*BIRTH RECORD*'.

Code between 0 and 10 for Apgar score.

Code '99' for unknown.

Code '77' for fetal deaths ( Auto fill).

**PHYSICIAN ATTENDING** . . . . . The physician attending the delivery.  
**DELIVERY**

Found on the '*BIRTH RECORD*' or the '*OPERATIVE RECORD*'.

Code using the Provincial Medical Board Registration Number.

88888 = Not registered in Nova Scotia

Code '99999' for unknown.

**PRIMARY INDICATION** . . . . . Primary Indication for C-Section.

**FOR C-SECTION**

Found on the '*OPERATIVE REPORT*' or the '*BIRTH RECORD*' or the '*PROGRESS NOTES*' or the '*CONSULTATION NOTE*'.

Code using one of the following:

- APL . . . . . Abruptio placenta
- BCH . . . . . Breech
- CXD . . . . . Diseases of the cervix
- DBT . . . . . Diabetes
- DYS . . . . . Dystocia  
*(Cephalopelvic disproportion, (C.P.D.), Failure-to-progress, Maternal exhaustion, Failed Induction, Cervical Stenosis)*
- FDS . . . . . Fetal distress
- FGT . . . . . Fetal growth restriction  
*(retardation)*
- HSV . . . . . Maternal herpes simplex infection
- HTD . . . . . Hypertensive disorders
- ISO . . . . . Isoimmunization
- MLP . . . . . Malpresentation  
*(e.g. shoulder, transverse lie, brow; exclude breech and occiput posterior)*
- OTR . . . . . Other
- PCS . . . . . Previous C-section  
*(Cannot be secondary indication)*
- PLC . . . . . Prolapsed cord
- PLP . . . . . Placenta previa
- PRM . . . . . Prolonged rupture of membranes
- UTS . . . . . Uterine surgery, previous
- VAG . . . . . Vaginal delivery  
*(e.g. not applicable)*

Code '999' for unknown.

**SECONDARY INDICATION** . . . . . Same as Primary Indication with the  
**FOR C-SECTION** following additions:

HSN . . . . . History of C-section  
N-A . . . . . No secondary indication

*History of C-section (HSN) can only be considered as the secondary indication for C-section when one or more of the following conditions are met:*

*1. Patient had a trial of labour, and primary indication for C-section is:*

*Dystocia . . . . . (DYS) or  
Fetal distress . . . . . (FDS) or  
Prolapsed cord . . . . . (PLC)*

*2. Position is breech, and primary indication for C-section is*

*Breech . . . . . (BCH)*

*3. Primary indication for C-section is:*

*Malpresentation . . . . . (MLP) or  
Fetal growth restriction (retardation) . . . . . (FGT)*

*NOTE: PCS can not be coded as a secondary indication.*

**A.S.A. CLASSIFICATION** . . . . . ASA classification for anesthetic administration.

Found on the '*ANESTHESIA RECORD*'.

Code using one of the following:

- 0 . . . . Not applicable  
(*No anesthetic administered*)
- 1 . . . . Class 1
- 2 . . . . Class 2
- 3 . . . . Class 3
- 4 . . . . Class 4
- 5 . . . . Class 5

Code '9' for unknown.

If there is more than one Anesthesia Record on the chart, and the value differs on each record, record the highest value of the two.

**MATERNAL POSTPARTUM ANTI -D Rh IMMUNE GLOBULIN** . . . . . Found on the *Rh IMMUNOGLOBULIN REPORTING FORM*.

Code using one of the following:

- Y . . . . Yes
- N . . . . No

Code '9' for unknown.

**MOTHER DISCHARGED TO** . . . . . The immediate destination of patient on discharge.

Found in the '*NURSES' NOTES*' or the '*HOSPITAL ADMISSION FORM*' or the '*PHYSICIANS' ORDER SHEET*'.

Code using one of the standard 2 digit provincial codes for hospitals found on pages 1-2.

*If patient is discharged home, code 0.*

Code '9' for *Maternal Death*

**MATERNAL ULTRASOUND** . . . . . Maternal Ultrasound.

Found on an '*ULTRASOUND REPORT*' anywhere within the chart.

Enter **Y** for *Yes, if an Ultrasound Report is found on the chart*. When 'Y' is entered, the Ultrasound screen will pop up. Enter appropriate values.

Enter **N** for *No, if an Ultrasound report is not found on the chart*. When an 'N' is entered, the Ultrasound Screen will not pop up as no details need be entered in the Ultrasound screen.

**FETUS NUMBER** . . . . . This column hold a value which differentiates between ultrasound studies for multiple births.

For singleton pregnancies, the number will always be 1.

In multiple pregnancies, study 1 for first reported baby, study 2 for second, etc

**DATE OF FIRST ULTRASOUND** . . . . . Date of **earliest** ultrasound during this pregnancy that is found on the chart.

Found on the '*ULTRASOUND REPORT*' .

Use the following format: 'DDMMYYYY'.

If an ultrasound is not available on the chart, leave field blank.

**CROWN/RUMP LENGTH** . . . . . Crown/rump length measurement recorded on first ultrasound done during this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'XX.X' (in centimetres)

Decimal points must be entered.

If the crown/rump length is not recorded on the first ultrasound done during this pregnancy, leave this field blank, and code values for the following four variables: biparietal diameter, head circumference, abdominal circumference, and femur length.

If an ultrasound is not available on the chart, leave field blank.

**BIPARIETAL DIAMETER** . . . . . Biparietal diameter measurement recorded on first ultrasound done during this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'XX.X' (in centimetres)

Decimal points must be entered.

If the crown/rump length has been coded from the report, leave this field blank. If an ultrasound is not available on the chart, leave variable field blank. If this measurement is not available on the ultrasound report, leave field blank.

**HEAD CIRCUMFERENCE** . . . . . Head circumference measurement recorded on first ultrasound done during this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'XX.X'(in centimetres)

Decimal points must be entered.

If the crown/rump length has been coded from the report, leave this field blank. If an ultrasound is not available on the chart, leave variable field blank. If this measurement is not available on the ultrasound report, leave field blank.

**ABDOMINAL CIRCUMFERENCE** . . . . . Abdominal circumference measurement recorded on first ultrasound done during this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'XX.X'( in centimetres)

Decimal points must be entered.

If the crown/rump length has been coded from the report, leave this field blank. If an ultrasound is not available on the chart, leave variable field blank. If this measurement is not available on the ultrasound report, leave field blank.

**FEMUR LENGTH** . . . . . Femur length measurement recorded on first ultrasound done during this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'XX.X'( in centimetres)

Decimal points must be entered.

If the crown/rump length has been coded from the report, leave this field blank. If an ultrasound is not available on the chart, leave variable field blank. If this measurement is not available on the ultrasound report, leave field blank.



**TIME OF FETAL DEATH** . . . . . When fetal death occurred.

Found on the '*BIRTH RECORD*' or the '*AUTOPSY REPORT*'.

Code using one of the following:

- AA . . After admission and before labour
- BA . . Before admission
- IP . . . Intrapartum
- NA . . Not applicable
- UK . . Unknown

**INFANT'S A/S/D NUMBER** . . . . . Hospital number referring to the infant's present admission.

Found on the infant's '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'XXYYYYYY' where "XX" denotes the year (April 1 to March 31), changing on April 1st of each year, and "YYYYYY" is an ascension number related to the number of admissions of the year.

*Zeroes before the ascension number must be entered if number does not have 5 digits, e.g. 00123.*

Code '9999999' for unknown value.  
Code '7777777' for fetal deaths (auto filled)

**INFANT'S HEALTH** ..... Infant's health card number.  
**CARD NUMBER**

Found on the '*HOSPITAL ADMISSION FORM*'.

*Record Nova Scotia Health Card Numbers only.*

Code using one of the following if HCN  
unavailable:

- 0 ..... N.S. patient, lost card
- 0 ..... Armed Forces
- 0 ..... RCMP
- 0 ..... First Nations
- 0 ..... Self-paying
- 1 ..... Patient from outside N.S.
- 7 ..... Fetal death (auto filled)

**INFANT'S ATTENDING** ..... Physician most responsible for infant's care *while in*  
**PHYSICIAN** *hospital.*

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board  
Registration Number.

*Code '88888' when physician is not registered in  
Nova Scotia*

Code '99999' for unknown.  
Code '77777' for fetal deaths (auto filled)

**CLINICAL ESTIMATE OF GESTATIONAL AGE** . . . . . The closest approximation in weeks to the gestational age obtained by physical examination of the infant.

Found on the '*PHYSICIAN NEWBORN EXAMINATION*' or the '*NEWBORN BIRTH ASSESSMENT*' or clearly stated by the physician.

Code stated number of completed weeks. The following is a guide:

38+ weeks . . . . . 38  
38-40 weeks . . . . . 39  
38-39 weeks . . . . . 38  
> 39 . . . . . 39  
Term . . . . . 40

Code '99' for unknown.

**FETAL SCALP BLOOD ACID-BASE** . . . . . Fetal scalp blood acid-base completed.

Found on the '*LAB REPORTS*' or the '*PROGRESS NOTES*'.

Code using one of the following:

Y . . . . . Yes  
N . . . . . No

Code '9' for unknown.

*If 'Y' is entered, the Infant Diagnosis screen pop up with code 3100 SCPH. Enter appropriate modifier.*

**CORD ARTERY ACID-BASE** . . . . . Cord artery acid-base completed.

Found on the '*LAB REPORTS*' or the '*PROGRESS NOTES*'.

Code using one of the following:

Y . . . . . Yes  
N . . . . . No

Code '9' for unknown.

**CORD ARTERY pH VALUE** . . . . . Cord artery pH value .

Found on the '*LAB REPORTS*'.

Use the following format: 'X.XX'

Decimal points must be entered if the value is not a whole number, e.g. 7.14.

If the value is a whole number enter that number e.g. 7

Allowed range is: 6.4 to 7.8

Code '99' for unknown.

**PCO2 VALUE** . . . . . PCO2 value.

Found on the '*LAB REPORTS*'.

*Enter value as recorded on lab reports*

Use the following format: 'XXX.X'

Decimal points must be entered if the value is not a whole number, e.g 56.9.

If the value is a whole number, enter that number, e.g. 56.

Allowed range is: 0 to 130.

Code '999' for unknown

**BASE EXCESS VALUE** . . . . . Base excess value.

Found on the '*LAB REPORTS*'.

Use the following format:

'YXX' where Y is a negative sign (-) and 'XX' is the value or 'XX' where the value is positive.

Allowed range is: 10 to -30.

Code '99' for unknown.

**SNCU** ..... Infant admitted to the Special Neonatal Care Nursery or Premature Nursery; or infants requiring special care in normal nursery where premature nursery not available.

Found in the '*PROGRESS NOTES*'.

Code using one of the following:

Y ..... Yes

N ..... No

If 'Y' is entered, the screen SCN dates will pop up. Enter the admit and discharge dates to and from the Special Care Nursery.

If there is more than one admission and discharge to the Special Care Nursery during the same admission, enter the dates of the second in the next row, etc.

**OUTCOME OF INFANT** ..... Outcome of infant at time of discharge.

Found on the '*INFANT'S PROGRESS NOTES*'.

Code using one of the following:

LVD ..... Infant lived to be discharged from hospital.

NND ..... Liveborn infant who died before being discharged home from hospital.

FTD ..... Fetal death before birth.

**BREAST FEEDING** . . . . . Infant breastfeeding at time of discharge from hospital.

Found in the 'NURSES' NOTES' or the 'PHYSICIAN NEWBORN ADMISSION' or the 'DISCHARGE FORM'.

Code using one of the following:

Y . . . . . Yes

N . . . . . No

Code Y for breastfeeding if infant is breastfeeding and being supplemented with formula at discharge.

Code '9' for unknown.

**INFANT'S DISCHARGE DATE** . . . . . Discharge date of infant's admission to the hospital of birth .

Found in the 'NURSES' NOTES'.

Use the following format: 'DDMMYYYY'

If the date of infant's discharge is unknown, leave 'Infant's Discharge Date' blank, and code '9' in the field immediately following.

For fetal death discharge date will auto fill to correspond to birth date.

**INFANT'S DISCHARGE TIME** . . . . . Discharge time of infant's admission to the hospital of birth.

Found in the 'NURSES' NOTES'.

Use the following format: 'HHMM'

"HH" is in the range 0-23, "MM" is in range 0-59

If the time of infant's discharge is unknown, leave 'Infant's Discharge Time' blank, and code '9' in the field immediately following.

For fetal death discharge date will auto fill to correspond to birth time.

**DISCHARGED TO** ..... Immediate destination of infant on discharge from hospital.

Found in the '*PHYSICIANS' PROGRESS NOTES*' or the '*NURSES' NOTES*' or the '*PHYSICIANS' ORDER SHEET*'.

Code using one of the standard 2 digit provincial codes for hospitals found on pages 1-2.

*If patient is discharged home, code '0'*

Code '-9' for *Infant Death*

**AUTOPSY** ..... Completion of infant autopsy.

Found on the '*NEWBORN CODING SHEET*' or the '*AUTOPSY REPORT*'.

Code using one of the following:

LVD ..... Lived (e.g., not applicable)

YES ..... Died and autopsy done

NO ..... Died but autopsy not done

**INFANT'S PRIMARY CAUSE OF DEATH** . . . . . Found on the "AUTOPSY REPORT" or stated by the physician.

Leave blank if infant lived.

If area is greyed out, not applicable to the coder.

Use one of the following codes:

- ABRP . . . . . Abruptio placenta
- ANEC . . . . . Acute necrotizing enterocolitis
- OAIR . . . . . Airway failure
- AMNO . . . . . Amniocentesis
- ANAL . . . . . Analgesia or anaesthesia
- CPDP . . . . . Chronic pulmonary disease
- COTR . . . . . Complications of treatment
- ANOM . . . . . Congenital anomaly
- CRLK . . . . . Cord loops and/or knots
- CORP . . . . . Cord prolapse
- CDOT . . . . . Cord, miscellaneous
- DBRN . . . . . Degenerative brain disease
- DUCT . . . . . Ductus syndrome of prematurity
- EXTX . . . . . Exchange transfusion
  
- FETH . . . . . Fetal hemorrhage
  
- FMAL . . . . . Fetal malnutrition
- HMDD . . . . . Hyaline membrane disease
- HYDR . . . . . Idiopathic hydrops
  
- IBOM . . . . . Inborn errors of metabolism
- INFT . . . . . Infection
- ISOM . . . . . Isoimmunization
- IVTF . . . . . Intravascular transfusion
  
- KERN . . . . . Kernicterus
- MALP . . . . . Malpresentation
  
- DIAB . . . . . Maternal diabetes
- SHOC . . . . . Maternal shock
- MUSF . . . . . Multi-system failure
  
- MINF . . . . . Myocardial infarction
- NEOP . . . . . Neoplasia
- TTTX . . . . . Parabiologic syndrome
- PPFC . . . . . Persistent fetal circulation
- PLPV . . . . . Placenta previa



**INFANT'S PRIMARY CAUSE  
OF DEATH CON'T**

AIRL . . . . . Pneumothorax, pneumomediastinum  
and/or pneumopericardium  
PIVH . . . . . Primary intraventricular hemorrhage  
PULH . . . . . Primary pulmonary hemorrhage  
RUPU . . . . . Ruptured uterus  
  
THAB . . . . . Therapeutic abortions  
TOXM . . . . . Toxemia  
TRAS . . . . . Tracheal stenosis  
TRAU . . . . . Trauma (Obstretrical)  
UXPA . . . . . Unexplained peripartum asphyxia  
UNEX . . . . . Unexplained  
VOLV . . . . . Acquired volvulus

**DATE OF DEATH** . . . . . Date of infant's death.

Found in the '*NURSES' NOTES*' or the '*NEWBORN CODING SHEET*'.

Use the following format: 'DDMMYYYY'

*When infant weighed 400 grams or more, code date of fetal death.*

If Date of Death is unknown, or if infant weighed less than 400 grams, or if weight is unknown, leave 'Death Date' blank, and code '9' in the field immediately following.

**TIME OF DEATH** . . . . . Time of infant's death.

Found in the '*NURSES' NOTES*', or the '*NEWBORN CODING SHEET*'.

Use the following format: 'HHMM'

"HH" is in the range 0-23, "MM" is in range 0-59

If Time of Death is unknown, or if infant weighed less than 400 grams, or if weight is unknown, leave 'Death Time' blank, and code '9' in the field immediately following.

**ROUTINE INFORMATION -UNDELIVERED ADMISSIONS**

**UNDELIVERED ADMISSIONS:** . . . . . *Any admission of a woman during pregnancy.*

**MOTHER'S UNIT NUMBER** . . . . . Mother's hospital unit number.

Found on the health record folder or the  
'*HOSPITAL ADMISSION FORM*' .

**CONTACT HOSPITAL** . . . . . Hospital in which the chart is being coded.  
*When only one hospital is associated with a coder user name, this field will be auto-filled.*

Found on the '*HOSPITAL ADMISSION FORM*'

Code using one of the standard 2 digit provincial codes for hospitals found on pages 1-2.

**MOTHER'S ADMISSION DATE** . . . . . Mother's admission date to hospital.

Found on the '*HOSPITAL ADMISSION FORM*' .

Use the following format: 'DDMMYYYY'

**MOTHER'S ADMISSION TIME** . . . . . Mother's admission time to hospital.

Found on the '*HOSPITAL ADMISSION FORM*' .

Use the following format: 'HHMM'

"HH" is in the range 0-23, "MM" is in range 0-59

**GIVEN NAME(S)** ..... Mother's given name(s).

Found on the '*HOSPITAL ADMISSION FORM*'.

**SURNAME** ..... Mother's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

**PREVIOUS SURNAME** ..... Mother's maiden name or other previous surname.  
*This field can be left blank if not documented.*

Found on the '*HOSPITAL ADMISSION FORM*'

**MOTHER'S A/S/D NUMBER** ..... Hospital number referring to the mother's present admission.

Found on the mother's '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'XXYYYYYY' where "XX" denotes the year (April 1 to March 31), changing on April 1st of each year, and "YYYYYY" is an ascension number related to the number of admissions of the year.

*Zeroes before the ascension number must be entered if number does not have 5 digits, e.g. 00123.*

Code '9999999' for other provincial account numbers, or when unknown.

**MATERNAL HEALTH CARD NUMBER** ..... Mother's health card number.

Found on the '*HOSPITAL ADMISSION FORM*'.

*Record Nova Scotia Health Card Numbers only.*

Code using one of the following if HCN unavailable:

- 0 ..... N.S. patient, lost card
- 0 ..... Armed Forces
- 0 ..... RCMP
- 0 ..... First Nations
- 0 ..... Self-paying
- 1 ..... Patient from outside N.S.

**MOTHER'S BIRTH DATE** ..... Mother's date of birth.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

**MUNICIPAL CODE FOR MOTHER'S RESIDENCE** ..... Mother's municipal code.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using municipal code listing found on pages 6-8.

**MARITAL STATUS** ..... Mother's marital status.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using one of the following:

- 1 ..... Single
- 2 ..... Married
- 3 ..... Widowed
- 4 ..... Divorced
- 5 ..... Separated
- 6 ..... Common Law

Code '7' for unknown.

**STREET ADDRESS** ..... Mother's street address.

Found on the '*HOSPITAL ADMISSION FORM*' .

Example: 4 King Street

**MAIL ADDRESS** ..... Mother's mail address.

*This field can be left blank if mail address is not documented or the same as street address.*

Found on the '*HOSPITAL ADMISSION FORM*' .

Example: P.O. Box 40, RR#2

**POSTAL CODE** ..... Mother's postal code.

Found on the '*HOSPITAL ADMISSION FORM*' .

Use the following format: 'A1A1A1'  
where "A" is an alphabetic character and "1" is a number.

*Code '888888' when the postal code is known and outside of country, e.g. U.S.A., Britain, St. Pierre-Miquelon.*

Code '999999' for unknown.

**CITY/TOWN** ..... Mother's city, town or village of residence.

Found on the '*HOSPITAL ADMISSION FORM*' .

**PROVINCE** ..... Mother's province of residence.

Found on the '*HOSPITAL ADMISSION FORM*'.

- AB ..... Alberta
- BC ..... British Columbia
- MB ..... Manitoba
- NS ..... Nova Scotia
- NB ..... New Brunswick
- NF ..... Newfoundland
- ON ..... Ontario
- PE ..... Prince Edward Island
- QC ..... Quebec
- SK ..... Saskatchewan
- YT ..... Yukon
- NU ..... Nunavut
- NT ..... Western Territory
- US ..... USA
- XX ..... Other countries

**MOTHER'S ATTENDING PHYSICIAN** ..... Physician most responsible for the patient's care *while in hospital*.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Registration Number.

*Code '88888' when physician is not registered in Nova Scotia.*

Code '99999' for unknown.

**DISCHARGE DATE** ..... Mother's discharge date from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'DDMMYYYY'.

**DISCHARGE TIME** ..... Mother's discharge time from hospital.

Found on the '*NURSES NOTES*'

Use the following format: 'HHMM'

"HH" is in the range 0-23, "MM" is in range 0-59

If Discharge Time is not documented enter 1200.

**DISCHARGE DISPOSITION** ..... (Not Applicable at this time)

**CONTACT TYPE** ..... The contact type will automatically fill

**SEX** ..... The sex will automatically fill as **F** for female.

**MOTHER'S PROCESS STATUS** ..... Indicates the coding status of the admission information.

Code using one of the following:

1 . . . . Patient discharged, chart to be coded

2 . . . . Coding of chart in process'

*The case is set to 2 automatically when it is accessed by the coder for the first time.*

3 . . . . Coding of admission information completed

The information which has been entered into the **Admits Screen** will automatically be transferred to the **Undelivered Screen**. Begin abstracting with the **Admitted From** variable.

**ADMITTED FROM** ..... Patient's location immediately prior to admission to hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

If patient is transferred from another hospital, record the standard 2 digit provincial code number for that facility found on pages 1-2.

*If patient comes from home, code '0'.*

**DATE OF LAST NORMAL MENSTRUAL PERIOD** ..... Date of patient's last normal menstrual period.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Use the following format: 'DDMMYYYY'.

If the date of the last normal menstrual period is unknown, leave 'LMP date' blank and code '9' in the field immediately following.

**GRAVIDA** ..... The number of pregnancies, including the present pregnancy, which the patient has had.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '99' for unknown.



**PARA** ..... The number of pregnancies, excluding the present pregnancy, which resulted in one or more infants weighing 500 gm or more at birth (regardless of whether such infants were stillborn, died after birth or lived).

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '99' for unknown.

**ABORTIONS** ..... The number of pregnancies, excluding the present pregnancy, which resulted in a fetus weighing less than 500 grams or, when weight not known, less than 20 weeks gestation, regardless of whether the fetus was born alive.

Found on the '*PRENATAL RECORD*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Code '99' for unknown.

**REASON FOR ADMISSION** ..... The reason, as stated, for admission, regardless if this reason is later ruled out.

Found on the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*' or the '*NURSES' NOTES*'.

Code using the reason for admission listing found on pages 20-21.

**DISCHARGED TO** ..... The immediate destination of patient on discharge.

Found in the 'NURSES' NOTES' or the 'HOSPITAL ADMISSION FORM' or the 'PHYSICIANS' ORDER SHEET'.

Code using one of the standard 2 digit provincial codes for hospitals found on pages 1-2.

*If patient is discharged home, code 0.*

Code '-9' for *Maternal Death*.

**PATIENT'S PROCESS STATUS** ..... Indicates the coding status of **undelivered** routine information

Code using one of the following:

- 1 . . . . Patient discharged, chart to be coded
- 2 . . . . Coding of chart in process'  
*The case is set to 2 automatically when it is accessed by the coder for the first time.*
- 3 . . . . Coding of **undelivered routine** information completed
- 4 . . . . Frozen  
*The data can be viewed, but not changed. Indicates data are ready to be transferred to DataMart.*
- 5 . . . . Frozen  
*The data can be viewed, but not changed. Indicates data have been transferred to DataMart.*

Once data have been frozen, requests for any necessary changes or corrections must be sent to RCP.

**“LEFT BLANK INTENTIONALLY”**

**ROUTINE INFORMATION -POSTPARTUM ADMISSIONS**

**POSTPARTUM ADMISSION:** . . . . . *Any admission of a woman up to 6 weeks postpartum.*

**NOTE** . . . . . *If a mother is admitted after an emergency birth which occurred in a hospital not providing maternity services or at home, whether planned or unplanned and the mother and baby are transferred to another facility, the hospital receiving the transfer is responsible for coding the case as a **DELIVERED ADMISSION** not a postpartum admission.*

**MOTHER'S UNIT NUMBER** . . . . . Mother's hospital unit number.

Found on the health record folder or the 'HOSPITAL ADMISSION FORM'.

**CONTACT HOSPITAL** . . . . . Hospital in which the chart is being coded.

*When only one hospital number is associated with a coder user name, this field will be auto-filled.*

Found on the 'HOSPITAL ADMISSION FORM'

Code using one of the standard 2 digit provincial codes for hospitals found on pages 1-2.

**MOTHER'S ADMISSION DATE** . . . . . Mother's admission date to hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

**MOTHER'S ADMISSION TIME** . . . . . Mother's admission time to hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'

"HH" is in the range 0-23, "MM" is in range 0-59

**GIVEN NAME(S)** . . . . . Mother's given name(s).

Found on the '*HOSPITAL ADMISSION FORM*'.

**SURNAME** . . . . . Mother's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

**PREVIOUS SURNAME** . . . . . Mother's maiden name or other previous surname  
*This field can be left blank if not documented.*

Found on the '*HOSPITAL ADMISSION FORM*'.

**MOTHER'S A/S/D NUMBER** . . . . . Hospital number referring to the mother's present admission.

Found on the mother's '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'XXYYYYY' where "XX" denotes the year (April 1 to March 31), changing on April 1st of each year, and "YYYYY" is an ascension number related to the number of admissions of the year.

*Zeroes before the ascension number must be entered if number does not have 5 digits, e.g. 00123.*

Code '9999999' for other provincial account numbers, or when unknown.

**MATERNAL HEALTH CARD NUMBER** . . . . . Mother's health card number.

Found on the '*HOSPITAL ADMISSION FORM*'.

*Record Nova Scotia Health Card Numbers only.*

Code using one of the following if HCN unavailable:

- 0 . . . . . N.S. patient, lost card
- 0 . . . . . Armed Forces
- 0 . . . . . RCMP
- 0 . . . . . First Nations
- 0 . . . . . Self-paying
- 1 . . . . . Patient from outside N.S.

**MOTHER'S BIRTH DATE** . . . . . Mother's date of birth.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'

**MUNICIPAL CODE** ..... Mother's municipal code.

**FOR MOTHER'S RESIDENCE**

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using municipal code listing found on pages 6-8.

**MARITAL STATUS** ..... Mother's marital status.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using one of the following:

- 1 ..... Single
- 2 ..... Married
- 3 ..... Widowed
- 4 ..... Divorced
- 5 ..... Separated
- 6 ..... Common Law

Code '7' for unknown.

**STREET ADDRESS** ..... Mother's street address.

Found on the '*HOSPITAL ADMISSION FORM*'

Example: 4 King Street

**MAIL ADDRESS** ..... Mother's mail address.

*This field can be left blank if mail address is not documented or is the same as street address.*

Found on the '*HOSPITAL ADMISSION FORM*'

Example: P.O.Box 40, RR #2

**POSTAL CODE** ..... Mother's postal code.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'A1A1A1' where "A" is an alphabetic character and "1" is a number.

*Code '888888' when the postal code is known and outside of country, e.g. U.S.A., Britain, St. Pierre-Miquelon.*

Code '999999' for unknown.

**CITY/TOWN** ..... Mother's City, Town or Village of residence.

Found on the '*HOSPITAL ADMISSION FORM*'.

**PROVINCE** ..... Mother's province of residence.

Found on the '*HOSPITAL ADMISSION FORM*'

- AB ..... Alberta
- BC ..... British Columbia
- MB ..... Manitoba
- NS ..... Nova Scotia
- NB ..... New Brunswick
- NF ..... Newfoundland
- ON ..... Ontario
- PE ..... Prince Edward Island
- QC ..... Quebec
- SK ..... Saskatchewan
- YT ..... Yukon
- NU ..... Nunavut
- NT ..... Western Territory
- US ..... USA
- XX ..... Other countries



**MOTHER'S ATTENDING PHYSICIAN** ..... Physician most responsible for the patient's care *while in hospital*.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Registration Number.

*Code '88888' when physician is not registered in Nova Scotia.*

Code '99999' for unknown.

**DISCHARGE DATE** ..... Mother's discharge date from hospital.

Found on the '*NURSES NOTES*'

Use the following format: 'DDMMYYYY'.

**DISCHARGE TIME** ..... Mother's discharge time from hospital.

Found on the '*NURSES NOTES*'

Use the following format: 'HHMM'.

"HH" is in the range 0-23, "MM" is in range 0-59

If Discharge Time is not documented enter 1200.

**DISCHARGE DISPOSITION** ..... (Not Applicable at this time)

**CONTACT TYPE** ..... The contact type will automatically fill

**SEX** ..... The sex will automatically fill as **F** for female.

**MOTHER'S PROCESS STATUS** . . . . . Indicates the coding status of the admission information.

Code using one of the following:

1 . . . . Patient discharged, chart to be coded

2 . . . . Coding of chart in process'  
*The case is set to 2 automatically when it is accessed by the coder for the first time.*

3 . . . . Coding of admission information completed

The information which has been entered into the **Admit Screen** will automatically be transferred to the **Postpartum Screen**. Begin abstracting with the **Admitted From** variable.

**ADMITTED FROM** ..... Patient's location immediately prior to admission to hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

If patient is transferred from another hospital, record the standard 2 digit provincial code number for that facility found on pages 1-2.

*If patient comes from home, code '0'.*

**DATE OF LAST NORMAL MENSTRUAL PERIOD** ..... Date of patient's last normal menstrual period.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Use the following format: 'DDMMYYYY'

If the date of the last normal menstrual period is unknown, leave 'LMP date' blank and code '9' in the field immediately following.

**GRAVIDA** ..... The number of pregnancies, including the most recent pregnancy, which the patient has had..

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '99' for unknown.

**PARA** ..... The number of pregnancies, including the most recent pregnancy which resulted in one or more infants weighing 500 gm or more at birth (regardless of whether such infants were stillborn, died after birth or lived).

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '99' for unknown.

**ABORTIONS** ..... The number of pregnancies, including the most recent pregnancy, which resulted in a fetus weighing less than 500 grams or, when weight not known, less than 20 weeks gestation, regardless of whether the fetus was born alive.

Found on the '*PRENATAL RECORD*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Code '99' for unknown.

**REASON FOR ADMISSION** ..... The reason, as stated, for admission, regardless if this reason is later ruled out.

Found on the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*' or the '*NURSES' NOTES*'.

Code using the following reason for admission:

- 33 ..... Postpartum admission
- 37 ..... Mom accompanying sick  
baby, e.g.
- 40 ..... Other

**DISCHARGED TO** ..... The immediate destination of patient on discharge.

Found in the 'NURSES' NOTES' or the 'HOSPITAL ADMISSION FORM' or the 'PHYSICIANS' ORDER SHEET'.

Code using one of the standard 2 digit provincial codes for hospitals found on pages 1-2.

*If patient is discharged home, code 0.*

Code '-9' for *Maternal Death*.

**POSTPARTUM PROCESS STATUS** ... Indicates the coding status of **postpartum** routine information

Code using one of the following:

- 1 . . . . Patient discharged, chart to be coded
- 2 . . . . Coding of chart in process'  
*The case is set to 2 automatically when it is accessed by the coder for the first time.*
- 3 . . . . Coding of **postpartum routine** information completed
- 4 . . . . Frozen  
*The data can be viewed, but not changed. Indicates data are ready to be transferred to DataMart.*
- 5 . . . . Frozen  
*The data can be viewed, but not changed. Indicates data have been transferred to DataMart.*

Once data have been frozen, requests for any necessary changes or corrections must be sent to RCP.

**ROUTINE INFORMATION-NEONATAL ADMISSIONS**

**NEONATAL ADMISSIONS:**

- 1) Any infant with a birth weight of 500 grams or more, or a gestational age at birth of 20 or more completed weeks admitted or re-admitted to hospital up to 27 days, 23 hours, 59 minutes after birth.
- 2) Any infant transferred between hospitals, who had not been discharged home from hospital.
- 3) Any admission to the Special Care Nursery.

**INFANT'S UNIT NUMBER** . . . . . Infant's hospital unit number.

Found on the health record folder or the  
*'HOSPITAL ADMISSION FORM'* .

**CONTACT HOSPITAL** . . . . . Hospital in which the chart is being coded.  
*When only one hospital number is associated with a  
coder user name, this field will be auto-filled.*

Found on the *'HOSPITAL ADMISSION FORM'*

Code using one of the standard 2 digit provincial  
codes for hospitals found on pages 1-2.

**INFANT'S ADMISSION DATE** . . . . . Infant's admission date to hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

**INFANT'S ADMISSION TIME** . . . . . Infant's admission time to hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'.

"HH" is in the range 0-23, "MM" is in range 0-59

**GIVEN NAME(S)** . . . . . Infant's given name(s).

Found on the '*HOSPITAL ADMISSION FORM*'.

**SURNAME** . . . . . Infant's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

**INFANT'S A/S/D NUMBER** . . . . . Hospital number referring to the mother's present admission.

Found on the mother's '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'XXYYYYYY'  
where "XX" denotes the year (April 1 to March 31),  
changing on April 1st of each year, and "YYYYYY"  
is an ascension number related to the number of  
admissions of the year.

*Zeroes before the ascension number must be  
entered if number does not have 5 digits, e.g.  
00123.*

Code '999999' for other provincial account  
numbers, or when unknown.

**INFANT'S HEALTH CARD NUMBER** ..... Infant's health card number.

Found on the '*HOSPITAL ADMISSION FORM*'.

*Record Nova Scotia Health Card Numbers only.*

Code using one of the following if HCN unavailable:

- 0 ..... N.S. patient, lost card
- 0 ..... Armed Forces
- 0 ..... RCMP
- 0 ..... First Nations
- 0 ..... Self-paying
- 1 ..... Patient from outside N.S.

**INFANT'S BIRTH DATE** ..... Infant's date of birth.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

**MUNICIPAL CODE FOR INFANT'S RESIDENCE** ..... Infant's municipal code.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using municipal code listing found on pages 6-8.

**STREET ADDRESS** ..... Infant's street address.

Found on the '*HOSPITAL ADMISSION FORM*'

Example: 4 King Street

**MAIL ADDRESS** ..... Infant's mail address.

*This field can be left blank if mail address is not documented or the same as street address*

Found on the '*HOSPITAL ADMISSION FORM*'

Example: P.O. Box 40, RR#2



**POSTAL CODE** ..... Infant's postal code.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'A1A1A1'  
where "A" is an alphabetic character and "1" is a number.

*Code '888888' when the postal code is known and outside of country, e.g. U.S.A., Britain, St. Pierre-Miquelon.*

Code '999999' for unknown.

**CITY/TOWN** ..... Infant's city, town or village of residence.

Found on the '*HOSPITAL ADMISSION FORM*'

**PROVINCE** ..... Infant's province of residence.

Found on the '*HOSPITAL ADMISSION FORM*'

AB ..... Alberta  
BC ..... British Columbia  
MB ..... Manitoba  
NS ..... Nova Scotia  
NB ..... New Brunswick  
NF ..... Newfoundland  
ON ..... Ontario  
PE ..... Prince Edward Island  
QC ..... Quebec  
SK ..... Saskatchewan  
YT ..... Yukon  
NU ..... Nunavut  
NT ..... Western Territory  
US ..... USA  
XX ..... Other countries

**INFANT'S ATTENDING PHYSICIAN** ..... Physician most responsible for the patient's care *while in hospital*.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Registration Number.

*Code '88888' when physician is not registered in Nova Scotia.*

Code '99999' for unknown.

**DISCHARGE DATE** ..... Infant's discharge date from hospital

Found on the '*NURSES NOTES*'

Use the following format: 'DDMMYYYY'.

**DISCHARGE TIME** ..... Infant's discharge time from hospital

Found on the '*NURSES NOTES*'

Use the following format: 'HHMM'.

"HH" is in the range 0-23, "MM" is in range 0-59

If Discharge Time is not documented enter 1200.

**CONTACT TYPE** ..... The contact type will automatically fill.

**SEX** ..... The legal phenotypic sex of the infant, regardless of karyotype.

Found on the 'Birth Record'

Code using one of the following

F ..... Female

M ..... Male

A ..... Ambiguous

**NEONATAL PROCESS STATUS** . . . . . Indicates the coding status of the admission information.

Code using one of the following:

- 1 . . . . Patient discharged, chart to be coded.
- 2 . . . . Coding of chart in process'  
*The case is set to 2 automatically when it is accessed by the coder for the first time.*
- 3 . . . . Coding of admission information completed

The information which has been entered into the **Admits Screen** will automatically be transferred to the **Neonatal Screen** and **Address Screen**. Begin abstracting with the **Birth Order** variable

**BIRTH ORDER** ..... Infant's order of birth.

Found on the 'BIRTH RECORD' or the  
'*OPERATIVE REPORT*'.

Use one of the following codes:

- 1 . . . . Singleton, or first born of multiples.
  - 2 . . . . Second born of multiples.
  - 3 . . . . Third born of multiples..
  - 4 . . . . Fourth born of multiples.
- etc-

**ADMITTED FROM** ..... Infant's location immediately prior to admission to hospital.

Found on the 'HOSPITAL ADMISSION FORM'

If patient is transferred from another hospital,  
record the standard 2 digit provincial code number  
for that facility found on pages 1-2.

*If patient comes from home, code '0'*

**BIRTH HOSPITAL** ..... Infant's hospital of birth.

Found on the '*HOSPITAL ADMISSION FORM*' or  
the '*NURSES' NOTES*'.

Code using one of the standard 2 digit provincial  
codes for hospitals found on pages 1-2.

**SNCU** ..... Infant admitted to the Special Neonatal Care Nursery or Premature Nursery; or infants requiring special care in normal nursery where premature nursery not available.

Found in the '*PROGRESS NOTES*'.

Code using one of the following:

Y ..... Yes

N ..... No

If 'Y' is entered, the screen SCN dates will pop up. Enter the admit and discharge dates to and from the Special Care Nursery.

If there is more than one admission and discharge to the Special Care Nursery during the same admission, enter the dates of the second in the next row, etc.

**OUTCOME** ..... Found on the '*INFANT'S PROGRESS NOTES*'

Code using one of the following:

LVD ..... Infant lived to be discharged from hospital.

NND ..... Liveborn infant who died before being discharged home from hospital.

**DISCHARGED TO** ..... Immediate destination of infant on discharge from hospital.

Found in the '*PHYSICIANS' PROGRESS NOTES*' or the '*NURSES' NOTES*' or the '*PHYSICIANS' ORDER SHEET*'.

Code using one of the standard 2 digit provincial codes for hospitals found on pages 1-2.

*If patient is discharged home, code '0'*

Code '-9' for *Infant Death*

**AUTOPSY** ..... Completion of infant autopsy.

Found on the '*NEWBORN CODING SHEET*' or the '*AUTOPSY REPORT*'.

Code using one of the following:

LVD ..... Lived (e.g., not applicable)

YES ..... Died and autopsy done

NO ..... Died but autopsy not done

**INFANT'S PRIMARY CAUSE OF DEATH** ..... Found on the "*AUTOPSY REPORT*" or stated by the physician.

Leave blank if the infant lived.

SEE LISTING ON PAGES 58-59.

**DATE OF DEATH** ..... Date of infant's death.

Found in the '*NURSES' NOTES*' or the '*NEWBORN CODING SHEET*'.

Use the following format: 'DDMMYYYY'

*When infant weighed 400 grams or more, code date of fetal death.*

If Date of Death is unknown, or if infant weighed less than 400 grams, or if weight is unknown, leave 'Death Date' blank, and code '9' in the field immediately following.

**TIME OF DEATH** ..... Time of infant's death.

Found in the '*NURSES' NOTES*', or the '*NEWBORN CODING SHEET*'.

Use the following format: 'HHMM'

"HH" is in the range 0-23, "MM" is in range 0-59

If Time of Death is unknown, or if infant weighed less than 400 grams, or if weight is unknown, leave 'Death Time' blank, and code '9' in the field immediately following.

**NEONATAL PROCESS STATUS** . . . . . Indicates the coding status of **neonatal** routine information

Code using one of the following:

- 1 . . . . Patient discharged, chart to be coded.
- 2 . . . . Coding of chart in process'  
*The case is set to 2 automatically when it is accessed by the coder for the first time.*
- 3 . . . . Coding of **neonatal routine** information completed.
- 4 . . . . Frozen  
*The data can be viewed, but not changed.  
Indicates data are ready to be transferred to DataMart.*
- 5 . . . . Frozen  
*The data can be viewed, but not changed.  
Indicates data have been transferred to DataMart.*

Once data have been frozen, requests for any necessary changes or corrections must be sent to RCP.



**“LEFT BLANK INTENTIONALLY”**

**ROUTINE INFORMATION-ANOMALY ADMISSIONS**

**DEFINITION:** ..... An admission for a termination of pregnancy for a fetal or placental anomaly, regardless of the gestational age.

**PATIENT'S UNIT NUMBER** ..... Patient's hospital unit number.

Found on the health record folder or the '*HOSPITAL ADMISSION FORM*'.

**CONTACT HOSPITAL** ..... Hospital in which the chart is being coded.

*When only one hospital number is associated with a coder user name, this field will be auto-filled.*

Found on the '*HOSPITAL ADMISSION FORM*'

Code using one of the standard 2 digit provincial codes for hospitals found on pages 1-2.

**PATIENT'S ADMISSION DATE** ..... Patient's admission date to hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

**PATIENT'S ADMISSION TIME** ..... Patient's admission time to hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'.

"HH" is in the range 0-23, "MM" is in range 0-59

**GIVEN NAME(S)** ..... Patient's given name(s).

Found on the '*HOSPITAL ADMISSION FORM*'.

**SURNAME** ..... Patient's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

**PREVIOUS SURNAME** ..... Patient's maiden name or other previous surname.  
*This field can be left blank if not documented.*

Found on the '*HOSPITAL ADMISSION FORM*'

**PATIENT'S A/S/D NUMBER** ..... Hospital number referring to the patient's present admission.

Found on the mother's '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'XXYYYYYY'  
where "XX" denotes the year (April 1 to March 31),  
changing on April 1st of each year, and "YYYYYY"  
is an ascension number related to the number of  
admissions of the year.

*Zeroes before the ascension number must be  
entered if number does not have 5 digits, e.g.  
00123.*

Code '9999999' for other provincial account  
numbers, or when unknown.

**PATIENT'S HEALTH  
CARD NUMBER** ..... Patient's health card number.

Found on the '*HOSPITAL ADMISSION FORM*'.

*Record Nova Scotia Health Card Numbers only.*

Code using one of the following if HCN  
unavailable:

- 0 ..... N.S. patient, lost card
- 0 ..... Armed Forces
- 0 ..... RCMP
- 0 ..... First Nations
- 0 ..... Self-paying
- 1 ..... Patient from outside N.S.

**PATIENT'S BIRTH DATE** . . . . . Patient's date of birth.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'

**MUNICIPAL CODE FOR PATIENT'S RESIDENCE** . . . . . Patient's municipal code.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using municipal code listing found on pages 6-8.

**MARITAL STATUS** . . . . . Patient's marital status.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using one of the following:

- 1 . . . . . Single
- 2 . . . . . Married
- 3 . . . . . Widowed
- 4 . . . . . Divorced
- 5 . . . . . Separated
- 6 . . . . . Common Law

Code '7' for unknown.

**STREET ADDRESS** . . . . . Patient's street address.

Found on the '*HOSPITAL ADMISSION FORM*'

Example: 4 King Street

**MAIL ADDRESS** . . . . . Patient's mail address.

*This field can be left blank if mail address is not documented or the same as street address.*

Found on the '*HOSPITAL ADMISSION FORM*'

Example: P.O. Box 40, RR#2

**POSTAL CODE** ..... Patient's postal code.

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'A1A1A1'  
where "A" is an alphabetic character and "1" is a number.

*Code '888888' when the postal code is known and outside of country, e.g. U.S.A., Britain, St. Pierre-Miquelon.*

Code '999999' for unknown.

**CITY/ TOWN** ..... Patient's city, town or village of residence.

Found on the '*HOSPITAL ADMISSION FORM*'

**PROVINCE** ..... Patient's province of residence.

Found on the '*HOSPITAL ADMISSION FORM*'

AB ..... Alberta  
BC ..... British Columbia  
MB ..... Manitoba  
NS ..... Nova Scotia  
NB ..... New Brunswick  
NF ..... Newfoundland  
ON ..... Ontario  
PE ..... Prince Edward Island  
QC ..... Quebec  
SK ..... Saskatchewan  
YT ..... Yukon  
NU ..... Nunavut  
NT ..... Western Territory  
US ..... USA  
XX ..... Other countries

**PATIENT'S ATTENDING PHYSICIAN** ..... Physician most responsible for the patient's care *while in hospital*.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Registration Number.

*Code '88888' when physician is not registered in Nova Scotia.*

Code '99999' for unknown.

**DISCHARGE DATE** ..... Patient's discharge date from hospital

Found on the '*NURSES NOTES*'

Use the following format: 'DDMMYYYY'.

**DISCHARGE TIME** ..... Patient's discharge date from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'HHMM'.

"HH" is in the range 0-23, "MM" is in range 0-59

If Discharge Time is not documented enter 1200.

**DISCHARGE DISPOSITION** ..... (Not Applicable)

**CONTACT TYPE** ..... The contact type will automatically fill

**SEX** ..... The sex will automatically fill as **F** for female.

**PROCESS STATUS** . . . . . Indicates the coding status of the admission information.

Code using one of the following:

1 . . . . Patient discharged, chart to be coded.

2 . . . . Coding of chart in process'  
*The case is set to 2 automatically when it is accessed by the coder for the first time.*

3 . . . . Coding of admission information completed.

**HOSPITAL OF DELIVERY** . . . . . Hospital which the termination of pregnancy took place.

Found on the 'HOSPITAL ADMISSION FORM' or 'MATERNAL ADMISSION ASSESSMENT'.

Code using one of the standard 2 digit provincial codes for hospitals found on pages 1-2.

**ADMITTED FROM** . . . . . Patient's location immediately prior to admission to hospital.

Found on the '*HOSPITAL ADMISSION FORM*'.

If patient is transferred from another hospital, record the standard 2 digit provincial code number for that facility found on pages 1-2.

*If patient comes from home, code '0'.*

**DATE OF LAST NORMAL MENSTRUAL PERIOD** . . . . . Date of patient's last normal menstrual period.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Use the following format: 'DDMMYYYY'

If the date of the last normal menstrual period is unknown, leave 'LMP date' blank and code '9' in the field immediately following.

**PRE-CONCEPTUAL FOLATE INTAKE** . . . . . Patient's pre-conceptual folate intake.

Found on the '*PRENATAL RECORD*'.

Code using one of the following:

Y . . . . . Yes

N . . . . . No

Code '9' unknown.

**GRAVIDA** . . . . . The number of pregnancies, including the present pregnancy, which the patient has had.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '99' for unknown.

**PARA** . . . . . The number of pregnancies, excluding the present pregnancy, which resulted in one or more infants weighing 500 gm or more at birth (regardless of whether such infants were stillborn, died after birth or lived).

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '99' for unknown.



**ABORTIONS** ..... The number of pregnancies, excluding the present pregnancy, which resulted in a fetus weighing less than 500 grams or, when weight not known, less than 20 weeks gestation, regardless of whether the fetus was born alive.

Found on the '*PRENATAL RECORD*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Code '99' for unknown.

**NUMBER OF PREVIOUS FETAL DEATHS** ..... Number of previous fetal deaths specifically recorded as weighing 500 grams or more, and/or equal to or greater than 20 weeks gestation, or when documented as a fetal death by the physician.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '9' for unknown.

**NUMBER OF PREVIOUS NEONATAL DEATHS** ..... Number of previous neonatal deaths specifically recorded as weighing 500 grams or more *or* when documented as a neonatal death by the physician.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '9' for unknown.

**NUMBER OF PREVIOUS C-SECTIONS** ..... Number of previous C-sections.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIANS' ASSESSMENT*'.

Code '0' if no previous C-sections.

Code '9' for unknown.

**POSTPARTUM HEMORRHAGE  
IN A PREVIOUS PREGNANCY** . . . . . Postpartum hemorrhage in a previous pregnancy  
as stated *and/or* there has been blood loss > 500 ml.

Found on the '*PRENATAL RECORD*', or the  
'*PHYSICIANS' ASSESSMENT*' or the '*MATERNAL  
ADMISSION ASSESSMENT*'.

Code using one of the following:

Y . . . . . Yes

N . . . . . No

Code '9' for unknown.

**NUMBER OF PREVIOUS LOW  
BIRTH WEIGHT INFANTS** . . . . . Number of previous infants with birth weight less  
than or equal to 2499 grams (5lbs.8 oz.).

Found on the '*PRENATAL RECORD*' or the  
'*PHYSICIANS' ASSESSMENT*'.

Code '9' for unknown.

**NUMBER OF PREVIOUS  
OVERWEIGHT INFANTS** . . . . . Number of previous infants with birth weight  
greater than 4080 grams ( 9 pounds).

Found on the '*PRENATAL RECORD*' or the  
'*PHYSICIANS' ASSESSMENT*'.

Code '9' for unknown.

**PRE-PREGNANCY SMOKING** . . . . . Number of cigarettes smoked per day before the patient became pregnant.

Found on the '*PRENATAL RECORD*'.

Code the number of cigarettes smoked per day pre-pregnancy, with the following exceptions:

0 . . . . patient did not smoke pre-pregnancy

75 . . . patient smoked  $\geq 75$  cigarettes per day pre-pregnancy

88 . . . patient known to be a smoker pre-pregnancy, but number of cigarettes smoked per day is unknown

*NOTE: 1/2 PACK=13 CIGS, 1 PACK=25 CIGS*

*If the number is recorded in a range, code the highest number, e.g. 10-15 would be coded as 15.*

*If the number is contradicted on different forms, use the highest number recorded.*

Code '99' if not indicated whether or not patient smoked pre-pregnancy.

**SMOKING AT FIRST PRENATAL VISIT** . . . . . Number of cigarettes smoked per day at the time of the first prenatal visit.

Found on the '*PRENATAL RECORD*'.

Code the number of cigarettes smoked per day at the time of the first prenatal visit, with the following exceptions:

- 0 . . . . patient did not smoke at the time of the first prenatal visit
- 75 . . . patient smoked  $\geq 75$  cigarettes per day at the time of the first prenatal visit
- 88 . . . patient known to be a smoker at the time of the first prenatal visit, but number of cigarettes smoked per day is unknown

*NOTE: 1/2 PACK=13 CIGS, 1 PACK=25 CIGS  
If the number is recorded in a range, code the highest number, e.g. 10-15 would be coded as 15.*

*If the number is contradicted on different forms, use the highest number recorded.*

Code '99' if not indicated whether or not patient smoked at the time of the first prenatal visit.

**PRESENT PREGNANCY ANTEPARTUM BLEEDING  $\geq 20$  WEEKS** . . . . . Patient bleeding in present pregnancy greater than or equal to 20 weeks gestation.

Found on the '*PRENATAL RECORD*', or the '*PHYSICIANS' ASSESSMENT*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Code using one of the following:

- Y . . . . . Yes
- N . . . . . No

Code '9' for unknown.

**PREVIOUS GYN SURGERY** . . . . . Any uterine, tubal, vaginal or pelvic surgery, e.g. removal of: ovarian cysts, fibroids, surgery for endometriosis, anterior and posterior repair (bladder and bowel surgery), LEEP (Loop, electro, exisional procedure) repair of prolapses, suspension, and conizations, including laser and cryotherapy to cervix.

Found on the '*PRENATAL RECORD*', or the '*PHYSICIANS' ASSESSMENT*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

Code using one of the following:

Y . . . . . Yes  
N . . . . . No

*DO NOT INCLUDE diagnostic laparoscopies, (e.g. if done to investigate infertility, unless surgery is done at the same time), cervical punch biopsies, D and C, wart removal of any kind (even if the warts are on the cervix), or therapeutic abortions.*

Code '9' for unknown.

**PRE-PREGNANCY WEIGHT** . . . . . Patient's pre-pregnancy weight.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*'.

This field has been designed to allow either pounds (lbs.) or kilograms (kgs.) to be coded. If the weight is recorded in kilograms, it should be entered in kgs., and 'K' should be coded in the field immediately following, e.g. 60 K.

If the weight is recorded in pounds (lbs.), it should be entered in pounds, and 'P' should be coded in the field immediately following, e.g. 121 P.

*If weight not documented as a whole number, round to the nearest whole number.*

e.g. 60.2 kgs.=60 kgs.  
60.7 kgs.=61 kgs.

*If weight is recorded in a range, code the highest weight.*

e.g. 130-135 lbs.=135lbs.

*If pre-pregnancy weight is unknown, subtract weight gain from pre-delivery weight.*

Code '999' for unknown.

**PATIENT'S RH FACTOR** . . . . . Patient's Rh Status.

Found on the '*PRENATAL RECORD*', or the '*MATERNAL ADMISSION ASSESSMENT*', or the '*RED CROSS SHEET*' or the '*LAB REPORTS*'.

Code using one of the following:

POS . . . . . Rh positive  
NEG . . . . . Rh negative

Code '999' for unknown.

**PATIENT'S ANTEPARTUM ANTI-D Rh IMMUNE GLOBULIN** . . . . . Patient's antepartum anti-D Rh immune globulin administration.

Found on the '*PRENATAL RECORD*' or the '*MATERNAL ADMISSION ASSESSMENT*' or the '*RED CROSS SHEET*'.

Code using one of the following:

Y . . . . . Yes

N . . . . . No

Code '9' for unknown.

**ATTENDANCE AT PRENATAL CLASSES** . . . . . Patient's attendance at any prenatal classes.

Found on the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PRENATAL RECORD*'.

Code using one of the following:

Y . . . . . Yes

N . . . . . No

*Code for current pregnancy only.*

Code '9' for unknown.

**SMOKING AT TIME OF TERMINATION** . . . . . Number of cigarettes smoked per day at time of termination.

Found on the '*MATERNAL ADMISSION ASSESSMENT*' or the '*PHYSICIAN'S ASSESSMENT*' .

Code the number of cigarettes smoked per day at the time of the delivery, with the following exceptions:

- 0 . . . . patient did not smoke at the time of the delivery
- 75 . . . patient smoked  $\geq 75$  cigarettes per day at the time of the delivery
- 88 . . . patient known to be a smoker at the time of the delivery, but number of cigarettes smoked per day is unknown

*NOTE: 1/2 PACK=13 CIGS, 1 PACK=25 CIGS  
If the number is recorded in a range, code the highest number, e.g. 10-15 would be coded as 15.*

*If the number is contradicted on different forms, use the highest number recorded.*

Code '99' if not indicated whether or not patient smoked at the time of the delivery.



**PRESENT WEIGHT** ..... Patient's weight just before termination.

Found on the '*MATERNAL ADMISSION ASSESSMENT*', or the '*NURSES' NOTES*' or the '*PROGRESS NOTES*' **OR** patient's last weight (if within a week of delivery) on the '*PRENATAL RECORD*'

This field has been designed to allow either pounds (lbs.) or kilograms (kgs.) to be coded. If the weight is recorded in kilograms, it should be entered in kgs., and 'K' should be coded in the box immediately following, e.g. 60 K.

If the weight is recorded in pounds (lbs.), it should be entered in pounds, and 'P' should be coded in the box immediately following, e.g. 121 P.

*If weight not documented as a whole number, round to the nearest whole number.*

e.g. 60.2 kgs.=60 kgs.  
60.7 kgs.=61 kgs.

*If weight is recorded in a range, code the highest weight.*

e.g. 130-135 lbs.=135 lbs.

*If present weight is unknown, add pre-pregnancy and weight gain.*

Code '999' for unknown value.

**PATIENT'S PROCESS STATUS** . . . . . Indicates the coding status of **anomaly** routine information

Code using one of the following:

- 1 . . . . Patient discharged, chart to be coded
- 2 . . . . Coding of chart in process'  
*The case is set to 2 automatically when it is accessed by the coder for the first time.*
- 3 . . . . Coding of **anomaly routine** information completed
- 4 . . . . Frozen  
*The data can be viewed, but not changed. Indicates data are ready to be transferred to DataMart.*
- 5 . . . . Frozen  
*The data can be viewed, but not changed. Indicates data have been transferred to DataMart.*

**BIRTH ORDER** . . . . . Infant's order of birth during termination of pregnancy.

Found on the '*BIRTH RECORD*' or the '*OPERATIVE REPORT*'.

Use one of the following codes:

- 1 . . . . . Singleton, or first born of multiples,
- 2 . . . . . Second born of multiples,
- 3 . . . . . Third born of multiples,
- 4 . . . . . Fourth born of multiples
- etc-

**NUMBER OF FETUSES** ..... Code the number of fetuses which the mother carried to delivery during the present pregnancy.

Found on the '*BIRTH RECORD*' or the '*PRENATAL RECORD*', or the '*PHYSICIANS' ASSESSMENT*' or the '*MATERNAL ADMISSION ASSESSMENT*'.

- 1 ..... Singleton
- 2 ..... Twins
- 3 ..... Triplets
- 4 ..... Quadruplets
- etc-

**DATE OF INFANT'S BIRTH** ..... Date of infant's birth.

Found on the '*BIRTH RECORD*'.

Use the following format: 'DDMMYYYY'

If the date of infant's birth is unknown, leave 'birth date' blank, and code '9' in the field immediately following.

**TIME OF INFANT'S BIRTH** ..... Time of infant's birth.

Found on the '*BIRTH RECORD*'.

Use the following format: 'HHMM'

"HH" is in the range 0-23, "MM" is in range 0-59

If the time of infant's birth is unknown, leave 'birth time' blank, and code '9' in the field immediately following.

**SEX** ..... The legal phenotypic sex of the infant, regardless of karyotype.

Found on the '*BIRTH RECORD*'.

Code using one of the following:

F ..... Female

M ..... Male

A ..... Ambiguous

**BIRTH WEIGHT** ..... Infant's birth weight.

Found on the '*BIRTH RECORD*' or the '*NEWBORN WEIGHT GRAPH*' in grams.

If birth weight is  $\leq 40$  gms., code '40'.

If birth weights of abortions are unknown, code '40'.

If a viable infant ( $\geq 500$  gms or gest.  $\geq 20$  weeks) was born dead or died after birth and was not weighed, code '2501'.

*For Siamese twins, split weight between babies.*

*Do NOT take from Pathology Report.*

Code '9999' for unknown.

**PHYSICIAN ATTENDING TERMINATION** ..... The physician attending the termination.

Found on the '*BIRTH RECORD*' or the '*OPERATIVE RECORD*'.

Code using the Provincial Medical Board Registration Number.

*Code '88888' when physician is not registered in Nova Scotia.*

Code '99999' for unknown.

**PATIENT'S POSTPARTUM ANTI -D Rh IMMUNE GLOBULIN** . . . . . Found on the *Rh IMMUNOGLOBULIN REPORTING FORM*.

Code using one of the following:

Y . . . . Yes

N . . . . No

Code '9' for unknown.

**PATIENT DISCHARGED TO** . . . . . The immediate destination of patient on discharge.

Found in the '*NURSES' NOTES*' or the '*HOSPITAL ADMISSION FORM*' or the '*PHYSICIANS' ORDER SHEET*'.

Code using one of the standard 2 digit provincial codes for hospitals found on pages 1-2.

*If patient is discharged home, code 0.*

Code '-9' for *Maternal Death*

**MATERNAL ULTRASOUND** . . . . . Maternal Ultrasound.

Found on an '*ULTRASOUND REPORT*' anywhere within the chart.

Enter **Y** for *Yes, if an Ultrasound Report is found on the chart*. When 'Y' is entered, the Ultrasound screen will pop up. Enter appropriate values.

Enter **N** for *No, if an Ultrasound report is not found on the chart*. When an 'N' is entered, the Ultrasound Screen will not pop up as no details need be entered in the Ultrasound screen.

**DATE OF FIRST ULTRASOUND** . . . . . Date of **earliest** ultrasound during this pregnancy that is found on the chart.

Found on the '*ULTRASOUND REPORT*' .

Use the following format: 'DDMMYYYY' .

If an ultrasound is not available on the chart, leave field blank.

**CROWN/RUMP LENGTH** . . . . . Crown/rump length measurement recorded on first ultrasound done during this pregnancy.

Found on the '*ULTRASOUND REPORT*' .

Use the following format: 'XX.X' (in centimetres)

Decimal points must be entered.

If the crown/rump length is not recorded on the first ultrasound done during this pregnancy, leave this field blank, and code values for the following four variables: biparietal diameter, head circumference, abdominal circumference, and femur length.

If an ultrasound is not available on the chart, leave field blank.

**BIPARIETAL DIAMETER** . . . . . Biparietal diameter measurement recorded on first ultrasound done during this pregnancy.

Found on the '*ULTRASOUND REPORT*' .

Use the following format: 'XX.X' (in centimetres)

Decimal points must be entered.

If the crown/rump length has been coded from the report, leave this field blank. If an ultrasound is not available on the chart, leave variable field blank. If this measurement is not available on the ultrasound report, leave field blank.

**HEAD CIRCUMFERENCE** . . . . . Head circumference measurement recorded on first ultrasound done during this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'XX.X'(in centimetres)

Decimal points must be entered.

If the crown/rump length has been coded from the report, leave this field blank. If an ultrasound is not available on the chart, leave variable field blank. If this measurement is not available on the ultrasound report, leave field blank.

**ABDOMINAL CIRCUMFERENCE** . . . . . Abdominal circumference measurement recorded on first ultrasound done during this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'XX.X'( in centimetres)

Decimal points must be entered.

If the crown/rump length has been coded from the report, leave this field blank. If an ultrasound is not available on the chart, leave variable field blank. If this measurement is not available on the ultrasound report, leave field blank.

**FEMUR LENGTH** . . . . . Femur length measurement recorded on first ultrasound done during this pregnancy.

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'XX.X'( in centimetres)

Decimal points must be entered.

If the crown/rump length has been coded from the report, leave this field blank. If an ultrasound is not available on the chart, leave variable field blank. If this measurement is not available on the ultrasound report, leave field blank.

**CLINICAL ESTIMATE OF GESTATIONAL AGE** ..... The closest approximation in weeks to the gestational age obtained by physical examination of the infant.

Found on the '*PHYSICIAN NEWBORN EXAMINATION*' or the '*NEWBORN BIRTH ASSESSMENT*' or clearly stated by the physician.

Code stated number of completed weeks. The following is a guide:

- 38+ weeks ..... 38
- 38-40 weeks ..... 39
- 38-39 weeks ..... 38
- > 39 ..... 39
- Term ..... 40

Code '99' for unknown.

**OUTCOME OF INFANT** ..... Outcome of infant at time of discharge.

Found on the '*INFANT'S PROGRESS NOTES*'.

Code using one of the following:

- NND ..... Liveborn infant who died before being discharged home from hospital.
- FTD ..... Fetal death before birth.

**AUTOPSY** ..... Completion of infant autopsy.

Found on the '*NEWBORN CODING SHEET*' or the '*AUTOPSY REPORT*'.

Code using one of the following:

- YES ..... Died and autopsy done
- NO ..... Died but autopsy not done



**INFANT'S PRIMARY CAUSE OF DEATH** . . . . . This field will *auto fill* to **ANOM** congenital anomaly.

**PATIENT'S PROCESS STATUS** . . . . . Indicates the coding status of **anomaly** routine information

Code using one of the following:

- 1 . . . . Patient discharged, chart to be coded
- 2 . . . . Coding of chart in process'  
*The case is set to 2 automatically when it is accessed by the coder for the first time.*
- 3 . . . . Coding of **anomaly routine** information completed
- 4 . . . . Frozen  
*The data can be viewed, but not changed. Indicates data are ready to be transferred to DataMart.*
- 5 . . . . Frozen  
*The data can be viewed, but not changed. Indicates data have been transferred to DataMart.*

**DISEASES AND PROCEDURES****I. PREVIOUS PREGNANCY MATERNAL DISEASES**

- 0010 PHIL . . . . . Previous History of Personal Malignancy  
(Do not include Ca in-situ of cervix)  
000 = Previous history of personal malignancy
- 0040 PANT . . . . . Previously Sensitized Pregnancy  
(This code requires Code 0470 to be coded as well.  
Should be well documented, indicating that the antibodies now present are due to a  
previous pregnancy or abortion, e.g. not to include those due to a blood transfusion.)  
000 = Previously sensitized pregnancy
- 0050 PHIP . . . . . Hypertensive Disease In Previous Pregnancy  
(High blood pressure, toxemia, pre-eclampsia or hypertension, as stated in chart.)  
000 = Hypertensive disease in previous pregnancy
- 0060 PECL . . . . . Previous Eclampsia  
(Convulsions or eclampsia as stated on chart, excluding epilepsy.)  
000 = Previous eclampsia
- 0100 PECP . . . . . Previous Ectopic Pregnancy  
(Do not include blighted ovum.)  
000 = Previous ectopic pregnancy
- 0110 PMOL . . . . . Previous Molar Pregnancy  
(Do not include Blighted ovum. Do include Trophoblastic disease, hydatidiform  
mole, invasive mole, and choriocarcinoma, even if successfully treated in a previous  
pregnancy)  
000 = Previous molar pregnancy
- 0120 PLOH . . . . . Previous Anemia  
000 = Previous anemia
- 0130 PABP . . . . . Previous Abruptio Placenta  
000 = Previous abruptio placenta

0140 PRBR . . . . Previous Breech  
 000 = Previous breech

0150 PTEB . . . . Previous Thromboembolic Disease  
*(Code any previous Thrombophlebitis, deep vein thrombosis, pulmonary embolus wheher occurred during a pregnancy or not. Do not code if documented as superficial phlebitis.)*  
 000 = Previous thromboembolic disease

0160 PGLD . . . . Previous Gestational Diabetes  
 000 = Previous gestational diabetes

0170 PFER . . . . Previous History of Infertility  
*(As clearly indicated on the chart, eg. use of Clomid, or other fertility drugs. Do not code if secondary to tubal ligation.)*  
 000 = Previous history of infertility

0180 PPPD . . . . Previous Postpartum Depression  
 000 = Previous postpartum depression

**II. PRESENT PREGNANCY MATERNAL DIAGNOSES**

A. **OBSTETRICAL** *CODE ONLY IF PRESENT DURING ADMISSION. NOTE: ALL CODES, UNLESS OTHERWISE SPECIFIED, APPLY TO DELIVERED AND UNDELIVERED PATIENTS*

0190 ABRT . . . . Abortions  
*CODE ONLY IF OCCURS DURING ADMISSION.*  
 THR = Threatened abortion  
*(Uterine bleeding < 20 weeks gestation)*

**GUIDELINES FOR PREGNANCY-INDUCED HYPERTENSION****MILD PREGNANCY-INDUCED HYPERTENSION**

1. If P.I.H. is stated by the physician, it should always be coded (regardless of the values of the diastolic and systolic blood pressures).
2. If a patient is admitted from a physician's office with P.I.H., but it resolves on admission, code mild P.I.H. (NSV).
3. P.I.H. is to be coded if it occurs in the antepartum, intrapartum or postpartum period.
4. If Transient P.I.H. is stated as the diagnosis, code as mild (NSV).
5. If hypertension is *not* mentioned by the physician, do *not* code P.I.H. for an occasional elevation of the diastolic value > 90. The diastolic should be consistently elevated > 90 in a 24 hour period with at least 2 or more BP readings having been done.

**SEVERE PREGNANCY-INDUCED HYPERTENSION**

1. Code severe P.I.H. if:
  - the physician stated severe **OR**
  - the diastolic BP is  $\geq 110$  on at least 2 occasions within a 6 hour period.
2. Code severe P.I.H. if the patient has any degree of hypertension plus any one of a,b,c,d:
  - a) Magnesium sulfate is administered for hypertension
  - b) the patient has +2 or more protein (*provided there is no renal disease*)
  - c) the patient has coagulation problems (*decreased platelets, e.g. <100,000*)
  - d) the patient has liver involvement (*elevated liver enzymes, as per hospital lab values*)  
(Do not code Severe based on elevated Alk Phosphatase)
3. If the patient has P.I.H. with an occasional episode of BP 110 diastolic, but there is no real concern, code as mild (NSV)

**H.E.L.L.P. SYNDROME**

H.E.L.L.P. Syndrome should be clearly stated in the chart.

H.E.L.L.P. Syndrome and Severe P.I.H. are the most important to be captured as accurately and consistently as possible.

**PREGNANCY-INDUCED HYPERTENSION SUPERIMPOSED ON CHRONIC HYPERTENSION**

For P.I.H. superimposed on Chronic Hypertension, rely on the physician's diagnosis and code both PIHT and CHTD. Use the same guidelines for deciding on mild or severe P.I.H.

- 0200 CHTD . . . . Chronic Hypertensive Disease  
**CODE ONLY IF PRESENT DURING ADMISSION.**  
*(History of hypertensive disease when not pregnant prior to current pregnancy or prior to 20 weeks of current pregnancy; not due to trophoblastic disease--or as stated.)*  
000 = Chronic hypertensive disease
- 0210 PIHT . . . . Pregnancy-Induced Hypertension  
**CODE ONLY IF PRESENT DURING ADMISSION.**  
*(See guidelines on page 3. Include pre-eclampsia, toxemia and HELLP syndrome, or as stated by physician.)*  
HLP = HELLP syndrome  
*(Hemolysis, Elevated Liver Enzymes, Low Platelets. Do not need to code thrombocytopenia here.)*  
NSV = Not severe  
SEV = Severe
- 0220 ECLP . . . . Eclampsia  
**CODE ONLY IF PRESENT DURING ADMISSION.**  
*(One or more convulsions not attributable to other cerebral conditions such as epilepsy or cerebral hemorrhage in a patient with hypertension or as stated on chart by physician.)*  
000 = Eclampsia
- 0230 HEMS . . . . Hyperemesis Gravidarum  
**CODE ONLY IF PRESENT DURING ADMISSION.**  
*(Vomiting which required admission to hospital.)*  
*N.B. Do not include patients with vomiting due to other reasons.*  
000 = Hyperemesis gravidarum
- 0240 OLIG . . . . Oligohydramnios  
**CODE ONLY IF PRESENT DURING ADMISSION.**  
*(As stated in the chart.)*  
000 = Oligohydramnios
- 0250 POLY . . . . Polyhydramnios  
**CODE ONLY IF PRESENT DURING ADMISSION.**  
*(As stated in the chart or if more than 2000 cc's.)*  
000 = No treatment  
AMN = Amniocentesis  
IMT = Indomethacin

- 0260 PLPR . . . . Placenta Previa  
**CODE ONLY IF PRESENT DURING DELIVERED ADMISSION.**  
*(Confirmed by double set-up or at time of C-section. Diagnosis not to be made on ultrasound alone.)*  
000 = Placenta previa
- 0270 ABPL . . . . Abruptio Placenta  
**CODE ONLY IF PRESENT DURING DELIVERED ADMISSION.**  
*(Concealed or revealed placental abruption, not marginal separation, as stated at delivery -- diagnosis not to be made on ultrasound alone.)*  
000 = Abruptio placenta
- 0280 OTAH . . . . Other Antepartum Hemorrhage Per Vagina ( $\geq 20$  weeks gestation)  
**CODE ONLY IF PRESENT DURING ADMISSION.**  
*(Any unspecified hemorrhage occurring before the onset of labour,  $\geq 20$  weeks gestation. Include a suspected previa or abruptio in an undelivered patient. Include a patient who presents with bleeding which has resolved on admission.)*  
000 = Other antepartum hemorrhage per vagina
- 0290 PRUP . . . . Premature R.O.M.  
**CODE ONLY IF PRESENT DURING ADMISSION.**  
*(1. Spontaneous rupture of membranes before onset of contractions, regardless of gestation.*  
*2. Always code if stated by physician.*  
*3. Do NOT code if there is any uterine activity when membranes rupture, even if only irregular contractions or tightenings.*  
*The patient's membranes may rupture prematurely and then seal over. If there is clear documentation that there has been a previous ROM, before the onset of labour, code 0290.*  
000 = Premature R.O.M.
- 0300 FGAS . . . . Fetal Growth Concerns  
**CODE ONLY IF PRESENT DURING ADMISSION.**  
000 = Suspected or known IUGR or fetal malnutrition  
*(As stated in chart or if stated as known IUGR)*  
C01 = Suspected or known excessive fetal growth  
*(As stated in chart, e.g. due to maternal diabetes)*
- 0310 POST . . . . Post Dates (greater than 40 weeks)  
**CODE ONLY IF PRESENT DURING UNDELIVERED ADMISSION.**  
000 = Post dates

0320 PREM . . . . Premature Labour

**CODE ONLY IF PRESENT DURING UNDELIVERED ADMISSION.**

*(Admitted for suspected preterm labour. Onset of labour at 36 6/7 weeks gestation or less. Include patients who are suspected to be in premature labour, even if diagnosis is ruled out later.)*

000 = Premature labour

0330 ELSE . . . . Other Obstetrical Disease, Not Elsewhere Classifiable

**CODE ONLY IF PRESENT DURING ADMISSION.**

C00 = Uterine scar defect or dehiscence

*(As stated in operative report. Is usually not a serious situation and often is noted at the time of cesarean section as an unexpected finding in a woman who has had a previous cesarean section. May be described as marked "thinning" of the scar, or slight "separation" of the scar. If the wall has completely ruptured, see code C01.)*

C01 = Spontaneous ruptured uterus

*(As stated in operative report. A significant and serious event necessitating emergency surgery and can occur whether or not the woman has had a previous cesarean section. This is distinct from uterine scar dehiscence, see code C00.)*

C02 = Herpes gestationalis

C03 = Pruritic urticarial papules and plaques of pregnancy

C04 = Impetigo herpetiformis

*(Severe disease characterized by groups of pustules, affecting pregnant women.)*

C05 = Dermatitis herpetiformis

C06 = Separation of symphysis pubis

*(Includes symphysitis. Code only if requiring admission and code only for that admission.)*

0340 FLAB . . . . False Labour ( *Suspected Labour* )

**CODE ONLY IF PRESENT DURING UNDELIVERED ADMISSION.**

*(37 weeks gestation and over)*

000 = False labour

0350 MULG . . . . Multiple Gestation

**CODE ONLY IF PRESENT DURING UNDELIVERED ADMISSION.**

000 = Multiple gestation

0360 SUFA . . . . Suspected Fetal Anomaly

**CODE ONLY IF PRESENT DURING UNDELIVERED ADMISSION.**

000 = Suspected fetal anomaly

**B. NON-OBSTETRICAL****CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**

0370 GIDS . . . . . Gastro-Intestinal Disease

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**

CLL = Cholelithiasis

*(Do not code biliary colic)*

COL = Ulcerative colitis/proctitis

CRO = Crohn's disease

IBS = Irritable Bowel Syndrome

PCR = Pancreatitis, Acute and Chronic

RFG = Reflux Gastritis

ULC = Ulcers

*(All types)*

0380 DRUG . . . . . Maternal Drug Use During Present Pregnancy and/or Environmental Exposure

**CODE IF OCCURRED DURING CURRENT PREGNANCY**

C01 = Lithium

C02 = Maternal Exposure to noxious fumes (environmental)

C03 = Anti-hypertensives

C04 = Anti-depressives

C05 = Anti-epileptics

C06 = Anti-coagulation therapy

C07 = Chronic narcotic use

0390 ABUS . . . . . Chemical Abuse

**CODE IF OCCURRED DURING CURRENT PREGNANCY***(Includes alcohol, prescription medication and narcotic abuse. N.B. Code for hash, marijuana, cocaine, etc. if used anytime during pregnancy.)*

C01 = Alcohol abuse

*(Alcoholic or binge - NOT social)*

C02 = Chronic narcotic abuse and/or street drug abuse

*(e.g. morphine, cocaine, Demerol, heroin, hash, marijuana)*

C03 = Unspecific abuse

C04 = Prescription medication abuse

*(e.g. laxatives, sedatives such as Valium, Ativan, etc., over-the-counter drugs, "OTC's" such as Gravol)*



0400 PSIL . . . . . Psychiatric Illness

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**

- ANX = Anxiety disorders  
(*e.g. obsessive-compulsive disorders, agoraphobia, generalized anxiety disorders, panic disorders*)
- DEP = Depression
- EAT = Eating disorders  
(*e.g. anorexia nervosa, bulimia nervosa*)
- MDP = Manic-Depression
- SCH = Schizophrenia
- OTH = Other

0410 NRIL . . . . . Neurologic Illness **CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**

- BEP = Bell's palsy
- CBP = Cerebral palsy
- ESY = Epilepsy
- ICH = Intracerebral hemorrhage
- MUD = Muscular dystrophy
- MYG = Myasthenia gravis
- MUS = Multiple sclerosis
- ROD = Presence of Harrington Rod
- SAH = Subarachnoid hemorrhage
- SEZ = Seizure  
(*Antepartum, intrapartum, postpartum, NOT ECLAMPSIA*).
- TOS = Thoracic outlet syndrome
- TUS = Tuberos sclerosi
- OTH = Other  
(*Pseudotumour cerebri*)

## 0420 HRTD . . . . Heart Disease

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
**(Include rheumatic heart disease and congenital heart disease, as stated.)**

- ARR = Arrhythmias  
(S.V.T., P.A.T)
- CHD = Congenital heart disease  
(Not repaired)
- CRT = Cardiac arrest
- CTR = Coronary artery disease  
(Ischemic heart disease)
- EDC = Endocarditis
- HHR = History of heart disease or surgery  
(Congenital heart disease - repaired)
- MCF = Myocardial infarction
- MIT = Prolapsed mitral valve
- MYO = Cardiomyopathy
- MYS = Myocarditis
- PLH = Pulmonary hypertension
- RHD = Rheumatic heart disease
- VLV = Valve prosthesis  
(Takes precedence over other heart disease)
- WPW = Wolff Parkinson's White Syndrome
- OTH = Other acquired cardiac diseases

## 0430 GASI . . . . Gastroenteritis

**CODE IF PRESENT DURING ADMISSION**

- CND = Gastroenteritis, cause not determined
- FDP = Food poisoning, unspecified
- IFC = Infectious gastroenteritis
- SAL = Salmonella gastroenteritis
- VIR = Viral gastroenteritis

## 0440 THED . . . . Thromboembolic Disease - Antepartum

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
**(Exclude varicose veins; include thrombosis, deep vein thrombosis, pelvic thrombophlebitis, pulmonary embolism, prophylactic anticoagulation treatment.)**

- 000 = Thromboembolic disease

## 0450 AQCD . . . . Acquired Coagulation Disorder

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
**(Also code if occurs postpartum)**

- DIC = Disseminated intravascular coagulation (D.I.C.)
- HUS = Hemolytic uremic syndrome
- TTP = Thrombotic thrombocytopenic purpura

0460 JAUN . . . . Jaundice

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
**(Hyperbilirubinemia; use upper limit of normal for hospital laboratory values.)**

- FLP = Fatty liver of pregnancy  
 (Steatosis)  
 HEP = Serum Hepatitis Carrier  
 (Antigen positive; Hepatitis A, B, C, viral)  
 JOP = Jaundice of pregnancy/cholestatic liver disease of pregnancy

0470 MATB . . . . Maternal Antibodies

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
**(Use Red Cross Sheets)**

**RED BLOOD CELL ANTIBODIES**

- ALA = Anti-La  
 AND = Anti-D (*Rh*)  
 BGC = Anti-Big C (*C<sup>w</sup>*)  
 BGE = Anti-Big E  
 BGS = Anti-Big S  
 DHA = Anti-Dha (*DUCH*)  
 FYA = Anti-Fy<sup>a</sup> (*Duffy*)  
 KEL = Anti-Kell (*K<sub>1</sub>/K<sub>2</sub>*)  
 KID = Anti-Kidd (*JK<sub>a</sub>*)  
 LLC = Anti-Little c  
 LLE = Anti-Little e  
 LLS = Anti-Little s  
 LUT = Anti-Lutheran (*Lu<sup>a</sup>/Lu<sup>b</sup>*)  
 WRA = Anti-Wright (*Wr<sup>a</sup>/Wr<sup>b</sup>*)

**AUTOIMMUNE ANTIBODIES**

- ANC = Antinuclear Antibody (*ANA*)  
 CRN = Anti-Cardiolipin  
 DNA = Anti-DNA Antibody  
 LUP = Lupus Antibody (Lupus Anticoagulant)  
 SSA = Anti-SSA (*Ro*)

**ANTI-PLATELET ANTIBODIES**

- PLA = PL - A1 Platelet Antigen Negative

0480 FTTX . . . . Total Number of Fetal Transfusions During Current Pregnancy

*(Performed here or elsewhere)*

001 = One	006 = Six
002 = Two	007 = Seven
003 = Three	008 = Eight
004 = Four	009 = Nine
005 = Five	010 = Ten

*(Code on all admissions)*

0490 OTHR . . . . Other Non-Obstetrical Disease, Not Elsewhere Classifiable

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**

ANS = Ankylosing spondylitis  
CHS = Cholinesterase Deficiency  
MHT = Family or personal history of Malignant Hyperthermia  
NFM = Neurofibromatosis  
*(Von Recklinghausen's Disease)*  
PHY = Porphyria  
PKU = Maternal phenylketonuria  
RHA = Rheumatoid arthritis/Psoriatic  
SAR = Sarcoidosis  
SCD = Scleroderma  
SCO = Scoliosis  
SJO = Sjogren's Syndrome  
SLE = Systemic lupus  
SHM = Scheurmann's Disease

0510 CRIN . . . . Endocrine

**FOR APPLICABLE CONDITIONS, CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**

ADH = Disorder of Adrenal Gland  
DOV = Disorder of Ovary  
*(If significant and indicated by physician. For MALIGNANCY (TERATOMA) of OVARY - see CODE 0540)*  
HAS = Hashimoto's Thyroiditis  
*(Autoimmune thyroiditis)*  
HI2 = Hyperthyroidism with Goiter  
HI3 = Hyperthyroidism with Thyroid nodule  
HI4 = Hyperthyroidism with Goiter, nodular  
HI5 = Hyperthyroidism without Goiter  
HY2 = Hypothyroidism  
HIP = Hyperparathyroidism  
HYT = Disorder of Hypothalamus  
PIT = Disorder of Pituitary gland

## 0520 DIAB . . . . . Diabetes

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY UNDELIVERED PATIENTS ONLY.**

*(See CODE 2910 for Joslin Clinic and O'Sullivan values.*

*Determine class using duration of disease.)*

CLA = Class A *(Two abnormal values on a GTT, during pregnancy only - Gestational diabetes. If a patient's GTT values are unknown, or only 1 value is known, but patient is administered insulin, code as CLA.)*

CLB = Class B *(Less than 10 years duration, no vascular disease; onset after age 20 years.)*

CLC = Class C *(Duration 10-19 years, minimal vascular disease; onset after age 10 years.)*

CLD = Class D *(Duration 20 years or more; benign retinopathy; onset before age 10 years.)*

CLF = Class F *(Patient with Class D and nephropathy.)*

CLR = Class R *(Patient with proliferative retinopathy.)*

CLT = Class T **(Diagnosis made by level of Trutol equal to or greater than 10.3mmol/l)**

UKN = Class unknown

## 0530 RENL . . . . . Renal Disease

**UNLESS OTHERWISE SPECIFIED, CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**

*(Do not include lower urinary tract infection - code 1590)*

APN = Acute pyelonephritis

*(Code if present during admission. See 0530 HAP for previous resolved episodes during this pregnancy.)*

CAL = Renal calculus

GLO = Chronic glomerulonephritis

HAP = Previous episode of acute pyelonephritis during current pregnancy

HYD = Hydronephrosis

NEP = Nephropathy

NRS = Nephrotic syndrome

PCK = Polycystic kidney disease

PYL = Chronic pyelonephritis

RAG = Renal agenesis

*(Absent kidney)*

TPL = Renal transplant

UND = Chronic renal disease, type undetermined

UTP = Lower urinary tract problems

*(Include bladder diverticuli, Hunners ulcer, urinary reflux)*

## 0540 MLIG . . . . Neoplasms, Including Malignancies

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
**(For history of malignancy, see Code 0010.)**

BOW = Bowel

BRS = Breast

CVX = Cervix

OTH = Other

*(e.g. Hodgkin's, neurofibromatosis)*

OVA = Ovary (*Teratoma*)

*(Code ovarian cancer as active until 5 years has elapsed from the date of the last known treatment.)*

THD = Thyroid

VAG = Vagina

## 0550 BDYS . . . . Blood Dyscrasias

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**

ANM = Hemolytic anemia

*(e.g. hereditary spherocytosis)*

DFG = Dysfibrinogenemia

F12 = Factor 12 deficiency

FIB = Familial hypofibrinogenemia

FT8 = Factor VIII deficiency

G6P = G6PD deficiency

IHA = Idiopathic Hypoplastic Anemia

ITP = Idiopathic thrombocytopenic purpura

SIC = Sick cell anemia

THL = Thalassemia

VON = Von Willebrand's disease

FT5 = Factor V Leiden Deficiency

## 0551 THRM . . . . Thrombocytopenia

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
**(Code the lowest platelet count reported.)**

MLD = Mild (100,000-150,000 platelet count)

MOD = Moderate (50,000-<100,000 platelet count)

SVR = Severe (<50,000 platelet count)

## 0560 ANEM . . . . Anemia

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
**(Antepartum Hgb <10 gm% e.g. 9.5 Hgb (antepartum) recorded on Prenatal Record.)**

000 = Anemia

## 0570 UABN . . . . Uterine Abnormalities

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
**(Septate uterus, Unicornuate, Bicornuate, Cervical incompetence.**

**Exclude cervical stenosis and fibroids unless causing antenatal concern.)**

000 = Uterine abnormalities

## 0580 PULD . . . . Pulmonary Disease

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**

AMA = Asthma

CFS = Cystic fibrosis

OED = Pulmonary edema

**(Includes antepartum and intrapartum)**

OTH = Other significant pulmonary diseases

PNM = Pneumonia, antepartum

## 0591 OTHD . . . . Other Non-Obstetrical Disorders

**CODE ONLY IF PRESENT DURING ADMISSION**

ABA = Abscess of Bartholin's Gland

ANR = Anaphylactic reaction

**(Violent allergic reaction)**

CEV = Cervicitis

**(Code also any hemorrhage.)**

CYB = Cyst of Bartholin's Gland

LCV = Leukocytoclastic vasculitis

OAD = Other adverse drug reaction

**(e.g. drug overdose, blood transfusion reaction)**

## 0592 MCHA . . . Maternal Chromosomal Abnormalities

**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**

MSC = Mosaicism

**(As stated by physician or on the chromosome report; or if stated that there are two or more different cell lines.)**

OTH = Other chromosomal abnormalities

**(As stated by physician. Include trisomy, inversions, deletions, etc.)**

TRN = Translocation

**(As stated by physician or on the chromosome report.)**

**C. LABOUR COMPLICATIONS CODE IF CONDITION IS PRESENT DURING ADMISSION**

0600 FETD . . . . Fetal Distress (*As stated in the chart*)

SUS = Suspected (*Undelivered*)

000 = Fetal distress (*Delivered*)

1. *As stated by physician in chart, NOT by abnormal rhythms only.*
2. *"Prolonged tachycardia", "prolonged bradycardia", "prolonged decelerations" or "non-reassuring heart rate" requiring medical interventions", such as episiotomy, forceps, c/s and/or vacuum extraction. Do not include an induction if it is initiated for fetal distress.*
3. *A scalp pH < 7.2 is definitely fetal distress.*

0610 IHEM . . . . Intrapartum Hemorrhage

*(Blood loss of > 500 cc., during labour and before delivery of baby, or as stated by physician or nursing staff. Includes Cesarean section if blood loss occurs before delivery of baby.)*

000 = Intrapartum hemorrhage

0620 PYRL . . . . Pyrexia In Labour

*(Temperature elevation  $\geq 38.0$  C, during labour irrespective of cause.*

*e.g. If a patient has a U.T.I. causing the pyrexia, code both 0620 and 1590.)*

000 = Pyrexia in labour

0660 DXOP . . . . Destructive Operation

C01 = Drainage of head

C02 = Suprapubic drainage of myelomeningocele/meningocele

0681 CSHM . . . . Blood Loss During Cesarean Section

*(This code should be used for all C-section deliveries to indicate blood loss, so that patients are not inappropriately coded as postpartum or intrapartum hemorrhages. If a patient has an intrapartum hemorrhage clearly stated as blood loss during labour and not due to the c/s, 0610 IHEM may be used.)*

*(Postpartum hemorrhages (1100,1110) may also be coded, if applicable).*

C01 = < 500 cc's.

*(or stated as "normal" or "average")*

C02 = 500 - 700 cc's.

C03 = > 700 cc's.

UKN = Unknown/not specified



**D. NON-DELIVERY PROCEDURES**

## 0690 RSUT . . . . Removal of Cervical Suture

000 = No anesthesia  
ACU = Acupuncture  
DBN = Spinal/Epidural Double Needle  
*(Combined technique)*  
EPI = Epidural  
GEN = General  
HYP = Hypnosis  
KET = Neuroleptic  
LOC = Local  
SPL = Spinal

## 0700 TUBE . . . . Tubal Sterilization

000 = No anesthesia  
ACU = Acupuncture  
DBN = Spinal/Epidural Double Needle  
*(Combined technique)*  
EPI = Epidural  
GEN = General  
HYP = Hypnosis  
KET = Neuroleptic  
LOC = Local  
SPL = Spinal

## 0710 CSUT . . . . Cervical Encerclage

*(Any surgical procedure for incompetent cervix)*

000 = No anesthesia  
ACU = Acupuncture  
DBN = Spinal/Epidural Double Needle  
*(Combined technique)*  
EPI = Epidural  
GEN = General  
HYP = Hypnosis  
KET = Neuroleptic  
LOC = Local  
SPL = Spinal

## 0720 LAPR . . . . Laparoscopy

000 = No anesthesia  
ACU = Acupuncture  
DBN = Spinal/Epidural Double Needle  
*(Combined technique)*  
EPI = Epidural  
GEN = General  
HYP = Hypnosis  
KET = Neuroleptic  
LOC = Local  
SPL = Spinal

## 0721 LAPT . . . . Laparotomy

000 = No anesthesia  
ACU = Acupuncture  
DBN = Spinal/Epidural Double Needle  
*(Combined technique)*  
EPI = Epidural  
GEN = General  
HYP = Hypnosis  
KET = Neuroleptic  
LOC = Local  
SPL = Spinal

## 0730 DILC . . . . Dilatation and Curettage of the uterus after delivery or abortion

000 = No anesthesia  
ACU = Acupuncture  
DBN = Spinal/Epidural Double Needle  
*(Combined technique)*  
EPI = Epidural  
GEN = General  
HYP = Hypnosis  
KET = Neuroleptic  
LOC = Local  
SPL = Spinal

## 0731 ODIL . . . . . Other dilatation and curettage (Diagnostic)

000 = No anesthesia  
ACU = Acupuncture  
DBN = Spinal/Epidural Double Needle (*Combined technique*)  
EPI = Epidural  
GEN = General  
HYP = Hypnosis  
KET = Neuroleptic  
LOC = Local  
SPL = Spinal

## 0740 MRPL . . . . . Manual Removal of Placenta

*(This is an invasive procedure involving insertion of the hand. Do not code if part of C-section procedure. Do not code if the physician merely uses forceps to remove membranes protruding through the cervix.)*

000 = No anesthesia  
ACU = Acupuncture  
DBN = Spinal/Epidural Double Needle (*Combined technique*)  
EPI = Epidural  
GEN = General  
HYP = Hypnosis  
KET = Neuroleptic  
LOC = Local  
SPL = Spinal

OTH = Other

*(any other agent used to perform this procedure such as Nitrous Oxide, Fentanyl and Nitroglycerine)*

## 0750 AMNI . . . . . Amniocentesis

*(Code reason test was performed. Code AMNIOCENTESIS for polyhydramnios treatment under 0250. Bring code forward to delivered admission. Code any amniocentesis performed out of province or at an other facility )*

GNT = Genetic testing  
ISO = Isoimmunization testing  
LUM = Lung maturity testing  
ATT = Amniocentesis attempted no fluid obtained

## 0751 CHVS . . . . . Chorionic Villi Sampling

*(Code reason test was performed. Bring code forward to the delivered admission. Code any Chorionic Villi Sampling performed out of province or at an other facility).*

GNT = Genetic testing

## 0760 OOPH . . . . Salpingo-oophorectomy

*(Code anesthetic under Codes 1020-1040.)*

C00 = Unilateral oophorectomy

C01 = Unilateral salpingectomy

C02 = Bilateral salpingectomy

C11 = Unilateral salpingo-oophorectomy

C12 = Bilateral salpingo-oophorectomy

C13 = Bilateral salpingectomy and unilateral oophorectomy

## 0770 APPD . . . . Appendectomy

000 = No anesthesia

ACU = Acupuncture

DBN = Spinal/Epidural Double Needle

*(Combined technique)*

EPI = Epidural

GEN = General

HYP = Hypnosis

KET = Neuroleptic

LOC = Local

SPL = Spinal

## 0780 HYST . . . . Hysterectomy

000 = No anesthesia

ACU = Acupuncture

DBN = Spinal/Epidural Double Needle

*(Combined technique)*

EPI = Epidural

GEN = General

HYP = Hypnosis

KET = Neuroleptic

LOC = Local

SPL = Spinal

## 0790 OPRO . . . . Other Non-Delivery Procedure

**(Include Manual Exploration of Uterine Cavity and/or drainage of a wound)**

000 = No anesthesia

ACU = Acupuncture

DBN = Spinal/Epidural Double Needle

*(Combined technique)*

EPI = Epidural

GEN = General

HYP = Hypnosis

KET = Neuroleptic

LOC = Local

SPL = Spinal

**E. ANALGESIA DURING LABOUR (EXCLUDE ANTEPARTUM STILLBIRTHS)  
CODE IF ADMINISTERED DURING DELIVERED ADMISSION.**

*For codes 0800 to 0931, use the modifiers listed below. Code all analgesics administered before delivery, during the delivered admission. If the same analgesic is administered more than once, code the administration closest to the time of delivery, even if the same analgesic is administered by a different route. Only code twice if the analgesic is administered by two different routes at the exact same time.*

- L10 = Administered via an unknown route, less than 1 hr. prior to delivery
- 120 = Administered via an unknown route, 1 to less than 2 hr. prior to delivery
- 240 = Administered via an unknown route, 2 to 4 hr. prior to delivery
- G40 = Administered via an unknown route, greater than 4 hr. prior to delivery
  
- L11 = Administered I.M., less than 1 hr. prior to delivery
- 121 = Administered I.M., 1 to less than 2 hr. prior to delivery
- 241 = Administered I.M., 2 to 4 hr. prior to delivery
- G41 = Administered I.M., greater than 4 hr. prior to delivery
  
- L12 = Administered I.V., less than 1 hr. prior to delivery
- 122 = Administered I.V., 1 to less than 2 hr. prior to delivery
- 242 = Administered I.V., 2 to 4 hr. prior to delivery
- G42 = Administered I.V., greater than 4 hr. prior to delivery

0800 NISL . . . . . Alphaprodine (Nisentil)  
*(SEE LIST OF MODIFIERS)*

0810 DEML . . . . . Meperidine (Demerol)  
*(SEE LIST OF MODIFIERS)*

0820 SECO . . . . . Secobarbital (Seconal)  
*(SEE LIST OF MODIFIERS)*

0830 TUIN . . . . . Amo-Secobarb Hypnotic (Tuinal)  
*(SEE LIST OF MODIFIERS)*

0840 NEMB . . . . . Pentobarbital Hypnotic (Nembutal)  
*(SEE LIST OF MODIFIERS)*

0850 VALM . . . . . Diazepam Tranquillizer (Valium)  
*(SEE LIST OF MODIFIERS)*

0860 SPAR . . . . Promazine Tranquillizer (Sparine)  
*(SEE LIST OF MODIFIERS)*

0870 LARG . . . . Chlorpromazine Tranquillizer (Largactil)  
*(SEE LIST OF MODIFIERS)*

0880 PHER . . . . Promethazine Tranquillizer (Phenergan)  
*(SEE LIST OF MODIFIERS)*

0890 MORF . . . . Morphine (includes Opium/Pantopon)  
*(SEE LIST OF MODIFIERS)*

0900 NUBN . . . . Nalbuphine (Nubain)  
*(SEE LIST OF MODIFIERS)*

0910 DILD . . . . Hydromorphone HCl (Dilaudid)  
*(SEE LIST OF MODIFIERS)*

0920 TLWN . . . . Pentazocine (Talwin)  
*(SEE LIST OF MODIFIERS)*

0930 FENL . . . . Sublimaze (Fentanyl)  
*(SEE LIST OF MODIFIERS)*

0931 OADB . . . . Other Analgesia During Labour  
*(SEE LIST OF MODIFIERS)*

**F. ANESTHESIA DURING LABOUR/DELIVERY**

0940 SPIN . . . . . Spinal Anesthesia

LAB = Labour only

DEL = Delivery only

LXD = Labour and delivery

0950 OADL . . . . . Other Anesthesia For Labour/Delivery

ACU = Acupuncture

HYP = Hypnotism

KET = Neuroleptic

0960 GENA . . . . . General Anesthesia

LAB = Labour only

DEL = Delivery only

LXD = Labour and delivery

0970 ETOX . . . . . Entonox (*Nitronox*)*(The effects of entonox last for approximately 30 seconds.)*

LAB = Labour only

DEL = Delivery only

LXD = Labour and delivery

0980 EPIS . . . . . Epidural - Single Administration

LAB = Labour only

DEL = Delivery only

LXD = Labour and delivery

0990 EPIC . . . . . Epidural - Continuous Catheter With Intermittent Drug Administration

LAB = Labour only

DEL = Delivery only

LXD = Labour and delivery

1000 IFUS . . . . . Epidural, Continuous Infusion of Drug (CIEA)

LAB = Labour only

DEL = Delivery only

LXD = Labour and delivery

1001 PCEA . . . . Patient Controlled Epidural Analgesia (PCEA)

LAB = Labour only  
DEL = Delivery only  
LXD = Labour and delivery

1002 PCIA . . . . Patient Controlled Intravenous Analgesia

**(Do not code narcotic administered)**

LAB = Labour only  
DEL = Delivery only  
LXD = Labour and Delivery  
PST = Post-operative  
*(After a C-Section, tubal ligation, other surgeries.)*

1010 PUDL . . . . Pudendal

000 = Pudendal

1011 SEDN . . . . Spinal/Epidural double needle

*(Combined technique. Code also 0990, 1000, and/or 1001, when applicable.)*

LAB = Labour only  
DEL = Delivery only  
LXD = Labour and delivery



**G. ANESTHESIA FOR NON-DELIVERY PROCEDURES**

*(Used only when anesthetic cannot be coded with the specific procedure.)*

1020 GASS . . . . Non-Delivery General Anesthesia  
000 = Non-delivery general anesthesia

1030 OEPI . . . . Non-Delivery Epidural Anesthesia  
**(Use for Repair of Tear after a delivered episode, and if an epidural is  
administrered during false labour.**  
000 = Non-delivery epidural anesthesia

1040 OTAN . . . . Other Anesthetic  
**(Use for Repair of Tear after a delivered episode, and if an epidural is administered  
during false labour.)**  
SPL = Spinal  
KET = Neuroleptic

## **H. LACERATIONS**

### 1050 LACR . . . . Laceration

*(As stated on Labour and Delivery Record, regardless of whether episiotomy was done. Code the highest degree of tear. If the degree of the tear is unspecified, code 1st degree. If cervical and/or periurethral tears are stated in addition to 1st, 2nd, 3rd, or 4th degree tears, code the cervical and/or the periurethral tear and the highest degree of the other tear.)*

FER = 1st degree tear

SEC = 2nd degree tear

ANA = 3rd degree tear or Anal sphincter

REC = 4th degree tear or Rectal mucosa

CER = Cervical tear

PTR = Periurethral tear

### 1060 OTMT . . . . Other Maternal Trauma

*(Includes laceration of uterine artery, severe extension of uterine incision, laceration of bladder, bowel, ureter, etc. Do not code minor perineal or vaginal lacerations.)*

000 = Other maternal trauma

**I. POSTPARTUM COMPLICATIONS*****CODE ONLY CONDITIONS PERTAINING TO POSTPARTUM PERIOD.***

- 1100 EPPH . . . . . Early Postpartum Hemorrhage  
*(Within the first 24 hours postpartum; as noted by the physician; or, if there has been estimated blood loss greater than 500 cc's.  
Code also Retained Placenta, 1120, if applicable.  
Code after a c-section if clearly stated as occurring postpartum)*  
000 = Early postpartum hemorrhage
- 1110 LPPH . . . . . Late Postpartum Hemorrhage  
*(After 24 hours postpartum, as noted by the attending physician.  
Code also Retained Placenta, 1120, if applicable.)*  
000 = Late postpartum hemorrhage
- 1120 RTPL . . . . . Retained Placenta  
*(The retention within the uterus of the placenta or a fragment of the placenta and/or membranes after 30 minutes postpartum or as stated. Do include clots with tissue, membranes or portions of membranes. Code also any postpartum hemorrhage, if applicable. For retained membranes, code ONLY IF DEFINITE. Do not code if stated as "questionable tissue in clot", or "possible tissue in clot". Do Code if clearly stated by physician even if the placenta has not been retained for 30 minutes and you are unable to code the corresponding Manual Removal of Placenta Code)*  
  
000 = Retained placenta
- 1130 IVUT . . . . . Inverted Uterus  
*(Code if occurs during a c-section and clearly stated by a physician)*  
000 = Inverted uterus
- 1140 HEMT . . . . . Hematoma  
EPY = Episiotomy or tear  
WND = Wound  
*(C/s wound)*  
PEL = Pelvic  
*(Not c/s wound, Ischio-rectal space, broad ligament)*  
LBL = Labial  
*(Vulvar)*
- 1150 DHIS . . . . . Wound Dehiscence  
*(Includes eviscerations and/or dehiscence as stated in chart, not gaping wound.)*  
000 = Wound dehiscence

- 1160 PPDP . . . . Postpartum Depression  
(*As noted by the psychiatric consultant.*)  
000 = Postpartum depression
- 1170 PEMB . . . . Pulmonary Embolus  
(*Proven or suspected to the extent that treatment was required.*)  
000 = Pulmonary embolus
- 1180 ATEL . . . . Pulmonary Atelectasis, postpartum  
(*Not due to anesthesia.*)  
000 = Pulmonary atelectasis
- 1190 EFFU . . . . Pleural Effusion or Pulmonary Edema, postpartum  
(*Not due to anesthesia.*)  
000 = Pleural effusion
- 1200 PNMO . . . . Pneumothorax, postpartum  
(*Not due to anesthesia.*)  
000 = Pneumothorax
- 1210 RENF . . . . Renal Failure  
000 = Renal failure
- 1220 HRTF . . . . Heart Failure  
000 = Heart failure
- 1230 EVAC . . . . Evacuation of Hematoma  
000 = No anesthesia  
ACU = Acupuncture  
DBN = Spinal/Epidural Double Needle  
(*Combined technique*)  
EPI = Epidural  
GEN = General  
HYP = Hypnosis  
KET = Neuroleptic  
LOC = Local  
SPL = Spinal

1240 OTPC . . . . Other Postpartum Complications

- FTD = Foot drop  
*(Not due to anesthesia. Foot Drop due to anesthesia, see Code 1850 FDRP.)*
- HBD = Hypoxic brain damage  
*(Encephalopathy)*
- ILS = Paralytic ileus  
*(Include post-operative ileus)*
- OBS = Bowel obstruction
- ONI = Other neurological injury/deficit resulting from delivery  
*(eg. numbness, limb weakness, femoral/peripheral nerve injury)*
- OSC = Other significant postpartum complications

1250 PPAN . . . . Postpartum Anemia

- (As stated in chart.)*
- 000 = Postpartum anemia  
*(Hgb < 10 gm%)*

**J. POSTPARTUM INFECTION IF MOTHER IS A MABLE PATIENT, CODE DIAGNOSIS AS STATED BY MABLE NURSE AND/OR PATIENT.**

1300 ENDM . . . . Endometritis

000 = Endometritis

1310 MAST . . . . Mastitis

000 = Mastitis

1320 URTI . . . . Urinary Tract Infection

*(Confirmed by positive urine culture of > 100,000 colonies/ml.)*

000 = Urinary tract infection

1330 WINF . . . . Wound Infection

*(Infected abdominal or episiotomy wound - code if stated by physician or if documented as passage of significant amount of purulent material from the wound site. Do not code if described as scant, or as small purulent pustules at the staples or stitches.)*

CSN = Abdominal incision

EPY = Episiotomy or tear

1340 TPHB . . . . Thrombophlebitis, include DVT

000 = Thrombophlebitis

1350 SEPT . . . . Septicemia

*(Noted by a positive blood culture - presence of any bacteria.)*

000 = Septicemia

1360 PERT . . . . Peritonitis

000 = Peritonitis

1370 OPPI . . . . . Other Postpartum Infections  
(*Code only if first reported in postpartum period.*)

ADS = A.I.D.S.  
CHL = Chlamydia  
CON = Condyloma acuminata  
GBS = Group B Streptococcus  
GON = Gonorrhea  
HER = Herpes  
LIS = Listeria  
MYC = Mycoplasma  
SYP = Syphilis  
VAR = Varicella

1380 PUKO . . . . . Pyrexia, Unknown Cause, as stated on chart  
(*1 episode or more of  $\geq 38^{\circ}\text{C}$ , postpartum.*)

000 = Pyrexia, unknown cause

1390 PUER . . . . . Puerperal Morbidity  
( *$38^{\circ}\text{C}$ . or more on 2 or more occasions, at least 4 hours apart, in any 48 hour period, excluding the first 24 hours after delivery, regardless of cause.*)

000 = Puerperal morbidity

1400 PULM . . . . . Pulmonary Infection  
(*Includes postpartum pneumonia*)

000 = Pulmonary infection

**K. MATERNAL THERAPY**

1460 EXTV . . . . External Version

*(Code if done anytime during pregnancy. INCLUDE external versions performed in OPD, physicians' offices, or during hospital admission, including delivered admissions.)*

SUC = Successful - vertex position at completion of procedure

UNS = Unsuccessful - NOT vertex position at completion of procedure

1470 OTTX . . . . Other Transfusions

ALB = Albumin

CRY = Cryoprecipitate Transfusion

FFP = Fresh Frozen Plasma

GAM = Gamma Globulin

PEX = Plasma Exchange/Plasmapheresis

PLT = Platelet Transfusion

1480 MSO4 . . . . Magnesium sulfate therapy(MgSO4)

*(Used for hypertension or seizures. Code 1530 TOTH for tocolytic use.)*

000 = Magnesium sulfate therapy

1490 TRYL . . . . Attempted vaginal delivery after previous C-section

*(This is a planned attempt for vaginal delivery after a previous C-section delivery, whether or not it is successful. The previous C-section delivery does not have to be the most recent delivery.)*

*Do not include patients who unexpectedly go into labour and who then undergo planned repeat C-section although earlier than patient had been booked for; these patients should be coded as repeat C-section.*

*DO INCLUDE patients who have planned to have repeat C-section, but unexpectedly go into labour and undergo a trial of labour. The end result may be a vaginal delivery, or a repeat C-section for another reason (e.g. Fetal Distress, Failure to Progress)*

000 = No anesthetic analgesia

ACU = Acupuncture

DBN = Spinal/Epidural Double Needle (*Combined technique*)

EPI = Epidural

GEN = General

HYP = Hypnosis

KET = Neuroleptic

LOC = Local

SPL = Spinal



## 1500 BLTX . . . . Blood Transfusions

- 001 = 1 Unit of blood
- 002 = 2 Units of blood - etc. -

## 1530 TOTH . . . . Tocolytic Agents

*(Any other medication given to the mother to prevent or stop premature labour.)*

- C01 = Ritodrine  
*(Yutopar)*
- C02 = Terbutaline  
*(Bricanyl)*
- C03 = Ventolin
- C04 = Indocid  
*(Indomethacin)*
- C05 = Alcohol
- C06 = Isoxsuprine  
*(Vasodilan)*
- C07 = Atosiban
- C08 = Magnesium Sulfate (MgSO<sub>4</sub>)

## 1531 INSL . . . . Diabetic Therapy

- INS = Insulin
- ORH = Other Hypoglycemic Agent (eg. Diabinese)

## 1540 LSUP . . . . Lactation Suppression

*(Code regardless of whether used for pathological or physiological reason.)*

- DDU = Testosterone-estradiol  
*(Deladumone)*
- EST = Estrand
- PAR = Bromocriptine  
*(Parlodel)*
- STL = Diethylstilbestrol  
*(Stilbestrol)*
- TCE = Tace  
*(Chlorotrianisene)*

## 1541 ASAT . . . . Maternal ASA Therapy

*(Code if administered during pregnancy or admission)*

- ASA = Low dose aspirin (ASA) therapy, eg. for Lupus, and other autoimmune diseases

L. **MATERNAL DEATH OR UNDELIVERED FETAL DEATH**

1550 MATD . . . . Maternal Death  
000 = Maternal death

1560 FDTH . . . . Fetal Death  
*(Undelivered patients only)*  
000 = Fetal death

**M. INFECTION IN PRESENT PREGNANCY****CODE POSTPARTUM INFECTIONS SEPARATELY - SEE SECTION I.*****CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY***

- 1590 UTIN . . . . . Lower Urinary Tract Infection  
***CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY***  
***(Confirmed by culture of >100,000 colonies/ml, or as stated by physician.)***  
000 = Lower urinary tract infection
- 1600 GBSI . . . . . Group B Streptococcal Infection  
***CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY***  
***(Most Group B strep. will be colonization only. If it is stated that the patient had a Group B Strep Urinary Tract Infection, code it as GBI. Group B Strep can be present in the urine without being an infection; in this case, code GBC. If it is stated that the patient has Chorioamnionitis or Endometritis due to Group B Strep, code GBI. If group B strep infection was diagnosed at one point and followed by colonization at a later date, code both the infection and the colonization.)***  
GBC = Colonized with Group B streptococcus  
GBI = Group B streptococcal infection
- 1610 LIST . . . . . Listeria Infection  
***CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY***  
000 = Listeria infection
- 1620 LUES . . . . . Syphilis  
***CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY***  
000 = Syphilis
- 1630 GONO . . . . . Gonorrhea  
***CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY***  
000 = Gonorrhea
- 1640 HERP . . . . . Herpes Simplex Infection  
***CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY***  
***(Herpes labialis, oral herpes, herpes genitalis, genital herpes.***  
***Do not code those with a history of Herpes. Do not include a Herpes outbreak post-Epidural - due to Morphine in Epimorph.)***  
OHS = Oral Herpes Simplex  
GHS = Genital Herpes Simplex  
OTH = Other (Herpes labialis, herpes gestationalis)
- 1650 RUBE . . . . . Rubella  
***CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY***  
000 = Rubella

- 1660 SPTC . . . . . Septicemia  
**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
*(Defined by positive blood culture(s).)*  
000 = Septicemia
- 1670 COND . . . . . Condyloma acuminata  
**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
*(Venereal warts, Human Papilloma Virus. Code H.P.V. only if there is a manifestation of warts.)*  
000 = Condyloma acuminata
- 1680 AIDS . . . . . Acquired Immune Deficiency Syndrome  
**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
ASP = Asymptomatic A.I.D.S., H.I.V. positive  
SPM = Symptomatic A.I.D.S.
- 1690 TOXO . . . . . Prenatal toxoplasmosis  
**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
000 = Prenatal toxoplasmosis
- 1700 WOUN . . . . . Wound infection, antepartum  
**CODE ONLY IF PRESENT DURING ADMISSION**  
*(e.g. postoperative, Appendectomy)*  
000 = Wound infection
- 1710 VIRD . . . . . Viral Diseases  
**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
C01 = Parvovirus (Fifth's Disease)  
C02 = Meningitis
- 1720 TEST . . . . . Abnormal Findings  
**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
*(Immunological)*  
TB+ = Positive Tuberculin Test  
*(Mantoux)*

- 1730 VARC . . . . Varicella  
**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
CHP = Chickenpox  
(*Varicella*)  
HPZ = Shingles  
(*Herpes Zoster*)
- 1740 MYCP . . . . Mycoplasma Disease  
**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
(*Code also Neonatal Code 1810.*)  
000 = Mycoplasma disease
- 1750 CHLM . . . . Chlamydia  
**CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY**  
(*Code also Neonatal Code 1800.*)  
000 = Chlamydia
- 1760 INFB . . . . Bacterial Infections, Antepartum  
**CODE IF PRESENT DURING ADMISSION ONLY**  
(*e.g Pilonidal Cyst, Abscess Tooth*)  
000 = Bacterial infections, antepartum

**N. COMPLICATIONS OF ANESTHESIA**

- 1790 BLPT . . . . . Blood Patching  
000 = Blood patching
- 1800 TXIV . . . . . Intravenous Injection  
000 = Toxic intravenous injection  
*(Causing systemic reaction)*  
C01 = Epi-catheter intravenous only  
*(Incidental only)*
- 1810 DTAP . . . . . Accidental Dural Tap  
*(Code also Blood Patching 1790 BLPT, if applicable.)*  
000 = Accidental dural tap
- 1820 TOXS . . . . . Total Spinal Anesthesia  
*(Respiratory paralysis)*  
000 = Total spinal anesthesia
- 1830 LEPI . . . . . Prolonged Epidural Block  
000 = Prolonged epidural block
- 1840 MBLK . . . . . High Epidural/Subdural Block  
000 = High epidural/subdural block
- 1850 FDRP . . . . . Foot drop  
*(Specifically stated as due to anesthesia.)*  
000 = Foot drop
- 1860 EPIH . . . . . Epidural hematoma  
000 = Epidural hematoma
- 1870 EPIA . . . . . Epidural Abscess  
000 = Epidural abscess
- 1880 SCRDL . . . . . Spinal Cord Lesion  
000 = Spinal cord lesion

1890 ASPN . . . . Aspiration Pneumonitis  
000 = Aspiration pneumonitis

1900 CARR . . . . Cardiac Arrest  
000 = Cardiac arrest

1910 OANC . . . . Other Anesthetic Complication  
*(Specifically stated by anesthesiologist on anesthetic record. If in doubt, ask anesthesiologist.)*  
C01 = Post-dural puncture headache  
C02 = Paraesthesia  
C03 = Hypotension  
C04 = Back pain

1914 FIGA . . . . Failed Intubation for General Anesthetic  
000 = Failed intubation for general anesthetic

**O. ANTIBIOTIC THERAPY**  
***(CODE WHEN ANTIBIOTICS ARE ADMINISTERED)***

2000 ANTB . . . . Antibiotics

***(CODE ONLY IF ADMINISTERED DURING ADMISSION)***

ANT = Administered during antepartum period

INT = Administered during intrapartum period from the beginning of labour to the delivery of the placenta, including administration during a C-section delivery.

PPP = Administered during postpartum period



**P. FETAL PROCEDURES**

- 2200 CHDO . . . . Cordocentesis  
*(Umbilical cord vessel sampling. Code reason test was performed. Bring forward to the delivered admission)*  
GNT = Genetic testing  
ISO = Isoimmunization  
OTH = Other
- 2210 FETP . . . . Fetal Peritoneal Tap  
INV = Investigative  
FAC = To facilitate delivery  
*(Fetal Abdominal Paracentesis)*
- 2220 AMNF . . . . Amnioinfusion  
*(To prevent cord compression)*  
000 = Amnioinfusion
- 2230 FETT . . . . Fetal Thoracentesis  
*(To correct fetal defect)*  
000 = Fetal thoracentesis
- 2240 CORE . . . . Embolization of Umbilical Vessels By Cordocentesis  
000 = Embolization of umbilical vessels by cordocentesis

**Q. METHODS OF INDUCTION/ATTEMPTED INDUCTION**

*Codes 3000 through to 3040 apply to inductions only. Do not code for augmentations.*

*A period of greater than 24 hours between subsequent doses of medication (prostaglandin and/or oxytocin) for the purpose of inducing labour defines a new induction attempt. Note: the administration of prostaglandin, for the purpose of cervical ripening, is considered part of the induction process.*

*If the patient goes into labour more than 24 hours after the last administration of medication (prostaglandin and/or oxytocin) for the purpose of inducing labour, the labour should be coded as spontaneous.*

*The third character of the modifiers for codes 3000 through to 3040 identifies the attempt at induction designated as "A" for the first attempt, "B" for the second attempt, and so forth.*

1. *Codes 3000 and 3010*

*The first character of the modifiers for codes 3000 and 3010 indicates the number of prostaglandin administrations in the **OPD** during that induction attempt. **Code OPD prostaglandin administrations occurring within the 24 hours prior to admission only**, unless previous administrations are clearly indicated on the delivered admission.*

*The second character of the modifier indicates the number of **in-patient** prostaglandin administrations during that induction attempt. If the mother is given more than 9 administrations in one attempt, code 9.*

*For example, if a mother received 3 doses of intracervical prostaglandin in the OPD, and then 24 hours later is admitted, and receives 2 doses of intracervical prostaglandin, her case would be coded as 3000 PGCC 30A and 3000 PGCC 02B.*

2. *Codes 3000, 3010, and 3020*

*A mother will often receive prostaglandin followed by oxytocin. If the oxytocin is given within 24 hours of the last prostaglandin administration, this is considered one induction attempt. If 24 hours have passed since the last prostaglandin administration, then this is considered a second attempt.*

*For example, if a mother was admitted, and received 2 doses of prostaglandin, and then within 24 hours received oxytocin, her case would be coded as 3000 PGCC 02A and 3020 OXTC 00A. If the same mother received the oxytocin 24 hours after the last prostaglandin administration, her case would be coded as 3000 PGCC 02A and 3020 OXTC 00B.*

3. *Code 3020*

*In the case of an induction attempt with oxytocin alone, a new attempt occurs when a mother has not received oxytocin for a 24 hour period. If the oxytocin is shut off for a few hours and then started again, within 24 hours of the last administration, then this is considered one induction attempt.*

*For example, if a mother is receiving her first oxytocin administration, and the oxytocin is shut off for 3 hours, and then started again, her case would be coded as 3020 OXTC 00A. However, if in this same case the oxytocin was started 24 hours after it had been shut off, her case would be coded as 3020 OCTX 00B.*

- 3000 PGCC . . . . Intracervical Prostaglandin  
*(Intracervical prostaglandin is administered in a .5mg dose.)*
- 01A = No OPD prostaglandin administrations, one in-patient prostaglandin administration, 1st induction attempt
  - 11A = One OPD prostaglandin administration, one in-patient prostaglandin administration, 1st induction attempt
  - 21B = Two OPD prostaglandin administrations, one in-patient prostaglandin administration, 2nd induction attempt
  - 30B = Three OPD prostaglandin administrations, no in-patient prostaglandin administrations, 2nd induction attempt.....etc.
- 3010 PGCV . . . . Vaginal Prostaglandin (Includes Cytotec)  
*(Vaginal prostaglandin is administered in a 1 to 2mg dose. If the route of administration or dosage of prostaglandin is not specified , code vaginal.)*
- 01A = No OPD prostaglandin administrations, one in-patient prostaglandin administration, 1st induction attempt
  - 11A = One OPD prostaglandin administration, one in-patient prostaglandin administration, 1st induction attempt
  - 21B = Two OPD prostaglandin administrations, one in-patient prostaglandin administration, 2nd induction attempt
  - 30B = Three OPD prostaglandin administrations, no in-patient prostaglandin administrations, 2nd induction attempt.....etc.
- 3020 OXTC . . . . Oxytocin (Pitocin, Syntocin)
- 00A = Administered during first induction attempt
  - 00B = Administered during second induction attempt....etc
- 3030 PGOR . . . . Oral Prostaglandin (Includes Cytotec)
- 00A = Administered during first induction attempt
  - 00B = Administered during second induction attempt....etc
- 3040 OTAG . . . . Other agents (*Laminaria tents, Intracervical catheter-induction*)
- 00A = Administered during first induction attempt
  - 00B = Administered during second induction attempt....etc

**1. METHODS OF INDUCTION FOR TERMINATION FOR ANOMALY ADMISSIONS**

**Codes 3050 through to 3090 apply to Termination for Anomaly cases only.** Do not use these codes for Inductions or Augmentations for delivery of a viable infant.

**1. Code 3050**

*The first character of the modifier for code 3050 indicates the number of Misoprostol (Cytotec) administered on an out-patient basis to induce labour for a termination for an anomaly. If the mother is given more than 9 administrations to induce labour, code 9*

*The second character of the modifier for code 3050 indicates the number of Misoprostol (Cytotec) administered on an in-patient basis to induce labour for a termination for an anomaly. If the mother is given more than 9 administrations to induce labour, code 9*

*The third character of the modifier for code 3050 indicates the method of administration of Misoprostol (Cytotec). **V** indicates a vaginal administration of Misoprostol (Cytotec) and **R** indicates an Oral administration of Misoprostol (Cytotec)*

*For example, if a mother received 2 doses of vaginal Misoprostol (Cytotec) in the OPD, and one dose Misoprostol (Cytotec) as in in-patient, her case would be coded as **3050 PGMV...21V***

*For example, if a mother received 1 doses of Oral Misoprostol (Cytotec) in the OPD, and two dose Misoprostol (Cytotec) as in in-patient, her case would be coded as **3050 PGMV...12R***

## 3050 PGMV . . . Misoprostol (Cytotec)

01V = No OPD vaginal administrations and “ONE” in-patient vaginal administration of Misoprostol. If either are greater than 9, code 9.

11V = “ONE” OPD vaginal administration and “ONE ” in-patient vaginal administration of Misoprostol. If either are greater than 9, code 9.

21V = “TWO” OPD vaginal administrations and “ONE ” in-patient vaginal administration given of Misoprostol,..... etc. If either are greater than 9, code 9.

01R =”No” OPD Oral administrations and “ONE ” in-patient Oral administration of Misoprostol. If either are greater than 9, code 9.

11R = “ONE” OPD Oral administration and “ONE ” in-patient Oral administration of Misoprostol. If either are greater than 9, code 9.

21R = “TWO” OPD Oral administrations and “ONE ” in-patient Oral administration given of Misoprostol,..... etc. If either are greater than 9, code 9.

## 3060 SAIN . . . . Saline Injection and IV Syntocin

000 = Saline Injection and IV Syntocin administered during termination.

## 3070 DILE . . . . Dilatation and Evacuation

000 = Dilatation and Evacuation during termination.

## 3080 KCLI . . . . KCL Intracardiac Injection

000 = KCL Intracardiac Injection during termination.

## 3090 OCTV . . . . IV Syntocin

000 = IV Syntocin  
(May be used after misoprostol administration(s))

**CLASSIFICATION OF NEONATAL DISEASES AND PROCEDURES****I. PLACENTA AND UMBILICAL CORD ANOMALIES**

- 0010 VINS . . . . . Velamentous Insertion of Cord  
000 = Velamentous insertion of cord
- 0020 MINS . . . . . Marginal Insertion of Cord  
*(Battledore placenta)*  
000 = Marginal insertion of cord
- 0030 CIRV . . . . . Circumvallate Placenta  
*(Involving entire placental margin)*  
000 = Circumvallate placenta
- 0040 ANOD . . . . . Amnionodosum  
*(As stated on the pathology report.)*  
000 = Amnionodosum
- 0050 SUCL . . . . . Succenturiate Lobe  
*(Accessory lobe/Bilobed placenta/Bipartite)*  
000 = Succenturiate lobe
- 0060 CHOR . . . . . Chorioamnionitis, Marked or Severe  
*(Not Chorionitis or Chorangiomas, as stated on the pathology report.)*  
000 = Chorioamnionitis, marked or severe
- 0070 FUNI . . . . . Funisitis  
*(As stated on pathology report.)*  
000 = Funisitis  
C01 = Necrotizing funisitis  
CAN = Candida
- 0080 SUMA . . . . . Single Umbilical Artery  
*(Presence of one umbilical artery instead of the normal 2.)*  
000 = Single umbilical artery

0090 CPRO . . . . Cord Prolapse  
           000 = Cord prolapse

0100 PLUC . . . . Miscellaneous Placenta and/or Umbilical Cord Abnormality  
           C01 = Membranous placenta  
           C02 = Placenta accreta, Placenta Increta, Placenta Percreta  
                   (As stated by the physician, or on pathology report)  
           C03 = True knot in cord  
                   (Can be recorded on pathology report, delivery record or O.R. sheet.)  
           C04 = Trophoblastic disease  
                   (Including hydatidiform mole, invasive mole, choriocarcinoma. As stated  
                   on the pathology report.)  
           C05 = Vasa previa  
           C06 = Insertio funiculi furcata  
                   (As stated on the pathology report.)  
           C08 = Chorioangioma of placenta and/or cord  
                   (As stated on the pathology report.)  
           C09 = Hematoma of umbilical cord  
           C10 = Placental floor infarct

## **II. FETAL MALNUTRITION**

0110 WAST . . . . Fetal Clinical Soft Tissue Wasting  
                   (Present at birth)  
           MOD = Moderate  
           SEV = Severe

**III. ANOMALIES**

*Code all anomalies associated with syndromes.*

**A. CARDIOVASCULAR ANOMALIES**

0130 CARD . . . . Congenital Heart Disease (*C.H.D.*)

AOS = Aortic arch stenosis/ascending aortic stenosis

APR = Anomalous pulmonary venous return

APW = Aortico-pulmonary window

AVS = Aortic valve stenosis

BAV = Bicuspid aortic valve

CFO = Premature closure of foramen ovale  
(*Closure before birth*)

CGV = Corrected left transposition

COA = Coarctation of the aorta

DAA = Double aortic arch

DBL = Double outlet left ventricle

DBR = Double outlet right ventricle

DPV = Dysplastic pulmonary valve

EBS = Ebstein's malformation of tricuspid valve

ECD = Endocardial cushion defect  
(*A.V. canal*)

EDF = Endocardial Fibroelastosis

HLH = Hypoplastic left heart syndrome

IMV = Insufficiency/cleft of mitral valve

ITA = Interrupted aortic arch

MTA = Mitral atresia

MTS = Mitral stenosis

MUR = Cardiac murmur, cause unknown  
(*Code only if present at discharge and not due to any other cardiac disease;  
include physiologic peripheral pulmonary artery stenosis.*)

OSP = Ostium primum defect

OSS = Ostium secundum defect  
(*A.S.D. inter-atrial defect*)

PAA = Pulmonary artery atresia  
(*Do not code right heart hypoplasia.*)



0130 CARD . . . . Congenital Heart Disease (*C.H.D.*) (CONTINUED)

- PAS = Pulmonary artery stenosis (Pathologic)  
PDA = Patent ductus arteriosus  
*(Do not code for premature babies. See Code 0140.)*  
PST = Pseudotruncus
- PVA = Pulmonary vein atresia  
PVI = Pulmonary valve insufficiency  
PVS = Pulmonary valve stenosis/atresia  
*(Include thickened pulmonary valve.)*
- RAA = Right aortic arch  
SAT = Single atrium  
*(Absence of atrial septum)*  
SUS = Suspect congenital heart disease  
*(Cardiac murmur with abnormal ECG or abnormal heart on X-ray.)*
- SVV = Single ventricle  
TAR = Tuncus arteriosus  
TAT = Tricuspid atresia
- TCI = Tricuspid insufficiency  
TET = Tetralogy of Fallot  
TGV = Transposition of great arteries or great vessels
- UCH = C.H.D., type unknown  
UNC = C.H.D., unclassifiable  
*(Use specific code if possible.)*  
VSP = Ventricular septal defect  
*(Do not code if part of tetralogy of fallot.)*

0140 DUCT . . . . Ductus Syndrome of Prematurity  
*(Patent ductus arteriosus. Code only if requires treatment.)*

- 000 = No surgery  
SUR = Surgical ligation of the ductus

0150 CARR . . . . Cardiac Arrhythmia  
(*Include pathologic bradycardia or tachycardia, e.g. P.A.T., heart block.*)  
(*Excludes Sinus Tachycardia*)

AEB = Atrial ectopic beats  
ATF = Atrial flutter  
AVB = AV Block (Incomplete) not due to digitalis  
AVD = Complete AV dissociation  
(*Complete heart block*)  
CAT = Coatic atrial tachycardia  
OTH = Other  
(*Include premature ventricular contractions*)  
PAT = Paroxysmal atrial tachycardia  
SAR = Sinus arrest  
UBC = Unexplained bradycardia  
VTC = Ventricular tachycardia  
(*Idiopathic*)  
WPW = Wolff-Parkinson Syndrome

0160 DEXT . . . . Dextrocardia

ABI = Isolated abdominal situs inversus  
(*Heterotaxy Syndrome*)  
IDX = Isolated  
MES = Mesocardia  
WSI = With situs inversus

0170 PFCS . . . . Persistent Fetal Circulation Syndrome  
(*Occurs within 1 week of age*)

*Persistent fetal circulation syndrome caused by the following:*

CHD = Congenital heart disease  
CUK = Cause Unknown  
FMB = Fetomaternal bleed  
HMD = Hyaline membrane disease  
MEC = Meconium aspiration  
PHP = Pulmonary hypoplasia  
PNM = Pneumonia  
PPH = Primary Pulmonary Hypertension

0180 PABS . . . . Parabiatic Syndrome

DON = Donor  
REC = Recipient

0190 CVSA . . . . Miscellaneous Cardiovascular Anomaly

- C01 = Asplenia
- C02 = Absence of pericardium or pericardial defect
- C03 = Aneurysm of vein of Galen
- C04 = Intracardiac mass
- C05 = Acardia
- C06 = Congenital cardiomyopathy
- C07 = Arterio-venous malformation of lung
- C08 = Intrathoracic (vascular) ring

**B. GASTRO-INTESTINAL ANOMALIES**

- 0210 IINA . . . . . Intestinal Atresia  
COL = Colonic  
DUO = Duodenal  
ILE = Ileal  
JEJ = Jejunal  
UKN = Site unknown
- 0220 IINS . . . . . Intrinsic Intestinal Stenosis  
ANS = Anal stenosis  
COL = Colonic  
DUO = Duodenal  
ILE = Ileal  
JEJ = Jejunal  
RTM = Rectum  
UKN = Site unknown
- 0230 EINO . . . . . Extrinsic Intestinal Obstruction  
ANP = Annular pancreas  
COB = Colonic bands  
DUB = Duodenal bands  
JEB = Jejunal bands  
SMB = Small bowel
- 0240 TEFA . . . . . Tracheo-Esophageal Fistula/Atresia  
C01 = Tracheo-esophageal fistula and/or atresia  
*(Distinguish from 0350, Tracheal Atresia ONLY.)*  
C02 = Atresia of esophagus  
C03 = Tracheo-esophageal cleft
- 0250 MALR . . . . . Intestinal Malrotation  
000 = Intestinal malrotation
- 0260 BILA . . . . . Biliary Atresia  
BIA = Biliary atresia  
OBO = Other biliary obstruction  
*(Stenosis, Choledochal Cyst)*

0270 HIRD . . . . . Hirschsprung's Disease  
*(Intestinal aganglionosis)*  
000 = Hirschsprung's disease

0280 IMPA . . . . . Imperforate Anus  
000 = Imperforate anus

0290 GIAN . . . . . Miscellaneous GI Anomaly  
C01 = Microcolon  
C02 = Microcolon-megacystis-hypoperistalsis syndrome  
C03 = Duplication of bowel  
C04 = Alagilles' syndrome  
C05 = Hepato-veno-occlusive disease of liver  
C06 = Pyloric stenosis  
C07 = Multiple echodensities within the peritoneal cavity and/or liver, unexplained  
C08 = Paucity of intrahepatic bile duct  
*(Non-syndromic)*  
C09 = Meckel's Diverticulum

0300 VOLV . . . . . Volvulus  
COL = Colon  
ILE = Ileum  
JEJ = Jejunum  
SMB = Small bowel

**C. RESPIRATORY ANOMALIES**

0320 PHYP . . . . Pulmonary Hypoplasia/Agenesis

BIL = Bilateral

LEF = Left

RIT = Right

0330 DIAH . . . . Diaphragmatic Hernia

LPL = Left posterolateral

RPL = Right posterolateral

RTS = Retrosternal

0340 BRGC . . . . Bronchogenic Cyst

000 = Bronchogenic cyst

0350 RAUN . . . . Miscellaneous Respiratory Anomaly

C01 = Acinar dysplasia

C02 = Tracheal atresia

C03 = Pulmonary hyperplasia

C04 = Tracheal agenesis

C05 = Pulmonary Sequestria

0360 HYPD . . . . Hypoplasia of Diaphragm

PAR = Partial

*(Including eventration of the diaphragm)*

TOT = Total

**D. EYE, EAR, NOSE, MOUTH, AND THROAT ANOMALIES**

- 0380 CTLP . . . . . Cleft Lip and/or Palate  
(*Includes absent palate, maxilla and nasal cartilage.*)  
CTL = Cleft lip only  
CTP = Cleft palate only  
CLP = Cleft lip and palate
- 0390 BCSF . . . . . Branchial Cleft Anomaly (cyst, sinus, fistula)  
LEF = Left  
RIT = Right  
BIL = Bilateral  
MDL = Midline branchial cleft anomaly
- 0400 CTAR . . . . . Cataracts  
LEF = Left  
RIT = Right  
BIL = Bilateral
- 0410 SKTP . . . . . Pre-auricular Skin Tag, Pit or Sinus  
LEF = Left  
RIT = Right  
BIL = Bilateral
- 0420 EARS . . . . . Stenosis or Atresia of External Auditory Meatus or Canal  
LEF = Left  
RIT = Right  
BIL = Bilateral
- 0430 COPA . . . . . Opacities of Cornea, Congenital  
CRD = Corneal dermoid  
CUK = Unknown  
PAN = Peter anomaly  
SLC = Scleralization of cornea
- 0440 MCGN . . . . . Micrognathia  
000 = Micrognathia

- 0450 MCOP . . . . Microphthalmia  
LEF = Left  
RIT = Right  
BIL = Bilateral
- 0460 GLAC . . . . Glaucoma  
ACQ = Acquired  
CNG = Congenital
- 0470 COLB . . . . Coloboma  
LEF = Left  
RIT = Right  
BIL = Bilateral
- 0480 INLD . . . . Congenital Impatency of the Naso-Lacrimal Duct  
LEF = Left  
RIT = Right  
BIL = Bilateral
- 0490 EAUC . . . . Miscellaneous Eye, Ear, Nose, Mouth, Throat Anomaly  
C01 = Ranula  
C02 = Laryngeal atresia and/or severe congenital laryngeal stenosis  
C03 = Opacities of vitreous humour /persistent hyperplastic primary vitreous  
C04 = Aniridia (*Absence of iris*)  
C05 = Laryngeal diverticulum  
C06 = Microstomia  
C07 = Eyelid fibrous bands (palpebral fissure band)  
C08 = Facial cleft  
C09 = Hypoplastic ears or absent pinna (microtia external ear)  
C10 = Anophthalmia  
C11 = Optic atrophy or optic nerve hypoplasia  
C12 = Central blindness  
C13 = Radicular cysts (apex of tooth)  
C14 = Retinal dysplasia  
C15 = Macrostomia



0500 CHOA . . . . Choanal Atresia  
000 = Choanal atresia

0510 THYG . . . . Thyroglossal Anomalies  
CST = Thyroglossal cyst  
SKT = Skin tag

**E. ANOMALIES OF INGUINAL CANAL**

0520 CORC . . . . Cryptorchidism  
*(Code for term infants if testes not palpable. If stated as retractable or testes in canal, do not code.)*

LEF = Left  
RIT = Right  
BIL = Bilateral  
UKN = Unknown

0530 INGH . . . . Inguinal Hernia

LEF = Left  
RIT = Right  
BIL = Bilateral

0540 FEMH . . . . Femoral Hernia

LEF = Left  
RIT = Right  
BIL = Bilateral

**F. GENITOURINARY ANOMALIES**

- 0550 HSPD . . . . Hypospadias Complex  
*(Hypospadias, chordee, bifid scrotum)*  
1ST = First degree  
*(Glandular)*  
2ND = Second degree  
*(Coronal)*  
3RD = Third degree  
*(Shaft)*  
4TH = Fourth degree  
*(Perineal)*  
UKN = Unknown
- 0560 EPSD . . . . . Epispadias  
000 = Epispadias
- 0570 POLY . . . . Polycystic Kidney  
*(Potter's classification)*  
TP1 = Type I  
*(Congenital)*  
TP2 = Type II  
*(Multicystic)*  
TP3 = Type III  
*(Adult)*  
TP4 = Type IV  
*(Secondary to partial ureteral obstruction)*  
UKN = Type unknown
- 0580 AGEN . . . . . Agenesis/Hypoplasia/Atrophy of Kidney  
LEF = Left  
RIT = Right  
BIL = Bilateral
- 0590 HNHU . . . . . Hydronephrosis and/or Hydroureter and/or RenalPelviectasis  
*(Include all causes)*  
LEF = Left  
RIT = Right  
BIL = Bilateral

- 0600 RDYS . . . . Renal Dysplasia  
*(Dysplastic kidney)*  
LEF = Left  
RIT = Right  
BIL = Bilateral
- 0610 DSYS . . . . Double Urinary System  
*(Include all types)*  
BLD = Double bladder  
*(Also double urethra)*  
RAS = Double renal arteries  
PLV = Double pelvis  
*(Code for duplication of right kidney and double renal collecting system)*  
UTR = Double ureter
- 0620 GAGN . . . . Genital Agenesis/Hypoplasia  
000 = Genital agenesis/hypoplasia
- 0630 RECT . . . . Renal Ectopia  
FUS = Horseshoe kidney  
PEL = Pelvic kidney
- 0640 UROB . . . . Urinary Obstruction  
BNO = Bladder neck obstruction  
PUV = Posterior urethral valve  
UAS = Ureteral atresia/stenosis  
UCL = Ureterocele  
UDV = Ureteral diverticulum  
UPJ = Ureteropelvic junction obstruction  
*(Also code any applicable surgery, see code 3280 SURG...UPJ)*  
UTO = Urethral obstruction
- 0650 IHYM . . . . Imperforate Hymen  
000 = Imperforate hymen
- 0660 UBAN . . . . Urinary Bladder Anomalies  
EXB = Exstrophy  
EXC = Cloacal Exstrophy  
AGB = Agenesis of the Bladder

0670 GUAN . . . . Miscellaneous G.U. Anomaly

- C01 =Torsion of testis
- C02 = Urogenital sinus
- C03 = Bicornuate uterus
- C04 = Transposition of the scrotum
- C05 = Urachal cyst
- C06 = Congenital vaginal cyst
- C07 = Ovarian cyst
- C08 = Torsion of ovary
- C09 = Absent uterus and/or absent Fallopian tubes and/or absent ovaries
- C10 = Rectal-ano-urethral fistula
- C11 = Large echodense kidneys, etiology unknown
- C12 = Double vagina
- C13 = Rectovaginal fistula
- C14 = Hypoplasia of uterus
- C15 = Patent (persistent) urachus
- C16 = Nephrotic Syndrome
- C17 = Vesicoureteric Reflux

**G. SKIN ANOMALIES**

- 0700 HANG . . . . Hemangioma  
*(Do not code capillary hemangiomas on eyelid or base of neck - "stork bites/angel kisses" - or for birth marks only.)*  
CAV = Cavernous  
CAP = Capillary  
*(Strawberry nevus)*  
PWS = Port-wine stain  
UKN = Type unknown
- 0710 PIGN . . . . . Pigmented Nevus  
000 = Pigmented nevus
- 0711 DPIG . . . . . Depigmented Skin Lesions  
ANM = Nevus Anemicus
- 0720 CDER . . . . . Congenital Dermatosis  
AED = Anhidrotic ectodermal dysplasia  
BUK = Bullous, type unknown  
CMC = Cutis marmorata congenita  
CTA = Cutis aplasia  
*(Skin defect. Almost always depression on skin of scalp, not properly developed.)*  
EPB = Epidermolysis bullosa  
GOL = Goltz syndrome  
*(Focal dermal hypoplasia)*  
ICP = Incontinentia pigmenti  
NUK = Non-bullous, type unknown  
URT = Urticaria pigmentosa  
*(Mast cell disease)*
- 0730 SUPN . . . . . Supernumerary Nipple  
*(Additional/accessory nipple)*  
LEF = Left  
RIT = Right  
BIL = Bilateral
- 0731 ABBR . . . . . Absent Breasts  
LEF = Left  
RIT = Right  
BIL = Bilateral

- 0740 AMNB . . . . Deformities Due to Amniotic Bands, Amniotic Band Syndrome, Early Amnion Rupture Sequence  
000 = Deformities due to amniotic bands, amniotic band syndrome, early amnion rupture sequence
- 0750 ICTH . . . . Ichthyosis  
*(Include all types)*  
000 = Ichthyosis
- 0760 CUTL . . . . Cutis Laxa/Hyperelastica  
LAX = Cutis laxa  
ELS = Cutis hyperelastica
- 0770 SKAN . . . . Miscellaneous Skin Abnormality  
C01 = Dysplastic or absent nails  
C02 = Inclusion cyst of skin  
*(Epidermoid cyst)*  
C03 = Miscellaneous  
C04 = Cafe-au-lait spot  
C05 = Sebaceous nevus  
C06 = Dermatographia

**H. MUSCULOSKELETAL ANOMALIES**

0780 NECK . . . . Short Neck Disorders

INI = Iniencephalus

KPL = Klippel-Feil Syndrome

0790 CLFT . . . . Club Foot

*(Talipes equinovarus, talipes calcaneovalgus, or calcaneovarus)*

LEF = Left

RIT = Right

BIL = Bilateral

0800 CHIP . . . . Congenital Hip

*(Dislocatable, reducible)*

C01 = Diagnosed after discharge from hospital

DLC = Dislocation

LUX = Subluxation

0810 POLD . . . . Polydactyly

000 = Polydactyly

0820 SYND . . . . Syndactyly

000 = Syndactyly

0830 CSTN . . . . Craniosynostosis/Craniostenosis

COR = Coronal

CRZ = Crouzon's disease

FRN = Frontal (Metopic)

KLB = Kleeblattschadel

LAM = Lambdoid

SAG = Sagittal

TRG = Trigonocephaly

0840 UMBD . . . . Umbilical Defect

**(Do not code diastasis recti)**

GSC = Gastroschisis

OMC = Omphalomesenteric cyst

OMP = Omphalocele

UMH = Umbilical hernia



- 0850 HAND . . . . Other Anomalies of the Hand/Foot  
(*Include missing digit, claw hand, hypoplasia of 1st metacarpal.*)  
000 = Claw hand, other anomalies of hand, other anomalies of foot  
C01 = Hypoplastic disease, small digits (*Fingers/toes*)  
C02 = Bifid thumb  
CDY = Camptodactyly  
TRP = Triphalangeal thumb (*2 joints*)
- 0860 PHOC . . . . Phocomelia/Amelia/Limb Reduction  
(*Includes hypoplasia of fibula.*)  
000 = Phocomelia/amelia/limb reduction
- 0870 ACON . . . . Osteochondroplasia  
ACH = Achondroplasia  
CND = Chondrodystrophy  
DDS = Diastrophic dysplasia syndrome
- 0880 TORT . . . . Torticollis  
TSM = Tumour of sternocleidomastoid
- 0890 VERT . . . . Vertebral anomalies  
BIF = Bifid Rib  
BKV = Block vertebra  
ELR = Eleven ribs  
HEM = Hemivertebra, bifid vertebra, butterfly vertebra, caranal cleft vertebra  
MUL = Multiple  
SCA = Sacrococcygeal agenesis, partial or total and/or bifid sacrum  
(Caudal regression syndrome, Absent sacrum)  
SUP = Supernumerary vertebra  
TRT = Thirteen ribs  
KPS = Kyphoscoliosis
- 0900 APCM . . . . Absence/hypoplasia of pectoralis major  
LEF = Left  
RIT = Right  
BIL = Bilateral
- 0910 SMEL . . . . Sirenomelus  
000 = Sirenomelus

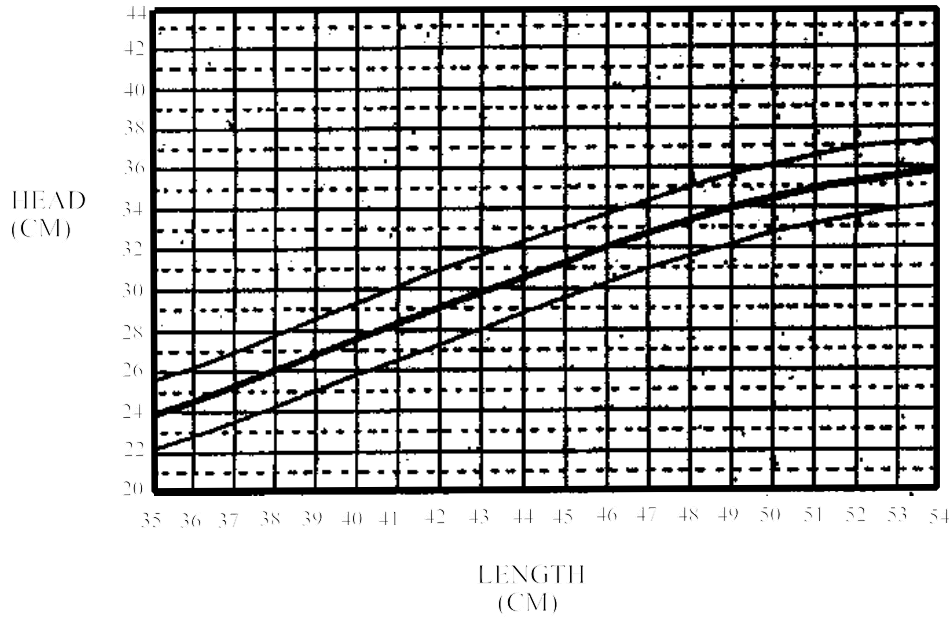
- 0920 BBD . . . . . Osteogenesis Imperfecta  
*(Include other metabolic bone disease but exclude rickets.)*  
OSG = Osteogenesis imperfecta  
MFR = Fractures-cause unknown  
HPS = Hypophosphatasia
- 0930 THDW . . . . . Thanatophoric Dwarfism  
000 = Thanatophoric dwarfism
- 0940 RADA . . . . . Radial Aplasia/Hypoplasia  
IRD = Isolated aplasia/hypoplasia of radius  
ITH = Isolated aplasia/hypoplasia of thumb  
THR = Aplasia/hypoplasia of both the radius and thumb
- 0950 MSAN . . . . . Miscellaneous anomaly of musculo-skeletal system  
C01 = Genu recurvatum  
C02 = Hemihypertrophy  
*(Musculoskeletal)*  
C03 = Skull depression, unknown etiology  
C04 = Absence or hypoplasia of depressor anguli oris muscle  
C05 = Myotonic dystrophy  
C06 = Absent ulna  
C07 = Sprengel's deformity of shoulder  
C08 = Dislocation of knee  
C09 = Complete absence of abdominal wall  
C10 = Myasthenia gravis - newborn  
C11 = Congenital short femur  
C12 = Hypoplastic calvaria  
C13 = Dislocation of radial heads  
C14 = Epigastric hernia  
*(Ventral or abdominal wall)*
- 0960 MYOP . . . . . Myopathy  
NUC = Centronuclear  
MTB = Myotubular

**I. CENTRAL NERVOUS SYSTEM ANOMALIES**

- 0970 CNSA . . . . C.N.S. Anomaly, Miscellaneous  
*(Does not include radicular cysts - code 0490)*
- C01 = Lipomeningocele
  - C02 = Agenesis of Corpus Callosum  
*(Hypoplasia)*
  - C03 = Arachnoid cyst
  - C05 = Non-specific brain anomalies
  - C06 = Moebius syndrome
  - C07 = Polymicrogyria
  - C08 = Lissencephaly
  - C09 = Schizencephaly
  - C10 = Pachygyria  
*(Macrogyria)*

0980 MICC . . . . Microcephaly  
*(Head circumference less than 2 standard deviations for length- see head/length growth graph - below.)*  
 000 = Microcephaly

**HEAD/LENGTH GROWTH GRAPH**



**NOTE:** Always code 1030 MEGC .... Megalocephaly if the head circumference is greater than 37 cm.

*Usher, R., M.D., The Journal of Pediatrics,  
 Vol. 74, No. 6, Pages 901-910, June, 1969*

- 0990 SBIF . . . . . Incomplete Closure of Neural Tube  
CRB = Cranium bifidum  
DFS = Dermal fistula  
*(Leaking spinal fluid, fluid drainage)*  
DSN = Dermal sinus  
*(Code only if the bottom of the depression cannot be seen and there is no drainage. Do not code dimples with closed or blind ends.)*  
ENC = Encephalocele  
MGC = Meningocele  
MMC = Meningomyelocele  
RHS = Rachischisis  
SPB = Spina bifida
- 1000 ANEN . . . . . Anencephaly  
000 = Anencephaly
- 1010 HYDN . . . . . Hydranencephaly  
000 = Hydranencephaly
- 1020 CHYP . . . . . Brain Hypoplasia  
000 = Brain hypoplasia  
CBL = Cerebellar hypoplasia  
DYS = Cortical dysplasia
- 1030 MEGC . . . . . Megalocephaly  
*(Macrocephaly. Head circumference more than 2 standard deviations for length- see head/length growth graph - page 23.)*  
HCP = Hydrocephalus  
*(Include both congenital and acquired forms.)*  
MGU = Megalocephaly, type unknown  
DWS = Dandy-Walker Syndrome
- 1040 DIAS . . . . . Diastematomyelia  
*(Diplomyelia. Congenital separation of lateral halves of spinal cord.)*  
000 = Diastematomyelia
- 1050 CLOP . . . . . Cyclopia-Arhinencephaly Series  
ARN = Arhinencephaly  
CEB = Cebocephaly  
*(Monkey face)*  
CYC = Cyclops  
HOL = Holoprosencephaly

- 1060 ARMC . . . . Arthrogryposis/contractures (*see Smith, 3rd edition, p. 533*)
- TP1 = Neurologic abnormality
  - TP2 = Muscle problems  
(*Muscle agenesis, myopathies, myotonic dystrophy*)
  - TP3 = Joint disease  
(*Synostosis, lack of joint development, aberrant fixation as in diastrophic dwarfism, Larsen syndrome, popliteal web syndrome.*)
  - TP4 = Fetal crowding/constraint  
(*As in multiple fetuses, and oligohydramnios.*)
  - CUK = Contractures, cause unknown
- 
- 1061 PHAK . . . . Phakomatoses
- CRA = Cerebro-retinal angiomas
  - NFB = Neurofibromatosis
  - SWS = Sturge-Webber (encephalotrigeminal angiomas)
  - TSC = Tuberous sclerosis
- 
- 1062 SPMA . . . . Spinal Muscular Atrophy
- WHD = Werdnig-Hoffmann Disease

**J. MULTIPLE ANOMALIES**

## 1070 CHRM . . . . Multiple Anomalies Due to Chromosomal Aberrations

CRI = Cri-du-chat Syndrome

C1P = Chromosome 1p+

C9P = Chromosome 9p+

ESL = 12/21 Balanced Translocation

GQ- = Deletion of part of # 14 Chromosome

GSI = Gonosomal Intersex

GSL = Balanced 14-21 Translocation

HP+ = 15 P+ Syndrome

KP- = 18 P- Syndrome

KQ- = 18Q- Syndrome

MX0 = Mosaic Turner's Syndrome

M12 = Mosaic Trisomy 12

M13 = Mosaic 13 Syndrome

M21 = Mosaic Down's Syndrome

R05 = Ring 5

R13 = Chromosome Ring 13

R14 = Chromosome Ring 14

R15 = Chromosome Ring 15

TGC = Trisomy C group (includes Trisomy 8)

TRI = Triploidy

TUR = Turner's Syndrome

T07 = Trisomy 7

T09 = Trisomy 9

T13 = Trisomy 13

T14 = Trisomy 14

T18 = Trisomy 18

T19 = Trisomy 19

T21 = Down's Syndrome (Trisomy/Translocation 21)

T22 = Trisomy 22

UKN = Unknown type

WFS = Wolf Syndrome

XQ+ = X Chromosome Q+

XXY = Klinefelters Syndrome

XXZ = Marker Chromosome (*female*)

XYY = XYY Syndrome

XYZ = Marker Chromosome (*male*)

Z01 = 47XY

Z02 = Tetrasomy 12p

1070 CHRM . . . . Multiple Anomalies Due to Chromosomal Aberrations (**CONTINUED**)

2Q+ = 2Q+Syndrome

2Q- = 2Q- Syndrome

4Q- = 4Q- Syndrome

4Q+ = 4Q+Syndrome

5Q+ = 5Q+ Syndrome

6Q+ = 6Q+ Syndrome

9Q+ = 9Q+ Syndrome

FQ- = 13Q- Syndrome

13B = 13 Balanced Translocation

13L = Translocation 13

18B = 18 Balanced Translocation

21L = Translocation 21

57L = 5 to 7 Translocation

79L = 7 to 9 Translocation

## 1075 MDEL . . . . Chromosomal Deletion

PWS = Prader-Willi Syndrome

## 1080 NOTC . . . . Multiple Anomalies Not Due to Chromosomal Aberrations

ADO = Adams-Oliver Syndrome

APT = Apert's Syndrome

ASS = Asplenia Syndrome

BEC = Beckwith's Syndrome

BOR = Branchio-Oto-Renal Syndrome

BSA = Body Stalk Anomaly

CAR = Carpenter Syndrome

CCD = Cleido-Cranial dysostosis

CDL = Cornelia de Lange Syndrome

CHG = CHARGE Association

CNR = Conradi's Disease

CMT = Charcot-Marie-Tooth Syndrome

COS = Fraser's Syndrome

*(Cryptophthalmus Syndrome)*

CPT = Camptomelic Syndrome

DGS = DiGeorge Syndrome

EEC = Ectrodactyly - ectodermal dysplasia

*(EEC Syndrome)*

FAS = Fetal Alcohol Syndrome



- 1080 NOTC . . . . Multiple Anomalies Not Due to Chromosomal Aberrations (**CONTINUED**)
- FHS = Fetal Hydantoin Syndrome  
FND = Frontal-Nasal Dysplasia Sequence  
GOS = Goldenhar Syndrome
- HFD = Hypomandibular faciocranial dystosis  
HOS = Holt Oram Syndrome  
*(Cardiac Limb Syndrome)*
- KTW = Klippel-Trenaunay-Weber Syndrome  
LOW = Lowe's Syndrome  
MFN = Marfan's Syndrome  
MGR = Meckel-Gruber Syndrome
- NOO = Noonan Syndrome  
OFD = Oto-Facial-Digital  
OMH = Oromandibular Limb Hypogenesis Syndrome
- OTO = Otocephaly
- PBS = Prune Belly Syndrome  
*(Triad Syndrome)*
- PE1 = Pena Shokeir, Type 1 Phenotype  
PE2 = Pena Shokeir, Type 2 Phenotype  
PHC = Phenocopy  
PLD = Poland Syndrome  
POC = Pentalogy of Cantrell  
PRS = Pierre-Robin Syndrome  
PSS = Polysplenia Syndrome  
PTY = Multiple Pterygium Syndrome  
RBT = Rubinstein-Taybi
- ROB = Roberts' Syndrome  
RSS = Russell-Silver Syndrome  
RZM = Rhizomelic Dwarfism
- SGB = Simpson-Golabi-Behemel Syndrome  
SLO = Smith-Lemli-Opitz Syndrome  
STK = Stickler's Syndrome

1080 NOTC . . . . Multiple Anomalies Not Due to Chromosomal Aberrations (**CONTINUED**)

TCS = Treacher-Collins' Syndrome

TBS = Townes-Brock Syndrome

UNC = Unclassifiable

VAT = Vater Association

*(V.A.C.T.E.R.L. Syndrome - Vertebra, Anus, Cardiac, Trachea, Esophagus, Renal, Limb)*

WIM = Williams' Syndrome

WWS = Walker-Warburg Syndrome

*(Cerebro-Ocular dysgenesis)*

1090 OLIG . . . . Oligohydramnios Syndrome

*(Oligohydramnios, Potter's facies, and pulmonary hypoplasia)*

CUK = Oligohydramnios, cause unknown

FMN = Fetal malnutrition

LMB = Leaking amniotic fluid

OUA = Urinary anomalies excluding renal agenesis

NOL = Potter's Syndrome without oligohydramnios

*(Renal agenesis)*

POT = Potter's Syndrome with oligohydramnios

*(Renal agenesis)*

**IV. ASPHYCTIC CONDITIONS**

- 1100 ASPH . . . . Depression at Birth (Asphyxia Neonatorum)  
*(Depression at birth, requiring intermittent positive pressure breathing. If both mask and tube are used for resuscitation, code as resuscitation by tube. Code the duration as the sum of both the mask and tube resuscitation. Or if masked and stopped and restarted again code combined time of mask)*
- M01 = Resuscitation by mask < 1 minute duration
  - M02 = Resuscitation by mask 1 to 3 minutes duration
  - M03 = Resuscitation by mask > 3 minutes duration
  - MUK = Resuscitation by mask unknown duration
- 
- T01 = Resuscitation by tube < 1 minute duration
  - T02 = Resuscitation by tube 1 to 3 minutes duration
  - T03 = Resuscitation by tube > 3 minutes duration
  - TUK = Resuscitation by tube unknown duration
- 1101 ELNR . . . . Elective Non-Resuscitation
- 000 = Elective non-resuscitation
  - C01 = DNR order written on chart
  - C02 = Withdrawl of ventilator care and DNR order written on chart
- 1110 PADP . . . . Post-Asphyctic CNS Depression
- 000 = Post-asphyctic CNS depression
- 1120 PAEX . . . . Post-asphyctic CNS excitation
- 000 = Post-asphyctic CNS excitation
- 1130 PAIP . . . . Post-asphyctic increased intracranial pressure
- 000 = Post-asphyctic increased intracranial pressure
- 1140 PACV . . . . Post-asphyctic convulsions  
*(Include those convulsions associated with I.V.H.)*
- 000 = Post-asphyctic convulsions
- 1150 PABN . . . . Post-asphyctic brain necrosis  
*(Infarction)*
- 000 = Post-asphyctic brain necrosis

- 1160 AXSH . . . . Anoxic subarachnoid hemorrhage  
*(Includes all subarachnoid bleeds.)*  
000 = Anoxic subarachnoid hemorrhage
- 1170 IVHR . . . . Intra-ventricular hemorrhage  
*(Includes all intra-ventricular hemorrhage and all sub-ependymal hemorrhage, regardless of cause or predisposing factor.)*  
GR1 = Grade I  
*(Sub-ependymal, choroid plexus hemorrhage.)*  
GR2 = Grade II  
*(Hemorrhage into ventricle without dilation of ventricle.)*  
GR3 = Grade III  
*(Hemorrhage into ventricle with dilation of ventricle.)*  
GR4 = Grade IV  
*(Hemorrhage into brain; thalamic hemorrhage, cortical hemorrhage.)*
- 1180 ASPN . . . . Aspiration Pneumonitis (*Perinatal Aspiration*)  
AFA = Amniotic fluid aspiration  
*(Requires some evidence of fetal distress or intrauterine asphyxia; CXR shows densities with hyperaeration and there is no evidence of meconium or infection.)*  
MEC = Meconium Aspiration Syndrome  
*(Clinical syndrome with evidence of fetal distress or intrauterine asphyxia and presence of meconium.)*
- 1190 PCHF . . . . Post-Asphyctic Congestive Heart Failure  
000 = Congestive heart failure  
TCI = Tricuspid insufficiency due to congestive heart failure
- 1200 PATN . . . . Post-Asphyctic Acute Tubular Necrosis and Hemorrhagic  
Necrosis of Kidney  
000 = Post-asphyctic acute tubular necrosis and hemorrhagic necrosis of kidney
- 1210 PALN . . . . Post-Asphyctic Liver and/or Adrenal Necrosis  
ADH = Adrenal  
LIV = Liver

**V. TRAUMA**

1220 FRAC . . . . Fracture

CLV = Clavicle  
FEM = Femur  
HUM = Humerus  
OTH = Other  
RIB = Rib(s)  
SKL = Skull1230 FACP . . . . Facial Palsy (*Exclude other cranial nerve palsies. See CODE 2050.*)LEF = Left  
RIT = Right  
BIL = Bilateral

1240 BRPP . . . . Brachial Plexus (Erb's and Klumpke's) Palsy

LEF = Left  
RIT = Right  
BIL = Bilateral  
RAD = Radial nerve palsy  
(*"Wrist drop"*)

1250 PHRP . . . . Phrenic Palsy

LEF = Left  
RIT = Right  
BIL = Bilateral

1260 SPCI . . . . Spinal Cord Trauma

000 = Spinal cord trauma

1270 ICHR . . . . Traumatic Intra-Cranial Hemorrhage

PCD = Combined posterior fossa subdural and epidural hemorrhage  
PED = Posterior fossa epidural hemorrhage  
(*Cerebellar*)  
PSD = Posterior fossa subdural hemorrhage  
(*Cerebellar*)  
SCD = Combined supratentorial and epidural hemorrhage  
SED = Supratentorial epidural hemorrhage  
SSD = Supratentorial subdural hemorrhage  
UKN = Type unknown

- 1280 CHEM . . . . Cephalohematoma  
(Code all as stated, including those found by clinical clerk, on admission examination.)  
LEF = Left  
RIT = Right  
BIL = Bilateral  
OTH = Other, including occipital  
UKN = Unknown
- 1290 SHEM . . . . Scalp Hemorrhage  
000 = Scalp hemorrhage  
SGL = Instances of subgaleal (subaponeurotic) hemorrhage
- 1300 PHEM . . . . Perineal hematoma  
000 = Perineal hematoma
- 1310 LHEM . . . . Subcapsular hemorrhage of liver  
000 = Subcapsular hemorrhage of liver
- 1320 LACL . . . . Laceration of Liver and/or Spleen  
000 = Laceration of liver and/or spleen
- 1330 MISS . . . . Miscellaneous Trauma  
C01 = Adrenal hemorrhage  
C02 = Perforated eardrum  
C03 = Laryngeal palsy
- 1340 SPCH . . . . Spinal Cord Subdural and/or Epidural Hemorrhage  
000 = Spinal cord subdural and/or epidural hemorrhage
- 1350 TENT . . . . Tentorial Tear  
000 = Tentorial tear
- 1360 SDYS . . . . Shoulder Dystocia  
000 = Shoulder dystocia
- 1370 SCFN . . . . Subcutaneous Fat Necrosis  
000 = Subcutaneous fat necrosis

**LIST OF ORGANISMS**

The following list of organisms can be used for some of the codes in the following infection section. It will be noted with the code when to use the list of organisms.

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**GRAM-POSITIVE ORGANISMS**

CLS	=	Clostridium
CNS	=	Coagulase-negative Staph.
CPS	=	Coagulase-positive Staph. (Staph. aureus)
ECO	=	Enterococcus
GAS	=	Group A streptococcus
GBS	=	Group B streptococcus
GNS	=	Other streptococcus
LIS	=	Listeria
PNC	=	Pneumococcus

**GRAM-NEGATIVE ORGANISMS**

AER	=	Aerobacter <b>or</b> Enterobacter <b>or</b> Citrobacter (Acinetobacter)
BPT	=	Bordetella Pertussis
BTR	=	Bacteroides
CAM	=	Campylobacter
ECL	=	E.coli
GON	=	Gonococcus
HPH	=	Hemophilus
KSL	=	Klebsiella
MEN	=	Meningococcus
OTH	=	Other
PRT	=	Proteus/Morganella
PSM	=	Pseudomonas
SAL	=	Salmonella/Shigella
SER	=	Serratia

**MISC.CAUSATIVE ORGANISMS**

CAN	=	Candida
CLM	=	Chlamydia
FUG	=	Fungal
MYC	=	Mycoplasma
VIR	=	Viral
CUK	=	Cause unknown

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**VI. INFECTIONS****A. INFECTIOUS DISEASES**

- 1380 SISU . . . . . Systemic Infection, Site Unknown  
*(Clinical diagnosis, signs of sepsis, cultures negative)*  
000 = Systemic infection, site unknown
- 1390 SEPT . . . . . Septicemia  
*(Positive blood culture with organism identified.)*  
*(SEE LIST OF ORGANISMS)*
- 1400 POSB . . . . . Positive Blood Culture Without Other Evidence For Septicemia  
*(SEE LIST OF ORGANISMS)*  
CSF = Positive CSF culture without other evidence of meningitis
- 1410 GAST . . . . . Gastroenteritis  
*(SEE LIST OF ORGANISMS)*  
DUK = Diarrhea of unknown etiology  
GST = Gastroenteritis, cause unknown  
PDR = Parenteral diarrhea
- 1420 UTIN . . . . . Urinary Tract Infection  
*(SEE LIST OF ORGANISMS)*  
BCU = Bacteriuria without other evidence for U.T.I.  
*(Large number of bacteria in urinalysis - uncontaminated specimen only.)*  
PYU = Pyuria without other evidence for U.T.I. (>5 WBC/HPF)
- 1430 OMPH . . . . . Omphalitis  
*(SEE LIST OF ORGANISMS)*  
*(Umbilical phlebitis coded to 1630)*
- 1440 MENG . . . . . Meningitis (*Ventriculitis*)  
*(SEE LIST OF ORGANISMS)*  
BAC = Bacterial, unknown type  
VSH = Ventriculitis-shunt
- 1450 ENCC . . . . . Encephalitis  
*(SEE LIST OF ORGANISMS)*



- 1460 RHIN . . . . . Rhinitis  
(*SEE LIST OF ORGANISMS*)
- 1470 INFC . . . . . Infected Cephalohematoma  
(*SEE LIST OF ORGANISMS*)
- 1480 ANEC . . . . . Acute Necrotizing Enterocolitis  
AUT = Gross and microscopic appearance of the gut at autopsy  
SUR = Gross and microscopic appearance of the gut at surgery  
XRA = Definite pneumatosis intestinalis or definite portal gas on X-ray temporally  
associated with hemochezia
- 1490 PERT . . . . . Peritonitis  
(*SEE LIST OF ORGANISMS*)  
MEC = Meconium
- 1500 NEPH . . . . . Nephritis  
(*SEE LIST OF ORGANISMS*)  
CHR = Chronic interstitial
- 1510 ENDC . . . . . Endocarditis  
(*SEE LIST OF ORGANISMS*)
- 1520 ARTH . . . . . Arthritis  
(*SEE LIST OF ORGANISMS*)
- 1530 MYOC . . . . . Myocarditis  
(*SEE LIST OF ORGANISMS*)
- 1540 ABSS . . . . . Abscess  
BRN = Brain  
EMP = Empyema  
KDN = Kidney  
LNG = Lung

- 1550 BINF . . . . . Bone Infection  
OCH = Osteochondritis  
*(Metaphyseal rarefaction associated with chronic intrauterine infection.)*  
OSM = Osteomyelitis
- 1560 CONJ . . . . . Conjunctivitis  
*(SEE LIST OF ORGANISMS)*  
*(Coagulase negative staph. is not usually a causative organism. Code if purulent drainage from conjunctiva or if treated with antibiotics excluding initial erythromycin.)*
- 1570 SINP . . . . . Skin Infection  
CAN = Candida (diaper rash)  
PYO = Pyoderma  
*(Pustulosis or impetigo due to coagulase-positive staph or beta-hemolytic streptococcus.)*  
RTD = Ritter's disease
- 1580 OTSH . . . . . Oral Thrush  
000 = Oral thrush
- 1590 SCAB . . . . . Subcutaneous Abscess or Carbuncle  
*(Include wound abscess or wound infection.)*  
*(SEE LIST OF ORGANISMS)*
- 1600 CELL . . . . . Cellulitis  
*(Includes paronychia)*  
*(SEE LIST OF ORGANISMS)*
- 1610 IUPN . . . . . Intrauterine Pneumonia  
*(Congenital onset, within 24 hours of birth.)*  
*(SEE LIST OF ORGANISMS)*
- 1620 PNPV . . . . . Postnatal Pneumonia  
*(Onset after 24 hours of age)*  
*(SEE LIST OF ORGANISMS)*

- 1630 MINF . . . . . Miscellaneous Infections
- C01 = Dacryocystitis
  - C02 = Otitis media
  - C03 = Otitis externa
  - C04 = Pericarditis
  - C05 = Trichomonas vaginalis
  - C06 = Ureaplasma colonization
  - C07 = Phlebitis (*also umbilical*)
  - C08 = Lymphadenitis

1640 SCOL . . . . . Organism Suspected of Causing Systemic Infection Because of Surface Colonization  
(*'TRUE' SWABS - Throat, Rectum, Umbilicus, Ear*)

Use specific organism when that organism is actually suspected of causing systemic infection. For example:

1. An infant may have a negative blood culture yet still show signs of infection, e.g. increased WBC, increased temperature, irritability. If surface swabs are positive for GBS, GBS would be the organism suspected of causing systemic infection therefore code 1640 SCOL GBS. Also code 1380 SISU 000, systemic infection, site unknown.
2. An infant may have pneumonia yet the blood or endotracheal tube culture is negative. If surface swabs are positive for GBS, then GBS would be the organism suspected of causing the pneumonia; therefore code 1640 SCOL GBS. Also code 1610 IUPN CUK or 1620 PNP CUK because the organism is not proven, only suspected.

If there are no signs of systemic infection, yet surface swabs are positive for GBS, then code 1640 SCOL C01.

- C01 = Group B streptococcus-positive surface cultures not causing systemic infection
- C02 = Listeria-positive surfaces not causing systemic infection
- C03 = Salmonella-positive surface cultures not causing systemic infection
- C04 = Serratia-positive surface cultures not causing systemic infection

**B. CHRONIC INTRA-UTERINE INFECTION**

1650 RBEL . . . . Rubella

000 = Rubella

1660 CMVI . . . . Cytomegalovirus (CMV) Infection

*(Cytomegalic inclusion disease)*

CLN = CMV positive plus evidence for clinical C.I.D.

TIS = CMV positive plus tissue evidence of intracellular  
invasion without evidence for clinical C.I.D.

POS = CMV positive alone

*(Include cellular inclusions in urine sediment)*

1670 LUES . . . . Syphilis

ACT = Active syphilis

STS = Positive serologic test for syphilis only

1680 TOXO . . . . Toxoplasmosis

000 = Toxoplasmosis

1690 CIU . . . . Chronic Intrauterine Infection, Causative Agent Unknown

000 = Chronic intrauterine infection, causative agent unknown

**C. ACUTE VIRAL INFECTIONS**

## 1720 VIRD . . . . . Miscellaneous Viral Disease

- C01 = Picorna virus
- C02 = Adenovirus
- C03 = ECHO virus
- C04 = Rota virus
- C05 = A.I.D.S.
- C06 = HIV antibody screen - positive without infection
- C07 = Influenza A virus
- C08 = Parvovirus  
*(or suspected)*
- C09 = Varicella virus  
*(Chicken pox)*
- C10 = Parainfluenza virus
- RSV = Respiratory syncytial virus

## 1730 HERP . . . . . Herpes Simplex

- 000 = Herpes simplex

## 1740 COXK . . . . . Coxsackie Infection

- A01 - A16 = To identify specific type
- B01 - B05 = To identify specific type

**D. INFECTION MISCELLANEOUS**

1750 PUKO . . . . Pyrexia of Unknown Origin (**P.U.O. - NO KNOWN CAUSE**)  
*> 37.5° C on 2 occasions, at least 4 hours apart*

000 = Pyrexia of unknown origin  
*(Not due to incubator heat)*

1760 HIGM . . . . Elevated IgM Without Other Evidence of Infection

000 = Elevated IgM without other evidence of infection

Elevated IgM:

<b>BIOCHEMISTRY</b>	
0 - 5 days	≥ .23 g/L
6 - 10 days	≥ .39 g/L
11 - 15 days	≥ .44 g/L
16 - 20 days	≥ .49 g/L

1790 MORG . . . . Miscellaneous Causative Organism

CAN = Candida

*(See code 1570 for Candida diaper rash.)*

FUG = Fungal

1800 CLAM . . . . Chlamydial Disease

C01 = Mother is culture positive without neonatal chlamydial disease

*(Any time during pregnancy)*

C02 = Mother not known to have chlamydial disease and infant culture positive

C03 = Infant with definite clinical chlamydial disease

1810 MYCO . . . . Mycoplasma Disease (*Ureaplasma*)

C01 = Mother is culture positive without neonatal mycoplasma disease

C02 = Mother not known to have mycoplasma disease and infant culture positive

C03 = Infant with definite clinical mycoplasma disease

**VII. CNS DISEASES**

1820 SLIN . . . . Supero-Lateral Infarction of Brain (*Diagnosed on ultra-sound*)  
000 = Supero-lateral infarction of brain

1830 BHEM . . . . Brain Hemorrhage  
BRS = Brain stem  
CER = Cerebral  
CBL = Cerebellar

1840 CHCA . . . . Convulsion - Due to Hypocalcemia  
000 = Convulsion due to hypocalcemia

1850 CHGL . . . . Convulsion - Due to Hypoglycemia  
000 = Convulsion due to hypoglycemia

1860 CHNA . . . . Convulsion - Due to Hyponatremia  
000 = Convulsion due to hyponatremia

1870 CHMG . . . . Convulsion - Due to Hypomagnesemia  
000 = Convulsion due to hypomagnesemia

1880CALK . . . . Convulsion - Due to Alkalosis  
000 = Convulsion due to alkalosis

1890 CMEN . . . . Convulsion - Due to Meningitis  
000 = Convulsion due to meningitis

1900 CPYR . . . . Convulsion - Due to Pyridoxine Dependency or Deficiency  
000 = Convulsion due to pyridoxine dependency or deficiency

1910 CKER . . . . Convulsion - Due to Kernicterus  
000 = Convulsion due to kernicterus

- 1920 CBRN . . . . Convulsion - Due to Brain Edema  
000 = Convulsion due to brain edema  
HCA = Hypercapnia
- 1930 CDWD . . . Convulsion - Due to Drug Withdrawal  
000 = Convulsion due to drug withdrawal
- 1940 CCUK . . . . Convulsion - Cause Unknown or Other  
BFN = Benign familial neonatal  
CBH = Cerebral hemorrhage  
CUK = Cause unknown  
HPX = Hypoxia  
*(Not birth depression - asphyxia neonatorum)*  
IEM = Inborn error of metabolism  
INF = Infarction  
VNS = Venous thrombosis
- 1941 CCMB . . . . Convulsion Due to Congenital Malformation of Brain  
ARN = Arhinencephaly  
*(Include holoprosencephaly)*  
HCP = Hydrocephaly or hydranencephaly  
OBA = Other brain anomaly
- 1950 ACEX . . . . Abnormal Cerebral Irritation/Hypertonicity  
*(Exclude post-asphyctic)*  
000 = Abnormal cerebral irritation/hypertonicity  
HXA = Hyperreflexia (Hereditary Startle Disease)
- 1960 ACDP . . . . Abnormal Cerebral Depression/Hypotonicity  
*(Not occurring in delivery room. Exclude post-asphyctic and apnea.)*  
000 = Abnormal cerebral depression/hypotonicity  
MAD = Abnormal cerebral depression due to maternal analgesia.  
*(As stated by physician)*



## 1970 DWDW . . . Drug Withdrawal Syndrome

*(Do Not Code 1950 or 1960 with this code)*

BAR = Barbiturate  
BZM = Benzomorphan  
CCN = Cocaine  
DEM = Meperidine (Demerol)  
DIA = Diazepam (Valium)  
ETH = Ethchlorvynol (Placidyl)  
HER = Heroin  
MOR = Morphine  
MTH = Methadone  
TLW = Pentazocine (Talwin)

## 1980 KERN . . . . Kernicterus

000 = Kernicterus

## 1990 CEDM . . . . Cerebral Edema, Regardless of Cause; Pathologic Diagnosis only

000 = Cerebral edema

2000 DGBD . . . . Hypotrophic Brain Disease, Acquired, Not Due to Asphyxia in utero

ATR = Cortical atrophy  
ECM = Encephalomalacia  
GIL = Gilles telencephalic leucoencephalopathy  
INF = Infarction  
POR = Porencephalic cyst(s)  
PVL = Periventricular leukomalacia

## 2010 ACSF . . . . Abnormalities of C.S.F.

*(See code 1400 for positive CSF without other evidence of meningitis.)*

GPR = Low glucose + high protein  
HGO = Low glucose only  
*(< 50% of serum glucose)*  
PGP = Pleocytosis + low glucose + high protein  
PLG = Pleocytosis + low glucose  
PLO = Pleocytosis only  
*(Increased WBC and lymphocytes)*  
PLP = Pleocytosis + high protein  
PRO = High protein only  
*(>2.0g/L in the absence of blood)*

- 2020 HPAR . . . . Hemiparesis  
TRR = Transient  
*(Not present at discharge from hospital)*  
PER = Permanent  
*(Present at time of discharge)*
- 2030 APNE . . . . Apneic Spells  
*(Idiopathic apnea. Lack of breathing, accompanied by cyanosis and bradycardia.)*  
000 = Apneic spells
- 2040 OCNS . . . . CNS Abnormality, Miscellaneous  
C01 = Retinal hemorrhage involving the macula  
C02 = Chorioretinitis  
C03 = Congenital subdural effusion  
C04 = Periventricular calcification  
C05 = Ondines's Curse  
C06 = Opsoclonus
- 2050 CRAN . . . . Cranial Nerve Palsy  
*(Exclude facial (7th) nerve palsy; see CODE 1230)*  
003 = 3rd or oculomotor nerve  
004 = 4th or trochlear nerve  
005 = 5th or trigeminal nerve  
006 = 6th or abducens nerve  
010 = 10th or vagus nerve  
*(Include vocal cord paralysis due to laryngeal nerve palsy)*

**VIII. RESPIRATORY DISEASE**

2060 IRDS . . . . . Respiratory Distress Syndromes

TRD = Transient respiratory distress

*(Duration of > 1 hour and < 6 hours.**Do not code if cause of T.R.D. is identified, e.g. pneumothorax.)*

MID =Mild I.R.D.S

*(<35% O<sub>2</sub>)*

MRD = Mod. I.R.D.S.

*(35% O<sub>2</sub> or CPAP)*

SRD = Severe I.R.D.S.

*(Ventilated)*

TTN = Transient tachypnea

of the newborn

**Guidelines for MID, MRD, SRD***Grunting, retractions, and decreased air entry - occurring before 3 hours of age and persisting beyond 6 hours of age and not explained by any other disease***Guidelines for TTN***Onset <3 hours of persistent tachypnea over 80/min. for more than 24 hours having a benign course and never requiring more than 40% O<sub>2</sub>; may not require any oxygen to be administered. chest x-ray shows normal or increased inflation with peri-hilar streaking and fluid in the fissures or in the pleural space*

BRD = Benign respiratory distress

*(Persists beyond 6 hours of age)*

HMF = Hyaline membrane formation not due to H.M.D.

*(Path diagnosis)*

EMF = Pulmonary edema without hyaline membrane formation

*(Path diagnosis)*

2070 PNTH . . . . . Pneumothorax

*(Exclude surgical pneumothorax)*

RIT = Right

LEF = Left

BIL = Bilateral

*(Both sides involved sometime during neonatal hospital course)*

2080 PNMS . . . . . Pneumomediastinum

*(Exclude surgical pneumomediastinum)*

000 = Pneumomediastinum

2090 IPEP . . . . . Interstitial Pulmonary Emphysema

*(Also bilateral bullous)*

000 = Interstitial pulmonary emphysema

2100 PNPC . . . . . Pneumopericardium  
*(Exclude surgical pneumopericardium)*  
000 = Isolated pneumopericardium

2110 CPDP . . . . . Chronic Pulmonary Disease of Prematurity  
*Defined as two of the following:*

1. *Abnormal chest x-ray not typical of other disease.*
2. *Clinical respiratory distress greater than 2 weeks.*
3. *PCO<sub>2</sub> of greater than 60 mm Hg on 2 or more occasions after 1 week of age with no other obvious cause.*

WM1 = Wilson-Mikity Syndrome\* - not ventilated; no cystic change

WM2 = Wilson-Mikity Syndrome\* - not ventilated; with cystic changes

BP1 = Bronchopulmonary dysplasia - ventilated; no cystic change

BP2 = Bronchopulmonary dysplasia - ventilated; with cystic changes

*(\*Note that some infants with Wilson-Mikity Syndrome may have been ventilated but this must have been late (e.g., after 2 weeks of age) and ventilation must have been begun after the clearly established onset of chronic lung disease.)*

2120 STRI . . . . . Congenital Stridor  
CUK = Cause unknown  
HVC = Hyperplasia of vocal cords  
LGM = Laryngomalacia  
OMH = Oromandibular Limb Hypogenesis Syndrome  
TBM = Acquired tracheobronchomalacia  
TCM = Tracheomalacia  
TRM = Traumatic  
RPM = Retropharyngeal mass

2130 PULH . . . . . Pulmonary Hemorrhage  
000 = Pulmonary hemorrhage

2140 ATEL . . . . . Atelectasis (Lobar) Not diffuse  
000 = Atelectasis

2150 PEMB . . . . . Pulmonary Embolus and/or Infarct  
000 = Pulmonary embolus

- 2160 PHYS . . . . Pulmonary Emphysema  
BGC = Lobar emphysema due to bronchogenic cyst  
CUK = Cause unknown  
IDI = Congenital idiopathic lobar emphysema
- 2170 CFIB . . . . Cystic Fibrosis  
*(Includes meconium ileus)*  
000 = Cystic fibrosis
- 2180 LCYS . . . . Lung Cyst  
000 = Lung cyst
- 2190 CCAM . . . . Cystic Adenomatoid Malformation of Lung  
000 = Cystic adenomatoid malformation of lung
- 2200 CPLA . . . . Congenital Pulmonary Lymphangiectasia  
000 = Congenital pulmonary lymphangiectasia
- 2210 RESD . . . . Miscellaneous Respiratory Disease  
C01 = Chronic cor pulmonale  
C02 = Chylothorax (Include congenital, acquired, surgical)  
C03 = Pulmonary hypertension  
*(Due to chronic lung disease)*  
C04 = Foreign body granuloma of airway or lung  
C05 = Fixed diaphragm  
*(Not due to paralysis)*  
C06 = Acquired aspiration pneumonitis (eg. gastric contents, formula)

**IX. G.I. DISEASES**

- 2230 LFIB . . . . . Liver Fibrosis  
PPF = Periportal fibrosis
- 2240 CHAL . . . . . Gastro-esophageal Reflux (Chalasia)  
000 = With no evidence of hiatal hernia or pyloric stenosis  
HIA = Hiatus hernia
- 2250 PINC . . . . . Pharyngeal Incoordination  
*(Clinical diagnosis confirmed by barium swallow during fluoroscopy.)*  
000 = Pharyngeal incoordination
- 2260 MALS . . . . . Malabsorption Syndrome  
000 = Malabsorption syndrome
- 2270 HEPT . . . . . Hepatitis  
CUK = Unknown  
TOX = Toxic  
VIR = Viral
- 2280 PERF . . . . . Perforation of G.I. Tract  
*(Include meconium peritonitis)*  
APP = Appendix  
COL = Cecum/colon  
DUO = Duodenum  
ESO = Esophagus  
ILE = Ileum  
JEJ = Jejunum  
RTM = Rectum  
STO = Stomach  
UKN = Site unknown
- 2290 LACI . . . . . Lactose Intolerance  
ACQ = Acquired  
HAL = Hereditary alactasia  
*(Flat lactose tolerance curve and/or no lactase on biopsy)*  
HLI = Hereditary infantile lactose intolerance  
*(Lactosuria)*  
CCU = Congenital, cause unknown

2300 IFAR . . . . . Intestinal Infarction  
000 = Intestinal infarction

2310 APEN . . . . . Appendicitis  
000 = Appendicitis

2320 GIDS . . . . . Miscellaneous G.I. Disease  
C01 = Pneumoperitoneum, cause unknown  
C02 = Acquired stricture  
C03 = Peptic ulcer  
C04 = Rectal prolapse  
C05 = Hydrops of gall bladder  
C06 = Lactobezoar  
C07 = Acquired volvulus  
C08 = Cholelithiasis  
C09 = Functional bowel obstruction, cause unknown  
C10 = Cloacel Maldevelopment  
C11 = Ectopic Anus  
CUK = Cause unknown

2330 MECP . . . . . Meconium Plug Syndrome  
000 = Meconium plug syndrome

**X. HEMATOLOGIC DISEASES**

2350 BLUD . . . . Miscellaneous Hematologic Disease

- C01 = Sickle cell trait  
 C02 = Methemoglobinemia  
 C03 = Isoimmune neutropenia  
 C04 = Perinatal hemochromatosis  
 C05 = Neutropenia, < 1,000 pmns (mature or bands per cu.mm)

*use following formula:*

Multiply the total corrected WBC's by the % of pmns (polymorphoneutrophils) and bands.

e.g. total WBC = 15,000  
 pmns = 5%  
 bands = 1%

Therefore:

Total pmns (mature and immature)= 0.06 x 15,000=900 (neutropenia)

2360 ABOI . . . . ABO Isoimmunization

ABO SET-UP:

- 1) MOTHER BLOOD TYPE:O  
BABY BLOOD TYPE: A or B or AB
- 2) MOTHER BLOOD TYPE:A  
BABY BLOOD TYPE: B
- 3) MOTHER BLOOD TYPE:B  
BABY BLOOD TYPE: A

DEF = Definite

*(ABO set-up, positive direct Coombs' test)*

PBL = Possible

*(ABO set-up, negative direct Coombs' test, positive indirect Coombs' test, and total bilirubin >15 mg% or 259 microM/L; or unconjugated bilirubin ≥ 230 microM/L)*

UKN = Isoimmunization type unknown

**(ABO groups compatible, positive direct Coombs' test, and no other known isoimmunization)**



**ISOIMMUNIZATIONS - NON-ABO**

**NOTE: A POSITIVE COOMBS' TEST IS REQUIRED FOR THE FOLLOWING ISOIMMUNIZATIONS - NOT JUST A CORD SERUM**

2370 DISO . . . . . D Isoimmunization  
000 = D isoimmunization

2380 LTLC . . . . Little c Isoimmunization  
000 = Little c isoimmunization

2390 BIGC . . . . . Big C Isoimmunization  
000 = Big C isoimmunization

2400 BIGE . . . . . Big E Isoimmunization  
000 = Big E isoimmunization

2410 KELL . . . . . Kell Isoimmunization  
000 = Kell isoimmunization

2420 FYAI . . . . . Fya Isoimmunization (*Duffy*)  
000 = Fya isoimmunization

2430 KIDD . . . . . Miscellaneous Isoimmunization  
C01 = Kidd  
C02 = Wright  
C03 = MNS blood groups  
C04 = Positive DAT  
**(Coombs' test) due to complement, no ABO set-up**  
C05 = Little "e"  
C06 = Little "s"

- 2440 HBIL . . . . . Hyperbilirubinemia  
*(Total bilirubin > 15 mg% or > 258 microM/L; or unconjugated or indirect bilirubin ≥ 230 microM/L)*  
CSC = Congenital spherocytosis  
CUK = Cause unknown  
HEP = Hepatitis  
HOH = Hepatic disease other than Hepatitis  
ISO = Isoimmunization  
POL = Polycythemia  
RES = Resorption of hematoma  
SEP = Sepsis (Infection)
- 2450 HEMR . . . . . Hemorrhage  
*(Not due to asphyxia, trauma, or coagulation disorder when otherwise listed.)*  
ADH = Adrenal  
CHZ = Hematochezia  
**(Frank bleeding; do not code occult blood only or ingested maternal blood)**  
FMB = Fetomaternal  
FPL = Fetoplacental  
HPC = Hemopericardium  
HPT = Hemoperitoneum  
HTH = Hemothorax  
HUR = Hematuria  
IAT = Iatrogenic  
TTT = Twin-Twin Transfusion  
UKN = Site unknown  
UMB = Hemorrhage from umbilical or placental vessels  
VOM = Hematemesis
- 2460 COAG . . . . . Coagulopathy  
AHG = AHG deficiency  
*(Antihemophilic globulin, blood coagulation Factor VIII - hemophilia)*  
ART = Arterial thrombosis  
CUK = Cause unknown  
DIC = Disseminated intravascular coagulation  
F13 = Factor XIII deficiency  
HDN = Hemorrhagic disease of the newborn  
HDS = Coagulation disorder due to hepatic disease  
HLK = Circulating anti-thrombin (Heparin-like substance)  
PTA = PTA deficiency  
*(Plasma thromboplastin antecedent, blood coagulation Factor XI)*  
VON = Von Willebrand's disease  
VTH = Venous thrombosis

## 2470 ANEM . . . . Anemia

*(Hgb < 14 gm% or <140 g/L or Hct < 42% in the first week;*

*Hgb < 10 gm% or <100 g/L or Hct < 30% at any age.*

*Code the cause based on the first low hemoglobin, unless clearly stated otherwise.)*

BLL = Blood-letting

*(Due to multiple blood tests)*

CSC = Congenital spherocytosis

CUK = Cause unknown

EXT = Exchange transfusion

FMB = Fetomaternal bleed

G6P = Glucose-6-phosphate dehydrogenase deficiency

HMR = Hemorrhage

ISO = Isoimmunization

**(Requires a positive direct Coombs')**

IFN = Infection

PKD = Pyruvate kinase deficiency

PMY = Prematurity

*(After 7 days of age)*

NPD = Neoplastic disease

SMC = Stomatocytosis

TOX = Toxic hemolytic anemia

TTT = Twin-Twin transfusion

VED = Vitamin E deficiency syndrome

## 2480 POLC . . . . Polycythemia

*(Central Hgb >21 gm% (210 g/L), central Hct >63% (.630 L/L),*

*capillary Hgb >25 gm% (250 g/L), or capillary Hct >75% (.750 L/L);*

*both Hgb and Hct must be above normal on a single sample, or at least one of Hgb or Hct is above normal on 2 or more consecutive samples.)*

000 = Polycythemia

- 2490 THRM . . . . Thrombocytopenia  
*(Platelet count <100,000 on one occasion with bleeding, or on 2 occasions when no clinical bleeding evident.)*  
BGI = Blood Group Isoimmunization  
CUK = Cause unknown  
EXT = Exchange transfusion  
DIC = Disseminated intravascular coagulation  
ISO = Isoimmune due to ITP (*Idiopathic maternal thrombocytopenia*)  
NPD = Neoplastic disease  
PA1 = Isoimmune due to PLA1  
SEP = Sepsis  
TSA = Thrombocytopenia-absent radii syndrome
- 2500 OBST . . . . Obstructive Jaundice  
*(Direct bilirubin , or conjugated, >2.0 mg% or >34.5 micromol/L)*  
000 = Obstructive jaundice
- 2510 INRC . . . . Increased Nucleated RBC and/or Normoblastemia  
*(>15% or greater than 18 nRBCs on 0-5 days;  
>1% or greater than 2 NRBCS after 5 days)*  
000 = Increased nucleated RBC and/or normoblastemia
- 2520 RETC . . . . Reticulocytosis  
*(>7% on days 1-2; >5% on days 3-6;  
>3% on days 7 and thereafter)*  
000 = Reticulocytosis
- 2530 LEUK . . . . Leukemia  
000 = Leukemia
- 2540 RBCD . . . . Red Cell Defects  
CSC = Congenital spherocytosis  
G6P = Glucose-6-phosphate dehydrogenase deficiency  
PKD = Pyruvate kinase deficiency  
PPK = Pyropoikilocytosis  
SMC = Hereditary stomatocytosis

2550 NEOP . . . . Neoplasms

- CON = Connective tissue
- CYS = Cystadenoma
- END = Endothelial tissue
  
- EN1 = Insulinoma
- EPI = Epithelial tissue
- EPY = Ependymoma
  
- FOL = Follicular cyst
- GLI = Nasal glioma
- HPB = Hepatoblastoma
  
- HYG = Cystic hygroma
- LAN = Lymphangioma
- MEB = Mesoblastic nephroma
  
- MUS = Muscle
- NBL = Neuroblastoma
- NMB = Medulloblastoma
  
- RHA = Rhabdomyoma
- TER = Teratoma, embryonic rests
- TGO = Teratoma, gonads
  
- TSU = Teratoma, site unknown
- UKN = Mass, unknown type
- WIL = Wilms' tumour

**XI. ENDOCRINE DISEASES**

- 2560 GOIT . . . . Congenital Goiter  
000 = Congenital goiter
- 2570 PSUH . . . . Male Pseudohermaphroditism  
TFS = Testicular feminizing syndrome  
XOM = Male pseudohermaphroditism with XO-XY mosaicism  
XYK = Male pseudohermaphroditism with XY karyotype  
RFS = Reifenstein's syndrome  
BHS = 3-Beta-Hydroxysteroid dehydrogenase deficiency  
LAH = Lipoid adrenal hyperplasia  
DES = 17-20 desmolase deficiency  
**(Zachmann-Prader syndrome)**  
CUK = Cause unknown
- 2580 CRET . . . . Hypothyroidism  
ATH = Aplasia/hypoplasia  
**(Athyrotic cretinism, ectopic thyroid)**  
CUK = Type unknown  
HYP = Hypothalamic  
IDD = Iodine deficiency  
**(Endemic cretinism)**  
MAA = Maternal Antibodies  
MDI = Maternal drug ingestion  
**(Propylthiouracil, iodides)**  
NGC = Defective synthesis  
**(Non-endemic goitrous cretinism)**
- 2590 ADIS . . . . Adrenal Insufficiency Syndrome  
AHP = Congenital adrenal hypoplasia/aplasia  
AHR = Adrenal hemorrhage  
DEH = Defect of dehydrogenation of 18-hydroxycorticosterone  
18H = Defect of 18-hydroxylation of corticosterone  
21H = 21-Hydroxylase deficiency

2600 HIT4 . . . . . Hyperthyroidism  
 C01 = Asymptomatic elevated serum T<sub>4</sub>  
 C02 = Symptomatic SEE VALUES:

AGE	Total T4 (nanomol/L)		TSH (mu/L)	
	MEAN	RANGE	MEAN	RANGE
Cord Blood	131	95 - 167	9.0	<2.5 - 17.4
1 - 3 days	221	151 - 290	8.0	<2.5 - 13.3
1 - 2 week	169	126 - 213	---	---
2 - 4 week	141	88 - 192	4.0	0.6 - 10.0
1 - 4 months	132	92 - 185	<2.5	<2.5
4 - 12 months	141	100 - 212	2.1	0.6 - 6.3
1 - 5 year	135	94 - 192	2.0	0.6 - 6.3
5 - 10 year	119	82 - 170	2.0	0.6 - 6.3
10 - 15 year	104	72 - 150	1.9	0.6 - 6.3
Adult	108	55 - 160	1.8	0.2 - 7.6

*From LaFranchi 1979*

2601 LOPA . . . . . Hypoparathyroidism  
 000 = Hypoparathyroidism

2610 DIBM . . . . . Diabetes Mellitus  
 000 = Diabetes mellitus

2620 RICK . . . . . Rickets  
 C01 = Elevated alkaline phosphatase only  
 (>406 I.U.)  
 C02 = Evidence of bone demineralization with or without  
 abnormal alkaline phosphatase  
 C03 = Clinical rickets  
 (*Classical rickets.*  
*Rickets with fractures.*)  
 C04 = Clinical/Classical Rickets with Fracture

2630 ABIG . . . . . Ambiguous Genitalia  
 (See CODE 2830 = *Miscellaneous endocrine disease*)  
 000 = Ambiguous genitalia

**XII. METABOLIC DISEASES**

- 2640 LOGL . . . . Hypoglucosemia  
(*<30 mgm% or <1.67 mmol/L*)  
000 = Hypoglucosemia
- 2650 HIGL . . . . Hyperglucosemia  
(*>125 mg% or >6.94 mmol/L*)  
000 = Hyperglucosemia
- 2660 LOCA . . . . Hypocalcemia ( See code 2830MISC...C10 for Hypercalcemia)  
(*7.0 mg% or less; 1.75 mmol/L or less; ionized  $\leq$  1.0 mmol/L*)  
NOC = Without convulsions  
TTY = Neonatal tetany  
(*Not post-asphyctic convulsions*)
- 2670 LMBA . . . . Late Metabolic Acidosis  
(*After 72 hours of age; base deficit > -10 mEq/L or > -10 mmol/L*)  
000 = Non-persistent  
RTA = Renal tubular acidosis
- 2680 LOSK . . . . Hypokalemia  
(*<3.0 mEq/L or <3.0 mmol/L*)  
000 = Hypokalemia
- 2690 HISK . . . . Hyperkalemia  
(*7.0 mEq/L or more; 7.0 mmol/L or more*)  
000 = Hyperkalemia
- 2700 LONA . . . . Hyponatremia  
(*130 mEq/L or less; 130 mmol/L or less*)  
000 = Hyponatremia
- 2710 HINA . . . . Hypernatremia  
(*>155 mEq/L or >155 mmol/L*)  
000 = Hypernatremia



- 2720 HIUN . . . . Azotemia  
(*BUN 20 mg% or more; 7.14 mmol/L or more, urea value*)  
000 = Azotemia
- 2730 HICR . . . . Hypercreatininemia  
(*2.0 mg% or more; 177 micromol/L or more*)  
000 = Hypercreatininemia
- 2740 LOUO . . . . Oliguria  
(*<15 ml/Kgm/day on Day 2 or <20 ml/Kgm/day after 2 days*)  
000 = Oliguria
- 2750 LOPR . . . . Hypoproteinemia  
(*4.0 gm% or less; 40 gm/L or less*)  
000 = Hypoproteinemia
- 2751 LOAL . . . . Hypoalbuminemia  
(*≤2.4 gm% or ≤24 gm/L*)  
000 = Hypoalbuminemia
- 2760 LOMG . . . . Hypomagnesemia  
(*1.3 mEq/L or less; 0.53 mmol/L or less*)  
000 = Hypomagnesemia
- 2770 HIMG . . . . Hypermagnesemia  
(*>2.5 mEq/L or >1.03 mmol/L*)  
000 = Hypermagnesemia
- 2780 HIPP . . . . Hyperphosphatemia  
(*8.0 mg% or more; 2.58 mmol/L or more*)  
000 = Hyperphosphatemia

- 2790 PHEN . . . . Phenylalaninemia  
CUK = Type unknown  
PMY = Phenylalaninemia of prematurity  
TP1 = Phenylalaninemia Type I  
*(Classical phenylketonuria)*  
TP2 = Phenylalaninemia Type II  
*(Atypical phenylketonuria)*  
TPA = Transient phenylketonuria  
TPB = Benign hyperphenylalaninemia
- 2800 PROL . . . . Hyperprolinemia  
000 = Hyperprolinemia
- 2810 TYRO . . . . Hypertyrosinemia  
*(5.0 mgm% or more)*  
000 = Hypertyrosinemia
- 2820 HNH3 . . . . Hyperammonemia  
*(>150 microgm% or >107 micromol/L)*  
000 = Hyperammonemia
- 2821 URIC . . . . Hyperuricemia  
*(>400 micromol/L)*  
000 = Hyperuricemia
- 2830 MISC . . . . Miscellaneous Endocrine and Metabolic  
C01 = Zinc deficiency  
C02 = Albinism  
C03 = Copper deficiency  
C04 = Fabry's disease  
**(Alpha-glucosidase deficiency)**  
C05 = Storage disease, type unknown  
C06 = Diabetes Insipidus  
C07 = Galactosemia  
C08 = Mucopolidoses  
**(Include Sialidosis, I-cell disease, pseudo-Hurler polydystrophy)**  
C09 = Nesidioblastosis  
**(Pancreatic cell hyperplasia)**  
C10 = Hypercalcemia  
*(≥3.0 mmol/L; ionized - ≥1.5 mmol/L)*  
C11 = Urea cycle defect  
**(Argininosuccinic aciduria)**  
C12 = Carnitine deficiency  
C13 = SIADH  
**(Syndrome of inappropriate secretion of anti-diuretic hormone)**  
C14 = Cystathioninuria  
C15 = Low serum alkaline/phosphatase ( < 120 IU/L )

2830 MISC . . . . . Miscellaneous Endocrine and Methobolic(**Continued**)

C16 = Hepato-Renal Syndrome (As stated by Physician)

C17 = Zellweger Syndrome

2840 LOPP . . . . . Hypophosphatemia

(*<4.0 mg% or <1.29 mmol/L*)

000 = Hypophosphatemia

2850 ORGD . . . . . Organic Acidosis

PDD = Pyruvate dehydrogenase deficiency (Congenital Lactic Acidosis)

PYD = Pyruvate carboxylase deficiency (Congenital Lactic Acidosis)

**XIII. MISCELLANEOUS DISORDERS**

2860 CCVH . . . . Complication of Vascular Catheter

ARR = Arrhythmia

EDM = Edema

PCE = Pericardial effusion

PFH = Perforation of heart

PLE = Pleural effusion

PNP = Phrenic nerve palsy

RPT = Ruptured vessel

THB = Thrombophlebitis

VSS = Vasospasm

*(Severe)*

2870 NCAL . . . . Nephrocalcinosis

000 = Nephrocalcinosis

2880 MUSC . . . . Acquired Muscle Contracture Due to IM Injections

000 = Acquired muscle contracture due to IM injections

2890 NSID . . . . Non-SIDS Death After Discharge

000 = Non-SIDS death after discharge

2900 RLFP . . . . Retrolental fibroplasia

*(Retinopathy of prematurity)*

ST0 = Stage 0

*(Peripheral pallor)*

ST1 = Stage 1

*(Peripheral vascular straightening)*

ST2 = Stage 2

*(Peripheral shunt well seen)*

ST3 = Stage 3

*(Vessels growing into vitreous; vitreous . hemorrhages)*

ST4 = Stage 4

*(Retinal detachment)*

2910 IKDM . . . . Infant of diabetic mother

*(See Maternal Code 0520 for definition of maternal diabetes. If there is no history of diabetes, and no record of GTT results, but the mother is on insulin, code infant of gestational diabetic. If the F.B.S is equal to or greater than 7.0mmol/L a code infant of gestational diabetic. )*

- CLA = Infant of a known diabetic mother, Class A  
*(Define as abnormal maternal glucose tolerance test using either the Joslin Clinic or the O'Sullivan criteria, whichever is positive.)*
- CLB = Infant of a known diabetic mother, Class B
- CLC = Infant of a known diabetic mother, Class C
- CLD = Infant of a known diabetic mother, Class D
- CLF = Infant of a known diabetic mother, Class F
- CLR = Infant of a known diabetic mother, Class R
- CLU = Infant of a known diabetic mother, Class unknown
- CAD = Clinical appearance of an I.D.M. when mother not known to be a diabetic
- CLT = Infant of mother with diagnosis of gestational diabetes made by level of greater than or equal to 10.3mmol/l trutol test.

**JOSLIN CLINIC**

**[Both values must be abnormal]**

**Peak . . . . . 180 mg% or more; 10.0 mmol/L or more**  
**1/2 hour post peak . . . 130 mg% or more; 7.2 mmol/L or more**

**O'SULLIVAN**

**[2 or more abnormal values]**

**F.B.S. . . 105 mg% or more; 5.3 mmol/L or more**  
**1 Hour . 190 mg% or more; 10.6 mmol/L or more**  
**2 Hour . 165 mg% or more; 8.9 mmol/L or more**

- 2920 HRTF . . . . Congestive Heart Failure  
*(Not post-asphyctic, baby will usually receive digitalis or diuretics.)*  
ANE = Anemia  
AVA = Arteriovenous (AV) Aneurysm  
BPD = Bronchopulmonary dysplasia  
CHD = Congenital Heart Disease  
CUK = Cause unknown  
LOG = Hypoglycemia  
MOP = Cardiomyopathy  
MYO = Myocarditis  
PAT = Paroxysmal atrial tachycardia  
SEP = Sepsis  
TTT = Twin-to-twin transfusion
- 2921 ACDM . . . . Acquired Cardiomyopathy  
STR = Steroid induced
- 2930 SCLR . . . . Sclerema  
000 = Sclerema
- 2940 RENF . . . . Renal Failure  
000 = Renal failure
- 2950 HYDR . . . . Hydrops Fetalis  
*(Immune and non-immune)*  
ANA = Anasarca  
*(Generalized edema)*  
IAS = Isolated ascites
- 2970 LOWT . . . . Hypothermia  
355 = 35.0 - 35.5<sup>0</sup>C  
350 = Below 35.0<sup>0</sup>C.
- 2980 RVTH . . . . Renal Vein Thrombosis  
LEF = Left  
RIT = Right  
BIL = Bilateral

- 2990 LPFO . . . . Large Posterior Fontanelle  
*(Admits tip of examiner's 5th finger)*  
000 = Large posterior fontanelle
- 3000 FCAC . . . . Fetal Complications of Amniocentesis and/or Intrauterine Fetal Transfusion  
HOM = Herniation of omentum  
PTX = Pneumothorax  
RUV = Rupture umbilical vessels
- 3010 CETT . . . . Complications of Endotracheal Tube  
LPD = Lip or palate deformity  
LPR = Laryngeal/esophageal perforation  
NLT = Necrotizing laryngitis-tracheitis  
PTS = Persistent post-intubation stridor, specific lesion not demonstrated  
*(Include causes not found and not looked for)*  
STN = Laryngeal and/or subglottic stenosis  
TPR = Tracheal perforation  
ULC = Ulceration and/or squamous metaplasia
- 3020 DIGX . . . . Digitalis Intoxication  
*(Include all digitalis-like drugs)*  
000 = Digitalis intoxication
- 3030 BURN . . . . Burns  
CHE = Chemical  
ELE = Electrical  
TML = Thermal

- 3040 DRUG . . . . Drug intoxication
- ALC = Alcohol  
(*>50 mgm% or >11 mmol/L*)
  
  - CAF = Caffeine  
(*>40 mgm/L or >210 micromol/L*)
  
  - CHL = Chloramphenicol  
(*>40 microgm/ml or >125 micromol/L*)
  
  - DIL = Dilantin  
(*>40 mgm/L or >160 micromol/L*)
  
  - GLY = Aminoglycoside intoxication  
(*Defined by "toxic" blood levels:*  
*Gentamicin trough (Pre) > 3 mgm/L*  
*peak (Post) > 15 mgm/L*  
*Amikacin trough (Pre) > 15 mgm/L*  
*peak (Post) > 50 mgm/L*  
*Tobramycin trough (Pre) > 3 mgm/L*  
*peak (Post) > 15 mgm/L*)
  
  - PBR = Phenobarbital  
(*>40 mgm/L or >174 micromol/L*)
  
  - PBZ = Phenoxybenzamine
  
  - VAN = Vancomycin  
*trough(Pre) > 15 mgm/L*  
*peak (Post) > 45 mgm/L*

- 3050 AIRE . . . . Air Embolism
- 000 = Air embolism

- 3060 FAHT . . . . Deaf At Discharge
- BIL = Bilateral
  - LEF = Left
  - RIT = Right

- 3070 DDEF . . . . Definitely Deaf  
(*Failed hearing test after 3 months of age.*)
- BIL = Bilateral
  - LEF = Left
  - RIT = Right



- 3080 SIDS . . . . . Sudden Unexpected Infant Death Syndrome
- C01 = Died in hospital from S.I.D.S. before discharge
  - C02 = Died after discharge from hospital
  - C03 = "Near miss"  
**(Survivor of cardiac arrest, who was resuscitated.)**
  - C04 = Monitored at home because previous sibling had SIDS
  - C05 = Monitored at home because of apnea  
and/or bradycardia spells
- 3090 FNSS . . . . . Families In Need of Extra Services
- C01 = Child abuse
  - C02 = Child neglect
  - C03 = High risk situation in home for abuse/neglect
  - C04 = Apprehension of Infant by Authorities
- 3100 SCPH . . . . . Last Scalp Ph
- C01 = >7.20
  - C02 = 7.10-7.19
  - C03 = <7.10
- 3120 MCEL . . . . . Miscellaneous Disorders
- C01 = Myocardial infarction
  - C02 = Twin fetus papyraceus (Infant not listed as twin)
  - C03 = Aborted twin or triplet  
**(Infant not listed as a twin or triplet)**
  - C04 = Accidental drug injection into presenting part
  - C05 = Aborted fetus papyraceus  
**(Infant not listed as twin)**
  - C06 = Perforation of lung by pleural drain (chest tube)
  - C07 = Scalp electrode complication
  - C08 = Fetus in fetu
  - C09 = Subcutaneous emphysema
  - C10 = Incisional hernia
  - C11 = Skin slough
  - C12 = Neonatal lupus erythematosus
  - C13 = Hemorrhage  
**(Into tumour)**
  - C14 = Renal calculi
  - C15 = Pericardial effusion
  - C16 = Metastatic calcification of soft tissue
  - C17 = Cardiac Tamponade

**XIV. TREATMENTS AND PROCEDURES**

- 3130 CVPL . . . . Central Venous Line  
*(Exclude umbilical vein catheter)*  
000 = Central venous line
- 3140 RADC . . . . Non-Umbilical Artery Catheter  
000 = Non-umbilical artery catheter
- 3150 UACA . . . . Umbilical Artery Catheter  
000 = Umbilical artery catheter
- 3160 UVCA . . . . Umbilical Vein Catheter  
*(Do not code if part of a procedure, e.g. exchange transfusion.)*  
000 = Umbilical vein catheter
- 3170 IPPV . . . . Intermittent Positive Pressure Ventilation  
IPV = Ventilated  
CPP = Tube C.P.A.P. only
- 3171 HIFV . . . . High Frequency Ventilation  
HFI = High frequency ventilation  
VSO = Ventilation for Surgery only
- 3180 CPAP . . . . Nasal CPAP  
*(Include only nasal CPAP used before intubation and IPPV  
Exclude nasal CPAP used during weaning from ventilator.)*  
000 = Nasal CPAP
- 3190 PDRN . . . . Pleural Drain/Chest Tube  
LEF = Left  
RIT = Right  
BIL = Bilateral  
TND = Thoracentesis, no drain  
*(Needle drainage of pleural cavity)*

3200 EXCH . . . . Exchange Transfusion  
001 = 1 transfusion  
002 = 2 transfusions  
003 = 3 transfusions  
004 = 4 transfusions  
005 = 5 transfusions  
006 = 6 transfusions  
007 = 7 transfusions  
008 = 8 transfusions  
009 = 9 transfusions

3210 NOJF . . . . Tube Feedings  
OGG = Gastric tube feeds  
*(Include orogastric, nasogastric, and gavage feedings. Do not include jejunal feedings.)*  
NJJ = Jejunal tube feeds

3220 PNUT . . . . Parenteral Nutrition  
*(If there is no route (peripheral or central line) indicated, code peripheral. Not eating via the gastro-intestinal tract, e.g. baby receives Vamin or Intralipid.)*  
000 = Peripheral vein or umbilical catheter  
C01 = Central line  
*(Not umbilical artery catheter or umbilical vein catheter)*

3230 STIM . . . . Stimulants Used in the Treatment of Apnea  
AMI = Theophylline  
*(Aminophylline)*  
CAF = Caffeine  
DOX = Doxapram

3240 PHOT . . . . Phototherapy  
000 = Phototherapy

## 3250 STER . . . . Maternal Systemic Steroid Therapy

*(In stillbirths, estimate duration of therapy to time of delivery.**Record 1st dose of 1st course.)*

B12 = Betamethasone (Celestone), first dose given &lt; 24 hours before delivery

B24 = Betamethasone, first dose given 24 to 47 hours before delivery

B48 = Betamethasone, first dose given 48 hours to 1 week before delivery

B1W = Betamethasone, first dose given more than 1 week before delivery

D12 = Dexamethasone (Decadron), first dose given &lt; 24 hours before delivery

D24 = Dexamethasone (Decadron), first dose given 24 to 47 hours before delivery

D48 = Dexamethasone (Decadron), first dose given 48 hours to 1 week before delivery

D1W = Dexamethasone (Decadron), first dose given more than 1 week before delivery

HCS = Hydrocortisone

PRD = Prednisone

PDS = Prednisolone

## 3260 TRAC . . . . Tracheostomy

000 = Tracheostomy

## 3270 CCTH . . . . Cardiac catheterization

*(If done for congenital heart disease, indicate the cardiac defect found as listed under Congenital Heart Disease -- See Code 0130.)*

BAL = Balloon dilatation

BPD = Bronchopulmonary dysplasia

DSP = Ductus syndrome of prematurity

OTH = Other Angiocardiology

## 3271 CARB . . . . Cardiopulmonary Bypass

000 = Cardiopulmonary bypass

## 3280 SURG . . . . Major surgery

*(Indicate the post-op surgical diagnosis; list surgical ligation of the ductus arteriosus for the ductus syndrome of prematurity under Code 0140.)*

ABD = Abdominal-perineal pull-through

**(Include Swenson pull-through)**

ANS = Repair of imperforate anus

*(Anoplasty)*

APP = Appendectomy

ASW = Switching of coronary arteries or great arteries (*Arterial switch*)

ATS = Atrial septectomy

AVO = Aortic valvotomy

BDR = Bile duct repair

BLA = Bladder surgery

BRN = Brain

CHC = Cholecystectomy

CHD = Congenital heart disease

CHO = Excision of choanal atresia

CLY = Colostomy

COA = Repair of coarctation of aorta

COL = Colon

CRN = Craniotomy

CTA = Cutis aplasia congenita

DAA = Division of double aortic arch

DFS = Dermal fistula

DIH = Diaphragmatic hernia

DSN = Dermal sinus

DUJ = Duodenojejunostomy

DUO = Duodenum

ECD = Repair of atrioventricular canal defect

ENC = Encephalocele

ESO = Esophagus

EXB = Repair of bladder exstrophy

FUN = Fundoplication

GLI = Removal of nasal glioma

GSC = Gastroschisis

3280 SURG . . . . Major surgery (*continued*)

*(Indicate the post-op surgical diagnosis; list surgical ligation of the ductus arteriosus for the ductus syndrome of prematurity under Code 0014.)*

HAR = Hemangioma resection

HCP = Hydrocephalus

*(Includes CNS/ventricular shunts)*

HDS = Hepatic disease

HLH = Hypoplastic left heart

ILE = Ileum

ING = Inguinal hernia

IPD = Surgical ligation/closure of patent ductus arteriosus  
**(Not of prematurity)**

JEJ = Jejunal

MEK = Removal of Meckel's Diverticulum

MGC = Meningocele

MMC = Meningomyelocele

NEF = Nephrectomy

NPD = Neoplastic disease

OMP = Omphalocele

OOP = Oophorectomy/salpingo-oophorectomy

ORC = Orchiectomy

ORP = Orchidopexy

OVC = Removal of ovarian cyst

PAB = Banding pulmonary artery

PCT = Pancreatectomy, partial

PNV = Pneumonectomy

POD = Plication of diaphragm

PRS = Repair of Pierre-Robin Syndrome  
*(Tongue, lip, adhesions)*

PTU = Patent urachus

PVO = Pulmonary valvotomy

PVR = Total repair of total anomalous pulmonary venous defect

PYE = Pyeloplasty

PYM = Pyloromyotomy

RAN = Surgical repair of ranula

RTM = Rectum

SKL = Elevation of depressed skull fracture

- 3280 SURG . . . . Major surgery (*continued*)  
*(Indicate the post-op surgical diagnosis; list surgical ligation of the ductus arteriosus for the ductus syndrome of prematurity under Code 0014.)*
- SMB = Repair of small bowel  
STO = Stomach  
SPS = Shunt of systemic pulmonary artery  
*(Includes central shunt, other cardiac shunts)*
- TAR = Repair of truncus arteriosus  
TEF = Repair of tracheoesophageal fistula  
TGV = Correction of transposition of great vessels  
*(Not an “arterial switch”- see ASW)*
- TRR = Tetralogy repair  
TTA = Excision of Teratoma  
TWN = Separation of conjoined twins
- UMH = Repair of Umbilical Hernia  
UPJ = Surgery for UPJ Obstruction  
VSP = Repair of ventricular septal defect
- 3290 INDO . . . . Indomethacin therapy  
000 = Indomethacin therapy
- 3300 TOLZ . . . . Tolazoline (Vasodilator)  
000 = Tolazoline
- 3301 VASO . . . . Magnesium Sulphate (MgSO<sub>4</sub>) (Vasodilator)  
000 = Magnesium sulphate
- 3302 INOX . . . . Nitric Oxide Therapy  
000 = Nitric oxide therapy
- 3310 NITP . . . . Nitroprusside  
000 = Nitroprusside
- 3320 PGPG . . . . Prostaglandin E  
000 = Prostaglandin E

- 3330 MIST . . . . . Miscellaneous Treatment or Procedure
- C02 = Steroid therapy for infant after birth  
(*I.M., I.V., P.O.*)
  - C03 = Peritoneal dialysis
  - C04 = Needle biopsy of liver
  - C05 = Muscle biopsy
  - C06 = Intestinal biopsy (rectum, colon)
  - C07 = Lung biopsy
  - C08 = Vesicostomy
  - C09 = Pericardiocentesis
  - C10 = Subdural peritoneal shunt
  - C11 = Nephrostomy, percutaneous
  - C12 = Myocardial biopsy
  - C13 = Granulocyte transfusion
  - C14 = Cystoscopy
  - C15 = Varicella zoster immune globulin injection
  - C16 = Skin biopsy
  - C17 = Metoclopramide  
(*Gastrointestinal therapy*)
  - C18 = BCG vaccination
  - C20 = Balloon atrial septostomy
  - C21 = Biopsy of kidney( Needle or Open)
  - C22 = Cardiac massage  
(*External*)
  - C23 = Hemofiltration
  - C24 = Fulguration (repair) of posterior urethral valves
  - C25 = Insertion of ventricular access device  
(*Intraventricular reservoir*)
  - C26 = Inhaled aerosol steroid therapy  
(*Becloforte, Beclomethasone Dipropionate, Pulmicort, Budesonide*)
  - C27 = Extracorporeal membrane oxygenation (E.C.M.O.)
  - C28 = Jejunostomy for feeding purposes
  - C29 = Cardiac Massage  
(*Open*)
  - C30 = Thoracotomy to drain pericardium
  - C31 = Clipping of Sublingual Frenulum (Tongue Tied)
  - C32 = Bone Marrow Aspiration or Biopsy
- 3340 CIRC . . . . . Circumcision
- 000 = Circumcision
- 3350 VITE . . . . . Pharmacologic Vitamin E Therapy
- 000 = Pharmacologic vitamin E therapy
- 3360 GASY . . . . . Gastrostomy for Medical Reasons
- 000 = Gastrostomy for feeding purposes



- 3370 PAGT . . . . Paralyzing Agent  
000 = Paralyzing agent  
PAV = Pavulon  
*(Pancuronium bromide)*
- 3380 MYRN . . . Myringotomy  
*(Include myringotomy tubes)*  
000 = Myringotomy
- 3390 APAR . . . . Abdominal paracentesis  
000 = Abdominal paracentesis
- 3400 BRON . . . . Bronchoscopy  
000 = Bronchoscopy
- 3410 CRYO . . . . Cryosurgery  
000 = Retina
- 3411 PAGT . . . . Laser Therapy  
LOP = Left eye  
ROP = Right eye
- 3420 HEPB . . . . Hepatitis B Prophylaxis  
HBG = Hepatitis B globulin  
VAC = Hepatitis B vaccine
- 3421 IMMZ . . . . Immunizations  
FLU = Viral influenza  
HIB = Hemophilus influenza, B conjugate vaccine (**HIB**)  
RSV = Respiratory Synticial Virus Vaccine
- 3430 VITD . . . . Pharmacologic Vitamin D  
000 = Pharmacologic vitamin D  
*(Code only > 1,000 units/d.)*
- 3440 DPTP . . . . DPTP Immunization  
000 = DPTP  
DPT = DPT only  
*(No pertussis)*

3450 HOME . . . . Home oxygen therapy  
000 = Home oxygen therapy

3460 SURF . . . . Surfactant Administration  
EXO = Exosurf (artificial)  
SVA = Survanta (natural)  
BLE = BLES Surfactant

3461 . . . . . CISA Cisapride Therapy  
000 = Cisapride

3470 DEXA . . . . Dexamethasone Therapy  
000 = Dexamethasone

## **XV. TWINS**

3500 TWIN . . . . Twin type  
ONE = Monoamniotic  
(*One amniotic sac*)  
MON = Monochorionic, diamniotic  
DSB = Dichorionic, dissimilar sexes or blood groups  
SSB = Dichorionic, similar sexes and blood groups  
SSU = Dichorionic, similar sexes, blood groups . undetermined  
UND = Undetermined  
SIA = Siamese (Conjoined) twins

**XVI - MISCELLANEOUS**

3510 INSL . . . . . Insulin Administration

000 = Insulin Administration

3520 DOPA . . . . . Dopamine Administration

*(Blood pressure supportive agent)*

000 = Dopamine administration

3521 ISUP . . . . . Isuprel Administration

*(Blood pressure supportive agent)*

000 = Isuprel administration

3522 DOBT . . . . . Dobutamine Administration

*(Blood pressure supportive agent)*

000 = Dobutamine Administration

3530 PACE . . . . . Cardiac Pacemaker

000 = Cardiac pacemaker

3540 ANHT . . . . . Antihypertensive Therapy

CPL = Captopril

HYD = Hydralozine

PRO = Propranol

DIU = Diuretics used for treatment of hypertension (e.g Furosemide,  
Hydrochlorothiazide)

3550 ANTV . . . . . Antiviral Therapy

ACY = Acyclovir

AZT = AZT (Zidovudine)

RIV = Ribavirin

3551 COFT . . . . . Cofactor Treatment

BIO = Biotin

THI = Thiamine





**INDEX OF MATERNAL DISEASES AND PROCEDURES**

- A -

	<b>CODE #</b>
Abnormalities:	
chromosomal . . . . .	0592
uterine . . . . .	0570
Abortion:	
missed . . . . .	0190
spontaneous . . . . .	0190
threatened . . . . .	0190
Abruptio placenta:	
in a previous pregnancy . . . . .	0130
in present pregnancy . . . . .	0270
Abscess:	
Bartholin's Gland . . . . .	0591
epidural . . . . .	1870
Absence, kidney . . . . .	0530
Abuse:	
alcohol . . . . .	0390
chemical, unspecified . . . . .	0390
narcotics . . . . .	0390
prescription medications . . . . .	0390
street drugs . . . . .	0390
Accidental dural tap . . . . .	1810
Acquired immune deficiency syndrome (A.I.D.S.) . . . . .	1680
Acupuncture, analgesia/anesthesia:	
for labour/delivery . . . . .	0950
for non-delivery procedure . . . . .	0790
Administration:	
oral prostaglandin . . . . .	3030
Oxytocin, Syntocin, Pitocin . . . . .	3020
Agenesis, renal . . . . .	0530
Agoraphobia . . . . .	0400
AIDS, (symptomatic/asymptomatic):	
during pregnancy . . . . .	1680
postpartum . . . . .	1370
Albumin transfusion . . . . .	1470
Alcohol abuse . . . . .	0390
Alcohol therapy for tocolysis . . . . .	1530
Alphaprodine (Nisentil) analgesia . . . . .	0800

## - A -

Amniocentesis:	
for genetics . . . . .	0750
for isoimmunization . . . . .	0750
for lung maturity . . . . .	0750
for polyhydramnios . . . . .	0250
Amnioinfusion . . . . .	2220
Amo-secobarbital (Tuinal) hypnotic . . . . .	0830
Anal sphincter laceration . . . . .	1050
Analgesia:	
Alphaprodine (Nisentil) . . . . .	0800
Amo-Secobarb (Tuinal) . . . . .	0830
Chlorpromazine (Largactil) . . . . .	0870
Diazepam (Valium) . . . . .	0850
Hydromorphone HCl (Dilaudid) . . . . .	0910
Meperidine (Demerol) . . . . .	0810
Morphine (Opium//Pantopon) . . . . .	0890
Nalbuphine (Nubain) . . . . .	0900
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Pentazocine (Talwin) . . . . .	0920
Pentobarbital Hypnotic (Nembutal) . . . . .	0840
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Promethazine (Phenergan) . . . . .	0880
Secobarbital (Seconal) . . . . .	0820
Sublimaze (Fentanyl) . . . . .	0930
Anaphylactic reaction . . . . .	0591
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hemolytic . . . . .	0550
postpartum . . . . .	1250
Sickle Cell . . . . .	0550

## - A -

Anesthesia:	
entonox, for labour/delivery . . . . .	0970
epidural, continuous catheter, for labour/delivery . . . . .	0990
epidural, continuous infusion (CIEA), for labour/delivery . . . . .	1000
epidural, for non-delivery procedure . . . . .	1030
epidural, single, for labour/delivery . . . . .	0980
general, for labour/delivery . . . . .	0960
general, for non-delivery procedure . . . . .	1020
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spinal, for non-delivery procedure . . . . .	1040
spinal, non-delivery . . . . .	1040
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Ankylosing spondylitis . . . . .	0490
Anomaly, fetal, suspected [Undelivered patients only] . . . . .	0360
Anorexia Nervosa . . . . .	0400
Antibiotic therapy . . . . .	2000
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Platelet antigen negative . . . . .	0470
Antibodies, autoimmune:	
Anti-Cardiolipin . . . . .	0470
Anti-DNA . . . . .	0470
Antinuclear (ANA) . . . . .	0470
Anti-SSA (Ro) . . . . .	0470
Lupus . . . . .	0470
Antibodies, red blood cell:	
Anti-Big C . . . . .	0470
Anti-Big E . . . . .	0470
Anti-Big S . . . . .	0470
Anti-D . . . . .	0470
Anti-Dha . . . . .	0470
Anti-Fy <sup>a</sup> . . . . .	0470
Anti-Kell . . . . .	0470
Anti-Kidd . . . . .	0470
Anti-La . . . . .	0470
Anti-Little c . . . . .	0470
Anti-Little e . . . . .	0470
Anti-Little s . . . . .	0470
Anti-Lutheran . . . . .	0470
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Anti-coagulation drug therapy during pregnancy . . . . .	0380



## - A -

Anti-depressive drug use during pregnancy .....	0380
Anti-epileptic drug use during pregnancy .....	0380
Anti-hypertensive drug use during pregnancy .....	0380
Anxiety disorders .....	0400
Appendectomy .....	0770
Arrest:	
cardiac, complicating anesthesia .....	1900
cardiac, during pregnancy .....	0420
Arrhythmias, cardiac .....	0420
Arthritis, rheumatoid .....	0490
ASA therapy for autoimmune diseases .....	1541
Aspiration pneumonitis, complicating anesthesia .....	1890
Asthma .....	0580
Atelectasis, pulmonary .....	1180
Atosiban therapy for tocolysis .....	1530
Autoimmune thyroiditis .....	0510

## - B -

Back pain, post anesthetic . . . . .	1910
Bacterial infection, antepartum . . . . .	1760
Bell's Palsy . . . . .	0410
Bicornuate, uterine abnormalities . . . . .	0570
Bladder diverticuli . . . . .	0530
Bleeding disorder . . . . .	0550
Block:	
high epidural/subdural . . . . .	1840
prolonged epidural . . . . .	1830
Blood dyscrasia . . . . .	0550
Blood loss during Cesarean section . . . . .	0681
Blood patch, to seal dural tear . . . . .	1790
Blood transfusions, number of . . . . .	1500
Bowel carcinoma . . . . .	0540
Bowel obstruction, postpartum . . . . .	1240
Breast carcinoma . . . . .	0540
Breech presentation in a previous pregnancy . . . . .	0140
Bricanyl (Terbutaline) therapy for tocolysis . . . . .	1530
Bromocriptine (Parlodel) lactation suppression . . . . .	1540
Bulimia nervosa . . . . .	0400

## - C -

Calculus, renal . . . . .	0530
Carcinoma . . . . .	0540
Cardiac:	
arrest . . . . .	0420
arrest, complicating anesthesia . . . . .	1900
Cardiomyopathy . . . . .	0420
Carrier, serum hepatitis . . . . .	0460
Cerebral palsy . . . . .	0410
Cervical:	
carcinoma . . . . .	0540
encerclage . . . . .	0710
incompetence . . . . .	0570
laceration . . . . .	1050
suture, removal of . . . . .	0690
Cervicitis . . . . .	0591
Chickenpox . . . . .	1730
Chlamydia(Code also under Infant Disease):	
during pregnancy . . . . .	1750
postpartum . . . . .	1370
Chlorpromazine (Largactil) tranquilizer . . . . .	0870
Cholelithiasis . . . . .	0370
Cholestatic liver disease of pregnancy . . . . .	0460
Cholinesterase deficiency . . . . .	0490
Choriocarcinoma . . . . .	0110
Chorionic villi sampling . . . . .	0751
Chromosomal abnormalities . . . . .	0592
Chronic hypertensive disease . . . . .	0200
Coagulation disorder, acquired . . . . .	0450
Colitis, ulcerative . . . . .	0370
Complications, postpartum, other . . . . .	1240
Concerns, fetal growth . . . . .	0300
Condyloma acuminata:	
during pregnancy . . . . .	1670
postpartum . . . . .	1370
Congenital heart disease . . . . .	0420
Convulsions:	
due to eclampsia in current pregnancy . . . . .	0220
due to eclampsia in previous pregnancy . . . . .	0050
due to epilepsy . . . . .	0410
Cordocentesis . . . . .	2200
Cordocentesis for embolization of umbilical vessels . . . . .	2240
Coronary artery disease . . . . .	0420
Crohn's disease . . . . .	0370
Cryoprecipitate transfusion . . . . .	1470
Cyst of Bartholin's gland . . . . .	0591
Cystic fibrosis . . . . .	0580
Cytotec ( Induction for Termination for Anomaly) . . . . .	3050

## - D -

Damage, hypoxic brain .....	1240
Death:	
fetal [Undelivered patients only] .....	1560
maternal .....	1550
Deep vein thrombosis:	
antepartum .....	0440
in a previous pregnancy .....	0150
Defect/dehiscence of uterine scar .....	0330
Deficiency:	
cholinesterase .....	0490
Factor 8 .....	0550
Factor 12 .....	0550
G6PD .....	0550
Deficit:	
neurologic, resulting from delivery .....	1240
Dehiscence, wound .....	1150
Deladumone lactation suppression .....	1540
Deletions, chromosomal .....	0592
Demerol analgesia .....	0810
Depression:	
in pregnancy .....	0400
manic .....	0400
postpartum:	
current .....	1160
previous pregnancy .....	0180
Dermatitis herpetiformis .....	0330
Destructive operation to effect delivery .....	0660
Diabetes:	
gestational, in a previous pregnancy .....	0160
maternal [Undelivered patients only] .....	0520
maternal [Delivered] See Infant Disease Codes	
Diabetic therapy .....	1531
Diabinese therapy .....	1531
Diazepam (Valium) tranquilizer .....	0850
D.I.C (Disseminated Intravascular Coagulation). .....	0450
Diethylstilbestrol (Stilbestrol) lactation suppression .....	1540
Dilatation and curettage:	
after delivery or abortion .....	0730
diagnostic .....	0731
Dilatation and Evacuation .....	3070
Dilaudid therapy .....	0910

## - D -

## Disease:

cardiac	0420
cholestatic liver disease of pregnancy	0460
congenital heart	0420
coronary artery	0420
Crohn's	0370
Fifth's	1710
gastrointestinal	0370
hypertensive, chronic	0200
liver, cholestatic	0460
mycoplasma	1740
other non-obstetrical, NEC	0490
other obstetrical NEC	0330
polycystic kidney	0530
pulmonary	0580
renal	0530
rheumatic heart	0420
Scheurmann's	0490
thromboembolic	0440
viral	1710
Von Recklinghausen's	0490
Von Willebrand's	0550

## Disorder:

acquired coagulation	0450
adrenal gland	0510
anxiety	0400
eating	0400
generalized anxiety	0400
hypothalamus	0510
non-obstetrical, other	0591
obsessive compulsive	0400
ovary	0510
panic	0400
pituitary	0510
Disseminated intravascular coagulation (D.I.C.)	0450
Distress, fetal	0600
Diverticuli, bladder	0530
Drainage:	
fetal head to effect delivery	0660
suprapubic of myelocele/meningocele	0660

## - D -

Drop, foot:	
due to anesthesia .....	1850
not due to anesthesia .....	1240
Drug abuse .....	0390
Drug, maternal use during present pregnancy .....	0380
Dural tap, accidental .....	1810
Dyscrasia, blood .....	0550
Dysfibrinogenemia .....	0550
Dystrophy, muscular .....	0410

## - E -

Early postpartum hemorrhage .....	1100
Eating disorders .....	0400
Eclampsia:	
in present pregnancy .....	0220
in previous pregnancy .....	0050
Ectopic pregnancy in a previous pregnancy .....	0100
Edema:	
pulmonary .....	0580
pulmonary, postpartum, (not due to anesthesia) .....	1190
Effusion, pleural .....	1190
Embolism, pulmonary .....	0440
Embolization of umbilical vessels by cordocentesis .....	2240
Embolus, pulmonary:	
current pregnancy .....	1170
previous pregnancy .....	0150
Encephalopathy, postpartum .....	1240
Encerclage, cervical .....	0710
Endocarditis .....	0420
Endocrine diseases .....	0510
Endometritis .....	1300
Entonox anesthesia for labour/delivery .....	0970
Epidural:	
abscess, complicating epidural block .....	1870
anesthesia, continuous catheter, for labour/delivery .....	0990
anesthesia, continuous infusion (CIEA), for labour/delivery .....	1000
anesthesia, single, for labour/delivery .....	0980
block, high .....	1840
block, prolonged .....	1830
hematoma, complicating epidural block .....	1860
non-delivery procedures .....	1030
patient controlled (PCEA), for labour/delivery .....	1001
Epilepsy .....	0410
Episiotomy hematoma .....	1140
Excessive fetal growth, suspected .....	0300
Extension, uterine incision .....	1060
Evacuation of hematoma .....	1230
Evisceration, due to wound dehiscence .....	1150
Exchange, plasma .....	1470
Exposure, noxious fumes (environmental) .....	0380
External version .....	1460

## - F -

Factor V Leiden Deficiency .....	0550
Factor 8 deficiency .....	0550
Factor 12 deficiency .....	0550
Failed intubation for general anesthetic .....	1914
Failure:	
heart .....	1220
renal .....	1210
False labour [Undelivered patients only] .....	0340
Familial hypofibrinogenemia .....	0550
Fatty liver of pregnancy .....	0460
Fentanyl analgesia .....	0930
Fetal anomaly, suspected [Undelivered patients only] .....	0360
Fetal death [Undelivered patients only] .....	1560
Fetal distress .....	0600
Fetal growth concerns .....	0300
Fetal peritoneal tap .....	2210
Fetal thoracentesis .....	2230
Fetal transfusions, total number during pregnancy .....	0480
Fifth's disease .....	1710
Food poisoning .....	0430
Foot drop:	
complicating epidural or subdural block .....	1850
postpartum (not due to anesthesia) .....	1240



## - G -

G6PD deficiency .....	0550
Gamma globulin transfusion .....	1470
Gastritis, reflux .....	0370
Gastroenteritis:	
infectious .....	0430
noninfectious .....	0430
salmonella .....	0430
viral .....	0430
Gastro-intestinal disease .....	0370
General anesthesia:	
for labour/delivery .....	0960
for non-delivery procedure .....	1020
Genital herpes .....	1640
Gestation, multiple .....	0350
Gestational diabetes in a previous pregnancy .....	0160
Glomerulonephritis, chronic .....	0530
Gonorrhea:	
during pregnancy .....	1630
postpartum .....	1370
Group B streptococcal infection:	
during pregnancy .....	1600
postpartum .....	1370
Growth, fetal, excessive .....	0300

## - H -

Harrington Rod, presence of .....	0410
Hashimoto's Thyroiditis .....	0510
Headache, post-dural puncture .....	1910
Heart disease .....	0420
Heart failure, postpartum .....	1220
HELLP syndrome .....	0210
Hematoma:	
epidural, complicating epidural block .....	1860
episiotomy .....	1140
evacuation of .....	1230
labial .....	1140
pelvic .....	1140
wound .....	1140
Hemolytic:	
anemia .....	0550
uremic syndrome .....	0450
Hemorrhage:	
antepartum, < 20 weeks gestation .....	0190
antepartum, ≥ 20 weeks gestation .....	0280
intracerebral .....	0410
intrapartum .....	0610
early postpartum .....	1100
late postpartum .....	1110
subarachnoid .....	0410
Hepatitis .....	0460
Herpes:	
genitalis .....	1640
gestationalis .....	0330
labialis .....	1640
postpartum .....	1370
simplex infection .....	1640
zoster .....	1730
High blood pressure in previous pregnancy .....	0050

## - H -

## History:

heart disease or surgery . . . . .	0420
infertility . . . . .	0170
malignancy . . . . .	0010
malignant hyperthermia (family/personal) . . . . .	0490
previous pregnancy:	
abruptio placenta . . . . .	0130
anemia . . . . .	0120
breech presentation . . . . .	0140
diabetes, gestational . . . . .	0160
eclampsia . . . . .	0060
ectopic pregnancy . . . . .	0100
embolus, pulmonary . . . . .	0150
hydatidiform mole . . . . .	0110
hypertensive disease . . . . .	0050
sensitized pregnancy . . . . .	0040
thromboembolic disease . . . . .	0150
thrombophlebitis . . . . .	0150
thrombosis, deep vein . . . . .	0150
pyelonephritis, acute, during current pregnancy . . . . .	0530
Hunners ulcer . . . . .	0530
Hydatidiform mole . . . . .	0110
Hydromorphone analgesia . . . . .	0910
Hydronephrosis . . . . .	0530
Hyperbilirubinemia . . . . .	0460
Hyperemesis gravidarum . . . . .	0230
Hypertension, pulmonary . . . . .	0420
Hypertensive disease:	
chronic . . . . .	0200
in previous pregnancy . . . . .	0050
pregnancy-induced . . . . .	0210
Hyperparathyroidism . . . . .	0510
Hyperthyroidism . . . . .	0510
Hypnotic:	
amo-secobarbital (Tuinal) . . . . .	0830
pentobarbital (Nembutal) . . . . .	0840
secobarbital (Seconal) . . . . .	0820
Hypnotism for labour/delivery . . . . .	0950
Hypofibrinogenemia . . . . .	0550
Hypoplastic anemia, idiopathic . . . . .	0550
Hypotension, post anesthetic . . . . .	1910
Hypothyroidism . . . . .	0510
Hypoxic brain damage . . . . .	1240
Hysterectomy . . . . .	0780

## - I -

Idiopathic thrombocytopenic purpura . . . . .	0550
Ileus, paralytic, postpartum . . . . .	1240
Illness, psychiatric . . . . .	0400
Impetigo herpetiformis . . . . .	0330
Incompetence, cervical . . . . .	0570
Indocid (Indomethacin) therapy for tocolysis . . . . .	1530
Indomethacin therapy (polyhydramnios) . . . . .	0250
Induction, intracervical catheter . . . . .	3040
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AIDS:	
during pregnancy . . . . .	1680
postpartum . . . . .	1370
bacterial, antepartum . . . . .	1760
chlamydia:	
during pregnancy - See Also Infant Disease Codes . . . . .	1750
postpartum . . . . .	1370
condylomata:	
during pregnancy . . . . .	1670
postpartum . . . . .	1370
episiotomy . . . . .	1330
gonococcal:	
during pregnancy . . . . .	1630
postpartum . . . . .	1370
group B streptococcus:	
during pregnancy . . . . .	1600
postpartum . . . . .	1370
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during pregnancy . . . . .	1640
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mycoplasma:	
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urinary tract:	
lower, during pregnancy . . . . .	1590
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epi-catheter . . . . .	1800
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laminaria tents . . . . .	3040
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Invasive mole . . . . .	0110
Inversions, chromosomal . . . . .	0592
Inverted uterus . . . . .	1130
Irritable bowel syndrome . . . . .	0370
Isoxsuprine (Vasodilan) therapy for tocolysis . . . . .	1530
I.U.G.R., suspected . . . . .	0300
IV Syntocin (Only) . . . . .	3090
IV Syntocin(Saline Injection and IV Syntocin) . . . . .	3060

## - J -

Jaundice of pregnancy . . . . . 0460

## -K-

KCL Intracardiac Injection . . . . . 3080

## - L -

Labial hematoma . . . . . 1140

## Labour:

    false [Undelivered patients only] . . . . . 0340

    premature [Undelivered patients only] . . . . . 0320

    pyrexia in . . . . . 0620

    trial of . . . . . 1490

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use, chronic, during pregnancy .....	0380
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Nephropathy .....	0530
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Neuroleptic:	
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Neurologic illness .....	0410
Nisentil analgesia .....	0800
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Pelvic hematoma .....	1140
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manual removal of .....	0740
previa .....	0260
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## - P -

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- P -

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## - S -

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## - S -

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Deladumone .....	1540
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Symphysitis .....	0330
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## - T -

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## -A-

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Aortic arch stenosis . . . . .	0130



## -A-

Aortic-pulmonary window .....	0130
Aortic valve stenosis .....	0130
Aortic valvotomy .....	3280
Apert's syndrome .....	1080
Aplasia:	
adrenal, congenital .....	2590
radius and/or thumb .....	0940
Apnea, idiopathic of prematurity .....	2030
Apneic spells .....	2030
Appendectomy .....	3280
Appendicitis .....	2310
Appendix, perforation .....	2280
Apprehension of infant by authorities .....	3090
Arachnoid cyst .....	0970
Arginosuccinic aciduria (urea cell defect) .....	2830
Arhinencephaly .....	1050
Arrest, sinus .....	0150
Arrhythmia, cardiac .....	0150
Arterial catheter:	
non-umbilical .....	3140
umbilical .....	3150
Arterial thrombosis .....	2460
Arteries, transposition great .....	0130
Arterio-venous malformation of lung .....	0190
Arteriosus:	
patent ductus .....	0140
truncus .....	0130
Artery, single umbilical .....	0080
Arthritis .....	1520
Arthrogryposis .....	1060
Ascites, isolated .....	2950
Asphyxia:	
neonatorum .....	1100
Aspiration:	
bone marrow .....	3330
meconium .....	0170
pneumonitis .....	1180
Asplenia .....	0190
Asplenia syndrome .....	1080
Association:	
CHARGE .....	1080
Vater .....	1080
Atelectasis .....	2140
Athyreotic cretinism .....	2580

## -A-

## Atresia:

biliary	0260
choanal	0500
esophagus	0240
external auditory meatus or canal	0420
intestinal	0210
laryngeal	0490
mitral	0130
pulmonary artery	0130
pulmonary valve	0130
pulmonary vein	0130
tracheal	0350
tracheo-esophageal	0240
tricuspid	0130
ureteral	0640
Atrial coatic tachycardia	0150
Atrial ectopic beats	0150
Atrial flutter	0150
Atrioventricular canal defect, repair	3280
Atrio-ventricular dissociation	0150
Atrial septectomy	3280
Atrium, single	0130
Atrophy:	
cortical	2000
kidney	0580
optic nerve	0490
Auditory meatus or canal, stenosis or atresia of	0420
AV Block	0150
Azotemia	2720
AZT(Zidovudine) therapy	3550

## - B -

Bacteriuria without other evidence for U.T.I. ....	1420
Balloon atrial septostomy .....	3330
Balloon dilatation .....	3270
Bands, eyelid fibrous (palpebral fissure) .....	0490
Barbiturate withdrawal .....	1970
Battledore placenta .....	0020
BCG vaccination .....	3330
Beats, atrial ectopic .....	0150
Beckwith syndrome .....	1080
Benign:	
respiratory distress .....	2060
hyperphenylalaninemia .....	2790
Benzomorphan withdrawal .....	1970
Beta-hydroxysteroid dehydrogenase deficiency .....	2570
Betamethasone therapy, maternal .....	3250
Bicornuate uterus .....	0670
Bicuspid aortic valve .....	0130
Bifid:	
rib .....	0890
sacrum .....	0890
scrotum .....	0550
thumb .....	0850
vertebra .....	0890
Big C-isoimmunization .....	2390
Big E-isoimmunization .....	2400
Bile duct repair .....	3280
Biliary atresia .....	0260
Bilobed placenta .....	0050
Biopsy:	
bone marrow .....	3330
intestinal (rectum, colon) .....	3330
kidney (needle) .....	3330
liver (needle) .....	3330
lung .....	3330
muscle .....	3330
myocardial .....	3330
skin .....	3330
Biotin therapy .....	3551
Bipartite placenta .....	0050
Bladder:	
double .....	0610
neck obstruction .....	0640
surgery .....	3280
Bladder exstrophy, repair .....	3280
Bleed, fetomaternal .....	0170
BLES surfactant .....	3460
Blindness, central .....	0490

## -B-

Block:	
AV, not due to digitalis . . . . .	0150
vertebra . . . . .	0890
Blood:	
culture positive without septicemia . . . . .	1400
blood group isoimmunization . . . . .	2490
letting, anemia due to . . . . .	2470
Bone fractures:	
cause unknown . . . . .	0920
due to trauma . . . . .	1220
secondary to Ricket's . . . . .	2620
Bone infection . . . . .	1550
Bowel:	
duplication . . . . .	0290
obstruction, functional, cause unknown . . . . .	2320
Brachial plexus palsy . . . . .	1240
Bradycardia, unexplained . . . . .	0150
Brain:	
abscess . . . . .	1540
disease, degenerative, acquired . . . . .	2000
hemorrhage . . . . .	1830
hypoplasia . . . . .	1020
infarction, morphologic . . . . .	2000
infarction, ultra-sound . . . . .	1820
necrosis, post-asphyctic infarction . . . . .	1150
stem hemorrhage . . . . .	1830
surgery . . . . .	3280
Branchial cleft cyst, sinus, or fistula . . . . .	0390
Branchio-Oto-Renal syndrome . . . . .	1080
Breast, absent . . . . .	0731
Bronchogenic cyst . . . . .	0340
Bronchopulmonary dysplasia . . . . .	2110
Bronchoscopy . . . . .	3400
Bullous dermatosis . . . . .	0720
Burns . . . . .	3030
Butterfly vertebra . . . . .	0890
Bypass, cardiopulmonary . . . . .	3271

## - C -

Cafe-au-lait spot . . . . .	0770
Caffeine:	
intoxication . . . . .	3040
therapy . . . . .	3230
Calcification:	
metastatic of soft tissue . . . . .	3120
periventricular . . . . .	2040
Calculi, renal . . . . .	3120
Calvaria, hypoplastic . . . . .	0950
Camptodactyly . . . . .	0850
Camptomelic syndrome . . . . .	1080
Candida:	
diaper . . . . .	1570
infection . . . . .	1790
Captopril therapy . . . . .	3540
Caranal cleft vertebra . . . . .	0890
Carbuncle . . . . .	1590
Cardiac:	
arrhythmia . . . . .	0150
catheterization . . . . .	3270
massage . . . . .	3330
murmur . . . . .	0130
pacemaker . . . . .	3530
tamponade . . . . .	3120
Cardiomyopathy, congenital . . . . .	0190
Cardiopulmonary bypass . . . . .	3271
Carnitine deficiency . . . . .	2830
Carpenter syndrome . . . . .	1080
Cataracts . . . . .	0400
Catheter:	
central line (for parenteral nutrition) . . . . .	3220
central venous . . . . .	3130
non-umbilical artery . . . . .	3140
peripheral vein or umbilical (for parenteral nutrition) . . . . .	3220
umbilical artery . . . . .	3150
umbilical venous . . . . .	3160
Catheterization, cardiac . . . . .	3270
Cebocephaly . . . . .	1050
Cecal perforation . . . . .	2280
Cecum/colon, perforation . . . . .	2280
Cellulitis (paronychia) . . . . .	1600
Central blindness . . . . .	0490
Central line(not umbilical artery or umbilical vein catheter) . . . . .	3220
Central venous line (not umbilical vein) . . . . .	3130
Centronuclear myopathy . . . . .	0960
Cephalohematoma . . . . .	1280
Cephalohematoma, infected . . . . .	1470

## - C -

Cerebellar:	
hemorrhage	1830
hypoplasia	1020
Cerebral:	
edema	1990
hemorrhage	1830
Cerebro-retinal angiomatosis	1061
Cerebro-spinal fluid abnormalities	2010
Chalasia	2240
CHARGE association	1080
Chemical burns	3030
Chest compressions	3330
Chest tube (pleural drain)	3190
Chicken Pox	1720
Child:	
abuse	3090
neglect	3090
Chlamydial disease	1800
Chloramphenicol intoxication	3040
Choanal atresia	0500
Cholecystectomy	3280
Cholelithiasis	2320
Chondrodystrophy	0870
Chordee	0550
Chorioamnionitis, marked or severe	0060
Chorioangioma of placenta/cord	0100
Chorio-carcinoma	0100
Chorioretinitis	2040
Chromosomal aberrations, anomalies due to	1070
Chronic:	
cor pulmonale	2210
interstitial nephritis	1500
intra-uterine infection, cause unknown	1690
pulmonary disease of prematurity	2110
Chylothorax	2210
Circulating anti-thrombin (heparin-like) substance	2460
Circumcision	3340
Circumvallate placenta	0030
Clavicle fracture	1220
Claw hand	0850
Cleft:	
branchial	0390
facial	0490
lip or palate	0380
mitral valve	0130
tracheo-esophageal	0240
Cleido-cranial dysostosis	1080

- C-

## Clinical:

appearance of an infant of a diabetic mother . . . . .	2910
rickets . . . . .	2620

Clipping of sublingual Frenulum (tongue tie) . . . . .	3330
Cloacel maldevelopment . . . . .	2320

## Closure:

incomplete, neural tube . . . . .	0990
premature of foramen ovale . . . . .	0130

Club foot . . . . .	0790
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CMV infection . . . . .	1660
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## CNS:

abnormality, miscellaneous . . . . .	2040
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## Coagulation:

disorder due to hepatic disease . . . . .	2460
disseminated intravascular . . . . .	2460

Coagulopathy . . . . .	2460
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Coarctation of the aorta . . . . .	0130
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Coarctation of the aorta, repair . . . . .	3280
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Cocaine withdrawal . . . . .	1970
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Cofactor treatment . . . . .	3551
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Coloboma . . . . .	0470
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Colonic perforation . . . . .	2280
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Colonization, ureaplasma . . . . .	1630
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Colostomy . . . . .	3280
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## Complication:

endotracheal tube . . . . .	3010
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fetal, of amniocentesis and/or intrauterine fetal transfusion . . . . .	3000
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scalp electrode . . . . .	3120
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vascular catheter . . . . .	2860
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Compressions, chest . . . . .	3330
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## Congenital:

adrenal hypoplasia/aplasia . . . . .	2590
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cardiomyopathy . . . . .	0190
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dermatosis . . . . .	0720
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glaucoma . . . . .	0460
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goiter . . . . .	2560
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heart disease . . . . .	0130
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hip . . . . .	0800
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idiopathic lobar emphysema . . . . .	2160
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impatency of the Naso-Lacrimal duct . . . . .	0480
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lactose intolerance . . . . .	2290
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laryngeal stenosis . . . . .	0490
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opacities of cornea . . . . .	0430
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pneumonia . . . . .	1610
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pulmonary lymphangiectasia . . . . .	2200
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short femur . . . . .	0950
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spherocytosis . . . . .	2540
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## - C -

Congenital:	
stridor .....	2120
subdural effusion .....	2040
vaginal cyst .....	0670
Congestive heart failure:	
not post-asphyctic .....	2920
post-asphyctic .....	1190
Conjunctivitis .....	1560
Connective tissue neoplasm .....	2550
Conradi's disease .....	1080
Continuous positive airway pressure:	
by endotracheal tube only .....	3170
nasal .....	3180
Contracture:	
muscle, due to IM injections .....	2880
leg, cause unknown (arthrogryposis) .....	1060
Convulsions:	
benign familial neonatal .....	1940
cause unknown .....	1940
due to alkalosis .....	1880
due to arhinencephaly .....	1941
due to brain anomaly .....	1941
due to brain edema .....	1920
due to cerebral hemorrhage .....	1940
due to congenital malformation of brain .....	1941
due to drug withdrawal .....	1930
due to hydrocephaly/hydroencephaly .....	1941
due to hypocalcemia .....	1840
due to hypoglycemia .....	1850
due to hypomagnesemia .....	1870
due to hyponatremia .....	1860
due to hypoxia .....	1940
due to inborn error of metabolism .....	1940
due to infarction .....	1940
due to kernicterus .....	1910
due to meningitis .....	1890
due to pyridoxine dependency or deficiency .....	1900
due to venous thrombosis .....	1940
post-asphyctic .....	1140
Copper deficiency .....	2830
Cor pulmonale, chronic .....	2210
Cord prolapse .....	0090



## - C-

Corneal:	
opacities . . . . .	0430
scleralization . . . . .	0430
Cornelia de Lange syndrome . . . . .	1080
Corpus callosum, agenesis . . . . .	0970
Corrected left transposition . . . . .	0130
Correction of transposition of great vessels . . . . .	3280
Cortical:	
atrophy . . . . .	2000
dysplasia . . . . .	1020
Coxsackie infection . . . . .	1740
C.P.A.P.:	
by endotracheal tube only . . . . .	3170
nasal . . . . .	3180
Cranial nerve palsies:	
excluding facial or VII nerve . . . . .	2050
facial or VII nerve palsy . . . . .	1230
Craniostenosis . . . . .	0830
Craniosynostosis . . . . .	0830
Craniotomy . . . . .	3280
Cranium bifidum . . . . .	0990
Cretinism:	
athyreotic . . . . .	2580
due to iodine deficiency . . . . .	2580
endemic . . . . .	2580
goitrous, non-endemic . . . . .	2580
Cri-du-chat syndrome . . . . .	1070
Crouzon's disease . . . . .	0830
Cryosurgery, retina . . . . .	3410
Cryptophthalmus syndrome (Fraser's Syndrome) . . . . .	1080
Cryptorchidism . . . . .	0520
C.S.F. abnormalities . . . . .	2010
Cutis:	
aplasia . . . . .	0720
aplasia, surgery for . . . . .	3280
hyperelastica . . . . .	0760
laxa . . . . .	0760
marmorata congenita . . . . .	0720
Cyclopia-arhinencephaly series . . . . .	1050
Cyclops . . . . .	1050

## - C -

## Cyst:

arachnoid .....	0970
branchial .....	0390
bronchogenic .....	0340
epidermoid .....	0770
follicular .....	2550
lung .....	2180
omphalomesenteric .....	0840
ovarian .....	0670
porencephalic .....	2000
skin, inclusion .....	0770
radicular .....	0490
thyroglossal .....	0510
urachal .....	0670
vaginal, congenital .....	0670
Cystadenoma .....	2550
Cystathioninuria .....	2830
Cystic:	
adenomatoid malformation of lung .....	2190
fibrosis (including meconium ileus) .....	2170
hygroma .....	2550
Cytomegalovirus (CMV) infection .....	1660
Cystoscopy .....	3330

## - D -

Dacryocystitis .....	1630
Dandy-Walker syndrome .....	1030
Deaf at discharge .....	3060
Deafness confirmed .....	3070
Death after discharge:	
due to S.I.D.S. ....	3080
not due to S.I.D.S. ....	2890
Defect:	
dehydrogenation of 18-hydroxycorticosterone .....	2590
endocardial cushion .....	0130
18-hydrogenation of corticosterone .....	2590
isolated ostium primum .....	0130
isolated ostium secundum .....	0130
isolated ventricular septal .....	0130
pericardial .....	0190
red blood cell .....	2540
umbilical .....	0840
urea cycle .....	2830
Deficiency:	
3-beta-hydroxysteroid dehydrogenase .....	2570
17-20 desmolase .....	2570
21-hydroxylase .....	2590
AHG .....	2460
Alpha-glucosidase .....	2830
carnitine .....	2830
copper .....	2830
factor XIII .....	2460
glucose-6-phosphate dehydrogenase .....	2540
iodine .....	2580
PTA .....	2460
pyruvate carboxylase .....	2850
pyruvate kinase .....	2540
zinc .....	2830
Deformities:	
due to amniotic bands .....	0740
lip or palate, complication of endotracheal tube .....	3010
Sprengel's, shoulder .....	0950
Deletion, part of #14 chromosome .....	1070
Depigmented skin lesions .....	0711
Depression:	
at birth .....	1100
cerebral, abnormal .....	1960
post-asphyctic CNS .....	1110
skull .....	0950
Depressor anguli-oris muscle, absence or hypoplasia of .....	0950

## - D -

Dermal:	
fistula . . . . .	0990
sinus . . . . .	0990
Dermatographia . . . . .	0770
Dermatosis, congenital . . . . .	0720
Dermoid, corneal . . . . .	0430
Desmolase deficiency (Zachmann-Prader syndrome) . . . . .	2570
Dexamethasone:	
therapy, infant . . . . .	3470
therapy, maternal . . . . .	3250
Dextrocardia . . . . .	0160
Di George's syndrome . . . . .	1080
Diabetes:	
insipidus . . . . .	2830
mellitus, infant . . . . .	2610
mellitus, mother . . . . .	2910
Dialysis, peritoneal . . . . .	3330
Diaper rash . . . . .	1570
Diaphragm, fixed . . . . .	2210
Diaphragmatic:	
eventration . . . . .	0360
hernia . . . . .	0330
hypoplasia . . . . .	0360
Diarrhea:	
cause unknown . . . . .	1410
parenteral . . . . .	1410
Diastematomyelia . . . . .	1040
Diazepam (Valium)withdrawal . . . . .	1970
Digit, missing . . . . .	0850
Digitalis intoxication . . . . .	3020
Dilantin intoxication . . . . .	3040
Dilatation, balloon . . . . .	3270
Diphenyl hydantoin intoxication . . . . .	3040
Diplomyelia . . . . .	1040
Disease:	
Conradi's . . . . .	1080
Couzon's . . . . .	0830
Fabry's . . . . .	2830
G.I., miscellaneous . . . . .	2320
heart, congenital . . . . .	0130
heart, congenital, due to congestive heart failure . . . . .	2920
hematologic, miscellaneous . . . . .	2350
hemorrhagic disease of newborn . . . . .	2460
hepatic, other than hepatitis . . . . .	2440
hepato-veno-occlusive of liver . . . . .	0290
hyaline membrane . . . . .	0170
hypoplastic, small digits . . . . .	0850

- D -

## Disease: (Continued)

Hypotrophic Brain Disease .....	2000
Hurshsprung's .....	0270
I-cell .....	2830
joint .....	1060
liver, hepato-veno occlusive .....	0290
mast cell .....	0720
pulmonary, of prematurity, chronic .....	2110
Ritter's .....	1570
storage .....	2830
trophoblastic .....	0100
Von Willebrand's .....	2460
D Isoimmunization .....	2370
Dislocation:	
hip, congenital .....	0800
knee .....	0950
radial heads .....	0950
Disorder:	
coagulation, due to hepatic disease .....	2460
miscellaneous .....	3120
Disseminated intravascular coagulation .....	2460
Dissociation, complete AV .....	0150
Diuretic used for antihypertensive therapy .....	3540
Diverticulum:	
laryngeal .....	0490
ureteral .....	0640
Division of double aortic arch .....	3280
Dobutamine administration .....	3522
Do Not Resuscitate Order on chart .....	1101
Dopamine administration .....	3520
Double:	
aortic arch .....	0130
bladder .....	0610
outlet right ventricle .....	0130
pelvis (renal) .....	0610
renal arteries .....	0610
ureter .....	0610
urethra .....	0610
urinary system .....	0610
vagina .....	0670
Duffy Isoimmunization .....	2420
Duodenojejunostomy .....	3280
Down's syndrome .....	1070
Doxapram therapy .....	3230
DPT Immunization .....	3440
DPTP immunization .....	3440

- D -

Drug:	
injection into presenting part, accidental . . . . .	3120
intoxication . . . . .	3040
withdrawal convulsions . . . . .	1930
withdrawal syndrome . . . . .	1970
Ductus syndrome of prematurity . . . . .	0140
Duodenojejunostomy . . . . .	3280
Duodenal perforation . . . . .	2280
Duodenum:	
perforation . . . . .	2280
Duplication of bowel . . . . .	0290
Dwarfism:	
rhizomelic . . . . .	1080
thanatophoric . . . . .	0930
Dysgenesis, cerebro-ocular . . . . .	1080
Dysostosis:	
Cleido-Cranial . . . . .	1080
hypomandibular faciocranial . . . . .	1080
Dysplasia:	
acinar . . . . .	0350
anhidrotic ectodermal . . . . .	0720
bronchopulmonary . . . . .	2110
bronchopulmonary, causing congestive heart failure . . . . .	2920
cortical . . . . .	1020
diastrophic . . . . .	0870
ectodermal . . . . .	1080
renal . . . . .	0600
retinal . . . . .	0490
Dysplastic:	
or absent nails . . . . .	0770
kidney . . . . .	0600
pulmonary valve . . . . .	0130
Dystocia, shoulder . . . . .	1360
Dystrophy, myotonic . . . . .	0950

## - E -

Eardrum, perforated . . . . .	1330
Ears, hypoplastic . . . . .	0490
Ebstein's malformation of tricuspid valve . . . . .	0130
ECHO virus infection . . . . .	1720
Echodense kidneys . . . . .	0670
Echodensities, multiple, within peritoneal cavity &/or liver . . . . .	0290
Ectopia, renal . . . . .	0630
Ectopic	
anus . . . . .	2320
thyroid . . . . .	2580
Ectrodactyly, ectodermal . . . . .	1080
Edema:	
cerebral . . . . .	1990
complication of vascular catheter . . . . .	2860
generalized, cause unknown . . . . .	2950
pulmonary, without hyaline membrane formation . . . . .	2060
Effusion:	
pericardial . . . . .	3120
subdural, congenital . . . . .	2040
Elective non-resuscitation . . . . .	1101
Electrical burns . . . . .	3030
Elevated IgM without other evidence of infection . . . . .	1760
Elevation of depressed skull fracture . . . . .	3280
Eleven ribs . . . . .	0890
Embolus:	
air . . . . .	3050
pulmonary . . . . .	2150
Emphysema:	
lobar, due to bronchogenic cyst . . . . .	2160
lobar, idiopathic . . . . .	2160
pulmonary . . . . .	2160
pulmonary, interstitial . . . . .	2090
subcutaneous . . . . .	3120
Empyema . . . . .	1540
Encephalitis . . . . .	1450
Encephalocele . . . . .	0990
Encephalomalacia . . . . .	2000
Endemic cretinism . . . . .	2580
Endocardial cushion defect . . . . .	0130
Endocardial fibroelastosis . . . . .	0130
Endocarditis . . . . .	1510
Endocrine disorders, miscellaneous . . . . .	2830
Endothelial tissue neoplasm . . . . .	2550
Endotracheal tube, complications of . . . . .	3010
Enterocolitis, acute necrotizing . . . . .	1480
Ependymoma . . . . .	2550
Epidermolysis bullosa . . . . .	0720

## - E -

Epigastric hernia .....	0950
Epispadias .....	0560
Epithelial tissue neoplasm .....	2550
Erb's palsy .....	1240
Esophageal perforation:	
due to other causes .....	2280
due to tracheal intubation .....	3010
Ethchlororvynol (Placidyl) withdrawal .....	1970
Eventration of the diaphragm .....	0360
Exchange transfusion .....	3200
Excision of choanal atresia .....	3280
Excitation, post-asphyctic CNS .....	1120
Exstrophy of the bladder .....	0660
Extra:	
material of P (short arm) of one of #15 chromosomes .....	1070
services, families in need of .....	3090
Extracorporeal membrane oxygenation (E.C.M.O.) .....	3330
Eyelid fibrous bands .....	0490



## - F -

Fabry's disease (Alpha-glucosidase deficiency) . . . . .	2830
Facial:	
cleft . . . . .	0490
nerve palsy . . . . .	1230
Factor XIII deficiency . . . . .	2460
Factor VIII . . . . .	2460
Factor XI . . . . .	2460
Failed hearing test . . . . .	3060
Failure:	
congestive heart . . . . .	2920
congestive heart, post-asphyctic . . . . .	1190
renal . . . . .	2940
Families in need of extra services . . . . .	3090
Fat necrosis, subcutaneous . . . . .	1370
Feedings, tube (gastric or jejunal) . . . . .	3210
Femoral hernia . . . . .	0540
Femur fracture . . . . .	1220
Fetal:	
alcohol syndrome . . . . .	1080
complications of amnio and/or intrauterine transfusion . . . . .	3000
crowding/constraint . . . . .	1060
hemorrhage from umbilical or placental vessels . . . . .	2450
hydantoin syndrome . . . . .	1080
malnutrition . . . . .	0110
Feto-maternal hemorrhage . . . . .	2450
Feto-maternal hemorrhage, anemia due to . . . . .	2470
Feto-placental hemorrhage . . . . .	2450
Fetus:	
in fetu . . . . .	3120
papyraceus . . . . .	3120
Fibroelastosis, endocardial . . . . .	0130
Fibrosis, liver (periportal) . . . . .	2230
Fibroplasia, retrolental . . . . .	2900
Fifth nerve palsy . . . . .	2050
Fistula:	
branchial . . . . .	0390
dermal . . . . .	0990
recto-ano-urethral . . . . .	0670
rectovaginal . . . . .	0670
tracheo-esophageal . . . . .	0240
Fixed diaphragm, not due to paralysis . . . . .	2210
Flutter, atrial . . . . .	0150
Follicular cyst . . . . .	2550
Fontanelle, posterior, large . . . . .	2990
Foramen ovale, premature closure . . . . .	0130
Foreign body, granuloma of airway or lung . . . . .	2210
Fourth nerve palsy . . . . .	2050

## - F -

Fractures:	
cause unknown .....	0920
due to trauma .....	1220
secondary to Ricket's .....	2620
Frank Bleeding .....	2450
Fraser's syndrome .....	1080
Fronto-nasal dysplasia sequence .....	1080
Fulguration of posterior urethral valves .....	3330
Functional bowel obstruction, cause unknown .....	2320
Fundoplication .....	3280
Fungal infection .....	1790
Funisitis .....	0070
Fy <sup>a</sup> -isoimmunization (Duffy) .....	2420

## - G -

Galactosemia .....	2830
Galen, aneurysm of vein of .....	0190
Gall bladder, hydrops of .....	2320
Gastric:	
perforation .....	2280
tube feeds .....	3210
Gastroenteritis .....	1410
Gastro-esophageal reflux .....	2240
Gastroschisis .....	0840
Gastrostomy for medical reason .....	3360
Genital agenesis/hypoplasia .....	0620
Genitalia, ambiguous .....	2630
Genu recurvatum .....	0950
G.I.:	
disease, miscellaneous .....	2320
stricture, acquired .....	2320
Gilles telencephalic leucoencephalopathy .....	2000
Glaucoma:	
acquired .....	0460
congenital .....	0460
Glioma, nasal .....	2550
Glucose-6-phosphate dehydrogenase deficiency .....	2540
Glucose-6-phosphate dehydrogenase deficiency, anemia due to .....	2470
Goiter, congenital .....	2560
Goitrous cretinism, non-endemic .....	2580
Goldenhar syndrome .....	1080
Goltz syndrome .....	0720
Gonosomal intersex .....	1070
Granulocyte transfusion .....	3330
Granuloma foreign of airway/lung .....	2210

## - H -

Hand:	
anomalies . . . . .	0850
claw hand deformity . . . . .	0850
Heart failure:	
not post-asphyctic . . . . .	2920
post-asphyctic . . . . .	1190
Hemangioma, cavernous, capillary or port-wine stain . . . . .	0700
Hemangioma resection . . . . .	3280
Hematemesis . . . . .	2450
Hematochezia . . . . .	2450
Hematochromatosis, perinatal . . . . .	2350
Hematologic disease, miscellaneous . . . . .	2350
Hematoma:	
perineal . . . . .	1300
resorption of . . . . .	2440
umbilical cord . . . . .	0100
Hematuria . . . . .	2450
Hemiparesis . . . . .	2020
Hemivertebra . . . . .	0890
Hemofiltration . . . . .	3330
Hemorrhage:	
adrenal:	
causing adrenal insufficiency syndrome . . . . .	2590
not due to asphyxia, coagulation disorder when otherwise listed . . . . .	2450
brain . . . . .	1830
due to trauma . . . . .	1330
epidural . . . . .	1340
fetomaternal . . . . .	2450
fetoplacental . . . . .	2450
iatrogenic . . . . .	2450
into tumour . . . . .	3120
intra-cranial, traumatic . . . . .	1270
intra-ventricular . . . . .	1170
liver, subcapsular . . . . .	1310
not due to asphyxia, trauma, or coagulation disorder . . . . .	2450
pulmonary . . . . .	2130
retinal, involving macula . . . . .	2040
scalp . . . . .	1290
spinal cord subdural . . . . .	1340
subaponeurotic . . . . .	1290
subgaleal . . . . .	1290
subarachnoid, anoxic . . . . .	1160
twin to twin transfusion . . . . .	2450
umbilical or placental vessels . . . . .	2450

## - H -

Hemorrhagic disease of the newborn . . . . .	2460
Hemihypertrophy . . . . .	0950
Hemiparesis . . . . .	2020
Hemivertebra . . . . .	0890
Hemochromatosis, perinatal . . . . .	2350
Hemofiltration . . . . .	3330
Hemopericardium . . . . .	2450
Hemoperitoneum . . . . .	2450
Hemothorax . . . . .	2450
Hepatic disease, coagulation disorder due to . . . . .	2460
Hepatitis:	
B prophylaxis . . . . .	3420
causing to hyperbilirubinemia . . . . .	2440
toxic . . . . .	2270
viral . . . . .	2270
Hepatoblastoma . . . . .	2550
Hepato-Renal syndrome . . . . .	2830
Hepato-veno-occlusive disease of liver . . . . .	0290
Hereditary:	
alactasia . . . . .	2290
infantile lactose intolerance (lactosuria) . . . . .	2290
Hernia:	
diaphragmatic . . . . .	0330
epigastric . . . . .	0950
femoral . . . . .	0540
hiatus . . . . .	2240
inguinal . . . . .	0530
incisional . . . . .	3120
umbilical . . . . .	0840
Hereditary:	
alactasia . . . . .	2290
infantile lactose intolerance . . . . .	2290
stomatocytosis . . . . .	2540
Herniation of omentum, due to amnio./intrauterine transfusion . . . . .	3000
Heroin withdrawal . . . . .	1970
Herpes simplex infection . . . . .	1730
Hiatus hernia . . . . .	2240
High risk situation in home for abuse/neglect . . . . .	3090
Hip, dislocated or subluxated, congenital . . . . .	0800
Hirschsprung's disease . . . . .	0270
H.I.V. antibody screen positive . . . . .	1720
Holoprosencephaly . . . . .	1050
Holt Oram syndrome . . . . .	1080
Home oxygen therapy . . . . .	3450
Horseshoe kidney . . . . .	0630
Humerus fracture . . . . .	1220

## - H -

Hyaline membrane:	
disease	0170
formation not due to H.M.D.	2060
Hydantoin syndrome (fetal)	1080
Hydatidiform mole	0100
Hydralozine therapy	3540
Hydranencephaly	1010
Hydrocephalus	1030
Hydrocortisone therapy, maternal	3250
Hydronephrosis or hydroureter	0590
Hydrops:	
fetalis	2950
gall bladder	2320
Hydroxylase deficiency	2590
Hydroxysteroid dehydrogenase deficiency	2570
Hygroma, cystic	2550
Hymen, imperforate	0650
Hyperammonemia	2820
Hyperbilirubinemia	2440
Hypercalcemia	2830
Hypercreatininemia	2730
Hyperglucosemia	2650
Hyperkalemia	2690
Hypermagnesemia	2770
Hypernatremia	2710
Hyperphenylalaninemia, benign	2790
Hyperphosphatemia	2780
Hyperplasia:	
lipoid adrenal	2570
pancreatic cell	2830
pulmonary	0350
vocal cords	2120
Hyperplastic primary vitreous, persistent	0490
Hyperprolinemia	2800
Hypertension:	
persistent pulmonary	0170
pulmonary, due to chronic lung disease	2210
Hyperthyroidism	2600
Hypertonicity, not post-asphyctic	1950
Hypertyrosinemia	2810
Hyperuricemia	2821
Hypoalbuminemia	2751
Hypocalcemia	2660
Hypocalcemic convulsions	1840
Hypoglucosemia	2640
Hypoglycemia, causing to congestive heart failure	2920
Hypoglycemic convulsions	1850

## - H -

Hypokalemia . . . . .	2680
Hypomagnesemia . . . . .	2760
Hypomagnesemic convulsions . . . . .	1870
Hypomandibular faciocranial dystosis . . . . .	1080
Hyponatremia . . . . .	2700
Hypoparathyroidism . . . . .	2610
Hyponatremic convulsions . . . . .	1860
Hypophosphatasia . . . . .	0920
Hypophosphatemia . . . . .	2840
Hypoplasia:	
adrenal, congenital . . . . .	2590
brain . . . . .	1020
cerebellar . . . . .	1020
corpus callosum . . . . .	0970
depressor anguli oris muscle . . . . .	0950
diaphragm . . . . .	0360
fibula . . . . .	0860
focal dermal . . . . .	0720
genital . . . . .	0620
kidney . . . . .	0580
optic nerve . . . . .	0490
pectoralis major . . . . .	0900
pulmonary (in Oligohydramnios Syndrome) . . . . .	1090
pulmonary (in persistent fetal circulation) . . . . .	0170
pulmonary (respiratory) . . . . .	0320
radius and/or thumb . . . . .	0940
uterus . . . . .	0670
Hypoplastic:	
calvaria . . . . .	0950
disease of small digits . . . . .	0850
ears . . . . .	0490
left heart syndrome . . . . .	0130
Hypoplastic left heart, surgery . . . . .	3280
Hypoproteinemia . . . . .	2750
Hypospadias complex . . . . .	0550
Hypothermia . . . . .	2970
Hypothyroidism:	
due to defective synthesis . . . . .	2580
due to iodine deficiency . . . . .	2580
due to maternal drug ingestion:	
iodides . . . . .	2580
propylthiouracil . . . . .	2580
type unknown . . . . .	2580
Hypotonicity, not post-asphyctic . . . . .	1960

## - I -

Iatrogenic blood-letting	2450
Ichthyosis	0750
Idiopathic respiratory distress syndrome	2060
IgM elevated without other evidence of infection	1760
Ileal perforation	2280
Immunization:	
DPT	3440
DPTP	3440
Flu(viral influenza)	3421
Impatency, naso-lacrimal duct, congenital	0480
Imperforate:	
anus	0280
hymen	0650
Incisional hernia	3120
Incontinentia pigmenti	0720
Incoordination, pharyngeal	2250
Increased intracranial pressure, post-asphyctic	1130
Increased nucleated RBC and/or normoblastemia	2510
Indomethacin therapy for patent ductus arteriosus	3290
Infant of diabetic mother	2910
Infarct:	
placental floor	0100
pulmonary	2150
Infarction:	
brain, morphologic	2000
brain, ultra-sound	1820
cerebral, not due to asphyxia	2000
cerebral, post-asphyctic	1150
intestinal	2300
myocardial	3120
Infected cephalohematoma	1470
Infection:	
bone	1550
Coxsackie	1740
Cytomegalovirus (CMV)	1660
intrauterine, chronic	1690
miscellaneous	1630
skin	1570
systemic	1380
systemic, due to surface colonization	1640
urinary tract	1420
Influenza A virus	1720
Incisional hernia	3120
Inguinal hernia	0530
Inhaled aerosol steroid therapy	3330
Iniencephalus	0780



- I -

Injection:	
drug into presenting part, accidental	3120
varicella zoster immune globulin	3330
Insertio funiculi furcata	0100
Insertion:	
cord, marginal	0020
cord, velamentous	0010
ventricular access device (intraventricular reservoir)	3330
Insufficiency/cleft, mitral valve	0130
Insufficiency:	
pulmonary valve	0130
tricuspid	0130
tricuspid, due to congestive heart failure	1190
Insulin	3510
Insulinoma	2550
Intermittent positive pressure ventilator	3170
Interrupted aortic arch	0130
Interstitial:	
nephritis	1500
pulmonary emphysema	2090
Intestinal:	
atresia	0210
biopsy (rectal, colonic)	3330
infarction	2300
malrotation	0250
obstruction, extrinsic	0230
stenosis, intrinsic	0220
Intolerance, lactose (lactosuria)	2290
Intoxication:	
digitalis	3020
drug	3040
Intracardiac mass	0190
Intra-cranial hemorrhage, due to trauma	1270
Intrathoracic (vascular) ring	0190
Intrauterine:	
fetal transfusion, complications of	3000
infection, chronic	1690
pneumonia	1610
Intra-ventricular hemorrhage	1170
Iodides, hypothyroidism due to maternal ingestion of	2580
I.P.P.V.	
for surgery only	3170
tube C.P.A.P only	3170
ventilated	3170
Irritation, cerebral, not post-asphyctic	1950

- I -

Isoimmunization:

ABO .....	2360
miscellaneous .....	2430
neutropenia .....	2350
thrombocytopenia .....	2490
other .....	2370 to 2430

Isolated:

abdominal situs inversus .....	0160
ascites .....	2950
dextrocardia .....	0160
patent ductus arteriosus .....	0130
ventricular septal defect .....	0130

Isuprel administration .....	3521
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## - J -

Jaundice, obstructive .....	2500
Jaw, anomalies of .....	0440
Jejunal:	
feeding .....	3210
perforation .....	2280
Jejunostomy for medical reasons .....	3330

## - K -

Kell-isoimmunization .....	2410
Kernicteric convulsions .....	1910
Kernicterus .....	1980
Kidd-isoimmunization .....	2430
Kidney:	
abscess .....	1540
dysplastic .....	0600
hemorrhagic necrosis, post-asphyctic .....	1200
horseshoe .....	0630
large echodense, etiology unknown .....	0670
pelvic .....	0630
polycystic .....	0570
Kleblattschadel .....	0830
Klippel-Feil Syndrome .....	0780
Klumpke's palsy .....	1240
Knee dislocation .....	0950
Knot in cord (true) .....	0100
Kyphoscoliosis .....	0890

## - L -

Laceration of liver and/or spleen .....	1320
Lactobezoar .....	2320
Lactose intolerance .....	2290
Lactosuria .....	2290
Large posterior fontanelle .....	2990
Laryngeal:	
atresia .....	0490
diverticulum .....	0490
palsy .....	1330
perforation due to tracheal intubation .....	3010
stenosis due to tracheal intubation .....	3010
Laryngomalacia .....	2120
Late metabolic acidosis .....	2670
Leaking amniotic fluid .....	1090
Lesions, skin, depigmented .....	0711
Leucoencephalopathy, Gilles .....	2000
Leucomalacia:	
periventricular .....	2000
ultrasound diagnosis .....	1820
Leukemia .....	2530
Ligation:	
ductus arteriosus .....	0140
P.D.A. (not of prematurity) .....	3280
Limb reduction .....	0860
Lip, cleft .....	0380
Lip deformity due to tracheal intubation .....	3010
Lipoid adrenal hyperplasia .....	2570
Lipomeningocele .....	0970
Lissencephaly .....	0970
Little c-isoimmunization .....	2380
Little "e" isoimmunization .....	2430
Little "s" isoimmunization .....	2430
Liver:	
biopsy .....	3330
fibrosis .....	2230
laceration .....	1320
necrosis, post-asphyctic .....	1210
subcapsular hemorrhage .....	1310
Lobar emphysema:	
due to bronchogenic cyst .....	2160
idiopathic .....	2160
Lowe's syndrome .....	1080
Low serum alkaline/phosphatase .....	2830
Lues (Syphilis) .....	1670

- L -

## Lung:

abscess .....	1540
biopsy .....	3330
cyst .....	2180
malformation, cystic adenomatiod .....	2190
perforation, by pleural drain(chest tube) .....	3120
Lupus, erythematous, neonatal .....	3120
Lymphadenitis .....	1630
Lymphangiectasia, pulmonary, congenital .....	2200
Lymphangioma .....	2550

## - M -

Macrocephaly .....	1030
Macrogyria .....	0970
Macrostomia .....	0490
Macula, retinal hemorrhage involving .....	2040
Magnesium sulphate therapy(vasodilator) .....	3301
Major surgery .....	3280
Malabsorption syndrome .....	2260
Male pseudohermaphroditism:	
with XO-YY mosaicism .....	2570
with XY karyotype .....	2570
Maldevelopment, cloacel .....	2320
Malformation:	
arterio-venous, lung .....	0190
cystic adenomatoid, lung .....	2190
Ebstein's, tricuspid valve .....	0130
Malnutrition:	
fetal .....	0110
Malrotation	
intestinal .....	0250
Marfan's syndrome .....	1080
Marginal insertion of cord .....	0020
Marker chromosome .....	1070
Mass:	
intracardiac .....	0190
retropharyngeal .....	2120
unknown type .....	2550
Massage, cardiac .....	3330
Mast cell disease .....	0720
Maternal:	
diabetes .....	2910
steroid therapy .....	3250
Meckel Gruber syndrome .....	1080
Meckel's Diverticulum .....	0290
Meconium:	
aspiration syndrome .....	1180
ileus .....	2170
plug syndrome .....	2330
Medulloblastoma .....	2550
Megalocephaly .....	1030
Meningitic convulsions .....	1890
Meningitis .....	1440
Meningocele .....	0990
Meningomyelocele .....	0990
Meperidine (Demerol)withdrawal .....	1970
Mesoblastic nephroma .....	2550
Mesocardia .....	0160

## - M -

Metabolic acidosis, late . . . . .	2670
Metabolic, miscellaneous . . . . .	2830
Metacarpal, first, hypoplasia of . . . . .	0850
Metaplasia, squamous/ulceration, complication, endotracheal tube . . .	3010
Metastatic calcification of soft tissue . . . . .	3120
Methadone withdrawal . . . . .	1970
Methemoglobinemia . . . . .	2350
Metoclopramide therapy . . . . .	3330
Microcephaly . . . . .	0980
Microcolon . . . . .	0290
Microcolon-megacystis-hypoperistalsis syndrome . . . . .	0290
Micrognathia . . . . .	0440
Micropenis . . . . .	0620
Microphthalmia . . . . .	0450
Microstomia . . . . .	0490
Miscellaneous:	
Disorders . . . . .	3120
endocrine and metabolic . . . . .	2830
G.I. disease . . . . .	2320
hematologic disease . . . . .	2350
infections . . . . .	1630
treatment or procedure . . . . .	3330
viral disease . . . . .	1720
Mitral :	
atresia . . . . .	0130
stenosis . . . . .	0130
Mitral valve insufficiency/cleft . . . . .	0130
MNS blood groups, iso-immunisation due to . . . . .	2430
Moebius syndrome . . . . .	0970
Morphine withdrawal . . . . .	1970
Mosaic:	
Down's Syndrome . . . . .	1070
trisomy 12 . . . . .	1070
trisomy 13 . . . . .	1070
Turner's syndrome . . . . .	1070
Mucopolysaccharidoses . . . . .	2830
Multiple pterygium syndrome . . . . .	1080
Multiple vertebra . . . . .	0890
Murmur, cardiac, cause unknown . . . . .	0130
Muscle:	
agenesis . . . . .	1060
biopsy . . . . .	3330
contracture due to IM injections . . . . .	2880
neoplasm . . . . .	2550
problems . . . . .	1060
Musculo-skeletal anomalies . . . . .	0950
Myasthenia gravis, newborn . . . . .	0950

## - M -

Mycoplasma infection .....	1810
Myocardial:	
infarction .....	3120
biopsy .....	3330
Myocarditis .....	1530
Myocarditis, due to congestive heart failure .....	2920
Myopathies .....	0960
Myotonic dystrophy .....	0950
Myotubular myopathy .....	0960
Myringotomy .....	3380



## - N -

Nails, dysplastic or absent . . . . .	0770
Nasal glioma . . . . .	2550
Nasal glioma, removal . . . . .	3280
Nasojunal feeding . . . . .	3210
Naso-lacrimal duct, congenital impatency of . . . . .	0480
Neck, short neck disorders . . . . .	0780
Necrosis:	
adrenal, post-asphyctic . . . . .	1210
brain, post-asphyctic . . . . .	1150
hemorrhagic, kidney . . . . .	1200
liver, post-asphyctic . . . . .	1210
subcutaneous fat . . . . .	1370
tubular, acute post-asphyctic . . . . .	1200
Necrotizing:	
enterocolitis, acute . . . . .	1480
laryngitis - tracheitis (complication of endotracheal tube) . . . . .	3010
Neglect, child . . . . .	3090
Neoplasms . . . . .	2550
Neoplastic disease, anemia due to . . . . .	2470
Nephritis, chronic interstitial . . . . .	1500
Nephrocalcinosis . . . . .	2870
Nephroma, mesoblastic . . . . .	2550
Nephrostomy, percutaneous . . . . .	3330
Nephrotic syndrome . . . . .	0670
Nesidioblastosis . . . . .	2830
Neural tube, incomplete closure of . . . . .	0990
Neuroblastoma . . . . .	2550
Neurofibromatosis . . . . .	1061
Neurologic abnormality . . . . .	1060
Neutropenia . . . . .	2350
Nevus:	
pigmented . . . . .	0710
sebaceous . . . . .	0770
Nitric oxide therapy . . . . .	3302
Nitroprusside therapy . . . . .	3310
Non-bullous dermatosis . . . . .	0720
Non-endemic goitrous cretinism . . . . .	2580
Non-persistent acidosis . . . . .	2670
Non-umbilical artery catheter . . . . .	3140
Non-SIDS death after discharge . . . . .	2890
Noonan syndrome . . . . .	1080
Normoblastemia . . . . .	2510
Nucleated RBC increased . . . . .	2510
Nutrition, parenteral . . . . .	3220

## - O -

Obstruction:	
bladder neck	0640
bowel, functional	2320
extrinsic intestinal	0230
extrinsic small bowel	0230
ureteropelvic junction	0640
urethral	0640
urinary	0640
Obstructive jaundice	2500
Occlusive disease, hepato-veno	0290
Oculomotor nerve palsy	2050
Oligohydramnios syndrome	1090
Oliguria	2740
Omentum, herniation due to amnio/intrauterine transfusion	3000
Omphalitis	1430
Omphalocele	0840
Omphalomesenteric cyst	0840
Ondine's Curse	2040
Oophorectomy	3280
Opacities:	
cornea	0430
vitreous humour	0490
Opsoclonus	2040
Oral thrush	1580
Orchidectomy	3280
Orchidopexy	3280
Organic acidoses	2850
Organisms:	
causative, miscellaneous	1790
suspected of causing systemic infection	1640
Orojejunal feeding	3210
Oromandibular limb hydrogenesis syndrome	1080
Osteochondritis	1550
Osteochondroplasia	0870
Osteogenesis imperfecta	0920
Osteomyelitis	1550
Ostium:	
primum defect	0130
secundum defect	0130
Otitis:	
externa	1630
media	1630
Otocephaly	1080
Oto-Facial-Digital	1080

- O -

Ovarian cyst .....	0670
Ovary, torsion of .....	0670
Oxygen, home therapy .....	3450
Oxygenation, extracorporeal membrane(E.C.M.O.) .....	3330

## - P -

Pacemaker, cardiac .....	3530
Pachygyria .....	0970
Palate, cleft .....	0380
Palate deformity due to tracheal intubation .....	3010
Palpebral fissure band .....	0490
Palsy:	
brachial plexus .....	1240
cranial nerve .....	2050
Erb's .....	1240
facial nerve .....	1230
Klumpke's .....	1240
laryngeal .....	1330
phrenic .....	1250
phrenic nerve (complication of vascular catheter) .....	2860
vocal cord .....	2050
Pancreatectomy .....	3280
Parabiotic syndrome .....	0180
Parabiotic syndrome, due to hemorrhage .....	2450
Paracentesis, abdominal .....	3390
Parainfluenza virus .....	1720
Paralysing agent .....	3370
Parenteral nutrition .....	3220
Paronychia(cellulitis) .....	1600
Paroxysmal atrial tachycardia .....	0150
Parvovirus .....	1720
Patent ductus arteriosus .....	0130
Patent(persistent) urachus .....	0670
Paucity of intrahepatic bile duct .....	0290
Pavulon .....	3370
Pectoralis major, absence of .....	0900
Pelvic kidney .....	0630
Pelvis, double .....	0610
Pena Shokeir:	
Type 1 phenotype .....	1080
Type 2, phenotype .....	1080
Penis, hypoplasia of (micropenis) .....	0620
Pentazocine(Talwin)withdrawal .....	1970
Peptic ulcer .....	2320
Perforated eardrum .....	1330
Perforation:	
G.I. tract .....	2280
heart, complication of vascular catheter .....	2860
laryngeal/esophageal, complication of endotracheal tube .....	3010
lung by pleural drain (chest tube) .....	3120
tracheal, complication of endotracheal tube .....	3010
Pericardial effusion .....	3120
Pericardiocentesis .....	3330

## - P -

Pericarditis .....	1630	
Pericardium, absent or defective .....	0190	
Perinatal hemochromatosis .....	2350	
Perineal hematoma .....	1300	
Peripheral vein catheter .....	3220	Periportal
fibrosis 2230		
Peritoneal dialysis .....	3330	
Peritoneal shunt, subdural .....	3330	
Peritonitis .....	1490	
Peritonitis, meconium due to perforation of G.I. tract .....	2280	
Periventricular:		
leucomalacia .....	2000	
calcification .....	2040	
Persistent:		
fetal circulation syndrome .....	0170	
hyperplastic primary vitreous .....	0490	
post-intubation stridor .....	3010	
Peter anomaly .....	0430	
pH, scalp .....	3100	
Pharmacologic:		
Vitamin D .....	3430	
Vitamin E .....	3350	
Pharyngeal incoordination .....	2250	
Phenobarbital intoxication .....	3040	
Phenocopy .....	1080	
Phenoxybenzamine intoxication .....	3040	
Phenylalaninemia:		
of prematurity .....	2790	
Type I .....	2790	
Type II .....	2790	
Phenylketonuria:		
atypical .....	2790	
classical .....	2790	
transient .....	2790	
Phlebitis .....	1630	
Umbilical .....	1630	
Phocomelia .....	0860	
Phototherapy .....	3240	
Phrenic nerve palsy .....	1250	
Picornavirus infection .....	1720	
Pierre-Robin syndrome .....	1080	
Pigmented nevus .....	0710	
Pit, pre-auricular .....	0410	

## - P -

Placenta:	
accreta	0100
circumvallate	0030
increta	0100
membranous	0100
percreta	0100
Placental floor infarct	0100
Pleural drain (chest tube)	3190
Plasma thromboplastin antecedent (PTA deficiency)	2460
Pneumatosis intestinalis	1480
Pneumomediastinum	2080
Pneumonectomy	3280
Pneumonia:	
congenital	1610
in persistent fetal circulation	0170
intrauterine	1610
postnatal	1620
Pneumonitis, aspiration	1180
Pneumopericardium	2100
Pneumoperitoneum, cause unknown	2320
Pneumothorax	2070
Pneumothorax, due to amnio./intrauterine transfusion	3000
Poland syndrome	1080
Polycystic kidney	0570
Polycythemia	2480
Polydactyly	0810
Polymicrogyria	0970
Polysplenia syndrome	1080
Porencephalic cyst(s)	2000
Port-wine stain	0700
Positive:	
blood culture without other evidence for septicemia	1400
DAT (Coombs' test) due to complement, no ABO set-up	2430
H.I.V. antibody screen	1720
serology for syphilis	1670
Posterior:	
fontanelle, large	2990
fossa hemorrhage	1270
urethral valve	0640

## -P-

Post-asphyctic:	
acute tubular necrosis and hemorrhagic necrosis of kidney . . . . .	1200
adrenal necrosis . . . . .	1210
brain necrosis . . . . .	1150
CNS depression . . . . .	1110
CNS excitation . . . . .	1120
congestive heart failure . . . . .	1190
convulsions . . . . .	1140
increased intracranial pressure . . . . .	1130
liver and/or adrenal necrosis . . . . .	1210
Postnatal pneumonia . . . . .	1620
Post-intubation stridor, persistent . . . . .	3010
Potter's syndrome (renal agenesis) . . . . .	1090
Pre-auricular skin tag, pit or sinus . . . . .	0410
Prednisolone therapy, maternal . . . . .	3250
Prednisone therapy, maternal . . . . .	3250
Premature closure of foramen ovale . . . . .	0130
Presenting part, accidental injection of drug into . . . . .	3120
Pressure, intracranial, increased post-asphyctic . . . . .	1130
Primary pulmonary hypertension . . . . .	0170
Prolapse:	
cord . . . . .	0090
rectal . . . . .	2320
Propranolol antihypertensive therapy . . . . .	3540
Prophylaxis, hepatitis B . . . . .	3420
Propylthiouracil, hypothyroidism due to maternal ingestion of . . . . .	2580
Prostaglandin E therapy . . . . .	3320
Prune belly syndrome . . . . .	1080
Pseudohermaphroditism, male . . . . .	2570
Pseudo-truncus . . . . .	0130
Pseudo-Hurler polydystrophy . . . . .	2830
PTA deficiency . . . . .	2460
Pterygium syndrome . . . . .	1080

## -P-

## Pulmonary:

agenesis . . . . .	0320
artery atresia . . . . .	0130
artery stenosis, pathologic . . . . .	0130
disease of prematurity, chronic . . . . .	2110
edema without hyaline membrane formation . . . . .	2060
embolus . . . . .	2150
emphysema . . . . .	2160
emphysema, interstitial . . . . .	2090
hemorrhage . . . . .	2130
hyperplasia . . . . .	0350
hypertension . . . . .	2210
hypoplasia (in persistent fetal circulation) . . . . .	0170
hypoplasia (respiratory) . . . . .	0320
infarct . . . . .	2150
lymphangiectasia, chronic . . . . .	2200
sequestria . . . . .	0350
valve insufficiency . . . . .	0130
valve stenosis or atresia . . . . .	0130
vein atresia . . . . .	0130
P.U.O. . . . .	1750
Pyeloplasty . . . . .	3280
Pyloric stenosis . . . . .	0290
Pyloromyotomy . . . . .	3280
Pyoderma . . . . .	1570
Pyrexia of unknown origin (P.U.O.) . . . . .	1750
Pyridoxine dependency convulsions . . . . .	1900
Pyropoikilocytosis . . . . .	2540
Pyruvate:	
carboxylase deficiency . . . . .	2850
kinase deficiency . . . . .	2540
kinase deficiency, anemia due to . . . . .	2470
Pyuria without evidence for U.T.I. . . . .	1420



## - R -

Rachischisis .....	0990
Radial:	
aplasia or hypoplasia .....	0940
heads, dislocation .....	0950
nerve palsy .....	1240
Radicular cysts .....	0490
Ranula .....	0490
Rectal-ano-urethral fistula .....	0670
Rectal:	
perforation .....	2280
prolapse .....	2320
Rectovaginal fistula .....	0670
Red cell defects .....	2540
Reduction, limb .....	0860
Reflux:	
gastro-esophageal .....	2240
vesicoureteric .....	0670
Reifenstein's syndrome .....	2570
Removal:	
Meckel's Diverticulum .....	3280
nasal glioma .....	3280
ovarian cyst .....	3280
Renal:	
arteries, double .....	0610
atrophy .....	0580
calculi .....	3120
dysplasia (dysplastic kidneys) .....	0600
failure .....	2940
hypoplasia .....	0580
necrosis, hemorrhagic, post-asphyctic .....	1200
pelviectasis .....	0590
tubular acidosis .....	2670
vein thrombosis .....	2980
Renal agenesis:	
oligohydramnios syndrome .....	0580
Potter's syndrome .....	1090

## - R -

## Repair:

atrioventricular canal defect . . . . .	3280
bladder exstrophy . . . . .	3280
coarctation of aorta . . . . .	3280
imperforate anus . . . . .	3280
Pierre-Robin Syndrome (tongue, lip, adhesions) . . . . .	3280
ranula, surgical . . . . .	3280
small bowel . . . . .	3280
tetralogy repair . . . . .	3280
total anomalous pulmonary venous defect . . . . .	3280
tracheoesophageal fistula . . . . .	3280
truncus arteriosus . . . . .	3280
umbilical hernia . . . . .	3280
ventricular septal defect . . . . .	3280
Resection, hemangioma . . . . .	3280
Resorption of hematoma . . . . .	2440
Respiratory:	
disease, miscellaneous . . . . .	2210
distress syndrome . . . . .	2060
syncytial virus . . . . .	1720
Reticulocytosis . . . . .	2520
Retinal dysplasia . . . . .	0490
Retinal hemorrhage involving macula . . . . .	2040
Retinopathy of prematurity . . . . .	2900
Retrolental fibroplasia . . . . .	2900
Retropharyngeal mass . . . . .	2120
Rhabdomyoma . . . . .	2550
Rhachischisis . . . . .	0990
Rhinitis . . . . .	1460
Rhizomelic Dwarfism . . . . .	1080
Rib, bifid . . . . .	0890
Rib fracture . . . . .	1220
Ribavirin therapy . . . . .	3550
Ribs, eleven . . . . .	0890
Ribs, thirteen . . . . .	0890
Rickets	
clinical . . . . .	2620
classical with fractures . . . . .	2620
Right aortic arch . . . . .	0130
Ring, intrathoracic (vascular) . . . . .	0190
Ritter's disease . . . . .	1570
Roberts syndrome . . . . .	1080
Rota virus . . . . .	1720
Rubella . . . . .	1650
Rubinstein-Taybi syndrome . . . . .	1080

-R-

Ruptured:

umbilical vessel, due to amnio./intrauterine transfusion . . . . .	3000
vessel (complication of vascular catheter) . . . . .	2860
Russell-Silver syndrome . . . . .	1080

## - S -

Sacrococcygeal agenesis .....	0890
Sacrum, bifid .....	0890
Salpingo-oophorectomy .....	3280
Scalp:	
electrode complication .....	3120
hemorrhage .....	1290
Ph .....	3100
Scleralization, cornea .....	0430
Sclerema .....	2930
Sclerosis, tuberous .....	1061
Schizencephaly .....	0970
Scrotum, transposition of .....	0670
Sebaceous nevus .....	0770
Sepsis, causing to congestive heart failure .....	2920
Septectomy, atrial .....	3280
Septicemia .....	1390
Septostomy, balloon atrial .....	3330
Sequence:	
early amnion rupture .....	0740
frontal-nasal dysplasia .....	1080
Sequestria, pulmonary .....	0350
Serology positive for syphilis .....	1670
Seventh nerve palsy .....	1230
Short:	
femur, congenital .....	0950
neck disorders .....	0780
Shoulder dystocia .....	1360
Shunt:	
subdural peritoneal .....	3330
systemic pulmonary artery .....	3280
ventricular .....	3280
S.I.A.D.H. ....	2830
Sialidosis .....	2830
Sickle cell trait .....	2350
S.I.D.S. ....	3080
Simpson-Golabi-Behemel syndrome .....	1080
Single:	
atrium .....	0130
umbilical artery .....	0080
ventricle .....	0130
Sinus:	
arrest .....	0150
branchial cleft .....	0390
dermal .....	0990
pre-auricular .....	0410
urogenital .....	0670

## -S-

Sirenomelus .....	0910
Situs inversus, abdominal .....	0160
Sixth nerve palsy .....	2050
Skin:	
biopsy .....	3330
infection .....	1570
lesions, depigmented .....	0700
slough .....	3120
tag, pit or sinus, pre-auricular .....	0410
tag, thyroglossal .....	0510
Skull:	
depression, unknown etiology .....	0950
fracture .....	1220
Slough, skin .....	3120
Smith Lemli-Opitz syndrome .....	1080
Soft tissue wasting .....	0110
Spells, apneic .....	2030
Spherocytosis, congenital .....	2540
Sprengel's deformity of shoulder .....	0950
Spina bifida .....	0990
Spinal cord trauma .....	1260
Spleen laceration .....	1320
Spot, cafe-au-lait .....	0770
Stain, port-wine .....	0700
Stenosis:	
anal .....	0220
ascending aorta .....	0130
aortic arch .....	0130
aortic valve .....	0130
external auditory meatus or canal .....	0420
intrinsic intestinal .....	0220
laryngeal, congenital .....	0490
laryngeal and/or subglottic, complication, endotracheal tube ...	3010
pulmonary artery .....	0130
pulmonary valve .....	0130
pyloric .....	0290
ureteral .....	0640
Sternocleidomastoid, tumour of .....	0880
Steroid therapy	
infant .....	3330
maternal .....	3250
Stickler's syndrome .....	1080
Stimulants used in the treatment of apnea .....	3230
Stomach, perforation .....	2280

## -S-

Stomatocytosis:	
anemia due to	2470
hereditary	2540
Storage disease, type unknown	2830
Stricture, G.I., acquired	2320
Stridor:	
congenital	2120
persistent post-intubation, complication, endotracheal tube	3010
Stroke:	
not due to asphyxia	2000
post-asphyctic	1150
STS positive (Syphilis)	1670
Sturge-Webber(encephalotrigeminal angiomatosis)	1061
Subaponeurotic hemorrhage	1290
Subarachnoid hemorrhage	1160
Subcapsular hemorrhage of liver	1310
Subcutaneous:	
abscess/carbuncle	1590
emphysema	3120
fat necrosis	1370
Subependymal hemorrhage	1170
Subgaleal hemorrhage	1290
Subglottic stenosis due to tracheal intubation	3010
Sublingual frenulum(clipping of)	3330
Subluxated hip, congenital	0800
Succenturiate lobe	0050
Sudden unexpected infant death syndrome	3080
Supernumerary:	
nipple	0730
vertebra	0890
Supero-lateral infarction of brain (ultra-sound)	1820
Supratentorial hemorrhage	1270
Surfactant	3460

-S-

## Surgery: (see also repair)

abdominal-perineal pull-through . . . . .	3280
appendectomy . . . . .	3280
arterial switch . . . . .	3280
Atrial septectomy . . . . .	3280
aortic valvotomy . . . . .	3280
banding pulmonary artery . . . . .	3280
bile duct repair . . . . .	3280
bladder surgery . . . . .	3280
brain . . . . .	3280
cholecystectomy . . . . .	3280
colon . . . . .	3280
congenital heart disease . . . . .	3280
craniotomy . . . . .	3280
cutis aplasia congenita . . . . .	3280
dermal fistula . . . . .	3280
dermal sinus . . . . .	3280
diaphragmatic hernia . . . . .	3280
division of double aortic arch . . . . .	3280
duodenojejunostomy . . . . .	3280
duodenum . . . . .	3280
encephalocele . . . . .	3280
esophagus . . . . .	3280
fundoplication . . . . .	3280
gastroschisis . . . . .	3280
hemangioma resection . . . . .	3280
hepatic disease . . . . .	3280
hydrocephalus . . . . .	3280
hypoplastic left heart . . . . .	3280
ileum . . . . .	3280
inguinal hernia . . . . .	3280
jejunal . . . . .	3280
ligation/closure of patent ductus arteriosus . . . . .	3280
meningocele . . . . .	3280
meningomyelocele . . . . .	3280
nephrectomy . . . . .	3280
neoplastic disease . . . . .	3280
omphalocele . . . . .	3280
oophorectomy/salpingo-oophorectomy . . . . .	3280
orchidectomy . . . . .	3280
orchidopexy . . . . .	3280
pyeloplasty . . . . .	3280
rectum . . . . .	3280
stomach . . . . .	3280
Ureteropelvic junction obstruction . . . . .	3280

## -S-

Survanta .....	3460
Swenson pull-through .....	3280
Switching of coronary arteries or great arteries .....	3280
Syndactyly .....	0820
Syndrome:	
adrenal insufficiency .....	2590
Alagilles .....	0290
amniotic band .....	0740
Apert's .....	1080
Asplenia .....	1080
Beckwith's .....	1080
Camptomelic .....	1080
cardiac limb .....	1080
Cornelia de Lange .....	1080
Cri-du-chat .....	1070
Cryptophthalmus .....	1080
Dandy-Walker syndrome .....	1030
diastrophic dysplasia .....	0870
DiGeorge .....	1080
Down's .....	1070
drug withdrawal .....	1970
ductus, of prematurity .....	0140
ductus, of prematurity, treated with cardiac catheterization .....	3270
due to chromosomal aberrations .....	1070
EEC .....	1080
18 P- .....	1070
18 Q- .....	1070
Fetal Alcohol .....	1080
Fetal Hydantoin .....	1080
15P+ .....	1070
5Q+ .....	1070
4Q- .....	1070
Fraser's .....	1080
Goldenhar .....	1080
Goltz .....	0720
Hepato-Renal .....	2830
Heterotaxy .....	0160
hypoplastic left heart .....	0130
Holt Oram .....	1080
inappropriate secretion of antidiuretic hormone .....	2830
Klippel-Feil .....	0780
Klippel-Trenaunay-Weber Syndrome .....	1080
Lowe's .....	1080
malabsorption .....	2260
Marfan's .....	1080
Meckel-Gruber .....	1080



-S-

Syndrome: **(Continued)**

meconium aspiration .....	1180
meconium plug .....	2330
microcolon-megacystis-hypperistalsis .....	0290
Moebius .....	0970
Mosaic Down's .....	1070
Mosaic Turner's .....	1070
nephrotic .....	0670
9Q+ .....	1070
Noonan .....	1080
not due to chromosomal aberrations .....	1080
oligohydramnios .....	1090
oromandibular limb hypogenesis .....	2120
parabiotic .....	0180
parabiotic, due to hemorrhage .....	2450
persistent fetal circulation .....	0170
Pierre-Robin .....	1080
Poland .....	1080
Polysplenia .....	1080
Potter's .....	1090
Prune Belly .....	1080
Pterygium, multiple .....	1080
Reifenstein's .....	2570
respiratory distress .....	2060
Ring 13 .....	1070
Ring 5 .....	1070
Robert's .....	1080
Rubinstein-Taybi .....	1080
Russell-Silver .....	1080
S.I.D.S. .....	3080
6Q+ .....	1070
Smith-Lemli-Opitz .....	1080
Stickler's .....	1080
Testicular feminizing .....	2570
Thrombocytopenia-absent radii .....	2490
Townes-Brock .....	1080
Treacher-Collins' .....	1080
Triad .....	1080
Turner's .....	1070
2Q+ .....	1070
2Q- .....	1070
V.A.C.T.E.R.L. .....	1080
Walker-Warburg .....	1080
Williams' .....	1080
Wilson-Mikity .....	2110
Zwelleger .....	2830

-S-

Syndrome: **(Continued)**

Wolff-Parkinson .....	1070
XYY .....	1070
Zachmann-Prader .....	2570
Synthesis, defective causing hypothyroidism .....	2580
Syphilis .....	1670
Systemic infection, site unknown .....	1380

## - T -

Tachycardia:	
atrial, coatic . . . . .	0150
paroxysmal atrial . . . . .	0150
paroxysmal atrial, due to congestive heart failure . . . . .	2920
ventricular . . . . .	0150
Tachypnea, transient of the newborn . . . . .	2060
Tag:	
pre-auricular skin . . . . .	0410
skin . . . . .	0410
Tamponade, cardiac . . . . .	3120
Tear, tentorial . . . . .	1350
Tenth nerve palsy . . . . .	2050
Tentorial tear . . . . .	1350
Teratoma:	
embryonic rests . . . . .	2550
gonads . . . . .	2550
Testis, undescended . . . . .	0520
Testicular feminizing syndrome . . . . .	2570
Testis, torsion of . . . . .	0670
Tetany . . . . .	2660
Tetralogy of Fallot . . . . .	0130
Thanatophoric dwarfism . . . . .	0930
Theophylline therapy . . . . .	3230
Therapy:	
aminophylline . . . . .	3230
antihypertensive . . . . .	3540
antiviral . . . . .	3550
caffeine . . . . .	3230
captopril . . . . .	3540
cisapride . . . . .	3461
dexamethasone . . . . .	3470
doxapram . . . . .	3230
exosurf (artificial) . . . . .	3460
gastrointestinal . . . . .	3330
hepatitis B globulin . . . . .	3420
hepatitis B vaccine . . . . .	3420
home oxygen . . . . .	3450
indomethacin . . . . .	3290
magnesium sulphate(vasodilator) . . . . .	3301
metoclopramide (antiviral therapy) . . . . .	3550
metoclopramide (gastrointestinal therapy) . . . . .	3330
nitric oxide . . . . .	3280
nitroprusside . . . . .	3310
pancuronium bromide . . . . .	3370
pharmacologic vitamin D . . . . .	3430
pharmacologic vitamin E . . . . .	3350

## -T-

Therapy:(cont.)	
prostaglandin E . . . . .	3320
Ribavirin . . . . .	3550
steroid, infant (after birth) . . . . .	3330
steroid, infant, aerosol . . . . .	3330
steroid, systemic, maternal . . . . .	3250
survanta . . . . .	3460
tolazoline(vasodilator) . . . . .	3300
theophylline(aminophlline) . . . . .	3230
Thermal burns . . . . .	3030
Thiamine therapy . . . . .	3551
Third nerve palsy . . . . .	2050
Thirteen ribs . . . . .	0890
Thoracentesis, no drain . . . . .	3190
Thoracostomy . . . . .	3190
Thoracotomy to drain pericardium . . . . .	3330
Thrombocytopenia . . . . .	2490
Blood group isoimmunization . . . . .	2490
Thrombocytopenia-absent radii syndrome . . . . .	2490
Thrombocytopenia due to PLA1 isoimmunization . . . . .	2490
Thrombophlebitis (complication of vascular catheter) . . . . .	2860
Thrombosis:	
arterial or venous . . . . .	2460
renal vein . . . . .	2980
venous, causing convulsions . . . . .	1940
Thrush, oral . . . . .	1580
Thumb:	
aplasia or hypoplasia . . . . .	0940
bifid . . . . .	0850
triphalangeal . . . . .	0850
Thyroid:	
aplasia . . . . .	2580
ectopic . . . . .	2580
hypoplasia . . . . .	2580
Thyroglossal :	
cyst . . . . .	0510
skin tag . . . . .	0510
Thyroxine (T <sub>4</sub> ), serum level elevated, asymptomatic . . . . .	2600
Tolazoline therapy(vasodilator) . . . . .	3300
Torsion:	
ovary . . . . .	0670
testis . . . . .	0670
Torticollis . . . . .	0880
Total anomalous pulmonary venous return . . . . .	0130
Townes-Brock syndrome . . . . .	1080

## -T-

Toxic hemolytic anemia . . . . .	2470
Toxoplasmosis . . . . .	1680
Tracheal:	
agenesis . . . . .	0350
atresia . . . . .	0350
Tracheal perforation due to tracheal intubation . . . . .	3010
Tracheitis-laryngitis, necrotizing (complication) . . . . .	3010
Tracheobronchomalacia (stridor) . . . . .	2120
Tracheomalacia, acquired . . . . .	2120
Tracheo-esophageal atresia of fistula . . . . .	0240
Tracheostomy . . . . .	3260
Transfusion:	
exchange . . . . .	3200
granulocyte . . . . .	3330
twin to twin . . . . .	2450
twin to twin, causing to congestive heart failure . . . . .	2920
Transient:	
phenylketonuria . . . . .	2790
respiratory distress . . . . .	2060
tachypnea of the newborn . . . . .	2060
Translocation:	
5 to 7 . . . . .	1070
7 to 9 . . . . .	1070
12/21 balanced . . . . .	1070
13 . . . . .	1070
13 balanced . . . . .	1070
18 balanced . . . . .	1070
21 . . . . .	1070
Transposition:	
corrected . . . . .	0130
great arteries/vessels . . . . .	0130
scrotum . . . . .	0670
Trauma:	
miscellaneous . . . . .	1330
spinal cord . . . . .	1260
Traumatic:	
intra-cranial hemorrhage . . . . .	1270
stridor . . . . .	2120
Treacher-Collins' syndrome . . . . .	1080
Treatment, cofactor . . . . .	3551
Triad syndrome . . . . .	1080
Trichomonas vaginalis . . . . .	1630
Tricuspid:	
atresia . . . . .	0130
insufficiency . . . . .	0130
Trigeminal nerve palsy . . . . .	2050

## -T-

Trigonocephaly .....	0830
Triphalangeal thumb .....	0850
Triplet, aborted .....	3120
Triploidy .....	1070
Trisomy:	
C group .....	1070
9 .....	1070
13 .....	1070
14 .....	1070
18 .....	1070
21 .....	1070
Trochlear nerve palsy .....	2050
Trophoblastic disease .....	0100
True:	
knot in cord .....	0100
swabs, organisms colonized .....	1640
Truncus arteriosus .....	0130
Tube feedings .....	3210
Tuberous sclerosis .....	1061
Tubular necrosis, acute, post-asphyctic .....	1200
Tumour:	
sternocleidomastoid .....	0880
Wilm's .....	2550
Turner's syndrome .....	1070
Twin:	
aborted .....	3120
fetus papyraceus(infant not listed as twin) .....	3120
type .....	3500
Twins:	
dichorionic, dissimilar sexes or blood groups .....	3500
dichorionic, similar sexes and blood groups .....	3500
dichorionic, similar sexes, blood groups undetermined .....	3500
monoamniotic .....	3500
monochorionic, diamniotic .....	3500
Siamese (Conjoined) .....	3500
undetermined .....	3500
Twin-twin transfusion:	
anemia due to .....	2470
hemorrhage due to .....	2450

## - U -

Ulcer, peptic .....	2320
Ulceration/squamous metaplasia, complication, endotracheal tube ...	3010
Umbilical:	
arterial catheter .....	3150
artery, single .....	0080
defects .....	0840
hernia .....	0840
vessels, rupture .....	3000
vein catheter .....	3160
Undescended testes .....	0520
Urachal cyst .....	0670
Urachus, patent(persistent) .....	0670
Urea cycle defect .....	2830
Ureaplasma infection .....	1810
Ureter, double .....	0610
Ureteral:	
atresia or stenosis .....	0640
diverticulum .....	0640
Ureterocele .....	0640
Urinary:	
obstruction .....	0640
tract infection .....	1420
Urogenital sinus .....	0670
Urticaria pigmentosa .....	0720
Uterus, bicornuate .....	0670

- V -

Vaccination, BCG .....	3330
Vaccine:	
hepatitis B .....	3420
respiratory syncytial virus .....	3421
Hemophilus influenza, B conjugate (HIB) .....	3421
DPT .....	3440
DPT only .....	3440
Vagina, double .....	0670
Vaginal cyst, congenital .....	0670
Vagus palsy .....	2050
Valvotomy:	
aortic .....	3280
pulmonary .....	3280
Vancomycin intoxication .....	3040
Varicella virus(chicken pox) .....	1720
Varicella zoster immune globulin injection .....	3330
Vasa previa .....	0100
Vascular ring .....	0190
Vasospasm (complication of vascular catheter) .....	2860
Vater association .....	1080
Vein of Galen, aneurysm of .....	0190
Velamentous insertion of cord .....	0010
Venous:	
catheter, central .....	3130
thrombosis .....	2460
Ventilation:	
high frequency .....	3171
intermittent positive pressure .....	3170
for surgery only .....	3170
withdrawal of ventilator care and DNR order on chart .....	1101
Ventricle, single .....	0130
Ventricular shunt .....	3280
Ventriculitis .....	1440
Vertebral anomalies .....	0890
Vesicostomy .....	3330
Vesicoureteric reflux .....	0670
Vessels, transposition great .....	0130
Viral disease, miscellaneous .....	1720
Virus:	
ECHO .....	1720
influenza A .....	1720
parainfluenza .....	1720
picorna .....	1720
respiratory syncytial .....	1720
rota .....	1720
varicella .....	1720



-V-

## Vitamin:

D, pharmacologic .....	3430
E deficiency syndrome, anemia due to .....	2470
E therapy .....	3350

## Vocal cords:

hyperplasia of .....	2120
paralysis .....	2050

Volvulus .....	0300
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Volvulus, acquired .....	2320
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## - W -

Walker-Warbury syndrome .....	1080
Wasting, clinical soft-tissue .....	0110
William's syndrome .....	1080
Wilm's tumour .....	2550
Wilson-Mikity syndrome .....	2110
Withdrawal syndrome .....	1970
Wolff-Parkinson syndrome .....	1070
Wound abscess .....	1590
Wright-isoimmunization .....	2430
Wrist Drop .....	1240

## - Z -

Zachmann-Prader syndrome (17-20 desmolase deficiency) .....	2570
Zinc deficiency .....	2830