

Nova Scotia Atlee Perinatal Database Coding Manual 14th Edition (Version 14.0.0)

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LISTING OF HOSPITALS

Hospitals appearing in bold are currently providing maternity services.	HOSPITAL #
Aberdeen Hospital New Glasgow	
All Saints Hospital Springhill	12
Annapolis Community Health Centre Annapolis Royal	
Antepartum Mable Home	
Bayview Memorial Health Center Advocate Harbour	
Buchanan Memorial Hospital Neil's Harbour	
Cape Breton Health Care Complex: Glace Bay Site	
Northside (North Sydney Site) Sydney Site	87
CFB Cornwallis Cornwallis	79
CFB Stadacona Halifax	78
Chaleur Regional Hospital New Brunswick	10
Colchester Regional Hospital Truro	18
Cumberland Regional Healthcare Centre Amherst	30
Dartmouth General Hospital Dartmouth	65
Digby General Hospital Digby	20

Hospitals appearing in bold are currently providing maternity services.	HOSPITAL #
East Coast Forensic Dartmouth	71
Eastern Memorial Hospital Canso	22
Eastern Shore Memorial Hospital Sheet Harbour	23
Fishermen's Memorial Hospital Lunenburg	24
George Dumont Hospital New Brunswick	11
Glace Bay Health Care Corporation (See Cape Breton Healthcare Complex)	87
Guysborough Memorial Hospital Guysborough	27
Hants Community Hospital Windsor	37
Health Services Association of the South Shore Bridgewater	14
Home of the Guardian Angel Halifax(Use for discharged to only if Mom and Babe both go to the Home)	88
Intended Delivery at home (NOT Attended by a Health Care Professional) Home	-7
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Inverness Consolidated Memorial Hospital Inverness	
IWK Health Centre Halifax	86

Hos	pitals aı	ppearing	in bold	are currently	v providina	a maternity	/ services.

	HOSPITAL #
Lillian Fraser Memorial Hospital Tatamagouche	32
Moncton Hospital (The) New Brunswick	12
Musquodoboit Valley Memorial Hospital Middle Musquodoboit	33
New Waterford Consolidated Hospital New Waterford	63
North Cumberland Memorial Hospital Pugwash	35
Northside General Hospital(See Cape Breton Healthcare Complex)	87
Nova Scotia Hospital Dartmouth	77
Point Pleasant Lodge Halifax	64
Prince County Hospital Prince Edward Island	13
Queen Elizabeth Hospital Prince Edward Island	14
Queen Elizabeth II Health Sciences Centre Halifax	85
Queens General Hospital Liverpool	38
Roseway Hospital Shelburne	39

Hospitals appearing in bold are currently providing maternity services.	HOSPITAL #
Sackville Memorial Hospital New Brunswick	
Sacred Heart Hospital	
Cheticamp	47
Self Discharge Home	6
Soldiers Memorial Hospital Middleton	48
South Cumberland Community Care Centre Parrsboro	49
St. Anne's Hospital Arichat	40
St. Martha's Regional Hospital Antigonish	43
St. Mary's Memorial Hospital Sherbrooke	45
Strait Richmond Hospital Cleveland	68
Sutherland-Harris Memorial Hospital Pictou	50
Twin Oaks Memorial Hospital Musquodoboit Harbour	52
Valley Regional Hospital Kentville	67
Victoria County Memorial Hospital Baddeck	53
Western Kings Memorial Health Centre	5.F

Hospitals appearing in bold are currently providing maternity services.

	HOSPITAL #
Western Regional Health Centre Yarmouth	56
Hospitals in Alberta Alberta	16
Hospitals in Bermuda Bermuda	31
Hospitals in British Columbia British Columbia	17
Hospitals in Manitoba Manitoba	18
Hospitals in Newfoundland and Labrador Newfoundland /and Labrador	19
Hospitals in New Brunswick (other than those listed) New Brunswick	20
Hospitals in Northwest Territories Northwest Territories	21
Hospitals in Ontario Ontario	22
Hospitals in PEI (other than those listed) Prince Edward Island	23
Hospitals in Quebec Quebec	24
Hospitals in Saskatchewan Saskatchewan	25
Hospitals in United States United States	26
Hospitals in Yukon Yukon	27

Hospitals appearing in bold are currently providing maternity services.	
	HOSPITAL #
Hospitals in Nunavut	

Nunavut --28

Hospital not in list
Non-Specific --32

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ADMISSION INFORMATION

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 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 10-14.

DISCHARGE DATE Patient's discharge date from hospital.

Found on the 'NURSES NOTES'.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME Patient's discharge time from hospital.

Found on the 'NURSES NOTES'.

Use the following format: 'HHMM'.

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

If Discharge Time is not documented leave Discharge Time blank

and code '9' in the field immediately following.

ADMISSION DATE Patient's admission date to hospital.

Found on the 'HOSPITAL ADMISSION FORM'.

Use the following format: 'YYYYMMDD'. Patient's admission time to hospital.

ADMISSION TIME

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) Patient's given name(s).

Found on the 'HOSPITAL ADMISSION FORM'.

SURNAME Patient's surname.

Found on the 'HOSPITAL ADMISSION FORM'.

ADMISSION TYPE Type of Admission

Found on 'ADMISSION SEPARATION SHEET'.

1 Delivered Admission

2 Undelivered Admission

3 Postpartum Admission

5 Neonatal Admission

PREVIOUS SURNAME Patient's maiden name or other previous surname.

Found on the 'HOSPITAL ADMISSION FORM'.

Leave blank for Neonatal Admissions.

This field can be left blank if not documented.

A/S/D NUMBER

Hospital number referring to the patient's present admission.

Found on the patient's 'HOSPITAL ADMISSION FORM'.

Use the following format: 'CCNNNNNNN/YY':where "CC" is the admit type, "NNNNNN" is an ascension number related to the number of admissions of the year and "YY" denotes the fiscal year (April 1 to March 31), changing on April 1st of each year. The / has to be entered before the YY denoting the fiscal year.

Zeroes before the ascension number must be entered if number does not have 7 digits, e.g. AS0000123/05.

Code '9999999999' for other provincial account numbers, or when unknown.

HEALTH CARD NUMBER

Found on the 'HOSPITAL ADMISSION FORM'.

Record the patients' **Nova Scotia** Health Card Number or hospital generated '8000' number for;

- Nova Scotia residents admitted without a Nova Scotia Health Card Number
- Patients from outside Nova Scotia

If a Nova Scotia Health Card Number or hospital generated '8000' number is not available, code;

- 0 Nova Scotia patient, cards not available
- 0 Armed Forces
- 0 RCMP
- 0 First Nations
- 0 Self-paying
- 1 Patient from outside Nova Scotia

BIRTH DATE

Patient's date of birth.

Found on the 'HOSPITAL ADMISSION FORM'.

Use the following format: 'YYYYMMDD'

MUNICIPAL CODE FOR RESIDENCE

Patient's municipal code.

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 RESIDENCE (con't)

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 (not Bedford, Dartmouth or Halifax)

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 RESIDENCE (con't)

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 and Labrador
- 86 Ontario
- 87 Prince Edward Island
- 88 Quebec
- 89 Saskatchewan
- 90 Yukon
- 91 Northwest Territories
- 92 Nunavut
- 97 USA
- 95 Bermuda
- 98 Other countries
- 99 Unknown

MARITAL STATUS

Patient's marital status.

Found on the 'HOSPITAL ADMISSION FORM' or 'PRENATAL RECORD'.

Code using one of the following:

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

Marital Status will automatically blank out for Neonatal Admissions

ATTENDING CARE PROVIDER

Care Provider most responsible for the patient's care *while in hospital.*

Found on the 'HOSPITAL ADMISSION FORM'.

Code using the Provincial Medical Board Number or Provider Number for Midwives.

Code '88888' if physician is not registered in Nova Scotia. Code '99999' for unknown.

SEX

For adult patients the sex will automatically fill as **F** for female.

For neonatal admissions select the legal phenotypical sex of the infant regardless of Karyotype.

F Female

M Male

A Ambiguous

9 Unknown

STREET ADDRESS Patient's street address at time of admission

Found on the 'HOSPITAL ADMISSION FORM'.

Example: 4 King Street

MAIL ADDRESS Patient's mailing address.

This field can be left blank if mailing address is not documented

or same as street address.

Found on the 'HOSPITAL ADMISSION FORM'.

Example: PO Box 40 or RR#2

<u>CITY/TOWN</u> Patient's city, town or village of residence.

Found on the 'HOSPITAL ADMISSION FORM'.

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. USA, Britain, St. Pierre-Miguelon.

Code '999999' for unknown.

PROVINCE/COUNTRY OF RESIDENCE

Patient's province of residence.

Found on the 'HOSPITAL ADMISSION FORM'.

Code using one of the following:

AB Alberta

BC British Columbia

MB Manitoba NS Nova Scotia NB New Brunswick

NL Newfoundland and Labrador

NT Northwest Territories

NU Nunavut ON Ontario

PE Prince Edward Island

QC Quebec

SK Saskatchewan

YT Yukon US USA

XX Not for Canada or USA

ADMISSION PROCESS STATUS

Indicates the coding status of the admission information.

Code using one of the following:

- 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.

Once the case is saved (status 4 or 5) the data can be viewed, but not changed. Status 4 indicates that the data is ready to be transferred; status 5 indicates that data has been transferred.

Once data has been frozen (status 4 or 5), requests for any necessary changes or corrections must be forwarded to the Clinical Data Coordinator at RCP.

ROUTINE INFORMATION - DELIVERED ADMISSION

DELIVERED ADMISSION

Any admission of a pregnant woman resulting in the delivery of;

- 1. a live born fetus OR
- 2. a fetus that has reached 20 or more weeks gestation OR
- 3. a fetus weighing 500 or more grams OR
- 4. a fetus that was one of a set of multiples where at least one met any of the previous three criteria.

DELIVERY HOSPITAL

Hospital in which the delivery of the infant took place.

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

Code using one of the standard 2 digit provincial codes for hospitals found on pages 10-14.

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

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
- -5 Midwife attended home delivery

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 10-14.

If patient comes from home, code '0'

Code the following for the unusual situations:

- -7 Intended delivery at home without help of a Health Care Provider (not midwife)
- -8 Intended delivery at home with help of a Health Care Provider (not midwife)

If a patient comes from the emergency room of another facility without having been admitted to the facility Code '0' admitted from home.

PRENATAL RECORD ON CHART AT TIME OF CODING

The prenatal record was filed on the chart at the time of coding

Code using one of the following

Y Yes Prenatal record on chart at time of coding

N No Prenatal record not on chart at time of coding

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: 'YYYYMMDD'

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

If unsure is ticked in the box but a date is given, enter the date given in the field provided.

PRE-CONCEPTUAL FOLATE INTAKE

Maternal pre-conceptual folate intake.

Found on the 'PRENATAL RECORD'.

Code using one of the following:

Y Yes

N No

9 Unknown

GRAVIDA

The number of pregnancies, <u>including the present pregnancy</u>.

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

Code '99' for unknown.

PARA

The number of pregnancies, <u>excluding</u> the <u>present</u> <u>pregnancy</u>, which resulted in one or more infants weighing 500 grams or more at birth or 20 weeks or greater gestational age (regardless of whether such infants lived, were stillborn or died after birth).

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

Code '99' for unknown

SPONTANEOUS ABORTIONS

Number of Spontaneous Abortions

Enter the number occurring within the documented category

Found on the 'PRENATAL RECORD'

Code '99' for unknown if it is not documented to indicate the number of the category.

THERAPEUTIC ABORTIONS

Number of Therapeutic Abortions

Enter the number occurring within the documented category.

Found on the 'PRENATAL RECORD

Code '99' for unknown if it is not documented to indicate the number of the category.

UNSPECIFIED ABORTIONS

Number Unspecified as Spontaneous or Therapeutic Abortions

Found on the 'PRENATAL RECORD

Code '99' for unknown if it is not documented to indicate the number of each category.

FETAL DEATHS WEIGHING 500 GRAMS OR MORE

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 or stillbirth by the physician.

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

Code '9' for unknown.

NUMBER OF PREVIOUS NEONATAL DEATHS WEIGHING 500 GRAMS OR MORE

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 FORM' or the 'PHYSICIANS' ASSESSMENT FORM'.

Code '9' for unknown.

NUMBER OF PREVIOUS C-SECTIONS

Number of previous C-sections.

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

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 FORM' or the 'MATERNAL ADMISSION ASSESSMENT FORM'.

Code using one of the following:

Y Yes

N No

9 Unknown

PREVIOUS PRE-TERM DELIVERY

Number of pre-term deliveries in previous pregnancies.

Found on the 'PRENATAL RECORD".

Code the number of deliveries excluding the present pregnancy where the delivery took place after 20 weeks of gestation and less than 36 weeks gestational age. This includes live born and stillborn deliveries

Code '9' for unknown

NUMBER OF PREVIOUS PRE-TERM DELIVERIES IN EACH CATEGORY

Enter the number occurring within the appropriate gestational age category.

Found on the 'PRENATAL RECORD'.

Previous PTD < 28 6/7 weeks (28 completed weeks)

Previous PTD 29 0/7 to 32 6/7 weeks # Previous PTD 33 0/7 to 36 6/7 weeks # Previous PTD weeks unspecified

NUMBER OF PREVIOUS LOW BIRTH WEIGHT INFANTS

Number of previous infants with birth weight less than or equal to **2499 grams** (5 lbs. 8 oz.).

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

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 FORM'.

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 prepregnancy, with the following **exceptions**:

- O Patient did not smoke pre-pregnancy
- 75 Patient smoked ≥ 75 cigarettes per day prepregnancy
- Patient known to be a smoker pre-pregnancy, but number of cigarettes smoked per day is unknown
- Not indicated whether or not the patient smoked prepregnancy

NOTE: ½ 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.

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 first prenatal visit, with the following **exceptions**:

- O Patient did not smoke at the time of the first prenatal visit
- 75 Patient smoked ≥ 75 cigarettes per day at the time of the first prenatal visit
- Patient known to be a smoker pre-pregnancy, but number of cigarettes smoked per day is unknown
- Not indicated at the first prenatal visit whether or not the patient smoked before she was pregnant.

NOTE: ½ 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.

SMOKING AT 20 WEEKS

Number of cigarettes smoked per day at the time of prenatal visit from 18-22 weeks.

Found on the 'PRENATAL RECORD'.

Code the number of cigerettes smoked per day at the time of prenatal visit from 18-22 weeks, with the following **exceptions:**

- O Patient did not smoke at the time of prenatal visit from 18-22 weeks.
- 75 Patient smoked.≥ 75 cigarettes per day at the time of prenatal visit from 18-22 weeks.
- 88 Patient known to be a smoker but number of cigarettes smoked per day is unknown at the time of prenatal visit from 18-22 weeks.
- 99 Not indicated at time of prenatal visit from 18-22 weeks or not the patient smoked.

Note: ½ 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.

HIGHEST LEVEL OF EDUCATION

Highest level of education completed.

Found on the 'PRENATAL RECORD'.

- Less than Secondary Education (Some High School)
- 2 Secondary Education (Completion of High School)
- Technical/ Some Post Secondary Education (Community College or working on a Bachelor's Degree)
- 4 Post Secondary Education (Completion of a Bachelor's Degree ie. Arts, Commerce or Science)
- 5 Graduate Level (Completion of Masters Degree ie. Masters in Nursing or Education)
- 6 Post Graduate Level (Completion of Doctorate ie. Doctor of Philosophy)
- 7 Professional Degree (ie. Physician, Lawyer, or Dentist)

Code '99' for unknown

MATERNAL RACE/ ETHNICITY

Maternal Race/ Ethnicity.

Found on the 'PRENATAL RECORD'.

Choose ALL applicable categories documented on the "Prenatal Record"

ACA Acadian

AFC African Canadian

ASN Asian

CAU Caucasian

FNA First Nations

HIS Hispanic

JSH Jewish

MED Mediterranean

MDE Middle Eastern

QUE Quebecois

OTH Other

Code '999' for Unknown

INTENT TO BREASTFEED

Maternal intention to breastfeed.

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

Code using one of the following:

Y Yes

N No

U Unsure

Code '9' for Unknown

PRE-PREGNANCY WEIGHT

Maternal pre-pregnancy weight.

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

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.

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

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

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

Code '999' for unknown.

MATERNAL HEIGHT

Maternal Height.

Found on the 'PRENATAL RECORD'.

Refers to mother's height in feet and inches or centimeters

For measurements in feet and inches round up to the next whole number for inches. Example: 5' 3.5" record as 5' 4".

For measurements in centimeters round up to the next whole number. Example: 150.6cm record as 151cm.

Code '999' in the centimeters field for an unknown value.

ATTENDANCE AT PRENATAL CLASSES OR RECEIVED ANY PRENATAL EDUCATION

Maternal attendance at any prenatal classes or education such as videos, seminars or other educational tools

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

Code for <u>current</u> pregnancy only.

Code using one of the following:

Y Yes

N No

Code '9' for unknown

SMOKING AT TIME OF ADMISSION

Number of cigarettes smoked per day at time of the delivery.

Found on the 'MATERNAL ADMISSION ASSESSMENT FORM', the 'MATERNAL NURSING REASSESSMENT FORM' or the 'PHYSICIAN'S ASSESSMENT FORM'

If none of these forms are present or the information is missing, if the most recent prenatal visit documented is within 7 days of the delivery admission and smoking data were recorded at that visit enter that number.

If there is no information about maternal smoking within 7 days of the delivery admission, code 99 for unknown.

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

- 0 Patient did not smoke at the time of delivery
- 75 Patient smoked ≥ 75 cigarettes per day at the time of delivery
- 88 Patient known to be a smoker at the time of delivery, but number of cigarettes smoked per day is unknown.
- 99 Not indicated whether or not the patient smoked at the time of delivery.

NOTE: ½ 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

PRESENT WEIGHT

Patient's weight just before delivery.

Found on the 'MATERNAL ADMISSION ASSESSMENT FORM', **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.
$$60.2 \text{ kg} = 60 \text{ kg}$$

 $60.7 \text{ kg} = 61 \text{ kg}$

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.

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 FORM' or the 'MATERNAL ADMISSION ASSESSMENT FORM'...

Use one of the following codes:

- 1 Singleton
- 2 Twins
- 3 Triplets
- 4 Quadruplets
- 5 Quintuplets

MATERNAL ULTRASOUND

Maternal Ultrasound.

Found on an 'ULTRASOUND REPORT' within the chart.

Indicate Y if an ultrasound report is on the chart. When Y is entered, the ultrasound screen will pop up. Enter appropriate values.

If there is no ultrasound report on the chart but it is documented that the patient had an ultrasound, record **Y** indicating that the patient had an ultrasound and click the box stating ultrasound done but no values recorded.

If there is no ultrasound report on the chart and it is not documented that an ultrasound has been done record **N**.

FETUS NUMBER

This column holds a value to differentiate between ultrasound studies for multiple births.

For singleton pregnancies, the number will always be 1.

In multiple pregnancies, fetus # 1 for first reported baby, fetus # 2 for second, etc.

If there is no indication of an ultrasound being done, leave field blank.

DATE OF FIRST ULTRASOUND

Date of **earliest** ultrasound during this pregnancy where measurements or gestational age of the fetus are recorded.

Found on the 'ULTRASOUND REPORT'.

Use the following date format: 'YYYYMMDD'.

If there is no indication of an ultrasound being done, leave field blank.

NO APPLICABLE DATA RECORDED

No Applicable Data Recorded

If it is indicated on the chart that an Obstetrical Ultrasound was done but none of the applicable values recorded click the NAD box to indicate this fact.

CHOOSE APPLICABLE CATEGORY

Choose a category dependent on the manner in which the data on the earliest Ultrasound is reported.

Chose Applicable Category:

Measurements Gestational Age

If the earliest Ultrasound is reported in both category types, choose one and enter the data in that category completely.

CROWN/RUMP LENGTH MEASUREMENT

Crown/rump length recorded as a measurement during the first ultrasound done in this pregnancy.

Found on the 'ULTRASOUND REPORT'.

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

Decimal points must be entered.

If the crown rump length is completed by 14 6/7 weeks gestation, capture this measurement only.

If the crown/rump length is <u>not</u> recorded on the first ultrasound (with measurements) for this pregnancy, leave this field blank, and record values for the following four variables: **biparietal diameter**, **head circumference**, **abdominal circumference**, and **femur length**.

If the **crown/rump** length is recorded you do not have to fill in the other values.

BIPARIETAL DIAMETER MEASUREMENT

Biparietal diameter recorded as a measurement during the first ultrasound done in this pregnancy.

Found on the 'ULTRASOUND REPORT'.

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

Decimal points must be entered.

If the **crown/rump length** measurement has been recorded, leave this field blank.

HEAD CIRCUMFERENCE MEASUREMENT

Head circumference recorded as a measurement during the first ultrasound done in this pregnancy.

Found on the 'ULTRASOUND REPORT'.

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

Decimal points must be entered.

If the **crown/rump length** measurement has been recorded, leave this field blank.

ABDOMINAL CIRCUMFERENCE MEASUREMENT

Abdominal circumference recorded as a measurement during the first ultrasound done in this pregnancy.

Found on the 'ULTRASOUND REPORT'.

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

Decimal points must be entered.

If the **crown/rump length** measurement has been recorded, leave this field blank.

FEMUR LENGTH MEASUREMENT

Femur length recorded as a measurement during the first ultrasound done in this pregnancy.

Found on the 'ULTRASOUND REPORT'.

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

Decimal points must be entered.

If the **crown/rump length** measurement has been recorded, leave this field blank.

CROWN/RUMP LENGTH GESTATIONAL AGE

Crown/rump length recorded as gestational age (in weeks and days) during the first ultrasound done in this pregnancy.

Found on the 'ULTRASOUND REPORT'.

Use the following format: weeks and days.

If the crown rump length is completed by 14 6/7 weeks gestation, capture this gestational age only.

If the crown/rump length gestational age is <u>not</u> recorded on the first ultrasound (in weeks and days) for this pregnancy, leave this field blank, and record values for the following four variables: **biparietal diameter** gestational age, **head circumference** gestational age, **abdominal circumference** gestational age, and **femur length** gestational age.

If the **crown/rump length** gestational age is recorded you do not have to fill in the other values

BIPARIETAL DIAMETER GESTATIONAL AGE

Biparietal diameter recorded as gestational age (in weeks and days) during the first ultrasound done in this pregnancy.

Found on the 'ULTRASOUND REPORT'.

Use the following format: weeks and days.

If the **crown/rump length** gestational age has been recorded, leave this field blank.

HEAD CIRCUMFERENCE GESTATIONAL AGE

Head circumference recorded as gestational age (in weeks and days) during the first ultrasound done in this pregnancy.

Found on the 'ULTRASOUND REPORT'.

Use the following format: weeks and days.

If the **crown/rump length** gestational age has been recorded, leave this field blank.

ABDOMINAL CIRCUMFERENCE GESTATIONAL AGE

Abdominal circumference recorded as gestational age (in weeks and days) during the first ultrasound done in this pregnancy.

Found on the 'ULTRASOUND REPORT'.

Use the following format: weeks and days.

If the **crown/rump length** gestational age has been recorded, leave this field blank.

FEMUR LENGTH GESTATIONAL AGE

Femur length recorded as gestational age (in weeks and days) during the first ultrasound done in this pregnancy.

Found on the 'ULTRASOUND REPORT'.

Use the following format: weeks and days.

If the **crown/rump length** gestational age has been recorded, leave this field blank

MATERNAL SCREENING TEST

Found on 'LAB REPORTS', 'DIAGNOSTIC IMAGING REPORTS' or documented on the 'PRENATAL RECORD'.

Review Lab/Diagnostic Imaging Reports for evidence that specified screening tests were done. If Lab/Diagnostic Imaging Reports are not available, review the Prenatal Record for evidence that the screening was done or not done.

If there is no documentation indicate Unknown.

Group B Strep Screening (usually done at 35-37 weeks)

Y = Yes - done

N = No - not done

U = Unknown

Nuchal Translucency

Y = Yes - done

N = No - not done

U = Unknown

HIV Testing

Y = Yes - done

D = Declined

U = Unknown

N= No - not, done

Maternal Serum

Y = Yes - done

D = Declined

U = Unknown

N= No - not, done

Capture as Yes if only one of the two tests/screens have been completed.

^{*} Nuchal Translucency is an ultrasound review done between 10 and 14 weeks gestation only and reported as nuchal translucency. Do not capture as Yes if noted as nuchal fold or nuchal thickness.

DISCHARGE DATE

Mother's discharge date from hospital.

Found on the 'NURSES NOTES'.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME

Mother's discharge time from hospital.

Found on the 'NURSES NOTES'.

Use the following format: 'HHMM'.

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

If discharge time is not documented leave blank and code '9' in the field immediately following.

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 10-14 or use one of the following codes:

- -9 Maternal death
- 0 Home

MATERNAL PRIMARY CAUSE OF DEATH

Found on 'DEATH CERTIFICATE" or stated by the physician.

This field will autofill if mother lived.

Use **one** of the following options:

77777 Lived OTHR Other

PEMB Pulmonary Embolus PPHM Postpartum Hemorrhage

STRK Stroke

AUTOPSY

Completion of maternal autopsy.

Found on the "DEATH CERTIFICATE" or the 'AUTOPSY REPORT'.

The field will Autofill if the mother lived.

Code using one of the following:

LVD Lived (not applicable)Y Died and autopsy doneN Died but autopsy not done

MATERNAL STEROID THERAPY

Found on the 'MEDICATION SHEET' or on the 'PRENATAL RECORD'

Code the earliest dose of the first course of treatment. For stillbirths, estimate duration of therapy to time of delivery.

In the case of multiples code for birth order 1 only. Code one of the following:

Dexamethasone

- 1 <24 hours before delivery
- 2 24 to 48 hours before delivery
- 3 >48 hours but less than or equal to 7 days before delivery
- 4 >7 days before delivery
- 5 Unknown when administered

Betamethasone (Celestone)

- 6 <24 hours before delivery
- 7 24 to 48 hours before delivery
- 8 >48 hours but less than or equal to 7 days before delivery
- 9 >7 days before delivery
- 10 Unknown when administered

Unknown Steroid

- 11 <24 hours before delivery
- 12 24 to 48 hours before delivery
- 13 >48 hours but less than or equal to 7 days before delivery
- 14 >7 days before delivery
- 15 Unknown when administered

ANALGESIA ADMINISTERED DURING LABOUR

(Exclude antepartum stillbirths)

Found on the 'BIRTH RECORD', MEDICATION SHEETS' or the PARTOGRAM'.

Choose only <u>one</u> drug and the route administered. Choose the drug administered **closest** to the time of delivery.

Drug

1	Demerol (Meperidine)
2	Dilaudid (Hydromorphone HCI)
3	Fentanyl (Sublimaze)
4	Largactil (ChlorpromazineTranquillizer)
5	Morphine (includes Opium;Pantopon)
6	Nembutal (Pentobarbital Hypnotic)
7	Nubain (Nalbuphine)
8	Phenergan (PromethazineTranquillizer)
9	Seconal (Secobarbital)
10	Sparine (Promazine Tranquillizer)
11	Talwin (Pentazocine)
12	Tuinal (Amo-Secobarb Hypnotic)
13	Valium (Diazepam Tranquillizer)
14	Other Specified Analgesia During Labour

ROUTE OF ADMINISTRATION

Choose only <u>one</u> route of administration for the drug given closest to the time of delivery

- 1 Unknown route, < 1hr. prior to delivery
- 2 Unknown route, 1 to <2 hr. prior to delivery
- 3 Unknown route, 2 to 4 hr. prior to delivery
- 4 Unknown route, >4 hr. prior to delivery
- 5 I.M., < 1hr. prior to delivery
- 6 I.M., 1 to <2 hr. prior to delivery
- 7 I.M., 2 to 4 hr. prior to delivery
- 8 I.M., >4 hr. prior to delivery
- 9 I.V., <1 hr. prior to delivery
- 10 I.V., 1 to <2 hr. prior to delivery
- 11 I.V., 2 to 4 hr. prior to delivery
- 12 I.V., >4 hr. prior to delivery

ANTIBIOTIC THERAPY ADMINISTERED DURING ANTEPARTUM PERIOD

Antibiotic therapy administered during the antepartum period.

Found on the 'BIRTH RECORD', 'MEDICATION SHEETS' or the 'PARTOGRAM'.

If documented, enter 'Y' for YES. If no antiboitics were administered, leave blank

Code Y if antibiotic is given during the admission, even if it is for a non-pregnancy related condition.

If the antibiotic therapy was started before the admission and is still being taken during the admission, code the time and date started within 10 days of admission if documented. If the mother was on antibiotics prior to admission and the date is not documented, record unknown.

ANTIBIOTIC THERAPY ADMINISTERED DURING INTRAPARTUM PERIOD (NOT GBS)

Antibiotic therapy administered during the intrapartum period (not GBS), **including administration during C-Section.**

Found on the 'BIRTH RECORD', 'MEDICATION SHEETS' or the 'PARTOGRAM'.

If documented, enter 'Y' for YES. If no antibiotics were adminstered, leave blank.

Code Y if antibiotic is given during the admission, even if it is for a non-pregnancy related condition.

ANTIBIOTIC THERAPY ADMINISTERED DURING POSTPARTUM PERIOD

Antibiotic Therapy administered during Postpartum Period

Found on the 'BIRTH RECORD', 'MEDICATION SHEETS' or the 'PARTOGRAM'

If documented, enter 'Y' for YES. If no antibiotics were administered, leave blank.

Code Y if antibiotic is given during the admission, even if it is for a non-pregnancy related condition.

PROPHYLAXIS FOR GBS ADMINISTERED DURING INTRAPARTUM PERIOD

Prophylaxis for GBS administered during Intrapartum Period

Found on the 'BIRTH RECORD', 'MEDICATION SHEETS' or the 'PARTOGRAM'

.If documented, enter 'Y' for YES. If an antibiotic is given as prophylaxis for GBS, enter a Y in that field only. If no antibiotics were adminstered, leave blank.

ANTIBIOTIC DATE

Date antibiotic therapy first given.

Found on 'MEDICATION SHEETS'.

Use the following format: 'YYYYMMDD'.

Record the date of the first antibiotic therapy given to the mother during the hospital stay.

If date of first antibiotic therapy is not documented, leave date field blank and enter '9' in the field immediately following.

If the mother was on antibiotics at admission, enter the date of the start of the antibiotic before admission,

if documented. If the mother was on antibiotics prior to admission and the date not documented, record unknown.

Enter '9' in this field to indicate the date antibiotic therapy first given is missing.

ANTIBIOTIC TIME

Time antibiotic therapy first given.

Found on 'MEDICATION SHEETS'.

Use the following format: 'HHMM'.

'HH' is in range 0-23, 'MM' is in range 0-59.

Record the time of the first antibiotic therapy given to the mother during the hospital stay

If time of first antibiotic therapy is not documented, leave time field blank and enter '9' in the field immediately following.

If the mother was on antibiotics at admission, enter the time of the start of the antibiotic before admission, if documented. If the mother was on antibiotics prior to admission and the time not documented, record unknown.

Enter '9' in this field to indicate the time antibiotic therapy first given is missing.

PROCESS STATUS

Indicates the coding status of delivered routine information.

Select one of the following:

- 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.

Once data has been 'frozen' (status 4 or 5), any necessary changes or corrections must be forwarded to the Clinical Data Coordinator at RCP.

ROUTINE INFORMATION - LABOUR

BIRTH ORDER

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
- 5 Fifth born of multiples

-etc-

DATE OF RUPTURE OF MEMBRANES

Date of rupture of membranes (ROM).

Found on the 'BIRTH RECORD'.

Use the following format: 'YYYYMMDD'.

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' where 'HH' is in the range of 0-23 and 'MM' is in the range of 0-59.

If there is more than one rupture of membranes, record the earliest time. If the patient has a 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 is 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 (ROM).

Found on the 'BIRTH RECORD'.

Code using one of the following:

S Spontaneous

A Artificial

C Suspected

9 Unknown

If there is more than one rupture of membranes, code the type based on the first rupture of membranes.

If the patient has a C-section and there is no history of prior rupture of membranes, code the type of rupture as 'artificial'.

Code Suspected if documented as suspected on the Birth Record with no other documentation of an actual time or date of a spontaneous or artificial rupture of membranes.

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 '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)
- A Attempted Induction. This is to be used if an attempt at inducing labour has been made but no labour happens. (Failed induction)

If the cervical dilatation is ≥ 3 cm **and** regular contractions are present when the oxytocin and/or prostin is initiated, code labour as spontaneous (S).

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

INDICATION FOR INDUCTION OF LABOUR

Reason for induction of labour.

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

Code using one of the following:

- 0 Not induced
- 1 Elective
- 2 Fetal growth restriction
- 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
- 17 Multiple pregnancies
- 18 PUPP
- 19 Cholestatic jaundice
- 20 Thrombocytopenia
- 21 Previous fetal death/poor obstetrical history
- 22 Seizure
- 23 Macrosomia
- 24 No indication given
- 25 Advanced maternal age
- 26 Maternal request
- 27 Vaginal bleeding
- 28 Positive Group B Strep with rupture of Membranes

INDUCTION OR ATTEMPT AT INDUCTION OF LABOUR PLACE

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

- 1 Inpatient
- 2 Outpatient
- 3 Both inpatient and outpatient

Code '9' for unknown

INDUCTION OR ATTEMPT AT INDUCTION OF LABOUR (METHODS/AGENTS)

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

If labour was induced, enter "Y" for each documented method/agent used in an attempt to induce labour.

Artificial rupture of membranes, if clearly stated to induce labour

Y = Yes

Cervical Catheter

Y = Yes

Oxytocin

Y = Yes

If Oxytocin is given, when you enter Y, the date and time fields immediately following will open to be entered.

OXYTOCIN DATE

Date oxytocin therapy first given.

Found on 'PARTOGRAM'.

Use the following format: 'YYYYMMDD'.

If date of Oxytocin therapy is not documented, leave date field blank and enter '9' in the field immediately following.

If Oxytocin is administered more than one time during a delivered admission, record the date of the administration that started labour and resulted in the delivery of an infant(s).

OXYTOCIN TIME

Time oxytocin therapy first given.

Found on 'PARTOGRAM'.

Use the following format: 'HHMM'.

'HH' is in the range of 0-23, 'MM' is in the range of 0-59.

If time of Oxytocin therapy is not documented, leave time field blank and enter '9' in the field immediately following.

If Oxytocin is administered more than one time during a delivered admission, record the time of the administration that started labour and resulted in the delivery of an infant(s).

INDUCTION OR ATTEMPT AT INDUCTION OF LABOUR METHODS/AGENTS (con't)

Prostaglandin Oral Y = Yes

Prostaglandin Vaginal or Cervical Y = Yes

Other Specified Agents Y = Yes

If method/agent of induction is **not known or documented**, code 9 in the Artificial Rupture of Membranes field to indicate Unknown.

DATE OF ADMISSION TO LABOUR/DELIVERY ROOM

Date of admission to the labour and delivery room and delivered before discharged from the unit.

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

Use the following format: 'YYYYMMDD'.

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 and delivered before discharged from the unit.

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

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

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 and delivered before discharge from the unit.

Found on the 'PARTOGRAM'.

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

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

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

9 Unknown

7 Not applicable

DATE OF MEDICAL AUGMENTATION

Date of initiation of Oxytocin administration for medical augmentation.

Found on the 'PARTOGRAM'.

Use the following format: 'YYYYMMDD'

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

TIME 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 DILATION AT TIME OF MEDICAL AUGMENTATION

Cervical dilatation at time of medical augmentation.

Found on the 'PARTOGRAM'.

Code using the following format: 'XX' where 'XX' represents the dilation in centimeters.

Round the dilatation down to the nearest centimeter, 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 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 4 cm.

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

Use the following format: 'YYYYMMDD'.

Code when first indicated by physician or nurse.

If the patient goes into labour, but has a C-section AND dilatation at C-section is <4 cm, leave '4 cm date' blank, and code '7' in the field immediately following.

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

TIME WHEN CERVICAL DILATATION AT 4 CENTIMETRES

Time when cervical dilatation at 4 cm.

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 not recorded on the Partogram, but dilatation before and after 4 cm is recorded, estimate the time when dilatation would have been 4 cm.

If the patient goes into labour, but has a C-section AND dilatation at C-section is <4 cm, leave '4 centimetres time' blank, and code '7' in the field immediately following.

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

INITIAL MOTHER AND BABY CONTACT

Found on the 'PARTOGRAM OR NURSES NOTES'

Code using one of the following:

Y Yes, the boxes skin to skin contact inititiated

or baby to breast have been ticked

N No, if no skin to skin contact or baby to

breast is indicated

9 Unknown, if none of the applicable boxes are

checked.

DATE OF ONSET OF SECOND STAGE OF LABOUR

Defined as full cervical dilatation (10 cm).

Found on the 'BIRTH RECORD'.

Use the following format: 'YYYYMMDD'.

If the patient goes into labour, but does not get to second stage prior to having C-section, leave 'Stage 2 Date' blank, and code '7' in the field immediately following.

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

TIME OF ONSET OF SECOND STAGE OF LABOUR

Defined as full cervical dilatation (10 cms).

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 'Stage 2 Time' blank, and code '7' in the field immediately following.

If time of stage 2 is unknown, leave 'Stage 2 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 T and J incision. (This refers to the uterine
	incision, not skin incision.)
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:

ACH Forceps to after-coming head (**Breech - vaginal** delivery only)

BRE Breech extraction (Vaginal delivery only)

CSF C-section with forceps CSV C-section with vacuum

CSC C-section with vacuum and 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 FVC Attempted forceps and vacuum followed by C-section using forceps and/or vacuum

FVV Attempted forceps followed by vacuum vaginal delivery

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 VCV Attempted vacuum followed by C-section using forceps and/or vacuum

999 Unknown method of delivery

CERVICAL DILATATION DURING LAST EXAM PRIOR TO C-SECTION

Cervical dilatation during last exam prior to C-section.

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

Code using the following format: 'XX' where 'XX' represents the dilation in centimeters.

Round the dilatation down to the nearest centimeter, 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 Persistent occiput posterior (ROP, LOP, OP)

SHL Shoulder presentation

VTX Vertex (includes LOA, ROA, OT, ROT, LOT, OA,

Transverse)

999 Unknown

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 FORM' when the patient is admitted for delivery is vertex, code VTX.

If the position has been rotated during the delivery or prior to delivery, code the position the baby is currently in at the time of delivery. For example was POP and manually rotated to LOA in time of delivery. Code position at delivery as LOA

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
- 9 Unknown

BIRTH WEIGHT

Infant's birth weight. First weight noted after birth.

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

If an infant (≥500 gms or gest. ≥20 weeks) was born dead or died after birth and was not weighed, code '9999'.

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 AT 1 MINUTE APGAR score at 1 minute.

Found on the 'BIRTH RECORD'.

Code between 0 and 10 for APGAR score.

Code '99' for unknown.

'77' for fetal death will autofill

APGAR SCORE AT 5 MINUTES APGAR score at 5 minutes

Found on the 'BIRTH RECORD'.

Code between 0 and 10 for APGAR score.

Code '99' for unknown.

'77' for fetal death will autofill

APGAR SCORE AT 10 MINUTES APGAR score at 10 minutes.

Found on the 'BIRTH RECORD'.

Code between 0 and 10 for APGAR score.

Code '99' for unknown.

'77' for fetal death will autofill

CARE PROVIDER ATTENDING DELIVERY

The care provider attending the delivery.

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

Code using the Provincial Medical Board Number or Provider Number for Midwives.

Code '88888' - if physician is not registered in Nova Scotia.

Code '99999' - if unknown.

PRIMARY INDICATION FOR C-SECTION

Primary Indication for C-Section.

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

Code using one of the following:

AMA Advanced Maternal Age APL Abruption placenta

BCH Breech DBT Diabetes

CXD Diseases of the cervix

DYS Dystocia (Cephalopelvic disproportion, (C.P.D.), Failureto-progress, Maternal exhaustion, Cervical stenosis POP, OP)

FID Failed induction FDS Fetal distress

FGT Fetal growth restriction (*retardation*)
HIV Human Immunodeficiency Virus
HSV Maternal herpes simplex infection

HTD Hypertensive disorders

ISO Isoimmunization

MAC Macrosomia suspected

MAT Maternal choice (excludes due to previous c-section)
MLP Malpresentation (e.g. shoulder, brow, face; exclude breech and transverse lie)

MTP Multiple pregnancy

OOC Other obstetrical conditions

OFC Other fetal conditions
PCS Previous C-section
PLC Prolapsed cord

PLP Placenta previa

PTD Previous Traumatic Delivery (eg. 3rd or 4th degree tear)

_

PRIMARY INDICATION FOR C-SECTION (con't)

PMC Postmortem C-section

PRM Prolonged rupture of membranes

SFA Suspected fetal anomaly

SUR Suspected/imminent uterine rupture

TLI Transverse Lie (include unstable lie and oblique lie)

UTS Uterine surgery, previous

VAG Vaginal delivery (i.e. not applicable)

999 Unknown

ROUTINE INFORMATION - INFANT

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

Found on the health record folder or the 'HOSPITAL

ADMISSION FORM'

In a fetal death this field will auto fill '777777777'.

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

Found on the 'HOSPITAL ADMISSION FORM''.

SURNAME Infant's surname.

Found on the 'HOSPITAL ADMISSION FORM'.

<u>SEX</u>

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

DATE OF INFANT'S BIRTH

Date of infant's birth.

Found on the 'BIRTH RECORD'.

Use the following format: 'YYYYMMDD'.

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.

<u>DATE OF INFANT'S</u> ADMISSION TO HOSPITAL

Date of infant's admission to hospital

Found on the 'HOSPITAL ADMISSION FORM'

Date of infant's admission to hospital where abstract is coded. Will usually be the same as the birth date. Will be different when the baby was born at home and subsequently needed to be admitted to hospital; en route to hospital; or in a non-obstetric hospital.

Use the following format: 'YYYYMM

BABY NOT ADMITTED TO HOSPITAL

If Infant was not admitted to hospital but Mother was, contact RCP Clinical Data Coordinator

TIME OF INFANT'S ADMISSION TO HOSPITAL

Time of infant's admission to hospital.

Found on the 'HOSPITAL ADMISSION SHEET'

Time of infant's admission to hospital where abstract is coded. Will usually be the same as the birth time. Will be different when the baby was born at home and subsequently needed to be admitted to hospital; en route to hospital; or in a non-obstetric hospital. Use the following format 'HHMM'.

'HH is in the range of 0-23, 'MM' is in the range of 0-59.

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 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: 'CCNNNNNNN/YY' where "CC" is the admit type, "NNNNNNN" is an ascension number related to the number of admissions of the year and "YY" denotes the fiscal year (April 1 to March 31), changing on April 1st of each year. The / has to be entered before the YY denoting the fiscal year.

Zeroes before the ascension number must be entered if number does not have 7 digits, e.g. AS0000123/05.

In a fetal death this field will autofill to '77777777777'.

INFANT'S HEALTH CARD NUMBER

Infant's health card number.

Found on the 'HOSPITAL ADMISSION FORM'.

Record the patients **Nova Scotia** Health Card Number or the hospital generated '8000' number for;

Nova Scotia residents admitted without a Nova Scotia Health Card Number

Patients from outside Nova Scotia

If a Nova Scotia Health Card Number or hospital generated '8000' number is not available, code;

- 0 Nova Scotia patient, card not available
- 0 Armed Forces
- 0 RCMP
- 0 First Nations
- 0 Self-paying
- 1 Patient from outside Nova Scotia
- 7 will auto fill for fetal deaths

INFANT'S ATTENDING CARE PROVIDER(PMB#)

Care provider most responsible for care of the infant while in hospital.

Found on the 'HOSPITAL ADMISSION FORM'.

Code using the Provincial Medical Board Number or Provider Number for Midwives.

Code '88888' if physician is not registered in Nova Scotia. Code '99999' for unknown.

In a fetal death this field will autofill to '77777'.

INFANT LENGTH

Found on 'PHYSICIANS NEWBORN ASSESSMENT FORM' or 'NEWBORN NURSING ASSESSMENT FORM'.

Refers to infant length in centimeters (cm).

Enter length in centimetres, rounding to the closest whole number. Example: 51.7 cms record as 52 cms.

Enter '99' for an unknown value.

HEAD CIRCUMFERENCE

Found on 'PHYSICIANS NEWBORN EXAMINATION FORM' or 'NEWBORN NURSING ASSESSMENT' FORM'.

Refers to infant head circumference in centimeters (cm).

Enter head circumference in centimeters, rounding to the closest whole number. Example: 39.7 cms record as 40 cms.

Enter '99' for an unknown value.

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 FORM' or the 'NEWBORN BIRTH ASSESSMENT FORM' or clearly stated by the physician.

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

Documented as	Use:
38+ weeks	38
38-40 weeks	39
38-39 weeks	38
> 39 weeks	39
Term	40
Not documented	99 (unknown)

SCN ADMISSION

Infant admitted to the Special Care 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:

Υ Yes Ν No

If 'Y' is entered, complete the SCN screen by entering 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. Continue until all SCN admissions are recorded.

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

FTD

BREASTFEEDING

Record one of the following to indicate the method of feeding during the hospital stay.

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

Code using one of the following:

E Breast milk was exclusively given, breast milk, or expressed breast milk (EBM) during the hospital stay

Cannot be given any food or liquid other than breast milk. Exception: May be given undiluted drops of syrups consisting of vitamins, mineral supplements, or medicines. Breast milk may be given by the mother, health care provider or family member/supporter.

If the baby was given breast milk and water or glucose water record as breast milk and formula

N Baby was not given any breast milk or expressed breast milk during hospital stay

S Baby was given both breast milk and other supplements, e.g formula, water, glucose water during hospital stay

There is no documentation as to how the baby was fed during the hospital stay

9

INFANT'S DISCHARGE DATE

Discharge date of infant's admission to the hospital of birth.

Found in the 'NURSES NOTES'.

Use the following format: 'YYYYMMDD'.

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.

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 10-14 or use one of the following codes:

- 0 Home
- -9 Infant Death

AUTOPSY

Completion of infant autopsy.

Found on the 'NEWBORN CODING SHEET' "DEATH CERTIFICATE" or the 'AUTOPSY REPORT'.

Code using one of the following:

LVD Lived (not applicable)Y Died and autopsy doneN Died but autopsy not done

INFANT'S PRIMARY CAUSE OF DEATH

Found on the 'AUTOPSY REPORT' or stated by the physician.

Use **one** of the following codes:

7777	Infant lived			
ABRP	Abruptio placenta			
ANEC	Acute necrotizing enterocolitis			
OAIR	Airway failure			
AMNO	Amniocentesis			
ANAL	Analgesia or anaesthesia			
ASPN	Aspiration			
CPDP	Chronic pulmonary disease			
COTR	Complications of treatment			
ANOM	Congenital anomaly			
CRLK	Cord loops and/or knots			
CDOT	Cord, miscellaneous			
CORP	Cord prolapse			
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			
IVTF	Intravascular transfusion			
ISOM	Isoimmunization			
KERN	Kernicterus			
MALP	Malpresentation			
DIAB	Maternal diabetes			
SHOC	Maternal shock			
MUSF	Multi-system failure			
MINF	Myocardial infarction			
NEOP	Neoplasia			
TTTX	Twin-to-twin transfusion (Parabiotic 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 PPHN Primary Pulmonary hypertension PULH Primary pulmonary hemorrhage

RUPU Ruptured uterus

SIDS Sudden Infant death syndrom

THAB Therapeutic abortions

TOXM Toxemia

TRAS Tracheal stenosis
TRAU Trauma (obstetrical)

UNEX Unexplained

UXPA Unexplained peripartum asphyxia

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: 'YYYYMMDD'.

If death date is unknown, leave 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 death time is unknown, leave blank and code '9' in the field immediately following.

CORD ARTERY pH

Cord artery pH completed.

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

Code using one of the following:

Y Yes N No

9 Unknown

CORD ARTERY pH VALUE

Cord artery pH value.

Found on the 'LAB REPORTS'.

Use the following format: 'X.XX'

Decimal point 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.

If it is outside this range and valid contact the RCP Clinical Data Coordinator.

Code '99' for unknown

77 will autofill for not applicable or fetal death.

pCO₂ VALUE

pCO₂ value.

Found on the '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.

If it is outside this range and valid contact the RCP Clinical Data Coordinator.

Code '999' for unknown.

777 will autofill for not applicable or fetal death.

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

If it is outside this range and valid contact the RCP Clinical Data Coordinator.

Code '99' for unknown.

77 will autofill for not applicable or fetal death.

FETAL MALNUTRITION/ SOFT TISSUE WASTING

Fetal malnutrition or soft tissue wasting.

Found in the 'DISCHARGE SUMMARY' or NEONATOLOGIST'S LISTING'

Choose one of the following:

- 1 Moderate Wasting
- 2 Severe Wasting

TWIN TYPE

Found on the 'DISCHARGE SUMMARY' or 'NEONATOLOGIST'S LISTING'

Choose one from the following list:

- 1 Monoamniotic (one amniotic sac)
- 2 Monochorionic, diamniotic
- 3 Dichorionic, dissimilar sexes or blood groups
- 4 Dichorionic, similar sexes and blood groups
- 5 Dichorionic, similar sexes, blood groups
 - undetermined
- 6 Undetermined
- 7 Siamese (Conjoined) twins

ELECTIVE NON-RESUSCITATION

Found on the 'DISCHARGE SUMMARY' or 'NEONATOLOGIST'S LISTING'.

Choose from the following list:

- 1 Do not resuscitate order on chart
- 2 Withdrawal of ventilator care with do not

resuscitate order on chart

3 Non-resuscitation in labour and delivery room

RETINOPATHY OF PREMATURITY

Found on the 'DISCHARGE SUMMARY'.

Code one of the following:

1	Stage 1	Peripheral vascular
		straightening
2	Stage 2	Peripheral shunt well seen
3	Stage 3	Vessels growing into vitreous
4	Stage 4	Retinal detachment

CHROMOSOMAL ABNORMALITIES

Found on 'GENETICS REPORT' or 'NEONATOLOGIST LISTING'

Code one chromosomal abnormality from the listing:

- 1 Aneuploidy
- 2 Chimerism
- 3 Mosaicism
- 4 Triploidy
- 5 Deletion
- 6 Duplication
- 7 Microdeletion
- 8 Monosomy
- 9 Ring
- 10 Tandem repeat
- 11 Trisomy
- 12 Uniparental disomy
- 13 Translocation

Please note that chromosome numbers are from 1 to 23 and X and Y.

If Aneuploidy, Chimerism or Triploidy are selected you DO NOT have to code the chromosome affected, the affected arm (p or q) or the site on the arm.

If Mosaicism, Deletion, Duplication, Microdeletion, Monosomy, Ring, Tandem Repeat, Trisomy or Uniparental Disomy are selected code also the affected chromosome. You DO NOT have to code the affected arm (p or q) or the site on the arm if not documented.

If Translocation is selected <u>two</u> chromosomes should be coded. You DO NOT have to code the affected arm (p or q) or the site on the arm if not documented.

ROUTINE INFORMATION-UNDELIVERED

UNDELIVERED ADMISSION

Any admission of a woman to a facility during pregnancy in which a delivery does not take place.

ADMITTED FROM

Patient'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 10-14.

If patient comes from home, code '0'.

If patient comes from the Emergency room of another facility without having been admitted to the facility, code '0', admitted from home.

GRAVIDA

The number of pregnancies, <u>including the present pregnancy</u>.

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

Code '99' for unknown.

PARA

The number of pregnancies, <u>excluding</u> the <u>present pregnancy</u>, which resulted in one or more infants weighing 500 grams or more at birth or 20 weeks gestation or greater gestational age regardless of whether such infants were stillborn, died after birth or lived.

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

Code '99' for unknown.

ABORTIONS

The number of pregnancies, <u>excluding the present pregnancy</u>, 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 FORM'.

Code '99' for unknown.

SPONTANEOUS ABORTIONS

Number of Spontaneous Abortions

Enter the number occurring within the documented category.

Found on the 'PRENATAL RECORD

Code '99' for unknown if it is not documented to indicate the number of the category.

THERAPEUTIC ABORTIONS

Number of Therapeutic Abortions

Enter the number occurring within the

documented category.

Found on the 'PRENATAL RECORD

Code '99' for unknown if it is not documented

to indicate the number of the category.

UNSPECIFIED ABORTIONS

Number Unspecified as Spontaneous or Therapeutic Abortions

Found on the 'PRENATAL RECORD

Code '99' for unknown if it is not documented to indicate the number of each category

SCREENING TESTS

Found on 'LAB REPORTS', 'DIAGNOSTIC IMAGING REPORTS' or documented on the 'PRENATAL RECORD'

Look for Lab/Diagnostic Imaging Reports showing that specified screening tests were done. If Lab/Diagnostic Imaging Reports are not available, review the Prenatal Record for evidence that the screening was done or not done. If there is no documentation indicate Unknown.

Group B Strep Screening

Y = Yes, done N = Not done U = Unknown

Nuchal Translucency Screening

Y = Yes, done N = Not done U = Unknown

* Nuchal Translucency is an ultrasound review done between 10 and 14 weeks gestation only and reported as nuchal translucency. Do not capture as Yes if noted as nuchal fold or nuchal thickness

HIV Testing

Y = Yes, done D = Declined U = Unknown N = Not done

Maternal Serum

Y = Yes, done D = Declined U = Unknown N= Not done

Capture as Yes if only one of the two tests/screens have been completed.

DISCHARGE DATE

Patient's discharge date from hospital.

Found on the 'NURSES NOTES'.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME

Patient's discharge time from hospital.

Found on the 'NURSES NOTES'.

Use the following format: 'HHMM'.

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

If Discharge Time is not documented enter '9' in the field immediately following.

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 10-14 or use one of the following codes:

If patient is discharged home, code 0.

Code '-9' for Death.

MATERNAL PRIMARY CAUSE OF DEATH

Found on 'DEATH CERTIFICATE" or stated by the physician.

This field will autofill if mother lived.

Use **one** of the following options:

77777 Lived OTHR Other

PEMB Pulmonary Embolus
PPHM Postpartum Hemorrhage

STRK Stroke

AUTOPSY

Completion of maternal autopsy.

Found on the "DEATH CERTIFICATE" or the 'AUTOPSY REPORT'.

Code using one of the following:

LVD Lived (not applicable)Y Died and autopsy doneN Died but autopsy not done

ANTIBIOTIC THERAPY

Antibiotics administered during admission.

Found on the, 'MEDICATION SHEETS'.

Enter **Y** if antibiotics administered. If no antibiotics administered, leave **blank**.

Code Y if antibiotic is given during the admission, even if it is for a non-pregnancy related condition.

If the antibiotic therapy was started before the admission and is still being taken during the admission, code the time and date started within 10 days of admission if documented. If not, code the first documented dosage after admission.

ANTIBIOTIC DATE

Date antibiotic therapy first given.

Found on 'MEDICATION SHEETS'.

Use the following format: 'YYYYMMDD'.

Record the date of the first antibiotic therapy given to the mother during the hospital stay.

If date of first antibiotic therapy is not documented, leave date field blank and enter '9' in the field immediately following.

If the mother was on antibiotics at admission, enter the date of the start of the antibiotic before admission, if documented. If the mother was on antibiotics prior to admission and the date is not documented, record unknown.

ANTIBIOTIC TIME

Time antibiotic therapy first given.

Found on 'MEDICATION SHEETS'

Use the following format: 'HHMM'.

'HH' is in range 0-23, 'MM' is in range 0-59.

Record the time of the first antibiotic therapy given to the mother during the hospital stay.

If time of first antibiotic therapy is not documented, leave time field blank and enter '9' in the field immediately following.

If the mother was on antibiotics at admission, enter the time of the start of the antibiotic before admission, if documented. If the mother was on antibiotics prior to admission and the time is not documented, record unknown.

PATIENT'S PROCESS STATUS

Indicates the coding status of undelivered routine information.

Code using one of the following:

- 2 Coding of chart in process. The case is set to 2 automatically when it is accessed by the coder for the first time.
- Coding of undelivered information completed.

Once the case is saved (status 4 or 5) the data can be viewed, but not changed. Status 4 indicates that the data is ready to be transferred, status 5 indicates that data has been transferred.

Once data has been frozen (status 4 or 5), requests for any necessary changes or corrections must be sent to the Clinical Data Coordinator at RCP.

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Version 14.0.0 Release 9.0.0 April 1, 2010

ROUTINE INFORMATION - POSTPARTUM ADMISSION

POSTPARTUM ADMISSIONS

Any admission of a woman up to 6 weeks postpartum.

Also include any admission beyond 6 weeks from delivery if the reason for the admission is stated as related to or caused by the pregnancy and or delivery.

NOTE:

If a mother is admitted after an emergency birth which occurred in a hospital not providing maternity services or delivery at home, whether planned or unplanned and the mother and baby were transferred to another facility, the hospital receiving the transfer is requested to code the case as a 'DELIVERED ADMISSION' and not a postpartum admission.

ADMITTED FROM

Patient'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 10-14.

If patient comes from home, code '0'.

If a patient comes from the Emergency Room of another facility without having been admitted to the facility, code '0', admitted from home.

GRAVIDA

The number of pregnancies, including the present pregnancy.

Found on the 'PHYSICIANS' ASSESSMENT FORM' or 'PRENATAL RECORD'

Code '99' for unknown.

<u>PARA</u>

The number of pregnancies, **including** the present pregnancy, which resulted in one or more infants weighing 500 grams or more at birth or 20 weeks gestation or greater gestational age regardless of whether such infants were stillborn, died after birth or lived.

Found on the 'PHYSICIANS' ASSESSMENT FORM' or 'PRENATAL RECORD'

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 'PHYSICIANS ASSESSMENT FORM' or 'PRENATAL RECORD'

Code '99' for unknown.

SPONTANEOUS ABORTIONS

Number of Spontaneous Abortions

Enter the number occurring within the documented category.

Found on the 'PRENATAL RECORD'

Code '99' for unknown if it is not documented to indicate the

number of the category.

THERAPEUTIC ABORTIONS

Number of Therapeutic Abortions

Enter the number occurring within the documented category.

Found on the 'PRENATAL RECORD'

Code '99' for unknown if it is not documented to indicate the

number of the category.

UNSPECIFIED ABORTIONS

Number Unspecified as Spontaneous or Therapeutic Abortions

Found on the 'PRENATAL RECORD'Code '99' for unknown if it is not documented to indicate the number of each category.

DISCHARGE DATE

Patient's discharge date from hospital.

Found on the 'NURSES NOTES'.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME

Patient's discharge time from hospital.

Found on the 'NURSES NOTES'.

Use the following format: 'HHMM'.

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

If discharge time is not documented enter '9' in the field immediately following.

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 10-14 or use one of the following codes:

If patient is discharged home, code 0.

-9 Maternal Death.

MATERNAL PRIMARY CAUSE OF DEATH

Found on 'DEATH CERTIFICATE" or stated by the physician.

This field will autofill if mother lived.

Use **one** of the following options:

77777 Lived OTHR Other

PEMB Pulmonary Embolus
PPHM Postpartum Hemorrhage

STRK Stroke

AUTOPSY

Completion of maternal autopsy.

Found on the "DEATH CERTIFICATE" or the 'AUTOPSY REPORT'.

This field will autofill if mother lived.

Code using one of the following:

LVD Lived (not applicable)Y Died and autopsy doneN Died but autopsy not done

ANTIBIOTIC THERAPY

Antibiotics administered during admission.

Found on the 'MEDICATION SHEETS'.

Enter **Y** if antibiotics administered. If no antibiotics administered, leave **blank**.

Code Y if antibiotic is given during the admission, even if it is for a non-pregnancy related condition.

If the antibiotic therapy was started before the admission and is still being taken during the admission, code the time and date started within 10 days of admission if documented. If not, code the first documented dosage after admission.

ANTIBIOTIC DATE

Date antibiotic therapy first given.

Found on 'MEDICATION SHEETS'.

Use the following format: 'YYYYMMDD'.

Record the date of the first antibiotic therapy given to the mother during the hospital stay.

If date of first antibiotic therapy is not documented, leave date field blank and enter '9' in the field immediately following.

If the mother was on antibiotics at admission, enter the date of the start of the antibiotic before admission, if documented. If the mother was on antibiotics prior to admission and the date not documented, record unknown.

ANTIBIOTIC TIME

Time antibiotic therapy first given.

Found on 'MEDICATION SHEETS'.

Use the following format: 'HHMM'.

'HH' is in range 0-23, 'MM' is in range 0-59.

Record the time of the first antibiotic therapy given to the mother during the hospital stay.

If time of first antibiotic therapy is not documented, leave time field blank and enter '9' in the field immediately following.

If the mother was on antibiotics at admission, enter the time of the start of the antibiotic before admission ,if documented. If the mother was on antibiotics prior to admission and the time not documented, record unknown.

PROCESS STATUS

Indicates the coding status of undelivered routine information.

Code using one of the following:

- 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 information completed.

Once the case is frozen (status 4 or 5) the data can be viewed, but not changed. Status 4 indicates that the data is ready to be transferred, status 5 indicates that the data has been transferred.

Once data has been frozen (status 4 or 5), requests for any necessary changes or corrections must be sent to the Clinical Data Coordinator at RCP.

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Version 14.0.0 Release 9.0.0 April 1, 2010

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 readmitted 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.

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.
- 5 Fifth born of multiples.

-etc-

ADMITTED FROM

Infant'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 10-14.

If a patient comes from the Emergency Room of another facility without having been admitted to the facility, code '0', admitted from home.

If patient comes from home, code '0'

ADMITTED FROM 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 10-14.

If Birth Hospital is not documented, enter 99 for unknown

SCN

Infant admitted to the Special 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 admission in the next row. Continue until all admissions to Special Care Nursery are recorded.

OUTCOME

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.

BREASTFEEDING

Record one of the following to indicate the method of feeding during the hospital stay.

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

Code using one of the following:

E Breast milk was exclusively given, breast milk, or expressed breast milk (EBM) during the hospital stay.

Cannot be given any food or liquid other than breast milk. Exception: May be given undiluted drops of syrups consisting of vitamins, mineral supplements, or medicines. Breast milk may be given by the mother, health care provider or family member/supporter.

If the baby was given breast milk and water or glucose water record as breast milk and formula

- N Baby was not given any breast milk or expressed breast milk during hospital stay
- S Baby was given both breast milk and other supplements, e.g formula, water, glucose water during hospital stay
- 9 There is no documentation as to how the baby was fed during the hospital stay

DISCHARGE DATE

Patient's discharge date from hospital.

Found on the 'NURSES NOTES'.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME

Patient's discharge time from hospital.

Found on the 'NURSES NOTES'.

Use the following format: 'HHMM'.

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

If Discharge Time is not documented enter '9' in the field immediately following.

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 10-14 or use one of the following codes:

If patient is discharged home, code 0.

-9 death.

Completion of infant autopsy.

AUTOPSY

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

The field will autofill if infant lived

Code using one of the following:

LVD Lived (e.g., not applicable)Y Died and autopsy doneN Died but autopsy not done

PRIMARY CAUSE OF DEATH

Found on the 'AUTOPSY REPORT' or stated by the physician.

The field will autofill if infant lived

Use **one** of the following codes:

7777 Infant lived
ABRP Abruptio placenta

ANEC Acute necrotizing enterocolitis

OAIR Airway failure AMNO Amniocentesis

ANAL Analgesia or anaesthesia

ASPN Aspiration

CPDP Chronic pulmonary disease COTR Complications of treatment

ANOM Congenital anomaly
CRLK Cord loops and/or knots
CDOT Cord, miscellaneous

CORP Cord prolapse

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

PRIMARY CAUSE OF DEATH (con't)

IVTF Intravascular transfusion ISOM Isoimmunization

KERN Kernicterus
MALP Malpresentation
DIAB Maternal diabetes
SHOC Maternal shock
MUSF Multi-system failure
MINF Myocardial infarction

NEOP Neoplasia

TTTX Twin-to-twin transfusion (Parabiotic syndrome)

PPFC Persistent fetal circulation

PLPV Placenta previa

AIRL Pneumothorax pneumomediastinum and/or

pneumopericardium

PIVH Primary intraventricular hemorrhage
PPHN Primary pulmonary hypertension
PULH Primary pulmonary hemorrhage

RUPU Ruptured uterus

SIDS Sudden Infant death syndrome

THAB Therapeutic abortions

TOXM Toxemia

TRAS Tracheal stenosis
TRAU Trauma (obstetrical)

UNEX Unexplained

UXPA Unexplained peripartum asphyxia

VOLV Acquired volvulus

DATE OF DEATH

Date of infant's death.

Found in the 'NURES' NOTES' or the 'NEWBORN CODING SHEET'.

Use the following format: 'YYYYMMDD'.

If date of death is unknown, enter '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 code '9' in the field immediately following.

FETAL MALNUTRITION/SOFT TISSUE WASTING

Fetal malnutrition or soft tissue wasting.

Found in 'DISCHARGE SUMMARY' or 'NEONATOLOGIST'S LISTING'

Choose one of the following:

- 1 Moderate Wasting
- 2 Severe Wasting

TWIN TYPE

Found on 'DISCHARGE SUMMARY' or 'NEONATOLOGIST'S LISTING'

Choose one from the following list:

- 1 Monoamniotic (one amniotic sac)
- 2 Monochorionic, diamniotic
- 3 Dichorionic, dissimilar sexes or blood groups
- 4 Dichorionic, similar sexes and blood groups
- 5 Dichorionic, similar sexes, blood groups
 - undetermined
- 6 Undetermined
- 7 Siamese (Conjoined) twins

ELECTIVE NON-RESUSCITATION

Found on the 'DISCHARGE SUMMARY' or 'NEONATOLOGIST'S LISTING'

Choose from the following list:

- 1 Do not resuscitate order on chart
- 2 Withdrawal of ventilator care with do not resuscitate order on chart
- 3 Non-resuscitation in labour and delivery room

MATERNAL STEROID THERAPY

Found on the 'MEDICATION SHEET' or on the 'PRENATAL RECORD'

Code the earliest dose of the first course of treatment. In a fetal death, estimate the duration of therapy from the first dosage to time of delivery

Code one of the following:

Dexamethasone

- 1 <24 hours before delivery
- 2 24 to 48 hours before delivery
- 3 >48 hours but less than or equal to 7 days before delivery
- 4 >7 days before delivery
- 5 Unknown when administered

Betamethasone (Celestone)

- 6 <24 hours before delivery
- 7 24 to 48 hours before delivery
- 8 >48 hours but less than or equal to 7
 - days before delivery
- 9 >7 days before delivery
- 10 Unknown when administered

Unknown Steroid

- 11 <24 hours before delivery
- 12 24 to 48 hours before delivery
- 13 >48 hours but less than or equal to 7 days before delivery
- 14 >7 days before delivery
- 15 Unknown when administered

RETINOPATHY OF PREMATURITY

Found on the 'DISCHARGE SUMMARY'.

Code one of the following:

1	Stage 1	Peripheral vascular straightening
2	Stage 2	Peripheral shunt well seen
3	Stage 3	Vessels growing into vitreous
4	Stage 4	Retinal detachment

CHROMOSOMAL ABNORMALITIES

Found on 'GENETICS REPORT' or 'NEONATOLOGIST LISTING'

Code one chromosomal abnormality from the listing:

- 1 Aneuploidy
- 2 Chimerism
- 3 Mosaicism
- 4 Triploidy
- 5 Deletion
- 6 Duplication
- 7 Microdeletion
- 8 Monosomy
- 9 Ring
- 10 Tandem Repeat
- 11 Trisomy
- 12 Uniparental Disomy
- 13 Translocation

Please note that chromosome numbers are from 1 to 23 and X and Y.

If Aneuploidy, Chimerism or Triploidy are selected you DO NOT have to code the chromosome affected, the affected arm (p or q) or the site on the arm.

If Mosaicism, Deletion, Duplication, Microdeletion, Monosomy, Ring, Tandem Repeat, Trisomy or Uniparental Disomy are selected code also the affected chromosome. You DO NOT have to code the affected arm (p or q) or the site on the arm if not documented.

If Translocation is selected <u>two</u> chromosomes should be coded. You DO NOT have to code the affected arm (p or q) or the site on the arm if not documented

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ADULT RCP CODES

MATERNAL ANTIBODY CONDITIONS DURING PREGNANCY	Found on the 'RED CROSS SHEETS' Choose as many as are indicated;	
(R001) (ANTIBODY CONDITIONS)	100 200	Anti-La Anti-D (Rh)
For use with: Delivered	300	Anti-Big C (Cw)
Undelivered	400 500	Anti-Big E Anti-Big S
	600	Anti-Dha (DUCH)
	700 800	Anti-Fya (Duffy) Anti-Kell (K1/K2)
	900	Anti-Kidd (JKa)
	1000	Anti-Little c
	1100 1200	Anti-Little e Anti-Little s
	1300	Anti-Lutheran (Lua/Lub)
	1400	Anti-Wright (Wra/Wrb)
	1500 1600	Antinuclear Antibody (ANA) Anti-Cardiolipin
	1700	Anti-DNA Antibody
	1800	Lupus Antibody (Lupus Anticoaguant)
	1900	Anti-SSA (Ro)
	2000 2100	Anti-Phospholipid Factor V Leiden
	2200	PL-A1 Platelet Antigen Negative

MATERNAL CARRIER STATES AND/OR CHRONIC INFECTION DURING	Found on the 'PRENATAL RECORD' or 'DISCHARGE SUMMARY'.		
PREGNANCY (R002)	Choose	as many as are indicated;	
(CARRIER-STATE/CHRONIC INFECTIONS)	100 200 300	Cytomegalovirus Group B Strep Herpes Simplex	
For Use With: Delivered Undelivered	400 600 700 800	HIV/Acquired Immune Deficiency Syndrome Syphilis Toxoplasmosis Serum Hepatitis Carrier (Antigen positive; Hepatitis A)	
	900 1000 1100	Serum Hepatitis Carrier (Antigen positive; Hepatitis B) Serum Hepatitis Carrier (Antigen positive; Hepatitis C) Serum Hepatitis Carrier (Antigen positive; Hepatitis viral)	

MATERNAL DRUG THERAPIES	Found on the 'PRENATAL RECORD'.		
FOR SPECIFIC CONDITIONS OF	Choose	as many as are indicated;	
PREGNANCY, DELIVERY AND			
<u>POSTPARTUM</u>	100	Adalat (nifedipine) for premature labour	
<u>(R003)</u>	300	Atosiban for premature labour	
	400	Hemabate for Postpartum Hemorrhage	
(DRUGS FOR CONDITIONS	500	Indocid (Indomethacin) for premature labour	
PREG/PP)	600	Indocid (Indomethacin) for tx of Polyhydramnios	
•	700	Magnesium sulfate therapy (MgSO ₄)(for hypertension	
For Use With: Delivered		or seizures, e.g. Eclampsia prophylaxis or treatment).	
Undelivered	800	Magnesium Sulfate (MgSO ₄) for premature labour	
Postpartum	900	Pentaspan for Postpartum Hemorrhage	
·	1000	Terbutaline (Bricanyl) for premature labour	
	1100	Ventolin for premature labour	
	1200	Other Drugs for Specific Pregnancy, Delivery or	
		Postpartum conditions	
	1300	Ergot for Postpartum Hemorrhage	
	1400	Misoprostil for Postpartum Hemorrhage	

MATERNAL DRUG THERAPY DURING PREGNANCY/POSTPARTUM	Found on the 'PRENATAL RECORD'. Choose as many as are indicated;			
PERIOD (R004)	Code if noted taken before found out was pregnant			
(DRUG THERAPY IN PREG/PP)	100	Anti-coagulation therapy		
(Bride Friedrich Friedrich	200	Anti-Depressives		
For Use With: Delivered	300	Anti-epileptics		
Undelivered	400	Anti-hypertensives		
Postpartum	500	Chronic Narcotic Use (Not Abuse, when indicated for		
		medical problems, e.g. Back pain)		
	600	Lithium		
	700	Methadone (Therapy, not abuse)		
	800	Other Psychiatric Medications		
	900	Other Specified		
	1000	ASA Therapy (Low dose aspirin therapy for Lupus		
		and/or any other autoimmune conditions)		
	1100	Insulin therapy		
	1200	Thyroid Medication		
	1300	Anti-Anxiety Medication		
	1400	Nicotine Replacement Therapy		
	1500	Tamiflu		
	1600	Relenza		

MATERNAL DRUG AND CHEMICAL ABUSE DURING PREGNANCY

(R005)

(DRUGS-ABUSE IN PREG)

For Use with: Delivered

Undelivered

Found on the 'PRENATAL RECORD'. Choose as many as are indicated;

Code if noted used before found out was pregnant.

200	Ativan
300	Cocaine/Crack
400	Codeine
500	Demerol
600	Dilaudid
700	Hash
800	Heroin
900	Marijuana
1000	Methadone
1100	Morphine
1200	Prescription Medication Abuse
1300	Solvents
1400	Valium
1500	Other Specified Abuse
1600	OxyContin
1700	Ecstacy
1800	Alcohol Abuse- Binge
1900	Alcohol Abuse - Chronic
2000	Alcohol Abuse - unknown Binge or Chronic

Found on the 'PRENATAL RECORD'. MATERNAL/FETAL DIAGNOSTIC AND Choose as many as are indicated; THERAPEUTIC PROCEDURES (R006) 100 Amniocentesis for Genetic testing 200 Amniocentesis for Isoimmunization For Use With: Delivered 300 Amniocentesis for Lung Maturity Undelivered 400 Amnioreduction (Polyhydramios, Twin to Twin Transfusion) 500 Amnioinfusion during labour 600 Chorionic Villi Sampling 700 Cordocentesis 801 One (1) Fetal Blood transfusion Two (2) Fetal Blood transfusions 802 803 Three (3) Fetal Blood transfusions 804 Four (4) Fetal Blood transfusions 805 Five (5) Fetal Blood transfusions 806 Six (6) Fetal Blood transfusions 807 Seven (7) Fetal Blood transfusions 808 Eight (8) Fetal Blood transfusions 809 Nine (9) Fetal Blood transfusions 810 Ten (10) Fetal Blood transfusions 900 Fetal Drainage (eg. Thoracentesis, hydrocephalus, Urinary) 1000 Fetal Reduction 1100 Feto/placental laser 1200 Fetal Stent Placement 1300 Forceps rotation during delivery 1400 Manual rotation during delivery 1500 Vacuum rotation during delivery 1600 Removal of device, cervix of cerclage suture 1700 **External Version** 1800 Internal Version

Insertion of device, Cervix of Cerclage suture

1900

LABOUR AND DELIVERY (R010)	Choose delivery	e as many as were administered during labour and v.
For Use With: Delivered	100 200 300	Entonox (Nitronox) Epidural - Single Administration Epidural - Continuous Catheter With Intermittent Drug
		Administration
	400	Epidural - Continuous Infusion of Drug (CIEA)
	500	Epidural - Patient Controlled Epidural Analgesia (PCEA)
	600	General Anaesthesia
	700	Patient Controlled Intravenous Analgesia
	800	Pudendal
	900	Spinal Anaesthesia
	1000	Spinal/Epidural double needle
	1100	Other specified Anaesthesia (eg. Acupuncture,
		Hypnotism Neuroleptic
ANAESTHESIA DURING	Found	on the 'ANAESTHESIA RECORD'.
LABOUR ONLY		on the 'ANAESTHESIA RECORD'. e as many as were administered.
LABOUR ONLY	Choose	e as many as were administered.
LABOUR ONLY (R011)	Choose	e as many as were administered. Entonox (Nitronox)
LABOUR ONLY (R011)	100 200	e as many as were administered. Entonox (Nitronox) Epidural - Single Administration Epidural - Continuous Catheter With Intermittent Drug
LABOUR ONLY (R011)	100 200 300	Entonox (Nitronox) Epidural - Single Administration Epidural - Continuous Catheter With Intermittent Drug Administration
LABOUR ONLY (R011)	100 200 300 400	Entonox (Nitronox) Epidural - Single Administration Epidural - Continuous Catheter With Intermittent Drug Administration Epidural - Continuous Infusion of Drug (CIEA) Epidural - Patient Controlled Epidural Analgesia
LABOUR ONLY (R011)	100 200 300 400 500	Entonox (Nitronox) Epidural - Single Administration Epidural - Continuous Catheter With Intermittent Drug Administration Epidural - Continuous Infusion of Drug (CIEA) Epidural - Patient Controlled Epidural Analgesia (PCEA)
LABOUR ONLY (R011)	100 200 300 400 500	Entonox (Nitronox) Epidural - Single Administration Epidural - Continuous Catheter With Intermittent Drug Administration Epidural - Continuous Infusion of Drug (CIEA) Epidural - Patient Controlled Epidural Analgesia (PCEA) General Anaesthesia
LABOUR ONLY (R011)	100 200 300 400 500 600 700	Entonox (Nitronox) Epidural - Single Administration Epidural - Continuous Catheter With Intermittent Drug Administration Epidural - Continuous Infusion of Drug (CIEA) Epidural - Patient Controlled Epidural Analgesia (PCEA) General Anaesthesia Patient Controlled Intravenous Analgesia
LABOUR ONLY (R011)	100 200 300 400 500 600 700 800	Entonox (Nitronox) Epidural - Single Administration Epidural - Continuous Catheter With Intermittent Drug Administration Epidural - Continuous Infusion of Drug (CIEA) Epidural - Patient Controlled Epidural Analgesia (PCEA) General Anaesthesia Patient Controlled Intravenous Analgesia Pudendal

Found on the 'ANAESTHESIA RECORD'

ANAESTHESIA DURING

Other specified Anaesthesia (eg.Acupuncture,

Hypnotism, Neuroleptic

1100

ANAESTHESIA DURING DELIVERY ONLY (R012)

Found on the 'ANAESTHESIA RECORD'.

Choose as many as were administered.

For Use With: Delivered	100	Entonox (Nitronox)
	200	Epidural - Single Administration
	300	Epidural - Continuous Catheter With Intermittent Drug
		Administration
	400	Epidural - Continuous Infusion of Drug (CIEA)
	500	Epidural - Patient Controlled Epidural Analgesia
		(PCEA)
	600	General Anaesthesia
	700	Patient Controlled Intravenous Analgesia
	800	Pudendal
	900	Spinal Anaesthesia
	1000	Spinal/Epidural double needle
	1100	Other specified Anaesthesia (eg. Acupuncture,
		Hypnotism, Neuroleptic)

COMPLICATIONS OF ANESTHESIA (R013)

Found on the 'ANAESTHESIA RECORD' or 'DISCHARGE SUMMARY'

Failed Intubation for General Anesthetic

Choose from the following.

For use with:	Delivered Undelivered Postpartum	100 200 300 400 500 600 700 800 900	Blood Patching Toxic Intravenous Injection (systemic reaction) Epi-catheter Intravenous Accidental Dural Tap Total Spinal Anesthesia Prolonged Epidural Block High Epidural/Subdural Block Foot Drop Epidural Hematoma
		1000 1100	Epidural Abscess Spinal Cord Lesion
		1200	Aspiration Pneumonitis
		1300	Cardiac Arrest
		1400	Post-dural Puncture Headache
		1500	Paraesthesia
		1600	Hypotension
		1700	Back Pain

1800

OTHER OBSTETRICAL CONDITIONS AFFECTING PREGNANCY (R014)

Found on the 'PRENATAL RECORD' or 'DISCHARGE SUMMARY'

Choose as many as documented

		100	Pruritic urticarial papules and plaques of
For use with:	Delivered		pregnancy
	Undelivered	200	Impetigo herpetiformis
	Postpartum	300	Dermatitis herpetiformis
	,	400	Separation of symphysis pubis
		500	Gestational [pregnancy-induced] hypertension without significant proteinuria.Includes: Gestational
			hypertension NOS, Mild pre-eclampsia
		550	Hypertension, unspecified type
		600	Gestational [pregnancy-induced] hypertension with
			significant proteinuria.Includes: HELLP (syndrome)
			(hemolysis/elevated liver enzymes/low platelets)
		700	Pre-existing hypertension complicating pregnancy,
			childbirth and the puerperium
		800	Pre-existing hypertensive disorder with
			superimposed proteinuria
		900	Pre-existing diabetes mellitus, Type 1
		1000	Pre-existing diabetes mellitus, Type 2
		1100	Pre-existing diabetes mellitus of other specified
			type present when became pregnant during this
			pregnancy
		1200	Pre-existing diabetes mellitus, of unspecified type
			present when became pregnant during this
			pregnancy
		1300	Diabetes mellitus arising in
			pregnancy.Includes:Gestational diabetes
		1400	Diabetes mellitus in pregnancy, unspecified
		1500	Anemia in Pregnancy (Hb < 10% in pregnancy)
		1600	Febrile Morbidity
			(38 degrees or more on 2 or more occasions at
			least 4 hours, in any 48 hour period, excluding the
			first 24 hours after delivery, regardless of cause.)
		1700	Maternal Fever >38 degrees

GASTRO-INTESTINAL Found on the 'PRENATAL RECORD' or 'DISCHARGE SUMMARY' **DISEASES**

(CODE IF CONDITION IS OR WAS PRESENT DURING THE Choose as many as documented

100 Cholelithiasis **PREGNANCY**) 200 Ulcerative colitis/proctitis

> 300 Crohn's disease

400 Irritable Bowel Syndrome For use with: Delivered

Pancreatitis, Acute and Chronic 500 Undelivered

600 **Reflux Gastritis** Postpartum 700 Ulcers(all types)

Found on the 'PRENATAL RECORD' or 'DISCHARGE **PSYCHIATRIC ILLNESS**

SUMMARY'

(CODE IF CONDITION IS OR WAS PRESENT DURING THE

PREGNANCY)

(R015)

100 Anxiety disorders (R016)

Depression 200

300 Eating disorders (e.g. anorexia nervosi, bulimia

nervosa)

Choose as many as documented

For use with: Delivered 400 Manic-Depression

Undelivered Schizophrenia 500 Postpartum

600 Other

NEUROLOGICAL ILLNESS

Found on the 'PRENATAL RECORD' or 'DISCHARGE SUMMARY'

(CODE IF THE CONDITION IS OR WAS PRESENT DURING THE CURRENT PREGNANCY) (R017)

Choose as many as documented

(11011)			
		100	Bell's palsy
For use with:	Delivered Undelivered Postpartum	200	Cerebral palsy
		300	Epilepsy
		400	Intracerebral hemorrhage
		500	Muscular dystrophy
		600	Myasthenia gravis
		700	Multiple sclerosis
		800	Presence of Harrington Rod
		900	Subarachnoid hemorrhage
		1000	Seizure
		1100	Tuberous sclerosis
		1200	Thoracic outlet syndrome

1300

Other

Found on the 'PRENATAL RECORD' or 'DISCHARGE SUMMARY'

(CODE IF THE CONDITION IS
OR WAS PRESENT DURING
CURRENT PREGNANCY)
(R018)

Choose as many as documented

(R018)		100	Arrhythmia
		200	Congenital heart disease
For use with:	r use with: Delivered Undelivered Postpartum	300	Cardiac Arrest
		400	Coronary artery disease
		500	Endocarditis
		600	History of heart disease or surgery

700 Myocardial infarction
800 Prolapsed mitral valve
900 Cardiomyopathy
1000 Myocarditis

1100 Pulmonary hypertension1200 Rheumatic heart disease1300 Valve prosthesis

1400 Wolff Parkinson's White Syndrome
1500 Other acquired cardiac diseases
1600 Thromboembolic Disease

ENDOCRINE DISEASE

Found on the 'PRENATAL RECORD' or 'DISCHARGE SUMMARY'

(CODE IF THE CONITION IS OR WAS PRESENT DURING THE CURRENT PREGNANCY)

Choose as many as documented

CURRENT PREGNANCY)				
(R019)		100	Disorder of Adrenal Gland	
For use with:		200	Disorder of Ovary	
	Delivered	300	Hashimoto's Thyroiditis	
	Undelivered	400	Hyperthyroidism with Goiter	
	Postpartum	500	Hyperthyroidism with Thyroid nodule	
	·	600	Hyperthyroidism with Goiter, nodular	
		700	Hyperthyroidism without Goiter	
		800	Hypothyroidism	
		900	Hyperparathyroidism	
		1000	Disorder of Hypothalamus	
		1100	Disorder of Pituitary gland	

RENAL DISEASE		Found on the 'PRENATAL RECORD' or 'DISCHARGE		
		SUMMA	RY	
(CODE IF TH	E CONDITION IS			
OR WAS PRESENT DURING		Choose as many as documented		
THE CURRENT PREGNANCY)				
(R020)		100	Acute pyelonephritis	
		200	Renal calculus	
For use with:	Delivered	300	Chronic glomerulonephritis	
Und	Undelivered	400	Previous episode of acute pyelonephritis during	
	Postpartum		current pregnancy	
	•	500	Hydronephrosis	
		600	Nephropathy	
		700	Nephrotic syndrome	
		800	Polycystic kidney disease	
		900	Chronic pyelonephritis	
		1000	Renal agenesis	
		1100	Renal transplant	
		1200	Chronic renal disease, type undetermined	
		1300	Urinary tract Infection	

NEOPLASM, INCLUDING **MALIGNANCIES**

Found on the 'PRENATAL RECORD' or 'DISCHARGE SUMMARY'

(CODE IF CONDITION IS OR WAS PRESENT DURING THE

Choose as many as documented

WAS PRESEN	II DURING I HE	<u> </u>	
CURRENT PR	EGNANCY)	100	Bowel
(R021)		200	Breast
		300	Cervix
For use with:	Delivered Undelivered	400	Other
		500	Ovary (Teratoma)

Undelivered Thyroid 600 Postpartum Vagina 700

BLOOD	DYSCRASIAS

Found on the 'PRENATAL RECORD' or 'DISCHARGE SUMMARY'

(CODE IF THE CONDITION IS
OR WAS PRESENT DURING
THE CURRENT PREGNANCY/
POSTPARTUM PERIOD)
(R022)

Choose as many as documented

Thrombocytopenia

POSTPARTUM PERIOD) 100		100	Hemolytic anemia
(R022)		200	Dysfibrinogenemia
		300	Factor 12 deficiency
L	Delivered Undelivered	400	Familial hypofibrinogenemia
		500	Factor VIII deficiency
	Postpartum	600	G6PD deficiency
		700	Idiopathic Hypoplastic Anemia
		800	Idiopathic thrombocytopenic purpura (ITP)
		900	Sickle cell anemia
		1000	Thalassemia
		1100	Von Willebrand's disease
		1200	Thrombotic Thrombocyopenia purprua(TTP)

1300

Found on the 'PRENATAL RECORD' or 'DISCHARGE PULMONARY DISEASE SUMMARY' (CODE IF THE CONDITION IS Choose as many as documented OR WAS PRESENT DURING **CURRENT PREGNANCY**) 100 Asthma (R023) Cystic fibrosis 200 300 Pulmonary edema For use with: Delivered Other significant pulmonary diseases 400 Undelivered 500 Pneumonia, antepartum Postpartum Laboratory confirmed H1N1 Influenza 600

OTHER NON-OBSTETRICAL DISEASES, NOT ELSEWHERE CLASSIFIABLE		Found on the 'PRENATAL RECORD' or 'DISCHARGE SUMMARY'		
<u>OLAGOII IADI</u>	<u></u>	Choose as many as documented		
(CODE IF TH	E CONDITION IS			
OR WAS PRESENT DURING		100	Ankylosing spondylitis	
THE CURRENT PREGNANCY		200	Cholinesterase Deficiency	
(R024)		300	Family or personal history of Malignant	
			Hyperthermia	
For use with:	Delivered Undelivered Postpartum	400	Neurofibromatosis (Von Recklinghausen's	
r or doc main			Disease)	
		500	Porphyria	
		600	Maternal phenylketonuria	
		700	Rheumatoid arthritis/Psoriatic	
		800	Sarcoidosis	
		900	Scleroderma	
		1000	Scoliosis	
		1100	Sjogren's Syndrome	
		1200	Systemic lupus	

1300

Scheurmann's Disease

PREVIOUS PREGNANCY MATERNAL DISEASES (R025)

Found on the 'PRENATAL RECORD' or 'DISCHARGE SUMMARY'

Choose as many as documented

For use with: Delivered

Undelivered Postpartum

100 Previous History of Personal Malignancy

200 Previously Sensitized Pregnancy

300 Hypertensive Disease In Previous Pregnancy

400 Previous Eclampsia

500 Previous Ectopic Pregnancy600 Previous Molar Pregnancy

700 Previous Anemia

800 Previous Abruptio Placenta

900 Previous Breech

1000 Previous Thromboembolic Disease
1100 Previous Gestational Diabetes
1200 Previous History of Infertility

1300 Previous Postpartum Depression

MATERNAL TRANSFUSIONS. BLOOD AND OTHER PRODUCTS (R026)

Found on the 'PRENATAL RECORD' or 'DISCHARGE SUMMARY or OPERATIVE REPORT'

Choose as many as documented

For use with: Delivered 100 One Maternal Blood Transfusion
Undelivered 200 Two Maternal Blood Transfusions

Postpartum 300 Three Maternal Blood Transfusions

400 Four Maternal Blood Transfusion
500 Five Maternal Blood Transfusion
600 Six Maternal Blood Transfusion
700 Seven Maternal Blood Transfusion

Seven Maternal Blood Transfusions
 Eight Maternal Blood Transfusions
 Nine Maternal Blood Transfusions
 Ten Maternal Blood Transfusions

1100 More than 10 Maternal Blood Transfusions

1200 Albumin Transfusion

1300 Cryoprecipitate Transfusion

1400 Fresh Frozen Plasma Transfusion

1500 Gamma Globulin Transfusion

1600 Plasma Exchange/Plasmapheresis Transfusion

1700 Platelet Transfusion

REASON FOR MATERNAL BLOOD TRANSFUSION (R027)

Found on the 'PRENATAL RECORD' or 'DISCHARGE SUMMARY or OPERATIVE REPORT'

Choose as many as documented

For use with: Delivered

Undelivered 100 Anemia in Pregnancy
Postpartum 200 Antepartum Hemorrhage
300 Intrapartum Hemorrhage

400 Postpartum Hemorrhage

500 Other

IMMUNIZATIONS (R028) Found on the 'PRENATAL RECORD or MATERNAL

ASSESSMENT FORM'

For use with: Delivered

Undelivered Postpartum

Choose all documented Vaccines.

Seasonal Influenza Vaccine
H1N1 Influenza Vaccine
Unknown Influenza Vaccine

PROCEDURES FOR
POSTPARTUM HEMORRHAGE
(029)

Found on the 'BIRTH RECORD, PARTOGRAM, DISCHARGE SUMMARY or OPERATIVE REPORT'

Choose all documented procedures

For use with: Delivered 100 B-Lynch Suture

Postpartum

200 Tying of Uterine Arteries
300 Embolization of Arteries
400 Packing for Backri Balloon

FETAL SURVEILLANCE METHODS (R030)

Found on the 'PARTOGRAM or MATERNAL ASSESSMENT FORM'

Choose all documented methods used during monitoring.

For use with: Delivered

Undelivered

Do not include admission strip monitoring in this code

100 Intermittent Auscultation200 External Auscultation300 Internal Auscultation

INFANT RCP CODES

PLACENTAL OR CORD ANOMALIES (R051)

Found in 'OBSTETRICIAN'S REPORT' or PLACENTAL PATHOLOGY REPORT'

Code <u>all</u> that are applicable.

100	Amnionodosum
200	Chorioamnionitis, marked or severe
300	Choroangioma of placenta
400	Circumvallate placenta
500	Funisitis
600	Funisitis, necrotizing
700	Funisitis, candidal
800	Hematoma of umbilical cord
900	Marginal insertion of cord/Batteldore
1000	Membranous placenta
1100	Placenta accreta
1200	Placenta Increta
1300	Placenta percreta
1400	Single umbilical artery
1500	True knot in cord
1600	Vasa previa
1700	Velamentous insertion of cord

ANOMALY/METABOLIC SYNDROMES AND CONDITIONS (R054)

Found on the 'DISCHARGE SUMMARY' or 'NEONATOLOGIST LISTING' or 'CHROMOSOMAL REPORT'

Code all that are applicable;

Code all	that are applicable,
100	Aarskog syndrome
200	Aase syndrome
300	Acardia
400	Accutane embryopathy
500	Achondrogenesis type Ia
600	Achondrogenesis type Ib
700	Achondrogenesis type II
800	Achondrogenesis-dysplasia congenita type II
900	Achondroplasia
1000	Acoustic neurofibromatosis
1100	Acrocallosal syndrome
1200	Acrocephalosyndactyly syndrome
1300	Acrodysostosis
1400	Acrofacial dysostosis syndrome
1500	Acromegaly
1600	Acromesomelic dwarfism (dysplasia)
1700	Acro-osteolysis syndrome (Artho-dento-osteo
	dysplasia)
1800	Adactyly
1900	Adams-Oliver syndrome
2000	Adenoma sebaceum
2100	Adrenal hyperplasia
2200	Adrenal hypoplasia
2300	Adrenoleukodystrophy
2400	Aec syndrome (Ankyloblepharon-ectodermal
0500	dysplasia-clefting syndrome)
2500	Agenesis of corpus callosum
2600	Aglossia-adactyly syndrome
2700	Alicardia syndrome
2800	Akinesia sequence
2900	Alleright boroditory estandystrophy
3000	Albright hereditary osteodystrophy
3100	Alopecia
3200 3300	Aminopterin embryopathy Amnion rupture sequence
3400	Amyoplasia congenita disruptive sequence
3500	Anal atresia
3600	Anencephaly
3700	Aneurysm of the vein of Galen
3700	Amounyam of the voil of Galen

CYNDDOMEC AND	2000	Amiridia
SYNDROMES AND	3900	Aniridia
CONDITIONS	4000 4100	Aniridia-Wilm's tumor association Anodontia
(R054) (con't)	4200	Anorectal malformation
	4300	
	4300 4400	Antley-Bixler syndrome Apert syndrome
	4500	Arachnodactyly
	4600	Arachnoid cyst
	4700	Argininaemia
	4800	Argininaeriia Argininosuccinic aciduria
	4900	Arteriohepatic dysplasia
	5000	Arteriovenous malformation of the lung
	5100	Arthrogryposis, muscular
	5200	Arthrogryposis, neurogenic
	5300	Arthro-ophthalmopathy (Stickler Syndrome)
	5400	Asphyxiating thoracic dystrophy
	5500	Asplenia syndrome
	5600	Ataxia - telangiectasia syndrome (Lovis-Bar
		Syndrome)
	5700	Atelosteogenesis, type I (Chondrodysplasia, giant cell)
	5800	Athyrotic hypothyroidism sequence
	5900	Atr-x syndrome
	6000	Baller Gerold syndrome
	6100	Bannayan syndrome (Bannayan-Riley-Ruvalcaba
		syndrome)
	6200	Bardet-Biedl syndrome
	6300	Beals syndrome (Beals contractural arachnodactyly)
	6400	Beckwith syndrome (Beckwith-Wiederman Syndrome)
	6500	Berardinelli lipodystrophy syndrome
	6600	Bicorunate uterus
	6700	Bifid scrotum
	6800	Bifid uvula
	6900	Bladder exstrophy
	7000	Blepharophimosis
	7100	Bloch-sulzberger syndrome
	7200	Bloom syndrome
	7300	Blue sclera
	7400	Body stalk anomaly
	7500	Bor syndrome (Brachio-oto-renal syndrome)
	7600	B_rjeson-Forssman-Lehmann syndrome
	7700	Brachmann-de Lange syndrome (Cornelia deLange
		syndrome)
	7800	Brachydactyly
	7900	Branchial sinus

	8000	Branchio-oculo-facial syndrome
SYNDROMES AND	8100	Breech deformation sequence
CONDITIONS	8200	Brushfield spots
(R054) (con't)	8300	Buru-Baraister syndrome
(1034) (COIT)	8400	Caffey pseudo-hurler syndrome
	8500	Campomelic dysplasia
	8600	Camurati-Engelmann syndrome
	8700	Capillary hemangioma
	8800	Cardio-facio-cutaneous syndrome (CFC)
	8900	Cardiomyopathy, congenital
	9000	Carnitine deficiency
	9100	Carpenter syndrome
	9200	Cartilage-hair hypoplasia syndrome
	9300	Catel-Manzke syndrome
	9400	Cat-eye syndrome
	9500	Caudal dysplasia sequence
	9600	Caudal regression syndrome
	9700	Cavernous hemangioma
	9800	Cebocephaly
	9900	Cephalopolysyndactyly syndrome (Greig Syndrome)
	10000	Cerebellar calcification
	10100	Cerebellar hypoplasia
	10200	Cerebral calcification
	10300	Cerebral gigantism syndrome
	10400	Cerebro-costo-mandibular syndrome
	10500	Cerebro-oculo facio-skeletal (cofs) syndrome
	10600	Cerevico-oculo-acoustic syndrome
	10700	Charcot-Marie-Tooth syndrome
	10800	Charge syndrome
	10900	Child Syndrome (Congenital hemidysplasia)
	11000	Choanal atresia
	11100	Chondrodysplasia punctata (Condracli-Hünermann Syndrome)
	11200	Chondrodystrophica myotonia (Schwartz-Jampel Syndrome)
	11300	Chondroectodermal dysplasia (Ellis-van Creveld syndrome)
	11400	Chondromatosis
	11500	Citrullinaemia
	11600	Cleft face
	11700	Cleft lip, unilateral
	11800	Cleft lip, bilateral
	11900	Cleft tongue
	12000	Cleft palate
	300	I

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SYNDROMES AND	12100	Cleidocranial dysostosis
CONDITIONS	12200	Clinodactyly
(R054) (con't)	12300	Cloacal exstrophy
	12400	Clouston syndrome
	12500	Cloverleaf skull
	12600	Clubfoot
	12700	Cockayne syndrome
	12800	Coffin-Lowry syndrome
	12900	Coffin-Siris syndrome
	13000	Cohen syndrome
	13100	Coloboma of iris
	13200	Colon, malrotation
	13300	Congenital adrenal hyperplasia
	13400	Congenital hypothyroidism
	13500	Congenital microgastria-limb reduction complex
	13600	Conjoined twins
	13700	Cortical hypoplasia
	13800	Costello syndrome
	13900	Coumarin embryology effects
	14000	Craniofacial dysostosis (Crouzon Syndrome)
	14100	Craniofrontonasal dysplasia
	14200	Craniometaphyseal dysplasia
	14300	Craniosynostosis
	14400	Craniosynostosis, coronal
	14500	Craniosynostosis, frontal
	14600	Craniosynostosis, Kleeblattschadel
	14700	Craniosynostosis, lambdoid
	14800	Craniosynostosis, sagittall
	14900	Crainiosynostosis, trigonocephaly
	15000	Cri du chat syndrome
	15100	Cryptophthalmos anomaly (Fraser Syndrome)
	15200	Cryptorchidism
	15300	Cubitus valgus
	15400	Cutis aplasia
	15500	Cutis hyperelastica
	15600	Cutis laxa
	15700	Cutis marmorata
	15800	Cyclopia
	15900	Cyclops
	16000	Cystathionuria
	. 5555	5,5.au ilonana

ANOMALY/METABOLIC	16100	Cystic adenomatoid malformation of the lung
SYNDROMES AND	16200	Cytomegalic inclusion disease
CONDITIONS	16300	Dandy-walker syndrome
(R054) (con't)	16400	Darwinian tubercle
(1004)	16500	Dental cyst
	16600	Deprivation syndrome
	16700	Dermal ridge, aberrant
	16800	Desanctis-Cacchione syndrome
	16900	Diabetes insipidus
	17000	Diabetes mellitus
	17100	Diaphagmatic hernia
	17200	Diaphyseal aclasis
	17300	Diastriophic dyslasia
	17400	Diastrophic nanism
	17500	DiGeorge syndrome
	17600	Dilantin embryopathy
	17700	Dimple, sacral
	17800	Distal arthogyrposis syndrome
	17900	Distichiasis-lymphedema syndrome
	18000	Donohue syndrome (Leprechaunism Syndrome)
	18100	Down syndrome
	18200	Dubowitz syndrome
	18300	Duodenal atresia
	18400	Dwarfism, acromesomelic
	18500	Dwarfism, metatrophic
	18600	Dyggve-Melchoir-Clausen syndrome
	18700	Dysencephalia splanchnocystica (Meckel-Gruber
		Syndrome)
	18800	Dyskeratosis congenita syndrome
	18900	Dystrophia myotonica, Steinert (Myotonic dystrophy)
	19000	Early urethral obstruction syndrome
	19100	Ectodermal dysplasia
	19200	Ectrodactyly, tibial
	19300	Ectrodactyly-ectodermal dysplasia-clefting syndrome (EEC)
	19400	Eczema
	19500	Ehlers-danlos syndrome
	19600	Elbow dysplasia
	19700	Enamel hypoplasia
	19800	Encephalocele
	19900	Encephalocraniocutaneous lipomatosis

ANOMALY/METABOLIC	20000	Endocrine neoplasia,multiple, type 2
SYNDROMES AND	20100	Epidermal nevus syndrome
	20200	Epiphyseal calcification
CONDITIONS (POSA) (con/4)	20300	Epiphyseal dysplasia, multiple
(R054) (con't)	20400	Equinovarus deformity
	20500	Escobar syndrome (Multiple pterygum dysplasia)
	20600	Esophageal atresia
	20700	Exomphalos
	20800	External chonromatosis
	20900	Fabry's disease
	21000	Falx calcification
	21100	Familial blepharophimosis syndrome
	21200	Familial short stature
	21300	Fanconi syndrome
	21400	Fetal alcohol syndrome (FAS)
	21500	Femoral hypoplasia-unusal facies syndrome
	21600	Fetal face syndrome (Robinow Syndrome)
	21700	Fg syndrome
	21800	Fibrochondrogenesis
	21900	Fibrodysplasia ossificans progressiva syndrome
	22000	First and second brachial arch syndrome
	22100	Floating-habour syndrome
	22200	Fragile x syndrome (Martin-Bell Syndrome)
	22300	Franceschetti-Klein syndrome (Treacher-Collins
		Syndrome)
	22400	Freeman-Sheldon syndrome (Whistling Face
		Syndrome)
	22500	Frenula, absent
	22600	Frontal bossing
	22700	Frontometaphyseal dysplasia
	22800	Frontonasal dysplasia sequence
	22900	Fryns syndrome
	23000	Galactosemia
	23100	Gastroschisis
	23200	Geleophysic dysplasia
	23300	Gilles telencephalic leucoencephalopathy
	23400	Glaucoma
	23500	Glossopalatine ankylosis syndrome
	23600	B-glucuidase deficiency
	23700	Glycogen storage disease
	23800	Goiter
	23900	Goldenhar syndrome
	24000	Goltz syndrome

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ANOMALY/METABOLIC	24100	Gonadal dysgenesis
SYNDROMES AND	24200	Gorlin syndrome (Nevoid basal cell carcinoma)
CONDITIONS	24300	Grebe syndrome
(R054) (con't)	24400	Hallerman-streiff syndrome
	24500	Hamartosis
	24600	Hemangioma
	24700	Hemangioma, capillary
	24800	Hemangioma, cavernous
	24900	Hemangioma, port-wine
	25000	Hecht syndrome
	25100	Hemifacial microsomia
	25200	Hemochromatosis
	25300	Hemorrhagic telangiectasia, hereditary
	25400	Hereditary arthro-ophthalmopathy
	25500	Hereditary osteo-onchodysplasia (Nail patella
	0=000	syndrome)
	25600	Hirshsprung aganglionosis
	25700	Holoprosencephaly
	25800	Holt-oram syndrome
	25900	Homocystinuria syndrome
	26000	Homozygous Leri-Weill syndrome
	26100	Hunter syndrome
	26200	Hurler syndrome
	26300	Hurler-Scheie syndrome
	26400	Hutchinson-Gilford syndrome (Progeria Syndrome)
	26500	Hydantoin embryology
	26600	Hydatidiform placenta
	26700	Hydranenecephaly
	26800	Hydrocele
	26900	Hydrocephalus
	27000	Hydrops fetalis
	27100	Hyperammonaemia
	27200	Hypochondrogenesis
	27300	Hypochondroplasia
	27400	Hypodactyly, hypoglossal
	27500	Hypodontia
	27600	Hypogenitalism
	27700	Hypoglossia-hypodactyly syndrome
	27800	Hypogonadism
	27900	Hypohidrotic ectodermal dysplasia (Rapp-Hodgkin
		ectoderma)
	28000	Hypomelanosis of ito

	00400	
ANOMALY/METABOLIC	28100	Hypomellia-hypotrichosis-facial hemangioma
SYNDROMES AND	00000	syndrome
CONDITIONS	28200	Hypospadius
(R054) (con't)	28300	Hypospadius, glandular (first degree)
	28400	Hypospadius, coronal (second degree)
	28500	Hypospadius, shaft (third degree)
	28600	Hypospadius, perineal (fourth degree)
	28700	Hypotrichosis
	28800	Icthyosiform erythroderma (Senter-Kid Syndrome)
	28900	Immune deficiency
	29000	Immunoglobulin deficiency
	29100	Imperforate anus
	29200	Iniencephaly
	29300	Intestinal atresia
	29400	Intestinal atresia, anal
	29500	Intestinal atresia, colonic
	29600	Intestinal atresia, duodenal
	29700	Intestinal atresia, ileal
	29800	Intestinal atresia, jejunal
	29900	Intestinal stenosis
	30000	Intestinal stenosis, anal
	30100	Intestinal stenosis, colonic
	30200	Intestinal stenosis, duodenal
	30300	Intestinal stenosis, ileal
	30400	Intestinal stenosis, jejunal
	30500	Intestinal stenosis, rectal
	30600	Intracardiac mass
	30700	Intrathoracic vascular ring
	30800	Ivenmark syndrome
	30900	Jackson-Lawler pachyonchia congenita syndrome
	31000	Jadossohn-Lewandowski pachyonychia congenita
		syndrome
	31100	Jansen-type metaphyseal dysplasia
	31200	Jarcho-Levin syndrome
	31300	Johanson-Blizzard syndrome
	31400	Jugular lymphatic obstruction sequence
	31500	Kabuki syndrome
	31600	Kartagener syndrome
	31700	Keratoconus
	31800	Killian/Teschler-Nicola syndrome (Pallister mosaic syndrome)
	31900	Kinky hair syndrome (Menkes Syndrome)
	32000	Klein-Waardenburg syndrome
		- -

SYNDROMES AND CONDITIONS 32300 Klippel-Trenaunay-Weber syndrome (R054) (con't) 32400 Kniest dysplasia 32500 Lacrimal-auriculo-dento-digital syndrome 32700 Ladd syndrome 32800 Langer-Gideon Syndrome 32900 Langer-Saldino achondrogenesis 33000 Larsen syndrome 33100 Laryngeal abnormality 33200 Laryngeal atresia 33300 Left-sidedness sequence 33500 Lens, dislocation 33600 Lenticular opacity 33700 Lentigines, multiple 33800 Lenz-Majewski hyperostosis syndrome 34900 Leryn-Weill dyschondrosteosis 34100 Lery-Weill dyschondrosteosis 34100 Lery-Weill dyschondrosteosis 34100 Lethal multiple pterygium syndrome 34200 Lesch-Nylan syndrome 34300 Lethal multiple pterygium syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipoatrophy, generalized 34900 Lipoatrophy, generalized	ANOMALY/METABOLIC	32100	Klinefelter syndrome
R054 (con't) 32400	SYNDROMES AND	32200	Klippel-Feil sequence
(R054) 32400 Kniest dysplasia 32500 Kozlowski spondylometaphyseal dysplasia 32600 Lacrimal-auriculo-dento-digital syndrome 32700 Ladd syndrome 32800 Langer-Gideon Syndrome 32900 Langer-Saldino achondrogenesis 33000 Larsen syndrome 33100 Laryngeal abnormality 33200 Laryngeal web 3400 Left-sidedness sequence 3500 Lens, dislocation 33600 Lenticular opacity 33700 Lentigines, multiple 33800 Lenz-Majewski hyperostosis syndrome 34900 Leopard syndrome 34000 Leri-weill dyschondrosteosis 34100 Lero-Waljewski hyperostosis syndrome 34000 Lein-weill dyschondrosteosis 34100 Lero-Waljewski hyperostosis syndrome 34200 Lesch-Nylan syndrome 34200 Lesch-Nylan syndrome 34200 Lesch-Nylan syndrome 34500 Lipoatrophy 34700 Lipoatrophy 34700	CONDITIONS	32300	Klippel-Trenaunay-Weber syndrome
32500 Kozlowski spondylometaphyseal dysplasia 32600 Lacrimal-auriculo-dentro-digital syndrome 32800 Langer-Gideon Syndrome 32900 Langer-Saldino achondrogenesis 33000 Larsen syndrome 33100 Laryngeal abnormality 33200 Laryngeal atresia 33300 Lens, dislocation 33600 Lenticular opacity 33700 Lentigines, multiple 33800 Lenz-Majewski hyperostosis syndrome 34000 Leri-weill dyschondrosteosis 34100 Letri-weill dyschondrosteosis 34100 Letha multiple pterygium syndrome 34200 Lesch-Nylan syndrome 34300 Lethal multiple pterygium syndrome 34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipoatrophy 34700 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Macrogoria 35600 Macrogoria 35600 Macrogoria 35600 Macrosomia 35900 Macrosomia 35900 Macrosomia 36000 Malefung deformity 36100 Maler hypoplasia		32400	Kniest dysplasia
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32800 Langer-Gideon Syndrome 32900 Langer-Saldino achondrogenesis 33000 Larsen syndrome 33100 Laryngeal abnormality 33200 Laryngeal atresia 33300 Laryngeal web 33400 Left-sidedness sequence 33500 Lens, dislocation 33600 Lenticular opacity 33700 Lentigines, multiple 33800 Lenz-Majewski hyperostosis syndrome Leopard syndrome 34000 Leri-weill dyschondrosteosis 34100 Leroy I-cell syndrome 34200 Lesch-Nylan syndrome 34400 Ley-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipoatrophy 34700 Lipodsis, neurovisceral 34800 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrogephaly 35500 Macrogephaly 35500 Macroghosia 35600 Macrosomia 35900 Macrosomia 35900 Macrosomia 36000 Madelung deformity 36100 Malfrucci syndrome 36200 Malar hypoplasia		32600	Lacrimal-auriculo-dento-digital syndrome
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33100 Laryngeal abnormality 33200 Laryngeal atresia 33300 Laryngeal web 33400 Left-sidedness sequence 33500 Lens, dislocation 33600 Lenticular opacity 33700 Lentigines, multiple 33800 Lenz-Majewski hyperostosis syndrome 34900 Leri-weill dyschondrosteosis 34100 Leroyl-cell syndrome 34200 Lesch-Nylan syndrome 34200 Lesch-Nylan syndrome 34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipoatrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macroglossia 35600 Macrosomia 35900 Macrosomia 35900 Macrosomia 36000 Madelung deformity 36100 Malar hypoplasia		32900	Langer-Saldino achondrogenesis
33200 Laryngeal atresia 33300 Laryngeal web 33400 Left-sidedness sequence 33500 Lens, dislocation 33600 Lenticular opacity 33700 Lentigines, multiple 33800 Lenz-Majewski hyperostosis syndrome 34900 Leri-weill dyschondrosteosis 34100 Leroy I-cell syndrome 34200 Lethal multiple pterygium syndrome 34300 Lethal multiple pterygium syndrome 34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Macroephaly 35500 Macroephaly		33000	Larsen syndrome
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33400 Left-sidedness sequence 33500 Lens, dislocation 33600 Lenticular opacity 33700 Lentigines, multiple Lenz-Majewski hyperostosis syndrome 33900 Leopard syndrome 34000 Leri-weill dyschondrosteosis 34100 Leroy I-cell syndrome 34200 Lesch-Nylan syndrome 34300 Lethal multiple pterygium syndrome 34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Wan der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Macrosophial 35400 Macrocephaly 35500 Macrosomia 35600 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		33200	Laryngeal atresia
33500 Lens, dislocation 33600 Lenticular opacity 33700 Lentigines, multiple 33800 Lenz-Majewski hyperostosis syndrome 33900 Leopard syndrome 34000 Leri-weill dyschondrosteosis 34100 Leri-weill dyschondrosteosis 34100 Leri-weill dyschondrome 34200 Lesch-Nylan syndrome 34300 Lethal multiple pterygium syndrome 34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		33300	Laryngeal web
33600 Lenticular opacity 33700 Lentigines, multiple 33800 Lenz-Majewski hyperostosis syndrome 33900 Leopard syndrome 34000 Leri-weill dyschondrosteosis 34100 Leroy I-cell syndrome 34200 Lesch-Nylan syndrome 34200 Lethal multiple pterygium syndrome 34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipodosis, neurovisceral 34800 Lipodosis, neurovisceral 34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephally Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephally 35500 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 36900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		33400	Left-sidedness sequence
Lentigines, multiple 33800 Lenz-Majewski hyperostosis syndrome 33900 Leopard syndrome 34000 Leri-weill dyschondrosteosis 34100 Leroy I-cell syndrome 34200 Lesch-Nylan syndrome 34300 Lethal multiple pterygium syndrome 34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrosomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		33500	Lens, dislocation
33800 Lenz-Majewski hyperostosis syndrome 33900 Leopard syndrome 34000 Leri-weill dyschondrosteosis 34100 Leroy I-cell syndrome 34200 Lesch-Nylan syndrome 34300 Lethal multiple pterygium syndrome 34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrostomia 36900 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		33600	Lenticular opacity
33900 Leopard syndrome 34000 Leri-weill dyschondrosteosis 34100 Leroy I-cell syndrome 34200 Lesch-Nylan syndrome 34300 Lethal multiple pterygium syndrome 34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrosomia 35900 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		33700	Lentigines, multiple
34000 Leri-weill dyschondrosteosis 34100 Leroy I-cell syndrome 34200 Lesch-Nylan syndrome 34300 Lethal multiple pterygium syndrome 34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macroephaly 35500 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrosomia 35900 Macrosomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		33800	Lenz-Majewski hyperostosis syndrome
34100 Leroy I-cell syndrome 34200 Lesch-Nylan syndrome 34300 Lethal multiple pterygium syndrome 34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		33900	Leopard syndrome
34200 Lesch-Nylan syndrome 34300 Lethal multiple pterygium syndrome 34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		34000	Leri-weill dyschondrosteosis
Lethal multiple pterygium syndrome 34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrosomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		34100	Leroy I-cell syndrome
34400 Levy-Hollister syndrome 34500 Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		34200	Lesch-Nylan syndrome
Limb-body wall complex 34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		34300	Lethal multiple pterygium syndrome
34600 Lipoatrophy 34700 Lipodosis, neurovisceral 34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		34400	Levy-Hollister syndrome
Lipodosis, neurovisceral 34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrostomia 35900 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		34500	Limb-body wall complex
34800 Lipodystrophy, generalized 34900 Lipomatosis, encephalocraniocutaneous 35000 Lippit-cleft hip syndrome (Van der Woude Syndrome) 35100 Lissencephaly Syndrome (Miller-Dreker Syndrome) 35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		34600	Lipoatrophy
Lipomatosis, encephalocraniocutaneous Lippit-cleft hip syndrome (Van der Woude Syndrome) Lissencephaly Syndrome (Miller-Dreker Syndrome) Lobstein disease Lupus, neonatal Macrocephaly Macrocephaly Macroglossia Macrogyria Macro-orchidism Macrosomia Macrosomia Macrostomia Macrostomia Macrostomia Maffucci syndrome Malar hypoplasia		34700	Lipodosis, neurovisceral
Lippit-cleft hip syndrome (Van der Woude Syndrome) Lissencephaly Syndrome (Miller-Dreker Syndrome) Lobstein disease Lupus, neonatal Lupus, neonatal Macrocephaly Macroglossia Macrogyria Macro-orchidism Macrosomia Macrostomia Macrostomia Madelung deformity Maffucci syndrome Malar hypoplasia		34800	Lipodystrophy, generalized
Lissencephaly Syndrome (Miller-Dreker Syndrome) Lobstein disease Lupus, neonatal Macrocephaly Macroglossia Macrogyria Macro-orchidism Macrosomia Macrostomia Macrostomia Madelung deformity Malar hypoplasia		34900	Lipomatosis, encephalocraniocutaneous
35200 Lobstein disease 35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		35000	Lippit-cleft hip syndrome (Van der Woude Syndrome)
35300 Lupus, neonatal 35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		35100	Lissencephaly Syndrome (Miller-Dreker Syndrome)
35400 Macrocephaly 35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		35200	Lobstein disease
35500 Macroglossia 35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		35300	Lupus, neonatal
35600 Macrogyria 35700 Macro-orchidism 35800 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		35400	Macrocephaly
35700 Macro-orchidism 35800 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		35500	Macroglossia
35800 Macrosomia 35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		35600	
35900 Macrostomia 36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia		35700	
36000 Madelung deformity 36100 Maffucci syndrome 36200 Malar hypoplasia			
36100 Maffucci syndrome 36200 Malar hypoplasia			
36200 Malar hypoplasia			
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36300 Male pseudohermaphroditism			
		36300	Male pseudohermaphroditism

ANOMALY/METABOLIC	36400	Mandibular hypodontia
SYNDROMES AND	36500	Marden-Walker syndrome
CONDITIONS	36600	Marfan syndrome
(R054) (con't)	36700	Maroteaux-Lamy (mucopolysaccharidosis syndrome)
(304)	36800	Marshall syndrome
	36900	Marshell-Smith syndrome
	37000	Masa syndrome (X-linked hydrocephalus syndrome
	37100	Maternal phenylkentonuruia, fetal effects
	37200	Maxillary hypoplasia
	37300	Mccune-Albright syndrome (osteitis fibrosa cystica)
	37400	Mckusick type metaphyseal dysplasia
	37500	Meckel diverticulum
	37600	Median cleft face syndrome
	37700	Melanomata
	37800	Melanosis, neurocutaneous
	37900	Melnick-Fraser syndrome
	38000	Melnick-needles syndrome
	38100	Meningocele
	38200	Meningomylocele
	38300	Metacarpal hypoplasia
	38400	Metaphyseal dysplasia, Jansen type
	38500	Metaphyseal dysplasia, Mckusick type
	38600	Metaphyseal dysplasia, Pyle type
	38700	Metaphyseal dysplasia, Schmid type
	38800	Metatarsal hypoplasia
	38900	Metatarsus adductus
	39000	Metatropic dwarfism
	39100	Metatropic dysplasia
	39200	Methioninaemia
	39300	Methotrexate embryology
	39400	Microcephaly
	39500	Microcolon
	39600	Microcolon-megacystis-hypoperistalsis syndrome
	39700	Microcornea
	39800	Microdeletion syndrome
	39900	Microdontia
	40000	Microgastria
	40100	Microglossia
	40200	Micrognathia
	40300	Micropenis
	40400	Microphthalmia
	40500	Microstomia
	40600	Miller syndrome (postaxial acrofacial dysostosis)

ANOMALY/METABOLIC	40700	Moebius syndrome
SYNDROMES AND	40800	Mohr syndrome (OFD)
<u>CONDITIONS</u>	40900	Morquio syndrome
(R054) (con't)	41000	Mucolipidosis III (pseudo Hurler)
	41100	Mucopolysaccharidosis I s (Scheie Syndrome)
	41200	Mucopolysaccharidosis III, types a, b, c, d
	41300	Mucopolysaccharidosis VII (Sly Syndrome)
	41400	Mulibrey nanism syndrome (Perheentupu Syndrome)
	41500	Multiple endocrine neoplasia, type 2b
	41600	Multiple neuroma syndrome
	41700	Multiple synostosis syndrome (Symphalanyism
		Syndrome)
	41800	Murcs association
	41900	Myasthenia gravis, newborn
	42000	Myopathy, centronuclear
	42100	Myopathy, myotubular
	42200	Nanism, diastrophic
	42300	Nasal dysplasia
	42400	Neonatal lupus
	42500	Neonatal teeth
	42600	Nesidioblastosis
	42700	Neu-laxova syndrome
	42800	Neural tube defect
	42900	Neurocutaneous melanosis syndrome
	43000	Neurofibromatosis syndrome
	43100	Neuromuscular defect
	43200	Neurovisceral lipidosis, familial
	43300	Noonan syndrome
	43400	Occult spinal dysraphism
	43500	Oculo-auriculo-vertebral defect spectrum
	43600	Oculodentodigital syndrome
	43700	Oculo-genito-laryngeal syndrome (Optiz Syndrome)
	43800	Odontoid hypoplasia
	43900	Oculo-facial-digital syndrome, type I (OFD-I)
	44000	Oculo-digital-facial syndrome type III (OFD-III)
	44100	Oligohydramnios sequence
	44200	Ollier disease (osteochondromatosis syndrome)
	44300	Omphalocele
	44400	Optic nerve dysplasia
	44500	Oromandibular-limb hypogenesis spectrum
	44600	Osteochondrodysplasia
	44700	Osteodysplasia
	44800	Osteogenesis imperfecta, type I
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ANOMALY/METABOLIC	44900	Osteogenesis imperfecta, type II
SYNDROMES AND	45000	Osteolysis
CONDITIONS	45100	Osteo-onychodysplasia
(R054) (con't)	45200	Osteopetrosis
(1034) (COIT)	45300	Otocephaly
	45400	Oto-palato-digital syndrome, type I (Taybi Syndrome)
	45500	Oto-palato-digital syndrome, type II
	45600	Pachydermoperiostosis syndrome
	45700	Pachygyria
	45800	Pachyonchia congenita syndrome
	45900	Pallister-Hall syndrome
	46000	Parabiotic syndrome, donor (Twin-to-twin transfer)
	46100	Parabiotic syndrome, recipient (Twin-to-twin transfer)
	46200	Pectus carinatum
	46300	Pectus excavatum
	46400	Pena Shokeir phenotype, type I
	46500	Pena-Shokeir phenotype, type II
	46600	Penta x syndrome
	46700	Pentrology of cantrell
	46800	Perinatal lethal hypophosphotasia
	46900	Peters'-plus syndrome
	47000	Peutz Jeghers syndrome
	47100	Pfeiffer syndrome
	47200	Phenylketonuria
	47300	Phenylketonuria, maternal effects
	47400	Photosensitive dermatitis
	47500	Pierre Robin syndrome
	47600	Pitting, lip
	47700	Pitting, preauricular
	47800	Poikiloderma congenitale syndrome (Rothmund-
		Thomson)
	47900	Poland sequence
	48000	Polydactyly
	48100	Polymicrogyria
	48200	Polysplenia syndrome
	48300	Popliteal pteryguim syndrome
	48400	Porencephalic cyst
	48500	Port wine stain
	48600	Potter syndrome
	48700	Prader-Willi syndrome
	48800	Preauricular tags
	48900	Preauricular pits
	49000	Prognathism

ANOMALY/METABOLIC	49100	Porteus syndrome
SYNDROMES AND	49200	Pseudoachondroplasia
CONDITIONS	49300	Pseudocamptodactyly
(R054) (con't)	49400	Pulmonary agenesis
(1004)	49500	Pulmonary hypoplasia
	49600	Pulmonary lymphangectasia, congenital
	49700	Pyknodysostosis
	49800	Pyle disease (Pyle metaphyeal dysplasia)
	49900	Pyruvate carboxylase deficiency
	50000	Pyruvate dehydrogenase deficiency
	50100	Rachischisis
	50200	Ranula
	50300	Rectal atresia
	50400	Rectal atresia, with fistula
	50500	Refsum's disease
	50600	Reifenstein's syndrome
	50700	Restrictive dermopathy
	50800	Retinoic acid embryopathy
	50900	Rhizomelic chondrodysplasia punctata
	51000	Rieger syndrome
	51100	Right-sidedness sequence
	51200	Rokitansky malformation sequence
	51300	Rubinstein-Taybi syndrome
	51400	Russell-Silver syndrome (Silver Syndrome)
	51500	Saddle nose
	51600	Saethre-Chotzen syndrome
	51700	Salino-noonan short rib-polydactyly syndrome
	51800	Sc phocomelia
	51900	Schinzel-Giedion syndrome
	52000	Schimd type metaphyseal dysplasia
	52100	Schizenecephaly
	52300	Sclerosteosis
	52500	Scrotum, shawl
	52600	Seckel syndrome
	52700	Septo-optic dysplasia sequence
	52800	Short bowel syndrome
	52900	Short rib-polydactyly syndrome, type II
	53000	Shprintzen syndrome
	53100	Shwachman syndrome
	53200	Simpson-Golabi-Behmel syndrome
	53300	Sirenomelia sequence
	53400	Smith-Lemli-Opitz Syndrome
	53500	Spondylocarpotarsal synostosis syndrome

	3600	
	3700	Spondylometaphyseal dysplasia, Kozlowski
		Stenal malformation-vascular dysplasia spectrum
		Struge-Weber sequence
(00111)		Sulfite oxidase deficiency
		Sugarman syndrome
		Syndactyly
		Tar syndrome (thromocytopenia absent radius)
		Taurodontism
		Tdo syndrome
5		Testicular feminization syndrome
5		Tesetis, hydrocele
5	54900	Tethered cord malformation syndrome
5	5000	Thanatophoric dysplasia
5	5100	Thyroglossal cyst
5	55200	Thrombocytopenia abent radius syndrome
5	5300	Thurston syndrome
5	55400	Tibial aplasia-ectrodactyly syndrome
5	55500	Townes-brock syndrome
5	5600	Tracheoesophageal fistula
5	5700	Transcobalamin II deficiency
5	5800	Trapezoidcephaly
5	5900	Tricho-rhino-phalangeal syndrome, type I
5	6000	Tridione embryopathy
5	6100	Trimethadione embryopathy
5	6200	Triphalangeal thumb
5	6300	Triploidy
5	6400	Trp I
5	6500	Turner syndrome
5	6600	Turner-like syndrome
5		Umbilical hernia
5	6800	Urorectal septum malformation sequence
5	6900	Uterus, ambiguous
5	7300	Vagina, double
5		Valproate embryopathy
5		Varadi-Papp syndrome
		Vater association
		Vein of Galen, aneurysm
		Vertebral defect
		Volvulus, colon
		Volvulus, ileum
		Volvulus, jejunum
5	8200	Volvulus, small bowel

ANOMALY/METABOLIC	58300	Von Hippel-Lindau syndrome
SYNDROMES AND	58400	Vrolik diease
CONDITIONS	58500	Waardenburg syndrome, type I
(R054) (con't)	58600	Waardenburg syndrome, type II
	58700	Waardenburg syndrome, type III
	58800	Wagr syndrome
	58900	Walker-Warburg syndrome
	59000	Warfarin embryology
	59100	Weaver syndrome
	59200	Weill-Marchesani syndrome
	59300	Werner syndrome
	59400	Whelan synrdome
	59500	Williams syndrome
	59600	Xeroderma pigmentosa syndrome
	59700	Yunis-Varon syndrome
	59800	Zellweger syndrome
	59900	Zollinger-ellison syndrome

DEPRESSION AT BIRTH (R055)

Found on the 'BIRTH RECORD', 'DISCHARGE SUMMARY' or 'NEONATOLOGIST'S LISTING'

If more than one procedure is performed during a delivery, code each separately.

If the same procedure is performed more than once code the total time that procedure was performed.

100	Bag and Mask < 1 minute
200	Bag and Mask 1 to 3 minutes
300	Bag and Mask > 3 minutes
400	Bag and Mask unknown duration
500	Endotracheal Tube <1 minute
600	Endortracheal Tube 1 to 3 minutes
700	Endotracheal Tube >3 minutes
800	Endotracheal Tube unknown duration
900	CPAP/T-Piece/Neopuff < 1 minute
1000	CPAP/T-Piece/Neopuff 1 to 3 minutes
1100	CPAP/T-Piece/Neopuff > 3 minutes
1200	CPAP/T-Piece/Neopuff unknown duration

PATENT DUCTUS ARTERIOSUS (R057)

PATENT DUCTUS ARTERIOSUS Found on the 'DISCHARGE SUMMARY'.

Choose one of the following;

100	Non-surgical closure
200	Surgical closure
300	Treatment not stated

PERSISTENT FETAL
CIRCULATION/
PERSISTENT PULMONARY
HYPERTENSION OF THE
NEWBORN
(R058)

Found on the 'DISCHARGE SUMMARY'.

Choose one of the following causes;

CHOOSE	one of the following causes,
100	Congenital heart disease
200	Fetomaternal bleed
300	Hyaline membrane disease
400	Meconium aspiration
500	Pulmonary hypoplasia
600	Pneumonia
700	Primary pulmonary hypertension
800	Cause not stated

RESPIRATORY DISTRESS SYNDROMES (R059)

Found on the 'DISCHARGE SUMMARY'.

Choose one of the following;

100

200	IRDS, mild
300	IRDS, moderate
400	IRDS, severe
500	IRDS, severity not stated
600	Transient Tachypnea of the newborn
700	Benign respiratory distress

Transient respiratory distress

CHRONIC PULMONARY DISEASE OF PREMATURITY (R060)

Found on the 'DISCHARGE SUMMARY'.

Choose one of the following;

100	Wilson-Mikity syndrome,non-cystic
200	Wilson-Mikity syndrome, cystic
300	Bronchopulmonary dysplasia, non-cystic
400	Bronchopulmonary dysplasia, cystic

REQUIREMENT FOR HOME OXYGEN (RO61)

Found on the 'DISCHARGE SUMMARY'.

100 Patient requires home oxygen.

BIRTH ASPHYXIA SEQUELLA (R062)

Found on the 'DISCHARGE SUMMARY'.

Choose as many as are present.

100	Post-Asphyctic CNS Depression
200	Post-Asphyctic CNS Excitation
300	Post-Asphyctic Increase Intracranial Pressure
400	Post-Asphyctic Brain Necrosis
500	Post-Asphyctic Congestive Heart Failure
600	Post-Asphyctic Acute Tubular Necrosis
700	Post-Asphyctic Liver and/or Adrenal Necrosis

CONVULSIONS/SEIZURES (R063)

Convulsions or seizures due to a stated condition.

Found on the 'DISCHARGE SUMMARY'.

Choose as many as are present.

100	Alkalosis
200	Arhinencephaly
300	Benign Familial
400	Brain Edema
500	Cerebral Anomaly, Unspecified
600	Drug Withdrawal
700	Hemorrhage, Brain Stem
800	Hemorrhage, Cerebellar
900	Hemorrhage, Cerebral
1000	Holoprosencephaly
1100	Hydrocephaly
1200	Hydranencephaly
1300	Hypercapnia
1400	Hypocalcemia
1500	Hypocapnia
1600	Hypoglycemia
1700	Hypomagnesemia
1800	Hyponatremia
1900	Inborn Error of Metabolism
2000	Infarction
2100	Kernicterus
2200	Meningitis
2300	Post-asphyctic
2400	Pyridoxine Deficiency
2500	Pyridoxine Dependency
2600	Unknown
2700	Venous Thrombosis

NEOPLASMS (R064)

Found on the 'DISCHARGE SUMMARY'.

Code all that are applicable.

100	Astrocytoma
200	Choroid Plexus Papilloma
300	Connective Tissue
400	Craniopharyngioma
500	Cystadenoma
600	Cystic Hygroma
700	Endothelial Tissue
800	Ependymona
900	Epithelial Tissue
1000	Familial Erythrophagocytic Lymphohistiocytosis
1100	Fibroma
1200	Follicular Cyst
1300	Glioma
1400	Hemangioma, Cavernous
1500	Hemangioma, Capillary
1600	Hepatobalstoma
1700	Histiocytosis
1800	Insulinoma
1900	Leukemia
2000	Lipoma
2100	Lymphangioma
2200	Lymphoma
2300	Mass, Unknown Type
2400	Medulloblastoma
2500	Melanoma
2600	Melanotic Neuroectodermal Tumor
2700	Mesoblastic Nephroma
2800	Muscle
2900	Myxofibrosarcoma
3000	Nasal Glioma
3100	Nephroblastoma
3200	Nesidioblastosis
3300	Neuroblastoma
3400	Neuroectodermal Tumor
3500	Neurofibroma
3600	Retinoblastoma
3700	Rhabdomyoma, Cardiac
3800	Rhabdomyoma

NEOPLASMS	3900	Sarcoma
(R064) (con't)	4000	Teratoma, Cardiac
	4100	Teratoma, Embryotic Rests
	4200	Teratoma, Gonads
	4300	Teratoma, Sacrococcygeal
	4400	Teratoma, Site Not Specified
	4500	Wilm's Tumor
	4600	Hemangioma
	4700	Hemangioma, port-wine

MEDICATIONS

Found on 'MEDICATION SHEETS' or 'DISCHARGE SUMMARY'

<u>MEDICATIONS</u>	Found	on ' <i>MEDICATION SHEETS</i> ' or ' <i>DISCHARGE SUMI</i>
<u>(R066)</u>		
	400	Acyclovir
(Not coded at IWK)	500	Adenosine
	600	Adrenalin
	1000	Alprostadel (Prostagladin e.; Prostin)
	1400	Amoxicillin
	1600	Ampicillin
	3100	Cefazidime
	3200	Cefazolin
	3300	Cefotaxime
	3400	Ceftriaxone
	3500	Cefuroxime
	4000	Cloxacillin
	4200	Colfosceril palmitate [Exosurf] Cortisol (Exosurf
		[Surfactant]
	4600	Diazapam
	4800	Digoxin
	4900	Dilantin (Phenytoin)
	5000	Dobutamine
	5200	Dopamine
	5400	Epinephrine
	5600	Erythromycin
	5700	Fentanyl
	5900	Flagyl (Metronidazole)
	6300	Furosemide (Lasix)
	6400	Gentamicin
	6500	Glucagon
	7500	Insulin
	7800	Kayexalate
	7900	Morphine

	8800	Naloxone (Narcan)
<u>MEDICATIONS</u>	9500	Penicillin
(R066) (con't)	9600	Phenobarbital
	9700	Potassiun chloride
(Not coded at IWK)	10000	Propranolol
	10300	Salbutamol (Ventolin)
	10400	Septra (Sulfamethoxazole/trimethoprim)
	11100	Ticarcillin
	11200	Tobramycin
	11400	Trimethoprim
	11700	Vancomycin
	11900	Tamiflu
	12000	Relenza

DRUG WITHDRAWL FROM MATERNAL USE (R067)

Found on the 'DISCHARGE SUMMARY'

Code ALL applicable drugs

100	Alprazolam (Xanax)
200	Barbituate
300	Benzodiazapam
400	Citalopram (Celexa)
500	Cocaine
600	Diazapam (Valium)
700	Fluoxetine (Prozac)
800	Ethchlorvyol (Placidyl)
900	Heroin
1000	Hydromorphone (Dilaudid)
1100	Lorazopam (Ativan)
1200	Meperidine (Demerol)
1300	Methadone
1400	Morphine
1500	Oxazepam
1600	Paroxetine (Paxil)
1700	Pentazocine (Talwin)
1800	Sertraline (Zoloft)
1900	Unknown
2000	Venlafaxine (Effexor)
2010	OxyContin

CENTRAL VENOUS CATHETERS (R069)

Found on the 'OPERATIVE REPORT' or on the 'DISCHARGE SUMMARY'.

Code all applicable catheters along with the number of times each were inserted.

110	Umbilical vein, direct (1 time)
120	Umbilical vein, direct (2 times)
130	Umbilical vein, direct (3 times)
140	Umbilical vein, direct (4 times)
150	Umbilical vein, direct (5 times)
160	Umbilical vein, direct (more than 5 times)
210	Upper limb, direct (1 time)
220	Upper limb, direct (2 times)
230	Upper limb, direct (3 times)
240	Upper limb, direct (4 times)
250	Upper limb, direct (5 times)
260	Upper limb, direct (more than 5 times)
310	Upper limb, percutaneous (PICC) (1 time)
320	Upper limb,percutaneous (PICC) (2 times)
330	Upper limb,percutaneous (PICC) (3 times)
340	Upper limb,percutaneous (PICC) (4 times)
350	Upper limb,percutaneous (PICC) (5 times)
360	Upper limb,percutaneous (PICC) (more than 5 times)
410	Upper limb, cut down (surgical) (1 time)
420	Upper limb, cut down (surgical) (2 times)
430	Upper limb, cut down (surgical) (3 times)
440	Upper limb, cut down (surgical) (4 times)
450	Upper limb, cut down (surgical) (5 times)
460	Upper limb, cut down (surgical) (more than 5 times)
510	Upper limb, Broviac (1 time)
520	Upper limb, Broviac (2 times)
530	Upper limb, Broviac (3 times)
540	Upper limb, Broviac (4 times)
550	Upper limb, Broviac (5 times)
560	Upper limb, Broviac (more than 5 times)
610	Lower limb, direct (1 time)
620	Lower limb, direct (2 times)
630	Lower limb, direct (3 times)
640	Lower limb, direct (4 times)
650	Lower limb, direct (5 times)
660	Lower limb, direct (more than 5 times)

CENTRAL VENOUS	710	Lower limb, percutaneous (PICC) (1 time)
CATHETERS	720	Lower limb,percutaneous (PICC) (2 times)
(R069) (con't)	730	Lower limb, percutaneous (PICC) (3 times)
	740	Lower limb, percutaneous (PICC) (4 times)
	750	Lower limb, percutaneous (PICC) (5 times)
	760	Lower limb, percutaneous (PICC) (more than 5 times)
	810	Lower limb, cut down (surgical) (1 time)
	820	Lower limb, cut down (surgical) (2 times)
	830	Lower limb, cut down (surgical) (3 times)
	840	Lower limb, cut down (surgical) (4 times)
	850	Lower limb, cut down (surgical) (5 times)
	860	Lower limb, cut down (surgical) (more than 5 times)
	910	Lower limb, Brioviac (1 time)
	920	Lower limb, Brioviac (2 times)
	930	Lower limb, Brioviac (3 times)
	940	Lower limb, Brioviac (4 times)
	950	Lower limb, Brioviac (5 times)
	960	Lower limb, Brioviac (more than 5 times)
	1100	Other (1 time)
	1120	Other (2 times)
	1130	Other (3 times)
	1140	Other (4 times)
	1150	Other (5 times)
	1160	Other(more than 5 times)

ARTERIAL CATHETERS (RO70)

Found on the 'OPERATIVE REPORT' or on the 'DISCHARGE SUMMARY'.

Code all applicable catheters along with the number of times each were inserted.

110	Umbilical, direct (1 time)
120	Umbilical, direct (2 times)
130	Umbilical, direct (3 times)
140	Umbilical, direct (4 times)
150	Umbilical, direct (5 times)
160	Umbilical, direct (more than 5 times)
210	Radial, direct (1 time)
220	Radial, direct (2 times)
230	Radial, direct (3 times)
240	Radial, direct (4 times)
250	Radial, direct (5 times)
260	Radial, direct (more than 5 times)

ARTERIAL CATHETERS	310	Radial, percutaneous (PICC) (1 time)
RO70) (con't)	320	Radial, percutaneous (PICC) (2 times)
	330	Radial, percutaneous (PICC) (3 times)
	340	Radial, percutaneous (PICC) (4 times)
	350	Radial, percutaneous (PICC) (5 times)
	360	Radial, percutaneous (PICC) (more than 5 times)
	410	Radial, cut down (surgical) (1 time)
	420	Radial, cut down (surgical) (2 times)
	430	Radial, cut down (surgical) (3 times)
	440	Radial, cut down (surgical) (4 times)
	450	Radial, cut down (surgical) (5 times)
	460	Radial, cut down (surgical) (more than 5 times)
	510	Pedal, direct (1 time)
	520	Pedal, direct (2 times)
	530	Pedal, direct (3 times)
	540	Pedal, direct (4 times)
	550	Pedal, direct (5 times)
	560	Pedal, direct (more than 5 times)
	610	Pedal, percutaneous (PICC) (1 time)
	620	Pedal, percutaneous (PICC) (2 times)
	630	Pedal, percutaneous (PICC) (3 times)
	640	Pedal, percutaneous (PICC) (4 times)
	650	Pedal, percutaneous (PICC) (5 times)
	660	Pedal, percutaneous (PICC) (more than 5 times)
	710	Pedal, cut down (surgical) (1 time)
	720	Pedal, cut down (surgical) (2 times)
	730	Pedal, cut down (surgical) (3 times)
	740	Pedal, cut down (surgical) (4 times)
	750	Pedal, cut down (surgical) (5 times)
	760	Pedal, cut down (surgical) (more than 5 times)
	810	Femoral, direct (1 time)
	820	Femoral, direct (2 times)
	830	Femoral, direct (3 times)
	840	Femoral, direct (4 times)
	850	Femoral, direct (5 times)
	860	Femoral, direct (more than 5 times)
	910	Femoral, percutaneous (PICC) (1 time)
	920	Femoral, percutaneous (PICC) (2 times)
	930	Femoral, percutaneous (PICC) (3 times)
	940	Femoral, percutaneous (PICC) (4 times)
	950	Femoral, percutaneous (PICC) (5 times)
	960	Femoral, percutaneous (PICC) (more than 5 times)

ARTERIAL CATHETERS	1100	Femoral, cut down (surgical) (1 time)
(RO70) (con't)	1200	Femoral, cut down (surgical) (2 times)
	1300	Femoral, cut down (surgical) (3 times)
	1400	Femoral, cut down (surgical) (4 times)
	1500	Femoral, cut down (surgical) (5 times)
	1600	Femoral, cut down (surgical) (more than 5 times)

MODE OF VENTILATION (R071)

Found on the 'RESPIRATORY THERAPY RECORD' or on the 'DISCHARGE SUMMARY'.

Code ALL that are applicable.

100	Intermittent mandatory ventilation (IMV)
200	Synchronized mandatory ventilation (SIMV)
300	Pressure support (PS)
400	Continuous positive airway pressure (CPAP)
500	High frequency Oscillatory ventilation (HFOV)
600	Positive pressure ventilation (PPV)

COMPLICATIONS OF ENDOTRACEAL INTUBATION (R072)

Found on the 'DISCHARGE SUMMARY'.

Esophageal perforation

Code $\underline{\mathsf{ALL}}$ complications of an endotracheal intubation that are applicable.

	1 5 1
200	Granuloma
300	Laryngeal perforation
400	Laryngeal stenosis
500	Lip deformity
600	Necrotizing laryngitis
700	Necrotizing trachetis
800	Palate deformity
900	Squamous metaplasia
1000	Stridor
1100	Subglottic stenosis
1200	Tracheal perforation
1300	Tracheobronchomalacia
1400	Ulceration

100

VASCULAR CATHETERS (R073)

Found on the 'OPERATIVE REPORT' or on the 'DISCHARGE SUMMARY'.

Code <u>ALL</u> complications of a vascular catheter that are applicable.

100	Arterial thrombosis
200	Cardiac tamponade
300	Edema
400	Loss of finger(s)
500	Loss of toe(s)
600	Pericardial effusion
700	Perforation of the heart
800	Pleural effusion
900	Phrenic nerve palsy
1000	Ruptured vessel
1100	Thrombophlebitis
1200	Vasospasm
1300	Venous thrombosis

NASO/ORO GASTRIC TUBES (R074)

Found on the 'DISCHARGE SUMMARY'.

Code $\underline{\mathsf{ALL}}$ complications of a naso/oro gasric tube that are applicable.

100	Perforation, esophagus
200	Perforation, stomach
300	Perforation, small bowel

COMPLICATIONS OF MEDICATIONS (R075)

Found on the 'DISCHARGE SUMMARY'.

Code ALL applicable complications due to a medication.

100	Cardiomyopathy, steroid induced
200	Contracture, secondary to IM injection
300	Nephrocalcinosis, diuretic induced
500	Skin slough

COMPLICATIONS OF SURGERY (R076)

Found on the 'OPERATIVE REPORT' or on the 'DISCHARGE SUMMARY'.

Code <u>ALL</u> applicable complications due to a surgical procedure.

100 Diaphragmatic paralysis200 Vocal cord paralysis

BURNS (R077)

Found on the 'DISCHARGE SUMMARY'.

Code ALL applicable burns.

100 Chemical200 Electrical300 Thermal

PHOTOTHERAPY (RO78)

Found on the 'DISCHARGE SUMMARY'

100 Phototherapy

100

IMMUNIZATIONS (R079)

Found on the 'DISCHARGE SUMMARY'

Code <u>ALL</u> applicable immunizations given to the infant.

DPTP (Diptheria, Pertussis, Tetanus, Polio)

	· · · · · · · · · · · · · · · · · · ·
200	DPT (Diptheria, Pertussis, Tetanus)
300	Hepatitis B globulin
400	Hepatitis B vaccine
500	Viral Influenza
600	Hemophilus Influenza B Conjugate
700	RSV (Respiratory Syncytial Virus) Vaccine
800	Varicella (Chicken Pox) Vaccine
900	H1N1 Influenza Vaccine

Found on 'DISCHARGE SUMMARY OR LAB SHEETS' LAB RESULTS (R<u>080)</u> 100 Neutropenia, (Not coded at IWK) < 1,000 pmns (mature or bands per cu.mm) (Refer to reference lab sheet for use following formula: Multiply the total corrected WBC's by the % ranges) of pmns (polymorphoneutrophils) and bands. e.g.total WBC=15,000 pmns= 5% bands= 1% 200 ABO Immunizations- Definite 300 D isoimmunization 400 Little c Isoimmunization 500 Big C Isoimmunization 600 Big E Isoimmunization 700 Kell Isoimmunization 800 Fya Isoimmunization (Duffy) 900 Kidd 1000 Wright MNS blood groups 1100

1700	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.)
1800	Thrombocytopenia (Platelet count <100,000 on greater than two occasions only
1900	Obstructive Jaundice (Direct bilirubin, or conjugated, >2.0 mg% or >34.5 micromol/L
2000	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)
2100	Reticulocytosis (>7% on days 1-2; >5% on days 3-6; >3% on days 7 and thereafter)
2200	Hyperthyroidism
2300	Rickets - Elevated alkaline phosphatase only (>406 I.U.)
2400	Hypoglucosemia (<30 mgm% or <1.67 mmol/L
2500	Hyperglucosemia (>125 mg% or >6.94 mmol/L)
2600	Hypocalcemia (7.0 mg% or less; 1.75 mmol/L or less; ionized ≤ 1.0 mmol/L)
2700	Late Metabolic Acidosis (After 72 hours of age; base deficit > -10 mEq/L or > -10 mmol/L)
2800	Hypokalemia (<3.0 mEq/L or <3.0 mmol/L
2900	Hyperkalemia (7.0 mEq/L or more; 7.0 mmol/L or more)
3000	Hyponatremia (130 mEq/L or less; 130 mmol/L or less)
3100	Hypernatremia (>155 mEq/L or >155 mmol/L

LAB RESULTS (R080) (con't)

3200	Azotemia
	(BUN 20 mg% or more; 7.14 mmol/L or more,
urea val	ue)
3300	Hypercreatininemia
	2.0 mg% or more; 177 micromol/L or more)
3400	Oliguria
	(<15 ml/Kgm/day on Day 2 or <20 ml/Kgm/day
	after 2 days)
3500	Hypoproteinemia
	(4.0 gm% or less; 40 gm/L or less)
3600	Hypoalbuminemia
	(≤2.4 gm% or ≤24 gm/L)
3700	Hypomagnesemia
	(1.3 mEq/L or less; 0.53 mmol/L or less)
3800	Hypermagnesemia
	(>2.5 mEq/L or >1.03 mmol/L)
3900	Hyperphosphatemia
	(8.0 mg% or more; 2.58 mmol/L or more)
4000	Hypertyrosinemia
	(5.0 mgm% or more)
4100	Hyperammonemia
	(>150 microgm% or >107 micromol/L)
4200	Hyperuricemia
	(>400 micromol/L)
4300	Hypercalcemia
	(≥3.0 mmol/L; ionized - ≥1.5 mmol/L)
4400	Low serum alkaline/phosphatase
	(< 120 IU/L)
4500	Hypophosphatemia
	(<4.0 mg% or <1.29 mmol/L)
	_

LAB RESULTS (R080) (con't)

INTRA-VENTRICULAR HEMORRHAGE	Found or	n the 'DISCHARGE SUMMARY'
(R081)	100	Grade 1 (sub-ependymal, choriod Plexus hemorrhage)
	200	Grade 2 (Hemorrhage into ventricle without dilatation of ventricle)
	300	Grade III (Hemorrhage into ventricle with dilatation of ventricle)
	400	Grade IV (Hemorrhage into brain: thalamic hemorrhage, cortical hemorrhage)

TRAUMA (R082)

Found on the 'DISCHARGE SUMMARY'

Code **ALL** applicable traumas

100	Fracture Clavicle
200	Fracture Femur
300	Fracture Humerus
400	Fracture Other
500	Fracture Rib (s)
600	Fracture Skull
700	Cephalohematoma Left
800	Cephalohematoma Right
900	Cephalohematoma Bilateral
1000	Cephalohematoma Other, including Occipital
1100	Cephalohematoma Unknown
1200	Shoulder Dystocia

NON-SPECIFIC NEUROLOGICAL FINDINGS (R083)

Found on the 'DISCHARGE SUMMARY'

Code **ALL** applicable Findings

100	Abnormal Cerebral Irritation/Hypertoncity
200	Hyperexlixia (Hereditary Startle Disease)
300	Abnormal Cerebral Depression/Hypotonicity
400	Abnormal Cerebral Depression due to Maternal
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500	Cerebral Edema
600	Cortical Atrophy
700	Encephalomalacia
800	Gilles Telencephalic Leucoencephalopathy
900	Infarction
1000	Porencephalic cyst(s)
1100	Periventricular Leukomalacia

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Found on the 'DISCHARGE SUMMARY'

Code **ALL** applicable Findings

100	Facial Palsy Left
200	Facial Palsy Right
300	Facial Palsy Bilateral
400	Brachial Plexus (Erb's & Klumpke's) Palsy, Left
500	Brachial Plexus (Erb's & Klumpke's) Palsy, Right
600	Brachial Plexus (Erb's & Klumpke's) Palsy,
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700	Brachial Plexus (Erb's & Klumpke's) Palsy,
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800	Phrenic Nerve, Left
900	Phrenic Nerve, Right
1000	Phrenic Nerve, Bilateral
1100	Hemiparesis Transient (NOT present at time of
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1200	Hemiparesis Transient (Present at time of
	discharge from hospital)
1300	Retinal hemorrhage involving the macula
1400	Chorioretinitis
1500	Congenital Subdural Effusion
1600	Periventricular Calcification
1700	Ondines's Curses
1800	Opsocionus
1900	Cranial Nerve Palsy 3 rd or Oculomotor Nerve
2000	Cranial Nerve Palsy 4 th or Trochlear Nerve
2100	Cranial Nerve Palsy 5 th or Trigeminal Nerve
2200	Cranial Nerve Palsy 6 th or Abducens Nerve
2300	Cranial Nerve Palsy 10 th or Vagus Nerve

<u>APNEA</u> (R085) Found on the "DISCHARGE SUMMARY OR NURSES NOTES"

100 Apneic Spells

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Found on the 'BIRTH RECORD or DISCHARGE SUMMARY'

Code ALL applicable codes

100 Oxygen

300 Chest Compressions

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100 Laboratory confirmed H1N1 Influenza

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Found on 'DISCHARGE SUMMARY or NURSES NOTES'

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