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(Use for “discharge to” only if mom and baby both go to the home)
## LISTING OF HOSPITALS

Hospitals appearing in bold provide maternity services.

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<td>Sutherland–Harris Memorial Hospital</td>
<td>Pictou</td>
<td>50</td>
</tr>
<tr>
<td>Twin Oaks Memorial Hospital</td>
<td>Musquodoboit Harbour</td>
<td>52</td>
</tr>
<tr>
<td><strong>Valley Regional Hospital</strong></td>
<td>Kentville</td>
<td>67</td>
</tr>
<tr>
<td>Victoria County Memorial Hospital</td>
<td>Baddeck</td>
<td>53</td>
</tr>
<tr>
<td>Western Kings Memorial Health Centre</td>
<td>Berwick</td>
<td>55</td>
</tr>
<tr>
<td><strong>Western Regional Health Centre</strong></td>
<td>Yarmouth</td>
<td>56</td>
</tr>
<tr>
<td>Hospital in Alberta</td>
<td>Alberta</td>
<td>-16</td>
</tr>
<tr>
<td>Hospital in Bermuda</td>
<td>Bermuda</td>
<td>-31</td>
</tr>
<tr>
<td>Hospital in British Columbia</td>
<td>British Columbia</td>
<td>-17</td>
</tr>
<tr>
<td>Hospital in Manitoba</td>
<td>Manitoba</td>
<td>-18</td>
</tr>
<tr>
<td>Hospital in Newfoundland &amp; Labrador</td>
<td>Newfoundland &amp; Labrador</td>
<td>-19</td>
</tr>
<tr>
<td>Hospital in New Brunswick (other than those listed)</td>
<td>New Brunswick</td>
<td>-20</td>
</tr>
<tr>
<td>Hospital in Northwest Territories</td>
<td>Northwest Territories</td>
<td>-21</td>
</tr>
<tr>
<td>Hospital in Nunavut</td>
<td>Nunavut</td>
<td>-28</td>
</tr>
<tr>
<td>Hospital not in list</td>
<td>Non-specific</td>
<td>-32</td>
</tr>
<tr>
<td>Hospital in Ontario</td>
<td>Ontario</td>
<td>-22</td>
</tr>
<tr>
<td>Hospital in PEI (other than those listed)</td>
<td>Prince Edward Island</td>
<td>-23</td>
</tr>
<tr>
<td>Hospital in Quebec</td>
<td>Quebec</td>
<td>-24</td>
</tr>
<tr>
<td>Hospital in Saskatchewan</td>
<td>Saskatchewan</td>
<td>-25</td>
</tr>
<tr>
<td>Hospital in United States</td>
<td>United States</td>
<td>-26</td>
</tr>
<tr>
<td>Hospital in Yukon</td>
<td>Yukon</td>
<td>-27</td>
</tr>
</tbody>
</table>
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 13-17.

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’.

‘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’.

**ADMISSION TIME**

Patient’s admission time to hospital.

Found on the ‘**HOSPITAL ADMISSION FORM**’.

Use the following format: ‘HHMM’.

‘HH’ is in range 0-23, ‘MM’ is in range 0-59.

**GIVEN NAME(S)**

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**’.

<table>
<thead>
<tr>
<th></th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Delivered Admission</td>
</tr>
<tr>
<td>2</td>
<td>Undelivered Admission</td>
</tr>
<tr>
<td>3</td>
<td>Postpartum Admission</td>
</tr>
<tr>
<td>5</td>
<td>Neonatal Admission</td>
</tr>
</tbody>
</table>

**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: ‘CCNNNNNNNN/YY’ where ‘CC’ is the admit type, ‘NNNNNNNN’ 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 ‘999999999999’ for other provincial account numbers, or when unknown.

HEALTH CARD NUMBER

Found on the ‘HOSPITAL ADMISSION FORM’.

Record the patient’s Nova Scotia Health Card Number or Nova Scotia 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;

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Nova Scotia patient health card #, card not available</td>
</tr>
<tr>
<td>0</td>
<td>Armed Forces</td>
</tr>
<tr>
<td>0</td>
<td>First Nations</td>
</tr>
<tr>
<td>0</td>
<td>Self-paying</td>
</tr>
<tr>
<td>1</td>
<td>Patient from outside Nova Scotia</td>
</tr>
</tbody>
</table>

BIRTH DATE

Patient’s date of birth.

Found on the ‘HOSPITAL ADMISSION FORM’.

Use the following format: ‘YYYYMMDD’.
**MUNICIPAL CODE**  
Patient’s municipal code.

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

<table>
<thead>
<tr>
<th>ANnapolis county</th>
<th>12</th>
<th>annapolis municipality</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Annapolis Royal</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Bridgetown</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Middleton</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>aNTIGOnish county</th>
<th>14</th>
<th>Antigonish Municipality</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Town of Antigonish</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cape Breton county</th>
<th>22</th>
<th>Cape Breton Municipality</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>dominion</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Glace Bay</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Louisbourg</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>New Waterford</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>North Sydney</td>
<td></td>
</tr>
<tr>
<td>67</td>
<td>Sydney</td>
<td></td>
</tr>
<tr>
<td>68</td>
<td>Sydney Mines</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ColChester county</th>
<th>26</th>
<th>Colchester Municipality</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>Stewiacke</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>Truro</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cumberland county</th>
<th>11</th>
<th>Amherst</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Cumberland Municipality</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Oxford</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Parrsboro</td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>Springhill</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DigBy county</th>
<th>24</th>
<th>Clare Municipality</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>Digby Municipality</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Town of Digby</td>
<td></td>
</tr>
</tbody>
</table>
## MUNICIPAL CODE (con’t)

<table>
<thead>
<tr>
<th>GUYSBOROUGH COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 Canso</td>
</tr>
<tr>
<td>33 Guysborough Municipality</td>
</tr>
<tr>
<td>50 Mulgrave</td>
</tr>
<tr>
<td>66 St. Mary’s Municipality</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HALIFAX COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>77 Bedford</td>
</tr>
<tr>
<td>28 Dartmouth</td>
</tr>
<tr>
<td>34 Halifax</td>
</tr>
<tr>
<td>35 Halifax Municipality (not Bedford, Dartmouth or Halifax)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HANTS COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>38 Hantsport</td>
</tr>
<tr>
<td>36 East Hants Municipality</td>
</tr>
<tr>
<td>37 West Hants Municipality</td>
</tr>
<tr>
<td>73 Windsor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INVERNESS COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>39 Inverness Municipality</td>
</tr>
<tr>
<td>58 Port Hawkesbury</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KINGS COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Berwick</td>
</tr>
<tr>
<td>41 Kentville</td>
</tr>
<tr>
<td>42 Kings Municipality</td>
</tr>
<tr>
<td>74 Wolfville</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LUNENBURG COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 Bridgewater</td>
</tr>
<tr>
<td>23 Chester Municipality</td>
</tr>
<tr>
<td>46 Lunenburg Municipality</td>
</tr>
<tr>
<td>47 Lunenburg Town</td>
</tr>
<tr>
<td>48 Mahone Bay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PICTOU COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>51 New Glasgow</td>
</tr>
<tr>
<td>56 Pictou Municipality</td>
</tr>
<tr>
<td>57 Pictou Town</td>
</tr>
<tr>
<td>64 Stellarton</td>
</tr>
<tr>
<td>69 Trenton</td>
</tr>
<tr>
<td>72 Westville</td>
</tr>
<tr>
<td>MUNICIPAL CODE (con’t)</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>QUEENS COUNTY</td>
</tr>
<tr>
<td>43 Liverpool</td>
</tr>
<tr>
<td>59 Queens Municipality</td>
</tr>
<tr>
<td>RICHMOND COUNTY</td>
</tr>
<tr>
<td>60 Richmond Municipality</td>
</tr>
<tr>
<td>SHELBURNES COUNTY</td>
</tr>
<tr>
<td>17 Barrington Municipality</td>
</tr>
<tr>
<td>25 Clark’s Harbour</td>
</tr>
<tr>
<td>44 Lockeport</td>
</tr>
<tr>
<td>61 Shelburne Municipality</td>
</tr>
<tr>
<td>62 Shelburne Town</td>
</tr>
<tr>
<td>VICTORIA COUNTY</td>
</tr>
<tr>
<td>71 Victoria Municipality</td>
</tr>
<tr>
<td>YARMOUTH COUNTY</td>
</tr>
<tr>
<td>16 Argyle Municipality</td>
</tr>
<tr>
<td>75 Yarmouth Municipality</td>
</tr>
<tr>
<td>76 Yarmouth Town</td>
</tr>
<tr>
<td>OUT OF PROVINCE RESIDENTS</td>
</tr>
<tr>
<td>81 Alberta</td>
</tr>
<tr>
<td>82 British Columbia</td>
</tr>
<tr>
<td>83 Manitoba</td>
</tr>
<tr>
<td>84 New Brunswick</td>
</tr>
<tr>
<td>85 Newfoundland and Labrador</td>
</tr>
<tr>
<td>86 Ontario</td>
</tr>
<tr>
<td>87 Prince Edward Island</td>
</tr>
<tr>
<td>88 Quebec</td>
</tr>
<tr>
<td>89 Saskatchewan</td>
</tr>
<tr>
<td>90 Yukon</td>
</tr>
<tr>
<td>91 Northwest Territories</td>
</tr>
<tr>
<td>92 Nunavut</td>
</tr>
<tr>
<td>95 Bermuda</td>
</tr>
<tr>
<td>97 USA</td>
</tr>
<tr>
<td>98 Other countries</td>
</tr>
<tr>
<td>99 Unknown</td>
</tr>
</tbody>
</table>
**MARITAL STATUS**

Patient’s marital status

Found on the ‘HOSPITAL ADMISSION FORM’ or ‘PRESHITAL RECORD’.

Code using one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Single</td>
</tr>
<tr>
<td>2</td>
<td>Married</td>
</tr>
<tr>
<td>3</td>
<td>Widowed</td>
</tr>
<tr>
<td>4</td>
<td>Divorced</td>
</tr>
<tr>
<td>5</td>
<td>Separated</td>
</tr>
<tr>
<td>6</td>
<td>Common-law</td>
</tr>
<tr>
<td>7</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Marital status will automatically blank out for neonatal admissions.

**CARE PROVIDER ATTENDING**

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.

**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.

<table>
<thead>
<tr>
<th>F</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Male</td>
</tr>
<tr>
<td>A</td>
<td>Ambiguous</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**STREET ADDRESS**

Patient’s street address.

Found on the ‘HOSPITAL ADMISSION FORM’.

Example: 4 King Street

**MAILING 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

**CITY/TOWN**

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-Miquelon.

Code ‘999999’ for unknown.

**PROVINCE**

Patient’s province of residence.

Found on the ‘HOSPITAL ADMISSION FORM’.

Code using one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Province</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB</td>
<td>Alberta</td>
</tr>
<tr>
<td>BC</td>
<td>British Columbia</td>
</tr>
<tr>
<td>MB</td>
<td>Manitoba</td>
</tr>
<tr>
<td>NS</td>
<td>Nova Scotia</td>
</tr>
<tr>
<td>NB</td>
<td>New Brunswick</td>
</tr>
<tr>
<td>NL</td>
<td>Newfoundland and Labrador</td>
</tr>
<tr>
<td>NT</td>
<td>Northwest Territories</td>
</tr>
<tr>
<td>NU</td>
<td>Nunavut</td>
</tr>
<tr>
<td>ON</td>
<td>Ontario</td>
</tr>
<tr>
<td>PE</td>
<td>Prince Edward Island</td>
</tr>
<tr>
<td>QC</td>
<td>Quebec</td>
</tr>
<tr>
<td>SK</td>
<td>Saskatchewan</td>
</tr>
<tr>
<td>YT</td>
<td>Yukon</td>
</tr>
<tr>
<td>US</td>
<td>USA</td>
</tr>
<tr>
<td>XX</td>
<td>Not Canada or USA</td>
</tr>
</tbody>
</table>
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 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 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.
DELIVERED ADMISSION

Routine Information – Delivered Admission

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

1. a live born infant
   OR
2. an infant that has reached 20 or more completed weeks gestation
   OR
3. an infant weighting 500 or more grams
   OR
4. an infant that is one of a set of multiples where the above criteria has been achieved.

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 13-17.

If a birth occurs in a hospital without an obstetrical service, and the mother and baby are transferred to a facility with an obstetrical service, the hospital receiving the transfer is to collect this 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>-1</td>
<td>Unplanned out of hospital, e.g. delivery en route to hospital, unplanned birth at home.</td>
</tr>
<tr>
<td>-2</td>
<td>Planned birth at home</td>
</tr>
<tr>
<td>-5</td>
<td>Midwife attended home delivery</td>
</tr>
</tbody>
</table>
**ADMITTED FROM**
Mother’s location immediately prior to admission.

Found on the ‘HOSPITAL ADMISSION FORM’.

If the patient is transferred from another hospital, record the standard 2 digits provincial code numbers for that facility found on page 13-17.

*If patient comes from home, code ‘0’*

Code the following for the unusual situations:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>-7</td>
<td>Intended delivery at home without the help of a health care provider (not a midwife)</td>
</tr>
<tr>
<td>-8</td>
<td>Intended delivery at home with the help of a health care provider (not a midwife)</td>
</tr>
</tbody>
</table>

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

---

**PRENATAL RECORD ON CHART AT TIME OF CODING**
The complete prenatal record (3pgs.) is filed on chart at time of coding

Code using one of the following

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>YES Prenatal record on chart at time of coding</td>
</tr>
<tr>
<td>N</td>
<td>No Prenatal record not on chart at time of coding</td>
</tr>
</tbody>
</table>
**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 on the prenatal record but a date is documented as well, enter the date given in the field provided.

**PRE-CONCEPTUAL FOLATE INTAKE**

Maternal pre-conceptual folate intake. Found on the ‘PRENATAL RECORD’.

If noted on prenatal record as “started after found out was pregnant” enter ‘N’.

Code using one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes</td>
</tr>
<tr>
<td>N</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
GRAVIDA

The number of pregnancies, **including the present pregnancy**.

Found on the ‘PRENATAL RECORD’ or the ‘MATERNAL ADMISSION ASSESSMENT’ or the ‘PHYSICIANS ASSESSMENT’.

Code ‘99’ for unknown.

PARA

The number of pregnancies, **excluding the present pregnancy**, which resulted in one or more infants weighting 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’ 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’ or the ‘PHYSICIANS ASSESSMENT’.

Code ‘99’ for unknown.

SPONTANEOUS ABORTIONS

Number of spontaneous abortions.

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  
Found on the PRENATAL RECORD.  
Code ‘99’ for unknown if it is not documented to indicate the number of the category. |
|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **UNSPECIFIED ABORTIONS** | Number of abortions not specified as spontaneous or therapeutic  
Found on the ‘PRENATAL RECORD’.  
Code ‘99’ for unknown if it is not documented to indicate the number of each category. |
| **NUMBER OF PREVIOUS FETAL DEATHS** | Number of previous fetal deaths specifically recorded as weighing 500 grams or more, and/or equal to or greater than 20 weeks gestation or when documented as a fetal death or stillbirth by the physician.  
Found on the ‘PRENATAL RECORD’ or the ‘MATERNAL ADMISSION ASSESSMENT’ or the ‘PHYSICIANS ASSESSMENT’.  
Code ‘9’ for unknown. |
| **NUMBER OF PREVIOUS NEONATAL DEATHS** | Number of previous neonatal deaths specifically recorded weighing 500 grams or more, and/or equal to or greater than 20 weeks gestation or when documented as a neonatal death by the physician.  
Found on the ‘PRENATAL RECORD’ or the ‘MATERNAL ADMISSION ASSESSMENT’ or the ‘PHYSICIANS ASSESSMENT’.  
Code ‘9’ for unknown. |
**NUMBER OF PREVIOUS C-SECTIONS**

Number of previous C-sections.

Found on the ‘PRENATAL RECORD’ or the ‘MATERNAL ADMISSION ASSESSMENT’ or the ‘PHYSICIANS ASSESSMENT’.

Code ‘0’ if no previous C-sections.

Code ‘9’ for unknown.

**POSTPARTUM HEMORRHAGE IN A PREVIOUS PREGNANCY**

Postpartum hemorrhage in a previous pregnancy.

Found on the ‘PRENATAL RECORD’ or the ‘MATERNAL ADMISSION ASSESSMENT’ or the ‘PHYSICIANS ASSESSMENT’.

Code using one of the following:

<table>
<thead>
<tr>
<th>Y</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**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 completed weeks of gestation.

This includes liveborn and stillborn deliveries.

Code ‘9’ for unknown
**NUMBER OF PREVIOUS PRE-TERM DELIVERIES IN EACH CATEGORY**

Enter the number of pre-term deliveries 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

Code ‘9’ for unknown

---

**NUMBER OF PREVIOUS LOW BIRTH WEIGHT INFANTS**

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

Found on the ‘PRENATAL RECORD’ or ‘PHYSICIANS ASSESSMENT’.

Code ‘9’ for unknown.

---

**NUMBER OF PREVIOUS OVERWEIGHT INFANTS**

Number of previous infants with birth weight greater than **4080 grams** (9 lbs.).

Found on the ‘PRENATAL RECORD’ or ‘PHYSICIANS ASSESSMENT’.

Code ‘9’ for unknown.
PRE-PREGNANCY SMOKING

Number of cigarettes smoked per day before the mother became pregnant.

Found on the ‘PRENATAL RECORD’.

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Patient did not smoke pre-pregnancy</td>
</tr>
<tr>
<td>75</td>
<td>Patient smoked ≥ 75 cigarettes per day pre-pregnancy</td>
</tr>
<tr>
<td>88</td>
<td>Patient known to be a smoker pre-pregnancy, but number of cigarettes smoked per day is unknown</td>
</tr>
<tr>
<td>99</td>
<td>Not indicated whether or not the patient smoked pre-pregnancy</td>
</tr>
</tbody>
</table>

**NOTE:** \( \frac{1}{2} \) PACK = 13 CIGS, 1 PACK = 25 CIGS

If the number is recorded in a range, code the highest number, e.g. 10 to 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 the first prenatal visit, with the following exceptions:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Patient did not smoke at the time of the first prenatal visit</td>
</tr>
<tr>
<td>75</td>
<td>Patient smoked ≥ 75 cigarettes per day at the time of the first prenatal visit</td>
</tr>
<tr>
<td>88</td>
<td>Patient known to be a smoker at first prenatal visit, but number of cigarettes smoked per day is unknown</td>
</tr>
<tr>
<td>99</td>
<td>Not indicated whether or not the patient smoked at time of first prenatal visit</td>
</tr>
</tbody>
</table>

NOTE: ½ PACK = 13 CIGS, 1 PACK = 25 CIGS

If the number is recorded in a range, code the highest number, e.g. 10 to 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 cigarettes smoked per day at the time of prenatal visit from 18-22 weeks, with the following **exceptions**:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Patient did not smoke at the time of prenatal visit from 18-22 weeks.</td>
</tr>
<tr>
<td>75</td>
<td>Patient smoked ≥ 75 cigarettes per day at the time of the prenatal visit from 18-22 weeks.</td>
</tr>
<tr>
<td>88</td>
<td>Patient known to be a smoker but number of cigarettes smoked per day at the time of prenatal visit from 18-22 weeks is unknown</td>
</tr>
<tr>
<td>99</td>
<td>Not indicated at the time of prenatal visit from 18-22 weeks whether or not the patient smoked.</td>
</tr>
</tbody>
</table>

**NOTE**: ½ PACK = 13 CIGS, 1 PACK = 25 CIGS  
If the number is recorded in a range, code the highest number, e.g. 10 to 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 ‘PRESNATAL RECORD’.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Less than Secondary Education (some High School)</td>
</tr>
<tr>
<td>2</td>
<td>Secondary Education (completion of High School)</td>
</tr>
<tr>
<td>3</td>
<td>Technical/some Post Secondary Education (Community College or working on a Bachelor’s Degree)</td>
</tr>
<tr>
<td>4</td>
<td>Post Secondary Education (completion of Bachelor’s Degree e.g. Arts, Commerce or Science)</td>
</tr>
<tr>
<td>5</td>
<td>Graduate Level (completion of Masters Degree e.g. Masters in Nursing or Education)</td>
</tr>
<tr>
<td>6</td>
<td>Post Graduate Level (completion of Doctorate e.g. Doctor of Philosophy)</td>
</tr>
<tr>
<td>7</td>
<td>Professional Degree (e.g. Physician, Lawyer or Dentist)</td>
</tr>
<tr>
<td>99</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

### MATERNAL RACE/ETHNICITY

Maternal Race/Ethnicity

Found on the ‘PRESNATAL RECORD’.

Choose ALL applicable categories documented on the ‘Prenatal Record’.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA</td>
<td>Acadian</td>
</tr>
<tr>
<td>AFC</td>
<td>African Canadian</td>
</tr>
<tr>
<td>ASN</td>
<td>Asian</td>
</tr>
<tr>
<td>CAU</td>
<td>Caucasian</td>
</tr>
<tr>
<td>FNA</td>
<td>First Nations</td>
</tr>
<tr>
<td>HIS</td>
<td>Hispanic</td>
</tr>
<tr>
<td>JSH</td>
<td>Jewish</td>
</tr>
<tr>
<td>MED</td>
<td>Mediterranean</td>
</tr>
<tr>
<td>MDE</td>
<td>Middle Eastern</td>
</tr>
<tr>
<td>QUE</td>
<td>Quebecois</td>
</tr>
<tr>
<td>OTH</td>
<td>Other</td>
</tr>
<tr>
<td>999</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
**INTENT TO BREASTFEED**

Maternal intention to breastfeed.

Found on the ‘*Prenatal Record*’ or the ‘*Maternal Admission Assessment*’.

Code using one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes</td>
</tr>
<tr>
<td>N</td>
<td>No</td>
</tr>
<tr>
<td>U</td>
<td>Unsure</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**PRE-PREGNANCY WEIGHT**

Maternal pre-pregnancy weight.

Found on the ‘*Prenatal Record*’ or the ‘*Maternal Admission Assessment*’.

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

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

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

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

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

If pre-pregnancy weight is unknown, subtract weight gain from pre-delivery weight if noted on the Maternal Nurses Assessment.

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, if not recorded as a whole number, round up to the next whole number for inches. Example: 5’3.5” record as 5’4”.

For measurements in centimeters, if not recorded as a whole number, round up to the next whole number. Example: 150.6cm record as 151 cm.

Code ‘999’ in centimeters field for an unknown value.
BISHOP SCORE

Bishop Score. Found on the ‘PREADMISSION MATERNITY ASSESSMENT’

Bishop Score is only completed on patients with induced (I) or an attempt to induce (A) labour type.

Code using one of the following

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes, Bishop Score completed</td>
</tr>
<tr>
<td>N</td>
<td>No, Bishop Score not done</td>
</tr>
</tbody>
</table>

If Y is coded for Bishop Score please enter the value of the test in the field adjacent

VALUE OF BISHOP SCORE

Bishop Score Value Found on the ‘PREADMISSION MATERNITY ASSESSMENT’

Enter value of the first Bishop Score assigned by clinical individuals even if not all values are noted on the document. If noted as a range, choose the lower of the values.

If all values (Dilatation, Effacement, Station, Consistency and Position) are documented but the score is not tallied, add the numbers together and enter the value.

If all values are not documented, enter ‘99’ for unknown.
SMOKING AT TIME OF ADMISSION

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

Found on the ‘MATERNAL ADMISSION ASSESSMENT’, the ‘MATERNAL NURSING REASSESSMENT’ or the ‘PHYSICIANS ASSESSMENT’.

If none of these forms are present or the information is missing, but the most recent prenatal visit documented is within 7 days of the delivery admission and the 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 admission, with the following exceptions:

<table>
<thead>
<tr>
<th>0</th>
<th>Patient did not smoke at the time of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>75</td>
<td>Patient smoked $\geq 75$ cigarettes per day at the time of delivery</td>
</tr>
<tr>
<td>88</td>
<td>Patient known to be a smoker at the time of delivery but number of cigarettes smoked per day is unknown</td>
</tr>
<tr>
<td>99</td>
<td>Not indicated whether or not the patient smoked at the time of delivery</td>
</tr>
</tbody>
</table>

*NOTE: ½ PACK = 13 CIGS, 1 PACK = 25 CIGS*

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

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

Patient’s weight recorded prior to delivery.

Found on the ‘MATERNAL ADMISSION ASSESSMENT’, OR patient’s last weight on the ‘PRENATAL RECORD’ (if it was within a week of delivery).

This field has been designed to allow either pounds (lbs.) or kilograms (kg) to be coded. If the weight is recorded in kilograms, it should be entered in kilograms, 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 the weight is not documented as a whole number, round to the nearest whole number*

- e.g. 60.2 kg = 60 kg
- e.g. 60.7 kg = 61 kg.

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

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

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

Code ‘999’ for unknown value

**NUMBER OF FETUSES**

Code the number of fetuses the mother carried to delivery during the present pregnancy.

Found on the ‘BIRTH RECORD’ or the ‘PRENATAL RECORD’ or the ‘PHYSICIANS ASSESSMENT’ or The ‘MATERNAL ADMISSION ASSESSMENT’.

Use one of the following codes:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Singleton</td>
</tr>
<tr>
<td>2</td>
<td>Twins</td>
</tr>
<tr>
<td>3</td>
<td>Triplets</td>
</tr>
<tr>
<td>4</td>
<td>Quadruplets</td>
</tr>
<tr>
<td>5</td>
<td>Quintuplets</td>
</tr>
</tbody>
</table>
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 ultrasound, fetus #2 for second, etc.

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’.
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.

Choose 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 recorded, capture this measurement only.

If the crown-rump length is not 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.
<table>
<thead>
<tr>
<th><strong>BIPARIETAL DIAMETER MEASUREMENT</strong></th>
<th>Biparietal diameter recorded as a measurement during the first ultrasound done in this pregnancy.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Found on the ‘ULTRASOUND REPORT’.</td>
</tr>
<tr>
<td></td>
<td>Use the following format: ‘XX.X’ (in centimeters).</td>
</tr>
<tr>
<td></td>
<td>Decimal points must be entered.</td>
</tr>
<tr>
<td></td>
<td>If the <strong>crown-rump</strong> length measurement has been recorded, leave the field blank.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>HEAD CIRCUMFERENCE MEASUREMENT</strong></th>
<th>Head circumference recorded as a measurement during the first ultrasound done in this pregnancy.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Found on the ‘ULTRASOUND REPORT’.</td>
</tr>
<tr>
<td></td>
<td>Use the following format: ‘XX.X’ (in centimeters).</td>
</tr>
<tr>
<td></td>
<td>Decimal points must be entered.</td>
</tr>
<tr>
<td></td>
<td>If the <strong>crown-rump</strong> length measurement has been recorded, leave the field blank.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ABDOMINAL CIRCUMFERENCE MEASUREMENT</strong></th>
<th>Abdominal circumference recorded as a measurement during the first ultrasound done in this pregnancy.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Found on the ‘ULTRASOUND REPORT’.</td>
</tr>
<tr>
<td></td>
<td>Use the following format: ‘XX.X’ (in centimeters).</td>
</tr>
<tr>
<td></td>
<td>Decimal points must be entered.</td>
</tr>
<tr>
<td></td>
<td>If the <strong>crown-rump</strong> length measurement has been recorded, leave the field blank.</td>
</tr>
</tbody>
</table>
| 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 the 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 gestational age is recorded, capture this gestational age only.  
<p>|                                  | If the crown rump-length gestational age is not 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, head circumference, abdominal circumference and femur length. |</p>
<table>
<thead>
<tr>
<th><strong>BIPARIETAL DIAMETER</strong>&lt;br&gt;<strong>GESTATIONAL AGE</strong></th>
<th>Biparietal diameter recorded as gestational age (in weeks and days) during the first ultrasound done in this pregnancy.</th>
<th>Found on the ‘ULTRASOUND REPORT’.&lt;br&gt;Use the following format: weeks and days.&lt;br&gt;If the <strong>crown-rump</strong> length gestational age has been recorded, leave this field blank.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEAD CIRCUMFERENCE</strong>&lt;br&gt;<strong>GESTATIONAL AGE</strong></td>
<td>Head circumference recorded as gestational age (in weeks and days) during the first ultrasound done in this pregnancy.</td>
<td>Found on the ‘ULTRASOUND REPORT’.&lt;br&gt;Use the following format: weeks and days.&lt;br&gt;If the <strong>crown-rump</strong> length gestational age has been recorded, leave this field blank.</td>
</tr>
<tr>
<td><strong>ABDOMINAL CIRCUMFERENCE</strong>&lt;br&gt;<strong>GESTATIONAL AGE</strong></td>
<td>Abdominal circumference recorded as gestational age (in weeks and days) during the first ultrasound done in this pregnancy.</td>
<td>Found on the ‘ULTRASOUND REPORT’.&lt;br&gt;Use the following format: weeks and days.&lt;br&gt;If the <strong>crown-rump</strong> length gestational age has been recorded, leave this field blank.</td>
</tr>
</tbody>
</table>
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 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)

<table>
<thead>
<tr>
<th>Y</th>
<th>Yes, done</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Declined</td>
</tr>
<tr>
<td>N</td>
<td>No, not done</td>
</tr>
<tr>
<td>U</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**Nuchal Translucency**

<table>
<thead>
<tr>
<th>Y</th>
<th>Yes, done</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>No, not done</td>
</tr>
<tr>
<td>U</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

*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**

<table>
<thead>
<tr>
<th>Y</th>
<th>Yes, done</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Declined</td>
</tr>
<tr>
<td>U</td>
<td>Unknown</td>
</tr>
<tr>
<td>N</td>
<td>No, not done</td>
</tr>
</tbody>
</table>

**Maternal Serum**

<table>
<thead>
<tr>
<th>Y</th>
<th>Yes, done</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Declined</td>
</tr>
<tr>
<td>U</td>
<td>Unknown</td>
</tr>
<tr>
<td>N</td>
<td>No, not done</td>
</tr>
</tbody>
</table>
### 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 DISCHARGE 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 13-17 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77777</td>
<td>Lived</td>
</tr>
<tr>
<td>OTHR</td>
<td>Other</td>
</tr>
<tr>
<td>PEMB</td>
<td>Pulmonary Embolus</td>
</tr>
<tr>
<td>PPHM</td>
<td>Postpartum Hemorrhage</td>
</tr>
<tr>
<td>STRK</td>
<td>Stroke</td>
</tr>
</tbody>
</table>

**MATERNAL AUTOPSY**

Completion of maternal autopsy.

Found on the ‘DEATH CERTIFICATE’ or the ‘AUTOPSY REPORT’.

This field will autofill if the mother lived.

Code using one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LVD</td>
<td>Lived ( not applicable)</td>
</tr>
<tr>
<td>YES</td>
<td>Died and autopsy done</td>
</tr>
<tr>
<td>NO</td>
<td>Died but autopsy not done</td>
</tr>
</tbody>
</table>
**MATERNAL STEROID THERAPY**

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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&lt; 24 hours before delivery</td>
</tr>
<tr>
<td>2</td>
<td>24 to 48 hours before delivery</td>
</tr>
<tr>
<td>3</td>
<td>&gt;48 hours but less than or equal to 7 days before delivery</td>
</tr>
<tr>
<td>4</td>
<td>&gt;7 days before delivery</td>
</tr>
<tr>
<td>5</td>
<td>Unknown when administered</td>
</tr>
</tbody>
</table>

**Betamethasone (Celestone)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>&lt; 24 hours before delivery</td>
</tr>
<tr>
<td>7</td>
<td>24 to 48 hours before delivery</td>
</tr>
<tr>
<td>8</td>
<td>&gt;48 hours but less than or equal to 7 days before delivery</td>
</tr>
<tr>
<td>9</td>
<td>&gt;7 days before delivery</td>
</tr>
<tr>
<td>10</td>
<td>Unknown when administered</td>
</tr>
</tbody>
</table>

**Unknown Steroid**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>&lt; 24 hours before delivery</td>
</tr>
<tr>
<td>12</td>
<td>24 to 48 hours before delivery</td>
</tr>
<tr>
<td>13</td>
<td>&gt;48 hours but less than or equal to 7 days before delivery</td>
</tr>
<tr>
<td>14</td>
<td>&gt;7 days before delivery</td>
</tr>
<tr>
<td>15</td>
<td>Unknown when administered</td>
</tr>
</tbody>
</table>
**ANALGESIA ADMINISTERED DURING LABOUR**
(excluding stillbirths)

Analgesia Administered during labour.

Found on the ‘BIRTH RECORD’, ‘MEDICATION SHEETS’ or the ‘PARTOGRAM’.

Choose only **one** drug and the route administered.

Choose the drug administered **closest** to the time of delivery.

**Drug**

<table>
<thead>
<tr>
<th></th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Demerol (Meperidine)</td>
</tr>
<tr>
<td>2</td>
<td>Dilaudid (Hydromorphone HCl)</td>
</tr>
<tr>
<td>3</td>
<td>Fentanyl (Sublimaze)</td>
</tr>
<tr>
<td>4</td>
<td>Largactil (Chlorpromazine Tranquillizer)</td>
</tr>
<tr>
<td>5</td>
<td>Morphine (includes Opium; Pantopon)</td>
</tr>
<tr>
<td>6</td>
<td>Nembutal (Pentobarbital Hypnotic)</td>
</tr>
<tr>
<td>7</td>
<td>Nubain (Nalbuphine)</td>
</tr>
<tr>
<td>8</td>
<td>Phenergan (Promethazine Tranquillizer)</td>
</tr>
<tr>
<td>9</td>
<td>Seconal (Secobarbital)</td>
</tr>
<tr>
<td>10</td>
<td>Sparine (Promazine Tranquillizer)</td>
</tr>
<tr>
<td>11</td>
<td>Talwin (Pentazocine)</td>
</tr>
<tr>
<td>12</td>
<td>Tuinal (Amo-Secobarb Hynotic)</td>
</tr>
<tr>
<td>13</td>
<td>Valium (Diazepam Tranquillizer)</td>
</tr>
<tr>
<td>14</td>
<td>Other Specified Analgesia during labour</td>
</tr>
</tbody>
</table>

**ROUTE OF ANAGLESIA ADMINISTERED**

Route of Administration.

Choose only **one** route of administration for the drug given closest to the time of delivery.

<table>
<thead>
<tr>
<th></th>
<th>Route of Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unknown route, &lt;1 hr. prior to delivery</td>
</tr>
<tr>
<td>2</td>
<td>Unknown route, 1&lt;2 hr. prior to delivery</td>
</tr>
<tr>
<td>3</td>
<td>Unknown route, 2-4 hr. prior to delivery</td>
</tr>
<tr>
<td>4</td>
<td>Unknown route, &gt; 4 hr., prior to delivery</td>
</tr>
<tr>
<td>5</td>
<td>I.M., &lt;1 hr. prior to delivery</td>
</tr>
<tr>
<td>6</td>
<td>I.M., 1-2 hr. prior to delivery</td>
</tr>
<tr>
<td>7</td>
<td>I.M., 2-4hr. prior to delivery</td>
</tr>
<tr>
<td>8</td>
<td>I.M., &gt;4 hr. prior to delivery</td>
</tr>
<tr>
<td>9</td>
<td>I.V., &lt;1 hr. prior to delivery</td>
</tr>
<tr>
<td>10</td>
<td>I.V., 1-2 hr. prior to delivery</td>
</tr>
<tr>
<td>11</td>
<td>I.V., 2-4 hr. prior to delivery</td>
</tr>
<tr>
<td>12</td>
<td>I.V., &gt;4 hr. prior to delivery</td>
</tr>
</tbody>
</table>
**ANTIBIOTIC THERAPY**

**ADMINISTERED DURING ANTEPARTUM PERIOD**

Antibiotic therapy administrated during the antepartum 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.

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

---

**ANTIBIOTIC THERAPY**

**ADMINISTERED DURING INTRAPARTUM PERIOD (NOT FOR GBS)**

Antibiotic therapy administered during the intrapartum period (not for 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 administered, leave blank.

Code Y if antibiotic is given during the admission, even if it is for a non-pregnancy related condition.
<table>
<thead>
<tr>
<th><strong>ANTIBIOTIC THERAPY</strong></th>
<th>Antibiotic therapy administered during postpartum period.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADMINISTERED DURING</strong></td>
<td>Found on the ‘BIRTH RECORD’, ‘MEDICATION SHEETS’ or the ‘PARTOGRAM’.</td>
</tr>
<tr>
<td><strong>POSTPARTUM PERIOD</strong></td>
<td>If documented, enter ‘Y’ for Yes. If no antibiotics were administered, leave blank.</td>
</tr>
<tr>
<td></td>
<td>Code ‘Y’ if antibiotic is given during the admission, even if it is for a non-pregnancy related condition.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PROPHYLAXIS FOR GBS</strong></th>
<th>Prophylaxis for GBS administered during intrapartum period.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADMINISTERED DURING</strong></td>
<td>Found on the ‘BIRTH RECORD’, ‘MEDICATION SHEETS’ or the ‘PARTOGRAM’.</td>
</tr>
<tr>
<td><strong>INTRAPARTUM PERIOD</strong></td>
<td>If documented as “prophylaxis for GBS” code ‘Y’ for Yes.</td>
</tr>
<tr>
<td></td>
<td>If there is NO note to indicate administration is for GBS prophylaxis but antibiotics given during the intrapartum period, code as administered during intrapartum period.</td>
</tr>
</tbody>
</table>
**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 the 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.
Routine Information – Labour

**BIRTH ORDER**

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

Use one of the following codes:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Singleton, or first born of multiples</td>
</tr>
<tr>
<td>2</td>
<td>Second born of multiples</td>
</tr>
<tr>
<td>3</td>
<td>Third born of multiples</td>
</tr>
<tr>
<td>4</td>
<td>Fourth born of multiples</td>
</tr>
<tr>
<td>5</td>
<td>Fifth born of multiples</td>
</tr>
</tbody>
</table>

-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 recorded.

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 ‘Rupture Date’ blank and code ‘9’ in the field immediately following.
TIME OF RUPTURE OF MEMBRANES

Time of rupture of membranes (ROM).

Found on the ‘BIRTH RECORD’.

Use the following format: ‘HHMM’

‘HH’ is in 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 to be ruptured to deliver.

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 ‘Rupture 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 ‘Rupture Time’ blank and code ‘9’ in the field immediately following.

If the time of rupture of membranes is unknown, leave ‘Rupture 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:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Spontaneous</td>
</tr>
<tr>
<td>A</td>
<td>Artificial</td>
</tr>
<tr>
<td>C</td>
<td>Suspected</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes</td>
</tr>
<tr>
<td>N</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
Initiation of labour.

Found on the ‘BIRTH RECORD’ or ‘PARTOGRAM’.

Code using one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Spontaneous onset of labour (include augmentation of spontaneous labour)</td>
</tr>
<tr>
<td>I</td>
<td>Artificial induction of labour (does not include augmentation of labour)</td>
</tr>
<tr>
<td>N</td>
<td>No labour prior to delivery (e.g. elective repeat C-section)</td>
</tr>
<tr>
<td>A</td>
<td>Attempted induction. This is to be used if an attempt at inducing labour has been made but no labour happens. (Failed induction)</td>
</tr>
</tbody>
</table>

If the cervical dilatation is \( \geq 3 \text{cm} \) when the oxytocin and/or prostaglandin is initiated, code labour as spontaneous (S)

If the cervical dilatation is \(< 3 \text{ cm} \) 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’ or the ‘MATERNAL ADMISSION ASSESSMENT’.

Code using one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not induced</td>
</tr>
<tr>
<td>1</td>
<td>Elective (Non-Medical/Social)</td>
</tr>
<tr>
<td>2</td>
<td>Fetal growth restriction</td>
</tr>
<tr>
<td>3</td>
<td>Diabetes</td>
</tr>
<tr>
<td>4</td>
<td>Post dates</td>
</tr>
<tr>
<td>5</td>
<td>Premature rupture of membranes without chorioamnionitis</td>
</tr>
<tr>
<td>6</td>
<td>Premature rupture of membranes with clinical chorioamnionitis</td>
</tr>
<tr>
<td>7</td>
<td>Isoimmunization</td>
</tr>
<tr>
<td>8</td>
<td>History of precipitate labour</td>
</tr>
<tr>
<td>9</td>
<td>Concern for fetal well being*</td>
</tr>
<tr>
<td>10</td>
<td>Intrauterine death</td>
</tr>
<tr>
<td>11</td>
<td>Geographic</td>
</tr>
<tr>
<td>12</td>
<td>Hypertension</td>
</tr>
<tr>
<td>13</td>
<td>Other</td>
</tr>
<tr>
<td>14</td>
<td>Oligohydramnios (decreased amniotic fluid)</td>
</tr>
<tr>
<td>15</td>
<td>Fetal anomaly</td>
</tr>
<tr>
<td>16</td>
<td>Polyhydramnios</td>
</tr>
<tr>
<td>17</td>
<td>Multiple pregnancy</td>
</tr>
<tr>
<td>18</td>
<td>PUPP</td>
</tr>
<tr>
<td>19</td>
<td>Cholestatis of pregnancy</td>
</tr>
<tr>
<td>20</td>
<td>Thrombocytopenia</td>
</tr>
<tr>
<td>21</td>
<td>Previous fetal death/poor obstetrical history</td>
</tr>
<tr>
<td>22</td>
<td>Seizure</td>
</tr>
<tr>
<td>23</td>
<td>Macrosomia</td>
</tr>
<tr>
<td>24</td>
<td>No indication given</td>
</tr>
<tr>
<td>25</td>
<td>Advanced maternal age</td>
</tr>
<tr>
<td>26</td>
<td>Maternal request</td>
</tr>
<tr>
<td>27</td>
<td>Vaginal bleeding</td>
</tr>
<tr>
<td>28</td>
<td>Positive Group B Strep with rupture of membranes</td>
</tr>
</tbody>
</table>

*Concern for fetal well being: abnormal biophysical profile, abnormal or atypical NST, abnormal amniotic fluid assessment or abnormal Doppler.*
INDUCTION OR ATTEMPT AT INDUCTION OF LABOUR PLACE

Induction or attempt at induction of labour place.

Found on the ‘BIRTH RECORD’, the ‘PHYSICIANS ASSESSMENT’, or the ‘MATERNAL ADMISSION ASSESSMENT’.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inpatient</td>
</tr>
<tr>
<td>2</td>
<td>Outpatient</td>
</tr>
<tr>
<td>3</td>
<td>Both inpatient and outpatient</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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

Induction or attempt at induction of labour methods/agents

Found on the ‘BIRTH RECORD’, the ‘PHYSICIANS ASSESSMENT’, or the ‘MATERNAL ADMISSION ASSESSMENT’.

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 induced 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.
<table>
<thead>
<tr>
<th><strong>OXYTOCIN DATE</strong></th>
<th>Date Oxytocin therapy administered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Found on ‘PARTOGRAM’.</td>
<td>Use the following format: ‘YYYYMMDD’.</td>
</tr>
<tr>
<td>If date of Oxytocin therapy is not documented, leave date field blank and enter ‘9’ in the field immediately following.</td>
<td></td>
</tr>
<tr>
<td>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).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>OXYTOCIN TIME</strong></th>
<th>Time Oxytocin therapy administered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Found on ‘PARTOGRAM’.</td>
<td>Use the following format: ‘HHMM’.</td>
</tr>
<tr>
<td>‘HH is the range of 0-23, ‘MM’ is in the range of 0-59.</td>
<td></td>
</tr>
<tr>
<td>If time of Oxytocin therapy is not documented, leave time field blank and enter ‘9’ in the field immediately following.</td>
<td></td>
</tr>
<tr>
<td>If Oxytocin is administered more than once during a delivered admission, record the time of the administration that started labour and resulted in the delivery of an infant(s).</td>
<td></td>
</tr>
</tbody>
</table>
**INDUCTION OR ATTEMPT AT INDUCTION OF LABOUR METHODS/AGENTS**

Induction or attempt at induction of labour methods/agents

**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**

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

Found on the ‘PARTOGRAM’ or the ‘PROGESS NOTES’ or ‘MATERNAL ADMISSION ASSESSMENT’.

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 ‘PROGESS NOTES’ or ‘MATERNAL ADMISSION ASSESSMENT’.

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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes</td>
</tr>
<tr>
<td>N</td>
<td>No</td>
</tr>
<tr>
<td>7</td>
<td>Not applicable</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**DATE OF MEDICAL AUGMENTATION**

Date of initiation of Oxytocin to augment labour.

Found on the ‘PARTOGRAM’.

Use the following format: ‘YYYYMMDD’.

If date of medical augmentation is unknown, leave ‘Augmentation Date’ blank and code ‘9’ in the field immediately following.
<table>
<thead>
<tr>
<th><strong>TIME OF MEDICAL AUGMENTATION</strong></th>
<th>Time of initiation of Oxytocin to augment labour.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Found on the ‘PARTOGRAM’.</td>
</tr>
<tr>
<td></td>
<td>Use the following format: ‘HHMM’</td>
</tr>
<tr>
<td></td>
<td>‘HH’ is the range 0-23. ‘MM’ is in range 0-59.</td>
</tr>
<tr>
<td></td>
<td>If time of medical augmentation is unknown, leave</td>
</tr>
<tr>
<td></td>
<td>‘Augmentation Time’ blank, and code ‘9’ in the</td>
</tr>
<tr>
<td></td>
<td>field immediately following.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DILATATION AT TIME OF MEDICAL AUGMENTATION</strong></th>
<th>Dilatation at time of augmentation of labour.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Found on the ‘PARTOGRAM’.</td>
</tr>
<tr>
<td></td>
<td>Code using the following format: ‘XX’ where ‘XX’ represents the dilatation in centimeters.</td>
</tr>
<tr>
<td></td>
<td>Round the dilatation down to the nearest centimeter, e.g. 3.5 would be coded as 3.</td>
</tr>
<tr>
<td></td>
<td>If the dilatation is not documented at time of augmentation, code the last dilatation recorded during the two hours prior to the initiation of the Oxytocin.</td>
</tr>
<tr>
<td></td>
<td>Code ‘99’ for unknown.</td>
</tr>
</tbody>
</table>
| **DATE WHEN CERVICAL DILATATION AT 4 CENTIMETERS** | Date when cervical dilatation is 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 of cervical dilatation at 4 cm is unknown, leave ‘4 cms date’ blank and code ‘9’ in the field immediately following. |
| **TIME WHEN CERVICAL DILATATION AT 4 CENTIMETERS** | Time when cervical dilatation is 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 cm time’ blank and code ‘7’ in the field immediately following.  
If time of cervical dilatation at 4 cm is unknown, leave ‘4 cm time’ blank and code ‘9’ in the field immediately following. |
INITIAL MOTHER
BABY CONTACT

Initial mother and baby contact.

Found on the ‘PARTOGRAM’ or ‘NURSES NOTES’.

Code using one of the following:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes, skin to skin contact initiated or baby to breast has been noted on Partogram</td>
</tr>
<tr>
<td>N</td>
<td>No, no skin to skin contact or baby to breast is indicated</td>
</tr>
<tr>
<td>7</td>
<td>If fetal death, enter 7 for not applicable</td>
</tr>
<tr>
<td>9</td>
<td>Unknown, if none of the applicable boxes are checked</td>
</tr>
</tbody>
</table>

FETAL SURVEILLANCE
IN LABOUR

Fetal surveillance in labour.

Found on the ‘PARTOGRAM’

Enter ‘Y’ if a fetal surveillance method has been used for clinical care and labour is spontaneous or induced.

Do not enter ‘Y’ if the reading is an admission strip.

When ‘Y’ is entered, a surveillance methods screen will pop up.

Enter all documented methods used during monitoring of the labour

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intermittent auscultation</td>
</tr>
<tr>
<td>2</td>
<td>External monitoring</td>
</tr>
<tr>
<td>3</td>
<td>Internal monitoring</td>
</tr>
</tbody>
</table>
SUPPORTIVE CARE IN LABOUR

Supportive Care in labour.

Found on the ‘PARTOGRAM’

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Supportive care measures provided in labour</td>
</tr>
<tr>
<td>N</td>
<td>No supportive care measures provide in labour</td>
</tr>
</tbody>
</table>

When ‘Y’ is entered, a screen outlining the measures will pop up to allow the types of supportive care provided to be captured.

Enter ‘Y’ if any Supportive Care Measure is noted in the Supportive Care Area of the Partogram.

MEASURES OF SUPPORTIVE CARE IN LABOUR

Measures of Supportive Care in Labour.

Found on the ‘PARTOGRAM’.

Code all of the following provided:

| AT | Aromatherapy |
| CC | Cool compresses |
| CP | Counter pressure |
| FL | Fluids |
| IP | Ice Pack |
| MS | Massage |
| MU | Music |
| RF | Reflexology |
| SH | Shower |
| TW | Tub/Whirlpool |
| TE | TENS |
| PC | Pericare |
| WC | Warm compresses |
| OT | Other |
DATE OF ONSET OF SECOND STAGE OF LABOUR

Defined as full cervical dilatation (10 cms.).

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 a 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABD</td>
<td>Abdominal</td>
</tr>
<tr>
<td>CSC</td>
<td>C-section combined transverse and vertical incision—inverted T and J incision. (This refers to the uterine incision, not skin incision)</td>
</tr>
<tr>
<td>CSH</td>
<td>C-section / hysterectomy</td>
</tr>
<tr>
<td>CST</td>
<td>C-section, transverse incision</td>
</tr>
<tr>
<td>CSV</td>
<td>C-section, classical incision (vertical incision in the body of uterus)</td>
</tr>
<tr>
<td>CSU</td>
<td>C-section, type unknown</td>
</tr>
<tr>
<td>LVS</td>
<td>C-section, low vertical incision</td>
</tr>
<tr>
<td>VAG</td>
<td>Vaginal</td>
</tr>
</tbody>
</table>
METHOD OF DELIVERY

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

If more than one method of delivery is noted on the birth record, code to the highest degree of intervention. For example, low and mid forceps noted on birth record, enter mid forceps in the data entry screen.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABR</td>
<td>Assisted breech</td>
</tr>
<tr>
<td>ACH</td>
<td>Forceps to after-coming head (Breech – vaginal delivery only)</td>
</tr>
<tr>
<td>BRE</td>
<td>Breech extraction (Vaginal delivery only)</td>
</tr>
<tr>
<td>CSC</td>
<td>C-section with vacuum and forceps</td>
</tr>
<tr>
<td>CSF</td>
<td>C-section with forceps</td>
</tr>
<tr>
<td>CSN</td>
<td>C-section</td>
</tr>
<tr>
<td>CSV</td>
<td>C-section with vacuum</td>
</tr>
<tr>
<td>FAF</td>
<td>Failed forceps or failed trail of forceps followed by C-section</td>
</tr>
<tr>
<td>FCF</td>
<td>Failed forceps followed by C-section with forceps</td>
</tr>
<tr>
<td>FVC</td>
<td>Attempted forceps and vacuum followed by C-section using forceps and/or vacuum</td>
</tr>
<tr>
<td>FVV</td>
<td>Attempted forceps followed by vacuum vaginal delivery</td>
</tr>
<tr>
<td>HIF</td>
<td>High forceps</td>
</tr>
<tr>
<td>HIV</td>
<td>High vacuum</td>
</tr>
<tr>
<td>LWF</td>
<td>Low forceps</td>
</tr>
<tr>
<td>LWV</td>
<td>Low vacuum</td>
</tr>
<tr>
<td>MIF</td>
<td>Mid-forceps</td>
</tr>
<tr>
<td>MIV</td>
<td>Mid vacuum</td>
</tr>
<tr>
<td>OUF</td>
<td>Outlet forceps</td>
</tr>
<tr>
<td>OUV</td>
<td>Outlet vacuum</td>
</tr>
<tr>
<td>PVE</td>
<td>Podalic version and extraction (Do Not use for C-section)</td>
</tr>
<tr>
<td>SPT</td>
<td>Spontaneous vaginal</td>
</tr>
<tr>
<td>VAC</td>
<td>Vacuum followed by C-section</td>
</tr>
<tr>
<td>VAF</td>
<td>Vacuum followed by forceps</td>
</tr>
<tr>
<td>VEX</td>
<td>Vacuum extraction, malstrum extraction</td>
</tr>
<tr>
<td>VCV</td>
<td>Attempted vacuum followed by C-section using forceps and/or vacuum</td>
</tr>
<tr>
<td>VFC</td>
<td>Vacuum followed by forceps and than by C-section</td>
</tr>
<tr>
<td>999</td>
<td>Unknown method of delivery</td>
</tr>
</tbody>
</table>
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 dilatation in centimeters.

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

Code ‘99’ for unknown.

PRESENTATION AT DELIVERY

Presentation of infant at delivery.

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

Enter VTX (includes Cephalic, LOA, ROA, OT, ROT, LOT, OA, Transverse)

UNLESS NOTED AS ONE of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCH</td>
<td>Breech, other or specified</td>
</tr>
<tr>
<td>BOW</td>
<td>Brow</td>
</tr>
<tr>
<td>CPD</td>
<td>Compound presentation</td>
</tr>
<tr>
<td>FAC</td>
<td>Face</td>
</tr>
<tr>
<td>FRB</td>
<td>Frank breech</td>
</tr>
<tr>
<td>FTB</td>
<td>Footling breech</td>
</tr>
<tr>
<td>POP</td>
<td>Persistent occiput posterior (ROP, LOP, OP)</td>
</tr>
<tr>
<td>SHL</td>
<td>Shoulder presentation</td>
</tr>
<tr>
<td>999</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
EPISIOTOMY

Episiotomy.

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

Code using **one** of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not done</td>
</tr>
<tr>
<td>4</td>
<td>Medio-lateral</td>
</tr>
<tr>
<td>6</td>
<td>Midline</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

BIRTH WEIGHT

Infant’s birth weight.

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

First weight noted after birth.

If an infant was born dead or died after birth and was not weighed, code ‘**9999**’.

*For conjoined twins, split weight between babies.*

*If a baby has a tumor or growth at time of birth and the tumor or growth is removed shortly after, record actual weight at birth, including tumor 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 Care Provider 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMA</td>
<td>Advanced maternal age</td>
</tr>
<tr>
<td>APL</td>
<td>Abruptio placenta</td>
</tr>
<tr>
<td>BCH</td>
<td>Breech</td>
</tr>
<tr>
<td>CXD</td>
<td>Diseases of the cervix</td>
</tr>
<tr>
<td>DBT</td>
<td>Diabetes</td>
</tr>
<tr>
<td>DYS</td>
<td>Dystocia (Cephalopelvic disproportion, (C.P.D), Failure-to-progress, Maternal exhaustion, Cervical stenosis POP, OP)</td>
</tr>
<tr>
<td>FDS</td>
<td>Concern for fetal well being *</td>
</tr>
<tr>
<td>FGT</td>
<td>Fetal growth restriction (retardation)</td>
</tr>
<tr>
<td>FID</td>
<td>Failed induction</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HSV</td>
<td>Maternal herpes simplex infection</td>
</tr>
<tr>
<td>HTD</td>
<td>Hypertensive disorders</td>
</tr>
<tr>
<td>ISO</td>
<td>Isoimmunization</td>
</tr>
<tr>
<td>MAC</td>
<td>Macrosomia suspected</td>
</tr>
<tr>
<td>MAT</td>
<td>Maternal choice (excludes due to previous c-section or if any medical indication is needed)</td>
</tr>
<tr>
<td>MLP</td>
<td>Malpresentation (e.g. shoulder, brow, face; excludes breech and transverse lie)</td>
</tr>
<tr>
<td>MTP</td>
<td>Multiple pregnancy</td>
</tr>
<tr>
<td>OFC</td>
<td>Other fetal conditions</td>
</tr>
<tr>
<td>OOC</td>
<td>Other obstetrical conditions</td>
</tr>
<tr>
<td>PCS</td>
<td>Previous C-section</td>
</tr>
<tr>
<td>PLC</td>
<td>Prolapsed cord</td>
</tr>
<tr>
<td>PLP</td>
<td>Placenta previa</td>
</tr>
<tr>
<td>PMC</td>
<td>Postmortem C-section</td>
</tr>
<tr>
<td>PRM</td>
<td>Prolonged rupture of membranes</td>
</tr>
<tr>
<td>PTD</td>
<td>Previous traumatic delivery (e.g.3rd or 4th degree tear)</td>
</tr>
<tr>
<td>SFA</td>
<td>Fetal anomaly (suspected or diagnosis)</td>
</tr>
<tr>
<td>SUR</td>
<td>Suspected/imminent uterine rupture</td>
</tr>
<tr>
<td>TLI</td>
<td>Transverse lie (includes unstable lie and oblique lie)</td>
</tr>
<tr>
<td>UTS</td>
<td>Uterine Surgery, previous</td>
</tr>
<tr>
<td>VAG</td>
<td>Vaginal delivery</td>
</tr>
<tr>
<td>999</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

* Concern for fetal well being: abnormal biophysical profile, abnormal or atypical NST, abnormal amniotic fluid assessment or abnormal Doppler.
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 ‘7777777777’

**GIVEN NAME(S)**  
Infant’s given name (s).  
Found on the ‘HOSPITAL ADMISSION FORM’.

**SURNAME**  
Infant’s surname.  
Found on the ‘HOSPITAL ADMISSION FORM’

**SEX**  
The legal phenotype of the infant regardless of karyotype.  
Found on the ‘BIRTH RECORD’.  
Code using one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Female</td>
</tr>
<tr>
<td>M</td>
<td>Male</td>
</tr>
<tr>
<td>A</td>
<td>Ambiguous</td>
</tr>
</tbody>
</table>
| **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. |
| **DATE OF INFANT’S ADMISSION TO HOSPITAL** | Date of infant’s admission to hospital.  
Found on the ‘HOSPITAL ADMISSION FORM’.  
Date of infant’s admission to hospital will autofill and be the same as birth date if baby is born at the contact hospital.  
If baby was born at home, enroute or in a hospital without obstetrical services, the admit date will be after the birth date. If delivery hospital indicates one of the noted delivery places, data entry screens will apply appropriate edits.  
Use the following format: ‘YYYYMMDD’. |
| **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 will autofill and be the same as birth time if baby is born at the contact hospital.

If baby was born at home, en-route or in a hospital without obstetrical services, the admit time will be after the birth time. If delivery hospital indicates one of the noted delivery places, data entry will apply applicable edits.

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

Time fetal death occurred.

Found on the ‘BIRTH RECORD’ or the ‘AUTOPSY REPORT’.

Code using one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>After admission and before labour</td>
</tr>
<tr>
<td>BA</td>
<td>Before admission</td>
</tr>
<tr>
<td>IP</td>
<td>Intrapartum</td>
</tr>
<tr>
<td>NA</td>
<td>Not applicable</td>
</tr>
<tr>
<td>UK</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
**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: ‘CCNNNNNNNN/YY’ where ‘CC’ is the admit type, ‘NNNNNNNN’ 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 ‘999999999999’ for unknown value

In the case of a fetal death this field will auto fill to ‘777777777777’.

---

**INFANT'S HEALTH CARD NUMBER**

Infant’s Nova Scotia health card number.

Found on the ‘HOSPITAL ADMISSION FORM’.

Record the patient’s Nova Scotia Health Card Number or the hospital generated ‘8000’ number for Nova Scotia residents admitted without a Nova Scotia Health Card Number or a facility assigned number for patients that reside 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 Care Provider is not registered in Nova Scotia. Code ‘99999’ for unknown.

In the case of a fetal death these fields will auto fill to ‘77777’.

INFANT LENGTH  
Infant length in centimeters (cm).

Found on ‘NEWBORN ADMISSION/DISCHARGE’ or ‘NEWBORN NURSING ASSESSMENT FORM’.

Enter length in centimeters, rounding to the closest whole number. e.g.: 51.7 record as 52 cms.

Enter ‘99’ for unknown value.

HEAD CIRCUMFERENCE  
Infant head circumference in centimeters (cm).

Found on ‘NEWBORN ADMISSION/DISCHARGE’ or ‘NEWBORN NURSING ASSESSMENT FORM’.

Enter head circumference in centimeters, rounding to the closest whole number. e.g.: 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 the physical examination of the infant.

Found on the ‘NEWBORN ADMISSION/ DISCHARGE’ or ‘NEWBORN BIRTH ASSESSMENT’ or clearing stated by the physician.

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

<table>
<thead>
<tr>
<th>Documented as …</th>
<th>Use:</th>
</tr>
</thead>
<tbody>
<tr>
<td>38 + weeks</td>
<td>38</td>
</tr>
<tr>
<td>38-40 weeks</td>
<td>39</td>
</tr>
<tr>
<td>38-39 weeks</td>
<td>38</td>
</tr>
<tr>
<td>&gt;39 weeks</td>
<td>39</td>
</tr>
<tr>
<td>Term</td>
<td>40</td>
</tr>
<tr>
<td>unknown</td>
<td>99</td>
</tr>
</tbody>
</table>

**NICU**

Infants admitted to the NICU or infants requiring special care in a normal nursery where a NICU is not available.

Found in the ‘PROGRESS NOTES’.

Code using one of the following:

Y Yes
N No

If ‘Y’ is entered, the screen NICU date and time will pop up. Enter the admit and discharge date and time to and from the NICU.

If there is more than one admission and discharge to the NICU during the same admission, enter the date and time of the second admission in the next row. Continue until all admissions to the Unit 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LVD</td>
<td>Infant lived to be discharged from hospital</td>
</tr>
<tr>
<td>NND</td>
<td>Live born infant who died before being discharged home from hospital</td>
</tr>
<tr>
<td>FTD</td>
<td>Fetal death</td>
</tr>
</tbody>
</table>

BREASTFEEDING INITIATION

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

Found in the ‘NURSES NOTES’ or ‘NEWBORN ADMISSION/DISCHARGE FORM’.

If the infant is put to breast in the Labour and Delivery Room and then receives no further human milk during the stay, record this as Non-Exclusive Breastfeeding

Code using one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td><strong>Exclusive Breastfeeding</strong>: The infant/child receives human milk (including expressed or donor milk) and allows the infant to receive oral rehydration solutions (ORS), syrup, (vitamins, mineral supplements, medicines) but does not allow the infant to receive anything else.</td>
</tr>
<tr>
<td>S</td>
<td><strong>Non-Exclusive Breastfeeding</strong>: The infant/child has received human milk (including expressed or donor milk) and water, water-based drinks, fruit juice, ritual fluids or any other liquid including non-human milk or solids</td>
</tr>
<tr>
<td>N</td>
<td><strong>No Breastfeeding</strong>: The infant/child receives no human milk.</td>
</tr>
<tr>
<td>9</td>
<td>There is no documentation as to how the baby was fed during the hospital stay.</td>
</tr>
</tbody>
</table>
**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.

**DISCHARGE 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 coded for hospitals found on pages 13-17 or use one of the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Home</td>
</tr>
<tr>
<td>-9</td>
<td>Infant Death</td>
</tr>
</tbody>
</table>

**AUTOPSY**  
Completion of infant autopsy.  
Found on the ‘NEWBORN CODING SHEET’ or the ‘DEATH CERTIFICATE’ or the ‘AUTOPSY REPORT’.  
Code using one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LVD</td>
<td>Lived ( not applicable)</td>
</tr>
<tr>
<td>YES</td>
<td>Died and autopsy done</td>
</tr>
<tr>
<td>NO</td>
<td>Died but autopsy not done</td>
</tr>
</tbody>
</table>
Infant’s primary cause of death.

Found on the ‘AUTOPSY REPORT’ or stated by the physician.

Use one of the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7777</td>
<td>Infant lived</td>
</tr>
<tr>
<td>ABRP</td>
<td>Abruptio placenta</td>
</tr>
<tr>
<td>ANEC</td>
<td>Acute necrotizing enterocolitis</td>
</tr>
<tr>
<td>OAIR</td>
<td>Airway failure</td>
</tr>
<tr>
<td>AMNO</td>
<td>Amniocentesis</td>
</tr>
<tr>
<td>ANAL</td>
<td>Analgesia or anaesthesia</td>
</tr>
<tr>
<td>ASPN</td>
<td>Aspiration</td>
</tr>
<tr>
<td>CPDP</td>
<td>Chronic pulmonary disease</td>
</tr>
<tr>
<td>COTR</td>
<td>Complications of treatment</td>
</tr>
<tr>
<td>ANOM</td>
<td>Congenital anomaly</td>
</tr>
<tr>
<td>CRLK</td>
<td>Cord loops and/or knots</td>
</tr>
<tr>
<td>CDOT</td>
<td>Cord, miscellaneous</td>
</tr>
<tr>
<td>CORP</td>
<td>Cord prolapse</td>
</tr>
<tr>
<td>DBRN</td>
<td>Degenerative brain disease</td>
</tr>
<tr>
<td>DUCT</td>
<td>Ductus syndrome of prematurity</td>
</tr>
<tr>
<td>EXTX</td>
<td>Exchange transfusion</td>
</tr>
<tr>
<td>FETH</td>
<td>Fetal hemorrhage</td>
</tr>
<tr>
<td>FMAL</td>
<td>Fetal malnutrition</td>
</tr>
<tr>
<td>HMDD</td>
<td>Hyaline membrane disease</td>
</tr>
<tr>
<td>HYDR</td>
<td>Idiopathic hydrops</td>
</tr>
<tr>
<td>IBOM</td>
<td>Inborn errors of metabolism</td>
</tr>
<tr>
<td>INFT</td>
<td>Infection</td>
</tr>
<tr>
<td>IVTF</td>
<td>Intravascular transfusion</td>
</tr>
<tr>
<td>ISOM</td>
<td>Isoimmunization</td>
</tr>
<tr>
<td>KERN</td>
<td>Kernicterus</td>
</tr>
<tr>
<td>MALP</td>
<td>Malpresentation</td>
</tr>
<tr>
<td>DIAB</td>
<td>Maternal diabetes</td>
</tr>
<tr>
<td>SHOC</td>
<td>Maternal shock</td>
</tr>
<tr>
<td>MUSF</td>
<td>Multi-system failure</td>
</tr>
<tr>
<td>MINF</td>
<td>Myocardial infarction</td>
</tr>
<tr>
<td>NEOP</td>
<td>Neoplasia</td>
</tr>
<tr>
<td>TTTX</td>
<td>Twin-to-twin transfusion (Para biotic syndrome)</td>
</tr>
<tr>
<td>PPFC</td>
<td>Persistent fetal circulation</td>
</tr>
<tr>
<td>PLPV</td>
<td>Placenta previa</td>
</tr>
</tbody>
</table>
INFANT'S PRIMARY CAUSE OF DEATH (con't)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIRL</td>
<td>Pneumothorax pneumomediastinum and/or pneumopericardium</td>
</tr>
<tr>
<td>PIVH</td>
<td>Primary intraventricular hemorrhage</td>
</tr>
<tr>
<td>PPHN</td>
<td>Primary pulmonary hypertension</td>
</tr>
<tr>
<td>PULH</td>
<td>Primary pulmonary hemorrhage</td>
</tr>
<tr>
<td>RUPU</td>
<td>Ruptured uterus</td>
</tr>
<tr>
<td>SIDS</td>
<td>Sudden infant death syndrome</td>
</tr>
<tr>
<td>THAB</td>
<td>Therapeutic abortions</td>
</tr>
<tr>
<td>TOXM</td>
<td>Toxemia</td>
</tr>
<tr>
<td>TRAS</td>
<td>Tracheal stenosis</td>
</tr>
<tr>
<td>TRAU</td>
<td>Trauma (obstetrical)</td>
</tr>
<tr>
<td>UNEX</td>
<td>Unexplained</td>
</tr>
<tr>
<td>UXPA</td>
<td>Unexplained peripartum asphyxia</td>
</tr>
<tr>
<td>VOLV</td>
<td>Acquired volvulus</td>
</tr>
</tbody>
</table>

DATE OF DEATH

Date of infant’s death.

Found in the ‘NURSES NOTES’ or the ‘DISCHARGE NOTE’.

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 ‘DISCHARGE NOTE’.

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:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes</td>
</tr>
<tr>
<td>N</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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 value is outside the range, contact the RCP Clinical Data Coordinator.

Code ‘99’ for unknown.

‘77’ will auto fill 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 value is outside the range, contact the RCP Clinical Data Coordinator.

Code ‘999’ for unknown.

‘777’ will auto fill 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 -30 to 10**

If value is outside the range, contact the RCP Clinical Data Coordinator.

Code ‘999’ for unknown.

‘777’ will auto fill for not applicable or fetal death.
FETAL MALNUTRITION/ SOFT TISSUE WASTING

Fetal malnutrition or soft tissue wasting.

Found in the ‘DISCHARGE SUMMARY’ or ‘NEONATOLOGIST LISTING’.

Choose one of the following:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Moderate wasting</td>
</tr>
<tr>
<td>2</td>
<td>Severe wasting</td>
</tr>
</tbody>
</table>

TWIN TYPE

Twin type.

Found in the ‘DISCHARGE SUMMARY’ or ‘NEONATOLOGIST LISTING’.

Choose from the following list:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Monoamniotic (one amniotic sac)</td>
</tr>
<tr>
<td>2</td>
<td>Monochorionic, diamniotic</td>
</tr>
<tr>
<td>3</td>
<td>Dichorionic, dissimilar sexes or blood groups</td>
</tr>
<tr>
<td>4</td>
<td>Dichorionic, similar sexes and blood groups</td>
</tr>
<tr>
<td>5</td>
<td>Dichorionic, similar sexes, blood groups</td>
</tr>
<tr>
<td></td>
<td>undetermined</td>
</tr>
<tr>
<td>6</td>
<td>Undetermined</td>
</tr>
<tr>
<td>7</td>
<td>Conjoined twins</td>
</tr>
</tbody>
</table>
**ELECTIVE NON-RESUSCITATION**

Elective non-resuscitation.

Found in the ‘DISCHARGE SUMMARY’ or ‘NEONATOLOGIST LISTING’.

Choose from the following list:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do not resuscitate order on chart</td>
</tr>
<tr>
<td>2</td>
<td>Withdrawal of ventilator care with do not resuscitate order on chart</td>
</tr>
<tr>
<td>3</td>
<td>Non-resuscitation in labour and delivery room</td>
</tr>
</tbody>
</table>

**RETINOPATHY OF PREMATURITY**

Retinopathy of prematurity.

Found on the ‘DISCHARGE SUMMARY’.

Code one of the following:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Stage 1</td>
<td>Peripheral vascular straightening</td>
</tr>
<tr>
<td>2</td>
<td>Stage 2</td>
<td>Peripheral shunt well seen</td>
</tr>
<tr>
<td>3</td>
<td>Stage 3</td>
<td>Vessels growing into vitreous</td>
</tr>
<tr>
<td>4</td>
<td>Stage 4</td>
<td>Retinal detachment</td>
</tr>
</tbody>
</table>

**FINNEGAN SCORE**

Finnegan score.

Found on the ‘DISCHARGE SUMMARY’.

Code one of the following:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Neonatal abstinence syndrome diagnosis, treated with narcotics</td>
</tr>
<tr>
<td>2</td>
<td>Neonatal abstinence syndrome diagnosis, not treated with narcotics</td>
</tr>
<tr>
<td>3</td>
<td>No neonatal abstinence syndrome diagnosis</td>
</tr>
</tbody>
</table>
CHROMOSOMAL ABNORMALITIES

Chromosomal abnormalities.

Found in the ‘GENETICS REPORT’ or ‘NEONATOLOGIST LISTING’.

Code one chromosomal abnormality from the listing:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aneuploidy</td>
</tr>
<tr>
<td>2</td>
<td>Chimerism</td>
</tr>
<tr>
<td>3</td>
<td>Mosaicism</td>
</tr>
<tr>
<td>4</td>
<td>Triploidy</td>
</tr>
<tr>
<td>5</td>
<td>Deletion</td>
</tr>
<tr>
<td>6</td>
<td>Duplication</td>
</tr>
<tr>
<td>7</td>
<td>Microdeletion</td>
</tr>
<tr>
<td>8</td>
<td>Monosomy</td>
</tr>
<tr>
<td>9</td>
<td>Ring</td>
</tr>
<tr>
<td>10</td>
<td>Tandem repeat</td>
</tr>
<tr>
<td>11</td>
<td>Trisomy</td>
</tr>
<tr>
<td>12</td>
<td>Uniparental disomy</td>
</tr>
<tr>
<td>13</td>
<td>Translocation</td>
</tr>
</tbody>
</table>

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. You DO NOT have to code 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 two 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.
UNDELIVERED ADMISSION

Routine information – undelivered

Any admission of a woman to a facility during pregnancy in which 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 page 13-17.

If patient comes from 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 ‘PRENATAL RECORD’, or the ‘MATERNAL ADMISSION ASSESSMENT FORM’.

Code ‘99’ for unknown.
**PARA**

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

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

Code ‘99’ for unknown.

**ABORTIONS**

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

Found on ‘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 of abortions unspecified as spontaneous or therapeutic.

Found on the ‘PRENATAL RECORD’.

Code ‘99’ for unknown if it is not documented to indicate the number of each category.
SCREENING TESTS

Screening test.

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**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes - done</td>
</tr>
<tr>
<td>N</td>
<td>No - not done</td>
</tr>
<tr>
<td>D</td>
<td>Declined</td>
</tr>
<tr>
<td>U</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**Nuchal Translucency Screening**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes - done</td>
</tr>
<tr>
<td>N</td>
<td>No - not done</td>
</tr>
<tr>
<td>U</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes – done</td>
</tr>
<tr>
<td>D</td>
<td>Declined</td>
</tr>
<tr>
<td>U</td>
<td>Unknown</td>
</tr>
<tr>
<td>N</td>
<td>Not done</td>
</tr>
</tbody>
</table>

**Maternal Serum**

**Maternal Serum Screening**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes – done</td>
</tr>
<tr>
<td>D</td>
<td>Declined</td>
</tr>
<tr>
<td>U</td>
<td>Unknown</td>
</tr>
<tr>
<td>N</td>
<td>Not done</td>
</tr>
</tbody>
</table>

Yes, if any maternal serum screening is completed during the pregnancy.
<table>
<thead>
<tr>
<th><strong>DISCHARGE DATE</strong></th>
<th>Patient’s discharge date from hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Found on the ‘NURSES NOTES’.</td>
</tr>
<tr>
<td></td>
<td>Use the following format: ‘YYYYMMDD’.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DISCHARGE TIME</strong></th>
<th>Patient’s discharge time from hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Found on the ‘NURSES NOTES’.</td>
</tr>
<tr>
<td></td>
<td>Use the following format: ‘HHMM’. ‘HH’ is in range 0-23, ‘MM’ is in range 0-59</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DISCHARGE TO</strong></th>
<th>The immediate destination of patient on discharge.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Found in the ‘NURSES NOTES’ or the ‘HOSPITAL ADMISSION FORM’ or the ‘PHYSICIANS ORDER SHEET’.</td>
</tr>
<tr>
<td></td>
<td>Code using one of the standard 2-digit provincial codes for hospitals found on pages 13-17 or use one of the following codes:</td>
</tr>
<tr>
<td></td>
<td>If patient is discharged home, code 0.</td>
</tr>
<tr>
<td></td>
<td>Code ‘-9’ for Death.</td>
</tr>
</tbody>
</table>
**MATERNAL PRIMARY CAUSE OF DEATH**

Maternal primary cause of death.

Found on ‘DEATH CERTIFICATE’ or stated by the physician.

This field will auto fill if mother lived.

Use **one** of the following options:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77777</td>
<td>Lived</td>
</tr>
<tr>
<td>OTHR</td>
<td>Other</td>
</tr>
<tr>
<td>PEMB</td>
<td>Pulmonary embolus</td>
</tr>
<tr>
<td>PPHM</td>
<td>Postpartum hemorrhage</td>
</tr>
<tr>
<td>STRK</td>
<td>Stroke</td>
</tr>
</tbody>
</table>

**AUTOPSY**

Completion of maternal autopsy.

Found on the ‘DEATH CERTIFICATE’ or the ‘AUTOPSY REPORT’.

This field will auto fill if mother lived.

Code using one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LVD</td>
<td>Lived (not applicable)</td>
</tr>
<tr>
<td>YES</td>
<td>Died and autopsy done</td>
</tr>
<tr>
<td>NO</td>
<td>Died but autopsy not done</td>
</tr>
</tbody>
</table>
**ANTIBIOTIC THERAPY**

Antibiotic therapy.

Antibiotics administered during or within 10 days prior to admission.

Found on the ‘MEDICATION SHEETS’.

Enter ‘Y’ if antibiotics administered. If no antibiotics administered, leave blank.

Code Y if antibiotic is given during or within 10 days of admission, even if it is for a non-pregnancy related condition.

---

**ANTIBIOTIC DATE**

Date antibiotic therapy first given.

Antibiotics administered during or within 10 days prior to admission.

Found on ‘MEDICATION SHEETS’.

Use the following format: ‘YYYYMMDD’.

Record the date of the first antibiotic therapy given to the mother during admission or within 10 days of admission.

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 antibiotics, if documented. If the mother was on antibiotic prior to admission and date is not documented, enter ‘9’ in the field immediately following.
**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 admission or within 10 days of admission.

If the mother was on antibiotics at admission, enter the time of the start of the antibiotics, if documented. If the mother was on antibiotic prior to admission and time is not documented, enter ‘9’ in the field immediately following.

---

**MATERNAL STEROID THERAPY**

Maternal steroid therapy.

Found on the ‘MEDICATION SHEETS’ or ‘DISCHARGE SUMMARY’.

Code using one of the following:

2= Betamethasone (Celestone)
1= Dexamethasone
3= Unknown steroid

Chose value as documented on chart, or leave blank.

---

**MATERNAL STEROID DATE**

Date first maternal steroid administered.

Found on ‘MEDICATION SHEETS’ or ‘DISCHARGE SUMMARY’.

Use the following format: ‘YYYYMMDD’.

Record the date of the first steroid given to the mother during the hospital stay or up to 12 hours prior to admission to hospital.

If date of first steroid is not documented, leave date field blank and enter ‘9’ in the field immediately following.
**MATERNAL STEROID TIME**

Time first maternal steroid administered.

Found on ‘MEDICATION SHEETS’ or ‘DISCHARGE SUMMARY’.

Use the following format: ‘HHMM’.

‘HH’ is in range 0-23; ‘MM’ is in range 0-59.

Record the time of the first steroid given to the mother during the hospital stay or up to 12 hours prior to admission to hospital.

If time of the first steroid is not documented, leave time field blank and enter ‘9’ in the field immediately following.

---

**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.

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 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.*
LEFT BLANK INTENTIONALLY
POSTPARTUM ADMISSIONS

Routine Information – Postpartum Admission

Any admission of women 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 13-17.

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 recent pregnancy.

Found on the ‘PHYSICANS’ ASSESSMENT’

Code ‘99’ for unknown.

**PARA**

The number of pregnancies, including the recent 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 ‘PHYSICANS ASSESSMENT’

Code ‘99’ for unknown.

**ABORTIONS**

The number of pregnancies, including the recent pregnancy, which resulted in a fetus weighting 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 ‘PHYSICANS ASSESSMENT’

Code ‘99’ for unknown.
SPONTANEOUS ABORTIONS

Number of spontaneous abortions.

Enter the number occurring within the documented category.

Found on the ‘PHYSICIANS ASSESSMENT’.

Code ‘99’ for unknown if there is no documentation to indicate the number of spontaneous abortions.

THERAPEUTIC ABORTIONS

Number of therapeutic abortions.

Enter the number occurring within the documented category.

Found on the ‘PHYSICIANS ASSESSMENT’.

Code ‘99’ for unknown if there is no documentation to indicate the number of therapeutic abortions.

UNSPECIFIED ABORTIONS

Number of abortions not specified as spontaneous or therapeutic

Found on the ‘PHYSICIANS ASSESSMENT’.

Code ‘99’ for unknown if it is not documented to indicate the number of unspecified abortions.
<table>
<thead>
<tr>
<th><strong>DISCHARGE DATE</strong></th>
<th>Patient’s discharge date from hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Found on the ‘<strong>NURSES NOTES</strong>’.</td>
</tr>
<tr>
<td></td>
<td>Use the following format: ‘<strong>YYYYMMDD</strong>’.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DISCHARGE TIME</strong></th>
<th>Patient’s discharge time from hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Found on the ‘<strong>NURSES NOTES</strong>’.</td>
</tr>
<tr>
<td></td>
<td>Use the following format: ‘<strong>HHMM</strong>’</td>
</tr>
<tr>
<td></td>
<td>‘<strong>HH</strong>’ is in range 0-23; ‘<strong>MM</strong>’ is in range 0-59.</td>
</tr>
<tr>
<td></td>
<td>If discharge time is not documented enter ‘9’ in the field immediately following.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DISCHARGE TO</strong></th>
<th>The immediate destination of patient on discharge.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Found in the ‘<strong>NURSES NOTES</strong>’ or the ‘<strong>HOSPITAL ADMISSION FORM</strong>’ or the ‘<strong>PHYSICIANS ORDER SHEET</strong>’.</td>
</tr>
<tr>
<td></td>
<td>Code using one of the standard 2-digit provincial codes for hospitals found on page 13-17 or use one of the following codes:</td>
</tr>
<tr>
<td></td>
<td><em>If patient is discharge home, code 0.</em></td>
</tr>
<tr>
<td></td>
<td>-9    <em>Maternal Death.</em></td>
</tr>
</tbody>
</table>
MATERNAL PRIMARY CAUSE OF 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77777</td>
<td>Lived</td>
</tr>
<tr>
<td>OTHR</td>
<td>Other</td>
</tr>
<tr>
<td>PEMB</td>
<td>Pulmonary embolus</td>
</tr>
<tr>
<td>PPHM</td>
<td>Postpartum hemorrhage</td>
</tr>
<tr>
<td>STRK</td>
<td>Stroke</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LVD</td>
<td>Lived (not applicable)</td>
</tr>
<tr>
<td>YES</td>
<td>Died and autopsy done</td>
</tr>
<tr>
<td>NO</td>
<td>Died but autopsy not done</td>
</tr>
</tbody>
</table>

ANTIBIOTIC THERAPY
Antibiotics administered during postpartum period.

Found on the ‘MEDICATIONS SHEETS’.

Enter ‘Y’ if antibiotics administered. If no antibiotics administered, leave blank.

If antibiotic therapy was started within 10 days of admission code ‘Y’

Code ‘Y’ if an antibiotic is given, even for a non-pregnancy related condition.
**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 admission or within 10 days of admission.

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, enter ‘9’ in the field immediately following.

**ANTIBIOTIC TIME**

Time antibiotic therapy first given.

Found on ‘MEDICATION SHEETS’.

Use the following format: ‘HHMM’.

‘HH’ is in the range 0-23; ‘MM’ is in range 0-59.

Record the time of the first antibiotic therapy given to the mother during admission or within 10 days of admission.

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, enter ‘9’ in the field immediately following.
**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 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.
PAGE LEFT BLANK INTENTIONALLY
NEONATAL ADMISSIONS

Routine Information – 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 that 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:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Singleton, or first born of multiples.</td>
</tr>
<tr>
<td>2</td>
<td>Second born of multiples.</td>
</tr>
<tr>
<td>3</td>
<td>Third born of multiples</td>
</tr>
<tr>
<td>4</td>
<td>Fourth born of multiples</td>
</tr>
<tr>
<td>5</td>
<td>Fifth born of multiples.</td>
</tr>
</tbody>
</table>

-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 13-17.

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

If patient comes from home, code ‘0’

BIRTH HOSPITAL
Infant’s hospital of birth.

Found on the ‘HOSPITAL ADMISSION FORM’ or the ‘NURSES NOTES’.

Code using one of the standard 2-digit provincial codes for hospitals found on page 13-17.

If birth hospital is not documented, enter ‘99’ for unknown.

NICU
Infants admitted to the NICU or infants requiring special care in a normal nursery where a NICU is not available.

Found in the ‘PROGRESS NOTES’.

Code using one of the following:

Y Yes
N No

If ‘Y’ is entered, the screen NICU date and time will pop up. Enter the admit and discharge date and time to and from the NICU.

If there is more than one admission and discharge to the NICU during the same admission, enter the dates of the second admission in the next row. Continue until all admissions to the Unit are recorded.
OUTCOME

 Outcome of infant at time of discharge

Found on the ‘INFANT’S PROGRESS NOTES’.

Code using one of the following:

<table>
<thead>
<tr>
<th>LVD</th>
<th>Infant lived to be discharged from hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>NND</td>
<td>Live born infant who died before being discharged home from hospital</td>
</tr>
</tbody>
</table>

BREASTFEEDING

INITIATION

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’.

If the infant/child is put to breast shortly in the Labour and Delivery Room and then receives no further human milk during the stay, record this as Non-Exclusive Breastfeeding.

Code using one of the following:

<table>
<thead>
<tr>
<th>E</th>
<th>Exclusive Breastfeeding: The infant/child receives human milk (including expressed or donor milk) and allows the infant to receive oral rehydration solutions (ORS), syrup, (vitamins, mineral supplements, medicines) but does not allow the infant to receive anything else.</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Non-Exclusive Breastfeeding: The infant/child has received human milk (including expressed or donor milk) and water, water-based drinks, fruit juice, ritual fluids or any other liquid including non-human milk or solids</td>
</tr>
<tr>
<td>N</td>
<td>No Breastfeeding: The infant/child receives no human milk.</td>
</tr>
<tr>
<td>9</td>
<td>There is no documentation as to how the baby was fed during the hospital stay.</td>
</tr>
<tr>
<td><strong>DISCHARGE DATE</strong></td>
<td>Patient’s discharge date from hospital. Found on the ‘NURSES NOTES’. Use the following format: ‘YYYYMMDD’.</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>DISCHARGE TIME</strong></td>
<td>Patient’s discharge time from hospital. Found on the ‘NURSES NOTES’. Use the following format: ‘HHMM’. ‘HH’ is in the range 0-23; ‘MM’ is in the range 0-59. If discharge time is not documented enter ‘9’ in the field immediately following.</td>
</tr>
</tbody>
</table>
| **DISCHARGE TO**   | The immediate destination of patient on discharge. Found on the ‘NURSES NOTES’ or the ‘HOSPITAL ADMISSION FORM’ or the ‘PHYSICIAN ORDER SHEET’. Code using one of the standard 2-digit provincial codes for hospitals found on pages 13-17 or use one of the following codes:  

  *If patient is discharge home, code ‘0’.  
  -9 Death* |
AUTOPSY

Completion of infant autopsy.

Found on the ‘NEWBORN CODING SHEET’ or the ‘AUTOPSY REPORT’.

The fields will auto fill if infant lived.

Code using one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LVD</td>
<td>Lived (e.g., not applicable)</td>
</tr>
<tr>
<td>YES</td>
<td>Died and autopsy done</td>
</tr>
<tr>
<td>NO</td>
<td>Died but autopsy not done</td>
</tr>
</tbody>
</table>

PRIMARY CAUSE
OF DEATH

Primary cause of death.

Found on the ‘AUTOPSY REPORT’ or stated by physician.

The fields will autofill if infant lived.

Use **one** of the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7777</td>
<td>Infant lived</td>
</tr>
<tr>
<td>ABRP</td>
<td>Abruptio placenta</td>
</tr>
<tr>
<td>ANEC</td>
<td>Acute necrotizing enterocolitis</td>
</tr>
<tr>
<td>OAIR</td>
<td>Airway failure</td>
</tr>
<tr>
<td>AMNO</td>
<td>Amniocentesis</td>
</tr>
<tr>
<td>ANAL</td>
<td>Analgesia or anesthesia</td>
</tr>
<tr>
<td>ASPN</td>
<td>Aspiration</td>
</tr>
<tr>
<td>CPDP</td>
<td>Chronic pulmonary disease</td>
</tr>
<tr>
<td>COTR</td>
<td>Complications of treatment</td>
</tr>
<tr>
<td>ANOM</td>
<td>Congenital anomaly</td>
</tr>
<tr>
<td>CRLK</td>
<td>Cord loops and/or knots</td>
</tr>
<tr>
<td>CDOT</td>
<td>Cord, miscellaneous</td>
</tr>
<tr>
<td>CORP</td>
<td>Cord prolapsed</td>
</tr>
<tr>
<td>DBRN</td>
<td>Degenerative brain disease</td>
</tr>
<tr>
<td>DUCT</td>
<td>Ductus syndrome of prematurity</td>
</tr>
<tr>
<td>EXTX</td>
<td>Exchange transfusion</td>
</tr>
<tr>
<td>FETH</td>
<td>Fetal hemorrhage</td>
</tr>
<tr>
<td>FMAL</td>
<td>Fetal malnutrition</td>
</tr>
<tr>
<td>HMDD</td>
<td>Hyaline membrane disease</td>
</tr>
<tr>
<td>HYDR</td>
<td>Idiopathic hydrops</td>
</tr>
<tr>
<td>IBOM</td>
<td>Inborn errors of metabolism</td>
</tr>
<tr>
<td>INFT</td>
<td>Infection</td>
</tr>
</tbody>
</table>
### PRIMARY CAUSE OF DEATH (Con’t)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVTF</td>
<td>Intravascular transfusion</td>
</tr>
<tr>
<td>ISOM</td>
<td>Isoimmunization</td>
</tr>
<tr>
<td>KERN</td>
<td>Kernicterus</td>
</tr>
<tr>
<td>MALP</td>
<td>Malpresentation</td>
</tr>
<tr>
<td>DIAB</td>
<td>Maternal diabetes</td>
</tr>
<tr>
<td>SHOC</td>
<td>Maternal shock</td>
</tr>
<tr>
<td>MUSF</td>
<td>Multi-system failure</td>
</tr>
<tr>
<td>MINF</td>
<td>Myocardial infarction</td>
</tr>
<tr>
<td>NEOP</td>
<td>Neoplasia</td>
</tr>
<tr>
<td>TTTX</td>
<td>Twin-to-twin transfusion (Parabiotic syndrome)</td>
</tr>
<tr>
<td>PPFC</td>
<td>Persistent fetal circulation</td>
</tr>
<tr>
<td>PLPV</td>
<td>Placenta previa</td>
</tr>
<tr>
<td>AIRL</td>
<td>Pneumothorax pneumomediastinum and/or pneumopericardium</td>
</tr>
<tr>
<td>PIVH</td>
<td>Primary intraventricular hemorrhage</td>
</tr>
<tr>
<td>PPHN</td>
<td>Primary pulmonary hypertension</td>
</tr>
<tr>
<td>PULH</td>
<td>Primary pulmonary hemorrhage</td>
</tr>
<tr>
<td>RUPE</td>
<td>Ruptured uterus</td>
</tr>
<tr>
<td>SIDS</td>
<td>Sudden infant death syndrome</td>
</tr>
<tr>
<td>THAB</td>
<td>Therapeutic abortions</td>
</tr>
<tr>
<td>TOXM</td>
<td>Toxemia</td>
</tr>
<tr>
<td>TRAS</td>
<td>Tracheal stenosis</td>
</tr>
<tr>
<td>TRAU</td>
<td>Trauma (obstetrical)</td>
</tr>
<tr>
<td>UNEX</td>
<td>Unexplained</td>
</tr>
<tr>
<td>UXPA</td>
<td>Unexplained peripartum asphyxia</td>
</tr>
<tr>
<td>VOLV</td>
<td>Acquired volvulus</td>
</tr>
</tbody>
</table>

### DATE OF DEATH

Date of infant’s death.

Found in the ‘NURSES 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, enter ‘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:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Moderate wasting</td>
</tr>
<tr>
<td>2</td>
<td>Severe wasting</td>
</tr>
</tbody>
</table>

TWIN TYPE

Twin type.

Found in ‘DISCHARGE SUMMARY’ or ‘NEONATOLOGIST’S LISTING’.

Choose one from the following list:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Monoamniotic (one amniotic sac)</td>
</tr>
<tr>
<td>2</td>
<td>Monochorionic, diamniotic</td>
</tr>
<tr>
<td>3</td>
<td>Dichorionic, dissimilar sexes or blood groups</td>
</tr>
<tr>
<td>4</td>
<td>Dichorionic, similar sexes and blood groups</td>
</tr>
<tr>
<td>5</td>
<td>Dichorionic, similar sexes, blood groups undetermined</td>
</tr>
<tr>
<td>6</td>
<td>Undetermined</td>
</tr>
<tr>
<td>7</td>
<td>Conjoined twins</td>
</tr>
</tbody>
</table>
ELECTIVE NON-RESUSCITATION

Elective non-resuscitation.

Found in ‘DISCHARGE SUMMARY’ or ‘NEONATOLOGIST’S LISTING’.

Choose one from the following list:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do not resuscitate order on chart</td>
</tr>
<tr>
<td>2</td>
<td>Withdrawal of ventilator care with do not resuscitate order on chart</td>
</tr>
<tr>
<td>3</td>
<td>Non-resuscitation in labour and delivery room</td>
</tr>
</tbody>
</table>
Maternal steroid therapy.

Found on the ‘MEDICATION SHEET’ or on the ‘PRENATAL RECORD’.

Code the earliest dose of the first course of treatment.

Code one of the following:

**Betamethasone (Celestone)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>&lt; 24 hours before delivery</td>
</tr>
<tr>
<td>7</td>
<td>24 to 48 hours before delivery</td>
</tr>
<tr>
<td>8</td>
<td>&gt;48 hours but less than or equal to 7 days before delivery</td>
</tr>
<tr>
<td>9</td>
<td>&gt;7 days before delivery</td>
</tr>
<tr>
<td>10</td>
<td>Unknown when administered</td>
</tr>
</tbody>
</table>

**Dexamethasone**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&lt; 24 hours before delivery</td>
</tr>
<tr>
<td>2</td>
<td>24 to 48 hours before delivery</td>
</tr>
<tr>
<td>3</td>
<td>&gt;48 hours but less than or equal to 7 days before delivery</td>
</tr>
<tr>
<td>4</td>
<td>&gt;7 days before delivery</td>
</tr>
<tr>
<td>5</td>
<td>Unknown when administered</td>
</tr>
</tbody>
</table>

**Unknown Steroid**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>&lt; 24 hours before delivery</td>
</tr>
<tr>
<td>12</td>
<td>24 to 48 hours before delivery</td>
</tr>
<tr>
<td>13</td>
<td>&gt;48 hours but less than or equal to 7 days before delivery</td>
</tr>
<tr>
<td>14</td>
<td>&gt;7 days before delivery</td>
</tr>
<tr>
<td>15</td>
<td>Unknown when administered</td>
</tr>
</tbody>
</table>
**RETINOPATHY OF PREMATURITY**

Retinopathy of prematurity.

Found on the ‘DISCHARGE SUMMARY’.

Code one of the following:

<table>
<thead>
<tr>
<th></th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Peripheral vascular straightening</td>
<td>Peripheral shunt well seen</td>
<td>Vessels growing into vitreous</td>
<td>Retinal detachment</td>
</tr>
</tbody>
</table>

**FINNEGAN SCORE**

Finnegan score.

Found on the ‘DISCHARGE SUMMARY’.

Code one of the following:

<table>
<thead>
<tr>
<th></th>
<th>Neonatal abstinence syndrome diagnosis, treated with narcotics</th>
<th>Neonatal abstinence syndrome diagnosis, not treated with narcotics</th>
<th>No neonatal abstinence syndrome diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHROMOSOMAL ABNORMALITIES

Chromosomal abnormalities.

Found in the ‘GENETICS REPORT’ or NEONATOLOGIST’S LISTING’.

Code one chromosomal abnormality from the listing:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aneuploidy</td>
</tr>
<tr>
<td>2</td>
<td>Chimerism</td>
</tr>
<tr>
<td>3</td>
<td>Mosaicism</td>
</tr>
<tr>
<td>4</td>
<td>Triploidy</td>
</tr>
<tr>
<td>5</td>
<td>Deletion</td>
</tr>
<tr>
<td>6</td>
<td>Duplication</td>
</tr>
<tr>
<td>7</td>
<td>Microdeletion</td>
</tr>
<tr>
<td>8</td>
<td>Monosomy</td>
</tr>
<tr>
<td>9</td>
<td>Ring</td>
</tr>
<tr>
<td>10</td>
<td>Tandem repeat</td>
</tr>
<tr>
<td>11</td>
<td>Trisomy</td>
</tr>
<tr>
<td>12</td>
<td>Uniparental disomy</td>
</tr>
<tr>
<td>13</td>
<td>Translocation</td>
</tr>
</tbody>
</table>

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

If Aneuploidy, Chimerson or Triploidy are selected you DO NOT have to code the chromosome affected. You DO NOT have to code 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 is 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 two 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.
LEFT BLANK INTENTIONALLY
ADULT RCP CODES

**MATERNAL ANTIBODY CONDITIONS DURING PREGNANCY (R001)**

Maternal antibody conditions during pregnancy.

Found on the ‘RED CROSS SHEETS’.

Choose as many as are indicated.

<table>
<thead>
<tr>
<th>Code</th>
<th>Antibody Considering...</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Anti-La</td>
</tr>
<tr>
<td>200</td>
<td>Anti-D (Not to be used to indicate Rh-mom)</td>
</tr>
<tr>
<td>300</td>
<td>Anti-Big C (CW)</td>
</tr>
<tr>
<td>400</td>
<td>Anti-Big E</td>
</tr>
<tr>
<td>500</td>
<td>Anti-Big S</td>
</tr>
<tr>
<td>600</td>
<td>Anti-Dha (DUCH)</td>
</tr>
<tr>
<td>700</td>
<td>Anti-Fya (Duffy)</td>
</tr>
<tr>
<td>800</td>
<td>Anti-Kell (K1/K2)</td>
</tr>
<tr>
<td>900</td>
<td>Anti-Kidd (JKa)</td>
</tr>
<tr>
<td>1000</td>
<td>Anti-Little c</td>
</tr>
<tr>
<td>1100</td>
<td>Anti-Little e</td>
</tr>
<tr>
<td>1200</td>
<td>Anti-Little s</td>
</tr>
<tr>
<td>1300</td>
<td>Anti-Lutheran (Lua/Lub)</td>
</tr>
<tr>
<td>1400</td>
<td>Anti-Wright</td>
</tr>
<tr>
<td>1500</td>
<td>Antinuclear Antibody (ANA)</td>
</tr>
<tr>
<td>1600</td>
<td>Anti-Cardiolipin</td>
</tr>
<tr>
<td>1700</td>
<td>Anti-Cardiolipin</td>
</tr>
<tr>
<td>1800</td>
<td>Anti-DNA Antibody</td>
</tr>
<tr>
<td>1900</td>
<td>Lupus Antibody (Lupus Anticoagulant)</td>
</tr>
<tr>
<td>2000</td>
<td>Anti-Phospholipid</td>
</tr>
<tr>
<td>2100</td>
<td>Factor V Leiden</td>
</tr>
<tr>
<td>2200</td>
<td>PL-A1 Platelet Antigen Negative</td>
</tr>
</tbody>
</table>
MATERNAL CARRIER
STATUS AND/OR
CHRONIC INFECTION
DURING PREGANCY (R002)

Maternal carrier status and/or chronic infection during pregnancy.

Found on the ‘PRENATAL RECORD’ or ‘DISCHARGE SUMMARY’.

Choose as many as are indicated:

<table>
<thead>
<tr>
<th>Code</th>
<th>Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Cytomegalovirus</td>
</tr>
<tr>
<td>200</td>
<td>Group B streptococcus (GBS)</td>
</tr>
<tr>
<td>300</td>
<td>Herpes Simplex</td>
</tr>
<tr>
<td>400</td>
<td>HIV/Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>600</td>
<td>Syphilis</td>
</tr>
<tr>
<td>700</td>
<td>Toxoplasmosis</td>
</tr>
<tr>
<td>800</td>
<td>Serum Hepatitis Carrier (Antigen positive: Hepatitis A)</td>
</tr>
<tr>
<td>900</td>
<td>Serum Hepatitis Carrier (Antigen positive: Hepatitis B)</td>
</tr>
<tr>
<td>1000</td>
<td>Serum Hepatitis Carrier (Antigen positive: Hepatitis C)</td>
</tr>
<tr>
<td>1100</td>
<td>Serum Hepatitis Carrier (Antigen positive: Hepatitis viral)</td>
</tr>
<tr>
<td>1200</td>
<td>Gonorrhea</td>
</tr>
<tr>
<td>1300</td>
<td>Chlamydia</td>
</tr>
<tr>
<td>1400</td>
<td>Genital Warts</td>
</tr>
</tbody>
</table>
Maternal drug therapies for specific conditions of pregnancy, deliveries and postpartum.

Choose as many as are indicated as being taken during the pregnancy and postpartum period anywhere in the Health Record

<table>
<thead>
<tr>
<th>Code</th>
<th>Medication and Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Adalat (nifedipine) for premature labour</td>
</tr>
<tr>
<td>300</td>
<td>Atosiban for premature labour</td>
</tr>
<tr>
<td>400</td>
<td>Hemabate for postpartum hemorrhage</td>
</tr>
<tr>
<td>500</td>
<td>Indocid (Indomethacin) for premature labour</td>
</tr>
<tr>
<td>600</td>
<td>Indocid (Indomethacin) for tx of polyhydramnios</td>
</tr>
<tr>
<td>*700</td>
<td>MgSO₄ for hypertension or seizures (i.e. Eclampsia prophylaxis or treatment).</td>
</tr>
<tr>
<td>900</td>
<td>Pentaspan for postpartum hemorrhage</td>
</tr>
<tr>
<td>1000</td>
<td>Terbutaline (Bricanyl) for premature labour</td>
</tr>
<tr>
<td>1100</td>
<td>Ventolin for premature labour</td>
</tr>
<tr>
<td>1200</td>
<td>Other Drugs for specific pregnancy, delivery or postpartum conditions</td>
</tr>
<tr>
<td>1300</td>
<td>Ergot for postpartum hemorrhage</td>
</tr>
<tr>
<td>1400</td>
<td>Misoprostil for postpartum hemorrhage</td>
</tr>
<tr>
<td>*1500</td>
<td>MgSO₄ therapy for neuroprotection</td>
</tr>
<tr>
<td>*1600</td>
<td>MgSO₄ therapy for unknown reason</td>
</tr>
<tr>
<td>1700</td>
<td>Adalat for hypertension</td>
</tr>
<tr>
<td>1800</td>
<td>Ephedrine for hypotension, post-epidural or spinal anesthesia</td>
</tr>
<tr>
<td>1900</td>
<td>Phenylephrine for hypotension, post-epidural or spinal anesthesia</td>
</tr>
<tr>
<td>2000</td>
<td>Progesterone for Premature Labour</td>
</tr>
</tbody>
</table>

*Note: There should be clear documentation for the use of MgSO₄ (Magnesium Sulfate therapy) noted in the chart. If it is not noted as being used for hypertension or as a neuroprotector, then code as unknown use.
MATERNAL DRUG THERAPIES DURING PREGNANCY/POSTPARTUM (R004)

Maternal drug therapies for specific conditions of pregnancy, and postpartum.

Choose as many as are indicated.

Code drug therapy if noted taken before pregnancy diagnosis.

Code drug therapy even if condition has not been diagnosed on chart but drug is prescribed and taken, such as Synthroids prescribed and taken during pregnancy but no diagnosis of Hypothyroidism documented, code the drug taken by the patient.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Anti-coagulation therapy</td>
</tr>
<tr>
<td>200</td>
<td>Anti-depressives</td>
</tr>
<tr>
<td>300</td>
<td>Anti-epileptics</td>
</tr>
<tr>
<td>400</td>
<td>Anti-hypertensive’s</td>
</tr>
<tr>
<td>500</td>
<td>Chronic narcotic use (not abuse, when indicated for medical problems, i.e. back pain)</td>
</tr>
<tr>
<td>600</td>
<td>Lithium</td>
</tr>
<tr>
<td>700</td>
<td>Methadone (therapy, not abuse)</td>
</tr>
<tr>
<td>800</td>
<td>Other psychiatric medications</td>
</tr>
<tr>
<td>900</td>
<td>Other specified</td>
</tr>
<tr>
<td>1000</td>
<td>ASA therapy given during pregnancy</td>
</tr>
<tr>
<td>1100</td>
<td>Insulin therapy</td>
</tr>
<tr>
<td>1200</td>
<td>Thyroid medication</td>
</tr>
<tr>
<td>1300</td>
<td>Anti-anxiety medication</td>
</tr>
<tr>
<td>1400</td>
<td>Nicotine replacement</td>
</tr>
<tr>
<td>1500</td>
<td>Tamiflu</td>
</tr>
<tr>
<td>1600</td>
<td>Relenza</td>
</tr>
<tr>
<td>1700</td>
<td>E-Cigarette (vaping)</td>
</tr>
</tbody>
</table>

* If a patient has taken anti-anxiety medication before pregnancy confirmed or in early pregnancy but discontinues once pregnancy confirmed capture under this code.

*This is not considered nicotine replacement. If patient is using a nicotine replacement therapy as well, code both
Maternal drug and chemical abuse during pregnancy.

Found on the ‘PRENATAL RECORD’.

Choose as many as are indicated.

Code if noted used before found out was pregnant.

<table>
<thead>
<tr>
<th>Code</th>
<th>Drug/Chemical</th>
</tr>
</thead>
<tbody>
<tr>
<td>200</td>
<td>Ativan</td>
</tr>
<tr>
<td>300</td>
<td>Cocaine/Crack</td>
</tr>
<tr>
<td>400</td>
<td>Codeine</td>
</tr>
<tr>
<td>500</td>
<td>Demerol</td>
</tr>
<tr>
<td>600</td>
<td>Dilaudid</td>
</tr>
<tr>
<td>700</td>
<td>Hash</td>
</tr>
<tr>
<td>800</td>
<td>Heroin</td>
</tr>
<tr>
<td>900</td>
<td>Marijuana</td>
</tr>
<tr>
<td>1000</td>
<td>Methadone</td>
</tr>
<tr>
<td>1100</td>
<td>Morphine</td>
</tr>
<tr>
<td>1200</td>
<td>Prescription medication abuse</td>
</tr>
<tr>
<td>1300</td>
<td>Solvents</td>
</tr>
<tr>
<td>1400</td>
<td>Valium</td>
</tr>
<tr>
<td>1500</td>
<td>Other specified abuse</td>
</tr>
<tr>
<td>1600</td>
<td>Oxycontin</td>
</tr>
<tr>
<td>1700</td>
<td>Ecstasy</td>
</tr>
<tr>
<td>1800</td>
<td>Alcohol abuse – chronic</td>
</tr>
<tr>
<td>1900</td>
<td>Alcohol abuse - binge</td>
</tr>
<tr>
<td>2000</td>
<td>Alcohol abuse – unknown binge or chronic</td>
</tr>
</tbody>
</table>
Maternal/Fetal diagnostic and therapeutic procedures.

Found on the ‘PRENATAL RECORD’.

Choose as many as are indicated:

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Amniocentesis for genetic testing</td>
</tr>
<tr>
<td>200</td>
<td>Amniocentesis for isoimmunization</td>
</tr>
<tr>
<td>300</td>
<td>Amniocentesis for lung maturity</td>
</tr>
<tr>
<td>400</td>
<td>Amnioreduction (polyhyramnios, twin to twin transfusion)</td>
</tr>
<tr>
<td>500</td>
<td>Amnioinfusion during labour</td>
</tr>
<tr>
<td>600</td>
<td>Chorionic villus sampling (CVS),</td>
</tr>
<tr>
<td>700</td>
<td>Cordocentesis</td>
</tr>
<tr>
<td>801</td>
<td>One fetal blood transfusion</td>
</tr>
<tr>
<td>802</td>
<td>Two fetal blood transfusions</td>
</tr>
<tr>
<td>803</td>
<td>Three fetal blood transfusions</td>
</tr>
<tr>
<td>804</td>
<td>Four fetal blood transfusions</td>
</tr>
<tr>
<td>805</td>
<td>Five fetal blood transfusions</td>
</tr>
<tr>
<td>806</td>
<td>Six fetal blood transfusions</td>
</tr>
<tr>
<td>807</td>
<td>Seven fetal blood transfusions</td>
</tr>
<tr>
<td>808</td>
<td>Eight fetal blood transfusions</td>
</tr>
<tr>
<td>809</td>
<td>Nine fetal blood transfusions</td>
</tr>
<tr>
<td>810</td>
<td>Ten fetal blood transfusions</td>
</tr>
<tr>
<td>900</td>
<td>Fetal drainage (i.e. thoracentesis, hydrocephalus, urinary)</td>
</tr>
<tr>
<td>910</td>
<td>Fetal Fibronectin</td>
</tr>
<tr>
<td>1000</td>
<td>Fetal reduction</td>
</tr>
<tr>
<td>1100</td>
<td>Feto/placental laser</td>
</tr>
<tr>
<td>1200</td>
<td>Fetal stent placement</td>
</tr>
<tr>
<td>1300</td>
<td>Forceps rotation during delivery</td>
</tr>
<tr>
<td>1400</td>
<td>Manual rotation during delivery</td>
</tr>
<tr>
<td>1500</td>
<td>Vacuum rotation during delivery</td>
</tr>
<tr>
<td>1600</td>
<td>Removal of device, cervix of cerclage suture</td>
</tr>
<tr>
<td>1700</td>
<td>External version, including attempt*</td>
</tr>
<tr>
<td>1800</td>
<td>Internal Version</td>
</tr>
<tr>
<td>1900</td>
<td>Insertion of device, cervix of cerclage suture</td>
</tr>
</tbody>
</table>

*code version or rotation if attempted whether successful or unsuccessful.
### ANAESTHESIA DURING LABOUR AND DELIVERY (R010)

Anaesthesia during labour and delivery.

Found on the ‘ANAESTHESIA RECORD’.

Choose as many as were administered during labour and delivery.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Entonox (nitronox)</td>
</tr>
<tr>
<td>200</td>
<td>Epidural-single administration</td>
</tr>
<tr>
<td>300</td>
<td>Epidural-continuous catheter with intermittent drug administration</td>
</tr>
<tr>
<td>400</td>
<td>Epidural-continuous infusion of drug (CIEA)</td>
</tr>
<tr>
<td>500</td>
<td>Epidural-patient controlled epidural analgesia (PCEA)</td>
</tr>
<tr>
<td>600</td>
<td>General anaesthesia</td>
</tr>
<tr>
<td>700</td>
<td>Patient controlled intravenous analgesia</td>
</tr>
<tr>
<td>800</td>
<td>Pudendal</td>
</tr>
<tr>
<td>900</td>
<td>Spinal anaesthesia</td>
</tr>
<tr>
<td>1000</td>
<td>Spinal-epidural double needle</td>
</tr>
<tr>
<td>1100</td>
<td>Other specified anaesthesia (e.g. acupuncture, hypnotism, neuroleptic)</td>
</tr>
</tbody>
</table>

### ANAESTHESIA DURING LABOUR ONLY (R011)

Anaesthesia during labour only.

Found on the ‘ANAESTHESIA RECORD’.

Choose as many as were administered.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Entonox (nitronox)</td>
</tr>
<tr>
<td>200</td>
<td>Epidural-single administration</td>
</tr>
<tr>
<td>300</td>
<td>Epidural-continuous catheter with intermittent drug administration</td>
</tr>
<tr>
<td>400</td>
<td>Epidural-continuous infusion of drug (CIEA)</td>
</tr>
<tr>
<td>500</td>
<td>Epidural-patient controlled epidural analgesia (PCEA)</td>
</tr>
<tr>
<td>600</td>
<td>General anaesthesia</td>
</tr>
<tr>
<td>700</td>
<td>Patient controlled intravenous analgesia</td>
</tr>
<tr>
<td>800</td>
<td>Pudendal</td>
</tr>
<tr>
<td>900</td>
<td>Spinal anaesthesia</td>
</tr>
<tr>
<td>1000</td>
<td>Spinal-epidural double needle</td>
</tr>
<tr>
<td>1100</td>
<td>Other specified anaesthesia (e.g. acupuncture, hypnotism, neuroleptic)</td>
</tr>
</tbody>
</table>
Anaesthesia during delivery only.

Found on the ‘ANAESTHESIA RECORD’.

Choose as many as were administered.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Entonox (Nitronox)</td>
</tr>
<tr>
<td>200</td>
<td>Epidural-single administration</td>
</tr>
<tr>
<td>300</td>
<td>Epidural-continuous catheter with intermittent drug administration</td>
</tr>
<tr>
<td>400</td>
<td>Epidural-continuous infusion of drug (CIEA)</td>
</tr>
<tr>
<td>500</td>
<td>Epidural-patient controlled epidural analgesia (PCEA)</td>
</tr>
<tr>
<td>600</td>
<td>General anesthesia</td>
</tr>
<tr>
<td>700</td>
<td>Patient controlled intravenous analgesia</td>
</tr>
<tr>
<td>800</td>
<td>Pudendal</td>
</tr>
<tr>
<td>900</td>
<td>Spinal anesthesia</td>
</tr>
<tr>
<td>1000</td>
<td>Spinal-epidural double needle</td>
</tr>
<tr>
<td>1100</td>
<td>Other specified anaesthesia (e.g. acupuncture, hypnotism, neuroleptic)</td>
</tr>
</tbody>
</table>
Complications of Anaesthesia.

Found on the ‘ANAESTHESIA RECORD’ or ‘DISCHARGE SUMMARY’.

Choose as many as documented.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Blood patching</td>
</tr>
<tr>
<td>200</td>
<td>Toxic intravenous injection (systemic reaction)</td>
</tr>
<tr>
<td>300</td>
<td>Epi-catheter intravenous</td>
</tr>
<tr>
<td>400</td>
<td>Accidental dural tap</td>
</tr>
<tr>
<td>500</td>
<td>Total spinal anaesthesia</td>
</tr>
<tr>
<td>600</td>
<td>Prolonged epidural block</td>
</tr>
<tr>
<td>700</td>
<td>High epidural/subdural block</td>
</tr>
<tr>
<td>800</td>
<td>Foot drop</td>
</tr>
<tr>
<td>900</td>
<td>Epidural hematoma</td>
</tr>
<tr>
<td>1000</td>
<td>Epidural abscess</td>
</tr>
<tr>
<td>1100</td>
<td>Spinal cord lesion</td>
</tr>
<tr>
<td>1200</td>
<td>Aspiration pneumonitis</td>
</tr>
<tr>
<td>1300</td>
<td>Cardiac arrest</td>
</tr>
<tr>
<td>1400</td>
<td>Post-dural puncture headache</td>
</tr>
<tr>
<td>1500</td>
<td>Paraesthesia</td>
</tr>
<tr>
<td>1600</td>
<td>Hypotension</td>
</tr>
<tr>
<td>1700</td>
<td>Back pain</td>
</tr>
<tr>
<td>1800</td>
<td>Failed intubation for general anesthetic</td>
</tr>
</tbody>
</table>
Other obstetrical conditions affecting pregnancy.

Found on the ‘PRENATAL RECORD’ or ‘DISCHARGE SUMMARY’.

Choose as many as documented:

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Pruritic urticarial papules and plaques of pregnancy (PUPP)</td>
</tr>
<tr>
<td>200</td>
<td>Impetigo herpetiformis</td>
</tr>
<tr>
<td>300</td>
<td>Dermatitis herpetiformis</td>
</tr>
<tr>
<td>400</td>
<td>Separation of symphysis pubis</td>
</tr>
<tr>
<td>500</td>
<td>Gestational (pregnancy-induced) hypertension without significant proteinuria, includes: gestational hypertension NOS, mild pre-eclampsia</td>
</tr>
<tr>
<td>550</td>
<td>Hypertension, unspecified type</td>
</tr>
<tr>
<td>600</td>
<td>Gestational (pregnancy-induced) hypertension with significant proteinuria, includes: HELLP (syndrome)</td>
</tr>
<tr>
<td>700</td>
<td>Pre-existing hypertension complicating pregnancy, childbirth and the puerperium</td>
</tr>
<tr>
<td>800</td>
<td>Pre-existing hypertensive disorder with superimposed proteinuria</td>
</tr>
<tr>
<td>900</td>
<td>Pre-existing diabetes mellitus, type 1</td>
</tr>
<tr>
<td>1000</td>
<td>Pre-existing diabetes mellitus, type 2</td>
</tr>
<tr>
<td>1100</td>
<td>Pre-existing diabetes mellitus of other specified type present when pregnant during this pregnancy</td>
</tr>
<tr>
<td>1200</td>
<td>Pre-existing diabetes mellitus of unspecified type present when pregnant during this pregnancy</td>
</tr>
<tr>
<td>1300</td>
<td>Diabetes mellitus arising in pregnancy, includes gestational diabetes</td>
</tr>
<tr>
<td>1400</td>
<td>Diabetes mellitus in pregnancy, unspecified</td>
</tr>
<tr>
<td>1500</td>
<td>Anemia in Pregnancy (HB &lt; 10gms% in pregnancy)</td>
</tr>
<tr>
<td>1600</td>
<td>Febrile morbidity( 38 degrees or more on 2 or more occasions at least 4 hours apart, in any 48 hour period, excluding the first 24 hours after delivery, regardless of cause.)</td>
</tr>
<tr>
<td>1700</td>
<td>Maternal fever &gt; 38 degrees</td>
</tr>
</tbody>
</table>
### Gastro-Intestinal Diseases

Gastro-intestinal diseases.

**CODE IF CONDITION IS OR WAS PRESENT DURING THE PREGNANCY (R015)**

Found on the ‘PRENATAL RECORD’ or ‘DISCHARGE SUMMARY’.

Choose as many as documented.

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Cholelithiasis</td>
</tr>
<tr>
<td>200</td>
<td>Ulcerative colitis/proctitis</td>
</tr>
<tr>
<td>300</td>
<td>Crohn’s disease</td>
</tr>
<tr>
<td>400</td>
<td>Irritable bowel syndrome</td>
</tr>
<tr>
<td>500</td>
<td>Pancreatitis, acute and chronic</td>
</tr>
<tr>
<td>600</td>
<td>Reflux gastritis</td>
</tr>
<tr>
<td>700</td>
<td>Ulcers (all types)</td>
</tr>
</tbody>
</table>

### Psychiatric Illness

Psychiatric illness.

**CODE IF CONDITIONS IS OR WAS PRESENT DURING THE PREGNANCY (R016)**

Found on the ‘PRENATAL RECORD’ or ‘DISCHARGE SUMMARY’.

Choose as many as documented.

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Anxiety disorders</td>
</tr>
<tr>
<td>200</td>
<td>Depression</td>
</tr>
<tr>
<td>300</td>
<td>Eating disorders (e.g. anorexia nervosa, bulimia nervosa)</td>
</tr>
<tr>
<td>400</td>
<td>Manic – depression</td>
</tr>
<tr>
<td>500</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>600</td>
<td>Other</td>
</tr>
</tbody>
</table>
**NEUROLOGICAL ILLNESS**

Neurological illness.

**CODE IF THE CONDITION IS FOUND ON THE 'PRENATAL RECORD' OR WAS PRESENT DURING THE CURRENT PREGNANCY (R017)**

Found on the ‘PRENATAL RECORD’ or ‘DISCHARGE SUMMARY’.

Choose as many as documented.

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Bell’s palsy</td>
</tr>
<tr>
<td>200</td>
<td>Cerebral palsy</td>
</tr>
<tr>
<td>300</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>400</td>
<td>Intracerebral hemorrhage</td>
</tr>
<tr>
<td>500</td>
<td>Muscular dystrophy</td>
</tr>
<tr>
<td>600</td>
<td>Myasthenia gravis</td>
</tr>
<tr>
<td>700</td>
<td>Multiple sclerosis</td>
</tr>
<tr>
<td>800</td>
<td>Presence of Harrington Rod</td>
</tr>
<tr>
<td>900</td>
<td>Subarachnoid hemorrhage</td>
</tr>
<tr>
<td>1000</td>
<td>Seizure</td>
</tr>
<tr>
<td>1100</td>
<td>Tuberous sclerosis</td>
</tr>
<tr>
<td>1200</td>
<td>Thoracic outlet syndrome</td>
</tr>
<tr>
<td>1300</td>
<td>Other</td>
</tr>
</tbody>
</table>
HEART DISEASE

Heart disease.

CODE IF THE CONDITION IS FOUND ON THE ‘PRENATAL RECORD’ OR WAS PRESENT DURING THE CURRENT PREGNANCY (R018)

Choose as many as documented.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Arrhythmia</td>
</tr>
<tr>
<td>200</td>
<td>Congenital heart disease</td>
</tr>
<tr>
<td>300</td>
<td>Cardiac arrest</td>
</tr>
<tr>
<td>400</td>
<td>Coronary artery disease</td>
</tr>
<tr>
<td>500</td>
<td>Endocarditis</td>
</tr>
<tr>
<td>600</td>
<td>History of heart disease or surgery</td>
</tr>
<tr>
<td>700</td>
<td>Myocardial infarction</td>
</tr>
<tr>
<td>800</td>
<td>Prolapsed mitral value</td>
</tr>
<tr>
<td>900</td>
<td>Cardiomyopathy</td>
</tr>
<tr>
<td>1000</td>
<td>Myocarditis</td>
</tr>
<tr>
<td>1100</td>
<td>Pulmonary hypertension</td>
</tr>
<tr>
<td>1200</td>
<td>Rheumatic heart disease</td>
</tr>
<tr>
<td>1300</td>
<td>Valve prosthesis</td>
</tr>
<tr>
<td>1400</td>
<td>Wolff Parkinson’s White syndrome</td>
</tr>
<tr>
<td>1500</td>
<td>Other acquired cardiac diseases</td>
</tr>
<tr>
<td>1600</td>
<td>Thromboembolic disease</td>
</tr>
</tbody>
</table>

ENDOCRINE DISEASE

Endocrine disease.

CODE IF THE CONDITION IS FOUND ON THE ‘PRENATAL RECORD’ OR WAS PRESENT DURING THE CURRENT PREGNANCY (R019)

Choose as many as documented.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Disorder of adrenal gland</td>
</tr>
<tr>
<td>200</td>
<td>Disorder of ovary</td>
</tr>
<tr>
<td>300</td>
<td>Hashimoto’s thyroiditis</td>
</tr>
<tr>
<td>400</td>
<td>Hyperthyroidism with goiter</td>
</tr>
<tr>
<td>500</td>
<td>Hyperthyroidism with thyroid nodule</td>
</tr>
<tr>
<td>600</td>
<td>Hyperthyroidism with goiter, nodular</td>
</tr>
<tr>
<td>700</td>
<td>Hyperthyroidism without Goiter</td>
</tr>
<tr>
<td>800</td>
<td>Hypothyroidism</td>
</tr>
<tr>
<td>900</td>
<td>Hyperparathyroidism</td>
</tr>
<tr>
<td>1000</td>
<td>Disorder of hypothalamus</td>
</tr>
<tr>
<td>1100</td>
<td>Disorder of pituitary gland</td>
</tr>
</tbody>
</table>
RENAL DISEASE

Renal disease.

CODE IF THE CONDITION IS OR WAS PRESENT DURING THE CURRENT PREGNANCY (R020)

Found on the ‘PRENATAL RECORD’ or ‘DISCHARGE SUMMARY’.

Choose as many as documented.

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Acute pyelonephritis</td>
</tr>
<tr>
<td>200</td>
<td>Renal calculus</td>
</tr>
<tr>
<td>300</td>
<td>Chronic glomerulonephritis</td>
</tr>
<tr>
<td>400</td>
<td>Previous episode of acute pyelonephritis during current pregnancy</td>
</tr>
<tr>
<td>500</td>
<td>Hydronephrosis</td>
</tr>
<tr>
<td>600</td>
<td>Nephropathy</td>
</tr>
<tr>
<td>700</td>
<td>Nephritic syndrome</td>
</tr>
<tr>
<td>800</td>
<td>Polycystic kidney disease</td>
</tr>
<tr>
<td>900</td>
<td>Chronic pyelonephritis</td>
</tr>
<tr>
<td>1000</td>
<td>Renal agenesis</td>
</tr>
<tr>
<td>1100</td>
<td>Renal transplant</td>
</tr>
<tr>
<td>1200</td>
<td>Chronic renal disease, type undetermined</td>
</tr>
<tr>
<td>1300</td>
<td>Urinary tract infection</td>
</tr>
</tbody>
</table>
### NEOPLASM, INCLUDING MALIGNANCIES

Neoplasm, including malignancies

**CODE IF CONDITION IS OR WAS PRESENT DURING THE CURRENT PREGNANCY (R021)**

Found on the ‘PRENATAL RECORD’ or ‘DISCHARGE SUMMARY’.

Choose as many as documented.

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Bowel</td>
</tr>
<tr>
<td>200</td>
<td>Breast</td>
</tr>
<tr>
<td>300</td>
<td>Cervix</td>
</tr>
<tr>
<td>400</td>
<td>Other</td>
</tr>
<tr>
<td>500</td>
<td>Ovary (teratoma)</td>
</tr>
<tr>
<td>600</td>
<td>Thyroid</td>
</tr>
<tr>
<td>700</td>
<td>Vagina</td>
</tr>
</tbody>
</table>

### BLOOD DYSCRASIAS

Blood dyscrasias.

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

Found on the ‘PRENATAL RECORD’ or ‘DISCHARGE SUMMARY’.

Choose as many as documented.

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Hemolytic anemia</td>
</tr>
<tr>
<td>200</td>
<td>Dysfibrinogenemia</td>
</tr>
<tr>
<td>300</td>
<td>Factor 12 deficiency</td>
</tr>
<tr>
<td>400</td>
<td>Familial hypofibrinogenemia</td>
</tr>
<tr>
<td>500</td>
<td>Factor VIII deficiency</td>
</tr>
<tr>
<td>600</td>
<td>G6PD deficiency</td>
</tr>
<tr>
<td>700</td>
<td>Idiopathic hypoplastic anemia</td>
</tr>
<tr>
<td>800</td>
<td>Idiopathic thrombocytopenic purpura (ITP)</td>
</tr>
<tr>
<td>900</td>
<td>Sickle cell anemia</td>
</tr>
<tr>
<td>1000</td>
<td>Thalassemia</td>
</tr>
<tr>
<td>1100</td>
<td>Von Willebrand’s disease</td>
</tr>
<tr>
<td>1200</td>
<td>Thrombotic thrombocytopenic purpura (TTP)</td>
</tr>
<tr>
<td>1300</td>
<td>Thrombocytopenia</td>
</tr>
</tbody>
</table>
**PULMONARY DISEASE**

*(CODE IF THE CONDITION IS FOUND ON THE ‘PRENATAL RECORD’ OR ‘DISCHARGE SUMMARY’)*

*(R023)*

Choose as many as documented.

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Asthma</td>
</tr>
<tr>
<td>200</td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td>300</td>
<td>Pulmonary edema</td>
</tr>
<tr>
<td>400</td>
<td>Other significant pulmonary diseases</td>
</tr>
<tr>
<td>500</td>
<td>Pneumonia, antepartum</td>
</tr>
<tr>
<td>600</td>
<td>Laboratory confirmed H1N1 Influenza</td>
</tr>
</tbody>
</table>

**OTHER NON-OBSTETRICAL DISEASES, NOT ELSEWHERE CLASSIFIABLE**

*(R024)*

Choose as many as documented.

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Ankylosing spondylitis</td>
</tr>
<tr>
<td>200</td>
<td>Cholinesterase deficiency</td>
</tr>
<tr>
<td>300</td>
<td>Family or personal history of malignant hyperthermia</td>
</tr>
<tr>
<td>400</td>
<td>Neurofibromatosis (Von Recklinghausen’s disease)</td>
</tr>
<tr>
<td>500</td>
<td>Porphyria</td>
</tr>
<tr>
<td>600</td>
<td>Maternal phenylketonuria</td>
</tr>
<tr>
<td>700</td>
<td>Rheumatoid arthritis/psoriatic</td>
</tr>
<tr>
<td>800</td>
<td>Sarcoidosis</td>
</tr>
<tr>
<td>900</td>
<td>Scleroderma</td>
</tr>
<tr>
<td>1000</td>
<td>Scoliosis</td>
</tr>
<tr>
<td>1100</td>
<td>Sjogren’s syndrome</td>
</tr>
<tr>
<td>1200</td>
<td>Systemic lupus</td>
</tr>
<tr>
<td>1300</td>
<td>Scheurmann’s disease</td>
</tr>
</tbody>
</table>
Previous pregnancy – maternal diseases

Found on the ‘PRENATAL RECORD’ or ‘DISCHARGE SUMMARY’.

Choose as many as documented.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Previous history of personal malignancy</td>
</tr>
<tr>
<td>200</td>
<td>Previous sensitized pregnancy</td>
</tr>
<tr>
<td>300</td>
<td>Hypertensive disease in previous pregnancy</td>
</tr>
<tr>
<td>400</td>
<td>Previous eclampsia</td>
</tr>
<tr>
<td>500</td>
<td>Previous ectopic pregnancy</td>
</tr>
<tr>
<td>600</td>
<td>Previous molar pregnancy</td>
</tr>
<tr>
<td>700</td>
<td>Previous anemia</td>
</tr>
<tr>
<td>800</td>
<td>Previous abruptio placenta</td>
</tr>
<tr>
<td>900</td>
<td>Previous breech</td>
</tr>
<tr>
<td>1000</td>
<td>Previous thromboembolic disease</td>
</tr>
<tr>
<td>1100</td>
<td>Previous gestational diabetes</td>
</tr>
<tr>
<td>1200</td>
<td>Previous history of infertility</td>
</tr>
<tr>
<td>1300</td>
<td>Previous postpartum depression</td>
</tr>
</tbody>
</table>
Maternal transfusions, blood and other products.

Found on the ‘PRENATAL RECORD’ or ‘DISCHARGE SUMMARY’ or ‘OPERATIVE REPORT’.

Choose as many as documented.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>One maternal blood transfusion</td>
</tr>
<tr>
<td>200</td>
<td>Two maternal blood transfusions</td>
</tr>
<tr>
<td>300</td>
<td>Three maternal blood transfusions</td>
</tr>
<tr>
<td>400</td>
<td>Four maternal blood transfusions</td>
</tr>
<tr>
<td>500</td>
<td>Five maternal blood transfusions</td>
</tr>
<tr>
<td>600</td>
<td>Six maternal blood transfusions</td>
</tr>
<tr>
<td>700</td>
<td>Seven maternal blood transfusions</td>
</tr>
<tr>
<td>800</td>
<td>Eight maternal blood transfusions</td>
</tr>
<tr>
<td>900</td>
<td>Nine maternal blood transfusions</td>
</tr>
<tr>
<td>1000</td>
<td>Ten maternal blood transfusions</td>
</tr>
<tr>
<td>1100</td>
<td>More than ten maternal blood transfusions</td>
</tr>
<tr>
<td>1200</td>
<td>Albumin transfusion</td>
</tr>
<tr>
<td>1300</td>
<td>Cryoprecipitate transfusion</td>
</tr>
<tr>
<td>1400</td>
<td>Fresh frozen plasma transfusion</td>
</tr>
<tr>
<td>1500</td>
<td>Gamma globulin transfusion</td>
</tr>
<tr>
<td>1600</td>
<td>Plasma exchange/plasmapheresis transfusion</td>
</tr>
<tr>
<td>1700</td>
<td>Platelet transfusion</td>
</tr>
</tbody>
</table>

Reason for maternal blood transfusion.

Found on the ‘PRENATAL RECORD’ or ‘DISCHARGE SUMMARY’ or ‘OPERATIVE REPORT’.

Choose as many as documented.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Anemia in pregnancy</td>
</tr>
<tr>
<td>200</td>
<td>Antepartum hemorrhage</td>
</tr>
<tr>
<td>300</td>
<td>Intrapartum hemorrhage</td>
</tr>
<tr>
<td>400</td>
<td>Postpartum hemorrhage</td>
</tr>
<tr>
<td>500</td>
<td>Other</td>
</tr>
</tbody>
</table>
IMMUNIZATIONS (R028)

Immunizations.

Found on the ‘PRENATAL RECORD’ or ‘MATERNAL ASSESSMENT FORM’.

Choose all documented vaccines.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Seasonal influenza vaccine</td>
</tr>
<tr>
<td>400</td>
<td>Pertussis</td>
</tr>
<tr>
<td>500</td>
<td>Measles, Mumps, Rubella (MMR)</td>
</tr>
</tbody>
</table>

PROCEDURES FOR POSTPARTUM HEMORRHAGE (R029)

Procedures for postpartum hemorrhage.

Found on the ‘BIRTH RECORD’ or ‘PARTOGRAM’, ‘DISCHARGE SUMMARY’ or ‘OPERATIVE REPORT’.

Choose all documented procedures.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Uterine compression suture (e.g. B-Lynch or Cho)</td>
</tr>
<tr>
<td>200</td>
<td>Tying (ligation) of uterine arteries</td>
</tr>
<tr>
<td>300</td>
<td>Embolization of uterine arteries</td>
</tr>
<tr>
<td>400</td>
<td>Uterine tamponade (use of Bakri balloon or uterine packing) not to be confused with vaginal packing</td>
</tr>
</tbody>
</table>
**INFANT RCP CODES**

Placental or cord anomalies.

Found in ‘OBSTETRICIAN’S REPORT’ or ‘PLACENTAL PATHOLOGY REPORT’.

Code all that are applicable.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Amnionodosum</td>
</tr>
<tr>
<td>200</td>
<td>Chorioamnionitis, marked or severe</td>
</tr>
<tr>
<td>300</td>
<td>Choroangioma of placenta</td>
</tr>
<tr>
<td>400</td>
<td>Circumvallate placenta</td>
</tr>
<tr>
<td>500</td>
<td>Funisitis</td>
</tr>
<tr>
<td>600</td>
<td>Funisitis, necrotizing</td>
</tr>
<tr>
<td>700</td>
<td>Funisitis, candidal</td>
</tr>
<tr>
<td>800</td>
<td>Hematoma of umbilical cord</td>
</tr>
<tr>
<td>900</td>
<td>Marginal insertion of cord / Battledore</td>
</tr>
<tr>
<td>1000</td>
<td>Membranous placenta</td>
</tr>
<tr>
<td>1100</td>
<td>Placenta accreta</td>
</tr>
<tr>
<td>1200</td>
<td>Placenta increta</td>
</tr>
<tr>
<td>1300</td>
<td>Placenta percreta</td>
</tr>
<tr>
<td>1400</td>
<td>Single umbilical artery</td>
</tr>
<tr>
<td>1500</td>
<td>True knot in cord</td>
</tr>
<tr>
<td>1600</td>
<td>Vasa previa</td>
</tr>
<tr>
<td>1700</td>
<td>Velamentous insertion of cord</td>
</tr>
</tbody>
</table>
Anomaly/metabolic syndromes and conditions

Found on the ‘DISCHARGE SUMMARY’ or ‘NEONATOLIST LISTING’ or ‘CHROMOSOMAL REPORT’.

Code all that are applicable.

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Aarskog syndrome</td>
</tr>
<tr>
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### ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

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### ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

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ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

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### ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

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</table>
**DEPRESSION AT BIRTH (R055)**

Depression at birth.

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
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</tr>
<tr>
<td>200</td>
<td>Bag and mask 1-3 minutes</td>
</tr>
<tr>
<td>300</td>
<td>Bag and mask &gt; 3 minutes</td>
</tr>
<tr>
<td>400</td>
<td>Bag and mask unknown duration</td>
</tr>
<tr>
<td>500</td>
<td>Endotracheal tube &lt; 1 minute</td>
</tr>
<tr>
<td>600</td>
<td>Endotracheal tube 1-3 minutes</td>
</tr>
<tr>
<td>700</td>
<td>Endotracheal tube &gt; 3 minutes</td>
</tr>
<tr>
<td>800</td>
<td>Endotracheal tube unknown duration</td>
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<tr>
<td>900</td>
<td>CPAP/T-piece/neopuff &lt; 1 minute</td>
</tr>
<tr>
<td>1000</td>
<td>CPAP/T-piece/neopuff 1-3 minutes</td>
</tr>
<tr>
<td>1100</td>
<td>CPAP/T-piece/neopuff &gt; 3 minutes</td>
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<tr>
<td>1200</td>
<td>CPAP/T-piece/neopuff unknown duration</td>
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**PATENT DUCTUS ARTERIOSUS (R057)**

Patent ductus arteriosus.

Found on the 'DISCHARGE SUMMARY'.

Choose one of the following.

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<tbody>
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<tr>
<td>200</td>
<td>Surgical closure</td>
</tr>
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PERSISTENT FETAL CIRCULATION/
PERSISTENT PULMONARY HYPERTENSION OF THE NEWBORN (R058)

Persistent fetal circulation/persistent pulmonary hypertension of the newborn.

Found on the ‘DISCHARGE SUMMARY’.

Choose one of the following causes.

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<td>Fetomaternal bleed</td>
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<td>Hyaline membrane disease</td>
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<td>Meconium aspiration</td>
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<td>500</td>
<td>Pulmonary hypoplasia</td>
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<tr>
<td>600</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>700</td>
<td>Primary pulmonary hypertension</td>
</tr>
<tr>
<td>800</td>
<td>Cause not stated</td>
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RESPIRATORY DISTRESS SYNDROME (R059)

Respiratory distress syndrome.

Found on the ‘DISCHARGE SUMMARY’.

Choose one of the following.

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<td>IRDS, moderate</td>
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<tr>
<td>400</td>
<td>IRDS, severe</td>
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<tr>
<td>500</td>
<td>IRDS, severity not stated</td>
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<tr>
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<td>Transient Tachypnea of the newborn</td>
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<tr>
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### CHRONIC PULMONARY DISEASE OF PREMATURITY (R060)

Chronic pulmonary disease of prematurity.

Found on the ‘DISCHARGE SUMMARY’.

Choose one of the following.

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<tr>
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<th>Description</th>
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<tbody>
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<tr>
<td>200</td>
<td>Wilson-Mikity syndrome, cystic</td>
</tr>
<tr>
<td>300</td>
<td>Bronchopulmonary dysplasia, non-cystic</td>
</tr>
<tr>
<td>400</td>
<td>Bronchopulmonary dysplasia, cystic</td>
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</table>

### REQUIREMENT FOR HOME OXYGEN (RO61)

Requirement for home oxygen.

Found on the ‘DISCHARGE SUMMARY’.

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### BIRTH ASPHYXIA SEQUELAE (R062)

Birth asphyxia sequelae

Found on the ‘DISCHARGE SUMMARY’.

Choose as many as are present.

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<tr>
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<td>Post-asphyctic CNS excitation</td>
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<tr>
<td>300</td>
<td>Post-asphyctic increase intracranial pressure</td>
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<td>Post-asphyctic congestive heart failure</td>
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<td>Post-asphyctic acute tubular necrosis</td>
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<td>Post-asphyctic liver and/or adrenal necrosis</td>
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</table>
CONVULSIONS/SEIZURES
(R063)

Convulsions or seizures due to a stated condition.

Found on the ‘DISCHARGE SUMMARY’.

Choose as many as are present.

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<td>300</td>
<td>Benign familial</td>
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<td>400</td>
<td>Brain edema</td>
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<tr>
<td>500</td>
<td>Cerebral anomaly, unspecified</td>
</tr>
<tr>
<td>600</td>
<td>Drug withdrawal</td>
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<tr>
<td>700</td>
<td>Hemorrhage, brain stem</td>
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<tr>
<td>800</td>
<td>Hemorrhage, cerebellar</td>
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<td>Hemorrhage, cerebral</td>
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<td>Holoprosencephaly</td>
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<td>Hypercapnia</td>
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<td>Hypocapnia</td>
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<td>Venous thrombosis</td>
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**NEOPLASM**
(R064)

Neoplasm

Found on the ‘DISCHARGE SUMMARY’.

Code all that are applicable.

<table>
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<th>Description</th>
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</thead>
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<td>Choroid plexus papilloma</td>
</tr>
<tr>
<td>300</td>
<td>Connective tissue</td>
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<tr>
<td>400</td>
<td>Craniopharyngioma</td>
</tr>
<tr>
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<tr>
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<tr>
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<td>Epithelial tissue</td>
</tr>
<tr>
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<td>Familial erythrophagocytic lymphohistiocytosis</td>
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<tr>
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<td>Fibroma</td>
</tr>
<tr>
<td>1200</td>
<td>Follicular cyst</td>
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<td>Glioma</td>
</tr>
<tr>
<td>1400</td>
<td>Hemangioma, cavernous</td>
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<tr>
<td>1500</td>
<td>Hemangioma, capillary</td>
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<tr>
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<td>Hepatoblastoma</td>
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<tr>
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<tr>
<td>1900</td>
<td>Leukemia</td>
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<td>2000</td>
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<td>Lymphangioma</td>
</tr>
<tr>
<td>2200</td>
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</tr>
<tr>
<td>2300</td>
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<td>2400</td>
<td>Medulloblastoma</td>
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<tr>
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</tr>
<tr>
<td>2600</td>
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<tr>
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<td>Myxofibrosarcoma</td>
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<tr>
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</tr>
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<td>3500</td>
<td>Neurofibroma</td>
</tr>
<tr>
<td>3600</td>
<td>Retinoblastoma</td>
</tr>
<tr>
<td>3700</td>
<td>Rhabdomyoma, cardiac</td>
</tr>
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<td>3800</td>
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### NEOPLASM

(R064) (con’t)

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<td>3900</td>
<td>Sarcoma</td>
</tr>
<tr>
<td>4000</td>
<td>Teratoma, cardiac</td>
</tr>
<tr>
<td>4100</td>
<td>Teratoma, embryotic rests</td>
</tr>
<tr>
<td>4200</td>
<td>Teratoma, gonads</td>
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<tr>
<td>4300</td>
<td>Teratoma, sacrococcygeal</td>
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</tr>
<tr>
<td>4600</td>
<td>Hemangioma</td>
</tr>
<tr>
<td>4700</td>
<td>Hemangioma, port-wine</td>
</tr>
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</table>

### MEDICATIONS

(R066)

Medications.

Found on ‘MEDICATION SHEETS’ or ‘DISCHARGE SUMMARY’.

(Not coded at IWK)

Choose all applicable medications

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<thead>
<tr>
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<th>Medication</th>
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</thead>
<tbody>
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<td>0100</td>
<td>Acyclovir</td>
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<tr>
<td>0200</td>
<td>Adenosine</td>
</tr>
<tr>
<td>0900</td>
<td>Adrenalin</td>
</tr>
<tr>
<td>1100</td>
<td>Alprostadel (prostaglandin, e.g.; prostin)</td>
</tr>
<tr>
<td>1600</td>
<td>Amoxicillin</td>
</tr>
<tr>
<td>1700</td>
<td>Ampicillin</td>
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<tr>
<td>1800</td>
<td>Cefazidime</td>
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<tr>
<td>1900</td>
<td>Cefazolin</td>
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<tr>
<td>2000</td>
<td>Cefotaxime</td>
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<tr>
<td>2100</td>
<td>Ceftriaxone</td>
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<tr>
<td>2200</td>
<td>Cefuroxime</td>
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<tr>
<td>2300</td>
<td>Cloxacillin</td>
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<tr>
<td>2400</td>
<td>Surfactant</td>
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<tr>
<td>2500</td>
<td>Diazepam</td>
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<tr>
<td>2600</td>
<td>Digoxin</td>
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<tr>
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<td>Dilantin (phenytoin)</td>
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<tr>
<td>2800</td>
<td>Dobutamine</td>
</tr>
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<td>Dopamine</td>
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<tr>
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<td>Epinephrine</td>
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<tr>
<td>3100</td>
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</tr>
<tr>
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<td>Glucagon</td>
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<td>Insulin</td>
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<td>3800</td>
<td>Kayexalate</td>
</tr>
<tr>
<td>3900</td>
<td>Morphine</td>
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MEDICATIONS  
(R066) (con’t)  

<table>
<thead>
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<th>Code</th>
<th>Drug Name</th>
<th>Notes</th>
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<tbody>
<tr>
<td>8800</td>
<td>Naloxone (narcan)</td>
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</tr>
<tr>
<td>9500</td>
<td>Penicillin</td>
<td></td>
</tr>
<tr>
<td>9600</td>
<td>Phenobarbital</td>
<td></td>
</tr>
<tr>
<td>9700</td>
<td>Potassium Chloride</td>
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</tr>
<tr>
<td>10000</td>
<td>Propranolol</td>
<td></td>
</tr>
<tr>
<td>10300</td>
<td>Salbutamol (ventolin)</td>
<td></td>
</tr>
<tr>
<td>10400</td>
<td>Septra (sulfamethoxazole / trimethoprim)</td>
<td></td>
</tr>
<tr>
<td>11100</td>
<td>Ticarcillin</td>
<td></td>
</tr>
<tr>
<td>11200</td>
<td>Tobramycin</td>
<td></td>
</tr>
<tr>
<td>11400</td>
<td>Trimethoprim</td>
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</tr>
<tr>
<td>11700</td>
<td>Vancomycin</td>
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</tr>
<tr>
<td>11900</td>
<td>Tamiflu</td>
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</tr>
<tr>
<td>12000</td>
<td>Relenza</td>
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<tr>
<td>12100</td>
<td>Clindamycin</td>
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</table>

(Not coded at IWK)

NEONATAL ABSTINENCE SYNDROME  
(R067)  

Neonatal abstinence syndrome. Drug withdrawal from maternal use. Found on the ‘DISCHARGE SUMMARY’.

Code ALL applicable drugs

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<th>Drug Name</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
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<td>Alprazolam (xanax)</td>
<td></td>
</tr>
<tr>
<td>200</td>
<td>Barbituate</td>
<td></td>
</tr>
<tr>
<td>300</td>
<td>Benzodiazepam</td>
<td></td>
</tr>
<tr>
<td>400</td>
<td>Citalopram (celexa)</td>
<td></td>
</tr>
<tr>
<td>500</td>
<td>Cocaine</td>
<td></td>
</tr>
<tr>
<td>600</td>
<td>Diazepam (valium)</td>
<td></td>
</tr>
<tr>
<td>700</td>
<td>Fluoxetine (prozac)</td>
<td></td>
</tr>
<tr>
<td>800</td>
<td>Ethchlorvynol (placidyl)</td>
<td></td>
</tr>
<tr>
<td>900</td>
<td>Heroin</td>
<td></td>
</tr>
<tr>
<td>1000</td>
<td>Hydromorphone (dilaudid)</td>
<td></td>
</tr>
<tr>
<td>1100</td>
<td>Lorazepam (ativan)</td>
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</tr>
<tr>
<td>1200</td>
<td>Meperidine (demerol)</td>
<td></td>
</tr>
<tr>
<td>1300</td>
<td>Methadone</td>
<td></td>
</tr>
<tr>
<td>1400</td>
<td>Morphine</td>
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<tr>
<td>1500</td>
<td>Oxazepam</td>
<td></td>
</tr>
<tr>
<td>1600</td>
<td>Paroxetine (paxil)</td>
<td></td>
</tr>
<tr>
<td>1700</td>
<td>Pentazocine (talwin)</td>
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</tr>
<tr>
<td>1800</td>
<td>Sertraline (Zoloft)</td>
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<td>Unknown</td>
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<td>Venlafaxine</td>
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<tr>
<td>2100</td>
<td>OxyContin</td>
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</tr>
<tr>
<td>2200</td>
<td>Other</td>
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</tr>
</tbody>
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**CENTRAL VENOUS**  Central venous catheters.

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>110</td>
<td>Umbilical vein, direct (1 time)</td>
</tr>
<tr>
<td>120</td>
<td>Umbilical vein, direct (2 times)</td>
</tr>
<tr>
<td>130</td>
<td>Umbilical vein, direct (3 times)</td>
</tr>
<tr>
<td>140</td>
<td>Umbilical vein, direct (4 times)</td>
</tr>
<tr>
<td>150</td>
<td>Umbilical vein, direct (5 times)</td>
</tr>
<tr>
<td>160</td>
<td>Umbilical vein, direct (more than 5 times)</td>
</tr>
<tr>
<td>210</td>
<td>Upper limb, direct (1 time)</td>
</tr>
<tr>
<td>220</td>
<td>Upper limb, direct (2 times)</td>
</tr>
<tr>
<td>230</td>
<td>Upper limb, direct (3 times)</td>
</tr>
<tr>
<td>240</td>
<td>Upper limb, direct (4 times)</td>
</tr>
<tr>
<td>250</td>
<td>Upper limb, direct (5 times)</td>
</tr>
<tr>
<td>260</td>
<td>Upper limb, direct (more than 5 times)</td>
</tr>
<tr>
<td>310</td>
<td>Upper limb, percutaneous (PICC) (1 time)</td>
</tr>
<tr>
<td>320</td>
<td>Upper limb, percutaneous (PICC) (2 times)</td>
</tr>
<tr>
<td>330</td>
<td>Upper limb, percutaneous (PICC) (3 times)</td>
</tr>
<tr>
<td>340</td>
<td>Upper limb, percutaneous (PICC) (4 times)</td>
</tr>
<tr>
<td>350</td>
<td>Upper limb, percutaneous (PICC) (5 times)</td>
</tr>
<tr>
<td>360</td>
<td>Upper limb, percutaneous (PICC) (more than 5 times)</td>
</tr>
<tr>
<td>410</td>
<td>Upper limb, cut down (surgical) (1 time)</td>
</tr>
<tr>
<td>420</td>
<td>Upper limb, cut down (surgical) (2 times)</td>
</tr>
<tr>
<td>430</td>
<td>Upper limb, cut down (surgical) (3 times)</td>
</tr>
<tr>
<td>440</td>
<td>Upper limb, cut down (surgical) (4 times)</td>
</tr>
<tr>
<td>450</td>
<td>Upper limb, cut down (surgical) (5 times)</td>
</tr>
<tr>
<td>460</td>
<td>Upper limb, cut down (surgical) (more than 5 times)</td>
</tr>
<tr>
<td>510</td>
<td>Upper limb, Broviac (1 time)</td>
</tr>
<tr>
<td>520</td>
<td>Upper limb, Broviac (2 times)</td>
</tr>
<tr>
<td>530</td>
<td>Upper limb, Broviac (3 times)</td>
</tr>
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<td>540</td>
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<td>Lower limb, direct (1 time)</td>
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<tr>
<td>620</td>
<td>Lower limb, direct (2 times)</td>
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<tr>
<td>630</td>
<td>Lower limb, direct (3 times)</td>
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<tr>
<td>640</td>
<td>Lower limb, direct (4 times)</td>
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<tr>
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<td>Lower limb, direct (5 times)</td>
</tr>
<tr>
<td>660</td>
<td>Lower limb, direct (more than 5 times)</td>
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### CENTRAL VENOUS CATHETERS (R069) (con’t)

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<td>720</td>
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<td>740</td>
<td>Lower limb, percutaneous (PICC)</td>
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</tr>
<tr>
<td>750</td>
<td>Lower limb, percutaneous (PICC)</td>
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</tr>
<tr>
<td>760</td>
<td>Lower limb, percutaneous (PICC)</td>
<td>more than 5 times</td>
</tr>
<tr>
<td>810</td>
<td>Lower limb, cut down (surgical)</td>
<td>1 time</td>
</tr>
<tr>
<td>820</td>
<td>Lower limb, cut down (surgical)</td>
<td>2 times</td>
</tr>
<tr>
<td>830</td>
<td>Lower limb, cut down (surgical)</td>
<td>3 times</td>
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<tr>
<td>840</td>
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<td>860</td>
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<td>more than 5 times</td>
</tr>
<tr>
<td>910</td>
<td>Lower limb, Brioviac</td>
<td>1 time</td>
</tr>
<tr>
<td>920</td>
<td>Lower limb, Brioviac</td>
<td>2 times</td>
</tr>
<tr>
<td>930</td>
<td>Lower limb, Brioviac</td>
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</tr>
<tr>
<td>940</td>
<td>Lower limb, Brioviac</td>
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<tr>
<td>950</td>
<td>Lower limb, Brioviac</td>
<td>5 times</td>
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<tr>
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<td>Other</td>
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<td>1140</td>
<td>Other</td>
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</tr>
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### ARTERIAL CATHETERS (R070)

Arterial catheters.

Found on the ‘OPERATIVE REPORT’ or on the ‘DISCHARGE SUMMARY’.

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

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<th>Description</th>
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<td>130</td>
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<tr>
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<td>Radial, direct</td>
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<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>310</td>
<td>Radial, percutaneous (PICC) (1 time)</td>
</tr>
<tr>
<td>320</td>
<td>Radial, percutaneous (PICC) (2 times)</td>
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<tr>
<td>410</td>
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<tr>
<td>420</td>
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<td>460</td>
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<td>Pedal, direct (1 time)</td>
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<td>520</td>
<td>Pedal, direct (2 times)</td>
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<td>530</td>
<td>Pedal, direct (3 times)</td>
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<tr>
<td>540</td>
<td>Pedal, direct (4 times)</td>
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<tr>
<td>560</td>
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<td>610</td>
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<tr>
<td>620</td>
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</tr>
<tr>
<td>630</td>
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<tr>
<td>640</td>
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<tr>
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<tr>
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<tr>
<td>710</td>
<td>Pedal, cut down (surgical) (1 time)</td>
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<tr>
<td>720</td>
<td>Pedal, cut down (surgical) (2 times)</td>
</tr>
<tr>
<td>730</td>
<td>Pedal, cut down (surgical) (3 times)</td>
</tr>
<tr>
<td>740</td>
<td>Pedal, cut down (surgical) (4 times)</td>
</tr>
<tr>
<td>750</td>
<td>Pedal, cut down (surgical) (5 times)</td>
</tr>
<tr>
<td>760</td>
<td>Pedal, cut down (surgical) (more than 5 times)</td>
</tr>
<tr>
<td>810</td>
<td>Femoral, direct (1 time)</td>
</tr>
<tr>
<td>820</td>
<td>Femoral, direct (2 times)</td>
</tr>
<tr>
<td>830</td>
<td>Femoral, direct (3 times)</td>
</tr>
<tr>
<td>840</td>
<td>Femoral, direct (4 times)</td>
</tr>
<tr>
<td>850</td>
<td>Femoral, direct (5 times)</td>
</tr>
<tr>
<td>860</td>
<td>Femoral, direct (more than 5 times)</td>
</tr>
<tr>
<td>910</td>
<td>Femoral, percutaneous (PICC) (1 time)</td>
</tr>
<tr>
<td>920</td>
<td>Femoral, percutaneous (PICC) (2 times)</td>
</tr>
<tr>
<td>930</td>
<td>Femoral, percutaneous (PICC) (3 times)</td>
</tr>
<tr>
<td>940</td>
<td>Femoral, percutaneous (PICC) (4 times)</td>
</tr>
<tr>
<td>950</td>
<td>Femoral, percutaneous (PICC) (5 times)</td>
</tr>
<tr>
<td>960</td>
<td>Femoral, percutaneous (PICC) (more than 5 times)</td>
</tr>
</tbody>
</table>
### ARTERIAL CATHETERS

(R070) (con’t)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1010</td>
<td>Femoral, cut down (surgical) (1 time)</td>
</tr>
<tr>
<td>1020</td>
<td>Femoral, cut down (surgical) (2 times)</td>
</tr>
<tr>
<td>1030</td>
<td>Femoral, cut down (surgical) (3 times)</td>
</tr>
<tr>
<td>1040</td>
<td>Femoral, cut down (surgical) (4 times)</td>
</tr>
<tr>
<td>1050</td>
<td>Femoral, cut down (surgical) (5 times)</td>
</tr>
<tr>
<td>1060</td>
<td>Femoral, cut down (surgical) (more than 5 times)</td>
</tr>
<tr>
<td>1110</td>
<td>Other (1 time)</td>
</tr>
<tr>
<td>1120</td>
<td>Other (2 times)</td>
</tr>
<tr>
<td>1130</td>
<td>Other (3 times)</td>
</tr>
<tr>
<td>1140</td>
<td>Other (4 times)</td>
</tr>
<tr>
<td>1150</td>
<td>Other (5 times)</td>
</tr>
<tr>
<td>1160</td>
<td>Other (more than 5 times)</td>
</tr>
</tbody>
</table>

### MODE OF VENTILATION

(R071)

Mode of ventilation.

Found on the ‘RESPIRATORY THERAPY RECORD’ or on the ‘DISCHARGE SUMMARY’.

Code ALL that are applicable.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Intermittent mandatory ventilation (IMV)</td>
</tr>
<tr>
<td>200</td>
<td>Synchronized mandatory ventilation (SIMV)</td>
</tr>
<tr>
<td>300</td>
<td>Pressure support (PS)</td>
</tr>
<tr>
<td>400</td>
<td>Continuous positive airway pressure (CPAP)</td>
</tr>
<tr>
<td>500</td>
<td>High frequency oscillatory ventilation (HFOV)</td>
</tr>
<tr>
<td>600</td>
<td>Positive pressure ventilation (PPV)</td>
</tr>
</tbody>
</table>
**COMPLICATIONS OF ENDOTRACHEAL INTUBATION** *(RO72)*

Complications of endotracheal intubation.

Found on the ‘DISCHARGE SUMMARY’.

Code ALL complications of an endotracheal intubation that are applicable.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Esophageal perforation</td>
</tr>
<tr>
<td>200</td>
<td>Granuloma</td>
</tr>
<tr>
<td>300</td>
<td>Laryngeal perforation</td>
</tr>
<tr>
<td>400</td>
<td>Laryngeal stenosis</td>
</tr>
<tr>
<td>500</td>
<td>Lip deformity</td>
</tr>
<tr>
<td>600</td>
<td>Necrotizing laryngitis</td>
</tr>
<tr>
<td>700</td>
<td>Necrotizing tracheitis</td>
</tr>
<tr>
<td>800</td>
<td>Palate deformity</td>
</tr>
<tr>
<td>900</td>
<td>Squamous metaplasia</td>
</tr>
<tr>
<td>1000</td>
<td>Stridor</td>
</tr>
<tr>
<td>1100</td>
<td>Subglottic stenosis</td>
</tr>
<tr>
<td>1200</td>
<td>Tracheal perforation</td>
</tr>
<tr>
<td>1300</td>
<td>Tracheobronchomalacia</td>
</tr>
<tr>
<td>1400</td>
<td>Ulceration</td>
</tr>
</tbody>
</table>

**COMPLICATIONS OF VASCULAR CATHETERS** *(RO73)*

Complications of vascular catheters.

Found on the ‘OPERATIVE REPORT’ or on the ‘DISCHARGE SUMMARY’.

Code ALL complications of a vascular catheter that are applicable.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Arterial thrombosis</td>
</tr>
<tr>
<td>200</td>
<td>Cardiac tamponade</td>
</tr>
<tr>
<td>300</td>
<td>Edema</td>
</tr>
<tr>
<td>400</td>
<td>Loss of finger(s)</td>
</tr>
<tr>
<td>500</td>
<td>Loss of toe(s)</td>
</tr>
<tr>
<td>600</td>
<td>Pericardial effusion</td>
</tr>
<tr>
<td>700</td>
<td>Perforation of the heart</td>
</tr>
<tr>
<td>800</td>
<td>Pleural effusion</td>
</tr>
<tr>
<td>900</td>
<td>Phrenic nerve palsy</td>
</tr>
<tr>
<td>1000</td>
<td>Ruptured vessel</td>
</tr>
<tr>
<td>1100</td>
<td>Thrombophlebitis</td>
</tr>
<tr>
<td>1200</td>
<td>Vasospasm</td>
</tr>
<tr>
<td>1300</td>
<td>Venous thrombosis</td>
</tr>
</tbody>
</table>
**COMPLICATIONS OF NASO/ORO GASTRIC TUBES (R074)**

Complications of NASO/ORO gastric tubes.

Found on the ‘DISCHARGE SUMMARY’.

Code ALL complications of a naso/oro gastric tube that are applicable.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Perforation, esophagus</td>
</tr>
<tr>
<td>200</td>
<td>Perforation, stomach</td>
</tr>
<tr>
<td>300</td>
<td>Perforation, small bowel</td>
</tr>
</tbody>
</table>

**COMPLICATIONS OF MEDICATIONS (R075)**

Complications of medications.

Found on the ‘DISCHARGE SUMMARY’.

Code ALL applicable complications due to a medication.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Cardiomyopathy, steroid induced</td>
</tr>
<tr>
<td>200</td>
<td>Contracture, secondary to IM injection</td>
</tr>
<tr>
<td>300</td>
<td>Nephrocalcinosis, diuretic induced</td>
</tr>
<tr>
<td>500</td>
<td>Skin slough</td>
</tr>
</tbody>
</table>

**COMPLICATIONS OF SURGERY (R076)**

Complications of surgery.

Found on the ‘OPERATIVE REPORT’ or on the ‘DISCHARGE SUMMARY’.

Code ALL applicable complications due to a surgical procedure.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Diaphragmatic paralysis</td>
</tr>
<tr>
<td>200</td>
<td>Vocal cord paralysis</td>
</tr>
</tbody>
</table>

**COMPLICATIONS OF BURNS (R077)**

Complications of the following types of burns.

Found on the ‘DISCHARGE SUMMARY’.

Code ALL applicable complications due to burns.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Chemical</td>
</tr>
<tr>
<td>200</td>
<td>Electrical</td>
</tr>
<tr>
<td>300</td>
<td>Thermal</td>
</tr>
</tbody>
</table>
PHOTOTHERAPY  
(RO78)  

Phototherapy.

Found on the ‘DISCHARGE SUMMARY’.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Phototherapy</td>
</tr>
</tbody>
</table>

IMMUNIZATIONS 
(R079)  

Immunizations.

Found on the ‘DISCHARGE SUMMARY’.

Code ALL applicable immunizations given to the infant.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>DPTP (diptheria, pertussis, tetanus, polio)</td>
</tr>
<tr>
<td>200</td>
<td>DPT (diptheria, pertussis, tetanus)</td>
</tr>
<tr>
<td>300</td>
<td>Hepatitis B globulin</td>
</tr>
<tr>
<td>400</td>
<td>Hepatitis B vaccine</td>
</tr>
<tr>
<td>500</td>
<td>Viral influenza</td>
</tr>
<tr>
<td>600</td>
<td>Hemophilus influenza B conjugate</td>
</tr>
<tr>
<td>700</td>
<td>RSV (respiratory syncytial virus) vaccine</td>
</tr>
<tr>
<td>800</td>
<td>Varicella (chicken pox) vaccine</td>
</tr>
<tr>
<td>1000</td>
<td>Prevnar</td>
</tr>
<tr>
<td>1100</td>
<td>Rota teq for Rota Virus</td>
</tr>
<tr>
<td>1200</td>
<td>Rotarix for Rota Virus</td>
</tr>
</tbody>
</table>
Lab results

(Not coded at IWK)

Found on ‘DISCHARGE SUMMARY’ OR ‘LAB SHEETS’.

(Refer to reference lab sheet for ranges)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Neutropenia</td>
</tr>
<tr>
<td></td>
<td>&lt;1,000 pmns(mature or bands per cu.mm)</td>
</tr>
<tr>
<td><strong>Use following formula:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multiply the total corrected WBC’s by the % of pmns (polymorphonuetrophils) and bands.</td>
</tr>
<tr>
<td></td>
<td>e.g. total WBC – 15,000</td>
</tr>
<tr>
<td></td>
<td>pmns = 5%</td>
</tr>
<tr>
<td></td>
<td>Bands = 1%</td>
</tr>
<tr>
<td>200</td>
<td>ABO immunizations – definite</td>
</tr>
<tr>
<td>300</td>
<td>D Isoimmunization</td>
</tr>
<tr>
<td>400</td>
<td>Little c Isoimmunization</td>
</tr>
<tr>
<td>500</td>
<td>Big C Isoimmunization</td>
</tr>
<tr>
<td>600</td>
<td>Big E Isoimmunization</td>
</tr>
<tr>
<td>700</td>
<td>Kell Isoimmunization</td>
</tr>
<tr>
<td>800</td>
<td>Fya Isoimmunization (Duffy)</td>
</tr>
<tr>
<td>900</td>
<td>Kidd</td>
</tr>
<tr>
<td>1000</td>
<td>Wright</td>
</tr>
<tr>
<td>1100</td>
<td>MNS blood groups</td>
</tr>
<tr>
<td>1200</td>
<td>Positive DAT</td>
</tr>
<tr>
<td>1300</td>
<td>Misc. Isoimmunization – Little ‘e’</td>
</tr>
<tr>
<td>1400</td>
<td>Misc. Isoimmunization – Little ‘s’</td>
</tr>
<tr>
<td>1500</td>
<td>Hyperbilirubinemia</td>
</tr>
<tr>
<td></td>
<td>(Total bilirubin &gt; 15 mg% or &gt; 258 microM/L; or unconjugated or indirect bilirubin ≥ 230 microM/L)</td>
</tr>
<tr>
<td>1600</td>
<td>Anemia</td>
</tr>
<tr>
<td></td>
<td>(Hgb &lt; 14 gm% or &lt;140g/L or Hct &lt;42% in the first week; Hgb &lt;10gm% or &lt;100g/L or Hct &lt; 30% at any age.</td>
</tr>
<tr>
<td></td>
<td>Code the cause based on the first low haemoglobin, unless clearly stated otherwise)</td>
</tr>
<tr>
<td>Line</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| **1700** | Polycythemia  
(Central Hgb > 21 gm% (210 g/L), central >63% (.630 L/L), capillary Hgb >25 gm% (250 g/L) or capillary Hct > 75% (750 L/L); both Hgb and Hct is 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 0-5days; >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 phosphatise only (>406 I.U.) |
| **2400** | Hypoglucosemia  
(<30 mgm% or <1.67 mmol/L) |
| **2500** | Hyperglucosemia  
(>125 mg% or >6.94 mmol/L) |
| **2600** | Hypocalcemia  
(7.0mg% 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** | Hyponatremia  
(>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 value)** |
| 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 < 1.03 mmol/L)** |
| 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)** |
**INTRA-VENTRICULAR HEMORRHAGE**  
(R081)

Intra-ventricular hemorrhage.

Found on the ‘DISCHARGE SUMMARY’.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Grade 1 (sub-ependymal, choroid Plexus hemorrhage)</td>
</tr>
<tr>
<td>200</td>
<td>Grade 2 (Hemorrhage into ventricle without dilatation of ventricle)</td>
</tr>
<tr>
<td>300</td>
<td>Grade III (Hemorrhage into ventricle with dilatation of ventricle)</td>
</tr>
<tr>
<td>400</td>
<td>Grade IV (Hemorrhage into brain: thalamic hemorrhage, cortical hemorrhage)</td>
</tr>
</tbody>
</table>

**TRAUMA**  
(R082)

Trauma.

Found on the ‘DISCHARGE SUMMARY’.

Code **ALL** applicable traumas

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Fracture clavicle</td>
</tr>
<tr>
<td>200</td>
<td>Fracture femur</td>
</tr>
<tr>
<td>300</td>
<td>Fracture humerus</td>
</tr>
<tr>
<td>400</td>
<td>Fracture other</td>
</tr>
<tr>
<td>500</td>
<td>Fracture rib(s)</td>
</tr>
<tr>
<td>600</td>
<td>Fracture skull</td>
</tr>
<tr>
<td>700</td>
<td>Cephalohematoma left</td>
</tr>
<tr>
<td>800</td>
<td>Cephalohematoma right</td>
</tr>
<tr>
<td>900</td>
<td>Cephalohematoma bilateral</td>
</tr>
<tr>
<td>1000</td>
<td>Cephalohematoma other, including occipital</td>
</tr>
<tr>
<td>1100</td>
<td>Cephalohematoma unknown</td>
</tr>
<tr>
<td>1200</td>
<td>Shoulder dystocia</td>
</tr>
</tbody>
</table>
Non-specific neurological findings.

Found on the ‘**DISCHARGE SUMMARY**’.

Code **ALL** applicable findings.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Abnormal cerebral irritation/hypertonicity</td>
</tr>
<tr>
<td>200</td>
<td>Hyperexplixia (Hereditary Startle Disease)</td>
</tr>
<tr>
<td>300</td>
<td>Abnormal cerebral depression/hypotonicity</td>
</tr>
<tr>
<td>400</td>
<td>Abnormal cerebral depression due to maternal analgesia</td>
</tr>
<tr>
<td>500</td>
<td>Cerebral edema</td>
</tr>
<tr>
<td>600</td>
<td>Cortical atrophy</td>
</tr>
<tr>
<td>700</td>
<td>Encephalomalacia</td>
</tr>
<tr>
<td>800</td>
<td>Gilles telencephalic leucoencephalopathy</td>
</tr>
<tr>
<td>900</td>
<td>Infarction</td>
</tr>
<tr>
<td>1000</td>
<td>Porencephalic cyst(s)</td>
</tr>
<tr>
<td>1100</td>
<td>Periventricular leukomalacia</td>
</tr>
</tbody>
</table>
### OTHER SPECIFIC NEUROLOGICAL FINDINGS (R084)

Other neurological findings.

Found on the ‘DISCHARGE SUMMARY’.

Code **ALL** applicable findings.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Facial palsy left</td>
</tr>
<tr>
<td>200</td>
<td>Facial palsy right</td>
</tr>
<tr>
<td>300</td>
<td>Facial palsy bilateral</td>
</tr>
<tr>
<td>400</td>
<td>Brachial plexus (Erb’s &amp; Klumpke’s) Palsy, Left</td>
</tr>
<tr>
<td>500</td>
<td>Brachial plexus (Erb’s &amp; Klumpke’s) Palsy, Right</td>
</tr>
<tr>
<td>600</td>
<td>Brachial plexus (Erb’s &amp; Klumpke’s) Palsy, bilateral</td>
</tr>
<tr>
<td>700</td>
<td>Brachial plexus (Erb’s &amp; Klumpke’s) Palsy, Radial Nerve (Wrist Drop)</td>
</tr>
<tr>
<td>800</td>
<td>Phrenic nerve, left</td>
</tr>
<tr>
<td>900</td>
<td>Phrenic nerve, right</td>
</tr>
<tr>
<td>1000</td>
<td>Phrenic nerve, bilateral</td>
</tr>
<tr>
<td>1100</td>
<td>Hemiparesis transient (NOT present at time of discharge from hospital)</td>
</tr>
<tr>
<td>1200</td>
<td>Hemiparesis transient (present at time of discharge from hospital)</td>
</tr>
<tr>
<td>1300</td>
<td>Retinal hemorrhage involving the macula</td>
</tr>
<tr>
<td>1400</td>
<td>Chorioretinitis</td>
</tr>
<tr>
<td>1500</td>
<td>Congenital subdural effusion</td>
</tr>
<tr>
<td>1600</td>
<td>Periventricular calcification</td>
</tr>
<tr>
<td>1700</td>
<td>Ondines curse</td>
</tr>
<tr>
<td>1800</td>
<td>Opsoclonus</td>
</tr>
<tr>
<td>1900</td>
<td>Cranial nerve palsy 3rd or oculomotor nerve</td>
</tr>
<tr>
<td>2000</td>
<td>Cranial nerve palsy 4th or trochlear nerve</td>
</tr>
<tr>
<td>2100</td>
<td>Cranial nerve palsy 5th or trigeminal nerve</td>
</tr>
<tr>
<td>2200</td>
<td>Cranial nerve palsy 6th or abducens nerve</td>
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<tr>
<td>2300</td>
<td>Cranial nerve palsy 10th or vagus nerve</td>
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### APNEA (R085)

Apnea

Found on the ‘DISCHARGE SUMMARY OR NURSES NOTE’

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<tbody>
<tr>
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<td>Apneic spells</td>
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</table>
**RESUSCITATION AT DELIVERY (R086)**

Resuscitation at delivery.

Found on the ‘BIRTH RECORD’ or ‘DISCHARGE SUMMARY’

Code **ALL** applicable codes.

<table>
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<td>Oxygen</td>
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<td>300</td>
<td>Chest compressions</td>
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<td>400</td>
<td>Other medications</td>
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<td>Narcan</td>
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<tr>
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<td>Epinephrine</td>
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**H1N1 (R087)**

H1N1.

Found on ‘DISCHARGE SUMMARY’

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**PERIPHERAL IV (R088)**

Peripheral IV.

Found on ‘DISCHARGE SUMMARY’ or ‘NURSES NOTES’.

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**TREATMENT FOR RETINOPATHY OF PREMATURITY (R089)**

Treatment of retinopathy

Found on the ‘DISCHARGE SUMMARY’

Code **ALL** applicable codes.

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<tr>
<td>200</td>
<td>Laser surgery</td>
</tr>
<tr>
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<td>Intra-ocular injection (Avastin)</td>
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<tr>
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<td>Abscess:</td>
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<tr>
<td>Epidural</td>
<td>R013</td>
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<td>Absence, kidney</td>
<td>R020</td>
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<td>Abuse:</td>
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<td>Alcohol</td>
<td>R005</td>
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<td>Ativan</td>
<td>R005</td>
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<td>Cocaine/Crack</td>
<td>R005</td>
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<td>Codeine</td>
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<td>Morphine</td>
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<td>Oxycontin</td>
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<td>Albumin transfusion</td>
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<td>Alcohol abuse</td>
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<td>Amniocentesis:</td>
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<td>for genetics</td>
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<td>for isoimmunisation</td>
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<td>for lung maturity</td>
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<td>Amnioinfusion</td>
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<td>Amnioreduction</td>
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<td>Anaesthesia during labour and delivery</td>
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<td>Anaesthesia during labour only</td>
<td>R011</td>
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<tr>
<td>Anaesthesia during delivery only</td>
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  Epidural, continuous infusion (CIEA) ................... R010, R011 and/or R012
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<td>Sensitized pregnancy</td>
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<td>Problems, lower urinary tract</td>
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<tr>
<td>Procedures, postpartum hemorrhage</td>
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<td>Proctitis, ulcerative</td>
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<td>Progesterone or premature labour</td>
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<td>Prolapsed mitral valve</td>
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<td>Prolonged epidural block</td>
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<td>Prostaglandin (administration):</td>
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<td>Intracervical</td>
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<td>Vaginal</td>
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<td>Prosthesis, valve (heart)</td>
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<tr>
<td>Pruritic urticarial papules and plaques of pregnancy</td>
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<tr>
<td>Pseudotumor cerebri</td>
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<tr>
<td>Psychiatric illness</td>
<td>R016</td>
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<tr>
<td>Pudendal anesthesia for labour/delivery</td>
<td>R010, R011 and/or R012</td>
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<td>Disease</td>
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<td>Edema, antepartum/intrapartum</td>
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<td>Pyelonephritis:</td>
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<td>R020</td>
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<td>Chronic</td>
<td>R020</td>
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<td>Reflux: gastritis</td>
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<td>Removal cervical suture</td>
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- Iniencephaly
- Insulin, infant medications
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- IV Peripheral
- Intestinal atresia
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- Intestinal atresia, duodenal
- Intestinal atresia, ileal
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