Nova Scotia Atlee Perinatal Database Coding Manual 23rd Edition (Version 23.0.0)

April 2019

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ADULT RCP CODES

INFANT RCP CODES

LISTING OF HOSPITALS

Hospitals appearing in bold provide maternity services

Hospital #

LISTING OF HOSPITALS

Hospitals appearing in bold provide maternity services.

Hospital #

East Coast Forensic
Dartmouth 71

Eastern Kings Memorial
Wolfville 21

Eastern Memorial Hospital
Canso 22

Eastern Shore Memorial Hospital
Sheet Harbour 23

Fishermen's Memorial Hospital
Lunenburg 24

George Dumont Hospital
New Brunswick ..... -11

Glace Bay Health Care Facility
(See Cape Breton Healthcare Complex) 87

Guysborough Memorial Hospital
Guysborough 27

Hants Community Hospital
Windsor 37

Home of the Guardian Angel
Halifax 88
(Use for "discharge to" only if mom and baby both go to the home)

Home
Home 0

Intended delivery at home (**NOT** attended by a health care professional)
Home ..... -7

Intended Delivery at home (attended by a health care professional)
Home ..... -8

Inverness Consolidated Memorial Hospital
Inverness 34

LISTING OF HOSPITALS

Hospitals appearing in bold provide maternity services.

LISTING OF HOSPITALS

Hospitals appearing in bold provide maternity services.

Hospital #

Queen Elizabeth II Health Sciences Centre
Halifax 85

Queens General Hospital
Liverpool..... 38

Roseway Hospital
Shelburne 39

Sackville Memorial Hospital
New Brunswick..... -15

Sacred Heart Hospital
Cheticamp 47

Self-Discharge
Home .....-6

Soldiers Memorial Hospital
Middleton 48

South Cumberland Community Care Centre
Parrsboro..... 49

South Shore Regional Hospital
Bridgewater..... 14

St. Anne's Hospital
Arichat 40

St. Martha's Regional Hospital
Antigonish..... 43

St. Mary's Memorial Hospital
Sherbrooke 45

Strait Richmond Hospital
Cleveland 68

Sutherland–Harris Memorial Hospital
Pictou 50

LISTING OF HOSPITALS

Hospitals appearing in bold provide maternity services.

Hospital #

Hospitals out of province **HOSPITAL#**

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 13-18.

DISCHARGE DATE

Patient's discharge date from hospital.

Found on the *'NURSES NOTES'*.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME

Patient's discharge time from hospital.

Found on the 'NURSES NOTES'.

Use the following format: 'HHMM'.

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

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

ADMISSION DATE

Patient's admission date to hospital.

Found on the '*HOSPITAL ADMISSION FORM'*.

Use the following format: 'YYYYMMDD'.

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'*.

1	Delivered Admission
2	Undelivered Admission
3	Postpartum Admission
5	Neonatal Admission

PREVIOUS SURNAME

Patient's maiden name or other previous surname.

Found on the '*HOSPITAL ADMISSION FORM'*.

Leave blank for neonatal admissions.

This field can be left blank if not documented.

A/S/D NUMBER

Hospital number referring to the patient's present admission.

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

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

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

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.

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

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

0	Nova Scotia patient health card #, card not available
0	Armed Forces
0	First Nations
0	Self-paying
1	Patient from outside Nova Scotia

BIRTH DATE

Patient's date of birth.

Found on the '*HOSPITAL ADMISSION FORM'*.

Use the following format: 'YYYYMMDD'.

MUNICIPAL CODE

Patient's municipal code.

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

ANNAPOLIS COUNTY	
12	Annapolis Municipality
13	Annapolis Royal
19	Bridgetown
49	Middleton

ANTIGONISH COUNTY	
14	Antigonish Municipality
15	Town of Antigonish

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

COLCHESTER COUNTY	
26	Colchester Municipality
65	Stewiacke
70	Truro

CUMBERLAND COUNTY	
11	Amherst
27	Cumberland Municipality
54	Oxford
55	Parrsboro
63	Springhill

DIGBY COUNTY	
24	Clare Municipality
29	Digby Municipality
30	Town of Digby

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

HALIFAX COUNTY	
77	Bedford
28	Dartmouth
34	Halifax
35	Halifax Municipality (not Bedford, Dartmouth or Halifax)

HANTS COUNTY	
38	Hantsport
36	East Hants Municipality
37	West Hants Municipality
73	Windsor

INVERNESS COUNTY	
39	Inverness Municipality
58	Port Hawkesbury

KINGS COUNTY	
18	Berwick
41	Kentville
42	Kings Municipality
74	Wolfville

LUNENBURG COUNTY	
20	Bridgewater
23	Chester Municipality
46	Lunenburg Municipality
47	Lunenburg Town
48	Mahone Bay

PICTOU COUNTY	
51	New Glasgow
56	Pictou Municipality
57	Pictou Town
64	Stellarton
69	Trenton
72	Westville

QUEENS COUNTY	
43	Liverpool
59	Queens Municipality

RICHMOND COUNTY	
60	Richmond Municipality

SHELBURNE COUNTY	
17	Barrington Municipality
25	Clark’s Harbour
44	Lockeport
61	Shelburne Municipality
62	Shelburne Town

VICTORIA COUNTY	
71	Victoria Municipality

YARMOUTH COUNTY	
16	Argyle Municipality
75	Yarmouth Municipality
76	Yarmouth Town

OUT OF PROVINCE RESIDENTS	
81	Alberta
82	British Columbia
83	Manitoba
84	New Brunswick
85	Newfoundland and Labrador
86	Ontario
87	Prince Edward Island
88	Quebec
89	Saskatchewan
90	Yukon
91	Northwest Territories
92	Nunavut
95	Bermuda
97	USA
98	Other countries
99	Unknown

MARITAL STATUS

Patient's marital status.

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

Code using one of the following:

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

Marital status will automatically blank out for neonatal admissions.

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.

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

SEX

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

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

F	Female
M	Male
A	Ambiguous
9	Unknown

STREET ADDRESS

Patient's street address.

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:

AB	Alberta
BC	British Columbia
MB	Manitoba
NS	Nova Scotia
NB	New Brunswick
NL	Newfoundland and Labrador
NT	Northwest Territories
NU	Nunavut
ON	Ontario
PE	Prince Edward Island
QC	Quebec
SK	Saskatchewan
YT	Yukon
US	USA
XX	Not Canada or USA

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

Code using one of the following:

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

3 Coding of admission information completed.

Once the case is 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 liveborn 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. 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 one of the standard 2 digit provincial codes for hospitals found on pages 13-18.

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 one of the following for the unusual situations:

-1	Unplanned out of hospital, e.g. delivery en route to hospital, unplanned birth at home.
-2	Planned birth at home
-5	Midwife attended home delivery

ADMITTED FROM

Mother's location immediately prior to admission.

Found on the '*HOSPITAL ADMISSION FORM'*.

If the patient is transferred from another hospital, record the standard 2 digits provincial code numbers for that facility found on page 13-18.

If patient comes from home, code '0'

Code one of the following for the unusual situations:

-7	Intended delivery at home without the help of a health care provider (not a midwife)
-8	Intended delivery at home with the help of a health care provider (not a midwife)

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

If a patient is admitted from the Nova Institution for Women enter '92'

PRENATAL RECORD ON CHART AT TIME OF CODING

The complete prenatal record (3pgs.) should be filed on chart at time of coding

Code one of the following:

Y	Yes	Prenatal record on chart at time of coding
N	No	Prenatal record not on chart at time of coding

DATE OF LAST NORMAL MENSTRUAL PERIOD

Date of patient's last normal menstrual period.

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

Use the following format: 'YYYYMMDD'

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

If unsure is ticked in the box on the prenatal record but a date is documented as well, enter the date given in the field provided.

PRE-CONCEPTION FOLATE INTAKE

Maternal pre-conception folate intake.

Found on the *'PRENATAL RECORD'*.

If noted on prenatal record as "started after found out was pregnant" enter 'N'.

Code one of the following:

Y	Yes
N	No
9	Unknown

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 spontaneous abortions.

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 therapeutic abortions.

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 abortions in 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 one of the following:

Y	Yes
N	No
9	Unknown

PREVIOUS PRE-TERM DELIVERY

Number of pre-term deliveries in previous pregnancies.

Found on the '*PRENATAL RECORD*'.

Code the number of deliveries excluding the present pregnancy where the delivery took place after 20 0/7 weeks of gestation and less than 36 6/7 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**:

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

NOTE: ½ PACK = 13 CIGS, 1 PACK = 25 CIGS
If the number is recorded in a range, code the highest number, e.g. 10 to15 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**:

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

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 from18-22 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**:

0	Patient did not smoke at the time of prenatal visit from 18-22 weeks.
75	Patient smoked ≥ 75 cigarettes per day at the time of the prenatal visit from 18-22 weeks.
88	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
99	Not indicated at the time of prenatal visit from 18-22 weeks whether or not the patient smoked.

NOTE: ½ PACK = 13 CIGS, 1 PACK = 25 CIGS
If the number is recorded in a range, code the highest number, e.g. 10 to15 would be coded as 15.

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

HIGHEST LEVEL OF EDUCATION

Highest level of education completed.

Found on the *'PRENATAL RECORD'*.

Code one of the following:

1	Less than Secondary Education (some High School)
2	Secondary Education (completion of High School)
3	Technical/some Post-Secondary Education (Community College or working on a Bachelor's Degree)
4	Post-Secondary Education (completion of Bachelor's Degree e.g. Arts, Commerce or Science)
5	Graduate Level (completion of Master's Degree e.g. Masters in Nursing or Education)
6	Post Graduate Level (completion of Doctorate e.g. Doctor of Philosophy)
7	Professional Degree (e.g. Physician, Lawyer or Dentist)
99	Unknown

MATERNAL RACE/ETHNICITY

Maternal race/ethnicity.

Found on the '*PRENATAL RECORD'*.

Choose **ALL** applicable categories documented on the 'Prenatal Record'.

ACA	Acadian
AFC	African Canadian
ASN	Asian
CAU	Caucasian
FNA	First Nations
HIS	Hispanic
JSH	Jewish
MED	Mediterranean
MDE	Middle Eastern
QUE	Quebecois
OTH	Other
999	Unknown

INTENT TO BREASTFEED

Maternal intention to breastfeed.

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

Code one of the following:

Y	Yes
N	No
U	Unsure
9	Unknown

PRE- PREGNANCY WEIGHT

Maternal pre-pregnancy weight.

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

This field has been designed to allow either pounds (lbs.) or kilograms (kgs.) to be coded. If the weight is recorded in kilograms, it should be entered in 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 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, e.g. 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, e.g. 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 one of the following:

Y	Yes, Bishop Score completed
N	No, Bishop Score not done

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 REASSMENT'* 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**:

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

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

Code one of the following:

1	Singleton
2	Twins
3	Triplets
4	Quadruplets
5	Quintuplets

MATERNAL ULTRASOUND Maternal ultrasound.

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

Indicate '**Y**' if an ultrasound report is on the chart.

When '**Y**' is entered, the ultrasound screen will pop up. Enter appropriate values.

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

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

FETUS NUMBER 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 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

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 by Measurements
Gestational Age

If the earliest ultrasound is reported in more than one 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.**

BIPARIETAL DIAMETER MEASUREMENT

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

Found on the '*ULTRASOUND REPORT'*.

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

Decimal points must be entered.

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

HEAD CIRCUMFERENCE MEASUREMENT

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

Found on the '*ULTRASOUND REPORT'*.

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

Decimal points must be entered.

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

ABDOMINAL CIRCUMFERENCE MEASUREMENT

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

Found on the '*ULTRASOUND REPORT'*.

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

Decimal points must be entered.

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

FEMUR LENGTH MEASUREMENT

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

Found on the '*ULTRASOUND REPORT'*.

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

Decimal points must be entered.

If the **crown-rump** length measurement has been recorded, leave 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.

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**.

BIPARIETAL DIAMETER GESTATIONAL AGE

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

Found on the '*ULTRASOUND REPORT'*.

Use the following format: weeks and days.

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

HEAD CIRCUMFERENCE GESTATIONAL AGE

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

Found on the '*ULTRASOUND REPORT*'.

Use the following format: weeks and days.

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

ABDOMINAL CIRCUMFERENCE GESTATIONAL AGE

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

Found on the '*ULTRASOUND REPORT*'.

Use the following format: weeks and days.

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

FEMUR LENGTH GESTATIONAL AGE

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

Found on the '*ULTRASOUND REPORT'*.

Use the following format: weeks and days.

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

GESTATIONAL AGE

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.

Enter gestational age noted as weeks and days on an Ultrasound report that is not associated with any measurments.

MATERNAL SCREENING TESTS Maternal screening tests.

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)

Y	Yes, done
D	Declined
N	No, not done
U	Unknown

Nuchal Translucency

Y	Yes, done
N	No, not done
U	Unknown

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

HIV Testing

Y	Yes, done
D	Declined
U	Unknown
N	No, not done

Maternal Serum

C	Completed
D	Declined
N	No, not done –includes pts who are presenting too late to complete test.
U	Unknown

*Capture completed, if only one of the two tests/screens have been completed.

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 mother upon 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 13-18 or use one of the following codes:

-9 Maternal death
0 Home

If a patient is discharged to the Nova Institution for Woman code '92'

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.

Code one of the following:

77777	Lived
OTHR	Other
PEMB	Pulmonary Embolus
PPHM	Postpartum Hemorrhage
STRK	Stroke

MATERNAL AUTOPSY

Completion of maternal autopsy.

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

This field will autofill if the mother lived.

Code one of the following:

LVD	Lived (not applicable)
YES	Died and autopsy done
NO	Died but autopsy not done

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

1	< 24 hours before delivery
2	24 to 48 hours before delivery
3	> 48 hours to 7 days before delivery
4	> 7 days before delivery
5	Unknown when administered

Betamethasone (Celestone)

6	< 24 hours before delivery
7	24 to 48 hours before delivery
8	> 48 hours to 7 days before delivery
9	> 7 days before delivery
10	Unknown when administered

Unknown steroid

11	< 24 hours before delivery
12	24 to 48 hours before delivery
13	> 48 hours to 7 days before delivery
14	> 7 days before delivery
15	Unknown when administered

ANALGESIA ADMINISTERED DURING LABOUR
(excluding stillbirths)

Analgesia administered during labour.

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

Choose only **one** drug and the route administered.
Choose the drug administered **closest** to the time of delivery.

Drug

1	Demerol (Meperidine)
2	Dilaudid (Hydromorphone HCl)
3	Fentanyl (Sublimaze)
4	Largactil (Chlorpromazine Tranquillizer)
5	Morphine (includes Opium; Pantopon)
6	Nembutal (Pentobarbital Hypnotic)
7	Nubain (Nalbuphine)
8	Phenergan (Promethazine Tranquillizer)
9	Seconal (Secobarbital)
10	Sparine (Promazine Tranquillizer)
11	Talwin (Pentazocine)
12	Tuinal (Amo-Secobarb Hynotic)
13	Valium (Diazepam Tranquillizer)
14	Other specified analgesia during labour

ROUTE OF ANAGLESIA ADMINISTERED

Route of administration.

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

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

ANTIBIOTIC THERAPY AMINISTERED DURING ANTEPARTUM PERIOD

Antibiotic therapy administrated during the antepartum period.

Found on the *'BIRTH RECORD'*, '*MEDICATION SHEETS'* or the 'P*ARTOGRAM*'.

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 '*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.

ANTIBIOTIC THERAPY ADMINISTERED DURING POSTPARTUM PERIOD

Antibiotic therapy administered during postpartum period.

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

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

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

PROPHYLAXIS FOR GBS ADMINISTERED DURING INTRAPARTUM PERIOD

Prophylaxis for GBS administered during intrapartum period.

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

If documented as "prophylaxis for GBS" code 'Y' for Yes.

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.

ANTIBIOTIC DATE

Date antibiotic therapy first given.

Found on *'MEDICATION SHEETS'*.

Use the following format: 'YYYYMMDD'.

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

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

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

ANTIBIOTIC TIME

Time antibiotic therapy first given.

Found on '*MEDICATION SHEETS'*.

Use the following format: 'HHMM'.

'HH' is in 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 is not documented, record unknown.

Routine Information – Labour

BIRTH ORDER

Birth order.

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

Code one of the following:

1	Singleton, or first born of multiples
2	Second born of multiples
3	Third born of multiples
4	Fourth born of multiples
5	Fifth born of multiples

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 one of the following:

S	Spontaneous
A	Artificial
C	Suspected
9	Unknown

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

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

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

MECONIUM STAINING

Meconium staining of the amniotic fluid.

Found on the '*BIRTH RECORD'* or the '*NURSES NOTES'*.

Do not code 'Y' if documentation states 'as noted at time of birth or delivery'.

Code one of the following:

Y	Yes
N	No
9	Unknown

LABOUR

Initiation of labour.

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

Code one of the following:

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

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

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

INDICATION FOR INDUCTION OF LABOUR

Reason for induction of labour.

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

Code one of the following:

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

***Concern for fetal wellbeing: 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'*.

Code one of the following:

1	Inpatient
2	Outpatient
3	Both inpatient and outpatient
9	Unknown

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.

OXYTOCIN DATE

Date Oxytocin therapy administered.

Found on '*PARTOGRAM*'.

Use the following format: 'YYYYMMDD'.

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

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

OXYTOCIN TIME

Time Oxytocin therapy administered.

Found on '*PARTOGRAM*'.

Use the following format: 'HHMM'.

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

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

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

INDUCTION OR ATTEMPT AT INDUCTION OF LABOUR METHODS/AGENTS

Induction or attempt at induction of labour methods/agents.

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

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/delivery room (LDR) 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/delivery room (LDR) 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/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

Medical augmentation.

Use of Oxytocin to improve contractions after labour has started spontaneously.

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

Code one of the following:

Y	Yes
N	No
7	Not applicable
9	Unknown

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.

TIME OF MEDICAL AUGMENTATION

Time of initiation of Oxytocin to augment labour.

Found on the *'PARTOGRAM'*.

Use the following format: 'HHMM'

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

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

DILATATION AT TIME OF MEDICAL AUGMENTATION

Dilatation at time of augmentation of labour.

Found on the '*PARTOGRAM'*.

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

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

If the dilatation is not documented at time of augmentation, code the last dilatation recorded during the two hours prior to the initiation of the Oxytocin.

Code '**99**' for unknown.

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 dilation 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 one of the following:

Y	Yes, skin to skin contact initiated or baby to breast has been noted on Partogram
N	No, no skin to skin contact or baby to breast is indicated
7	If fetal death, enter 7 for not applicable
9	Unknown, if none of the applicable boxes are checked

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.

Code all documented methods used during monitoring of the labour.

1	Intermittent auscultation
2	External monitoring
3	Internal monitoring

DATE OF ONSET OF SECOND STAGE OF LABOUR

Date of onset of second stage of labour.

Defined as full cervical dilatation (10cms).

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

Use the following format: 'YYYMMDD'.

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

Time of onset of second stage of labour.

Defined as full cervical dilatation (10cms).

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

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 one of the following:

ABD	Abdominal
CSC	C-section combined transverse and vertical incision– inverted T and J incision. (This refers to the uterine incision, not skin incision)
CSH	C-section//hysterectomy
CST	C-section, transverse incision
CSV	C-section, classical incision (vertical incision in the body of uterus)
CSU	C-section, type unknown
LVS	C-section, low vertical incision
VAG	Vaginal

METHOD OF DELIVERY

Method of delivery.

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

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. Code one of the following:

ABR	Assisted breech
ACH	Forceps to after-coming head **(Breech – vaginal delivery only)**
BRE	Breech extraction **(Vaginal delivery only)**
CSC	C-section with vacuum and forceps
CSF	C-section with forceps
CSN	C-section
CSV	C-section with vacuum
FAF	Failed forceps or failed trail of forceps followed by C-section
FCF	Failed forceps followed by C-section with forceps
FVC	Attempted forceps and vacuum followed by C-section using forceps and/or vacuum
FVV	Attempted forceps followed by vacuum vaginal delivery
HIF	High forceps
HIV	High vacuum
LWF	Low forceps
LWV	Low vacuum
MIF	Mid forceps
MIV	Mid vacuum
OUF	Outlet forceps
OUV	Outlet vacuum
PVE	Podalic version and extraction
SPT	Spontaneous vaginal
VAC	Vacuum followed by C-section
VAF	Vacuum followed by forceps
VEX	Vacuum extraction
VCV	Attempted vacuum followed by C-section using forceps and/or vacuum
VFC	Vacuum followed by forceps and then by C-section
999	Unknown method of delivery

CORD MILKING

Cord Milking at time of delivery.

Found on the *'BIRTH RECORD'*

Code one of the following:

Y	Yes
N	No
7	For fetal death will autofill.
9	Unknown

DELAYED CORD CLAMPING

Delayed Cord Clamping at time of delivery.

Found on the *'BIRTH RECORD'*

Code one of the following:

1	< 30 seconds
2	30-60 seconds
3	>1 minute to 3 minutes
4	>3 minutes
7	for fetal death will autofill.
8	Not done
9	Unknown

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 OF INFANT 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:

BCH	Breech, other or specified
BOW	Brow
CPD	Compound presentation
FAC	Face
FRB	Frank breech
FTB	Footling breech
POP	Persistent occiput posterior (ROP,LOP,OP)
SHL	Shoulder presentation
999	Unknown

EPISIOTOMY

Episiotomy.

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

Code one of the following:

0	Not done
4	Medio-lateral
6	Midline
9	Unknown

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

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

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

CARE PROVIDER ATTENDING DELIVERY

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 one of the following:

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

*** 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 one of the following:

F	Female
M	Male
A	Ambiguous

DATE OF INFANT'S BIRTH

Date of infant's birth.

Found on the '*BIRTH RECORD'*.

Use the following format: 'YYYYMMDD'.

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

TIME OF INFANT'S BIRTH

Time of infant's birth.

Found on the '*BIRTH RECORD'*.

Use the following format: 'HHMM'.

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

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

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, en-route 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

Baby not admitted to hospital.

If Infant was not admitted to hospital and 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.

FETAL DEATH

Fetal death occurred.

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

Code one of the following:

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

INFANT A/S/D NUMBER

Hospital number referring to the infant's present admission.

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

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

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

Code '**999999999999**' for unknown value

In the case of a fetal death this field will auto fill to'**777777777777**'.

INFANT HEALTH CARD NUMBER

Found on the '*HOSPITAL ADMISSION FORM'*.

Record the patient's **Nova Scotia** Health Card Number.

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

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

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

INFANT'S ATTENDING CARE PROVIDER (PMB#)

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

Found on the *'HOSPITAL ADMISSION FORM'*.

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

Code '**88888**' if Care Provider is not registered in Nova Scotia.
Code '**99999**' for unknown.

In the case of a fetal death this field 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. If more than one measurement taken, record the measurement documented closest to discharge.

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 '*.

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

Documented as …	**Use:**
38 + weeks	38
38-40 weeks	39
38-39 weeks	38
> 39 weeks	39
Term	40
unknown	99

NEONATAL INTENSIVE CARE UNIT (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 one of the following:

Y Yes
N No

If 'Y' is entered, the screen NICU date and time will pop up. Enter 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.

.

PEDIATRIC INTENSIVE CARE UNIT (PICU)
(IWK ONLY)

Infants admitted to the PICU at the IWK only.

Found in the '*PROGRESS NOTES'*.

Code one of the following:

Y Yes
N No

If 'Y' is entered, the screen PICU date and time will pop up. Enter admit and discharge date and time to and from the PICU.

If there is more than one admission and discharge to the PICU 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 one of the following:

LVD	Infant lived to be discharged from hospital
NND	Liveborn infant who died before being discharged home from hospital
FTD	Fetal death

FEEDING DURING ADMISSION

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.

If the infant is supplemented with expressed breast milk, capture as exclusive breastfeeding

Code one of the following:

E	**Exclusive Breastfeeding**: The infant/child received 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.
S	**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
N	**No Breastfeeding:** the infant/child received no human milk.
9	There is no documentation as to how the baby was fed during the hospital stay.

SUPPLEMENTATION INDICATION

Record one of the following reasons for supplementation of breastfeeding during the hospital stay.

Found on the *'DAILY BREASTFEEDING RECORD' 'NEWBORN ADMISSION/DISCHARGE' or 'NEWBORN NURSING ASSESSMENT' FORM*.

If the infant has received supplementation to breastfeeding, please indicate reason noted.

Code one of the following:

M	Medical indication for supplementation
N	Non-medical indication for supplementation
9	No indication for supplementation

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 one of the standard 2-digit provincial facility numbers noted on pages 13-18 or use one of the following codes:

If a patient is discharged to the Nova Institution for Woman code 92

0	Home
-9	Infant Death

INFANT'S PRIMARY CAUSE OF DEATH

Infant's primary cause of death.

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

Code one of the following:

7777	Infant lived
ABRP	Abruptio placenta
ANEC	Acute necrotizing enterocolitis
OAIR	Airway failure
AMNO	Amniocentesis
ANAL	Analgesia or anesthesia
ASPN	Aspiration
CPDP	Chronic pulmonary disease
COTR	Complications of treatment
ANOM	Congenital anomaly
CRLK	Cord loops and/or knots
CDOT	Cord, miscellaneous
CORP	Cord prolapse
DIAB	Maternal diabetes
DBRN	Degenerative brain disease
DUCT	Ductus syndrome of prematurity
EXTX	Exchange transfusion
FETH	Fetal hemorrhage
FMAL	Fetal malnutrition
HMDD	Hyaline membrane disease
HYDR	Idiopathic hydrops
IBOM	Inborn errors of metabolism
INFT	Infection
IVTF	Intravascular transfusion
ISOM	Isoimmunization
KERN	Kernicterus
MALP	Malpresentation
SHOC	Maternal shock
MUSF	Multi-system failure
MINF	Myocardial infarction
NEOP	Neoplasia
TTTX	Twin-to-twin transfusion (Parabiotic syndrome)
PPFC	Persistent fetal circulation
PLPV	Placenta previa

INFANT'S PRIMARY CAUSE OF DEATH (con't)

Infant's primary cause of death.

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

AUTOPSY

Completion of infant autopsy.

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

Code one of the following:

LVD	Lived (not applicable)
YES	Died and autopsy done
NO	Died but autopsy not done

AUTOPSY TYPE

Infant autopsy type.

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

Code one of the following:

C	Complete autopsy (includes CNS)
D	Direct (non-invasive)
G	General autopsy (does not include CNS)
U	Unspecified type
7	Not-applicable

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 one of the following:

Y	Yes
N	No
9	Unknown

CORD ARTERY pH VALUE

Cord artery pH value.

Found on the *'LAB REPORTS'*.

Use the following format: X.XX'

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

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

Allowed range is 6.4 to 7.8.

If 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.

$pC0_2$ VALUE

$pC0_2$ 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 '99' for unknown.

'77' will auto fill for not applicable or fetal death.

CCHD SCREENING

Critical Congenital Heart Disease Screening

Found on the '*NEWBORN ADMISSION/DISCHARGE FORM'* or '*NEWBORN NURSING ASSESSMENT'*.

Code one of the following:

COM	Completed- Not specified
DEC	Declined
NCA	Not clinically appropriate
PAS	Passed
REF	Referred
777	Autofill for fetal death
999	Unknown

If completed is checked off but no indication if the result was passed or referred, enter completed - not specified. If there is absolutely nothing ticked on either sheet to indicate if the test was completed or not, please enter 999 for unknown

FETAL MALNUTRITION/ SOFT TISSUE WASTING

Fetal malnutrition or soft tissue wasting.

Found in the '*DISCHARGE SUMMARY'* or '*NEONATOLOGIST LISTING'*.

Code one of the following:

1	Moderate wasting
2	Severe wasting

TWIN TYPE

Twin type.

Found in the '*DISCHARGE SUMMARY'* or '*NEONATOLOGIST LISTING'*.

Code one of the following:

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

ELECTIVE NON-RESUSCITATION

Elective non-resuscitation.

Found in the '*DISCHARGE SUMMARY'* or '*NEONATOLOGIST LISTING'*.

Code one of the following:

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

RETINOPATHY OF PREMATURITY

Retinopathy of prematurity.

Found on the *'DISCHARGE SUMMARY'*.

Code one of the following:

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

FINNEGAN SCORE

Finnegan score.

Found on the *'DISCHARGE SUMMARY'*.

Code one of the following:

1	Neonatal abstinence syndrome diagnosis, treated with narcotics*
2	Neonatal abstinence syndrome diagnosis, not treated with narcotics
3	No neonatal abstinence syndrome diagnosis

*if NAS is diagnosed and treated with a narcotic, choose treatment drug from code R066

CHROMOSOMAL ABNORMALITIES

Chromosomal abnormalities.

Found in the '*GENETICS REPORT'* or '*NEONATOLOGIST LISTING'*.

Code one chromosomal abnormality from the listing:

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

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

If Aneuploidy, Chimersion 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 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.

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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 13-18.

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

If a patient comes from the Nova Institution for Woman code '92'

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 or more regardless of whether such infants were 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 tests.

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

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

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

Y	Yes, done
D	Declined
N	No, not done
U	Unknown

Nuchal Translucency

Y	Yes, done
N	No, not done
U	Unknown

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

HIV Testing

Y	Yes, done
D	Declined
U	Unknown
N	No, not done

Maternal Serum

C	Completed
D	Declined
N	No, not done-include those noted as too late to complete
U	Unknown

*Capture completed, if only one of the two tests/screens have been completed.

DISCHARGE DATE

Patient's discharge date from hospital.

Found on the *'NURSES NOTES'*.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME

Patient's discharge time from hospital.

Found on the *'NURSES NOTES'*.

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

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

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 one of the standard 2-digit provincial codes for hospitals found on pages 13-18 or use one of the following codes:

If patient is discharged home, code 0.

If a patient is discharged to the Nova Institue for Women code 92

Code '**-9**' for Death.

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.

Code one of the following:

77777	Lived
OTHR	Other
PEMB	Pulmonary embolus
PPHM	Postpartum hemorrhage
STRK	Stroke

AUTOPSY

Completion of maternal autopsy.

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

This field will auto fill if mother lived.

Code one of the following:

LVD	Lived (not applicable)
YES	Died and autopsy done
NO	Died but autopsy not done

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.

STEROID THERAPY

Maternal steroid therapy.

Found on the *'MEDICATION SHEETS' or 'DISCHARGE SUMMARY'*.

Code using one of the following:

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

Chose value as documented on chart, or leave **blank**.

STEROID THERAPY 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.

STEROID THERAPY 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 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.

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POSTPARTUM ADMISSION

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 13-18.

*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, enter '0' admitted from home.

If a patient comes from the Nova Institution for Women enter '92'.

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 one or more infants 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.

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.

DISCHARGE DATE

Patient's discharge date from hospital.

Found on the '*NURSES NOTES'*.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME

Patient's discharge time from hospital.

Found on the '*NURSES NOTES'*.

Use the following format: 'HHMM'.

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

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

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 one of the standard 2-digit provincial codes for hospitals found on page 13-18 or use one of the following codes:

If patient is discharge home, code 0.

If patient is discharged to the Nova Institution for Women code 92

-9 Maternal Death.

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.

Code one of the following:

77777	Lived
OTHR	Other
PEMB	Pulmonary embolus
PPHM	Postpartum hemorrhage
STRK	Stroke

MATERNAL AUTOPSY

Completion of maternal autopsy.

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

This field will autofill if mother lived.

Code one of the following:

LVD	Lived (not applicable)
YES	Died and autopsy done
NO	Died but autopsy not done

ANTIBIOTIC THERAPY

Antibiotics administered during postpartum period.

Found on the *'MEDICATION 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 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

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'*.

Code one of the following:

1	Singleton, or first born of multiples.
2	Second born of multiples.
3	Third born of multiples
4	Fourth born of multiples
5	Fifth born of multiples.

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 13-18.

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**'.

If a patient comes from the Nova Institution for Women code '92'

BIRTH HOSPITAL

Infant's hospital of birth.

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

Code one of the standard 2-digit provincial codes for hospitals found on page 13-18.

If a patient comes from the Nova Institution for Women code '92'

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

NEONATAL INTENSIVE CARE UNIT (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 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.

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PEDIATRIC INTENSIVE CARE UNIT (PICU)
(IWK ONLY)

Infants admitted to the PICU at the IWK only.

Found in the '*PROGRESS NOTES'*.

Code using one of the following:

Y Yes
N No

If 'Y' is entered, the screen PICU date and time will pop up. Enter admit and discharge date and time to and from the PICU.

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

CCHD SCREENING

Critical Congenital Heart Disease Screening

Found on the '*NEWBORN ADMISSION/DISCHARGE FORM'* or '*NEWBORN NURSING ASSESSMENT'*.

Code one of the following:

COM	Completed- Not specified
DEC	Declined
NCA	Not clinically appropriate
PAS	Passed
REF	Referred
777	Autofill for fetal death
999	Unknown

If completed is checked off but no indication if the result was passed or referred, enter completed but not specified. If there is absolutely nothing ticked on either sheet to indicate if the test was completed or not, please enter 999 for unknown

OUTCOME

Outcome of infant at time of discharge.

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

Code one of the following:

LVD	Infant lived to be discharged from hospital
NND	Liveborn infant who died before being discharged home from hospital
FTD	Fetal death

FEEDING DURING ADMISSION

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.

If the infant is supplemented with expressed breast milk, capture as exclusive breastfeeding

Code one of the following:

E	**Exclusive Breastfeeding**: The infant/child received 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.
S	**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
N	**No Breastfeeding:** the infant/child received no human milk.
9	There is no documentation as to how the baby was fed during the hospital stay.

SUPPLEMENTATION INDICATION

Record one of the following reasons for supplementation of breastfeeding during the hospital stay.

Found in the *'DAILY BREASTFEEDING RECORD ''NEWBORN ADMISSION/DISCHARGE or 'NEWBORN NURSING ASSESSMENT' FORM*.

If the infant has received supplementation to breastfeeding, please indicate reason noted.

Code one of the following:

M	Medical indication for supplementation
N	Non-medical indication for supplementation
9	No indication for supplementation

DISCHARGE DATE

Patient's discharge date from hospital.

Found on the '*NURSES NOTES'*.

Use the following format: 'YYYYMMDD'.

DISCHARGE TIME

Patient's discharge time from hospital.

Found on the '*NURSES NOTES'*.

Use the following format: 'HHMM'.

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

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

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 one of the standard 2-digit provincial codes for hospitals found on pages 13-18 or use one of the following codes:

*If patient is discharge home, code '**0**'.*

If patient is discharge to Nova Institution for Women, code 92

-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 one of the following:

LVD	Lived (e.g., not applicable)
YES	Died and autopsy done
NO	Died but autopsy not done

AUTOPSY TYPE

Infant autopsy type.

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

Code one of the following:

C	Complete autopsy (includes CNS)
D	Direct (non-invasive)
G	General autopsy (does not include CNS)
U	Unspecified type
7	Non-applicable

PRIMARY CAUSE OF DEATH

Primary cause of death.

Found on the *'AUTOPSY REPORT'* or stated by physician. The fields will autofill if infant lived.

Code one of the following:

7777	Infant lived
ABRP	Abruptio placenta
ANEC	Acute necrotizing enterocolitis
OAIR	Airway failure
AMNO	Amniocentesis
ANAL	Analgesia or anesthesia
ASPN	Aspiration
CPDP	Chronic pulmonary disease
COTR	Complications of treatment
ANOM	Congenital anomaly
CRLK	Cord loops and/or knots
CDOT	Cord, miscellaneous
CORP	Cord prolapsed
DBRN	Degenerative brain disease
DUCT	Ductus syndrome of prematurity
EXTX	Exchange transfusion
FETH	Fetal hemorrhage
FMAL	Fetal malnutrition
HMDD	Hyaline membrane disease
HYDR	Idiopathic hydrops
IBOM	Inborn errors of metabolism
INFT	Infection

PRIMARY CAUSE OF DEATH (Con't)

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

DATE OF DEATH`

Date of infant's death.

Found in the *'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'*.

Code one of the following:

1	Moderate wasting
2	Severe wasting

TWIN TYPE

Twin type.

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

Code one of the following:

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

ELECTIVE NON-RESUSCITATION

Elective non-resuscitation.

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

Code one of the following:

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

MATERNAL STEROID THERAPY

Maternal steroid therapy.

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

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

In the case of multiples code for birth order 1 only.

Code one of the following:

Dexamethasone

1	< 24 hours before delivery
2	24 to 48 hours before delivery
3	> 48 hours to 7 days before delivery
4	> 7 days before delivery
5	Unknown when administered

Betamethasone (Celestone)

6	< 24 hours before delivery
7	24 to 48 hours before delivery
8	> 48 hours to 7 days before delivery
9	> 7 days before delivery
10	Unknown when administered

Unknown steroid

11	< 24 hours before delivery
12	24 to 48 hours before delivery
13	> 48 hours to 7 days before delivery
14	> 7 days before delivery
15	Unknown when administered

RETINOPATHY OF PREMATURITY

Retinopathy of prematurity.

Found on the *'DISCHARGE SUMMARY'*.

Code one of the following:

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

FINNEGAN SCORE

Finnegan score.

Found on the *'DISCHARGE SUMMARY'*.

Code one of the following:

1	Neonatal abstinence syndrome diagnosis, treated with narcotics
2	Neonatal abstinence syndrome diagnosis, not treated with narcotics*
3	No neonatal abstinence syndrome diagnosis

*if NAS is diagnosed and treated with a narcotic, choose the narcotic from code R066

CHROMOSOMAL ABNORMALITIES

Chromosomal abnormalities.

Found in the '*GENETICS REPORT'* or *NEONATOLOGIST''S LISTING'*.

Code one chromosomal abnormality from the listing:

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

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

If Aneuploidy, Chimersion 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 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.

ADULT RCP CODES

MATERNAL ANTIBODY CONDITIONS DURING PREGNANCY (R001)

Maternal antibody conditions during pregnancy.

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

Code all documented

100	Anti-La
200	Anti-D (Not to be used to indicate Rh-mom)
300	Anti-Big C (CW)
400	Anti-Big E
500	Anti-Big S
600	Anti-Dha (DUCH)
700	Anti-Fya (Duffy)
800	Anti-Kell (K1/K2)
900	Anti-Kidd (JKa)
1000	Anti-Little c
1100	Anti-Little e
1200	Anti-Little s
1300	Anti-Lutheran (Lua/Lub)
1400	Anti- Wright
1500	Antinuclear Antibody (ANA)
1600	Anti-Cardiolipin
1700	Anti-DNA Antibody
1800	Lupus Antibody (Lupus Anticoagulant)
1900	Anti-SSA (Ro)
2000	Anti-Phospholipid
2100	Factor V Leiden
2200	PL-A1 Platelet Antigen Negative

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'*.

Code all documented

100	Cytomegalovirus
200	Group B streptococcus (GBS)
300	Herpes Simplex
400	HIV/Acquired Immune Deficiency Syndrome
600	Syphilis
700	Toxoplasmosis
800	Serum Hepatitis Carrier (Antigen positive: Hepatitis A)
900	Serum Hepatitis Carrier (Antigen positive: Hepatitis B)
1000	Serum Hepatitis Carrier (Antigen positive: Hepatitis C)
1100	Serum Hepatitis Carrier (Antigen positive: Hepatitis viral)
1200	Gonorrhea
1300	Chlamydia
1400	Genital Warts/Human Papillomavirus (HPV)
1500	Zika virus (confirmed cases only)

MATERNAL DRUG THERAPIES FOR SPECIFIC CONDITIONS OF PREGNANCY (R003)

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

Found on the *'PRENATAL RECORD'*.

Code all documented as being taken during the pregnancy and postpartum period anywhere in the Health Record.

100	Adalat (nifedipine) for premature labour
300	Atosiban for premature labour
400	Hemabate for postpartum hemorrhage
500	Indocid (Indomethacin) for premature labour
600	Indocid(Indomethacin) for tx of polyhydramnios
*700	$MgSO_4$ for hypertension or seizures (i.e. Eclampsia prophylaxis or treatment).
800	$MgSO_4$ for prematurity
900	Pentaspan for postpartum hemorrhage
1000	Terbutaline (Bricanyl) for premature labour
1100	Ventolin for premature labour
1200	Other Drugs for specific pregnancy, delivery or postpartum conditions
1300	Ergot for postpartum hemorrhage
1400	Misoprostil for postpartum hemorrhage
*1500	$MgSO_4$ therapy for neuroprotection
*1600	$MgSO_4$ therapy for unknown reason
1700	Adalat for hypertension
1800	Ephedrine for hypotension, post-epidural or spinal anesthesia
1900	Phenylephrine for hypotension, post-epidural or spinal anesthesia
2000	Progesterone for Premature Labour
2100	IV iron therapy admininstered before delivery
2150	IV iron therapy administered after delivery
2200	Tranexamic Acid for postpartum hemorrhage
2300	Labetalol for hypertension

*Note: There should be clear document for the use of $MgSO_4$ (Magnesium Sulfate therapy) noted in the chart. If it is not noted as being used for hypertension or as neuroprotection, then code as unknown use.

MATERNAL DRUG THERAPIES DURING PREGNANCY/POSTPARTUM (R004)

Maternal drug therapies for specific conditions of pregnancy and postpartum.

Found on the *'PRENATAL RECORD'*.

Code all documented.

Code drug therapy if noted taken before pregnancy known.

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

100	Anti-coagulation therapy
200	Anti-depressives
300	Anti-epileptics
400	Anti-hypertensive
500	Chronic narcotic use (not abuse, when indicated for medical problems, i.e. back pain)
600	Lithium
700	Methadone Opioid Agonist Therapy
710	Buprenorphine/naloxone(Suboxone) Opioid Agonist Therapy
720	Buprenorphine/(Subutex) Opioid Agonist Therapy
730	Other Opioid Agonist Therapy
800	Other psychiatric medications
900	Other specified
1000	ASA therapy given during pregnancy
1100	Insulin therapy
1110	Metformin for diabetes
1200	Thyroid medication
*1300	Anti-anxiety medication
1500	Tamiflu
1600	Relenza
1800	Metformin for Polycystic Ovarian syndrome (PCOS)

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

MATERNAL DRUG AND CHEMICAL USE DURING PREGNANCY (R005)

Maternal drug and chemical use during pregnancy.

Found on the *'PRENATAL RECORD'*.

Code all documented

Code if noted used before found out was pregnant.

200	Ativan
300	Cocaine /Crack
400	Codeine
500	Demerol
600	Dilaudid
700	Hash
800	Heroin
900	Marijuana
1000	Methadone
1100	Morphine
1200	Prescription medication abuse
1300	Solvents
1400	Valium
1500	Other specified abuse
1600	OxyContin
1700	Ecstasy
1800	Alcohol abuse – chronic
1900	Alcohol abuse - binge
2000	Alcohol abuse – unknown binge or chronic
*2100	E-Cigarettes (Vaping)
2200	Nicotine Replacement
2300	Chewing tobacco

*This is not considered Nicotine replacement. If patient is using a nicotine replacement therapy as well, code both.

MATERNAL/FETAL DIAGNOSTIC AND THERAPEUTIC PROCEDURES (R006)

Maternal/fetal diagnostic and therapeutic procedures.

Found on the *'PRENATAL RECORD'*.

Code all documented

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

*Code version or rotation if attempted whether successful or unsuccessful.

ANESTHESIA DURING LABOUR AND DELIVERY (R010)

Anesthesia during labour and delivery.

Found on the '*ANESTHESIA RECORD'*.

Code all documented as administered during labour and delivery.

100	Entonox (nitrous)
200	Epidural-single administration
300	Epidural-continuous catheter with intermittent drug administration
400	Epidural-continuous infusion of drug (CIEA)
500	Epidural-patient controlled epidural analgesia (PCEA)
600	General anesthesia
700	Patient controlled intravenous analgesia
800	Pudendal
900	Spinal anesthesia
1000	Spinal-epidural double needle
1100	Other specified anesthesia (e.g. acupuncture, hypnotism, neuroleptic)

ANESTHESIA DURING LABOUR ONLY (R011)

Anesthesia during labour only.

Found on the *'ANESTHESIA RECORD'*.

Code all documented as administered during labour only.

100	Entonox (nitrous)
200	Epidural-single administration
300	Epidural-continuous catheter with intermittent drug administration
400	Epidural-continuous infusion of drug (CIEA)
500	Epidural-patient controlled epidural analgesia (PCEA)
600	General anesthesia
700	Patient controlled intravenous analgesia
800	Pudendal
900	Spinal anesthesia
1000	Spinal-epidural double needle
1100	Other specified anesthesia (e.g. acupuncture, hypnotism, neuroleptic)

ANESTHESIA DURING DELIVERY ONLY (R012)

Anesthesia during delivery only.

Found on the *'ANESTHESIA RECORD'*.

Code all documented as administered during delivery only.

100	Entonox (nitrous)
200	Epidural-single administration
300	Epidural-continuous catheter with intermittent drug administration
400	Epidural-continuous infusion of drug (CIEA)
500	Epidural-patient controlled epidural analgesia (PCEA)
600	General anesthesia
700	Patient controlled intravenous analgesia
800	Pudendal
900	Spinal anesthesia
1000	Spinal-epidural double needle
1100	Other specified anesthesia (e.g. acupuncture, hypnotism, neuroleptic)

COMPLICATIONS OF ANESTHESIA (R013)

Complications of anesthesia.

Found on the *'ANESTHESIA RECORD'* or *'DISCHARGE SUMMARY'*.

Code all documented.

100	Blood patching
200	Toxic intravenous injection (systemic reaction)
300	Epi-catheter intravenous
400	Accidental dural tap
500	Total spinal anesthesia
600	Prolonged epidural block
700	High epidural/subdural block
800	Foot drop
900	Epidural hematoma
1000	Epidural abscess
1100	Spinal cord lesion
1200	Aspiration pneumonitis
1300	Cardiac arrest
1400	Post-dural puncture headache
1500	Paraesthesia
1600	Hypotension
1700	Back pain
1800	Failed intubation for general anesthetic

OTHER OBSTETRICAL CONDITIONS AFFECTING PREGNANCY (R014)

Other obstetrical conditions affecting pregnancy.

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

Code all documented

100	Pruritic urticarial papules and plaques of pregnancy (PUPP)
200	Impetigo herpetiformis
300	Dermatitis herpetiformis
400	Separation of symphysis pubis
500	Gestational (pregnancy-induced) hypertension without proteinuria, includes: gestational hypertension NOS, mild pre-eclampsia
550	Hypertension, unspecified type
700	Pre-existing hypertension complicating pregnancy, childbirth and the puerperium
800	Pre-existing hypertensive disorder with superimposed proteinuria*
900	Pre-existing diabetes mellitus, type 1
1000	Pre-existing diabetes mellitus, type 2
1100	Pre-existing diabetes mellitus of other specified type present when pregnant during this pregnancy
1200	Pre-existing diabetes mellitus of unspecified type present during this pregnancy
1300	Diabetes mellitus arising in pregnancy, includes gestational diabetes
1400	Diabetes mellitus in pregnancy, unspecified
1500	Anemia in pregnancy (HB < 10gms% in pregnancy, as recorded **before** delivery)
1550	Anemia in pregnancy (HB < 10gms% in pregnancy, as recorded **after** delivery)
1600	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.)
1700	Maternal fever > 38 degrees
1800	Gestational hypertension with significant proteinuria
1900	HELLP Syndrome (Hemolysis, elevated liver enzymes, low platelet count)

*Proteinuria is defined using the following criteria:

24 hr urine - protein greater than or equal to 0.3g/day, or
Urine dipstick (P.O.C.) – greater than or equal to 1+ protein, or
Protein-Creatinine ratio (PrCr) –greater than or equal to 30g/mol

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'*.

Code all documented

100	Cholelithiasis
200	Ulcerative colitis/proctitis
300	Crohn's disease
400	Irritable bowel syndrome
500	Pancreatitis, acute and chronic
600	Reflux gastritis
700	Ulcers (all types)

PSYCHIATRIC ILLNESS

Psychiatric illness.

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

Found on the *'PRENATAL RECORD'* or `*DISCHARGE SUMMARY'*.

Code all documented

100	Anxiety disorders
200	Depression
300	Eating disorders (e.g. anorexia nervosa, bulimia nervosa)
400	Manic – depression
500	Schizophrenia
600	Other

NEUROLOGICAL ILLNESS

Neurological illness.

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

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

Code all documented

100	Bell's palsy
200	Cerebral palsy
300	Epilepsy
400	Intracerebral hemorrhage
500	Muscular dystrophy
600	Myasthenia gravis
700	Multiple sclerosis
800	Presence of Harrington Rod
900	Subarachnoid hemorrhage
1000	Seizure
1100	Tuberous sclerosis
1200	Thoracic outlet syndrome
1300	Other

HEART DISEASE

Heart disease.

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

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

Code all documented

100	Arrhythmia
200	Congenital heart disease
300	Cardiac arrest
400	Coronary artery disease
500	Endocarditis
600	History of heart disease or surgery
700	Myocardial infarction
800	Prolapsed mitral value
900	Cardiomyopathy
1000	Myocarditis
1100	Pulmonary hypertension
1200	Rheumatic heart disease
1300	Valve prosthesis
1400	Wolff-Parkinson-White syndrome
1500	Other acquired cardiac diseases
1600	Thromboembolic disease

ENDOCRINE DISEASE

Endocrine disease.

CODE IF THE CONDITION IS OR WAS PRESENT DURING THE CURRENT PREGNANCY (R019)

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

Code all documented

100	Disorder of adrenal gland
200	Disorder of ovary
300	Hashimoto's thyroiditis
400	Hyperthyroidism with goiter
500	Hyperthyroidism with thyroid nodule
600	Hyperthyroidism with goiter, nodular
700	Hyperthyroidism without Goiter
800	Hypothyroidism
900	Hyperparathyroidism
1000	Disorder of hypothalamus
1100	Disorder of pituitary gland

RENAL DISEASE

Renal disease.

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

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

Code all documented

100	Acute pyelonephritis
200	Renal calculus
300	Chronic glomerulonephritis
400	Previous episode of acute pyelonephritis during current pregnancy
500	Hydronephrosis
600	Nephropathy
700	Nephritic syndrome
800	Polycystic kidney disease
900	Chronic pyelonephritis
1000	Renal agenesis
1100	Renal transplant
1200	Chronic renal disease, type undetermined
1300	Urinary tract infection

NEOPLASM, INCLUDING MALIGNANCIES

Neoplasm, including malignancies.

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

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

Code all documented

100	Bowel
200	Breast
300	Cervix
400	Other
500	Ovary (teratoma)
600	Thyroid
700	Vagina

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'*.

Code all documented

100	Hemolytic anemia
200	Dysfibrinogenemia
300	Factor 12 deficiency
400	Familial hyperfibrinogenemia
500	Factor VIII deficiency
600	G6PD deficiency
700	Idiopathic hypoplastic anemia
800	Idiopathic thrombocytopenic purpura (ITP)
900	Sickle cell anemia
1000	Thalassemia
1100	Von Will brand's disease
1200	Thrombotic thrombocytopenia purpura (TTP)
1300	Thrombocytopenia

PULMONARY DISEASE

Pulmonary disease.

CODE IF THE CONDITION IS OR WAS PRESENT DURING CURRENT PREGNANCY (R023)

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

Code all documented

100	Asthma
200	Cystic fibrosis
300	Pulmonary edema
400	Other significant pulmonary diseases
500	Pneumonia, antepartum
600	Laboratory confirmed H1N1 Influenza

OTHER NON-OBSTETRICAL DISEASES, NOT ELSEWHERE CLASSIFIABLE

Other non-obstetrical disease, not elsewhere classifiable.

CODE IF THE CONDITION IS OR WAS PRESENT DURING CURRENT PREGNANCY (R024)

Found on the '*PRENTAL RECORD'* or '*DISCHARGE SUMMARY'*.

Code if condition is or was present during the current pregnancy

Code all documented

100	Ankylosing spondylitis
200	Cholinesterase deficiency
300	Family or personal history of malignant hyperthermia
400	Neurofibromatosis (Von Recklinghausen's disease)
500	Porphyria
600	Maternal phenylketonuria
700	Rheumatoid arthritis/psoriatic
800	Sarcoidosis
900	Scleroderma
1000	Scoliosis
1100	Sjogren's syndrome
1200	Systemic lupus
1300	Schumann's disease

PREVIOUS PREGNANCY MATERNAL DISEASES (R025)

Previous pregnancy maternal diseases.

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

Code all documented

100	Previous history of personal malignancy
200	Previous sensitized pregnancy
300	Hypertensive disease in previous pregnancy
400	Previous eclampsia
500	Previous ectopic pregnancy
600	Previous molar pregnancy
700	Previous anemia
800	Previous abruptio placenta
900	Previous breech
1000	Previous thromboembolic disease
1100	Previous gestational diabetes
1200	Previous history of infertility
1300	Previous postpartum depression

MATERNAL TRANSFUSIONS BLOOD AND OTHER PRODUCTS (R026)

Maternal transfusions, blood and other products.

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

Code all documented

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

REASON FOR MATERNAL BLOOD TRANSFUSION (R027)

Reason for maternal blood transfusion.

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

Code all documented

100	Anemia in pregnancy
200	Antepartum hemorrhage
300	Intrapartum hemorrhage
400	Postpartum hemorrhage
500	Other

IMMUNIZATIONS (R028)

Immunizations.

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

Code all documented

100	Seasonal influenza vaccine
400	Pertussis
500	Measles, Mumps, Rubella (MMR)

PROCEDURES FOR POSTPARTUM HEMORRHAGE (R029)

Procedures for postpartum hemorrhage.

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

Code all documented

100	Uterine compression suture (e.g. B-Lynch or Cho)
200	Tying (ligation) of uterine arteries
300	Embolization of uterine arteries
400	Uterine tamponade (use of Bakri balloon or uterine packing) not to be confused with vaginal packing

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INFANT RCP CODES

PLACENTAL OR CORD ANOMALIES (R051)

Placental or cord anomalies.

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

Code all documented

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

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

Anomaly/metabolic syndromes and conditions.

Found on the *'DISCHARGE SUMMARY'* or *'NEONATAL LISTING'* or *'CHROMOSOMAL REPORT'*.

Code all documented

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

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

3900	Aniridia
4000	Aniridia-Wilm's tumor association
4100	Anodontia
4200	Anorectal malformation
4300	Antley-Bixler syndrome
4400	Apert syndrome
4500	Arachnodactyly
4600	Arachnoid cyst
4700	Argininaemia
4800	Argininosuccinic aciduria
4900	Arteriohepatic dysplasia
5000	Arteriovenous malformation of the lung
5100	Arthrogryposis, muscular
5200	Arthrogryposis, neurogenic
5300	Arthro-ophthalnopathy (Stickler Syndrome)
5400	Asphyxiating thoracic dystrophy
5500	Asplenia syndrome
5600	Ataxia – telangiectasia syndrome (Louis-Bar Syndrome)
5700	Atelosteogenesis, type 1 (Chondrodysplasia, giant cell)
5800	Athyrotic hypothyroidism sequence
5900	Atr-x syndrome
6000	Baller-Gerold syndrome
6100	Bannayan syndrome (Bannayan-Riley-Ruvalcaba syndrome)
6200	Bardet-Biedl syndrome
6300	Beals syndrome (Beals contractural arachnodactyly)
6400	Beckwith syndrome (Beckwith-Wiederman Syndrome)
6500	Berardinelli lipodystrophy syndrome
6600	Bicorunate uterus
6700	Bifid scrotum
6800	Bifid uvula
6900	Bladder exstrophy
7000	Blepharophimosis
7100	Bloch-Sulzberger syndrome
7200	Bloom syndrome
7300	Blue sclera
7400	Body stalk anomaly
7500	Bor syndrome (Brachio-oto-renal syndrome)
7600	Borjeson-Forssman-Lehmann syndrome
7700	Brachmann-de Lange Syndrome (Cornelia deLange syndrome)
7800	Brachydactyly
7900	Branchial sinus
8000	Branchio-oculo-facial syndrome
8100	Breech deformation sequence

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

8200	Brushfield spots
8300	Buru-Baraister syndrome
8400	Caffey pseudo-Hurler syndrome
8500	Campomelic dysplasia
8600	Camurati-Engelmann syndrome
8700	Capillary hemangioma
8800	Cardio-facio-cutaneous syndrome (CFC)
8900	Cardiomyopathy, congenital
9000	Carnitine deficiency
9100	Carpenter syndrome
9200	Cartilage-hair hypoplasia syndrome
9300	Catel-Manzke syndrome
9400	Cat-eye syndrome
9500	Caudal dysplasia sequence
9600	Caudal regression syndrome
9700	Cavernous hemangioma
9800	Cebocephaly
9900	Cephalopolysyndactyly syndrome (Greig Syndrome)
10000	Cerebellar calcification
10100	Cerebellar hypoplasia
10200	Cerebral calcification
10300	Cerebral gigantism syndrome
10400	Cerebro-costo-mandibular syndrome
10500	Cerebro-oculo facio-skeletal (cofs) syndrome
10600	Cervico-oculo-acoustic syndrome
10700	Charcot-Marie-Tooth syndrome
10800	Charge syndrome
10900	Child Syndrome (Congenital hemidysplasia)
11000	Choanal atresia
11100	Chondrodysplasia punctata (Condradi-Hünermann Syndrome)
11200	Chondrodystrophica myotonia (Schwartz-Jampel Syndrome)
11300	Chondroectodermal dysplasia (Ellis-van Creveld syndrome)
11400	Chondromatosis
11500	Citrullinaemia
11600	Cleft face
11700	Cleft lip, unilateral
11800	Cleft lip, bilateral
11900	Cleft tongue
12000	Cleft palate

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

12100	Cleidocranial dysostosis
12200	Clinodactyly
12300	Cloacal exstrophy
12400	Clouston syndrome
12500	Cloverleaf skull
12600	Clubfoot
12700	Cockayne syndrome
12800	Coffin-Lowry syndrome
12900	Coffin-Siris syndrome
13000	Cohen syndrome
13100	Coloboma of iris
13200	Colon, malrotation
13300	Congenital adrenal hyperplasia
13400	Congenital hypothyroidism
13500	Congenital microgastria-limb reduction complex
13600	Conjoined twins
13700	Cortical hypoplasia
13800	Costello syndrome
13900	Coumarin embryology effects
14000	Craniofacial dysostosis (Crouzon Syndrome)
14100	Craniofrontonasal dysplasia
14200	Craniometaphyseal dysplasia
14300	Craniosynostosis
14400	Craniosynostosis, coronal
14500	Craniosynostosis, frontal
14600	Craniosynostosis, Kleeblattschadel
14700	Craniosynostosis, lambdoid
14800	Craniosynostosis, sagittal
14900	Crainiosynostosis, trigonocephaly
15000	Cri du chat syndrome
15100	Cryptophthalmos anomaly (Fraser Syndrome)
15200	Cryptorchidism
15300	Cubitus valgus
15400	Cutis aplasia
15500	Cutis hyperelastica
15600	Cutis laxa
15700	Cutis marmorata
15800	Cyclopia
15900	Cyclops
16000	Cystathionuria

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

16100	Cystic adenomatoid malformation of the lung
16200	Cytomegalic inclusion disease
16300	Dandy-walker syndrome
16400	Darwinian tubercle
16500	Dental cyst
16600	Deprivation syndrome
16700	Dermal ridge, aberrant
16800	Desanctis-Cacchione syndrome
16900	Diabetes insipidus
17000	Diabetes mellitus
17100	Diaphagmatic hernia
17200	Diaphyseal aclasis
17300	Diastriophic dyslasia
17400	Diastrophic nanism
17500	DiGeorge syndrome
17600	Dilantin embryopathy
17700	Dimple, sacral
17800	Distal arthogyrposis syndrome
17900	Distichiasis-lymphedema syndrome
18000	Donohue syndrome (Leprechaunism Syndrome)
18100	Down syndrome
18200	Dubowitz syndrome
18300	Duodenal atresia
18400	Dwarfism, acromesomelic
18500	Dwarfism, metatrophic
18600	Dyggve-Melchoir-Clausen syndrome
18700	Dysencephalia splanchnocystica (Meckel-Gruber Syndrome)
18800	Dyskeratosis congenita syndrome
18900	Dystrophia myotonica, Steinert (Myotonic dystrophy)
19000	Early urethral obstruction syndrome
19100	Ectodermal dysplasia
19200	Ectrodactyly, tibial
19300	Ectrodactyly-ectodermal dysplasia-clefting syndrome (EEC)
19400	Eczema
19500	Ehlers-Danlos syndrome
19600	Elbow dysplasia
19700	Enamel hypoplasia
19800	Encephalocele
19900	Encephalocraniocutaneous lipomatosis

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

20000	Endocrine neoplasia,multiple, type 2
20100	Epidermal nevus syndrome
20200	Epiphyseal calcification
20300	Epiphyseal dysplasia, multiple
20400	Equinovarus deformity
20500	Escobar syndrome (Multiple pteryguim dysplasia)
20600	Esophageal atresia
20700	Exomphalos
20800	External chonromatosis
20900	Fabry's disease
21000	Falx calcification
21100	Familial blepharophimosis syndrome
21200	Familial short stature
21300	Fanconi syndrome
21400	Fetal alcohol syndrome (FAS)
21500	Femoral hypoplasia-unusual facies syndrome
21600	Fetal face syndrome (Robinow Syndrome)
21700	Fg syndrome
21800	Fibrochondrogenesis
21900	Fibrodysplasia ossificans progressiva syndrome
22000	First and second brachial arch syndrome
22100	Floating-harbour syndrome
22200	Fragile x syndrome (Martin-Bell Syndrome)
22300	Franceschetti-Klein syndrome (Treacher-Collins Syndrome)
22400	Freeman-Sheldon syndrome (Whistling Face Syndrome)
22500	Frenula, absent
22600	Frontal bossing
22700	Frontometaphyseal dysplasia
22800	Frontonasal dysplasia sequence
22900	Fryns syndrome
23000	Galactosemia
23100	Gastroschisis
23200	Geleophysic dysplasia
23300	Gilles telencephalic leucoencephalopathy
23400	Glaucoma
23500	Glossopalatine ankylosis syndrome
23600	B-glucuridase deficiency
23700	Glycogen storage disease
23800	Goiter
23900	Goldenhar syndrome
24000	Goltz syndrome

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

24100	Gonadal dysgenesis
24200	Gorlin syndrome (Nevoid basal cell carcinoma)
24300	Grebe syndrome
24400	Hallerman-Streiff syndrome
25000	Hecht syndrome
25100	Hemifacial microsomia
25200	Hemochromatosis
25300	Hemorrhagic telangiectasia, hereditary
25400	Hereditary arthro-ophthalmopathy
25500	Hereditary osteo-onchodysplasia (Nail-patella syndrome)
25600	Hirshsprung aganglionosis
25700	Holoprosencephaly
25800	Holt-Oram syndrome
25900	Homocystinuria syndrome
26000	Homozygous Leri-Weill syndrome
26100	Hunter syndrome
26200	Hurler syndrome
26300	Hurler-Scheie syndrome
26400	Hutchinson-Gilford syndrome (Progeria Syndrome)
26500	Hydantoin embryology
26600	Hydatidiform placenta
26700	Hydranenecephaly
26800	Hydrocele
26900	Hydrocephalus
27000	Hydrops fetalis
27100	Hyperammonaemia
27200	Hypochondrogenesis
27300	Hypochondroplasia
27400	Hypodactyly, hypoglossal
27500	Hypodontia
27600	Hypogenitalism
27700	Hypoglossia-hypodactyly syndrome
27800	Hypogonadism
27900	Hypohidrotic ectodermal dysplasia (Rapp-Hodgkin ectoderma)
28000	Hypomelanosis of Ito

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

28100	Hypomellia-hypotrichosis-facial hemangioma syndrome
28200	Hypospadias
28300	Hypospadias, glandular (first degree)
28400	Hypospadias, coronal (second degree)
28500	Hypospadias, shaft (third degree)
28600	Hypospadias, perineal (fourth degree)
28700	Hypotrichosis
28800	Icthyosiform erythroderma (Senter-Kid Syndrome)
28900	Immune deficiency
29000	Immunoglobulin deficiency
29100	Imperforate anus
29200	Iniencephaly
29300	Intestinal atresia
29400	Intestinal atresia, anal
29500	Intestinal atresia, colonic
29700	Intestinal atresia, ileal
29800	Intestinal atresia, jejunal
29900	Intestinal stenosis
30000	Intestinal stenosis, anal
30100	Intestinal stenosis, colonic
30200	Intestinal stenosis, duodenal
30300	Intestinal stenosis, ileal
30400	Intestinal stenosis, jejunal
30500	Intestinal stenosis, rectal
30600	Intracardiac mass
30700	Intrathoracic vascular ring
30800	Ivenmark syndrome
30900	Jackson-Lawler pachyonychia congenita syndrome
31000	Jadossohn-Lewandowski pachyonychia congenita syndrome
31100	Jansen-type metaphyseal dysplasia
31200	Jarcho-Levin syndrome
31300	Johanson-Blizzard syndrome
31400	Jugular lymphatic obstruction sequence
31500	Kabuki syndrome
31600	Kartagener syndrome
31700	Keratoconus
31800	Killian/Teschler-Nicola syndrome (Pallister mosaic syndrome)
31900	Kinky hair syndrome (Menkes Syndrome)
32000	Klein-Waardenburg syndrome

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

32200	Klippel-Feil sequence
32300	Klippel-Trenaunay-Weber syndrome
32400	Kniest dysplasia
32500	Kozlowski spondylometaphyseal dysplasia
32600	Lacrimal-auriculo-dento-digital syndrome
32700	Ladd syndrome
32800	Langer-Gideon Syndrome
32900	Langer-Saldino achondrogenesis
33000	Larsen syndrome
33100	Laryngeal abnormality
33200	Laryngeal atresia
33300	Laryngeal web
33400	Left-sidedness sequence
33500	Lens, dislocation
33600	Lenticular opacity
33700	Lentigines, multiple
33800	Lenz-Majewski hyperostosis syndrome
33900	Leopard syndrome
34000	Leri-Weill dyschondrosteosis
34100	Leroy I-cell syndrome
34200	Lesch-Nylan syndrome
34300	Lethal multiple pterygium syndrome
34400	Levy-Hollister syndrome
34500	Limb-body wall complex
34600	Lipoatrophy
34700	Lipodosis, neurovisceral
34800	Lipodystrophy, generalized
34900	Lipomatosis, encephalocraniocutaneous
35000	Lippit-cleft hip syndrome (Van der Woude Syndrome)
35100	Lissencephaly Syndrome (Miller-Dieker Syndrome)
35200	Lobstein disease
35300	Lupus, neonatal
35400	Macrocephaly
35500	Macroglossia
35600	Macrogyria
35700	Macro-orchidism
35800	Macrosomia
35900	Macrostomia
36000	Madelung deformity
36100	Maffucci syndrome
36200	Malar hypoplasia
36400	Mandibular hypodontia
36500	Marden-Walker syndrome
36600	Marfan syndrome
36700	Maroteaux-Lamy (mucopolysaccharidosis

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

	syndrome)
36800	Marshall syndrome
36900	Marshall-Smith syndrome
37000	Masa syndrome (X-linked hydrocephalus sequence)
37100	Maternal phenylketonuria, fetal effects
37200	Maxillary hypoplasia
37300	McCune-Albright syndrome (osteitis fibrosa cystica)
37400	McKusick type metaphyseal dysplasia
37500	Meckel diverticulum
37600	Median cleft face syndrome
37700	Melanomata
37800	Melanosis, neurocutaneous
37900	Melnick-Fraser syndrome
38000	Melnick-Needles syndrome
38100	Meningocele
38200	Meningomyelocele
38300	Metacarpal hypoplasia
38400	Metaphyseal dysplasia, Jansen type
38500	Metaphyseal dysplasia, McKusick type
38600	Metaphyseal dysplasia, Pyle type
38700	Metaphyseal dysplasia, Schmid type
38800	Metatarsal hypoplasia
38900	Metatarsus adductus
39000	Metatropic dwarfism
39100	Metatropic dysplasia
39200	Methioninaemia
39300	Methotrexate embryology
39400	Microcephaly
39500	Microcolon
39600	Microcolon-megacystis-hypoperistalsis syndrome
39700	Microcornea
39800	Microdeletion syndrome
39900	Microdontia
40000	Microgastria
40100	Microglossia
40200	Micrognathia
40300	Micropenis
40400	Microphthalmia
40500	Microstomia
40600	Miller syndrome (postaxial acrofacial dysostosis)
40700	Moebius syndrome
40800	Mohr syndrome (OFD)
40900	Morquio syndrome
41000	Mucolipidosis III (pseudo Hurler)
41100	Mucopolysaccharidosis I s (Scheie Syndrome)
41200	Mucopolysaccharidosis III, types a, b, c, d

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

41300	Mucopolysaccharidosis VII (Sly Syndrome)
41500	Multiple endocrine neoplasia, type 2b
41600	Multiple neuroma syndrome
41700	Multiple synostosis syndrome (Symphalangism Syndrome)
41800	Murcs association
41900	Myasthenia gravis, newborn
42000	Myopathy, centronuclear
42100	Myopathy, myotubular
42200	Nanism, diastrophic
42300	Nasal dysplasia
42400	Neonatal lupus
42500	Neonatal teeth
42600	Nesidioblastosis
42700	Neu-laxova syndrome
42800	Neural tube defect
42900	Neurocutaneous melanosis syndrome
43000	Neurofibromatosis syndrome
43100	Neuromuscular defect
43200	Neurovisceral lipidosis, familial
43300	Noonan syndrome
43400	Occult spinal dysraphism
43500	Oculo-auriculo-vertebral defect spectrum
43600	Oculodentodigital syndrome
43700	Oculo-genito-laryngeal syndrome (Optiz Syndrome)
43800	Odontoid hypoplasia
43900	Oculo-facial-digital syndrome, type I (OFD-I)
44000	Oculo-facial-digital syndrome type III (OFD-III)
44100	Oligohydramnios sequence
44200	Ollier disease (osteochondromatosis syndrome)
44300	Omphalocele
44400	Optic nerve dysplasia
44500	Oromandibular-limb hypogenesis spectrum
44600	Osteochondrodysplasia
44700	Osteodysplasia
44800	Osteogenesis imperfecta, type I
44900	Osteogenesis imperfecta, type II
45000	Osteolysis
45100	Osteo-onychodysplasia
45200	Osteopetrosis
45300	Otocephaly
45400	Oto-palato-digital syndrome, type I (Taybi Syndrome)
45500	Oto-palato-digital syndrome, type II
45600	Pachydermoperiostosis syndrome
45700	Pachygyria
45800	Pachyonchia congenita syndrome
45900	Pallister-Hall syndrome

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

46000	Parabiotic syndrome, donor (twin-twin transfer)
46100	Parabiotic syndrome, recipient (twin-twin transfer)
46200	Pectus carinatum
46300	Pectus excavatum
46400	Pena-Shokeir phenotype, type I
46500	Pena-Shokeir phenotype, type II
46600	Penta x syndrome
46700	Pentalogy of Cantrell
46800	Perinatal lethal hypophosphotasia
46900	Peters plus syndrome
47000	Peutz-Jeghers syndrome
47100	Pfeiffer syndrome
47200	Phenylketonuria
47300	Phenylketonuria, maternal effects
47400	Photosensitive dermatitis
47500	Pierre Robin syndrome
47600	Pitting, lip
47700	Pitting, preauricular
47800	Poikiloderma congenitale syndrome (Rothmund-Thomson syndrome)
47900	Poland sequence
48000	Polydactyly
48100	Polymicrogyria
48200	Polysplenia syndrome
48300	Popliteal pterygium syndrome
48400	Porencephalic cyst
48500	Port wine stain
48600	Potter syndrome
48700	Prader-Willi syndrome
48800	Preauricular tags
48900	Preauricular pits
49000	Prognathism
49100	Proteus syndrome
49200	Pseudoachondroplasia
49300	Pseudocamptodactyly
49400	Pulmonary agenesis
49500	Pulmonary hypoplasia
49600	Pulmonary lymphangectasia, congenital
49700	Pyknodysostosis
49800	Pyle disease (Pyle metaphyseal dysplasia)
49900	Pyruvate carboxylase deficiency
50000	Pyruvate dehydrogenase deficiency
50100	Rachischisis
50200	Ranula
50300	Rectal atresia
50400	Rectal atresia, with fistula
50500	Refsum's disease
50600	Reifenstein's syndrome

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

50700	Restrictive dermopathy
50800	Retinoic acid embryopathy
50900	Rhizomelic chondrodysplasia punctata
51000	Rieger syndrome
51100	Right-sidedness sequence
51200	Rokitansky malformation sequence
51300	Rubinstein-Taybi syndrome
51400	Russell-Silver syndrome (Silver Syndrome)
51500	Saddle nose
51600	Saethre-Chotzen syndrome
51700	Salino-Noonan short rib-polydactyly syndrome
51800	Sc phocomelia
51900	Schinzel-Giedion syndrome
52000	Schmid type metaphyseal dysplasia
52100	Schizenecephaly
52300	Sclerosteosis
52500	Scrotum, shawl
52600	Seckel syndrome
52700	Septo-optic dysplasia sequence
52800	Short bowel syndrome
52900	Short rib-polydactyly syndrome, type II
53000	Shprintzen syndrome
53100	Shwachman syndrome
53200	Simpson-Golabi-Behmel syndrome
53300	Sirenomelia sequence
53400	Smith-Lemli-Opitz Syndrome
53500	Spondylocarpotarsal synostosis syndrome
53600	Spondyloepiphyseal dysplasia
53700	Spondylometaphyseal dysplasia, Kozlowski
53800	Sternal malformation-vascular dysplasia spectrum
53900	Struge-Weber sequence
54000	Sulfite oxidase deficiency
54100	Sugarman syndrome
54200	Syndactyly
54300	Tar syndrome (thrombocytopenia absent radius)
54400	Taurodontism
54600	Tdo syndrome
54700	Testicular feminization syndrome
54800	Testis, hydrocele
54900	Tethered cord malformation syndrome
55000	Thanatophoric dysplasia
55100	Thyroglossal cyst
55300	Thurston syndrome
55400	Tibial aplasia-ectrodactyly syndrome
55500	Townes-brocks syndrome
55600	Tracheoesophageal fistula
55700	Transcobalamin II deficiency
55800	Trapezoidcephaly

ANOMALY / METABOLIC SYNDROMES AND CONDITIONS (R054)

55900	Tricho-rhino-phalangeal syndrome, type I
56000	Tridione embryopathy
56100	Trimethadione embryopathy
56200	Triphalangeal thumb
56300	Triploidy
56500	Turner syndrome
56600	Turner-like syndrome
56700	Umbilical hernia
56800	Urorectal septum malformation sequence
56900	Uterus, ambiguous
57300	Vagina, double
57400	Valproate embryopathy
57500	Varadi-Papp syndrome
57600	Vater association
57700	Vein of Galen, aneurysm
57800	Vertebral defect
57900	Volvulus, colon
58000	Volvulus, ileum
58100	Volvulus, jejunum
58200	Volvulus, small bowel
58300	Von Hippel-Lindau syndrome
58400	Vrolik disease
58500	Waardenburg syndrome, type I
58600	Waardenburg syndrome, type II
58700	Waardenburg syndrome, type III
58800	Wagr syndrome
58900	Walker-Warburg syndrome
59000	Warfarin embryology
59100	Weaver syndrome
59200	Weill-Marchesani syndrome
59300	Werner syndrome
59400	Whelan syndrome
59500	Williams syndrome
59600	Xeroderma pigmentosa syndrome
59700	Yunis-Varon syndrome
59800	Zellweger syndrome
59900	Zollinger-Ellison syndrome

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.

500	Endotracheal tube < 1 minute
600	Endotracheal tube 1-3 minutes
700	Endotracheal tube > 3 minutes
800	Endotracheal tube unknown duration
900	CPAP < 1 minute
1000	CPAP 1-3 minutes
1100	CPAP > 3 minutes
1200	CPAP unknown duration
1300	LMA < 1 minute
1400	LMA 1-3 minutes
1500	LMA > 3 minutes
1600	LMA unknown duration
1700	PPV < 1 minute
1800	PPV 1-3 minutes
1900	PPV >3 minutes
2000	PPV unknown duration

PATENT DUCTUS ARTERIOSUS (R057)

Patent ductus arteriosus.

Found on the *'DISCHARGE SUMMARY'*.

Choose one of the following.

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

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

Persistent fetal circulation/persistent pulmonary hypertension of the newborn.

Found on the 'DISCHARGE SUMMARY'.

Choose **one** of the following causes.

100	Congenital heart disease
200	Fetomaternal bleed
300	Hyaline membrane disease
400	Meconium aspiration
500	Pulmonary hypoplasia
600	Pneumonia
700	Primary pulmonary hypertension
800	Cause not stated

RESPIRATORY DISTRESS SYNDROME (R059)

Respiratory distress syndrome.

Found on the 'DISCHARGE SUMMARY'.

Choose one of the following.

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

CHRONIC PULMONARY DISEASE OF PREMATURITY (R060)

Chronic pulmonary disease of prematurity.

Found on the 'DISCHARGE SUMMARY'.

Choose one of the following.

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

REQUIREMENT FOR HOME OXYGEN) (R061

Requirement for home oxygen.

Found on the 'DISCHARGE SUMMARY'.

100	Patient requires home oxygen

.

BIRTH ASPHYXIA SEQUELAE (R062)

Birth asphyxia sequelae.

Found on the 'DISCHARGE SUMMARY'.

Code all documented.

100	Post-asphyctic CNS depression
200	Post-asphyctic CNS excitation
300	Post-asphyctic increase intracranial pressure
400	Post-asphyctic brain necrosis
500	Post-asphyctic congestive heart failure
600	Post-asphyctic acute tubular necrosis
700	Post-asphyctic liver and/or adrenal necrosis

CONVULSIONS/SEIZURES (R063)

Convulsions or seizures due to a stated condition.

Found on the '*DISCHARGE SUMMARY'*.

Code all documented.

100	Alkalosis
200	Arhinencephaly
300	Benign familial
400	Brain edema
500	Cerebral anomaly, unspecified
600	Drug withdrawal
700	Hemorrhage, brain stem
800	Hemorrhage, cerebellar
900	Hemorrhage, cerebral
1000	Holoprosencephaly
1100	Hydrocephaly
1200	Hydranencephaly
1300	Hypercapnia
1400	Hypocalcemia
1500	Hypocapnia
1600	Hypoglycemia
1700	Hypomagnesemia
1800	Hyponatremia
1900	Inborn error of metabolism
2000	Infarction
2100	Kernicterus
2200	Meningitis
2300	Post-asphyctic
2400	Pyridoxine deficiency
2500	Pyridoxine dependency
2600	Unknown
2700	Venous thrombosis

NEOPLASM (R064)

Neoplasm.

Found on the '*DISCHARGE SUMMARY'*.

Code all documented

100	Astrocytoma
200	Choroid plexus papilloma
300	Connective tissue
400	Craniopharyngioma
500	Cystadenoma
600	Cystic hygroma
700	Endothelial tissue
800	Ependymona
900	Epithelial tissue
1000	Familial erythrophagocytic lymphohistiocytosis
1100	Fibroma
1200	Follicular cyst
1300	Glioma
1400	Hemangioma, cavernous
1500	Hemangioma, capillary
1600	Hepatobalstoma
1700	Histiocytosis
1800	Insulinoma
1900	Leukemia
2000	Lipoma
2100	Lymphangioma
2200	Lymphoma
2300	Mass, unknown type
2400	Medulloblastoma
2500	Melanoma
2600	Melanotic neuroectodermal tumor
2700	Mesoblastic nephroma
2800	Muscle
2900	Myxofibrosarcoma
3000	Nasal glioma
3100	Nephroblastoma
3200	Nesidioblastosis
3300	Neuroblastoma
3400	Neuroectodermal tumor
3500	Neurofibroma
3600	Retinoblastoma
3700	Rhabdomyoma, cardiac
3800	Rhabdomyoma

NEOPLASM
(R064) (con't)

3900	Sarcoma
4000	Teratoma, cardiac
4100	Teratoma, embryotic rests
4200	Teratoma, gonads
4300	Teratoma, sacrococcygeal
4400	Teratoma, site not specified
4500	Wilm's tumor
4600	Hemangioma
4700	Hemangioma, port-wine

MEDICATIONS
(R066)

Medications.

Found on '*MEDICATION SHEETS'* or '*DISCHARGE SUMMARY'*.

(Not coded at IWK)

Code all documented

400	Acyclovir
500	Adenosine
600	Adrenalin
1000	Alprostadel (prostaglandin, e.g.; prostin)
1400	Amoxicillin
1600	Ampicillin
3100	Ceftazidime
3200	Cefazolin
3300	Cefotaxime
3400	Ceftriaxone
3500	Cefuroxime
4000	Cloxacillin
4200	Surfactant
4600	Diazepam
4800	Digoxin
4900	Dilantin (phenytoin)
5000	Dobutamine
5200	Dopamine
5400	Epinephrine
5600	Erythromycin
5700	Fentanyl
5900	Flagyl (metronidazole)
6300	Furosemide (lasix)
6400	Gentamicin
6500	Glucagon
7500	Insulin
7800	Kayexalate
7900	Morphine

MEDICATIONS (R066) (con't)

(Not coded at IWK)

8800	Naloxone (narcan)
9500	Penicillin
9600	Phenobarbital
9700	Potassium Chloride
10000	Propranolol
10300	Salbutamol (ventolin)
10400	Septra (sulfamethoxazole / trimethoprim)
11100	Ticarcillin
11200	Tobramycin
11400	Trimethoprim
11700	Vancomycin
11900	Tamiflu
12000	Relenza
12100	Clindamycin
12200	Buprenorphine (subutex)
12300	Suboxone (buprenorphine + naloxone)
12400	Methadone

NEONATAL ABSTINENCE SYNDROME (R067)

Neonatal abstinence syndrome.

Drug withdrawal from maternal use.

Found on the *'DISCHARGE SUMMARY'*.

Code all documented

100	Alprazolam (xanax)
200	Barbiturate
300	Benzodiazepam/Benzodiazepine
400	Citalopram (celexa)
500	Cocaine
600	Diazepam (valium)
700	Fluoxetine (prozac)
800	Ethchlorvyol (placidyl)
900	Heroin
1000	Hydromorphone (dilaudid)
1100	Lorazepam (ativan)
1200	Meperidine (demerol)
1300	Methadone
1400	Morphine
1500	Oxazepam
1600	Paroxetine (paxil)
1700	Pentazocine (talwin)
1800	Sertraline (zoloft)
1900	Unknown
2000	Venlafaxine
2100	OxyContin
2200	Other
2300	Buprenorphine (subutex)
2400	Suboxone (buprenorphine + naloxone)

CENTRAL VENOUS CATHETERS (R069)

Central venous catheters.

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

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

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

CENTRAL VENOUS CATHETERS (R069) (con't)

710	Lower limb, percutaneous (PICC) (1 time)
720	Lower limb, percutaneous (PICC) (2 times)
730	Lower limb, percutaneous (PICC) (3 times)
740	Lower limb, percutaneous (PICC) (4 times)
750	Lower limb, percutaneous (PICC) (5 times)
760	Lower limb, percutaneous (PICC) (more than 5 times)
810	Lower limb, cut down (surgical) (1 time)
820	Lower limb, cut down (surgical) (2 times)
830	Lower limb, cut down (surgical) (3 times)
840	Lower limb, cut down (surgical) (4 times)
850	Lower limb, cut down (surgical) (5 times)
860	Lower limb, cut down (surgical) (more than 5 times)
910	Lower limb, Brioviac (1 time)
920	Lower limb, Brioviac (2 times)
930	Lower limb, Brioviac (3 times)
940	Lower limb, Brioviac (4 times)
950	Lower limb, Brioviac (5 times)
960	Lower limb, Brioviac (more than 5 times)
1010	Other (1 time)
1020	Other (2 times)
1030	Other (3 times)
1040	Other (4 times)
1050	Other (5 times)
1060	Other (more than 5 times)

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.

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

ARTERIAL CATHETERS
(R070)

310	Radial, percutaneous (PICC) (1 time)
320	Radial, percutaneous (PICC) (2 times)
330	Radial, percutaneous (PICC) (3 times)
340	Radial, percutaneous (PICC) (4 times)
350	Radial, percutaneous (PICC) (5 times)
360	Radial, percutaneous (PICC) (more than 5 times)
410	Radial, cut down (surgical) (1 time)
420	Radial, cut down (surgical) (2 times)
430	Radial, cut down (surgical) (3 times)
440	Radial, cut down (surgical) (4 times)
450	Radial, cut down (surgical) (5 times)
460	Radial, cut down (surgical) (more than 5 times)
510	Pedal, direct (1 time)
520	Pedal, direct (2 times)
530	Pedal, direct (3 times)
540	Pedal, direct (4 times)
550	Pedal, direct (5 times)
560	Pedal, direct (more than 5 times)
610	Pedal, percutaneous (PICC) (1 time)
620	Pedal, percutaneous (PICC) (2 times)
630	Pedal, percutaneous (PICC) (3 times)
640	Pedal, percutaneous (PICC) (4 times)
650	Pedal, percutaneous (PICC) (5 times)
660	Pedal, percutaneous (PICC) (more than 5 times)
710	Pedal, cut down (surgical) (1 time)
720	Pedal, cut down (surgical) (2 times)
730	Pedal, cut down (surgical) (3 times)
740	Pedal, cut down (surgical) (4 times)
750	Pedal, cut down (surgical) (5 times)
760	Pedal, cut down (surgical) (more than 5 times)
810	Femoral, direct (1 time)
820	Femoral, direct (2 times)
830	Femoral, direct (3 times)
840	Femoral, direct (4 times)
850	Femoral, direct (5 times)
860	Femoral, direct (more than 5 times)
910	Femoral, percutaneous (PICC) (1 time)
920	Femoral, percutaneous (PICC) (2 times)
930	Femoral, percutaneous (PICC) (3 times)
940	Femoral, percutaneous (PICC) (4 times)
950	Femoral, percutaneous (PICC) (5 times)
960	Femoral, percutaneous (PICC) (more than 5 times)

ARTERIAL CATHETERS (R070) (con't)

1010	Femoral, cut down (surgical) (1 time)
1020	Femoral, cut down (surgical) (2 times)
1030	Femoral, cut down (surgical) (3 times)
1040	Femoral, cut down (surgical) (4 times)
1050	Femoral, cut down (surgical) (5 times)
1060	Femoral, cut down (surgical) (more than 5 times)
1110	Other (1 time)
1120	Other (2 times)
1130	Other (3 times)
1140	Other (4 times)
1150	Other (5 times)
1160	Other (more than 5 times)

MODE OF VENTILATION (R071)

Mode of ventilation.

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

Code all documented.

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

COMPLICATIONS OF ENDOTRACHEAL INTUBATION (RO72)

Complications of endotracheal intubation.

Found on the '*DISCHARGE SUMMARY'*.

Code all documented.

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

COMPLICATIONS OF VASCULAR CATHETERS (R073)

Complications of vascular catheters.

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

Code all documented.

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

COMPLICATIONS OF NASO/ORO GASTRIC TUBES (R074)

Complications of Naso/Oro gastric tubes.

Found on the '*DISCHARGE SUMMARY'*.

Code all documented.

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

COMPLICATIONS OF MEDICATIONS (R075)

Complications of medications.

Found on the *'DISCHARGE SUMMARY'*.

Code all documented

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

COMPLICATIONS OF SURGERY (R076)

Complications of surgery.

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

Code all documented

100	Diaphragmatic paralysis
200	Vocal cord paralysis

COMPLICATIONS OF BURNS (R077)

Complications of the following types of burns.

Found on the '*DISCHARGE SUMMARY'*.

Code all documented

100	Chemical
200	Electrical
300	Thermal

PHOTOTHERAPY (RO78)

Phototherapy.

Found on the *'DISCHARGE SUMMARY'*.

100	Phototherapy

IMMUNIZATIONS (R079)

Immunizations.

Found on the '*DISCHARGE SUMMARY'*.

Code all documented

100	DPTP (diptheria,pertussis,tetanus,polio)
200	DPT (diptheria,pertussis,tetanus)
300	Hepatitis B globulin
400	Hepatitis B vaccine
500	Viral influenza
600	Hemophilus influenza B conjugate
700	RSV (respiratory syncytial virus) vaccine
800	Varicella (chicken pox) vaccine
1000	Prevnar
1100	Rota teq for Rota Virus
1200	Rotarix for Rota Virus

LAB RESULTS
(R080)
(Not coded at IWK)

(Refer to reference lab sheet for ranges)

Lab results.

Found on *'DISCHARGE SUMMARY'* OR *'LAB SHEETS'*.

Code all documented

100	Neutropenia <1,000 pmns(mature or bands per cu.mm) **Use following formula:** Multiply the total corrected WBC's by the % of pmns (polymorphoneutrophils) and bands. e.g. total WBC – 15,000 pmns = 5% Bands = 1%
200	ABO immunizations – definite
300	D Isoimmunization
400	Little c Isoimmunization
500	Big C Isoimmunization
600	Big E Isoimmunization
700	Kell Isoimmunization
800	Fya Isoimmunization (Duffy)
900	Kidd
1000	Wright
1100	MNS blood groups
1200	Positive DAT
1300	Misc. Isoimmunization – Little 'e'
1400	Misc. Isoimmunization – Little 's'
1500	Hyperbilirubinemia **(Total bilirubin > 15 mg% or > 258 microM/L; or unconjugated or indirect bilirubin ≥ 230 microM/L**)
1600	Anemia **(Hgb < 14 gm% or < 140g/L or Hct < 42% in the first week; Hgb < 10gm% or < 100g/L or Hct < 30% at any age.** **Code the cause based on the first low hemoglobin, unless clearly stated otherwise)**

LAB RESULTS
(R080) (con't)

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 phosphata se 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	Hypernatremia **(> 155 mEq/L or 155 mmol/L)**

LAB RESULTS
(R080) (con't)

3200	Azotemia **(BUN 20 mg% or more; 7.14 mmol/L or more urea value)**
3300	Hypercreatininemia **(2.0mg% or more; 177 micromol/L or more)**
3400	Oliguria **(< 15 ml/Kgm/day on day2 or < 20 ml/Kgm/day after 2 days)**
3500	Hypoproteinemia **(4.0 gm% or less; 40 gm/L or less)**
3600	Hypoalbuminemia **(≤ 2.4gm% 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)**

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INTRA-VENTRICULAR HEMORRHAGE (R081)

Intra-ventricular hemorrhage.

Found on the *'DISCHARGE SUMMARY'*.

100	Grade 1 (sub-ependymal, choroid Plexus hemorrhage)
200	Grade 2 (Hemorrhage into ventricle without dilatation of ventricle)
300	Grade III (Hemorrhage into ventricle with dilatation of ventricle)
400	Grade IV (Hemorrhage into brain: thalamic hemorrhage, cortical hemorrhage)

TRAUMA (R082)

Trauma.

Found on the '*DISCHARGE SUMMARY'*.

Code all documented

100	Fracture clavicle
200	Fracture femur
300	Fracture humerus
400	Fracture other
500	Fracture rib(s)
600	Fracture skull
700	Cephalohematoma left
800	Cephalohematoma right
900	Cephalohematoma bilateral
1000	Cephalohematoma other, including occipital
1100	Cephalohematoma unknown
1200	Shoulder dystocia

NON-SPECIFIC NEUROLOGICAL FINDINGS (R083)

Non–specific neurological findings.

Found on the *'DISCHARGE SUMMARY'*.

Code all documented

100	Abnormal cerebral irritation/hypertonicity
200	Hyperexplixia (Hereditary Startle Disease)
300	Abnormal cerebral depression/hypotonicity
400	Abnormal cerebral depression due to maternal analgesia
500	Cerebral edema
600	Cortical atrophy
700	Encephalomalacia
800	Gilles telencephalic leucoencephalopathy
900	Infarction
1000	Porencephalic cyst(s)
1100	Periventricular leukomalacia

OTHER SPECIFIC NEUROLOGICAL FINDINGS (R084)

Other neurological findings.

Found on the '*DISCHARGE SUMMARY'*.

Code all documented

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

APNEA (R085)

Apnea.

Found on the '*DISCHARGE SUMMARY' OR' NURSES NOTE'*

100	Apneic spells

RESUSCITATION AT DELIVERY (R086)

Resuscitation at delivery.

Found on the '*BIRTH RECORD'* or *'DISCHARGE SUMMARY'*

Code all documented

100	Oxygen
300	Chest compressions
400	Other medications
500	Narcan
600	Epinephrine

H1N1 (R087)

H1N1.

Found on *'DISCHARGE SUMMARY'*

100	Laboratory confirmed H1N1 influenza

PERIPHERAL IV (R088)

Peripheral IV.

Found on *'DISCHARGE SUMMARY'* or *'NURSES NOTES'*.

100	Peripheral IV Peripheral IV

TREATMENT FOR RETINOPATHY OF PREMATURITY (R089)

Treatment of retinopathy.

Found on the *'DISCHARGE SUMMARY'*

Code all documented

100	Cryotherapy
200	Laser surgery
300	Intra-ocular injection (Avastin)

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