Nova Scotia Atlee Perinatal Database Coding Manual 7th Edition

(REVISED)

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LISTING OF HOSPITALS

Hospitals appearing in bold are currently providing maternity services.

Aberdeen Hospital . . . . . 11 . . . New Glasgow
All Saints Hospital . . . . . 12 . . . Springhill
Annapolis Community Health Centre . . . . . 13 . . . Annapolis Royal

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Cape Breton Healthcare Complex:
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Northside (North Sydney Site) . . . . . 41 . . . North Sydney
Sydney Site . . . . . 73 . . . Sydney
CFB Cornwallis . . . . . 79 . . . Cornwallis
CFB Stadacona . . . . . 78 . . . Halifax
Chaleur Regional Hospital . . . . . -10 . . New Brunswick
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Dartmouth General Hospital . . . . . 65 . . . Dartmouth
Digby General Hospital . . . . . 20 . . . Digby

Eastern Memorial Hospital . . . . . 22 . . . Canso
Eastern Shore Memorial Hospital . . . . . 23 . . . Sheet Harbour

Fishermen's Memorial Hospital . . . . . 24 . . . Lunenburg

George Dumont Hospital . . . . . -11 . . New Brunswick
Glace Bay Health Care Corporation . . . . . (See Cape Breton Healthcare Complex)
Guysborough Memorial Hospital . . . . . 27 . . . Guysborough

Hants Community Hospital . . . . . 37 . . . Windsor
Health Services Assoc. of the South Shore . . . . . 14 . . . Bridgewater
Highland View Regional Hospital . . . . . 30 . . . Amherst
Home of the Guardian Angel . . . . . 88 . . . Halifax
(Use for discharged to only if Mom and Babe both go to the Home)

Inverness Consolidated Memorial Hospital. . . . . 34 . . . Inverness
IWK Grace Health Centre . . . . . 86 . . . Halifax

Lillian Fraser Memorial Hospital . . . . . 32 . . . Tatamagouche

MABLE . . . . . 90 . . . Mable Discharge
Moncton Hospital(The) . . . . . -12 . . New Brunswick
Musquodoboit Valley Memorial Hospital . . . . . 33 . . . Middle Musquodoboit

LISTING OF HOSPITALS

New Waterford Consolidated Hospital	63	New Waterford
North Cumberland Memorial Hospital	35	Pugwash
Northside Harbour View Hospital	**(See Cape Breton Healthcare Complex)**	
Nova Scotia Hospital	77	Dartmouth
Point Pleasant Lodge	64	Halifax
Prince County Hospital	-13	Prince Edward Island
Queen Elizabeth Hospital	-14	Prince Edward Island
Queen Elizabeth II Health Sciences Centre	85	Halifax
Queens General Hospital	38	Liverpool
Roseway Hospital	39	Shelburne
Sacred Heart Hospital	47	Cheticamp
Sackville Memorial Hospital	-15	New Brunswick
Soldiers Memorial Hospital	48	Middleton
South Cumberland Community Care Centre	49	Parrsboro
St. Anne's Hospital	40	Arichat
St. Martha's Regional Hospital	43	Antigonish
St. Mary's Memorial Hospital	45	Sherbrooke
Strait Richmond Hospital	68	Cleveland
Sutherland-Harris Memorial Hospital	50	Pictou
Twin Oaks Memorial Hospital	52	Musquodoboit Harbour
Valley Regional Hospital	67	Kentville
Victoria County Memorial Hospital	53	Baddeck
Western Kings Memorial Health Centre	55	Berwick
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ROUTINE INFORMATION - DELIVERED ADMISSIONS

DELIVERED ADMISSIONS:

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME . . . . . Mother's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

Found on the *'HOSPITAL ADMISSION FORM'*

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

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

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

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

*Record **Nova Scotia** Health Card Numbers only*.

Code using one of the following if HCN is unavailable:

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'

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

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

ANNAPOLIS COUNTY

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

ANTIGONISH COUNTY

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

CAPE BRETON COUNTY

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

COLCHESTER COUNTY

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

CUMBERLAND COUNTY

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

DIGBY COUNTY

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

MUNICIPAL CODE FOR MOTHER'S RESIDENCE

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

HALIFAX COUNTY

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

HANTS COUNTY

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

INVERNESS COUNTY

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

KINGS COUNTY

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

LUNENBURG COUNTY

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

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

MUNICIPAL CODE FOR MOTHER'S RESIDENCE

QUEENS COUNTY
43 . . . . . Liverpool
59 . . . . . Queens Municipality

RICHMOND COUNTY

60 . . . . . Richmond Municipality

SHELBURNE COUNTY

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

VICTORIA COUNTY

71 . . . . . Victoria Municipality

YARMOUTH COUNTY

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

OUT OF PROVINCE RESIDENTS

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using one of the following:

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

Code '7' for unknown.

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

Found on the '*HOSPITAL ADMISSION FORM'*.

Example: 4 King Street

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

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

Found on the '*HOSPITAL ADMISSION FORM'*.

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Code '999999' for unknown.

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

Found on the *'HOSPITAL ADMISSION FORM'*.

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

Found on the *'HOSPITAL ADMISSION FORM'*.

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Registration Number.

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

Code '99999' for unknown.

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

Found on the '*NURSES NOTES'*.

Use the following format: 'DDMMYYYY'.

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

Found on the '*NURSES NOTES'*.

Use the following format: 'HHMM'.

If Discharge Time is not documented enter 1200.

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

DISCHARGE DISPOSITION . . . . . (Not Applicable)

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

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

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

Code using one of the following:

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

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

3 . . . . Coding of admission information completed
The data can be viewed, but not changed. '4' actually indicates that data is ready to be transferred to the Data Mart

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

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

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

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

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

Code the following for the unusual situations:

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

-2 . . . Planned birth at home.

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

If patient comes from home, code '0'.

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

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

Use the following format: 'DDMMYYYY'.

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

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

Found on the '*PRENATAL RECORD*'.

Code using one of the following:

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

Code '9' unknown.

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

Code '9' for unknown.

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

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

Code '9' for unknown.

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

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

Code '0' if no previous C-sections.

Code '9' for unknown.

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

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

Code using one of the following:

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

Code '9' for unknown.

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

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

Code '9' for unknown.

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

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

Code '9' for unknown.

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

Found on the '*PRENATAL RECORD*'.

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

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

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

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

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

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

Found on the '*PRENATAL RECORD*'.

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

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

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

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

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

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

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

Code using one of the following:

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

Code '9' for unknown.

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

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

Code using one of the following:

Y . . . . . Yes
N . . . . . No
U . . . . . Unsure

Code '9' for unknown.

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

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

Code using one of the following:

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

Code '9' for unknown.

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

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

Code using one of the following:

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

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

Code '9' for unknown.

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

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

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

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

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

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

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

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

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

Code '999' for unknown.

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

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

Code using one of the following:

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

Code '999' for unknown.

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

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

Code using one of the following:

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

Code '9' for unknown.

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

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

Code using one of the following:

1 . . . . . Pregnancy in labour
2 . . . . . Elective C-section
3 . . . . . Fetal growth assessment
4 . . . . . Post dates
5 . . . . . Multiple pregnancy

8 . . . . . Hypertensive disease of pregnancy
9 . . . . . Diabetes
10 . . . . . Iso-immunization
11 . . . . . Possible fetal distress (includes induction for low Planning Score)

12 . . . . . Spontaneous rupture of membranes
13 . . . . . Intrauterine death
14 . . . . . Antepartum hemorrhage
15 . . . . . Pyelonephritis
16 . . . . . Premature labour

17 . . . . . Eclampsia
18 . . . . . Hydramnios or polyhydramnios
19 . . . . . Hyperemesis, nausea or vomiting of pregnancy

REASON FOR MOTHER'S ADMISSION CON'T

20 . . . . . Respiratory infection
21 . . . . . Asthma
22 . . . . . Low back pain
23 . . . . . Abdominal pain
24 . . . . . Anemia
25 . . . . . Thrombo-embolic disease
26 . . . . . Cholecystitis
27 . . . . . Pancreatitis
28 . . . . . Renal colic
29 . . . . . Suspected fetal anomaly
30 . . . . . Excessive weight gain and/or edema
31 . . . . . Liver disease, e.g. hepatitis
32 . . . . . Proteinuria
33 . . . . . Postpartum admission
34 . . . . . Incompetent cervix
35 . . . . . Colitis, e.g. Crohn's disease
36 . . . . . Elective induction
37 . . . . . Mom accompanying sick baby, e.g. breastfeeding
38 . . . . . Oligohydramnios
40 . . . . . Other

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

ATTENDANCE AT PRENATAL CLASSES . . . . . Maternal attendance at any prenatal classes.

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

Code using one of the following:

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

Code for current pregnancy only.

Code '9' for unknown.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Code '999' for unknown value.

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

Code using one of the following:

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

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

3 . . . . Coding of delivered information completed.

4 . . . . Frozen.
The data can be viewed, but not changed. Indicates data are ready to be transferred to DataMart.

5 . . . . Frozen.
The data can be viewed, but not changed. Indicates data have been transferred to DataMart.

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

ROUTINE INFORMATION - LABOUR AND INFANT

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

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

Use one of the following codes:

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

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME . . . . . Infant's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Use one of the following codes:

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

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

Found on the '*BIRTH RECORD*'.

Use the following format: 'DDMMYYYY'.

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

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

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

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

Found on the '*BIRTH RECORD*'.

Use the following format: 'HHMM'.

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

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

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

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

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

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

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

Found on the '*BIRTH RECORD*'.

Code using one of the following:

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

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

Code '9' for unknown.

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

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

Code using one of the following:

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

Code '9' for unknown.

LABOUR . . . . . Initiation of labour.

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

Code using one of the following:

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

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

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

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

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

Code using one of the following:

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

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

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

Use the following format: 'DDMMYYYY'.

In the case of an in-patient induction with oxytocin or prostaglandin, record the date that the drug was initiated.
In the case of an out-patient induction with prostaglandin, record the date of admission to the LDR in apparent labour and delivered before discharged from the unit.

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

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

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

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

In the case of an in-patient induction with oxytocin record the time the drug was initiated.
In the case of an inpatient induction with prostaglandin, record the time of the last administration which initiated labour.
In the case of an out-patient induction with prostaglandin, record the time of admission to the LDR in apparent labour and delivered before discharged from the unit.

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

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

Found on the 'PARTOGRAM'.

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

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

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

Code '99' for unknown.

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

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

Code using one of the following:

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

Code '9' for unknown.

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

Found on the '*PARTOGRAM*'.

Use the following format: 'DDMMYYYY'

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

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

Found on the '*PARTOGRAM*'.

Use the following format: 'HHMM'

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

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

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

CERVICAL DILATATION TIME OF MEDICAL AUGMENTATION . . . . . Cervical dilatation at time of augmentation.

Found on the '*PARTOGRAM*'.

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

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

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

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

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

Code '99' for unknown.

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

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

Use the following format: 'DDMMYYYY'.

Code when first indicated by physician or nurse.

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

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

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

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

Use the following format: 'HHMM'.

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

Code when first indicated by physician or nurse.

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

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

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

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

Found on the '*BIRTH RECORD'*.

Use the following format: 'DDMMYYYY'.

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

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

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

Found on the '*BIRTH RECORD'*.

Use the following format: 'HHMM'

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

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

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

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

Found on the '*BIRTH RECORD*'.

Use the following format: 'DDMMYYYY'

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

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

Found on the '*BIRTH RECORD*'.

Use the following format: 'HHMM'

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

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

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

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

Code using one of the following:

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

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

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

Code using one of the following:

ABR . . . . . Assisted breech
ACH . . . . . Forceps to after-coming head (***Breech - vaginal delivery only***)
BRE . . . . . Breech extraction ***(Vaginal delivery only)***

CSF . . . . . C-section with forceps
CSN . . . . . C-section
FAF . . . . . Failed forceps or failed trial of forceps followed by C-section
FCF . . . . . Failed forceps followed by C-section with forceps

HIF . . . . . High forceps
LMF . . . . . Low-mid forceps
LOF . . . . . Low or outlet forceps
MIF . . . . . Mid-forceps

PVE . . . . . Podalic version and extraction ***(Do not use for C-section)***

SPT . . . . . Spontaneous vaginal

VAC . . . . . Vacuum followed by C-section
VAF . . . . . Vacuum followed by forceps
VEX . . . . . Vacuum extraction, malstrum extraction
VFC . . . . . Vacuum followed by forceps and then C-section

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

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

Code using one of the following:

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

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

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

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

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

Code '9' for unknown.

CERVICAL DILATATION 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 centimetres.

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

Code '99' for unknown.

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

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

Code using one of the following:

BCH . . . . . Breech, other or unspecified
BOW . . . . . Brow
CPD . . . . . Compound presentation
FAC . . . . . Face
FRB . . . . . Frank breech
FTB . . . . . Footling breech
POP . . . . . Occiput posterior (OP)
SHL . . . . . Shoulder presentation
TLI . . . . . Transverse lie
VTX . . . . . Vertex (includes LOA, ROA, OT)

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

Code '999' for unknown.

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

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

Code using one of the following:

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

EPISIOTOMY . . . . . Episiotomy.

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

Code using one of the following:

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

Code '9' for unknown.

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

Found on the '*BIRTH RECORD*'.

Code using one of the following:

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

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

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

First weight noted after birth

If birth weight is ≤ 40 gms., code '40'.

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

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

For Siamese twins, split weight between babies.

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

***DO NOT** take from Pathology Report.*

Code '9999' for unknown.

APGAR SCORE 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.

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

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.

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

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

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

Code using the Provincial Medical Board Registration Number.

88888 = Not registered in Nova Scotia

Code '99999' for unknown.

PRIMARY INDICATION FOR C-SECTION . . . . . Primary Indication for C-Section.

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

Code using one of the following:

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

Code '999' for unknown.

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

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

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

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

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

2. Position is breech, and primary indication for C- section is
Breech . . . . . (BCH)

3. Primary indication for C-section is:
Malpresentation . . . . . (MLP) or
Fetal growth restriction (retardation) . . . . (FGT)

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

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

Found on the '*ANESTHESIA RECORD*'.

Code using one of the following:

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

Code '9' for unknown.

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

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

Code using one of the following:

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

Code '9' for unknown.

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

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

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

If patient is discharged home, code 0.

Code '-9 ' for *Maternal Death*

MATERNAL ULTRASOUND . . . . . Maternal Ultrasound.

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

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

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

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

For singleton pregnancies, the number will always be 1.

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

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

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'DDMMYYYY'.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

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

Code using one of the following:

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

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

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

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

*Record **Nova Scotia** Health Card Numbers only*.

Code using one of the following if HCN unavailable:

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Registration Number.

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

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

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

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

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

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

Code '99' for unknown.

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

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

Code using one of the following:

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

Code '9' for unknown.

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

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

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

Code using one of the following:

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

Code '9' for unknown.

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

Found on the '*LAB REPORTS'*.

Use the following format: 'X.XX'

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

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

Allowed range is: 6.4 to 7.8

Code '99' for unknown.

PCO2 VALUE . . . . . PCO2 value.

Found on the 'LAB REPORTS'.

Enter value as recorded on lab reports
Use the following format: 'XXX.X'

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

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

Allowed range is: 0 to 130.

Code '999' for unknown

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

Found on the '*LAB REPORTS'*.

Use the following format:

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

Allowed range is: 10 to -30.

Code ' 99' for unknown.

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

Found in the '*PROGRESS NOTES'*.

Code using one of the following:

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

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

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

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

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

Code using one of the following:

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

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

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

Code using one of the following:

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

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

Code '9' for unknown.

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

Found in the '*NURSES' NOTES'*.

Use the following format: 'DDMMYYYY'

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

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

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

Found in the '*NURSES' NOTES'*.

Use the following format: 'HHMM'

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

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

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

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

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

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

If patient is discharged home, code '0'

Code '-9 ' for *Infant Death*

AUTOPSY . . . . . Completion of infant autopsy.

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

Code using one of the following:

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

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

Leave blank if infant lived.

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

Use one of the following codes:

ABRP . . . . . Abruptio placenta
ANEC . . . . . Acute necrotizing enterocolitis
OAIR . . . . . Airway failure
AMNO . . . . . Amniocentesis
ANAL . . . . . Analgesia or anaesthesia
CPDP . . . . . Chronic pulmonary disease
COTR . . . . . Complications of treatment
ANOM . . . . . Congenital anomaly
CRLK . . . . . Cord loops and/or knots
CORP . . . . . Cord prolapse
CDOT . . . . . Cord, miscellaneous
DBRN . . . . . Degenerative brain disease
DUCT . . . . . Ductus syndrome of prematurity
EXTX . . . . . Exchange transfusion

FETH . . . . . Fetal hemorrhage

FMAL . . . . . Fetal malnutrition
HMDD . . . . . Hyaline membrane disease
HYDR . . . . . Idiopathic hydrops

IBOM . . . . . Inborn errors of metabolism
INFT . . . . . Infection
ISOM . . . . . Isoimmunization
IVTF . . . . . Intravascular transfusion

KERN . . . . . Kernicterus
MALP . . . . . Malpresentation

DIAB . . . . . Maternal diabetes
SHOC . . . . . Maternal shock
MUSF . . . . . Multi-system failure

MINF . . . . . Myocardial infarction
NEOP . . . . . Neoplasia
TTTX . . . . . Parabiotic syndrome
PPFC . . . . . Persistent fetal circulation
PLPV . . . . . Placenta previa

INFANT'S PRIMARY CAUSE OF DEATH CON'T

AIRL . . . . . Pneumothorax, pneumomediastinum and/or pneumopericardium
PIVH . . . . . Primary intraventricular hemorrhage
PULH . . . . . Primary pulmonary hemorrhage
RUPU . . . . . Ruptured uterus

THAB . . . . . Therapeutic abortions
TOXM . . . . . Toxemia
TRAS . . . . . Tracheal stenosis
TRAU . . . . . Trauma (Obstretrical)
UXPA . . . . . Unexplained peripartum asphyxia
UNEX . . . . . Unexplained
VOLV . . . . . Acquired volvulus

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

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

Use the following format: 'DDMMYYYY'

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

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

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

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

Use the following format: 'HHMM'

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

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

ROUTINE INFORMATION -UNDELIVERED ADMISSIONS

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME . . . . . Mother's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

Found on the *'HOSPITAL ADMISSION FORM'*

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

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

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

*Record **Nova Scotia** Health Card Numbers only*.

Code using one of the following if HCN unavailable:

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using one of the following:

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

Code '7' for unknown.

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

Found on the '*HOSPITAL ADMISSION FORM'* .

Example: 4 King Street

MAIL ADDRESS . . . . . Mother's mail address.
This field can be left blank if mail address is not documented or the same as street address.

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Code '999999' for unknown.

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

Found on the *'HOSPITAL ADMISSION FORM'*.

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

Found on the *'HOSPITAL ADMISSION FORM'*.

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Registration Number.

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

Code '99999' for unknown.

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

Found on the '*NURSES NOTES'*.

Use the following format: 'DDMMYYYY'.

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

Found on the '*NURSES NOTES'*

Use the following format: 'HHMM'

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

If Discharge Time is not documented enter 1200.

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

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

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

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

Code using one of the following:

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

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

3 . . . . Coding of admission information completed

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

If patient comes from home, code '0'.

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

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

Use the following format: 'DDMMYYYY'.

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

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

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

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

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

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

If patient is discharged home, code 0.

Code '-9 ' for *Maternal Death.*

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

Code using one of the following:

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

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

3 . . . . Coding of undelivered routine information completed

4 . . . . Frozen
The data can be viewed, but not changed. Indicates data are ready to be transferred to DataMart.

5 . . . . Frozen
The data can be viewed, but not changed. Indicates data have been transferred to DataMart.

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

“LEFT BLANK INTENTIONALLY”

ROUTINE INFORMATION -POSTPARTUM ADMISSIONS

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

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

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME . . . . . Mother's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

Found on the *'HOSPITAL ADMISSION FORM'*.

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

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

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

*Record **Nova Scotia** Health Card Numbers only*.

Code using one of the following if HCN unavailable:

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using one of the following:

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

Code '7' for unknown.

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

Found on the '*HOSPITAL ADMISSION FORM'*

Example: 4 King Street

MAIL ADDRESS . . . . . Mother's mail address.
This field can be left blank if mail address is not documented or is the same as street address.

Found on the '*HOSPITAL ADMISSION FORM'*

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Code '999999' for unknown.

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

Found on the *'HOSPITAL ADMISSION FORM'.*

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

Found on the *'HOSPITAL ADMISSION FORM'*

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Registration Number.

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

Code '99999' for unknown.

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

Found on the '*NURSES NOTES'*

Use the following format: 'DDMMYYYY'.

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

Found on the '*NURSES NOTES'*

Use the following format: 'HHMM'.

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

If Discharge Time is not documented enter 1200.

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

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

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

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

Code using one of the following:

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

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

3 . . . . Coding of admission information completed

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

If patient comes from home, code '0'.

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

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

Use the following format: 'DDMMYYYY'

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

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

Code using the following reason for admission:

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

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

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

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

If patient is discharged home, code 0.

Code '-9 ' for *Maternal Death.*

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

Code using one of the following:

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

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

3 . . . . Coding of postpartum routine information completed

4 . . . . Frozen
The data can be viewed, but not changed. Indicates data are ready to be transferred to DataMart.

5 . . . . Frozen
The data can be viewed, but not changed. Indicates data have been transferred to DataMart.

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

ROUTINE INFORMATION-NEONATAL ADMISSIONS

NEONATAL ADMISSIONS:

1) Any infant with a birth weight of 500 grams or more, or a gestational age at birth of 20 or more completed weeks admitted or re-admitted to hospital up to 27 days, 23 hours, 59 minutes after birth.

2) Any infant transferred between hospitals, who had not been discharged home from hospital.

3) Any admission to the Special Care Nursery.

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'.

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME . . . . . Infant's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

*Record **Nova Scotia** Health Card Numbers only*.

Code using one of the following if HCN unavailable:

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Found on the '*HOSPITAL ADMISSION FORM'*

Example: 4 King Street

MAIL ADDRESS . . . . . Infant's mail address.
This field can be left blank if mail address is not documented or the same as street address

Found on the '*HOSPITAL ADMISSION FORM '*

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Code '999999' for unknown.

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

Found on the *'HOSPITAL ADMISSION FORM'*

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

Found on the *'HOSPITAL ADMISSION FORM'*

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Registration Number.

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

Code '99999' for unknown.

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

Found on the '*NURSES NOTES'*

Use the following format: 'DDMMYYYY'.

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

Found on the '*NURSES NOTES'*

Use the following format: 'HHMM'.

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

If Discharge Time is not documented enter 1200.

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

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

Found on the 'Birth Record'

Code using one of the following

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

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

Code using one of the following:

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

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

3 . . . . Coding of admission information completed

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

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

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

Use one of the following codes:

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

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

Found on the 'HOSPITAL ADMISSION FORM'

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

If patient comes from home, code '0'

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

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

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

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

Found in the *'PROGRESS NOTES'*.

Code using one of the following:

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

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

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

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

Code using one of the following:

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

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

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

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

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

If patient is discharged home, code '0'

Code '-9 ' for *Infant Death*

AUTOPSY . . . . . Completion of infant autopsy.

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

Code using one of the following:

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

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

Leave blank if the infant lived.

SEE LISTING ON PAGES 58-59.

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

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

Use the following format: 'DDMMYYYY'

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

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

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

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

Use the following format: 'HHMM'

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

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

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

Code using one of the following:

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

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

3 . . . . Coding of neonatal routine information completed.

4 . . . . Frozen
The data can be viewed, but not changed. Indicates data are ready to be transferred to DataMart.

5 . . . . Frozen
The data can be viewed, but not changed. Indicates data have been transferred to DataMart.

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

“LEFT BLANK INTENTIONALLY”

ROUTINE INFORMATION-ANOMALY ADMISSIONS

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

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'.

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME . . . . . Patient's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

Found on the *'HOSPITAL ADMISSION FORM'*

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

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

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

*Record **Nova Scotia** Health Card Numbers only*.

Code using one of the following if HCN unavailable:

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using one of the following:

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

Code '7' for unknown.

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

Found on the '*HOSPITAL ADMISSION FORM'*

Example: 4 King Street

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

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

Found on the '*HOSPITAL ADMISSION FORM'*

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Code '999999' for unknown.

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

Found on the *'HOSPITAL ADMISSION FORM'*

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

Found on the *'HOSPITAL ADMISSION FORM'*

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Registration Number.

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

Code '99999' for unknown.

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

Found on the '*NURSES NOTES'*

Use the following format: 'DDMMYYYY'.

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

Found on the '*NURSES NOTES'*.

Use the following format: 'HHMM'.

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

If Discharge Time is not documented enter 1200.

DISCHARGE DISPOSITION . . . . . (Not Applicable)

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

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

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

Code using one of the following:

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

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

3 . . . . Coding of admission information completed.

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

If patient comes from home, code '0'.

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

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

Use the following format: 'DDMMYYYY'

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

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

Found on the '*PRENATAL RECORD*'.

Code using one of the following:

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

Code '9' unknown.

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

Code '9' for unknown.

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

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

Code '9' for unknown.

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

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

Code '0' if no previous C-sections.

Code '9' for unknown.

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

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

Code using one of the following:

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

Code '9' for unknown.

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

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

Code '9' for unknown.

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

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

Code '9' for unknown.

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

Found on the '*PRENATAL RECORD*'.

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

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

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

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

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

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

Found on the '*PRENATAL RECORD*'.

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

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

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

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

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

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

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

Code using one of the following:

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

Code '9' for unknown.

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

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

Code using one of the following:

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

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

Code '9' for unknown.

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

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

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

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

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

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

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

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

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

Code '999' for unknown.

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

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

Code using one of the following:

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

Code '999' for unknown.

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

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

Code using one of the following:

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

Code '9' for unknown.

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

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

Code using one of the following:

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

Code for current pregnancy only.

Code '9' for unknown.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Code '999' for unknown value.

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

Code using one of the following:

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

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

3 . . . . Coding of anomaly routine information completed

4 . . . . Frozen
The data can be viewed, but not changed. Indicates data are ready to be transferred to DataMart.

5 . . . . Frozen
The data can be viewed, but not changed. Indicates data have been transferred to DataMart.

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

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

Use one of the following codes:

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

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

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

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

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

Found on the '*BIRTH RECORD*'.

Use the following format: 'DDMMYYYY'

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

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

Found on the '*BIRTH RECORD*'.

Use the following format: 'HHMM'

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

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

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

Found on the '*BIRTH RECORD*'.

Code using one of the following:

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

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

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

If birth weight is ≤ 40 gms., code '40'.

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

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

For Siamese twins, split weight between babies.

Do NOT take from Pathology Report.

Code '9999' for unknown.

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

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

Code using the Provincial Medical Board Registration Number.

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

Code '99999' for unknown.

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

Code using one of the following:

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

Code '9' for unknown.

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

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

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

If patient is discharged home, code 0.

Code '-9 ' for *Maternal Death*

MATERNAL ULTRASOUND . . . . . Maternal Ultrasound.

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

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

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

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

Found on the '*ULTRASOUND REPORT*'.

Use the following format: 'DDMMYYYY'.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

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

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

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

Code '99' for unknown.

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

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

Code using one of the following:

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

AUTOPSY . . . . . Completion of infant autopsy.

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

Code using one of the following:

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

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

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

Code using one of the following:

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

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

3 . . . . Coding of anomaly routine information completed

4 . . . . Frozen
The data can be viewed, but not changed. Indicates data are ready to be transferred to DataMart.

5 . . . . Frozen
The data can be viewed, but not changed. Indicates data have been transferred to DataMart.

DISEASES AND PROCEDURES

I. PREVIOUS PREGNANCY MATERNAL DISEASES

0010 PHIL . . . . . Previous History of Personal Malignancy
(Do not include Ca in-situ of cervix)
000 = Previous history of personal malignancy

0040 PANT . . . . Previously Sensitized Pregnancy
(This code requires Code 0470 to be coded as well.
Should be well documented, indicating that the antibodies now present are due to a previous pregnancy or abortion, e.g. not to include those due to a blood transfusion.)
000 = Previously sensitized pregnancy

0050 PHIP . . . . . Hypertensive Disease In Previous Pregnancy
(High blood pressure, toxemia, pre-eclampsia or hypertension, as stated in chart.)
000 = Hypertensive disease in previous pregnancy

0060 PECL . . . . . Previous Eclampsia
(Convulsions or eclampsia as stated on chart, excluding epilepsy.)
000 = Previous eclampsia

0100 PECP . . . . . Previous Ectopic Pregnancy
(Do not include blighted ovum.)
000 = Previous ectopic pregnancy

0110 PMOL . . . . Previous Molar Pregnancy
(Do not include Blighted ovum. Do include Trophoblastic disease, hydatidiform mole, invasive mole, and choriocarcinoma, even if successfully treated in a previous pregnancy)
000 = Previous molar pregnancy

0120 PLOH . . . . Previous Anemia
000 = Previous anemia

0130 PABP . . . . Previous Abruptio Placenta
000 = Previous abruptio placenta

0140 PRBR . . . . Previous Breech
000 = Previous breech

0150 PTEB . . . . . Previous Thromboembolic Disease
(Code any previous Thrombophlebitis, deep vein thrombosis, pulmonary embolus wheher occurred during a pregnancy or not. Do not code if documented as superficial phlebitis.)
000 = Previous thromboembolic disease

0160 PGLD . . . . Previous Gestational Diabetes
000 = Previous gestational diabetes

0170 PFER . . . . . Previous History of Infertility
(As clearly indicated on the chart, eg. use of Clomid, or other fertility drugs. Do not code if secondary to tubal ligation.)
000 = Previous history of infertility

0180 PPPD . . . . . Previous Postpartum Depression
000 = Previous postpartum depression

II. PRESENT PREGNANCY MATERNAL DIAGNOSES

A. **OBSTETRICAL** ***CODE ONLY IF PRESENT DURING ADMISSION. NOTE: ALL CODES, UNLESS OTHERWISE SPECIFIED, APPLY TO DELIVERED AND UNDELIVERED PATIENTS***

0190 ABRT . . . . Abortions
CODE ONLY IF OCCURS DURING ADMISSION.
THR = Threatened abortion
(Uterine bleeding < 20 weeks gestation)

GUIDELINES FOR PREGNANCY-INDUCED HYPERTENSION

MILD PREGNANCY-INDUCED HYPERTENSION

1. If P.I.H. is stated by the physician, it should always be coded (regardless of the values of the diastolic and systolic blood pressures).

2. If a patient is admitted from a physician's office with P.I.H., but it resolves on admission, code mild P.I.H. (NSV).

3. P.I.H. is to be coded if it occurs in the antepartum, intrapartum or postpartum period.

4. If Transient P.I.H. is stated as the diagnosis, code as mild (NSV).

5. If hypertension is *not* mentioned by the physician, do *not* code P.I.H. for an occasional elevation of the diastolic value > 90. The diastolic should be consistently elevated > 90 in a 24 hour period with at least 2 or more BP readings having been done.

SEVERE PREGNANCY-INDUCED HYPERTENSION

1 Code severe P.I.H. if:
- the physician stated severe **OR**
- the diastolic BP is ≥ 110 on at least 2 occasions within a 6 hour period.

2. Code severe P.I.H. if the patient has any degree of hypertension plus any one of a,b,c,d:
   a) Magnesium sulfate is administered for hypertension
   b) the patient has +2 or more protein (*provided there is no renal disease)*
   c) the patient has coagulation problems *(decreased platelets, e.g.<100,000)*
   d) the patient has liver involvement (*elevated liver enzymes, as per hospital lab values)*
   (Do not code Severe based on elevated Alk Phosphatase)
3. If the patient has P.I.H. with an occasional episode of BP 110 diastolic, but there is no real concern, code as mild (NSV)

H.E.L.L.P. SYNDROME

H.E.L.L.P. Syndrome should be clearly stated in the chart.

H.E.L.L.P. Syndrome and Severe P.I.H. are the most important to be captured as accurately and consistently as possible.

PREGNANCY-INDUCED HYPERTENSION SUPERIMPOSED ON CHRONIC HYPERTENSION

For P.I.H. superimposed on Chronic Hypertension, rely on the physician's diagnosis and code both PIHT and CHTD. Use the same guidelines for deciding on mild or severe P.I.H.

0200 CHTD . . . . Chronic Hypertensive Disease
CODE ONLY IF PRESENT DURING ADMISSION.
(History of hypertensive disease when not pregnant prior to current pregnancy or prior to 20 weeks of current pregnancy; not due to trophoblastic disease--or as stated.)
000 = Chronic hypertensive disease

0210 PIHT . . . . . Pregnancy-Induced Hypertension
CODE ONLY IF PRESENT DURING ADMISSION.
(See guidelines on page 3. Include pre-eclampsia, toxemia and HELLP syndrome, or as stated by physician.)
HLP = HELLP syndrome
(Hemolysis, Elevated Liver Enzymes, Low Platelets. Do not need to code thrombocytopenia here.)
NSV = Not severe
SEV = Severe

0220 ECLP . . . . . Eclampsia
CODE ONLY IF PRESENT DURING ADMISSION.
(One or more convulsions not attributable to other cerebral conditions such as epilepsy or cerebral hemorrhage in a patient with hypertension or as stated on chart by physician.)
000 = Eclampsia

0230 HEMS . . . . Hyperemesis Gravidarum
CODE ONLY IF PRESENT DURING ADMISSION.
(Vomiting which required admission to hospital.)
N.B. Do not include patients with vomiting due to other reasons.
000 = Hyperemesis gravidarum

0240 OLIG . . . . . Oligohydramnios
CODE ONLY IF PRESENT DURING ADMISSION.
(As stated in the chart.)
000 = Oligohydramnios

0250 POLY . . . . Polyhydramnios
CODE ONLY IF PRESENT DURING ADMISSION.
(As stated in the chart or if more than 2000 cc's.)
000 = No treatment
AMN = Amniocentesis
IMT = Indomethacin

0260 PLPR . . . . . Placenta Previa

CODE ONLY IF PRESENT DURING DELIVERED ADMISSION.

(Confirmed by double set-up or at time of C-section. Diagnosis not to be made on ultrasound alone.)

000 = Placenta previa

0270 ABPL . . . . Abruptio Placenta

CODE ONLY IF PRESENT DURING DELIVERED ADMISSION.

(Concealed or revealed placental abruption, not marginal separation, as stated at delivery -- diagnosis not to be made on ultrasound alone.)

000 = Abruptio placenta

0280 OTAH . . . . Other Antepartum Hemorrhage Per Vagina **(≥20 weeks gestation)**

CODE ONLY IF PRESENT DURING ADMISSION.

(Any unspecified hemorrhage occurring before the onset of labour, ≥ 20 weeks gestation. Include a suspected previa or abruptio in an undelivered patient. Include a patient who presents with bleeding which has resolved on admission.)

000 = Other antepartum hemorrhage per vagina

0290 PRUP . . . . Premature R.O.M.

CODE ONLY IF PRESENT DURING ADMISSION.

(1. Spontaneous rupture of membranes before onset of contractions, regardless of gestation.

2. Always code if stated by physician.

3. Do NOT code if there is any uterine activity when membranes rupture, even if only irregular contractions or tightenings.

The patient's membranes may rupture prematurely and then seal over. If there is clear documentation that there has been a previous ROM, before the onset of labour, code 0290.

000 = Premature R.O.M.

0300 FGAS . . . . Fetal Growth Concerns

CODE ONLY IF PRESENT DURING ADMISSION.

000 = Suspected or known IUGR or fetal malnutrition
(As stated in chart or if stated as known IUGR)

C01 = Suspected or known excessive fetal growth
(As stated in chart, e.g. due to maternal diabetes)

0310 POST . . . . . Post Dates (greater than 40 weeks)

CODE ONLY IF PRESENT DURING UNDELIVERED ADMISSION.

000 = Post dates

0320 PREM . . . . Premature Labour

CODE ONLY IF PRESENT DURING UNDELIVERED ADMISSION.

(Admitted for suspected preterm labour. Onset of labour at 36 6/7 weeks gestation or less. Include patients who are suspected to be in premature labour, even if diagnosis is ruled out later.)

000 = Premature labour

0330 ELSE . . . . . Other Obstetrical Disease, Not Elsewhere Classifiable

CODE ONLY IF PRESENT DURING ADMISSION.

C00 = Uterine scar defect or dehiscence

(As stated in operative report. Is usually not a serious situation and often is noted at the time of cesarean section as an unexpected finding in a woman who has had a previous cesarean section. May be described as marked "thinning" of the scar, or slight "separation" of the scar. If the wall has completely ruptured, see code C01.)

C01 = Spontaneous ruptured uterus

(As stated in operative report. A significant and serious event necessitating emergency surgery and can occur whether or not the woman has had a previous cesarean section. This is distinct from uterine scar dehiscence, see code C00.)

C02 = Herpes gestationalis

C03 = Pruritic urticarial papules and plaques of pregnancy

C04 = Impetigo herpetiformis

(Severe disease characterized by groups of pustules, affecting pregnant women.)

C05 = Dermatitis herpetiformis

C06 = Separation of symphysis pubis

(Includes symphysitis. Code only if requiring admission and code only for that admission.)

0340 FLAB . . . . False Labour (*Suspected Labour)*

CODE ONLY IF PRESENT DURING UNDELIVERED ADMISSION.

(37 weeks gestation and over)

000 = False labour

0350 MULG . . . . Multiple Gestation

CODE ONLY IF PRESENT DURING UNDELIVERED ADMISSION.

000 = Multiple gestation

0360 SUFA . . . . Suspected Fetal Anomaly

CODE ONLY IF PRESENT DURING UNDELIVERED ADMISSION.

000 = Suspected fetal anomaly

B. **NON-OBSTETRICAL**
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY

0370 GIDS . . . . . Gastro-Intestinal Disease
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
CLL = Cholelithiasis
(Do not code biliary colic)
COL = Ulcerative colitis/proctitis
CRO = Crohn's disease
IBS = Irritable Bowel Syndrome
PCR = Pancreatitis, Acute and Chronic
RFG = Reflux Gastritis
ULC = Ulcers
(All types)

0380 DRUG . . . . Maternal Drug Use During Present Pregnancy and/or Environmental Exposure
CODE IF OCCURRED DURING CURRENT PREGNANCY
C01 = Lithium
C02 = Maternal Exposure to noxious fumes (environmental)
C03 = Anti-hypertensives
C04 = Anti-depressives
C05 = Anti-epileptics
C06 = Anti-coagulation therapy
C07 = Chronic narcotic use

0390 ABUS . . . . Chemical Abuse
CODE IF OCCURRED DURING CURRENT PREGNANCY
(Includes alcohol, prescription medication and narcotic abuse. N.B. Code for hash, marijuana, cocaine, etc. if used anytime during pregnancy.)
C01 = Alcohol abuse
(Alcoholic or binge - NOT social)
C02 = Chronic narcotic abuse and/or street drug abuse
(e.g. morphine, cocaine, Demerol, heroin, hash, marijuana)
C03 = Unspecific abuse
C04 = Prescription medication abuse
(e.g. laxatives, sedatives such as Valium, Ativan, etc., over-the-counter drugs, "OTC's" such as Gravol)

0400 PSIL . . . . . Psychiatric Illness

CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY

ANX = Anxiety disorders
(e.g. obsessive-compulsive disorders, agoraphobia, generalized anxiety disorders, panic disorders)
DEP = Depression
EAT = Eating disorders
(e.g. anorexia nervosa, bulimia nervosa)
MDP = Manic-Depression
SCH = Schizophrenia
OTH = Other

0410 NRIL . . . . . Neurologic Illness ***CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY***

BEP = Bell's palsy
CBP = Cerebral palsy
ESY = Epilepsy
ICH = Intracerebral hemorrhage
MUD = Muscular dystrophy
MYG = Myasthenia gravis
MUS = Multiple sclerosis
ROD = Presence of Harrington Rod
SAH = Subarachnoid hemorrhage
SEZ = Seizure
(Antepartum, intrapartum, postpartum, NOT ECLAMPSIA).
TOS = Thoracic outlet syndrome
TUS = Tuberous sclerosis
OTH = Other
(Pseudotumour cerebri)

0420 HRTD . . . . Heart Disease

CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Include rheumatic heart disease and congenital heart disease, as stated.)

ARR = Arrhythmias
(S.V.T., P.A.T)
CHD = Congenital heart disease
(Not repaired)
CRT = Cardiac arrest
CTR = Coronary artery disease
(Ischemic heart disease)
EDC = Endocarditis
HHR = History of heart disease or surgery
(Congenital heart disease - repaired)
MCF = Myocardial infarction
MIT = Prolapsed mitral valve
MYO = Cardiomyopathy
MYS = Myocarditis
PLH = Pulmonary hypertension
RHD = Rheumatic heart disease
VLV = Valve prosthesis
(Takes precedence over other heart disease)
WPW = Wolff Parkinson's White Syndrome
OTH = Other acquired cardiac diseases

0430 GASI . . . . . Gastroenteritis

CODE IF PRESENT DURING ADMISSION

CND = Gastroenteritis, cause not determined
FDP = Food poisoning, unspecified
IFC = Infectious gastroenteritis
SAL = Salmonella gastroenteritis
VIR = Viral gastroenteritis

0440 THED . . . . Thromboembolic Disease - Antepartum

CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Exclude varicose veins; include thrombosis, deep vein thrombosis, pelvic thrombophlebitis, pulmonary embolism, prophylactic anticoagulation treatment.)

000 = Thromboembolic disease

0450 AQCD . . . . Acquired Coagulation Disorder

CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Also code if occurs postpartum)

DIC = Disseminated intravascular coagulation (D.I.C.)
HUS = Hemolytic uremic syndrome
TTP = Thrombotic thrombocytopenic purpura

0460 JAUN . . . . Jaundice

CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Hyperbilirubinemia; use upper limit of normal for hospital laboratory values.)

FLP = Fatty liver of pregnancy
(Steatosis)
HEP = Serum Hepatitis Carrier
(Antigen positive; Hepatitis A, B, C, viral)
JOP = Jaundice of pregnancy/cholestatic liver disease of pregnancy

0470 MATB . . . . Maternal Antibodies

CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Use Red Cross Sheets)

RED BLOOD CELL ANTIBODIES

ALA = Anti-La
AND = Anti-D *(Rh)*
BGC = Anti-Big C *(C^w)*
BGE = Anti-Big E
BGS = Anti-Big S
DHA = Anti-Dha *(DUCH)*
FYA = Anti-Fy^a *(Duffy)*
KEL = Anti-Kell *(K_1/K_2)*
KID = Anti-Kidd *(JK_a)*
LLC = Anti-Little c
LLE = Anti-Little e
LLS = Anti-Little s
LUT = Anti-Lutheran *(Lu^a/Lu^b)*
WRA = Anti-Wright *(Wr^a/Wr^b)*

AUTOIMMUNE ANTIBODIES

ANC = Antinuclear Antibody *(ANA)*
CRN = Anti-Cardiolipin
DNA = Anti-DNA Antibody
LUP = Lupus Antibody (Lupus Anticoagulant)
SSA = Anti-SSA *(Ro)*

ANTI-PLATELET ANTIBODIES

PLA = PL - A1 Platelet Antigen Negative

0480 FTTX . . . . Total Number of Fetal Transfusions During Current Pregnancy
(Performed here or elsewhere)

001	=	One	006	=	Six
002	=	Two	007	=	Seven
003	=	Three	008	=	Eight
004	=	Four	009	=	Nine
005	=	Five	010	=	Ten

(Code on all admissions)

0490 OTHR . . . . Other Non-Obstetrical Disease, Not Elsewhere Classifiable
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY

ANS = Ankylosing spondylitis
CHS = Cholinesterase Deficiency
MHT = Family or personal history of Malignant Hyperthermia
NFM = Neurofibromatosis
(Von Recklinghausen's Disease)
PHY = Porphyria
PKU = Maternal phenylketonuria
RHA = Rheumatoid arthritis/Psoriatic
SAR = Sarcoidosis
SCD = Scleroderma
SCO = Scoliosis
SJO = Sjogren's Syndrome
SLE = Systemic lupus
SHM = Scheurmann's Disease

0510 CRIN . . . . . Endocrine
FOR APPLICABLE CONDITIONS, CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY

ADH = Disorder of Adrenal Gland
DOV = Disorder of Ovary
(If significant and indicated by physician. For MALIGNANCY (TERATOMA) of OVARY - see CODE 0540)
HAS = Hashimoto's Thyroiditis
(Autoimmune thyroiditis)
HI2 = Hyperthyroidism with Goiter
HI3 = Hyperthyroidism with Thyroid nodule
HI4 = Hyperthyroidism with Goiter, nodular
HI5 = Hyperthyroidism without Goiter
HY2 = Hypothyroidism
HIP = Hyperparathyroidism
HYT = Disorder of Hypothalamus
PIT = Disorder of Pituitary gland

0520 DIAB . . . . . Diabetes

CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY UNDELIVERED PATIENTS ONLY.
(See CODE 2910 for Joslin Clinic and O'Sullivan values.
Determine class using duration of disease.)

CLA = Class A ***(Two abnormal values on a GTT, during pregnancy only - Gestational diabetes. If a patient's GTT values are unknown, or only 1 value is known, but patient is administered insulin, code as CLA.)***

CLB = Class B ***(Less than 10 years duration, no vascular disease; onset after age 20 years.)***

CLC = Class C ***(Duration 10-19 years, minimal vascular disease; onset after age 10 years.)***

CLD = Class D ***(Duration 20 years or more; benign retinopathy; onset before age 10 years.)***

CLF = Class F ***(Patient with Class D and nephropathy.)***

CLR = Class R ***(Patient with proliferative retinopathy.)***

CLT = Class T **(Diagnosis made by level of Trutol equal to or greater than 10.3mmol/l)**

UKN = Class unknown

0530 RENL . . . . Renal Disease

UNLESS OTHERWISE SPECIFIED, CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Do not include lower urinary tract infection - code 1590)

APN = Acute pyelonephritis
(Code if present during admission. See 0530 HAP for previous resolved episodes during this pregnancy.)

CAL = Renal calculus

GLO = Chronic glomerulonephritis

HAP = Previous episode of acute pyelonephritis during current pregnancy

HYD = Hydronephrosis

NEP = Nephropathy

NRS = Nephrotic syndrome

PCK = Polycystic kidney disease

PYL = Chronic pyelonephritis

RAG = Renal agenesis
(Absent kidney)

TPL = Renal transplant

UND = Chronic renal disease, type undetermined

UTP = Lower urinary tract problems
(Include bladder diverticuli, Hunners ulcer, urinary reflux)

0540 MLIG . . . . Neoplasms, Including Malignancies

CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(For history of malignancy, see Code 0010.)

BOW = Bowel
BRS = Breast
CVX = Cervix
OTH = Other
(e.g. Hodgkin's, neurofibromatosis)
OVA = Ovary *(Teratoma)*
(Code ovarian cancer as active until 5 years has elapsed from the date of the last known treatment.)
THD = Thyroid
VAG = Vagina

0550 BDYS . . . . Blood Dyscrasias

CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY

ANM = Hemolytic anemia
(e.g. hereditary spherocytosis)
DFG = Dysfibrinogenemia
F12 = Factor 12 deficiency
FIB = Familial hypofibrinogenemia
FT8 = Factor VIII deficiency
G6P = G6PD deficiency
IHA = Idiopathic Hypoplastic Anemia
ITP = Idiopathic thrombocytopenic purpura
SIC = Sickle cell anemia
THL = Thalassemia
VON = Von Willebrand's disease
FT5 = Factor V Leiden Deficiency

0551 THRM . . . . Thrombocytopenia

CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Code the lowest platelet count reported.)

MLD = Mild (100,000-150,000 platelet count)
MOD = Moderate (50,000-<100,000 platelet count)
SVR = Severe (<50,000 platelet count)

0560 ANEM . . . . Anemia

CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Antepartum Hgb <10 gm% e.g. 9.5 Hgb (antepartum) recorded on Prenatal Record.)

000 = Anemia

0570 UABN . . . . Uterine Abnormalities
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Septate uterus, Unicornuate, Bicornuate, Cervical incompetence.
Exclude cervical stenosis and fibroids unless causing antenatal concern.)
000 = Uterine abnormalities

0580 PULD . . . . Pulmonary Disease
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
AMA = Asthma
CFS = Cystic fibrosis
OED = Pulmonary edema
(Includes antepartum and intrapartum)
OTH = Other significant pulmonary diseases
PNM = Pneumonia, antepartum

0591 OTHD . . . . Other Non-Obstetrical Disorders
CODE ONLY IF PRESENT DURING ADMISSION
ABA = Abscess of Bartholin's Gland
ANR = Anaphylactic reaction
(Violent allergic reaction)
CEV = Cervicitis
(Code also any hemorrhage.)
CYB = Cyst of Bartholin's Gland
LCV = Leukocytoclastic vasculitis
OAD = Other adverse drug reaction
(e.g. drug overdose, blood transfusion reaction)

0592 MCHA . . . Maternal Chromosomal Abnormalities
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
MSC = Mosaicism
(As stated by physician or on the chromosome report; or if stated that there are two or more different cell lines.)
OTH = Other chromosomal abnormalities
(As stated by physician. Include trisomy, inversions, deletions, etc.)
TRN = Translocation
(As stated by physician or on the chromosome report.)

C. LABOUR COMPLICATIONS *CODE IF CONDITION IS PRESENT DURING ADMISSION*

0600 FETD . . . . Fetal Distress ***(As stated in the chart)***
SUS = Suspected *(Undelivered)*
000 = Fetal distress *(Delivered)*

1. ***As stated by physician in chart, NOT by abnormal rhythms only.***
2. ***"Prolonged tachycardia", "prolonged bradycardia", "prolonged decelerations" or "non-reassuring heart rate" requiring medical interventions", such as episiotomy, forceps, c/s and/or vacuum extraction. Do not include an induction if it is initiated for fetal distress.***
3. ***A scalp pH < 7.2 is definitely fetal distress***.

0610 IHEM . . . . Intrapartum Hemorrhage
(Blood loss of > 500 cc., during labour and before delivery of baby, or as stated by physician or nursing staff. Includes Cesarean section if blood loss occurs before delivery of baby.)
000 = Intrapartum hemorrhage

0620 PYRL . . . . Pyrexia In Labour
(Temperature elevation ≥ 38.0 C, during labour irrespective of cause.
e.g. If a patient has a U.T.I. causing the pyrexia, code both 0620 and 1590.)
000 = Pyrexia in labour

0660 DXOP . . . . Destructive Operation
C01 = Drainage of head
C02 = Suprapubic drainage of myelomeningocele/meningocele

0681 CSHM . . . . Blood Loss During Cesarean Section
(This code should be used for all C-section deliveries to indicate blood loss, so that patients are not inappropriately coded as postpartum or intrapartum hemorrhages. If a patient has an intrapartum hemorrhage clearly stated as blood loss during labour and not due to the c/s, 0610 IHEM may be used.)

(Postpartum hemorrhages (1100,1110) may also be coded, if applicable).
C01 = < 500 cc's.
(or stated as "normal" or "average")
C02 = 500 - 700 cc's.
C03 = > 700 cc's.
UKN = Unknown/not specified

D. NON-DELIVERY PROCEDURES

0690 RSUT . . . . Removal of Cervical Suture
- 000 = No anesthesia
- ACU = Acupuncture
- DBN = Spinal/Epidural Double Needle ***(Combined technique)***
- EPI = Epidural
- GEN = General
- HYP = Hypnosis
- KET = Neuroleptic
- LOC = Local
- SPL = Spinal

0700 TUBE . . . . Tubal Sterilization
- 000 = No anesthesia
- ACU = Acupuncture
- DBN = Spinal/Epidural Double Needle ***(Combined technique)***
- EPI = Epidural
- GEN = General
- HYP = Hypnosis
- KET = Neuroleptic
- LOC = Local
- SPL = Spinal

0710 CSUT . . . . Cervical Encerclage
(Any surgical procedure for incompetent cervix)
- 000 = No anesthesia
- ACU = Acupuncture
- DBN = Spinal/Epidural Double Needle ***(Combined technique)***
- EPI = Epidural
- GEN = General
- HYP = Hypnosis
- KET = Neuroleptic
- LOC = Local
- SPL = Spinal

0720 LAPR . . . . Laparoscopy
- 000 = No anesthesia
- ACU = Acupuncture
- DBN = Spinal/Epidural Double Needle ***(Combined technique)***
- EPI = Epidural
- GEN = General
- HYP = Hypnosis
- KET = Neuroleptic
- LOC = Local
- SPL = Spinal

0721 LAPT . . . . Laparotomy
- 000 = No anesthesia
- ACU = Acupuncture
- DBN = Spinal/Epidural Double Needle ***(Combined technique)***
- EPI = Epidural
- GEN = General
- HYP = Hypnosis
- KET = Neuroleptic
- LOC = Local
- SPL = Spinal

0730 DILC . . . . . Dilatation and Curettage of the uterus after delivery or abortion
- 000 = No anesthesia
- ACU = Acupuncture
- DBN = Spinal/Epidural Double Needle ***(Combined technique)***
- EPI = Epidural
- GEN = General
- HYP = Hypnosis
- KET = Neuroleptic
- LOC = Local
- SPL = Spinal

0731 ODIL . . . . . Other dilatation and curettage (Diagnostic)

000 = No anesthesia
ACU = Acupuncture
DBN = Spinal/Epidural Double Needle ***(Combined technique)***
EPI = Epidural
GEN = General
HYP = Hypnosis
KET = Neuroleptic
LOC = Local
SPL = Spinal

0740 MRPL . . . . Manual Removal of Placenta

(This is an invasive procedure involving insertion of the hand. Do not code if part of C-section procedure. Do not code if the physician merely uses forceps to remove membranes protruding through the cervix.)

000 = No anesthesia
ACU = Acupuncture
DBN = Spinal/Epidural Double Needle ***(Combined technique)***
EPI = Epidural
GEN = General
HYP = Hypnosis
KET = Neuroleptic
LOC = Local
SPL = Spinal
OTH = Other

(any other agent used to perform this procedure such as Nitrous Oxide, Fentanyl and Nitroglycerine)

0750 AMNI . . . . Amniocentesis

(Code reason test was performed. Code AMNIOCENTESIS for polyhydramnios treatment under 0250.Bring code forward to delivered admission. Code any amniocentesis performed out of province or at an other facility)

GNT = Genetic testing
ISO = Isoimmunization testing
LUM = Lung maturity testing
ATT = Amniocentesis attempted no fluid obtained

0751 CHVS . . . . Chorionic Villi Sampling

(Code reason test was performed. Bring code forward to the delivered admission. Code any Chorionic Villi Sampling performed out of province or at an other facility).

GNT = Genetic testing

0760 OOPH . . . . Salpingo-oophorectomy
(Code anesthetic under Codes 1020-1040.)
C00 = Unilateral oophorectomy
C01 = Unilateral salpingectomy
C02 = Bilateral salpingectomy
C11 = Unilateral salpingo-oophorectomy
C12 = Bilateral salpingo-oophorectomy
C13 = Bilateral salpingectomy and unilateral oophorectomy

0770 APPD . . . . Appendectomy
000 = No anesthesia
ACU = Acupuncture
DBN = Spinal/Epidural Double Needle
(Combined technique)
EPI = Epidural
GEN = General
HYP = Hypnosis
KET = Neuroleptic
LOC = Local
SPL = Spinal

0780 HYST . . . . Hysterectomy
000 = No anesthesia
ACU = Acupuncture
DBN = Spinal/Epidural Double Needle
(Combined technique)
EPI = Epidural
GEN = General
HYP = Hypnosis
KET = Neuroleptic
LOC = Local
SPL = Spinal

0790 OPRO . . . . Other Non-Delivery Procedure
(Include Manual Exploration of Uterine Cavity and/or drainage of a wound)
000 = No anesthesia
ACU = Acupuncture
DBN = Spinal/Epidural Double Needle
(Combined technique)
EPI = Epidural
GEN = General
HYP = Hypnosis
KET = Neuroleptic
LOC = Local
SPL = Spinal

E. ANALGESIA DURING LABOUR (EXCLUDE ANTEPARTUM STILLBIRTHS)
CODE IF ADMINISTERED DURING DELIVERED ADMISSION.

For codes 0800 to 0931, use the modifiers listed below. Code all analgesics administered before delivery, during the delivered admission. If the same analgesic is administered more than once, code the administration closest to the time of delivery, even if the same analgesic is administered by a different route. Only code twice if the analgesic is administered by two different routes at the exact same time.

L10 = Administered via an unknown route, less than 1 hr. prior to delivery
120 = Administered via an unknown route, 1 to less than 2 hr. prior to delivery
240 = Administered via an unknown route, 2 to 4 hr. prior to delivery
G40 = Administered via an unknown route, greater than 4 hr. prior to delivery

L11 = Administered I.M., less than 1 hr. prior to delivery
121 = Administered I.M., 1 to less than 2 hr. prior to delivery
241 = Administered I.M., 2 to 4 hr. prior to delivery
G41 = Administered I.M., greater than 4 hr. prior to delivery

L12 = Administered I.V., less than 1 hr. prior to delivery
122 = Administered I.V., 1 to less than 2 hr. prior to delivery
242 = Administered I.V., 2 to 4 hr. prior to delivery
G42 = Administered I.V., greater than 4 hr. prior to delivery

0800 NISL . . . . . Alphaprodine (Nisentil)
(SEE LIST OF MODIFIERS)

0810 DEML . . . . Meperidine (Demerol)
(SEE LIST OF MODIFIERS)

0820 SECO . . . . Secobarbital (Seconal)
(SEE LIST OF MODIFIERS)

0830 TUIN . . . . . Amo-Secobarb Hypnotic (Tuinal)
(SEE LIST OF MODIFIERS)

0840 NEMB . . . . Pentobarbital Hypnotic (Nembutal)
(SEE LIST OF MODIFIERS)

0850 VALM . . . . Diazepam Tranquillizer (Valium)
(SEE LIST OF MODIFIERS)

0860 SPAR . . . . Promazine Tranquillizer (Sparine)
(SEE LIST OF MODIFIERS)

0870 LARG . . . . Chlorpromazine Tranquillizer (Largactil)
(SEE LIST OF MODIFIERS)

0880 PHER . . . . Promethazine Tranquillizer (Phenergan)
(SEE LIST OF MODIFIERS)

0890 MORF . . . . Morphine (includes Opium/Pantopon)
(SEE LIST OF MODIFIERS)

0900 NUBN . . . . Nalbuphine (Nubain)
(SEE LIST OF MODIFIERS)

0910 DILD . . . . . Hydromorphone HCl (Dilaudid)
(SEE LIST OF MODIFIERS)

0920 TLWN . . . . Pentazocine (Talwin)
(SEE LIST OF MODIFIERS)

0930 FENL . . . . Sublimaze (Fentanyl)
(SEE LIST OF MODIFIERS)

0931 OADB . . . . Other Analgesia During Labour
(SEE LIST OF MODIFIERS)

F. ANESTHESIA DURING LABOUR/DELIVERY

0940 SPIN . . . . . Spinal Anesthesia
LAB = Labour only
DEL = Delivery only
LXD = Labour and delivery

0950 OADL . . . . Other Anesthesia For Labour/Delivery
ACU = Acupuncture
HYP = Hypnotism
KET = Neuroleptic

0960 GENA . . . . General Anesthesia
LAB = Labour only
DEL = Delivery only
LXD = Labour and delivery

0970 ETOX . . . . Entonox ***(Nitronox)***
(The effects of entonox last for approximately 30 seconds.)
LAB = Labour only
DEL = Delivery only
LXD = Labour and delivery

0980 EPIS . . . . . Epidural - Single Administration
LAB = Labour only
DEL = Delivery only
LXD = Labour and delivery

0990 EPIC . . . . . Epidural - Continuous Catheter With Intermittent Drug Administration
LAB = Labour only
DEL = Delivery only
LXD = Labour and delivery

1000 IFUS . . . . . Epidural, Continuous Infusion of Drug (CIEA)
LAB = Labour only
DEL = Delivery only
LXD = Labour and delivery

1001 PCEA . . . . Patient Controlled Epidural Analgesia (PCEA)
LAB = Labour only
DEL = Delivery only
LXD = Labour and delivery

1002 PCIA . . . . . Patient Controlled Intravenous Analgesia
(Do not code narcotic administered)
LAB = Labour only
DEL = Delivery only
LXD = Labour and Delivery
PST = Post-operative
(After a C-Section, tubal ligation, other surgeries.)

1010 PUDL . . . . Pudendal
000 = Pudendal

1011 SEDN . . . . Spinal/Epidural double needle
(Combined technique. Code also 0990, 1000, and/or 1001, when applicable.)
LAB = Labour only
DEL = Delivery only
LXD = Labour and delivery

G. ANESTHESIA FOR NON-DELIVERY PROCEDURES

(Used only when anesthetic cannot be coded with the specific procedure.)

1020 GASS . . . . Non-Delivery General Anesthesia
000 = Non-delivery general anesthesia

1030 OEPI . . . . . Non-Delivery Epidural Anesthesia
(Use for Repair of Tear after a delivered episode, and if an epidural is administrered during false labour.
000 = Non-delivery epidural anesthesia

1040 OTAN . . . . Other Anesthetic
(Use for Repair of Tear after a delivered episode, and if an epidural is administered during false labour.)
SPL = Spinal
KET = Neuroleptic

H. LACERATIONS

1050 LACR . . . . Laceration

(As stated on Labour and Delivery Record, regardless of whether episiotomy was done. Code the highest degree of tear. If the degree of the tear is unspecified, code 1st degree. If cervical and/or periurethral tears are stated in addition to 1st, 2nd, 3rd, or 4th degree tears, code the cervical and/or the periurethral tear and the highest degree of the other tear.)

FER = 1st degree tear
SEC = 2nd degree tear
ANA = 3rd degree tear or Anal sphincter
REC = 4th degree tear or Rectal mucosa
CER = Cervical tear
PTR = Periurethral tear

1060 OTMT . . . . Other Maternal Trauma

(Includes laceration of uterine artery, severe extension of uterine incision, laceration of bladder, bowel, ureter, etc. Do not code minor perineal or vaginal lacerations.)

000 = Other maternal trauma

I. POSTPARTUM COMPLICATIONS

CODE ONLY CONDITIONS PERTAINING TO POSTPARTUM PERIOD.

1100 EPPH . . . . . Early Postpartum Hemorrhage

(Within the first 24 hours postpartum; as noted by the physician; or, if there has been estimated blood loss greater than 500 cc's.
Code also Retained Placenta, 1120, if applicable.
Code after a c-section if clearly stated as occurring postpartum)

000 = Early postpartum hemorrhage

1110 LPPH . . . . . Late Postpartum Hemorrhage

(After 24 hours postpartum, as noted by the attending physician.
Code also Retained Placenta, 1120, if applicable.)

000 = Late postpartum hemorrhage

1120 RTPL . . . . . Retained Placenta

(The retention within the uterus of the placenta or a fragment of the placenta and/or membranes after 30 minutes postpartum or as stated. Do include clots with tissue, membranes or portions of membranes. Code also any postpartum hemorrhage, if applicable. For retained membranes, code ONLY IF DEFINITE. Do not code if stated as "questionable tissue in clot", or "possible tissue in clot". Do Code if clearly stated by physician even if the placenta has not been retained for 30 minutes and you are unable to code the corresponding Manual Removal of Placenta Code)

000 = Retained placenta

1130 IVUT . . . . . Inverted Uterus

(Code if occurs during a c-section and clearly stated by a physician)

000 = Inverted uterus

1140 HEMT . . . . Hematoma

EPY = Episiotomy or tear
WND = Wound
(C/s wound)
PEL = Pelvic
(Not c/s wound, Ischio-rectal space, broad ligament)
LBL = Labial
(Vulvar)

1150 DHIS . . . . . Wound Dehiscence

(Includes eviscerations and/or dehiscence as stated in chart, not gaping wound.)

000 = Wound dehiscence

1160 PPDP . . . . . Postpartum Depression
(As noted by the psychiatric consultant.)
000 = Postpartum depression

1170 PEMB . . . . Pulmonary Embolus
(Proven or suspected to the extent that treatment was required.)
000 = Pulmonary embolus

1180 ATEL . . . . Pulmonary Atelectasis, postpartum
(Not due to anesthesia.)
000 = Pulmonary atelectasis

1190 EFFU . . . . . Pleural Effusion or Pulmonary Edema, postpartum
(Not due to anesthesia.)
000 = Pleural effusion

1200 PNMO . . . . Pneumothorax, postpartum
(Not due to anesthesia.)
000 = Pneumothorax

1210 RENF . . . . Renal Failure
000 = Renal failure

1220 HRTF . . . . Heart Failure
000 = Heart failure

1230 EVAC . . . . Evacuation of Hematoma
000 = No anesthesia
ACU = Acupuncture
DBN = Spinal/Epidural Double Needle
(Combined technique)
EPI = Epidural
GEN = General
HYP = Hypnosis
KET = Neuroleptic
LOC = Local
SPL = Spinal

1240 OTPC . . . . Other Postpartum Complications

FTD = Foot drop
(Not due to anesthesia. Foot Drop due to anesthesia, see Code 1850 FDRP.)

HBD = Hypoxic brain damage
(Encephalopathy)

ILS = Paralytic ileus
(Include post-operative ileus)

OBS = Bowel obstruction

ONI = Other neurological injury/deficit resulting from delivery
(eg. numbness, limb weakness, femoral/peripheral nerve injury)

OSC = Other significant postpartum complications

1250 PPAN . . . . Postpartum Anemia
(As stated in chart.)

000 = Postpartum anemia
(Hgb < 10 gm%)

J. POSTPARTUM INFECTION *IF MOTHER IS A MABLE PATIENT, CODE DIAGNOSIS AS STATED BY MABLE NURSE AND/OR PATIENT.*

1300 ENDM . . . . Endometritis
000 = Endometritis

1310 MAST . . . . Mastitis
000 = Mastitis

1320 URTI . . . . . Urinary Tract Infection
(Confirmed by positive urine culture of > 100,000 colonies/ml.)
000 = Urinary tract infection

1330 WINF . . . . Wound Infection
(Infected abdominal or episiotomy wound - code if stated by physician or if documented as passage of significant amount of purulent material from the wound site. Do not code if described as scant, or as small purulent pustules at the staples or stitches.)
CSN = Abdominal incision
EPY = Episiotomy or tear

1340 TPHB . . . . Thrombophlebitis, include DVT
000 = Thrombophlebitis

1350 SEPT . . . . . Septicemia
(Noted by a positive blood culture - presence of any bacteria.)
000 = Septicemia

1360 PERT . . . . . Peritonitis
000 = Peritonitis

1370 OPPI . . . . . Other Postpartum Infections
(Code only if first reported in postpartum period.)
ADS = A.I.D.S.
CHL = Chlamydia
CON = Condyloma acuminata
GBS = Group B Streptococcus
GON = Gonorrhea
HER = Herpes
LIS = Listeria
MYC = Mycoplasma
SYP = Syphilis
VAR = Varicella

1380 PUKO . . . . Pyrexia, Unknown Cause, as stated on chart
(1 episode or more of ≥ 38°C, postpartum.)
000 = Pyrexia, unknown cause

1390 PUER . . . . Puerperal Morbidity
(38^0 C. or more on 2 or more occasions, at least 4 hours apart, in any 48 hour period, excluding the first 24 hours after delivery, regardless of cause.)
000 = Puerperal morbidity

1400 PULM . . . . Pulmonary Infection
(Includes postpartum pneumonia)
000 = Pulmonary infection

K. MATERNAL THERAPY

1460 EXTV . . . . External Version

(Code if done anytime during pregnancy. INCLUDE external versions performed in OPD, physicians' offices, or during hospital admission, including delivered admissions.)

SUC = Successful - vertex position at completion of procedure
UNS = Unsuccessful - NOT vertex position at completion of procedure

1470 OTTX . . . . Other Transfusions

ALB = Albumin
CRY = Cryoprecipitate Transfusion
FFP = Fresh Frozen Plasma
GAM = Gamma Globulin
PEX = Plasma Exchange/Plasmapheresis
PLT = Platelet Transfusion

1480 MSO4 . . . . Magnesium sulfate therapy(MgSO4)

(Used for hypertension or seizures. Code 1530 TOTH for tocolytic use.)

000 = Magnesium sulfate therapy

1490 TRYL . . . . Attempted vaginal delivery after previous C-section

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

Do not include patients who unexpectedly go into labour and who then undergo planned repeat C-section although earlier than patient had been booked for; these patients should be coded as repeat C-section.

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

000 = No anesthetic analgesia
ACU = Acupuncture
DBN = Spinal/Epidural Double Needle ***(Combined technique)***
EPI = Epidural
GEN = General
HYP = Hypnosis
KET = Neuroleptic
LOC = Local
SPL = Spinal

1500 BLTX . . . . Blood Transfusions
001 = 1 Unit of blood
002 = 2 Units of blood - etc. -

1530 TOTH . . . . Tocolytic Agents
(Any other medication given to the mother to prevent or stop premature labour.)
C01 = Ritodrine
(Yutopar)
C02 = Terbutaline
(Bricanyl)
C03 = Ventolin
C04 = Indocid
(Indomethacin)
C05 = Alcohol
C06 = Isoxsuprine
(Vasodilan)
C07 = Atosiban
C08 = Magnesium Sulfate (MgSO4)

1531 INSL . . . . . Diabetic Therapy
INS = Insulin
ORH = Other Hypoglycemic Agent (eg. Diabinese)

1540 LSUP . . . . . Lactation Suppression
(Code regardless of whether used for pathological or physiological reason.)
DDU = Testerone-estradiol
(Deladumone)
EST = Estrand
PAR = Bromocriptine
(Parlodel)
STL = Diethylstilbestrol
(Stilbestrol)
TCE = Tace
(Chlorotrianisene)

1541 ASAT . . . . Maternal ASA Therapy
(Code if administered during pregnancy or admission)
ASA = Low dose aspirin (ASA) therapy, eg. for Lupus, and other autoimmune diseases

L. **MATERNAL DEATH OR UNDELIVERED FETAL DEATH**

1550 MATD . . . . Maternal Death
000 = Maternal death

1560 FDTH . . . . Fetal Death
(Undelivered patients only)
000 = Fetal death

M. INFECTION IN PRESENT PREGNANCY

CODE POSTPARTUM INFECTIONS SEPARATELY - SEE SECTION I .
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY

1590 UTIN . . . . . Lower Urinary Tract Infection
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Confirmed by culture of >100,000 colonies/ml, or as stated by physician.)
000 = Lower urinary tract infection

1600 GBSI . . . . . Group B Streptococcal Infection
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Most Group B strep. will be colonization only. If it is stated that the patient had a Group B Strep Urinary Tract Infection, code it as GBI. Group B Strep can be present in the urine without being an infection; in this case, code GBC. If it is stated that the patient has Chorioamnionitis or Endometritis due to Group B Strep, code GBI.
If group B strep infection was diagnosed at one point and followed by colonization at a later date, code both the infection and the colonization.)
GBC = Colonized with Group B streptococcus
GBI = Group B streptococcal infection

1610 LIST . . . . . Listeria Infection
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
000 = Listeria infection

1620 LUES . . . . Syphilis
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
000 = Syphilis

1630 GONO . . . . Gonorrhea
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
000 = Gonorrhea

1640 HERP . . . . Herpes Simplex Infection
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Herpes labialis, oral herpes, herpes genitalis, genital herpes.
Do not code those with a history of Herpes. Do not include a Herpes outbreak post-Epidural - due to Morphine in Epimorph.)
OHS = Oral Herpes Simplex
GHS = Genital Herpes Simplex
OTH = Other (Herpes labialis, herpes gestationalis)

1650 RUBE . . . . Rubella
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
000 = Rubella

1660 SPTC . . . . . Septicemia
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY (Defined by positive blood culture(s).)
000 = Septicemia

1670 COND . . . . Condyloma acuminata
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY (Venereal warts, Human Papilloma Virus. Code H.P.V. only if there is a manifestation of warts.)
000 = Condyloma acuminata

1680 AIDS . . . . . Acquired Immune Deficiency Syndrome
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
ASP = Asymptomatic A.I.D.S., H.I.V. positive
SPM = Symptomatic A.I.D.S.

1690 TOXO . . . . Prenatal toxoplasmosis
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
000 = Prenatal toxoplasmosis

1700 WOUN . . . Wound infection, antepartum
CODE ONLY IF PRESENT DURING ADMISSION
(e.g. postoperative, Appendectomy)
000 = Wound infection

1710 VIRD . . . . . Viral Diseases
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
C01 = Parvovirus (Fifth's Disease)
C02 = Meningitis

1720 TEST . . . . . Abnormal Findings
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY (Immunological)
TB+ = Positive Tuberculin Test
(Mantoux)

1730 VARC . . . . Varicella
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
CHP = Chickenpox
(Varicella)
HPZ = Shingles
(Herpes Zoster)

1740 MYCP . . . . Mycoplasma Disease
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Code also Neonatal Code 1810.)
000 = Mycoplasma disease

1750 CHLM . . . . Chlamydia
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Code also Neonatal Code 1800.)
000 = Chlamydia

1760 INFB . . . . . Bacterial Infections, Antepartum
CODE IF PRESENT DURING ADMISSION ONLY
(e.g Pilonidal Cyst, Abscess Tooth)
000 = Bacterial infections, antepartum

N. COMPLICATIONS OF ANESTHESIA

1790 BLPT . . . . . Blood Patching
000 = Blood patching

1800 TXIV . . . . . Intravenous Injection
000 = Toxic intravenous injection
(Causing systemic reaction)
C01 = Epi-catheter intravenous only
(Incidental only)

1810 DTAP . . . . Accidental Dural Tap
(Code also Blood Patching 1790 BLPT, if applicable.)
000 = Accidental dural tap

1820 TOXS . . . . Total Spinal Anesthesia
(Respiratory paralysis)
000 = Total spinal anesthesia

1830 LEPI . . . . . Prolonged Epidural Block
000 = Prolonged epidural block

1840 MBLK . . . . High Epidural/Subdural Block
000 = High epidural/subdural block

1850 FDRP . . . . Foot drop
(Specifically stated as due to anesthesia.)
000 = Foot drop

1860 EPIH . . . . . Epidural hematoma
000 = Epidural hematoma

1870 EPIA . . . . . Epidural Abscess
000 = Epidural abscess

1880 SCRD . . . . Spinal Cord Lesion
000 = Spinal cord lesion

1890 ASPN . . . . Aspiration Pneumonitis
000 = Aspiration pneumonitis

1900 CARR . . . . Cardiac Arrest
000 = Cardiac arrest

1910 OANC . . . . Other Anesthetic Complication
(Specifically stated by anesthetist on anesthetic record. If in doubt, ask anesthetist.)
C01 = Post-dural puncture headache
C02 = Paraesthesia
C03 = Hypotension
C04 = Back pain

1914 FIGA . . . . . Failed Intubation for General Anesthetic
000 = Failed intubation for general anesthetic

O. ANTIBIOTIC THERAPY
(CODE WHEN ANTIBIOTICS ARE ADMINISTERED)

2000 ANTB . . . . Antibiotics
(CODE ONLY IF ADMINISTERED DURING ADMISSION)
ANT = Administered during antepartum period
INT = Administered during intrapartum period from the beginning of labour to the delivery of the placenta, including administration during a C-section delivery.
PPP = Administered during postpartum period

P. FETAL PROCEDURES

2200 CHDO . . . . Cordocentesis
(Umbilical cord vessel sampling. Code reason test was performed. Bring forward to the delivered admission)
GNT = Genetic testing
ISO = Isoimmunization
OTH = Other

2210 FETP . . . . . Fetal Peritoneal Tap
INV = Investigative
FAC = To facilitate delivery
(Fetal Abdominal Paracentesis)

2220 AMNF . . . . Amnioinfusion
(To prevent cord compression)
000 = Amnioinfusion

2230 FETT . . . . . Fetal Thoracentesis
(To correct fetal defect)
000 = Fetal thoracentesis

2240 CORE . . . . Embolization of Umbilical Vessels By Cordocentesis
000 = Embolization of umbilical vessels by cordocentesis

Q. METHODS OF INDUCTION/ATTEMPTED INDUCTION

Codes 3000 through to 3040 apply to inductions only. Do not code for augmentations.

A period of greater than 24 hours between subsequent doses of medication (prostaglandin and/or oxytocin) for the purpose of inducing labour defines a new induction attempt. Note: the administration of prostaglandin, for the purpose of cervical ripening, is considered part of the induction process.

If the patient goes into labour more than 24 hours after the last administration of medication (prostaglandin and/or oxytocin) for the purpose of inducing labour, the labour should be coded as spontaneous.

The third character of the modifiers for codes 3000 through to 3040 identifies the attempt at induction designated as "A" for the first attempt, "B" for the second attempt, and so forth.

1. Codes 3000 and 3010

The first character of the modifiers for codes 3000 and 3010 indicates the number of prostaglandin administrations in the ***OPD*** *during that induction attempt.* ***Code OPD prostaglandin administrations occurring within the 24 hours prior to admission only****, unless previous administrations are clearly indicated on the delivered admission.*

The second character of the modifier indicates the number of ***in-patient*** *prostaglandin administrations during that induction attempt. If the mother is given more than 9 administrations in one attempt, code 9.*

For example, if a mother received 3 doses of intracervical prostaglandin in the OPD, and then 24 hours later is admitted, and receives 2 doses of intracervical prostaglandin, her case would be coded as 3000 PGCC 30A and 3000 PGCC 02B.

2. Codes 3000, 3010, and 3020

A mother will often receive prostaglandin followed by oxytocin. If the oxytocin is given within 24 hours of the last prostaglandin administration, this is considered one induction attempt. If 24 hours have passed since the last prostaglandin administration, then this is considered a second attempt.

For example, if a mother was admitted, and received 2 doses of prostaglandin, and then within 24 hours received oxytocin, her case would be coded as 3000 PGCC 02A and 3020 OXTC 00A. If the same mother received the oxytocin 24 hours after the last prostaglandin administration, her case would be coded as 3000 PGCC 02A and 3020 OXTC 00B.

3. Code 3020

In the case of an induction attempt with oxytocin alone, a new attempt occurs when a mother has not received oxytocin for a 24 hour period. If the oxytocin is shut off for a few hours and then started again, within 24 hours of the last administration, then this is considered one induction attempt.

For example, if a mother is receiving her first oxytocin administration, and the oxytocin is shut off for 3 hours, and then started again, her case would be coded as 3020 OXTC 00A. However, if in this same case the oxytocin was started 24 hours after it had been shut off, her case would be coded as 3020 OCTX 00B.

3000 PGCC . . . . Intracervical Prostaglandin
(Intracervical prostaglandin is administered in a .5mg dose.)
01A = No OPD prostaglandin administrations, one in-patient prostaglandin administration, 1st induction attempt
11A = One OPD prostaglandin administration, one in-patient prostaglandin administration, 1st induction attempt
21B = Two OPD prostaglandin administrations, one in-patient prostaglandin administration, 2nd induction attempt
30B = Three OPD prostaglandin administrations, no in-patient prostaglandin administrations, 2nd induction attempt.....etc.

3010 PGCV . . . . Vaginal Prostaglandin (Includes Cytotec)
(Vaginal prostaglandin is administered in a 1 to 2mg dose. If the route of administration or dosage of prostaglandin is not specified , code vaginal.)
01A = No OPD prostaglandin administrations, one in-patient prostaglandin administration, 1st induction attempt
11A = One OPD prostaglandin administration, one in-patient prostaglandin administration, 1st induction attempt
21B = Two OPD prostaglandin administrations, one in-patient prostaglandin administration, 2nd induction attempt
30B = Three OPD prostaglandin administrations, no in-patient prostaglandin administrations, 2nd induction attempt.....etc.

3020 OXTC . . . . Oxytocin (Pitocin, Syntocin)
00A = Administered during first induction attempt
00B = Administered during second induction attempt....etc

3030 PGOR . . . . Oral Prostaglandin (Includes Cytotec)
00A = Administered during first induction attempt
00B = Administered during second induction attempt....etc

3040 OTAG . . . . Other agents ***(Laminaria tents, Intracervical catheter-induction)***
00A = Administered during first induction attempt
00B = Administered during second induction attempt....etc

1. METHODS OF INDUCTION FOR TERMINATION FOR ANOMALY ADMISSIONS

Codes 3050 through to 3090 apply to Termination for Anomaly cases only. Do not use these codes for Inductions or Augmentations for delivery of a viable infant.

1. Code 3050

The first character of the modifier for code 3050 indicates the number of Misoprostol (Cytotec) administered on an out-patient basis to induce labour for a termination for an anomaly. If the mother is given more than 9 administrations to induce labour, code 9

The second character of the modifier for code 3050 indicates the number of Misoprostol (Cytotec) administered on an in-patient basis to induce labour for a termination for an anomaly. If the mother is given more than 9 administrations to induce labour, code 9

The third character of the modifier for code 3050 indicates the method of administration of Misoprostol (Cytotec). ***V*** *indicates a vaginal administration of Misoprostol (Cytotec) and* ***R*** *indicates an Oral administration of Mistoprostol (Cytotec)*

For example, if a mother received 2 doses of vaginal Misoprostol (Cytotec) in the OPD, and one dose Misoprostol (Cytotec) as in in-patient, her case would be coded as ***3050 PGMV...21V***

For example, if a mother received 1 doses of Oral Misoprostol (Cytotec) in the OPD, and two dose Misoprostol (Cytotec) as in in-patient, her case would be coded as ***3050 PGMV...12R***

3050 PGMV . . . Misoprostol (Cytotec)

01V = No OPD vaginal administrations and "ONE " in-patient vaginal administration of Misoprostol. If either are greater than 9, code 9.

11V = "ONE" OPD vaginal administration and "ONE " in-patient vaginal administration of Misoprostol. If either are greater than 9, code 9.

21V = "TWO" OPD vaginal administrations and "ONE " in-patient vaginal administration given of Misoprostol,..... etc. If either are greater than 9, code 9.

01R ="No" OPD Oral administrations and "ONE " in-patient Oral administration of Misoprostol. If either are greater than 9, code 9.

11R = "ONE" OPD Oral administration and "ONE " in-patient Oral administration of Misoprostol. If either are greater than 9, code 9.

21R = "TWO" OPD Oral administrations and "ONE " in-patient Oral administration given of Misoprostol,..... etc. If either are greater than 9, code 9.

3060 SAIN . . . . Saline Injection and IV Syntocin

000 = Saline Injection and IV Syntocin administered during termination.

3070 DILE . . . . Dilatation and Evacuation

000 = Dilatation and Evacuation during termination.

3080 KCLI . . . . KCL Intracardiac Injection

000 = KCL Intracardiac Injection during termination.

3090 OCTV . . . . IV Syntocin

000 = IV Syntocin
(May be used after misoprostol administration(s))

CLASSIFICATION OF NEONATAL DISEASES AND PROCEDURES

I. PLACENTA AND UMBILICAL CORD ANOMALIES

0010 VINS . . . . . Velamentous Insertion of Cord
000 = Velamentous insertion of cord

0020 MINS . . . . . Marginal Insertion of Cord
(Battledore placenta)
000 = Marginal insertion of cord

0030 CIRV . . . . . Circumvallate Placenta
(Involving entire placental margin)
000 = Circumvallate placenta

0040 ANOD . . . . Amnionodosum
(As stated on the pathology report.)
000 = Amnionodosum

0050 SUCL . . . . Succenturiate Lobe
(Accessory lobe/Bilobed placenta/Bipartite)
000 = Succenturiate lobe

0060 CHOR . . . . Chorioamnionitis, Marked or Severe
(Not Chorionitis or Chorangiosis, as stated on the pathology report.)
000 = Chorioamnionitis, marked or severe

0070 FUNI . . . . . Funisitis
(As stated on pathology report.)
000 = Funisitis
C01 = Necrotizing funisitis
CAN = Candida

0080 SUMA . . . . Single Umbilical Artery
(Presence of one umbilical artery instead of the normal 2.)
000 = Single umbilical artery

0090 CPRO . . . . Cord Prolapse
000 = Cord prolapse

0100 PLUC . . . . Miscellaneous Placenta and/or Umbilical Cord Abnormality
C01 = Membranous placenta
C02 = Placenta accreta, Placenta Increta, Placenta Percreta
(As stated by the physician, or on pathology report)
C03 = True knot in cord
(Can be recorded on pathology report, delivery record or O.R. sheet.)
C04 = Trophoblastic disease
(Including hydatidiform mole, invasive mole, choriocarcinoma. As stated on the pathology report.)
C05 = Vasa previa
C06 = Insertio funiculi furcata
(As stated on the pathology report.)
C08 = Chorioangioma of placenta and/or cord
(As stated on the pathology report.)
C09 = Hematoma of umbilical cord
C10 = Placental floor infarct

II. FETAL MALNUTRITION

0110 WAST . . . . Fetal Clinical Soft Tissue Wasting
(Present at birth)
MOD = Moderate
SEV = Severe

III. ANOMALIES

Code all anomalies associated with syndromes.

A. CARDIOVASCULAR ANOMALIES

0130 CARD . . . . Congenital Heart Disease ***(C.H.D.)***

AOS = Aortic arch stenosis/ascending aortic stenosis
APR = Anomalous pulmonary venous return
APW = Aortico-pulmonary window

AVS = Aortic valve stenosis
BAV = Bicuspid aortic valve
CFO = Premature closure of foramen ovale
(Closure before birth)

CGV = Corrected left transposition
COA = Coarctation of the aorta
DAA = Double aortic arch

DBL = Double outlet left ventricle
DBR = Double outlet right ventricle
DPV = Dysplastic pulmonary valve

EBS = Ebstein's malformation of tricuspid valve
ECD = Endocardial cushion defect
(A.V. canal)
EDF = Endocardial Fibroelastosis

HLH = Hypoplastic left heart syndrome
IMV = Insufficiency/cleft of mitral valve
ITA = Interrupted aortic arch

MTA = Mitral atresia
MTS = Mitral stenosis
MUR = Cardiac murmur, cause unknown
(Code only if present at discharge and not due to any other cardiac disease; include physiologic peripheral pulmonary artery stenosis.)

OSP = Ostium primum defect
OSS = Ostium secundum defect
(A.S.D. inter-atrial defect)
PAA = Pulmonary artery atresia
(Do not code right heart hypoplasia.)

0130 CARD . . . . Congenital Heart Disease ***(C.H.D.)*** **(CONTINUED)**

PAS = Pulmonary artery stenosis (Pathologic)
PDA = Patent ductus arteriosus
(Do not code for premature babies. See Code 0140.)
PST = Pseudotruncus

PVA = Pulmonary vein atresia
PVI = Pulmonary valve insufficiency
PVS = Pulmonary valve stenosis/atresia
(Include thickened pulmonary valve.)

RAA = Right aortic arch
SAT = Single atrium
(Absence of atrial septum)
SUS = Suspect congenital heart disease
(Cardiac murmur with abnormal ECG or abnormal heart on X-ray.)

SVV = Single ventricle
TAR = Tuncus arteriosus
TAT = Tricuspid atresia

TCI = Tricuspid insufficiency
TET = Tetralogy of Fallot
TGV = Transposition of great arteries or great vessels

UCH = C.H.D., type unknown
UNC = C.H.D., unclassifiable
(Use specific code if possible.)
VSP = Ventricular septal defect
(Do not code if part of tetralogy of fallot.)

0140 DUCT . . . . Ductus Syndrome of Prematurity
(Patent ductus arteriosus. Code only of requires treatment.)
000 = No surgery
SUR = Surgical ligation of the ductus

0150 CARR . . . . Cardiac Arrhythmia
(Include pathologic bradycardia or tachycardia, e.g. P.A.T., heart block.)
(Excludes Sinus Tachycardia)
AEB = Atrial ectopic beats
ATF = Atrial flutter
AVB = AV Block (Incomplete) not due to digitalis
AVD = Complete AV dissociation
(Complete heart block)
CAT = Coatic atrial tachycardia
OTH = Other
(Include premature ventricular contractions)
PAT = Paroxysmal atrial tachycardia
SAR = Sinus arrest
UBC = Unexplained bradycardia
VTC = Ventricular tachycardia
(Idiopathic)
WPW = Wolff-Parkinson Syndrome

0160 DEXT . . . . Dextrocardia
ABI = Isolated abdominal situs inversus
(Heterotaxy Syndrome)
IDX = Isolated
MES = Mesocardia
WSI = With situs inversus

0170 PFCS . . . . . Persistent Fetal Circulation Syndrome
(Occurs within 1 week of age)
Persistent fetal circulation syndrome caused by the following:
CHD = Congenital heart disease
CUK = Cause Unknown
FMB = Fetomaternal bleed
HMD = Hyaline membrane disease
MEC = Meconium aspiration
PHP = Pulmonary hypoplasia
PNM = Pneumonia
PPH = Primary Pulmonary Hypertension

0180 PABS . . . . . Parabiotic Syndrome
DON = Donor
REC = Recipient

0190 CVSA . . . . Miscellaneous Cardiovascular Anomaly

C01 = Asplenia
C02 = Absence of pericardium or pericardial defect
C03 = Aneurysm of vein of Galen
C04 = Intracardiac mass
C05 = Acardia
C06 = Congenital cardiomyopathy
C07 = Arterio-venous malformation of lung
C08 = Intrathoracic (vascular) ring

B. GASTRO-INTESTINAL ANOMALIES

0210 IINA . . . . . Intestinal Atresia
- COL = Colonic
- DUO = Duodenal
- ILE = Ileal
- JEJ = Jejunal
- UKN = Site unknown

0220 IINS . . . . . Intrinsic Intestinal Stenosis
- ANS = Anal stenosis
- COL = Colonic
- DUO = Duodenal
- ILE = Ileal
- JEJ = Jejunal
- RTM = Rectum
- UKN = Site unknown

0230 EINO . . . . . Extrinsic Intestinal Obstruction
- ANP = Annular pancreas
- COB = Colonic bands
- DUB = Duodenal bands
- JEB = Jejunal bands
- SMB = Small bowel

0240 TEFA . . . . . Tracheo-Esophageal Fistula/Atresia
- C01 = Tracheo-esophageal fistula and/or atresia ***(Distinguish from 0350, Tracheal Atresia ONLY.)***
- C02 = Atresia of esophagus
- C03 = Tracheo-esophageal cleft

0250 MALR . . . . Intestinal Malrotation
- 000 = Intestinal malrotation

0260 BILA . . . . . Biliary Atresia
- BIA = Biliary atresia
- OBO = Other biliary obstruction ***(Stenosis, Choledochal Cyst)***

0270 HIRD . . . . . Hirschsprung's Disease
(Intestinal aganglionosis)
000 = Hirschsprung's disease

0280 IMPA . . . . . Imperforate Anus
000 = Imperforate anus

0290 GIAN . . . . . Miscellaneous GI Anomaly
C01 = Microcolon
C02 = Microcolon-megacystis-hypoperistalsis syndrome
C03 = Duplication of bowel
C04 = Alagilles' syndrome
C05 = Hepato-veno-occlusive disease of liver
C06 = Pyloric stenosis
C07 = Multiple echodensities within the peritoneal cavity and/or liver, unexplained
C08 = Paucity of intrahepatic bile duct
(Non-syndromic)
C09 = Meckel’s Diverticulum

0300 VOLV . . . . Volvulus
COL = Colon
ILE = Ileum
JEJ = Jejunum
SMB = Small bowel

C. RESPIRATORY ANOMALIES

0320 PHYP . . . . Pulmonary Hypoplasia/Agenesis
- BIL = Bilateral
- LEF = Left
- RIT = Right

0330 DIAH . . . . . Diaphragmatic Hernia
- LPL = Left posterolateral
- RPL = Right posterolateral
- RTS = Retrosternal

0340 BRGC . . . . Bronchogenic Cyst
- 000 = Bronchogenic cyst

0350 RAUN . . . . Miscellaneous Respiratory Anomaly
- C01 = Acinar dysplasia
- C02 = Tracheal atresia
- C03 = Pulmonary hyperplasia
- C04 = Tracheal agenesis
- C05 = Pulmonary Sequestria

0360 HYPD . . . . Hypoplasia of Diaphragm
- PAR = Partial
  (Including eventration of the diaphragm)
- TOT = Total

D. EYE, EAR, NOSE, MOUTH, AND THROAT ANOMALIES

0380 CTLP . . . . . Cleft Lip and/or Palate
(Includes absent palate, maxilla and nasal cartilage.)
CTL = Cleft lip only
CTP = Cleft palate only
CLP = Cleft lip and palate

0390 BCSF . . . . . Branchial Cleft Anomaly (cyst, sinus, fistula)
LEF = Left
RIT = Right
BIL = Bilateral
MDL = Midline branchial cleft anomaly

0400 CTAR . . . . Cataracts
LEF = Left
RIT = Right
BIL = Bilateral

0410 SKTP . . . . . Pre-auricular Skin Tag, Pit or Sinus
LEF = Left
RIT = Right
BIL = Bilateral

0420 EARS . . . . Stenosis or Atresia of External Auditory Meatus or Canal
LEF = Left
RIT = Right
BIL = Bilateral

0430 COPA . . . . Opacities of Cornea, Congenital
CRD = Corneal dermoid
CUK = Unknown
PAN = Peter anomaly
SLC = Scleralization of cornea

0440 MCGN . . . . Micrognathia
000 = Micrognathia

0450 MCOP . . . . Microphthalmia
LEF = Left
RIT = Right
BIL = Bilateral

0460 GLAC . . . . Glaucoma
ACQ = Acquired
CNG = Congenital

0470 COLB . . . . Coloboma
LEF = Left
RIT = Right
BIL = Bilateral

0480 INLD . . . . . Congenital Impatency of the Naso-Lacrimal Duct
LEF = Left
RIT = Right
BIL = Bilateral

0490 EAUC . . . . Miscellaneous Eye, Ear, Nose, Mouth, Throat Anomaly
C01 = Ranula
C02 = Laryngeal atresia and/or severe congenital laryngeal stenosis
C03 = Opacities of vitreous humour /persistent hyperplastic primary vitreous
C04 = Aniridia ***(Absence of iris)***
C05 = Laryngeal diverticulum
C06 = Microstomia
C07 = Eyelid fibrous bands (palpebral fissure band)
C08 = Facial cleft
C09 = Hypoplastic ears or absent pinna (microtia external ear)
C10 = Anophthalmia
C11 = Optic atrophy or optic nerve hypoplasia
C12 = Central blindness
C13 = Radicular cysts (apex of tooth)
C14 = Retinal dysplasia
C15 = Macrostomia

0500 CHOA . . . . Choanal Atresia
000 = Choanal atresia

0510 THYG . . . . Thyroglossal Anomalies
CST = Thyroglossal cyst
SKT = Skin tag

E. ANOMALIES OF INGUINAL CANAL

0520 CORC . . . . Cryptorchidism
(Code for term infants if testes not palpable. If stated as retractable or testes in canal, do not code.)
LEF = Left
RIT = Right
BIL = Bilateral
UKN = Unknown

0530 INGH . . . . . Inguinal Hernia
LEF = Left
RIT = Right
BIL = Bilateral

0540 FEMH . . . . Femoral Hernia

LEF = Left
RIT = Right
BIL = Bilateral

F. GENITOURINARY ANOMALIES

0550 HSPD . . . . Hypospadias Complex
(Hypospadias, chordee, bifid scrotum)
1ST = First degree
(Glandular)
2ND = Second degree
(Coronal)
3RD = Third degree
(Shaft)
4TH = Fourth degree
(Perineal)
UKN = Unknown

0560 EPSD . . . . . Epispadias
000 = Epispadias

0570 POLY . . . . Polycystic Kidney
(Potter's classification)
TP1 = Type I
(Congenital)
TP2 = Type II
(Multicystic)
TP3 = Type III
(Adult)
TP4 = Type IV
(Secondary to partial ureteral obstruction)
UKN = Type unknown

0580 AGEN . . . . Agenesis/Hypoplasia/Atrophy of Kidney
LEF = Left
RIT = Right
BIL = Bilateral

0590 HNHU . . . . Hydronephrosis and/or Hydroureter and/or RenalPelviectasis
(Include all causes)
LEF = Left
RIT = Right
BIL = Bilateral

0600 RDYS . . . . Renal Dysplasia
(Dysplastic kidney)
LEF = Left
RIT = Right
BIL = Bilateral

0610 DSYS . . . . Double Urinary System
(Include all types)
BLD = Double bladder
(Also double urethra)
RAS = Double renal arteries
PLV = Double pelvis
(Code for duplication of right kidney and double renal collecting system)
UTR = Double ureter

0620 GAGN . . . . Genital Agenesis/Hypoplasia
000 = Genital agenesis/hypoplasia

0630 RECT . . . . Renal Ectopia
FUS = Horseshoe kidney
PEL = Pelvic kidney

0640 UROB . . . . Urinary Obstruction
BNO = Bladder neck obstruction
PUV = Posterior urethral valve
UAS = Ureteral atresia/stenosis
UCL = Ureterocele
UDV = Ureteral diverticulum
UPJ = Ureteropelvic junction obstruction
(Also code any applicable surgery, see code 3280 SURG...UPJ)
UTO = Urethral obstruction

0650 IHYM . . . . Imperforate Hymen
000 = Imperforate hymen

0660 UBAN . . . . Urinary Bladder Anomalies
EXB = Exstrophy
EXC = Cloacal Exstrophy
AGB = Agensis of the Bladder

0670 GUAN . . . . Miscellaneous G.U. Anomaly

C01 =Torsion of testis
C02 = Urogenital sinus
C03 = Bicornuate uterus
C04 = Transposition of the scrotum
C05 = Urachal cyst
C06 = Congenital vaginal cyst
C07 = Ovarian cyst
C08 = Torsion of ovary
C09 = Absent uterus and/or absent Fallopian tubes and/or absent ovaries
C10 = Rectal-ano-urethral fistula
C11 = Large echodense kidneys, etiology unknown
C12 = Double vagina
C13 = Rectovaginal fistula
C14 = Hypoplasia of uterus
C15 = Patent (persistent) urachus
C16 = Nephrotic Syndrome
C17 = Vesicoureteric Reflux

G. SKIN ANOMALIES

0700 HANG . . . . Hemangioma
(Do not code capillary hemangiomas on eyelid or base of neck - "stork bites/angel kisses" - or for birth marks only.)
CAV = Cavernous
CAP = Capillary
(Strawberry nevus)
PWS = Port-wine stain
UKN = Type unknown

0710 PIGN . . . . . Pigmented Nevus
000 = Pigmented nevus

0711 DPIG . . . . . Depigmented Skin Lesions
ANM = Nevus Anemicus

0720 CDER . . . . Congenital Dermatosis
AED = Anhidrotic ectodermal dysplasia
BUK = Bullous, type unknown
CMC = Cutis marmorata congenita
CTA = Cutis aplasia
(Skin defect. Almost always depression on skin of scalp, not properly developed.)
EPB = Epidermolysis bullosa
GOL = Goltz syndrome
(Focal dermal hypoplasia)
ICP = Incontinentia pigmenti
NUK = Non-bullous, type unknown
URT = Urticaria pigmentosa
(Mast cell disease)

0730 SUPN . . . . Supernumerary Nipple
(Additional/accessory nipple)
LEF = Left
RIT = Right
BIL = Bilateral

0731 ABBR . . . . Absent Breasts
LEF = Left
RIT = Right
BIL = Bilateral

0740 AMNB . . . . Deformities Due to Amniotic Bands, Amniotic Band Syndrome, Early Amnion Rupture Sequence
000 = Deformities due to amniotic bands, amniotic band syndrome, early amnion rupture sequence

0750 ICTH . . . . . Ichthyosis
(Include all types)
000 = Ichthyosis

0760 CUTL . . . . Cutis Laxa/Hyperelastica
LAX = Cutis laxa
ELS = Cutis hyperelastica

0770 SKAN . . . . Miscellaneous Skin Abnormality
C01 = Dysplastic or absent nails
C02 = Inclusion cyst of skin
(Epidermoid cyst)
C03 = Miscellaneous
C04 = Cafe-au-lait spot
C05 = Sebaceous nevus
C06 = Dermatographia

H. **MUSCULOSKELETAL ANOMALIES**

0780 NECK . . . . Short Neck Disorders
- INI = Iniencephalus
- KPL = Klippel-Feil Syndrome

0790 CLFT . . . . . Club Foot
(Talipes equinovarus, talipes calcaneovalgus, or calcaneovarus)
- LEF = Left
- RIT = Right
- BIL = Bilateral

0800 CHIP . . . . . Congenital Hip
(Dislocatable, reducible)
- C01 = Diagnosed after discharge from hospital
- DLC = Dislocation
- LUX = Subluxation

0810 POLD . . . . Polydactyly
- 000 = Polydactyly

0820 SYND . . . . Syndactyly
- 000 = Syndactyly

0830 CSTN . . . . Craniosynostosis/Craniostenosis
- COR = Coronal
- CRZ = Crouzon's disease
- FRN = Frontal (Metopic)
- KLB = Kleeblattschadel
- LAM = Lambdoid
- SAG = Sagittal
- TRG = Trigonocephaly

0840 UMBD . . . . Umbilical Defect
(Do not code diastasis recti)
- GSC = Gastroschisis
- OMC = Omphalomesenteric cyst
- OMP = Omphalocele
- UMH = Umbilical hernia

0850 HAND . . . . Other Anomalies of the Hand/Foot
(Include missing digit, claw hand, hypoplasia of 1st metacarpal.)
000 = Claw hand, other anomalies of hand, other anomalies of foot
C01 = Hypoplastic disease, small digits ***(Fingers/toes)***
C02 = Bifid thumb
CDY = Camptodactyly
TRP = Triphalangeal thumb ***(2 joints)***

0860 PHOC . . . . Phocomelia/Amelia/Limb Reduction
(Includes hypoplasia of fibula.)
000 = Phocomelia/amelia/limb reduction

0870 ACON . . . . Osteochondroplasia
ACH = Achondroplasia
CND = Chondrodystrophy
DDS = Diastrophic dysplasia syndrome

0880 TORT . . . . Torticollis
TSM = Tumour of sternocleidomastoid

0890 VERT . . . . Vertebral anomalies
BIF = Bifid Rib
BKV = Block vertebra
ELR = Eleven ribs
HEM = Hemivertebra, bifid vertebra, butterfly vertebra, caranal cleft vertebra
MUL = Multiple
SCA = Sacrococcygeal agenesis, partial or total and/or bifid sacrum
(Caudal regression syndrome, Absent sacrum)
SUP = Supernumerary vertebra
TRT = Thirteen ribs
KPS = Kyphoscoliosis

0900 APCM . . . . Absence/hypoplasia of pectoralis major
LEF = Left
RIT = Right
BIL = Bilateral

0910 SMEL . . . . Sirenomelus
000 = Sirenomelus

0920 BBD . . . . . Osteogenesis Imperfecta
(Include other metabolic bone disease but exclude rickets.)
OSG = Osteogenesis imperfecta
MFR = Fractures-cause unknown
HPS = Hypophosphatasia

0930 THDW . . . Thanatophoric Dwarfism
000 = Thanatophoric dwarfism

0940 RADA . . . . Radial Aplasia/Hypoplasia
IRD = Isolated aplasia/hypoplasia of radius
ITH = Isolated aplasia/hypoplasia of thumb
THR = Aplasia/hypoplasia of both the radius and thumb

0950 MSAN . . . . Miscellaneous anomaly of musculo-skeletal system
C01 = Genu recurvatum
C02 = Hemihypertrophy
(Musculoskeletal)
C03 = Skull depression, unknown etiology
C04 = Absence or hypoplasia of depressor anguli oris muscle
C05 = Myotonic dystrophy
C06 = Absent ulna
C07 = Sprengel's deformity of shoulder
C08 = Dislocation of knee
C09 = Complete absence of abdominal wall
C10 = Myasthenia gravis - newborn
C11 = Congenital short femur
C12 = Hypoplastic calvaria
C13 = Dislocation of radial heads
C14 = Epigastric hernia
(Ventral or abdominal wall)

0960 MYOP . . . . Myopathy
NUC = Centronuclear
MTB = Myotubular

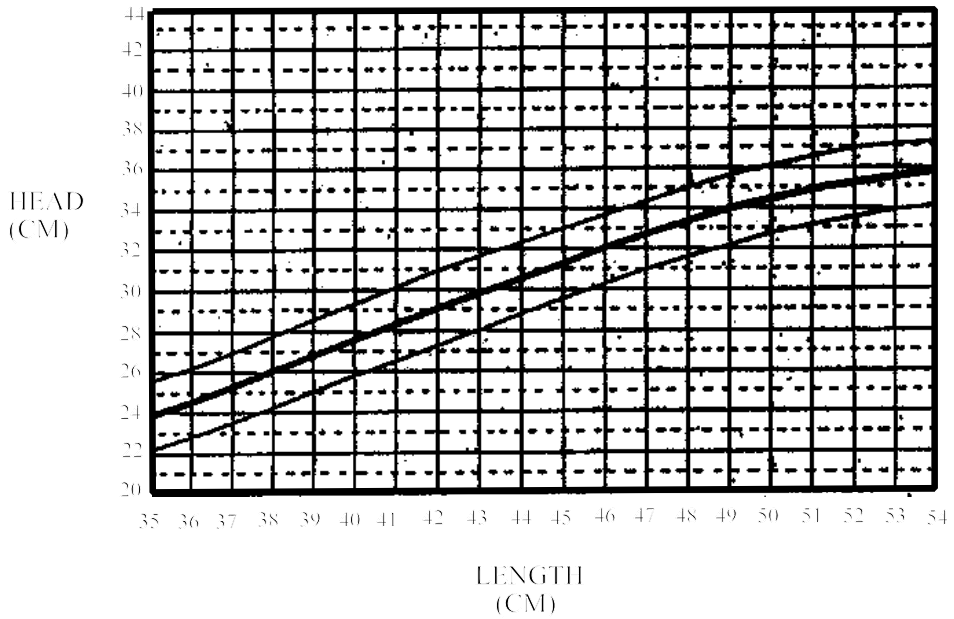
I. CENTRAL NERVOUS SYSTEM ANOMALIES

0970 CNSA . . . . C.N.S. Anomaly, Miscellaneous
(Does not include radicular cysts - code 0490)

C01 = Lipomeningocele
C02 = Agenesis of Corpus Callosum
(Hypoplasia)
C03 = Arachnoid cyst
C05 = Non-specific brain anomalies
C06 = Moebius syndrome
C07 = Polymicrogyria
C08 = Lissencephaly
C09 = Schizencephaly
C10 = Pachygyria
(Macrogyria)

0980 MICC .... Microcephaly
(Head circumference less than 2 standard deviations for length- see head/length growth graph - below.)
000 = Microcephaly

HEAD/LENGTH GROWTH GRAPH



NOTE: Always code **1030 MEGC .... Megalocephaly** if the head circumference is greater than 37 cm.

Usher, R., M.D., The Journal of Pediatrics,
Vol. 74, No. 6, Pages 901-910, June, 1969

0990 SBIF . . . . . Incomplete Closure of Neural Tube
CRB = Cranium bifidum
DFS = Dermal fistula
(Leaking spinal fluid, fluid drainage)
DSN = Dermal sinus
(Code only if the bottom of the depression cannot be seen and there is no drainage. Do not code dimples with closed or blind ends.)
ENC = Encephalocele
MGC = Meningocele
MMC = Meningomyelocele
RHS = Rachischisis
SPB = Spina bifida

1000 ANEN . . . . Anencephaly
000 = Anencephaly

1010 HYDN . . . . Hydranencephaly
000 = Hydranencephaly

1020 CHYP . . . . Brain Hypoplasia
000 = Brain hypoplasia
CBL = Cerebellar hypoplasia
DYS = Cortical dysplasia

1030 MEGC . . . . Megalocephaly
(Macrocephaly. Head circumference more than 2 standard deviations for length- see head/length growth graph - page 23.)
HCP = Hydrocephalus
(Include both congenital and acquired forms.)
MGU = Megalocephaly, type unknown
DWS = Dandy-Walker Syndrome

1040 DIAS . . . . . Diastematomyelia
(Diplomyelia. Congenital separation of lateral halves of spinal cord.)
000 = Diastematomyelia

1050 CLOP . . . . Cyclopia-Arhinencephaly Series
ARN = Arhinencephaly
CEB = Cebocephaly
(Monkey face)
CYC = Cyclops
HOL = Holoprosencephaly

1060 ARMC . . . . Arthrogryposis/contractures ***(see Smith, 3rd edition, p. 533)***

TP1 = Neurologic abnormality
TP2 = Muscle problems
(Muscle agenesis, myopathies, myotonic dystrophy)
TP3 = Joint disease
(Synostosis, lack of joint development, aberrant fixation as in diastrophic dwarfism, Larsen syndrome, popliteal web syndrome.)
TP4 = Fetal crowding/constraint
(As in multiple fetuses, and oligohydramnios.)
CUK = Contractures, cause unknown

1061 PHAK . . . . Phakomatoses

CRA = Cerebro-retinal angiomatosis
NFB = Neurofibromatosis
SWS = Sturge-Webber (encephalotrigeminal angiomatosis)
TSC = Tuberous sclerosis

1062 SPMA . . . . Spinal Muscular Atrophy

WHD = Werdnig-Hoffmann Disease

J. MULTIPLE ANOMALIES

1070 CHRM . . . . Multiple Anomalies Due to Chromosomal Aberrations

CRI = Cri-du-chat Syndrome
C1P = Chromosome 1p+
C9P = Chromosome 9p+

ESL = 12/21 Balanced Translocation
GQ- = Deletion of part of # 14 Chromosome
GSI = Gonosomal Intersex

GSL = Balanced 14-21 Translocation
HP+ = 15 P+ Syndrome
KP- = 18 P- Syndrome

KQ- = 18Q- Syndrome
MX0 = Mosaic Turner's Syndrome
M12 = Mosaic Trisomy 12

M13 = Mosaic 13 Syndrome
M21 = Mosaic Down's Syndrome

R05 = Ring 5
R13 = Chromosome Ring 13
R14 = Chromosome Ring 14
R15 = Chromosome Ring 15

TGC = Trisomy C group (includes Trisomy 8)

TRI = Triploidy
TUR = Turner's Syndrome

T07 = Trisomy 7
T09 = Trisomy 9
T13 = Trisomy 13
T14 = Trisomy 14
T18 = Trisomy 18
T19 = Trisomy 19
T21 = Down's Syndrome (Trisomy/Translocation 21)
T22 = Trisomy 22
UKN = Unknown type

WFS = Wolf Syndrome
XQ+ = X Chromosome Q+
XXY = Klinefelters Syndrome
XXZ = Marker Chromosome ***(female)***
XYY = XYY Syndrome
XYZ = Marker Chromosome ***(male)***

Z01 = 47XY
Z02 = Tetrasomy 12p

1070 CHRM . . . . Multiple Anomalies Due to Chromosomal Aberrations **(CONTINUED)**

2Q+ = 2Q+Syndrome
2Q- = 2Q- Syndrome
4Q- = 4Q- Syndrome
4Q+ = 4Q+Syndrome
5Q+ = 5Q+ Syndrome

6Q+ = 6Q+ Syndrome
9Q+ = 9Q+ Syndrome
FQ- = 13Q- Syndrome

13B = 13 Balanced Translocation
13L = Translocation 13
18B = 18 Balanced Translocation

21L = Translocation 21
57L = 5 to 7 Translocation
79L = 7 to 9 Translocation

1075 MDEL . . . . Chromosomal Deletion

PWS = Prader-Willi Sydrome

1080 NOTC . . . . Multiple Anomalies Not Due to Chromosomal Aberrations

ADO = Adams-Oliver Syndrome
APT = Apert's Syndrome
ASS = Asplenia Syndrome

BEC = Beckwith's Syndrome
BOR = Branchio-Oto-Renal Syndrome
BSA = Body Stalk Anomaly

CAR = Carpenter Syndrome
CCD = Cleido-Cranial dysostosis
CDL = Cornelia de Lange Syndrome
CHG = CHARGE Association
CNR = Conradi's Disease
CMT = Charcot-Marie-Tooth Syndrome
COS = Fraser's Syndrome
(Cryptophthalmus Syndrome)
CPT = Camptomelic Syndrome

DGS = DiGeorge Syndrome
EEC = Ectrodactyly - ectodermal dysplasia
(EEC Syndrome)
FAS = Fetal Alcohol Syndrome

1080 NOTC . . . . Multiple Anomalies Not Due to Chromosomal Aberrations **(CONTINUED)**

FHS = Fetal Hydantoin Syndrome
FND = Frontal-Nasal Dysplasia Sequence
GOS = Goldenhar Syndrome

HFD = Hypomandibular faciocranial dystosis
HOS = Holt Oram Syndrome
(Cardiac Limb Syndrome)
KTW = Klippel-Trenaunay-Weber Syndrome
LOW = Lowe's Syndrome
MFN = Marfan's Syndrome
MGR = Meckel-Gruber Syndrome

NOO = Noonan Syndrome
OFD = Oto-Facial-Digital
OMH = Oromandibular Limb Hypogenesis Syndrome

OTO = Otocephaly

PBS = Prune Belly Syndrome
(Triad Syndrome)
PE1 = Pena Shokeir, Type 1 Phenotype
PE2 = Pena Shokeir, Type 2 Phenotype
PHC = Phenocopy
PLD = Poland Syndrome
POC = Pentalogy of Cantrell
PRS = Pierre-Robin Syndrome
PSS = Polysplenia Syndrome
PTY = Multiple Pterygium Syndrome
RBT = Rubinstein-Taybi

ROB = Roberts' Syndrome
RSS = Russell-Silver Syndrome
RZM = Rhizomelic Dwarfism

SGB = Simpson-Golabi-Behemel Syndrome
SLO = Smith-Lemli-Opitz Syndrome
STK = Stickler's Syndrome

1080 NOTC . . . . Multiple Anomalies Not Due to Chromosomal Aberrations **(CONTINUED)**

TCS = Treacher-Collins' Syndrome
TBS = Townes-Brock Syndrome
UNC = Unclassifiable
VAT = Vater Association
(V.A.C.T.E.R.L. Syndrome - Vertebra, Anus, Cardiac, Trachea, Esophagus, Renal, Limb)

WIM = Williams' Syndrome
WWS = Walker-Warburg Syndrome
(Cerebro-Ocular dysgenesis)

1090 OLIG . . . . . Oligohydramnios Syndrome
(Oligohydramnios, Potter's facies, and pulmonary hypoplasia)

CUK = Oligohydramnios, cause unknown
FMN = Fetal malnutrition
LMB = Leaking amniotic fluid
OUA = Urinary anomalies excluding renal agenesis
NOL = Potter's Syndrome without oligohydramnios
(Renal agenesis)
POT = Potter's Syndrome with oligohydramnios
(Renal agenesis)

IV. ASPHYCTIC CONDITIONS

1100 ASPH . . . . Depression at Birth (Asphyxia Neonatorum**)**

(Depression at birth, requiring intermittent positive pressure breathing. If both mask and tube are used for resuscitation, code as resuscitation by tube. Code the duration as the sum of both the mask and tube resuscitation. Or if masked and stopped and restarted again code combined time of mask)

M01 = Resuscitation by mask < 1 minute duration
M02 = Resuscitation by mask 1 to 3 minutes duration
M03 = Resuscitation by mask > 3 minutes duration
MUK = Resuscitation by mask unknown duration

T01 = Resuscitation by tube < 1 minute duration
T02 = Resuscitation by tube 1 to 3 minutes duration
T03 = Resuscitation by tube > 3 minutes duration
TUK = Resuscitation by tube unknown duration

1101 ELNR . . . . Elective Non-Resuscitation

000 = Elective non-resuscitation
C01 = DNR order written on chart
C02 = Withdrawl of ventilator care and DNR order written on chart

1110 PADP . . . . Post-Asphyctic CNS Depression

000 = Post-asphyctic CNS depression

1120 PAEX . . . . Post-asphyctic CNS excitation

000 = Post-asphyctic CNS excitation

1130 PAIP . . . . . Post-asphyctic increased intracranial pressure

000 = Post-asphyctic increased intracranial pressure

1140 PACV . . . . Post-asphyctic convulsions

(Include those convulsions associated with I.V.H.)

000 = Post-asphyctic convulsions

1150 PABN . . . . Post-asphyctic brain necrosis

(Infarction)

000 = Post-asphyctic brain necrosis

1160 AXSH . . . . Anoxic subarachnoid hemorrhage
(Includes all subarachnoid bleeds.)
000 = Anoxic subarachnoid hemorrhage

1170 IVHR . . . . . Intra-ventricular hemorrhage
(Includes all intra-ventricular hemorrhage and all sub-ependymal hemorrhage, regardless of cause or predisposing factor.)
GR1 = Grade I
(Sub-ependymal, choroid plexus hemorrhage.)
GR2 = Grade II
(Hemorrhage into ventricle without dilation of ventricle.)
GR3 = Grade III
(Hemorrhage into ventricle with dilation of ventricle.)
GR4 = Grade IV
(Hemorrhage into brain; thalamic hemorrhage, cortical hemorrhage.)

1180 ASPN . . . . Aspiration Pneumonitis *(Perinatal Aspiration)*
AFA = Amniotic fluid aspiration
(Requires some evidence of fetal distress or intrauterine asphyxia; CXR shows densities with hyperaeration and there is no evidence of meconium or infection.)
MEC = Meconium Aspiration Syndrome
(Clinical syndrome with evidence of fetal distress or intrauterine asphyxia and presence of meconium.)

1190 PCHF . . . . . Post-Asphyctic Congestive Heart Failure
000 = Congestive heart failure
TCI = Tricuspid insufficiency due to congestive heart failure

1200 PATN . . . . Post-Asphyctic Acute Tubular Necrosis and Hemorrhagic Necrosis of Kidney
000 = Post-asphyctic acute tubular necrosis and hemorrhagic necrosis of kidney

1210 PALN . . . . Post-Asphyctic Liver and/or Adrenal Necrosis
ADH = Adrenal
LIV = Liver

V. TRAUMA

1220 FRAC . . . . Fracture
- CLV = Clavicle
- FEM = Femur
- HUM = Humerus
- OTH = Other
- RIB = Rib(s)
- SKL = Skull

1230 FACP . . . . . Facial Palsy ***(Exclude other cranial nerve palsies. See CODE 2050.)***
- LEF = Left
- RIT = Right
- BIL = Bilateral

1240 BRPP . . . . . Brachial Plexus (Erb's and Klumpke's) Palsy
- LEF = Left
- RIT = Right
- BIL = Bilateral
- RAD = Radial nerve palsy ***("Wrist drop")***

1250 PHRP . . . . . Phrenic Palsy
- LEF = Left
- RIT = Right
- BIL = Bilateral

1260 SPCI . . . . . Spinal Cord Trauma
- 000 = Spinal cord trauma

1270 ICHR . . . . . Traumatic Intra-Cranial Hemorrhage
- PCD = Combined posterior fossa subdural and epidural hemorrhage
- PED = Posterior fossa epidural hemorrhage ***(Cerebellar)***
- PSD = Posterior fossa subdural hemorrhage ***(Cerebellar)***
- SCD = Combined supratentorial and epidural hemorrhage
- SED = Supratentorial epidural hemorrhage
- SSD = Supratentorial subdural hemorrhage
- UKN = Type unknown

1280 CHEM . . . . Cephalohematoma
(Code all as stated, including those found by clinical clerk, on admission examination.)
LEF = Left
RIT = Right
BIL = Bilateral
OTH = Other, including occipital
UKN = Unknown

1290 SHEM . . . . Scalp Hemorrhage
000 = Scalp hemorrhage
SGL = Instances of subgaleal (subaponeurotic) hemorrhage

1300 PHEM . . . . Perineal hematoma
000 = Perineal hematoma

1310 LHEM . . . . Subcapsular hemorrhage of liver
000 = Subcapsular hemorrhage of liver

1320 LACL . . . . Laceration of Liver and/or Spleen
000 = Laceration of liver and/or spleen

1330 MISS . . . . . Miscellaneous Trauma
C01 = Adrenal hemorrhage
C02 = Perforated eardrum
C03 = Laryngeal palsy

1340 SPCH . . . . . Spinal Cord Subdural and/or Epidural Hemorrhage
000 = Spinal cord subdural and/or epidural hemorrhage

1350 TENT . . . . Tentorial Tear
000 = Tentorial tear

1360 SDYS . . . . Shoulder Dystocia
000 = Shoulder dystocia

1370 SCFN . . . . . Subcutaneous Fat Necrosis
000 = Subcutaneous fat necrosis

LIST OF ORGANISMS

The following list of organisms can be used for some of the codes in the following infection section. It will be noted with the code when to use the list of organisms.

GRAM-POSITIVE ORGANISMS

CLS	=	Clostridium
CNS	=	Coagulase-negative Staph.
CPS	=	Coagulase-positive Staph. (Staph. aureus)
ECO	=	Enterococcus
GAS	=	Group A streptococcus
GBS	=	Group B streptococcus
GNS	=	Other streptococcus
LIS	=	Listeria
PNC	=	Pneumococcus

GRAM-NEGATIVE ORGANISMS

AER	=	Aerobacter **or** Enterobacter **or** Citrobacter (Acinetobacter)
BPT	=	Bordetella Pertussis
BTR	=	Bacteroides
CAM	=	Campylobacter
ECL	=	E.coli
GON	=	Gonococcus
HPH	=	Hemophilus
KSL	=	Klebsiella
MEN	=	Meningococcus
OTH	=	Other
PRT	=	Proteus/Morganella
PSM	=	Pseudomonas
SAL	=	Salmonella/Shigella
SER	=	Serratia

MISC.CAUSATIVE ORGANISMS

CAN	=	Candida
CLM	=	Chlamydia
FUG	=	Fungal
MYC	=	Mycoplasma
VIR	=	Viral
CUK	=	Cause unknown

VI. INFECTIONS

A. INFECTIOUS DISEASES

1380 SISU . . . . . Systemic Infection, Site Unknown
(Clinical diagnosis, signs of sepsis, cultures negative)
000 = Systemic infection, site unknown

1390 SEPT . . . . . Septicemia
(Positive blood culture with organism identified.)
(SEE LIST OF ORGANISMS)

1400 POSB . . . . . Positive Blood Culture Without Other Evidence For Septicemia
(SEE LIST OF ORGANISMS)
CSF = Positive CSF culture without other evidence of meningitis

1410 GAST . . . . Gastroenteritis
(SEE LIST OF ORGANISMS)
DUK = Diarrhea of unknown etiology
GST = Gastroenteritis, cause unknown
PDR = Parenteral diarrhea

1420 UTIN . . . . . Urinary Tract Infection
(SEE LIST OF ORGANISMS)
BCU = Bacteriuria without other evidence for U.T.I.
(Large number of bacteria in urinalysis - uncontaminated specimen only.)
PYU = Pyuria without other evidence for U.T.I. ***(>5 WBC/HPF)***

1430 OMPH . . . . Omphalitis
(SEE LIST OF ORGANISMS)
(Umbilical phlebitis coded to 1630)

1440 MENG . . . . Meningitis ***(Ventriculitis)***
(SEE LIST OF ORGANISMS)
BAC = Bacterial, unknown type
VSH = Ventriculitis-shunt

1450 ENCC . . . . Encephalitis
(SEE LIST OF ORGANISMS)

1460 RHIN . . . . . Rhinitis
(SEE LIST OF ORGANISMS)

1470 INFC . . . . . Infected Cephalohematoma
(SEE LIST OF ORGANISMS)

1480 ANEC . . . . Acute Necrotizing Enterocolitis
AUT = Gross and microscopic appearance of the gut at autopsy
SUR = Gross and microscopic appearance of the gut at surgery
XRA = Definite pneumatosis intestinalis or definite portal gas on X-ray temporally associated with hematochezia

1490 PERT . . . . . Peritonitis
(SEE LIST OF ORGANISMS)
MEC = Meconium

1500 NEPH . . . . Nephritis
(SEE LIST OF ORGANISMS)
CHR = Chronic interstitial

1510 ENDC . . . . Endocarditis
(SEE LIST OF ORGANISMS)

1520 ARTH . . . . Arthritis
(SEE LIST OF ORGANISMS)

1530 MYOC . . . . Myocarditis
(SEE LIST OF ORGANISMS)

1540 ABSS . . . . . Abscess
BRN = Brain
EMP = Empyema
KDN = Kidney
LNG = Lung

1550 BINF . . . . . Bone Infection
OCH = Osteochondritis
(Metaphyseal rarefaction associated with chronic intrauterine infection.)
OSM = Osteomyelitis

1560 CONJ . . . . . Conjunctivitis
(SEE LIST OF ORGANISMS)
(Coagulase negative staph. is not usually a causative organism. Code if purulent drainage from conjunctiva or if treated with antibiotics excluding initial erythromycin.)

1570 SINF . . . . . Skin Infection
CAN = Candida (diaper rash)
PYO = Pyoderma
(Pustulosis or impetigo due to coagulase-positive staph or beta-hemolytc streptococcus.)
RTD = Ritter's disease

1580 OTSH . . . . Oral Thrush
000 = Oral thrush

1590 SCAB . . . . Subcutaneous Abscess or Carbuncle
(Include wound abscess or wound infection.)
(SEE LIST OF ORGANISMS)

1600 CELL . . . . . Cellulitis
(Includes paronychia)
(SEE LIST OF ORGANISMS)

1610 IUPN . . . . . Intrauterine Pneumonia
(Congenital onset, within 24 hours of birth.)
(SEE LIST OF ORGANISMS)

1620 PNPN . . . . Postnatal Pneumonia
(Onset after 24 hours of age)
(SEE LIST OF ORGANISMS)

1630 MINF . . . . . Miscellaneous Infections

C01 = Dacryocystitis
C02 = Otitis media
C03 = Otitis externa
C04 = Pericarditis
C05 = Trichomonas vaginalis
C06 = Ureaplasma colonization
C07 = Phlebitis ***(also umbilical)***
C08 = Lymphadenitis

1640 SCOL . . . . Organism Suspected of Causing Systemic Infection Because of Surface Colonization ***('TRUE' SWABS - Throat, Rectum, Umbilicus, Ear)***

Use specific organism when that organism is actually suspected of causing systemic infection. For example:

1. An infant may have a negative blood culture yet still show signs of infection, e.g. increased WBC, increased temperature, irritability. If surface swabs are positive for GBS, GBS would be the organism suspected of causing systemic infection therefore code 1640 SCOL GBS. Also code 1380 SISU 000, systemic infection, site unknown.
2. An infant may have pneumonia yet the blood or endotracheal tube culture is negative. If surface swabs are positive for GBS, then GBS would be the organism suspected of causing the pneumonia; therefore code 1640 SCOL GBS. Also code 1610 IUPN CUK or 1620 PNPN CUK because the organism is not proven, only suspected.

If there are no signs of systemic infection, yet surface swabs are positive for GBS, then code 1640 SCOL C01.

C01 = Group B streptococcus-positive surface cultures <u>not</u> causing systemic infection
C02 = Listeria-positive surfaces <u>not</u> causing systemic infection
C03 = Salmonella-positive surface cultures <u>not</u> causing systemic infection
C04 = Serratia-positive surface cultures <u>not</u> causing systemic infection

B. **CHRONIC INTRA-UTERINE INFECTION**

1650 RBEL . . . . Rubella
000 = Rubella

1660 CMVI . . . . Cytomegalovirus (CMV) Infection
(Cytomegalic inclusion disease)
CLN = CMV positive plus evidence for clinical C.I.D.
TIS = CMV positive plus tissue evidence of intracellular invasion without evidence for clinical C.I.D.
POS = CMV positive alone
(Include cellular inclusions in urine sediment)

1670 LUES . . . . . Syphilis
ACT = Active syphilis
STS = Positive serologic test for syphilis only

1680 TOXO . . . . Toxoplasmosis
000 = Toxoplasmosis

1690 CIIU . . . . . Chronic Intrauterine Infection, Causative Agent Unknown
000 = Chronic intrauterine infection, causative agent unknown

C. ACUTE VIRAL INFECTIONS

1720 VIRD . . . . . Miscellaneous Viral Disease

C01 = Picorna virus
C02 = Adenovirus
C03 = ECHO virus
C04 = Rota virus
C05 = A.I.D.S.
C06 = HIV antibody screen - positive without infection
C07 = Influenza A virus
C08 = Parvovirus
(or suspected)
C09 = Varicella virus
(Chicken pox)
C10 = Parainfluenza virus
RSV = Respiratory syncytial virus

1730 HERP . . . . Herpes Simplex

000 = Herpes simplex

1740 COXK . . . . Coxsackie Infection

A01 - A16 = To identify specific type
B01 - B05 = To identify specific type

D. INFECTION MISCELLANEOUS

1750 PUKO . . . . Pyrexia of Unknown Origin **(P.U.O. - NO KNOWN CAUSE**)
> 37.5^0 C on 2 occasions, at least 4 hours apart
000 = Pyrexia of unknown origin
(Not due to incubator heat)

1760 HIGM . . . . Elevated IgM Without Other Evidence of Infection
000 = Elevated IgM without other evidence of infection

Elevated IgM:

BIOCHEMISTRY

0 - 5 days	≥	.23 g/L
6 - 10 days	≥	.39 g/L
11 - 15 days	≥	.44 g/L
16 - 20 days	≥	.49 g/L

1790 MORG . . . . Miscellaneous Causative Organism
CAN = Candida
(See code 1570 for Candida diaper rash.)
FUG = Fungal

1800 CLAM . . . . Chlamydial Disease
C01 = Mother is culture positive without neonatal chlamydial disease
(Any time during pregnancy)
C02 = Mother not known to have chlamydial disease and infant culture positive
C03 = Infant with definite clinical chlamydial disease

1810 MYCO . . . Mycoplasma Disease ***(Ureaplasma)***
C01 = Mother is culture positive without neonatal mycoplasma disease
C02 = Mother not known to have mycoplasma disease and infant culture positive
C03 = Infant with definite clinical mycoplasma disease

VII. CNS DISEASES

1820 SLIN . . . . . Supero-Lateral Infarction of Brain ***(Diagnosed on ultra-sound)***
000 = Supero-lateral infarction of brain

1830 BHEM . . . . Brain Hemorrhage
BRS = Brain stem
CER = Cerebral
CBL = Cerebellar

1840 CHCA . . . . Convulsion - Due to Hypocalcemia
000 = Convulsion due to hypocalcemia

1850 CHGL . . . . Convulsion - Due to Hypoglycemia
000 = Convulsion due to hypoglycemia

1860 CHNA . . . . Convulsion - Due to Hyponatremia
000 = Convulsion due to hyponatremia

1870 CHMG . . . . Convulsion - Due to Hypomagnesemia
000 = Convulsion due to hypomagnesemia

1880CALK . . . . . Convulsion - Due to Alkalosis
000 = Convulsion due to alkalosis

1890 CMEN . . . . Convulsion - Due to Meningitis
000 = Convulsion due to meningitis

1900 CPYR . . . . Convulsion - Due to Pyridoxine Dependency or Deficiency
000 = Convulsion due to pyridoxine dependency or deficiency

1910 CKER . . . . Convulsion - Due to Kernicterus
000 = Convulsion due to kernicterus

1920 CBRN . . . . Convulsion - Due to Brain Edema
- 000 = Convulsion due to brain edema
- HCA = Hypercapnia

1930 CDWD . . . Convulsion - Due to Drug Withdrawal
- 000 = Convulsion due to drug withdrawal

1940 CCUK . . . . Convulsion - Cause Unknown or Other
- BFN = Benign familial neonatal
- CBH = Cerebral hemorrhage
- CUK = Cause unknown
- HPX = Hypoxia
  (Not birth depression - asphyxia neonatorum)
- IEM = Inborn error of metabolism
- INF = Infarction
- VNS = Venous thrombosis

1941 CCMB . . . . Convulsion Due to Congenital Malformation of Brain
- ARN = Arhinencephaly
  (Include holoprosencephaly)
- HCP = Hydrocephaly or hydranencephaly
- OBA = Other brain anomaly

1950 ACEX . . . . Abnormal Cerebral Irritation/Hypertonicity
(Exclude post-asphyctic)
- 000 = Abnormal cerebral irritation/hypertonicity
- HXA = Hyperexplexia (Hereditary Startle Disease)

1960 ACDP . . . . Abnormal Cerebral Depression/Hypotonicity
(Not occurring in delivery room. Exclude post-asphyctic and apnea.)
- 000 = Abnormal cerebral depression/hypotonicity
- MAD = Abnormal cerebral depression due to maternal analgesia.
  (As stated by physician)

1970 DWDW . . . Drug Withdrawal Syndrome
(Do Not Code 1950 or 1960 with this code)
BAR = Barbiturate
BZM = Benzomorphan
CCN = Cocaine
DEM = Meperidine (Demerol)
DIA = Diazepam (Valium)
ETH = Ethchlorvynol (Placidyl)
HER = Heroin
MOR = Morphine
MTH = Methadone
TLW = Pentazocine (Talwin)

1980 KERN . . . . Kernicterus
000 = Kernicterus

1990 CEDM . . . . Cerebral Edema, Regardless of Cause; Pathologic Diagnosis only
000 = Cerebral edema

2000 DGBD . . . . Hypotrophic Brain Disease, Acquired, Not Due to Asphyxia <u>in utero</u>
ATR = Cortical atrophy
ECM = Encephalomalacia
GIL = Gilles telencephalic leucoencephalopathy
INF = Infarction
POR = Porencephalic cyst(s)
PVL = Periventricular leukomalacia

2010 ACSF . . . . . Abnormalities of C.S.F.
(See code 1400 for positive CSF without other evidence of meningitis.)
GPR = Low glucose + high protein
HGO = Low glucose only
(< 50% of serum glucose)
PGP = Pleocytosis + low glucose + high protein
PLG = Pleocytosis + low glucose
PLO = Pleocytosis only
(Increased WBC and lymphocytes)
PLP = Pleocytosis + high protein
PRO = High protein only
(>2.0g/L in the absence of blood)

2020 HPAR . . . . Hemiparesis
TRS = Transient
(Not present at discharge from hospital)
PER = Permanent
(Present at time of discharge)

2030 APNE . . . . Apneic Spells
(Idiopathic apnea. Lack of breathing, accompanied by cyanosis and bradycardia.)
000 = Apneic spells

2040 OCNS . . . . CNS Abnormality, Miscellaneous
C01 = Retinal hemorrhage involving the macula
C02 = Chorioretinitis
C03 = Congenital subdural effusion
C04 = Periventricular calcification
C05 = Ondines's Curse
C06 = Opsoclonus

2050 CRAN . . . . Cranial Nerve Palsy
(Exclude facial (7th) nerve palsy; see CODE 1230)
003 = 3rd or oculomotor nerve
004 = 4th or trochlear nerve
005 = 5th or trigeminal nerve
006 = 6th or abducens nerve
010 = 10th or vagus nerve
(Include vocal cord paralysis due to laryngeal nerve palsy)

VIII. RESPIRATORY DISEASE

2060 IRDS . . . . . Respiratory Distress Syndromes

TRD = Transient respiratory distress
(Duration of > 1 hour and < 6 hours.
Do not code if cause of T.R.D. is identified, e.g. pneumothorax.)

MID =Mild I.R.D.S **(<35% O_2)**
MRD = Mod. I.R.D.S. **(35% O_2 or CPAP)**
SRD = Severe I.R.D.S. **(Ventilated)**

Guidelines for MID, MRD, SRD
Grunting, retractions, and decreased air entry - occurring before 3 hours of age and persisting beyond 6 hours of age and not explained by any other disease

TTN = Transient tachypnea of the newborn

Guidelines for TTN
Onset <3 hours of persistent tachypnea over 80/min. for more than 24 hours having a benign course and never requiring more than 40% O_2; may not require any oxygen to be administered. chest x-ray shows normal or increased inflation with peri-hilar streaking and fluid in the fissures or in the pleural space

BRD = Benign respiratory distress
(Persists beyond 6 hours of age)
HMF = Hyaline membrane formation not due to H.M.D.
(Path diagnosis)
EMF = Pulmonary edema without hyaline membrane formation
(Path diagnosis)

2070 PNTH . . . . Pneumothorax
(Exclude surgical pneumothorax)
RIT = Right
LEF = Left
BIL = Bilateral
(Both sides involved sometime during neonatal hospital course)

2080 PNMS . . . . Pneumomediastinum
(Exclude surgical pneumomediastinum)
000 = Pneumomediastinum

2090 IPEP . . . . . Interstitial Pulmonary Emphysema
(Also bilateral bullous)
000 = Interstitial pulmonary emphysema

2100 PNPC . . . . . Pneumopericardium
(Exclude surgical pneumopericardium)
000 = Isolated pneumopericardium

2110 CPDP . . . . . Chronic Pulmonary Disease of Prematurity
Defined as two of the following:

1. ***Abnormal chest x-ray not typical of other disease.***
2. ***Clinical respiratory distress greater than 2 weeks.***
3. ***PCO_2 of greater than 60 mm Hg on 2 or more occasions after 1 week of age with no other obvious cause.***

WM1 = Wilson-Mikity Syndrome* - not ventilated; no cystic change
WM2 = Wilson-Mikity Syndrome* - not ventilated; with cystic changes
BP1 = Bronchopulmonary dysplasia - ventilated; no cystic change
BP2 = Bronchopulmonary dysplasia - ventilated; with cystic changes

(*Note that some infants with Wilson-Mikity Syndrome may have been ventilated but this must have been late (e.g., after 2 weeks of age) and ventilation must have been begun <u>after</u> the clearly established onset of chronic lung disease.)

2120 STRI . . . . . Congenital Stridor
CUK = Cause unknown
HVC = Hyperplasia of vocal cords
LGM = Laryngomalacia
OMH = Oromandibular Limb Hypogenesis Syndrome
TBM = Acquired tracheobronchomalacia
TCM = Tracheomalacia
TRM = Traumatic
RPM = Retropharyngeal mass

2130 PULH . . . . Pulmonary Hemorrhage
000 = Pulmonary hemorrhage

2140 ATEL . . . . Atelectasis (Lobar) Not diffuse
000 = Atelectasis

2150 PEMB . . . . Pulmonary Embolus and/or Infarct
000 = Pulmonary embolus

2160 PHYS . . . . Pulmonary Emphysema
BGC = Lobar emphysema due to bronchogenic cyst
CUK = Cause unknown
IDI = Congenital idiopathic lobar emphysema

2170 CFIB . . . . . Cystic Fibrosis
(Includes meconium ileus)
000 = Cystic fibrosis

2180 LCYS . . . . Lung Cyst
000 = Lung cyst

2190 CCAM . . . . Cystic Adenomatoid Malformation of Lung
000 = Cystic adenomatoid malformation of lung

2200 CPLA . . . . Congenital Pulmonary Lymphangiectasia
000 = Congenital pulmonary lymphangiectasia

2210 RESD . . . . Miscellaneous Respiratory Disease
C01 = Chronic cor pulmonale
C02 = Chylothorax (Include congenital, acquired, surgical)
C03 = Pulmonary hypertension
(Due to chronic lung disease)
C04 = Foreign body granuloma of airway or lung
C05 = Fixed diaphragm
(Not due to paralysis)
C06 = Acquired aspiration pneumonitis (eg. gastric contents, formula)

IX. G.I. DISEASES

2230 LFIB . . . . . Liver Fibrosis
PPF = Periportal fibrosis

2240 CHAL . . . . Gastro-esophageal Reflux (Chalasia)
000 = With no evidence of hiatal hernia or pyloric stenosis
HIA = Hiatus hernia

2250 PINC . . . . . Pharyngeal Incoordination
(Clinical diagnosis confirmed by barium swallow during fluoroscopy.)
000 = Pharyngeal incoordination

2260 MALS . . . . Malabsorption Syndrome
000 = Malabsorption syndrome

2270 HEPT . . . . . Hepatitis
CUK = Unknown
TOX = Toxic
VIR = Viral

2280 PERF . . . . . Perforation of G.I. Tract
(Include meconium peritonitis)
APP = Appendix
COL = Cecum/colon
DUO = Duodenum
ESO = Esophagus
ILE = Ileum
JEJ = Jejunum
RTM = Rectum
STO = Stomach
UKN = Site unknown

2290 LACI . . . . Lactose Intolerance
ACQ = Acquired
HAL = Hereditary alactasia
(Flat lactose tolerance curve and/or no lactase on biopsy)
HLI = Hereditary infantile lactose intolerance
(Lactosuria)
CCU = Congenital, cause unknown

2300 IFAR . . . . . Intestinal Infarction
000 = Intestinal infarction

2310 APEN . . . . Appendicitis
000 = Appendicitis

2320 GIDS . . . . . Miscellaneous G.I. Disease
C01 = Pneumoperitoneum, cause unknown
C02 = Acquired stricture
C03 = Peptic ulcer
C04 = Rectal prolapse
C05 = Hydrops of gall bladder
C06 = Lactobezoar
C07 = Acquired volvulus
C08 = Cholelithiasis
C09 = Functional bowel obstruction, cause unknown
C10 = Cloacel Maldevelopment
C11 = Ectopic Anus
CUK = Cause unknown

2330 MECP . . . . Meconium Plug Syndrome
000 = Meconium plug syndrome

X. HEMATOLOGIC DISEASES

2350 BLUD . . . . Miscellaneous Hematologic Disease

C01 = Sickle cell trait
C02 = Methemoglobinemia
C03 = Isoimmune neutropenia
C04 = Perinatal hemochromatosis
C05 = Neutropenia, < 1,000 pmns (mature or bands per cu.mm)
use following formula:

Multiply the total corrected WBC's by the % of pmns (polymorphoneutrophils) and bands.

e.g. total WBC = 15,000
pmns = 5%
bands = 1%

Therefore:
Total pmns (mature and immature)= 0.06 x 15,000=900 (neutropenia)

2360 ABOI . . . . . ABO Isoimmunization

ABO SET-UP:

1) MOTHER BLOOD TYPE:O
   BABY BLOOD TYPE: A or B or AB
2) MOTHER BLOOD TYPE:A
   BABY BLOOD TYPE: B
3) MOTHER BLOOD TYPE:B
   BABY BLOOD TYPE: A

DEF = Definite
(ABO set-up, positive direct Coombs' test)

PBL = Possible
(ABO set-up, negative direct Coombs' test, positive indirect Coombs' test, and total bilirubin >15 mg% or 259 microM/L; or unconjugated bilirubin ≥ 230 microM/L)

UKN = Isoimmunization type unknown
(ABO groups compatible, positive direct Coombs' test, and no other known isoimmunization)

ISOIMMUNIZATIONS - NON-ABO

NOTE: A POSITIVE COOMBS' TEST IS REQUIRED FOR THE FOLLOWING ISOIMMUNIZATIONS - NOT JUST A CORD SERUM

2370 DISO . . . . . D Isoimmunization
000 = D isoimmunization

2380 LTLC . . . . Little c Isoimmunization
000 = Little c isoimmunization

2390 BIGC . . . . . Big C Isoimmunization
000 = Big C isoimmunization

2400 BIGE . . . . . Big E Isoimmunization
000 = Big E isoimmunization

2410 KELL . . . . Kell Isoimmunization
000 = Kell isoimmunization

2420 FYAI . . . . . Fya Isoimmunization ***(Duffy)***
000 = Fya isoimmunization

2430 KIDD . . . . Miscellaneous Isoimmunization
C01 = Kidd
C02 = Wright
C03 = MNS blood groups
C04 = Positive DAT
(Coombs' test) due to complement, no ABO set-up
C05 = Little "e"
C06 = Little "s"

2440 HBIL . . . . . Hyperbilirubinemia

(Total bilirubin > 15 mg% or > 258 microM/L; or unconjugated or indirect bilirubin ≥ 230 microM/L)

CSC = Congenital spherocytosis
CUK = Cause unknown
HEP = Hepatitis
HOH = Hepatic disease other than Hepatitis
ISO = Isoimmunization
POL = Polycythemia
RES = Resorption of hematoma
SEP = Sepsis (Infection)

2450 HEMR . . . . Hemorrhage

(Not due to asphyxia, trauma, or coagulation disorder when otherwise listed.)

ADH = Adrenal
CHZ = Hematochezia
(Frank bleeding; do not code occult blood only or ingested maternal blood)
FMB = Fetomaternal
FPL = Fetoplacental
HPC = Hemopericardium
HPT = Hemoperitoneum
HTH = Hemothorax
HUR = Hematuria
IAT = Iatrogenic
TTT = Twin-Twin Transfusion
UKN = Site unknown
UMB = Hemorrhage from umbilical or placental vessels
VOM = Hematemesis

2460 COAG . . . . Coagulopathy

AHG = AHG deficiency
(Antihemophilic globulin, blood coagulation Factor VIII - hemophilia)
ART = Arterial thrombosis
CUK = Cause unknown
DIC = Disseminated intravascular coagulation
F13 = Factor XIII deficiency
HDN = Hemorrhagic disease of the newborn
HDS = Coagulation disorder due to hepatic disease
HLK = Circulating anti-thrombin (Heparin-like substance)
PTA = PTA deficiency
(Plasma thromboplastin antecedent, blood coagulation Factor XI)
VON = Von Willebrand's disease
VTH = Venous thrombosis

2470 ANEM . . . . Anemia

(Hgb < 14 gm% or <140 g/L or Hct < 42% in the first week;
Hgb < 10 gm% or <100 g/L or Hct < 30% at any age.
Code the cause based on the first low hemoglobin, unless clearly stated otherwise.)

BLL = Blood-letting
(Due to multiple blood tests)
CSC = Congenital spherocytosis
CUK = Cause unknown

EXT = Exchange transfusion
FMB = Fetomaternal bleed
G6P = Glucose-6-phosphate dehydrogenase deficiency

HMR = Hemorrhage
ISO = Isoimmunization
(Requires a positive direct Coombs')
IFN = Infection

PKD = Pyruvate kinase deficiency
PMY = Prematurity
(After 7 days of age)
NPD = Neoplastic disease

SMC = Stomatocytosis
TOX = Toxic hemolytic anemia
TTT = Twin-Twin transfusion

VED = Vitamin E deficiency syndrome

2480 POLC . . . . Polycythemia

(Central Hgb >21 gm% (210 g/L), central Hct >63% (.630 L/L),
capillary Hgb >25 gm% (250 g/L), or capillary Hct >75% (.750 L/L);
both Hgb and Hct must be above normal on a single sample, or at least one of Hgb or Hct is above normal on 2 or more consecutive samples.)
000 = Polycythemia

2490 THRM . . . . Thrombocytopenia

(Platelet count <100,000 on one occasion with bleeding, or on 2 occasions when no clinical bleeding evident.)

BGI = Blood Group Isoimmunization
CUK = Cause unknown
EXT = Exchange transfusion
DIC = Disseminated intravascular coagulation
ISO = Isoimmune due to ITP ***(Idiopathic maternal thrombocytopenia)***
NPD = Neoplastic disease
PA1 = Isoimmune due to PLA1
SEP = Sepsis
TSA = Thrombocytopenia-absent radii syndrome

2500 OBST . . . . Obstructive Jaundice

(Direct bilirubin , or conjugated, >2.0 mg% or >34.5 micromol/L)

000 = Obstructive jaundice

2510 INRC . . . . . Increased Nucleated RBC and/or Normoblastemia

(>15% or greater than 18 nRBCs on 0-5 days;
>1% or greater than 2 NRBCS after 5 days)

000 = Increased nucleated RBC and/or normoblastemia

2520 RETC . . . . Reticulocytosis

(>7% on days 1-2; >5% on days 3-6;
>3% on days 7 and thereafter)

000 = Reticulocytosis

2530 LEUK . . . . Leukemia

000 = Leukemia

2540 RBCD . . . . Red Cell Defects

CSC = Congenital spherocytosis
G6P = Glucose-6-phosphate dehydrogenase deficiency
PKD = Pyruvate kinase deficiency
PPK = Pyropoikilocytosis
SMC = Hereditary stomatocytosis

2550 NEOP . . . . Neoplasms

CON = Connective tissue
CYS = Cystadenoma
END = Endothelial tissue

EN1 = Insulinoma
EPI = Epithelial tissue
EPY = Ependymoma

FOL = Follicular cyst
GLI = Nasal glioma
HPB = Hepatoblastoma

HYG = Cystic hygroma
LAN = Lymphangioma
MEB = Mesoblastic nephroma

MUS = Muscle
NBL = Neuroblastoma
NMB = Medulloblastoma

RHA = Rhabdomyoma
TER = Teratoma, embryonic rests
TGO = Teratoma, gonads

TSU = Teratoma, site unknown
UKN = Mass, unknown type
WIL = Wilms' tumour

XI. ENDOCRINE DISEASES

2560 GOIT . . . . . Congenital Goiter
- 000 = Congenital goiter

2570 PSUH . . . . Male Pseudohermaphroditism
- TFS = Testicular femininizing syndrome
- XOM = Male pseudohermaphroditism with XO-XY mosaicism
- XYK = Male pseudohermaphroditism with XY karyotype
- RFS = Reifenstein's syndrome
- BHS = 3-Beta-Hydroxysteroid dehydrogenase deficiency
- LAH = Lipoid adrenal hyperplasia
- DES = 17-20 desmolase deficiency
  (Zachmann-Prader syndrome)
- CUK = Cause unknown

2580 CRET . . . . Hypothyroidism
- ATH = Aplasia/hypoplasia
  (Athyreotic cretinism, ectopic thyroid)
- CUK = Type unknown
- HYP = Hypothalamic
- IDD = Iodine deficiency
  (Endemic cretinism)
- MAA = Maternal Antibodies
- MDI = Maternal drug ingestion
  (Propylthiouracil, iodides)
- NGC = Defective synthesis
  (Non-endemic goitrous cretinism)

2590 ADIS . . . . . Adrenal Insufficiency Syndrome
- AHP = Congenital adrenal hypoplasia/aplasia
- AHR = Adrenal hemorrhage
- DEH = Defect of dehydrogenation of 18-hydroxycorticosterone
- 18H = Defect of 18-hydroxylation of corticosterone
- 21H = 21-Hydroxylase deficiency

2600 HIT4 . . . . . Hyperthyroidism
C01 = Asymptomatic elevated serum T_4
C02 = Symptomatic SEE VALUES:

	Total T4 (nanomol/L)		TSH (mu/L)	
AGE	**MEAN**	**RANGE**	**MEAN**	**RANGE**
Cord Blood	131	95 - 167	9.0	<2.5 - 17.4
1 - 3 days	221	151 - 290	8.0	<2.5 - 13.3
1 - 2 week	169	126 - 213	---	---
2 - 4 week	141	88 - 192	4.0	0.6 - 10.0
1 - 4 months	132	92 - 185	<2.5	<2.5
4 - 12 months	141	100 - 212	2.1	0.6 - 6.3
1 - 5 year	135	94 - 192	2.0	0.6 - 6.3
5 - 10 year	119	82 - 170	2.0	0.6 - 6.3
10 - 15 year	104	72 - 150	1.9	0.6 - 6.3
Adult	108	55 - 160	1.8	0.2 - 7.6

From LaFranchi 1979

2601 LOPA . . . . Hypoparathyroidism
000 = Hypoparathyroidism

2610 DIBM . . . . Diabetes Mellitus
000 = Diabetes mellitus

2620 RICK . . . . . Rickets
C01 = Elevated alkaline phosphatase only
(>406 I.U.)
C02 = Evidence of bone demineralization with or without abnormal alkaline phosphatase
C03 = Clinical rickets
(Classical rickets.
Rickets with fractures.)
C04 = Clinical/Classical Rickets with Fracture

2630 ABIG . . . . . Ambiguous Genitalia
(See CODE 2830 = Miscellaneous endocrine disease)
000 = Ambiguous genitalia

XII. METABOLIC DISEASES

2640 LOGL . . . . Hypoglucosemia
(<30 mgm% or <1.67 mmol/L)
000 = Hypoglucosemia

2650 HIGL . . . . . Hyperglucosemia
(>125 mg% or >6.94 mmol/L)
000 = Hyperglucosemia

2660 LOCA . . . . Hypocalcemia (See code 2830MISC...C10 for Hypercalcemia)
(7.0 mg% or less; 1.75 mmol/L or less; ionized ≤ 1.0 mmol/L)
NOC = Without convulsions
TTY = Neonatal tetany
(Not post-asphyctic convulsions)

2670 LMBA . . . . Late Metabolic Acidosis
(After 72 hours of age; base deficit > -10 mEq/L or > -10 mmol/L)
000 = Non-persistent
RTA = Renal tubular acidosis

2680 LOSK . . . . Hypokalemia
(<3.0 mEq/L or <3.0 mmol/L)
000 = Hypokalemia

2690 HISK . . . . . Hyperkalemia
(7.0 mEq/L or more; 7.0 mmol/L or more)
000 = Hyperkalemia

2700 LONA . . . . Hyponatremia
(130 mEq/L or less; 130 mmol/L or less)
000 = Hyponatremia

2710 HINA . . . . Hypernatremia
(>155 mEq/L or >155 mmol/L)
000 = Hypernatremia

2720 HIUN . . . . Azotemia
(BUN 20 mg% or more; 7.14 mmol/L or more, urea value)
000 = Azotemia

2730 HICR . . . . . Hypercreatininemia
(2.0 mg% or more; 177 micromol/L or more)
000 = Hypercreatininemia

2740 LOUO . . . . Oliguria
(<15 ml/Kgm/day on Day 2 or <20 ml/Kgm/day after 2 days)
000 = Oliguria

2750 LOPR . . . . Hypoproteinemia
(4.0 gm% or less; 40 gm/L or less)
000 = Hypoproteinemia

2751 LOAL . . . . Hypoalbuminemia
(≤2.4 gm% or ≤24 gm/L)
000 = Hypoalbuminemia

2760 LOMG . . . . Hypomagnesemia
(1.3 mEq/L or less; 0.53 mmol/L or less)
000 = Hypomagnesemia

2770 HIMG . . . . Hypermagnesemia
(>2.5 mEq/L or >1.03 mmol/L)
000 = Hypermagnesemia

2780 HIPP . . . . . Hyperphosphatemia
(8.0 mg% or more; 2.58 mmol/L or more)
000 = Hyperphosphatemia

2790 PHEN . . . . Phenylalaninemia
- CUK = Type unknown
- PMY = Phenylalaninemia of prematurity
- TP1 = Phenylalaninemia Type I
  (Classical phenylketonuria)
- TP2 = Phenylalaninemia Type II
  (Atypical phenylketonuria)
- TPA = Transient phenylketonuria
- TPB = Benign hyperphenylalaninemia

2800 PROL . . . . Hyperprolinemia
- 000 = Hyperprolinemia

2810 TYRO . . . . Hypertyrosinemia
(5.0 mgm% or more)
- 000 = Hypertyrosinemia

2820 HNH3 . . . . Hyperammonemia
(>150 microgm% or >107 micromol/L)
- 000 = Hyperammonemia

2821 URIC . . . . . Hyperuricemia
(>400 micromol/L)
- 000 = Hyperuricemia

2830 MISC . . . . . Miscellaneous Endocrine and Metabolic
- C01 = Zinc deficiency
- C02 = Albinism
- C03 = Copper deficiency
- C04 = Fabry's disease
  (Alpha-glucosidase deficiency)
- C05 = Storage disease, type unknown
- C06 = Diabetes Insipidus
- C07 = Galactosemia
- C08 = Mucolipidoses
  (Include Sialidosis, I-cell disease, pseudo-Hurler polydystrophy)
- C09 = Nesidioblastosis
  (Pancreatic cell hyperplasia)
- C10 = Hypercalcemia
  (≥3.0 mmol/L; ionized - ≥1.5 mmol/L)
- C11 = Urea cycle defect
  (Argininosuccinic aciduria)
- C12 = Carnitine deficiency
- C13 = SIADH
  (Syndrome of inappropriate secretion of anti-diuretic hormone)
- C14 = Cystathioninuria
- C15 = Low serum alkaline/phosphatase (< 120 IU/L)

2830 MISC . . . . . Miscellaneous Endocrine and Methobolic**(Continued)**

C16 = Hepato-Renal Syndrome (As stated by Physician)

C17 = Zellweger Syndrome

2840 LOPP . . . . . Hypophosphatemia

(<4.0 mg% or <1.29 mmol/L)

000 = Hypophosphatemia

2850 ORGD . . . . Organic Acidosis

PDD = Pyruvate dehydrogenase deficiency (Congenital Lactic Acidosis)

PYD = Pyruvate carboxylase deficiency (Congenital Lactic Acidosis)

XIII. MISCELLANEOUS DISORDERS

2860 CCVH . . . . Complication of Vascular Catheter
- ARR = Arrhythmia
- EDM = Edema
- PCE = Pericardial effusion
- PFH = Perforation of heart
- PLE = Pleural effusion
- PNP = Phrenic nerve palsy
- RPT = Ruptured vessel
- THB = Thrombophlebitis
- VSS = Vasospasm
  (Severe)

2870 NCAL . . . . Nephrocalcinosis
- 000 = Nephrocalcinosis

2880 MUSC . . . . Acquired Muscle Contracture Due to IM Injections
- 000 = Acquired muscle contracture due to IM injections

2890 NSID . . . . . Non-SIDS Death After Discharge
- 000 = Non-SIDS death after discharge

2900 RLFP . . . . . Retrolental fibroplasia
(Retinopathy of prematurity)
- ST0 = Stage 0
  (Peripheral pallor)
- ST1 = Stage 1
  (Peripheral vascular straightening)
- ST2 = Stage 2
  (Peripheral shunt well seen)
- ST3 = Stage 3
  (Vessels growing into vitreous; vitreous . hemorrhages)
- ST4 = Stage 4
  (Retinal detachment)

2910 IKDM . . . . Infant of diabetic mother

(See Maternal Code 0520 for definition of maternal diabetes. If there is no history of diabetes, and no record of GTT results, but the mother is on insulin, code infant of gestational diabetic. If the F.B.S is equal to or greater than 7.0mmol/L a code infant of gestational diabetic.)

CLA = Infant of a known diabetic mother, Class A
(Define as abnormal maternal glucose tolerance test using either the Joslin Clinic or the O'Sullivan criteria, whichever is positive.)
CLB = Infant of a known diabetic mother, Class B
CLC = Infant of a known diabetic mother, Class C
CLD = Infant of a known diabetic mother, Class D
CLF = Infant of a known diabetic mother, Class F
CLR = Infant of a known diabetic mother, Class R
CLU = Infant of a known diabetic mother, Class unknown
CAD = Clinical appearance of an I.D.M. when mother not known to be a diabetic
CLT = Infant of mother with diagnosis of gestational diabetes made by level of greater than or equal to 10.3mmol/l trutol test.

JOSLIN CLINIC

[Both values must be abnormal]

Peak . . . . . 180 mg% or more; 10.0 mmol/L or more
1/2 hour post peak . . . 130 mg% or more; 7.2 mmol/L or more

O'SULLIVAN

[2 or more abnormal values]

F.B.S. . . 105 mg% or more; 5.3 mmol/L or more
1 Hour . 190 mg% or more; 10.6 mmol/L or more
2 Hour . 165 mg% or more; 8.9 mmol/L or more

2920 HRTF . . . . Congestive Heart Failure
(Not post-asphyctic, baby will usually receive digitalis or diuretics.)
ANE = Anemia
AVA = Arteriovenous (AV) Aneurysm
BPD = Bronchopulmonary dysplasia
CHD = Congenital Heart Disease
CUK = Cause unknown
LOG = Hypoglycemia
MOP = Cardiomyopathy
MYO = Myocarditis
PAT = Paroxysmal atrial tachycardia
SEP = Sepsis
TTT = Twin-to-twin transfusion

2921 ACDM . . . Acquired Cardiomyopathy
STR = Steroid induced

2930 SCLR . . . . Sclerema
000 = Sclerema

2940 RENF . . . . Renal Failure
000 = Renal failure

2950 HYDR . . . . Hydrops Fetalis
(Immune and non-immune)
ANA = Anasarca
(Generalized edema)
IAS = Isolated ascites

2970 LOWT . . . . Hypothermia
355 = 35.0 - 35.5^{0}C
350 = Below 35.0^{0}C.

2980 RVTH . . . . Renal Vein Thrombosis
LEF = Left
RIT = Right
BIL = Bilateral

2990 LPFO . . . . . Large Posterior Fontanelle
(Admits tip of examiner's 5th finger)
000 = Large posterior fontanelle

3000 FCAC . . . . Fetal Complications of Amniocentesis and/or Intrauterine Fetal Transfusion
HOM = Herniation of omentum
PTX = Pneumothorax
RUV = Rupture umbilical vessels

3010 CETT . . . . Complications of Endotracheal Tube
LPD = Lip or palate deformity
LPR = Laryngeal/esophageal perforation
NLT = Necrotizing laryngitis-tracheitis
PTS = Persistent post-intubation stridor, specific lesion not demonstrated
(Include causes not found and not looked for)
STN = Laryngeal and/or subglottic stenosis
TPR = Tracheal perforation
ULC = Ulceration and/or squamous metaplasia

3020 DIGX . . . . Digitalis Intoxication
(Include all digitalis-like drugs)
000 = Digitalis intoxication

3030 BURN . . . . Burns
CHE = Chemical
ELE = Electrical
TML = Thermal

3040 DRUG . . . . Drug intoxication
ALC = Alcohol
(>50 mgm% or >11 mmol/L)

CAF = Caffeine
(>40 mgm/L or >210 micromol/L)

CHL = Chloramphenicol
(>40 microgm/ml or >125 micromol/L)

DIL = Dilantin
(>40 mgm/L or >160 micromol/L)

GLY = Aminoglycoside intoxication
(Defined by "toxic" blood levels:
Gentamicin trough (Pre) > 3 mgm/L
peak (Post) > 15 mgm/L
Amikacin trough (Pre) > 15 mgm/L
peak (Post) > 50 mgm/L
Tobramycin trough (Pre) > 3 mgm/L
peak (Post) > 15 mgm/L)

PBR = Phenobarbital
(>40 mgm/L or >174 micromol/L)

PBZ = Phenoxybenzamine

VAN = Vancomycin
trough(Pre) > 15 mgm/L
peak (Post) > 45 mgm/L

3050 AIRE . . . . . Air Embolism
000 = Air embolism

3060 FAHT . . . . Deaf At Discharge
BIL = Bilateral
LEF = Left
RIT = Right

3070 DDEF . . . . Definitely Deaf
(Failed hearing test after 3 months of age.)
BIL = Bilateral
LEF = Left
RIT = Right

3080 SIDS . . . . . Sudden Unexpected Infant Death Syndrome

C01 = Died in hospital from S.I.D.S. before discharge
C02 = Died after discharge from hospital
C03 = "Near miss"
(Survivor of cardiac arrest, who was resuscitated.)
C04 = Monitored at home because previous sibling had SIDS
C05 = Monitored at home because of apnea
and/or bradycardia spells

3090 FNSS . . . . . Families In Need of Extra Services

C01 = Child abuse
C02 = Child neglect
C03 = High risk situation in home for abuse/neglect
C04 = Apprehension of Infant by Authorities

3100 SCPH . . . . Last Scalp Ph

C01 = >7.20
C02 = 7.10-7.19
C03 = <7.10

3120 MCEL . . . . Miscellaneous Disorders

C01 = Myocardial infarction
C02 = Twin fetus papyraceus (Infant not listed as twin)
C03 = Aborted twin or triplet
(Infant not listed as a twin or triplet)
C04 = Accidental drug injection into presenting part
C05 = Aborted fetus papyraceus
(Infant not listed as twin)
C06 = Perforation of lung by pleural drain (chest tube)
C07 = Scalp electrode complication
C08 = Fetus in fetu
C09 = Subcutaneous emphysema
C10 = Incisional hernia
C11 = Skin slough
C12 = Neonatal lupus erythematosus
C13 = Hemorrhage
(Into tumour)
C14 = Renal calculi
C15 = Pericardial effusion
C16 = Metastatic calcification of soft tissue
C17 = Cardiac Tamponade

XIV. TREATMENTS AND PROCEDURES

3130 CVPL . . . . Central Venous Line
(Exclude umbilical vein catheter)
000 = Central venous line

3140 RADC . . . . Non-Umbilical Artery Catheter
000 = Non-umbilical artery catheter

3150 UACA . . . . Umbilical Artery Catheter
000 = Umbilical artery catheter

3160 UVCA . . . . Umbilical Vein Catheter
(Do not code if part of a procedure, e.g. exchange transfusion.)
000 = Umbilical vein catheter

3170 IPPV . . . . . Intermittent Positive Pressure Ventilation
IPV = Ventilated
CPP = Tube C.P.A.P. only

3171 HIFV . . . . . High Frequency Ventilation
HFI = High frequency ventilation
VSO = Ventilation for Surgery only

3180 CPAP . . . . Nasal CPAP
(Include only nasal CPAP used before intubation and IPPV
Exclude nasal CPAP used during weaning from ventilator.)
000 = Nasal CPAP

3190 PDRN . . . . Pleural Drain/Chest Tube
LEF = Left
RIT = Right
BIL = Bilateral
TND = Thoracentesis, no drain
(Needle drainage of pleural cavity)

3200 EXCH . . . . Exchange Transfusion
- 001 = 1 transfusion
- 002 = 2 transfusions
- 003 = 3 transfusions
- 004 = 4 transfusions
- 005 = 5 transfusions
- 006 = 6 transfusions
- 007 = 7 transfusions
- 008 = 8 transfusions
- 009 = 9 transfusions

3210 NOJF . . . . . Tube Feedings
- OGG = Gastric tube feeds

(Include orogastric, nasogastric, and gavage feedings. Do not include jejunal feedings.)
- NJJ = Jejunal tube feeds

3220 PNUT . . . . Parenteral Nutrition

(If there is no route (peripheral or central line) indicated, code peripheral. Not eating via the gastro-intestinal tract, e.g. baby receives Vamin or Intralipid.)
- 000 = Peripheral vein or umbilical catheter
- C01 = Central line

(Not umbilical artery catheter or umbilical vein catheter)

3230 STIM . . . . . Stimulants Used in the Treatment of Apnea
- AMI = Theophylline

(Aminophylline)
- CAF = Caffeine
- DOX = Doxapram

3240 PHOT . . . . Phototherapy
- 000 = Phototherapy

3250 STER . . . . . Maternal Systemic Steroid Therapy

(In stillbirths, estimate duration of therapy to time of delivery.
Record 1st dose of 1st course.)

B12 = Betamethasone (Celestone), first dose given < 24 hours before delivery
B24 = Betamethasone, first dose given 24 to 47 hours before delivery
B48 = Betamethasone, first dose given 48 hours to 1 week before delivery
B1W = Betamethasone, first dose given more than 1 week before delivery
D12 = Dexamethasone (Decadron), first dose given < 24 hours before delivery
D24 = Dexamethasone (Decadron), first dose given 24 to 47 hours before delivery
D48 = Dexamethasone (Decadron), first dose given 48 hours to 1 week before delivery
D1W = Dexamethasone (Decadron), first dose given more than 1 week before delivery
HCS = Hydrocortisone
PRD = Prednisone
PDS = Prednisolone

3260 TRAC . . . . Tracheostomy

000 = Tracheostomy

3270 CCTH . . . . Cardiac catheterization

(If done for congenital heart disease, indicate the cardiac defect found as listed under Congenital Heart Disease -- See Code 0130.)

BAL = Balloon dilatation
BPD = Bronchopulmonary dysplasia
DSP = Ductus syndrome of prematurity
OTH = Other Angiocardiography

3271 CARB . . . . Cardiopulmonary Bypass

000 = Cardiopulmonary bypass

3280 SURG . . . . Major surgery

(Indicate the post-op surgical diagnosis; list surgical ligation of the ductus arteriosus for the ductus syndrome of prematurity under Code 0140.)

ABD = Abdominal-perineal pull-through
(Include Swenson pull-through)
ANS = Repair of imperforate anus
(Anoplasty)
APP = Appendectomy

ASW = Switching of coronary arteries or great arteries ***(Arterial switch)***
ATS = Atrial septectomy
AVO = Aortic valvotomy

BDR = Bile duct repair
BLA = Bladder surgery
BRN = Brain

CHC = Cholecystectomy
CHD = Congenital heart disease
CHO = Excision of choanal atresia

CLY = Colostomy
COA = Repair of coarctation of aorta
COL = Colon

CRN = Craniotomy
CTA = Cutis aplasia congenita
DAA = Division of double aortic arch

DFS = Dermal fistula
DIH = Diaphragmatic hernia
DSN = Dermal sinus

DUJ = Duodenojejunostomy
DUO = Duodenum
ECD = Repair of atrioventricular canal defect

ENC = Encephalocele
ESO = Esophagus
EXB = Repair of bladder exstrophy

FUN = Fundoplication
GLI = Removal of nasal glioma
GSC = Gastroschisis

3280 SURG . . . . Major surgery *(continued)*

(Indicate the post-op surgical diagnosis; list surgical ligation of the ductus arteriosus for the ductus syndrome of prematurity under Code 0014.)

HAR = Hemangioma resection
HCP = Hydrocephalus
(Includes CNS/ventricular shunts)
HDS = Hepatic disease

HLH = Hypoplastic left heart
ILE = Ileum
ING = Inguinal hernia

IPD = Surgical ligation/closure of patent ductus arteriosus
(Not of prematurity)
JEJ = Jejunal
MEK = Removal of Meckel's Diverticulum

MGC = Meningocele
MMC = Meningomyelocele
NEF = Nephrectomy

NPD = Neoplastic disease
OMP = Omphalocele
OOP = Oophorectomy/salpingo-oophorectomy

ORC = Orchidectomy
ORP = Orchidopexy
OVC = Removal of ovarian cyst

PAB = Banding pulmonary artery
PCT = Pancreatectomy, partial
PNV = Pneumonectomy

POD = Plication of diaphragm
PRS = Repair of Pierre-Robin Syndrome
(Tongue, lip, adhesions)
PTU = Patent urachus

PVO = Pulmonary valvotomy
PVR = Total repair of total anomalous pulmonary venous defect
PYE = Pyeloplasty
PYM = Pyloromyotomy

RAN = Surgical repair of ranula
RTM = Rectum
SKL = Elevation of depressed skull fracture

3280 SURG . . . . Major surgery *(continued)*

(Indicate the post-op surgical diagnosis; list surgical ligation of the ductus arteriosus for the ductus syndrome of prematurity under Code 0014.)

SMB = Repair of small bowel
STO = Stomach
SPS = Shunt of systemic pulmonary artery
(Includes central shunt, other cardiac shunts)

TAR = Repair of truncus arteriosus
TEF = Repair of tracheoesophageal fistula
TGV = Correction of transposition of great vessels
(Not an "arterial switch"- see ASW)

TRR = Tetralogy repair
TTA = Excision of Teratoma
TWN = Separation of conjoined twins

UMH = Repair of Umbilical Hernia
UPJ = Surgery for UPJ Obstruction
VSP = Repair of ventricular septal defect

3290 INDO . . . . Indomethacin therapy
000 = Indomethacin therapy

3300 TOLZ . . . . Tolazoline (Vasodilator)
000 = Tolazoline

3301 VASO . . . . Magnesium Sulphate (MgSO4) (Vasodilator)
000 = Magnesium sulphate

3302 INOX . . . . Nitric Oxide Therapy
000 = Nitric oxide therapy

3310 NITP . . . . . Nitroprusside
000 = Nitroprusside

3320 PGPG . . . . Prostaglandin E
000 = Prostaglandin E

3330 MIST . . . . . Miscellaneous Treatment or Procedure

C02 = Steroid therapy for infant after birth
(I.M., I.V., P.O.)
C03 = Peritoneal dialysis
C04 = Needle biopsy of liver
C05 = Muscle biopsy
C06 = Intestinal biopsy (rectum, colon)
C07 = Lung biopsy
C08 = Vesicostomy
C09 = Pericardiocentesis
C10 = Subdural peritoneal shunt
C11 = Nephrostomy, percutaneous
C12 = Myocardial biopsy
C13 = Granulocyte transfusion
C14 = Cystoscopy
C15 = Varicella zoster immune globulin injection
C16 = Skin biopsy
C17 = Metoclopramide
(Gastrointestinal therapy)
C18 = BCG vaccination
C20 = Balloon atrial septostomy
C21 = Biopsy of kidney(Needle or Open)
C22 = Cardiac massage
(External)
C23 = Hemofiltration
C24 = Fulguration (repair) of posterior urethral valves
C25 = Insertion of ventricular access device
(Intraventricular reservoir)
C26 = Inhaled aerosol steroid therapy
(Becloforte, Beclomethasone Dipropionate, Pulmicort, Budesonide)
C27 = Extracorporeal membrane oxygenation (E.C.M.O.)
C28 = Jejunostomy for feeding purposes
C29 = Cardiac Massage
(Open)
C30 = Thoracotomy to drain pericardium
C31 = Clipping of Sublingual Frenulum (Tongue Tied)
C32 = Bone Marrow Aspiration or Biopsy

3340 CIRC . . . . . Circumcision

000 = Circumcision

3350 VITE . . . . . Pharmacologic Vitamin E Therapy

000 = Pharmacologic vitamin E therapy

3360 GASY . . . . Gastrostomy for Medical Reasons

000 = Gastrostomy for feeding purposes

3370 PAGT . . . . Paralysing Agent
000 = Paralysing agent
PAV = Pavulon
(Pancuronium bromide)

3380 MYRN . . . Myringotomy
(Include myringotomy tubes)
000 = Myringotomy

3390 APAR . . . . Abdominal paracentesis
000 = Abdominal paracentesis

3400 BRON . . . . Bronchoscopy
000 = Bronchoscopy

3410 CRYO . . . . Cryosurgery
000 = Retina

3411 PAGT . . . . Laser Therapy
LOP = Left eye
ROP = Right eye

3420 HEPB . . . . Hepatitis B Prophylaxis
HBG = Hepatitis B globulin
VAC = Hepatitis B vaccine

3421 IMMZ . . . . Immunizations
FLU = Viral influenza
HIB = Hemophilus influenza, B conjugate vaccine **(HIB)**
RSV = Respiratory Synticial Virus Vaccine

3430 VITD . . . . . Pharmacologic Vitamin D
000 = Pharmacologic vitamin D
(Code only > 1,000 units/d.)

3440 DPTP . . . . . DPTP Immunization
000 = DPTP
DPT = DPT only
(No pertussis)

3450 HOME . . . . Home oxygen therapy
000 = Home oxygen therapy

3460 SURF . . . . Surfactant Administration
EXO = Exosurf (artificial)
SVA = Survanta (natural)
BLE = BLES Surfactant

3461 . . . . . CISA Cisapride Therapy
000 = Cisapride

3470 DEXA . . . . Dexamethasone Therapy
000 = Dexamethasone

XV. TWINS

3500 TWIN . . . . Twin type
ONE = Monoamniotic
(One amniotic sac)
MON = Monochorionic, diamniotic
DSB = Dichorionic, dissimilar sexes or blood groups
SSB = Dichorionic, similar sexes and blood groups
SSU = Dichorionic, similar sexes, blood groups . undetermined
UND = Undetermined
SIA = Siamese (Conjoined) twins

XVI - MISCELLANEOUS

3510 INSL . . . . . Insulin Administration
000 = Insulin Administration

3520 DOPA . . . . Dopamine Administration
(Blood pressure supportive agent)
000 = Dopamine administration

3521 ISUP . . . . . Isuprel Administration
(Blood pressure supportive agent)
000 = Isuprel administration

3522 DOBT . . . . Dobutamine Administration
(Blood pressure supportive agent)
000 = Dobutamine Administration

3530 PACE . . . . Cardiac Pacemaker
000 = Cardiac pacemaker

3540 ANHT . . . . Antihypertensive Therapy
CPL = Captopril
HYD = Hydralozine
PRO = Propranol
DIU = Diuretics used for treatment of hypertension (e.g Furosemide, Hydrochlorothiazide)

3550 ANTV . . . . Antiviral Therapy
ACY = Acyclovir
AZT = AZT (Zidovudine)
RIV = Ribavirin

3551 COFT . . . . Cofactor Treatment
BIO = Biotin
THI = Thiamine

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Syndrome: **(Continued)**

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