

**Nova Scotia Atlee
Perinatal Database
Coding Manual
8th Edition
(Version 8.0)**

April 2001

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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
Bayview Memorial Health Centre	58	... Advocate Harbour
Buchanan Memorial Hospital	15	... Neil's Harbour
Cape Breton Healthcare Complex:		
Glace Bay Site	75	... Glace Bay
North Sydney Site	41	... North Sydney
Sydney Site	73	... Sydney
Cape Breton Regional Hospital	73	... Sydney
CFB Cornwallis	79	... Cornwallis
CFB Stadacona	78	... Halifax
Chaleur Regional Hospital	-10	.. New Brunswick
Colchester Regional Hospital	18	... Truro
Dartmouth General Hospital	65	... Dartmouth
Digby General Hospital	20	... Digby
Eastern Memorial Hospital	22	... Canso
Eastern Shore Memorial Hospital	23	... Sheet Harbour
Fishermen's Memorial Hospital	24	... Lunenburg
George Dumont Hospital	-11	.. New Brunswick
Glace Bay Health Care Corporation	75	(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	41	(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
Western Regional Health Centre	56	..	Yarmouth
Hospitals in Alberta	-16	..	Alberta
Hospitals in British Columbia	-17	..	British Columbia
Hospitals in Manitoba	-18	..	Manitoba
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Hospitals in New Brunswick (other than those above)	-20	..	New Brunswick
Hospitals in Northwest Territories	-21	..	Northwest Territories
Hospitals in Ontario	-22	..	Ontario
Hospitals in PEI (other than those above)	-23	..	Prince Edward Island
Hospitals in Quebec	-24	..	Quebec
Hospitals in Saskatchewan	-25	..	Saskatchewan
Hospitals in United States	-26	..	United States
Hospitals in Yukon	-27	..	Yukon
Hospitals in Nunavut	-28	..	Nunavut

ROUTINE INFORMATION - DELIVERED ADMISSIONS

DELIVERED ADMISSIONS:

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME Mother's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

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

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

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

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

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

MATERNAL HEALTH Mother's health card number.
CARD NUMBER

Found on the '*HOSPITAL ADMISSION FORM*'.

Record Nova Scotia Health Card Numbers only.

Code using one of the following if HCN is unavailable:

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'

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

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

ANNAPOLIS COUNTY

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

ANTIGONISH COUNTY

- 14 Antigonish Municipality
- 15 Town of Antigonish

CAPE BRETON COUNTY

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

COLCHESTER COUNTY

- 26 Colchester Municipality
- 65 Stewiacke
- 70 Truro

CUMBERLAND COUNTY

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

DIGBY COUNTY

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

**MUNICIPAL CODE FOR
MOTHER'S RESIDENCE**

GUYSBOROUGH COUNTY

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

HALIFAX COUNTY

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

HANTS COUNTY

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

INVERNESS COUNTY

- 39 Inverness Municipality
- 58 Port Hawkesbury

KINGS COUNTY

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

LUNENBURG COUNTY

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

PICTOU COUNTY

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

MUNICIPAL CODE FOR
MOTHER'S RESIDENCE

QUEENS COUNTY

43 Liverpool
59 Queens Municipality

RICHMOND COUNTY

60 Richmond Municipality

SHELBURNE COUNTY

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

VICTORIA COUNTY

71 Victoria Municipality

YARMOUTH COUNTY

16 Argyle Municipality
75 Yarmouth Municipality
76 Yarmouth Town

OUT OF PROVINCE RESIDENTS

81 Alberta
82 British Columbia
83 Manitoba
84 New Brunswick
85 Newfoundland
86 Ontario
87 Prince Edward Island
88 Quebec
89 Saskatchewan
90 Yukon
92 Nunavut
93 Northwest 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 Northwest Territory
US USA
XX Other countries

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board
Registration Number.

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

Code '99999' for unknown.

DISCHARGE DATE Mother's discharge date from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'DDMMYYYY'.

DISCHARGE TIME Mother's discharge time from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'HHMM'.

If Discharge Time is not documented enter 1200.

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

DISCHARGE DISPOSITION (Not Applicable)

CONTACT TYPE The contact type will automatically fill.

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

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

Code using one of the following:

1 Patient discharged, chart to be coded

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

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

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

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

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

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

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

Code the following for the unusual situations:

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

ADMITTED FROM Mother's location immediately prior to admission.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

If patient comes from home, code '0'.

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

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

Use the following format: 'DDMMYYYY'.

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

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

Found on the '*PRENATAL RECORD*'.

Code using one of the following:

Y Yes

N No

Code '9' unknown.

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

Code '9' for unknown.

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

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

Code '9' for unknown.

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

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

Code '0' if no previous C-sections.

Code '9' for unknown.

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

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

Code using one of the following:

Y Yes
N No

Code '9' for unknown.

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

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

Code '9' for unknown.

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

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

Code '9' for unknown.

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

Found on the 'PRENATAL RECORD'.

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

- 0 patient did not smoke pre-pregnancy
- 75 . . . patient smoked ≥ 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 Maternal bleeding in present pregnancy greater than or equal to 20 weeks gestation.
ANTEPARTUM BLEEDING
≥ 20 WEEKS

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

Code using one of the following:

Y Yes
N No

Code '9' for unknown.

INTENT TO BREASTFEED Maternal intention to breastfeed.

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

Code using one of the following:

Y Yes
N No
U Unsure

Code '9' for unknown.

PREVIOUS BREASTFEEDING Mother's previous breastfeeding experience.
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

<u>REASON FOR MOTHER'S</u>	20	Respiratory infection
<u>ADMISSION CON'T</u>	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: 1/2 PACK=13 CIGS, 1 PACK=25 CIGS
If the number is recorded in a range, code the highest number, e.g. 10-15 would be coded as 15.*

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

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

PRESENT WEIGHT Patient's weight just before delivery.

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

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

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

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

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

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

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

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

Code '999' for unknown value.

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

Code using one of the following:

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

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

ROUTINE INFORMATION - LABOUR AND INFANT

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

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

Use one of the following codes:

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

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME Infant's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Use one of the following codes:

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

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

Found on the '*BIRTH RECORD*'.

Use the following format: 'DDMMYYYY'.

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

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

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

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

Found on the 'BIRTH RECORD'.

Use the following format: 'HHMM'.

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

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

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

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

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

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

TYPE OF RUPTURE OF MEMBRANES Type of rupture of membranes.

Found on the '*BIRTH RECORD*'.

Code using one of the following:

S Spontaneous

A Artificial

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

Code '9' for unknown.

MECONIUM STAINING Meconium staining of the amniotic fluid.

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

Code using one of the following:

Y Yes

N No

Code '9' for unknown.

LABOUR Initiation of labour.

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

Code using one of the following:

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

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

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

INDICATION FOR INDUCTION Reason for induction of labour.
OF LABOUR

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

Code using one of the following:

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

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

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

Use the following format: 'DDMMYYYY'.

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

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

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

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

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

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

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

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

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

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

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

Found on the 'PARTOGRAM'.

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

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

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

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

Code '99' for unknown.

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

Found on the 'PARTOGRAM or BIRTH RECORD.'

Code using one of the following:

Y Yes
N No

Code '9' for unknown.

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

Found on the '*PARTOGRAM*'.

Use the following format: 'DDMMYYYY'

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

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

Found on the '*PARTOGRAM*'.

Use the following format: 'HHMM'

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

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

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

CERVICAL DILATATION Cervical dilatation at time of augmentation.

**TIME OF MEDICAL
AUGMENTATION**

Found on the 'PARTOGRAM'.

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

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

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

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

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

Code '99' for unknown.

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

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

Use the following format: 'DDMMYYYY'.

Code when first indicated by physician or nurse.

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

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

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

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

Use the following format: 'HHMM'.

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

Code when first indicated by physician or nurse.

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

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

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

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

STAGE OF LABOUR

Found on the '*BIRTH RECORD*'.

Use the following format: 'DDMMYYYY'.

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

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

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

STAGE OF LABOUR

Found on the '*BIRTH RECORD*'.

Use the following format: 'HHMM'

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

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

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

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

Found on the '*BIRTH RECORD*'.

Use the following format: 'DDMMYYYY'

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

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

Found on the '*BIRTH RECORD*'.

Use the following format: 'HHMM'

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

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

MODE OF DELIVERY Mode of delivery.

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

Code using one of the following:

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

METHOD OF DELIVERY Method of delivery.

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

Code using one of the following:

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

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

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

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

- SPT Spontaneous vaginal

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

TRIAL OF LABOUR Attempted vaginal delivery after previous C-section

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

Code using one of the following:

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

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

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

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

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

Code '9' for unknown.

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

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 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 Apgar score at 1 minute.
AT 1 MINUTE

Found on the '*BIRTH RECORD*'.

Code between 0 and 10 for Apgar score.

Code '99' for unknown.

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

APGAR SCORE Apgar score at 5 minutes.
AT 5 MINUTES

Found on the '*BIRTH RECORD*'.

Code between 0 and 10 for Apgar score.

Code '99' for unknown.

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

PHYSICIAN ATTENDING The physician attending the delivery.
DELIVERY

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

Code using the Provincial Medical Board Registration Number.

88888 = Not registered in Nova Scotia

Code '99999' for unknown.

PRIMARY INDICATION Primary Indication for C-Section.

FOR C-SECTION

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

Code using one of the following:

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

Code '999' for unknown.

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

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

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

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

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

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

Breech (BCH)

3. Primary indication for C-section is:

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

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

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

Found on the 'ANESTHESIA RECORD'.

Code using one of the following:

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

Code '9' for unknown.

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

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

Code using one of the following:

- Y Yes
- N No

Code '9' for unknown.

MOTHER DISCHARGED TO The immediate destination of patient on discharge.

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

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

If patient is discharged home, code 0.

Code '9' for *Maternal Death*

MATERNAL ULTRASOUND Maternal Ultrasound.

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

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

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

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

For singleton pregnancies, the number will always be 1.

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

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

Found on the '*ULTRASOUND REPORT*' .

Use the following format: 'DDMMYYYY'.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

TIME OF FETAL DEATH When fetal death occurred.

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

Code using one of the following:

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

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

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

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Record Nova Scotia Health Card Numbers only.

Code using one of the following if HCN
unavailable:

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board
Registration Number.

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

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

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

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

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

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

Code '99' for unknown.

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

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

Code using one of the following:

Y Yes
N No

Code '9' for unknown.

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

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

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

Code using one of the following:

Y Yes
N No

Code '9' for unknown.

CORD ARTERY pH VALUE Cord artery pH value .

Found on the '*LAB REPORTS*'.

Use the following format: 'X.XX'

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

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

Allowed range is: 6.4 to 7.8

Code '99' for unknown.

PCO2 VALUE PCO2 value.

Found on the '*LAB REPORTS*'.

Enter value as recorded on lab reports

Use the following format: 'XXX.X'

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

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

Allowed range is: 0 to 130.

Code '999' for unknown

BASE EXCESS VALUE Base excess value.

Found on the '*LAB REPORTS*'.

Use the following format:

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

Allowed range is: 10 to -30.

Code '99' for unknown.

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

Found in the '*PROGRESS NOTES*'.

Code using one of the following:

Y Yes

N No

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

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

OUTCOME OF INFANT Outcome of infant at time of discharge.

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

Code using one of the following:

LVD Infant lived to be discharged from hospital.

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

FTD Fetal death before birth.

BREAST FEEDING Infant breastfeeding at time of discharge from hospital.

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

Code using one of the following:

Y Yes

N No

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

Code '9' for unknown.

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

Found in the '*NURSES' NOTES*'.

Use the following format: 'DDMMYYYY'

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

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

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

Found in the '*NURSES' NOTES*'.

Use the following format: 'HHMM'

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

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

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

DISCHARGED TO Immediate destination of infant on discharge from hospital.

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

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

If patient is discharged home, code '0'

Code '-9' for *Infant Death*

AUTOPSY Completion of infant autopsy.

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

Code using one of the following:

LVD Lived (e.g., not applicable)

YES Died and autopsy done

NO Died but autopsy not done

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

Leave blank if infant lived.

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

Use one of the following codes:

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

- FETH Fetal hemorrhage

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

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

- KERN Kernicterus
- MALP Malpresentation

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

- MINF Myocardial infarction
- NEOP Neoplasia
- TTTX Parabiologic syndrome
- PPFC Persistent fetal circulation
- PLPV Placenta previa

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

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

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

DATE OF DEATH Date of infant's death.

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

Use the following format: 'DDMMYYYY'

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

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

TIME OF DEATH Time of infant's death.

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

Use the following format: 'HHMM'

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

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

ROUTINE INFORMATION-UNDELIVERED ADMISSIONS

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

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

Found on the '*HOSPITAL ADMISSION FORM*' .

Use the following format: 'DDMMYYYY'

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

Found on the '*HOSPITAL ADMISSION FORM*' .

Use the following format: 'HHMM'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME Mother's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

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

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

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

Code '999999' 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 Northwest Territory
- US USA
- XX Other countries

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Registration Number.

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

Code '99999' for unknown.

DISCHARGE DATE Mother's discharge date from hospital.

Found on the '*NURSES NOTES*'.

Use the following format: 'DDMMYYYY'.

DISCHARGE TIME Mother's discharge time from hospital.

Found on the '*NURSES NOTES*'

Use the following format: 'HHMM'

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

If Discharge Time is not documented enter 1200.

DISCHARGE DISPOSITION (Not Applicable at this time)

CONTACT TYPE The contact type will automatically fill

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

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

Code using one of the following:

1 Patient discharged, chart to be coded

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

3 Coding of admission information completed

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

If patient comes from home, code '0'.

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

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

Use the following format: 'DDMMYYYY'.

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

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

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

DISCHARGED TO The immediate destination of patient on discharge.

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

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

If patient is discharged home, code 0.

Code '-9' for *Maternal Death*.

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

Code using one of the following:

1 Patient discharged, chart to be coded

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

3 Coding of **undelivered routine** information completed

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

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

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

“LEFT BLANK INTENTIONALLY”

ROUTINE INFORMATION-POSTPARTUM ADMISSIONS

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

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

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

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

CONTACT HOSPITAL Hospital in which the chart is being coded.

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

Found on the 'HOSPITAL ADMISSION FORM'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME Mother's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

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

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

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

MATERNAL HEALTH CARD NUMBER Mother's health card number.

Found on the '*HOSPITAL ADMISSION FORM*'.

Record Nova Scotia Health Card Numbers only.

Code using one of the following if HCN unavailable:

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

MARITAL STATUS Mother's marital status.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using one of the following:

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

Code '7' for unknown.

STREET ADDRESS Mother's street address.

Found on the '*HOSPITAL ADMISSION FORM*'

Example: 4 King Street

MAIL ADDRESS Mother's mail address.

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

POSTAL CODE Mother's postal code.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Code '999999' for unknown.

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

Found on the '*HOSPITAL ADMISSION FORM*'.

PROVINCE Mother's province of residence.

Found on the '*HOSPITAL ADMISSION FORM*'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Registration Number.

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

Code '99999' for unknown.

DISCHARGE DATE Mother's discharge date from hospital.

Found on the '*NURSES NOTES*'

Use the following format: 'DDMMYYYY'.

DISCHARGE TIME Mother's discharge time from hospital.

Found on the '*NURSES NOTES*'

Use the following format: 'HHMM'.

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

If Discharge Time is not documented enter 1200.

DISCHARGE DISPOSITION (Not Applicable at this time)

CONTACT TYPE The contact type will automatically fill

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

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

Code using one of the following:

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

If patient comes from home, code '0'.

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

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

Use the following format: 'DDMMYYYY'

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

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

Code '99' for unknown.

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

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

Code using the following reason for admission:

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

DISCHARGED TO The immediate destination of patient on discharge.

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

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

If patient is discharged home, code 0.

Code '-9' for *Maternal Death*.

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

Code using one of the following:

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

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

ROUTINE INFORMATION-NEONATAL ADMISSIONS

NEONATAL ADMISSIONS:

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

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

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

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

Found on the *'HOSPITAL ADMISSION FORM'*

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'.

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME Infant's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Record Nova Scotia Health Card Numbers only.

Code using one of the following if HCN unavailable:

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

STREET ADDRESS Infant's street address.

Found on the '*HOSPITAL ADMISSION FORM*'

Example: 4 King Street

MAIL ADDRESS Infant's mail address.

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

POSTAL CODE Infant's postal code.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Code '999999' for unknown.

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

Found on the '*HOSPITAL ADMISSION FORM*'

PROVINCE Infant's province of residence.

Found on the '*HOSPITAL ADMISSION FORM*'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using the Provincial Medical Board Registration Number.

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

Code '99999' for unknown.

DISCHARGE DATE Infant's discharge date from hospital

Found on the '*NURSES NOTES*'

Use the following format: 'DDMMYYYY'.

DISCHARGE TIME Infant's discharge time from hospital

Found on the '*NURSES NOTES*'

Use the following format: 'HHMM'.

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

If Discharge Time is not documented enter 1200.

CONTACT TYPE The contact type will automatically fill.

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

Found on the 'Birth Record'

Code using one of the following

F Female

M Male

A Ambiguous

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

Code using one of the following:

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

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

BIRTH ORDER Infant's order of birth.

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

Use one of the following codes:

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

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

Found on the 'HOSPITAL ADMISSION FORM'

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

If patient comes from home, code '0'

BIRTH HOSPITAL Infant's hospital of birth.

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

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

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

Found in the '*PROGRESS NOTES*'.

Code using one of the following:

Y Yes

N No

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

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

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

Code using one of the following:

LVD Infant lived to be discharged from hospital.

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

DISCHARGED TO Immediate destination of infant on discharge from hospital.

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

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

If patient is discharged home, code '0'

Code '-9' for *Infant Death*

AUTOPSY Completion of infant autopsy.

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

Code using one of the following:

LVD Lived (e.g., not applicable)

YES Died and autopsy done

NO Died but autopsy not done

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

Leave blank if the infant lived.

SEE LISTING ON PAGES 58-59.

DATE OF DEATH Date of infant's death.

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

Use the following format: 'DDMMYYYY'

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

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

TIME OF DEATH Time of infant's death.

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

Use the following format: 'HHMM'

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

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

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

Code using one of the following:

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

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

“LEFT BLANK INTENTIONALLY”

ROUTINE INFORMATION-ANOMALY ADMISSIONS

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

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

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

CONTACT HOSPITAL Hospital in which the chart is being coded.

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'.

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'HHMM'.

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

SURNAME Patient's surname.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

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

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

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

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Record Nova Scotia Health Card Numbers only.

Code using one of the following if HCN
unavailable:

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

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

Found on the '*HOSPITAL ADMISSION FORM*'.

Use the following format: 'DDMMYYYY'

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

Found on the '*HOSPITAL ADMISSION FORM*'.

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

MARITAL STATUS Patient's marital status.

Found on the '*HOSPITAL ADMISSION FORM*'.

Code using one of the following:

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

Code '7' for unknown.

STREET ADDRESS Patient's street address.

Found on the '*HOSPITAL ADMISSION FORM*'

Example: 4 King Street

MAIL ADDRESS Patient's mail address.

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

Found on the '*HOSPITAL ADMISSION FORM*'

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

POSTAL CODE Patient's postal code.

Found on the '*HOSPITAL ADMISSION FORM*'.

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

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

Code '999999' for unknown.

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

Found on the '*HOSPITAL ADMISSION FORM*'

PROVINCE Patient's province of residence.

Found on the '*HOSPITAL ADMISSION FORM*'

AB Alberta
BC British Columbia
MB Manitoba
NS Nova Scotia
NB New Brunswick
NF Newfoundland
ON Ontario
PE Prince Edward Island
QC Quebec
SK Saskatchewan
YT Yukon
NU Nunavut
NT Northwest 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'

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.

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.

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.

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).

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.

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.

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.

Code '9' for unknown.

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

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.

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.).

Code '9' for unknown.

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

Code '9' for unknown.

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

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.

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 Patient bleeding in present pregnancy greater than or equal to 20 weeks gestation.

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.

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.

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 '*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.

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.

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 delivery.

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

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

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

PRESENT WEIGHT Patient's weight just before delivery.

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 at delivery.

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 patient delivered.

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

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

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.

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.

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

For Siamese twins, split weight between babies.

Do NOT take from Pathology Report.

Code '9999' for unknown.

PHYSICIAN ATTENDING DELIVERY The physician attending the delivery.

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*'

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

If patient is discharged home, code 0.

Code '-9' for *Maternal Death*

MATERNAL ULTRASOUND Maternal Ultrasound.

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

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

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

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

Found on the '*ULTRASOUND REPORT*' .

Use the following format: 'DDMMYYYY'.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

Found on the '*ULTRASOUND REPORT*'.

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

Decimal points must be entered.

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

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

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.

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 "*AUTOPSY REPORT*".

Code using one of the following:

YES Died and autopsy done
NO Died but autopsy not done

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

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

Code using one of the following:

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

DISEASES AND PROCEDURES**I. PREVIOUS PREGNANCY MATERNAL DISEASES**

- 0010 PHIL Previous History of Personal Malignancy
(Do not include Ca in-situ of cervix)
000 = Previous history of personal malignancy
- 0040 PANT Previously Sensitized Pregnancy
(This code requires Code 0470 to be coded as well.
Should be well documented, indicating that the antibodies now present are due to a
previous pregnancy or abortion, e.g. not to include those due to a blood transfusion.)
000 = Previously sensitized pregnancy
- 0050 PHIP Hypertensive Disease In Previous Pregnancy
(High blood pressure, toxemia, pre-eclampsia or hypertension, as stated in chart.)
000 = Hypertensive disease in previous pregnancy
- 0060 PECL Previous Eclampsia
(Convulsions or eclampsia as stated on chart, excluding epilepsy.)
000 = Previous eclampsia
- 0100 PECP Previous Ectopic Pregnancy
(Do not include blighted ovum.)
000 = Previous ectopic pregnancy
- 0110 PMOL Previous Molar Pregnancy
(Do not include Blighted ovum. Do include Trophoblastic disease, hydatidiform
mole, invasive mole, and choriocarcinoma, even if successfully treated in a previous
pregnancy)
000 = Previous molar pregnancy
- 0120 PLOH Previous Anemia
000 = Previous anemia
- 0130 PABP Previous Abruptio Placenta
000 = Previous abruptio placenta

0140 PRBR Previous Breech
 000 = Previous breech

0150 PTEB Previous Thromboembolic Disease
(Code any previous Thrombophlebitis, deep vein thrombosis, pulmonary embolus wheher occurred during a pregnancy or not. Do not code if documented as superficial phlebitis.)
 000 = Previous thromboembolic disease

0160 PGLD Previous Gestational Diabetes
 000 = Previous gestational diabetes

0170 PFER Previous History of Infertility
(As clearly indicated on the chart, eg. use of Clomid, or other fertility drugs. Do not code if secondary to tubal ligation.)
 000 = Previous history of infertility

0180 PPPD Previous Postpartum Depression
 000 = Previous postpartum depression

II. PRESENT PREGNANCY MATERNAL DIAGNOSES

A. **OBSTETRICAL** *CODE ONLY IF PRESENT DURING ADMISSION. NOTE: ALL CODES, UNLESS OTHERWISE SPECIFIED, APPLY TO DELIVERED AND UNDELIVERED PATIENTS*

0190 ABRT Abortions
CODE ONLY IF OCCURS DURING ADMISSION.
 THR = Threatened abortion
(Uterine bleeding < 20 weeks gestation)

GUIDELINES FOR PREGNANCY-INDUCED HYPERTENSION**MILD PREGNANCY-INDUCED HYPERTENSION**

1. If P.I.H. is stated by the physician, it should always be coded (regardless of the values of the diastolic and systolic blood pressures).
2. If a patient is admitted from a physician's office with P.I.H., but it resolves on admission, code mild P.I.H. (NSV).
3. P.I.H. is to be coded if it occurs in the antepartum, intrapartum or postpartum period.
4. If Transient P.I.H. is stated as the diagnosis, code as mild (NSV).
5. If hypertension is *not* mentioned by the physician, do *not* code P.I.H. for an occasional elevation of the diastolic value > 90. The diastolic should be consistently elevated > 90 in a 24 hour period with at least 2 or more BP readings having been done.

SEVERE PREGNANCY-INDUCED HYPERTENSION

1. Code severe P.I.H. if:
 - the physician stated severe **OR**
 - the diastolic BP is ≥ 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 = Tuberosus 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 (*K₁/K₂*)
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 ADMISSION0600 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 $\geq 38^{\circ}\text{C}$, postpartum.)

000 = Pyrexia, unknown cause

1390 PUER Puerperal Morbidity
(38°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 = Testosterone-estradiol
(Deladumone)
- EST = Estrand
- PAR = Bromocriptine
(Parlodel)
- STL = Diethylstilbestrol
(Stilbestrol)
- TCE = Tace
(Chlorotrianisene)

1541 ASAT Maternal ASA Therapy

(Code if administered during pregnancy or admission)

- ASA = Low dose aspirin (ASA) therapy, eg. for Lupus, and other autoimmune diseases

L. MATERNAL DEATH OR UNDELIVERED FETAL DEATH

1550 MATD Maternal Death
000 = Maternal death

1560 FDTH Fetal Death
(Undelivered patients only)
000 = Fetal death

M. INFECTION IN PRESENT PREGNANCY**CODE POSTPARTUM INFECTIONS SEPARATELY - SEE SECTION I.*****CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY***

- 1590 UTIN Lower Urinary Tract Infection
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Confirmed by culture of >100,000 colonies/ml, or as stated by physician.)
 000 = Lower urinary tract infection
- 1600 GBSI Group B Streptococcal Infection
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Most Group B strep. will be colonization only. If it is stated that the patient had a Group B Strep Urinary Tract Infection, code it as GBI. Group B Strep can be present in the urine without being an infection; in this case, code GBC. If it is stated that the patient has Chorioamnionitis or Endometritis due to Group B Strep, code GBI. If group B strep infection was diagnosed at one point and followed by colonization at a later date, code both the infection and the colonization.)
 GBC = Colonized with Group B streptococcus
 GBI = Group B streptococcal infection
- 1610 LIST Listeria Infection
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
 000 = Listeria infection
- 1620 LUES Syphilis
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
 000 = Syphilis
- 1630 GONO Gonorrhea
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
 000 = Gonorrhea
- 1640 HERP Herpes Simplex Infection
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Herpes labialis, oral herpes, herpes genitalis, genital herpes. Do not code those with a history of Herpes. Do not include a Herpes outbreak post-Epidural - due to Morphine in Epimorph.)
 OHS = Oral Herpes Simplex
 GHS = Genital Herpes Simplex
 OTH = Other (Herpes labialis, herpes gestationalis)
- 1650 RUBE Rubella
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
 000 = Rubella

- 1660 SPTC Septicemia
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Defined by positive blood culture(s).)
000 = Septicemia
- 1670 COND Condyloma acuminata
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Venereal warts, Human Papilloma Virus. Code H.P.V. only if there is a manifestation of warts.)
000 = Condyloma acuminata
- 1680 AIDS Acquired Immune Deficiency Syndrome
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
ASP = Asymptomatic A.I.D.S., H.I.V. positive
SPM = Symptomatic A.I.D.S.
- 1690 TOXO Prenatal toxoplasmosis
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
000 = Prenatal toxoplasmosis
- 1700 WOUN Wound infection, antepartum
CODE ONLY IF PRESENT DURING ADMISSION
(e.g. postoperative, Appendectomy)
000 = Wound infection
- 1710 VIRD Viral Diseases
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
C01 = Parvovirus (Fifth's Disease)
C02 = Meningitis
- 1720 TEST Abnormal Findings
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(Immunological)
TB+ = Positive Tuberculin Test
(Mantoux)

- 1730 VARC Varicella
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
CHP = Chickenpox
(*Varicella*)
HPZ = Shingles
(*Herpes Zoster*)
- 1740 MYCP Mycoplasma Disease
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(*Code also Neonatal Code 1810.*)
000 = Mycoplasma disease
- 1750 CHLM Chlamydia
CODE IF CONDITION IS or WAS PRESENT DURING CURRENT PREGNANCY
(*Code also Neonatal Code 1800.*)
000 = Chlamydia
- 1760 INFB Bacterial Infections, Antepartum
CODE IF PRESENT DURING ADMISSION ONLY
(*e.g Pilonidal Cyst, Abscess Tooth*)
000 = Bacterial infections, antepartum

N. COMPLICATIONS OF ANESTHESIA

- 1790 BLPT Blood Patching
000 = Blood patching
- 1800 TXIV Intravenous Injection
000 = Toxic intravenous injection
(Causing systemic reaction)
C01 = Epi-catheter intravenous only
(Incidental only)
- 1810 DTAP Accidental Dural Tap
(Code also Blood Patching 1790 BLPT, if applicable.)
000 = Accidental dural tap
- 1820 TOXS Total Spinal Anesthesia
(Respiratory paralysis)
000 = Total spinal anesthesia
- 1830 LEPI Prolonged Epidural Block
000 = Prolonged epidural block
- 1840 MBLK High Epidural/Subdural Block
000 = High epidural/subdural block
- 1850 FDRP Foot drop
(Specifically stated as due to anesthesia.)
000 = Foot drop
- 1860 EPIH Epidural hematoma
000 = Epidural hematoma
- 1870 EPIA Epidural Abscess
000 = Epidural abscess
- 1880 SCRDL Spinal Cord Lesion
000 = Spinal cord lesion

1890 ASPN Aspiration Pneumonitis
000 = Aspiration pneumonitis

1900 CARR Cardiac Arrest
000 = Cardiac arrest

1910 OANC Other Anesthetic Complication
(Specifically stated by anesthesiologist on anesthetic record. If in doubt, ask anesthesiologist.)
C01 = Post-dural puncture headache
C02 = Paraesthesia
C03 = Hypotension
C04 = Back pain

1914 FIGA Failed Intubation for General Anesthetic
000 = Failed intubation for general anesthetic

O. ANTIBIOTIC THERAPY
(CODE WHEN ANTIBIOTICS ARE ADMINISTERED)

2000 ANTB Antibiotics

(CODE ONLY IF ADMINISTERED DURING ADMISSION)

ANT = Administered during antepartum period

INT = Administered during intrapartum period from the beginning of labour to the delivery of the placenta, including administration during a C-section delivery.

PPP = Administered during postpartum period

P. FETAL PROCEDURES

- 2200 CHDO Cordocentesis
(Umbilical cord vessel sampling. Code reason test was performed. Bring forward to the delivered admission)
GNT = Genetic testing
ISO = Isoimmunization
OTH = Other
- 2210 FETP Fetal Peritoneal Tap
INV = Investigative
FAC = To facilitate delivery
(Fetal Abdominal Paracentesis)
- 2220 AMNF Amnioinfusion
(To prevent cord compression)
000 = Amnioinfusion
- 2230 FETT Fetal Thoracentesis
(To correct fetal defect)
000 = Fetal thoracentesis
- 2240 CORE Embolization of Umbilical Vessels By Cordocentesis
000 = Embolization of umbilical vessels by cordocentesis

Q. METHODS OF INDUCTION/ATTEMPTED INDUCTION

Codes 3000 through to 3040 apply to inductions only. Do not code for augmentations.

A period of greater than 24 hours between subsequent doses of medication (prostaglandin and/or oxytocin) for the purpose of inducing labour defines a new induction attempt. Note: the administration of prostaglandin, for the purpose of cervical ripening, is considered part of the induction process.

If the patient goes into labour more than 24 hours after the last administration of medication (prostaglandin and/or oxytocin) for the purpose of inducing labour, the labour should be coded as spontaneous.

The third character of the modifiers for codes 3000 through to 3040 identifies the attempt at induction designated as "A" for the first attempt, "B" for the second attempt, and so forth.

1. *Codes 3000 and 3010*

*The first character of the modifiers for codes 3000 and 3010 indicates the number of prostaglandin administrations in the **OPD** during that induction attempt. **Code OPD prostaglandin administrations occurring within the 24 hours prior to admission only**, unless previous administrations are clearly indicated on the delivered admission.*

*The second character of the modifier indicates the number of **in-patient** prostaglandin administrations during that induction attempt. If the mother is given more than 9 administrations in one attempt, code 9.*

For example, if a mother received 3 doses of intracervical prostaglandin in the OPD, and then 24 hours later is admitted, and receives 2 doses of intracervical prostaglandin, her case would be coded as 3000 PGCC 30A and 3000 PGCC 02B.

2. *Codes 3000, 3010, and 3020*

A mother will often receive prostaglandin followed by oxytocin. If the oxytocin is given within 24 hours of the last prostaglandin administration, this is considered one induction attempt. If 24 hours have passed since the last prostaglandin administration, then this is considered a second attempt.

For example, if a mother was admitted, and received 2 doses of prostaglandin, and then within 24 hours received oxytocin, her case would be coded as 3000 PGCC 02A and 3020 OXTC 00A. If the same mother received the oxytocin 24 hours after the last prostaglandin administration, her case would be coded as 3000 PGCC 02A and 3020 OXTC 00B.

3. *Code 3020*

In the case of an induction attempt with oxytocin alone, a new attempt occurs when a mother has not received oxytocin for a 24 hour period. If the oxytocin is shut off for a few hours and then started again, within 24 hours of the last administration, then this is considered one induction attempt.

For example, if a mother is receiving her first oxytocin administration, and the oxytocin is shut off for 3 hours, and then started again, her case would be coded as 3020 OXTC 00A. However, if in this same case the oxytocin was started 24 hours after it had been shut off, her case would be coded as 3020 OCTX 00B.

- 3000 PGCC Intracervical Prostaglandin
(Intracervical prostaglandin is administered in a .5mg dose.)
- 01A = No OPD prostaglandin administrations, one in-patient prostaglandin administration, 1st induction attempt
 - 11A = One OPD prostaglandin administration, one in-patient prostaglandin administration, 1st induction attempt
 - 21B = Two OPD prostaglandin administrations, one in-patient prostaglandin administration, 2nd induction attempt
 - 30B = Three OPD prostaglandin administrations, no in-patient prostaglandin administrations, 2nd induction attempt.....etc.
- 3010 PGCV Vaginal Prostaglandin (Includes Cytotec)
(Vaginal prostaglandin is administered in a 1 to 2mg dose. If the route of administration or dosage of prostaglandin is not specified , code vaginal.)
- 01A = No OPD prostaglandin administrations, one in-patient prostaglandin administration, 1st induction attempt
 - 11A = One OPD prostaglandin administration, one in-patient prostaglandin administration, 1st induction attempt
 - 21B = Two OPD prostaglandin administrations, one in-patient prostaglandin administration, 2nd induction attempt
 - 30B = Three OPD prostaglandin administrations, no in-patient prostaglandin administrations, 2nd induction attempt.....etc.
- 3020 OXTC Oxytocin (Pitocin, Syntocin)
- 00A = Administered during first induction attempt
 - 00B = Administered during second induction attempt....etc
- 3030 PGOR Oral Prostaglandin (Includes Cytotec)
- 00A = Administered during first induction attempt
 - 00B = Administered during second induction attempt....etc
- 3040 OTAG Other agents (*Laminaria tents, Intracervical catheter-induction*)
- 00A = Administered during first induction attempt
 - 00B = Administered during second induction attempt....etc

R. METHODS OF INDUCTION FOR TERMINATION FOR ANOMALY ADMISSIONS

Codes 3050 through to 3090 apply to Termination for Anomaly cases only. Do not use these codes for Inductions or Augmentations for delivery of a viable infant.

1. Code 3050

The first character of the modifier for code 3050 indicates the number of Misoprostol (Cytotec) administered on an out-patient basis to induce labour for a termination for an anomaly. If the mother is given more than 9 administrations to induce labour, code 9

The second character of the modifier for code 3050 indicates the number of Misoprostol (Cytotec) administered on an in-patient basis to induce labour for a termination for an anomaly. If the mother is given more than 9 administrations to induce labour, code 9

*The third character of the modifier for code 3050 indicates the method of administration of Misoprostol (Cytotec). **V** indicates a vaginal administration of Misoprostol (Cytotec) and **R** indicates an Oral administration of Misoprostol (Cytotec)*

*For example, if a mother received 2 doses of vaginal Misoprostol (Cytotec) in the OPD, and one dose Misoprostol (Cytotec) as in in-patient, her case would be coded as **3050 PGMV...21V***

*For example, if a mother received 1 doses of Oral Misoprostol (Cytotec) in the OPD, and two dose Misoprostol (Cytotec) as in in-patient, her case would be coded as **3050 PGMV...12R***

3050 PGMV . . . Misoprostol (Cytotec)

01V = No OPD vaginal administrations and “ONE” in-patient vaginal administration of Misoprostol. If either are greater than 9, code 9.

11V = “ONE” OPD vaginal administration and “ONE ” in-patient vaginal administration of Misoprostol. If either are greater than 9, code 9.

21V = “TWO” OPD vaginal administrations and “ONE ” in-patient vaginal administration given of Misoprostol,..... etc. If either are greater than 9, code 9.

01R =”No” OPD Oral administrations and “ONE ” in-patient Oral administration of Misoprostol. If either are greater than 9, code 9.

11R = “ONE” OPD Oral administration and “ONE ” in-patient Oral administration of Misoprostol. If either are greater than 9, code 9.

21R = “TWO” OPD Oral administrations and “ONE ” in-patient Oral administration given of Misoprostol,..... etc. If either are greater than 9, code 9.

3060 SAIN Saline Injection and IV Syntocin

000 = Saline Injection and IV Syntocin administered during termination.

3070 DILE Dilatation and Evacuation

000 = Dilatation and Evacuation during termination.

3080 KCLI KCL Intracardiac Injection

000 = KCL Intracardiac Injection during termination.

3090 OCTV IV Syntocin

000 = IV Syntocin
(May be used after misoprostol administration(s))

CLASSIFICATION OF NEONATAL DISEASES AND PROCEDURES**I. PLACENTA AND UMBILICAL CORD ANOMALIES**

- 0010 VINS Velamentous Insertion of Cord
000 = Velamentous insertion of cord
- 0020 MINS Marginal Insertion of Cord
(Battledore placenta)
000 = Marginal insertion of cord
- 0030 CIRV Circumvallate Placenta
(Involving entire placental margin)
000 = Circumvallate placenta
- 0040 ANOD Amnionodosum
(As stated on the pathology report.)
000 = Amnionodosum
- 0050 SUCL Succenturiate Lobe
(Accessory lobe/Bilobed placenta/Bipartite)
000 = Succenturiate lobe
- 0060 CHOR Chorioamnionitis, Marked or Severe
(Not Chorionitis or Chorangiomas, as stated on the pathology report.)
000 = Chorioamnionitis, marked or severe
- 0070 FUNI Funisitis
(As stated on pathology report.)
000 = Funisitis
C01 = Necrotizing funisitis
CAN = Candida
- 0080 SUMA Single Umbilical Artery
(Presence of one umbilical artery instead of the normal 2.)
000 = Single umbilical artery

- 0090 CPRO Cord Prolapse
000 = Cord prolapse
- 0100 PLUC Miscellaneous Placenta and/or Umbilical Cord Abnormality
C01 = Membranous placenta
C02 = Placenta accreta, Placenta Increta, Placenta Percreta
(As stated by the physician, or on pathology report)
C03 = True knot in cord
(Can be recorded on pathology report, delivery record or O.R. sheet.)
C04 = Trophoblastic disease
(Including hydatidiform mole, invasive mole, choriocarcinoma. As stated on the pathology report.)
C05 = Vasa previa
C06 = Insertio funiculi furcata
(As stated on the pathology report.)
C08 = Chorioangioma of placenta and/or cord
(As stated on the pathology report.)
C09 = Hematoma of umbilical cord
C10 = Placental floor infarct

II. FETAL MALNUTRITION

- 0110 WAST Fetal Clinical Soft Tissue Wasting
(Present at birth)
MOD = Moderate
SEV = Severe

III. ANOMALIES*Code all anomalies associated with syndromes.***A. CARDIOVASCULAR ANOMALIES**0130 CARD Congenital Heart Disease (*C.H.D.*)

AOS = Aortic arch stenosis/ascending aortic stenosis

APR = Anomalous pulmonary venous return

APW = Aortico-pulmonary window

AVS = Aortic valve stenosis

BAV = Bicuspid aortic valve

CFO = Premature closure of foramen ovale
(*Closure before birth*)

CGV = Corrected left transposition

COA = Coarctation of the aorta

DAA = Double aortic arch

DBL = Double outlet left ventricle

DBR = Double outlet right ventricle

DPV = Dysplastic pulmonary valve

EBS = Ebstein's malformation of tricuspid valve

ECD = Endocardial cushion defect
(*A.V. canal*)

EDF = Endocardial Fibroelastosis

HLH = Hypoplastic left heart syndrome

IMV = Insufficiency/cleft of mitral valve

ITA = Interrupted aortic arch

MTA = Mitral atresia

MTS = Mitral stenosis

MUR = Cardiac murmur, cause unknown

*(Code only if present at discharge and not due to any other cardiac disease;
include physiologic peripheral pulmonary artery stenosis.)*

OSP = Ostium primum defect

OSS = Ostium secundum defect
(*A.S.D. inter-atrial defect*)PAA = Pulmonary artery atresia
(*Do not code right heart hypoplasia.*)

0130 CARD Congenital Heart Disease (*C.H.D.*) (CONTINUED)

- PAS = Pulmonary artery stenosis (Pathologic)
PDA = Patent ductus arteriosus
(Do not code for premature babies. See Code 0140.)
PST = Pseudotruncus
- PVA = Pulmonary vein atresia
PVI = Pulmonary valve insufficiency
PVS = Pulmonary valve stenosis/atresia
(Include thickened pulmonary valve.)
- RAA = Right aortic arch
SAT = Single atrium
(Absence of atrial septum)
SUS = Suspect congenital heart disease
(Cardiac murmur with abnormal ECG or abnormal heart on X-ray.)
- SVV = Single ventricle
TAR = Tuncus arteriosus
TAT = Tricuspid atresia
- TCI = Tricuspid insufficiency
TET = Tetralogy of Fallot
TGV = Transposition of great arteries or great vessels
- UCH = C.H.D., type unknown
UNC = C.H.D., unclassifiable
(Use specific code if possible.)
VSP = Ventricular septal defect
(Do not code if part of tetralogy of fallot.)

0140 DUCT Ductus Syndrome of Prematurity
(Patent ductus arteriosus. Code only if requires treatment.)

- 000 = No surgery
SUR = Surgical ligation of the ductus

0150 CARR Cardiac Arrhythmia
(*Include pathologic bradycardia or tachycardia, e.g. P.A.T., heart block.*)
(*Excludes Sinus Tachycardia*)

AEB = Atrial ectopic beats
ATF = Atrial flutter
AVB = AV Block (Incomplete) not due to digitalis
AVD = Complete AV dissociation
(*Complete heart block*)
CAT = Coatic atrial tachycardia
OTH = Other
(*Include premature ventricular contractions*)
PAT = Paroxysmal atrial tachycardia
SAR = Sinus arrest
UBC = Unexplained bradycardia
VTC = Ventricular tachycardia
(*Idiopathic*)
WPW = Wolff-Parkinson Syndrome

0160 DEXT Dextrocardia

ABI = Isolated abdominal situs inversus
(*Heterotaxy Syndrome*)
IDX = Isolated
MES = Mesocardia
WSI = With situs inversus

0170 PFCS Persistent Fetal Circulation Syndrome
(*Occurs within 1 week of age*)

Persistent fetal circulation syndrome caused by the following:

CHD = Congenital heart disease
CUK = Cause Unknown
FMB = Fetomaternal bleed
HMD = Hyaline membrane disease
MEC = Meconium aspiration
PHP = Pulmonary hypoplasia
PNM = Pneumonia
PPH = Primary Pulmonary Hypertension

0180 PABS 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 = Agenesis of the Bladder

0670 GUAN Miscellaneous G.U. Anomaly

- C01 =Torsion of testis
- C02 = Urogenital sinus
- C03 = Bicornuate uterus
- C04 = Transposition of the scrotum
- C05 = Urachal cyst
- C06 = Congenital vaginal cyst
- C07 = Ovarian cyst
- C08 = Torsion of ovary
- C09 = Absent uterus and/or absent Fallopian tubes and/or absent ovaries
- C10 = Rectal-ano-urethral fistula
- C11 = Large echodense kidneys, etiology unknown
- C12 = Double vagina
- C13 = Rectovaginal fistula
- C14 = Hypoplasia of uterus
- C15 = Patent (persistent) urachus
- C16 = Nephrotic Syndrome
- C17 = Vesicoureteric Reflux

G. SKIN ANOMALIES

- 0700 HANG Hemangioma
(Do not code capillary hemangiomas on eyelid or base of neck - "stork bites/angel kisses" - or for birth marks only.)
CAV = Cavernous
CAP = Capillary
(Strawberry nevus)
PWS = Port-wine stain
UKN = Type unknown
- 0710 PIGN Pigmented Nevus
000 = Pigmented nevus
- 0711 DPIG Depigmented Skin Lesions
ANM = Nevus Anemicus
- 0720 CDER Congenital Dermatosis
AED = Anhidrotic ectodermal dysplasia
BUK = Bullous, type unknown
CMC = Cutis marmorata congenita
CTA = Cutis aplasia
(Skin defect. Almost always depression on skin of scalp, not properly developed.)
EPB = Epidermolysis bullosa
GOL = Goltz syndrome
(Focal dermal hypoplasia)
ICP = Incontinentia pigmenti
NUK = Non-bullous, type unknown
URT = Urticaria pigmentosa
(Mast cell disease)
- 0730 SUPN Supernumerary Nipple
(Additional/accessory nipple)
LEF = Left
RIT = Right
BIL = Bilateral
- 0731 ABBR Absent Breasts
LEF = Left
RIT = Right
BIL = Bilateral

0740 AMNB Deformities Due to Amniotic Bands, Amniotic Band Syndrome, Early Amnion Rupture Sequence
000 = Deformities due to amniotic bands, amniotic band syndrome, early amnion rupture sequence

0750 ICTH Ichthyosis
(Include all types)
000 = Ichthyosis

0760 CUTL Cutis Laxa/Hyperelastica
LAX = Cutis laxa
ELS = Cutis hyperelastica

0770 SKAN Miscellaneous Skin Abnormality
C01 = Dysplastic or absent nails
C02 = Inclusion cyst of skin
(Epidermoid cyst)
C03 = Miscellaneous
C04 = Cafe-au-lait spot
C05 = Sebaceous nevus
C06 = Dermatographia

H. MUSCULOSKELETAL ANOMALIES

- 0780 NECK Short Neck Disorders
INI = Iniencephalus
KPL = Klippel-Feil Syndrome
- 0790 CLFT Club Foot
(Talipes equinovarus, talipes calcaneovalgus, or calcaneovarus)
LEF = Left
RIT = Right
BIL = Bilateral
- 0800 CHIP Congenital Hip
(Dislocatable, reducible)
C01 = Diagnosed after discharge from hospital
DLC = Dislocation
LUX = Subluxation
- 0810 POLD Polydactyly
000 = Polydactyly
- 0820 SYND Syndactyly
000 = Syndactyly
- 0830 CSTN Craniosynostosis/Craniostenosis
COR = Coronal
CRZ = Crouzon's disease
FRN = Frontal (Metopic)
KLB = Kleeblattschadel
LAM = Lambdoid
SAG = Sagittal
TRG = Trigenocephaly
- 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

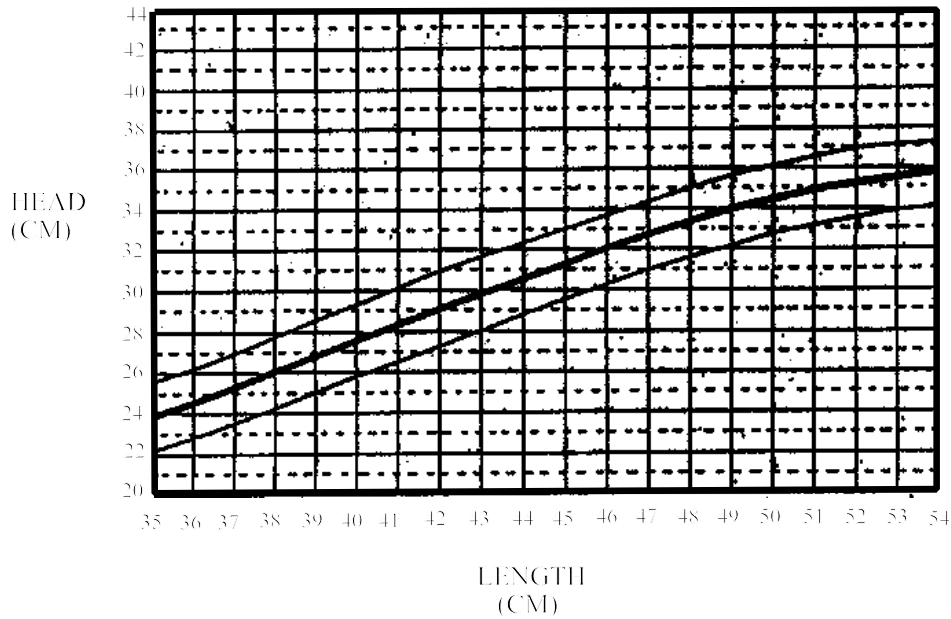
- 0920 BBD Osteogenesis Imperfecta
(Include other metabolic bone disease but exclude rickets.)
OSG = Osteogenesis imperfecta
MFR = Fractures-cause unknown
HPS = Hypophosphatasia
- 0930 THDW Thanatophoric Dwarfism
000 = Thanatophoric dwarfism
- 0940 RADA Radial Aplasia/Hypoplasia
IRD = Isolated aplasia/hypoplasia 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
(Macrogryria)

0980 MICC Microcephaly
 (Head circumference less than 2 standard deviations for length- see head/length growth graph - below.)
 000 = Microcephaly

HEAD/LENGTH GROWTH GRAPH



NOTE: Always code 1030 MEGC Megalocephaly if the head circumference is greater than 37 cm.

*Usher, R., M.D., The Journal of Pediatrics,
 Vol. 74, No. 6, Pages 901-910, June, 1969*

- 0990 SBIF Incomplete Closure of Neural Tube
CRB = Cranium bifidum
DFS = Dermal fistula
(Leaking spinal fluid, fluid drainage)
DSN = Dermal sinus
(Code only if the bottom of the depression cannot be seen and there is no drainage. Do not code dimples with closed or blind ends.)
ENC = Encephalocele
MGC = Meningocele
MMC = Meningomyelocele
RHS = Rachischisis
SPB = Spina bifida
- 1000 ANEN Anencephaly
000 = Anencephaly
- 1010 HYDN Hydranencephaly
000 = Hydranencephaly
- 1020 CHYP Brain Hypoplasia
000 = Brain hypoplasia
CBL = Cerebellar hypoplasia
DYS = Cortical dysplasia
- 1030 MEGC Megalocephaly
(Macrocephaly. Head circumference more than 2 standard deviations for length- see head/length growth graph - page 23.)
HCP = Hydrocephalus
(Include both congenital and acquired forms.)
MGU = Megalocephaly, type unknown
DWS = Dandy-Walker Syndrome
- 1040 DIAS Diastematomyelia
(Diplomyelia. Congenital separation of lateral halves of spinal cord.)
000 = Diastematomyelia
- 1050 CLOP Cyclopia-Arhinencephaly Series
ARN = Arhinencephaly
CEB = Cebocephaly
(Monkey face)
CYC = Cyclops
HOL = Holoprosencephaly

- 1060 ARMC Arthrogryposis/contractures (*see Smith, 3rd edition, p. 533*)
- TP1 = Neurologic abnormality
 - TP2 = Muscle problems
(*Muscle agenesis, myopathies, myotonic dystrophy*)
 - TP3 = Joint disease
(*Synostosis, lack of joint development, aberrant fixation as in diastrophic dwarfism, Larsen syndrome, popliteal web syndrome.*)
 - TP4 = Fetal crowding/constraint
(*As in multiple fetuses, and oligohydramnios.*)
 - CUK = Contractures, cause unknown
-
- 1061 PHAK Phakomatoses
- CRA = Cerebro-retinal angiomas
 - NFB = Neurofibromatosis
 - SWS = Sturge-Webber (encephalotrigeminal angiomas)
 - TSC = Tuberous sclerosis
-
- 1062 SPMA Spinal Muscular Atrophy
- WHD = Werdnig-Hoffmann Disease

J. MULTIPLE ANOMALIES

1070 CHRM Multiple Anomalies Due to Chromosomal Aberrations

CRI = Cri-du-chat Syndrome

C1P = Chromosome 1p+

C9P = Chromosome 9p+

ESL = 12/21 Balanced Translocation

GQ- = Deletion of part of # 14 Chromosome

GSI = Gonosomal Intersex

GSL = Balanced 14-21 Translocation

HP+ = 15 P+ Syndrome

KP- = 18 P- Syndrome

KQ- = 18Q- Syndrome

MX0 = Mosaic Turner's Syndrome

M12 = Mosaic Trisomy 12

M13 = Mosaic 13 Syndrome

M21 = Mosaic Down's Syndrome

R05 = Ring 5

R13 = Chromosome Ring 13

R14 = Chromosome Ring 14

R15 = Chromosome Ring 15

TGC = Trisomy C group (includes Trisomy 8)

TRI = Triploidy

TUR = Turner's Syndrome

T07 = Trisomy 7

T09 = Trisomy 9

T13 = Trisomy 13

T14 = Trisomy 14

T18 = Trisomy 18

T19 = Trisomy 19

T21 = Down's Syndrome (Trisomy/Translocation 21)

T22 = Trisomy 22

UKN = Unknown type

WFS = Wolf Syndrome

XQ+ = X Chromosome Q+

XXY = Klinefelters Syndrome

XXZ = Marker Chromosome (*female*)

XYY = XYY Syndrome

XYZ = Marker Chromosome (*male*)

Z01 = 47XY

Z02 = Tetrasomy 12p

1070 CHRM Multiple Anomalies Due to Chromosomal Aberrations (**CONTINUED**)

2Q+	=	2Q+Syndrome
2Q-	=	2Q- Syndrome
4Q-	=	4Q- Syndrome
4Q+	=	4Q+Syndrome
5Q+	=	5Q+ Syndrome
6Q+	=	6Q+ Syndrome
9Q+	=	9Q+ Syndrome
FQ-	=	13Q- Syndrome
13B	=	13 Balanced Translocation
13L	=	Translocation 13
18B	=	18 Balanced Translocation
21L	=	Translocation 21
57L	=	5 to 7 Translocation
79L	=	7 to 9 Translocation

1075 MDEL Chromosomal Deletion

PWS	=	Prader-Willi Syndrome
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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 (<i>Cryptophthalmus Syndrome</i>)
CPT	=	Camptomelic Syndrome
DGS	=	DiGeorge Syndrome
EEC	=	Ectrodactyly - ectodermal dysplasia (<i>EEC Syndrome</i>)
FAS	=	Fetal Alcohol Syndrome

- 1080 NOTC Multiple Anomalies Not Due to Chromosomal Aberrations (**CONTINUED**)
- FHS = Fetal Hydantoin Syndrome
FND = Frontal-Nasal Dysplasia Sequence
GOS = Goldenhar Syndrome
- HFD = Hypomandibular faciocranial dystosis
HOS = Holt Oram Syndrome
(Cardiac Limb Syndrome)
- KTW = Klippel-Trenaunay-Weber Syndrome
LOW = Lowe's Syndrome
MFN = Marfan's Syndrome
MGR = Meckel-Gruber Syndrome
- NOO = Noonan Syndrome
OFD = Oto-Facial-Digital
OMH = Oromandibular Limb Hypogenesis Syndrome
- OTO = Otocephaly
- PBS = Prune Belly Syndrome
(Triad Syndrome)
- PE1 = Pena Shokeir, Type 1 Phenotype
PE2 = Pena Shokeir, Type 2 Phenotype
PHC = Phenocopy
PLD = Poland Syndrome
POC = Pentalogy of Cantrell
PRS = Pierre-Robin Syndrome
PSS = Polysplenia Syndrome
PTY = Multiple Pterygium Syndrome
RBT = Rubinstein-Taybi
- ROB = Roberts' Syndrome
RSS = Russell-Silver Syndrome
RZM = Rhizomelic Dwarfism
- SGB = Simpson-Golabi-Behemel Syndrome
SLO = Smith-Lemli-Opitz Syndrome
STK = Stickler's Syndrome

1080 NOTC Multiple Anomalies Not Due to Chromosomal Aberrations (**CONTINUED**)

TCS = Treacher-Collins' Syndrome

TBS = Townes-Brock Syndrome

UNC = Unclassifiable

VAT = Vater Association

(V.A.C.T.E.R.L. Syndrome - Vertebra, Anus, Cardiac, Trachea, Esophagus, Renal, Limb)

WIM = Williams' Syndrome

WWS = Walker-Warburg Syndrome

(Cerebro-Ocular dysgenesis)

1090 OLIG Oligohydramnios Syndrome

(Oligohydramnios, Potter's facies, and pulmonary hypoplasia)

CUK = Oligohydramnios, cause unknown

FMN = Fetal malnutrition

LMB = Leaking amniotic fluid

OUA = Urinary anomalies excluding renal agenesis

NOL = Potter's Syndrome without oligohydramnios

(Renal agenesis)

POT = Potter's Syndrome with oligohydramnios

(Renal agenesis)

IV. ASPHYCTIC CONDITIONS

- 1100 ASPH Depression at Birth (Asphyxia Neonatorum)
(Depression at birth, requiring intermittent positive pressure breathing. If both mask and tube are used for resuscitation, code as resuscitation by tube. Code the duration as the sum of both the mask and tube resuscitation. Or if masked and stopped and restarted again code combined time of mask)
- M01 = Resuscitation by mask < 1 minute duration
 - M02 = Resuscitation by mask 1 to 3 minutes duration
 - M03 = Resuscitation by mask > 3 minutes duration
 - MUK = Resuscitation by mask unknown duration
-
- T01 = Resuscitation by tube < 1 minute duration
 - T02 = Resuscitation by tube 1 to 3 minutes duration
 - T03 = Resuscitation by tube > 3 minutes duration
 - TUK = Resuscitation by tube unknown duration
- 1101 ELNR Elective Non-Resuscitation
- 000 = Elective non-resuscitation
 - C01 = DNR order written on chart
 - C02 = Withdrawl of ventilator care and DNR order written on chart
- 1110 PADP Post-Asphyctic CNS Depression
- 000 = Post-asphyctic CNS depression
- 1120 PAEX Post-asphyctic CNS excitation
- 000 = Post-asphyctic CNS excitation
- 1130 PAIP Post-asphyctic increased intracranial pressure
- 000 = Post-asphyctic increased intracranial pressure
- 1140 PACV Post-asphyctic convulsions
(Include those convulsions associated with I.V.H.)
- 000 = Post-asphyctic convulsions
- 1150 PABN Post-asphyctic brain necrosis
(Infarction)
- 000 = Post-asphyctic brain necrosis

- 1160 AXSH Anoxic subarachnoid hemorrhage
(Includes all subarachnoid bleeds.)
000 = Anoxic subarachnoid hemorrhage
- 1170 IVHR Intra-ventricular hemorrhage
(Includes all intra-ventricular hemorrhage and all sub-ependymal hemorrhage, regardless of cause or predisposing factor.)
GR1 = Grade I
(Sub-ependymal, choroid plexus hemorrhage.)
GR2 = Grade II
(Hemorrhage into ventricle without dilation of ventricle.)
GR3 = Grade III
(Hemorrhage into ventricle with dilation of ventricle.)
GR4 = Grade IV
(Hemorrhage into brain; thalamic hemorrhage, cortical hemorrhage.)
- 1180 ASPN Aspiration Pneumonitis (*Perinatal Aspiration*)
AFA = Amniotic fluid aspiration
(Requires some evidence of fetal distress or intrauterine asphyxia; CXR shows densities with hyperaeration and there is no evidence of meconium or infection.)
MEC = Meconium Aspiration Syndrome
(Clinical syndrome with evidence of fetal distress or intrauterine asphyxia and presence of meconium.)
- 1190 PCHF Post-Asphyctic Congestive Heart Failure
000 = Congestive heart failure
TCI = Tricuspid insufficiency due to congestive heart failure
- 1200 PATN Post-Asphyctic Acute Tubular Necrosis and Hemorrhagic
Necrosis of Kidney
000 = Post-asphyctic acute tubular necrosis and hemorrhagic necrosis of kidney
- 1210 PALN Post-Asphyctic Liver and/or Adrenal Necrosis
ADH = Adrenal
LIV = Liver

V. TRAUMA

1220 FRAC Fracture

CLV = Clavicle
FEM = Femur
HUM = Humerus
OTH = Other
RIB = Rib(s)
SKL = Skull1230 FACP Facial Palsy (*Exclude other cranial nerve palsies. See CODE 2050.*)LEF = Left
RIT = Right
BIL = Bilateral

1240 BRPP Brachial Plexus (Erb's and Klumpke's) Palsy

LEF = Left
RIT = Right
BIL = Bilateral
RAD = Radial nerve palsy
(*"Wrist drop"*)

1250 PHRP Phrenic Palsy

LEF = Left
RIT = Right
BIL = Bilateral

1260 SPCI Spinal Cord Trauma

000 = Spinal cord trauma

1270 ICHR Traumatic Intra-Cranial Hemorrhage

PCD = Combined posterior fossa subdural and epidural hemorrhage
PED = Posterior fossa epidural hemorrhage
(*Cerebellar*)
PSD = Posterior fossa subdural hemorrhage
(*Cerebellar*)
SCD = Combined supratentorial and epidural hemorrhage
SED = Supratentorial epidural hemorrhage
SSD = Supratentorial subdural hemorrhage
UKN = Type unknown

- 1280 CHEM Cephalohematoma
(Code all as stated, including those found by clinical clerk, on admission examination.)
LEF = Left
RIT = Right
BIL = Bilateral
OTH = Other, including occipital
UKN = Unknown
- 1290 SHEM Scalp Hemorrhage
000 = Scalp hemorrhage
SGL = Instances of subgaleal (subaponeurotic) hemorrhage
- 1300 PHEM Perineal hematoma
000 = Perineal hematoma
- 1310 LHEM Subcapsular hemorrhage of liver
000 = Subcapsular hemorrhage of liver
- 1320 LACL Laceration of Liver and/or Spleen
000 = Laceration of liver and/or spleen
- 1330 MISS Miscellaneous Trauma
C01 = Adrenal hemorrhage
C02 = Perforated eardrum
C03 = Laryngeal palsy
- 1340 SPCH Spinal Cord Subdural and/or Epidural Hemorrhage
000 = Spinal cord subdural and/or epidural hemorrhage
- 1350 TENT Tentorial Tear
000 = Tentorial tear
- 1360 SDYS Shoulder Dystocia
000 = Shoulder dystocia
- 1370 SCFN Subcutaneous Fat Necrosis
000 = Subcutaneous fat necrosis

LIST OF ORGANISMS

The following list of organisms can be used for some of the codes in the following infection section. It will be noted with the code when to use the list of organisms.

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 hemochezia
- 1490 PERT Peritonitis
(*SEE LIST OF ORGANISMS*)
MEC = Meconium
- 1500 NEPH Nephritis
(*SEE LIST OF ORGANISMS*)
CHR = Chronic interstitial
- 1510 ENDC Endocarditis
(*SEE LIST OF ORGANISMS*)
- 1520 ARTH Arthritis
(*SEE LIST OF ORGANISMS*)
- 1530 MYOC Myocarditis
(*SEE LIST OF ORGANISMS*)
- 1540 ABSS Abscess
BRN = Brain
EMP = Empyema
KDN = Kidney
LNG = Lung

- 1550 BINF Bone Infection
OCH = Osteochondritis
(Metaphyseal rarefaction associated with chronic intrauterine infection.)
OSM = Osteomyelitis
- 1560 CONJ Conjunctivitis
(SEE LIST OF ORGANISMS)
(Coagulase negative staph. is not usually a causative organism. Code if purulent drainage from conjunctiva or if treated with antibiotics excluding initial erythromycin.)
- 1570 SINP Skin Infection
CAN = Candida (diaper rash)
PYO = Pyoderma
(Pustulosis or impetigo due to coagulase-positive staph or beta-hemolytic streptococcus.)
RTD = Ritter's disease
- 1580 OTSH Oral Thrush
000 = Oral thrush
- 1590 SCAB Subcutaneous Abscess or Carbuncle
(Include wound abscess or wound infection.)
(SEE LIST OF ORGANISMS)
- 1600 CELL Cellulitis
(Includes paronychia)
(SEE LIST OF ORGANISMS)
- 1610 IUPN Intrauterine Pneumonia
(Congenital onset, within 24 hours of birth.)
(SEE LIST OF ORGANISMS)
- 1620 PNPB Postnatal Pneumonia
(Onset after 24 hours of age)
(SEE LIST OF ORGANISMS)

- 1630 MINF Miscellaneous Infections
- C01 = Dacryocystitis
 - C02 = Otitis media
 - C03 = Otitis externa
 - C04 = Pericarditis
 - C05 = Trichomonas vaginalis
 - C06 = Ureaplasma colonization
 - C07 = Phlebitis (*also umbilical*)
 - C08 = Lymphadenitis

1640 SCOL Organism Suspected of Causing Systemic Infection Because of Surface Colonization
(*'TRUE' SWABS - Throat, Rectum, Umbilicus, Ear*)

Use specific organism when that organism is actually suspected of causing systemic infection. For example:

1. An infant may have a negative blood culture yet still show signs of infection, e.g. increased WBC, increased temperature, irritability. If surface swabs are positive for GBS, GBS would be the organism suspected of causing systemic infection therefore code 1640 SCOL GBS. Also code 1380 SISU 000, systemic infection, site unknown.
2. An infant may have pneumonia yet the blood or endotracheal tube culture is negative. If surface swabs are positive for GBS, then GBS would be the organism suspected of causing the pneumonia; therefore code 1640 SCOL GBS. Also code 1610 IUPN CUK or 1620 PNP CUK because the organism is not proven, only suspected.

If there are no signs of systemic infection, yet surface swabs are positive for GBS, then code 1640 SCOL C01.

- C01 = Group B streptococcus-positive surface cultures not causing systemic infection
- C02 = Listeria-positive surfaces not causing systemic infection
- C03 = Salmonella-positive surface cultures not causing systemic infection
- C04 = Serratia-positive surface cultures not causing systemic infection

B. CHRONIC INTRA-UTERINE INFECTION

1650 RBEL Rubella

000 = Rubella

1660 CMVI Cytomegalovirus (CMV) Infection

(Cytomegalic inclusion disease)

CLN = CMV positive plus evidence for clinical C.I.D.

TIS = CMV positive plus tissue evidence of intracellular
invasion without evidence for clinical C.I.D.

POS = CMV positive alone

(Include cellular inclusions in urine sediment)

1670 LUES Syphilis

ACT = Active syphilis

STS = Positive serologic test for syphilis only

1680 TOXO Toxoplasmosis

000 = Toxoplasmosis

1690 CIU Chronic Intrauterine Infection, Causative Agent Unknown

000 = Chronic intrauterine infection, causative agent unknown

C. ACUTE VIRAL INFECTIONS

1720 VIRD Miscellaneous Viral Disease

- C01 = Picorna virus
- C02 = Adenovirus
- C03 = ECHO virus
- C04 = Rota virus
- C05 = A.I.D.S.
- C06 = HIV antibody screen - positive without infection
- C07 = Influenza A virus
- C08 = Parvovirus
(or suspected)
- C09 = Varicella virus
(Chicken pox)
- C10 = Parainfluenza virus
- RSV = Respiratory syncytial virus

1730 HERP Herpes Simplex

- 000 = Herpes simplex

1740 COXK Coxsackie Infection

- A01 - A16 = To identify specific type
- B01 - B05 = To identify specific type

D INFECTION MISCELLANEOUS

1750 PUKO Pyrexia of Unknown Origin (**P.U.O. - NO KNOWN CAUSE**)
> 37.5^o 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

1880 CALK Convulsion - Due to Alkalosis
000 = Convulsion due to alkalosis

1890 CMEN Convulsion - Due to Meningitis
000 = Convulsion due to meningitis

1900 CPYR Convulsion - Due to Pyridoxine Dependency or Deficiency
000 = Convulsion due to pyridoxine dependency or deficiency

1910 CKER Convulsion - Due to Kernicterus
000 = Convulsion due to kernicterus

- 1920 CBRN Convulsion - Due to Brain Edema
000 = Convulsion due to brain edema
HCA = Hypercapnia
- 1930 CDWD . . . Convulsion - Due to Drug Withdrawal
000 = Convulsion due to drug withdrawal
- 1940 CCUK Convulsion - Cause Unknown or Other
BFN = Benign familial neonatal
CBH = Cerebral hemorrhage
CUK = Cause unknown
HPX = Hypoxia
(Not birth depression - asphyxia neonatorum)
IEM = Inborn error of metabolism
INF = Infarction
VNS = Venous thrombosis
- 1941 CCMB Convulsion Due to Congenital Malformation of Brain
ARN = Arhinencephaly
(Include holoprosencephaly)
HCP = Hydrocephaly or hydranencephaly
OBA = Other brain anomaly
- 1950 ACEX Abnormal Cerebral Irritation/Hypertonicity
(Exclude post-asphyctic)
000 = Abnormal cerebral irritation/hypertonicity
HXA = Hyperreflexia (Hereditary Startle Disease)
- 1960 ACDP Abnormal Cerebral Depression/Hypotonicity
(Not occurring in delivery room. Exclude post-asphyctic and apnea.)
000 = Abnormal cerebral depression/hypotonicity
MAD = Abnormal cerebral depression due to maternal analgesia.
(As stated by physician)

1970 DWDW . . . Drug Withdrawal Syndrome

(Do Not Code 1950 or 1960 with this code)

BAR = Barbiturate
BZM = Benzomorphan
CCN = Cocaine
DEM = Meperidine (Demerol)
DIA = Diazepam (Valium)
ETH = Ethchlorvynol (Placidyl)
HER = Heroin
MOR = Morphine
MTH = Methadone
TLW = Pentazocine (Talwin)

1980 KERN Kernicterus

000 = Kernicterus

1990 CEDM Cerebral Edema, Regardless of Cause; Pathologic Diagnosis only

000 = Cerebral edema

2000 DGBD Hypotrophic Brain Disease, Acquired, Not Due to Asphyxia in utero

ATR = Cortical atrophy
ECM = Encephalomalacia
GIL = Gilles telencephalic leucoencephalopathy
INF = Infarction
POR = Porencephalic cyst(s)
PVL = Periventricular leukomalacia

2010 ACSF Abnormalities of C.S.F.

(See code 1400 for positive CSF without other evidence of meningitis.)

GPR = Low glucose + high protein
HGO = Low glucose only
(< 50% of serum glucose)
PGP = Pleocytosis + low glucose + high protein
PLG = Pleocytosis + low glucose
PLO = Pleocytosis only
(Increased WBC and lymphocytes)
PLP = Pleocytosis + high protein
PRO = High protein only
(>2.0g/L in the absence of blood)

2020 HPAR Hemiparesis

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% O₂)

MRD = Mod. I.R.D.S.

(35% O₂ or CPAP)

SRD = Severe I.R.D.S.

(Ventilated)

TTN = Transient tachypnea

of the newborn

Guidelines for MID, MRD, SRD*Grunting, retractions, and decreased air entry - occurring before 3 hours of age and persisting beyond 6 hours of age and not explained by any other disease***Guidelines for TTN***Onset <3 hours of persistent tachypnea over 80/min. for more than 24 hours having a benign course and never requiring more than 40% O₂; 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. *PCO₂ of greater than 60 mm Hg on 2 or more occasions after 1 week of age with no other obvious cause.*

WM1 = Wilson-Mikity Syndrome* - not ventilated; no cystic change

WM2 = Wilson-Mikity Syndrome* - not ventilated; with cystic changes

BP1 = Bronchopulmonary dysplasia - ventilated; no cystic change

BP2 = Bronchopulmonary dysplasia - ventilated; with cystic changes

*(*Note that some infants with Wilson-Mikity Syndrome may have been ventilated but this must have been late (e.g., after 2 weeks of age) and ventilation must have been begun after the clearly established onset of chronic lung disease.)*

2120 STRI Congenital Stridor
CUK = Cause unknown
HVC = Hyperplasia of vocal cords
LGM = Laryngomalacia
OMH = Oromandibular Limb Hypogenesis Syndrome
TBM = Acquired tracheobronchomalacia
TCM = Tracheomalacia
TRM = Traumatic
RPM = Retropharyngeal mass

2130 PULH Pulmonary Hemorrhage
000 = Pulmonary hemorrhage

2140 ATEL Atelectasis (Lobar) Not diffuse
000 = Atelectasis

2150 PEMB Pulmonary Embolus and/or Infarct
000 = Pulmonary embolus

- 2160 PHYS Pulmonary Emphysema
BGC = Lobar emphysema due to bronchogenic cyst
CUK = Cause unknown
IDI = Congenital idiopathic lobar emphysema
- 2170 CFIB Cystic Fibrosis
(Includes meconium ileus)
000 = Cystic fibrosis
- 2180 LCYS Lung Cyst
000 = Lung cyst
- 2190 CCAM Cystic Adenomatoid Malformation of Lung
000 = Cystic adenomatoid malformation of lung
- 2200 CPLA Congenital Pulmonary Lymphangiectasia
000 = Congenital pulmonary lymphangiectasia
- 2210 RESD Miscellaneous Respiratory Disease
C01 = Chronic cor pulmonale
C02 = Chylothorax (Include congenital, acquired, surgical)
C03 = Pulmonary hypertension
(Due to chronic lung disease)
C04 = Foreign body granuloma of airway or lung
C05 = Fixed diaphragm
(Not due to paralysis)
C06 = Acquired aspiration pneumonitis (eg. gastric contents, formula)

IX G.I. DISEASES

- 2230 LFIB Liver Fibrosis
PPF = Periportal fibrosis
- 2240 CHAL Gastro-esophageal Reflux (Chalasia)
000 = With no evidence of hiatal hernia or pyloric stenosis
HIA = Hiatus hernia
- 2250 PINC Pharyngeal Incoordination
(Clinical diagnosis confirmed by barium swallow during fluoroscopy.)
000 = Pharyngeal incoordination
- 2260 MALS Malabsorption Syndrome
000 = Malabsorption syndrome
- 2270 HEPT Hepatitis
CUK = Unknown
TOX = Toxic
VIR = Viral
- 2280 PERF Perforation of G.I. Tract
(Include meconium peritonitis)
APP = Appendix
COL = Cecum/colon
DUO = Duodenum
ESO = Esophagus
ILE = Ileum
JEJ = Jejunum
RTM = Rectum
STO = Stomach
UKN = Site unknown
- 2290 LACI Lactose Intolerance
ACQ = Acquired
HAL = Hereditary alactasia
(Flat lactose tolerance curve and/or no lactase on biopsy)
HLI = Hereditary infantile lactose intolerance
(Lactosuria)
CCU = Congenital, cause unknown

- 2300 IFAR Intestinal Infarction
000 = Intestinal infarction
- 2310 APEN Appendicitis
000 = Appendicitis
- 2320 GIDS Miscellaneous G.I. Disease
C01 = Pneumoperitoneum, cause unknown
C02 = Acquired stricture
C03 = Peptic ulcer
C04 = Rectal prolapse
C05 = Hydrops of gall bladder
C06 = Lactobezoar
C07 = Acquired volvulus
C08 = Cholelithiasis
C09 = Functional bowel obstruction, cause unknown
C10 = Cloacel Maldevelopment
C11 = Ectopic Anus
CUK = Cause unknown
- 2330 MECP Meconium Plug Syndrome
000 = Meconium plug syndrome

X HEMATOLOGIC DISEASES

2350 BLUD Miscellaneous Hematologic Disease

- C01 = Sickle cell trait
 C02 = Methemoglobinemia
 C03 = Isoimmune neutropenia
 C04 = Perinatal hemochromatosis
 C05 = Neutropenia, < 1,000 pmns (mature or bands per cu.mm)

use following formula:

Multiply the total corrected WBC's by the % of pmns (polymorphoneutrophils) and bands.

e.g. total WBC = 15,000
 pmns = 5%
 bands = 1%

Therefore:

Total pmns (mature and immature)= 0.06 x 15,000=900 (neutropenia)

2360 ABOI ABO Isoimmunization

ABO SET-UP:

- 1) MOTHER BLOOD TYPE:O
BABY BLOOD TYPE: A or B or AB
- 2) MOTHER BLOOD TYPE:A
BABY BLOOD TYPE: B
- 3) MOTHER BLOOD TYPE:B
BABY BLOOD TYPE: A

DEF = Definite

(ABO set-up, positive direct Coombs' test)

PBL = Possible

(ABO set-up, negative direct Coombs' test, positive indirect Coombs' test, and total bilirubin >15 mg% or 259 microM/L; or unconjugated bilirubin ≥ 230 microM/L)

UKN = Isoimmunization type unknown

(ABO groups compatible, positive direct Coombs' test, and no other known isoimmunization)

ISOIMMUNIZATIONS - NON-ABO

NOTE: A POSITIVE COOMBS' TEST IS REQUIRED FOR THE FOLLOWING ISOIMMUNIZATIONS - NOT JUST A CORD SERUM

2370 DISO D Isoimmunization
000 = D isoimmunization

2380 LTLC Little c Isoimmunization
000 = Little c isoimmunization

2390 BIGC Big C Isoimmunization
000 = Big C isoimmunization

2400 BIGE Big E Isoimmunization
000 = Big E isoimmunization

2410 KELL Kell Isoimmunization
000 = Kell isoimmunization

2420 FYAI Fya Isoimmunization (*Duffy*)
000 = Fya isoimmunization

2430 KIDD Miscellaneous Isoimmunization
C01 = Kidd
C02 = Wright
C03 = MNS blood groups
C04 = Positive DAT
(Coombs' test) due to complement, no ABO set-up
C05 = Little "e"
C06 = Little "s"

2440 HBIL Hyperbilirubinemia
(*Total bilirubin > 15 mg% or > 258 microM/L; or unconjugated or indirect bilirubin ≥ 230 microM/L*)

CSC = Congenital spherocytosis
CUK = Cause unknown
HEP = Hepatitis
HOH = Hepatic disease other than Hepatitis
ISO = Isoimmunization
POL = Polycythemia
RES = Resorption of hematoma
SEP = Sepsis (Infection)

2450 HEMR Hemorrhage
(*Not due to asphyxia, trauma, or coagulation disorder when otherwise listed.*)

ADH = Adrenal
CHZ = Hematochezia
(**Frank bleeding; do not code occult blood only or ingested maternal blood**)
FMB = Fetomaternal
FPL = Fetoplacental
HPC = Hemopericardium
HPT = Hemoperitoneum
HTH = Hemothorax
HUR = Hematuria
IAT = Iatrogenic
TTT = Twin-Twin Transfusion
UKN = Site unknown
UMB = Hemorrhage from umbilical or placental vessels
VOM = Hematemesis

2460 COAG Coagulopathy

AHG = AHG deficiency
(*Antihemophilic globulin, blood coagulation Factor VIII - hemophilia*)
ART = Arterial thrombosis
CUK = Cause unknown
DIC = Disseminated intravascular coagulation
F13 = Factor XIII deficiency
HDN = Hemorrhagic disease of the newborn
HDS = Coagulation disorder due to hepatic disease
HLK = Circulating anti-thrombin (Heparin-like substance)
PTA = PTA deficiency
(*Plasma thromboplastin antecedent, blood coagulation Factor XI*)
VON = Von Willebrand's disease
VTH = Venous thrombosis

2470 ANEM Anemia

(Hgb < 14 gm% or <140 g/L or Hct < 42% in the first week;

Hgb < 10 gm% or <100 g/L or Hct < 30% at any age.

Code the cause based on the first low hemoglobin, unless clearly stated otherwise.)

BLL = Blood-letting

(Due to multiple blood tests)

CSC = Congenital spherocytosis

CUK = Cause unknown

EXT = Exchange transfusion

FMB = Fetomaternal bleed

G6P = Glucose-6-phosphate dehydrogenase deficiency

HMR = Hemorrhage

ISO = Isoimmunization

(Requires a positive direct Coombs')

IFN = Infection

PKD = Pyruvate kinase deficiency

PMY = Prematurity

(After 7 days of age)

NPD = Neoplastic disease

SMC = Stomatocytosis

TOX = Toxic hemolytic anemia

TTT = Twin-Twin transfusion

VED = Vitamin E deficiency syndrome

2480 POLC Polycythemia

(Central Hgb >21 gm% (210 g/L), central Hct >63% (.630 L/L),

capillary Hgb >25 gm% (250 g/L), or capillary Hct >75% (.750 L/L);

both Hgb and Hct must be above normal on a single sample, or at least one of Hgb or Hct is above normal on 2 or more consecutive samples.)

000 = Polycythemia

- 2490 THRM Thrombocytopenia
(Platelet count <100,000 on one occasion with bleeding, or on 2 occasions when no clinical bleeding evident.)
BGI = Blood Group Isoimmunization
CUK = Cause unknown
EXT = Exchange transfusion
DIC = Disseminated intravascular coagulation
ISO = Isoimmune due to ITP (*Idiopathic maternal thrombocytopenia*)
NPD = Neoplastic disease
PA1 = Isoimmune due to PLA1
SEP = Sepsis
TSA = Thrombocytopenia-absent radii syndrome
- 2500 OBST Obstructive Jaundice
(Direct bilirubin , or conjugated, >2.0 mg% or >34.5 micromol/L)
000 = Obstructive jaundice
- 2510 INRC Increased Nucleated RBC and/or Normoblastemia
*(>15% or greater than 18 nRBCs on 0-5 days;
>1% or greater than 2 NRBCS after 5 days)*
000 = Increased nucleated RBC and/or normoblastemia
- 2520 RETC Reticulocytosis
*(>7% on days 1-2; >5% on days 3-6;
>3% on days 7 and thereafter)*
000 = Reticulocytosis
- 2530 LEUK Leukemia
000 = Leukemia
- 2540 RBCD Red Cell Defects
CSC = Congenital spherocytosis
G6P = Glucose-6-phosphate dehydrogenase deficiency
PKD = Pyruvate kinase deficiency
PPK = Pyropoikilocytosis
SMC = Hereditary stomatocytosis

2550 NEOP Neoplasms

- CON = Connective tissue
- CYS = Cystadenoma
- END = Endothelial tissue

- EN1 = Insulinoma
- EPI = Epithelial tissue
- EPY = Ependymoma

- FOL = Follicular cyst
- GLI = Nasal glioma
- HPB = Hepatoblastoma

- HYG = Cystic hygroma
- LAN = Lymphangioma
- MEB = Mesoblastic nephroma

- MUS = Muscle
- NBL = Neuroblastoma
- NMB = Medulloblastoma

- RHA = Rhabdomyoma
- TER = Teratoma, embryonic rests
- TGO = Teratoma, gonads

- TSU = Teratoma, site unknown
- UKN = Mass, unknown type
- WIL = Wilms' tumour

XI ENDOCRINE DISEASES

- 2560 GOIT Congenital Goiter
000 = Congenital goiter
- 2570 PSUH Male Pseudohermaphroditism
TFS = Testicular feminizing syndrome
XOM = Male pseudohermaphroditism with XO-XY mosaicism
XYK = Male pseudohermaphroditism with XY karyotype
RFS = Reifenstein's syndrome
BHS = 3-Beta-Hydroxysteroid dehydrogenase deficiency
LAH = Lipoid adrenal hyperplasia
DES = 17-20 desmolase deficiency
(Zachmann-Prader syndrome)
CUK = Cause unknown
- 2580 CRET Hypothyroidism
ATH = Aplasia/hypoplasia
(Athyrotic cretinism, ectopic thyroid)
CUK = Type unknown
HYP = Hypothalamic
IDD = Iodine deficiency
(Endemic cretinism)
MAA = Maternal Antibodies
MDI = Maternal drug ingestion
(Propylthiouracil, iodides)
NGC = Defective synthesis
(Non-endemic goitrous cretinism)
- 2590 ADIS Adrenal Insufficiency Syndrome
AHP = Congenital adrenal hypoplasia/aplasia
AHR = Adrenal hemorrhage
DEH = Defect of dehydrogenation of 18-hydroxycorticosterone
18H = Defect of 18-hydroxylation of corticosterone
21H = 21-Hydroxylase deficiency

2600 HIT4 Hyperthyroidism
 C01 = Asymptomatic elevated serum T₄
 C02 = Symptomatic SEE VALUES:

AGE	Total T4 (nanomol/L)		TSH (mu/L)	
	MEAN	RANGE	MEAN	RANGE
Cord Blood	131	95 - 167	9.0	<2.5 - 17.4
1 - 3 days	221	151 - 290	8.0	<2.5 - 13.3
1 - 2 week	169	126 - 213	---	---
2 - 4 week	141	88 - 192	4.0	0.6 - 10.0
1 - 4 months	132	92 - 185	<2.5	<2.5
4 - 12 months	141	100 - 212	2.1	0.6 - 6.3
1 - 5 year	135	94 - 192	2.0	0.6 - 6.3
5 - 10 year	119	82 - 170	2.0	0.6 - 6.3
10 - 15 year	104	72 - 150	1.9	0.6 - 6.3
Adult	108	55 - 160	1.8	0.2 - 7.6

From LaFranchi 1979

2601 LOPA Hypoparathyroidism
 000 = Hypoparathyroidism

2610 DIBM Diabetes Mellitus
 000 = Diabetes mellitus

2620 RICK Rickets
 C01 = Elevated alkaline phosphatase only
 (>406 I.U.)
 C02 = Evidence of bone demineralization with or without
 abnormal alkaline phosphatase
 C03 = Clinical rickets
 (*Classical rickets.*
Rickets with fractures.)
 C04 = Clinical/Classical Rickets with Fracture

2630 ABIG Ambiguous Genitalia
 (See CODE 2830 = *Miscellaneous endocrine disease*)
 000 = Ambiguous genitalia

XII METABOLIC DISEASES

- 2640 LOGL Hypoglucosemia
(*<30 mgm% or <1.67 mmol/L*)
000 = Hypoglucosemia
- 2650 HIGL Hyperglucosemia
(*>125 mg% or >6.94 mmol/L*)
000 = Hyperglucosemia
- 2660 LOCA Hypocalcemia (See code 2830MISC...C10 for Hypercalcemia)
(*7.0 mg% or less; 1.75 mmol/L or less; ionized \leq 1.0 mmol/L*)
NOC = Without convulsions
TTY = Neonatal tetany
(*Not post-asphyctic convulsions*)
- 2670 LMBA Late Metabolic Acidosis
(*After 72 hours of age; base deficit > -10 mEq/L or > -10 mmol/L*)
000 = Non-persistent
RTA = Renal tubular acidosis
- 2680 LOSK Hypokalemia
(*<3.0 mEq/L or <3.0 mmol/L*)
000 = Hypokalemia
- 2690 HISK Hyperkalemia
(*7.0 mEq/L or more; 7.0 mmol/L or more*)
000 = Hyperkalemia
- 2700 LONA Hyponatremia
(*130 mEq/L or less; 130 mmol/L or less*)
000 = Hyponatremia
- 2710 HINA Hypernatremia
(*>155 mEq/L or >155 mmol/L*)
000 = Hypernatremia

- 2720 HIUN Azotemia
(*BUN 20 mg% or more; 7.14 mmol/L or more, urea value*)
000 = Azotemia
- 2730 HICR Hypercreatininemia
(*2.0 mg% or more; 177 micromol/L or more*)
000 = Hypercreatininemia
- 2740 LOUO Oliguria
(*<15 ml/Kgm/day on Day 2 or <20 ml/Kgm/day after 2 days*)
000 = Oliguria
- 2750 LOPR Hypoproteinemia
(*4.0 gm% or less; 40 gm/L or less*)
000 = Hypoproteinemia
- 2751 LOAL Hypoalbuminemia
(*≤2.4 gm% or ≤24 gm/L*)
000 = Hypoalbuminemia
- 2760 LOMG Hypomagnesemia
(*1.3 mEq/L or less; 0.53 mmol/L or less*)
000 = Hypomagnesemia
- 2770 HIMG Hypermagnesemia
(*>2.5 mEq/L or >1.03 mmol/L*)
000 = Hypermagnesemia
- 2780 HIPP Hyperphosphatemia
(*8.0 mg% or more; 2.58 mmol/L or more*)
000 = Hyperphosphatemia

- 2790 PHEN Phenylalaninemia
CUK = Type unknown
PMY = Phenylalaninemia of prematurity
TP1 = Phenylalaninemia Type I
(Classical phenylketonuria)
TP2 = Phenylalaninemia Type II
(Atypical phenylketonuria)
TPA = Transient phenylketonuria
TPB = Benign hyperphenylalaninemia
- 2800 PROL Hyperprolinemia
000 = Hyperprolinemia
- 2810 TYRO Hypertyrosinemia
(5.0 mgm% or more)
000 = Hypertyrosinemia
- 2820 HNH3 Hyperammonemia
(>150 microgm% or >107 micromol/L)
000 = Hyperammonemia
- 2821 URIC Hyperuricemia
(>400 micromol/L)
000 = Hyperuricemia
- 2830 MISC Miscellaneous Endocrine and Metabolic
C01 = Zinc deficiency
C02 = Albinism
C03 = Copper deficiency
C04 = Fabry's disease
(Alpha-glucosidase deficiency)
C05 = Storage disease, type unknown
C06 = Diabetes Insipidus
C07 = Galactosemia
C08 = Mucopolidoses
(Include Sialidosis, I-cell disease, pseudo-Hurler polydystrophy)
C09 = Nesidioblastosis
(Pancreatic cell hyperplasia)
C10 = Hypercalcemia
(≥3.0 mmol/L; ionized - ≥1.5 mmol/L)
C11 = Urea cycle defect
(Argininosuccinic aciduria)
C12 = Carnitine deficiency
C13 = SIADH
(Syndrome of inappropriate secretion of anti-diuretic hormone)
C14 = Cystathioninuria
C15 = Low serum alkaline/phosphatase (< 120 IU/L)

2830 MISC Miscellaneous Endocrine and Methobolic(**Continued**)

C16 = Hepato-Renal Syndrome (As stated by Physician)

C17 = Zellweger Syndrome

2840 LOPP Hypophosphatemia

(*<4.0 mg% or <1.29 mmol/L*)

000 = Hypophosphatemia

2850 ORGD Organic Acidosis

PDD = Pyruvate dehydrogenase deficiency (Congenital Lactic Acidosis)

PYD = Pyruvate carboxylase deficiency (Congenital Lactic Acidosis)

XIII MISCELLANEOUS DISORDERS

2860 CCVH Complication of Vascular Catheter

ARR = Arrhythmia

EDM = Edema

PCE = Pericardial effusion

PFH = Perforation of heart

PLE = Pleural effusion

PNP = Phrenic nerve palsy

RPT = Ruptured vessel

THB = Thrombophlebitis

VSS = Vasospasm

(Severe)

2870 NCAL Nephrocalcinosis

000 = Nephrocalcinosis

2880 MUSC Acquired Muscle Contracture Due to IM Injections

000 = Acquired muscle contracture due to IM injections

2890 NSID Non-SIDS Death After Discharge

000 = Non-SIDS death after discharge

2900 RLFP Retrolental fibroplasia

(Retinopathy of prematurity)

ST0 = Stage 0

(Peripheral pallor)

ST1 = Stage 1

(Peripheral vascular straightening)

ST2 = Stage 2

(Peripheral shunt well seen)

ST3 = Stage 3

(Vessels growing into vitreous; vitreous . hemorrhages)

ST4 = Stage 4

(Retinal detachment)

2910 IKDM Infant of diabetic mother

(See Maternal Code 0520 for definition of maternal diabetes. If there is no history of diabetes, and no record of GTT results, but the mother is on insulin, code infant of gestational diabetic. If the F.B.S is equal to or greater than 7.0mmol/L a code infant of gestational diabetic.)

- CLA = Infant of a known diabetic mother, Class A
(Define as abnormal maternal glucose tolerance test using either the Joslin Clinic or the O'Sullivan criteria, whichever is positive.)
- CLB = Infant of a known diabetic mother, Class B
- CLC = Infant of a known diabetic mother, Class C
- CLD = Infant of a known diabetic mother, Class D
- CLF = Infant of a known diabetic mother, Class F
- CLR = Infant of a known diabetic mother, Class R
- CLU = Infant of a known diabetic mother, Class unknown
- CAD = Clinical appearance of an I.D.M. when mother not known to be a diabetic
- CLT = Infant of mother with diagnosis of gestational diabetes made by level of greater than or equal to 10.3mmol/l trutol test.

JOSLIN CLINIC

[Both values must be abnormal]

Peak 180 mg% or more; 10.0 mmol/L or more
1/2 hour post peak . . . 130 mg% or more; 7.2 mmol/L or more

O'SULLIVAN

[2 or more abnormal values]

F.B.S. . . 105 mg% or more; 5.3 mmol/L or more
1 Hour . 190 mg% or more; 10.6 mmol/L or more
2 Hour . 165 mg% or more; 8.9 mmol/L or more

- 2920 HRTF Congestive Heart Failure
(Not post-asphyctic, baby will usually receive digitalis or diuretics.)
ANE = Anemia
AVA = Arteriovenous (AV) Aneurysm
BPD = Bronchopulmonary dysplasia
CHD = Congenital Heart Disease
CUK = Cause unknown
LOG = Hypoglycemia
MOP = Cardiomyopathy
MYO = Myocarditis
PAT = Paroxysmal atrial tachycardia
SEP = Sepsis
TTT = Twin-to-twin transfusion
- 2921 ACDM . . . Acquired Cardiomyopathy
STR = Steroid induced
- 2930 SCLR Sclerema
000 = Sclerema
- 2940 RENF Renal Failure
000 = Renal failure
- 2950 HYDR Hydrops Fetalis
(Immune and non-immune)
ANA = Anasarca
(Generalized edema)
IAS = Isolated ascites
- 2970 LOWT Hypothermia
355 = 35.0 - 35.5⁰C
350 = Below 35.0⁰C.
- 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 Angiocardiology

3271 CARB Cardiopulmonary Bypass

000 = Cardiopulmonary bypass

3280 SURG Major surgery

(Indicate the post-op surgical diagnosis; list surgical ligation of the ductus arteriosus for the ductus syndrome of prematurity under Code 0140.)

ABD = Abdominal-perineal pull-through

(Include Swenson pull-through)

ANS = Repair of imperforate anus

(Anoplasty)

APP = Appendectomy

ASW = Switching of coronary arteries or great arteries (*Arterial switch*)

ATS = Atrial septectomy

AVO = Aortic valvotomy

BDR = Bile duct repair

BLA = Bladder surgery

BRN = Brain

CHC = Cholecystectomy

CHD = Congenital heart disease

CHO = Excision of choanal atresia

CLY = Colostomy

COA = Repair of coarctation of aorta

COL = Colon

CRN = Craniotomy

CTA = Cutis aplasia congenita

DAA = Division of double aortic arch

DFS = Dermal fistula

DIH = Diaphragmatic hernia

DSN = Dermal sinus

DUJ = Duodenojejunostomy

DUO = Duodenum

ECD = Repair of atrioventricular canal defect

ENC = Encephalocele

ESO = Esophagus

EXB = Repair of bladder exstrophy

FUN = Fundoplication

GLI = Removal of nasal glioma

GSC = Gastroschisis

3280 SURG Major surgery (*continued*)

(Indicate the post-op surgical diagnosis; list surgical ligation of the ductus arteriosus for the ductus syndrome of prematurity under Code 0014.)

HAR = Hemangioma resection

HCP = Hydrocephalus

(Includes CNS/ventricular shunts)

HDS = Hepatic disease

HLH = Hypoplastic left heart

ILE = Ileum

ING = Inguinal hernia

IPD = Surgical ligation/closure of patent ductus arteriosus
(Not of prematurity)

JEJ = Jejunal

MEK = Removal of Meckel's Diverticulum

MGC = Meningocele

MMC = Meningomyelocele

NEF = Nephrectomy

NPD = Neoplastic disease

OMP = Omphalocele

OOP = Oophorectomy/salpingo-oophorectomy

ORC = Orchiectomy

ORP = Orchidopexy

OVC = Removal of ovarian cyst

PAB = Banding pulmonary artery

PCT = Pancreatectomy, partial

PNV = Pneumonectomy

POD = Plication of diaphragm

PRS = Repair of Pierre-Robin Syndrome

(Tongue, lip, adhesions)

PTU = Patent urachus

PVO = Pulmonary valvotomy

PVR = Total repair of total anomalous pulmonary venous defect

PYE = Pyeloplasty

PYM = Pyloromyotomy

RAN = Surgical repair of ranula

RTM = Rectum

SKL = Elevation of depressed skull fracture

- 3280 SURG Major surgery (*continued*)
(Indicate the post-op surgical diagnosis; list surgical ligation of the ductus arteriosus for the ductus syndrome of prematurity under Code 0014.)
- SMB = Repair of small bowel
 - STO = Stomach
 - SPS = Shunt of systemic pulmonary artery
(Includes central shunt, other cardiac shunts)

 - TAR = Repair of truncus arteriosus
 - TEF = Repair of tracheoesophageal fistula
 - TGV = Correction of transposition of great vessels
(Not an "arterial switch"- see ASW)

 - TRR = Tetralogy repair
 - TTA = Excision of Teratoma
 - TWN = Separation of conjoined twins

 - UMH = Repair of Umbilical Hernia
 - UPJ = Surgery for UPJ Obstruction
 - VSP = Repair of ventricular septal defect
- 3290 INDO Indomethacin therapy
000 = Indomethacin therapy
- 3300 TOLZ Tolazoline (Vasodilator)
000 = Tolazoline
- 3301 VASO Magnesium Sulphate (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 Paralyzing Agent
000 = Paralyzing agent
PAV = Pavulon
(Pancuronium bromide)
- 3380 MYRN . . . Myringotomy
(Include myringotomy tubes)
000 = Myringotomy
- 3390 APAR Abdominal paracentesis
000 = Abdominal paracentesis
- 3400 BRON Bronchoscopy
000 = Bronchoscopy
- 3410 CRYO Cryosurgery
000 = Retina
- 3411 PAGT Laser Therapy
LOP = Left eye
ROP = Right eye
- 3420 HEPB Hepatitis B Prophylaxis
HBG = Hepatitis B globulin
VAC = Hepatitis B vaccine
- 3421 IMMZ Immunizations
FLU = Viral influenza
HIB = Hemophilus influenza, B conjugate vaccine (**HIB**)
RSV = Respiratory Syntical 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

“LEFT BLANK INTENTIONALLY”

“LEFT BLANK INTENTIONALLY”

INDEX OF MATERNAL DISEASES AND PROCEDURES

- A -

	CODE #
Abnormalities:	
chromosomal	0592
uterine	0570
Abortion:	
missed	0190
spontaneous	0190
threatened	0190
Abruptio placenta:	
in a previous pregnancy	0130
in present pregnancy	0270
Abscess:	
Bartholin's Gland	0591
epidural	1870
Absence, kidney	0530
Abuse:	
alcohol	0390
chemical, unspecified	0390
narcotics	0390
prescription medications	0390
street drugs	0390
Accidental dural tap	1810
Acquired immune deficiency syndrome (A.I.D.S.)	1680
Acupuncture, analgesia/anesthesia:	
for labour/delivery	0950
for non-delivery procedure	0790
Administration:	
oral prostaglandin	3030
Oxytocin, Syntocin, Pitocin	3020
Agenesis, renal	0530
Agoraphobia	0400
AIDS, (symptomatic/asymptomatic):	
during pregnancy	1680
postpartum	1370
Albumin transfusion	1470
Alcohol abuse	0390
Alcohol therapy for tocolysis	1530
Alphaprodine (Nisentil) analgesia	0800

- A -

Amniocentesis:	
for genetics	0750
for isoimmunization	0750
for lung maturity	0750
for polyhydramnios	0250
Amnioinfusion	2220
Amo-secobarbital (Tuinal) hypnotic	0830
Anal sphincter laceration	1050
Analgesia:	
Alphaprodine (Nisentil)	0800
Amo-Secobarb (Tuinal)	0830
Chlorpromazine (Largactil)	0870
Diazepam (Valium)	0850
Hydromorphone HCl (Dilaudid)	0910
Meperidine (Demerol)	0810
Morphine (Opium//Pantopon)	0890
Nalbuphine (Nubain)	0900
Other	0931
Patient controlled epidural (PCEA)	1001
Patient controlled intravenous	1002
Pentazocine (Talwin)	0920
Pentobarbital Hypnotic (Nembutal)	0840
Promazine (Sparine)	0860
Promethazine (Phenergan)	0880
Secobarbital (Seconal)	0820
Sublimaze (Fentanyl)	0930
Anaphylactic reaction	0591
Anemia:	
antepartum	0560
in a previous pregnancy	0120
idiopathic hypoplastic	0550
hemolytic	0550
postpartum	1250
Sickle Cell	0550

- A -

Anesthesia:	
entonox, for labour/delivery	0970
epidural, continuous catheter, for labour/delivery	0990
epidural, continuous infusion (CIEA), for labour/delivery	1000
epidural, for non-delivery procedure	1030
epidural, single, for labour/delivery	0980
general, for labour/delivery	0960
general, for non-delivery procedure	1020
neuroleptic, for non-delivery procedure	1040
other, for labour/delivery	0950
pudendal for labour/delivery	1010
spinal/epidural double needle, for labour/delivery	1011
spinal, for labour/delivery	0940
spinal, for non-delivery procedure	1040
spinal, non-delivery	1040
spinal, total (respiratory paralysis)	1820
Ankylosing spondylitis	0490
Anomaly, fetal, suspected [Undelivered patients only]	0360
Anorexia Nervosa	0400
Antibiotic therapy	2000
Antibodies, anti-platelet:	
Platelet antigen negative	0470
Antibodies, autoimmune:	
Anti-Cardiolipin	0470
Anti-DNA	0470
Antinuclear (ANA)	0470
Anti-SSA (Ro)	0470
Lupus	0470
Antibodies, red blood cell:	
Anti-Big C	0470
Anti-Big E	0470
Anti-Big S	0470
Anti-D	0470
Anti-Dha	0470
Anti-Fy ^a	0470
Anti-Kell	0470
Anti-Kidd	0470
Anti-La	0470
Anti-Little c	0470
Anti-Little e	0470
Anti-Little s	0470
Anti-Lutheran	0470
Anti-Wright	0470
Anti-coagulation drug therapy during pregnancy	0380

- A -

Anti-depressive drug use during pregnancy	0380
Anti-epileptic drug use during pregnancy	0380
Anti-hypertensive drug use during pregnancy	0380
Anxiety disorders	0400
Appendectomy	0770
Arrest:	
cardiac, complicating anesthesia	1900
cardiac, during pregnancy	0420
Arrhythmias, cardiac	0420
Arthritis, rheumatoid	0490
ASA therapy for autoimmune diseases	1541
Aspiration pneumonitis, complicating anesthesia	1890
Asthma	0580
Atelectasis, pulmonary	1180
Atosiban therapy for tocolysis	1530
Autoimmune thyroiditis	0510

- B -

Back pain, post anesthetic	1910
Bacterial infection, antepartum	1760
Bell's Palsy	0410
Bicornuate, uterine abnormalities	0570
Bladder diverticuli	0530
Bleeding disorder	0550
Block:	
high epidural/subdural	1840
prolonged epidural	1830
Blood dyscrasia	0550
Blood loss during Cesarean section	0681
Blood patch, to seal dural tear	1790
Blood transfusions, number of	1500
Bowel carcinoma	0540
Bowel obstruction, postpartum	1240
Breast carcinoma	0540
Breech presentation in a previous pregnancy	0140
Bricanyl (Terbutaline) therapy for tocolysis	1530
Bromocriptine (Parlodel) lactation suppression	1540
Bulimia nervosa	0400

- C -

Calculus, renal	0530
Carcinoma	0540
Cardiac:	
arrest	0420
arrest, complicating anesthesia	1900
Cardiomyopathy	0420
Carrier, serum hepatitis	0460
Cerebral palsy	0410
Cervical:	
carcinoma	0540
encerclage	0710
incompetence	0570
laceration	1050
suture, removal of	0690
Cervicitis	0591
Chickenpox	1730
Chlamydia(Code also under Infant Disease):	
during pregnancy	1750
postpartum	1370
Chlorpromazine (Largactil) tranquilizer	0870
Cholelithiasis	0370
Cholestatic liver disease of pregnancy	0460
Cholinesterase deficiency	0490
Choriocarcinoma	0110
Chorionic villi sampling	0751
Chromosomal abnormalities	0592
Chronic hypertensive disease	0200
Coagulation disorder, acquired	0450
Colitis, ulcerative	0370
Complications, postpartum, other	1240
Concerns, fetal growth	0300
Condyloma acuminata:	
during pregnancy	1670
postpartum	1370
Congenital heart disease	0420
Convulsions:	
due to eclampsia in current pregnancy	0220
due to eclampsia in previous pregnancy	0050
due to epilepsy	0410
Cordocentesis	2200
Cordocentesis for embolization of umbilical vessels	2240
Coronary artery disease	0420
Crohn's disease	0370
Cryoprecipitate transfusion	1470
Cyst of Bartholin's gland	0591
Cystic fibrosis	0580
Cytotec (Induction for Termination for Anomaly)	3050

- D -

Damage, hypoxic brain	1240
Death:	
fetal [Undelivered patients only]	1560
maternal	1550
Deep vein thrombosis:	
antepartum	0440
in a previous pregnancy	0150
Defect/dehiscence of uterine scar	0330
Deficiency:	
cholinesterase	0490
Factor 8	0550
Factor 12	0550
G6PD	0550
Deficit:	
neurologic, resulting from delivery	1240
Dehiscence, wound	1150
Deladumone lactation suppression	1540
Deletions, chromosomal	0592
Demerol analgesia	0810
Depression:	
in pregnancy	0400
manic	0400
postpartum:	
current	1160
previous pregnancy	0180
Dermatitis herpetiformis	0330
Destructive operation to effect delivery	0660
Diabetes:	
gestational, in a previous pregnancy	0160
maternal [Undelivered patients only]	0520
maternal [Delivered] See Infant Disease Codes	
Diabetic therapy	1531
Diabinese therapy	1531
Diazepam (Valium) tranquilizer	0850
D.I.C (Disseminated Intravascular Coagulation).	0450
Diethylstilbestrol (Stilbestrol) lactation suppression	1540
Dilatation and curettage:	
after delivery or abortion	0730
diagnostic	0731
Dilatation and Evacuation	3070
Dilaudid therapy	0910

- D -

Disease:

cardiac	0420
cholestatic liver disease of pregnancy	0460
congenital heart	0420
coronary artery	0420
Crohn's	0370
Fifth's	1710
gastrointestinal	0370
hypertensive, chronic	0200
liver, cholestatic	0460
mycoplasma	1740
other non-obstetrical, NEC	0490
other obstetrical NEC	0330
polycystic kidney	0530
pulmonary	0580
renal	0530
rheumatic heart	0420
Scheurmann's	0490
thromboembolic	0440
viral	1710
Von Recklinghausen's	0490
Von Willebrand's	0550

Disorder:

acquired coagulation	0450
adrenal gland	0510
anxiety	0400
eating	0400
generalized anxiety	0400
hypothalamus	0510
non-obstetrical, other	0591
obsessive compulsive	0400
ovary	0510
panic	0400
pituitary	0510

Disseminated intravascular coagulation (D.I.C.) 0450

Distress, fetal 0600

Diverticuli, bladder 0530

Drainage:

fetal head to effect delivery	0660
suprapubic of myelocele/meningocele	0660

- D -

Drop, foot:	
due to anesthesia	1850
not due to anesthesia	1240
Drug abuse	0390
Drug, maternal use during present pregnancy	0380
Dural tap, accidental	1810
Dyscrasia, blood	0550
Dysfibrinogenemia	0550
Dystrophy, muscular	0410

- E -

Early postpartum hemorrhage	1100
Eating disorders	0400
Eclampsia:	
in present pregnancy	0220
in previous pregnancy	0050
Ectopic pregnancy in a previous pregnancy	0100
Edema:	
pulmonary	0580
pulmonary, postpartum, (not due to anesthesia)	1190
Effusion, pleural	1190
Embolism, pulmonary	0440
Embolization of umbilical vessels by cordocentesis	2240
Embolus, pulmonary:	
current pregnancy	1170
previous pregnancy	0150
Encephalopathy, postpartum	1240
Encerclage, cervical	0710
Endocarditis	0420
Endocrine diseases	0510
Endometritis	1300
Entonox anesthesia for labour/delivery	0970
Epidural:	
abscess, complicating epidural block	1870
anesthesia, continuous catheter, for labour/delivery	0990
anesthesia, continuous infusion (CIEA), for labour/delivery	1000
anesthesia, single, for labour/delivery	0980
block, high	1840
block, prolonged	1830
hematoma, complicating epidural block	1860
non-delivery procedures	1030
patient controlled (PCEA), for labour/delivery	1001
Epilepsy	0410
Episiotomy hematoma	1140
Excessive fetal growth, suspected	0300
Extension, uterine incision	1060
Evacuation of hematoma	1230
Evisceration, due to wound dehiscence	1150
Exchange, plasma	1470
Exposure, noxious fumes (environmental)	0380
External version	1460

- F -

Factor V Leiden Deficiency	0550
Factor 8 deficiency	0550
Factor 12 deficiency	0550
Failed intubation for general anesthetic	1914
Failure:	
heart	1220
renal	1210
False labour [Undelivered patients only]	0340
Familial hypofibrinogenemia	0550
Fatty liver of pregnancy	0460
Fentanyl analgesia	0930
Fetal abdominal paracentesis	2210
Fetal anomaly, suspected [Undelivered patients only]	0360
Fetal death [Undelivered patients only]	1560
Fetal distress	0600
Fetal growth concerns	0300
Fetal peritoneal tap	2210
Fetal thoracentesis	2230
Fetal transfusions, total number during pregnancy	0480
Fifth's disease	1710
Food poisoning	0430
Foot drop:	
complicating epidural or subdural block	1850
postpartum (not due to anesthesia)	1240

- G -

G6PD deficiency	0550
Gamma globulin transfusion	1470
Gastritis, reflux	0370
Gastroenteritis:	
infectious	0430
noninfectious	0430
salmonella	0430
viral	0430
Gastro-intestinal disease	0370
General anesthesia:	
for labour/delivery	0960
for non-delivery procedure	1020
Genital herpes	1640
Gestation, multiple	0350
Gestational diabetes in a previous pregnancy	0160
Glomerulonephritis, chronic	0530
Gonorrhea:	
during pregnancy	1630
postpartum	1370
Group B streptococcal infection:	
during pregnancy	1600
postpartum	1370
Growth, fetal, excessive	0300

- H -

Harrington Rod, presence of	0410
Hashimoto's Thyroiditis	0510
Headache, post-dural puncture	1910
Heart disease	0420
Heart failure, postpartum	1220
HELLP syndrome	0210
Hematoma:	
epidural, complicating epidural block	1860
episiotomy	1140
evacuation of	1230
labial	1140
pelvic	1140
wound	1140
Hemolytic:	
anemia	0550
uremic syndrome	0450
Hemorrhage:	
antepartum, < 20 weeks gestation	0190
antepartum, ≥ 20 weeks gestation	0280
intracerebral	0410
intrapartum	0610
early postpartum	1100
late postpartum	1110
subarachnoid	0410
Hepatitis	0460
Herpes:	
genitalis	1640
gestationalis	0330
labialis	1640
postpartum	1370
simplex infection	1640
zoster	1730
High blood pressure in previous pregnancy	0050

- H -

History:

heart disease or surgery	0420
infertility	0170
malignancy	0010
malignant hyperthermia (family/personal)	0490
previous pregnancy:	
abruptio placenta	0130
anemia	0120
breech presentation	0140
diabetes, gestational	0160
eclampsia	0060
ectopic pregnancy	0100
embolus, pulmonary	0150
hydatidiform mole	0110
hypertensive disease	0050
sensitized pregnancy	0040
thromboembolic disease	0150
thrombophlebitis	0150
thrombosis, deep vein	0150
pyelonephritis, acute, during current pregnancy	0530
Hunners ulcer	0530
Hydatidiform mole	0110
Hydromorphone analgesia	0910
Hydronephrosis	0530
Hyperbilirubinemia	0460
Hyperemesis gravidarum	0230
Hypertension, pulmonary	0420
Hypertensive disease:	
chronic	0200
in previous pregnancy	0050
pregnancy-induced	0210
Hyperparathyroidism	0510
Hyperthyroidism	0510
Hypnotic:	
amo-secobarbital (Tuinal)	0830
pentobarbital (Nembutal)	0840
secobarbital (Seconal)	0820
Hypnotism for labour/delivery	0950
Hypofibrinogenemia	0550
Hypoplastic anemia, idiopathic	0550
Hypotension, post anesthetic	1910
Hypothyroidism	0510
Hypoxic brain damage	1240
Hysterectomy	0780

- I -

Idiopathic thrombocytopenic purpura	0550
Ileus, paralytic, postpartum	1240
Illness, psychiatric	0400
Impetigo herpetiformis	0330
Incompetence, cervical	0570
Indocid (Indomethacin) therapy for tocolysis	1530
Indomethacin therapy (polyhydramnios)	0250
Induction, intracervical catheter	3040
Induction, for termination	3050
Infarction, myocardial	0420
Infection:	
AIDS:	
during pregnancy	1680
postpartum	1370
bacterial, antepartum	1760
chlamydia:	
during pregnancy - See Also Infant Disease Codes	1750
postpartum	1370
condylomata:	
during pregnancy	1670
postpartum	1370
episiotomy	1330
gonococcal:	
during pregnancy	1630
postpartum	1370
group B streptococcus:	
during pregnancy	1600
postpartum	1370
herpes simplex virus:	
during pregnancy	1640
postpartum	1370
listeria:	
during pregnancy	1610
postpartum	1370
mycoplasma:	
during pregnancy - See Also Infant Disease Codes	1740
postpartum	1370
postpartum, other	1370
rubella:	
during pregnancy	1650
postpartum	1370
septicemia:	
during pregnancy	1660
postpartum	1350
syphilis:	
during pregnancy	1620

- I -

Infection:	
postpartum	1370
urinary tract:	
lower, during pregnancy	1590
postpartum	1320
varicella:	
during pregnancy	1730
postpartum	1370
wound:	
antepartum	1700
postpartum	1330
Infectious gastroenteritis	0430
Infertility, previous history	0170
Injection:	
epi-catheter	1800
intravenous, toxic reaction to	1800
Injury, other neurological, resulting from delivery	1240
Insertion:	
intracervical catheter	3040
intracervical prostaglandin	3000
laminaria tents	3040
vaginal prostaglandin	3010
Insulin therapy	1531
Intracardiac Injection (KCL)	3080
Intracerebral hemorrhage	0410
Intrapartum hemorrhage	0610
Intravenous injection, toxic reaction to	1800
Invasive mole	0110
Inversions, chromosomal	0592
Inverted uterus	1130
Irritable bowel syndrome	0370
Isoxsuprine (Vasodilan) therapy for tocolysis	1530
I.U.G.R., suspected	0300
IV Syntocin (Only)	3090
IV Syntocin(Saline Injection and IV Syntocin)	3060

- J -

Jaundice of pregnancy 0460

-K-

KCL Intracardiac Injection 3080

- L -

Labial hematoma 1140

Labour:

 false [Undelivered patients only] 0340

 premature [Undelivered patients only] 0320

 pyrexia in 0620

 trial of 1490

Laceration:

 anal sphincter (third degree tear) 1050

 bowel, bladder, ureter 1060

 cervical 1050

 first degree 1050

 periurethral 1050

 rectal mucosa (fourth degree) 1050

 second degree 1050

 uterine artery 1060

Lactation suppression 1540

Laminaria tent insertion 3040

Laparoscopy 0720

Laparotomy 0721

Largactil analgesia 0870

Late postpartum hemorrhage 1110

Lesion, spinal cord 1880

Leukocytoclastic vasculitis 0591

Listeria infection:

 during pregnancy 1610

 postpartum 1370

Lithium, maternal use of 0380

Loss of blood during Cesarean section 0681

Lower urinary tract infection, during pregnancy 1590

Lower urinary tract problems 0530

Lues (Syphilis) 1620

Lupus, systemic 0490

- M -

Magnesium sulfate therapy:	
hypertension or seizures	1480
tocolysis	1530
Malignancy/Neoplasms	
current pregnancy	0540
previous pregnancy	0010
Malnutrition, fetal, suspected	0300
Manic-depression	0400
Manual removal of placenta	0740
Mastitis	1310
Maternal:	
antibodies	0470
death	1550
diabetes [Undelivered patients only]	0520
drug use during present pregnancy	0380
Meningitis	1710
Meperidine (Demerol) analgesia	0810
Missed abortion	0190
Mitral valve prolapse	0420
Misoprostol (Induction for Termination for Anomaly)	3050
Molar pregnancy in a previous pregnancy	0110
Morbidity, puerperal	1390
Morphine analgesia	0890
Mosaicism	0592
Multiple gestation [Undelivered patients only]	0350
Multiple sclerosis	0410
Muscular dystrophy	0410
Myasthenia gravis	0410
Mycoplasma disease (Code also under Infant Disease Code):	
during pregnancy	1740
postpartum	1370
Myocardial infarction	0420
Myocarditis	0420

- N -

Nalbuphine analgesia	0900
Narcotic:	
abuse, chronic, during pregnancy	0390
use, chronic, during pregnancy	0380
Nembutal hypnotic	0840
Neoplasms, including malignancies	0540
Nephropathy	0530
Nephrotic syndrome	0530
Nervosa, anorexia	0400
Neurofibromatosis	0490
Neuroleptic:	
delivery procedures	0950
non-delivery procedures	1040
Neurologic illness	0410
Nisentil analgesia	0800
Non-delivery general anesthesia	1020
Non-obstetrical disease, not elsewhere classifiable	0490
Nubain (Nalbuphine) analgesia	0900

- 0 -

Obsessive-compulsive disorders	0400
Obstetrical disease, other, NEC	0330
Obstruction, bowel, postpartum	1240
Oligohydramnios	0240
Oophorectomy	0760
Opium analgesia	0890
Oral herpes	1640
Ovarian carcinoma	0540
Oxytocin induction	3020

- P -

Pain, back, anesthetic complication	1910
Palsy:	
Bell's	0410
cerebral	0410
Pancreatitis, acute and chronic	0370
Pantopan analgesia	0890
Paracentesis, fetal abdominal	2210
Paraesthesia, post-anesthetic	1910
Paralysis, respiratory, due to anesthesia	1820
Paralytic ileus	1240
Parlodel lactation suppression	1540
Parvovirus	1710
Patch, blood	1790
Pelvic hematoma	1140
Pentazocine analgesia	0920
Pentobarbital (Nembutal) hypnotic	0840
Peritonitis	1360
Phenergan tranquillizer	0880
Phenylketonuria, maternal	0490
Pitocin induction	3020
Placenta:	
abruptio	0270
manual removal of	0740
previa	0260
retained	1120
Plasma exchange	1470
Plasma transfusion	1470
Plasmapheresis	1470
Platelet transfusion	1470
Pleural effusion	1190
Pneumonia, antepartum	0580
Pneumonitis, aspiration, complicating anesthesia	1890
Pneumothorax	1200
Poisoning, food	0430
Polycystic kidney disease	0530
Polyhydramnios	0250
Porphyria 0490	
Positive tuberculin test	1720
Post dates [Undelivered patients only]	0310
Post-dural puncture headache	1910
Postpartum:	
depression	1160
hemorrhage, early	1100
hemorrhage, late	1110

- P -

Pregnancy-induced hypertension	0210
Premature labour [Undelivered patients only]	0320
Premature rupture of membranes	0290
Prescription medication abuse during pregnancy	0390
Presence, Harrington Rod	0410
Pre-eclampsia:	
in present pregnancy	0210
in previous pregnancy	0050
Previous:	
abruptio placentae	0130
anemia	0120
breech	0140
deep vein thrombosis	0150
ectopic pregnancy	0100
gestational diabetes	0160
malignancy	0010
molar pregnancy	0110
postpartum depression	0180
pulmonary embolus	0150
pyelonephritis, acute, in current pregnancy	0530
thromboembolic disease	0150
thrombophlebitis	0150
sensitized pregnancy	0040
Problems, lower urinary tract	0530
Procedure, non-delivery, other	0790
Proctitis, ulcerative	0370
Prolapsed mitral valve	0420
Prolonged:	
bleeding time	0550
epidural block	1830
Promazine (Sparine) analgesia	0860
Promethazine (Phenergan) analgesia	0880
Prostaglandin (administration):	
intracervical	3000
oral	3030
vaginal	3010
Prosthesis, valve (heart)	0420
Pruritic urticarial papules and plaques of pregnancy	0330
Pseudotumor cerebri	0410
Psychiatric illness	0400
Pudendal anesthesia for labour/delivery	1010
Puerperal morbidity	1390

- P -

Pulmonary:	
atelectasis	1180
disease	0580
edema, antepartum/intrapartum	0580
edema, postpartum	1190
embolus in a previous pregnancy	0150
embolus in present pregnancy	1170
hypertension	0420
infection, postpartum	1400
Pyelonephritis:	
acute	0530
chronic	0530
Pyrexia:	
in labour	0620
unknown cause, postpartum	1380

- Q -

Quadruplets [Undelivered patients only]	0350
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- R -

Reaction:	
anaphylactic	0591
blood transfusion	0591
other adverse drug	0591
Rectal mucosa laceration	1050
Reflux:	
gastritis	0370
urinary	0530
Removal:	
cervical suture	0690
placenta, manual	0740
Renal:	
agenesis	0530
calculus	0530
disease (not U.T.I.)	0530
failure	1210
transplant	0530
Retained placenta	1120
Rheumatic heart disease	0420
Rheumatoid arthritis	0490
Ripening, cervix	3000
Ritodrine therapy for tocolysis	1530
Rubella	1650
Rupture: membranes, premature	0290
uterus:	
due to obstetrical trauma	1060
spontaneous	0330

- S -

Saline Injection and IV Syntocin	3060
Salmonella gastroenteritis	0430
Salpingectomy	0760
Salpingo-oophorectomy	0760
Sarcoidosis	0490
Scheurmann's disease	0490
Schizophrenia	0400
Scleroderma	0490
Sclerosis:	
muscular	0410
tuberous	0410
Scoliosis	0490
Secobarbital (Seconal) hypnotic	0820
Seconal analgesia	0820
Seizure:	
due to eclampsia	0220
due to eclampsia in a previous pregnancy	0050
due to neurologic illness	0410
Sensitized pregnancy previously	0040
Separation of symphysis pubis	0330
Septate uterus	0570
Septicemia:	
during postpartum period	1350
during pregnancy	1660
Serum hepatitis carrier	0460
Shingles	1730
Sickle cell anemia	0550
Sjogren's Syndrome	0490
Sparine tranquillizer	0860
Spherocytosis, hereditary	0550
Spinal anesthesia:	
labour and delivery	0940
total (respiratory paralysis)	1820
Spinal cord lesion, complicating epidural or subdural block	1880
Spinal/epidural double needle:	
labour/delivery	1011
Spondylitis, ankylosing	0490
Spontaneous abortion	0190
Sterilization, tubal	0700
Stilbestrol lactation suppression	1540
Street drug abuse during pregnancy	0390
Streptococcal infection, group B	1600
Subarachnoid hemorrhage	0410
Subdural block, high	1840

- S -

Sublimaze analgesia	0930
Suppressant, lactation:	
Bromocriptine	1540
Chlorotrianisene	1540
Deladumone	1540
Diethylstilbestrol	1540
Estrand	1540
Parlodel	1540
Tace	1540
Testerone-estradole	1540
Suspected:	
excessive fetal growth	0300
fetal anomaly [Undelivered patients only]	0360
IUGR	0300
Suture, cervical, removal of	0690
Symphysitis	0330
Syndrome:	
irritable bowel	0370
nephrotic	0530
Sjogren's	0490
Thoracic outlet	0410
Wolff Parkinson's White Syndrome	0420
Syntocin induction	3020
Syphilis:	
during pregnancy	1620
postpartum	1370
Systemic lupus	0490

- T -

Tace lactation suppression	1540
Talwin analgesia	0920
Tap:	
dural, accidental	1810
fetal peritoneal	2210
Tears/lacerations	1050
Terbutaline therapy for tocolysis	1530
Test, positive:	
Mantoux	1720
TB	1720
Tuberculin	1720
Thalassemia	0550
Therapy:	
anti-coagulation	0380
anti-depressives	0380
anti-epileptics	0380
anti-hypertensives	0380
ASA for autoimmune diseases	1541
diabetic	1531
Thoracentesis, fetal	2230
Thoracic outlet syndrome	0410
Threatened abortion	0190
Thrombocytopenia	0551
Thrombocytopenic purpura:	
idiopathic	0550
thrombotic	0450
Thromboembolic disease in present pregnancy	0440
Thrombophlebitis:	
in a previous pregnancy	0150
pelvic	0440
postpartum	1340
Thrombosis, deep vein:	
current pregnancy	0440
in a previous pregnancy	0150
Thrombotic thrombocytopenic purpura	0450
Thyroiditis:	
autoimmune	0510
Hashimoto	0510
Tocolytic agents	1530
Tocolytic alcohol	1530
Tocolytic isoxsuprine (Vasodilan)	1530
Total spinal anesthesia	1820
Toxemia:	
in present pregnancy	0210
in previous pregnancy	0050
Toxic intravenous injection	1800

- T -

Toxoplasmosis, prenatal	1690
Tranquillizer:	
chlorpromazine (Largactil)	0870
diazepam (Valium)	0850
promazine (Sparine)	0860
promethazine (Phenergan)	0880
Transfusions:	
albumin	1470
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- C-

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- C -

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DPTP immunization	3440

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ectodermal	1080
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or absent nails	0770
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Emphysema:	
lobar, due to bronchogenic cyst	2160
lobar, idiopathic	2160
pulmonary	2160
pulmonary, interstitial	2090
subcutaneous	3120
Empyema	1540
Encephalitis	1450
Encephalocele	0990
Encephalomalacia	2000
Endemic cretinism	2580
Endocardial cushion defect	0130
Endocardial fibroelastosis	0130
Endocarditis	1510
Endocrine disorders, miscellaneous	2830
Endothelial tissue neoplasm	2550
Endotracheal tube, complications of	3010
Enterocolitis, acute necrotizing	1480
Ependymoma	2550
Epidermolysis bullosa	0720

- E -

Epigastric hernia	0950
Epispadias	0560
Epithelial tissue neoplasm	2550
Erb's palsy	1240
Esophageal perforation:	
due to other causes	2280
due to tracheal intubation	3010
Ethchlororvynol (Placidyl) withdrawal	1970
Eventration of the diaphragm	0360
Exchange transfusion	3200
Excision of choanal atresia	3280
Excitation, post-asphyctic CNS	1120
Exstrophy of the bladder	0660
Extra:	
material of P (short arm) of one of #15 chromosomes	1070
services, families in need of	3090
Extracorporeal membrane oxygenation (E.C.M.O.)	3330
Eyelid fibrous bands	0490

- F -

Fabry's disease (Alpha-glucosidase deficiency)	2830
Facial:	
cleft	0490
nerve palsy	1230
Factor XIII deficiency	2460
Factor VIII	2460
Factor XI	2460
Failed hearing test	3060
Failure:	
congestive heart	2920
congestive heart, post-asphyctic	1190
renal	2940
Families in need of extra services	3090
Fat necrosis, subcutaneous	1370
Feedings, tube (gastric or jejunal)	3210
Femoral hernia	0540
Femur fracture	1220
Fetal:	
alcohol syndrome	1080
complications of amnio and/or intrauterine transfusion	3000
crowding/constraint	1060
hemorrhage from umbilical or placental vessels	2450
hydantoin syndrome	1080
malnutrition	0110
Feto-maternal hemorrhage	2450
Feto-maternal hemorrhage, anemia due to	2470
Feto-placental hemorrhage	2450
Fetus:	
in fetu	3120
papyraceus	3120
Fibroelastosis, endocardial	0130
Fibrosis, liver (periportal)	2230
Fibroplasia, retrolental	2900
Fifth nerve palsy	2050
Fistula:	
branchial	0390
dermal	0990
recto-ano-urethral	0670
rectovaginal	0670
tracheo-esophageal	0240
Fixed diaphragm, not due to paralysis	2210
Flutter, atrial	0150
Follicular cyst	2550
Fontanelle, posterior, large	2990
Foramen ovale, premature closure	0130
Foreign body, granuloma of airway or lung	2210
Fourth nerve palsy	2050

- F -

Fractures:	
cause unknown	0920
due to trauma	1220
secondary to Ricket's	2620
Frank Bleeding	2450
Fraser's syndrome	1080
Fronto-nasal dysplasia sequence	1080
Fulguration of posterior urethral valves	3330
Functional bowel obstruction, cause unknown	2320
Fundoplication	3280
Fungal infection	1790
Funisitis	0070
Fy ^a -isoimmunization (Duffy)	2420

- G -

Galactosemia	2830
Galen, aneurysm of vein of	0190
Gall bladder, hydrops of	2320
Gastric:	
perforation	2280
tube feeds	3210
Gastroenteritis	1410
Gastro-esophageal reflux	2240
Gastroschisis	0840
Gastrostomy for medical reason	3360
Genital agenesis/hypoplasia	0620
Genitalia, ambiguous	2630
Genu recurvatum	0950
G.I.:	
disease, miscellaneous	2320
stricture, acquired	2320
Gilles telencephalic leucoencephalopathy	2000
Glaucoma:	
acquired	0460
congenital	0460
Glioma, nasal	2550
Glucose-6-phosphate dehydrogenase deficiency	2540
Glucose-6-phosphate dehydrogenase deficiency, anemia due to	2470
Goiter, congenital	2560
Goitrous cretinism, non-endemic	2580
Goldenhar syndrome	1080
Goltz syndrome	0720
Gonosomal intersex	1070
Granulocyte transfusion	3330
Granuloma foreign of airway/lung	2210

- H -

Hand:	
anomalies	0850
claw hand deformity	0850
Heart failure:	
not post-asphyctic	2920
post-asphyctic	1190
Hemangioma, cavernous, capillary or port-wine stain	0700
Hemangioma resection	3280
Hematemesis	2450
Hematochezia	2450
Hematochromatosis, perinatal	2350
Hematologic disease, miscellaneous	2350
Hematoma:	
perineal	1300
resorption of	2440
umbilical cord	0100
Hematuria	2450
Hemiparesis	2020
Hemivertebra	0890
Hemofiltration	3330
Hemorrhage:	
adrenal:	
causing adrenal insufficiency syndrome	2590
not due to asphyxia, coagulation disorder when otherwise listed	2450
brain	1830
due to trauma	1330
epidural	1340
fetomaternal	2450
fetoplacental	2450
iatrogenic	2450
into tumour	3120
intra-cranial, traumatic	1270
intra-ventricular	1170
liver, subcapsular	1310
not due to asphyxia, trauma, or coagulation disorder	2450
pulmonary	2130
retinal, involving macula	2040
scalp	1290
spinal cord subdural	1340
subaponeurotic	1290
subgaleal	1290
subarachnoid, anoxic	1160
twin to twin transfusion	2450
umbilical or placental vessels	2450

- H -

Hemorrhagic disease of the newborn	2460
Hemihypertrophy	0950
Hemiparesis	2020
Hemivertebra	0890
Hemochromatosis, perinatal	2350
Hemofiltration	3330
Hemopericardium	2450
Hemoperitoneum	2450
Hemothorax	2450
Hepatic disease, coagulation disorder due to	2460
Hepatitis:	
B prophylaxis	3420
causing to hyperbilirubinemia	2440
toxic	2270
viral	2270
Hepatoblastoma	2550
Hepato-Renal syndrome	2830
Hepato-veno-occlusive disease of liver	0290
Hereditary:	
alactasia	2290
infantile lactose intolerance (lactosuria)	2290
Hernia:	
diaphragmatic	0330
epigastric	0950
femoral	0540
hiatus	2240
inguinal	0530
incisional	3120
umbilical	0840
Hereditary:	
alactasia	2290
infantile lactose intolerance	2290
stomatocytosis	2540
Herniation of omentum, due to amnio./intrauterine transfusion	3000
Heroin withdrawal	1970
Herpes simplex infection	1730
Hiatus hernia	2240
High risk situation in home for abuse/neglect	3090
Hip, dislocated or subluxated, congenital	0800
Hirschsprung's disease	0270
H.I.V. antibody screen positive	1720
Holoprosencephaly	1050
Holt Oram syndrome	1080
Home oxygen therapy	3450
Horseshoe kidney	0630
Humerus fracture	1220

- H -

Hyaline membrane:	
disease	0170
formation not due to H.M.D.	2060
Hydantoin syndrome (fetal)	1080
Hydatidiform mole	0100
Hydralozine therapy	3540
Hydranencephaly	1010
Hydrocephalus	1030
Hydrocortisone therapy, maternal	3250
Hydronephrosis or hydroureter	0590
Hydrops:	
fetalis	2950
gall bladder	2320
Hydroxylase deficiency	2590
Hydroxysteroid dehydrogenase deficiency	2570
Hygroma, cystic	2550
Hymen, imperforate	0650
Hyperammonemia	2820
Hyperbilirubinemia	2440
Hypercalcemia	2830
Hypercreatininemia	2730
Hyperglucosemia	2650
Hyperkalemia	2690
Hypermagnesemia	2770
Hypernatremia	2710
Hyperphenylalaninemia, benign	2790
Hyperphosphatemia	2780
Hyperplasia:	
lipoid adrenal	2570
pancreatic cell	2830
pulmonary	0350
vocal cords	2120
Hyperplastic primary vitreous, persistent	0490
Hyperprolinemia	2800
Hypertension:	
persistent pulmonary	0170
pulmonary, due to chronic lung disease	2210
Hyperthyroidism	2600
Hypertonicity, not post-asphyctic	1950
Hypertyrosinemia	2810
Hyperuricemia	2821
Hypoalbuminemia	2751
Hypocalcemia	2660
Hypocalcemic convulsions	1840
Hypoglucosemia	2640
Hypoglycemia, causing to congestive heart failure	2920
Hypoglycemic convulsions	1850

- H -

Hypokalemia	2680
Hypomagnesemia	2760
Hypomagnesemic convulsions	1870
Hypomandibular faciocranial dystosis	1080
Hyponatremia	2700
Hypoparathyroidism	2610
Hyponatremic convulsions	1860
Hypophosphatasia	0920
Hypophosphatemia	2840
Hypoplasia:	
adrenal, congenital	2590
brain	1020
cerebellar	1020
corpus callosum	0970
depressor anguli oris muscle	0950
diaphragm	0360
fibula	0860
focal dermal	0720
genital	0620
kidney	0580
optic nerve	0490
pectoralis major	0900
pulmonary (in Oligohydramnios Syndrome)	1090
pulmonary (in persistent fetal circulation)	0170
pulmonary (respiratory)	0320
radius and/or thumb	0940
uterus	0670
Hypoplastic:	
calvaria	0950
disease of small digits	0850
ears	0490
left heart syndrome	0130
Hypoplastic left heart, surgery	3280
Hypoproteinemia	2750
Hypospadias complex	0550
Hypothermia	2970
Hypothyroidism:	
due to defective synthesis	2580
due to iodine deficiency	2580
due to maternal drug ingestion:	
iodides	2580
propylthiouracil	2580
type unknown	2580
Hypotonicity, not post-asphyctic	1960

- I -

Iatrogenic blood-letting	2450
Ichthyosis	0750
Idiopathic respiratory distress syndrome	2060
IgM elevated without other evidence of infection	1760
Ileal perforation	2280
Immunization:	
DPT	3440
DPTP	3440
Flu(viral influenza)	3421
Impatency, naso-lacrimal duct, congenital	0480
Imperforate:	
anus	0280
hymen	0650
Incisional hernia	3120
Incontinentia pigmenti	0720
Incoordination, pharyngeal	2250
Increased intracranial pressure, post-asphyctic	1130
Increased nucleated RBC and/or normoblastemia	2510
Indomethacin therapy for patent ductus arteriosus	3290
Infant of diabetic mother	2910
Infarct:	
placental floor	0100
pulmonary	2150
Infarction:	
brain, morphologic	2000
brain, ultra-sound	1820
cerebral, not due to asphyxia	2000
cerebral, post-asphyctic	1150
intestinal	2300
myocardial	3120
Infected cephalohematoma	1470
Infection:	
bone	1550
Coxsackie	1740
Cytomegalovirus (CMV)	1660
intrauterine, chronic	1690
miscellaneous	1630
skin	1570
systemic	1380
systemic, due to surface colonization	1640
urinary tract	1420
Influenza A virus	1720
Incisional hernia	3120
Inguinal hernia	0530
Inhaled aerosol steroid therapy	3330
Iniiencephalus	0780

- I -

Injection:	
drug into presenting part, accidental	3120
varicella zoster immune globulin	3330
Insertio funiculi furcata	0100
Insertion:	
cord, marginal	0020
cord, velamentous	0010
ventricular access device (intraventricular reservoir)	3330
Insufficiency/cleft, mitral valve	0130
Insufficiency:	
pulmonary valve	0130
tricuspid	0130
tricuspid, due to congestive heart failure	1190
Insulin	3510
Insulinoma	2550
Intermittent positive pressure ventilator	3170
Interrupted aortic arch	0130
Interstitial:	
nephritis	1500
pulmonary emphysema	2090
Intestinal:	
atresia	0210
biopsy (rectal, colonic)	3330
infarction	2300
malrotation	0250
obstruction, extrinsic	0230
stenosis, intrinsic	0220
Intolerance, lactose (lactosuria)	2290
Intoxication:	
digitalis	3020
drug	3040
Intracardiac mass	0190
Intra-cranial hemorrhage, due to trauma	1270
Intrathoracic (vascular) ring	0190
Intrauterine:	
fetal transfusion, complications of	3000
infection, chronic	1690
pneumonia	1610
Intra-ventricular hemorrhage	1170
Iodides, hypothyroidism due to maternal ingestion of	2580
I.P.P.V.	
for surgery only	3170
tube C.P.A.P only	3170
ventilated	3170
Irritation, cerebral, not post-asphyctic	1950

- I -

Isoimmunization:

ABO	2360
miscellaneous	2430
neutropenia	2350
thrombocytopenia	2490
other	2370 to 2430

Isolated:

abdominal situs inversus	0160
ascites	2950
dextrocardia	0160
patent ductus arteriosus	0130
ventricular septal defect	0130

Isuprel administration	3521
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- J -

Jaundice, obstructive	2500
Jaw, anomalies of	0440
Jejunal:	
feeding	3210
perforation	2280
Jejunostomy for medical reasons	3330

- K -

Kell-isoimmunization	2410
Kernicteric convulsions	1910
Kernicterus	1980
Kidd-isoimmunization	2430
Kidney:	
abscess	1540
dysplastic	0600
hemorrhagic necrosis, post-asphyctic	1200
horseshoe	0630
large echodense, etiology unknown	0670
pelvic	0630
polycystic	0570
Kleblattschadel	0830
Klippel-Feil Syndrome	0780
Klumpke's palsy	1240
Knee dislocation	0950
Knot in cord (true)	0100
Kyphoscoliosis	0890

- L -

Laceration of liver and/or spleen	1320
Lactobezoar	2320
Lactose intolerance	2290
Lactosuria	2290
Large posterior fontanelle	2990
Laryngeal:	
atresia	0490
diverticulum	0490
palsy	1330
perforation due to tracheal intubation	3010
stenosis due to tracheal intubation	3010
Laryngomalacia	2120
Late metabolic acidosis	2670
Leaking amniotic fluid	1090
Lesions, skin, depigmented	0711
Leucoencephalopathy, Gilles	2000
Leucomalacia:	
periventricular	2000
ultrasound diagnosis	1820
Leukemia	2530
Ligation:	
ductus arteriosus	0140
P.D.A. (not of prematurity)	3280
Limb reduction	0860
Lip, cleft	0380
Lip deformity due to tracheal intubation	3010
Lipoid adrenal hyperplasia	2570
Lipomeningocele	0970
Lissencephaly	0970
Little c-isoimmunization	2380
Little "e" isoimmunization	2430
Little "s" isoimmunization	2430
Liver:	
biopsy	3330
fibrosis	2230
laceration	1320
necrosis, post-asphyctic	1210
subcapsular hemorrhage	1310
Lobar emphysema:	
due to bronchogenic cyst	2160
idiopathic	2160
Lowe's syndrome	1080
Low serum alkaline/phosphatase	2830
Lues (Syphilis)	1670

- L -

Lung:

abscess	1540
biopsy	3330
cyst	2180
malformation, cystic adenomatiod	2190
perforation, by pleural drain(chest tube)	3120
Lupus, erythematous, neonatal	3120
Lymphadenitis	1630
Lymphangiectasia, pulmonary, congenital	2200
Lymphangioma	2550

- M -

Macrocephaly	1030
Macrogyria	0970
Macrostomia	0490
Macula, retinal hemorrhage involving	2040
Magnesium sulphate therapy(vasodilator)	3301
Major surgery	3280
Malabsorption syndrome	2260
Male pseudohermaphroditism:	
with XO-YY mosaicism	2570
with XY karyotype	2570
Maldevelopment, cloacel	2320
Malformation:	
arterio-venous, lung	0190
cystic adenomatoid, lung	2190
Ebstein's, tricuspid valve	0130
Malnutrition:	
fetal	0110
Malrotation	
intestinal	0250
Marfan's syndrome	1080
Marginal insertion of cord	0020
Marker chromosome	1070
Mass:	
intracardiac	0190
retropharyngeal	2120
unknown type	2550
Massage, cardiac	3330
Mast cell disease	0720
Maternal:	
diabetes	2910
steroid therapy	3250
Meckel Gruber syndrome	1080
Meckel's Diverticulum	0290
Meconium:	
aspiration syndrome	1180
ileus	2170
plug syndrome	2330
Medulloblastoma	2550
Megalocephaly	1030
Meningitic convulsions	1890
Meningitis	1440
Meningocele	0990
Meningomyelocele	0990
Meperidine (Demerol)withdrawal	1970
Mesoblastic nephroma	2550
Mesocardia	0160

- M -

Metabolic acidosis, late	2670
Metabolic, miscellaneous	2830
Metacarpal, first, hypoplasia of	0850
Metaplasia, squamous/ulceration, complication, endotracheal tube	3010
Metastatic calcification of soft tissue	3120
Methadone withdrawal	1970
Methemoglobinemia	2350
Metoclopramide therapy	3330
Microcephaly	0980
Microcolon	0290
Microcolon-megacystis-hypoperistalsis syndrome	0290
Micrognathia	0440
Micropenis	0620
Microphthalmia	0450
Microstomia	0490
Miscellaneous:	
Disorders	3120
endocrine and metabolic	2830
G.I. disease	2320
hematologic disease	2350
infections	1630
treatment or procedure	3330
viral disease	1720
Mitral :	
atresia	0130
stenosis	0130
Mitral valve insufficiency/cleft	0130
MNS blood groups, iso-immunisation due to	2430
Moebius syndrome	0970
Morphine withdrawal	1970
Mosaic:	
Down's Syndrome	1070
trisomy 12	1070
trisomy 13	1070
Turner's syndrome	1070
Mucopolysaccharidoses	2830
Multiple pterygium syndrome	1080
Multiple vertebra	0890
Murmur, cardiac, cause unknown	0130
Muscle:	
agenesis	1060
biopsy	3330
contracture due to IM injections	2880
neoplasm	2550
problems	1060
Musculo-skeletal anomalies	0950
Myasthenia gravis, newborn	0950

- M -

Mycoplasma infection	1810
Myocardial:	
infarction	3120
biopsy	3330
Myocarditis	1530
Myocarditis, due to congestive heart failure	2920
Myopathies	0960
Myotonic dystrophy	0950
Myotubular myopathy	0960
Myringotomy	3380

- N -

Nails, dysplastic or absent	0770
Nasal glioma	2550
Nasal glioma, removal	3280
Nasojunal feeding	3210
Naso-lacrimal duct, congenital impatency of	0480
Neck, short neck disorders	0780
Necrosis:	
adrenal, post-asphyctic	1210
brain, post-asphyctic	1150
hemorrhagic, kidney	1200
liver, post-asphyctic	1210
subcutaneous fat	1370
tubular, acute post-asphyctic	1200
Necrotizing:	
enterocolitis, acute	1480
laryngitis - tracheitis (complication of endotracheal tube)	3010
Neglect, child	3090
Neoplasms	2550
Neoplastic disease, anemia due to	2470
Nephritis, chronic interstitial	1500
Nephrocalcinosis	2870
Nephroma, mesoblastic	2550
Nephrostomy, percutaneous	3330
Nephrotic syndrome	0670
Nesidioblastosis	2830
Neural tube, incomplete closure of	0990
Neuroblastoma	2550
Neurofibromatosis	1061
Neurologic abnormality	1060
Neutropenia	2350
Nevus:	
pigmented	0710
sebaceous	0770
Nitric oxide therapy	3302
Nitroprusside therapy	3310
Non-bullous dermatosis	0720
Non-endemic goitrous cretinism	2580
Non-persistent acidosis	2670
Non-umbilical artery catheter	3140
Non-SIDS death after discharge	2890
Noonan syndrome	1080
Normoblastemia	2510
Nucleated RBC increased	2510
Nutrition, parenteral	3220

- O -

Obstruction:	
bladder neck	0640
bowel, functional	2320
extrinsic intestinal	0230
extrinsic small bowel	0230
ureteropelvic junction	0640
urethral	0640
urinary	0640
Obstructive jaundice	2500
Occlusive disease, hepato-veno	0290
Oculomotor nerve palsy	2050
Oligohydramnios syndrome	1090
Oliguria	2740
Omentum, herniation due to amnio/intrauterine transfusion	3000
Omphalitis	1430
Omphalocele	0840
Omphalomesenteric cyst	0840
Ondine's Curse	2040
Oophorectomy	3280
Opacities:	
cornea	0430
vitreous humour	0490
Opsoclonus	2040
Oral thrush	1580
Orchidectomy	3280
Orchidopexy	3280
Organic acidoses	2850
Organisms:	
causative, miscellaneous	1790
suspected of causing systemic infection	1640
Orojejunal feeding	3210
Oromandibular limb hydrogenesis syndrome	1080
Osteochondritis	1550
Osteochondroplasia	0870
Osteogenesis imperfecta	0920
Osteomyelitis	1550
Ostium:	
primum defect	0130
secundum defect	0130
Otitis:	
externa	1630
media	1630
Otocephaly	1080
Oto-Facial-Digital	1080

- O -

Ovarian cyst	0670
Ovary, torsion of	0670
Oxygen, home therapy	3450
Oxygenation, extracorporeal membrane(E.C.M.O.)	3330

- P -

Pacemaker, cardiac	3530
Pachygyria	0970
Palate, cleft	0380
Palate deformity due to tracheal intubation	3010
Palpebral fissure band	0490
Palsy:	
brachial plexus	1240
cranial nerve	2050
Erb's	1240
facial nerve	1230
Klumpke's	1240
laryngeal	1330
phrenic	1250
phrenic nerve (complication of vascular catheter)	2860
vocal cord	2050
Pancreatectomy	3280
Parabiotic syndrome	0180
Parabiotic syndrome, due to hemorrhage	2450
Paracentesis, abdominal	3390
Parainfluenza virus	1720
Paralysing agent	3370
Parenteral nutrition	3220
Paronychia(cellulitis)	1600
Paroxysmal atrial tachycardia	0150
Parvovirus	1720
Patent ductus arteriosus	0130
Patent(persistent) urachus	0670
Paucity of intrahepatic bile duct	0290
Pavulon	3370
Pectoralis major, absence of	0900
Pelvic kidney	0630
Pelvis, double	0610
Pena Shokeir:	
Type 1 phenotype	1080
Type 2, phenotype	1080
Penis, hypoplasia of (micropenis)	0620
Pentazocine(Talwin)withdrawal	1970
Peptic ulcer	2320
Perforated eardrum	1330
Perforation:	
G.I. tract	2280
heart, complication of vascular catheter	2860
laryngeal/esophageal, complication of endotracheal tube	3010
lung by pleural drain (chest tube)	3120
tracheal, complication of endotracheal tube	3010
Pericardial effusion	3120
Pericardiocentesis	3330

- P -

Pericarditis	1630	
Pericardium, absent or defective	0190	
Perinatal hemochromatosis	2350	
Perineal hematoma	1300	
Peripheral vein catheter	3220	Periportal
fibrosis 2230		
Peritoneal dialysis	3330	
Peritoneal shunt, subdural	3330	
Peritonitis	1490	
Peritonitis, meconium due to perforation of G.I. tract	2280	
Periventricular:		
leucomalacia	2000	
calcification	2040	
Persistent:		
fetal circulation syndrome	0170	
hyperplastic primary vitreous	0490	
post-intubation stridor	3010	
Peter anomaly	0430	
pH, scalp	3100	
Pharmacologic:		
Vitamin D	3430	
Vitamin E	3350	
Pharyngeal incoordination	2250	
Phenobarbital intoxication	3040	
Phenocopy	1080	
Phenoxybenzamine intoxication	3040	
Phenylalaninemia:		
of prematurity	2790	
Type I	2790	
Type II	2790	
Phenylketonuria:		
atypical	2790	
classical	2790	
transient	2790	
Phlebitis	1630	
Umbilical	1630	
Phocomelia	0860	
Phototherapy	3240	
Phrenic nerve palsy	1250	
Picornavirus infection	1720	
Pierre-Robin syndrome	1080	
Pigmented nevus	0710	
Pit, pre-auricular	0410	

- P -

Placenta:	
accreta	0100
circumvallate	0030
increta	0100
membranous	0100
percreta	0100
Placental floor infarct	0100
Pleural drain (chest tube)	3190
Plasma thromboplastin antecedent (PTA deficiency)	2460
Pneumatosis intestinalis	1480
Pneumomediastinum	2080
Pneumonectomy	3280
Pneumonia:	
congenital	1610
in persistent fetal circulation	0170
intrauterine	1610
postnatal	1620
Pneumonitis, aspiration	1180
Pneumopericardium	2100
Pneumoperitoneum, cause unknown	2320
Pneumothorax	2070
Pneumothorax, due to amnio./intrauterine transfusion	3000
Poland syndrome	1080
Polycystic kidney	0570
Polycythemia	2480
Polydactyly	0810
Polymicrogyria	0970
Polysplenia syndrome	1080
Porencephalic cyst(s)	2000
Port-wine stain	0700
Positive:	
blood culture without other evidence for septicemia	1400
DAT (Coombs' test) due to complement, no ABO set-up	2430
H.I.V. antibody screen	1720
serology for syphilis	1670
Posterior:	
fontanelle, large	2990
fossa hemorrhage	1270
urethral valve	0640

-P-

Post-asphyctic:	
acute tubular necrosis and hemorrhagic necrosis of kidney	1200
adrenal necrosis	1210
brain necrosis	1150
CNS depression	1110
CNS excitation	1120
congestive heart failure	1190
convulsions	1140
increased intracranial pressure	1130
liver and/or adrenal necrosis	1210
Postnatal pneumonia	1620
Post-intubation stridor, persistent	3010
Potter's syndrome (renal agenesis)	1090
Pre-auricular skin tag, pit or sinus	0410
Prednisolone therapy, maternal	3250
Prednisone therapy, maternal	3250
Premature closure of foramen ovule	0130
Presenting part, accidental injection of drug into	3120
Pressure, intracranial, increased post-asphyctic	1130
Primary pulmonary hypertension	0170
Prolapse:	
cord	0090
rectal	2320
Propranolol antihypertensive therapy	3540
Prophylaxis, hepatitis B	3420
Propylthiouracil, hypothyroidism due to maternal ingestion of	2580
Prostaglandin E therapy	3320
Prune belly syndrome	1080
Pseudohermaphroditism, male	2570
Pseudo-truncus	0130
Pseudo-Hurler polydystrophy	2830
PTA deficiency	2460
Pterygium syndrome	1080

-P-

Pulmonary:

agenesis	0320
artery atresia	0130
artery stenosis, pathologic	0130
disease of prematurity, chronic	2110
edema without hyaline membrane formation	2060
embolus	2150
emphysema	2160
emphysema, interstitial	2090
hemorrhage	2130
hyperplasia	0350
hypertension	2210
hypoplasia (in persistent fetal circulation)	0170
hypoplasia (respiratory)	0320
infarct	2150
lymphangiectasia, chronic	2200
sequestria	0350
valve insufficiency	0130
valve stenosis or atresia	0130
vein atresia	0130
P.U.O.	1750
Pyeloplasty	3280
Pyloric stenosis	0290
Pyloromyotomy	3280
Pyoderma	1570
Pyrexia of unknown origin (P.U.O.)	1750
Pyridoxine dependency convulsions	1900
Pyropoikilocytosis	2540
Pyruvate:	
carboxylase deficiency	2850
kinase deficiency	2540
kinase deficiency, anemia due to	2470
Pyuria without evidence for U.T.I.	1420

- R -

Rachischisis	0990
Radial:	
aplasia or hypoplasia	0940
heads, dislocation	0950
nerve palsy	1240
Radicular cysts	0490
Ranula	0490
Rectal-ano-urethral fistula	0670
Rectal:	
perforation	2280
prolapse	2320
Rectovaginal fistula	0670
Red cell defects	2540
Reduction, limb	0860
Reflux:	
gastro-esophageal	2240
vesicoureteric	0670
Reifenstein's syndrome	2570
Removal:	
Meckel's Diverticulum	3280
nasal glioma	3280
ovarian cyst	3280
Renal:	
arteries, double	0610
atrophy	0580
calculi	3120
dysplasia (dysplastic kidneys)	0600
failure	2940
hypoplasia	0580
necrosis, hemorrhagic, post-asphyctic	1200
pelviectasis	0590
tubular acidosis	2670
vein thrombosis	2980
Renal agenesis:	
oligohydramnios syndrome	0580
Potter's syndrome	1090

- R -

Repair:

atrioventricular canal defect	3280
bladder exstrophy	3280
coarctation of aorta	3280
imperforate anus	3280
Pierre-Robin Syndrome (tongue, lip, adhesions)	3280
ranula, surgical	3280
small bowel	3280
tetralogy repair	3280
total anomalous pulmonary venous defect	3280
tracheoesophageal fistula	3280
truncus arteriosus	3280
umbilical hernia	3280
ventricular septal defect	3280
Resection, hemangioma	3280
Resorption of hematoma	2440
Respiratory:	
disease, miscellaneous	2210
distress syndrome	2060
syncytial virus	1720
Reticulocytosis	2520
Retinal dysplasia	0490
Retinal hemorrhage involving macula	2040
Retinopathy of prematurity	2900
Retrolental fibroplasia	2900
Retropharyngeal mass	2120
Rhabdomyoma	2550
Rhachischisis	0990
Rhinitis	1460
Rhizomelic Dwarfism	1080
Rib, bifid	0890
Rib fracture	1220
Ribavirin therapy	3550
Ribs, eleven	0890
Ribs, thirteen	0890
Rickets	
clinical	2620
classical with fractures	2620
Right aortic arch	0130
Ring, intrathoracic (vascular)	0190
Ritter's disease	1570
Roberts syndrome	1080
Rota virus	1720
Rubella	1650
Rubinstein-Taybi syndrome	1080

-R-

Ruptured:

umbilical vessel, due to amnio./intrauterine transfusion	3000
vessel (complication of vascular catheter)	2860
Russell-Silver syndrome	1080

- S -

Sacrococcygeal agenesis	0890
Sacrum, bifid	0890
Salpingo-oophorectomy	3280
Scalp:	
electrode complication	3120
hemorrhage	1290
pH	3100
Scleralization, cornea	0430
Sclerema	2930
Sclerosis, tuberous	1061
Schizencephaly	0970
Scrotum, transposition of	0670
Sebaceous nevus	0770
Sepsis, causing to congestive heart failure	2920
Septectomy, atrial	3280
Septicemia	1390
Septostomy, balloon atrial	3330
Sequence:	
early amnion rupture	0740
frontal-nasal dysplasia	1080
Sequestria, pulmonary	0350
Serology positive for syphilis	1670
Seventh nerve palsy	1230
Short:	
femur, congenital	0950
neck disorders	0780
Shoulder dystocia	1360
Shunt:	
subdural peritoneal	3330
systemic pulmonary artery	3280
ventricular	3280
S.I.A.D.H.	2830
Sialidosis	2830
Sickle cell trait	2350
S.I.D.S.	3080
Simpson-Golabi-Behemel syndrome	1080
Single:	
atrium	0130
umbilical artery	0080
ventricle	0130
Sinus:	
arrest	0150
branchial cleft	0390
dermal	0990
pre-auricular	0410
urogenital	0670

-S-

Sirenomelus	0910
Situs inversus, abdominal	0160
Sixth nerve palsy	2050
Skin:	
biopsy	3330
infection	1570
lesions, depigmented	0700
slough	3120
tag, pit or sinus, pre-auricular	0410
tag, thyroglossal	0510
Skull:	
depression, unknown etiology	0950
fracture	1220
Slough, skin	3120
Smith Lemli-Opitz syndrome	1080
Soft tissue wasting	0110
Spells, apneic	2030
Spherocytosis, congenital	2540
Sprengel's deformity of shoulder	0950
Spina bifida	0990
Spinal cord trauma	1260
Spleen laceration	1320
Spot, cafe-au-lait	0770
Stain, port-wine	0700
Stenosis:	
anal	0220
ascending aorta	0130
aortic arch	0130
aortic valve	0130
external auditory meatus or canal	0420
intrinsic intestinal	0220
laryngeal, congenital	0490
laryngeal and/or subglottic, complication, endotracheal tube	3010
pulmonary artery	0130
pulmonary valve	0130
pyloric	0290
ureteral	0640
Sternocleidomastoid, tumour of	0880
Steroid therapy	
infant	3330
maternal	3250
Stickler's syndrome	1080
Stimulants used in the treatment of apnea	3230
Stomach, perforation	2280

-S-

Stomatocytosis:	
anemia due to	2470
hereditary	2540
Storage disease, type unknown	2830
Stricture, G.I., acquired	2320
Stridor:	
congenital	2120
persistent post-intubation, complication, endotracheal tube	3010
Stroke:	
not due to asphyxia	2000
post-asphyctic	1150
STS positive (Syphilis)	1670
Sturge-Webber(encephalotrigeminal angiomatosis)	1061
Subaponeurotic hemorrhage	1290
Subarachnoid hemorrhage	1160
Subcapsular hemorrhage of liver	1310
Subcutaneous:	
abscess/carbuncle	1590
emphysema	3120
fat necrosis	1370
Subependymal hemorrhage	1170
Subgaleal hemorrhage	1290
Subglottic stenosis due to tracheal intubation	3010
Sublingual frenulum(clipping of)	3330
Subluxated hip, congenital	0800
Succenturiate lobe	0050
Sudden unexpected infant death syndrome	3080
Supernumerary:	
nipple	0730
vertebra	0890
Supero-lateral infarction of brain (ultra-sound)	1820
Supratentorial hemorrhage	1270
Surfactant	3460

-S-

Surgery: (see also repair)

abdominal-perineal pull-through	3280
appendectomy	3280
arterial switch	3280
Atrial septectomy	3280
aortic valvotomy	3280
banding pulmonary artery	3280
bile duct repair	3280
bladder surgery	3280
brain	3280
cholecystectomy	3280
colon	3280
congenital heart disease	3280
craniotomy	3280
cutis aplasia congenita	3280
dermal fistula	3280
dermal sinus	3280
diaphragmatic hernia	3280
division of double aortic arch	3280
duodenojejunostomy	3280
duodenum	3280
encephalocele	3280
esophagus	3280
fundoplication	3280
gastroschisis	3280
hemangioma resection	3280
hepatic disease	3280
hydrocephalus	3280
hypoplastic left heart	3280
ileum	3280
inguinal hernia	3280
jejunal	3280
ligation/closure of patent ductus arteriosus	3280
meningocele	3280
meningomyelocele	3280
nephrectomy	3280
neoplastic disease	3280
omphalocele	3280
oophorectomy/salpingo-oophorectomy	3280
orchidectomy	3280
orchidopexy	3280
pyeloplasty	3280
rectum	3280
stomach	3280
Ureteropelvic junction obstruction	3280

-S-

Survanta	3460
Swenson pull-through	3280
Switching of coronary arteries or great arteries	3280
Syndactyly	0820
Syndrome:	
adrenal insufficiency	2590
Alagilles	0290
amniotic band	0740
Apert's	1080
Asplenia	1080
Beckwith's	1080
Camptomelic	1080
cardiac limb	1080
Cornelia de Lange	1080
Cri-du-chat	1070
Cryptophthalmus	1080
Dandy-Walker syndrome	1030
diastrophic dysplasia	0870
DiGeorge	1080
Down's	1070
drug withdrawal	1970
ductus, of prematurity	0140
ductus, of prematurity, treated with cardiac catheterization	3270
due to chromosomal aberrations	1070
EEC	1080
18 P-	1070
18 Q-	1070
Fetal Alcohol	1080
Fetal Hydantoin	1080
15P+	1070
5Q+	1070
4Q-	1070
Fraser's	1080
Goldenhar	1080
Goltz	0720
Hepato-Renal	2830
Heterotaxy	0160
hypoplastic left heart	0130
Holt Oram	1080
inappropriate secretion of antidiuretic hormone	2830
Klippel-Feil	0780
Klippel-Trenaunay-Weber Syndrome	1080
Lowe's	1080
malabsorption	2260
Marfan's	1080
Meckel-Gruber	1080

-S-

Syndrome: **(Continued)**

meconium aspiration	1180
meconium plug	2330
microcolon-megacystis-hypperistalsis	0290
Moebius	0970
Mosaic Down's	1070
Mosaic Turner's	1070
nephrotic	0670
9Q+	1070
Noonan	1080
not due to chromosomal aberrations	1080
oligohydramnios	1090
oromandibular limb hypogenesis	2120
parabiotic	0180
parabiotic, due to hemorrhage	2450
persistent fetal circulation	0170
Pierre-Robin	1080
Poland	1080
Polysplenia	1080
Potter's	1090
Prune Belly	1080
Pterygium, multiple	1080
Reifenstein's	2570
respiratory distress	2060
Ring 13	1070
Ring 5	1070
Robert's	1080
Rubinstein-Taybi	1080
Russell-Silver	1080
S.I.D.S.	3080
6Q+	1070
Smith-Lemli-Opitz	1080
Stickler's	1080
Testicular feminizing	2570
Thrombocytopenia-absent radii	2490
Townes-Brock	1080
Treacher-Collins'	1080
Triad	1080
Turner's	1070
2Q+	1070
2Q-	1070
V.A.C.T.E.R.L.	1080
Walker-Warburg	1080
Williams'	1080
Wilson-Mikity	2110
Zwelleger	2830

-S-

Syndrome: **(Continued)**

Wolff-Parkinson	1070
XYY	1070
Zachmann-Prader	2570
Synthesis, defective causing hypothyroidism	2580
Syphilis	1670
Systemic infection, site unknown	1380

- T -

Tachycardia:	
atrial, coatic	0150
paroxysmal atrial	0150
paroxysmal atrial, due to congestive heart failure	2920
ventricular	0150
Tachypnea, transient of the newborn	2060
Tag:	
pre-auricular skin	0410
skin	0410
Tamponade, cardiac	3120
Tear, tentorial	1350
Tenth nerve palsy	2050
Tentorial tear	1350
Teratoma:	
embryonic rests	2550
gonads	2550
Testis, undescended	0520
Testicular feminizing syndrome	2570
Testis, torsion of	0670
Tetany	2660
Tetralogy of Fallot	0130
Thanatophoric dwarfism	0930
Theophylline therapy	3230
Therapy:	
aminophylline	3230
antihypertensive	3540
antiviral	3550
caffeine	3230
captopril	3540
cisapride	3461
dexamethasone	3470
doxapram	3230
exosurf (artificial)	3460
gastrointestinal	3330
hepatitis B globulin	3420
hepatitis B vaccine	3420
home oxygen	3450
indomethacin	3290
magnesium sulphate(vasodilator)	3301
metoclopramide (antiviral therapy)	3550
metoclopramide (gastrointestinal therapy)	3330
nitric oxide	3280
nitroprusside	3310
pancuronium bromide	3370
pharmacologic vitamin D	3430
pharmacologic vitamin E	3350

-T-

Therapy:(cont.)	
prostaglandin E	3320
Ribavirin	3550
steroid, infant (after birth)	3330
steroid, infant, aerosol	3330
steroid, systemic, maternal	3250
survanta	3460
tolazoline(vasodilator)	3300
theophylline(aminophlline)	3230
Thermal burns	3030
Thiamine therapy	3551
Third nerve palsy	2050
Thirteen ribs	0890
Thoracentesis, no drain	3190
Thoracostomy	3190
Thoracotomy to drain pericardium	3330
Thrombocytopenia	2490
Blood group isoimmunization	2490
Thrombocytopenia-absent radii syndrome	2490
Thrombocytopenia due to PLA1 isoimmunization	2490
Thrombophlebitis (complication of vascular catheter)	2860
Thrombosis:	
arterial or venous	2460
renal vein	2980
venous, causing convulsions	1940
Thrush, oral	1580
Thumb:	
aplasia or hypoplasia	0940
bifid	0850
triphalangeal	0850
Thyroid:	
aplasia	2580
ectopic	2580
hypoplasia	2580
Thyroglossal :	
cyst	0510
skin tag	0510
Thyroxine (T ₄), serum level elevated, asymptomatic	2600
Tolazoline therapy(vasodilator)	3300
Torsion:	
ovary	0670
testis	0670
Torticollis	0880
Total anomalous pulmonary venous return	0130
Townes-Brock syndrome	1080

-T-

Toxic hemolytic anemia	2470
Toxoplasmosis	1680
Tracheal:	
agenesis	0350
atresia	0350
Tracheal perforation due to tracheal intubation	3010
Tracheitis-laryngitis, necrotizing (complication)	3010
Tracheobronchomalacia (stridor)	2120
Tracheomalacia, acquired	2120
Tracheo-esophageal atresia of fistula	0240
Tracheostomy	3260
Transfusion:	
exchange	3200
granulocyte	3330
twin to twin	2450
twin to twin, causing to congestive heart failure	2920
Transient:	
phenylketonuria	2790
respiratory distress	2060
tachypnea of the newborn	2060
Translocation:	
5 to 7	1070
7 to 9	1070
12/21 balanced	1070
13	1070
13 balanced	1070
18 balanced	1070
21	1070
Transposition:	
corrected	0130
great arteries/vessels	0130
scrotum	0670
Trauma:	
miscellaneous	1330
spinal cord	1260
Traumatic:	
intra-cranial hemorrhage	1270
stridor	2120
Treacher-Collins' syndrome	1080
Treatment, cofactor	3551
Triad syndrome	1080
Trichomonas vaginalis	1630
Tricuspid:	
atresia	0130
insufficiency	0130
Trigeminal nerve palsy	2050

-T-

Trigonocephaly	0830
Triphalangeal thumb	0850
Triplet, aborted	3120
Triploidy	1070
Trisomy:	
C group	1070
9	1070
13	1070
14	1070
18	1070
21	1070
Trochlear nerve palsy	2050
Trophoblastic disease	0100
True:	
knot in cord	0100
swabs, organisms colonized	1640
Truncus arteriosus	0130
Tube feedings	3210
Tuberous sclerosis	1061
Tubular necrosis, acute, post-asphyctic	1200
Tumour:	
sternocleidomastoid	0880
Wilm's	2550
Turner's syndrome	1070
Twin:	
aborted	3120
fetus papyraceus(infant not listed as twin)	3120
type	3500
Twins:	
dichorionic, dissimilar sexes or blood groups	3500
dichorionic, similar sexes and blood groups	3500
dichorionic, similar sexes, blood groups undetermined	3500
monoamniotic	3500
monochorionic, diamniotic	3500
Siamese (Conjoined)	3500
undetermined	3500
Twin-twin transfusion:	
anemia due to	2470
hemorrhage due to	2450

- U -

Ulcer, peptic	2320
Ulceration/squamous metaplasia, complication, endotracheal tube ...	3010
Umbilical:	
arterial catheter	3150
artery, single	0080
defects	0840
hernia	0840
vessels, rupture	3000
vein catheter	3160
Undescended testes	0520
Urachal cyst	0670
Urachus, patent(persistent)	0670
Urea cycle defect	2830
Ureaplasma infection	1810
Ureter, double	0610
Ureteral:	
atresia or stenosis	0640
diverticulum	0640
Ureterocele	0640
Urinary:	
obstruction	0640
tract infection	1420
Urogenital sinus	0670
Urticaria pigmentosa	0720
Uterus, bicornuate	0670

- V -

Vaccination, BCG	3330
Vaccine:	
hepatitis B	3420
respiratory syncytial virus	3421
Hemophilus influenza, B conjugate (HIB)	3421
DPT	3440
DPT only	3440
Vagina, double	0670
Vaginal cyst, congenital	0670
Vagus palsy	2050
Valvotomy:	
aortic	3280
pulmonary	3280
Vancomycin intoxication	3040
Varicella virus(chicken pox)	1720
Varicella zoster immune globulin injection	3330
Vasa previa	0100
Vascular ring	0190
Vasospasm (complication of vascular catheter)	2860
Vater association	1080
Vein of Galen, aneurysm of	0190
Velamentous insertion of cord	0010
Venous:	
catheter, central	3130
thrombosis	2460
Ventilation:	
high frequency	3171
intermittent positive pressure	3170
for surgery only	3170
withdrawal of ventilator care and DNR order on chart	1101
Ventricle, single	0130
Ventricular shunt	3280
Ventriculitis	1440
Vertebral anomalies	0890
Vesicostomy	3330
Vesicoureteric reflux	0670
Vessels, transposition great	0130
Viral disease, miscellaneous	1720
Virus:	
ECHO	1720
influenza A	1720
parainfluenza	1720
picorna	1720
respiratory syncytial	1720
rota	1720
varicella	1720

-V-

Vitamin:	
D, pharmacologic	3430
E deficiency syndrome, anemia due to	2470
E therapy	3350
Vocal cords:	
hyperplasia of	2120
paralysis	2050
Volvulus	0300
Volvulus, acquired	2320

- W -

Walker-Warbury syndrome	1080
Wasting, clinical soft-tissue	0110
William's syndrome	1080
Wilm's tumour	2550
Wilson-Mikity syndrome	2110
Withdrawal syndrome	1970
Wolff-Parkinson syndrome	1070
Wound abscess	1590
Wright-isoimmunization	2430
Wrist Drop	1240

- Z -

Zachmann-Prader syndrome (17-20 desmolase deficiency)	2570
Zinc deficiency	2830