Emergency Department Data Collection Reference Manual

South Australian Emergency Department Activity Data Standards

Version 1
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Government of South Australia
SA Health

EDDC Reference Manual 2014

Information Assembly oversee the Emergency Department Data Collection (EDDC)

Contact personnel for EDDC are as follows:

Information Assembly can supply further information about:

Data submissions
Due dates for submissions
Obtaining reports or data
Category definitions
Data standards
Correcting errors
Content and maintenance of this manual

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EDDC Reference Manual 2014

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Abbreviations{ TC "Abbreviations" \f C \l "1" }

ACHA	Australian Health Care Agreement
ACHS	Australian Council of Healthcare Standards
ACS	Australian Coding Standards
AIHW	Australian Institute of Health and Welfare
AN-DRG	Australian National Diagnosis Related Groups
AR-DRG	Australian Refined Diagnosis Related Groups
DNW	Did not Wait
DOA	Dead on Arrival
DRG	Diagnosis Related Group
DVA	Department of Veterans' Affairs
ED	Emergency Department
EDDC	Emergency Department Data Collection
EECU	Extended Emergency Care Unit
FMC	Flinders Medical Centre
HASS-ED	Hospital Administration Software Solutions – Emergency Department
HIC	Health Insurance Commission
HIP	Health Information Portal
ICD	International Classification of Diseases
ICD-10-AM	International Classification of Diseasesand Related Health Problems, 10th Revision, Australian Modification
LMH	Lyell McEwin Hospital
MPH	Modbury Hospital
MTD	Month To Date
NHDD	National Health Data Dictionary
NHIA	National Health Information Agreement
NHS	Noarlunga Health Service
NMDS	National Minimum Data Set
PECU	Psychiatric Emergency Care Unit at RAH
RAH	Royal Adelaide Hospital
RGH	Repatriation General Hospital
SAHMDR	SA Health Metadata Repository
SLA	Statistical Local Area
TQEH	The Queen Elizabeth Hospital
URN	Unit Record Number
WCH	Women's and Childrens Hospital
WCH–Paed	Women's and Children's Hospital – Paediatric Services
WCH– AS	Women's and Children's Hospital – Women's Assessment Services
YTD	Year To Date

Purpose and Details of the ED Collection{ TC "Purpose and Details of the ED Collection" \f C \l "1" }

Overview   All public hospitals in South Australia are required to submit information about patient presentations to Emergency Departments, known as the Emergency Department Data Collection (EDDC).

Information is collected, processed and disseminated in accordance with South Australian Health Data Management Protocols for Data Custodians

Although no patient names or addresses are stored in the ED database, the sensitive nature of such clinical information is recognised. Personnel and systems are orientated to maintain confidentiality in line with SA Health confidentiality and data security policies.

Data submitted to EDDC should be timely, accurate and complete, reflecting the demographics and clinical details of patients seen at ED Departments. These guidelines represent SA Health policy and are intended to be a reference for all hospital personnel who are involved in the collection and use of ED data.

Introduction   Covered in this section is information regarding:
Purpose of the ED Data Collection
Unit of Measurement, Coverage and Scope
Items Collected
Rules for ED Patients

Purpose of the Collection   EDDC contains de-identified demographic, administrative and clinical data detailing presentations to Emergency Departments (ED) at public hospitals in South Australia.
The data collection provides the SA Health with a centralised repository of key data elements, which may be used to better understand and analyse ED activity and performance within the public health system.

The EDDC is based on "Non-Admitted Patient Emergency Department Care" National Minimum Data Set (NMDS). The purposes of collecting this data in SA are to:
Enable the collection of data for deriving ED performance indicators:
Enable comparisons of performance in respect to access to services, quality clinical outcomes, patient management, customer satisfaction and cost effectiveness; and
Satisfy the requirements for collecting non-admitted patient ED under the Australian Health Care and National Health Information Agreements (AHCA & NHIA)

Purpose and Details of the ED Collection   continued

Unit of Measurement	The unit of measurement of the EDDC is the patient's presentation to a Emergency Department. A presentations includes all presentations to the ED except for those patients who are Dead on Arrival and do not receive resuscitation. Presentations end with the patient's physical departure from the ED.
Coverage and Scope	The EDDC commenced in 2003. Although data was not routinely submitted until May 2004, data exists in the collection from January 2000. However, only data from the 2003/04 financial year onwards is available from the Central Data Warehouse/Health Information Portal (CWD/HIP). The scope of this data collection currently covers the Emergency Departments of all the major metropolitan public hospitals. Data is currently collected from: Metro Flinders Medical Centre (FMC) Lyell McEwin Hospital (LMH) Lyell McEwin Hospital – Women's Assessment Unit (LMH-WAU) Modbury Hospital (MPH) Noarlunga Health Service (NHS) Repatriation General Hosspital (RGH) Royal Adelaide Hospital (RAH) The Queen Elizabeth Hospital (TQEH) Women's and Children's Hospital – Paediatric Services (WCH-Paed) Women's and Children's Hospital – Women's Assessment Services (WCH-WAS) Note that WCH-WAS and LMH -WAU are not technically considered as ED services. All Country Hospitals with emergency departments are included. See Appendix 4.
Exclusions and Clarifications	The following patients are excluded from the EDDC: Patients who present at ED but are Dead on Arrival and do not receive resuscitation.

EDDC Data Item Details

Data Items Collected in EDDC{ TC "Data Items Collected in EDDC" \f C \l "1" }

Introduction   This section provides definitions of the concepts underlying the EDDC, and the items derived from the data collected by the Department.
The definitions contained in this section are based, wherever possible, on the National Health Data Dictionary (NHDD).
Each code set submitted by a hospital is mapped to State code sets which in turn are mapped to National code sets (as applicable)
All hospitals except FMC and MPH use codes and descriptions from the HASS-EDIS Corporate Reference File.
The following code files have been developed in EDDC with mappings to State and National codes as appropriate.

Key Definitions   Mandatory Status
The requirement for reporting to EDDC.
The items below must be reported for every presentation at ED for every patient.
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Data Item details{ TC "Data Item details" \f C \l "1" }

ITEM Name	ITEM Description	Corporate Code Values	SA Health Metadata Repository link
Accompanying Person	The person who has accompanied the patient to the ED	Collected but not used	Not in ED Repository
Arrival Mode – Transport	The Mode of transport by which the patient arrives at the ED	1-Air Ambulance; 2-Helicopter; 3-Ambulance Service; 4-Community/Public Transport; 5-Private Car; 6-Police Vehicle; 7-Walk In; 8-Other; 9-Volunteer Transport; 10-Taxi; 99-Unknown/Not State .	Episode of care—arrival mode, code NN
Clerical Date	Date the patient's details are checked and recorded by clerical staff in the ED.		Patient—clerical date, DDMMYYYY
Clerical Time	Time the patient's details are checked and recorded by clerical staff in the ED		Patient—clerical time, hhmm
Compensable Status (eg MVA, Workcover)	A patient who is entitled to receive or has received a compensation payment with respect to an injury or	C-Compensable-Other; CNM-Non-Medicare; CSH-Conpensable-Shipping; CV-Compensable-Vehicle	Patient—compensable status, code A[AA]

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	disease or • is entitled to claim damages under Motor Vehicle Third Party insurance or • is entitled to claim damages under worker's compensation; or • has an entitlement to claim under public liability or common law damages	Accident; CW-Compensable-Workers Compensation; DVA-Dept of Veterans Affairs; 9-Unknown	
Country of Birth	The country in which the person was born	This version is from 2008, wheras the Value Domain for the data Element in the Emergency Department Data Collection uses SACC 1998 codes	Patient—country of birth, code NNNN
Date of Birth	The date of birth of the patient		Patient—date of birth, DDMMYYYY
Admission Request Date from Nov 2011	Point in time at which ED clerical staff commence the process of finding a ward locale for a patient who is to be admitted		Patient admission—decision to admit date, DDMMYYYY
Admission Request Date from Nov 2011	Point in time at which ED clerical staff commence the process of finding a ward locale for a patient who is to be admitted.		Patient admission—decision to admit time, hhmm
Departure Date	The date on which the patient was discharged from ED, indicating the end of the ED episode. Patient may then be discharged form hospital, admitted to a ward, referred to another provider etc (Where the patient had been admitted to the EECU the departure date is the date the patient is discharged from the EECU)		Patient's separation from service—departure from ED date, DDMMYYYY
Departure Time	The time at which the patient was discharged from ED, indicating the end of the ED episode. Patient may then be discharged form hospital, admitted to a ward, referred to another provider etc (Where the patient had been admitted to the EECU the departure time is the time the patient is discharged from the EECU		Patient's separation from service—departure from ED time, hhmm
Departure Referral	The place or person to whom the patient was referred on departure from the Emergency Department	1-Not referred; 3-Other Private Health Practitioner; 4-Hospital OPD; 5-Community Mental Health; 6-Other Community Health; 7-Admission; 8-Nursing Home; 9-Police; 10-Other Hospital; 57-Private Specialist; 58-LMO/GP; 59-OPD-Diabeties; 60-Morgue; 61-Coroner; 98-Other; 99-Not Stated/Unknown	Patient's separation from service—referral destination code NN
Departure Status	The status of the patient at cessation of the non-admitted patient ED service episode	1-Episode complete-Home; 2-Admission to Ward; 3-Admission within ED; 4-Transfer out of this hospital to another; 5-Left at own risk after treatment started; 6-Did not wait to be seen (DNW); 7-Died within ED (includes DOA with resus); 8-Dead on Arrival, no	Patient's separation from service—nature of separation, departure status code NN

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		resus; 9-Episode complete-Nursing Home, 10-Admission to EECU; 85-Advised of Alternative Treatment Options (AATO); 98-Episode complete-Other; 99-Not Stated/Unknown	
Detained Patient Status	Indicates if the patient was being detained under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.	Collected but not used	Not in ED repository
Diagnosis	Diagnosis of patient's condition by Medical Officer in ED	ICD-10AM 8th Edition – all EDDC records are mapped to this current edition.	Patient—diagnosis type, code AN[NNN]
EECU Admit Date	The date on which the patient was discharged from ED, indicating the end of the ED episode and admitted to the Extended Emergency Care Unit (EECU) of the hospital.		Episode of care - EECU Arrival Date and Time, DD/MM/YY hh:mm:ss
EECU Admit Time	The time at which the patient was discharged from ED, indicating the end of the ED episode and admitted to the Extended Emergency Care Unit (EECU) of the hospital.		Episode of care - EECU Arrival Date and Time, DD/MM/YY hh:mm:ss
Gender	The gender of the patient	1-Male; 2-Female; 3-Intersex or Indeterminate; 9-Not Stated/Unknown	Patient—gender, code N
Hospital Identifier	Identifier for the establishment in which episode or event occurred. Each separately administered health care establishment to have a unique identifier at the national level	0001-WCH - Paed; 0003-WCH; 0005-FMC; 0014-TQEH; 0018-RGH; 0019-RAH; 0027-LMH; 0030-MPH; 0033-NHS	Hospital—administrative identifier code, NNNN
Indigenous Status	Indicates whether or not a person identifies themselves as being of Aboriginal and/or Torres Strait Islander origin. An Indigenous person is a person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander person.	1-Aboriginal but not Torres Strait Islander origin; 2-Torres Strait Islander but not Aboriginal origin; 3-Both Aboriginal and Torres Strait Islander origin; 4-Neither Aboriginal nor Torres Strait Islander origin; 9-Not Stated/inadequately described	Patient—indigenous status, code N
MDB	The Major Diagnostic Block (MDB) assigned to the presentation.	Per IHPA MDB version 1.4.2.1 Grouper	Not in ED repository
Patient Unit Number	The Patient Unit Record Number, also known as the Unit Record Number (or URN), is a unique identifying number which is allocated to a patient on the first visit or admission to the hospital/health care service and retained for all subsequent admissions and treatments at that hospital.		Patient admission—patient unit record number, identifier N(10)

Postcode of Usual Residence	Postcode of patient's usual place of residence		Patient—home postcode, code NNNN
Presenting Problem	Patient's Presenting Problem or Complaint as assessed by the Triage Nurse.	0100-Cardiovascular/Chest; 0200-Drug/Drug Reaction; 0300-Endocrine/Metabolic; 0400-ENT/Oral; 0500-Eyes; 0600-Abdomen/Gastrointestinal; 0700-Gynae/Female Pelvis (non pregnant); 0800-Haematology; 0900-Systemic Infection; 1000-Male Pelvis/Male reproductive System; 1100-Musculo-Skeletal; 1200-Head-Neurology/Neurolgical; 1300-Obstetrics; 1400-Poisoning; 1500-Psychosocial; 1600-Urology; 1700-Respiratory; 1800-Skin (Integument); 1900-Other Complaint (not elsewhere specified); 2000-Abrasion-Single Trauma; 2100-Amputation-Single Trauma; 2200-Bites//Stings-Single Trauma; 2300-Blunt Injury-Single Trauma; 2400-Burn/Scald-Single Trauma; 2500-Contusion/Soft Tissue Injury-Single Trauma; 2600-Crush-Single Trauma; 2700-Deformity/Swelling-Single Trauma; 2900-Fracture/Dislocation-Single Trauma; 3000-Laceration-Single Trauma; 3100-Penetration-Single Trauma; 3300-Other Non-Specified-Single Trauma; 4000-Multiple Trauma; 4600-Renal; 9999-Not Stated/Unknown	Patient—presenting problem group, code A[42] Also refer to Appendix 2
Residential LHN	The LHN of the patient's residential address derived from the patient's SLA.	303 – CHSALHN; 310 – CALHN; 311 – NALHN; 312 – SALHN; 999 – UNKNOWN	Not in ED repository
Referring Hospital	Referred by details - who or which unit referred the patient to the ED.	Relevant SA Hospital Identifier code; 5100-ACT; 5200-NSW; 5300-NT; 5400-QLD; 5500-TAS; 5600-VIC; 5700-WA; 8000-Other; 8888-Not Referred; 9999-Unknown	Episode of care—referring hospital name, code NNNN
SA2	The statistical area of the patient's usual residence.	A valid SA2 as described by ABS.	Not in ED repository
Seen by Doctor Date	The date on which the patient was seen by a treating doctor in ED.		Episode of care—seen by date, DDMMYYYY
Seen by Doctor Time	The time at which the patient was seen by a treating doctor in ED.		Episode of care—seen by time, hhmm
Seen by Nurse Date	The date on which the patient was seen by a treating nurse in ED.		Episode of care—seen by date, DDMMYYYY

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Seen by Nurse Time	The time at which the patient was seen by a treating nurse in ED		Episode of care—seen by time, hhmm
Source of Referral	Who referred patient to ED	1-Self/Family/Friends; 2-GP; 3-Police; 4-Hospital; 5-Private Medical Specialist//Other MO; 11-Nursing Home; 12-Locum Service; 13-Community Health; 15-First Aid Provider; 30-Disaster; 31-Other Department in this Hospital; 32-Other Private Health Provider; 34-Hostel; 35-ED Staff (for review); 36-Coroner; 37-SA Gov Health Call Centre; 98-Other; 99-Not Stated/Unknown	Patient admission—source of referral code, N[N]
Suburb/Locality of Usual Residence	Suburb or Locality (eg small town) where patient usually resides		Patient—home suburb/locality, identifier X[20]
Triage Category	The urgency of the patient's need for medical and nursing care, using a code set by the Australian College of Emergency Medicine	1-Resuscitation; 2-Emergency; 3-Urgent; 4-Semi-Urgent; 5-Non-Urgent	Patient—triage category, code N
Triage Date	The date on which the patient is triaged.		Episode of care—triage date, DDMMYYYY
Triage Time	The time at which the patient is triaged.		Episode of care—triage time, hhmm
Type of Visit to Emergency Department	The reason the patient presents to the Emergency Department.	1-Emergency; 2-Trauma; 3-Planned Review; 4-Unplanned Review; 5-Planned Admission; 98-Other; 99-Unknown	Episode of care—reason for ED visit, code NN
URG	The Urgency Related Group (URG) assigned to the presentation.	Per IHPA URG version 1.4.2.1 Grouper	Not in ED repository

Emergency Department Data Collection Related Terminology{ TC "Emergency Department Data Collection Related Terminology" \f C \l "1" }

ED Presentation	The episode of a patient's presentation to ED, and the patient's physical departure from ED or EECU. During this episode, a patient may be triaged, or leave without being seen or treated, or may leave at own risk, or may be admitted from ED as an in-patient to a ward at that hospital, or may be admitted to EECU, or the Inpatient overflow unit.
Presentation Date/Time	Presentation Date/Time is the earliest of the Triage Date/Time and the Clerical Date/Time. Episode of care—presentation date, DDMMYYYY
Seen by Date/Time	Seen by Date/Time is the earliest of the Nurse Seen by Date/Time and the Doctor Seen by Date/Time
Medical Decision to Admit Date/Time	The Medical Decision to Admit Date/Time is the date and time when the doctor or nurse decides to admit the patient to the hospital (as an in-patient) from the ED.
EECU Admit Date/Time	The date and time at which the patient is admitted to a hospital's Extended Emergency Care Unit. Note that MPH does not have a true EECU Unit.
EECU Inpatient Overflow	EECU Inpatient Overflow patients are those waiting for an in-patient bed, and are not true EECU patients. For EECU Inpatient overflow records, the Visit time is from the Presentation Date/Time to the EECU Admit Date/Time
Visit Time	Visit Time is the time from Presentation Date/Time to Departure Date/Time
Departure Date/Time	The date and time at which the patient physically departs from EECU or ED
Wait Time	The time between the patient's presentation in ED and first being seen by either the Doctor or Nurse.
Did not wait	A patient presents to ED and has a clerical and/or triage Date/Time recorded, but leaves before being seen by Doctor.
Left at Own Risk	A patient presents to ED and has a clerical and/or triage Date/Time recorded, but leaves before treatment is completed or medical decision is made.
PECU	Royal Adelaide Hospital have a Psychiatric Emergency Care Unit and use the EECU Admit Date/Time to record a patient's presentation in the PECU. (PECU patients have an original departure status code of 51 to distinguish them from EECU patients.
Date and Time fields	For all of the chronological data fields, such as Triage, Seen By, Clerical, Decision to Admit, Depart, EECU admit, the data in the .xml files is submitted in a combined field with Date and time. Once the ED data is processed, validated, and published on the Web site, the time and date fields for each chronolgical data item can be split into separate date and time fields for each data element.

Guidelines for Submission of ED Data{ TC "Guidelines for Submission of ED Data" \f C \l "1" }

Overview   All metropolitan public hospitals must submit Emergency Department Activity data to on a monthly basis in accordance with the data standards and submission schedule set by Information Assembly, SA Health.

Introduction   This section provides information regarding
                  Methods for submissions and due date for submissions
                  Data submission standards
                  Penalties

Methods of   Approved Hospitals are required to submit monthly data electronically via e-mail, by
Submission   the 5th working day of the month, as .xml files or .txt files.
Due date

Email address   Email Submissions: HEALTH:DMUED@health.sa.gov.au
for submissions

Data   All data submitted to EDDC must conform to the standards set by Information
Standards   Assembly, SA Health. This means all required items must be completed and all
                  responses must be within the valid range of codes.
                  Electronic submissions must also comply with the standard layout specifications and
                  variable coding structures relevant to the collection format, and should be encrypted.

Electronic   Data that is not in the specified format for the collection will need to be resubmitted in
Submission File   the correct format.
Format   Note: Testing of the EDDC data extract layout must be included as part of
                  implementing new versions of patient administration systems.

Record Format and Data Type[1]{ TC "**Record Format and Data Type**" \f C \l "1" }

Record format	DataType
Accompanying_Person_Desc	Text
Arrival_Mode_Code	Text
Admit_Date_Time	Date/Time
Clerical_Date_Time	Date/Time
Compensable_Status_Code	Text
Country_Of_Birth_Code	Text
Birth_Date	Date/Time
EECU_Arrival_Date_Time	Date/Time
Departure_Date_Time	Date/Time
Departure_Referral_Code	Text
Departure_Status_Code	Text
Detained_Patient_Code	Text
Diagnosis_Code	Text
Employment_Status_Code	Text
Hospital_Code	Text
Indigenous_Status_Code	Text
Insurance_Status_Code	Text
Patient_UR_Number	Text
Post_Code	Text
Presenting_Problem_Code	Text
Referring_Hospital_Code	Text
Seen_By_Doctor_Date_Time	Date/Time
Seen_By_Nurse_Date_Time	Date/Time
Gender_Code	Text
Source_Of_Referral_Code	Text
Suburb_Name	Text
Triage_Category_Code	Text
Triage_Date_Time	Date/Time
Type_Of_Visit_Code	Text
Decision_To_Admit_Date_Time	Date/Time

1. URG, MDB, SA2 and Residential LHN are all derived (text) fields post submission. Hence are not included in the hospitals submission to the department.

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Data Quality / Data load / Error Checks / Validations / Corrections / Business Rules{ TC "Data Quality / Data load / Error Checks / Validations / Corrections / Business Rules" \f C \l "1" }

Introduction	This topic provides information on the data quality checks applied to data submitted to the Emergency Department Data Collection.
Data Quality Checks	All data submitted to SA Health for EDDCs subjected to data quality checks. These ensure the business rules (instructions) have been adhered to and identify data that requires correcting.
	A standard suite of data quality (input edit) checks is applied to new data submissions. The EDDC data quality checks identify data errors (logical inconsistencies and invalid codes) and unusual circumstances (queries).
Corrections	All data errors must be corrected in EDDC as soon as possible Note: See Data Quality Checks and Error Correction Section for details about making corrections to records with errors.
Late data submission	There are no financial penalties imposed on hospitals for late submission, however, should submission be delayed significantly there is a risk that hospital data will not be available for pivotal monthly reporting, impacting on operational and strategic decision making.
Exemptions from submission deadlines	An exemption from submission deadlines may be negotiated with the Director, Information Management Data and Reporting Services if a hospital, or group of hospitals, is unable to meet a due date
Exemption Approval	All applications for exemptions must be approved by the Director, Information Management Data and Reporting Services. They must be made in advance of the due date.

Data Load Process and Data Quality{ TC "Data Load Process and Data Quality" \f C \l "1" }

Overview   This section provides details about the process of data load, and the data quality checks applied to data once it is submitted to the EDDC. It also provides information about correcting records with errors.

Data is loaded from each hospital file into the EDDC holding file using the EDDImport program, which checks for invalid data in the holding area and uses specific checks as well as looking up values against the lookup codes table. The following listed checks are of importance, many more are used but do not affect the quality of the data or the outcome. Any data that meets any of the following criteria are reported in an error report and this is then reported to each hospital for feedback/correction.

Error reports are generated for the following date fields which do not comply with the business rules:

    Triage Dates > Seen By Doctor Dates
    Triage Dates > Seen By Nurse Dates
    Seen by Doctor Dates > Departure Dates
    Seen by Nurse Dates > Departure Dates
    Departure Dates = null

The following code fields all report an error if the field is either null or does not have a valid code:

Arrival_Mode_Code	Compensable_Status_Code
Country_Of_Birth_Code	Departure_Referral_Code
Departure_Status_Code	Diagnosis_Code
Employment_Status_Code	Gender_Code
Indigenous_Status_Code	Insurance_Status_Code
Presenting_Problem_Code	Referring_Hospital_Code
Source_of_Referral_Code	Type_Of_Visit_Code
Triage_Category_Code	

Changes are made to the data in the holding area as advised by each hospital.
If no feedback is received from a hospital, the data may be changed as outlined below.

    The Seen By Date is populated.
This is determined by taking the earlier of either the Seen By Doctor Date/Time or the Seen By Nurse Date/Time

Null values in any of the code fields below are piped.
    Arrival Mode Code, Compensable Status Code, Country Of Birth Code,
    Departure Referral Code, Departure Status Code, Diagnosis Code
    Employment Status Code, Gender Code, Hospital Code, Indigenous Status Code
    Insurance Status Code, Presenting Problem Code, Referring Hospital Code;
    Source of Referral Code, Type Of Visit Code, Triage Category Code

The stored procedure updates the holding file and replaces NULL values with a '|' (pipe) (or '||||' (4 pipes) in the case of country of birth).   The reason for the '|' character to replace null values is for quality assurance and mapping of local code values to State and National code values.

Data Load Process and Data Quality   continued

Once all changes have been made, the stored procedure updates the data in the holding file before it is transferred to the EDDC database.

Once transferred: URG, MDB, SA2 and Residential LHN are all derived based on information submitted. URG and MDB by a Grouping program supplied by IHPA; SA2 via the ALVS process in partnership with DPTI; Residential LHN is derived from a patients SLA. Any unknown codes are given a '|' (pipe).

Records of all changes made during this step are kept in the monthly ED Data Quality network files, together with verifications from the sites where data is changed in EDDC which would affect the integrity of the data.

Validations to meet business rules{ TC "Validations to meet business rules" \f C \l "1" }

Below is a table of the validation checks and the manual changes which are made to the data, and the actions which can be implemented to ensure that the data conforms to business rules.

Field	Issue	Action
Patient Unit Number	= null	All records containing meaningful clinical/demographic data relevant to patient's ED presentation must have a Patient Unit Number.
Triage Category 1	Seen within threshold of 2 minutes	Records with Triage Category 1 should not have more than 2 minutes difference between Triage Date/Time and Seen By Date/time. Or If Clerical Date/Time is earlier than Triage Date/Time, no record should have a value greater than 2 minutes. All values greater than 2 minutes must be checked with sites.
Departure Status – did not wait	Triage category 1 and Did not Wait Departure Status	Records with a Triage Category of 1 must not have a departure status of Did not Wait and a Seen by Date/Time. Check correct Departure Status or Triage status with site.
EECU Admit Date/Time	Default date of 1/1/1900	EECU default date of 1/1/1900 is replaced with a null value
Admit Date/Time	Default date of 1/1/1900	Admit Date/Time of 1/1/1900 is replaced with a null value
Presenting problem code	Modbury Presenting problem field is a long field	The standard ED default is applied to Modbury Hospital's Presenting Problem field due to inconsistencies in data captured as free text..
Suburb names	Numeric characters in suburb names	The suburb name should only contain alpha characters, no street numbers. Numerical characters need to be removed from Suburb field.
Departure Date/Time	= null and SA Departure Status=6 (DNW) or 99 (Unknown)	No record can have a null departure time, except those with departure status of Did Not Wait or Unknown.

Field	Issue	Action
Patient Unit Number	= null	All records containing meaningful clinical/demographic data relevant to patient's ED presentation must have a Patient Unit Number.
Triage Category 1	Seen within threshold of 2 minutes	Records with Triage Category 1 should not have more than 2 minutes difference between Triage Date/Time and Seen By Date/time. Or If Clerical Date/Time is earlier than Triage Date/Time, no record should have a value greater than 2 minutes. All values greater than 2 minutes must be checked with sites.
Departure Status – did not wait	Triage category 1 and Did not Wait Departure Status	Records with a Triage Category of 1 must not have a departure status of Did not Wait and a Seen by Date/Time. Check correct Departure Status or Triage status with site.
EECU Admit Date/Time	Default date of 1/1/1900	EECU default date of 1/1/1900 is replaced with a null value
Admit Date/Time	Default date of 1/1/1900	Admit Date/Time of 1/1/1900 is replaced with a null value
Presenting problem code	Modbury Presenting problem field is a long field	The standard ED default is applied to Modbury Hospital's Presenting Problem field due to inconsistencies in data captured as free text..
Suburb names	Numeric characters in suburb names	The suburb name should only contain alpha characters, no street numbers. Numerical characters need to be removed from Suburb field.
	= null and SA Departure Status<>6 (DNW) or 8 (DOA) or 99 (Unknown)	Check for the correct Departure Date and Time with site.
Seen By Date/Time	= null and SA Departure Status=6 (DNW) or 99 (Unknown)	No record can have a null Seen by Date and Time, except those with departure status of 6 or 99. Check the Seen by Date and Time with site
Presentation Date/Time (earliest of either Triage Date/Time or Clerical Date/time)	If Date/Time Diff > minus 30 minutes	Change either the Triage Date/Time or Clerical Date/Time as deemed appropriate. Ensure that date sequencing still correct.
Wait Time (Seen By Date/Time minus Presentation Date/Time)	Negative value	Check for the correct value with the site. Ensure that date sequencing still correct.
	> 1440 minutes (24 hours)	Check for the correct value with the site. Ensure that date sequencing is still okay.
	> Visit Time	Change Departure Date/Time to equal Seen By Date/Time
Visit Time (Departure Date/Time minus Presentation Date/Time)	Negative	Check for the correct value with the site. Ensure that date sequencing still correct.
	High, > 7200hrs (5 days), and the presenting problem is not psychosocial.	If the Visit time is greater than 5 days, and the presenting problem is not psychosocial, confirm the correct value with site, before changing the value.
Birth Date	Compared with any other chronological data. Birth date should be less.	No other date values in the record should be less than the patient's birth date. Check any discrepancies with site.

Field	Issue	Action
Patient Unit Number	= null	All records containing meaningful clinical/demographic data relevant to patient's ED presentation must have a Patient Unit Number.
Triage Category 1	Seen within threshold of 2 minutes	Records with Triage Category 1 should not have more than 2 minutes difference between Triage Date/Time and Seen By Date/time. Or If Clerical Date/Time is earlier than Triage Date/Time, no record should have a value greater than 2 minutes. All values greater than 2 minutes must be checked with sites.
Departure Status – did not wait	Triage category 1 and Did not Wait Departure Status	Records with a Triage Category of 1 must not have a departure status of Did not Wait and a Seen by Date/Time. Check correct Departure Status or Triage status with site.
EECU Admit Date/Time	Default date of 1/1/1900	EECU default date of 1/1/1900 is replaced with a null value
Admit Date/Time	Default date of 1/1/1900	Admit Date/Time of 1/1/1900 is replaced with a null value
Presenting problem code	Modbury Presenting problem field is a long field	The standard ED default is applied to Modbury Hospital's Presenting Problem field due to inconsistencies in data captured as free text..
Suburb names	Numeric characters in suburb names	The suburb name should only contain alpha characters, no street numbers. Numerical characters need to be removed from Suburb field.
Birth Date	= null	If Hospital = WCH-Paed (0001) insert 1/7/2000, for other hospitals –use default 1/7/1950. Check with site for the correct birth date.
Accompanying Person Detained Person Postcode Suburb	= null	Insert '|'
Final Check	= null	All fields are re-checked to ensure there are no null values (exceptions Clerical Date/Time and Seen By DateTime if SA Departure Status = 6 or 99).

Code Field Mapping{ TC "CODE FIELD MAPPING" \f C \l "1" }

Hospitals may use their own codes for the following fields, but these codes are mapped to State and/or National codes using reference tables

EECU Departure Status code for true EECU patients is mapped from Departure Status 3 to Departure Status 10

EECU Departure Status code for true EECU patients at NHS is mapped from Departure Status 2 to Departure Status 50.

RAH PECU Departure Status is updated to 51.

Code File	Hospital or State based	SA Mapping (48083)	NMDS Mapping (48082	Mandatory Status
ArrivalMode	Hospital	Yes	Yes	Yes
COB	State	Yes	No	Yes
CompensableStatus	Hospital	Yes	Yes	Yes
DepartureReferral	Hospital	Yes	Yes	Yes
DepartureStatus	Hospital	Yes	Yes	Yes
Diagnosis	State	Yes	No	Yes
EmploymentStatus	Hospital	Yes	No	Yes
Gender	Hospital	Yes	Yes	Yes
Hospital	Hospital	Yes	No	Yes
IndigenousStatus	Hospital	Yes	Yes	Yes
InsuranceStatus	Hospital	Yes	No	Yes
PresentingProblem	Hospital	Yes	No	Yes
ReferringHospital	Hospital	Yes	No	Yes
SourceofReferral	Hospital	Yes	No	Yes
TriageCategory	Hospital	Yes	Yes	Yes
TypeofVisit	Hospital	Yes	Yes	Yes

Code Field Mapping{ TC "CODE FIELD MAPPING" \f C \l "1" }

ICD Code versions Implemented in SA{ TC "ICD Code versions Implemented in SA" \f C \l "1" }

All records in the ED Data Collection, including historical records, are now mapped to ICD-10-AM (8th Edition)

ICD Version	Implemented in SA
October 1979 (inc errata through Aug 1983)	1 January 1985
AIDS codes effective 1 October 1986	1 July 1987
October 1986 (including AIDS) 1987 & 1988	1 July 1989
October 1989 and 1990	1 January 1992
October 1991 and 1992	1 March 1993
Australian ICD-9-CM codes	1 July 1994
1995 Australian ICD-9-CM	1 July 1995
1996 Australian ICD-9-CM	1 July 1996
1999 Australian ICD-10-AM (1st Edition)	1 July 1999
2000 Australian ICD-10-AM (2nd Edition)	1 July 2000
2000 Australian ICD-10-AM (2nd Edition) addenda	1 July 2001
2002 ICD-10-AM (3rd Edition)	1 July 2002
2004 ICD-10-AM (4th Edition)	1 July 2004
2006 ICD-10-AM (5th Edition)	1 July 2006
2008 ICD-10-AM (6th Edition)	1 July 2008
2010 ICD-10-AM (7th Edition)	1 July 2010
2012 ICD-10-AM (8th Edition)	1 July 2013

APPENDIX 1 – ED Validation Rules (Cwlth 2011-12){ TC "APPENDIX 1 – ED Validation Rules (Cwlth 2011-12)" \f C \l "1" }

HEALTH SA   NEW Emergency Department Validation Rules
Based on Commonwealth ED Validation Rules   2011-12

CURRENT SA ED VALIDATION RULES
CURRENT SA ED EDITS

DATA PROBLEM	NATIONAL EDIT NUMBER	TYPE OF ERROR	EDIT NAME	DETAILED DESCRIPTION
Invalid field values		Critical	Check for Triage dates > then Seen by dates Doctor	SQL: If Triage Date_Time is >Doctor Seen by Date_Time, change Triage Date_Time to match earliest of either Doctor or Nurse Seen by Date_Time, if acceptable time difference
Invalid field values		Critical	Check for Triage dates > then Seen by dates Nurse	SQL: If Triage Date_Time is >Nurse Seen by Date_Time, change Triage Date_Time to match earliest of either Doctor or Nurse Seen by Date_Time, if acceptable time difference
Invalid field values	C12	Critical	Service commenced > DateTime of Physical Departure'	If Date & time of Service commencement > Date & time of physical departure end + 2 mins (2 mins is the tolerance on the timing of recording of end of episode). Excludes records where episode end status is Did not wait or Dead on arrival. See National edit C12
Invalid field values	C12	Critical	Check for Seen By dates > then departure dates Doctor	If Seen_By_Doctor_Date_Time is > Departure_Date_Time
Invalid field values	C12	Critical	Check for Seen By dates > then departure dates Nurse	If Seen_By_Nurse_Date_Time is > Departure_Date_Time
Invalid field values		Critical	Check for departure dates having a NULL value	Departure Date Is NULL
Invalid field values		Critical	Check for gender unknown where age >3 months	SQL: If patient age is > 3 months with an unknown gender, where gender code is <> M and <>F<> and birth date is not null.
Invalid field values		Critical	Check for Arrival Mode Code	SQL: If arrival model code does not exist or has expired, where arrival mode code is null.
Invalid field values	V09	Critical	Check for Compensable status code	IF Compensable status not in (1, 2, 9) (includes if compensable status missing)
Invalid field values	V06	Critical	Check for country of Birth code	IF Country of birth not valid SACC code. (ie if country name is missing and birth country not in [0,1,3,4,5])
Invalid field values		Critical	Check for Departure Referral Code	SQL :If departure referral code does not exist or has expired, or is Null
Invalid field values		Critical	Check for Departure Status Code	SQL: If departure status code does not exist or has expired, or is Null

Invalid field values		Critical	Check for Diagnosis Code	SQL: Remove decimal points in diagnosis code. If diagnosis code is null, or XXXXX or does not exist or has expired, where triage date_time is between diagnosis code start and diagnosis code end
Invalid field values		Critical	Check for Employment Status Code	SQL: If Employment status code does not exist or has expired, or employment status code is Null
Invalid field values	V08	Critical	Check for Indigenous Status Code	IF Indigenous status not in (1, 2, 3, 4, 9) (includes if indigenous status missing) National edit V08 SQL: If indigenous status code does not exist or has expired, or is null.
Invalid field values		Critical	Check for Insurance Status Code	SQL: If insurance status code does not exist or has expired, or is Null
Invalid field values		Critical	Check for Presenting Problem Code	SQL: If presenting problem code does not exist or has expired, or is Null
Invalid field values		Critical	Check for Referring Hospital Code	SQL: If referring hospital code does not exist or has expired, or is Null
Invalid field values		Critical	Check for Type of Visit Code	SQL: If type of visit code does not exist or has expired, or is Null
Invalid field values		Critical	Check for Triage Category code	SQL: If triage category code does not exist, or is not 1,2,3,4,5
Invalid field values	V02	Critical	Missing Date of birth'	IF Date of birth missing
Invalid field values	V05	Critical	Invalid Postcode'	IF postcode not valid within state of residence (ie if postcode name is missing and postcode is not in [8888, 9999])
Invalid field values	V07	Critical	Invalid Sex code'	IF sex not in (1, 2, 3, 9) (includes if sex missing**)**
Inconsistencies	C12	Critical	Service commenced > DateTime of Physical Departure'	**Critical query** IF Date & time of Service commencement > Date & time of physical departure end + 2 mins (2 mins is the tolerance on the timing of recording of end of episode). Excludes records where episode end status is Did not wait or Dead on arrival.
Missing data	V02	High	Missing Date of birth'	IF Date of birth missing
Invalid field values	V05	High	Invalid Postcode'	IF postcode not valid within state of residence (ie if postcode name is missing and postcode is not in [8888, 9999])
Invalid field values	V06	High	Invalid Country of Birth'	IF Country of birth not valid SACC code. (ie if country name is missing and birth country not in [0,1,3,4,5])
Invalid field values	V07	High	Invalid Sex code'	IF sex not in (1, 2, 3, 9) (includes if sex missing)
Invalid field values	V08	High	Invalid Indigenous status'	IF Indigenous status not in (1, 2, 3, 4, 9) (includes if indigenous status missing)
Invalid field values	V09	High	Invalid Compensable status'	IF Compensable status not in (1, 2, 9) (includes if compensable status missing)

New edits introduced 1 July 2012

EDIT NUMBER	EDIT NAME	ERROR DESCRIPTION	EDIT CONDITION
C01	Presentation date time	Date of presentation > End of reporting month for Hospital code ' + Extraction_Data.Hospital_Code+ '	IF Presentation DateTime > End of reporting month DateTime. (Note: Presentation Date is the earliest of the Triage Date or Clerical Date. End of Reporting Month DateTime is midnight of the last day of the calendar month.)
C02	Date of birth	Year of date of birth <1894 for Hospital code ' + Extraction_Data.Hospital_Code+ '	IF YEAR of Date of Birth < 1894
C03	Date of birth	Date of Birth > Presentation Date for Hospital code ' + Extraction_Data.Hospital_Code+ '	IF Date of Birth > Date of Presentation (Note: Presentation Date is the earliest of the Triage Date or Clerical Date)
C05	Presentation date time	Presentation DateTime > Seen By DateTime for Hospital code' + Extraction_Data.Hospital_Code+ '	IF Presentation DateTime > Seen By DateTime and Departure Status not equal to 06 or 6 or 87 or 88. (Note: Presentation DateTime is the earliest of the Triage Date/Time or Clerical DateTime. Seen by date and time is the earliest of Doctor Seen by DateTime or Nurse Seen by DateTime).
C07	Presentation date time	Presentation DateTime > Departure DateTime for Hospital code ' + Extraction_Data.Hospital_Code+ '	IF Presentation DateTime > "Departure Date and Time + 2 minutes" and Departure Status not equal to 06, 6, 87, 88 or Where Hospital code is 0001 or 0003 or 0014 or 0019 or 0027 or 0033 and EECU Admit Date/Time is not Null and Presentation DateTime > EECU Admit DateTime (Note: Presentation DateTime is the earliest of the Triage Date/Time or Clerical DateTime.)
C18	Departure status	Departure Status DOA and Type of Visit code is not 1, 2, 98 or 99 for Hospital code' + Extraction_Data.Hospital_Code+ '	IF Departure Status code is equal to 8 or 88 and Type of Visit is not 1 or 2 or 9 or 98 or 99.
C20	Visit time	Visit Time for Hospital code ' + Extraction_Data.Hospital_Code+ ', < zero or null	IF (Departure DateTime – Presentation DateTime) < zero or is Null where Departure Status is not 06, 6, 87, 88 or Where Hospital code is 0001 or 0003 or 0014 or 0019 or 0027 or 0033 and EECU Admit Date/Time is not Null and EECU Admit DateTime – Presentation DateTime < zero or is Null

			(Note: Presentation Date is the earliest of the Triage Date or Clerical Date
D23	Visit time	Visit Time for Hospital code ' + Extraction_Data.Hospital_Code+ ' > 480 minutes and Departure status code is not DNW	If(Departure DateTime – Presentation Date Time) > 480 minutes where Departure Status is not 06 or 6 or Where Hospital code is 0001 or 0003 or 0014 or 0019 or 0027 or 0033 and EECU Admit Date/Time is not Null and EECU Admit DateTime —— Presentation Date Time) > 480 minutes where Departure Status is not 06 or 6 (Note: Presentation Date is the earliest of the Triage Date or Clerical Date)
N01	Wait time	Wait Time for Hospital code ' + Extraction_Date.Hospital_Code+ ' >= 1440 min	If (Seen by DateTime – Presentation DateTime) >= 1440 minutes (Note: Presentation Date is the earliest of the Triage Date or Clerical Date. Seen by DateTime is the earliest of the Doctor Seen by DateTime and Nurse Seen by DateTime)
N02	Wait time	Wait Time for Hospital code ' + Extraction_Data.Hospital_Code+ ' > 12 hours	IF (Seen by DateTime – Presentation DateTime) > 720 minutes (Note: Presentation Date is the earliest of the Triage Date or Clerical Date. Seen by DateTime is the earliest of the Doctor Seen by Date and Nurse Seen by Date)
N05	Compensable Status	Compensable status for Hospital code ' + Extraction_Data.Hospital_Code+ ' is DVA and patient age < 18	IF patient age <18 years and Compensable status is DVA or 6 (Note: Patient age is Current date minus Birth date rounded to whole years)
N06	Triage category	Departure Status for Hospital code ' + Extraction_Data.Hospital_Code+ " is DOA and Triage category not 1 or 5.	IF Departure Status is 87 or 88 and Triage category is not 1 or 5, or 9
N08	Triage category	Triage 1 for Hospital code 'Extraction_Data.Hospital_Code +' with a wait time > 2 minutes'	IF Triage Category=1 and (Seen by Date/Time - Presentation Date/Time Patient Presents) >2 minutes (Note: Presentation Date/Time = Earliest of Triage Date/Time and Clerical Date/Time and Seen by Date/Time = Earliest of Seen_by_Doctor_DateTime and Seen_by_Nurse_DateTime)
N09	Triage category	Triage Category 1 for Hospital code ' + Extraction_Data.Hospital_Code +' and patient DNW	IF Triage Category = 1 and Departure Status = 6 or 06

New	Visit time	Visit Time for Hospital code ' + Extraction_Data.Hospital_Code+ 'is < Wait time.	IF (Departure DateTime – Presentation DateTime) < (Seen by DateTime – Presentation DateTime) and departure status is not 6 or 06 or 87 or 88 or Where Hospital code is 0001 or 0003 or 0014 or 0019 or 0027 or 0033 and EECU Admit Date/Time is not Null and (EECU Admit DateTime - Presentation DateTime) < (Seen by DateTime – Presentation DateTime) and departure status is not 6 or 06 or 87 or 88 (Note: Presentation DateTime is the earliest of the Triage DateTime or Clerical DateTime. Seen by DateTime is the earliest of the Doctor Seen by DateTime and Nurse Seen by DateTime)
V11a	Presentation date time	Presentation Date/Time for Hospital code ' + Extraction_Data.Hospital_Code+ ' is Null	IF Triage DateTime And Clerical DateTime is null
V13	Triage date time	Triage Date/Time for Hospital code ' + Extraction_Data.Hospital_Code+ ' is Null	IF Triage DateTime is null
V15	Seen by date time	Seen by DateTime for Hospital code ' + Extraction_Data.Hospital_Code+ ' is Null	IF Seen By Doctor DateTime and Seen by Nurse DateTime is Null and departure status code is not 6, 06, 87 or 88.
V17b	Departure date time	Departure DateTime for Hospital code ' + Extraction_Data.Hospital_Code+ ' is Null	IF Departure Date/Time is null and departure status is not 6, 06, 87 or 88
V24	Triage category	Triage Category for Hospital code ' + Extraction_Date.Hospital_Code+ ' is invalid or Null	IF Triage Category is not 1 or 2 or 3 or 4 or 5
V25	Wait time	Wait time for Hospital code ' + Extraction_Data.Hospital_Code+ ' is < 0 or null	IF Wait Time to is <0 or Null and departure status is not 6, 06, 87 or 88 Excludes records where Departure Status is DNW or DOA. (Note: Wait Time = Seen by DateTime – Presentation DateTime) (Note: Presentation DateTime is the earliest of the Triage Date or Clerical Date and Seen by DateTime is the earliest of the Doctor Seen by Date and Nurse Seen by Date)
V26	Visit time	Visit time for Hospital code ' + Extraction_Data.Hospital_Code+ ' is < 0 or null	IF (Departure DateTime – Presentation DateTime) is <0 or Null and departure status is not 6, 06, 87 or 88 or Where Hospital code is 0001 or 0003 or 0014 or 0019 or 0027 or 0033 and EECU Admit Date/Time is not Null and (EECU Admit DateTime - Presentation DateTime) <0 or

			Null and departure status is not 6 or 06 or 87 or 88
			(Note: Presentation DateTime is the earliest of the Triage Date or Clerical Date) (Note: Seen by DateTime is the earliest of the Doctor Seen by Date and Nurse Seen by Date)
V17a	Departure date time	Departure date for Hospital code ' + Extraction_Data.Hospital_Code+ ' is greater than reporting month	IF Departure DateTime > End Reporting Month DateTime (Note: End of Reporting Month DateTime is midnight of the last day of the calendar month).

APPENDIX 2 EDDC Supplementary Codes – Presenting problem codes{ TC "APPENDIX 2 EDDC Supplementary Codes – Presenting problem codes" \f C \l "1" }

Presenting Problem
0100 CARDIOVASCULAR/CHEST (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	0100	CHEST PAIN
NHS	0101	PALPITATIONS
NHS	0104	CHEST PAIN
NHS	0105	COLLAPSE - CONSCIOUS
NHS	0106	COLLAPSE - UNCONSCIOUS
NHS	0199	OTHER
RAH	0100	CVS
RAH	0101	ARRHYTHMIA
RAH	0102	CARDIAC ARREST
RAH	0104	CHEST PAIN
RAH	0105	COLLAPSE - CONSCIOUS
RAH	0106	COLLAPSE - UNCONSCIOUS
RAH	0107	ISCHAEMIC LIMB
RAH	0198	PROVISIONAL DIAGNOSIS
RAH	0199	OTHER
RGH	0100	CVS
RGH	0101	ARRHYTHMIA
RGH	0104	CHEST PAIN
RGH	0105	COLLAPSE - CONSCIOUS
RGH	0106	COLLAPSE - UNCONSCIOUS
RGH	0107	ISCHAEMIC LIMB
RGH	0198	PROVISIONAL DIAGNOSIS
RGH	0199	OTHER
TQEH	0100	CARDIOVASCULAR
TQEH	0101	ARRHYTHMIA
TQEH	0102	CARDIAC ARREST
TQEH	0103	CARDIAC DYSPNOEA
TQEH	0104	CHEST PAIN
TQEH	0105	COLLAPSE - CONSCIOUS
TQEH	0106	COLLAPSE - UNCONSCIOUS
TQEH	0107	ISCHAEMIC LIMB
TQEH	0198	PROVISIONAL DIAGNOSIS
TQEH	0199	OTHER
WCH - Paed	0100	CHEST PAIN
WCH - Paed	0101	PALPITATIONS
WCH - Paed	0104	CHEST PAIN
WCH - Paed	0105	COLLAPSE - CONSCIOUS
WCH - Paed	0106	COLLAPSE - UNCONSCIOUS
WCH - Paed	0198	PROVISIONAL DIAGNOSIS
WCH - Paed	0199	OTHER
WCH - WAS	0199	OTHER

0400 ENT/ORAL (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	0400	ENT/ORAL
NHS	0401	DENTAL
NHS	0403	EARACHE
NHS	0404	FOREIGN BODY
NHS	0405	EPISTAXIS
NHS	0406	MOUTH ULCERS
NHS	0407	SORE THROAT
NHS	0409	EAR DISCHARGE
NHS	0410	NOSE DISCHARGE
NHS	0498	PROVISIONAL DIAGNOSIS
NHS	0499	OTHER
RAH	0400	ENT/ORAL
RAH	0401	DENTAL
RAH	0402	DISCHARGE
RAH	0403	EARACHE
RAH	0404	FOREIGN BODY
RAH	0405	EPISTAXIS
RAH	0406	MOUTH ULCERS
RAH	0407	SORE THROAT
RAH	0498	PROVISIONAL DIAGNOSIS
RAH	0499	OTHER
RGH	0403	EARACHE
RGH	0405	EPISTAXIS
RGH	0499	OTHER
TQEH	0401	DENTAL
TQEH	0403	EARACHE
TQEH	0404	FOREIGN BODY
TQEH	0405	EPISTAXIS
TQEH	0406	MOUTH ULCERS
TQEH	0407	SORE THROAT
TQEH	0498	PROVISIONAL DIAGNOSIS
TQEH	0499	OTHER
WCH - Paed	0400	ENT/ORAL
WCH - Paed	0401	DENTAL
WCH - Paed	0403	EARACHE
WCH - Paed	0404	FOREIGN BODY
WCH - Paed	0405	EPISTAXIS
WCH - Paed	0406	MOUTH ULCERS
WCH - Paed	0407	SORE THROAT
WCH - Paed	0408	GUM PAIN / SWELLING / INFLAMMATION
WCH - Paed	0409	EAR DISCHARGE
WCH - Paed	0410	NOSE DISCHARGE
WCH - Paed	0498	PROVISIONAL DIAGNOSIS
WCH - Paed	0499	OTHER

0500 EYES (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	0500	EYES
NHS	0501	DISCHARGE
NHS	0502	FOREIGN BODY
NHS	0503	PAIN
NHS	0504	REVIEW
NHS	0505	PERI-ORBITAL SWELLING/INFLAMMATION
NHS	0506	VISUAL LOSS/DISTURBANCE
NHS	0507	RED EYE
NHS	0599	OTHER
RAH	0500	EYES
RAH	0501	DISCHARGE
RAH	0502	FOREIGN BODY
RAH	0503	PAIN
RAH	0504	REVIEW
RAH	0505	SWELLING
RAH	0506	VISUAL LOSS/DISTURBANCE
RAH	0598	PROVISIONAL DIAGNOSIS
RAH	0599	OTHER
RGH	0502	FOREIGN BODY
RGH	0503	PAIN
RGH	0505	SWELLING
RGH	0506	VISUAL LOSS/DISTURBANCE
RGH	0599	OTHER
TQEH	0501	DISCHARGE
TQEH	0502	FOREIGN BODY
TQEH	0503	PAIN
TQEH	0504	REVIEW
TQEH	0505	SWELLING
TQEH	0506	VISUAL LOSS/DISTURBANCE
TQEH	0598	PROVISIONAL DIAGNOSIS
TQEH	0599	OTHER
WCH - Paed	0500	EYES
WCH - Paed	0501	DISCHARGE
WCH - Paed	0502	FOREIGN BODY
WCH - Paed	0503	PAIN
WCH - Paed	0504	REVIEW
WCH - Paed	0505	PERI-ORBITAL SWELLING/INFLAMMATION
WCH - Paed	0506	VISUAL LOSS/DISTURBANCE
WCH - Paed	0507	RED EYE
WCH - Paed	0598	PROVISIONAL DIAGNOSIS
WCH - Paed	0599	OTHER

0600 ABDOMEN/GASTROINTESTINAL (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	0600	ABDOMEN
NHS	0601	ABDOMINAL PAIN
NHS	0602	CONSTIPATION
NHS	0603	DIARRHOEA & VOMITING
NHS	0604	DIARRHOEA
NHS	0605	EPIGASTRIC PAIN
NHS	0606	HAEMATEMESIS

Hosp	Hosp Code	Hosp Description
NHS	0608	NAUSEA/VOMITING
NHS	0609	RECTAL BLEED
NHS	0610	ABDOMINAL DISTENTION
NHS	0698	PROVISIONAL DIAGNOSIS
NHS	0699	OTHER
RAH	0600	GASTROINTESTINAL
RAH	0601	ABDOMINAL PAIN
RAH	0602	CONSTIPATION
RAH	0603	DIARRHOEA & VOMITING
RAH	0604	DIARRHOEA
RAH	0605	EPIGASTRIC PAIN
RAH	0606	HAEMATEMESIS
RAH	0607	JAUNDICE
RAH	0608	NAUSEA/VOMITING
RAH	0609	RECTAL BLEED
RAH	0698	PROVISIONAL DIAGNOSIS
RAH	0699	OTHER
RGH	0600	GASTROINTESTINAL
RGH	0601	ABDOMINAL PAIN
RGH	0602	CONSTIPATION
RGH	0603	DIARRHOEA & VOMITING
RGH	0604	DIARRHOEA
RGH	0605	EPIGASTRIC PAIN
RGH	0606	HAEMATEMESIS
RGH	0607	JAUNDICE
RGH	0608	NAUSEA/VOMITING
RGH	0609	PR BLEED
RGH	0698	PROVISIONAL DIAGNOSIS
RGH	0699	OTHER
TQEH	0600	GASTROINTESTINAL
TQEH	0601	ABDOMINAL PAIN
TQEH	0602	CONSTIPATION
TQEH	0603	DIARRHOEA & VOMITING
TQEH	0604	DIARRHOEA
TQEH	0605	EPIGASTRIC PAIN
TQEH	0606	HAEMATEMESIS
TQEH	0607	APPEARS JAUNDICE
TQEH	0608	NAUSEA/VOMITING
TQEH	0609	RECTAL BLEED
TQEH	0698	PROVISIONAL DIAGNOSIS
TQEH	0699	OTHER
WCH - Paed	0600	ABDOMEN
WCH - Paed	0601	ABDOMINAL PAIN
WCH - Paed	0602	CONSTIPATION
WCH - Paed	0603	DIARRHOEA & VOMITING
WCH - Paed	0604	DIARRHOEA
WCH - Paed	0605	EPIGASTRIC PAIN
WCH - Paed	0606	HAEMATEMESIS
WCH - Paed	0607	JAUNDICE
WCH - Paed	0608	NAUSEA/VOMITING
WCH - Paed	0609	RECTAL BLEED
WCH - Paed	0610	ABDOMINAL DISTENTION

Hosp	Hosp Code	Hosp Description
WCH - Paed	0698	PROVISIONAL DIAGNOSIS
WCH - Paed	0699	OTHER
WCH - WAS	0601	ABDOMINAL PAIN
WCH - WAS	0603	DIARRHOEA & VOMITING
WCH - WAS	0606	HAEMATEMESIS
WCH - WAS	0608	NAUSEA/VOMITING
WCH - WAS	0609	RECTAL BLEED
WCH - WAS	0698	PROVISIONAL DIAGNOSIS

0700 GYNAE/FEMALE PELVIS (NON PREGNANT) (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	0700	FEMALE PELVIS (NON-PREGNANT)
NHS	0701	BLEEDING
NHS	0702	PELVIC AREA
NHS	0703	VAGINAL DISCHARGE/IRRITATION/INFLAMMATION
NHS	0705	DYSURIA/FREQUENCY
NHS	0707	HAEMATURIA
NHS	0709	RETENTION
NHS	0799	OTHER
RAH	0700	GYNAE
RAH	0701	BLEEDING
RAH	0702	PELVIC AREA
RAH	0703	VAGINAL DISCHARGE
RAH	0798	PROVISIONAL DIAGNOSIS
RAH	0799	OTHER
RGH	0799	OTHER
TQEH	0701	BLEEDING
TQEH	0702	PELVIC AREA
TQEH	0703	VAGINAL DISCHARGE
TQEH	0798	PROVISIONAL DIAGNOSIS
TQEH	0799	OTHER
WCH - Paed	0700	FEMALE PELVIS (NON-PREGNANT)
WCH - Paed	0701	BLEEDING
WCH - Paed	0702	PELVIC AREA
WCH - Paed	0703	VAGINAL DISCHARGE/IRRITATION/INFLAMMATION
WCH - Paed	0705	DYSURIA/FREQUENCY
WCH - Paed	0707	HAEMATURIA
WCH - Paed	0708	OLIGURIA/ANURIA
WCH - Paed	0709	RETENTION
WCH - Paed	0710	LUMP
WCH - Paed	0798	PROVISIONAL DIAGNOSIS
WCH - Paed	0799	OTHER
WCH - WAS	0700	FEMALE PELVIS (NON-PREGNANT)
WCH - WAS	0701	BLEEDING
WCH - WAS	0702	PELVIC AREA
WCH - WAS	0703	VAGINAL DISCHARGE/IRRITATION/INFLAMMATION
WCH - WAS	0705	DYSURIA/FREQUENCY
WCH - WAS	0709	RETENTION
WCH - WAS	0710	LUMP
WCH - WAS	0798	PROVISIONAL DIAGNOSIS
WCH - WAS	0799	OTHER

0800 HAEMATOLOGY (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	0800	HAEMATOLOGY
NHS	0801	BRUISING

Hosp	Hosp Code	Hosp Description
NHS	0803	IMMUNE SYSTEM DISEASE
NHS	0804	NEUTROPENIA/FEBRILE
NHS	0805	PALLOR
NHS	0898	PROVISIONAL DIAGNOSIS
NHS	0899	OTHER
RAH	0800	HAEMATOLOGY
RAH	0802	CLOT/ BLEEDING DISORDER
RAH	0803	IMMUNE SYSTEM DISEASE
RAH	0804	NEUTROPENIA/FEBRILE
RAH	0805	PALLOR
RAH	0898	PROVISIONAL DIAGNOSIS
RAH	0899	OTHER
RGH	0804	NEUTROPENIA/FEBRILE
RGH	0898	PROVISIONAL DIAGNOSIS
RGH	0899	OTHER
TQEH	0801	BRUISING
TQEH	0802	CLOT/ BLEEDING DISORDER
TQEH	0804	FEBRILE ILLNESS
TQEH	0805	PALLOR
TQEH	0898	PROVISIONAL DIAGNOSIS
TQEH	0899	OTHER
WCH - Paed	0800	HAEMATOLOGY
WCH - Paed	0801	BRUISING
WCH - Paed	0804	NEUTROPENIA/FEBRILE
WCH - Paed	0805	PALLOR
WCH - Paed	0898	PROVISIONAL DIAGNOSIS
WCH - Paed	0899	OTHER

0900 SYSTEMIC INFECTION (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	0900	SYSTEMIC
NHS	0902	FEBRILE ILLNESS
NHS	0903	MALAISE
NHS	0999	OTHER
RAH	0900	SYSTEMIC
RAH	0901	ANAPHYLAXIS
RAH	0902	FEBRILE ILLNESS
RAH	0903	MALAISE
RAH	0904	SEPTIC
RAH	0998	PROVISIONAL DIAGNOSIS
RAH	0999	OTHER
RGH	0902	FEBRILE ILLNESS
RGH	0903	MALAISE
RGH	0904	SEPTIC
RGH	0999	OTHER
TQEH	0901	ALLERGIC REACTION
TQEH	0902	FEBRILE ILLNESS
TQEH	0903	MALAISE
TQEH	0904	SEPTIC
TQEH	0998	PROVISIONAL DIAGNOSIS
TQEH	0999	OTHER
WCH - Paed	0900	SYSTEMIC
WCH - Paed	0902	FEBRILE ILLNESS
WCH - Paed	0903	MALAISE

Hosp	Hosp Code	Hosp Description
WCH - Paed	0904	SEPTIC
WCH - Paed	0998	PROVISIONAL DIAGNOSIS
WCH - Paed	0999	OTHER
WCH - WAS	0902	FEBRILE ILLNESS
WCH - WAS	0999	OTHER

1000 MALE PELVIS/MALE REPRODUCTIVE SYSTEM (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	1000	MALE PELVIS
NHS	1001	PENILE DISCHARGE/IRRITATION/INFLAMMATION
NHS	1002	PENILE DISCHARGE/IRRITATION/INFLAMMATION
NHS	1003	TESTICULAR PAIN/SWELLING
NHS	1004	PELVIC AREA
NHS	1005	DYSURIA/FREQUENCY
NHS	1007	HAEMATURIA
NHS	1008	OLIGURIA/ANURIA
NHS	1009	RETENTION
NHS	1098	PROVISIONAL DIAGNOSIS
NHS	1099	OTHER
RAH	1002	PENILE DISCHARGE/IRRITATION/INFLAMMATION
RAH	1003	TESTICULAR PAIN/SWELLING
RAH	1099	OTHER
RGH	1003	TESTICULAR PAIN/SWELLING
RGH	1099	OTHER
TQEH	1001	PENILE DISCHARGE/IRRITATION/INFLAMMATION
TQEH	1002	PENILE DISCHARGE/IRRITATION/INFLAMMATION
TQEH	1003	TESTICLUAR PAIN/SWELLING
TQEH	1099	OTHER
WCH - Paed	1000	MALE PELVIS
WCH - Paed	1001	PENILE DISCHARGE/IRRITATION/INFLAMMATION
WCH - Paed	1002	PENILE DISCHARGE/IRRITATION/INFLAMMATION
WCH - Paed	1003	TESTICULAR PAIN/SWELLING
WCH - Paed	1004	PELVIC AREA
WCH - Paed	1005	DYSURIA/FREQUENCY
WCH - Paed	1006	ENURESIS
WCH - Paed	1007	HAEMATURIA
WCH - Paed	1008	OLIGURIA/ANURIA
WCH - Paed	1009	RETENTION
WCH - Paed	1098	PROVISIONAL DIAGNOSIS
WCH - Paed	1099	OTHER

1100 MUSCULO-SKELETAL (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	1100	MUSCULO-SKELETAL
NHS	1101	BACK PAIN
NHS	1102	JOINT PAIN
NHS	1103	NON-WEIGHT BEARING/ABNORMAL GAIT
NHS	1198	PROVISIONAL DIAGNOSIS
NHS	1199	OTHER
RAH	1100	MUSCULO-SKELETAL
RAH	1101	BACK PAIN
RAH	1102	JOINT PAIN
RAH	1198	PROVISIONAL DIAGNOSIS
RAH	1199	OTHER
RGH	1100	MUSCULO-SKELETAL
RGH	1101	BACK PAIN

Hosp	Hosp Code	Hosp Description
RGH	1102	JOINT PAIN
RGH	1103	NON WEIGHT BEARING (PAED)
RGH	1199	OTHER
TQEH	1101	BACK PAIN
TQEH	1102	JOINT PAIN
TQEH	1198	PROVISIONAL DIAGNOSIS
TQEH	1199	OTHER
WCH - Paed	1100	MUSCULO-SKELETAL
WCH - Paed	1101	BACK PAIN
WCH - Paed	1102	JOINT PAIN
WCH - Paed	1103	NON-WEIGHT BEARING/ABNORMAL GAIT
WCH - Paed	1104	LIMB SWELLING (NON-TRAUMATIC)
WCH - Paed	1105	LIMB PAIN / PARASTHESIA
WCH - Paed	1198	PROVISIONAL DIAGNOSIS
WCH - Paed	1199	OTHER
WCH - WAS	1101	BACK PAIN

1200 HEAD - NEUROLOGY/NEUROLOGICAL (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	1200	HEAD
NHS	1201	ALTERED CONSCIOUS STATE
NHS	1202	ALTERED MENTAL STATE
NHS	1203	HEADACHE
NHS	1204	SEIZURE
NHS	1205	DIZZINESS
NHS	1206	WEAKNESS/PARAESTHESIA
NHS	1299	OTHER
RAH	1200	NEUROLOGY/NEUROLOGICAL
RAH	1201	ALTERED CONSCIOUS STATE
RAH	1202	ALTERED MENTAL STATE
RAH	1203	HEADACHE
RAH	1204	SEIZURE
RAH	1205	VERTIGO
RAH	1206	WEAKNESS/PARAESTHESIA
RAH	1298	PROVISIONAL DIAGNOSIS
RAH	1299	OTHER
RGH	1200	NEUROLOGY/NEUROLOGICAL
RGH	1201	ALTERED CONSCIOUS STATE
RGH	1202	ALTERED MENTAL STATE
RGH	1203	HEADACHE
RGH	1204	SEIZURE
RGH	1205	VERTIGO
RGH	1206	WEAKNESS/PARAESTHESIA
RGH	1298	PROVISIONAL DIAGNOSIS
RGH	1299	OTHER
TQEH	1200	NEUROLOGY/NEUROLOGICAL
TQEH	1201	ALTERED CONSCIOUS STATE
TQEH	1202	ALTERED MENTAL STATE
TQEH	1203	HEADACHE
TQEH	1204	SEIZURE
TQEH	1205	VERTIGO
TQEH	1206	WEAKNESS/PARAESTHESIA
TQEH	1298	PROVISIONAL DIAGNOSIS
WCH - Paed	1200	HEAD

Hosp	Hosp Code	Hosp Description
WCH - Paed	1201	ALTERED CONSCIOUS STATE
WCH - Paed	1202	ALTERED MENTAL STATE
WCH - Paed	1203	HEADACHE
WCH - Paed	1204	SEIZURE
WCH - Paed	1205	DIZZINESS
WCH - Paed	1206	WEAKNESS/PARAESTHESIA
WCH - Paed	1298	PROVISIONAL DIAGNOSIS
WCH - Paed	1299	OTHER
WCH - WAS	1203	HEADACHE
WCH - WAS	1205	DIZZINESS

1300 OBSTETRICS (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	1300	OBSTETRICS
NHS	1301	BLEEDING
NHS	1303	PAIN
NHS	1304	TMC/MISCARRIAGE
NHS	1398	PROVISIONAL DIAGNOSIS
NHS	1399	OTHER
NHS	13993	HYPEREMESIS
NHS	13994	DECREASED FETAL MOVEMENTS
NHS	13995	ANTENATAL CHECKUP
NHS	13999	OTHER
RAH	1302	LABOUR/DELIVERY
RAH	1399	OTHER
TQEH	1301	BLEEDING
TQEH	13011	ANTE-PARTUM HAEMORRHAGE
TQEH	13014	OTHER
TQEH	1302	LABOUR/DELIVERY
TQEH	13026	PRE-TERM PRE-LABOUR, RUPTURE OF MEMBRANES
TQEH	13031	ABDOMINAL PAIN
TQEH	13041	TMC/MISCARRIAGE
TQEH	13042	COMPLETE MISCARRIAGE
TQEH	13043	OTHER
TQEH	1399	OTHER
WCH - WAS	1300	OBSTETRICS
WCH - WAS	1301	BLEEDING
WCH - WAS	1302	LABOUR/DELIVERY
WCH - WAS	13022	TERM - LABOUR
WCH - WAS	13024	BABY BORN BEFORE ARRIVAL
WCH - WAS	13025	THREATENED PRETERM LABOUR -T.P.L.
WCH - WAS	13026	PRE-TERM PRE-LABOUR, RUPTURE OF MEMBRANES
WCH - WAS	13027	PRE-LABOUR RUPTURE OF MEMBRANES - P.R.O.M.
WCH - WAS	13028	OTHER
WCH - WAS	1303	PAIN
WCH - WAS	1304	TMC/MISCARRIAGE
WCH - WAS	1398	PROVISIONAL DIAGNOSIS
WCH - WAS	1399	OTHER
WCH - WAS	13991	PRE-ECLAMPSIA
WCH - WAS	13994	DECREASED FETAL MOVEMENTS
WCH - WAS	13995	ANTENATAL CHECKUP
WCH - WAS	13996	POSTNATAL CHECKUP
WCH - WAS	13998	NEONATAL
WCH - WAS	13999	OTHER

1400 POISONING (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
RAH	1400	POISONING
RAH	1401	ALTERED CONSCIOUS STATE
RAH	1402	COLLAPSE - CONSCIOUS
RAH	1498	PROVISIONAL DIAGNOSIS
RAH	1499	OTHER
TQEH	1400	POISONING
TQEH	1401	ALTERED CONSCIOUS STATE
TQEH	1402	COLLAPSE - CONSCIOUS
TQEH	1403	ORGANOPHOSPHATE POISIONING
TQEH	1499	OTHER
WCH - Paed	1400	POISONING
WCH - Paed	1498	PROVISIONAL DIAGNOSIS
WCH - Paed	1499	OTHER

1500 PSYCHOSOCIAL (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	1500	PSYCHOSOCIAL
NHS	1501	ALCOHOL/DRUG SUBSTANCE MISUSE
NHS	1504	SITUATIONAL CRISIS
NHS	1505	SOCIAL PROBLEM
NHS	1506	VIOLENT AGGRESSIVE BEHAVIOUR
NHS	1507	AGITATION/DELUSIONAL/ANXIETY
NHS	1598	PROVISIONAL DIAGNOSIS
NHS	1599	OTHER
RAH	1500	PSYCHOSOCIAL
RAH	1501	ALCOHOL/DRUG/SUBSTANCE MISUSE
RAH	1503	PSYCHIATRIC ILLNESS
RAH	1504	SITUATIONAL CRISIS
RAH	1505	SOCIAL PROBLEM
RAH	1506	VIOLENT AGGRESSIVE BEHAVIOUR
RAH	1598	PROVISIONAL DIAGNOSIS
RAH	1599	OTHER
RGH	1501	ALCOHOL/DRUG/SUBSTANCE MISUSE
RGH	1503	PSYCHIATRIC ILLNESS
RGH	1504	SITUATIONAL CRISIS
RGH	1505	SOCIAL PROBLEM
RGH	1599	OTHER
TQEH	1501	ALCOHOL/DRUG SUBSTANCE MISUSE
TQEH	1503	PSYCHIATRIC ILLNESS
TQEH	1504	SITUATIONAL CRISIS
TQEH	1505	SOCIAL PROBLEM
TQEH	1506	VIOLENT AGGRESSIVE BEHAVIOUR
TQEH	1598	PROVISIONAL DIAGNOSIS
TQEH	1599	OTHER
WCH - Paed	1500	PSYCHOSOCIAL
WCH - Paed	1501	ALCOHOL/DRUG SUBSTANCE MISUSE
WCH - Paed	1502	NAI
WCH - Paed	1504	SITUATIONAL CRISIS
WCH - Paed	1505	SOCIAL PROBLEM
WCH - Paed	1506	VIOLENT AGGRESSIVE BEHAVIOUR
WCH - Paed	1507	AGITATION/DELUSIONAL/ANXIETY
WCH - Paed	1598	PROVISIONAL DIAGNOSIS
WCH - Paed	1599	OTHER

1600 UROLOGY (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	1601	COLICKY PAIN
RAH	1600	UROLOGY
RAH	1601	COLICKY PAIN
RAH	1602	DYSURIA/FREQUENCY
RAH	1604	HAEMATURIA
RAH	1605	OLIGURIA/ANURIA
RAH	1606	RETENTION
RAH	1698	PROVISIONAL DIAGNOSIS
RAH	1699	OTHER
RGH	1600	UROLOGY
RGH	1601	COLICKY PAIN
RGH	1602	DYSURIA/FREQUENCY
RGH	1604	HAEMATURIA
RGH	1606	RETENTION
RGH	1698	PROVISIONAL DIAGNOSIS
RGH	1699	OTHER
TQEH	1601	COLICKY PAIN
TQEH	1602	DYSURIA/FREQUENCY
TQEH	1604	HAEMATURIA
TQEH	1605	OLIGURIA/ANURIA
TQEH	1606	RETENTION
TQEH	1698	PROVISIONAL DIAGNOSIS
TQEH	1699	OTHER
WCH - Paed	1601	COLICKY PAIN

1700 RESPIRATORY (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	1701	APNOEIC EPISODES
NHS	1702	COUGH
NHS	1703	DISTRESS/SHORT OF BREATH
NHS	1704	HAEMOPTYSIS
NHS	1707	STRIDOR
NHS	1708	WHEEZE
RAH	1700	RESPIRATORY
RAH	1701	APNOEIC EPISODES
RAH	1702	COUGH
RAH	1703	DISTRESS/SHORT OF BREATH
RAH	1704	HAEMOPTYSIS
RAH	1705	INFECTION
RAH	1706	RESPIRATORY ARREST
RAH	1707	STRIDOR
RAH	1708	WHEEZE
RAH	1798	PROVISIONAL DIAGNOSIS
RAH	1799	OTHER
RGH	1700	RESPIRATORY
RGH	1702	COUGH
RGH	1703	DISTRESS/SHORT OF BREATH
RGH	1704	HAEMOPTYSIS
RGH	1705	INFECTION
RGH	1708	WHEEZE
RGH	1798	PROVISIONAL DIAGNOSIS
RGH	1799	OTHER
TQEH	1701	APNOEIC EPISODES
TQEH	1702	COUGH

Hosp	Hosp Code	Hosp Description
TQEH	1703	DISTRESS/SHORT OF BREATH
TQEH	1704	HAEMOPTYSIS
TQEH	1705	INFECTION
TQEH	1707	STRIDOR
TQEH	1708	WHEEZE
TQEH	1798	PROVISIONAL DIAGNOSIS
TQEH	1799	OTHER
WCH - Paed	1701	APNOEIC EPISODES
WCH - Paed	1702	COUGH
WCH - Paed	1703	RESP DISTRESS / SHORTNESS OF BREATH
WCH - Paed	1704	HAEMOPTYSIS
WCH - Paed	1706	RESPIRATORY ARREST
WCH - Paed	1707	STRIDOR
WCH - Paed	1708	WHEEZE
WCH - WAS	1703	RESP DISTRESS / SHORTNESS OF BREATH

1800 SKIN (INTEGUMENT) (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	1800	SKIN
NHS	1801	INFECTION
NHS	1802	LUMP
NHS	1803	RASH
NHS	1804	REDRESSING/WOUND REVIEW
NHS	1805	REMOVAL OF SUTURES
NHS	1806	ULCER
NHS	1807	INFLAMMATION/SWELLING
NHS	1899	OTHER
RAH	1800	SKIN
RAH	1801	INFECTION
RAH	1802	LUMP
RAH	1803	RASH
RAH	1804	REDRESSING/WOUND REVIEW
RAH	1805	REMOVAL OF SUTURES
RAH	1898	PROVISIONAL DIAGNOSIS
RAH	1899	OTHER
RGH	1801	INFECTION
RGH	1802	LUMP
RGH	1803	RASH
RGH	1804	REDRESSING/WOUND REVIEW
RGH	1805	REMOVAL OF SUTURES
RGH	1806	ULCER
RGH	1899	OTHER
TQEH	1801	INFECTION
TQEH	1802	LUMP
TQEH	1803	RASH
TQEH	1804	REDRESSING\WOUND REVIEW
TQEH	1805	REMOVAL OF SUTURES
TQEH	1806	ULCER
TQEH	1898	PROVISIONAL DIAGNOSIS
TQEH	1899	OTHER
WCH - Paed	1800	SKIN
WCH - Paed	1801	INFECTION
WCH - Paed	1802	LUMP
WCH - Paed	1803	RASH

Hosp	Hosp Code	Hosp Description
WCH - Paed	1804	REDRESSING/WOUND REVIEW
WCH - Paed	1805	REMOVAL OF SUTURES
WCH - Paed	1806	ULCER
WCH - Paed	1807	INFLAMMATION/SWELLING
WCH - Paed	1898	PROVISIONAL DIAGNOSIS
WCH - Paed	1899	OTHER
WCH - WAS	1801	INFECTION
WCH - WAS	1803	RASH
WCH - WAS	1805	REMOVAL OF SUTURES
WCH - WAS	1807	INFLAMMATION/SWELLING

1900 OTHER COMPLAINT (NOT ELSEWHERE SPECIFIED) (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	1900	OTHER
NHS	1901	BLOOD ALCOHOL
NHS	1908	IMMUNISATION
NHS	1909	E.C.P. (EMERGENCY CONTRACEPTN PILL-MAP)
NHS	1912	POP CHECK
NHS	1913	PRESCRIPTION
NHS	1915	REVIEW
NHS	1916	TEST RESULTS
NHS	1918	BLOOD TEST
NHS	1923	IRRITABLE BABY
NHS	1925	CERTIFICATE- REQUEST FOR
RAH	1900	OTHER
RAH	1901	BLOOD ALCOHOL
RAH	1902	BODY FLUIDS EXPOSURE
RAH	1904	ELECTROCUTION
RAH	1905	HYPERTHERMIA
RAH	1909	MAP
RAH	1910	NEEDLESTICK INJURY
RAH	1911	PALLIATIVE CARE
RAH	1912	POP CHECK
RAH	1913	PRESCRIPTION
RAH	1914	REFERRAL REQUEST
RAH	1915	REVIEW
RAH	1916	TEST RESULTS
RAH	1917	OTHER
RGH	1900	OTHER
RGH	1913	PRESCRIPTION
RGH	1915	REVIEW
RGH	1925	CERTIFICATE- REQUEST FOR
TQEH	1900	OTHER
TQEH	1901	BLOOD ALCOHOL
TQEH	1902	EXPOSURE TO BODY FLUIDS
TQEH	1906	HYPOTHERMIA
TQEH	1908	IMMUNIZATION
TQEH	1910	NEEDLESTICK INJURY
TQEH	1911	PALLIATAVE CARE
TQEH	1912	POP CHECK
TQEH	1913	PRESCRIPTION
TQEH	1914	REFERRAL REQUEST
TQEH	1915	REVIEW
TQEH	1916	TEST RESULTS

Hosp	Hosp Code	Hosp Description
TQEH	1917	OTHER
TQEH	1919	NEEDLESTICK INJURY
TQEH	1924	POST OP PROBLEM
TQEH	1925	CERTIFICATE- REQUEST FOR
WCH - Paed	1900	OTHER
WCH - Paed	1901	BLOOD ALCOHOL
WCH - Paed	1904	ELECTROCUTION
WCH - Paed	1907	IMMERSION
WCH - Paed	1908	IMMUNISATION
WCH - Paed	1912	POP CHECK
WCH - Paed	1913	PRESCRIPTION
WCH - Paed	1914	REFERRAL REQUEST
WCH - Paed	1915	REVIEW
WCH - Paed	1916	TEST RESULTS
WCH - Paed	1917	OTHER
WCH - Paed	1918	BLOOD TEST
WCH - Paed	1919	IV MEDICATION ADMINISTRATION
WCH - Paed	1923	IRRITABLE BABY
WCH - Paed	1924	POST OP PROBLEM
WCH - WAS	1900	OTHER
WCH - WAS	1908	IMMUNISATION
WCH - WAS	1909	E.C.P. (EMERGENCY CONTRACEPTN PILL-MAP)
WCH - WAS	1913	PRESCRIPTION
WCH - WAS	1915	REVIEW
WCH - WAS	1916	TEST RESULTS
WCH - WAS	1918	BLOOD TEST
WCH - WAS	1919	IV MEDICATION ADMINISTRATION
WCH - WAS	1924	POST OP PROBLEM
WCH - WAS	1925	CERTIFICATE- REQUEST FOR

2000 ABRASION-SINGLE TRAUMA (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	20	ABRASION
NHS	2000	SINGLE TRAUMA
NHS	2002	BACK PAIN
NHS	2004	FACE
NHS	2005	HEAD
NHS	2009	UPPER LIMB
NHS	2010	MULTIPLE SITES
RAH	2000	SINGLE TRAUMA
RAH	2004	FACE
RAH	2006	LOWER LIMB
RAH	2009	UPPER LIMB
RGH	2006	LOWER LIMB
RGH	2009	UPPER LIMB
TQEH	2003	CHEST PAIN
TQEH	2004	FACE
TQEH	2005	HEAD
TQEH	2006	LOWER LIMB
TQEH	2009	UPPER LIMB
WCH - Paed	20	ABRASION
WCH - Paed	2000	SINGLE TRAUMA
WCH - Paed	2002	BACK PAIN
WCH - Paed	2004	FACE

Hosp	Hosp Code	Hosp Description
WCH - Paed	2005	HEAD
WCH - Paed	2006	LOWER LIMB
WCH - Paed	2009	UPPER LIMB
WCH - Paed	2010	MULTIPLE SITES

2100 AMPUTATION-SINGLE TRAUMA (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	21	AMPUTATION
NHS	2109	UPPER LIMB
RAH	21	AMPUTATION
RAH	2106	LOWER LIMB
RAH	2109	UPPER LIMB
RGH	2109	UPPER LIMB
TQEH	2109	UPPER LIMB
WCH - Paed	21	AMPUTATION
WCH - Paed	2109	UPPER LIMB

2200 BITES/STINGS-SINGLE TRAUMA (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	22	BITE/STING
NHS	2201	ABDOMEN
NHS	2202	BACK PAIN
NHS	2204	FACE
NHS	2205	HEAD
NHS	2206	LOWER LIMB
NHS	2209	UPPER LIMB
RAH	22	BITE/STING
RAH	2203	CHEST PAIN
RAH	2204	FACE
RAH	2205	HEAD
RAH	2206	LOWER LIMB
RAH	2209	UPPER LIMB
RGH	2209	UPPER LIMB
TQEH	2201	ABDOMEN
TQEH	2202	BACK PAIN
TQEH	2203	CHEST PAIN
TQEH	2204	FACE
TQEH	2206	LOWER LIMB
TQEH	2209	UPPER LIMB
WCH - Paed	22	BITE/STING
WCH - Paed	2201	ABDOMEN
WCH - Paed	2202	BACK PAIN
WCH - Paed	2203	CHEST PAIN
WCH - Paed	2204	FACE
WCH - Paed	2205	HEAD
WCH - Paed	2206	LOWER LIMB
WCH - Paed	2209	UPPER LIMB

2300 BLUNT INJURY-SINGLE TRAUMA (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	23	BLUNT INJURY
NHS	2303	CHEST PAIN
NHS	2304	FACE
NHS	2305	HEAD
NHS	2306	LOWER LIMB
NHS	2309	UPPER LIMB
RAH	23	BLUNT INJURY

Hosp	Hosp Code	Hosp Description
RAH	2301	ABDOMEN
RAH	2302	BACK PAIN
RAH	2303	CHEST PAIN
RAH	2304	FACE
RAH	2305	HEAD
RAH	2306	LOWER LIMB
RAH	2307	NECK
RAH	2308	PELVIC AREA
RAH	2309	UPPER LIMB
TQEH	2301	ABDOMEN
TQEH	2302	BACK PAIN
TQEH	2303	CHEST PAIN
TQEH	2304	FACE
TQEH	2305	HEAD
TQEH	2306	LOWER LIMB
TQEH	2307	NECK
TQEH	2308	PELVIC AREA
TQEH	2309	UPPER LIMB
WCH - Paed	23	BLUNT INJURY
WCH - Paed	2301	ABDOMEN
WCH - Paed	2302	BACK PAIN
WCH - Paed	2303	CHEST PAIN
WCH - Paed	2304	FACE
WCH - Paed	2305	HEAD
WCH - Paed	2306	LOWER LIMB
WCH - Paed	2307	NECK
WCH - Paed	2308	PELVIC AREA
WCH - Paed	2309	UPPER LIMB

2400 BURN/SCALD-SINGLE TRAUMA (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	24	BURN
NHS	2402	BACK PAIN
NHS	2403	CHEST PAIN
NHS	2404	FACE
NHS	2406	LOWER LIMB
NHS	2409	UPPER LIMB
RAH	24	BURN
RAH	2401	ABDOMEN
RAH	2404	FACE
RAH	2405	HEAD
RAH	2406	LOWER LIMB
RAH	2408	PELVIC AREA
RAH	2409	UPPER LIMB
RGH	2404	FACE
RGH	2406	LOWER LIMB
TQEH	24	BURN
TQEH	2401	ABDOMEN
TQEH	2403	CHEST PAIN
TQEH	2404	FACE
TQEH	2406	LOWER LIMB
TQEH	2409	UPPER LIMB
WCH - Paed	24	BURN
WCH - Paed	2401	ABDOMEN

Hosp	Hosp Code	Hosp Description
WCH - Paed	2402	BACK PAIN
WCH - Paed	2403	CHEST PAIN
WCH - Paed	2404	FACE
WCH - Paed	2405	HEAD
WCH - Paed	2406	LOWER LIMB
WCH - Paed	2407	NECK
WCH - Paed	2408	PELVIC AREA
WCH - Paed	2409	UPPER LIMB
WCH - Paed	2410	MULTIPLE SITES

2500 CONTUSION/SOFT TISSUE INJURY-SINGLE TRAUMA (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	25	CONTUSION
NHS	2501	ABDOMEN
NHS	2502	BACK PAIN
NHS	2503	CHEST PAIN
NHS	2504	FACE
NHS	2505	HEAD
NHS	2506	LOWER LIMB
NHS	2507	NECK
NHS	2509	UPPER LIMB
NHS	2510	MULTIPLE SITES
RAH	25	CONTUSION
RAH	2503	CHEST PAIN
RAH	2504	FACE
RAH	2505	HEAD
RAH	2506	LOWER LIMB
RAH	2509	UPPER LIMB
RAH	32	SOFT TISSUE INJURY
RAH	3202	BACK PAIN
RAH	3203	CHEST PAIN
RAH	3204	FACE
RAH	3205	HEAD
RAH	3206	LOWER LIMB
RAH	3207	NECK
RAH	3208	PELVIC AREA
RAH	3209	UPPER LIMB
TQEH	2504	FACE
TQEH	2505	HEAD
TQEH	2506	LOWER LIMB
TQEH	2509	UPPER LIMB
TQEH	3201	ABDOMEN
TQEH	3202	BACK PAIN
TQEH	3203	CHEST PAIN
TQEH	3206	LOWER LIMB
TQEH	3207	NECK
TQEH	3208	PELVIC AREA
TQEH	3209	UPPER LIMB
WCH - Paed	25	CONTUSION
WCH - Paed	2501	ABDOMEN
WCH - Paed	2502	BACK PAIN
WCH - Paed	2503	CHEST PAIN
WCH - Paed	2504	FACE
WCH - Paed	2505	HEAD

Hosp	Hosp Code	Hosp Description
WCH - Paed	2506	LOWER LIMB
WCH - Paed	2507	NECK
WCH - Paed	2508	PELVIC AREA
WCH - Paed	2509	UPPER LIMB

2600 CRUSH-SINGLE TRAUMA (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	26	CRUSH
NHS	2606	LOWER LIMB
NHS	2609	UPPER LIMB
RAH	26	CRUSH
RAH	2601	ABDOMEN
RAH	2606	LOWER LIMB
RAH	2609	UPPER LIMB
TQEH	2603	CHEST PAIN
TQEH	2606	LOWER LIMB
TQEH	2609	UPPER LIMB
WCH - Paed	26	CRUSH
WCH - Paed	2601	ABDOMEN
WCH - Paed	2603	CHEST PAIN
WCH - Paed	2606	LOWER LIMB
WCH - Paed	2607	NECK
WCH - Paed	2609	UPPER LIMB

2700 DEFORMITY/SWELLING-SINGLE TRAUMA (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	27	DEFORMITY
NHS	2704	FACE
NHS	2706	LOWER LIMB
NHS	2708	PELVIC AREA
NHS	2709	UPPER LIMB
RAH	27	DEFORMITY
RAH	2701	ABDOMEN
RAH	2703	CHEST PAIN
RAH	2704	FACE
RAH	2705	HEAD
RAH	2706	LOWER LIMB
RAH	2709	UPPER LIMB
RGH	2706	LOWER LIMB
RGH	2709	UPPER LIMB
TQEH	2704	FACE
TQEH	2706	LOWER LIMB
TQEH	2709	UPPER LIMB
WCH - Paed	27	DEFORMITY
WCH - Paed	2703	CHEST PAIN
WCH - Paed	2704	FACE
WCH - Paed	2705	HEAD
WCH - Paed	2706	LOWER LIMB
WCH - Paed	2709	UPPER LIMB

2900 FRACTURE/DISLOCATION-SINGLE TRAUMA (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	29	FRACTURE/DISLOCATION
NHS	2904	FACE
NHS	2906	LOWER LIMB
NHS	2909	UPPER LIMB
RAH	28	DISLOCATION

Hosp	Hosp Code	Hosp Description
RAH	2804	FACIAL AREA(JAW)
RAH	2805	LOWER LIMB
RAH	2807	UPPER LIMB
RAH	29	FRACTURE
RAH	2902	BACK PAIN
RAH	2903	CHEST PAIN
RAH	2904	FACE
RAH	2905	HEAD
RAH	2906	LOWER LIMB
RAH	2907	NECK
RAH	2908	PELVIC AREA
RAH	2909	UPPER LIMB
RGH	2908	PELVIC AREA
TQEH	2804	FACE
TQEH	2806	LOWER LIMB
TQEH	2809	UPPER LIMB
TQEH	2904	FACE
TQEH	2906	LOWER LIMB
TQEH	2908	PELVIC AREA
TQEH	2909	UPPER LIMB
WCH - Paed	29	FRACTURE/DISLOCATION
WCH - Paed	2904	FACE
WCH - Paed	2905	HEAD
WCH - Paed	2906	LOWER LIMB
WCH - Paed	2907	NECK
WCH - Paed	2908	PELVIC AREA
WCH - Paed	2909	UPPER LIMB
WCH - Paed	2910	MULTIPLE SITES

3000 LACERATION-SINGLE TRAUMA (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	30	LACERATION
NHS	3001	ABDOMEN
NHS	3002	BACK PAIN
NHS	3004	FACE
NHS	3005	HEAD
NHS	3006	LOWER LIMB
NHS	3008	PELVIC AREA
NHS	3009	UPPER LIMB
RAH	30	LACERATION
RAH	3001	ABDOMEN
RAH	3003	CHEST PAIN
RAH	3004	FACE
RAH	3005	HEAD
RAH	3006	LOWER LIMB
RAH	3009	UPPER LIMB
RGH	30	LACERATION
RGH	3005	HEAD
RGH	3006	LOWER LIMB
RGH	3009	UPPER LIMB
TQEH	3001	ABDOMEN
TQEH	3002	BACK PAIN
TQEH	3003	CHEST PAIN
TQEH	3004	FACE

Hosp	Hosp Code	Hosp Description
TQEH	3005	HEAD
TQEH	3006	LOWER LIMB
TQEH	3008	PELVIC AREA
TQEH	3009	UPPER LIMB
WCH - Paed	30	LACERATION
WCH - Paed	3001	ABDOMEN
WCH - Paed	3002	BACK PAIN
WCH - Paed	3004	FACE
WCH - Paed	3005	HEAD
WCH - Paed	3006	LOWER LIMB
WCH - Paed	3007	NECK
WCH - Paed	3008	PELVIC AREA
WCH - Paed	3009	UPPER LIMB
WCH - Paed	3010	MULTIPLE SITES

3100 PENETRATION-SINGLE TRAUMA (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	31	PENETRATION
NHS	3106	LOWER LIMB
NHS	3109	UPPER LIMB
RAH	31	PENETRATION
RAH	3101	ABDOMEN
RAH	3102	BACK PAIN
RAH	3103	CHEST PAIN
RAH	3104	FACE
RAH	3105	HEAD
RAH	3106	LOWER LIMB
RAH	3109	UPPER LIMB
RGH	3109	UPPER LIMB
TQEH	3101	ABDOMEN
TQEH	3103	CHEST PAIN
TQEH	3104	FACE
TQEH	3106	LOWER LIMB
TQEH	3109	UPPER LIMB
WCH - Paed	31	PENETRATION
WCH - Paed	3102	BACK PAIN
WCH - Paed	3103	CHEST PAIN
WCH - Paed	3104	FACE
WCH - Paed	3105	HEAD
WCH - Paed	3106	LOWER LIMB
WCH - Paed	3107	NECK
WCH - Paed	3108	PELVIC AREA
WCH - Paed	3109	UPPER LIMB

3300 OTHER NON-SPECIFIED-SINGLE TRAUMA (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	33	OTHER
NHS	3303	CHEST PAIN
NHS	3304	FACE
NHS	3305	HEAD
NHS	3309	UPPER LIMB
RAH	33	OTHER
RAH	3301	ABDOMEN
RAH	3302	BACK PAIN
RAH	3303	CHEST PAIN
RAH	3304	FACE

Hosp	Hosp Code	Hosp Description
RAH	3305	HEAD
RAH	3306	LOWER LIMB
RAH	3307	NECK
RAH	3308	PELVIC AREA
RAH	3309	UPPER LIMB
RGH	33	OTHER
RGH	3304	FACE
RGH	3305	HEAD
TQEH	33	SINGLE TRAUMA
TQEH	3301	ABDOMEN
TQEH	3302	BACK PAIN
TQEH	3303	CHEST PAIN
TQEH	3304	FACE
TQEH	3306	LOWER LIMB
TQEH	3307	NECK
TQEH	3308	PELVIC AREA
TQEH	3309	UPPER LIMB
WCH - Paed	33	OTHER
WCH - Paed	3301	ABDOMEN
WCH - Paed	3302	BACK PAIN
WCH - Paed	3303	CHEST PAIN
WCH - Paed	3304	FACE
WCH - Paed	3305	HEAD
WCH - Paed	3306	LOWER LIMB
WCH - Paed	3307	NECK
WCH - Paed	3308	PELVIC AREA
WCH - Paed	3309	UPPER LIMB
WCH - Paed	3310	MULTIPLE SITES

4000 MULTIPLE TRAUMA (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	4000	MULTIPLE-TRAUMA
NHS	4001	Mulit-trauma - Major
NHS	4002	Mulit-trauma - Minor
RAH	4000	MULTIPLE-TRAUMA
RAH	4001	Mulit-trauma - Major
RAH	4002	Mulit-trauma - Minor
RGH	4000	MULTIPLE-TRAUMA
RGH	4001	Mulit-trauma - Major
RGH	4002	Mulit-trauma - Minor
TQEH	4000	MULTIPLE-TRAUMA
TQEH	4001	Mulit-trauma - Major
TQEH	4002	Mulit-trauma - Minor
WCH - Paed	4000	MULTIPLE-TRAUMA
WCH - Paed	4001	Mulit-trauma - Major
WCH - Paed	4002	Mulit-trauma - Minor
WCH - WAS	4000	MULTIPLE-TRAUMA
WCH - WAS	4001	Mulit-trauma - Major
WCH - WAS	4002	Mulit-trauma - Minor
LMHS	4000	MULTIPLE-TRAUMA
LMHS	4001	Mulit-trauma - Major
LMHS	4002	Mulit-trauma - Minor

4600 RENAL (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
NHS	4600	Renal

Hosp	Hosp Code	Hosp Description
NHS	4601	Shunt/fistula/vascath problem
NHS	4602	Acute Renal Failure
NHS	4603	Acute on Chronic Renal Failure
NHS	4604	Fluid Overload – any system
NHS	4605	Pyrexia – transplant
NHS	4606	Other – transplant
NHS	4607	Dialysis problem – haemo
NHS	4608	Dialysis problem – peritoneal
RGH	4600	Renal
RGH	4601	Shunt/fistula/vascath problem
RGH	4602	Acute Renal Failure
RGH	4603	Acute on Chronic Renal Failure
RGH	4604	Fluid Overload – any system
RGH	4605	Pyrexia – transplant
RGH	4606	Other – transplant
RGH	4607	Dialysis problem – haemo
RGH	4608	Dialysis problem – peritoneal
TQEH	4600	Renal
TQEH	4601	Shunt/fistula/vascath problem
TQEH	4602	Acute Renal Failure
TQEH	4603	Acute on Chronic Renal Failure
TQEH	4604	Fluid Overload – any system
TQEH	4605	Pyrexia – transplant
TQEH	4606	Other – transplant
TQEH	4607	Dialysis problem – haemo
TQEH	4608	Dialysis problem – peritoneal
RAH	4600	Renal
RAH	4601	Shunt/fistula/vascath problem
RAH	4602	Acute Renal Failure
RAH	4603	Acute on Chronic Renal Failure
RAH	4604	Fluid Overload – any system
RAH	4605	Pyrexia – transplant
RAH	4606	Other – transplant
RAH	4607	Dialysis problem – haemo
RAH	4608	Dialysis problem – peritoneal
LMHS	4600	Renal
LMHS	4601	Shunt/fistula/vascath problem
LMHS	4602	Acute Renal Failure
LMHS	4603	Acute on Chronic Renal Failure
LMHS	4604	Fluid Overload – any system
LMHS	4605	Pyrexia – transplant
LMHS	4606	Other – transplant
LMHS	4607	Dialysis problem – haemo
LMHS	4608	Dialysis problem – peritoneal
WCH - Paed	4600	Renal
WCH - Paed	4601	Shunt/fistula/vascath problem
WCH - Paed	4602	Acute Renal Failure
WCH - Paed	4603	Acute on Chronic Renal Failure
WCH - Paed	4604	Fluid Overload – any system
WCH - Paed	4605	Pyrexia – transplant
WCH - Paed	4606	Other – transplant
WCH - Paed	4607	Dialysis problem – haemo
WCH - Paed	4608	Dialysis problem – peritoneal

Hosp	Hosp Code	Hosp Description
WCH - WAS	4600	Renal
WCH - WAS	4601	Shunt/fistula/vascath problem
WCH - WAS	4602	Acute Renal Failure
WCH - WAS	4603	Acute on Chronic Renal Failure
WCH - WAS	4604	Fluid Overload – any system
WCH - WAS	4605	Pyrexia – transplant
WCH - WAS	4606	Other – transplant
WCH - WAS	4607	Dialysis problem – haemo
WCH - WAS	4608	Dialysis problem – peritoneal

9999 NOT STATED/UNKNOWN (Presenting Problem Group)

Hosp	Hosp Code	Hosp Description
MPH	|	Not Stated
TQEH	|	Not stated
WCH - WAS	|	Not stated

APPENDIX 3 EDDC Supplementary Codes – Referring Hospital Codes{ TC "APPENDIX 2 EDDC Supplementary Codes – Presenting problem codes" \f C \l "1" }

SA Code	SA Description
0003	W&CH
0005	FMC
0008	Hampstead
0014	TQEH
0015	TQEH-Dial
0018	RGH
0019	RAH
0020	Gawler
0027	LMHS
0028	LMHS-MH
0029	LMHS-WAU
0030	Modbury
0033	Noarlunga
0034	Noarlunga-MH
0035	Pregnancy
0036	Southern Districts
0042	St Margaret's
0045	Torrens House
0046	Andmaooka
0049	Angaston
0052	Balaklava
0055	Barmera
0058	Riverland
0061	Bishop Kirkby
0067	Booleroo
0070	Bordertown
0073	Burra
0076	Central Eyre
0079	Clare
0082	Cleve
0085	Coober Pedy
0088	Cowell
0091	Crystal Brook
0094	Cummins
0097	Elliston
0100	Eudunda
0103	Great Northern
0106	Gumeracha
0109	Jamestown
0112	Kangaroo Island
0115	Kapunda
0118	Karoonda
0121	Kimba
0124	Kingston
0127	Lameroo

SA Code	SA Description
0130	Laura
0133	Leigh Creek
0136	Lower Murray
0139	Loxton
0142	CYP (Maitland)
0145	Mannum
0148	Marree
0151	Meningie
0154	Millicent
0160	Mt Barker
0163	Mt Gambier
0166	Mt Pleasant
0169	Ceduna
0172	Murray Bridge
0175	Naracoorte
0181	Oodnadatta
0184	Orroroo
0187	Penola
0190	Peterborough
0193	Pinnaroo
0196	Port Augusta
0199	Port Broughton
0202	Port Lincoln
0205	Port Pirie
0208	Quorn
0211	Renmark
0214	Riverton
0217	Roxby Downs
0220	Snowtown
0223	South Coast
0226	Southern Yorke
0229	Strathalbyn
0232	Streaky Bay
0235	Tanunda
0238	Tarcoola
0241	Tumby Bay
0244	Waikerie
0247	Northern Yorke
0248	Woomera
0249	Whyalla
0250	Moonta Jubilee
0293	NWAMHS
0300	Glenside
0303	Hillcrest
0343	Hampstead-NH
4302	Ashford
4303	Blackwood
4304	Burnside
4305	Calvary
4306	College Grove
4308	Fullarton
4309	Glenelg
4310	Griffith

SA Code	SA Description
4311	Hartley
4313	Abergeldie
4314	Holdfast
4315	Hutt Street
4316	Kahlyn
4317	Kiandra
4319	The Vales
4320	Memorial
4321	Monreith
4322	North Eastern
4323	Northern
4324	Parkwynd
4325	Pier Private
4326	St Andrew's
4327	Stirling
4329	Wakefield
4330	Western
4331	Central Districts
4332	Harwin
4334	Adelaide Clinic
4336	Sportsmed(SA)-Day
4337	Noarlunga Private
4338	McLaren Vale
4339	Adelaide Day
4340	Northern Endoscopy
4341	Glenelg Day Surgery
4342	Gawler Private
4343	Hamilton House
4345	Oxford Day Surgery
4346	Sach Day Surgery
4347	Hill Day Surgery
4348	Sportsmed-Kiandra
4349	Torrens Valley
4350	Nth Adelaide Day
4351	Attunga Day Surgery
4352	Mary McHugh Day
4353	Glen Osmond Day surg
4354	327 Surgery
4355	Modbury Private Endo
4356	Brighton Day Surgery
4357	Fliders Private
4364	Laser Focus Day Surgery
4365	Modbury Dialysis Centre
4366	Repromed
4401	Ardrossan
4402	Hamley Bridge
4404	Keith
4405	Mallala
4406	Moonta Private
4407	Onkaparinga
4408	South Coast Private
4409	Northern Yorke Priv
4410	Riverland Private

SA Code	SA Description
4411	Mt Gambier Private
5100	ACT
5200	NSW
5300	NT
5400	QLD
5500	TAS
5600	VIC
5700	WA
8000	OTHER
8888	Not referred
9999	Unknown

APPENDIX 4 EDDC Supplementary Codes – Country Hospital Codes{ TC "APPENDIX 2 EDDC Supplementary Codes – Presenting problem codes" \f C \l "1" }

Code	Hospital Name
0020	Gawler
0049	Angaston
0052	Balaklava
0055	Barmera
0058	Riverland (Berri)
0067	Booleroo
0070	Bordertown
0073	Burra
0076	Wudinna
0079	Clare
0082	Cleve
0085	Coober Pedy
0088	Cowell
0091	Crystal Brook
0094	Cummins
0097	Elliston
0100	Eudunda
0103	Hawker
0106	Gumeracha
0109	Jamestown
0112	Kangaroo Island
0115	Kapunda
0118	Karoonda
0121	Kimba
0124	Kingston
0127	Lameroo
0130	Laura
0133	Leigh Creek
0136	Lower Murray (Tailem Bend)

0139	Loxton
0142	CYP (Maitland)
0145	Mannum
0151	Meningie
0154	Millicent
0160	Mt Barker
0163	Mt Gambier
0166	Mt Pleasant
0169	Ceduna
0172	Murray Bridge
0175	Naracoorte
0184	Ororoo
0187	Penola
0190	Peterborough
0193	Pinnaroo
0196	Port Augusta
0199	Port Broughton
0202	Port Lincoln
0205	Port Pirie
0208	Quorn
0211	Renmark
0214	Riverton
0217	Roxby Downs
0220	Snowtown
0223	South Coast
0226	Southern Yorke
0229	Strathalbyn
0232	Streaky Bay
0235	Tanunda
0241	Tumby Bay
0244	Waikerie
0247	Northern Yorke
0248	Woomera
0249	Whyalla