

## Table of Contents

Introduction.....	4
Chapter 01- Patient Information .....	16
Basic Information .....	17
Demographic Information .....	30
Social Information .....	38
Physical Characteristics .....	44
Health and Lifestyle Information .....	47
Insurance Information.....	68
Chapter 02- Healthcare Facility Information .....	72
Healthcare Facility Information .....	72
Healthcare / Hospital/ Clinic name.....	72
Healthcare Facility Information .....	73
Mental Medical Facility Information .....	101
Medical Facility Teaching Information .....	104
Chapter 03- Health Provision Information .....	106
Health Provision Information .....	106
Healthcare Provision Information .....	107
Emergency Medical Services .....	111
Cardiovascular Diseases .....	127
Maternity Information.....	133
Maternity: Labor Information .....	146
Maternity: Postnatal .....	163
Maternity: Immunization .....	168
Ambulatory Care Information .....	185
Vital Signs .....	206
Admission Information.....	213
Discharge Information .....	232

Hospital Care Information .....	239
Chapter 04- Mortality .....	263
Mortality Basic Information .....	264
Mortality Statistical Information .....	270
Chapter 05- Communicable Diseases .....	280
Communicable Diseases .....	281
Toxic Venom Incidents .....	302
Non Micro-biological Communicable Incidents.....	305
Chapter 06- Tumors .....	310
Tumor description and diagnosis .....	311
Tumor Treatment .....	323
Chapter 07- Burden of Disease Information .....	335
Cardiovascular Diseases CVD .....	336
Diabetes Mellitus.....	346
Obesity .....	357
Renal Disease Therapy .....	360
Chapter 08- Pharmaceuticals .....	362
Storing .....	363
Prescribing and Preparation .....	369
Pharmacovigilance .....	377
Utilization .....	382
Chapter 09- Health Facility Human Resources .....	392
Medical Human Resources .....	393
Chapter 10- Hajj (Pilgrimage) Information .....	408
Hajj (Pilgrimage) Information .....	409
Daily census of invasive cardiac.....	416
Procedures during Hajj season.....	416
Daily census of high cost radiology procedures .....	417
(CT and MRI) performed for Hajj patients .....	417

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Daily census of laboratory .....	418
Investigations performed for Hajj patients .....	418
Chapter 11- Facility Financial Information .....	421
Health Facility Assets .....	422
Health Facility Revenue .....	444
Health Facility Expenditure .....	451
Appendices.....	494
Appendix 1- Sample for Unique Facility Identifier.....	495
Appendix No. 2 .....	496
“Facility Medical Units and Departments Identifier” Code Values .....	496
Appendix No. 3 .....	505
Non-Medical Department & Units Identifier Code Values .....	505
Appendix No. 4- Healthcare Specialty Identifier Code Values .....	507
Appendix No. 5- Retired/Frozen Subspecialty\Units .....	512
Appendix 6- Saudi Health Data Dictionary Change Request Form .....	516

# Introduction

## INTRODUCTION

The legacy of human civilization, is a contribution by all mankind on earth, the science has without doubt been behind this development but the medical science can be considered among the mainstay of this civilization because it is among the few that are the human - centered.

The Saudi Health Council “SHC” to keep up with development plans in the Kingdom which comes in the forefront of the upgrade and health services for its citizens, which is considered as a mean of development to the community. This resulted in the increased interest among institutions and private sector to in the Kingdom to establish health facilities and institutions in support of this vision.

Saudi Health Data Dictionary is mainly focused on dealing with health metadata required for appropriate medical data collection. Medical Metadata is considered the cornerstone of the health information that will contribute to steer health service and planning in all governmental health sectors.

And as the health information system is one of the advanced strategic tools for the development of sustainable health care system in KSA. The use of the Saudi Health data dictionary will help to provide the correct and accurate data from all the Saudi health institutions.

One of the most important health management priorities in KSA is the standardization of data policies in support of the future development of the system of health information management. The first Saudi Health data dictionary was developed in 2016 by Saudi Health Council after two years of continuous collaborative work, and was made available to the Health Informatics industry. The objectives of this data dictionary are to; provide semantic understanding of data elements used in health care industry; conform to nationally accepted protocol standards; and to be consistent with international standards wherever applicable.

Further to this; the Saudi Health Council provided an electronic version of the dictionary through a new dedicated portal for the national health information center NHIC.

SHDD the first and the second versions were developed over many stages to reach the final result that is in alignment with international standards and concepts used in health information. Among the stages of development were:

- Through research in the national and international data dictionary products
- Gathering information used in Saudi health care facilities particularly
- Stage of analysis and comparison to reach more precise definitions best suited for the Kingdom health system.

The end result was the second release of the Saudi specific health data dictionary that is in alignment with the international definitions and benchmarks.

Saudi Health Data Dictionary takes into account the accuracy of expression and credibility of the significance of the terms used in health services, and will assist in the appropriate description of and stability of the data reporting and exchange used between the parties related in health sectors. There for, the continuous update and development of this dictionary became our priority, the reasons to develop the second version SHDD include:

- A need for more involvement from stakeholders.
- A need for more complete information about clients and/or services.
- To find out about the needs or the unmet needs of clients.
- To measure services, targets and outcomes.
- To meet reporting requirements of government departments, boards or other regulatory bodies.
- To compare information at different levels (for example: regional, governorates, national, and international).
- To exchange data seamlessly between systems, organizations or by making clear and unambiguous information available.

The product logo “the Dictionary” is viewed as major resource to fill a gap in the local and Arab Medical Library, but here our dictionary is mainly focused on dealing with health metadata required for appropriate medical data collection. Medical Metadata is considered the cornerstone of the health information that will contribute to steer health service and planning in all governmental health sectors.

## Objectives of SHDD:

SHDD was developed on basis of scientific research and clear obligation to respect for intellectual property rights in any of the quotes that suited the text. The dictionary approached data comprehensively took into account the diversity and availability of the following data:

- Health facility Data in terms of Types, level of care and sector.
- Service provider's data for both medical and nonmedical human resources operating the health facilities.
- Health service data that helps leaders and decision makers monitor specific indicators such as waiting time in the emergency department or the time required to start radiotherapy for a fully diagnosed cancer patient.
- Financial data for health facilities that provides insight on the assets and expenses and revenues

The team that developed the SHDD has taken into account during the development stage the fact that the health data in Saudi Arabia is suffering from lack of credibility and the wide variation in its method of usage in addition to the significance variation in the method of collecting such data. With such considerations in mind the end product will fit all the needs and requirement of all stakeholders in health services, including the providers, professional, researchers.

SHDD will help establish the specific meaning of the health data elements and put rules he rules and principles for electronic health record system, and will permit facilities to compare information and health indicators locally and internationally without doubt of its significance. In addition, it will also help to the standardized data and common method of representation.

## SHDD second version team:

This Dictionary is the result of the work of a collective effort action and close cooperation between a large sum of data of specialists in the KSA from various health sectors and some international organizations.

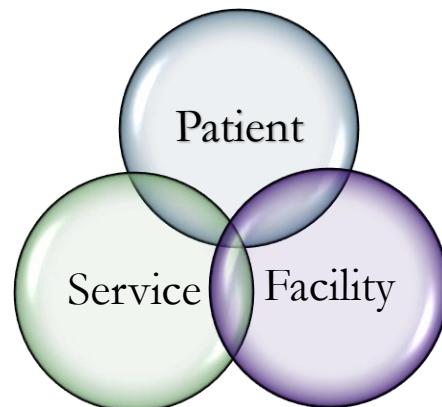
- Mr. Mohammad Ben Belkasem Al-Shehri – Chairman of the Technical Committee
- Mr. Ihab Abu Hamdeh – Consultant
- Ms. Honida Al-Mansori – Project Manager
- Eng. Hanan Al-Dosari – Project Member
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- Eng. Mohammad Al-Anizi
- Mr. Tariq Hakeem

The team would like to express their appreciation to all those who participated in the making of this work whether medical or non-medical staff in addition to all those who contributed at the workshops held in different regions of the Kingdom of Saudi Arabia for health sector feedback. Their dedication, hard work, and professional commitment were the pillars for the completion of this work. Saudi Health Data Dictionary team are happy to receive any comments, suggestions, and addition or change requisite at the email address [shdd@shc.gov.sa](mailto:shdd@shc.gov.sa).

As it was in the first version; the elements in the second version are divided into two main types a concept element which totaled 16 and the data element that form the rest of the content. The first are basically a concept builder that specifies the meaning of the information and can never be used as a data source, such as the data elements that have codes and code values to be utilized for data collection kingdom wide.

## Overview of the Dictionary:

SHDD is divided into eleven main parts that are further divided in subparts and divisions through which the data elements of the SHDD are all itemized in sequence that is logical to the user. The total number of the data elements included in this version is (389). The SHDD team has chosen to organize the dictionary into different parts to help the user allocate the information easier. This is contrary to many similar international products that chose only to list the element on alphabetical bases.



The patient data was chosen to be the first part to reflect the importance of the patient to the health system, not only that but are also considered the first pillar of any health service in the health system in the Kingdom. You will also notice that the SHDD first priorities are the medical provision cycle which includes the following main trade of patient, the facility and the service provided.

### Contents of the Dictionary

SHDD is a Meta data dictionary that and has nonlinguistic elements, it defines data standards and values. It provides guidance for information gathering and collection and does advocate the concept of data element unification among all the different health care providers in the kingdom. One of the solid examples why SHDD is required is a simple undefined age of children among many hospitals in the kingdom as the team noticed that there was major discrepancy on the maximum age of the pediatric patient, it varied among the surveyed facilities from age 12-14 years, in this version SHDD have standardized this element so the maximum is 14 years. This will help in gathering more specific information. on pediatric patient if required by any researcher, decision maker ...etc. and it will not show the discrepancy noticed among facilities before using this SHDD. The elements in this version are divided into two main types a concept element which totaled 16 and the data element that form the rest of the content. The first are basically a concept builder that specifies the meaning of the information and can never be used as a data source, such as the data elements that have codes and code values to be utilized for data collection kingdom wide.

## Part 1 (Patient information): Total numbers of elements are 43

It includes the following data elements, elements in this part are further divided to division and subdivision as the elements would need, and elements included are: displayed through the sections and sub-sections, as follows:

- Basic information: such as patient name, patient identification number, the nationality of the patient, the patient 's religion ... and others.
- Demography information: such as sex, age, age, date of birth, city of birth ... and others.
- Social information: such as civil status, educational status, occupation, required translation services ... and others.
- Physical characteristics of patient: height, weight.
- Health and lifestyle information: such as adequacy of physical activity, diet type, the status of tobacco smoking, history of allergies, the cause of allergies, this section also has the following subdivisions:
  - Substance Abuse: History of addiction to narcotic substances, the start of the treatment of addiction ... and other related topics.
  - Previous medical history of the disease: such as vascular procedures performed Date of treatment: medication, such as maintenance medication
- 6. Health insurance information: such as an insurance company, insurance policy number and other.

## **Part II(Health care facilities information):The total number of elements 23.**

The second part of the SHDD looks at health care facilities Information: such as name, address of the facility, emergency beds availability, the available operating rooms ...etc.

## **Part III (Health care provision information): The number of element 142.**

In this part the information included was a result of a priority system that was adopted by the technical committee to correctly include the most appropriate elements. This is important for the provision of care, as it will guide the decisions required to develop services that may have an actual impact on medical service and Saudi society in general.

This prioritization in the selection resulted in the consideration of certain diseases and health events more than others at this stage, and by releasing this second version of SHDD, it will be open for further data development in future versions. The current elements are considered the most important for the health services in the kingdom according to the following priority system used by this second version of the SHDD:

- Statistically the event is a source of a large volume of services such as The annual hajj medical service that may be a source of problems (Problem Prone).
- Statistically the services are actually causing a problem to the system (Actual Problem).
- High volume of the event, for example, is a major cause of death for the kingdom population

When priority system was applied to the map of diseases in the Kingdom, it resulted in a list of qualified diseases to be among the content of the dictionary. Saying so, the SHDD team emphasizes on the fact that in the newer versions future data can be added or may be deleted if it is proven to be of a value to the main objectives of this product.

Therefore, the current SHDD contained in this part the elements of a specific set of diseases and events based on the priority analysis such as the following:

### *1. Emergency Medical Services:*

Information in this section is focused on service monitoring taking in consideration the complete service cycle. Such as:

- Mode of arrival of the patient to the emergency department.
- Triage mechanism to determine the severity of the emergency situation... etc.

- In addition SHDD incorporated more information relevant to emergency departments in the sub - sections Example:
- Respiratory disease in adult patients and the children.
- Cardiovascular diseases being a major cause of death in Saudi Arabia.
- Coronary chest pain and the resulting series of the medical and health procedures when dealing with such illness.

## 2. *Maternity Information:*

The information for this section is further subdivided into the following:

- Prenatal: like the first day of the last menstrual cycle information, pregnancy, the expected date of delivery.
- Labor information: such as presentation of birth, method used for Augmentation of labor.
- Post natal information: such as postpartum disorders, the status of the perineum after childbirth.
- Immunization Information: Anti d immunization (route of administration, reason for use).
- Newborn Information: Apgar score, birth weight, head circumference .

3. Ambulatory medical services information: It includes information such as date and time of the presence of the patient, the main complaint.

4. Vital signs: Information includes heart rate, heart rhythm pattern, and respiratory rate.

5. Admission Information: Such as the status of acceptance, the date and time of admission.

6. Discharge from hospital: Such as the date and time of the discharge, final diagnosis

7. When you enter service information for hospital treatment:

Such as length of hospital stay, time spent in the operating room.

## **Part IV (Mortality): The number of elements 15.**

In this part it includes Mortality Information: such as the cause of death, the date and time of death, place of death.

## Part V (Communicable diseases): The number of elements 14

Communicable diseases included information such as bacterial diseases, viral diseases, fungal diseases, parasitic diseases. It also included non - microbiological communicable incidents such radiation contamination, chemical contamination.

## Part VI (Tumors): The number of elements 21

Tumors is considered one of the only health data information that was standardized among the health facility under what is known as the “National Cancer Registry”, But SHDD in its second version have exceeded the registry data elements by adding treatment monitors to its content.

SHDD introduced elements of the information of this part all the registry information and added the waiting time for chemotherapy and radiotherapy as a monitor on treatment activities.

## Part VII (The burden of diseases): The number of input elements 21.

This part looks at the burden of diseases information as follows:

### 1. CVD

- High blood pressure: a disease such as high blood pressure and classification of hypertension.
- Ischemic heart disease.

### 2. Diabetes: such as the classification of diabetes and complications of diabetes mellitus.

### 3. Obesity.

## Part VIII (Pharmaceutical information): Number of elements 24.

In this part it was dedicated to pharmaceuticals, where items reflect the full picture of handling pharmaceuticals in health facilities, SHDD took into account the cycle related to this service starting from drug storage information, and ending the usage information as follows:

1. Storage: Like the rejected drugs near expiry and expiry of products
2. Prescribing and preparation: such as unauthorized drug error, improper frequency and wrong dosage error.
3. Pharmacovigilance: such as adverse reaction
4. Utilization: such as pharmaceutical product type, and off label use

## **Part IX (Human resources): Number of elements 12.**

The human resources in the health facility included the following information:

1. Medical Human Resources: such as doctor and dentist and pharmacist and nurses
2. Non-Medical Human resources.
3. Other HR information: such as the hours on call, hours in patient contact.

## **Part X (Hajj): The number of elements 17.**

Information on the pilgrimage is what distinguishes this dictionary as it the only dictionary that will have such an interest, new concepts has been introduced in this version of SHDDD under this part to assist in helping in management of disaster that require the provision of care to a large number of patients in a narrow window of time elements in this part included:

1. Definition to Hajj patient.
2. Medical services during the Hajj season: defining the season, such as patient daily census outpatient / emergency patients daily are its to health care facilities for the Hajj.
3. Human Resources during the Hajj season: human resources, medical and non - medical.

## **Part XI (Health facility financial information): The number of elements 69.**

Finance is always a special element to health industry; in KSA such information is neither widely defined nor available due to the central approach to finance management. SHDD have included in its content elements related to facility assets, facility revenue, and expenditures.

### **Sources of data elements.**

Health data dictionaries are available in few countries since many years, and as a new product but similar to previous products in the international health data information management, it was decided to among the technical team that elements that have been used by an older international data dictionary sources will have the priority over the

nationally developed ones. Such a strategic approach was taken to assure users of SHDD that elements are in use and specific enough for application with in a health sector. From this standpoint SHDD have used several references to support its content and reliability, taking into account intellectual property rights and appropriateness for use in KSA:

1. Elements developed by SHC team contributed to 16% of the content.
2. The World Health Organization WHO – definitions were used 5% of the content
3. Australian national health data dictionary, version 14, 2008 definitions were used in 50% of the content.
4. Palestinian health data dictionary, version II, 2005 definitions were used in 13%.
5. Saudi Authority for Food and Drug definitions were used in 4% of the content.
6. US Health and Human Services, Agency for Healthcare Research and Quality 2015 and the US National Cancer Institute surveillance, epidemiology and outcomes – were used in 4%.
7. British National Health Service, the hospital interim statistics September 2010 the proportion of input quoted 2%
8. The Canadian government legal definitions adopted 20 September 2010 as part of the Canadian guidelines for criteria documents and normative values of reporting and the quality of coronary artery disease procedures - Ministry of Health - Ontario - Canada 2014- used in 2% of the content.
9. Saudi Commission for Health Specialties - 1% .
10. Philippine National health data, version 2, 2010 1% .
11. Malaysian national health data, version II 2013- 1%.
12. National minimum data set New Zealand (hospital cases), 2015- 1%.
13. Organization for Economic Cooperation and Development statistics and indicators for 30 countries, (OECD) , Paris, 2007, 0.3% .
14. The International Diabetes Federation in 2015, the seventh version of Atlas 0.3%.

Accordingly, SHDD team is happy to have completed this version that will provide the necessary support to the health professionals. Hoping this effort will put an end to data discrepancy among health providers.

The technical Committee welcomes any comments or observations on this important product. We encourage readers to submit their views and comments for the purpose of improving and updating the SHDD in the future.

# Chapter 01

## Patient Information

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## Basic Information

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<b>Patient Name</b>	
<b>Definition</b>	Name of patient as per an official picture identification document
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Basic patient information –Patient Name
<b>Reference ID</b>	AA001
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Name
<b>Data Type</b>	Alphab
<b>Format</b>	80A
<b>Maximum Field Size</b>	80
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	The element (Name) should be recorded as mentioned in the official Saudi proof of identity issued by The Ministry of interior. If the patient is non-Saudi and doesn't have the local proof of identity use passport information, the element should be entered in a format of: FIRST=First Given Name SECOND=Father's Name THIRD=Grandfather's Name LAST=Family Name The FIRST, SECOND and LAST must be entered and considered Essential unless it does not appear in the official document, while the THIRD is optional.
<b>Code Description and permissible Values</b>	Not Applicable

<b>Patient Identification number</b>	
Definition	National identifier that uniquely identifies an individual.
Metadata Type	Data Element
Data Concept	Basic patient information number
Reference ID	AA002
Synonyms	Not Applicable
Representation Class	Number
Data Type	Alphanumeric
Format	N10
Maximum Field Size	10
Date Created	19/05/2016
Date Updated	To be defined
Source	USA Health & Human Services, Agency for Healthcare Research & Quality 2015
Usage	This element is used to define the ID number of the patient: Saudi nationals use national ID Number –Non Saudi residents in KSA use the Saudi resident ID number –Non Saudi visitors in KSA the priority is to use passport number, if not available use other ID available with patient
Code Description and Permissible Values	Not Applicable

## Nationality

<b>Definition</b>	It is the code used to describe the Nationality of the patient as stated in the identification document used for patient identity proof
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Basic Patient information –patient Nationality
<b>Reference ID</b>	AA003
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element is to report patient nationality as per the ISO 3166-3 Standard ,2 <sup>nd</sup> edition , 3-character alphabetic codes
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>NNN=As per ISO 3166 -3 Numeric code</p>

Religion		
Definition	Religion refers to the person's self-identification as having a connection or affiliation with any religious denomination, group, body, sect, cult or other religiously defined community or system of belief. Religion is not limited to formal membership in a religious organization or group. For infants or children, religion refers to specific religious group or denomination in which they are being raised, if any.	
Metadata Type	Data Element	
Data Concept	Basic Patient information – patient Religion	
Reference ID	AA004	
Synonyms	Not Applicable	
Representation Class	Code	
Data Type	Numeric	
Format	N[N]	
Maximum Field Size	2	
Date Created	19/05/2016	
Date Updated	To be defined	
Source	Canadian Government variable Legal Definitions Approved March 18, 2013 as part of the guidelines for documents standards	
Usage	It is a description of the religion practiced by the patient.	
Code Description and Permissible Values	Codes used are: 0 = Others 1 = Muslim 2 = Christian 3 = Judaism 4 = Buddhism 5 = Zoroastrian 6 = ----	7 = Hinduism 8 = Sikh 9 = Without 98 = Not available 99 = Not Mentioned

## Medical Record Number

Medical Record Number	
Definition	The medical record number is organization specific. The number is used by the hospital as a systematic documentation of a patient's medical history and care during each hospital stay or visit
Metadata Type	Data Element
Data Concept	Basic Patient information - Medical Record Number
Reference ID	AA005
Synonyms	Not Applicable
Representation Class	Identifier
	Numeric
Data Type	
Format	12N
Maximum Field Size	12
Date Created	19/05/2016
Date Updated	To be define
Source	USA Health & Human Services, Agency for Healthcare Research & Quality 2015 / HHC modified
Usage	This element provides a specified key to a specified record. This medical record number, is unique within a region of interest and will fulfill all the requirements for linkage, which have been described under incident number
Code Description and Permissible Values	12N

## Patient Residential Telephone Number

<b>Definition</b>	The person's contact telephone number, as represented by number
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Basic Patient information - Residential Telephone Number
<b>Reference ID</b>	AA006
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Number
<b>Data Type</b>	Numeric
<b>Format</b>	(NNN)NN NNN NNNN
<b>Maximum Field Size</b>	14
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Permits follow-up with patient and facilitates billing
<b>Code Description and Permissible Values</b>	Codes used are: Concatenation of: NNN = Country Code NN = Area code NNNNNNNN = Phone number

<b>Patient Residential Address</b>	
<b>Definition</b>	The referential description of a location where an entity is located or can be otherwise reached or found
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Basic Patient information - Residential Address
<b>Reference ID</b>	AA007
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Address
<b>Data Type</b>	Alphanumeric
<b>Format</b>	Saudi Post format
<b>Maximum Field Size</b>	
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Philippines National Health Data Dictionary Version 2, 2010
<b>Usage</b>	This is as per the Yafi Data Standard version 1.2 issued and agreed on 12/11/2007. The national address is a standard address that was developed by the Saudi postal corporation.
<b>Code Description and Permissible Values</b>	Codes used are: - Building Number: Consists of four numbers, the number represents either a commercial or residential building; the numbers are unique and not repeated on the street. - Street Name: Represents the exact location of a certain building, entrance or shop that exists between several of buildings. - Neighborhood: Represents the area that consists of all these buildings. - City: Represents all the areas as a whole with its different neighborhoods, street names and building numbers. - Postal Code/Zip Code: Consists of five digits, each digit has a significant location. This code covers a specific geographical area such as a neighborhood or any residential community. - Additional Numbers: It is similar to the building number and also consists of four numbers.

KSA City	
Definition	It is the codes used to identify cities in KSA
Metadata Type	Data Element
Data Concept	Basic Patient information - KSA city
Reference ID	AA008
Synonyms	Not Applicable
Representation Class	Address
Data Type	Alphab
Format	Saudi Post format
Maximum Field Size	
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Health Council / Saudi Post City Code
Usage	
Code Description and Permissible Values	Codes Used are: Saudi Post City Codes

<b>Patient Mobile Number</b>	
<b>Definition</b>	Contact mobile telephone number as stated by the individual
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Basic Patient information—Patient mobile number.
<b>Reference ID</b>	AA009
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Number
<b>Data Type</b>	Numeric
<b>Format</b>	NNN)9N(
<b>Maximum Field Size</b>	12
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>Enter Mobile Phone Number [NNN] NNN NNNN NNNN</p>

### Patient Emergency contact Person

<b>Definition</b>	Name of person whom the patient designates to be primary contact if notification is necessary
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Basic Patient information—Patient Emergency contact person
<b>Reference ID</b>	AA010
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Free text
<b>Data Type</b>	Alphab
<b>Format</b>	80A
<b>Maximum Field Size</b>	80
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Philippines National Health Data Dictionary Version 2, 2010
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	Codes used are: Emergency contact information

## Relationship to Patient

<b>Definition</b>	The relationship of the designated contact person to the Healthcare user
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Basic Patient information—Relationship to Patient
<b>Reference ID</b>	AA011
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphap
<b>Format</b>	AAA
<b>Maximum Field Size</b>	Variable
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	This is used to facilitate contact with the patient family in case of emergency situations .
<b>Code Description and Permissible Values</b>	Codes used are: FAMMEMB = Family Member FRND = Unrelated friend FTH=Father MTH=Mother NOK=Next of kin SIB=Sibling SPS=Spouse

## Patient Emergency contact Telephone Number

<b>Definition</b>	Telephone number of person whom the patient designates it to be the primary contact if notification is necessary.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Basic Patient information—Patient Emergency contact Telephone Number
<b>Reference ID</b>	AA012
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Number
<b>Data Type</b>	Numeric
<b>Format</b>	[NNN] NN NNN NNNN
<b>Maximum Field Size</b>	14
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Philippines National Health Data Dictionary Version 2, 2010
<b>Usage</b>	Permits follow-up with patient and facilitates notification for the status of a patient in case of emergency.
<b>Code Description and Permissible Values</b>	Not Applicable

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## Demographic Information

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Gender	
Definition	This field contains a code which defines the sex of the patient
Metadata Type	Data Element
Data Concept	Patient Demographic Information—Gender
Reference ID	AB001
Synonyms	sex
Representation Class	code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	United Kingdom National health Services, Hospital Episode Statistics September 2010
Usage	<p>This gender codes are used according to the following Codes A &amp; B are used when describing a change in the sex of patient after being identified wrongly as an opposite sex. Code C is only used in situations when data is not collected and it is not known by the facility nor could be retrieved at the time of data entry. Such code is a temporary code and should not be used for final reporting.</p> <p>Codes M &amp; F are codes to describe patient gender, it is considered an essential data for medical record, and it should be always specified in clarity by using either codes.</p> <p>Code K is only used in rare conditions when handling dead bodies that are in physical condition that does not allow sex recognition.</p>

	<p>Code N will only be used when handling a newborn or a fetus that is not yet decided for whatever reasons not to be used for reporting purposes when data is not completed.</p> <p>Code U is used for cases where no data is available on the patient sex and can never be retrieved.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>A = Sex changed to Male</p> <p>B = Sex changed to female</p> <p>C = Not Completed</p> <p>F = Female</p> <p>M = Male</p> <p>N = Undifferentiated</p> <p>K = Unknown</p> <p>U = Undetermined</p>

<b>Age</b>	
<b>Definition</b>	The age of the person in (completed) years at a specified point in time
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Patient Demographic Information—age
<b>Reference ID</b>	AB002
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Age is a core data element in a wide range of social, labor and demographic statistics. It is used in the analyses of service utilization by age group and can be used as an assistance eligibility criterion
<b>Code Description and Permissible Values</b>	Codes used are: 99= Unknown/not stated

Age Group	
Definition	The category of the age that the person belongs to
Metadata Type	Data Element
Data Concept	Patient Demographic Information- Age Group
Reference ID	AB003
Synonyms	Not Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Canadian Government variable Legal Definitions  Approved May 22, 2007 as part of the Canadian guidelines for documents standards.
Usage	This element is used to define the age group of the patient for planning and statistics reason. The code values are modified to accommodate the specific age needs for special pediatric groups coded 1,2 and 3
Code Description and Permissible Values	Codes used are: 1=Fetus unborn pregnancy 2=Neonate 1-28 days 3=Infant 1-24 months 4=Child 2-14 years 5>Youth 15-24 years 6>Young Adult 25-45 years 7>Middle age Adult 46-65 years 8>Old age Adults 66-80 years 9>Senior>80 years

<b>Date of Birth</b>	
<b>Definition</b>	Date of birth as per identification document
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Patient Demographic Information—date of birth
<b>Reference ID</b>	AB004
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Malaysian Health Data Dictionary Second edition 2013
<b>Usage</b>	Extremely valuable for probabilistic linkage and calculation of accurate age information.
<b>Code Description and Permissible Values</b>	Codes used are: DDMMYYYY Century digits are considered essential

<b>City of Birth</b>	
<b>Definition</b>	Place of birth refers to the name of the city in which the person was born. It refers to a country if the person was born outside Saudi Arabia. The geographic location is specified according to boundaries current at the time the data are collected, not the boundaries at the time of birth.
<b>Metadata Type</b>	Data Element
<b>Data Concept:</b>	Birth event—city of birth
<b>Reference ID</b>	AB005
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Text
	Alphab
<b>Data Type</b>	
<b>Format</b>	40A
<b>Maximum Field Size</b>	40
<b>Date Created</b>	19/05/2016
<b>Date Update</b>	To be defined
<b>Source</b>	Canadian Government variable Legal Definitions Approved September 20, 2010 as part of the Canadian guidelines for documents standards
<b>Usage</b>	This data element is used as follows: 1- For Saudi Nationals enter name of city of birth mentioned in patient national Identification document as per the Saudi City code element values. 2- For Non Saudi residents in KSA enter name of city as stated by patient
<b>Code Description and Permissible Values</b>	Codes used are: Name of city entered as text

## Country of Birth

<b>Definition</b>	Place of birth refers to the name of the country in which the person was born. It refers to a country if the person was born outside Saudi Arabia. The geographic location is specified according to boundaries current at the time the data are collected, not the boundaries at the time of birth
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Birth event—Country of birth
<b>Reference ID</b>	AB006
<b>Synonyms</b>	
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element is to report patient nationality as per the ISO 3166 -3 standard, 2nd edition, 3-character alphabetic codes
<b>Code Description and Permissible Values</b>	

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## Social Information

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<b>Marital Status</b>	
<b>Definition</b>	This field contains a code that defines a patient's marital status
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Social information- civil status
<b>Reference ID</b>	AC001
<b>Synonyms</b>	Social status
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphab
<b>Format</b>	A
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	United Kingdom National health Services, Hospital Episode Statistics September 2010
<b>Usage</b>	Marital status is a core data element in a wide range of social, labor and demographic statistics. Its main purpose is to establish the living arrangements of individuals, to facilitate analysis of the association of marital status with the need for use of services and for epidemiological analysis
<b>Code Description and Permissible Values</b>	Codes used are: A = Separated D = Divorced M = Married S = Single U = Unknown W = Widowed

<b>Education Status / Level</b>	
<b>Definition</b>	The highest level of education completed in terms of the highest degree or the highest level of Schooling completed
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Social information- Education status
<b>Reference ID</b>	AC002
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Philippines National Health Data Dictionary Version 2, 2010
<b>Usage</b>	This is the code to be used to describe education level.
<b>Code Description and Permissible Values</b>	Codes used are illiterate =1 2 = Primary Education 3 = Intermediate Education 4 = Secondary Education 5 = University 6 = Higher Education 9 = Unknown

<b>Occupation</b>	
<b>Definition</b>	Self-reported employment status of a person, immediately prior to receive Healthcare services
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Social information - Occupation
<b>Reference ID</b>	AC003
<b>Synonyms</b>	Profession
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Public health: there is considerable user demand for data on occupation-related injury and illness
<b>Code Description and Permissible Values</b>	Codes used are: 01 = Administration 02 = Agriculture 03 = Business 04 = Education 05 = Housewife 06 = Marine 07 = Medical field 09 = Military 10 = Skilled worker 11 = Student 12 = Oil industries 13 = Unemployed 88 = Others 99 = Unknown

Interpreter Services Required	
Definition	Whether an interpreter service is required by or for the person, as represented by a code
Metadata Type	Data Element
Data Concept	Social Information - Interpreter services required
Reference ID	AC004
Synonyms	Not Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	This element Includes verbal language, nonverbal language and languages other than Arabic. Collection methods:  Recommended question: Do you [does the person] require an interpreter? Yes or No Persons requiring interpreter services for any form of sign language should be Code as Interpreter required.
Code Description and Permissible Values	Codes used are:  1= Yes interpreter required. 2= No interpreter not required.

Preferred language	
Definition	The language (including sign language) most preferred by the person for communication, as represented by a code
Metadata Type	Data Element
Data Concept	Social Information -Preferred language
Reference ID	AC005
Synonyms	Not Applicable
Representation Class	Code
Data Type	Alphab
Format	AA
Maximum Field Size	2
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008 / Saudi Health Council modified
Usage	This may be a language other than Arabic even where the person can speak fluent Arabic
Code Description and Permissible Values	<p>Codes used are</p> <p>Use the ISO 639-1 Standard for languages and language groups, 2nd edition, 2 character alphabetic codes</p> <p><a href="http://www.loc.gov/standards/iso6392/php/English_list.php">http://www.loc.gov/standards/iso6392/php/English_list.php</a></p>

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## Physical Characteristics

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<b>Height</b>	
Definition	The standing height or recumbent length of a body
Metadata Type	Data Element
Data Concept	Physical Characteristics—height
Reference ID	AD001
Synonyms	Not Applicable
Representation Class	Total
Data Type	Numeric
Format	NNN.N
Maximum Field Size	5
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	This element is used to describe the patient height as it is measured in centimeters
Code Description and Permissible Values	Codes used are: 999,9=Not measured

Weight	
Definition	Recent body weight of the patient at the beginning of each health encounter, not applicable on patients older than 365 days
Metadata Type	Data Element
Data Concept	Physical Characteristics—weight
Reference ID	AD002
Synonyms	Not Applicable
Representation Class	Total
Data Type	Numeric
Format	NNN.N
Maximum Field Size	5
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Health Council
Usage	This element is used to describe the patient weight, it is measured in kilograms except for infants 365 days of age, neonates & preterm. Any weight measurement should be as per definitions related to the specific age group defined in the dictionary
Code Description and Permissible Value	Codes used are 999,9=Not collected

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## Health and Lifestyle Information

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<b>Physical activity sufficiency status</b>	
<b>Definition</b>	Sufficiency of moderate or vigorous physical activity to confer a health benefit, as represented by a code
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Discharge—Physical activity sufficiency status
<b>Reference ID</b>	AE001
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>The clinician makes a judgment based on assessment of the person's reported physical activity history for a usual 7-day period where:</p> <p>CODE 1: Sufficient physical activity for health benefit for a usual 7-day period is calculated by summing the total minutes of walking, moderate and/or vigorous physical activity. Vigorous physical activity is weighted by a factor of two to account for its greater intensity. Total minutes for health benefit need to be equal to or more than 150 minutes per week.</p> <p>CODE 2: Insufficient physical activity for health benefit is where the sum of the total minutes of walking, moderate and/or vigorous physical activity for a usual 7-day period is less than 150 minutes but more than 0 minutes. CODE 3</p> <p>CODE 9: There is insufficient information to more accurately define the person's physical activity sufficiency status or the information is not known.</p> <p>Note: The National Heart Foundation of Australia and the National Physical Activity Guidelines for Australians describes moderate-intensity physical activity as causing a</p>

	<p>slight but noticeable, increase in breathing and heart rate and suggests that the person should be able to comfortably talk but not sing.</p> <p>Examples of moderate physical activity include brisk walking, low pace swimming, light to moderate intensity exercise classes. Vigorous physical activity is described as activity, which causes the person to 'huff and puff', and where talking in a full sentence between breaths is difficult. Examples of vigorous physical activity include jogging, swimming (freestyle) and singles tennis.</p> <p>Sedentary is where there has been no moderate and/or vigorous physical activity during a usual 7-day period.</p> <p><b>CODE 9:</b> There is insufficient information to more accurately define the person's physical activity sufficiency status or the information is not known.</p> <p>Note: The National Heart Foundation of Australia and the National Physical Activity Guidelines for Australians describes moderate-intensity physical activity as causing a slight but noticeable, increase in breathing and heart rate and suggests that the person should be able to comfortably talk but not sing.</p> <p>Examples of moderate physical activity include brisk walking, low pace swimming, light to moderate intensity exercise classes. Vigorous physical activity is described as activity, which causes the person to 'huff and puff', and where talking in a full sentence between breaths is difficult. Examples of vigorous physical activity include jogging, swimming (freestyle) and singles tennis.</p>
<b>Code Description and Permissible Values:</b>	<p>Codes used are:</p> <p>1 = Sufficient</p> <p>2 = Insufficient</p> <p>3 = Sedentary</p> <p>9 = Unknown</p>

Type of Diet	
Definition	The customary amount and kind of food and drink taken by a person from day to day; more narrowly, a diet planned to meet specified requirements of the individual, including or excluding certain foods.
Metadata Type	Data Element
Data Concept	Health and Lifestyle Information, Type of diet
Reference ID	AE002
Synonyms	Not Applicable
Representation Class	Code
Data Type	Numeric
Forma	
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Philippines National Health Data Dictionary Version 2, 2010
Usage	Code 1 Restaurant diets is used when the main source of food for the person is from standard, routine restaurant food that provides normal adequate diet, but they differ in type of cuisine and preparation. They are usually served at relatively large numbers of restaurants Code 2 Home diet is used when general, regular or full diet cooked at home is the source of 2000 –2500 kcal / day, 60-80 gram protein, and 80-100 gram of carbohydrates for adults. Code 3 Soft diet is used when person is using more solid than liquid diet. It contains food without strong seasoning with limited amount of fiber. If meat is ground and vegetables and fruits are pureed the diet is called pureed or strained soft diet. Partial vegetarian diet: Diet in which patient chooses to eat Fish and poultry but not beef or lamb .Vegan diet: Diet that contains foods of pure plants origin

<b>Code Description and Permissible Values</b>	Codes used are  1=Restaurant diet  2 = Home diet  3 = Soft diet  4 = Partial Vegetarian diet  5 = Vegan diet  8 = Others  9 = Unknown
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<b>Tobacco Smoking Status</b>	
<b>Definition</b>	A person's current and past smoking behavior
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health and Lifestyle Information- Tobacco Smoking Status
<b>Reference ID</b>	AE003
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	The below grouping subdivides a population into three mutually exclusive categories. Smoker: A person who smokes daily Non-smoker: A person who does not smoke at all. Ex-smoker: A person who does not smoke now and has smoked fewer than 100 cigarettes or similar amount of other tobacco products in his/her lifetime
<b>Code Description and Permissible Values</b>	Codes used are: 1=Cigarette Smoker 2=Shisha(Hubbly Bubbly) 3 = Non-smoker 4 = Ex-smoker 9 = Unknown

<b>Tobacco Smoking Consumption</b>	
<b>Definition</b>	The total number of cigarettes (manufactured or roll-your-own) smoked per day by a person
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health and Lifestyle Information- Tobacco Smoking Consumption
<b>Reference ID</b>	AE004
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	The below grouping subdivides a population into three mutually exclusive categories. Smoker = A person who smokes daily Non-smoker = A person who does not smoke at all. Ex-smoker = A person who does not smoke now and has smoked fewer than 100 cigarettes or similar amount of other tobacco products in his/her lifetime
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Smoking from 1-10 cigarettes / day</p> <p>2 = Smoking from 11 - 20 cigarettes / day</p> <p>3 = Smoking from 21 - 60 cigarettes / day</p> <p>4 = Smoking &gt; 60 per day</p> <p>5 = Smoking Shisha 15 minutes / day</p> <p>6 = Smoking Shisha 30 minutes / day</p> <p>7 = Smoking Shisha 60 minutes / day</p> <p>9 = Smoking unknown amount</p>

## History of Allergy

<b>Definition</b>	The documentation of a history of allergies or sensitivities to the administration of a medication or substance that was a known allergen to the patient.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health and Lifestyle Information - History of Allergy
<b>Reference ID</b>	AE005
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	USA Health & Human Services, Agency for Healthcare Research & Quality 2015
<b>Usage</b>	Allergies may be a life threatening condition and it is considered a mandatory to record allergy causes if known
<b>Code Description and Permissible Values</b>	Codes used are: 1 = No allergy 2 = Allergic 3 = Not Stated 9 = Unknown

<b>Allergy Reason</b>	
<b>Definition</b>	It is the specified reason of known allergy to food or substance
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health and Lifestyle Information- allergy reason
<b>Reference ID</b>	AE006
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Alphanumeric
<b>Format</b>	ANN.NN
<b>Maximum Field Size</b>	6
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	Enter the ICD10 AM code per the clinical final diagnosis or as indicated by patient history
<b>Code Description and Permissible Values</b>	ICD10 AM code value

## Substance Abuse History

<b>Definition</b>	Suspected alcohol or drug use by patient whether therapeutic or abuse
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health and Lifestyle Information Substance abuse history, code N
<b>Reference ID</b>	AE007
<b>Synonyms</b>	Addiction History
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Should be coded as yes whenever the EMS responder suspect's alcohol or drug use by the patient may have contributed to the injury. Not applicable should be used when there is no patient, such as in a standby response. If alcohol or drugs are totally unrelated to the incident, this field should be coded as no
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Yes 2 = No 9 = Unknown

<b>Date of commencement of treatment Episode for substance abuse</b>	
<b>Definition</b>	The date on which the first service contact within the treatment episode when assessment and/or treatment occurs.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Substance abuse /date of commencement of treatment episode for substance abuse
<b>Reference ID</b>	AE008
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	A patient is identified as commencing a treatment episode if one or more of the following apply: They are a new patient • They are a patient recommencing treatment after they have had no contact with the treatment provider for a period of three months or had any plan in place for further contact • Their principal drug of concern for alcohol and other drugs has changed • Their main treatment type for alcohol and other drugs has changed, • Their treatment delivery setting for alcohol and other drugs has changed.
<b>Code Description and Permissible Values</b>	Codes used are DDMMYYYY Century digits are considered essential

## Source of Referral for Abuse of Drugs Treatment Service

<b>Definition</b>	The source from which the person was transferred or referred to the alcohol and other drug treatment service, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Source of referral for abuse of drugs treatment service
<b>Reference ID</b>	AE009
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	CODE 3 = Primary Health care Center Includes medical specialists, registered general practitioners and other primary-care medical practitioners in private practice. CODE 04 = Hospital Includes public and private hospitals, hospitals specializing in dental, ophthalmic aids and other specialized medical or surgical care, satellite units managed and staffed by a hospital, emergency departments of hospitals, and mother craft hospitals.
<b>Code Description and Permissible Values</b>	Codes used are: 01 = Self 02 = Family member/friend 03 = Primary Healthcare Center 04 = Hospital 05 = Mental Health Care service

	<p>06 = Substance abuse treatment service</p> <p>07 = Other community/Healthcare service</p> <p>08 = Correctional service</p> <p>09 = Police diversion</p> <p>10 = Court diversion</p> <p>88 = Other</p> <p>99 = Not stated/inadequately described</p>
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## Treatment delivery Setting for Drug Abuse

<b>Definition</b>	The main physical setting in which the type of treatment that is the principal focus of a client's alcohol and other drug treatment episode is actually delivered irrespective of whether or not this is the same as the usual location of the service provider, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Episode of treatment for substance abuse —service delivery setting
<b>Reference ID</b>	AE010
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>This data element is used to prescribe the treatment setup used for substance abuse. Only one code to be selected at the end of the alcohol and other drug treatment episode. Agencies should report the setting in which most of the main type of treatment was received by the client during the treatment episode.</p> <p>Code 1 is used to describe any non-residential centre that provides alcohol and other drug treatment services, including hospital outpatient services and community health centres.</p>

	<p>Code 2 is used to refer to community-based settings in which patient reside either temporarily or long-term in a facility that is not their home or usual place of residence to receive alcohol and other drug treatment. This does not include ambulatory situations, but does include therapeutic community settings.</p> <p>Code 3 is used to refer to the patient's own home or usual place of residence</p>
<b>Code Description and Permissible Values</b>	<p>Total operational beds Value. Codes used are:</p> <p>1 = Non-residential treatment facility.</p> <p>2 = Residential treatment facility.</p> <p>3 = Home</p> <p>8 = Other</p>

## Past Medical Illness/Medical History

<b>Definition</b>	The patient's past experiences with any medical encounter including medical or surgical conditions. Whether temporary or permanent. A Past Medical History is considered one of three elements: - Past medical history: "the patient's past experiences with illnesses, operations, injuries and treatments"; - Family history: "a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk – Social history: "an age-appropriate review of past and current activities"
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health and Lifestyle Information-Past Medical Illness/Medical History
<b>Reference ID</b>	AE011
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Adapted from Centers for Medicare and Medicaid Services United States of America
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	Codes used are: 0 = No past history 1 = Positive for surgical history 2 = Positive for medical history 3 = Positive for both surgical and medical 9 = Unknown

<b>Vascular Procedures</b>	
<b>Definition</b>	The vascular procedures the person has undergone, as represented by a code
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Person—vascular procedure
<b>Reference ID</b>	AE012
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Ideally, vascular procedure information is derived from and substantiated by clinical documentation.
<b>Code Description and Permissible Values</b>	<p>Codes used are :</p> <p>1=Amputation for arterial vascular insufficiency      2 = Carotid end arterectomy      3 = Carotid angioplasty/stenting      4 = Coronary angioplasty/stenting      5 = Coronary artery bypass grafting      6 = Renal artery angioplasty/stenting      7 = Heart transplant      8 = Heart valve surgery      9 = Abdominal aortic aneurism repair/bypass graft/stenting      10 = Cerebral circulation angioplasty/stenting      11 = Femoral/popliteal bypass/graft/stenting      12 = Congenital heart and blood vessel defect surgery      13 = Permanent pacemaker implantation      14 = Implantable cardiac defibrillator      88 = Other      99 = Unknown/not recorded</p>

<b>Maintenance Medication</b>	
<b>Definition</b>	Medication taken to stabilize an illness or symptoms of illness
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health and Lifestyle Information-Maintenance Medication
<b>Reference ID</b>	AE013
<b>Synonyms</b>	Chronic Medications
<b>Representation Class</b>	Name
<b>Data Type</b>	Alphab
<b>Format</b>	
<b>Maximum Field Size</b>	
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Lexicon
<b>Usage</b>	This is an element used to describe the incident of use of pharmaceutical product that are maintaining the current health condition of the patient (chronic conditions such as antihypertensive medications), it does not record any past use of any products.
<b>Code Description and Permissible Values</b>	Mention name of pharmaceutical code used in accordance to definition

<b>Location of impairment</b>	
<b>Definition</b>	The location of a person's impairment in a specified body structure, as represented by a code
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health and Life style - Location of impairment
<b>Reference ID</b>	AE014
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This element contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person. Impairments of body structure are problems in body structure such as a loss or significant departure from population standards or averages. Use only one code. Select the one that best describes the situation with this structure. Combinations are not possible. This data element is to be used in conjunction with specified body structures, for example, 'impairment of proximal structures related to movement'. This data element may also be used in conjunction with Person-extent of impairment of body structure, code (ICF 2001) N and Person—nature of impairment of body structure, code (ICF 2001).

	<p><b>Code 0</b> is used when the impairment is present in more than one body location (but not bilaterally see code 3); for example, when burn scars affect many areas of skin.</p> <p><b>Code 1</b> is used when the impairment is present to the right of the midline of the person's body.</p> <p><b>Code 2</b> is used when the impairment is present to the left of the midline of the person's body.</p> <p><b>Code 3</b> is used when the impairment is two-sided and disposed on opposite sides of the midline axis of the body, for example bilateral joint deformities.</p> <p><b>Code 4</b> is used when the impairment is present in front of a line passing through the midline of the body when viewed from the side.</p> <p><b>Code 5</b> is used when the impairment is present behind a line passing through the midline of the body when viewed from the side.</p> <p><b>Code 6</b> is used when the impairment is situated towards the point of origin or attachment, as of a limb or bone (opposed to distal), for example the end of the structure that is closer to the center of the body.</p> <p><b>Code 7</b> is used when the impairment is situated away from the point of origin or attachment, as of a limb or bone (opposed to proximal), for example the end of structure that is further away from the center of the body.</p> <p><b>Code 8</b> is used when there is an impairment of body structure but the location of the impairment is not recorded.</p> <p><b>Code 9</b> is used when it is not appropriate to code the location of an impairment of body structure.</p>
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<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>0 = More than one region (except both sides)</p> <p>1 = Right</p> <p>2 = Left</p> <p>3 = Both sides (bilateral).</p> <p>4 = Front</p> <p>5 = Back</p> <p>6 = Proximal</p> <p>7 = Distal</p> <p>8 = Non specified</p> <p>9 = Not applicable</p>
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## Insurance Information

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<b>Insurance Company Name</b>	
<b>Definition</b>	The commercial name of the insurance company
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Insurance Information-Insurance Company Name
<b>Reference ID</b>	AF001
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Name
<b>Data Type</b>	Alphab
<b>Format</b>	80A
<b>Maximum Field Size</b>	80
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This item describes the insurance company name providing coverage for the patient current health event, in terms of reimbursement, health services research and administration, quality of customer care monitoring and evaluation, and financial analysis
<b>Code Description and Permissible Values</b>	Not Applicable

<b>Insurance Policy Number</b>	
<b>Definition</b>	The insurance policy number
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Insurance Information-The insurance policy number
<b>Reference ID</b>	AF002
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Number
<b>Data Type</b>	Numeric
<b>Format</b>	15N
<b>Maximum Field Size</b>	15
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be define
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This item describes the insurance policy number providing coverage for the patient current health event, in terms of reimbursement, health services research and administration, quality of customer care monitoring and evaluation, and financial analysis
<b>Code Description and Permissible Values</b>	Not Applicable

## Insurance Date of Expiration

<b>Definition</b>	The date by which the insurance policy ends
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Insurance Information-The date by which the insurance policy ends
<b>Reference ID</b>	AF003
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This item describes the insurance policy end date on which the insurance company providing coverage for the patient current health event is no longer valid.  The date ends on 23:59 of the date state
<b>Code Description and Permissible Values</b>	Codes used are:  DDMMYYYY Century digits are considered essential

# Chapter 02

## Healthcare Facility Information

Healthcare / Hospital/ Clinic name

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## Healthcare Facility Information

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<b>Facility address</b>	
<b>Definition</b>	Name of the Healthcare facility providing care to an individual, including hospitals, clinics in public and private sector.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility Information, Name of facility
<b>Reference ID</b>	BA001
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Name
<b>Data Type</b>	Alphab
<b>Format</b>	120A
<b>Maximum Field Size</b>	120
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Malaysian Health Data Dictionary Second edition 2013
<b>Usage</b>	This element is used to declare the official health facility name by text
<b>Code Description and Permissible Values</b>	State the legal name of the facility

<b>Healthcare / Hospital /Clinic Name</b>	
<b>Definition</b>	The physical address of a health facility.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility Information, Facility Address
<b>Reference ID</b>	BA002
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Address
<b>Data Type</b>	Alphanumeric
<b>Format</b>	120A/N
<b>Maximum Field Size</b>	120
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	New Zealand National Minimum Dataset (Hospital Events), Data Dictionary 2015
<b>Usage</b>	Use Saudi Postal Address
<b>Code Description and Permissible Values</b>	

## Healthcare Facility Sector identifier

<b>Definition</b>	Type of Health Care provider dealing with specified group of patients according to a certain set of regulations.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility Information, Facility Sector identifier
<b>Reference ID</b>	BA003
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphab
<b>Format</b>	A
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	14/05/2019
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	This element describes the health sector to which the facility providing care belongs; this will assist in understanding each sector care characteristics and statistical data separately. Such categorization helps future planning and performance comparison. Y code can be used for non-governmental can be applied for health delegates that accompany pilgrimage or other providers that may be considered in the future

<b>Code Description and Permissible Values</b>	<p><b>Codes used are:</b></p> <p><u>Government Sectors</u></p> <p>D = MOD Ministry of Defense Healthcare Facility</p> <p>E = MOE Ministry of Education Healthcare Facility</p> <p>H = MOH Ministry of Health Care Facility</p> <p>I = MOI Ministry of Interior Healthcare Facility</p> <p>N = NGHA Ministry of National Guard Health Care Facility</p> <p>L= Ministry of Labor and Social Development</p> <p>P = Public Organizations Healthcare Facility</p> <p>R= Royal commission for Jubail &amp; Yanbu</p> <p>S= Saudi Red Crescent</p> <p>X = Other Sectors Healthcare Facility</p> <p><u>Non-Government Sector</u></p> <p>C = Charity Healthcare Facility</p> <p>V = Private Healthcare Facility</p> <p>Y = Other Non-Government Health Care Facility</p>
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## Healthcare Facility Level of Care Identifier (primary / secondary / tertiary / quaternary)

<b>Definition</b>	A code that categorizes facilities into particular types
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility Information, Facility Level of Care Identifier
<b>Reference ID</b>	BA004
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	New Zealand National Minimum Dataset (Hospital Events) Data Dictionary 2015

<b>Usage</b>	<p>Healthcare facilities are not equal in terms of care provided. Any health system usually requires different levels of care to be able to serve the public health needs. In this element the facilities are identified in accordance with standards agreed upon at the Saudi Health Council per the meeting session number 52 dated 7/3/1431 H and Minister of Health Regulation No. 683151 Dated 1/1/2015 regulating private health facility licensing. This element is only used to describe the category of care provided at the facility, codes used are as follows:</p> <p><b>CODE A1</b> = Used to describe all facilities that provide medical care without any admission services. It includes Primary Healthcare centers, clinics, polyclinics, prehospital EMS units, and mobile clinics regardless if they are private or governmental services.</p> <p><b>CODE A2</b> = Allied Medical Service = Code used to describe all facilities that provide non hospital based allied medical services like radiology centers, medical laboratories, optician, pharmacies, regardless if they are private or governmental services</p> <p><b>CODE H1</b> = General Hospital = Code used to describe a general hospital facility that can handle most people and does not limit itself to a specified type of medical specialty or a higher level of medical care regardless if they are private or governmental services.</p> <p><b>CODE H2</b> = Specialist Hospital = Code used to describe all hospital facilities that has more than 300 operational hospital beds and recruits fully 30 medical consultants out of which 8 are subspecialties. This is applicable to all hospitals except Eye hospitals regardless if they are private or governmental services.</p> <p><b>CODE H3</b> = Medical City = Code used to describe the health facilities that are characterized by having more than one medical care without any admission services. It includes Primary Healthcare centers, clinics, polyclinics, pre hospital EMS units, and mobile clinics regardless if they are private or governmental services.</p> <p><b>CODE A2</b> = Allied Medical Service = Code used to describe all facilities that provide non hospital based</p>
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	<p>allied medical services like radiology centers, medical laboratories, optician, pharmacies, regardless if they are private or governmental services</p> <p>CODE H1 = General Hospital = Code used to describe a general hospital facility that can handle most people and does not limit itself to a specified type of medical specialty or a higher level of medical care regardless if they are private or governmental services.</p> <p>CODE H2 = Specialist Hospital = Code used to describe all hospital facilities that has more than 300 operational hospital beds and recruits fully 30 medical consultants out of which 8 are subspecialties. This is applicable to all hospitals except Eye hospitals regardless if they are private or governmental services.</p> <p>CODE H3 = Medical City = Code used to describe the health facilities that are characterized by having more than one hospital under direct operation and physically in one Location regardless of the type of service provided whether general care or specialized care. It is also applicable regardless if the facility is private or governmental services.</p> <p>CODE H4 = Field Hospital = Code used to describe a mobile health facility that provides full hospitalization services that are used in disaster management or abnormal situations regardless if the facility is private or governmental services.</p>
<p><b>Code Description and Permissible Values</b></p>	<p><b>Codes used are:</b></p> <p><b>Ambulatory &amp; Allied Medical Health Care Facilities</b></p> <p>A1 = Ambulatory Primary Health Care Facility</p> <p>A2 = Allied Medical services</p> <p><b>Hospital Care Facilities</b></p> <p>H1 = General Hospital</p> <p>H2 = Specialist Hospital</p> <p>H3 = Medical City</p> <p>H4 = Field Hospital</p>

## Healthcare Facility type of care

<b>Definition</b>	A code that categorizes facilities into particular medical service or function
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility Information, Facility Type of Care Identifier
<b>Reference ID</b>	BA005
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
	NNA
<b>Format</b>	
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/5/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	<p>Use codes in accordance with the following:</p> <p>Big city Location is any city where the population is = or &gt; 500,000</p> <p>Small City Location is any city where population is &lt; 500,000</p> <p>Specialized Hospital is any hospital that is operating 300 beds or higher with full time 30 consultants at least 8 of them in subspecialties.</p> <p>General Hospital is any hospital that is operating less than 300 beds and does not have full time 30 consultants.</p> <p>Important Note: Eye hospitals are exempted from this definition.</p> <p>Note: These definition of city size and specialized</p>

	<p>hospitals definitions are based on the agreement signed between Saudi health council resolution Number 55/3 Dated 11/7/1432H approved by Minister of health. Codes for specialized hospitals are only used to describe the specialty of the facility if they are independent facilities and not part of another organization such as medical cities.</p>
<b>Code Description and Permissible Values</b>	<p>General Hospital Codes are:</p> <p>GH1 = General Hospital in Big City</p> <p>GH2 = General Hospital in Small city</p> <p>Specialized Hospital Codes are:</p> <p>SH1 = Cancer Hospital</p> <p>SH2 = Day Surgery (If independent)</p> <p>SH3 = Long stay Healthcare facility</p> <p>SH4 = Maternity &amp; Children</p> <p>SH5 = Ophthalmology Hospital</p> <p>SH6 = Psychiatric Hospital</p> <p>SH7 = Rehabilitation Hospital</p>

Unique Healthcare facility Identifier	
Definition	A unique Healthcare Facility Identification code that identifies each facility.
Metadata Type	Data Element
Data Concept	Unique identification code for a Health Care Facility.
Reference ID	BA006
Synonyms	Not Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	14
Date Created	19/05/2016
Date Updated	08/09/2019
Source	Saudi Health Council
Usage	A unique facility code that identifies a healthcare facility in Saudi Arabia.
Code Description and Permissible Values	Code is automatically generated by NHIC's Organization Registry starting with the digit (1).

<b>Facility Medical Units and Departments identifier</b>	
<b>Definition</b>	Medical units and health facility department identification by code
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Medical units and health facility department identification by code
<b>Reference ID</b>	BA007
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AAN.NN
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	01/04/2019
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element is essential for coding the medical unit providing care in the facility.
<b>Code Description and Permissible Values</b>	Codes used are Available in Appendix 2 "Code values for "Health care facilities Medical departments and units Identifier"

<b>Facility NON MEDICAL Units and departments identifier</b>	
<b>Definition</b>	Non-Medical units and health facility department identification by code
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Medical units and health facility department identification by code
<b>Reference ID</b>	BA008
<b>Synonyms</b>	
<b>Representation Class</b>	
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AAN.NN
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	2019/04/01
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element is essential for coding the non-medical unit providing care in the facility.
<b>Code Description and Permissible Values</b>	Codes used are Available in Appendix 3 "Code values for "Health care facilities Non-Medical departments and units Identifier

## Number of available hospital Beds for admitted patients

<b>Definition</b>	The average number of beds which are immediately available for use by an admitted patient or resident within the establishment. A bed is immediately available for use if it is located in a suitable place for care with nursing and auxiliary staff available within a reasonable period.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility information - Number of available hospital Beds for admitted patients
<b>Reference ID</b>	BA009
<b>Synonyms</b>	Number of Empty Beds
<b>Representation Class</b>	Average
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	The average bed is to be calculated from monthly figures rounded to the nearest whole number.
<b>Code Description and Permissible Values</b>	Not Applicable

## Available Emergency Beds

<b>Definition</b>	The average number of beds which are immediately available for use by an emergency patient. A bed is immediately available for use if it is located in a suitable place for care with nursing and auxiliary staff available within a reasonable period
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility information - Number of available hospital Beds for Emergency patients
<b>Reference ID</b>	BA010
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Average
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/5/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	The average bed is to be calculated from monthly figures rounded to the nearest whole number
<b>Code Description and Permissible Values</b>	Not Applicable
<b>Usage</b>	The average bed is to be calculated from monthly figures rounded to the nearest whole number
<b>Code Description and Permissible Values</b>	Not Applicable

## Available Intensive Care Unit - Special Areas average beds

<b>Definition</b>	The average number of beds which are immediately available for use by a critical patient in need of intensive care services including ventilation support. A bed is immediately available for use if it is located in a suitable place for care with nursing and auxiliary staff available within a reasonable period.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility information - Number of available hospital Beds for Intensive care patients
<b>Reference ID</b>	BA011
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	average
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council / Adapted from Australian Health Data Dictionary Version 14, 2008
<b>Usage</b>	The average bed is to be calculated from monthly figures rounded to the nearest whole number.
<b>Code Description and Permissible Values</b>	Not Applicable

## Available Operating Rooms

Available Operating Rooms	
<b>Definition</b>	An operating room that is equipped and staffed and could be made available for patient care in a short period.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Available Operating Rooms. Total rooms
<b>Reference ID</b>	BA012
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	USA Health & Human Services, Agency for Healthcare Research & Quality 2005
<b>Usage</b>	The total number of operating rooms available for use to operate on patients that help manage OR time and waiting list when needed
<b>Code Description and Permissible Values</b>	Not Applicable

<b>Total Hospital Beds</b>	
<b>Definition</b>	Total hospital beds are all hospital beds which are regularly maintained and staffed and immediately available for the care of admitted patients.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility Information Total Hospital Beds
<b>Reference ID</b>	BA013
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	The Organization for Economic Cooperation and Development (OECD) Statistics and Indicators for 30 Countries, OECD, Paris, 2007, Data sources, definitions and methods.
<b>Usage</b>	This element is used with consideration to the following inclusions and exclusions: - Beds in all hospitals, including general hospitals, mental health and substance abuse hospitals, and other specialty hospitals - Occupied and unoccupied beds Exclusions: - Surgical tables, recovery trolleys, emergency stretchers, beds for same day care, cots for healthy infants - Beds in wards which were closed for any reason - Provisional and temporary beds - Beds in nursing and residential care facilities.
<b>Code Description and Permissible Values</b>	Total beds Value

<b>Total Staffed and Operational beds</b>	
<b>Definition</b>	Beds that are licensed and physically available for which staff is on hand to attend to the patient who occupies the bed. Staffed beds include those that are occupied and those that are vacant.
<b>Data Concept</b>	Total staffed and operational bed capacity of a hospital
<b>Reference ID</b>	BA014
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	USA Health & Human Services, Agency for Healthcare Research & Quality 2005
<b>Usage</b>	This is to describe the actual staffed beds and operational for planning purposes and bed management
<b>Code Description and Permissible Values</b>	Total operational beds Value

## 24 hours beds available

<b>Definition</b>	It is the informed estimate of fully operational vacant inpatient beds of all categories that can be made ready with 24 hours during management of disaster situations, to help health system managers dispose patients correctly. This would include created institutional surge beds as well as beds made available by discharging/transferring patients
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility information, 24 Hours beds available
<b>Reference ID</b>	BA015
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	USA Health & Human Services, Agency for Healthcare Research & Quality 2005
<b>Usage</b>	This element is used during disaster management to report the estimated number of beds that can be made available in the next 24 hours in disaster situations, this helps in managing the disaster and provide a good tool for bed management during such situations. The estimate is medically decided by treating physicians and is based on the patient's condition that supports discharge within 24 hours
<b>Code Description and Permissible Values</b>	Not Applicable

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## 72 hours beds available

Definition	<p>It is the informed estimate of fully operational vacant inpatient beds of all categories that can be made ready with 72 hours during management of disaster situations, to help health system managers dispose patients correctly. This would include created institutional surge beds as well as beds made available by discharging/transferring patients.</p>
Metadata Type	Data Element
Data Concept	Healthcare Facility information, 72 Hours beds available
Reference ID	BA016
Synonyms	Not Applicable
Representation Class	Total
Data Type	Numeric
Format	NNNN
Maximum Field Size	4
Date Created	19/05/2016
Date Updated	To be defined
Source	USA Health & Human Services, Agency for Healthcare Research & Quality 2005
Usage	<p>This element is used during disaster management to report the estimated number of beds that can be made available in the next 72 hours in disaster situations, this helps in managing the disaster and provide a good tool for bed management during such situations. The estimate is medically decided by treating physicians and is based on the patient's condition that supports discharge within 72</p>

	hours
Code Description and Permissible Values	Not Applicable

<b>Funding source for patient healthcare event</b>	
Definition	The principal source of funds for an admitted patient episode or non-admitted patient service event, as represented by a code.
Metadata Type	Data Element
Data Concept	Healthcare Facility Information - Funding source for hospital patient
Reference ID	BA017
Synonyms	Not Applicable
Representation Class	Code
Data Type	Numeric
Format	NN
Maximum Field Size	2
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008

<b>Usage</b>	If there is an expected funding source followed by a finalized actual funding source (for example, in relation to compensation claims), then the actual funding source known at the end of the reporting period should be recorded. The expected funding source should be reported if the fee has not been paid but is not to be waived. If a charge is raised for accommodation or facility fees for the episode / service event, the intent of this data element is to collect information on who is expected to pay, provided that the charge would cover most of the expenditure that would be estimated for the episode / service event. If the charge raised would cover less than half of the expenditure, then the funding source that represents the majority of the expenditure should be reported. The major source of funding should be reported for nursing- home type patients.
<b>Code Description and Permissible Values</b>	Codes used are: 01=MOH and other government sectors. 02 = Private health insurance 03 = Self-funded including the patient, patient's family, friends, or other benefactors. 04 = Other hospital or public authority 05 = Foreign government 06 = Reciprocal Healthcare agreements (with other countries) 07 = Overseas visitors for whom travel insurance is the major funding source 08 = Donor to hospital trust fund 09 = No charge Including patients admitted as an emergency to private hospital but eligible for government

	<p>care.</p> <p>10 = Charity organization</p> <p>88 = Others</p> <p>99 = Unknown</p>
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<b>Organization start date</b>	
<b>Definition</b>	The date on which an establishment, agency or organization started or commenced operations or service
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility Information - Organization start date
<b>Reference ID</b>	BA018
<b>Synonyms</b>	Organization inauguration date
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008

Usage	This field must— <ul style="list-style-type: none"><li>• Be a valid date;</li><li>• Be less than or equal to the Organization end date.</li></ul>
Code Description and Permissible Values	Codes used are  DDMMYYYY Century digits are considered essential

Postal Address	
Definition	Type of postal delivery service for a person, as represented by a code.
Data Concept	Healthcare Facility Information - Postal delivery service type - abbreviation
Reference ID	BA019
Synonyms	Not Applicable
Representation Class	Code
Data Type	Alphab
Format	
Maximum Field Size	
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	Use Saudi post standard
Code Description and Permissible Values	<p>Codes used are</p> <p><b>Saudi Post address code</b></p> <ul style="list-style-type: none"> <li>-Building Number: Consists of four numbers, the number represents either a commercial or residential building; the numbers are unique and not repeated on the street.</li> <li>-Street Name: Represents the exact location of a certain building, entrance or shop that exists between several of buildings.</li> <li>-Neighborhood: Represents the area that consists of all these buildings.</li> <li>-City: Represents all the areas as a whole with its different neighborhoods, street names and building numbers.</li> <li>-Postal Code/Zip Code: Consists of five digits, each digit</li> </ul>

	<p>has a significant location. This code covers a specific geographical area such as a neighborhood or any residential community.</p> <p>-Additional Numbers: It is similar to the building number and also consists of four numbers.</p>
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<b>Facility Operation status</b>	
<b>Definition</b>	It is the indicator of the facility status in reference to being operational on temporary or permanent bases
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility Information—Facility Operational Status
<b>Reference ID</b>	BA020
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element is used to describe the facility in reference to its operational status. Code 1 is used for all facilities that are physically present and operational all year round Code 2 is used for all facilities that operate only during special seasons regardless of their facility physical presence, as example it is applicable on facilities serving during pilgrimage (Hajj) and facilities used in disaster situations like field hospitals.
<b>Code Description and Permissible Values</b>	Codes used are: 1=Permanent Facility 2 = Temporary Facility

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## Mental Medical Facility Information

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<b>Specialized mental health service program type</b>	
<b>Definition</b>	Type of admitted patient care program provided by a specialized mental health service, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility Information - Specialized mental health service program type
<b>Reference ID</b>	BB001
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This data element is used to disaggregate data on beds; activity, expenditure and staffing for admitted patient settings in mental health service units (see Specialized mental health service— service setting, code N data element). The categorization of the admitted patient program is based on the principal purpose(s) of the program rather than the classification of the individual patients. Code 1 is to describe acute psychiatric care for people with acute episodes of mental disorder. Code 2 is for other reasons to admit patient to psychiatric hospital including rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients.
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Acute Psychiatric care 2 = Other reasons of admission

<b>Specialized mental health service setting</b>	
<b>Definition</b>	The setting for care provided by a specialized mental health service, as represented by a code
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility Information - Specialized mental health service setting.
<b>Reference ID</b>	BB002
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	A single mental health service unit may provide care in more than one setting. This data element is intended to allow staffing, resource and expenditure data related to these settings to be identified and reported separately. Code 1 to be used for admission to care setting including units in non-specialized psychiatric hospitals Code 2 to be used for ambulatory care setting including services in non-specialized psychiatric hospital and nonhospital community mental health services, such as crisis or mobile assessment and treatment services, day programs, outreach services and consultation / liaison services
<b>Code Description and Permissible Values</b>	Codes used are: 1= Admitted patient 2 = Ambulatory

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## Medical Facility Teaching Information

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<b>Teaching status</b>	
<b>Definition</b>	An indicator to identify the non-direct patient care activity of teaching for a particular establishment, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Healthcare Facility Information - Teaching status
<b>Reference ID</b>	BC001
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	In this context, teaching relates to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant government authority.
<b>Code Description and Permissible Values</b>	Codes used are: 1=Yes 2>No

# Chapter 03

## Health Provision Information

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## Healthcare Provision Information

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## Health Service Event

<b>Definition</b>	A health service event is one of either: Outpatient and Emergency Room care event: A contact between a Health care user and a health agency which involves an attendance at a Health care facility. Note: it does not involve an admission or discharge. It includes contact with a General Practitioner, medical specialist, surgeon or registrar where the patient visits the Healthcare facility. Hospital inpatient event: A contact between a Healthcare user and a health agency which involves the Healthcare user being admitted and discharged. Community care event: A contact between a Healthcare user and health agency at any place not defined as a Healthcare facility. Note: it includes home visits, place of recreation, and place of education
<b>Metadata Type</b>	Data Concept
<b>Data Concept</b>	Ambulatory Care Information —Health Service Event
<b>Reference ID</b>	CA001
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Concept
<b>Data Type</b>	
<b>Format</b>	
<b>Maximum Field Size</b>	
<b>Date Created</b>	
<b>Date Updated</b>	
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	

<b>Initial or subsequent service event</b>	
<b>Definition</b>	An indicator of whether the service event is the first service event for a new referral or a follow up service event
<b>Metadata type</b>	Data element
<b>Data concept</b>	Service event
<b>Reference ID</b>	CA002
<b>Synonyms</b>	Not applicable
<b>Represented class</b>	Code
<b>Data type</b>	Numeric
<b>Format</b>	N
<b>Maximum field size</b>	1
<b>Date created</b>	01/04/2019
<b>Date updated</b>	To be decided
<b>Source</b>	
<b>Usage</b>	
<b>Code description and permissible values</b>	1 Initial client service event 2Subsequent client service event

Care type	
Definition	The nature of clinical service provided to an admitted patient during an episode of care , acute vs. sub-acute, as represented by a code
Metadata type	Data element
Data concept	Care type
Reference ID	CA003
Synonyms	Not applicable
Represented class	Code
Data type	Numeric
Format	NN
Maximum field size	2
Date created	01/04/2019
Date updated	To be decided
Source	National Health Data Dictionary - Australia
Usage	
Code description and permissible values	01 Acute Care 02 Rehabilitation 03 General Maintenance 04 Complex Maintenance 05 Boarder 06 Palliative

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## Emergency Medical Services

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## Emergency Healthcare event

<b>Definition</b>	The acute medical care provision to patients who arrived without prior appointment to dedicated department or facility that provides care and treatment for illnesses due to trauma or medical condition that may threaten life.
<b>Metadata Type</b>	Data Concept
<b>Data Concept</b>	Emergency Medical Services (EMS)Emergency Healthcare event
<b>Reference ID</b>	CB001
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Concept
<b>Data Type</b>	
<b>Format</b>	
<b>Maximum Field Size</b>	
<b>Date Created</b>	
<b>Date Updated</b>	
<b>Source</b>	Saudi Health Council
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	

## Emergency department arrival mode – Transport

<b>Definition</b>	The mode of transport by which the person arrives at the emergency department, as represented by a code
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Emergency Medical Services, Arrival Mode
<b>Reference ID</b>	CB002
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This element describes the patient arrival mode which helps understand public behavior in emergency and assess pre-hospital care services in the health system
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>01 = Ground EMS Ambulance          02 = Ground MOH Ambulance          03 = Ground Civil Defense Ambulance          04 = Ground Military Ambulance 05 = Ground Private Ambulance          06 = EMS Air Ambulance          07 = Air Civil Defense Ambulance          08 = Air Military Ambulance          09 = Police Vehicle          10 = Other Government Vehicles 11 = Personal Vehicle          88 = Other          99 = Not stated/unknown</p>

## Triage

<b>Definition</b>	The role of the Triage is as a clinical tool for ensuring that patients are seen in a timely manner, commensurate with their clinical urgency.
<b>Metadata Type</b>	Data Concept
<b>Data Concept</b>	Emergency Medical Services Triage
<b>Reference ID</b>	CB003
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Concept
<b>Data Type</b>	
<b>Format</b>	
<b>Maximum Field Size</b>	
<b>Date Created</b>	
<b>Date Updated</b>	
<b>Source</b>	Policy on the Australian triage scale, Australian College of Emergency Medicine Version 4, 2013
<b>Usage</b>	The Triage should only be used to describe urgency. Separate measures are required to describe severity, complexity, quality of care, workload and staffing
<b>Code Description and Permissible Values</b>	

<b>Date of Triage</b>	
Definition	The date on which the patient is triaged
Metadata Type	Data Element
Data Concept	Emergency Medical Services - Date of triage
Reference ID	CB004
Synonyms	Not Applicable
Representation Class	Date
Data Type	Date/Time
Format	DDMMYYYY
Maximum Field Size	8
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	
Code Description and Permissible Values	Codes used are : DDMMYYYY Century digits are considered essential
Maximum Field Size	5
Date Created	19/05/2016
Date Created	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	
Code Description and Permissible Values	<p>Codes used are:</p> <p>This information is used to describe the triage time based on 24 hours' time format, use HHMM.</p> <p>HH ranges from 00 to 23;</p> <p>MM ranges from 00 to 59.</p> <p>Code 99 = Unknown values for both HH and MM.</p> <p>Use leading zeros to assure 2 character field widths for HH and MM. Code 0000 = Midnight, and begins the new day.</p>

<b>Time of Triage</b>	
<b>Definition</b>	The time at which the patient is triaged.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Emergency Medical Services - Time of triage
<b>Reference ID</b>	CB005
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Time
<b>Data Type</b>	Date/Time
<b>Format</b>	HH MM
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>This information is used to describe the triage time based on 24 hours' time format, use HHMM.</p> <p>HH ranges from 00 to 23;</p> <p>MM ranges from 00 to 59.</p> <p>Code 99 = Unknown values for both HH and MM.</p> <p>Use leading zeros to assure 2-character field widths for HH and MM.</p> <p>Code 0000 = Midnight, and begins the new day.</p>

## Triage Category

<b>Definition</b>	The category assigned to a PATIENT as a result of an initial assessment by medical or nursing staff in an Accident and Emergency Department. The triage category is used to determine the PATIENT's priority for treatment, and to inform the PATIENT of their waiting time
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Emergency Medical Services, Triage category
<b>Reference ID</b>	CB006
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	United Kingdom National health Services, Hospital Episode Statistics September 2010 / Triage and case mix accident and emergency medicine. Marrow, J. European Journal of Emergency Medicine 1998; 5: 53-58
<b>Usage</b>	The triage category is used to determine the PATIENT's priority for treatment. This allows ER staff to estimate time of service and be able to inform the patient of the time expected for his event to be completed. Apply the following categories to the type of patients described for each: Code 1 = is used for immediate PATIENT resuscitation category is used when PATIENTS are in need of immediate treatment for preservation of life. Code 2 = is used for very urgent PATIENT category that is seriously ill or injured PATIENTS whose lives are not in immediate danger. Code 3 = is used for urgent PATIENT with serious problems, but apparently stable condition. Code 4 = is used for standards ER PATIENT who is suffering from less severe symptoms or injuries, such as sprained ankle. Code 5 = is used for Non-urgent: PATIENT whose conditions are not true accidents or emergencies and requires regular clinic care.
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Immediate resuscitation 2 = Very urgent 3 = Urgent 4 = Standard ER 5 = Non-urgent

### Emergency Department waiting time performance indicator

<b>Definition</b>	The time elapsed for each patient from presentation to the emergency department till beginning of medical service that is based on his/her triage category
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Emergency Medical Services (EMS) - Emergency department waiting time monitor
<b>Reference ID</b>	CB007
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	GUIDELINES ON THE IMPLEMENTATION OF THE AUSTRALIAN TRIAGE SCALE IN EMERGENCY DEPARTMENT. Document 24 Version 3, November 2013
<b>Usage</b>	This element helps to monitor patient service time in ER, calculated from case disposition date and time minus date and time patient first presented to ER. The allowed time differ from category to another as follows: 1- Immediate Category: Permissible time is immediate 2- Very Urgent Category: Permissible time is < 15 minutes 3- Urgent Category: Permissible time is < 30 minutes 4- Standard ER Category: Permissible time is < 1 hour 5- Non Urgent Category: Permissible time is < 4 hours 6- Emergency Admission: Permissible time is < 12 hours
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Services provided within time 2 = Services provided out of time

### Emergency department waiting time to service delivery

<b>Definition</b>	The time elapsed in minutes for each patient from presentation in the emergency department to a service occurrence of a specified event related to service delivery.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Emergency Medical Services, Emergency department waiting time to service delivery
<b>Reference ID</b>	CB008
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNNN
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Calculated from date and time of service event minus date and time patient presents. Although triage category 1 is measured in seconds, it is recognized that the data will not be collected with this precision.
<b>Code Description and Permissible Values</b>	Not Applicable

## Length of non-admitted ER patient service episode

<b>Definition</b>	The amount of time, measured in minutes, between when a patient presents at an emergency department for an emergency department service episode, and when the non-admitted component of the emergency department service episode has concluded
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Emergency Medical Services, length of non-admitted patient emergency department episode .
<b>Reference ID</b>	CB009
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNNN
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 200
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	Codes used are: NNNNN=Total time in minutes

### Nature of main injury (non-admitted patient)

<b>Definition</b>	The nature of the injury chiefly responsible for the attendance of the non-admitted patient at the Healthcare facility, represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Emergency Medical Services, Nature of main injury (non-admitted patient)
<b>Reference ID</b>	CB010
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN.N
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>If the full ICD-10-AM code is used to code the injury, this metadata item is not required (see metadata items principal diagnosis and additional diagnosis) When coding to the full ICD-10-AM code is not possible, use this metadata item with the items external cause of injury-non admitted patient, external cause of injury-human intent and bodily location of main injury.</p> <p>Select the code which best characterizes the nature of the injury chiefly responsible for the attendance, on the basis of the information available at the time it is recorded.</p> <p>If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. A major injury, if present, should always be Code rather than a minor injury. If a major injury has been sustained (e.g. a fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be Code in preference to coding 'multiple injuries.'</p> <p>As a general guide, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as 'minor'. If the nature of the injury code is 01 to 12 or 26 to 29 then the metadata item Bodily location of main injury should be used to record the bodily location of the injury.</p> <p>If another code is used, bodily location is implicit or meaningless. Bodily location of main injury, category 22 may be used as a filler to indicate that specified body region is not required.</p>

Code Description and Permissible Values	Codes used are: 01 = Superficial (excludes eye injury code 13) 02 = Open wound (excludes eye injury code 13) 03 = Fracture (excludes dental injury code 21) 04 = Dislocation (includes ruptured disc, cartilage, ligament) 05 = Sprain or strain 06 = Injury to nerve (includes spinal cord; excludes intracranial injury code 20) 07 = Injury to blood vessel 08 = Injury to muscle or tendon 09 = Crushing injury 10 = Traumatic amputation (includes partial amputation) 11 = Injury to internal organ 12 = Burn or corrosion (excludes eye injury code 13) 13 = Eye injury (includes burns, excludes foreign body in external eye code 14.1) 14.1 = Foreign body in external eye 14.2 = Foreign body in ear canal 14.3 = Foreign body in nose 14.4 = Foreign body in respiratory tract (excludes foreign body in nose code 14.3) 14.5 = Foreign body in alimentary tract 14.6 = Foreign body in genitourinary tract 14.7 = Foreign body in soft tissue 14.9 = Foreign body, other/unspecified 20 = Intracranial injury (includes concussion) 21 = Dental injury (includes fractured tooth) 22 = Drowning, immersion 23 = Asphyxia or other threat to breathing (excludes drowning immersion code 22) 24 = Electrical injury 25 = Poisoning, toxic effect (excludes effect of venom, or any insect bite code 26) 26 = Effect of venom, or any insect bite 27 = Other specified nature of injury 28 = Injury of unspecified nature 29 = Multiple injuries of more than one 'nature' 30 = No injury detected
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## Ambulance Response Time

<b>Definition</b>	The time measured from the time a notice is received to the earlier of the following: 1. The arrival on-scene of a person equipped to provide any type of defibrillation to sudden cardiac arrest patients. 2. The arrival on-scene of the ambulance crew.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Emergency Medical Services, Ambulance response time (to service delivery), total minutes.
<b>Reference ID</b>	CB011
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNNN
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Ambulance Act No275/00, Canadian Ministry of Health Ontario.
<b>Usage</b>	Calculated from date and time of service request minus date and time patient is reached by ambulance team. Benchmark is: Sudden Cardiac Arrest = 6 minutes Resuscitation Patient = 8 Minutes Urgent Patient = 10 Minutes Less Urgent Patient = 12 Minutes.
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Services provided within time 2 = Services provided out of time

## Acute Asthma (Adult patients)

<b>Definition</b>	It is a disease characterized by recurrent attacks of breathlessness and wheezing in a patient older than 14 years of age. It varies in severity and frequency from person to person. In an individual, they may occur from hour to hour and day to day. This condition results from inflammation of the air passages in the lungs and affects the sensitivity of the nerve endings in the airways so they become easily irritated. In an attack, the lining of the passages swell causing the airways to narrow and reducing the flow of air in and out of the lungs.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Respiratory Diseases Acute Asthma (Adult Patient)
<b>Reference ID</b>	CB012
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	5N
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	World Health Organization (WHO)
<b>Usage</b>	This element is used to report the number of Acute Adult Asthma patients > 14 years of age, attending to ER for management of an acute attack.
<b>Code Description and Permissible Values</b>	Codes used are: Acute severe Asthma and Status Asthmaticus under ICD 10 AM codes J46 Total Number

## Acute Asthma (Pediatric patients)

<b>Definition</b>	It is a disease characterized by recurrent attacks of breathlessness and wheezing in a patient younger than 14 years of age. It varies in severity and frequency from person to person. In an individual, they may occur from hour to hour and day to day. This condition results from inflammation of the air passages in the lungs and affects the sensitivity of the nerve endings in the airways so they become easily irritated. In an attack, the lining of the passages swell causing the airways to narrow and reducing the flow of air in and out of the lungs.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Respiratory Diseases Acute Asthma (Pediatric Patient)
<b>Reference ID</b>	CB013
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	5N
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	World Health Organization (WHO)
<b>Usage</b>	This element is used to report the number of Acute Pediatric Asthma patients <14 years of age attending to ER for management of an acute attack.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>Acute severe Asthma and Status Asthmaticus under ICD 10 AM codes J46 Total Number</p>

ED Disposition	
Definition	Non-Admitted Patient Ed Service Episode-Episode End Status: The status of the patient at the end of the non-admitted patient emergency department service episode, as represented by a code
Metadata type	Data element
Data concept	Emergency department service episode
Reference ID	CB014
Synonyms	Not applicable
Represented class	Code
Data type	Numeric
Format	N
Maximum field size	1
Date created	01/04/2019
Date updated	To be decided
Source	National Health Data Dictionary - Australia
Usage	
Code description and permissible values	<ol style="list-style-type: none"> <li>1. Admitted to this hospital</li> <li>2. Non-admitted patient ED episode completed-departed without being admitted or referred to another hospital</li> <li>3. non admitted patient ED episode completed -referred to another hospital for admission</li> <li>4. did not wait to be attended by a health care professional</li> <li>5 left at own risk after being attended by a health care professional, but before the non-admitted patient ED service episode was completed</li> <li>6. Died in ED</li> <li>7. Dead on arrival</li> <li>8. Registered, advised of another health care service, and left the ED without being attended by a health care professional</li> </ol>



## Cardiovascular Diseases

Chest Pain Pattern Category	
Definition	The person chest pain pattern as represented by a code
Metadata Type	Data Element
Data Concept	Cardiovascular - Chest pain pattern
Reference ID	CC001
Synonyms	Not Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	<p>Chest pain or discomfort of myocardial ischemic origin is usually described as chest pain, discomfort or pressure, jaw pain, arm pain or other equivalent discomfort suggestive of cardiac ischemia. Ask the person when the symptoms first occurred or obtain this information from appropriate documentation to describe the following chest categories:</p> <p><b>1 Atypical chest pain:</b>          Use this code for pain, pressure, or discomfort in the chest, neck, or arms not clearly exertional or not otherwise consistent with pain or discomfort of myocardial ischemic origin.</p> <p><b>2 Stable chest pain patterns:</b>          Use this code for chest pain without a change in frequency or pattern for the 6 weeks before this presentation or procedure. Chest pain is controlled by rest and/or sublingual/oral/transcutaneous medications.</p> <p><b>3 Unstable chest pain pattern:</b>          (During rest and/or prolonged)          Use this code for chest pain that occurred at rest and was</p>

	<p>prolonged, usually lasting more than 10 minutes</p> <p><b>4 Unstable chest pain patterns:</b> New and severe Use this code for new-onset chest pain that could be described as at least Canadian Cardiovascular Society (CCS) classification III severity.</p> <p><b>5 Unstable chest pain pattern:</b> Accelerated and severe Use this code for recent acceleration of chest pain pattern that could be described by an increase in severity of at least 1 CCS class to at least CCS class III.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>1 = Atypical chest pain</li> <li>2 = Stable chest pain pattern</li> <li>3 = Unstable chest pain pattern: rest &amp;/or prolonged</li> <li>4 = Unstable chest pain pattern: new &amp; severe</li> <li>5 = Unstable chest pain pattern: accelerated and severe</li> <li>8 = No chest pain/discomfort</li> <li>9 = Not stated/inadequately described</li> </ul>

## Chest Pain Disposition

<b>Definition</b>	Chest pain patient disposition
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Coronary Artery Disease, Chest pain patient disposition
<b>Reference ID</b>	CC002
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element is used to describe chest pain patient disposition to reflect the resources utilized for this event. Disposition as admission for urgent procedure includes catheterization, PCI, fibrinolytic therapy & CABG
<b>Code Description and Permissible Values</b>	Codes used are: 1 = CCU Admission & Observation 2 = Urgent Admission for Urgent Procedure 3 = ER Treatment and Discharge 4 = No Treatment and Discharge

### Date of first angioplasty balloon inflation or stinting

<b>Definition</b>	Date of the first angioplasty balloon inflation or stent placement.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Cardiovascular Diseases - Date of first angioplasty balloon inflation or stenting
<b>Reference ID</b>	CC003
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/5/2019
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This element is used to report date on which date the stenting procedure or angioplasty was completed
<b>Code Description and Permissible Values</b>	Codes used are : DDMMYY Century digits are considered essential

## Coronary artery procedure waiting time

<b>Definition</b>	Time required for the patient with coronary artery disease to receive the intervention required for his/her management.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Cardiovascular Diseases—Coronary artery disease waiting time
<b>Reference ID</b>	CC004
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Benchmark values from Quality Based Procedures report for Coronary Artery diseases Ministry of Health Ontario Canada 2014
<b>Usage</b>	<p>The waiting time is calculated from the diagnosis date till the date of procedure completion, procedures included are Catheterization, PCI &amp; CABG.</p> <p><b>The indicated Catheterization procedure waiting time should be:</b></p> <ul style="list-style-type: none"> <li>• Urgent Cath. &lt; 7 days</li> <li>• Semi urgent Cath. &lt; 28 days</li> <li>• Elective &lt; 84 days –</li> </ul> <p><b>The indicated PCI procedure waiting time should be:</b></p> <ul style="list-style-type: none"> <li>• Urgent PCI &lt; 7 days</li> <li>• Semi urgent PCI &lt; 14 days</li> <li>• Elective PCI &lt; 28 days</li> </ul> <p><b>The indicated CABG procedure waiting time should be:</b></p> <ul style="list-style-type: none"> <li>• Urgent CABG &lt; 14 days</li> <li>• Semi urgent CABG &lt; 42 days</li> <li>• Elective &lt; 90 days</li> </ul>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Procedure done according to waiting time benchmark</p> <p>2 = Procedure done not according to waiting time benchmark</p>

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## Maternity Information

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## First Day of the Last Menstrual Period

<b>Definition</b>	Date of the first day of the mother's last menstrual period (LMP).
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Antenatal First day last menstrual period
<b>Reference ID</b>	CD001
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>This element is used to describe the first day of the LMP which is essential for calculation of gestational age, If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999).</p> <p>The first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>– DDMMYYYY Century digits are considered essential</li> <li>– 99999999 = Unknown</li> </ul>

<b>Gravidity</b>	
Definition	Number of pregnancies the women has had, including current pregnancy.
Metadata Type	Data Element
Data Concept	Antenatal Gravidity
Reference ID	CD002
Synonyms	Not Applicable
Representation Class	Total
Data Type	Numeric
Format	NN
Maximum Field Size	2
Date Created	19/05/2016
Date Updated	To be defined
Source	Palestinian Health Data Dictionary Second edition, 2005.
Usage	This includes all diagnosed pregnancies regardless of gestational age and outcome. i.e. miscarriage, ectopic pregnancies, preterm ,full term, and post term deliveries
Code Description and Permissible Values	Codes used are: NN = Gravidity Number

### Contraception End Date

<b>Definition</b>	The estimated date when contraception was discontinued prior to pregnancy, as reported by the woman.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Antenatal Contraception End of Date
<b>Reference ID</b>	CD003
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	The element is used to report the date the contraception use was ended as reported by the female patient
<b>Code Description and Permissible Values</b>	<p>Codes used are :</p> <p>DDMMYYYY Century digits are considered essential Use 00/00/0000 If contraception has never been used</p>

## Maternal medical conditions

<b>Definition</b>	Pre-existing maternal diseases and conditions, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity: Antenatal - Maternal medical conditions
<b>Reference ID</b>	CD004
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
<b>Format</b>	ANN.NN
<b>Maximum Field Size</b>	6
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. There is no arbitrary limit on the number of conditions specified
<b>Code Description and Permissible Values</b>	Codes used are: Appropriate ICD 10 Code

<b>Parity</b>	
<b>Definition</b>	The total number of previous pregnancies experienced by the woman that have resulted in a live birth or a stillbirth.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Antenatal, Parity
<b>Reference ID</b>	CD005
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Use the element to report previous pregnancy outcome
<b>Code Description and Permissible Values</b>	Not Applicable
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Use the element to report previous pregnancy outcome
<b>Code Description and Permissible Values</b>	Not Applicable

## Spontaneous Abortion

<b>Definition</b>	The total number of previous pregnancies of a female resulting in spontaneous abortion (less than 20 weeks' gestational age, or less than 400 g birth weight if gestational age is unknown)
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity, Antenatal, Abortion
<b>Reference ID</b>	CD006
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>A pregnancy resulting in multiple births should be counted as once pregnancy. In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:</p> <ul style="list-style-type: none"> <li>• All live births</li> <li>• Stillbirth</li> <li>• Spontaneous abortion</li> <li>• Induced abortion</li> <li>• Ectopic pregnancy</li> </ul> <p>Where the outcome was one stillbirth and one live birth, count as stillbirth. If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>NN = Number of abortions, unit is pregnancy  99 = Not stated</p>

## Outcome of last previous pregnancy

<b>Definition</b>	Outcome of the most recent pregnancy preceding this pregnancy, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Antenatal (last previous) - pregnancy outcome
<b>Reference ID</b>	CD007
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	The element helps reporting of the outcome of previous pregnancy. In the case of multiple pregnancy with fetal loss before 20 weeks, code on outcome of surviving fetus (es) beyond 20 weeks. This data item is recommended by the World Health Organization. It is collected in some regions. Adverse outcome in previous pregnancy is an important risk factor for subsequent pregnancy.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Single live birth - survived at least 28 days      2 = Single live birth - neonatal death (within 28 days)      3 = Single stillbirth      4 = Spontaneous abortion      5 = Induced abortion      6 = Ectopic pregnancy      7 = Multiple live birth - all survived at least 28 days      8 = Multiple birth - one or more neonatal deaths (within 28 days) or stillbirths</p>

### Expected Date of Delivery

<b>Definition</b>	The predicted date of a pregnant woman's delivery after completion of 40 weeks starting from the first day of the last menstrual period of the pregnant mother
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Antenatal Expected date of delivery
<b>Reference ID</b>	CD008
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/ Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	Codes used are: DDMMYYYY Century digits are considered essential

## Gestational Age: According to Last Menstrual Period

<b>Definition</b>	The term used during pregnancy to describe how far along the pregnancy is. It is usually measured in weeks, from the first day of the woman's last menstrual cycle to the current date. A normal pregnancy can range from 38 to 42 weeks.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Antenatal Gestational Age According to LMP
<b>Reference ID</b>	CD009
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	Codes used are: DDMMYYYY Century digits are considered essential

## Method of Delivery

<b>Definition</b>	The method of complete expulsion or extraction from its mother of a product of conception in a birth event, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Antenatal Intended Method of delivery
<b>Reference ID</b>	CD010
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>The followings are guidelines to consider when coding this element:</p> <ul style="list-style-type: none"> <li>- In a vaginal breech with forceps to the after coming head, code as vaginal - forceps.</li> <li>- In a vaginal breech that has been manually rotated, code as vaginal - non-instrumental.</li> <li>- Where forceps/vacuum extraction are used to assist the extraction of the baby at caesarean section, code as caesarean section.</li> <li>- Where a hysterectomy is performed to extract the baby, code as caesarean section.</li> <li>- In the case of multiple births, method of birth should be recorded for each baby born.</li> </ul>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Vaginal - non-instrumental      2 = Vaginal - with instruments      3 = Vaginal - vacuum extraction      4 = Caesarean section      9 = Not stated/inadequately described</p>

## Ultrasound Scan purpose: Mother

<b>Definition</b>	The reason an ultrasound scan is performed during pregnancy
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Antenatal Ultrasound scan purpose: Mother
<b>Reference ID</b>	CD011
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	CVS: Chronic villous sampling. ECV: External cephalic version
<b>Code Description and Permissible Values</b>	Codes used are: 01 = Amniotic fluid assessment 02 = Anomaly 03 = Biophysical profile 04 = Breech assessment 05 = Cervical length 06 = Confirmation of presentation 07 = Fetal viability 08 = Fetal growth assessment 09 = Fetal intervention e.g. Amniocentesis/ CVS, take sample, transfusion, ECV 10 = Gestational age assessment 11 = Following vaginal bleed 12 = Localization of placenta 13 = Nuchal translucency 14 = Placental blood flow 15 = Multiple gestation 16 = Sex determination 88 = Other

Length of stay (including leave days) (antenatal)	
Definition	The length of stay (LOS) of a woman before the birth of her baby, including leave days, measured in days.
Metadata Type	Data Element
Data Concept	Maternity: Antenatal - Length of stay (including leave days) (antenatal)
Reference ID	CD012
Synonyms	Not Applicable
Representation Class	Total
Data Type	Numeric
Format	NNN
Maximum Field Size	3
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	<p>Formula:</p> <p>LOS (antenatal) = baby's date of birth - mother's admission date</p> <p>Antenatal LOS is calculated by subtracting the mother's admission date from the baby's date of birth.</p> <p>It includes contact days and leave days. If the mother's admission date and the baby's date of birth are on the same date, count the LOS as 1 day.</p> <p>Antenatal length of stay refers only to the admission associated with the birth. Antenatal LOS relates only to the episode of admitted patient care associated with the birth.</p> <p>In a multiple pregnancy, the date of birth of the first baby born should be used to calculate the mother's antenatal LOS. To calculate the total LOS, use the data element - Episode of admitted patient care - length of stay (including leave days) total.</p>
Code Description and Permissible Values	Not Applicable

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## Maternity: Labor Information

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## Birth Outcome Live or stillbirth

<b>Definition</b>	An indicator of whether a birth is a live, stillbirth or neonatal death. A stillbirth is a birth after a gestation of 24 weeks (168 days) where the baby shows no identifiable signs of life at delivery
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Labor information Birth Outcome
<b>Reference ID</b>	CD013
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	The element codes are used with consideration to the following guidelines: Code 1 is used to describe Stillbirth antepartum - where intrauterine death was confirmed prior to the onset of labor. Code 2 is used to describe Stillbirth indeterminate - where it is not known whether the fetus was alive at the onset of labor Code 3 is used to describe Stillbirth intrapartum - where the fetus was known to be alive at the onset of labor
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Live 2 = Stillbirth antepartum 3 = Stillbirth indeterminate 4 = Stillbirth postpartum

## Live Birth

<b>Definition</b>	A live birth is defined by the World Health Organization to be the complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.
<b>Metadata Type</b>	Data Concept
<b>Data Concept</b>	Maternity Labor information Live Birth
<b>Reference ID</b>	CD014
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Concept
<b>Data Type</b>	Not Applicable
<b>Format</b>	Not Applicable
<b>Maximum Field Size</b>	Not Applicable
<b>Date Created</b>	19 / 5 /2016
<b>Date Updated</b>	To be decided
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	

## Stillbirth

<b>Definition</b>	A fetal death prior to the complete expulsion or extraction from its mother of a product of conception of after 22 completed weeks of gestation from LMP or at least 500 g birth weight; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.
<b>Metadata Type</b>	Data Concept
<b>Data Concept</b>	Maternity Labor information stillbirth
<b>Reference ID</b>	CD015
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Concept
<b>Data Type</b>	
<b>Format</b>	
<b>Maximum Field Size</b>	
<b>Date Created</b>	
<b>Date Updated</b>	
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	

## Intended Place of Delivery

<b>Definition</b>	The mother's initial intention for place of delivery
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Labor Information Intended Place of Delivery
<b>Reference ID</b>	CD016
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	This is an element that helps analyze the risk factors and outcomes by place of birth. While most deliveries occur within hospitals an increasing number of births now occur in other settings. It is important to monitor the births occurring outside hospitals and to ascertain whether or not the actual place of delivery was planned.
<b>Code Description and Permissible Values</b>	Codes used are: 01 = MOH general hospital 02 = MOH specialized hospital 03 = Specialized other Government Hospital 04 = Military Hospital 05 = Private hospital 06 = Home 88 = Other 99 = Unknown

## Actual Place of Birth

<b>Definition</b>	This field contains a code which defines the actual type of delivery place. This item appears for each baby on multiple birth delivery records
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Labor Information Actual Place of Delivery
<b>Reference ID</b>	CD017
<b>Synonyms</b>	Non Applicable
<b>Data Type</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	United Kingdom National health Services, Hospital Episode Statistics September 2010
<b>Usage</b>	This is an element that helps to analyze the risk factors and outcomes by place of birth.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>01 = MOH general hospital          02 = MOH specialized hospital          03 = Specialized other Government Hospital          04 = Military Hospital          05 = Private hospital          06 = Home          88 = Other          99 = Unknown</p>

<b>Birth Attendant</b>	
<b>Definition</b>	The type of practitioner conducting the delivery
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Labor Information Birth Attendant
<b>Reference ID</b>	CD018
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	This element is used to report the type of the practitioner who attended the birth
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>00 = None          01 = Consultant obstetrician          02 = Senior specialist          03 = Specialist          04 = Senior registrar          05 = Registrar          06 = Resident          07 = General Practitioner (GP)          08 = Medical Intern          09 = Medical student          10 = Midwife          11 = Student midwife          12 = Obstetric nurse          13 = Student nurse          14 = Paramedic          15 = Traditional Birth Attendant (TBA/Daya)          88 = Other          99 = Unknown</p>

Anesthesia	
Definition	Agents administered to the mother by injection or inhalation to relieve pain during labor and delivery.
Metadata Type	Data Element
Data Concept	Maternity Labor information Anesthesia
Reference ID	CD019
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Palestinian Health Data Dictionary Second edition, 2005
Usage	This element is to record the type of anesthesia given to the patient to help manage labor, Anesthetics can be used as general or local, whatever the modality used it does have an effect on both the fetus and the mother. That is why this element is very informative for clinical audit of cases that received any dose of anesthesia
Code Description and Permissible Values	<p>Codes used are:</p> <p>0 = None      1 = Combined spinal/epidural      2 = Conscious sedation      3 = General anesthesia      4 = Local anesthetic infiltration – perineal      5 = Lumbar epidural      6 = Nerve block – pudendal      7 = Spinal      8 = Other      9 = Unknown</p>

### Type of Labor Induction

<b>Definition</b>	The methods used for the induction of labor.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Labor information Type of labor Induction
<b>Reference ID</b>	CD020
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	This element reports the type of assistance chosen to help uterine contractions begin and be more effective in birth progress. Such procedures or pharmaceuticals are not without side effects or complications to both the mother and the fetus
<b>Code Description and Permissible Values</b>	

## Type of Augmentation of Labor

<b>Definition</b>	The method of augmentation used during labor. Action may be taken to augment the contractions when a diagnosis of delay in labor has been made
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Labor information Type of Augmentation of labor
<b>Reference ID</b>	CD021
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	This element reports the type of assistance chosen to help uterine contractions be more effective during birth progress as a result of clinical judgment established delay in labor. Such procedures or pharmaceuticals are not without side effects or complications to both the mother and the fetus.
<b>Code Description and Permissible Values</b>	

<b>Method of Birth</b>	
<b>Definition</b>	The method of complete expulsion or extraction from its mother of a product of conception.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Labor information Type of Augmentation of labor
<b>Reference ID</b>	CD022
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Use codes that are descriptive to procedure, pay attention to use non-instrumental code if none is used. Manual rotation is non-instrumental
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Vaginal - non-instrumental 2 = Vaginal - forceps 3 = Vaginal - vacuum extraction 4 = Caesarean section 9 = Unknown

<b>Presentation at Birth</b>	
<b>Definition</b>	The presenting part of the fetus at birth, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Labor information Presentation at Birth
<b>Reference ID</b>	CD023
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	The element is used to report the presenting part during labor, care should be practiced when coding presentation that are complicated
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Vertex 2 = Breach 3 = Face 4 = Brow 5 = Multiple presentation when associated with limbs 8 = Other Malpresentations 9 = Unknown

## Time of Delivery

<b>Definition</b>	The time of delivery for each registerable birth.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Labor information Time of delivery
<b>Reference ID</b>	CD024
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Time
<b>Data Type</b>	Date/Time
<b>Format</b>	HH:MM
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	<p>Codes used are:      This information is used to describe the admission time based on 24 hours' time format HHMM</p> <p>HH = Ranges from 00 to 23      MM = Ranges from 00 to 59      99 = Unknown values should be Code as 99 for HH or MM.</p> <p>Use leading zeros to assure 2 character field widths for HH and MM.</p> <p>0000 = Midnight is Code and begins the new day</p>

<b>Birth Plurality</b>	
<b>Definition</b>	An indicator of multiple births, showing the total number of births resulting from a single pregnancy.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Labor information Birth Plurality
<b>Reference ID</b>	CD025
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	The element to be used correctly, care should be practiced for: - Multiple fetuses with unknown gestational age - Consider only live births of any birth weight or gestational age - Fetuses weighing 400 g or more, are taken into account in determining plurality. Fetuses aborted before 20 completed weeks or fetuses compressed in the placenta at 20 or more weeks are excluded
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Singleton 2 = Twins 3 = Triplets 4 = Quadruplets 5 = Quintuplets 6 = Sextuplets 8 = Other 9 = Unknown

## Birth Order

<b>Definition</b>	The sequential order of each baby of a multiple birth, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Labor information Birth Order
<b>Reference ID</b>	CD026
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	In case of stillbirth being the first, a second live birth should be Coded by code 2
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Singleton of a multiple birth 2 = Second of a multiple birth 3 = Third of a multiple birth 4 = Fourth of a multiple birth 5 = Fifth of multiple birth 6 = Sixth of a multiple birth 8 = Other 9 = Not stated

## Complication of Labor

<b>Definition</b>	Complications experienced by the mother during or in the immediate post delivery period.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Labor Information Complication of Labor
<b>Reference ID</b>	CD027
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	This element is very crucial as it provides the important statistics of the complications that occur during management of labor and delivery. Such complications are associated with mortality and morbidity for both mother and fetus. Careful analysis of such data help overcome these complications
<b>Code Description and Permissible Values</b>	<p>Code used are:</p> <p>01 = Delay in first stage of labor - any cause      02 = Delay in second stage of labor - any cause      03 = Cord prolapse or presentation 04 = Antepartum Hemorrhage due to abruption of placenta (concealed or revealed)      05 = Antepartum Hemorrhage (cause unidentified)      06 = Antepartum Hemorrhage (placenta previa)      07 = Maternal pyrexia      08 = Malpresentation e.g. breech, transverse      09 = Malposition e.g. brow, face      10 = Sepsis      11 = Failed attempted instrumental or interventional vaginal delivery      12 = Maternal genital tract trauma      13 = Anemia      14 = postpartum hemorrhage      15 = Retained placenta or placental tissues      16 = Amniotic fluid embolism</p>

	<p>17 = Thromboembolism 18 = Cardiopulmonary arrest 19 = Intra or postpartum collapse (unidentified cause) 20 = Epileptiform fit including eclampsia 21 = Laparotomy excluding Caesarean Section 22 = Psychotic or severe mental health disorder requiring treatment with psychotropic medications 23 = Renal failure 24 = Clotting defect 25 = Severe proteinuric hypertension 26 = Acute diabetic complication (including diabetic ketoacidosis and Hypoglycemic shock) 88 = Other 99 = Unknown</p>
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## Maternity: Postnatal

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## Postnatal Problems/Complications

<b>Definition</b>	Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Postnatal information Postnatal Complications
<b>Reference ID</b>	CD029
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>00 = None          01 = Puerperal sepsis          02 = Secondary postpartum hemorrhage          03 = Infected / broken episiotomy or perineal laceration          04 = Piles          05 = Constipation          06 = Thromboembolism          07 = Urinary tract infection          08 = Urinary incontinence          09 = Fecal incontinence          10 = Pelvic musculoskeletal complication          11 = Psychotic or severe mental health disorder          88 = Other</p>

## Postpartum Complications

<b>Definition</b>	Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Postnatal information Postpartum Complication
<b>Reference ID</b>	CD030
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
<b>Format</b>	ANN.NN
<b>Maximum Field Size</b>	6
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM. There is no arbitrary limit on the number of conditions specified. Examples of such conditions include postpartum hemorrhage, retained placenta, puerperal infections, puerperal psychosis, essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. Complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalization after childbirth.
<b>Code Description and Permissible Values</b>	Codes used are: ICD - 10 - AM chapter 15 related to pregnancy, childbirth & Puerperium

<b>Length of stay (including leave days) (postnatal)</b>	
<b>Definition</b>	The length of stay (LOS) of a woman following the birth of her baby, including leave days, measured in days.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity: Postnatal - Length of stay (including leave days) (postnatal)
<b>Reference ID</b>	CD031
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p><b>Formula:</b></p> <p>LOS (postnatal) = mother's separation date - baby's date of birth Postnatal LOS is calculated by subtracting the baby's date of birth from the mother's date of separation. It includes contact days and leave days. If the mother's separation date and the baby's date of birth are on the same date, count the LOS as 1 day.</p> <p>In a multiple pregnancy, the date of birth of the first baby born should be used to calculate the mother's postnatal LOS. Postnatal length of stay refers only to the episode of care associated with the birth. To calculate the total length of stay, use the data element - Episode of admitted patient care - total length of stay (including leave days).</p>
<b>Code Description and Permissible Values</b>	Not Applicable

## Post Delivery Perineal status

<b>Definition</b>	The state of the perineum following birth, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity: Postnatal—Post delivery perineal status
<b>Reference ID</b>	CD032
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	Codes used are: 01 = Intact 02 = 1st degree laceration/vaginal graze 03 = 2nd degree laceration 04 = 3rd degree laceration 05 = 4th degree laceration 06 = Episiotomy 07 = Combined laceration and episiotomy 08 = 4th degree laceration 88 = Other 99 = Not stated



## Maternity: Immunization

## Anti-D Immunization: Administration

<b>Definition</b>	Records whether a Rhesus negative mother has received anti-D gamma globulin. Usually given within 72 hours of delivery or during pregnancy following invasive procedures and following any vaginal bleeding or abdominal trauma. May also be given as prophylactic measure during pregnancy
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Information Immunization Anti-D Administration
<b>Reference ID</b>	CD033
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	This element helps to report the status of Anti-D use with some required cases
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Given      2 = Required but not given      3 = Not required      4 = Declined by mother      8 = Other</p>

## Anti-D: Immunization: Reason

<b>Definition</b>	The reason why Anti-D immunization is administered to a woman.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Information Immunization Anti-D Reason
<b>Reference ID</b>	CD034
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>01 = Following amniocentesis/ CVS      02 = Following antepartum bleed      03 = Following termination of pregnancy      04 = Following miscarriage      05 = Following external cephalic version      06 = Following other invasive procedures      07 = After delivery as indicated      08 = Prophylactic during the third trimester      88 = Other      99 = Unknown</p>

## Rubella: Vaccination of Mother Postnatal

<b>Definition</b>	Records whether a mother has received Rubella vaccination in the postnatal period
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Information Immunization Rubella Vaccination of Mother
<b>Reference ID</b>	CD035
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Given      2 = Required but not given      3 = Not required      4 = Declined by mother      8 = Other</p>

Apgar score	
Definition	Numerical score to evaluate the baby's condition at 1, 5 or 10 minute after birth.
Metadata Type	Data Concept
Data Concept	Maternity Newborn Apgar Score
Reference ID	CD036
Synonyms	Not Applicable
Representation Class	Concept
Data Type	
Format	
Maximum Field Size	
Date Created	
Date Updated	
Source	Palestinian Health Data Dictionary Second edition, 2005
Usage	<p>The score introduced for use in 1953 and since then it is a reliable indicator of newborn status. It evaluates the newborn in 5 areas:</p> <ul style="list-style-type: none"> <li>1- Color</li> <li>2- Heart rate</li> <li>3- Muscle tone</li> <li>4- Reflexes and</li> <li>5- Respiratory effort.</li> </ul> <p>Each of these areas are Code from 0 to 2. The maximum score or best response of newborn will be equal to score 10</p>
Code Description and Permissible Values	Not Applicable

## Apgar Score at 1 Minute

<b>Definition</b>	Numerical score to evaluate the baby's condition at 1 minute after birth.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Newborn Apgar Score at 1 Minute
<b>Reference ID</b>	CD037
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Report Apgar Score at 1 Minute
<b>Code Description and Permissible Values</b>	Codes used are: 00 - 10 00 = Being Lowest when non-responsive increases to 10 maximum score according to clinical finding. 99 = Not stated

## Apgar Score at 5 Minutes

<b>Definition</b>	Numerical score to evaluate the baby's condition at 5 minutes after birth.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Newborn Apgar Score at 5 Minutes
<b>Reference ID</b>	CD038
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Report Apgar Score at 5 Minutes
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>00 – 10</p> <p>00 = Being Lowest when non-responsive increases to</p> <p>10 = Maximum score according to clinical finding.</p> <p>99 = Not stated</p>

## Apgar Score at 10 Minutes

<b>Definition</b>	Numerical score to evaluate the baby's condition at 10 minutes after birth.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Newborn Apgar Score at 10 Minutes
<b>Reference ID</b>	CD039
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Report Apgar Score at 10 Minutes
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>00 - 10</p> <p>00 = Being Lowest when non-responsive</p> <p>10 = Maximum score according to clinical finding</p> <p>99 = Not stated</p>

## Apgar Score at 20 Minutes

<b>Definition</b>	Numerical score to evaluate the baby's condition at 20 minutes after birth.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Newborn Apgar Score at 20 Minutes
<b>Reference ID</b>	CD040
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Report Apgar Score at 20 Minutes
<b>Code Description and Permissible Values</b>	Codes used are: 00 – 10 00 = Being Lowest when non-responsive 10 = Maximum score according to clinical finding 99 = Not stated

## Birth Weight

<b>Definition</b>	The weight of the baby immediately following delivery recorded in grams to the nearest gram and measured within the first hour of life. The World Health Organization further defines the following categories: - Extremely low birth weight: <1,000 g (up to and including 999 g) - Very low birth weight: <1,500 g (up to and including 1,499 g) - Low birth weight: <2,500 g (up to and including 2,499 g) - Normal weight: =2,500g – 4,000g. - Over weight: >4,000g
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Information Newborn, Birth weight
<b>Reference ID</b>	CD041
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	This element is used to report progress of weight; newborn's weight progress is in grams which reflect their positive gain and response to management.
<b>Code Description and Permissible Values</b>	Codes used are: NNNN = State the weight in Grams

## Neonatal Weight

<b>Definition</b>	The weight of the baby recorded in grams to the nearest gram and recorded at any time other than Birth Weight within the first 28 days of life.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Newborn Birth weight
<b>Reference ID</b>	CD042
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	This element is used to report progress of weight; newborn's weight progress is in grams which reflect their positive gain and response to management
<b>Code Description and Permissible Values</b>	State the weight in Grams

## Head Circumference: at Birth

<b>Definition</b>	The occipito-frontal circumference of a baby's head measured within first hour of life.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Newborn head Circumference
<b>Reference ID</b>	CD043
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Report actual head measurement in centimeter (CM)
<b>Code Description and Permissible Values</b>	State the head measurement in CM

## Suspected Congenital Anomaly

<b>Definition</b>	Records whether or not a congenital anomaly is suspected
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Suspected Congenital Anomaly
<b>Reference ID</b>	CD044
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Report clinical suspicion of congenital anomaly to indicate further assessment needs of the new birth
<b>Code Description and Permissible Values</b>	Codes used are: 0 = No 1 = Yes

## NICU Admission Source

<b>Definition</b>	The source of admission for a baby admitted to the Special Care Baby Unit
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Newborn NICU Admission Source
<b>Reference ID</b>	CD045
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Special area beds are high cost on any health system, information collected to analyze its use is considered very important as it helps understanding the pattern of use and can help in its management.
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Born at this hospital 2 = Transferred from another government hospital 3 = Transferred from private hospital 3 = Born before arrival 4 = Inutero transfer 5 = Home delivery 9 = Unknown

## Vitamin K (Prophylactic): Administration

<b>Definition</b>	Records whether Vitamin K is administered to the baby immediately after birth
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity Newborn Vitamin K (prophylactic) Administration
<b>Reference ID</b>	CD046
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Report Administration of Vitamin K as a compliance indicator with protocols for better maternity health practice
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Given 2 = Not given – clinical reasons 3 = Not given – other reasons 4 = Declined by parents

<b>Number of qualified days for newborns</b>	
<b>Definition</b>	The number of qualified newborn days occurring within a newborn episode of care.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity: Newborn - Number of qualified days for newborns
<b>Reference ID</b>	CD047
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	5N
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>The rules for calculating the number of qualified newborn days are outlined below.</p> <p>The number of qualified days is calculated with reference to the Episode of admitted patient care— admission date, DDMMYYYY, Episode of admitted patient care— separation date, DDMMYYYY and any Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY:</p> <ul style="list-style-type: none"> <li>• The date of admission is counted if the patient was qualified at the end of the day</li> <li>• The date of change to qualification status is counted if the patient was qualified at the end of the day</li> <li>• The date of separation is not counted, even if the patient was qualified on that day</li> <li>• The normal rules for calculation of patient days apply, for example in relation to leave and same day patients The length of stay for a newborn episode of care is equal to the sum of the qualified and unqualified days.</li> </ul>
<b>Code Description and Permissible Values</b>	Codes used are: 5N = Number of qualified newborn days

## Resuscitation of baby-method

<b>Definition</b>	Active measures taken immediately after birth to establish independent respiration and heart rate, or to treat depressed respiratory effect and to correct metabolic disturbances, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Maternity: Newborn - Resuscitation of baby—method
<b>Reference ID</b>	CD048
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This metadata item does not include drug therapy. Code the most severe measure used.
<b>Code Description and Permissible Values</b>	Codes used are: 1 = None 2 = Suction only 3 = Oxygen therapy only 4 = Intermittent positive pressure respiration (IPPR) through bag and mask 5 = Endotracheal intubation and IPPR 6 = External cardiac massage and ventilation 9 = Not stated

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## Ambulatory Care Information

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Indicator Procedure																	
Definition	Indicator procedure for which an elective surgery patient is waiting, as represented by a code.																
Metadata Type	Data Element																
Data Concept	Ambulatory Care Information - Indicator procedure																
Reference ID	CE001																
Synonyms	Non Applicable																
Representation Class	Code																
Data Type	Numeric																
Format	NN																
Maximum Field Size	2																
Date Created	19/05/2016																
Date Updated	To be defined																
Source	Australian National Health Data Dictionary Version 14, 2008																
Usage	<p>The procedure terms are defined by the Australian Classification of Health Interventions (ACHI) codes. Where a patient is awaiting more than one indicator procedure, all codes should be listed. This is because the intention is to count procedures rather than patients in this instance.</p> <p>These are planned procedures for the waiting list, not what is actually performed during hospitalization although this list is not exhaustive but is the most common which gives an appropriate indication for resource allocation</p>																
Code Description and Permissible Values	<p>Codes used are:</p> <table> <tbody> <tr> <td>01 = Cataract extraction</td> <td>09 = Myringotomy</td> </tr> <tr> <td>02 = Cholecystectomy</td> <td>10 = Prostatectomy</td> </tr> <tr> <td>03 = Coronary artery bypass graft</td> <td>11 = Septoplasty</td> </tr> <tr> <td>04 = Cystoscopy</td> <td>12 = Tonsillectomy</td> </tr> <tr> <td>05 = Haemorrhoidectomy</td> <td>13 = Total hip replacement</td> </tr> <tr> <td>06 = Hysterectomy</td> <td>14 = Total knee replacement</td> </tr> <tr> <td>07 = Inguinal herniorrhaphy</td> <td>15 = Varicose veins stripping and ligation</td> </tr> <tr> <td>08 = Myringoplasty</td> <td>16 = Not applicable</td> </tr> </tbody> </table>	01 = Cataract extraction	09 = Myringotomy	02 = Cholecystectomy	10 = Prostatectomy	03 = Coronary artery bypass graft	11 = Septoplasty	04 = Cystoscopy	12 = Tonsillectomy	05 = Haemorrhoidectomy	13 = Total hip replacement	06 = Hysterectomy	14 = Total knee replacement	07 = Inguinal herniorrhaphy	15 = Varicose veins stripping and ligation	08 = Myringoplasty	16 = Not applicable
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## Date Patient Presents

<b>Definition</b>	The Date on which the patient/client presents for the delivery of a service.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health service event—Date patient presents
<b>Reference ID</b>	CE002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	<p>For community Healthcare, outreach services and services provided via telephone or telehealth, this may be the date on which the service provider presents to the patient or the telephone/telehealth session commences. The date of patient presentation at the Emergency department is the earliest occasion of being registered clerically or triaged. The date that the patient presents is not necessarily:</p> <ul style="list-style-type: none"> <li>• The listing date for care (see listing date for care), nor</li> <li>• The date on which care is scheduled to be provided, nor</li> <li>• The date on which commencement of care actually occurs (for admitted patients see admission date, for hospital non- admitted patient care and community Healthcare see service commencement date).</li> </ul>
<b>Code Description and Permissible Values</b>	<p>Codes used are: DDMMYYYY Century digits are considered essential</p>

## Time Patient Presents

<b>Definition</b>	The time at which the patient presents for the delivery of a service. The service is defined as commencing when a Healthcare professional first takes responsibility for the patient/client's care.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health service event—Time patient presents
<b>Reference ID</b>	CE003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Time
<b>Data Type</b>	Date/Time
<b>Format</b>	HH:MM
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	<p>For community Healthcare, outreach services and services provided via telephone or telehealth, this may be the date on which the service provider presents to the patient or the telephone/telehealth session commences. The date of patient presentation at the Emergency department is the earliest occasion of being registered clerically or triaged. The date that the patient presents is not necessarily:</p> <ul style="list-style-type: none"> <li>• The listing date for care (see listing date for care), nor</li> <li>• The date on which care is Scheduled to be provided, nor</li> <li>• The date on which commencement of care actually occurs</li> </ul> <p>(for admitted patients see admission date, for hospital non-admitted patient care and community Healthcare see service commencement date).</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>State the admission time based on 24 hours' time format HH:MM.</p> <p>HH = Ranges from 00 to 23</p> <p>MM = Ranges from 00 to 59.</p> <p>99 = Unknown values for HH or MM</p> <p>Use leading zeros to assure 2-character field widths for HH and MM.</p> <p>0000 = Midnight Code, and begins the new day.</p>

<b>Chief Complaint</b>	
<b>Definition</b>	Statement of medical problem by patient or other person
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health service event—Chief Complaint
<b>Reference ID</b>	CE004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Text
<b>Data Type</b>	Alphab
<b>Format</b>	Free Text
<b>Maximum Field Size</b>	Free Text line
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	The data element may be useful, particularly with sophisticated text searching algorithms, for analysis of certain types of EMS incidents. Difficulties of categorization and interpretation were the primary reasons for labeling this item as desirable rather than essential.  The data element may be of use in correlating the perception of patients who utilize the EMS system with the objective outcome of the run. This information could be of use in directing public educational efforts concerning health or EMS use.
<b>Code Description and Permissible Values</b>	Codes used are:  Free text description of the patient's problem, usually as expressed by the patient or witnesses. When this information cannot be obtained (for instance, a comatose patient, or a patient injured without witnesses) it may be Coded as unknown  If there is no patient, such as in a standby call, this should be Coded as not applicable.

Difficulty with activities	
Definition	The level of difficulty a person has in performing the tasks and actions involved in specified life areas, as represented by a code.
Metadata Type	Data Element
Data Concept	Ambulatory Care Information - Difficulty with activities
Reference ID	CE005
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	<p>This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person. In the context of health, an activity is the execution of a task or action by an individual.</p> <p>Activity limitations are difficulties an individual may have in executing an activity. Difficulties with activities can arise when there is a qualitative or quantitative alteration in the way in which these activities are carried out.</p> <p>Difficulty includes matters such as 'with pain', 'time taken', 'number of errors', 'clumsiness', 'modification of manner in which an activity is performed' e.g. sitting to get dressed instead of standing. 'Difficulty' is a combination of the frequency with which the problem exists, the duration of the problem and the intensity of the problem.</p> <p>Activity limitations are assessed against a generally accepted population standard, relative to cultural and social expectations.</p> <p>Activity limitation varies with the environment and is assessed in relation to a particular environment; the absence or presence of assistance, including aids and equipment, is an aspect of the environment.</p>

	<p>The user will select the code that most closely summarizes, in terms of duration, frequency, manner or outcome, the level of difficulty of the person for whom the data is recorded.</p> <p>CODE 0 = No difficulty in this life area, is used when there is no difficulty in performing this activity. This scale has a margin of error of 5%. [0-4%]</p> <p>CODE 1 = Mild difficulty, is recorded for example, when the level of difficulty is below the threshold for medical intervention, the difficulty is experienced less than 25% of the time, and/or with a low alteration in functioning which may happen occasionally over the last 30 days. [5-24%].</p> <p>CODE 2 = Moderate difficulty, is used for example when the level of difficulty is experienced less than 50% of the time and/or with a significant, but moderate effect on functioning (Up to half the scale of total performance) which may happen regularly over the last 30 days. [25-49%]</p> <p>CODE 3 = Severe difficulty, is used for example when performance in this life area can be achieved, but with only extreme difficulty, and/or with an extreme effect on functioning which may happen often over the last 30 days. [50-95%]</p> <p>CODE 4 = Complete difficulty, is used when the person cannot perform in this life area due of the difficulty in doing so. This scale has a margin of error of 5%. [96-100%]</p> <p>CODE 8 = Not specified, is used where a person has difficulty with activities in a life area but there is insufficient information to use codes 0-4.</p> <p>CODE 9 = Not applicable, is used where a life area is not applicable to this person, e.g. domestic life for a child under 5.</p> <p>This data element, in conjunction with Person—activities and participation life area, code (ICF 2001) ANNNN, indicates the presence and extent of activity limitation in a given domain of activity.</p>
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<b>Code Description and Permissible Values</b>	Codes used are: 0 = No difficulty 1 = Mild difficulty 2 = Moderate difficulty 3 = Severe difficulty 4 = Complete difficulty 8 = Not specified 9 = Not applicable
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<b>External cause (non-admitted patient)</b>	
<b>Definition</b>	Environmental event, circumstance or condition as the cause of injury, poisoning or other adverse effect to a non-admitted patient.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Ambulatory Care Information - External cause (non-admitted patient)
<b>Reference ID</b>	CE006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>This data item is used for injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. Non-admitted patients in emergency departments). Select the item which best characterizes the circumstances of the injury, on the basis of the information available at the time it is recorded.</p> <p>If two or more categories are judged to be equally appropriate select the one that comes first in the code list. The external cause - non-admitted patient group must always be accompanied by an external cause - human intent code (see metadata item Injury event—external cause, non-admitted patient human intent code NN)</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>01 = Motor vehicle - driver</li> <li>02 = Motor vehicle - passenger or unspecified occupant</li> <li>03 = Motorcycle - driver</li> <li>04 = Motorcycle - passenger or unspecified</li> <li>05 = Pedal cyclist or pedal cycle passenger</li> <li>06 = Pedestrian</li> <li>07 = Other or unspecified transport-related circumstance</li> <li>08 = Horse-related (includes fall from, struck or bitten by)</li> <li>09 = Fall - low (on same level or</li> <li>10 = Fall - high (drop of 1 meter or more)</li> <li>11 = Drowning, submersion - swimming pool</li> <li>12 = Drowning, submersion - other than swimming pool</li> </ul>

	(excludes drowning associated with watercraft) 13 = Other threat to breathing (including strangling and asphyxia) 14 = Fire, flames, smoke 15 = Hot drink, food, water, other fluid, steam, gas or vapor 16 = Hot object or substance, not otherwise specified 17 = Poisoning - drugs or medicinal substance 18 = Poisoning - other substance 19 = Firearm 20 = Cutting, piercing object 21 = Dog-related 22 = Animal-related (excluding Horse and Dog) 23 = Machinery in operation 24 = Electricity 25 = Hot conditions (natural origin) sunlight 26 = Cold conditions (natural origins) 27 = Other specified external cause 28 = Unspecified external cause 29 = Struck by or collision with person 30 = Struck by or collision with object
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## Level of palliative care service

<b>Definition</b>	The level of specialization of the palliative care service delivered by a palliative care agency, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Ambulatory Care Information - Level of palliative care service
<b>Reference ID</b>	CE007
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>CODE 1 = Primary palliative care, Capability: Clinical management and care coordination including assessment, triage, and referral using a palliative approach for patients with uncomplicated needs associated with a life limiting illness and/or end of life care. Has formal links with a specialist palliative care provider for purposes of referral, consultation and access to specialist care as necessary. Typical resource profile: General medical practitioner, nurse practitioner, registered nurse, generalist community nurse, aboriginal health worker, allied health staff. Specialist Healthcare providers in other disciplines would be included at this level.</p> <p>CODE 2 = Specialist palliative care level 1, Capability: Provides palliative care for patients, primary carers and families whose needs exceed the capability of primary palliative care providers. Provides assessment and care consistent with needs and provides consultative support, information and advice to primary palliative care providers. Has formal links to primary palliative care providers and level 2 and/or 3 specialist palliative care providers to meet the needs of patients, carers and families with complex problems. Has quality and audit program. Typical resource profile: Multi-disciplinary team including medical practitioner with skills and experience in palliative care, clinical nurse specialist/consultant, allied health staff, pastoral care and volunteers. A designated staff member if available coordinates a volunteer service.</p>

	<p>CODE 3 = Specialist palliative care level 2, Capability: As for level 1, able to support higher resource level due to population base (e.g. regional area). Provides formal education programs to primary palliative care and level 1 providers and the community. Has formal links with primary palliative care providers and level 3 specialist palliative care services for patients, primary carers and families with complex needs. Typical resource profile: Interdisciplinary team including medical practitioner and clinical nurse specialist/consultant with specialist qualifications. Includes designated allied health and pastoral care staff.</p> <p>CODE 4 = Specialist palliative care level 3, Capability: Provides comprehensive care for the needs of patients, primary carers and families with complex needs. Provides local support to primary palliative care providers, regional level 1 and/or 2 services including education and formation of standards. Has a comprehensive research and teaching role. Has formal links with local primary palliative care providers and with specialist palliative care providers level 1 and 2, and relevant academic units including professorial chairs where available. Typical resource profile: Interdisciplinary team including a medical director and clinical nurse consultant/nurse practitioner and allied health staff with specialist qualifications in palliative care.</p>
Code Description and Permissible Values	<p>Codes used are:</p> <p>1 = Primary palliative care      2 = Specialist palliative care level 1      3 = Specialist palliative care level 2      4 = Specialist palliative care level 3</p>

### Mental health service contact date

<b>Definition</b>	The date of each mental health service contact between a health service provider and patient/client.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Ambulatory Care Information - Mental health service contact date
<b>Reference ID</b>	CE008
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	The service contact is required for clinical audit and other quality assurance purposes. Requires services to record the date of each service contact, including the same date where multiple visits are made on one day (except where the visits may be regarded as a continuation of the one service contact). Where an individual patient/client participates in a group activity, a service contact date is recorded if the person's participation in the group activity results in a dated entry being made in the patient's/client's record.
<b>Code Description and Permissible Values</b>	Codes used are : DDMMYYYY Century digits are considered essential

### Mental health service contact duration

<b>Definition</b>	The time from the start to finish of a service contact.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Ambulatory Care Information -Mental health service contact duration
<b>Reference ID</b>	CE009
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	For group sessions the time for the patient/client in the session is recorded for each patient/client, regardless of the number of patients/clients or third parties participating or the number of service providers providing the service. Writing up details of service contacts is not to be reported as part of the duration, except if during or contiguous with the period of patient/client or third party participation. Travel to or from the location at which the service is provided, for example to or from outreach facilities or private homes, is not to be reported as part of the duration of the service contact.
<b>Code Description and Permissible Values</b>	Not Applicable

### Number of service events (non-admitted patient)

<b>Definition</b>	The total number of service events provided to non-admitted patients in the reference period, for each of the clinical service types in the hospital.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Ambulatory Care Information -Number of service events (non-admitted patient)
<b>Reference ID</b>	CE010
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	7N
<b>Maximum Field Size</b>	7
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Count of non-admitted patient service events for each of the clinical service types listed in the value domain of the metadata item Non-admitted patient service event—service event type (clinical), code NN. For each Non-admitted patient service event count, specify the <ul style="list-style-type: none"> <li>• Non-admitted patient service event—service event type (clinical), code NN</li> <li>• Non-admitted patient service event—multidisciplinary team status, code N</li> <li>• Service contact—group session status, individual/group session indicator code ANN.N</li> <li>• Non-admitted patient service event—patient present status, code N</li> <li>• Non-admitted patient service event— service mode, hospital code N{N}</li> </ul>
<b>Code Description and Permissible Values</b>	Not Applicable

### Patient present status (non-admitted patient)

<b>Definition</b>	The presence or absence of a patient at a service event, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Ambulatory Care Information -Patient present status (non-admitted patient)
<b>Reference ID</b>	CE011
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Patient present with or without carer(s)/relative (s) 2 = Carer(s)/relative(s) of the patient only

<b>Service mode (non-admitted patient)</b>	
<b>Definition</b>	Relative physical location of the patient, provider and the hospital campus of the provider of a non-admitted patient service event, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Ambulatory Care Information -Service mode (non-admitted patient)
<b>Reference ID</b>	CE012
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>This element is used as follows:</p> <p>CODE 1.1 On the hospital campus of the provider, Patient and provider in the same physical location refers to face to face contacts. If this occurs at the hospital campus of the provider, use code 1.1</p> <p>CODE 1.2 Not on the hospital campus of the provider, If the service event does not occur on the hospital campus of the provider (hospital-based outreach services), use code 1.2. Hospital-based outreach service events occur when the patient is treated by hospital staff in a location that is not part of the hospital campus (such as in the patient's home or place of work). Patient and provider not in the same physical location refers to service events delivered via a telephone call or video link (telemedicine). The provider may or may not be physically present on their hospital campus. A service event delivered via a telephone call is included if:</p> <ul style="list-style-type: none"> <li>• it is a substitute for a face-to-face service event, and</li> <li>• it is prearranged, and</li> <li>• a record of the service event is included in the patient's medical record A service event can be counted at each site participating via a video link.</li> </ul>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Patient and provider in the same physical location</p> <p>1.1 = On the hospital campus of the provider</p> <p>1.2 = Not on the hospital campus of the provider</p> <p>2 = Patient and provider not in the same physical location, and communicating via:</p> <p>2.1 = Telephone</p> <p>2.2 = Telemedicine</p>

### Service type (non-admitted patient)

<b>Definition</b>	The type of clinical service provided to a non-admitted patient in a non-admitted patient service event, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Ambulatory Care Information—Service type (non-admitted patient)
<b>Reference ID</b>	CE013
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	Codes used are: 01 = Allied health and/or clinical nurse specialist 02 = Dental 03 = Emergency department 04 = Imaging 05 = Medical 06 = Obstetrics and Gynecology 07 = Oncology 08 = Pathology 09 = Pediatrics 10 = Pharmacy 11 = Psychiatric 12 = Surgical

<b>Multi-Disciplinary Team Status</b>	
Definition	Whether a non-admitted patient service event involved a multidisciplinary team, as represented by a code.
Metadata Type	Data Element
Data Concept	Ambulatory Care patient service event—multidisciplinary team status
Reference ID	CE014
Synonym	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	None
Code Description and Permissible Values	<p>Codes used are:</p> <p>1 = Non-admitted multidisciplinary team patient service event      2 = Other non-admitted patient service event</p>

<b>Individual/group session indicator</b>	
<b>Definition</b>	A code set representing whether services are provided to an individual or a group.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Ambulatory Care patient service event—Individual / group session indicator
<b>Reference ID</b>	CE015
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This excludes the situation where individuals all belong to the same family. In such cases, the service is being provided to the family unit and as a result the session should be counted as a single occasion of service to an individual
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Individual sessions 2 - Group sessions

<b>Place of occurrence of external cause of injury (Non-admitted patient)</b>	
<b>Definition</b>	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Ambulatory Care Information-Place of occurrence of external cause of injury (non-admitted patient)
<b>Reference ID</b>	CE016
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Date Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>To be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes.</p> <p>Select the code which best characterizes the type of place where the person was situated when the injury occurred on the basis of the information available at the time it is recorded.</p> <p>If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>00 = Home</li> <li>01 = Residential Institution</li> <li>02 = School, other institution and public administration area</li> <li>03 = School</li> <li>04 = Health service area</li> <li>05 = Building used by general public or public group</li> <li>06 = Sports and athletics area</li> <li>07 = Street and highway</li> <li>08 = Trade and service area</li> <li>09 = Industrial and construction area</li> <li>10 = Farm</li> <li>88 = Other specified places</li> <li>99 = Unspecified place</li> </ul>

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## Vital Signs

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<b>Heart Rate</b>	
Definition	The person's heart rate measured in beats per minute.
Metadata Type	Data Element
Data Concept	Vital Signs—pulse rate
Reference ID	CF001
Synonyms	Non Applicable
Representation Class	Total
Data Type	Numeric
Format	NNN
Maximum Field Size	3
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	This data element is used to collect data for Acute Coronary Syndrome (ACS) patient reporting, the data should be collected at time of presentation. If heart rate is not recorded at the exact time of presentation, record the first heart rate measured closest to the time of presentation. This element has a medico-legal importance
Code Description and Permissible Values	Codes used are: 997 = Cardiac arrest 998 = Not recorded 999 = Not stated/inadequately described

## Heart Rhythm Type

<b>Definition</b>	The type of rhythm associated with the beating of the heart as determined from the electrocardiogram (ECG), as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Vital Signs - Heart Rhythm Type
<b>Reference ID</b>	CF002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This data element is used to collect data for Acute Coronary Syndrome (ACS) patient reporting, the data should be collected at time of presentation. If heart rhythm type is not recorded at the exact time of presentation, record the first heart rate measured closest to the time of presentation. This element has a medico-legal importance
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>01 = Sinus rhythm</li> <li>02 = Atrial fibrillation</li> <li>03 = Atrial flutter</li> <li>04 = Second degree heart block</li> <li>05 = Complete heart block</li> <li>06 = Supraventricular tachycardia</li> <li>07 = Idioventricular rhythm</li> <li>08 = Ventricular tachycardia</li> <li>09 = Ventricular fibrillation</li> <li>10 = Paced</li> <li>88 = Other rhythm</li> <li>99 = Not stated/inadequately described</li> </ul>

## Respiratory Rate

<b>Definition</b>	Unassisted patient respiratory rate expressed as number per minute
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Vital Signs - Respiratory Rate
<b>Reference ID</b>	CF003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Respiratory rate is an important component of several triage scoring systems and provides some assessment of severity of illness or injury. If a patient is not breathing and requires artificial ventilation, this data element should be: Code 00 when patient is in need of artificial ventilation Code 88 when respiratory rate was not obtained Code 99 when respiratory rate was obtained but is unknown at the time of data entry
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>NN = Actual measurement          00 = Artificial ventilation          88 = Not obtained          99 = Unknown</p>

## Systolic Blood Pressure

<b>Definition</b>	The person's systolic blood pressure, measured in millimeters of mercury (mmHg).
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Vital Signs - Systolic Blood Pressure
<b>Reference ID</b>	CF004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This element is used to record the systolic blood pressure measured for patients that their condition mandates such assessment. The reading is entered as a value for the examination even if palpation method was used. Use Code '888', when it was not possible to measure the systolic blood pressure. Use Code '999', when no blood pressure was assessed
<b>Code Description and Permissible Values</b>	Codes used are: Measuring unit mm. HG (Millimetre of Mercury) NNN = Actual reading (3-digit field) 888 = Not measurable 999 = Unknown

## Diastolic Blood Pressure

<b>Definition</b>	The person's diastolic blood pressure, measured in millimetres of mercury (mmHg).
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Vital Signs - Diastolic Blood Pressure
<b>Reference ID</b>	CF005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	If the blood pressure was assessed by palpation or with a Doppler device, then this field should be Code as '888', as the diastolic blood pressure was, in fact, not measured. If this vital sign was not obtained, the field should be Code as '888', and if this vital sign was obtained but is unknown at the time of data entry, the field should be Code as '999'.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>– Measuring unit mm. HG (Millimetre of Mercury)</li> <li>– NNN = Actual reading (3-digit field)</li> <li>– 888 = Not measurable</li> <li>– 999 = Unknown</li> </ul>

## Body Temperature

<b>Definition</b>	Core body temperature measured at the beginning of health incident that mandates its recording
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Vital Signs - Body Temperature
<b>Reference ID</b>	CF006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NN
	2
<b>Maximum Field Size</b>	
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element is crucial when handling patients that suffer environmental injuries as the core body temperature is a main indicator of patient condition. Use Code 88 for unmeasured core temperature Use Code 99 when it is not known at the time of data entry
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>– Measuring unit is The Celsius scale (°C)</li> <li>– NN = Actual reading (2 digit field)</li> <li>– 88 = Not obtained</li> <li>– 99 = Unknown</li> </ul>

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## Admission Information

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## Admission Episode

<b>Definition</b>	Admission is the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical. Formal admission: The administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient. Statistical admission: The administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay.
<b>Metadata Type</b>	Data Concept
<b>Data Concept</b>	
<b>Reference ID</b>	CG001
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Concept
<b>Data Type</b>	
<b>Format</b>	
<b>Maximum Field Size</b>	
<b>Date Created</b>	
<b>Date Updated</b>	
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008.
<b>Usage</b>	Admitted patient care, this information is used to describe the admission senses in the Healthcare facility as an inpatient for a day care service or more. It excludes any temporary bed use in Emergency Room and for procedures done on ambulatory bases.
<b>Code Description and Permissible Values</b>	

## Admission Date

<b>Definition</b>	This field contains the date the patient was admitted to hospital at the start of a hospital spell
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Admission, Admission date
<b>Reference ID</b>	CG002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	United Kingdom National health Services, Hospital Episode Statistics September 2010
<b>Usage</b>	Required to identify the date of commencement of the episode or hospital stay, for calculation of length of stay.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>DDMMYYYY Century digits are considered essential</p>

<b>Admission Time</b>	
<b>Definition</b>	Time at which an admitted patient commences an episode of care.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Admission, Admission time
<b>Reference ID</b>	CG003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Time
<b>Data Type</b>	Date/Time
<b>Format</b>	HH:MM
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Required to identify the time of commencement of the episode or hospital stay, for calculation of waiting times and length of stay.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>This information is used to describe the admission time based on 24 hours' time format HHMM.</p> <ul style="list-style-type: none"> <li>– HH = Ranges from 00 to 23;</li> <li>– MM = Ranges from 00 to 59.</li> <li>– 0000 = Midnight is Code, and begins the new day.</li> <li>– 99 = Unknown values should be for HH or MM.</li> <li>– Use leading zeros to assure 2-character field widths for HH and MM.</li> </ul>

<b>Method of Admission</b>	
<b>Definition</b>	This field contains a code which identifies how the patient was admitted to hospital.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Admission-Method of Admission
<b>Reference ID</b>	CG004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	United Kingdom National health Services, Hospital Episode Statistics September 2010
<b>Usage</b>	This information is used to describe the priority used to complete the process of admission in an inpatient care facility. Code 01 for immediate admission is used for all Life Threatening Admission and is applicable as example on Cardiac infarction and severe trauma requiring immediate surgery after resuscitation. It is recorded on the first and also all subsequent episodes within the spell (ie where the spell is made up of more than one episode).
<b>Code Description and Permissible Values</b>	Codes used are: 01 = Immediate Admission 02 = Emergency Admission from hospital ER 03 = Emergency Admission from hospital outpatient 04 = Emergency Admission by referral from government primary Health Care center 05 = Emergency Admission by referral from general government hospital 06 = Emergency Admission by referral from private primary Healthcare center 07 = Emergency Admission by referral from private hospital 08 = Emergency Admission by insurance company 09 = Elective waiting list admission government free Scheme 10 = Elective waiting list admission self-payment Scheme 11 = Elective waiting list admission insurance coverage Scheme 12 = Emergency Maternity Birth Admission 13 = Planned Maternity Birth Admission 88 = Others 99 = Unknown

## Admitting Diagnosis

<b>Definition</b>	The diagnosis code describing the patient's diagnosis at the time of admission
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Admission-Admitting Diagnosis
<b>Reference ID</b>	CG005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
<b>Format</b>	ANN.NN
<b>Maximum Field Size</b>	6
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	USA Health & Human Services, Agency for Healthcare Research & Quality 2015
<b>Usage</b>	This information is used to describe the primary diagnosis of the patient on admission as stated by the treating physician. A great care should be practiced when coding an admission diagnosis as it is necessary to avoid inappropriate diagnosis that describes the circumstances that cause an injury, rather than the nature of the injury. As they cannot be accepted as an admission diagnosis in compliance with ICD 10 AM. Important Note: Use the admitting diagnosis when no other diagnostic information is available
<b>Code Description and Permissible Values</b>	Codes used are:  Approved ICD-10 – AM edition

<b>Date of diagnosis</b>	
<b>Definition</b>	The date on which a patient is diagnosed with a particular condition or disease.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Admission - Date of Diagnosis
<b>Reference ID</b>	CG006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This element is crucial for benchmarks used in the dictionary
<b>Code Description and Permissible Values</b>	Codes used are: DDMMYYYY Century digits are considered essential

### Date of procedure

<b>Definition</b>	The date on which a procedure commenced during an inpatient episode of care.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Admission - Date of procedure
<b>Reference ID</b>	CG007
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Required to provide information on the timing of the procedure in relation to the episode of care.
<b>Code Description and Permissible Values</b>	<p>Codes used are :</p> <p>DDMMYYYY Century digits are considered essential</p>

### Diagnosis Related Group

<b>Definition</b>	A patient classification scheme which provides a clinically meaningful way of relating the number and types of patients treated in a hospital to the resources required by the hospital, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Admission - Diagnosis Related Group
<b>Reference ID</b>	CG008
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
<b>Format</b>	ANNA
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	The Australian Refined Diagnosis Related Group is derived from a range of data collected on admitted patients, including diagnosis and procedure information, classified using ICD-10-AM. The data elements required are described in Related data elements.
<b>Code Description and Permissible Values</b>	Not Applicable

## Extended wait patient

<b>Definition</b>	Whether a patient is an extended wait patient, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Admission, Extended Wait Patient
<b>Reference ID</b>	CG009
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Data Type</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This metadata item is used to identify waiting time for elective procedures that needs admission including day surgery or procedure such as endoscopy, colonoscopy, tonsillectomy & hernial repair ...etc. Patients who had waited longer than 3 months should be reported as delayed. This does not code any urgent cases that are clinically identified as urgent priority. A patient is classified as an extended wait patient if the patient is in clinical urgency elective category patients waiting for procedure at the time of admission or at a census time and has been waiting for the elective surgery for > 3 Months
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Extended wait patient 2 = Other patient

### Place of occurrence of external cause of injury (Admitted Patient)

<b>Definition</b>	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code. (ICD-10AM)
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Ambulatory Care Information - Place of occurrence of external cause of injury
<b>Reference ID</b>	CG010
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
<b>Format</b>	ANN.NN
<b>Maximum Field Size</b>	6
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Enables categorization of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>Admitted patient: Use External Causes of Morbidity and Mortality Place of Occurrence codes from the approved ICD10-AM edition, with all ICD-10-AM external cause codes and assigned according to the Australian Coding Standards.</p> <p>External cause codes in the range W00 to Y34, except Y06 and Y07 must be accompanied by a place of occurrence code. External cause codes V01 to Y34 must be accompanied by an activity code</p>

### External Cause-Human intent of injury

<b>Definition</b>	The clinician's assessment identifying the most likely role of human intent in the occurrence of the injury or poisoning, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Admission, External cause, Human intent of injury
<b>Reference ID</b>	CG011
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008.
<b>Usage</b>	Enables categorization of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>01 = Accident - injury not intended      02 = Intentional self-harm      03 = Sexual assault      04 = Maltreatment by parent      05 = Maltreatment by spouse or partner      06 = Other and unspecified assault      07 = Event of undetermined intent      08 = Legal intervention (including police      09 = Terrorist Attack      10 = War Injury      11 = Adverse effect or complications of medical and surgical care      12 = Intent not specified      88 = Others      99 = Unknown</p>

## Major diagnostic category

<b>Definition</b>	The category, generally based on a single body system or a etiology that is associated with a particular medical specialty, into which the patient diagnosis and the associated Australian refined diagnosis related group (ARDRG) falls, as represented by a code
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Admission - Major diagnostic category
<b>Reference ID</b>	CG012
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	AR-DRG v6.0 Definitions Manual
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>00. MDC A = Transplant      01. MDC B = Nervous System      02. MDC C = Eye      03. MDC D = Ear, Nose Mouth and Throat      04. MDC E = Respiratory System      05. MDC F = Circulatory System      06. MDC G = Digestive System      07. MDC H = Hepatobiliary System and Pancreas      08. MDC I = Musculoskeletal System and Connective Tissue      09. MDC J = Skin, Subcutaneous Tissue and Breast      10. MDC K = Endocrine, Nutritional and Metabolic Diseases and Disorders      11. MDC L = Kidney and Urinary tract      12. MDC M = Male Reproductive System      13. MDC N = Female Reproductive System      14. MDC O = Pregnancy, Childbirth and the Puerperium      15. MDC P = Newborns and other Neonates      16. MDC Q = Blood and Blood Forming Organs and Immunological Disorders      17. MDC R = Neoplastic      18. MDC S,T = Infectious and Parasitic      19. MDC U = Mental Health      20. MDC V = Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders      21. MDC W, X = Injuries, Poisonings and Toxic Effects of Drugs      22. MDC Y = Burns      23. Z = Factors Influencing Health Status and Other Contacts with Health Services</p>

### Scheduled admission date

<b>Definition</b>	The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Admission - Scheduled admission date
<b>Reference ID</b>	CG013
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008.
<b>Usage</b>	This data element helps reporting of the extend wait patient element.
<b>Code Description and Permissible Values</b>	Codes used are : DDMMYYYY Century digits are considered essential.

Patient Clinical Complexity Level	
Definition	A measure of the cumulative effect of a patient's complications and comorbidities (CCs) that is calculated for each episode of admitted patient care. Each diagnosis is assigned CCL (Clinical Complexity Level)
Metadata type	Data element
Data concept	Patient clinical complexity
Reference ID	CG014
Synonyms	Not applicable
Represented class	Code
Data type	Numeric
Format	N
Maximum field size	1
Date created	01/04/2019
Date updated	To be decided
Source	AR-DRG v6.0 Definitions Manual
Usage	
Code description and permissible values	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>– 0 No CC effect</li> <li>– 1 Minor CC</li> <li>– 2 Moderate CC</li> <li>– 3 Severe CC</li> <li>– 4 Catastrophic CC</li> </ul>

<b>Encounter Type</b>	
<b>Definition</b>	The type of encounter/visit designated as Inpatient, day case, emergency, outpatient clinic, home health care or Primary Health Care, as represented by a code.
<b>Metadata type</b>	Data element
<b>Data concept</b>	The type of encounter/visit
<b>Reference ID</b>	CG014
<b>Synonyms</b>	Not applicable
<b>Represented class</b>	Code
<b>Data type</b>	Numeric
<b>Format</b>	N
<b>Maximum field size</b>	1
<b>Date created</b>	01/04/2019
<b>Date updated</b>	To be decided
<b>Source</b>	1. Abu Dhabi Health Authority (HAAD) -Claims Schema - Encounter Type. 2. SHDD concepts of Health Service Event (ID CA001) 3. SHDD Admission Episode (ID CG001)
<b>Usage</b>	
<b>Code description and permissible values</b>	<ol style="list-style-type: none"> <li>1. Hospital Inpatient - patient occupies inpatient bed and stays overnight.</li> <li>2. Day Case - patient occupies bed and is discharged on the same day.</li> <li>3. Emergency - patient is seen in Emergency Department and is not admitted to Inpatient Bed.</li> <li>4. Outpatient - patient not admitted and not seen in Emergency Department.</li> <li>5. Home Health Care - patient is seen in the Home.</li> <li>6. Primary Health Care - patient is seen in Primary health care setting , outside of the hospital.</li> </ol>

<b>Encounter number</b>	
<b>Definition</b>	Healthcare provider generated unique key that cannot be re-assigned to another encounter/visit
<b>Metadata type</b>	Data element
<b>Data concept</b>	Encounter number
<b>Reference ID</b>	CG015
<b>Synonyms</b>	Not applicable
<b>Represented class</b>	Code
<b>Data type</b>	Alphanumeric
<b>Format</b>	X
<b>Maximum field size</b>	12
<b>Date created</b>	01/04/2019
<b>Date updated</b>	To be decided
<b>Source</b>	1. Qatar Patient Minimum Data Set-The episode number specific to an individual admitted patient episode of care. 2. Health Authority Abu Dhabi-Claims Schema _ Encounter ID- A unique number assigned by the healthcare provider to identify an encounter
<b>Usage</b>	
<b>Code description and permissible values</b>	The format is "x" to accept numeric and alphanumeric numbers since it differs between facilities. SHDD team could unify the format in the new version after adding this new definition .

### Condition onset flag

<b>Definition</b>	A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code
<b>Metadata type</b>	Data element
<b>Data concept</b>	Condition onset flag
<b>Reference ID</b>	CG016
<b>Synonyms</b>	Not applicable
<b>Represented class</b>	Code
<b>Data type</b>	Numeric
<b>Format</b>	N
<b>Maximum field size</b>	1
<b>Date created</b>	01/04/2019
<b>Date updated</b>	To be decided
<b>Source</b>	National Health Data Dictionary - Australia
<b>Usage</b>	
<b>Code description and permissible values</b>	1 Condition with onset during the episode of admitted patient care 2 Condition not noted as arising during the episode of admitted patient care

Healthcare practitioner ID	
Definition	A valid unique identification code provided by the Saudi Commission for Health Specialties for the healthcare provider
Metadata type	Data element
Data concept	Healthcare practitioner ID as defined by Saudi Commission for Health Specialties
Reference ID	CG017
Synonyms	Not applicable
Represented class	Code
Data type	Alphanumeric
Format	N
Maximum field size	16
Date created	01/04/2019
Date updated	To be decided
Source	Saudi Commission for Health Specialties
Usage	
Code description and permissible values	

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## Discharge Information

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## Separtions / Discharge

<b>Definition</b>	The total number of separations (patient) occurring during the reference period. This includes both formal and statistical separations.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information-number of separations
<b>Reference ID</b>	CH001
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	6N
<b>Maximum Field Size</b>	6
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	May be calculated at: • individual establishment level; or • system (ie. Countrywide / Region) level i.e. the sum of the number of establishments. The sum of the number of separations where the separation date has a value: • $\geq$ the beginning of the reference period (typically a financial year); and • $\leq$ the end of the reference period.
<b>Code Description and Permissible Values</b>	Not Applicable

<b>Date of Discharge</b>	
<b>Definition</b>	The date the patient was discharged from the inpatient care referenced in the applicable hospitalization or hospice date.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Discharge-Date of Discharge
<b>Reference ID</b>	CH002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	USA Health & Human Services, Agency for Healthcare Research & Quality 2015
<b>Usage</b>	This information is used to describe the date patient was dismissed from inpatient care in the health facility. Required to identify the period in which an admitted hospital stage or episode occurred and for derivation of length of stay.
<b>Code Description and Permissible Values</b>	Codes used are :  DDMMYYYY Century digits are considered essential

## Time of Discharge

<b>Definition</b>	Time the patient was discharged from the inpatient care.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Discharge-Time of Discharge
<b>Reference ID</b>	CH003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Time
<b>Data Type</b>	Date/Time
<b>Format</b>	HH:MM
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	USA Health & Human Services, Agency for Healthcare Research & Quality 2015
<b>Usage</b>	This information is used to describe the time patient was dismissed from inpatient care in the health facility.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>24 hours' time format, use HH:MM.</p> <p>HH = Ranges from 00 to 23</p> <p>MM ranges from 00 to 59</p> <p>99 = Unknown values for HH or MM. Use leading zeros to assure 2 character field widths for HH and MM.</p> <p>00:00 = Midnight is Code, and begins the new day.</p>

## Mode of Discharge

<b>Definition</b>	This field contains a code which defines the circumstances under which a patient left hospital. For the majority of patients this is when they are discharged by the consultant.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Discharge-Mode of Discharge
<b>Reference ID</b>	CH004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	United Kingdom National health Services, Hospital Episode Statistics September 2010
<b>Usage</b>	This information is used to describe the reason behind discharge.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Patient is discharged by treating physician      2 = Patient is transferred by treating physician to another Healthcare Facility      3 = Patient is discharged against medical advice after signing necessary form      4 = Patient is discharged against medical advice without signing necessary form      5 = Patient died in hospital premises even if not admitted at the facility      6 = Patient is a stillbirth      8 = Other reasons      9 = Unknown reasons</p>

Principal Diagnosis	
Definition	The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code.
Metadata Type	Data Element
Data Concept	Discharge, Principal Diagnosis
Reference ID	CH005
Synonyms	Primary Diagnosis Major Diagnosis Main Diagnosis
Representation Class	Code
Data Type	Alphanumeric
Format	ANN.NN
Maximum Field Size	6
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	<p>The principal diagnosis must be determined in accordance with the Australian Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses.</p> <p>The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.</p> <p>As a minimum requirement the Principal diagnosis code must be a valid code from the current edition of ICD-10-AM. For episodes of admitted patient care, some diagnosis codes are too imprecise or inappropriate to be acceptable.</p> <p>as a principal diagnosis and will group to 951Z, 955Z and 956Z in the Australian Refined Diagnosis Related Groups.</p> <p>Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis. Diagnosis codes which are morphology codes cannot be used as principal diagnosis</p>
Code Description and Permissible Values	<p>Codes Used are:</p> <p>Code using ICD-10 – AM for principal disease</p>

<b>Additional Diagnosis</b>	
<b>Definition</b>	A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Discharge, Additional Diagnosis
<b>Reference ID</b>	CH006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
<b>Format</b>	ANN.NN
<b>Maximum Field Size</b>	6
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>Record each additional diagnosis relevant to the episode of care in accordance with the ICD-10-AM Australian Coding Standards. Generally, external cause, place of occurrence and activity codes will be included in the string of additional diagnosis codes.</p> <p>In some data collections these codes may also be copied into specific fields. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.</p> <p>Additional diagnoses give information on the conditions that are significant in terms of treatment required, investigations needed and resources used during the episode of care.</p> <p>They are used for case mix analyses relating to severity of illness and for correct classification of patients into Australian Refined Diagnosis Related Groups (AR-DRGs).</p>
<b>Code Description and Permissible Values</b>	Codes Used are: ICD-10 – AM for any additional disease.



## Hospital Care Information

### Intended length of hospital stay

<b>Definition</b>	The intention of the responsible clinician at the time of the patient's admission to hospital or at the time the patient is placed on an elective surgery waiting list, to discharge the patient either on the day of admission or a subsequent date, as represented by a code
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information—Intended length of hospital stay
<b>Reference ID</b>	CI001
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	The intended length of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Intended same day      2 = Intended overnight</p>

### Length of Stay (LOS)

<b>Definition</b>	The length of stay of a patient, excluding leave days, measured in days.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information—Length of Stay
<b>Reference ID</b>	CI002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Formula: LOS = Separation date - Admission date - Total leave days The calculation is inclusive of admission and separation dates.
<b>Code Description and Permissible Values</b>	Not Applicable

## Length of stay (including leave days)

<b>Definition</b>	The total length of stay (LOS) of a patient, including leave days, measured in days.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information—Length of stay (including leave days)
<b>Reference ID</b>	CI003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	All admitted patient episodes of care where it is required to know the total LOS in hospital (including leave days). Formula: LOS (including leave days) = separation date - admission date Total LOS is calculated by subtracting the patient's date of admission from their date of separation. It includes contact days and leave days. For babies born in hospital: 1) only calculate the total LOS of live births and 2) their admission date is the same as their date of birth. A same-day patient should be allocated a length of stay of one day. Total LOS relates to the episode of care associated with the birth. Babies born before arrival and stillbirths are not within scope of this data element and should not have a total length of stay reported.
<b>Code Description and Permissible Values</b>	Not Applicable

## Inter-hospital contracted patient

<b>Definition</b>	An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information—Inter-hospital contracted patient
<b>Reference ID</b>	CI004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	All services provided at both the originating and destination hospitals should be recorded and reported by the originating hospital. The destination hospital should record the admission as an 'Inter-hospital contracted patient' so that these services can be identified in the various statistics produced about hospital activity.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>1 = Inter-hospital contracted patient from public sector hospital</li> <li>2 = Inter-hospital contracted patient from private sector hospital</li> <li>3 = Not contracted</li> <li>9 = Not reported</li> </ul>

### Minutes of operating theatre time

<b>Definition</b>	Total time, in minutes, spent by a patient in operating theatres during current episode of hospitalization.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information - Minutes of operating theatre time
<b>Reference ID</b>	CI005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Time is calculated in minutes from actual presence of patient until physically removed out of OR
<b>Code Description and Permissible Values</b>	Codes used are: NNNN = Number of minutes

### Number of contacts-psychiatric Outpatient Clinic/day program

<b>Definition</b>	Number of days that a patient attended a psychiatric outpatient clinic or a day program during the relevant financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information-Number of contacts-psychiatric outpatient clinic/day program
<b>Reference ID</b>	CI006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This metadata item gives a measure of the level of service provided.
<b>Code Description and Permissible Values</b>	Codes used are:  NNN=Number of visits

Number of days in special/neonatal intensive care	
Definition	The total number of days spent by a neonate in a special care or neonatal intensive care nursery (in the hospital of birth).
Metadata Type	Data Element
Data Concept	Hospital Care Information—Number of days in special/neonatal intensive care
Reference ID	CI007
Synonyms	Non Applicable
Representation Class	Total
Data Type	Numeric
Format	NNN
Maximum Field Size	3
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	<p>This item is to be completed if baby has been treated in an intensive care unit or a special care nursery (SCN). An indicator of the requirements for hospital care of high risk babies in specialized nurseries that add to costs because of extra staffing and facilities.</p> <p>SCN are staffed and equipped to provide a full range of neonatal services for the majority of complicated neonatal problems, including short-term assisted ventilation and intravenous therapy. Neonatal intensive care nurseries (NICN) are staffed and equipped to treat critically ill newborn babies including those requiring prolonged assisted respiratory support, intravenous therapy, and alimentation and treatment of serious infections. Full supportive services are readily available throughout the hospital. These NICN also provide consultative services to other hospitals. The number of days is calculated from the date the baby left the special/neonatal intensive care unit minus the date the baby was admitted to the special/neonatal intensive care unit. The number of days is calculated from the date the baby left the special/neonatal intensive care unit minus the date the baby was admitted to the special/neonatal intensive care unit.</p>
Code Description and Permissible Values	<p>Codes used are:</p> <p>NNN = Number of days</p>

<b>Number of days of hospital-in-the-home care</b>	
<b>Definition</b>	The number of hospital-in-the-home days occurring within an episode of care for an admitted patient.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information—Number of days of hospital-in-the-home care
<b>Reference ID</b>	CI008
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>Number of days of hospital-in-the-home care data will be collected from all regions. The rules for calculating the number of hospital-in-the-home days are outlined below:</p> <ul style="list-style-type: none"> <li>• The number of hospital-in-the-home days is calculated with reference to the date of admission, date of separation, leave days and any date(s) of change between hospital and home accommodation;</li> <li>• The date of admission is counted if the patient was at home at the end of the day;</li> <li>• The date of change between hospital and home accommodation is counted if the patient was at home at the end of the day;</li> <li>• The date of separation is not counted, even if the patient was at home at the end of the day</li> <li>• The normal rules for calculation of patient days apply, for example in relation to leave and same day patients.</li> </ul>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>NNN = Number of days</p>

### Number of leave periods

<b>Definition</b>	Number of leave periods in a hospital stay (excluding one-day leave periods for admitted patients).
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information—Number of leave periods
<b>Reference ID</b>	CI009
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>Recording of leave periods allows for the calculation of patient days excluding leave.</p> <p>This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and separation rates, particularly for long-stay patients who may have several leave periods.</p> <p>If the period of leave is greater than seven days or the patient fails to return from leave, the patient is discharged.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>NNN = Number of days</p>

Number of occasions of service	
Definition	The total number of occasions of examination, consultation, treatment or other service provided to a patient.
Metadata Type	Data Element
Data Concept	Hospital Care Information—Number of occasions of service
Reference ID	CI010
Synonyms	Non Applicable
Representation Class	Total
Data Type	Numeric
Format	7N
Maximum Field Size	7
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	<p>The following guides for use apply:</p> <ul style="list-style-type: none"> <li>• An occasion of service is counted for each person attending in the capacity of a patient in their own right, even if other non-patient persons are present for the service.</li> <li>• Spouses, parents or carers attending the session are only counted if they are also participating in the service as a patient.</li> <li>• In the instance of a dependent child presenting to a clinic, the session is counted as a single Occasion of Service provided to the individual child for whom an event history is being recorded. Where parents/carers also attend in the capacity of patients themselves within a booked appointment, and receive the same services at the same time, the child and parent/carer can be counted as a group. In this instance a Group Session count would be recorded.</li> <li>• An occasion of service is counted for staff attending clinics of public hospitals only if they are attending as patients in their own right. Staff education and training is excluded.</li> <li>• Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or dialysis clinics are counted as group sessions, if two or more people receiving the same services at the same time.</li> </ul>
Code Description and Permissible Values	<p>Codes used are:</p> <p>7N = Number of occasions.</p>

### Number of service contact dates

<b>Definition</b>	The total number of dates where a service contact was recorded for the patient/client.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information—Number of service contact dates
<b>Reference ID</b>	CI011
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This metadata item is a count of service contact dates recorded on a patient or client record. Where multiple service contacts occur on the same date, the date is counted only once. For collection from community-based (ambulatory and non-residential) agencies. Includes mental health day programs and psychiatric outpatients. This metadata item gives a measure of the level of service provided to a patient/client.
<b>Code Description and Permissible Values</b>	Codes used are: NNN = Number of services contact dates

## Patient days

<b>Definition</b>	The total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information—Patient days
<b>Reference ID</b>	CI012
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	8N
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>A day is measured from midnight to 23:59 hours.</p> <p>The following basic rules are used to calculate the number of patient days for overnight stay patients:</p> <ul style="list-style-type: none"> <li>• The day the patient is admitted is a patient day</li> <li>• If the patient remains in hospital from midnight to 23:59 hours count as a patient day.</li> <li>• The day a patient goes on leave is counted as a leave day</li> <li>• If the patient is on leave from midnight to 23:59 hours count as a leave day.</li> <li>• The day the patient returns from leave is counted as a patient day</li> </ul> <p>The day the patient is separated is not counted as a patient day. The following additional rules cover special circumstances and in such cases, override the basic rules:</p> <ul style="list-style-type: none"> <li>• Patients admitted and separated on the same date (same-day patients) are to be given a count of one patient day.</li> <li>• If the patient is admitted and goes on leave on the same day, count as a patient day.</li> <li>• If the patient returns from leave and goes on leave on the same date, count as a leave day.</li> <li>• If the patient returns from leave and is separated, it is not counted as either a patient day or a leave day.</li> <li>• If a patient goes on leave the day they are admitted and does not return from leave until the day they are discharged, count as one patient day (the day of admission is counted as a patient day, the day of separation is not counted as a patient day). When calculating total patient days for a specified period:</li> </ul>

	<ul style="list-style-type: none"> <li>Count the total patient days of those patients separated during the specified period including those admitted before the specified period</li> <li>Do not count the patient days of those patients admitted during the specified period who did not separate until the following reference period</li> <li>Contact patient days are included in the count of total patient days. If it is a requirement to distinguish contact patient days from other patient days, they can be calculated by using the rules contained in the data element: total contact patient days</li> </ul>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>Total number of patient days calculated in days unit 8N</p>

## Procedure

<b>Definition</b>	A clinical intervention represented by a code that: <ul style="list-style-type: none"> <li>• Is surgical in nature, and/or</li> <li>• Carries a procedural risk, and/or</li> <li>• Carries an aesthetic risk, and/or</li> <li>• Requires specialized training, and/or</li> <li>• Requires special facilities or equipment only available in an acute care setting.</li> </ul>
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information—Procedure
<b>Reference ID</b>	CI013
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NNNNN-NN
<b>Maximum Field Size</b>	7
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Record and code all procedures undertaken during the episode of care. Procedures are derived from and must be substantiated by clinical documentation.
<b>Code Description and Permissible Values</b>	Not Applicable

## Satisfaction with participation

<b>Definition</b>	The degree to which a person is satisfied with their involvement in a specified life area, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information—Satisfaction with participation
<b>Reference ID</b>	CI014
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
	<p>This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person. In the context of health, participation is involvement in a life situation. Participation restrictions are problems an individual may experience in involvement in life situations.</p> <p>This metadata item gives a rating of the person's degree of satisfaction with participation in a domain of life, in relation to their current life goals. Satisfaction with participation corresponds to the person's own perspective on their participation, and reflects their attitude to their participation in the various life areas. It is essentially a summary measure in which are embedded the concepts of choice, opportunity and importance.</p> <p><u>CODE 1</u> High satisfaction with participation, used if a person is involved in the specified life situation as he or she wishes to fulfill his or her current life goals in terms of duration, frequency, manner and outcome.</p> <p><u>CODE 2</u> Moderate satisfactions with participation, used if the person is reasonably satisfied with their participation in this life situation, in terms of duration, frequency, manner and outcome. This could occur if one of the criteria (duration, frequency, manner or outcome) is not fulfilled and that criterion is not critical to the person's goals. For example, the person does not participate in the specified life situation as frequently as wished, but the other criteria are met and the frequency is not so affected that it is critical to the person's satisfaction.</p> <p><u>CODE 3</u> Neither satisfied nor dissatisfied with participation, used if the person is neither satisfied nor dissatisfied with</p>

	<p>their participation in this life situation, in terms of duration, frequency, manner and outcome.</p> <p><b>CODE 4</b> Moderate dissatisfaction with participation, used if two or three criteria (duration, frequency, manner or outcome) are not fulfilled, but are not so badly affected, in relation to the person's goals in that life area, that the person is extremely dissatisfied. For example, a person is able to participate in work, but is placed in supported employment rather than employment in the open labour market. This is not in line with the person's goals, so that the manner and outcome of the participation are not fulfilled.</p> <p><b>CODE 5</b> Extreme dissatisfaction with participation, used when all criteria (duration, frequency, manner and outcome) are not fulfilled for the specified life situation, or where any of the criteria are so badly affected in relation to the person's goals that they consider themselves to be extremely dissatisfied with this life area. An example of the latter would arise when a person is extremely dissatisfied with participation in interpersonal activities because his/her goal in terms of duration of social visits is never fulfilled, although other criteria (frequency and manner) may be fulfilled.</p> <p><b>CODE 6</b> Complete restriction and dissatisfaction, used when the person does not participate in this life situation in line with his or her own goals, i.e. in an area where they wish to participate and is completely dissatisfied with not participating in this life situation.</p> <p><b>CODE 9</b> Not applicable, used when participation in a life situation is not relevant, such as employment of an infant or where there is no participation and the person has no desire to participate in this area. For example, a personal preference not to participate in specified areas of community, social and civic life such as sport or hobbies. The area may not be applicable to the person's current life goals.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>1 = High satisfaction with participation</li> <li>2 = Moderate satisfaction with participation</li> <li>3 = Neither satisfied nor dissatisfied with participation</li> <li>4 = Moderate dissatisfaction with participation</li> <li>5 = Extreme dissatisfaction with participation</li> <li>6 = Complete restriction and dissatisfaction</li> <li>8 = Not specified</li> <li>9 = Not applicable</li> </ul>

Service contact date	
Definition	The date of service contact between a health service provider and patient/client.
Metadata Type	Data Element
Data Concept	Hospital Care Information—Service contact date
Reference ID	CI015
Synonyms	Non Applicable
Representation Class	Date
Data Type	Date/Time
Format	DDMMYYYY
Maximum Field Size	8
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	Requires services to record the date of each service contact, including the same date where multiple visits are made on one day (except where the visits may be regarded as a continuation of the one service contact). Where an individual patient/client participates in a group activity, a service contact date is recorded if the person's participation in the group activity results in a dated entry being made in the patient's/client's record.
Code Description and Permissible Values	Codes used are:  DDMMYYYY Century digits are considered essential

<b>Total leave days</b>	
<b>Definition</b>	Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information—Total leave days
<b>Reference ID</b>	CI016
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>A day is measured from midnight to midnight. The following rules apply in the calculation of leave days for both overnight and same-day patients:</p> <ul style="list-style-type: none"> <li>• The day the patient goes on leave is counted as a leave day.</li> <li>• The day the patient is on leave is counted as a leave day.</li> <li>• The day the patient returns from leave is counted as a patient day.</li> <li>• If the patient is admitted and goes on leave on the same day, this is counted as a patient day, not a leave day.</li> <li>• If the patient returns from leave and then goes on leave again on the same day, this is counted as a leave day.</li> <li>• If the patient returns from leave and is separated on the same day, the day should not be counted as either a patient day or a leave day.</li> </ul>
<b>Code Description and Permissible Values</b>	Not Applicable

## Waiting time at a census date

<b>Definition</b>	The time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list to a designated census date.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information—Waiting time at a census date
<b>Reference ID</b>	CI017
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>The number of days is calculated by subtracting the elective care waiting list episode—listing date for care, DDMMYYYY from the hospital census (of elective surgery waitlist patients)—census date, DDMMYYYY, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at the census date.</p> <p>Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'.</p> <p>If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at the census date, then the number of days waited at the less urgent elective surgery waiting list episode—clinical urgency, code N category should be subtracted from the total number of days waited.</p> <p>In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at census date) the number of days at the less urgent clinical urgency category should be calculated by subtracting the elective care waiting list episode—listing date for care, DDMMYYYY from the elective care waiting list episode—category reassignment date, DDMMYYYY.</p> <p>If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at the census date should be calculated by subtracting one elective care waiting list episode—category reassignment date, DDMMYYYY from the subsequent elective care waiting list episode—category reassignment date, DDMMYYYY, and then adding the days together.</p>

	<p>When a patient is admitted from an elective surgery waiting list but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue.</p> <p>Therefore at the census date the patient's waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>NNNN = Total number of days</p>

<b>Waiting time at removal from elective surgery waiting list</b>	
<b>Definition</b>	The time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to the date they were removed from the waiting list.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hospital Care Information—Waiting time at removal from elective surgery waiting list
<b>Reference ID</b>	CI018
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>The number of days is calculated by subtracting the listing date for care from the removal date, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at removal.</p> <p>Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'.</p> <p>If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at removal, then the number of days waited at the less urgent clinical urgency category should be subtracted from the total number of days waited.</p> <p>In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at removal) the number of days at the less urgent clinical urgency category should be calculated by subtracting the listing date for care from the category reassignment date.</p> <p>If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at removal should be calculated by subtracting one category reassignment date from the subsequent category reassignment date, and then adding the days together.</p>

	<p>When a patient is removed from an elective surgery waiting list, for admission on an elective basis for the procedure they were awaiting, but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue.</p> <p>Therefore, at the removal date, the patient's waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.</p>
Code Description and Permissible Values	Not Applicable

## Laboratory code

Laboratory code	
Definition	The tests, measurements, and observations conducted with value and unit, represented by codes
Metadata type	Data element
Data concept	Laboratory
Reference ID	CI019
Synonyms	Not applicable
Represented class	Code
Data type	Numeric
Format	NNNNNNN
Maximum field size	7
Date created	01/04/2019
Date updated	To be decided
Source	LOINC codes
Usage	
Code description and permissible values	

# Chapter 04

## Mortality



## Mortality Basic Information

## Cause of Death

<b>Definition</b>	The cause of death to be entered on the medical certificate of cause of death are all those diseases, morbid conditions or injuries which either resulted in or contributed to death and the circumstances of the accident or violence which produced any such injuries.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Mortality-cause of death
<b>Reference ID</b>	DA001
<b>Synonyms</b>	Non-Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
<b>Format</b>	ANN.N
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	Underlying cause of death: the underlying cause of death is: A) The disease or injury which initiated the train of events leading directly to death B) The circumstances of the accident or violence which produced the fatal injury. Contributory causes of death are more relevant, eg. diabetes in the case of myocardial infarction, malnutrition in the case of measles, or alcohol intake in the case of motor vehicle accident.
<b>Code Description and Permissible Values</b>	Codes used are: ICD-10 AM diagnosis code

## Date of Death

<b>Definition</b>	The date of the death of the person
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Mortality, Date of death
<b>Reference ID</b>	DA002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Use the Hijri calendar and the equivalent Gregorian dates to record the date of death.
<b>Code Description and Permissible Values</b>	Codes used are : DDMMYYYY Century digits are considered essential

## Time of Death

<b>Definition</b>	Time of the person's Death
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Mortality( —time of death
<b>Reference ID</b>	DA003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Time
<b>Data Type</b>	Date/Time
<b>Format</b>	HH:MM
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	This element is the standard time format used to document the death time of patients, it is based on 24 hours' time format..
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>– Time = HH:MM</li> <li>– HH = Ranges from 00 to 23;</li> <li>– MM = Ranges from 00 to 59.</li> <li>– 00:00 = Midnight, and begins the new day</li> <li>– 99 = Unknown values for HH or MM.</li> <li>– Use leading zeros to assure 2-character field widths for HH and MM.</li> </ul>

## Place of Death

<b>Definition</b>	The Place of death of the person
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Mortality(Person's)-place of death
<b>Reference ID</b>	DA004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	This element is used to collect data related to the place where death has occurred. This data will allow epidemiological analysis and documentation of all information related to the death incident.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>01 = Hospital      02 = Ambulatory Health Care      03 = Home / Residence      04 = Office      05 = Industrial place and premises      06 = Place for recreation or sport      07 = Street      08 = Public building</p> <p style="text-align: right;">10 = Male Educational Institution      11 = Transportation Vehicle</p> <p style="text-align: right;">12 = Temporary Accommodation for pilgrims      88 = Other</p> <p style="text-align: center;">99 = Unknown</p>

### Leading Cause of Mortality in a health facility

<b>Definition</b>	The most common cause of death in a particular Healthcare facility
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Mortality-Leading Cause of Mortality in the health facility
<b>Reference ID</b>	DA005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element is used to collect the total number of actual death that occurred at facility. It is used to report the top 10 reasons of death at any Healthcare facility each coded by ICD-AM code. Code 1 will be for male patients while code 2 will be for female patients.
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Male Patient leading cause 2 = Female Patient leading cause

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## Mortality Statistical Information

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## Crude Mortality Rate

<b>Definition</b>	It is the Mortality rate among all age groups and due to all causes.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Mortality Crude Mortality Rate
<b>Reference ID</b>	DB001
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Rate
<b>Data Type</b>	Numeric
<b>Format</b>	NN.NN
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	World Health Organization (WHO), ODI/HPN paper 52
<b>Usage</b>	Crude Mortality Rate CMR can be calculated by dividing the number of deaths within a year on the Total mid-year population, multiplied by 1,000. CDR=(No. of deaths within a year)/(Total mid-year population) X 1,000
<b>Code Description and Permissible Values</b>	Measured per 1000

## Neonatal Mortality Rate

<b>Definition</b>	Number of deaths during the first 28 completed days of life per 1 000 live births in a given year or period.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Mortality Neonatal Mortality Death Rate
<b>Reference ID</b>	DB002
<b>Synonyms :</b>	Non Applicable
<b>Representation Class</b>	Rate
<b>Data Type</b>	Numeric
<b>Format</b>	NN.NN
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	World Health Organization (WHO) 2005
<b>Usage</b>	The formula to calculate this rate is: Neonatal mortality rate = Number of neonatal deaths / Total number of live births X 1,000
<b>Code Description and Permissible Values</b>	Measured per 1000

## Infant mortality Rate

<b>Definition</b>	Infant mortality rate is the probability of a child born in a specific year or period dying before reaching the age of one, if subject to age-specific mortality rates of that period.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Mortality, Infant Mortality Rate
<b>Reference ID</b>	DB003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Rate
<b>Data Type</b>	Numeric
<b>Format</b>	NN.NN
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	World Health Organization (WHO) 2005
<b>Usage</b>	The formula to calculate this rate is: Infant mortality rate = Number of infant deaths / Total number of live births X 1,000
<b>Code Description and Permissible Values</b>	Measured per 1000

## Mortality Rate Under 5 years of age

<b>Definition</b>	Under-five mortality rate is the probability of a child born in a specific year or period dying before reaching the age of five, if subject to age-specific mortality rates of that period.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Mortality, Children Mortality Rate
<b>Reference ID</b>	DB004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Rate
<b>Data Type</b>	Numeric
<b>Format</b>	NN.NN
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	World Health Organization (WHO) 2005
<b>Usage</b>	The formula to calculate this rate Under 5 mortality rate = Deaths between 0-4 years during the year of calculation / Live births of newborns during the year of calculation X 1000 The data should include registered newborns weighing more than 500 grams at 22 weeks gestation.
<b>Code Description and Permissible Values</b>	Measured per 1000

## Maternal Mortality Ratio

<b>Definition</b>	Number of maternal deaths per 100 000 live births during a specified time period, usually one year
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Mortality Maternal Mortality Ratio
<b>Reference ID</b>	DB005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Ratio
<b>Data Type</b>	Numeric
<b>Format</b>	NN.NN
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	World Health Organization (WHO) 2005
<b>Usage</b>	This indicator estimates the proportion of pregnant women who die from causes related to or aggravated by the pregnancy or its management $\text{Maternal mortality ratio} = \frac{\text{Number of maternal deaths}}{\text{Total number of live births}} \times 100,000$
<b>Code Description and Permissible Values</b>	Measured per 100,000

## Maternal Death

<b>Definition</b>	The death of a woman while pregnant, or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management (from direct or indirect obstetric death)
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Mortality Maternal Death.
<b>Reference ID</b>	DB006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	World Health Organization (WHO) 2005
<b>Usage</b>	This element is measurement of maternal death in a year which reflects the care provided to pregnancy in a Healthcare system
<b>Code Description and Permissible Values</b>	Codes used are: NNNN = Maternity Death Total

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<b>Hajj (pilgrimage) Mortality</b>	
<b>Definition</b>	Death of any person performing hajj during the season regardless of the cause
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hajj (Pilgrimage) - Death during Hajj Death of Person
<b>Reference ID</b>	DB007
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNNN
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	Use this element to report the number of those who died during hajj (pilgrimage) regardless of the reason but it should only include the pilgrims only
<b>Code Description and Permissible Values</b>	Pilgrims deaths = NNNNN

<b>Main Causes of Hajj (pilgrimage) Mortality</b>	
<b>Definition</b>	Codes used to report the Main causes of death in Hajj season for those who are performing Hajj duties
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hajj (Pilgrimage) - Death during Hajj Death of Person
<b>Reference ID</b>	DB008
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	Use this element to report the total number of those who died during hajj (pilgrimage) due to a specific reason, it should only include the pilgrims only
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Heat Stroke 2 = Stampede 3 = Cardiac Emergency 4 = Passenger Car Accident 5 = Pedestrian Car Accident Code 6 = Fire Code 7 = Natural Death 8 = Other 9 = Unknown

### Mortality Due to specified Disease Related Group DRG

<b>Definition</b>	It is the total number of mortalities related to Saudi Health Council approved DRG "Disease Related Group"
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Mortality, Mortality Due to specified DRG
<b>Reference ID</b>	DB009
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
<b>Format</b>	ANN.NN
<b>Maximum Field Size</b>	6
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	United Kingdom National health Services, Hospital Episode Statistics September 2010
<b>Usage</b>	This element will outline the mortality map of the health in KSA and it should focus on high burden disease and its mortality rates as part of the DRG in KSA
<b>Code Description and Permissible Values</b>	Codes used are: The ICD 10 appropriate code

# Chapter 05

## Communicable Diseases

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## Communicable Diseases

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## Communicable Diseases

<b>Definition</b>	An illness caused by an infectious agent or its toxins that occurs through the direct or indirect transmission of the infectious agent or its products from an infected individual or via an animal, vector or the inanimate environment to a susceptible animal or human host.
<b>Metadata Type</b>	Data Concept
<b>Data Concept</b>	Communicable Disease
<b>Reference ID</b>	EA001
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Concept
<b>Data Type</b>	
<b>Format</b>	
<b>Maximum Field Size</b>	
<b>Date Created</b>	
<b>Date Updated</b>	
<b>Source</b>	USA, Department of Health and Human Services, Center of Disease Control and Prevention CDC
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	

## Bacterial Diseases

<b>Definition</b>	Codes used for Diseases diagnosed by treating physician as a main result of a bacterial infection that should be reported to health authorities in accordance with WHO and local protocols.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Communicable Diseases--Bacterial Diseases
<b>Reference ID</b>	EA002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AANN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Adopted from WHO recommended surveillance standards 2nd edition
<b>Usage</b>	<p>The principal diagnosis must be determined in accordance with the ICD-10 Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses.</p> <p>The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. Communicable diseases are categorized into 3 categories</p> <p><b>CATEGORY A: Immediate</b>  These are diseases of urgent public health importance and shall be reported instantly. They are categorized as IMMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY B: Intermediate</b>  These are diseases of urgent public health importance and shall be reported in three days. They are categorized as INTERMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY C: Delayed</b>  These are diseases of urgent public health importance and shall be reported in Five working days. They are categorized as DELAYED urgency for reporting to health authorities upon identification or suspicion of a case. Such cases may require public health intervention.</p>

	<p><b>CODING STRUCTURE :</b></p> <p>The structure created for the communicable diseases is a Local code created for each communicable disease composed of:</p> <ol style="list-style-type: none"> <li>1 - First Letter denotes urgency in reporting:</li> </ol> <p>A = Immediate      B = Intermediate      C = Delayed</p> <ol style="list-style-type: none"> <li>2 - Second Letter describes the causative organism / agent</li> </ol> <p>A = Adverse Events      B = Bacteria      C = Chlamydia      F = Fungus      I = Bite      M = Metazoal      P = Parasitic      S= Sexual      T= Tuberculosis      V= Viral</p> <ol style="list-style-type: none"> <li>3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease</li> </ol>																											
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### B Group B (Intermediate)

<b>Local 1</b>	<b>ICD 10</b>	<b>Disease</b>
BB01	A23	Brucellosis
BB02	A30	Leprosy
BB03	A27	Leptospirosis
BB04	G00.01-G00.9	Other Bacterial Meningitis
BB05	A79	Proteus Ox19+ve
BB06	A02	Salmonellosis
BB07	A38	Scarlet Fever
BB08	A40, A41	Septicemia
BB09	A03	Shigellosis
BB10	A37	Whooping cough
BB11	A01	Typhoid Fever
BB12	A01.1	Paratyphoid fever

### C Group C (Delayed)

<b>Local 1</b>	<b>ICD 10</b>	<b>Disease</b>
CB01	N01	Glomerulonephritis
CB02	J12-12	Pneumonia
CB03	I00-I02	Rheumatic
CB04	A71	Trachoma

## Viral Diseases

Definition	Codes used for Diseases diagnosed by treating physician as a main result of a viral infection that should be reported to health authorities in accordance with WHO and local protocols.
Metadata Type	Data Element
Data Concept	Communicable Diseases--Viral Diseases
Reference ID	EA003
Synonyms	Non Applicable
Representation Class	Total
Data Type	Alphanumeric
Format	AANN
Maximum Field Size	4
Date Created	19/05/2016
Date Updated	To be defined
Source	Adopted from WHO recommended surveillance standards 2nd edition
Usage	<p>The principal diagnosis must be determined in accordance with the ICD-10 Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. Communicable diseases are categorised into 3 categories.</p> <p><b>CATEGORY A: Immediate</b>        These are diseases of urgent public health importance and shall be reported instantly. They are categorised as IMMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY B: Intermediate</b>        These are diseases of urgent public health importance and shall be reported in three days. They are categorised as INTERMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY C: Delayed</b>        These are diseases of urgent public health importance and shall be reported in Five working days. They are categorised as DELAYED urgency for reporting to health authorities upon identification or suspicion of a case.        Such cases may require public health intervention.</p>

### CODING STRUCTURE:

The structure created for the communicable diseases is a Local code created for each communicable disease composed of:

1 - First Letter that denotes urgency in reporting:

- A = Immediate,
- B = Intermediate,
- C = Delayed

2 - Second Letter describes the causative organism / agent

A = Adverse Events

B = Bacteria

C = Chlamydia

F = Fungus

I = Bite

M = Metazoal

P = Parasitic

S= Sexual

T= Tuberculosis

V= Viral 3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease

### Code Description and Permissible Values

Codes used are:

#### Local Code Icd10 Code Groups

Group A (Immediate)	Group B (Intermediate)	Group C (Delayed)
AV01 A80 Acute poliomyelitis	BV01 B01 Chickenpox (Varicella)	CV01 J11 Influenza
AV02 B20-24 Aids/HIV	BV02 B19 Hepatitis Viral Unspecific	
AV03 J09.X2 Bird Flu	BV03 B15.9 Hepatitis A	
AV04 A99 Hemorrhagic fevers	BV04 B16.9 Hepatitis B cases	
AV05 B05 Measles	BV05 B18.1 Hepatitis B carrier	
AV06 G00.0 Meningitis Haemophilus influenzae	BV06 B17.1 Hepatitis C cases	
AV07 B34.2 MERS-COV (Corona Virus)	BV07 B18.2 Hepatitis C carrier	
AV08 B26 Mumps	BV08 A87 Meningitis Non specified	
AV09 A82 Rabies	BV09 A90 Dengue Fever	
AV10 A92.4 Rift Valley Fever		
AV11 B06 Rubella		
AV12 A95 Yellow fever		

## Fungal Diseases

<b>Definition</b>	Codes used for diseases diagnosed by treating physician as a main result of a fungal infection that should be reported to health authorities in accordance with WHO and local protocols.
<b>Metadata Type</b>	Data element
<b>Data Concept</b>	Communicable Diseases--Fungal Diseases
<b>Reference ID</b>	EA004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AANN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Adopted from WHO recommended surveillance standards 2nd edition
<b>Usage</b>	<p>The principal diagnosis must be determined in accordance with the ICD-10 Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. Communicable diseases are categorised into 3 categories</p> <p><b>CATEGORY A: Immediate</b>  These are diseases of urgent public health importance and shall be reported instantly. They are categorised as IMMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY B: Intermediate</b>  These are diseases of urgent public health importance and shall be reported in three days. They are categorised as INTERMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY C: Delayed</b>  These are diseases of urgent public health importance and shall be reported in Five working days. They are categorised as DELAYED urgency for reporting to health authorities upon identification or suspicion of a case. Such cases may require public health intervention.</p>

	<p><b>CODING STRUCTURE</b></p> <p>The structure created for the communicable diseases is a Local code created for each communicable disease composed of 1 - First Letter is that denotes urgency in reporting:</p> <ul style="list-style-type: none"> <li>A = Immediate</li> <li>B = Intermediate,</li> <li>C = Delayed</li> </ul> <p>2 - Second Letter describes the causative organism / agent</p> <ul style="list-style-type: none"> <li>A = Adverse Events</li> <li>B = Bacteria</li> <li>C = Chlamydia</li> <li>F = Fungus</li> <li>I = Bite</li> <li>M = Metazoal</li> <li>P = Parasitic</li> <li>S= Sexual</li> <li>T= Tuberculosis</li> <li>V= Viral 3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease</li> </ul>
Code Description and Permissible Values	<p>Codes used are:</p> <p>Group A Especially in immunocompromised patient Local Code ICD 10 Code</p> <p>AF01 B45.1 Cryptococcus Meningitis</p> <p>AF02 B39 Histoplasmosis</p>

## Parasitic Diseases (Metazoal)

<b>Definition</b>	Codes used for Diseases diagnosed by treating physician as a main result of a metazoal infection that should be reported to health authorities in accordance with WHO and local protocols.
<b>Metadata Type</b>	Data element
<b>Data Concept</b>	Communicable Diseases--Parasitic Diseases (Metazoal)
<b>Reference ID</b>	EA005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AANN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Adopted from WHO recommended surveillance standards 2nd edition
<b>Usage</b>	<p>The principal diagnosis must be determined in accordance with the ICD-10 Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. Communicable diseases are categorised into 3 categories</p> <p><b>CATEGORY A: Immediate</b>  These are diseases of urgent public health importance and shall be reported instantly. They are categorised as IMMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY B: Intermediate</b>  These are diseases of urgent public health importance and shall be reported in three days.  They are categorised as INTERMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p>

	<p><b>CATEGORY C: Delayed</b>  These are diseases of urgent public health importance and shall be reported in Five working days. They are categorised as DELAYED urgency for reporting to health authorities upon identification or suspicion of a case. Such cases may require public health intervention.</p> <p><b>CODING STRUCTURE</b></p> <p>The structure created for the communicable diseases is a Local code created for each communicable disease composed of :</p> <p>1 - First Letter is that denotes urgency in reporting:</p> <ul style="list-style-type: none"> <li>A = Immediate,</li> <li>B = Intermediate ,</li> <li>C = Delayed</li> </ul> <p>2 - Second Letter describes the causative organism / agent</p> <ul style="list-style-type: none"> <li>A = Adverse Events</li> <li>B = Bacteria</li> <li>C = Chlamydia</li> <li>F = Fungus</li> <li>I = Bite</li> <li>M = Metazoal</li> <li>P = Parasitic</li> <li>S= Sexual</li> <li>T= Tuberculosis</li> <li>V= Viral</li> </ul> <p>3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease</p>
Code Description and Permissible Values	<p>Codes used are:</p> <p>Local Code Icd10 Code Groups</p> <p>Group A None</p> <p>Group B</p> <p>BM01 B65 Schistosomiasis</p> <p>Group C</p> <p>CM01 B77 Ascariasis</p>

## Parasitic Diseases (Protozoal - Insect- Worm)

<b>Definition</b>	Diseases diagnosed by treating physician as a main result of a protozoal infection that should be reported to health authorities in accordance with WHO and local protocols
<b>Metadata Type</b>	Data element
<b>Data Concept</b>	Communicable Diseases--Parasitic Diseases (protozoal - Insect- Worm )
<b>Reference ID</b>	EA006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AANN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Adopted from WHO recommended surveillance standards 2nd edition
<b>Usage</b>	<p>The principal diagnosis must be determined in accordance with the ICD-10 Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. Communicable diseases are categorised into 3 categories</p> <p><b>CATEGORY A: Immediate</b>  These are diseases of urgent public health importance and shall be reported instantly. They are categorised as IMMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY B: Intermediate</b>  These are diseases of urgent public health importance and shall be reported in three days. They are categorised as INTERMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY C: Delayed</b>  These are diseases of urgent public health importance and shall be reported in Five working days. They are categorised as DELAYED urgency for reporting to health authorities upon identification or suspicion of a case. Such cases may require public health intervention.</p>

	<p><b>CODING STRUCTURE</b></p> <p>The structure created for the communicable diseases is a Local code created for each communicable disease composed of</p> <ol style="list-style-type: none"> <li>1 - First Letter is that denotes urgency in reporting:           <ul style="list-style-type: none"> <li>A = Immediate,</li> <li>B = Intermediate ,</li> <li>C = Delayed</li> </ul> </li> <li>2 - Second Letter describes the causative organism / agent           <ul style="list-style-type: none"> <li>A = Adverse Events</li> <li>B = Bacteria</li> <li>C = Chlamydia</li> <li>F = Fungus</li> <li>I = Bite</li> <li>M = Metazoal</li> <li>P = Parasitic</li> <li>S= Sexual</li> <li>T= Tuberculosis</li> <li>V= Viral</li> </ul> </li> <li>3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease</li> </ol>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>Local Code Icd10 Code:</p> <p>Groups B</p> <p>BP01 B55.1 Leishmania skin</p> <p>BP02 B55.0 Leishmania visceral</p> <p>BP03 B50-54 Malaria.</p> <p>Group C</p> <p>CP01 A06 Amebiasis</p> <p>CP02 B80 Enterobiasis</p> <p>CP03 A07.1 Giardiasis</p> <p>CP04 B67 HydatidDiseas</p> <p>CP05 B71 Hymenolepiasis</p> <p>CP06 B85 Pediculosis</p> <p>CP07 B86 Scabies</p> <p>CP08 B78 Strongyloidiasis</p> <p>CP09 B58 Toxoplasmosis</p> <p>CP10 B79 Trichuriasis</p>

<b>Rickettsial Diseases</b>	
<b>Definition</b>	Codes used for Diseases diagnosed by treating physician as a main result of a rickettsial infection that should be reported to health authorities in accordance with WHO and local protocols.
<b>Metadata Type</b>	Data element
<b>Data Concept</b>	Communicable Diseases—Rickettsial Diseases
<b>Reference ID</b>	EA007
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AANN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Adopted from WHO recommended surveillance standards 2nd edition
<b>Usage</b>	<p>The principal diagnosis must be determined in accordance with the ICD-10 Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. Communicable diseases are categorised into 3 categories:</p> <p><b>CATEGORY A: Immediate</b>        These are diseases of urgent public health importance and shall be reported instantly. They are categorised as <b>IMMEDIATE</b> urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY B: Intermediate</b> These are diseases of urgent public health importance and shall be reported in three days. They are categorised as <b>INTERMEDIATE</b> urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p>

	<p><b>CATEGORY C: Delayed</b>  These are diseases of urgent public health importance and shall be reported in Five working days. They are categorised as DELAYED urgency for reporting to health authorities upon identification or suspicion of a case. Such cases may require public health intervention.</p> <p><b>CODING STRUCTURE:</b>  The structure created for the communicable diseases is a Local code created for each communicable disease composed of</p> <p>1 - First Letter is that denotes urgency in reporting:  A = Immediate,  B = Intermediate ,  C = Delayed</p> <p>2 - Second Letter describes the causative organism / agent</p> <ul style="list-style-type: none"> <li>A = Adverse Events</li> <li>B = Bacteria</li> <li>C = Chlamydia</li> <li>F = Fungus</li> <li>I = Bite</li> <li>M = Metazoal</li> <li>P = Parasitic</li> <li>S= Sexual</li> <li>T= Tuberculosis</li> <li>V= Viral</li> </ul> <p>3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease</p>
<b>Code Description and Permissible Values</b>	Codes used are: Local Code Icd10 Code Groups  Group B BR01 A75 Typhus

## Sexually Transmitted Infection

<b>Definition</b>	Codes used for infections that are diagnosed by treating physician as a result of an infection due to sexual contact or from infected mother to infant during pregnancy, must be reported to health authorities in accordance with WHO or local protocols.
<b>Metadata Type</b>	Data element
<b>Data Concept</b>	Communicable Diseases--Sexually Transmitted Infection
<b>Reference ID</b>	EA008
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AANN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Adopted from WHO recommended surveillance standards 2nd edition
<b>Usage</b>	<p>The principal diagnosis must be determined in accordance with the ICD-10 Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. Communicable diseases are categorised into 3 categories:</p> <p><b>CATEGORY A: Immediate</b>  These are diseases of urgent public health importance and shall be reported instantly. They are categorised as IMMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY B: Intermediate</b>  These are diseases of urgent public health importance and shall be reported in three days. They are categorised as INTERMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY C: Delayed</b>  These are diseases of urgent public health importance and shall be reported in Five working days. They are categorised as DELAYED urgency for reporting to health</p>

	<p>authorities upon identification or suspicion of a case. Such cases may require public health intervention.</p> <p><b>CODING STRUCTURE</b></p> <p>The structure created for the communicable diseases is a Local code created for each communicable disease composed of</p> <ol style="list-style-type: none"> <li>1 - First Letter is that denotes urgency in reporting:           <ul style="list-style-type: none"> <li>A = Immediate,</li> <li>B = Intermediate ,</li> <li>C = Delayed</li> </ul> </li> <li>2 - Second Letter describes the causative organism / agent           <ul style="list-style-type: none"> <li>A = Adverse Events</li> <li>B = Bacteria</li> <li>C = Chlamydia</li> <li>F = Fungus</li> <li>I = Bite M = Metazoal</li> <li>P = Parasitic</li> <li>S= Sexual</li> <li>T= Tuberculosis</li> <li>V= Viral</li> </ul> </li> <li>3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease</li> </ol>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>Local Code Icd10 Code</p> <p>Groups Group B</p> <p>BS01 A50-A64 STD*</p> <p>BC02 A70 Chlamydial sexual diseases</p>

## Tuberculosis

Definition	TB disease results from Mycobacterium tuberculosis – bacteria that cause latent TB infection and TB disease. That occurs in the lungs, usually producing a cough that lasts 3 weeks or longer. Most TB disease is pulmonary
Metadata Type	Data element
Data Concept	Communicable Diseases—Tuberculosis
Reference ID	EA009
Synonyms	Non Applicable
Representation Class	Total
Data Type	Alphanumeric
Format	AANN
Maximum Field Size	4
Date Created	19/05/2016
Date Updated	To be defined
Source	USA, Department of Health and Human Services, Center of Disease Control and Prevention CDC
Usage	<p>The principal diagnosis must be determined in accordance with the ICD-10 Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. Communicable diseases are categorised into 3 categories</p> <p><b>CATEGORY A: Immediate</b>        These are diseases of urgent public health importance and shall be reported instantly. They are categorised as IMMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY B: Intermediate</b>        These are diseases of urgent public health importance and shall be reported in three days. They are categorised as INTERMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p>

	<p><b>CATEGORY C: Delayed</b></p> <p>These are diseases of urgent public health importance and shall be reported in Five working days. They are categorised as <b>DELAYED</b> urgency for reporting to health authorities upon identification or suspicion of a case. Such cases may require public health intervention.</p> <p><b>CODING STRUCTURE:</b></p> <p>The structure created for the communicable diseases is a Local code created for each communicable disease composed of</p> <ol style="list-style-type: none"> <li>1- First Letter is that denotes urgency in reporting:           <ul style="list-style-type: none"> <li>A = Immediate,</li> <li>B = Intermediate ,</li> <li>C = Delayed</li> </ul> </li> <li>2 - Second Letter describes the causative organism / agent           <ul style="list-style-type: none"> <li>A = Adverse Events</li> <li>B = Bacteria</li> <li>C = Chlamydia</li> <li>F = Fungus I = Bite</li> <li>M = Metazoal</li> <li>P = Parasitic</li> <li>S= Sexual</li> <li>T= Tuberculosis</li> <li>V= Viral</li> </ul> </li> <li>3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease.</li> </ol>
<b>Code Description and Permissible Values</b>	Codes used are: Local Code Icd10 Code Groups Group B BT01 A15,A16 TB pulmonary BT02 A17,A18 TB extra pulmonary

## Multi cause infectious diseases

<b>Definition</b>	Illnesses that are infectious and result from several biological organisms that may be viral or bacterial or others
<b>Metadata Type</b>	Data element
<b>Data Concept</b>	Communicable diseases, Multi Causative infectious diseases
<b>Reference ID</b>	EA010
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AANN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Adopted from WHO recommended surveillance standards 2nd edition
<b>Usage</b>	<p>The principal diagnosis must be determined in accordance with the ICD-10 Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. Communicable diseases are categorised into 3 categories</p> <p><b>CATEGORY A: Immediate</b>        These are diseases of urgent public health importance and shall be reported instantly. They are categorised as IMMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY B: Intermediate</b>        These are diseases of urgent public health importance and shall be reported in three days. They are categorised as INTERMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY C: Delayed</b>        These are diseases of urgent public health importance and shall be reported in Five working days. They are categorised as DELAYED urgency for reporting to health authorities upon identification or suspicion of a case. Such cases may require public health intervention.</p>

	<p><b>CODING STRUCTURE:</b></p> <p>The structure created for the communicable diseases is a Local code created for each communicable disease composed of</p> <ol style="list-style-type: none"> <li>1 - First Letter is that denotes urgency in reporting:           <ul style="list-style-type: none"> <li>A = Immediate,</li> <li>B = Intermediate ,</li> <li>C = Delayed</li> </ul> </li> <li>2 - Second Letter describes the causative organism / agent           <ul style="list-style-type: none"> <li>A = Adverse Events</li> <li>B = Bacteria</li> <li>C = Chlamydia</li> <li>F = Fungus</li> <li>I = Bite</li> <li>M = Metazoal</li> <li>P = Parasitic</li> <li>S= Sexual</li> <li>T= Tuberculosis</li> <li>V= Viral</li> </ul> </li> <li>3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease</li> </ol>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>Local Code Icd10 Code Groups</p> <p>Group A</p> <ul style="list-style-type: none"> <li>AX01 G82 AFP (Unspecified Cerebral) A05.1 AFP (Botulism)</li> <li>A80 AFP (Polio related)</li> <li>AX02 J80 ARDS</li> <li>AX03 G61 Guillain Barr</li> <li>AX04 G37.3 Transverse Myelitis</li> </ul>

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## Toxic Venom Incidents

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<b>Contagious non microbiological causes</b>	
<b>Definition</b>	Codes used for reporting non biological contagious condition
<b>Metadata Type</b>	Data element
<b>Data Concept</b>	Communicable Diseases-Contagious non microbiological causes
<b>Reference ID</b>	EB001
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AANN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	USA, Department of Health and Human Services, Center of Disease Control and Prevention CDC
<b>Usage</b>	<p>The principal diagnosis must be determined in accordance with the ICD-10 Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. Communicable diseases are categorised into 3 categories:</p> <p><b>CATEGORY A: Immediate</b>        These are diseases of urgent public health importance and shall be reported instantly. They are categorised as IMMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY B: Intermediate</b>        These are diseases of urgent public health importance and shall be reported in three days. They are categorised as INTERMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY C: Delayed</b>        These are diseases of urgent public health importance and shall be reported in Five working days. They are categorised as DELAYED urgency for reporting to health authorities upon identification or suspicion of a case. Such cases may require public health intervention.</p>

	<p><b>CODING STRUCTURE</b></p> <p>The structure created for the communicable diseases is a Local code created for each communicable disease composed of</p> <ol style="list-style-type: none"> <li>1 - First Letter is that denotes urgency in reporting:           <ul style="list-style-type: none"> <li>A = Immediate,</li> <li>B = Intermediate,</li> <li>C = Delayed</li> </ul> </li> <li>2 - Second Letter describes the causative organism / agent           <ul style="list-style-type: none"> <li>A = Adverse Events</li> <li>B = Bacteria</li> <li>C = Chlamydia</li> <li>F = Fungus</li> <li>I = Bite</li> <li>M = Metazoal</li> <li>P = Parasitic</li> <li>S= Sexual</li> <li>T= Tuberculosis</li> <li>V= Viral</li> </ul> </li> <li>3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease</li> </ol>
<b>Code Description and Permissible Values</b>	<p>Codes used are</p> <p>Local Code Icd10 Code Groups</p> <p>Group A</p> <p>CI01 T63.4 Tick paralysis</p> <p>Group C</p> <p>CI01 W55.8 Bite Animal (Other mammals)</p> <p>CI02 W54 Bite Dog</p> <p>CI03 T63.2 Bite Scorpion</p> <p>CI04 T63 Bite Snake (Toxic Venom unspecified)</p>

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## Non Micro-biological Communicable Incidents

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## Chemical Contamination Incident

<b>Definition</b>	A chemical emergency occurs when a hazardous chemical has been released and the release has the potential for harming people's health. Chemical releases can be unintentional, as in the case of an industrial accident, or intentional, as in the case of a terrorist attack.
<b>Metadata Type</b>	Data element
<b>Data Concept</b>	Communicable diseases, Contagious non microbiological causes, Chemical Contamination Incident
<b>Reference ID</b>	EC001
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AANN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	USA, Department of Health and Human Services, Center of Disease Control and Prevention CDC
<b>Usage</b>	<p>The principal diagnosis must be determined in accordance with the ICD-10 Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. Communicable diseases are categorised into 3 categories</p> <p><b>CATEGORY A: Immediate</b>        These are diseases of urgent public health importance and shall be reported instantly. They are categorised as IMMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY B: Intermediate</b>        These are diseases of urgent public health importance and shall be reported in three days. They are categorised as INTERMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY C: Delayed</b>        These are diseases of urgent public health importance and shall be reported in Five working days. They are categorised as DELAYED urgency for reporting to health authorities upon identification or suspicion of a case. Such cases may require public health intervention.</p>

	<p><b>CODING STRUCTURE</b></p> <p>The structure created for the communicable diseases is a Local code created for each communicable disease composed of:</p> <ol style="list-style-type: none"> <li>1. First Letter is that denotes urgency in reporting:            A = Immediate,            B = Intermediate ,            C = Delayed</li> <li>2 - Second Letter describes the causative organism / agent            A = Adverse Events            B = Bacteria            C = Chlamydia            F = Fungus            I = Bite            M = Metazoal            P = Parasitic            S= Sexual            T= Tuberculosis            V= Viral</li> <li>3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease</li> </ol>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>Local Code Icd10 Code            Groups Group A            AK01 Y38,7 Terrorism involving Chemical weapons            Group B            BK01 T30 Chemical Burn</p>

## Radioactive Contamination Incident

<b>Definition</b>	Radioactive contamination and radiation exposure could occur if radioactive materials are released into the environment as the result of an accident, an event in nature, or an act of terrorism. Such a release could expose people and contaminate their surroundings and personal property.
<b>Metadata Type</b>	Data element
<b>Data Concept</b>	Communicable diseases, Contagious non microbiological causes, Radioactive Contamination
<b>Reference ID</b>	EC002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AANN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	USA, Department of Health and Human Services, Center of Disease Control and Prevention CDC
<b>Usage</b>	<p>"Incidents related to chemical or radiological agents are a possibility in the current modern world either due to Terrorist attacks or incidental industrial hazard. In addition to these reasons such as the act of war and use of weapons of mass destruction may result in cases that are contaminated by chemical or radiological agents that can contaminate others. The principal diagnosis must be determined in accordance with the ICD-10 Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. Communicable diseases are categorised into 3 categories:</p> <p><b>CATEGORY A: Immediate</b>  These are diseases of urgent public health importance and shall be reported instantly. They are categorised as IMMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p>

	<p><b>CATEGORY B: Intermediate</b>  These are diseases of urgent public health importance and shall be reported in three days. They are categorised as INTERMEDIATE urgency for reporting to health authorities upon identification or suspicion of a case. Usually such cases require public health intervention.</p> <p><b>CATEGORY C: Delayed</b>  These are diseases of urgent public health importance and shall be reported in Five working days. They are categorised as DELAYED urgency for reporting to health authorities upon identification or suspicion of a case. Such cases may require public health intervention.</p> <p><b>CODING STRUCTURE</b>  The structure created for the communicable diseases is a Local code created for each communicable disease composed of</p> <p>1 - First Letter is that denotes urgency in reporting:  A = Immediate,  B = Intermediate ,  C = Delayed</p> <p>2 - Second Letter describes the causative organism / agent  A = Adverse Events  B = Bacteria  C = Chlamydia  F = Fungus  I = Bite  M = Metazoal  P = Parasitic  S= Sexual  T= Tuberculosis  V= Viral</p> <p>3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease</p>
<b>Code Description and Permissible Values</b>	Codes used are Local Code Icd10 Code Groups Group A AR 01 T30 Radiation Burn AR02 T66 Radiation sickness Group B BR01 T66 Effect of radiation therapy

# Chapter 06

## Tumors

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## Tumor description and diagnosis

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### Date of tumor diagnosis

<b>Definition</b>	The date when the tumor was diagnosed.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumors- Date of tumor diagnosis
<b>Reference ID</b>	FA001
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	Codes used are: DDMMYYYY Century digits are considered essential

## Tumor Topography

<b>Definition</b>	The topography code indicates the site of origin of a neoplasm; in other words, where the tumor arose. All neoplasms, whether malignant, benign, in situ, or uncertain whether benign or malignant, are coded with the same set of topography codes in ICD-O.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumors - Tumor Topography
<b>Reference ID</b>	FA002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
<b>Format</b>	CNN.N
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council / Saudi Cancer Registry form
<b>Usage</b>	Report information as per Saudi Cancer Registry criteria adapted from U.S. National Cancer Institute's Surveillance, Epidemiology and End Results (SEER)
<b>Code Description and Permissible Values</b>	Codes used are: Use codes as indicated by SEER

Tumor Morphology	
<b>Definition</b>	The histological classification of the cancer tissue (histopathological type) and a description of the course of development that a tumor is likely to take: benign or malignant (behavior), as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumors - Tumor Morphology
<b>Reference ID</b>	FA003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN/N
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi health council / Saudi Cancer Registry form
<b>Usage</b>	<p>Morphology in Saudi Cancer Registry is based on International Classification of Diseases for Oncology ICDO3.1, it describes histology and behavior as separate variables, recognizing that there are a large number of possible combinations.</p> <p>Morphology is a 4-digit number ranging from 8000 to 9989, and behavior is a single digit which can be 0, 1, 2, 3, 6 or 9. Record morphology codes in accordance with ICDO coding standards. Use the 5th-digit to record behavior.</p> <p>The 5th digit behavior code numbers used in ICDO are listed below:</p> <ul style="list-style-type: none"> <li>0 = Benign</li> <li>1 = Uncertain whether benign or malignant: - Borderline malignancy - Low malignant potential</li> <li>2 = Carcinoma in situ - Intraepithelial – Non infiltrating - Non-invasive</li> <li>3 = Malignant, primary site</li> <li>6 = Malignant, metastatic site - Malignant, secondary site</li> <li>9 = Malignant, uncertain whether primary or metastatic site</li> </ul>
<b>Code Description and Permissible Values</b>	Codes used are: As outlined in latest 2011 - ICDO3.1

### Tumor Behavior

<b>Definition</b>	The description of the tumor relation with the neighboring tissues represented by a code
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumors - Tumor behavior
<b>Reference ID</b>	FA004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council / Saudi Cancer Registry form
<b>Usage</b>	Tumor behavior code is used to describe whether the tumor is In situ or Malignant/Invasive
<b>Code Description and Permissible Values</b>	Codes used are: 2 = In situ 3 = Malignant/Invasive

## Tumor Grade

<b>Definition</b>	Tumor is graded based on the type of cancer. In general, tumors are graded as 1, 2, 3, or 4, depending on the amount of abnormality. Saudi Cancer Registry defined these codes into 9 different categories
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumors - Tumor Grade
<b>Reference ID</b>	FA005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi health Council / Saudi Cancer Registry form
<b>Usage</b>	This code is used to categorize the tumor cell differentiation
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Well differentiated / Differentiated, NOS.</p> <p>2 = Moderately / Moderately well differentiated.</p> <p>3 = Poorly differentiated.</p> <p>4 = Undifferentiated / Anaplastic.</p> <p>5 = T-Cell*.</p> <p>6 = B-Cell / Pre-B/B-cursor*.</p> <p>7 = Null Cell/Non-T-Non-B*.</p> <p>8 = Natural Killer Cell*.</p> <p>9 = Unknown*. * = For Leukemias and Lymphomas only.</p>

## Degree of spread of cancer

<b>Definition</b>	Degree of spread of cancer is a measure of the progression/extent of cancer at a particular point in time, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumor Grade—Degree of spread of cancer
<b>Reference ID</b>	FA006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>The following examples will help understanding which code should be used</p> <p>Examples for Code 1 :</p> <ol style="list-style-type: none"> <li>1) For colon cancer, the cancer has not progressed into the adventitia (peritoneal layer) surrounding the colon.</li> <li>2) For breast cancer, the cancer has not progressed into the underlying muscle layer (pectoral) or externally to the skin.</li> <li>3) For lung cancer, the cancer has not invaded the pleura.</li> </ol> <p>Examples for code 2 :</p> <ol style="list-style-type: none"> <li>1) For colon cancer, the cancer has progressed into the adventitia (peritoneal layer) surrounding the colon.</li> <li>2) For breast cancer, the degree of spread has progressed into the underlying muscle layer (pectoral) or externally into the skin.</li> <li>3) For lung cancer, the cancer has invaded the pleura or tissues of the mediastinum.</li> </ol> <p>Example for code 3 :</p> <p>The regional lymph nodes by site of primary cancer (International Union Against Cancer's definition).</p> <ol style="list-style-type: none"> <li>1) Head and neck: Cervical nodes</li> <li>2) Larynx: Cervical nodes</li> <li>3) Thyroid: Cervical and upper mediastinal nodes</li> <li>4) Stomach: Perigastric, peripancreatic, those located along the lesser and greater curvatures</li> <li>5) Colon &amp; Rectum: Pericolic, perirectal, those located along the ileocolic, right colic, middle colic, left colic, inferior mesenteric and superior rectal</li> <li>6) Anal: Perirectal, internal iliac, and inguinal lymph nodes</li> <li>7) Liver: Hepatoduodenal ligament</li> <li>8) Pancreas: Peripancreatic nodes</li> <li>9) Lung: Intrathoracic, scalene and supraclavicular</li> </ol>

	<p>9) Breast: Axillary, interpectoral, internal mammary      10) Cervix: Paracervical, parametrial, hypogastric, common, internal and external iliac, presacral and sacral      11) Ovary: Hypogastric (obturator), common iliac, external iliac, lateral, sacral, para-aortic and inguinal      12) Prostate &amp; bladder: Pelvic nodes below the bifurcation of the common iliac arteries      13) Testes: Abdominal, para-aortic and paracaval nodes, the intrapelvic and inguinal nodes 14) Kidney: Hilar, abdominal, para-aortic or paracaval</p>
<b>Code Description and Permissible Values</b>	<p>Code used are:</p> <p>1 = Localized to the tissue of origin. Includes a primary cancer where the spread is contained within the organ of origin. Note: this includes in situ breast (D05.0- D05.9) and in situ melanoma (D03.0-D03.9)</p> <p>2 = Invasion of adjacent tissue or organs. A primary cancer has spread to adjacent organs or tissue not forming part of the organ of origin. This category includes subcutaneous fat or muscle and organs adjacent to the primary cancer site.</p> <p>3 = Regional lymph nodes. The primary cancer has metastasized to the nearby draining lymph nodes.</p> <p>4 = Distant metastases. The primary cancer has spread to sites distant to the primary site, for example liver and lung and bone, or any lymph nodes not stated as regional to the site (see '3 - Regional lymph nodes' above).</p> <p>5 = Not applicable. This category applies for lymphatic and haematopoietic cancers, e.g. myelomas, Leukemias and lymphomas (C81.0 - C96.9) only.</p> <p>9 = Unknown. No information is available on the degree of spread at this episode or the available information is insufficient to allow classification into one of the preceding categories.</p>

## Tumor SEER Summary Stage

<b>Definition</b>	A summary staging based on the theory of tumor
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumor SEER Summary
<b>Reference ID</b>	FA007
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi health Council / Saudi Cancer Registry form
<b>Usage</b>	This code is used to categorize how far a cancer has spread from its point of origin.
<b>Code Description and Permissible Values</b>	Codes used are: 1 = In situ 2 = Localized 3 = Regional by direct extent 4 = Regional by lymph node 5 = Regional (both 3&4) 6 = Regional, NOS 7 = Distant Metastasis / Systemic disease 9 = Unknown

## Tumor Laterality

<b>Definition</b>	Describes which side of a paired organ is the origin of the primary cancer
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumors, Tumor Laterality
<b>Reference ID</b>	FA008
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi health Council / Saudi Cancer Registry form
<b>Usage</b>	<p>The valid International Classification of Diseases for Oncology values for the variable is provided in the list below:</p> <p>CODE 1 = Right Origin of primary site is on the left side of a paired organ. Paired organs are: Breast (C50), Lung (C34), Kidney (C64), Ovary (C56), Eyes (C69), Arms (C76.4, C44.6, C49.1, C47.1, C40.0, C77.3, ), Legs (C76.5, C44.7, C49.2, C47.2, C40.2, C77.4), Ears (C44.2, C49.0, C30.1), Testicles (C62), Parathyroid glands (C75.0), Adrenal glands (C74.9, C74.0, C74.1), Tonsils (C09.9, C02.4, C11.1, C09.0, C09.1, C03.9), Ureter (C66.9), Carotid body (C75.4), Vas deferens (C63.1), Optic nerve (C72.3)</p> <p>CODE 2 = Left Origin of primary site is on the right side of a paired organ.</p> <p>CODE 3 = Bilateral Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2), (M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumors (C64.9, M8960/3))</p> <p>Note: Bilateral cancers are very rare.</p> <p>CODE 9 = Unknown It is unknown whether, for a paired organ the origin of the cancer was on the left or right side of the body</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>0 = Not paired (Not Known, ill defined)</p> <p>1 = Right</p> <p>2 = Left</p> <p>3 = One side, but unknown</p> <p>4 = Bilateral Involvement, laterality origin unknown</p> <p>9 = Paired Site, Laterality Not Stated</p>

<b>Tumor Basis of Diagnosis</b>	
<b>Definition</b>	The basis on which the final diagnosis of cancer was made
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumors, basis of Diagnosis
<b>Reference ID</b>	FA009
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi health Council / Saudi Cancer Registry form
<b>Usage</b>	<p>This element describes the basis used to reach to the conclusion that cancer is the diagnosis; it includes a combination of clinical and investigative information that are usually used to make such a diagnosis.</p> <p>CODE 0 = Death certificate only: Information provided is from a death certificate.</p> <p>CODE 1 = Clinical: Diagnosis made before death, but without any of the following (codes 2-7).</p> <p>CODE 2 = Medical Imaging (radiology), including x-ray, endoscopy, CT imaging, MRI and ultrasound.</p> <p>CODE 3 = Surgery Visualization without Biopsy, exploratory surgery (e.g. laparotomy), and autopsy, without a tissue diagnosis</p> <p>CODE 4 = Laboratory test marker results Including biochemical and/or immunological markers that are specific for a tumor site</p> <p>CODE 5 = Cytology / Hematology: Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates.</p> <p>CODE 6 = Histology of metastasis: Histological examination of tissue from a metastasis, including autopsy specimens.</p> <p>CODE 7 = Histology of a primary tumor: Histological examination of tissue from primary tumor, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of</p>

	<p>primary tumor.</p> <p>CODE 8 = Autopsy report including histology whether from primary or metastatic site, or not otherwise specified.</p> <p>CODE 9 = Unknown</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>0 = Death Certificate Only DCO</p> <p>1 = Clinical</p> <p>2 = Medical Imaging (Radiology)</p> <p>3 = Surgery (Visualization without Biopsy)</p> <p>4 = Laboratory test (Tumor Marker)</p> <p>5 = Cytology / Hematology</p> <p>6 = Histology of Metastasis</p> <p>7 = Histology of a Primary Tumor</p> <p>8 = Autopsy</p> <p>9 = Unknown</p>

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## Tumor Treatment

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Intention of Treatment for Cancer	
Definition	The intention of the initial treatment for cancer for the particular patient, as represented by a code.
Metadata Type	Data Element
Data Concept	Tumor Treatment—Intention of treatment for cancer
Reference ID	FB001
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	<p>This element is used as follows:</p> <p>CODE 0 = Did not have treatment. This code is used when the patient did not have treatment as part of the initial management plan.</p> <p>CODE 1 = Prophylactic. This code is used when the cancer has not developed</p> <p>CODE 2 = Curative. This code is used when treatment is given for control of the disease</p> <p>CODE 3 = Non-curative or Palliative. This code is used when the cure is unlikely to be achieved and treatment is given primarily for the purpose of pain control. Other benefits of the treatment are considered secondary contributions to the patient's quality of life.</p> <p>CODE 9 = Intention was not stated patient had treatment for cancer but the intention was not stated.</p>
Code Description and Permissible Values	<p>Codes used are:</p> <p>0 = Did not have treatment</p> <p>1 = Prophylactic</p> <p>2 = Curative</p> <p>3 = Non-curative or Palliative</p> <p>9 = Intention was not stated</p>

<b>Date of surgical treatment for cancer</b>	
<b>Definition</b>	The date on which the cancer-directed surgical treatment was performed.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumor Treatment—Date of surgical treatment for cancer
<b>Reference ID</b>	FB002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	The date of each surgical treatment episode should be entered separately. Collected for curative and palliative surgery prior to the first recurrence.
<b>Code Description and Permissible Values</b>	Codes used are:  DDMMYYYY Century digits are considered essential

## Surgical treatment procedure for cancer

<b>Definition</b>	The surgical procedure used in the primary treatment of the cancer, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumor Treatment—Surgical treatment procedure for cancer
<b>Reference ID</b>	FB003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NNNNN-NN
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Each surgical treatment procedure used in the initial treatment of the cancer should be recorded. Surgical procedures performed for palliative purposes only should not be included. For surgical procedures involved in the administration of another modality (e.g. implantation of infusion pump, isolated limb perfusion/infusion, intra-operative radiotherapy) record both the surgery and the other modality. Any systemic treatment which can be coded as a procedure through ACHI should be so coded (e.g. stem cell or bone marrow infusion)
<b>Code Description and Permissible Values</b>	Codes used are: Australian Classification of Health Interventions (ACHI) 6th edition

### Tumour size at diagnosis (Solid Tumors)

<b>Definition</b>	The largest dimension of a solid tumor, measured in millimeters
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumor Treatment—Tumor size at diagnosis (solid tumors)
<b>Reference ID</b>	FB004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	The reporting standard for the size of solid tumors is: Breast cancer or other solid neoplasms - the largest tumor dimension, measured to a precision of 1mm.
<b>Code Description and Permissible Values</b>	Codes used are:  999 = Unknown Unit measurement = Millimeter

## Radiotherapy Treatment Type

<b>Definition</b>	The type of radiation therapy used in initial treatment of the cancer, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumor Treatment—Radiation Therapy Treatment Type
<b>Reference ID</b>	FB005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>More than one radiotherapy treatment type may be delivered during the course of treatment; select the appropriate code value. Most external beam radiotherapy is delivered on an outpatient basis.</p> <p>CODE 2 Brach therapy (radioactive implants) This code is likely to be listed as a procedure for admitted patients. The difference between the types of radiotherapy relates to the position of the radiation source:</p> <ul style="list-style-type: none"> <li>• External beam radiotherapy (EBRT) is delivered by directing the radiation at the tumor from outside the body.</li> <li>• Brach therapy or sealed source radiotherapy is delivered by placing the radiation source in close proximity to the tumor site.</li> <li>• Unsealed radioisotopes or systemic radioisotope therapy is delivered by infusion into the bloodstream or by ingestion and is a form of targeted therapy.</li> </ul>
<b>Code Description and Permissible Values:</b>	<p>Codes Used are:</p> <p>0 = No radiotherapy treatment given      1 = External radiotherapy treatment given      2 = Brach therapy (radioactive implants)      3 = Unsealed radioisotopes      9 = Radiotherapy was administered but method was not stated</p>

<b>Received radiation dose</b>	
<b>Definition</b>	The received dose of radiation measured in Gray (Gy) - ICRU.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumor Treatment—Received radiation dose 5N
<b>Reference ID</b>	FB006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	5N
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>The International Commission on Radiation Units (ICRU) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pairs and so on).</p> <p>The ICRU 50 reference dose should be recorded for photon therapy if available, otherwise a description of the received dose at the center of the planning target volume. The ICRU 58 should be recorded for brachytherapy. For maximum consistency in this field the ICRU recommendations should be followed whenever possible.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>00000 = No radiation therapy was administered</p> <p>99999 = Radiation therapy was administered but the dose is</p>

## Radiotherapy Waiting Time

<b>Definition</b>	Period between the date the diagnosis was established and the actual date Radiotherapy started
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumor treatment, Radiotherapy waiting time
<b>Reference ID</b>	FB007
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council / Canadian Institute For Health Information, Wait Times Benchmarks 2014 for cancer patients
<b>Usage</b>	<p>This is a benchmark for the cancer patient to receive the appropriate treatment in at the appropriate time, It is also considered a sensitive indicator for the health system to be able to cope with the urgent patient needs.</p> <p>This monitor works best for those patients that their main treatment plan requires radiotherapy but not appropriate for some cancer types that need adjuvant radiotherapy as standards may differ.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Waiting from 1 to 14 days      2 = Waiting from 15 to 28 days      3 = Waiting &gt; 28 days</p>

## Chemotherapy Waiting Time

<b>Definition</b>	Period between the date the diagnosis was established and the actual starting date of Chemotherapy
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumors, Chemotherapy waiting time
<b>Reference ID</b>	FB008
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Canadian Institute For Health Information, Wait Times Benchmarks 2014 for cancer patients
<b>Usage</b>	This is a benchmark for the diagnosed patient to receive the appropriate treatment at the appropriate time, It is also considered a sensitive indicator for the health system to be able to cope with the urgent patient needs.
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Waiting from 1 to 22 days 2 = Waiting from 23 to 45 days 3 = Waiting > 45 days

## Outcome of initial treatment

<b>Definition</b>	The response of the tumor at the completion of the initial treatment modalities, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumor Treatment—Outcome of initial treatment
<b>Reference ID</b>	FB009
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>To help data collection, the following is an explanation for how to use codes:</p> <p>CODE 1 = Complete response: Complete disappearance of all measurable disease, including tumor markers, for at least four weeks. No new lesions or new evidence of disease.</p> <p>CODE 2 = Partial response: A decrease by at least 50% of the sum of the products of the maximum diameter and perpendicular diameter of all measurable lesions, for at least four weeks. No new lesions or worsening of disease.</p> <p>CODE 3 = Stable or static disease: No change in measurable lesions qualifying as partial response or progression and no evidence of new lesions.</p> <p>CODE 4 = Progressive disease: An increase by at least 25% of the sum of the products of the maximum diameter and a perpendicular diameter of any measurable lesion, or the appearance of new lesions.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Complete response      2 = Partial response      3 = Stable or static disease      4 = Progressive disease      5 = Incomplete response      9 = Not assessed or unable to be assessed</p>

<b>Date of diagnosis of first recurrence</b>	
<b>Definition</b>	The date a medical practitioner confirms the diagnosis of a recurrent or metastatic cancer of the same histology.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumor Treatment—Date of diagnosis of first recurrence
<b>Reference ID</b>	FB010
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	DDMMYYYY
<b>Maximum Field Size</b>	8
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	The term 'recurrence' defines the return, reappearance or metastasis of cancer (of the same histology) after a disease free period.
<b>Code Description and Permissible Values</b>	Codes used are: DDMMYYYY Century digits are considered essential

## Region of first recurrence

<b>Definition</b>	The region of first recurrence of primary cancer after a disease free intermission or remission, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Tumor Treatment—Region of first recurrence
<b>Reference ID</b>	FB011
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>The region of the first recurrence following the initial diagnosis should be recorded. The record should not be updated with subsequent recurrences.</p> <p>The cancer may recur in more than one site (e.g. both regional and distant metastases). Record the highest numbered applicable response.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>0 = Local</li> <li>1 = Regional</li> <li>2 = Both local and regional</li> <li>3 = Distant</li> <li>4 = Distant and either local or regional</li> <li>5 = Local, regional and distant</li> <li>6 = Supplementary values: 0 None, patient is disease-free</li> <li>7 = Patient was never disease-free</li> <li>8 = Recurred but site unknown</li> <li>9 = Unknown if recurred</li> </ul>

# Chapter 07

## Burden of Disease Information

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## Cardiovascular Diseases CVD

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<b>Hypertension patient</b>	
<b>Definition</b>	When systolic blood pressure is equal to or above 140 mm hg and /or a diastolic blood pressure equal to or above 90 mm hg the blood pressure is considered to be raised or high.
<b>Metadata Type</b>	Data Concept
<b>Data Concept</b>	Burden of Disease Risk information ,CVD, Hypertension
<b>Reference ID</b>	GA001
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Concept
<b>Data Type</b>	
<b>Format</b>	
<b>Maximum Field Size</b>	
<b>Date Created</b>	
<b>Date Updated</b>	
<b>Source</b>	World Health organization
<b>Usage</b>	
<b>Code Description And Permissible Values</b>	

<b>Resistant Hypertension</b>	
<b>Definition</b>	Resistant hypertension is defined as the failure to achieve goal BP in patients who are adhering to full doses of an appropriate three-drug regimen that includes a diuretic.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hypertension—Resistant Hypertension
<b>Reference ID</b>	GA002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	code
<b>Data Type</b>	Numeric
<b>format</b>	N
<b>Maximum field size</b>	1
<b>Date created</b>	19/05/2016
<b>Date updated</b>	To be defined
<b>Source</b>	The seventh Report of the joint national committee JNC 7 on prevention, Detection, Evaluation, and Treatment of High Blood pressure 2004.
<b>Usage</b>	This is used to report total hypertension patients treated at a Healthcare facility according to their blood pressure resistance to treatment.
<b>Code description and permissible values</b>	Codes used are: 1=Resistant 2=Non Resistant

Hypertension Classification	
Definition	Identifies a person with or at risk of hypertension
Metadata type	Data Element
Data concept	Burden of Disease CVD ,Hypertension classification
Reference ID	GA003
Synonyms	Non applicable
Representation Class	Code
Data type	numeric
Format	N
Maximum field size	1
Data created	19/05/2016
Data Updated	To be defined
Source	Palestinian health data dictionary second edition,2005
Usage	<p>This element is used in public health, health care and clinic settings to report data related to one of the chronic illnesses that are considered a high burden on the Saudi health system.</p> <p>The Staging of the severity of hypertension and treating plan with pharmacological or non-pharmacological or both, According to the stage. Confirming the diagnosis of HTN is based on the latest guidelines issued by the USA JNC 8 report 2014 which confirms Hypertension at a subsequent visit one to four weeks after the first.<sup>2</sup> If blood pressure is very high (e.g., systolic 180 mmHg or higher), or timely follow-up unrealistic, treatment can be started after just one set of measurements.</p> <p>Hypertension classification is based on the following JNC 7 Classification of Blood Pressure:</p> <ul style="list-style-type: none"> <li>Normal = Systolic &lt;120 and Diastolic &lt;80</li> <li>Prehypertension = Systolic 120–139 or Diastolic 80–89</li> <li>Hypertension, Stage 1 = Systolic 140–159 or Diastolic 90–99</li> <li>Hypertension, Stage 2 = Systolic ≥160 or Diastolic ≥100</li> </ul>
Code Description and Permissible Values:	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>0 = Normal</li> <li>1 = Pre- Hypertension</li> <li>2 = Stage 1 Hypertension</li> <li>3 = Stage 2 Hypertension</li> </ul>

<b>Hypertension with Complications</b>	
<b>Definition</b>	These are the result of persistent elevated blood pressure, Causing secondary illness/disease.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Burden of Disease Risk Information, CVD, Hypertension with Complications
<b>Reference ID</b>	GA004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element is to report the cases of hypertension that Suffered a secondary illness due to hypertension. It should allow multiple entries per patient if more than one complication is noted.
<b>Code Description and Permissible Values</b>	Codes used are: 0 = Without complications 1 = With Ischemic Heart Diseases 2 = With Congestive Heart Failure 3 = With Stroke 4 = With Renal impairment 5 = With Visual impairment 9 = Unknown

Hypertension Therapy Type	
Definition	The type of hypertension therapy the person is currently using or receiving.
Metadata Type	Data Element
Data Concept	Burden of Disease Information CVD, Hypertension Therapy Type
Reference ID	GA005
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Palestinian Health Data Dictionary Second edition, 2005
Usage	This element is to report the management of hypertension patient which will help in analysis of service cost and its development. It will also collect the feedback on patients who are put on lifestyle modification versus those who were treated by pharmaceutical products and the Monitoring of the response to either method of treatment.
Code Description and Permissible Values	Codes used are: 0 = Lifestyle modifications 1 = One drug 2 = Two drugs 3 = Three drugs

### Hypertension Patient service location

<b>Definition</b>	It is the code used to identify service location of hypertension patient
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Burden of Disease Information CVD, Hypertension Patient Service Location
<b>Reference ID</b>	GA006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element is to report the location of management for Hypertension patient. This will help in analysis of service cost and service development
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Primary Health care center clinic 2 = Hospital Emergency Room 3 = Hospital Outpatient

<b>Admission due to Hypertension</b>	
<b>Definition</b>	The recorded number of patient whose main reason of admission is to manage Hypertension and provide close monitoring.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Burden of Disease Information, CVD, Admission due to hypertension
<b>Reference ID</b>	GA007
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	6N
<b>Maximum Field Size</b>	6
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This is used to report Admission due to hypertension
<b>Code Description and Permissible Values</b>	Codes used are: 6N = Total count per fiscal year

Year of Diagnosis of Hypertension	
Definition	The year a patient was first diagnosed as having hypertension
Metadata Type	Data Element
Data Concept	Burden of Disease Information, CVD, Year of Diagnosis of Hypertension
Reference ID	GA008
Synonyms	Non Applicable
Representation Class	Date
Data Type	Date/Time
Format	YYY
Maximum Field Size	4
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	Record the year that the patient was first diagnosed as having Hypertension
Code Description and Permissible Values	Codes Used are: 9999 = Not stated/inadequately described

### Types of Angina

<b>Definition</b>	Identifies a person with or at risk of IHD
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Burden of Disease Information, CVD, Types of Angina, Code N
<b>Reference ID</b>	GA009
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	This is used to report the types of angina seen at the emergency room
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Stable angina. 2 = New-onset exertional Angina (Initial). 3 = Angina of increasing frequency or duration or refractory to nitroglycerin (Crescendo) 4 = Angina at rest 5 = Variant angina (Prinzmetal angina). 6 = Other

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## Diabetes Mellitus

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Diabetes Mellitus Patient	
Definition	Diabetes is a chronic condition that occurs when the body cannot produce enough insulin or cannot use insulin.
Metadata Type	Data Concept
Data Concept	Burden of Disease Information, Diabetes Mellitus, Diabetes Mellitus Patient
Reference ID	GB001
Synonyms	Not Applicable
Representation Class	Concept
Data Type	
Format	
Maximum Field Size	
Date Created	
Date Updated	
Source	International Diabetes Federation 2015, 7th edition Atlas
Usage	
Code Description and Permissible Values	

Classification of Diabetes Mellitus	
Definition	Identifies a person with or at risk of diabetes
Metadata Type	Data Element
Data Concept	Burden of Disease Information, Classification of Diabetes Mellitus
Reference ID	GB002
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Palestinian Health Data Dictionary Second edition, 2005
Usage	<p>This element is used to report the diabetes cases in relation to its classification to help in depth understanding of the Disease nationally.</p> <p>Code 1 = Type 1: Characterized by beta cell destruction, Usually leading to absolute insulin deficiency. It has two forms: - Immune-mediated diabetes mellitus: Results from a cellular mediated autoimmune destruction of the beta cells of the pancreas. -Idiopathic diabetes mellitus: Refers to forms of the disease that have no known etiologies.</p> <p>Code 2 = Type 2: Disease of insulin resistance that usually has relative (rather than absolute) insulin deficiency: Can range from predominant insulin resistance with relative insulin deficiency to predominant insulin deficiency with some insulin resistance.</p> <p>Code 3 = Impaired Glucose Homeostasis: A metabolic stage intermediate between normal glucose homeostasis and diabetes (In the absence of pregnancy, these are not clinical entities on their own but rather risk factor for future diabetes and cardiovascular disease) - Impaired Fasting Glucose (IFG): Fasting plasma glucose higher than normal, and less than diagnostic - Impaired Glucose Tolerance (IGT): Plasma glucose higher than normal, and less than diagnostic, following administration of a glucose load of 75grams.</p> <p>Code 4 = Gestational Diabetes Mellitus: Glucose intolerance in pregnancy (Diabetes mellitus with onset or first recognition in pregnancy)</p>

	<p>Code 8 = Other Specific Types: Diabetes caused by other identifiable etiologies</p> <ul style="list-style-type: none"> <li>• Genetic defects of beta cell function (e.g., MODY* 1, 2, 3)</li> <li>• Genetic defects in insulin action • Diseases of the exocrine pancreas (e.g., cancer of the pancreas, cystic fibrosis, pancreatitis)</li> <li>• Endocrinopathies (e.g., Cushing's disease)</li> <li>• Drug or chemical induced (e.g., steroids)</li> <li>• Infection (e.g., rubella, Coxsackie, CMV)</li> <li>• Uncommon forms of immune- related diabetes</li> <li>• Other genetic syndromes.</li> </ul>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p style="text-align: center;">1 = Type 1</p> <p style="text-align: center;">2 = Type 2</p> <p style="text-align: center;">3 = Impaired Glucose Homeostasis</p> <p style="text-align: center;">4 = Gestational Diabetes</p> <p style="text-align: center;">8 = Other</p>

### Diabetes Mellitus Complications

<b>Definition</b>	Diabetic complications can be classified as: - Acute complications: Complication which arise within a short time Frame due to poor metabolic control. – Chronic complications: Chronic diabetic complications contribute significantly to morbidity and mortality in diabetes mellitus, they are insidious in onset but may be present in up to 30% of type 2 diabetes at diagnosis and good metabolic control Can prevent/delay progression of these complications.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Burden of Disease Information, Diabetes Mellitus Complications
<b>Reference ID</b>	GB003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Palestinian Health Data Dictionary Second edition, 2005
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p><b>1.0 Acute complications:</b></p> <ul style="list-style-type: none"> <li>1.1 Hypoglycemia</li> <li>1.2 Diabetic ketoacidosis (DKA)</li> <li>1.3 Hyperglycemic hyperosmolar state (HHS)</li> </ul> <p><b>2.0 Chronic complications:</b></p> <ul style="list-style-type: none"> <li><b>2.1 Microvascular</b> <ul style="list-style-type: none"> <li>2.1.1 Coronary artery disease</li> <li>2.1.2 Cerebrovascular disease</li> <li>2.1.3 Peripheral vascular disease</li> </ul> </li> <li><b>2.2 Microvascular</b> <ul style="list-style-type: none"> <li>2.2.1 Retinopathy,</li> <li>2.2.2 Nephropathy</li> <li>2.2.3 Neuropathy</li> </ul> </li> <li><b>2.3 Combination of microvascular and microvascular</b> <ul style="list-style-type: none"> <li>2.3.1 diabetic foot</li> <li>2.3.2 diabetic dermopathy</li> </ul> </li> <li><b>2.4 Others</b></li> </ul>

Diabetes Mellitus Therapy Type	
Definition	The type of diabetes therapy the person is currently receiving.
Metadata Type	Data Element
Data Concept	Burden of Disease Information Diabetes Mellitus Therapy Type
Reference ID	GB004
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Palestinian Health Data Dictionary Second edition, 2005
Usage	
Code Description and Permissible Values	Codes used are: 0 = Non pharmacological treatment only 1 = Pharmacological treatment 2 = Oral antidiuretic only 3 = Insulin only 4 = Combined 5 = Pharmacological and Non-pharmacological treatment 8 = Not stated/inadequately described

Diabetes Mellitus Patient service location	
Definition	It is the code used to identify service location of diabetes patient.
Metadata Type	Data Element
Data Concept	Burden of Disease Information Diabetes Mellitus Patient Service Location
Reference ID	GB005
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Palestinian Health Data Dictionary Second edition, 2005
Usage	This element is to report the location of management for hypertension patient. This will help in analysis of service cost and service development
Code Description and Permissible Values	Codes used are: 1 = Primary Health care center clinic 2 = Hospital Emergency Room 3 = Hospital Outpatient

<b>Admissions due to Diabetes Mellitus</b>	
<b>Definition</b>	The recorded number of patients who were admitted because of diabetes for management and close monitoring.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Burden of Disease Information, Total Diabetes Mellitus Admissions due to Diabetes Mellitus
<b>Reference ID</b>	GB006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	6N
<b>Maximum Field Size</b>	6
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This is used to report Admission due to diabetes
<b>Code Description and Permissible Values</b>	Codes used are: 6N = Total count per fiscal year

## Diabetes Therapy Type

<b>Definition</b>	The type of diabetes therapy the person is currently receiving, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Burden of Disease Information Diabetes Mellitus—Diabetes Therapy Type.
<b>Reference ID</b>	GB007
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>CODE 01 Diet &amp; exercise only This code includes the options of generalized prescribed diet; avoid added sugar/simple carbohydrates (CHOs); low joule diet; portion exchange diet and uses glycemic index and a recommendation for Increased exercise.</p> <p>CODE 98 Nil - not currently receiving Diabetes treatment. This code is used when there is no Current diet, tablets or insulin therapy (ies).</p> <p>CODE 99 Not stated/inadequately described Use this code when missing Information.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>01 = Diet &amp; exercise only</p> <p>02 = Oral hypoglycemic - sulphonylurea only</p> <p>03 = Oral hypoglycemic - biguanide (eg metformin) only</p> <p>04 = Oral hypoglycemic - alpha-glycosidase inhibitor only</p> <p>05 = Oral hypoglycemic - thiazolidinedione only</p> <p>06 = Oral hypoglycemic - meglitinide only</p> <p>07 = Oral hypoglycemic - combination (egbiguanide and sulphonylurea)</p> <p>08 = Oral hypoglycemic - other</p> <p>09 = Insulin only 10 = Insulin plus oral hypoglycemic</p> <p>98 = Nil - not currently receiving diabetes treatment.</p> <p>99 = Not stated/inadequately described</p>

### Health professionals attended (diabetes mellitus)

<b>Definition</b>	The health professionals that a person has attended in the last 12 months in relation to issues arising from diabetes mellitus, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Burden of Diseases Information, Diabetes Mellitus- Health professionals Attended for Diabetes Mellitus
<b>Reference ID</b>	GB008
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>This element helps record the type of medical specialty the diabetic patient is receiving care from. record a code sequentially for each health professional attended. A person may have attended several health professionals in the last 12 months; therefore, more than one code can be recorded sequentially.</p> <p>Example 1: If a person has attended a diabetes educator and a podiatrist in the last twelve months, the code recorded would be 15.</p> <p>Example 2: If all have been seen, the code recorded would be 12345.</p> <p>CODE 8 is used when the person answers 'No' to all the health professionals specified.</p> <p>CODE 9 should only be used in situations where it is not practicable to ask the questions.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>1 = Diabetes educator</li> <li>2 = Dietician</li> <li>3 = Ophthalmologist</li> <li>4 = Optometrist</li> <li>5 = Podiatrist</li> <li>8 = None of the above</li> <li>9 = Not stated/inadequately described</li> </ul>

<b>Year of Diagnosis of Diabetes Mellitus</b>	
<b>Definition</b>	The year a patient was first diagnosed as having diabetes.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Burden of disease information Year of Diagnosis of Diabetes Mellitus
<b>Reference ID</b>	GB009
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Date
<b>Data Type</b>	Date/Time
<b>Format</b>	YYYY
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Record the year that the patient was first diagnosed as having diabetes.
<b>Code Description and Permissible Values</b>	Codes used are: 9999 = Not stated/inadequately described

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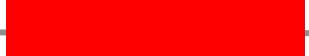
## Obesity

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Obesity patient	
<b>Definition</b>	A BMI greater than or equal to 25 is overweight A BMI Greater than or equal to 30 is obesity. BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of Adults. However, it should be considered a rough guide because it may not correspond to the same degree of fatness in different individuals.
<b>Metadata Type</b>	Data Concept
<b>Data Concept</b>	Burden of Diseases Information-Obesity
<b>Reference ID</b>	GC001
<b>Synonyms</b>	Not Applicable
<b>Representation Class</b>	Concept
<b>Data Type</b>	
<b>Format</b>	
<b>Maximum Field Size</b>	
<b>Date Created</b>	
<b>Date Updated</b>	
<b>Source</b>	World Health Organization
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	

Obesity Category	
<b>Definition</b>	It is the class of description of the patient weight in relation to his height (BMI) and are only valid as statistical categories. as determined by the WHO "BMI Classification" Global Database on Body Mass Index. World Health Organization Retrieved July 27, 2012. It regards a BMI smaller than 18.5 as underweight and may indicate a health Problem, or more likely nutritional or eating disorder. BMI equal to or greater than 25 is considered overweight and values above 30 is considered obese
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Burden of Disease Information, Obesity- Category
<b>Reference ID</b>	GC002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element needs to be adjusted for children as follows Children BMI (2-20 years) is used differently as it is calculated in the same way as for adults, but then compared. To typical values for other children of the same age. The following for children BMI is applied: CODE 1 = Underweight Children = BMI < 5th percentile CODE 3 = Overweight Children = BMI from 85th - 95 <sup>th</sup> percentile CODE 4 = Obese Children = BMI > 95th percentile
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Underweight ( BMI < 18.5 ) 2 = Normal weight - Ideal healthy ( BMI 18.5–24.9 ) 3 = Overweight ( BMI 25.0–29.9 ) 4 = Class I Obesity - Moderately Obese ( BMI 30.0–34.9 ) 5 = Class II Obesity - Severely Obese ( BMI 35.0–39.9 ) 6 = Class III Obesity - Very Severely Obese ( BMI ≥ 40.0 )

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## Renal Disease Therapy

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## Renal Disease Therapy

<b>Definition</b>	The therapy the person is receiving for renal disease, as Represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Burden of Diseases Information, Renal Disease Therapy
<b>Reference ID</b>	GD001
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>This element codes are used as per the following</p> <p>CODE 1 = Drugs for modification of renal disease , This code is used to indicate drugs for modification of renal disease, Includes drugs intended to slow progression of renal failure. Examples include anti proteinuria such as angiotensin converting enzyme inhibitors (ACEI), angiotensin II receptor Antagonists (ATRA) and immunosuppressant.</p> <p>CODE 2 = Drugs for treatment of complications of renal Disease. This code is used to indicate drugs for the Treatment of the complications of renal disease. Examples include antihypertensive agents and drugs that are intended To correct biochemical imbalances caused by renal disease. (E.g. loop diuretics, ACEI, erythropoietin, calcitriol ,etc ).</p> <p>CODE 3 = Peritoneal dialysis, This code is used to indicate peritoneal dialysis, chronic peritoneal dialysis, delivered at Home, at a dialysis satellite canter or in hospital.</p> <p>CODE 4 = Hemodialysis, This code is used to indicate hemodialysis, chronic hemodialysis delivered at home, at a Dialysis satellite canter or in hospital.</p> <p>CODE 5 = Functioning renal transplant, This code is used to indicate functioning renal transplant, the presence of a Functioning renal transplant.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Drugs for modification of renal disease</p> <p>2 = Drugs for treatment of complications of renal disease</p> <p>3 = Peritoneal dialysis</p> <p>4 = Hemodialysis</p> <p>5 = Functioning renal transplant</p>

# Chapter 8

## Pharmaceuticals

## Storing

## Pharmaceutical Storage Compliance

<b>Definition</b>	The compliance of the drugs storing activities at any health facility with the best practices standards and in accordance with the Guidelines for Stability Testing of Active Pharmaceutical Ingredients (APIs) and Finished Pharmaceutical Products (FPPs) published on the official Saudi Food and Drug Authority website.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Storing, Storing compliance
<b>Reference ID</b>	HA001
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Food and Drug Authority
<b>Usage</b>	<p>This data element is used to report on conditions of storage of the pharmaceuticals at a health facility in accordance with the best approved Saudi Food and Drug Authority (SFDA) national standards and manufacturer recommendations.</p> <p>The report should be generated and collected by INDEPENDENT supervising administration at the facility at Least quarterly.</p> <p>Code 1 = Equivalent to optimum conditions for all types of Storing conditions and compliance with policies.</p> <p>Code 2 = Equivalent to conditions when less than optimal adherence to policies but no serious malpractice behavior noted.</p> <p>Code 3 = Equivalent to conditions where one major element of storing activity is missing and an evidence of neglect is observed but not fatal to patient health</p> <p>Code 4 = Equivalent to conditions when more than one major element is missing and/or at least one observation that is fatal to patient care</p> <p>Code 5 = Failure to assess the facility</p>
<b>Code Description and Permissible Values</b>	<p>Code used are:</p> <p>1 = Complete compliance      2 = Partial compliance      3 = Poor compliance      4 = Non compliance      9 = No assessment</p>

### Un Received medication by hospital's store

<b>Definition</b>	Pharmaceutical product that is returned to supplier due to safety & storing reasons.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Storing, Returned Medications
<b>Reference ID</b>	HA002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This data element is used to define that the medication is returned from a patient and will not be used again
<b>Code Description and Permissible Values</b>	Code used are: 1 = Return to supplier due to noncompliance with expiry. 2 = Return to supplier due to noncompliance with packing terms. 3 = Return to supplier due to improper transportation & handling condition. 4 = Return to supplier due to item overstock at the receiving facility. 5 = Return to supplier due to lack of space at the receiving facility. 9 = Other reasons.

<b>Near Expiry Medication</b>	
<b>Definition</b>	It is the code used to describe the time remaining in the expiry period of the pharmaceutical products that are available in health facility warehouse and ready for use by patients. It collects data on 3 months and 6 months near expiry items.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Storing, Near Expiry
<b>Reference ID</b>	HA003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
<b>Format</b>	AAN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council.
<b>Usage</b>	This data element is used to define that the medication is nearly expire and has less than six or three months in its shelf life nearly expire period can be modified as per pharmacy policy.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>Code NE3 = Medication will expire after three months Code.</p> <p>Code NE6 = Medication will expire after six months.</p> <p>For the drug names use ICD 10 table of drug and chemicals.</p>

<b>Expired Medication</b>	
<b>Definition</b>	Medication that passes the expiration date printed in the container.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Storing, Expired Medication during storage
<b>Reference ID</b>	HA004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Food and Drug Authority
<b>Usage</b>	This data element is used to describe the total items expired medication at the storing facility that shouldn't be prescribed to a patient and should be quarantined and destroyed in accordance with protocols
<b>Code Description and Permissible Values</b>	Codes used are: Total number of items NNNN.

	<b>Expiration Date</b>
Definition	It is the last day of the month printed on individual container.
Metadata Type	Data Concept
Data Concept	Pharmaceuticals, Storing, Expiration Date
Reference ID	HA005
Synonyms	Non Applicable
Representation Class	Concept
Data Type	
Format	
Maximum Field Size	
Date Created	
Date Updated	
Source	Saudi Food and Drug Authority
Usage	
Code Description and Permissible Values	



## Prescribing and Preparation

Unauthorized Drug Error	
Definition	Patient prescribed a pharmaceutical product by an unauthorized health practitioner.
Metadata Type	Data Element
Data Concept	Pharmaceuticals, Unauthorized Drug Error
Reference ID	HB001
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Food and Drug Authority
Usage	<p>This is a data element that is used to describe conditions related to prescribing a pharmaceutical product by a no authorized Practitioner. This element is applicable in the following conditions:</p> <ul style="list-style-type: none"> <li>1- When a treating physician who is not specialized in the branch of medicine for which the pharmaceutical products is used (e.g. NON neurologist prescribing Antiepileptic)</li> <li>2- When a health practitioner whose medical rank is not privileged to prescribe certain Pharmaceutical product (e.g. A narcotic drug prescribed by Nurse or Intern)</li> </ul>
Code Description and Permissible Values	<p>Codes used are:</p> <p>Code 1 = Error due to wrong specialty</p> <p>Code 2 = Error due to wrong medical ranking</p>

<b>Improper frequency Error</b>	
<b>Definition</b>	Patient is prescribed or receiving an inappropriate frequency of a pharmaceutical product.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Improper frequency error
<b>Reference ID</b>	HB002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Food and Drug Authority
<b>Usage</b>	<p>This is a data element that is used to describe conditions related to prescribing or giving a wrong frequency of pharmaceutical product by an authorized practitioner. This element is applicable for inpatient care services in accordance with the following conditions:</p> <ul style="list-style-type: none"> <li>1- When a treating physician have ordered a wrong frequency</li> <li>2- When a health practitioner who is involved in giving the pharmaceutical product has given a wrong frequency</li> </ul>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>Code 1 = Error due to wrong prescription          Code 2 = Error due to wrong Administration</p>

### Wrong Dosage Form Error

<b>Definition</b>	Using pharmaceutical form that is different from what is originally prescribed by treating physician.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Wrong Dosage Form Error
<b>Reference ID</b>	HB003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Food and Drug Authority
<b>Usage</b>	Use this element to report any form of change from the prescription of the treating physician
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Correct dosage form of pharmaceutical product      2 = Wrong dosage form of pharmaceutical product used by in charge nurse      3 = Wrong dosage form of pharmaceutical product used by resident physician      4 = Wrong dosage form of pharmaceutical product used by Pharmacist</p>

### Wrong medication (Sources)

<b>Definition</b>	Giving the patient wrong pharmaceutical product that is different from what is originally prescribed by treating physician.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Wrong Medication
<b>Reference ID</b>	HB004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Food and Drug Authority
<b>Usage</b>	Use this element to report giving a patient wrong pharmaceutical product that is different from what is originally prescribed by treating physician. This is used for outpatient care and inpatient care facilities
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Wrong Medication given by Pharmacist      2 = Wrong Medication given by Nurse      3 = Wrong Medication given by Training Physician.      8 = others</p>

### Wrong preparation and administration

<b>Definition</b>	It is the incorrect preparation technique by pharmacist and / or wrong administration by treating health practitioner.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Wrong preparation and administration.
<b>Reference ID</b>	HB005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Food and Drug Authority.
<b>Usage</b>	Use this element to report the incorrect preparation technique by pharmacist and / or wrong administration of a pharmaceutical product by treating health practitioner in an inpatient facility only.
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Wrong Preparation by Pharmacist 2 = Wrong Prep by Nurse 3 = Wrong Administration by Nurse 4 = Wrong Administration by Training Physician

## Drug item code

<b>Definition</b>	The drugs dispensed for the treatment of ill health during this episode of care.
<b>Metadata type</b>	Data element
<b>Data concept</b>	Drugs item
<b>Reference ID</b>	HB006
<b>Synonyms</b>	Not applicable
<b>Represented class</b>	Code
<b>Data type</b>	Numeric
<b>Forma</b>	N
<b>Maximum field size</b>	14
<b>Date created</b>	01/04/2019
<b>Date updated</b>	To be decided
<b>Source</b>	GTIN codes for drugs can be obtained from the Saudi Food and Drug Authority
<b>Usage</b>	
<b>Code description and permissible values</b>	

### Drug Item unit (Quantity)

<b>Definition</b>	The quantity of each drug item defined in "Drug Item Codes" dispensed for the treatment of ill health during this encounter.
<b>Metadata type</b>	Data element
<b>Data concept</b>	Drugs item
<b>Reference ID</b>	HB007
<b>Synonyms</b>	Not applicable
<b>Represented class</b>	Code
<b>Data type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum field size</b>	3
<b>Date created</b>	01/04/2019
<b>Date updated</b>	To be decided
<b>Source</b>	Saudi Food and Drug Authority
<b>Usage</b>	
<b>Code description and permissible values</b>	

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## Pharmacovigilance

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### Pharmacovigilance (Concept Data)

<b>Definition</b>	The science and activities relating to the detection, assessment, understanding and prevention of adverse effects or any other drug-related problem.
<b>Metadata Type</b>	Data Concept
<b>Data Concept</b>	Pharmaceuticals, Pharmacovigilance (Concept Data)
<b>Reference ID</b>	HC001
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Concept
<b>Data Type</b>	
<b>Format</b>	
<b>Maximum Field Size</b>	
<b>Date Created</b>	
<b>Date Updated</b>	
<b>Source</b>	Saudi Food and Drug Authority
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	

<b>Adverse Effect/Reaction</b>	
<b>Definition</b>	An adverse reaction is a response to a medicinal product which is noxious and unintended.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Pharmacovigilance, adverse effect
<b>Reference ID</b>	HC002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric ANN.NN
<b>Format</b>	
<b>Maximum Field Size</b>	6
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Food and drug Authority / ICD 10-AM coding guidelines.
<b>Usage</b>	<p>Use this data element to report any medication adverse effect that may be noted during patient treatment, the following ICD 10 AM guidelines are important for good coding results Codes categories T36-T65 are combination codes that include the substance that was taken as well as the intent. No additional external cause code is required for poisonings, toxic effects, adverse effects and under dosing codes.</p> <ul style="list-style-type: none"> <li>• Do not code directly from the Table of Drugs and Chemicals. Always refer back to the Tabular List.</li> <li>• Use as many codes as necessary to describe completely all drugs, medicinal or biological substances.</li> <li>• If the same code would describe the causative agent for more than one adverse reaction, poisoning, toxic effect or under dosing, assign the code only once.</li> <li>• If two or more drugs, medicinal or biological substances are reported, code each individually unless a combination code is listed in the Table of drugs and Chemicals. When coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug (T36-T50). The code for the drug should have a 5th or 6th character “5” (for example T36.0X5-). Examples of the nature of an adverse effect are tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure.</li> </ul>
<b>Code Description and Permissible Values</b>	Codes used are : ICD10- AM codes for Adverse Drug Reactions (ADR).

<b>Poisoning by drugs and chemicals (Unintentional &amp; Intentional)</b>	
<b>Definition</b>	Overdose of a drug or chemical substance that caused an illness to a patient.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Pharmacovigilance, Poisoning by drugs & chemicals.
<b>Reference ID</b>	HC003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphanumeric
<b>Format</b>	ANN.NN
<b>Maximum Field Size</b>	6
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Food and drug Authority / ICD 10-AM Coding guidelines
<b>Usage</b>	<p>Use this data element to report any unintentional drug over dose by following these ICD 10 AM guidelines: When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), first assign the appropriate code from categories T36-T50.</p> <p>The poisoning codes have an associated intent as their 5<sup>th</sup> or 6<sup>th</sup> character (accidental, intentional self-harm, assault and undetermined). Use additional code(s) for all Manifestations of poisonings.</p> <p>If there is also a diagnosis of abuse or dependence of the substance, the abuse or dependence is assigned as an Additional code. Examples of poisoning include:</p> <ul style="list-style-type: none"> <li>• Errors made in drug prescription or in the administration of the drug by provider, nurse, patient, or other person.</li> <li>• If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be code as a poisoning.</li> <li>• If a non-prescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning.</li> <li>• When a reaction results from the interaction of a drugs) and alcohol, this would be classified as poisoning</li> </ul>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>ICD10- AM codes for Adverse Drug Reactions (ADR).</p>

<b>Under dose</b>	
Definition	Prescribing or giving patient a pharmaceutical dose that is Less than the therapeutic level (frequency or/and quantity).
Metadata Type	Data Element
Data Concept	Pharmaceuticals, Pharmacovigilance, Under dose
Reference ID	HC004
Synonyms	Non Applicable
Representation Class	Code
Data Type	Alphanumeric
Format	ANN.NN
Maximum Field Size	6
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Food and drug Authority / ICD 10-AM Coding guidelines
Usage	<p>Use this element to report a pharmaceutical dose that is less than the therapeutic level, the following ICD 10 coding guidelines are essential under dosing refers to taking less of a medication than is prescribed by a provider or a Manufacturer's instruction.</p> <p>For under dosing, assign the code from categories T36-T50 (Fifth or sixth character "6"). Codes for under dosing should never be assigned as principal or first-listed codes.</p> <p>If a patient has a relapse or exacerbation of the medical condition for which the drug is prescribed because of the reduction in dose, then the medical condition itself should be code. Noncompliance (Z91.12-, Z91.13-) or complications of care (Y63.6-Y63.9) codes are to be used With an under dosing code to indicate intent, if known.</p>
Code Description and Permissible Values	<p>Codes used are:</p> <p>ICD10- AM codes for Adverse Drug Reactions (ADR).</p>

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## Utilization

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### Pharmaceutical product type

<b>Definition</b>	It is the type of the pharmaceutical product used for patient treatment whether Generic, Bio similar or Herbal.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Utilization, Product type
<b>Reference ID</b>	HD001
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Food and Drug Authority
<b>Usage</b>	<p>This element helps to identify the type used for the treatment of the patient condition among the currently approved types by the Saudi Food and Drug Authority (SFDA) which are:</p> <p>CODE 1 = Generic Medication</p> <p>CODE 2 = Bio similar Medication: Therapeutic proteins produced by recombinant DNA technology or gene expression method following the footsteps of one licensed reference biotechnological. Product after the expiration of the innovator's patent.</p> <p>They are complex and heterogeneous in their nature; hence they are not considered generics, but as closely similar to the innovator's drug as possible.</p> <p>CODE 3 = Herbal Medications</p>
<b>Code Description and Permissible Values:</b>	<p>Codes used are:</p> <p>1 = Generic 2= Bio similar 3 = Herbal 8 = Others 9 = Unknown</p>

<b>Off Label Use</b>	
<b>Definition</b>	When a medicinal product is intentionally used for a medical purpose not in accordance with the authorized product information.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Utilization, Off Label use
<b>Reference ID</b>	HD002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Food and Drug Authority
<b>Usage</b>	<p>This element helps to identify the type used for the treatment of the patient condition among the currently approved types by the Saudi Food and Drug Authority (SFDA) which are:</p> <p>Code 1 to be used only when the treating physician is licensed by the SFDA to conduct a clinical trial on a specified pharmaceutical product</p> <p>Code 2 is descriptive of the condition when the treating physician is intentionally using a medication without clear indication from manufacturer</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Clinical Trial reasons</p> <p>2 = Noncompliance with indications</p> <p>9 = Unknown</p>

## Deteriorated Drug Error

<b>Definition</b>	It is the consumption of a pharmaceutical product that is either expired or is showing changes in its physical characteristics.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Utilization, Deteriorating Drug Error
<b>Reference ID</b>	HD003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Food and Drug Authority
<b>Usage</b>	This element is used to report any use of expired medication or physically changed from its original manufactured condition.
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Intake of expired medication 2 = Intake of physically changed medicine 9 = Unknown

<b>Monitoring Error</b>	
<b>Definition</b>	It is the failure to review treatment plans and the detection of patient problems or the failure to use the appropriate clinical and laboratory data to assess adequately the patient's response to prescribed medications.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals, Utilization, Monitoring Error
<b>Reference ID</b>	HD004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Food and Drug Authority
<b>Usage</b>	<p>This code is used to as an indicator for the monitoring of treatment plan by using the patient adequate response to pharmaceutical product prescribed</p> <p>CODE 1 = Is used when the treatment plan is fully revised in due time and with documented patient response to Treatment.</p> <p>CODE 2 = Is used when the treatment plan is irregularly followed with evidence of gaps in follow up and documentation related to patient response to prescribed medications.</p> <p>CODE 3 = Is used when the treatment plan is completely unrevised associated with absence of documentation of patient response to prescribed medications</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Adequate Review of treatment plan      2 = Inadequate Review of treatment plan      3 = No monitoring effort to Review treatment plan      9= Unknown</p>

## Expiration Date of Used Packages

<b>Definition</b>	The date provided by manufacturer on the individual container of a product by which the Active Pharmaceutical Ingredient (API) and Finished pharmaceutical product (FPP) are expected to remain within specifications, if product is Stored correctly.
<b>Metadata Type</b>	Data Concept
<b>Data Concept</b>	Pharmaceuticals, Utilization Expiration date Used packages
<b>Reference ID</b>	HD005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Concept
<b>Data Type</b>	
<b>Format</b>	
<b>Maximum Field Size</b>	
<b>Date Created</b>	
<b>Date Updated</b>	
<b>Source</b>	United Kingdom, National Health Trust Expiration Dates for Medications guidelines 2010
<b>Usage</b>	<p>This element is introduced in this data dictionary as a concept for health facilities to help them define expiry for all types of used medications and medication packs after opening especially at hospital wards and with patients at home where multi-unit packs are a standard and often it is not clear what to do after opening for first dose administration.</p> <p>All these expiries are applicable when proper storing Conditions are kept. All pharmacy services facilities should pay a great attention to the in-use shelf-life and in-use storage recommendation if applicable-should be included in the summary of the product characteristics (SPS), patient information leaflet (PIL) and on the product's labeling The following are expiry outline for most of packs used in pharmacies:</p> <p><b>A) Non Injectable</b></p> <p><b>1) ENT (Sterile Ear Nose Drops and Ointment)</b>  - Keep for 28 days from opening date unless specified otherwise by the manufacturer (If it contains no preservative, discard after use)</p> <p><b>2) Ophthalmic Products (Sterile Ear Nose Drops and Ointment)</b>  - Keep for 28 days from opening date unless specified otherwise by the manufacturer</p>

### **3) Topical preparations - Creams in jars, pots or tubs**

- Keep for 1 month only unless specified otherwise by manufacturer.
- Creams in Tubes or pumps dispenser keep for 3 months unless specified otherwise by manufacturer
- Ointments in jars, pots or tubs keep for 3 months only unless specified otherwise by manufacturer.
- Ointments Tubes or pumps dispenser keep for 6 months unless specified otherwise by manufacturer 4)
- Oral Preparation:
- Tablet & Capsules Medication kept in original blister preparations can be used as per expiry date specified by manufacturer
- Tablet & Capsules Medications that are dispensed in pharmacy bottles should be discarded 6 months after dispensing unless informed otherwise by dispensing pharmacist.
- Aspirin tablets dispensed in Pharmacy bottles should be discarded ONE month after dispensing if not used.
- Tablets & Capsules dispensed in Pharmacy packed blister Monitoring Dose System should be discarded 2 months after dispensing.
- Oral Liquids dispensed in original packs or in amber bottles should be discarded 6 months after opening except for antibiotics discard after completed dose.
- Glyceryl Trinitrate tablets should be discarded 2 months after opening. 5) Hospital Fluid preparations
- Antiseptics can be used up to 30 days after opening - Irrigation fluids can be used up to 3 months from opening date unless specified otherwise by manufacturer 6) Sprays and Inhalers
- Use as per manufacturer's expiry date specified. 7) Rectal Preparations - Diazepam Individual Foil wrapped suppositories can be kept as per manufacturer's expiry date
- Diazepam non wrapped should be discarded 6 months from opening

	<b>B) Injectable</b> <ul style="list-style-type: none"> <li>1) Ampules Can be stored and used up to THREE months from opening date with proper storage conditions or as indicated by manufacturer.</li> <li>2) Remainder of Single Dose Injectable that is Preservative Free should be discarded immediately after use.</li> <li>3) Remainder of Multiple dose Injectable vials that Contain Preservatives should be discarded immediately after use</li> <li>4) Insulin once opened discard after 4 weeks from date of opening unless manufacturer specified otherwise.</li> <li>5) BCG Vaccine should be discarded 4 weeks from opening date with proper storage conditions, unless manufacturer specified otherwise.</li> <li>6) Reconstituted Injectable (Multiple Dose Vials) should discarded 4 HOURS after reconstitution at refrigerator.</li> </ul>
<b>Code Description and Permissible Values</b>	

### Principal drug of concern

<b>Definition</b>	The main drug, as stated by the patient, that has led a person to seek treatment from the service, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals—Principal drug of concern
<b>Reference ID</b>	HD006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This element is used to report the principal drug of concern as stated by the patient and is the focus of the client's treatment episode. If the patient is referred into treatment and does not nominate a drug of concern, then the drug involved in the referral should be chosen.
<b>Code Description and Permissible Values</b>	Codes used are: 0 = Inadequately described. 1 = Opioid analgesics not further defined 2 = Psycho-stimulants not further defined 3 = Combination of stimulants and Hallucinogens

### Method of use for principal drug of concern

<b>Definition</b>	The patient's self-reported usual method of administering the principal drug of concern, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Pharmaceuticals—Method of Use of Principal Drug of concern
<b>Reference ID</b>	HD007
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This element is collected to with commencement of treatment. Identification of drug use methods is important for minimizing specified harms associated with drug use, and is consequently of value for informing treatment approaches.  CODE 1 = Refers to eating or drinking as the method of administering the principal drug of concern.
<b>Code Description and Permissible Values</b>	Codes used are:  1 = Ingests 2 = Smokes 3 = Injects 4 = Sniffs (powder) 5 = Inhales (vapors) 6 = Other 9= Not stated/inadequately described

# Chapter 09

## Health Facility Human Resources

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## Medical Human Resources

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Health Practitioner	
Definition	Those who have genuine qualifications and experiences for safe practice in the healthcare sector.
Metadata Type	Data Concept
Data Concept	Medical Human Resources, Health Practitioner
Reference ID	IA001
Synonyms	
Representation Class	Concept
Data Type	
Format	
Maximum Field Size	
Date Created	
Date Updated	
Source	Professional Classification and Registration of Health Practitioners Manual, 6th Edition 2014 Saudi Commission for Health Specialties SCFHS
Usage	
Code Description and Permissible Values	

### KSA Individual Provider Type

<b>Definition</b>	The code used to describe the type of the individual health provider practicing in Saudi healthcare system.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Medical Human Resources, KSA Individual Provider Type
<b>Reference ID</b>	IA002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Commission for Health Specialties
<b>Usage</b>	The element is used to determine the individual provider type as per the set of standards issued by the Saudi Commission for Health Specialties.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>1 = Physician</li> <li>2 = Dentist</li> <li>3 = Pharmacist</li> <li>4 = Nurse</li> <li>5 = Applied Medical</li> </ul>

Healthcare Provider Category	
Definition	The Code used to describe the category of the individual health provider practicing in Saudi healthcare system.
Metadata Type	Data Element
Data Concept	Medical Human Resources, Healthcare Provider Category
Reference ID	IA003
Synonyms	Non Applicable
Representation Class	Code
Data Type	Alphanumeric
Format	ANN
Maximum Field Size	3
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Commission for Health Specialties
Usage	The element is used to determine the individual provider category as per the set of standards issued by the Saudi Commission for Health Specialties
Code Description and Permissible Values	<p>Codes used are:</p> <p><b>Physicians Codes</b></p> <p>M01 = Consultant  M02 = Senior Registrar  M03 = Registrar  M04 = Resident  M05 = General Practitioner  M06 = Podiatric Physician  M07 = Non Practicing Practitioner</p> <p><b>Dentists Codes</b></p> <p>D01 = Consultant  D02 = Senior Registrar  D03 = Registrar  D04 = Resident  D05 = General Practitioner (Dentist)  D07 = Non Practicing Dentist</p> <p><b>Pharmacists Codes</b></p> <p>P01 = Consultant Pharmacist  P02 = Senior Pharmacist  P03 = Pharmacist  P07 = Non Practicing Pharmacist</p> <p><b>Nursing Codes</b></p> <p>N01 = Senior Specialist Consultant Nurse  N02 = Senior Specialist Nurse  N03 = Specialist Nurse  N04 = Technician Nurse  N05 = Health Assistant Nurse</p>

N07 = Non Practicing Nurse

**Allied Medical Codes**

L01 = Consultant Specialist (Non Physician)

L02 = Senior Specialist (Non Physician)

L03 = Specialist (Non Physician)

L04 = Technician Allied Medical

L05 = Health Assistant Allied Medical

L07 = Non Practicing Allied Medical Practitioner

## Health Specialty Identifier

Health Specialty Identifier	
<b>Definition</b>	It is the identifier of the specialty practiced by the health practitioner.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Medical HR, Employment Sector Identifier
<b>Reference ID</b>	IA004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	NN.NN
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	<p><b>Codes used are:</b></p> <p>As per Appendix 4 of medical specialties list approved by SCFHS.</p>

Non-Medical Staff	
Definition	It includes the non-medical staff providing all the support for the Healthcare Facility required for daily operation, maintenance and management.
Metadata Type	Data Element
Data Concept	Health facility HR, Non-Medical HR, Healthcare Management
Reference ID	IB001
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	NN
Maximum Field Size	2
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Health Council
Usage	<p>Usage of this element is as follows:</p> <ul style="list-style-type: none"> <li>Code 1 is to report all non-medical senior staff who are working in the capacity of:           <ul style="list-style-type: none"> <li>- CEO, CFO or COO</li> <li>- General manager</li> <li>- Assistant Manager</li> <li>- Head of section or sub department</li> </ul> </li> <li>Code 3 is to report all staff working on supporting the hospital cleaning process and waste management both inside and outside hospital facility.</li> <li>Code 11 is used to report all other administrative staff that are not in code 1</li> </ul>
Code Description and Permissible Values	<p>Codes used are:</p> <ul style="list-style-type: none"> <li>01 = Administrative Senior Management</li> <li>02 = Engineering Staff</li> <li>03 = Environmental Services staff</li> <li>04 = Finance and Human Resources Staff</li> <li>05 = General Admin staff</li> <li>06 = Information Management Staff</li> <li>07 = Logistics Support staff</li> <li>08 = Maintenance Staff</li> <li>09 = Patient relations staff</li> <li>10 = Purchase Management staff</li> <li>11 = Safety and Security support staff</li> <li>12 = Secretarial services staff</li> <li>13 = Training Administration</li> <li>14 = Transportation</li> <li>15 = Ware house staff</li> </ul>

<b>Hours on-call (not worked) by medical practitioner</b>	
<b>Definition</b>	The number of hours in a week that a medical practitioner is required to be available to provide advice, respond to any emergencies etc.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health facility HR, HR work data, Hours on-call (not worked)
<b>Reference ID</b>	IC001
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This metadata item relates to each position (job) held by a medical practitioner.
<b>Code Description and Permissible Values</b>	Codes used are: NNN = Unit of measure is Hour 999 = Not stated/inadequately described

### **Hours worked by medical practitioner in direct patient care**

<b>Definition</b>	The number of hours worked in a week by a medical practitioner on service provision to patients including direct contact with patients, providing care, instructions and counseling, and providing other related services such as writing referrals, prescriptions and phone calls.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health facility HR, HR work data, Hours worked by medical practitioner health in direct patient care
<b>Reference ID</b>	IC002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This metadata item relates to each position (job) held by a medical practitioner, not the aggregate of hours worked for all jobs.
<b>Code Description and Permissible Values</b>	Codes used are: NNN = Unit of measure is Hour 999 = Not stated/inadequately described

<b>Principal role of health professional</b>	
<b>Definition</b>	The principal role in which the health professional usually works the most hours each week, as represented by a code.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health Facility HR, HR work data, Principal Role of Health professional
<b>Reference ID</b>	IC003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	1
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>The following describe the usage for this element</p> <p>Code 1 = Clinician is a person mainly involved in the area of clinical practice, i.e. diagnosis, care and treatment, including recommended preventative action, to patients or clients. clinical practice may involve direct client contact or may be practiced indirectly through individual case material (as in radiology and laboratory medicine).</p> <p>Code 2 = Administrator in a health profession is a person whose main job is in an administrative capacity in the profession, e.g. directors of nursing, medical superintendents, medical advisors in government health authorities, health profession union administrators (e.g. Australian Medical Association, Australian Nurses Federation).</p> <p>Code 3 = A teacher/educator in a health profession is a person whose main job is employment by tertiary institutions or health institutions to provide education and training in the profession.</p> <p>Code 4 = Teacher / Educator in a health profession is a person whose main job is to conduct research in the field of the profession, especially in the area of clinical activity. Researchers are employed by tertiary institutions, medical research bodies, health institutions, health authorities, drug Companies and other bodies.</p>

	<p>Code 5 = Public health/health promotion, occupational health and environmental health are specialties in medicine, and fields of practice for some other health Professions. They are public health rather than clinical Practice, and hence are excluded from clinical practice.</p> <p>Code 6 = Occupational health</p> <p>Code 7 = Environmental health</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>1 = Clinician      2 = Administrator      3 = Teacher/educator      4 = Researcher      5 = Public health/health promotion      6 = Occupational health      7 = Environmental health 9 = Unknown</p>

### Total hours worked by a medical practitioner

<b>Definition</b>	The total hours worked in a week in a job by a medical practitioner, including any on-call hours actually worked (Includes patient care and administration).
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health Facility HR, HR work data, Total hours worked by medical practitioner
<b>Reference ID</b>	IC004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Total hours expressed as 000, 001 etc. This metadata item relates to each position (job) held by a medical practitioner, not the aggregate of hours worked in all.
<b>Code Description and Permissible Values</b>	Not Applicable

Provider occupation end date	
Definition	The date on which an individual Healthcare provider ceased practicing in an identified occupation.
Metadata Type	Data Element
Data Concept	Health Facility HR, HR work data, Provider occupation end date
Reference ID	IC005
Synonyms	Non Applicable
Representation Class	Date
Data Type	Date/Time
Format	DDMMYYYY
Maximum Field Size	8
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008.
Usage	
Code Description and Permissible Values	<p>Codes used are:</p> <p>Date format should be Code DD-MM-YYYY, and is recommended for data export purposes. Century digits are essentially.</p>

Provider occupation start date	
Definition	The date on which an individual Healthcare provider commenced practicing in an identified occupation.
Metadata Type	Data Element
Data Concept	Health Facility HR, HR work data, Provider occupation start date, DDMMYYYY
Reference ID	IC006
Synonyms	Non Applicable
Representation Class	Date
Data Type	Date/Time
Format	DDMMYYYY
Maximum Field Size	8
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	
Code Description and Permissible Values	<p>Codes used are:</p> <p>Date format should be Code DD-MM-YYYY,  And is recommended for data export purposes. Century digits are essentially.</p>

### Specialized mental health service-hours staffed

<b>Definition</b>	The average number of hours per day during which a residential mental health service has appropriately trained Staff employed on-site. Training may include formal Qualifications and/or on the job training.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Health Facility HR, HR work data, specialized mental health service, number of hours staffed
<b>Reference ID</b>	IC007
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Average
<b>Data Type</b>	Numeric
<b>Format</b>	NN
<b>Maximum Field Size</b>	2
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>The hours staffed provides a measure of service intensity for the reporting and analysis of staff, financial and activity data. For residential mental health services, this refers to the number of hours per day during which appropriately trained staff (either with formal qualifications and/or on the job training) are employed on site, as their normal place of employment, within the service unit.</p> <p>It excludes periods where the service unit is only staffed by a resident sleepover staff member or any period where staff are present but not employed on site at the service unit. excludes ambulatory and admitted patient services. Round to nearest whole hour. Where the number of hours staffed varies by day, average the number of hours staffed over a week, including the weekend.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>Whole numbers of hours staffed (no decimals or fractions). NN = Valid numbers are 1 to 24.</p>

# Chapter 10

## Hajj (Pilgrimage) Information

Hajj Season Medical Services

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## Hajj (Pilgrimage) Information

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## Hajj Season Medical services

<b>Definition</b>	All medical services delivered between 25/11 - 25/12 in Hijri calendar
<b>Metadata Type</b>	Data Concept
<b>Data Concept</b>	Hajj (Pilgrimage) _ Hajj season Medical Services
<b>Reference ID</b>	JA001
<b>Synonyms</b>	Pilgrimage Medical Services
<b>Representation Class</b>	Concept
<b>Data Type</b>	
<b>Format</b>	
<b>Maximum Field Size</b>	
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This is a concept definition that should be considered when providing care to pilgrimage during the dates specified. Any data requested related to pilgrimage should always consider the specified dates of reporting for such services. The reporting of data related to pilgrimage based on this concept has no relation to providing the service inside Makkah or Madinah, it covers all KSA borders and cities once the service is provided to a person performing Pilgrimage.
<b>Code Description and Permissible Values</b>	

## Pilgrim season patient

<b>Definition</b>	It is the code used to report any person seeking medical service during the Hajj (pilgrimage) season regardless of his/her status in relation to performance of hajj duties or nationality and travel area.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hajj (Pilgrim) season patient
<b>Reference ID</b>	JA002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Numeric
<b>Format</b>	N
<b>Maximum Field Size</b>	
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This data element is used to describe the status of the person seeking medical care at any facility in reference to his/her relation with pilgrimage season. It aims to separate data for those who are performing the duties of Hajj and those who are not
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Non Pilgrim Local living in the area 2 = Non Pilgrim worker serving in the area 3 = Pilgrim who is performing Hajj duties

### Daily Hospital Beds during hajj

<b>Definition</b>	Number of beds that are immediately available and suitable for patient condition at a hospital located in Hajj area and serving pilgrims reported every day during the season at 12 Noon
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hajj (Pilgrimage) - Daily Hospital beds during Hajj
<b>Reference ID</b>	JA003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Number
<b>Data Type</b>	Numeric
<b>Format</b>	NNN
<b>Maximum Field Size</b>	3
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	The element is used to gather the number of admission beds available in the city of Makkah, Jeddah, Madinah for Patient care during Hajj season. It is reported every day during the season at 12 noon
<b>Code Description and Permissible Values</b>	Codes used are: Number of Beds = NNN

## Daily census of Outpatient visits in Hajj healthcare facilities

<b>Definition</b>	It is the code used to report any person seeking medical service during the Hajj (pilgrimage) season in the outpatient setup regardless of his/her status in relation to performance of hajj duties or nationality and travel area.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hajj (Pilgrimage) - Daily census of outpatient visits during Hajj season
<b>Reference ID</b>	JA004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	6N
<b>Maximum Field Size</b>	6
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element serves the purpose of gathering information related to patient visits to outpatient facilities during the Hajj season. It includes: Code 1 = Hospital outpatient visits Code 2 = Primary health care center visits
<b>Code Description and Permissible Values</b>	Codes used are: 1 = Hospital Outpatient 2 = Primary Health care visit

## Daily census of Emergency patient visits in Hajj healthcare facilities

<b>Definition</b>	It is the code used to report any person seeking emergency medical service during the Hajj (pilgrimage) season in the emergency department set up regardless of his/her status in relation to performance of hajj duties or nationality and travel area.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hajj (Pilgrimage) - Daily census of Emergency patient during Hajj season
<b>Reference ID</b>	JA005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	5N
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element serves the purpose of gathering information related to patient visits to emergency rooms of the hospitals to analyze it use for future progress and development
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>NNNN = Total visits to Emergency Rooms in Hajj Healthcare Facility</p>

## Daily census of surgeries performed during Hajj season

<b>Definition</b>	The daily number of surgeries performed on Hajj patients During Hajj reported at 8 am every day of the season.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hajj (Pilgrimage) - Daily census of surgeries performed during Hajj season.
<b>Reference ID</b>	JA012
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element serves the purpose of gathering information related to Surgeries performed during the hajj season. This data will help in the analysis and management of such high demand services in the future.
<b>Code Description and Permissible Values</b>	Codes used are: NNNN = total Number of daily Surgeries during Hajj season

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## Daily census of invasive cardiac Procedures during Hajj season

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## Daily census of high cost radiology procedures (CT and MRI) performed for Hajj patients





## Daily census of laboratory

## Investigations performed for Hajj patients

## Medical Human Resources

<b>Definition</b>	Codes used to report the number of medical staff contributing to medical care during Hajj season
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hajj (Pilgrimage) - Medical Human Resources - Code by 5N
<b>Reference ID</b>	JA016
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Number
<b>Data Type</b>	Numeric
<b>Format</b>	NNNN
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>Code 1.0 = Physician          Code 1.1 = Consultant          Code 1.2 = Senior Registrar          Code 1.3 = Registrar          Code 1.4 = Residents          Code 2.0 = Nurses          Code 2.1 = Consultant Specialist Nurse          Code 2.2 = Specialist Nurses          Code 2.3 = Nurse technician          Code 3.0 = Allied Medical          Code 3.1 = Allied Medical Consultant (Non Physician)          Code 3.2 = Allied medical Specialist (Nonphysical)          Code 3.3 = Allied medical Technician          Code 8.0 = Other Medical Staff</p>

## Non-Medical Human Resources

<b>Definition</b>	Codes used to report the number of non-medical staff contributing to medical care during Hajj season
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Hajj (Pilgrimage) - Non Medical Human Resources - Code by 5N
<b>Reference ID</b>	JA017
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Number
<b>Data Type</b>	Numeric
<b>Format</b>	5N
<b>Maximum Field Size</b>	5
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	Codes used are: Code 1.0 = Non-Medical Administrative Code 1.1 = Human Resources Code Code 1.2 = Finance Code 1.3 = Healthcare Facility Managers Code 1.4 = Administrative assistant Code 2.0 = Non-medical Maintenance Code 3.0 = Drivers Code 4.0 = Logistics and Warehouse Code Code 5.0 = Environmental control

# Chapter 11

## Facility Financial Information



## Health Facility Assets

## Gross capital expenditure (accrual accounting) Buildings and building services

<b>Definition</b>	Expenditure, measured in Saudi Riyals, in a period on the acquisition or enhancement of buildings and building Services (including plant).
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Gross capital expenditure (accrual accounting)-buildings and building services
<b>Reference ID</b>	KA001
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This is to describe the total capital investment made on building of the facility and services related in case it is Enhanced or acquired. All costs should be rounded up to the nearest figure.
<b>Code Description and Permissible Values</b>	Not Applicable

## Gross capital expenditure (accrual accounting), Constructions

<b>Definition</b>	Expenditure, measured in Saudi Riyals, in a period on the acquisition or enhancement of constructions (other than Buildings).
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Gross capital expenditure (accrual accounting)—constructions
<b>Reference ID</b>	KA002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This is to describe the total capital investment made on construction of the facility in case it is enhanced or Acquired. All costs should be rounded up to the nearest figure.
<b>Code Description and Permissible Values</b>	Not Applicable

### **Gross capital expenditure (accrual accounting) Equipment**

<b>Definition</b>	Expenditure, measured in Saudi Riyals, in a period on the Acquisition or enhancement of equipment.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Gross capital expenditure (accrual accounting) equipment
<b>Reference ID</b>	KA003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This is to describe the total capital investment made on equipment in case it is enhanced or acquired. All costs should be rounded up to the nearest figure
<b>Code Description and Permissible Values</b>	Not Applicable

## Gross capital expenditure (accrual accounting), Information technology

<b>Definition</b>	Expenditure, measured in Saudi Riyals, in a period on the acquisition or enhancement of information technology (Software).
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Gross capital expenditure (accrual accounting) information technology
<b>Reference ID</b>	KA004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This is to describe the total capital investment made on Information technology in case it is enhanced or acquired. All costs should be rounded up to the nearest figure
<b>Code Description and Permissible Values</b>	Not Applicable

## Gross capital expenditure (accrual accounting), Intangible assets

<b>Definition</b>	Expenditure, measured in Saudi Riyals, in a period on the acquisition or enhancement of intangible assets.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Gross capital expenditure (accrual accounting)-intangible assets.
<b>Reference ID</b>	KA005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This is to describe the total capital investment made on any Intangible assets. All costs should be rounded up to the nearest figure. Saudi Accounting Standards should be applied when defining intangibles for healthcare facilities That are public in nature and not commercial.
<b>Code Description and Permissible Values</b>	Not Applicable

### Gross capital expenditure (accrual accounting), Land

<b>Definition</b>	Expenditure, measured in Saudi Riyals, in a period on the acquisition or enhancement of land.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Gross capital expenditure (accrual accounting)-land
<b>Reference ID</b>	KA006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This is to describe the total capital investment made on land acquisitions and enhancement. All costs should be rounded up to the nearest figure.
<b>Code Description and Permissible Values</b>	Not Applicable

## **Gross capital expenditure (accrual accounting), Major medical equipment**

<b>Definition</b>	Expenditure, measured in Saudi Riyals, in a period on the acquisition or enhancement of major medical equipment.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Gross capital expenditure (accrual accounting)—major medical equipment
<b>Reference ID</b>	KA007
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This element describes the gross capital expenses related to major medical equipment in the health facilities such as CT Scans, MRI. All expenses should be rounded up to the nearest figure.
<b>Code Description and Permissible Values</b>	Not Applicable

## **Gross capital expenditure (accrual accounting), other equipment**

<b>Definition</b>	Expenditure, measured in Saudi Riyals, in a period on the acquisition or enhancement of other equipment, such as furniture, art objects, professional instruments and containers.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Gross capital expenditure (accrual accounting)—other equipment
<b>Reference ID</b>	KA008
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This element describes the gross capital expenses related to equipment in the health facilities such as furniture, art Objects, professional instruments and containers. Saudi Ministry of Finance regulations related to depreciations of such equipment must be taken in consideration
<b>Code Description and Permissible Values</b>	Not Applicable

## Gross capital expenditure (accrual accounting), transport

<b>Definition</b>	Expenditure, measured in Saudi Riyals, in a period on the acquisition or enhancement of transport.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Gross capital expenditure (accrual accounting)—transport
<b>Reference ID</b>	KA009
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This element describes the gross capital expenses related to transportation in health facilities. Saudi Ministry of Finance regulations related to depreciations of such equipment must be taken in consideration
<b>Code Description and Permissible Values</b>	Not Applicable

### Gross capital expenditure, computer equipment/installations

<b>Definition</b>	Gross capital expenditure, measured in Saudi Riyals, on computer equipment/installations (Hardware).
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Gross capital expenditure computer equipment /installations
<b>Reference ID</b>	KA010
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This element describes any gross capital expenditure measured in Saudi Riyals, on computer equipment/installations (Hardware).
<b>Code Description and Permissible Values</b>	Not Applicable

<b>Gross capital expenditure, other</b>	
Definition	Other gross capital expenditure, measured in Saudi Riyals, which are not included elsewhere.
Metadata Type	Data Element
Data Concept	Facility Financial Information-Gross capital expenditure—other
Reference ID	KA011
Synonyms	Non Applicable
Representation Class	Total
Data Type	Currency
Format	9N
Maximum Field Size	9
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	This element describes any gross capital expenditure measured in Saudi Riyals, on all other expenses that are not included in other expenditure items.
Code Description and Permissible Values	Not Applicable

<b>Gross capital expenditure, plant and other equipment</b>	
<b>Definition</b>	Gross capital expenditure, measured in Saudi Riyals, on plant and other equipment.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Gross capital expenditure plant and other equipment.
<b>Reference ID</b>	KA012
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Gross capital expenditure related to plant and other equipment.
<b>Code Description and Permissible Values</b>	Not Applicable

### **Net capital expenditure (accrual accounting), buildings and building services**

<b>Definition</b>	Net capital expenditure, measured in Saudi Riyals, on buildings and building services (including plant).
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Net capital expenditure (accrual accounting)-buildings and building services.
<b>Reference ID</b>	KA013
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Round to nearest figure
<b>Code Description and Permissible Values</b>	Not Applicable

### Net capital expenditure (accrual accounting), constructions

Definition	Net capital expenditure, measured in Saudi Riyals, on constructions (other than buildings).
Metadata Type	Data Element
Data Concept	Facility Financial Information-net capital expenditure (accrual accounting)—constructions
Reference ID	KA014
Synonyms	Non Applicable
Representation Class	Total
Data Type	Currency
Format	9N
Maximum Field Size	9
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	Round to nearest figure
Code Description and Permissible Values	Not Applicable

<b>Net capital expenditure (accrual accounting), equipment</b>	
Definition	Net capital expenditure, measured in Saudi Riyals, on equipment.
Metadata Type	Data Element
Data Concept	Facility Financial Information-Net capital expenditure (accrual accounting)—equipment.
Reference ID	KA015
Synonyms	Non Applicable
Representation Class	Total
Data Type	Currency
Format	9N
Maximum Field Size	9
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	Round to nearest figure
Code Description and Permissible Values	Not Applicable

### **Net capital expenditure (accrual accounting), information technology**

<b>Definition</b>	Net capital expenditure, measured in Saudi Riyals, on information technology.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Net capital expenditure (accrual accounting)-information technology.
<b>Reference ID</b>	KA016
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Round to nearest figure
<b>Code Description and Permissible Values</b>	Not Applicable

<b>Net capital expenditure (accrual accounting), intangible assets</b>	
<b>Definition</b>	Net capital expenditure, measured in Saudi Riyals, on intangible assets.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Net capital expenditure (accrual accounting)—intangible assets
<b>Reference ID</b>	KA017
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Round to nearest figure
<b>Code Description and Permissible Values</b>	Not Applicable

<b>Net capital expenditure (accrual accounting), land</b>	
<b>Definition</b>	Net capital expenditure, measured in Saudi Riyals, on land.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Net capital expenditure (accrual accounting)—land
<b>Reference ID</b>	KA018
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Round to nearest figure
<b>Code Description and Permissible Values</b>	Not Applicable

## Net capital expenditure (accrual accounting), Major medical equipment

<b>Definition</b>	Net capital expenditure, measured in Saudi Riyals, on major medical equipment.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Net capital expenditure (accrual accounting)-major medical equipment.
<b>Reference ID</b>	KA019
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Round to nearest figure
<b>Code Description and Permissible Values</b>	Not Applicable

### **Net capital expenditure (accrual accounting), other equipment**

<b>Definition</b>	Net capital expenditure, measured in Saudi Riyals, on other equipment, such as furniture, art objects, professional instruments and containers.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Net capital expenditure (accrual accounting)—other equipment.
<b>Reference ID</b>	KA020
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Round to nearest figure
<b>Code Description and Permissible Values</b>	Not Applicable

Net capital expenditure (accrual accounting), transport	
Definition	Net capital expenditure measured in Saudi Riyals on transport.
Metadata Type	Data Element
Data Concept	Facility Financial Information-Net capital expenditure (accrual accounting)-transport
Reference ID	KA021
Synonyms	Non Applicable
Representation Class	Total
Data Type	Currency
Format	9N
Maximum Field Size	9
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	Round to nearest figure
Code Description and Permissible Values	Not Applicable

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## Health Facility Revenue

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Organization revenues	
Definition	Revenues of an organization relating to patient fees, recoveries, and other revenue in Saudi currency.
Metadata Type	Data Element
Data Concept	Facility Financial Information-Organization revenues
Reference ID	KB001
Synonyms	Non Applicable
Representation Class	Total
Data Type	Currency
Format	9N
Maximum Field Size	9
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	<p>Revenues are to be reported in millions to the nearest 100,000 e.g. SAR 4,064,000 should be reported as SAR 4.1 Million. Revenue arises from:</p> <ul style="list-style-type: none"> <li>• The sale of goods,</li> <li>• The rendering of services</li> <li>• The use by others of entity assets yielding interest, Royalties and dividends.</li> </ul> <p>Goods include goods produced by the entity for the purpose of sale and goods purchased for resale, such as merchandise purchased by a retailer or land and other property held for Resale. The rendering of services typically involves the performance by the entity of a contractually agreed task over an agreed period of time. The services may be rendered within a single period or over more than one period. Some contracts for the rendering of services are directly related to construction contracts, for example, Those for the services of project managers and architects. Revenue arising from these contracts is not dealt within this Standard but is dealt with in accordance with the Requirements for construction contracts.</p> <p>The use by others of entity assets gives rise to revenue in the form of: A- Interest – charges for the use of cash or cash equivalents or amounts due to the entity; B- Royalties -charges for the use of long-term assets of the entity, for example, patents, trademarks, copyrights and computer software C-Dividends-distributions of profits to holders of equity investments in proportion to their holdings of a particular class of capital.</p>
Code Description and Permissible Values	Not Applicable

Source of public and private revenue	
Definition	The source of revenue received by a health industry relevant organization, as represented by a code.
Metadata Type	Data Element
Data Concept	Facility Financial Information-Source of public and private revenue
Reference ID	KB002
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	NNN
Maximum Field Size	3
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	This element is to be used to report the source of the income to the facility in accordance with financial regulation of each organization
Code Description and Permissible Values	Codes used are: 1 = Government Fund 2 = Insurance Company 3 = Cash payment by patient 4 = Charity Organization 5 = Special donations fund 6 = Financial Trust dedicated to assist patients

## Source of Payment for Patient Care

<b>Definition</b>	The code used to describe the source of payment for patient care.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Source of Payment for patient care
<b>Reference ID</b>	KB003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Code
<b>Data Type</b>	Alphab
<b>Format</b>	AAA
<b>Maximum Field Size</b>	4
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Saudi Health Council
<b>Usage</b>	This element is used to describe the source of the payment for patient care.
<b>Code Description and Permissible Values</b>	<p><b>Codes used are:</b></p> <p>SELF = Self Pay  COMP = Company  DIPL = Diplomat  GOVE = Saudi Government  ROYA = Royal Orders  NSGO = Non-Saudi Government  CHOR = Charity Organization  CHPR = Charity Person</p>

<b>Revenue, other</b>	
<b>Definition</b>	All other revenue in Saudi Riyals received by the establishment for a financial year that is not included under patient revenue or recoveries (but not including revenue Payments received from government).
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Revenue—other
<b>Reference ID</b>	KB004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

<b>Revenue, patient</b>	
<b>Definition</b>	All revenue in Saudi Riyals for a financial year, received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Revenue—patient.
<b>Reference ID</b>	KB005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

<b>Revenue, recoveries</b>	
<b>Definition</b>	All revenue received in Saudi Riyals for a financial year that is in the nature of a recovery of expenditure incurred.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Revenue—recoveries
<b>Reference ID</b>	KB006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	This metadata item relates to all revenue received by establishments except for general revenue payments received from government consider splitting recoveries into use of hospital facilities (private practice) and other recoveries.
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.



## Health Facility Expenditure

## Recurrent expenditure (indirect Healthcare), Public health and monitoring services

<b>Definition</b>	Expenditure on indirect healthcare that is related to public health and monitoring services, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (indirect Healthcare)- public health and monitoring services.
<b>Reference ID</b>	KC001
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>To be provided at the sector level. Public or registered nonprofit services and organizations with centralized, kingdom Wide or national public health or monitoring services.</p> <p>These include programs concerned primarily with preventing the occurrence of diseases and mitigating their effect, and includes such activities as mass chest X-ray campaigns, immunization and vaccination programs, control of communicable diseases, antenatal and post-natal clinics, preschool and school medical services, infant welfare clinics, hygiene and nutrition advisory services, food and drug inspection services, regulation of standards of sanitation, quarantine services, pest control, anticancer, anti-drug and anti-smoking campaigns and other programs to increase public awareness of disease symptoms and health hazards, occupational health services, Included here would be child dental services comprising expenditure incurred (other than by individual establishments) or dental examinations, provision of preventive and curative dentistry, dental health education for infants and school children and expenditure incurred in the training of dental therapists.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure (indirect Healthcare), Central administrations

<b>Definition</b>	Expenditure measured in Saudi Riyals on indirect Health care related to central administrations, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (indirect Healthcare)-central administrations.
<b>Reference ID</b>	KC002
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	To be provided at the country level. expenditures relating to central health administration, research and planning for central and regional offices, Regional health directorates and other health authorities and related departments Record values up to hundreds of millions of Saudi Riyals. Rounded to the nearest whole Saudi Riyal
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal

## Recurrent expenditure (indirect Healthcare), Central and countrywide support services

<b>Definition</b>	Expenditure measured in Saudi Riyals on indirect Health care related to central and countrywide support services, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (indirect Healthcare)-central and countrywide support services.
<b>Reference ID</b>	KC003
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	To be provided at the country level. Public or registered services which provide central or countrywide support services for residential establishments within the scope of the public hospital establishment's national minimum dataset. These include central pathology services, central linen services and frozen food services and blood banks provided on a central or countrywide basis. Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest Whole Saudi Riyal.
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal

### Recurrent expenditure (indirect Healthcare), Other

<b>Definition</b>	Expenditure in Saudi Riyals on Healthcare that cannot be directly related to programs operated by a particular establishment and is not related to patient transport services, public health and monitoring services, central and countrywide support services or central administrations, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (indirect Healthcare), other
<b>Reference ID</b>	KC004
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	To be provided at the country level. Other: Any other indirect Healthcare expenditure as defined above not catered for in the following categories: - Patient transport services Public health and monitoring services – central and countrywide support services - central administrations. This might include such things as family planning and parental health counseling services and expenditure incurred in the registration of modifiable diseases and other medical information.
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

## Recurrent expenditure (indirect Health Care), Patient transport services

<b>Definition</b>	Expenditure measured in Saudi Riyals on indirect Health Care related to patient transport services, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (indirect Health Care)-patient transport services.
<b>Reference ID</b>	KC005
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	To be provided at the country level. Public or registered non-profit organizations which provide patient transport (or ambulance) for services associated with inpatient or residential episodes at residential establishments within the Scope of this data set. This category excludes patient transport services provided by other types of establishments (for example, public hospitals) as part of Their normal services. This category includes centralized and countrywide patient transport services which operate Independently of individual inpatient establishments.
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

## Recurrent expenditure (mental health), Non-salary operating costs

<b>Definition</b>	Total expenditure in Saudi Riyals by a mental health establishment relating to non-salary operating items.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (mental health)-non-salary operating costs.
<b>Reference ID</b>	KC006
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Report all expenditure in thousands of Saudi Riyals (i.e. SAR 000's). Expenditure should include both the specific costs directly associated with the service and indirect costs, for example personnel services. Research and academic units that function as an integral part of ambulatory care should be reported against the appropriate service. Depreciation is to be excluded from the non-salary operating costs.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## **Recurrent expenditure (salaries and wages), Administrative and clerical staff**

<b>Definition</b>	Salary and wage payments measured in Saudi Riyals to administrative and other clerical staff of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—administrative and clerical staff
<b>Reference ID</b>	KC007
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure (salaries and wages), carer consultants

<b>Definition</b>	Salary and wage payments to carer consultants of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—carer consultants.
<b>Reference ID</b>	KC008
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Carer consultants are persons employed (or engaged via contact) on a part-time or full-time paid basis to represent. The interests of carers and advocate for their needs. This implies the person received a salary or contact fee on a regular basis. It does not refer to arrangements where the carer only received reimbursements of expenses or occasional sitting fees for attendance at meetings.
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

## Recurrent expenditure (salaries and wages), consultant psychiatrists and psychiatrists

<b>Definition</b>	Salary and wage payments in Saudi Riyals to consultant psychiatrists and psychiatrists of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)-consultant psychiatrists and psychiatrists
<b>Reference ID</b>	KC009
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Obligation conditions:  1: reporting of this data element is optional for non-government residential mental health services and specialized mental health services provided by private hospitals that receive government funding.  2: If this data element cannot be supplied, the total salaries and wages for diagnostic and health professionals must be
<b>Code Description and Permissible Values</b>	Codes used are:  9N = Record values up to hundreds of Millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

## Recurrent expenditure (salaries and wages), diagnostic and health professionals

<b>Definition</b>	Salary and wage payments measured in Saudi Riyals to diagnostic and health professionals of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—diagnostic and health professionals
<b>Reference ID</b>	KC010
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>As per definition This data element should be derived from the salaries and wages paid to occupational therapists, social workers, psychologists and other diagnostic and Health professionals.</p> <p>Obligation conditions:</p> <p>1: Reporting of this data element is optional for non-government residential mental health services and specialized mental health services provided by private hospitals that receive Government funding.</p> <p>2: Must be Supplied if the subcategories cannot be supplied. Can also Be supplied if the sub-categories are supplied.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure (salaries and wages), domestic and other staff

<b>Definition</b>	Salary and wage payments measured in Saudi Riyals to domestic and other staff of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—domestic and other staff.
<b>Reference ID</b>	KC011
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure (salaries and wages), enrolled nurses

<b>Definition</b>	Salary and wage payments measured in Saudi Riyals to enrolled nurses of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—enrolled nurses.
<b>Reference ID</b>	KC012
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition, obligation condition: reporting of this data element is optional for non-government residential mental health services and specialized mental health services provided by private hospitals that receive government funding.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal</p>

## Recurrent expenditure (salaries and wages), occupational therapists

<b>Definition</b>	Salary and wage payments in Saudi Riyals to occupational therapists of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—occupational therapists.
<b>Reference ID</b>	KC013
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>As per definition, Obligation conditions:</p> <p>1: Reporting of this data element is optional for non-government residential mental health services and specialized mental health services provided by private hospitals that receive Government funding.</p> <p>2: If this data element cannot be supplied, the total salaries and wages for diagnostic and health professionals must be.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure (salaries and wages), other diagnostic and health professionals

<b>Definition</b>	Salary and wage payments in Saudi Riyals to other diagnostic and health professionals of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—other diagnostic and health professionals.
<b>Reference ID</b>	KC014
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>As per definition This data element should be derived from the salaries and wages paid to Occupational therapists, social workers, psychologists and other diagnostic and health professionals.</p> <p>Obligation conditions:</p> <ol style="list-style-type: none"> <li>1: reporting of this data element is optional for nongovernment residential mental health services and specialized mental health services provided by private hospitals that receive state or government funding.</li> <li>2: If this data element cannot be supplied, the total salaries and wages for diagnostic and health professionals must be.</li> </ol>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

<b>Recurrent expenditure (salaries and wages), Other physicians</b>	
<b>Definition</b>	Salary and wage payments in Saudi Riyals to other physicians of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)-other physicians.
<b>Reference ID</b>	KC015
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

## Recurrent expenditure (salaries and wages), other personal care staff

<b>Definition</b>	Salary and wage payments in Saudi Riyals to other personal care staff of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—other personal care staff.
<b>Reference ID</b>	KC016
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition This is the information related to visitor clinicians that are not permanently working in KSA.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure (salaries and wages), psychiatric registrars and trainees

<b>Definition</b>	Salary and wage payments to psychiatric registrars and trainees of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—psychiatric registrars and trainees
<b>Reference ID</b>	KC017
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure (salaries and wages), psychologists

<b>Definition</b>	Salary and wage payments in Saudi Riyals to psychologists of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—psychologists.
<b>Reference ID</b>	KC018
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008.
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

### Recurrent expenditure (salaries and wages), registered nurses

Definition	Salary and wage payments in Saudi Riyals to registered nurses of an establishment, for a financial year.
Metadata Type	Data Element
Data Concept	Facility Financial Information-Recurrent expenditure (salaries and wages)—registered nurses.
Reference ID	KC019
Synonyms	Non Applicable
Representation Class	Total
Data Type	Currency
Format	9N
Maximum Field Size	9
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	As per definition
Code Description and Permissible Values	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## **Recurrent expenditure (salaries and wages), salaried medical officers**

<b>Definition</b>	Salary and wage payments in Saudi Riyals to salaried medical officers of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—salaried medical officers
<b>Reference ID</b>	KC020
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure (salaries and wages), social workers

<b>Definition</b>	Salary and wage payments in Saudi Riyals to social workers of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—social workers.
<b>Reference ID</b>	KC021
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

<b>Recurrent expenditure (salaries and wages), student nurses</b>	
<b>Definition</b>	Salary and wage payments in Saudi Riyals to student nurses of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—student nurses
<b>Reference ID</b>	KC022
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

<b>Recurrent expenditure (salaries and wages), Total</b>	
Definition	Salary and wage payments in Saudi Riyals for all employees of the establishment (including contact staff employed by An agency, provided staffing data is also available).
Metadata Type	Data Element
Data Concept	Facility Financial Information-Recurrent expenditure (salaries and wages)—total
Reference ID	KC023
Synonyms	Non Applicable
Representation Class	Total
Data Type	Currency
Format	9N
Maximum Field Size	9
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	As per definition
Code Description and Permissible Values	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

## Recurrent expenditure (salaries and wages), Trainee/Pupil nurses

<b>Definition</b>	Salary and wage payments in Saudi Riyals to trainee/pupil nurses of an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure (salaries and wages)—trainee/pupil nurses
<b>Reference ID</b>	KC024
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure, National Mental Health Strategy funded

<b>Definition</b>	Total recurrent expenditure of the fund allocated by the government to assist in implementation of the National Mental Health Strategy.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure—National Mental Health Strategy funded
<b>Reference ID</b>	KC025
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure, Country or Region, health authority funded

<b>Definition</b>	The total recurrent expenditure from funds provided by the health authority which were used to support the delivery and/or administration of mental health services reported by the organization, region or central administration.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information—recurrent expenditure (Country, Region health authority funded).
<b>Reference ID</b>	KC026
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure, administrative expenses

<b>Definition</b>	The expenditure in Saudi Riyals incurred by establishments (but not central administrations) of a management expenses/administrative support nature such as any rates and taxes, printing, telephone, stationery and insurance (Including workers compensation), for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure-administrative expenses
<b>Reference ID</b>	KC027
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure, domestic services

<b>Definition</b>	The costs in Saudi Riyals of all domestic services including electricity, other fuel and power, domestic services for staff, accommodation and kitchen expenses but not including salaries and wages, food costs or equipment replacement And repair costs, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure domestic services.
<b>Reference ID</b>	KC028
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

### Recurrent expenditure, drug supplies

<b>Definition</b>	The cost in Saudi Riyals of all drugs including the cost of containers, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure-drug supplies.
<b>Reference ID</b>	KC029
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

<b>Recurrent expenditure, food supplies</b>	
Definition	The cost in Saudi Riyals of all food and beverages but not including kitchen expenses such as utensils, cleaning Materials, cutlery and crockery, for a financial year.
Metadata Type	Data Element
Data Concept	Facility Financial Information-Recurrent expenditure -food supplies.
Reference ID	KC030
Synonyms	Non Applicable
Representation Class	Total
Data Type	Currency
Format	9N
Maximum Field Size	9
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	As per definition
Code Description and Permissible Values	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

## Recurrent expenditure, interest payments

<b>Definition</b>	Payments in Saudi Riyals made by or on behalf of the establishment in respect of borrowings (e.g. interest on bank overdraft) provided the establishment is permitted to borrow, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure -interest payments.
<b>Reference ID</b>	KC031
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure, medical and surgical supplies

<b>Definition</b>	The cost in Saudi Riyals of all consumables of a medical or surgical nature (excluding drug supplies) but not including Expenditure on equipment repairs, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure— medical and surgical supplies
<b>Reference ID</b>	KC032
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## **Recurrent expenditure, non-salary operating costs (Excluding depreciation)**

<b>Definition</b>	Total expenditure in Saudi Riyals relating to non-salary operating items, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure—no salary operating costs (excluding depreciation)
<b>Reference ID</b>	KC033
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Format</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	As per definition
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

### Recurrent expenditure, other patient revenue funded

<b>Definition</b>	Recurrent expenditure funded from other revenue paid directly by patients or third parties, such as private health insurers, on behalf of patients under care of the organization, region or central administration mental health services, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure—other patient revenue funded.
<b>Reference ID</b>	KC034
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Currency
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Other patient revenue funded expenditure to be reported only once and for the specific statistical unit level at which The expenditure actually. Where other patient revenue funded expenditure could be allocated to more than one level, it is important to allocate it to the single most appropriate statistical unit level to avoid the possibility of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be Reported at the lowest statistical unit level possible only.
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Recurrent expenditure, other recurrent expenditure

<b>Definition</b>	All other recurrent expenditure in Saudi Riyals not included elsewhere in any of the recurrent expenditure categories, For a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure -other recurrent expenditure
<b>Reference ID</b>	KC035
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Record values up to hundreds of millions of Saudi Riyals. Rounded to nearest whole Riyal.
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

### Recurrent expenditure, other revenue funded

<b>Definition</b>	The total recurrent expenditure in Saudi Riyals funded from all other revenue that was received by the organization, region and central administration and has not been reported elsewhere.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure—other revenue funded
<b>Reference ID</b>	KC036
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Expenditure funded from all other revenue, excluding those reported separately, to be reported only once and for the specified statistical unit level at which the expenditure actually occurred e.g. at the government, regional or organizational level. Expenditure reported separately are in accordance with organization system
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

## Recurrent expenditure, patient transport

<b>Definition</b>	The direct cost in Saudi Riyals of transporting patients excluding salaries and wages of transport staff where payment is made by an establishment, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure— patient transport
<b>Reference ID</b>	KC037
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Record as currency up to hundreds of millions of Saudi Riyals Rounded to nearest whole Riyal
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

### Recurrent expenditure, payments to visiting medical officers

<b>Definition</b>	All payments in Saudi Riyals made by an institutional healthcare establishment to visiting medical officers for medical services provided to hospital (public) patients on an honorary, session ally paid, or fee for service basis, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure payments to visiting medical officers
<b>Reference ID</b>	KC038
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Record as currency up to hundreds of millions of Saudi Riyals Rounded to nearest whole Riyal
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

### Recurrent expenditure, recoveries funded

<b>Definition</b>	Recurrent expenditure in Saudi Riyals funded from revenue that is in the nature of a recovery of expenditure incurred, including income from provision of meals and accommodation, use of facilities, etc. for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure recoveries funded.
<b>Reference ID</b>	KC039
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>Expenditure funded from recoveries to be reported only once and for the specified statistical unit level at which the expenditure actually occurred e.g. at the country, regional or organizational level.</p> <p>Where expenditure funded from recoveries could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possibility of counting the expended funds more than once.</p> <p>For example, recoveries received through service delivery expenditure should be reported at the lowest statistical unit Level possible only.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

### **Recurrent expenditure, repairs and maintenance**

<b>Definition</b>	The costs in Saudi Riyals incurred in maintaining, repairing, replacing and providing additional equipment, maintaining and renovating building and minor additional works, for a financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure—repairs and maintenance
<b>Reference ID</b>	KC040
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated :</b>	To be defined
<b>Source :</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Record values up to hundreds of millions of Saudi Riyals. Rounded to nearest whole Saudi Riyal. Expenditure of a capital nature should not be included here. Do not include Salaries and wages of repair and maintenance staff. Gross expenditure should be reported with no revenue offsets (except for inter-hospital transfers).
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

<b>Recurrent expenditure, Total</b>	
<b>Definition</b>	Expenditure in Saudi Riyals relating to salaries and wages, non-salary recurrent expenditure and depreciation for a Financial year.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Recurrent expenditure—total
<b>Reference ID</b>	KC041
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	<p>Rounded to nearest whole Riyal. Total is calculated from expenditure including: salaries and wages; depreciation; and non-salary recurrent expenditure comprising: payments to visiting medical officers; superannuation employer contributions (including funding basis); drug supplies; medical and surgical supplies; food supplies; domestic services; repairs and maintenance; patient transport; administrative expenses; interest payments; and other recurrent expenditure.</p> <p>The total grant made to non-government residential mental health services and specialized mental health services provided by private hospitals that receive government.t Funding. can be reported as the total recurrent expenditure If detailed expenditure data are not available.</p>
<b>Code Description and Permissible Values</b>	<p>Codes used are:</p> <p>9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.</p>

## Residual expenditure (mental health service), workers Compensation

<b>Definition</b>	Expenditures in Saudi Riyals specialized mental health services that cannot be directly related to programs operated by a particular organization or service unit (that is, can only be indirectly related to a particular organization or Service unit). It refers to workers' compensation premiums and payments made by the organization, region or central administration on behalf of its employees and not reported elsewhere.
<b>Metadata Type</b>	Data Element
<b>Data Concept</b>	Facility Financial Information-Residual expenditure (mental health service)—workers' compensation.
<b>Reference ID</b>	KC042
<b>Synonyms</b>	Non Applicable
<b>Representation Class</b>	Total
<b>Data Type</b>	Numeric
<b>Format</b>	9N
<b>Maximum Field Size</b>	9
<b>Date Created</b>	19/05/2016
<b>Date Updated</b>	To be defined
<b>Source</b>	Australian National Health Data Dictionary Version 14, 2008
<b>Usage</b>	Excludes grants to non-government organizations for Services that are to be reported separately. These are grants for accommodation services, advocacy services, and community awareness services, counseling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
<b>Code Description and Permissible Values</b>	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

# Appendices

## Appendix 1- Sample for Unique Facility Identifier

### APPENDIX 1 SAMPLE FOR UNIQUE FACILITY IDENTIFIER

**1- Choose the REGION & CITY CODE AS PER the Saudi Post City Code**

**2- Choose the correct code for GOVERNMENT HEALTH SECTOR IDENTIFIER from List below**

D	E	H	I	L	N	P	X
Ministry of Defense	Ministry of Education	Ministry of health	Ministry of Interior	Ministry of Labor and Social Development	Ministry of National Guard	Royal Commission for Jubail & Yanbu	Saudi Red Crescent

**For NON GOVERNMENT HEALTH SECTOR IDENTIFIER**

C	V	Y
Charity Health Care Facility	Private Health Care Facility	Other Non-Governmental

**3- Choose the Health Facility Level of Care Code from list below**

A1	A2	H1	H2	H3	H4
Ambulatory Primary health Care	Allied Medical Services	General Hospital	Specialized Hospital	Medical City	Field Hospital

**4- Choose the Health Facility Type of Care Code from list below**

AP1	AP2	AP3	AP4	AM1	AM2	AM3	AM4	AM5	AM6	AM7	AM8	GH1	GH2	SH1	SH2	SH3	SH4	SH5	SH6	SH7	MC1	FH1	FH2
Clinic	Mobile clinic	Mobile clinic	Polyclinic	X Ray	Laboratory	Optician	Pharmacy	Artificial limb	Rehabilitation	Smoking Cessation Clinic	AM8 = Others	General Hospital in Big City	General Hospital in Small City	Cancer Hospital	Day Surgery	Long Stay	SH4 = Maternity Children	Ophthalmology Hospital	Physical Hospital	Rehabilitation Hospital	MCI = Medical City	FH1 = Disaster response	H2 = Seasonal Response

**5- Add the Serial Number of Facility according to your sector**

**Maximum characters are: NNNN**

## Appendix No. 2

### “Facility Medical Units and Departments Identifier” Code Values

Anesthesiology & Operating Rooms		MA
Anesthesia Department		MA1
Cardiac Anesthesia Section		MA1.1
General Anesthesia Section		MA1.2
Neuro - Anesthesia Section		MA1.3
Obstetrics Anesthesia Section		MA1.4
Pain Management Section		MA1.5
Pediatrics Anesthesia Section		MA1.6
Transplant Anesthesia Department		MA1.7
Operating Room Department		MA2
Cardiac Operation Unit		MA2.01
Main Operation Unit		MA2.02
Obstetrics Gynecology Operation Unit		MA2.03
Pediatrics Operation Unit		MA2.04
Central Sterilization Services Department		MA3
Cardiac Surgery & Cardiology		MB
Cardiac Surgery Department		MB1
Adult Cardiac Surgery Department		MB1.1
Pediatric Cardiac Surgery Department		MB1.2
Cardiology Department		MB2
Adult Cardiology Department		MB2.1
Cardiac Imaging Section		MB2.2
Catheterization Laboratory		MB2.3
Non-Invasive Laboratory		MB2.4
Pediatric Cardiology Department		MB2.5
Clinical Nutrition		MC
Clinical Nutrition Adult Department		MC1.1
Clinical Nutrition Outpatient Department		MC1.2
Clinical Nutrition Pediatric Department		MC1.3
Clinical Nutrition Dietetic Section		MC1.4
Dentistry Department		MD
Endodontics		MD1.1
General Dentistry		MD1.2
Oral Maxillofacial Surgery		MD1.3
Orthodontics		MD1.4
Pediatric Dentistry		MD1.5

	Periodontics	MD1.6
	Prosthodontics	MD1.7
	Restorative Dentistry	MD1.8
	Dental Screening Clinic	MD1.9
<b>Emergency Medicine</b>		ME
	Adult Emergency Department	ME1.1
	Disaster Management Department	ME1.2
	EMS Department	ME1.3
	Pediatric Emergency Department	ME1.4
	Poison Control Department	ME1.5
<b>Family Medicine and Employee Health Department</b>		MF
	Employees Clinics Section	MF1.1
	Family Medicine Clinics Section	MF1.2
	Family Medicine Screening Clinic	MF1.3
<b>Home Health Care</b>		MG
	Home Care Allied Health Department	MG1.1
	Home Care Nursing Department	MG1.2
	Home Care Respiratory Department	MG1.3
	Home Care Support Services Department	MG1.4
	Home Durable Medical Equipment Department	MG1.5
<b>Infection Control &amp; Environmental Health</b>		MH
	Infection Control Department	MH1.1
	Hospital Epidemiology Department	MH1.2
	Environmental Health Department	MH1.3
<b>Intensive Care Department</b>		MI
	Cardiac Intensive Care Unit	MI1.1
	Neonatal Intensive Care	MI1.2
	Neocritical Care Department	MI1.3
	Pediatric Intensive Care	MI1.4
	Step Down Intensive Care	MI1.5
	Surgical Intensive Care	MI1.6
<b>Obstetrics &amp; Gynecology Department</b>		MJ
	Gyn-Oncology Department	MJ1
	Maternal Fetal Medicine Department	MJ1.1
	Obstetrics and Gynecology Department	MJ1.2
	Reproductive Endocrine & Infertility Medicine Department	MJ1.3

	Urogynecology Department	MJ1.4
	Obstetrics & Gynecology Screening Clinic	MJ1.5
	Gynecology Oncology Diagnostic Clinic	MJ1.6
	Early Detection of Gynecology Oncology Clinic	MJ1.7
	High-risk Pregnancy Clinic	MJ1.8
	Pregnant control Clinic	MJ1.9
	Family Planning Clinic	MJ1.10
	Gestational Diabetes Clinic	MJ1.11
<b>Medical Imaging</b>		MK
	Body Imaging Department	MK1
	Abdominal Radiology Section	MK1.1
	Cardiothoracic Radiology Section	MK1.2
	General Radiology Technical Section	MK1.3
	CT Imaging Technical Section	MK1.4
	Musculoskeletal Radiology Section	MK1.5
	MR Imaging Technical Section	MK1.6
	Ultrasound Section	MK1.7
	Body Interventional Radiology Department	MK2
	Interventional Radiology Procedures Section	Mk2.1
	Interventional Vascular Radiology Section	Mk2.2
	Neuro - Imaging and Intervention Department	MK3
	Intervention Neuroradiology Section	MK3.1
	Neuroradiology Diagnostic Section	MK3.2
	Nuclear Medicine Department	MK4
	Nuclear Medicine Diagnostic Section	MK4.1
	Nuclear Medicine Treatment Section	MK4.2
	Pediatric Radiology Department	MK5
	Women's Imaging Department	MK6
	Mammography Section	MK6.1
	Pregnancy Ultrasound Section	MK6.2
<b>Medical Specialties Department</b>		ML
	Dermatology Section	ML1.1
	Endocrinology Section	ML1.2
	Gastroenterology Hepatology Section	ML1.3
	General Medicine Section	ML1.4
	Geriatric Medicine	ML1.5

	Infectious Diseases Section	ML1.6
	Nephrology Section	ML1.7
	Neurology Section	ML1.8
	Neurophysiology Section	ML1.9
	Pulmonology Section	ML1.10
	Rheumatology Section	ML1.11
<b>Mental Health</b>		MM
	Addiction Department	MM1.1
	Mental Health Department	MM1.2
	Rehabilitation Department	MM1.3
<b>Oncology Department</b>		MN
	Adult Hematology & Bone Marrow Transplant	MN1.1
	Adult Medical Oncology	MN1.2
	Palliative Care	MN1.3
	Pediatric Hematology & Oncology	MN1.4
	Radiation Oncology	MN1.5
	Radiotherapy	MN1.6
	Chemotherapy Clinic	MN1.7
<b>Pathology &amp; Clinical Laboratory</b>		MO
	Laboratory Department	MO1
	Biochemistry Section	MO1.1
	Biochemical genetic Section	MO1.2
	Emergency Room Satellite Lab	MO1.3
	Flowcytometry Section	MO1.4
	Hematology Section	MO1.5
	HLA Section	MO1.6
	Immunology Section	MO1.7
	Microbiology Section	MO1.8
	Molecular Microbiology Section	MO1.9
	Transfusion Medicine Service Department	MO1.10
	Toxicology Section	MO1.11
	Specimen Processing & Phlebotomy Section	MO1.12
	Serology Section	MO1.13
	Pathology Department	MO2
	Anatomic Pathology	MO2.1
	Clinical Pathology Section	MO2.2
	Cytogenetic Section	MO2.3
	Cytopathology Section	MO2.4

	Cellular Therapy Section	MO2.5
	Molecular Pathology Section	MO2.6
	Surgical Specimen Section	MO2.7
<b>Pediatric</b>		MP
	General Pediatrics	MP1
	Adolescent Medicine Section	MP1.1
	Allergy and Clinical Immunology Section	MP1.2
	Endocrinology Section	MP1.3
	Gastroenterology Section	MP1.4
	General Pediatrics Section	MP1.5
	Genetics Section	MP1.6
	Infectious Diseases Section	MP1.7
	Nephrology Section	MP1.8
	Neurology Section	MP1.9
	Pediatric Development & Behavioral Section	MP1.10
	Pulmonology Section	MP1.11
	Rheumatology Section	MP1.12
	Pediatric Screening Clinic	MP1.13
	Pediatric Diabetes and Endocrinology Screening Clinic	MP1.14
	Autism Spectrum Disorder	MP1.15
	Neonatology Department	MP2
	Pediatric Surgery Department	MP3
	Pediatric Surgery Screening Clinic	MP3.1
<b>Pharmacy Services</b>		MQ
	Ambulatory Pharmacy Department	MQ1
	Clinical Pharmacy Department	MQ2
	Pharmacy Supply Department	MQ3
<b>Rehabilitation</b>		MR
	Communication & Swallowing Disorders Department	MR1
	Audiology Unit	MR1.1
	Speech-Language Pathology Unit	MR1.2
	Swallowing Unit	MR1.3
	Rehabilitation Care Department	MR2
	Art Therapy Services	MR2.1
	Low Vision Rehabilitation	MR2.2
	Occupational Therapy	MR2.3
	Recreation Therapy Services	MR2.4
	Vocational Counseling	MR2.5

	Physical Medicine Department	MR3
	Rehabilitation Technology Department	MR4
	Assistive Devices Services	MR4.1
	Orthotic Services	MR4.2
	Prosthetic services	MR4.3
	Respiratory Therapy Department	MR5
	Ambulatory Respiratory Therapy	MR5.1
	Pulmonary Function Laboratory	MR5.2
<b>Surgical Specialties Department</b>		<b>MS</b>
	Bariatric Surgery	MS1.1
	General Surgery Section	MS1.2
	Neurosurgery Section	MS1.3
	Ophthalmology Section	MS1.4
	Oral and Maxillofacial Surgery Section	MS1.5
	Orthopedic Surgery Section	MS1.6
	Pediatric Surgery Section	MS1.7
	Plastic Surgery Section	MS1.8
	Podiatric Surgery Section	MS1.9
	Pediatric Neurosurgery Section	MS1.10
	Spinal Surgery Section	MS1.11
	Thoracic Surgery Section	MS1.12
	Urology Surgery Section	MS1.13
	Vascular Surgery Section	MS1.14
	General Surgery Screening Clinic	MS1.15
	Breast Tumors Diagnostic Clinic	MS1.16
	Colorectal Tumors Early Detection Clinic	MS1.17
	Colorectal Tumors Diagnostic Clinic	MS1.18
	<b>Orthopedic Surgery Department</b>	<b>MS2</b>
	Orthopedic Surgery Screening Clinic	MS2.1
	Orthopedic Surgery (Fractures) Clinic	MS2.2

Units For Primary Health Care Use		MT
	Chronic Diseases Clinic	MT1
	Maternity Care	MT3
	Well Baby and Vaccination Clinic	MT6
	Smoking Cessation Clinic	MT7
	Dressing	MT9
	Minor Surgery	MT11
	Family Medicine Clinic	MT14
	Health Promotion and Clinical Education Room	MT14.1
	Comprehensive guidance	MT14.2
	General Dentistry	MT15
	Pharmacy	MT16
	Laboratory Department	MT17
	X-Ray Department	MT18
	Ultrasound Unit	MT18.1
	Epidemiology Clinic	MT19
	Central Sterilization Room	MT20
	Internal Medicine	MT21
	Orthopedic Clinic	MT22
	Dermatology	MT23
	Ophthalmology	MT24
	ENT Clinic	MT25
	General Surgery	MT26
	Obstetrics & Gynecology Clinic	MT27
	General Pediatrics	MT28
	Cardiology Clinic	MT29
	Kidney Clinic	MT30
	Urology Clinic	MT31
	Nutrition Clinic	MT32
	Premarital Screening Clinic	MT33
	Premarital Counseling Clinic	MT34
	Breast Cancer	MT35
	Schools Examination and Vaccination	MT36
	Hepatitis	MT37
	Know Your Numbers	MT38
	Dexa Scan	MT39
	Obesity Clinic	MT40
	Physical Therapy	MT41
	Family Medicine Clinic (Consultant)	MT42
	Family Medicine Academy Clinic	MT43

<b>Ophthalmology Department</b>		<b>MU</b>
	Ophthalmology Screening Clinic	MU1
	Optometry and Contact Lenses Clinic	MU2
	Comprehensive Ophthalmology Clinic	MU3
	Diseases and Surgery of the Retina Clinic	MU4
	Glaucoma Clinic	MU5
	Neuro-Ophthalmology Clinic	MU6
	Ocular Oncology Clinic	MU7
	Oculoplastic Clinic	MU8
	Uveitis / Medical Rina Clinic	MU9
<b>Dermatology Department</b>		<b>MV</b>
	Dermatology Screening	MV1
	Derma Procedures Clinic	MV2
<b>Ear Nose &amp; Throat Department</b>		<b>MW</b>
	Ear Nose & Throat Screening Clinic	MW1
	Audio Vestibular Clinic	MW1
<b>Internal Medicine Department</b>		<b>MX</b>
	Internal Medicine Screening Clinic	MX1
	Endoscopy Clinic	MX2
	Counseling Clinic	MX3
	Down Syndrome Clinic	MX4
	Smoking Cessation Clinic	MX5
	Diabetes Screening Clinic	MX6
<b>Urology Department</b>		<b>MY</b>
	Urology Screening Clinic	MY1
	Laparoscopic Urology Clinic	MY2
	Neuro - Urology Clinic	MY3
	Oncology Urology Clinic	MY4
	Reconstruction Urology Clinic	MY5
<b>Allied Health</b>		<b>MZ</b>
	Allied Health Clinic	MZ1
	ECG Clinic	MZ2
	EEG Clinic	MZ3
	Optics Clinic	MZ4
	Clinical Dietitian Clinic	MZ5
	Diabetic Educator Clinic	MZ6
	Health Education Clinic	MZ7
	EMG Clinic	MZ8
	NCS-EMG Clinic	MZ9
	Stress Testing Clinic	MZ10
	Holter Clinic	MZ11
	Stress Echo Clinic	MZ12

	Pediatrics EEG Clinic	MZ13
	Premarital Screening Clinic	MZ14
	Premarital Counseling Clinic	MZ15
	Laser for Retinal Therapy Clinic	MZ16
	Insulin Pump Clinic	MZ17

### Appendix No. 3

#### Non-Medical Department & Units Identifier Code Values

<b>Administration /Department</b>	<b>Code</b>
<b>General Directorate of Health Affairs</b>	<b>NA</b>
Audit Administration	NA1
Clinical Audit Administration	NA2
Disaster & Emergency Management Administration	NA3
Electronic Health Administration	NA4
Employee rights Administration	NA5
Engineering Affairs Administration	NA6
Finance and Administrative Affairs Administration	NA7
General Director Administration	NA8
General Medical Commission	NA9
Hajj & Omra Administration	NA10
Legal Affairs Administration	NA11
Logistics Support Administration	NA12
Nursing Affairs Administration	NA13
Private Sector Affairs Administration	NA14
Public Health Administration	NA15
Public Relations Administration	NA16
Quality Management Administration	NA17
Religious Awareness Administration	NA18
Stock Control Administration	NA19
Supervision and Review Administration	NA20
Training and Development Administration	NA21
Treatment Services Administration	NA22
Primary Health Care and Preventive Medicine Administration	NA23
<b>Hospital Administration</b>	<b>NB</b>
General Management Administration	NB1
Finance Affairs Administration	NB2
Human Resources Administration	NB3
Medical Administration	NB4
Nursing Administration	NB5
Logistics Administration	NB6
Pharmaceutical Supplies Administration	NB7
Administrative Communications Administration	NB8
Credentialing & Verification Administration	NB9
Documentation and Information Administration	NB10

	Governmental Relation Administration	NB11
	Legal Affairs Administration	NB12
	Material Planning Administration	NB13

**Appendix No.3**  
**Non-Medical Department & Units Identifier Code Values**

	Patient Relations Administration	NB14
	Procurement and Contracts Administration	NB15
	Property Management Administration	NB16
	Public Relation & Media Administration	NB17
	Translation Administration	NB18
	Warehouse Administration	NB19
	Training Administration	NB20
<b>Hospital Health Facility Operation Administration and Support Services Administration</b>		<b>NC</b>
	Health Informatics and Information Technology Administration	NC1
	Biomedical Engineering Administration	NC2
	Catering Administration	NC3
	Environmental Safety Administration	NC4
	Housing Administration	NC5
	Laundry Services Administration	NC6
	Maintenance & Projects Administration	NC7
	Medical Record Administration	NC8
	Transportation Administration	NC9
<b>Patient Services Administration</b>		<b>ND</b>
	Religious Spiritual Counseling Administration	ND1
	Patients Information Administration	ND2
	Eligibility and Registration Administration	ND3
	Social Services Administration	ND4
<b>Primary Health Care Administration</b>		<b>NE</b>
	General Management Administration	NE1
	Medical Management Administration	NE2
	Finance and Administrative Affairs Administration	NE3
	Medical Records Administration	NE4

	Transportation Administration	NE5
	Maintenance & Projects Administration	NE6
	Warehouse Administration	NE7

#### Appendix No. 4- Healthcare Specialty Identifier Code Values

Specialty Name	Code	Subspecialty Name	Subspecialty Code
Anesthesiology Specialty	01	Ambulatory Anesthesia	01.01
		Anesthesia Cardiology	01.02
		Neuro-Anesthesia	01.03
		Obstetrics Anesthesia	01.04
		Pediatric Anesthesia	01.05
		Pediatric Cardiac Anesthesia	01.06
		Regional Anesthesia	01.07
		Vascular / Thoracic Anesthesia	01.08
		Chronic Pain	01.09
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Community Medicine Specialty	02		
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Dermatology Specialty	03	Dermatology Surgery	03.01
		Hair Implant Dermatology	03.02
		Pediatric Dermatology	03.03
		Dermatology	03.04
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Emergency Medicine Specialty	04	Adult Emergency Medicine	04.01
		Pediatric Emergency medicine	04.02
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Ear Nose & Throat Specialty	05	Adult ENT	05.01
		Laryngology	05.02
		Neuro - Otology & Otology	05.03
		Nose Ear Surgery	05.04
		Oral & Maxillofacial Surgery	05.05
		Otolaryngology	05.06
		Audio Vestibular	05.07
		Adult Audiology ENT	05.08
		Rhinology	05.09
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Family Medicine Specialty	06	Family Medicine	06.01
		Primary Care / Ophthalmology	06.02
		Primary Care / Pulmonary	06.03
		Primary Care Preventive Pediatrics	06.04

		Primary Health Care	06.05
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Forensic Medicine Specialty	07		
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Internal Medicine Specialty	08	Adolescent Medicine	08.01
		Cardiology	08.02
		Diabetics Medicine	08.03
		Endocrinology	08.04
		Gastroenterology	08.05
		Geriatrics	08.06
		Hematology	08.07
		Infectious diseases	08.08
		Nephrology	08.09
		Nuclear Medicine	08.10
		Oncology	08.11
		Palliative Medicine	08.12
		Pulmonology	08.13
		Rheumatology	08.14
		Sleep Medicine	08.15
		Sport Medicine	08.16
		Allergy	08.17
		Neurology	08.18
		Obesity	08.19
		Involuntary & Dementia movements	08.20
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Microbiology Specialty	09		
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Obstetrics & Gynecology Specialty	10	Gynecology Oncology	10.01
		Infertility	10.02
		IVF	10.03
		Perinatology	10.04
		Urogynecology	10.05
		General Ob/gyn	10.06
		High-risk Pregnancy	10.07
		Pregnant control	10.08
		Family Planning	10.09
		Early detection of Cancer	10.10
		Gestational Diabetes	10.11
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Ophthalmology Specialty	11	Comprehensive Ophthalmology	11.01
		Diseases and Surgery of the Retina	11.02
		Glaucoma	11.03
		Neuro-Ophthalmology	11.04

		Ocular Oncology	11.05
		Oculoplastic	11.06
		Ophthalmology	11.07
		Pediatric Ophthalmology and Strabismus	11.08
		Primary Care / Ophthalmology	11.09
		Uveitis / Medical Rina	11.10
		Optometry and Contact Lenses	11.11
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Orthopedic Specialty	12	Oncology Orthopedic	12.01
		Orthopedic Surgery	12.02
		Pediatrics Orthopedic	12.03
		Upper Limb Orthopedic	12.04
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Pathology Specialty	13	Bone & Soft Tissue Pathology	13.01
		Dermatopathology	13.02
		Gast. & Hepat Pathology	13.03
		Histopathology	13.04
		Lympha Pathology	13.05
		Pathology Dermatology	13.06
		Renal Pathology	13.07
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Pediatric Specialty	14	Fetal Medicine	14.01
		Neonatal Intensive Care	14.02
		Pediatric Imaging	14.03
		Pediatric Endocrinology	14.04
		Pediatric Gastroenterology	14.05
		Pediatric Genetics	14.06
		Pediatric Rheumatology	14.07
		Pediatric Sleep Medicine	14.08
		Pediatrics	14.09
		Pediatric Hematology	14.10
		Pediatric Infectious Diseases	14.11
		Pediatric Intensive Care	14.12
		Pediatric Nephrology	14.13
		Pediatric Pulmonary Diseases	14.14
		Primary Care Preventive Pediatrics	14.15
		Neonatology	14.16
		Disorders Inherited Metabolic	14.17
		Pediatric Epilepsy	14.18
		Pediatric Neurology	14.19
		Pediatric Cardiology	14.20

		Pediatric Allergy	14.21
		Pediatric Bronchial Asthma	14.22
		Pediatric ENT	14.23
		Pediatric Otolaryngology	14.24
		Pediatric Audiology	14.25
		Pediatric Speech	14.26
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Pediatric Surgery Specialty	15	Pediatric Cardiology surgery	15.01
		Pediatric Neurosurgery	15.02
		Pediatric Oncology	15.03
		Pediatric Plastic Surgery	15.04
		Pediatric Surgery	15.05
		Pediatrics Urology Surgery	15.06
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Physical Medicine & Rehabilitation Specialty	16	Physical Medicine & Rehabilitation	16.01
		Occupational Medicine	16.02
		Physiotherapy	16.03
		Speech & Language pathology	16.04
		Orthotics & Prosthetics	16.05
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Psychiatry Specialty	17	Addiction Medicine	17.01
		Child / Adolescent Psychiatry	17.02
		Consultation - Liaison Psychiatry	17.03
		Forensic Psychiatry	17.04
		Geriatric Psychiatry	17.05
		Mental Health	17.06
		Mood Disorders Psychiatry	17.07
		Psychiatry	17.08
		Rehabilitation Psychiatry	17.09
		Schizophrenia	17.10
		Psychological Evaluation	17.11
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Radiology Specialty	18	Body Imaging	18.01
		Breast Imaging	18.02
		Cardiac Imaging	18.03
		Chest Imaging	18.04
		Diagnostic Neuroradiology	18.05
		Diagnostic Radiology	18.06
		Emergency Radiology	18.07
		Interventional Neuroradiology	18.08

		Interventional Radiology	18.09
		Musculoskeletal Imaging	18.10
		Pediatric Imaging	18.11
		Women's Imaging	18.12
		Cardiac Echo	18.13
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Surgery Specialty	19	Arthroplasty Surgery	19.01
		Bariatric Surgery	19.02
		Cosmetic Surgery	19.03
		Craniofacial Surgery	19.04
		Endocrinology Surgery	19.05
		Facioplastics	19.06
		Foot & Ankle Surgery	19.07
		General Surgery	19.08
		Hand Surgery	19.09
		Hepatobiliary Surgery	19.10
		Neurosurgery	19.11
		Neurosurgery / Oncology	19.12
		Neurosurgery Vascular	19.13
		Plastic Surgery & Reconstructive	19.14
		Skull Base Surgery	19.15
		Spine Surgery	19.16
		Thoracic Surgery	19.17
		Trauma Surgery	19.18
		Vascular Surgery	19.19
		Cardio Surgery	19.20
		Podiatry	19.21
		Oncology Surgery	19.22
		Urology Surgery	19.23
		Laparoscopic Surgery	19.24
		Breast Surgery	19.25
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Urology Specialty	20	Gynecology Urology	20.01
		Laparoscopic Urology	20.02
		Neuro - Urology	20.03
		Oncology Urology	20.04
		Pediatrics Urology	20.05
		Reconstruction Urology	20.06
		Urology	20.07
		Andrology	20.08
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Dental Specialty	21	Dental Screening	21.01
		Restorative Conservative	21.02
		Endodontic	21.03
		Fixed Prosthetic	21.04

		Removable Prosthetic	21.05
		Orthodontic	21.06
		Pedodontic	21.07
		Oral Medicine Diagnosis	21.08
		Periodontics	21.09
		Oral Surgery	21.10
		Oral Maxillofacial Surgery	21.11
		Dental Implant	21.12
		Oral Hygiene	21.13
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Oncology Specialty	22	Radiotherapy	22.01
		Chemotherapy	22.02
Specialty Name	Code	Subspecialty Name	Subspecialty Code
Allied Health Specialty	23	ECG	23.01
		EEG	23.02
		Optics	23.03
		Clinical Dietitian	23.04
		Diabetic Educator	23.05
		Health Education	23.06
		EMG	23.07
		NCS-EMG	23.08
		Stress Testing	23.09
		Holter	23.10
		Stress Echo	23.11
		Pediatrics EEG	23.12

- Add Subspecialty Name
- Change Subspecialty Name
- Delete Subspecialty Name

#### Appendix No. 5- Retired/Frozen Subspecialty\Units

### Retired/Frozen Subspecialty|Units

Subspecialty/Unit Name	Subspecialty/Unit Name	Comments
Otolaryngology	05.06	
Primary Care / Ophthalmology	11.09	
Upper Limp Orthopedic	12.04	
Bone & Soft Tissue Pathology	13.01	
Dermatopathology	13.02	
Gast. & Hepat Pathology	13.03	
Histopathology	13.04	
Lymopha Pathology	13.05	
Pathology Dermatology	13.06	
Renal Pathology	13.07	
Pediatric Imaging	14.03	
Primary Care Preventive Pediatrics	14.15	
Psychiatry	17.08	Retired- duplicated with the specialty code 17.00
Body Imaging	18.01	
Breast Imaging	18.02	
Cardiac Imaging	18.03	
Chest Imaging	18.04	
Diagnostic Neuroradiology	18.05	
Diagnostic Radiology	18.06	
Emergency Radiology	18.07	
Interventional Neuroradiology	18.08	
Interventional Radiology	18.09	
Musculoskeletal Imaging	18.10	
Pediatric Imaging	18.11	
Women's Imaging	18.12	
Cardiac Echo	18.13	
Surgery	22.03	
Dermatology Screening	03.00	Changed-to unit
Derma Procedures Clinic	03.05	Changed-to unit
Ear Nose & Throat Screening Clinic	05.00	Changed-to unit
Audio Vestibular Clinic	05.07	Changed-to unit
Family Medicine Screening Clinic	06.00	Changed-to unit
Internal Medicine Screening Clinic	08.00	Changed-to unit
Endoscopy Clinic	08.21	Changed-to unit
Counseling Clinic	08.22	Changed-to unit
Down Syndrome Clinic	08.97	Changed-to unit
Smoking Cessation Clinic	08.98	Changed-to unit

Diabetes Screening Clinic	08.99	Changed-to unit
Obstetrics & Gynecology Screening Clinic	10.00	Changed-to unit
Gynecology Oncology diagnostic Clinic	10.01	Changed-to unit
Early Detection of Gynecology Oncology Clinic	10.10	Changed-to unit
High-risk Pregnancy Clinic	10.07	Changed-to unit
Pregnant control Clinic	10.08	Changed-to unit
Family Planning Clinic	10.09	Changed-to unit
Gestational Diabetes Clinic	10.11	Changed-to unit
Ophthalmology Screening Clinic	11.00	Changed-to unit
Optometry and Contact Lenses Clinic	11.11	Changed-to unit
Comprehensive Ophthalmology Clinic	11.01	Changed-to unit
Diseases and Surgery of the Retina Clinic	11.02	Changed-to unit
Glaucoma Clinic	11.03	Changed-to unit
Neuro-Ophthalmology Clinic	11.04	Changed-to unit
Ocular Oncology Clinic	11.05	Changed-to unit
Oculoplastic Clinic	11.06	Changed-to unit
Uveitis / Medical Rina Clinic	11.10	Changed-to unit
Orthopedic Surgery Screening Clinic	12.02	Changed-to unit
Orthopedic Surgery (Fractures) Clinic	12.99	Changed-to unit
Pediatric Screening Clinic	14.00	Changed-to unit
Pediatric Diabetes and Endocrinology Screening Clinic	14.99	Changed-to unit
Autism Spectrum Disorder	14.98	Changed-to unit
Pediatric Surgery Screening Clinic	15.00	Changed-to unit
General Surgery Screening Clinic	19.00	Changed-to unit
Breast Tumors Diagnostic Clinic	19.97	Changed-to unit
Colorectal Tumors Early Detection Clinic	19.98	Changed-to unit
Colorectal Tumors Diagnostic Clinic	19.99	Changed-to unit
Urology Screening Clinic	20.00	Changed-to unit
Laparoscopic Urology Clinic	20.02	Changed-to unit
Neuro - Urology Clinic	20.03	Changed-to unit
Oncology Urology Clinic	20.04	Changed-to unit
Reconstruction Urology Clinic	20.06	Changed-to unit
Dental Screening Clinic	21.01	Changed-to unit
Radiotherapy	22.01	Changed-to unit
Chemotherapy Clinic	22.02	Changed-to unit
Allied Health Clinic	23.00	Changed-to unit
ECG Clinic	23.01	Changed-to unit
EEG Clinic	23.02	Changed-to unit
Optics Clinic	23.03	Changed-to unit
Clinical Dietitian Clinic	23.04	Changed-to unit
Diabetic Educator Clinic	23.05	Changed-to unit

Health Education Clinic	23.06	Changed-to unit
EMG Clinic	23.07	Changed-to unit
NCS-EMG Clinic	23.08	Changed-to unit
Stress Testing Clinic	23.09	Changed-to unit
Holter Clinic	23.10	Changed-to unit
Stress Echo Clinic	23.11	Changed-to unit
Pediatrics EEG Clinic	23.12	Changed-to unit
Premarital Screening Clinic	23.96	Changed-to unit
Premarital Counseling Clinic	23.97	Changed-to unit
Laser for Retinal Therapy Clinic	23.98	Changed-to unit
Insulin Pump Clinic	23.99	Changed-to unit
Emergency Unit	T10	
Observation Room	T12	
Vital sign Unit	T13	
General Clinic	T2	
Pediatric Care	T4	
School Health Clinic	T8	

## Appendix 6- Saudi Health Data Dictionary Change Request Form



Type of change Request		
<input checked="" type="radio"/> Update	<input type="radio"/> Add	<input type="radio"/> Delete
Date:		
Organization of Requester:		
Name of Requester:		
Title of Request:		
Requester contact information:	Email:	Mobile:

Element Information	
Name of Element :	
Element reference Number:	
Element chapter:	
Element page number:	
Notes/remarks:	

For SHDD Team use:	
Change Proposal ID:	
Priority:	
Change Proposal Status:	
Date Proposal Received:	
Change Proposal ID:	
Section(s) affected:	
Severity:	

- Request to be sent to the email address: **shdd@shc.gov.sa**
- All fields must be completed
- In the case of adding a new element, element reference number and page number can be left blank
- Use additional supported document if needed.