# Nabiha Saifee Consult Data Dictionary

Files are tab delimited

* \_demog file: Demographic information
  + MRN
  + AdmissionAge: Age at admission (calculated using AdmitDtTm)
  + Sex
  + Race, RaceDescr: I would use RaceDescr unless it is blank and then see if Race has any information.
  + PatientDeathDtTm: Reported patient death date/time. If null, doesn’t mean patient is not dead, just unreported.
  + PatientDeathIndicator: Reported patient death date/time. If null, doesn’t mean patient is not dead, just unreported.
* \_visit file: Visit information
  + MRN
  + visitID: randomly assigned visitID to link to other files with visitID
  + ProcDate: date of procedure given with cohort file
  + AdmitDtTm
  + OriginalDischargeDtTm
  + AdmissionTypeDescr: This tells whether patient came in as Emergency or not
  + DischargeDispositionDescr: Some of the older records have this missing so look at DischargedToLocation for information that might be helpful
  + DischargedToLocation
  + PatientClass: Inpatient (IP), Observation (OBV), or Limited stay (LIM). I think this should be IP for all your patients; however, look at AdmissionTypeDescr to see if the patient came in as Emergency and transferred or not.
  + AccountStatus: Status of the visit. Mostly blank.
  + AssignedPatientLocationFacility: Facility
  + AssignedPatientLocationNurseUnit: Unit
  + HospitalService, HospitalServiceDescr: This is last service patient touched. Since we don’t have service information prior to 2010, I thought this might be helpful although it’s just the last service.
  + AttendingMDName: Whatever information available from our Admit/Discharge/Transfer system
  + AdmittingMDName: Whatever information available from our Admit/Discharge/Transfer system
* \_Dx: Diagnoses information (From Facilities Charges and Bills. If patient is not billed, we do not have a record unfortunately)
  + MRN
  + visitID: Link to visit information
  + DgDtTm: Diagnoses date/time
  + DxCode: Dx Code (ICD9)
  + DxCodingMethod: All likely be i9 which is ICD9
  + DxDescription
  + data\_src: Source of this Dx
    - dis = discharge abstract coded by coder
    - chg = charge diagnoses (can include ordering test for rule out)
    - adm = chief complaint diagnoses for admitting, not billed dx
    - NULL or er = this is older data so I’m not sure where this is from
* \_Pr: Procedure information (From Facilities Charges and Bills. If patient is not billed, we do not have a record unfortunately)
  + MRN
  + visitID: Link to visit information
  + PrDtTm: Procedure date/time
  + ProcedureCode: likely CPT, but some inpatient is billed ICD9
  + ProcedureCodingMethod:
    - pm: most likely CPT, but this is old data so can be difficult
    - cp: CPT
    - i9: ICD9 procedure codes, many inpatient procedures are billed ICD9
    - hc: old data, not sure where this is from
  + ProcedureDescription
  + data\_src: Source of this Dx
    - dis = discharge abstract coded by coder
    - chg = charge diagnoses (can include ordering test for rule out)
* \_Lab: Lab information from lab system
  + MRN
  + visitID: Link to visit information, but this is by looking to see tests performed during admit/discharge date/time
  + ObservationID: Lab code
  + Observation: Lab description
  + ObservationDtTm: Lab result date
  + ObservationValue: Lab value
* \_PhysLoc: Physical Location information. Unfortunately nothing prior to 2009
  + MRN
  + visitID: link to visit
  + LocUnit
  + LocRoom
  + LocFacility
  + LocBuilding
  + DateTimeIn
  + DateTimeOut
  + PatientStatus
* \_Service: Hospital service information. Unfortunately again nothing prior to 2009
  + MRN
  + visitID: link to visit
  + ServiceID, Service: Service description
  + DateTimeIn
  + DateTimeOut
  + PatientStatus