



CPQCC Network Database

2007 Member Instructions for Electronic Data Submission Version 06.07 December 19, 2007

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Acknowledgments

The CPQCC Data Center staff would like to thank the Data Contacts at all of the CPQCC member centers who have participated in Electronic Data Submission in past years, for their patience, effort, and dedication to data quality. We welcome additional feedback from all interested center contacts.

I. What Is Electronic Data Submission (EDS)?

Electronic Data Submission (EDS) is an optional method for submitting data to CPQCC. Centers who participate in EDS submit electronic data files, usually containing multiple infant records, instead of paper forms. There are some notable differences in the data submission procedures and data elements for the 2007 CPQCC Database.

EDS is optional, and all centers are welcome to participate and take advantages of the benefits EDS provides. However, there are some caveats as well, and EDS is not recommended for every member center.

- A. Benefits of EDS Participation.** When EDS works smoothly, both the member hospital and the CPQCC Data Center benefit from the efficiency of paperless transactions at every step. Laborious tasks such as abstracting, mailing, logging, filing, and entering data are eliminated. In place of these steps, computer queries, programs, logs, and output are stored electronically at the center, and electronic files are processed at CPQCC. There are savings for both the hospital staff and the Data Center in time, space, and paper.

- B. Caveats and Considerations.** Centers that elect to participate in EDS are usually those with an existing internal database, used for tracking admissions, discharges, clinical events, and outcomes in the NICU. At such centers, electronic files, which comply with CPQCC specifications, are extracted via database queries or other types of programming code. Utilizing such customized queries or programming statements, the member center's Data Contact is able to read in existing hospital data and to output files that are in compliance with the specifications described in these *Instructions*.

Each participating center must build a system that is compatible with their own resources. It is very important that the system produces output files that meet CPQCC requirements for both data submissions and for documentation of the eligibility and enrollment status of individual infants.

An experienced programmer or software developer is an integral part of the data collection team for any center interested in participating in EDS. Only centers with existing electronic databases *and* programming staff available for building and testing data extract procedures are encouraged to participate in EDS.

II. How To Participate in EDS

- A. **For Centers who currently participate in EDS.** Centers who have participated in EDS in past years for reporting their data are encouraged to continue. These *Instructions* give a summary of the changes to procedures and data elements being introduced for 2007. Please read through these instructions and contact the CPQCC Data Center with any specific questions you may have.
- B. **For Centers who are new to EDS.** Centers who have not participated in EDS in past years are encouraged to gather information by reading these *Instructions* and assessing their resources. If your center has the appropriate resources (at minimum, an existing clinical database from which CPQCC data elements can be extracted, and a programmer or developer available to build a system capable of producing CPQCC-standard files), we will be happy to facilitate your participation. Please contact the Data Center (support@cpqcc.org) to discuss your center's capacities and to make specific plans for submitting 2007 data electronically.

III. Glossary of Important Terms

- A. **Files.** A file is an electronic entity, which may be copied or transmitted using electronic media. Files can be sent in two accepted file formats. These include Microsoft Access files and comma-delimited ASCII text files.
- B. **File names.** In 2007, CPQCC will adhere to rigid guidelines for the naming of files. Data files submitted to CPQCC must observe these rules or else the files will be rejected. Filenames should follow this pattern: **HnnnnEDSxxxx** where "nnnn" represents the four-digit center ID number with leading zero(s) and "xxxx" represents a four-

digit sequential file number. The FILENUM field must be sequentially numbered by the Member's system to uniquely identify each electronic file submitted to the Network (no gaps in sequence). In 2006, CPQCC required members to assign their first file with number 1000. File numbers must stay sequential for all data submissions. Every file submitted after the first submission must have the file number incremented by 1 so that missing file submissions can be identified. Every record in an export file must have the same File Number, and no file will be processed until the previous File Number has been processed. In other words, you will eventually have files 1000, 1001, 1002, etc. For example, the first EDS file submitted by Center 999 would be called H0999EDS1000, the second H0999EDS1001, etc.

- C. File contents.** For all file types, the first row of data must contain the field names, in correct order. This row of field names should be repeated in the first row of all file submissions. The field names and their order are reviewed in the new 2007 CPQCC EDS Specifications. The contents of submitted files can vary somewhat, depending on the file type. Please be familiar with the file type rules for the file type your center produces.

Microsoft Access. CPQCC can only accept files generated in Access 2000, Access 2002 or Access 2003. The Access files must include a table. The table which contains the data must be named **CPQCC**. The file must be named using the specified file naming convention **HnnnnEDSxxx** and use the *.mdb extension.

NOTE: For 2007, Microsoft Access file submitters **MUST** submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. Refer to Appendix C for details.

Text files. These must be comma-delimited ASCII files. Remember to put the field names in the first row for each data file submitted. These files do not have component tables or worksheets. A text file submission would simply be a "flat file" named either **HnnnnEDSxxxx.csv** or **HnnnnEDSxxxx.txt**.

NOTE: For 2007, Text file submitters **MUST** submit all Date/Time variables as string variable values enclosed in quotes. In other words in a comma separated Ascii file, a date variable must be submitted as "12/12/2006{space}12:00" instead of 12/12/2006{space}12:00.

- D. Records.** Each unique admission reported in your data constitutes

a record. A Record is made up of its component Fields (for definition of Field, see below). The following is a glossary of common terminology that we will use in describing the records contained in submitted EDS files.

New Record. A record which has been sent to CPQCC for the first time, in a file that is compatible with our specifications, and is processed.

Updated Record. A record which has been resubmitted, and has changed since its prior submission to CPQCC.

Deleted Record. A record that has been resubmitted with the Delete field set to 1 (this field coded instructs the CPQCC Data Center to delete the record from the center's data). ID numbers for submitted records which are later deleted **CANNOT** be re-used for another infant's record.

Complete Record. A processed record in which there are no blank fields.

Correct Record. A Complete Record that has been checked by the CPQCC Data Center and determined to be without error.

- E. Fields.** A field contains a single piece of information about each unique admission being submitted to the CPQCC database. The new 2007 EDS Specifications for the combined CPQCC Network – CPeTS Database lists all of the fields required for electronic submitted of data beginning in 2007. The table also specifies the ranges and coding rules for each field. (Refer to Appendix C. 2007 EDS Specifications).

Submission of Date/Time Variables

Microsoft Access.

NOTE: For 2007, Microsoft Access file submitters **MUST** submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. Refer to Appendix C for details.

Text Files.

NOTE: For 2007, Text file submitters **MUST** submit all Date/Time variables as string variable values enclosed in quotes. In other words in a comma separated Ascii file, a date variable must be submitted as "12/12/2006{space}12:00" instead of 12/12/2006{space}12:00.

IV. Summary of EDS Procedures for 2007

- A. Data Center Procedures.** CPQCC will adhere to rigid specifications regarding file names, file types, file contents, and file submission procedures in 2007. Files will be screened within 24 hours of receipt, and the CPQCC Data Center will notify Members if there are any problems with the electronic data submission. Any files that do not meet the specifications described in these *Instructions* will be rejected. Our staff will be available to discuss emergent issues as files are passed through our screening procedures beginning in January 2007.
- B. How to submit EDS files for infants born in 2007.** Please send data files for infants born on or after January 1, 2007 in an e-mail attachment to eds@cpqcc.org. The attached file must be to the specifications described in these *Instructions*, and must be zipped and password protected. If you do not know your password, please contact the Data Center.

NOTE: Records of infants born in 2007 SHOULD NOT be submitted in the same file for any records of infants born BEFORE 2007, otherwise these files will be rejected.

- C. How to submit EDS files for infants born in 2006.** Records for infants born in 2006 MUST be submitted or updated in their original format in 2006. However, the files must comply with the 2006 All Baby EDS file specifications as described in the 2006 EDS Instructions. Send any new records or updates to records for infants born in 2006 as an e-mail attachment, zipped and password protected, to eds@cpqcc.org.
- D. How to update records for Still In House Babies born in 2005.** Records for infants born in 2005 MUST be submitted or updated through the on-line data management system through <http://www.cpqccdata.org>. The CPQCC Data Center will not process any 2005 EDS records, otherwise files will be rejected.

V. Summary of Changes to Data Elements and Procedures for 2007

- A. Combined CPQCC Network – California Perinatal Transport System (CPeTS) Database.** In 2007, CPQCC will be managing the CPeTS Database. The 2007 EDS file is divided into three sections: 1) ID section, 2) CPeTS section, and 3) CPQCC section.
- B. Tracking Fields.** The following fields are used for record and file

control. Although these fields are not included on the CPeTS and the CPQCC data forms, they are part of the export file structure as indicated in the new 2007 CPQCC EDS Specifications.

1. **File Number (FILENUM).** The FILENUM field must be sequentially numbered by the Member's system to uniquely identify each electronic file submitted to the Network (no gaps in sequence). The first file number submitted in 2007 MUST sequentially follow the last file number that was submitted in 2006. For example if the last file number submitted in 2006 was 999 then the first file number submitted for 2007 should be 1000. Every file submitted after the first submission must have the file number incremented by 1 so that missing file submissions can be identified (i.e., 1000, 1001, 1002). Every record in an export file must have the same File Number, and no file will be processed until the previous File Number has been processed.
2. **File Date (FILEDATE).** The FILEDATE field identifies the date that the file was exported from the Member's system. Every record in a file must have the same File Date.
3. **Deleted Records (DELETED).** There are occasions when an infant record must be removed from the database. For example, a user may discover that a reported infant was not eligible. To accommodate these situations, each record must include a field named DELETED. To delete a record, the DELETED field must be coded with the numeric value 1. For records that have not been deleted, the DELETED field should be left blank. When a valid or deleted record has been submitted to the Network, the ID number of the infant must not be re-used for another infant. Submitted records which have been deleted must remain in the system.

NOTE: Records deleted before being exported to the Network may be removed from the Member's computer system entirely and the ID number may be reused.

4. **Application Used to Submit Records (APPLICATION).** Beginning in 2005, this text field became available to include the name of the application used for data submissions. Although not required, the application name will be useful if Network assistance is needed to resolve file submission problems.

5. **Application Version (VERSION).** Since 2005, this text field allows a user to report the version number of the application used for data submissions. Although not required, the application version information will be useful if Network assistance is needed to resolve file submission problems.
 6. **Acute Transfer-In Eligibility (ACUTETRS).** In 2007, each record is tracked for eligibility into the CPeTS database. This field is required for all records submitted, otherwise files will be rejected. Infants who aren't eligible into the CPeTS Database should mark all CPeTS fields as Not Applicable.
- C. Record Keys.** The Center Number (HOSPNO) and CPQCC Network Patient Identification Number (ID) fields must uniquely identify each record in an exported file.
1. **Center Number (HOSPNO).** The HOSPNO field is the confidential code number representing the Center Number and has been provided to the Member by the Network. Except for special group submissions, each record in a file must have the same value for the HOSPNO field.
 2. **CPQCC Network Identification Number (ID).** Each infant record must include a unique CPQCC Network Identification Number (ID) and no two infants at a center may have the same ID.
- NOTE: 2007 Starting ID Number.** In 2007 all CPQCC members are advised NOT to skip 10 IDs between submission years UNLESS the user has not yet closed out for 2006. For example, if a user is still submitting IDs for infants born in 2006 AND is also submitting new IDs for infants born in 2007, you may still skip 10 IDs between submission years to avoid overlapping. Otherwise, please continue with the next ID number that is in sequence with the previous ID number. For example, if the last infant in 2006 was 490, then the 2007 Starting ID Number should be 491. If you are unsure about your Starting ID Number please contact support@cpqcc.org.
- D. Data Field Changes for 2007**
For Section II of the EDS specifications, refer to the CPeTS Manual of Definitions for Infants Born in 2007 for more specific data collection instructions.

For Section III of the EDS specifications, refer to the CPQCC Manual of Definitions for Infants Born in 2007 for more specific data collection instructions.

1. **Item Renumbering.** In 2007, a new section on Hyperbilirubinemia with three new variables (Items 50-52) has been added. Items 50 to 61 have been renumbered.
2. **Coding Rules.** The three variables (Items 50-52) measuring Hyperbilirubinemia pertain to ANY infant who was previously discharged home (PDH=1) and readmitted to your NICU by Day 28.
3. **Discontinued Fields.** There are no discontinued fields.
4. **Revised Fields.**
 - a. In 2007, the range of possible values for the File Submission Date (FILEDATE) is limited to **{01/01/2007-06/30/2008}**.
 - b. In 2007, the range of possible values for the birth year field (BYEAR) is limited to **{2007}**. For any infant born in 2005 or 2006, use the 2006 EDS Specifications.
 - c. The range of possible values for birth date (BDATE, Item 4) is limited to **{01/01/07 to 12/31/07}**.
 - d. Additional surgery codes have been added and one of the surgery code definitions has been revised in Appendix B. The changes are described in Appendix A.
 - e. **Submission of Date/Time Variables**

Microsoft Access.
NOTE: For 2007, Microsoft Access file submitters MUST submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. Refer to Appendix C for details.

Text Files.
NOTE: For 2007, Text file submitters MUST submit all Date/Time variables as string variable values

enclosed in quotes. In other words in a comma separated Ascii file, a date variable must be submitted as "12/12/2006{space}12:00" instead of 12/12/2006{space}12:00.

5. **New Fields and Field Descriptions.** In 2007, a new section on Hyperbilirubinemia has been added. The three variables (Items 50-52) measuring Hyperbilirubinemia pertain to ANY infant who was previously discharged home (PDH=1) and readmitted to your NICU by Day 28 of Life.

The new fields are:

- a. **BILILEVEL.** The maximum level of total serum bilirubin is measured (less than 25 mg/dL, 25 mg/dL to less than 30 mg/dL, greater than or equal to 30 mg/dL) during the current re-admission.
- b. **EXCHANGE.** Whether the infant received an exchange transfusion during the current re-admission.
- c. **LASTHOSPITAL.** The valid OSHPD code for the hospital that discharged the infant home (prior to re-admission.)

E. 2007 Admission/Discharge Records.

NOTE: Data definitions developed by CPQCC are consistent with the VLBW definitions developed by VON wherever feasible. CPQCC and VON are committed to using the identical data definitions to the greatest possible extent, to promote database compatibility. Please use the 2007 CPQCC Manual of Operations for instructions in completing the 2007 Admission/Discharge data items. Also, please note that for 2007, all data must be recorded using the new 2007 CPQCC EDS Specifications. Any EDS specifications released by VON or old 2004 Big Baby and Small Baby EDS specifications, or the 2005 EDS Specifications are not compatible with the 2007 CPQCC data entry system, and should not be used due to field reordering and the addition and deletion of fields.

1. **Selection Criteria.** An infant is eligible for inclusion in the 2007 CPQCC Database if any of the following three conditions apply:
 - a. The infant's birth weight is between 401 and 1500 grams.

- b. The infant's gestational age at birth is between 22 weeks 0 days and 29 weeks 6 days (less than 30 weeks).
 - c. The infant's birth weight is greater than 1500 grams AND the infant experienced one of the following events: 1) Infant Death, 2) Surgery, 3) Ventilation greater than 4 hours, 4) Acute transfer-in, 5) Acute transfer out, 6) Early bacterial sepsis, or 7) Infants previously discharged home (PDH=1) and readmitted to your NICU by Day 28 for Total Serum Bilirubin of => 25 mg/dL (427 micromols/Liter) and/or exchange transfusion.
- 2. There is no longer Big Baby or Small Baby datasets which previously required members to send two separate EDS files. There is only one dataset for 2007, which should be used on all infants that are eligible for inclusion in the 2007 dataset.
 - 3. All data submission is done at the time of discharge. There is no longer a 28-Day form as was used previously with the Small Baby dataset.
 - 4. **Assignment of IDs.** For the 2007 dataset, the unit of analysis is unique infants cared for at your center, whether over one admission or multiple admissions. All data forms are updated to include information from multiple admissions when necessary. New ID numbers are not assigned when infants are readmitted to your center from another hospital.

Note: Reassignment of New IDs for infants discharged home then readmitted back to your center. New ID Numbers MUST be assigned if a baby is discharged home from your center, AND THEN readmitted back to your center. Refer to Section XII. *Procedures for Completing Forms for specific instructions* of the CPQCC Manual of Definitions For Infants Born in 2007.

Note: Deletion of IDs. If an ineligible infant is incorrectly entered into the database, the particular ID will reflect in the Error Report as ineligible. Once this ID is deleted, it cannot be re-used or re-assigned to another infant. A list of deleted IDs is reflected in your Error and Warning Reports. Refer to Section X. *How the Database Work, CPQCC ID Numbers and Logs* of the CPQCC Manual of Definitions For Infants Born in 2007.

- F. Records of Infants Who Do Not Transfer.** If an infant does not transfer from your center to another hospital, all fields on the Transport/Post-Transport Form should be submitted with the appropriate N/A codes.

- G. Delivery Room Death Records.** For infants who die in the delivery room, the fields which appear on the Admission/Discharge Form and Transport/Post-Transport Form, but which do not appear on the Delivery Room Death Form, must be coded using the appropriate not applicable (N/A) code.

Appendix A Revisions for 2007

A. Introduction. This Appendix describes the changes in procedures or instructions for 2007 electronic data submissions, as compared to 2006.

B. Changes to CPQCC Network Database Eligibility. The selection criteria for infants with birth weight greater than 1500 grams has been amended to read:

The infant's birth weight is greater than 1500 grams AND the infant experienced one of the following events: 1) Infant Death, 2) Surgery, 3) Ventilation greater than 4 hours, 4) Acute transfer-in, 5) Acute transfer out, 6) Early bacterial sepsis, or 7) Infants previously discharged home (PDH=1) and readmitted to your NICU by Day 28 for Total Serum Bilirubin of greater than or equal to 25 mg/dL (427 micromols/Liter) and/or exchange transfusion.

C. Changes in the Record Structure.

1. **Combined CPQCC Network – CPeTS Database.** In 2007, CPQCC will be managing the CPeTS Database. The 2007 EDS file is divided into three sections: 1) ID section, 2) CPeTS section, and 3) CPQCC section.
2. **Acute Transfer-In Eligibility (ACUTETRS).** In 2007, each record is tracked for eligibility into the CPeTS database. This field is required for all records submitted, otherwise files will be rejected. Infants who aren't eligible into the CPeTS Database should mark all CPeTS fields as Not Applicable.

D. Changes in Definition or Description of Items.

1. In 2007, a new section on Hyperbilirubinemia has been added. The three variables (Items 50-52) measuring Hyperbilirubinemia pertain to ANY infant who was previously discharged home (PDH=1) and readmitted to your NICU by Day 28 of Life.

The new fields are:

- a. **BILILEVEL.** The maximum level of total serum bilirubin is measured (less than 25 mg/dL, 25 mg/dL to less than 30 mg/dL, greater than or equal to 30

mg/dL) during the current re-admission.

- b. EXCHANGE. Whether the infant received an exchange transfusion during the current re-admission.
- c. LASTHOSPITAL. The valid OSHPD code for the hospital that discharged the infant home (prior to re-admission.)

2. Additional surgery codes have been added to the Surgery Code Appendix (Appendix B). These include:

S107 Palliative or definitive repair of choanal atresia

S313* Drainage for intra-abdominal abscess. **See note.**

S330 Takedown of ostomy and/or reanastomosis of bowel (small or large)

S331 Ladd's or other procedure for correction of malrotation

S332 Appendectomy

S333* Primary peritoneal drainage for NEC, suspected NEC, or intestinal perforation. (If infant subsequently has other applicable surgical procedures, code those also.) **See note.**

- **NOTE:** Code S313 and code S333 were added during 2006 to distinguish between peritoneal drainage for draining an abscess and peritoneal drainage for NEC, suspected NEC or intestinal perforation. These codes apply to infants both in 2006 and 2007.

E. Specific requirements for the submission of Date/Time Variables

Microsoft Access.

NOTE: For 2007, Microsoft Access file submitters **MUST** submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. Refer to Appendix C for details.

Text Files.

NOTE: For 2007, Text file submitters **MUST** submit all Date/Time variables as string variable values enclosed in quotes. In other

words in a comma separated Ascii file, a date variable must be submitted as "12/12/2006{space}12:00" instead of 12/12/2006{space}12:00.

F. Summary of Changes implemented to Appendix C on May 10, 2007

1. To clarify required variables for submission, all redundant variables in the CPeTS section of the EDS Specifications have been deleted. The deleted rows contain Transport variables that are not required to be submitted in the CPeTS section: T_BWGT, GA WEEKS, GADAYS, SEX, T_BDCD1 to T_BDCD5, ASTER, DRSURF, T_REFDATETIME.
2. The description for Item T27 has been changed to: "Is this the first transfer for this infant?" As a result the coding rules have been updated as follows: 0=No, this was NOT the infant's first transfer; 1=Yes, infant transferred for the first time.
3. The Unknown codes have been deleted from Items T29, T30a, and T31.

G. Summary of Changes implemented to Appendix C on June 21, 2007

1. Only if [T_TYPE]=1, then T.15-T.25=7 or N/A.
2. T.20 the range has been changed to 0 to 400.
3. The range for T.21a has been changed to 0 to 140.
4. The range for T.21b has been changed to 0 to 100.
5. The range for T.23 has been changed to 20 to 45 degrees Celcius.

H. Summary of Changes implemented to Appendix C on December 19, 2007.

1. Corrected type on coding rule for N/A for item T.19.

Appendix B Surgery Codes for Item 43

NOTE: In 2007, four additional surgery codes that have been added appear in ***bold italics font***.

*** NOTE:** Code S313 and code S333 were added during 2006 to distinguish between peritoneal drainage for draining an abscess and peritoneal drainage for NEC, suspected NEC or intestinal perforation. These codes apply to infants both in 2006 and 2007.

Head and Neck

- S101 Tracheostomy
- S102 Cricoid split
- S103 Ophthalmologic surgery OTHER than laser or cryosurgery for ROP

Note: Record ROP surgery in item 42c. Do not record ROP surgery as 'Other Surgery'

- S104 Cleft lip or palate repair
- S105 Branchial cleft sinus excision
- S106 Thyroglossal duct excision
- S107 *Palliative or definitive repair of choanal atresia***
- S100 Other head and neck surgery requiring general or spinal Anesthesia
(**description required**)

Thorax

- S201 Tracheal Resection
- S202 Aortopexy
- S203 Tracheoesophageal atresia and/or fistula repair
- S204 Thoracoscopy (with or without pleural or lung biopsy)
- S205 Thoracotomy (with or without pleural or lung biopsy)
- S206 Thoracotomy (or thoracoscopy) with lobectomy or partial lobectomy
- S207 Resection of pulmonary sequestration (intrathoracic or extrathoracic)
- S208 Resection of mediastinal mass
- S209 Resection of chest wall
- S210 Bronchoscopy (with or without biopsy)
- S211 Esophagoscopy (with or without biopsy)
- S200 Other thoracic surgery requiring general or spinal anesthesia (**description required**)

Abdomen

Note: Record all applicable codes even if item 40b, NEC surgery, has already been checked, “Yes”

- S301 Rectal biopsy with or without anoscopy
- S302 Laparoscopy (diagnostic, with/without biopsy)
- S303 Laparotomy (diagnostic or exploratory, with/without biopsy)
- S304 Fundoplication

- S305 Pyloromyotomy
- S306 Pyloroplasty
- S307 Jejunostomy, ileostomy, colostomy for intestinal diversion (with/without bowel resection)
- S308 Small bowel resection
- S309 Large bowel resection
- S310 Duodenal Atresia/Stenosis Repair
- S311 Jejunal, ileal, or colonic atresia repair (or repair of multiple intestinal atresias)
- S312 Excision of Meckel’s diverticulum
- S313* *Drainage of intra-abdominal abscess (not as primary treatment for NEC, see code S333)***
- S314 Surgery for meconium ileus
- S315 Excision of omphalomesenteric duct or duct remnant
- S316 Gastroschisis repair (primary or staged)
- S317 Omphalocele repair (primary or staged)
- S318 Lysis of adhesions without other procedure
- S319 Repair of imperforate anus (with or without vaginal, urethral, or vesicle fistula)
- S320 Pull through for Hirschsprung’s disease (any technique)
- S321 Pancreatectomy (partial, near total or total)
- S322 Splenectomy (partial or total)
- S323 Resection of retroperitoneal tumor
- S324 Resection of sacrococcygeal tumor
- S325 Repair of diaphragmatic hernia
- S326 Plication of the diaphragm
- S327 Gastrostomy tube
- S328 Upper endoscopy (stomach or duodenum, with or without biopsy)
- S329 Colonoscopy (with or without biopsy)
- S330 *Takedown of ostomy and/or reanastomosis of bowel (small or large)***
- S331 *Ladd’s or other procedure for correction of malrotation***
- S332 *Appendectomy***
- S333* *Primary peritoneal drainage for NEC, suspected NEC, or intestinal perforation (If infant subsequently has other applicable surgical procedures, code those also.)***
- S300 Other abdominal surgery requiring general or spinal anesthesia (**description required**)

Genitourinary

- S401 Cystoscopy (diagnostic, with or without biopsy)
- S402 Adrenalectomy
- S403 Nephrectomy
- S404 Nephrostomy
- S405 Urteterostomy
- S406 Resection of urachal cyst
- S407 Cystostomy
- S408 Closure of bladder exstrophy
- S409 Resection of posterior urethral valves
- S410 Inguinal hernia repair
- S411 Orchidopexy
- S412 Orchiectomy
- S413 Drainage of ovarian cyst
- S414 Oophorectomy (partial or complete)
- S415 Circumcision
- S400 Other genitourinary surgery requiring general or spinal anesthesia
(**description required**)

Open Heart or Vascular Procedures

Note: PDA ligation is recorded in 39c. Do not record PDA Ligation as 'Other Surgery'

- S501 Vascular Ring division
- S502 Repair of coarctation of the aorta
- S503 Repair of major vascular injury
- S504 Repair or palliation of congenital heart disease
- S500 Other open heart or vascular surgery requiring general or spinal anesthesia (**description required**)

Diagnostic or interventional cardiac catheterization

- S601 Diagnostic cardiac catheterization
- S602 Interventional catheterization with balloon septostomy
- S603 Interventional catheterization with aortic valvuloplasty
- S604 Interventional catheterization with pulmonary valvuloplasty
- S600 Other interventional catheterization requiring general or spinal anesthesia
(**description required**)

Skin and Soft Tissue

S700 Skin or soft tissue surgery requiring general or spinal anesthesia
(**description required**)

Musculoskeletal System

S800 Other musculoskeletal surgery requiring general or spinal anesthesia
(**description required**)

Central Nervous System

S901 Ventriculoperitoneal or other ventricular shunt

S902 External ventricular drain

S903 Ventricular drain with reservoir

S904 Myelomeningocele repair

S900 Other central nervous system surgery requiring general or spinal
anaesthesia (**description required**)

Fetal Surgery (record if fetal surgery was done at your hospital or another hospital)

S1000 Fetal surgery at your hospital (**description required**)

S1001 Fetal surgery at another hospital (**description required**)

Appendix C. 2007 CPQCC EDS Specifications

2007 EDS Specifications for the combined CPQCC Network - CPeTS Database

Version 15.0 (December 19, 2007)

Summary of FIELDS for 2007

Section I. Tracking Fields

Tracking Fields

2007 Item	Field Name	Description	Field Type	Range of Possible Values	Coding Rules
None	FILENUM	File Submission Number	Integer	{1 - 9999}	Sequentially assigned file number, incremented with each submission
None	FILEDATE	File Submission Date	Date	01/01/2007-06/30/2008	Date on which data is exported to file for submission to CPQCC. Valid date, format should be mm/dd/yyyy
None	DELETED	Record deleted	Integer	{BLANK, 1}	BLANK=No, 1=Yes record deleted (but unique network ID number preserved)
None	APPLICATION	Application Submitting the Data File	Char25		Up to 25 alphanumeric characters
None	VERSION	Version of Application Submitting Data File	Char15		Up to 15 alphanumeric characters
None	HOSPNO	Center ID Number	Integer		Center ID Number as assigned by CPQCC
None	ID	Network ID Number	Integer	{00001 - 99998}	Each ID number is to be sequentially assigned by hospital
None	BYEAR	Birth Year	Integer	{2007}	For infants born on 2005 or 2006, EDS Specifications for 2005 and 2006 must be used respectively. Submit these files separately from any files with 2007 records.
None	ACUTETRS	Acute Transfer-In Eligibility	Integer	{0, 1}	0=No, 1=Yes. Each record is tracked for eligibility into the CPeTS database. If [ACUTETRS]=1, then all variables starting with [T_] must be filled out; otherwise if [ACUTETRS]=0, then CPeTS section should be Not Applicable. Records of infants MUST complete this field, otherwise files will be rejected.

Section II. 2007 EDS Specifications for the CPeTS Database					
Referral (T.1 - T.4)					
Transport Type					
2007 Item	Field Name	Description	Field Type	Range of Possible Values	Coding Rules
T.1	T_TYPE	Transport Type	Integer	{1 - 4, 7}	1=DR Attendance Requested, 2=Acute Neonatal, 3=Scheduled Neonatal, 4=Other (Describe), 7=N/A (only if [ACUTETRS]=0); Only if [T_TYPE]=1, then T.15-T.25=7 or N/A
	T_TYPEDESC	Type Describe	Char50	{Description, 77}	Up to 200 alphanumeric characters; 77=N/A (only if [ACUTETRS]=0)
Indication for Transport					
NOTE: A baby that is transferred into your hospital for reasons of Growth/Discharge Planning, Chronic, or Hospice Care is NOT eligible, and you do not need to fill out this form.					
T.2	T_TRANSCODE	Indication for Transport	Integer	{2, 3, 6, 7}	(Only if [ACUTETRS]=1): 2=Medical DX/RX Services, 3=Surgery, 6=Insurance, Growth/Discharge Planning (Not Available), Chronic or Hospice Care (Not Available) ; 7=N/A (only if [ACUTETRS]=0)
Referral Date and Time					
NOTE: This is the same as Referral Date/Time in Item T.14a. Submit this variable only once using this field.					
T.3	T_REFDATETIME	Date/Time of Referral	Char16	{01 - 12}/{01 - 31}/{(2007){space}{00}{00}}	16 alphanumeric characters using forward slashes for the date, a (space) between date and time, and a colon between hour and minutes=mm/dd/yyyy(space)hh:mm; 07/07/1907 07:07=N/A (only if [ACUTETRS]=0). NOTE: Microsoft Access file submitters MUST submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. While Text file submitters MUST submit all Date/Time variables as string variable values enclosed in quotes. In other words in a comma separated Ascii file, a Date/Time variable must be submitted as "12/12/2006(space)12:00" instead of 12/12/2006(space)12:00.
Date/Time of Acceptance					
T.4	T_ACCDATETIME	Date/Time of Acceptance	Char16	{01 - 12}/{01 - 31}/{(2007){space}{00}{00}}	16 alphanumeric characters using forward slashes for the date, a (space) between date and time, and a colon between hour and minutes=mm/dd/yyyy(space)hh:mm; 07/07/1907 07:07=N/A (only if [ACUTETRS]=0). NOTE: Microsoft Access file submitters MUST submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. While Text file submitters MUST submit all Date/Time variables as string variable values enclosed in quotes. In other words in a comma separated Ascii file, a Date/Time variable must be submitted as "12/12/2006(space)12:00" instead of 12/12/2006(space)12:00.

History and Demographics (T.5 - T.13)

Date & Time of Maternal Admission to Labor & Delivery					
T.5	T_MADMDATETIME	Date/Time of mother's admission to L&D	Char16	{01 - 12}/{01 - 31}/{2007}{space}{00};{00}	16 alphanumeric characters using forward slashes for the date, a (space) between date and time, and a colon between hour and minutes=mm/dd/yyyy(space)hh:mm; 07/07/1907 07:07=N/A (only if [ACUTETRS]=0). NOTE: Microsoft Access file submitters MUST submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. While Text file submitters MUST submit all Date/Time variables as string variable values enclosed in quotes. In other words in a comma separated Ascii file, a Date/Time variable must be submitted as "12/12/2006(space)12:00" instead of 12/12/2006(space)12:00.
Infant Birth Date and Time					
NOTE: If [ACUTETRS]=1, then T.6 [T_BDATETIME] must = [BDATE] in the CPQCC Section. Submit this variable twice.					
T.6	T_BDATETIME	Date/Time of birth	Char16	{01 - 12}/{01 - 31}/{2007}{space}{00};{00}	16 alphanumeric characters using forward slashes for the date, a (space) between date and time, and a colon between hour and minutes=mm/dd/yyyy(space)hh:mm; 07/07/1907 07:07=N/A (only if [ACUTETRS]=0). NOTE: Microsoft Access file submitters MUST submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. While Text file submitters MUST submit all Date/Time variables as string variable values enclosed in quotes. In other words in a comma separated Ascii file, a Date/Time variable must be submitted as "12/12/2006(space)12:00" instead of 12/12/2006(space)12:00. NOTE: If [ACUTETRS]=1, then T.6 [T_BDATE] must = [BDATE] in the CPQCC Section. Submit this variable twice.
Birth Weight					
NOTE: If [ACUTETRS]=1 AND [T_BWGT] is not equal to 9999, then T.7 [T_BWGT] must = [BWGT] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					
Best estimate of gestational age					
NOTE: If [ACUTETRS]=1, then T.8 [GAWEEKS, GADAYS] must = [GAWEEKS, GADAYS] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					
Infant Sex					
NOTE: If [ACUTETRS]=1, then T.9 [SEX] must = [SEX] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					

Congenital anomalies					
T.10a	T_CMAL	Major Birth Defect Diagnosed Prenatally	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [ACUTETRS]=0), 9=Unknown
NOTE: If [ACUTETRS]=1, then T.10b [T_BDCD1 to T_BDCD5] must = [BDCD1 to BDCD5] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section. For each record, there is a limit of only 5 birth defect codes regardless if prenatally or post-natally diagnosed.					
Number of Mother's Pregnancies Including the Current Pregnancies (Gravida)					
T.11	T_GRAVIDA	Gravida	Integer	{1 - 20, 77, 99}	1 - 20 = number of mother's pregnancies including current pregnancy, 77=N/A (only if [ACUTETRS]=0), 99 = Unknown
Antenatal Steroids					
NOTE: If [ACUTETRS]=1, then T.12a [ASTER] must = [ASTER] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					
Date & Time of Last Antenatal Steroid Administration					
T.12b	T_ASTERDATETIME	Date/Time of ANS administration	Char16	{01 - 12}/{01 - 31}/{2007}{space}{00}{:}{00}	16 alphanumeric characters using forward slashes for the date, a (space) between date and time, and a colon between hour and minutes=mm/dd/yyyy(space)hh:mm; 07/07/1907 07:07=N/A (only if [ACUTETRS]=0). NOTE: Microsoft Access file submitters MUST submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. While Text file submitters MUST submit all Date/Time variables as string variable values enclosed in quotes. In other words in a comma separated Ascii file, a Date/Time variable must be submitted as "12/12/2006(space)12:00" instead of 12/12/2006(space)12:00.
Surfactant Use					
NOTE: If [ACUTETRS]=1, then T.13a [DRSURF] must = [DRSURF] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					
T.13b	T_SURFX	Surfactant Given at any time	Integer	{0, 1, 7, 9}	0= No, 1= Yes, 7=N/A (only if [ACUTETRS]=0), 9= Unknown
T.13c	T_SURFXDATETIME	Date/Time of Surfactant administration	Char16	{01 - 12}/{01 - 31}/{2007}{space}{00}{:}{00}	16 alphanumeric characters using forward slashes for the date, a (space) between date and time, and a colon between hour and minutes=mm/dd/yyyy(space)hh:mm; 07/07/1907 07:07=N/A (only if [ACUTETRS]=0). NOTE: Microsoft Access file submitters MUST submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. While Text file submitters MUST submit all Date/Time variables as string variable values enclosed in quotes. In other words in a comma separated Ascii file, a Date/Time variable must be submitted as "12/12/2006(space)12:00" instead of 12/12/2006(space)12:00.

Infant Conditions (Items T.14 - T.25)					
Date/Time at which infant condition was evaluated					
NOTE: This is the same as Referral Date/Time in Item T.3. Submit this variable only once.					
Date/Time of Initial Evaluation by Transport Team within 15 minutes of Arrival at Referring Hospital					
T.14b	T_EVALINITDATETIME	Date/Time of Initial Evaluation by Transfer Team	Char16	{01 - 12}/{01 - 31}/{(2007){space}{00};{00}}	16 alphanumeric characters using forward slashes for the date, a (space) between date and time, and a colon between hour and minutes=mm/dd/yyyy(space)hh:mm; 07/07/1907 07:07=N/A (only if [ACUTETRS]=0). NOTE: Microsoft Access file submitters MUST submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. While Text file submitters MUST submit all Date/Time variables as string variable values enclosed in quotes. In other words in a comma separated Ascii file, a Date/Time variable must be submitted as "12/12/2006(space)12:00" instead of 12/12/2006(space)12:00.
Date/Time of Initial Evaluation by Transport Team within 15 minutes of Arrival at Referring Hospital					
T.14c	T_EVALNICUDATETIME	Date/Time of NICU Admission	Char16	{01 - 12}/{01 - 31}/{(2007){space}{00};{00}}	16 alphanumeric characters using forward slashes for the date, a (space) between date and time, and a colon between hour and minutes=mm/dd/yyyy(space)hh:mm; 07/07/1907 07:07=N/A (only if [ACUTETRS]=0). NOTE: Microsoft Access file submitters MUST submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. While Text file submitters MUST submit all Date/Time variables as string variable values enclosed in quotes. In other words in a comma separated Ascii file, a Date/Time variable must be submitted as "12/12/2006(space)12:00" instead of 12/12/2006(space)12:00.
Responsiveness					
T.15	T_RESP1	at Referral	Integer	{0, 1, 2, 3, 7}	0=Death; 1=None, Seizures, Muscle Relaxant; 2=Lethargic, no cry; 3=Vigorously withdraws, cry; 7=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1)
	T_RESP2	at Initial Evaluation	Integer	{0, 1, 2, 3, 7}	0=Death; 1=None, Seizures, Muscle Relaxant; 2=Lethargic, no cry; 3=Vigorously withdraws, cry; 7=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1)
	T_RESP3	at NICU Admission	Integer	{0, 1, 2, 3, 7}	0=Death; 1=None, Seizures, Muscle Relaxant; 2=Lethargic, no cry; 3=Vigorously withdraws, cry; 7=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1)
Respiratory Rate (0 to 130)					
T.16	T_RESPRATE1	at Referral	Integer	{0 - 130, 777}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1)
	T_RESPRATE2	at Initial Evaluation	Integer	{0 - 130, 777}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1)
	T_RESPRATE3	at NICU Admission	Integer	{0 - 130, 777}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1)

Oxygen Saturation (SaO2) (0 to 100)					
T.17	T_SAO21	at Referral	Integer	{0 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1), 999=Unknown
	T_SAO22	at Initial Evaluation	Integer	{0 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1), 999=Unknown
	T_SAO23	at NICU Admission	Integer	{0 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1), 999=Unknown
Respiratory Status					
T.18	T_RESPSTATUS1	at Referral	Integer	{1 , 2, 3, 7}	1=Respirator; 2=Severe apnea, gasping, intubated but not on respirator; 3=Other; 7=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1)
	T_RESPSTATUS2	at Initial Evaluation	Integer	{1 , 2, 3, 7}	1=Respirator; 2=Severe apnea, gasping, intubated but not on respirator; 3=Other; 7=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1)
	T_RESPSTATUS3	at NICU Admission	Integer	{1 , 2, 3, 7}	1=Respirator; 2=Severe apnea, gasping, intubated but not on respirator; 3=Other; 7=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1)
Oxygen Index (for infants on respirator only)					
T.19a	Mean Airway Pressure (MAP) (0 to 40)				
	T_MAP1	at Referral	Integer	{0 - 40, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS1]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown
	T_MAP2	at Initial Evaluation	Integer	{0 - 40, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS2]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown
T_MAP3	at NICU Admission	Integer	{0 - 40, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS3]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown	
T.19b	Inspired Oxygen Concentration (FIO2) (21 to 100)				
	T_FIO21	at Referral	Integer	{21 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS1]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown
	T_FIO22	at Initial Evaluation	Integer	{21 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS2]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown
T_FIO23	at NICU Admission	Integer	{21 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS3]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown	
T.19c	Arterial Oxygen (PAO2) (0 to 500)				
	T_PAO21	at Referral	Integer	{0 - 500, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS1]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown
	T_PAO22	at Initial Evaluation	Integer	{0 - 500, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS2]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown
T_PAO23	at NICU Admission	Integer	{0 - 500, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS3]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown	

Heart Rate (0 to 400)					
T.20	T_HEARTRATE1	at Referral	Integer	{0 - 400, 777}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1)
	T_HEARTRATE2	at Initial Evaluation	Integer	{0 - 400, 777}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1)
	T_HEARTRATE3	at NICU Admission	Integer	{0 - 400, 777}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1)
Blood Pressure					
T.21a	Systolic (0 to 140)				
	T_BPSYS1	at Referral	Integer	{0 - 140, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 999=Unknown
	T_BPSYS2	at Initial Evaluation	Integer	{0 - 140, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 999=Unknown
	T_BPSYS3	at NICU Admission	Integer	{0 - 140, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 999=Unknown
T.21b	Diastolic (0 to 100)				
	T_BPDIA1	at Referral	Integer	{0 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 999=Unknown
	T_BPDIA2	at Initial Evaluation	Integer	{0 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 999=Unknown
	T_BPDIA3	at NICU Admission	Integer	{0 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 999=Unknown
T.21c	Mean (0 to 100)				
	T_BPMEAN1	at Referral	Integer	{0 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 999=Unknown
	T_BPMEAN2	at Initial Evaluation	Integer	{0 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 999=Unknown
	T_BPMEAN3	at NICU Admission	Integer	{0 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 999=Unknown
Use of Pressors					
T.22	T_PRESSOR1	at Referral	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1)
	T_PRESSOR2	at Initial Evaluation	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1)
	T_PRESSOR3	at NICU Admission	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1)
Temperature (20 to 45 Celsius)					
T.23	T_TEMP1	at Referral	Double	{20.0 - 45.0, 777}	20.0 - 45.0 degrees Celsius, 777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1)
	T_TEMP2	at Initial Evaluation	Double	{20.0 - 45.0, 777}	28.0 - 42.0 degrees Celsius, 777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1)
	T_TEMP3	at NICU Admission	Double	{20.0 - 45.0, 777}	28.0 - 42.0 degrees Celsius, 777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1)
Blood Glucose (0 to 500)					
T.24	T_GLUPOSE1	at Referral	Integer	{0 - 500, 7777, 9999}	7777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 9999=Unknown
	T_GLUPOSE2	at Initial Evaluation	Integer	{0 - 500, 7777, 9999}	7777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 9999=Unknown
	T_GLUPOSE3	at NICU Admission	Integer	{0 - 500, 7777, 9999}	7777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 9999=Unknown
Respiratory Support					
T.25	T_VENTMODE1	at Referral	Integer	{0, 1, 2, 3, 7}	0=None, 1=Hood/NC, 2=Nasal CPAP, 3=ETT, 7=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1)
	T_VENTMODE2	at Initial Evaluation	Integer	{0, 1, 2, 3, 7}	0=None, 1=Hood/NC, 2=Nasal CPAP, 3=ETT, 7=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1)
	T_VENTMODE3	at NICU Admission	Integer	{0, 1, 2, 3, 7}	0=None, 1=Hood/NC, 2=Nasal CPAP, 3=ETT, 7=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1)

Referral Process (Items T.26 - T.34)					
Referring Hospital					
T.26	T_REFERRINGHOSPITAL	Referring Hospital	Char6	{OSHPD ID, 777777, 999999}	Valid OSHPD ID number (see list); 999999=Unknown; 777777=N/A (only if [ACUTETRS]=0)
Previous Transfer?					
T.27a	T_FIRSTTRANS	Was this infant previously transferred? Is this the first transfer for this infant?	Integer	{0, 1, 7, 9}	0=No, this was NOT the infant's first transfer, 1=Yes, infant transferred for the first time, 7=N/A (only if [ACUTETRS]=0), 9=Unknown
T.27b	T_PREVHOSPITAL	Previously Transfer Referring Hospital	Char6	{OSHPD ID, 777777, 999999}	Valid OSHPD ID number (see list); 777777=N/A (if [T_firstTrans] = 0) OR (only if [ACUTETRS]=0); 999999=Unknown (always if [T_firstTrans] = 9).
Location of Birth					
NOTE: If [ACUTETRS]=1, then T.28 [BIRTHLOCATION] must = [BIRTHLOCATION] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					
Transport Team On-Site Leader					
T.29	T_TEAMLEADER	Team Leader	Integer	{1, 2, 3, 4, 5, 6, 7, 9}	1=Sub-Specialist, 2=Pediatrician, 3=Other MD/Resident, 4=Neonatal Nurse Practitioner, 5=Transport Specialist, 6=Nurse, 7=N/A (only if [ACUTETRS]=0), 9=Unknown
Team Baser					
T.30a	T_TEAMBASE	Team Base	Integer	{1, 2, 3, 7, 9}	1=Receiving Hospital, 2=Contract Service, 3=Referring Hospital, 7=N/A (only if [ACUTETRS]=0), 9=Unknown
T.30b	T_TEAMBASECS	Contract Service used	Char4	{Contract Service ID Number, 7777}	If [T_teamBase]=2, valid contract service ID number (see list); 7777 if [T_teamBase] IN (1,3) or if N/A (only if [ACUTETRS]=0)
Mode of Transport					
T.31	T_TRANSMODE	Mode of Transport	Integer	{1, 2, 3, 7, 9}	1=Ground, 2=Helicopter, 3=Fixed Wing, 7=N/A (only if [ACUTETRS]=0), 9=Unknown
Date/Time of Transport Team Departure for Referring Hospital					
T.32	T_TTDEPDATETIME	Date/Time of transport team departure for referring hospital	Char16	{01 - 12}/{01 - 31}/{2007}{space}{00}:{00}	16 alphanumeric characters using forward slashes for the date, a (space) between date and time, and a colon between hour and minutes=mm/dd/yyyy(space)hh:mm; 07/07/1907 07:07=N/A (only if [ACUTETRS]=0). NOTE: Microsoft Access file submitters MUST submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. While Text file submitters MUST submit all Date/Time variables as string variable values enclosed in quotes. In other words in a comma separated Ascii file, a Date/Time variable must be submitted as "12/12/2006(space)12:00" instead of 12/12/2006(space)12:00.
Date/Time of Arrival of Transport Team at Referring Hospital					
T.33	T_TTARRDATETIME	Date/Time of transport team arrival at referring hospital	Char16	{01 - 12}/{01 - 31}/{2007}{space}{00}:{00}	16 alphanumeric characters using forward slashes for the date, a (space) between date and time, and a colon between hour and minutes=mm/dd/yyyy(space)hh:mm; 07/07/1907 07:07=N/A (only if [ACUTETRS]=0). NOTE: Microsoft Access file submitters MUST submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. While Text file submitters MUST submit all Date/Time variables as string variable values enclosed in quotes. In other words in a comma separated Ascii file, a Date/Time variable must be submitted as "12/12/2006(space)12:00" instead of 12/12/2006(space)12:00.

Section III. 2007 EDS Specifications for the CPQCC Network Database					
NOTE: NEW & REVISED FIELDS FOR 2007 ARE HIGHLIGHTED IN YELLOW					
Tracking Fields (See Section I for Tracking Fields)					
Identification and Demographics					
2007 Item	Field Name	Description	Field Type	Range of Possible Values	Coding Rules
NOTE: If [ACUTETRS]=1 AND [T_BWGT] is not equal to 9999, then T.7 [T_BWGT] must = [BWGT] in the CPQCC Section.					
1	BWGT	Birth Weight (in grams)	Long Integer	{1 - 7000}	For infants born in 2007, birth weight can be 400 grams or less ONLY IF [GAWEEKS] is between 22 and 29 weeks
2	BHEADCIR	Head Circumference at Birth (in cm to nearest)	Double	{10.0 - 70.0, 999.9}	10.0 to 70.0, 999.9=Unknown
NOTE: If [ACUTETRS]=1, then T.8 [GAWEEKS, GADAYS] must = [GAWEEKS, GADAYS] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					
3a	GAWEEKS	Best Estimate of Gestational Age -- Weeks	Integer	{15 - 46, 99}	If [ACUTETRS]=1, then T.8 [GAWEEKS] must = [GAWEEKS] in CPQCC Section; 99=Unknown
3b	GADAYS	Best Estimate of Gestational Age -- Days	Integer	{0 - 6, 99}	If [ACUTETRS]=1, then T.8 [GADAYS] must = [GADAYS] in CPQCC Section; 99=Unknown
NOTE: If [ACUTETRS]=1, then T.6 [T_BDATETIME] must = [BDATE] in the CPQCC Section. Submit this variable twice.					
4	BDATE	Birth Date	Date	01/01/2007 - 12/31/2007	Date format mm/dd/yyyy
NOTE: If [ACUTETRS]=1, then T.9 [SEX] must = [SEX] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					
5	SEX	Sex of infant	Integer	{0, 1, 9}	If [ACUTETRS]=1, then T.9 [SEX] must = [SEX] in CPQCC Section; 0=Female, 1=Male, 9=Unknown
6	DEL DIE	Delivery Room Death	Integer	{0, 1}	0=No, 1=Yes
7a	LOCATE	Location of Birth	Integer	{0, 1}	0=Inborn; 1=Outborn. Always 0 if [DEL DIE]=1
7b	DAYADMISS	Day of Admission (for gt 1500 grams or outborn)	Integer	{1 - 28, 77}	77 if [LOCATE]=0; 1 to 28 if [LOCATE]=1
NOTE: If [ACUTETRS]=1, then T.28 [BIRTHLOCATION] must = [BIRTHLOCATION] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					
7c	BIRTHLOCATION	Hospital of Birth (for outborn infants)	Char6	{OSHPD ID number, 777777, 999999}	777777 if [BYEAR]<2007 or [LOCATE]=0; valid OSHPD ID number (see list); 999999=Unknown
8a	PDH	Previously discharged home (for outborn infants)	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A (if [DEL DIE] = 1 or [LOCATE]=0)
8b	READMIT	Infant Readmitted to your hospital (for outborn infants)	Integer	{0, 1, 7}	0=No (if patient was discharged home and never admitted to your NICU before), 1=Yes (if patient was discharged home and was in your center's NICU prior to this home discharge), 7=N/A (if [DEL DIE]=1 or [LOCATE]=0 or [PDH]=0)

Maternal History, Delivery Room Care, and Surfactant Use					
9	MAGE	Mother's Age at Infant's birth (Age last birthday)	Integer	{10 - 60, 99}	99=Unknown
10a	HISP	Is mother of Hispanic origin?	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
10b	NEWRACE	Maternal Race	Integer	{1, 3, 4, 5, 6, 99}	1=Black, 3=White, 4=Asian or Pacific Islander, 5=Native American, 6=Other identified race, 99=Unknown
11	PCARE	Prenatal Care	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
12	GROUPBSTREP	Group B Strep Positive	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A, 9=Unknown
NOTE: If [ACUTETRS]=1, then T.12a [ASTER] must = [ASTER] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					
13	ASTER	Antenatal steroids received prior to delivery	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
14	SPLABOR	Spontaneous labor. Did the mother go into labor on her own?	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
15a	MULT	Multiple Births or Gestation	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown; Note: at least one fetus must survive beyond 20 weeks
15b	NBIRTHS	Number of Infants Delivered	Integer	{2 - 10, 77, 99}	77 if [MULT]=0 or [BYEAR]<2007; 2 TO 10 if [MULT]=1; 77=N/A; 99=Unknown
15c	BIRTHORDER	Birth order for multiple births	Integer	{1-[NBIRTHS], 77, 99}	77 if [MULT]=0 or [BYEAR]<2007; 1 TO [NBIRTHS] if [MULT]=1 and [NBIRTHS]=77; 77=N/A; 99=Unknown
16	DELMOD	Mode of Delivery	Integer	{0, 1, 2, 9}	0=Cesarean Section; 1=Normal or Spontaneous Vaginal; 2=Operative Vaginal, 9=Unknown

Antenatal Conditions: events that may affect the pregnancy and/or delivery of the infant					
Maternal					
17	ANCMNONE	No maternal complications	Integer	{0, 1}	0=No, 1=Yes
17	ANCMHYP	Maternal: Hypertension	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCMUIINF	Maternal: Uterine Infection	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCMOINF	Maternal: Other Infection	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCMDIA	Maternal: Diabetes	Integer	{0,1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCMCES	Maternal: Previous Cesaean	Integer	{0,1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCMOTH	Maternal: Other	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCMDESC	Description of 'Other'	Char50		Up to 50 alphanumeric characters; ??=N/A
17	ANCMUNK	Unknown maternal complications	Integer	{0, 1}	0=No, 1=Yes
Fetal					
17	ANCFNONE	No fetal complications	Integer	{0, 1}	0=No, 1=Yes
17	ANCFIUGR	Fetal: IUGR	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCFDIS	Fetal: Distress	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCFANO	Fetal: Anomaly	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCFOTH	Fetal: Other	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCFDESC	Description of 'Other'	Char50		Up to 50 alphanumeric characters; ??=N/A
17	ANCFUNK	Unknown fetal complications	Integer	{0, 1}	0=No, 1=Yes

Obstetrical					
17	ANCONONE	No obstetrical complications	Integer	{0, 1}	0=No, 1=Yes
17	ANCOPREROM	Obstetrical: Premature ROM	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCOPROM	Obstetrical: Prolonged ROM	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCOMAL	Obstetrical: Malpresentation / Breech	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCOBLEED	Obstetrical: Bleeding / Abruptio / Previa	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCOOTH	Obstetrical: Other	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	ANCODESC	Description of 'Other'	Char50		Up to 50 alphanumeric characters; 77=N/A
17	ANCOUNK	Unknown obstetrical complications	Integer	{0, 1}	0=No, 1=Yes

Indication for Cesarean Delivery. What are the indications? All applicable indications may be recorded.

NOTE: These indications only apply if the birth was cesarean. For Vaginal Births all of these must be coded 7 = N/A

18	INDCESNA	Indication for Cesarean Delivery Not Applicable	Integer	{0, 1}	0=No (only if [DELMOD]=0), 1=Yes (only if [DELMOD]=1,2,9)
18	INDCESBR	Indication for Cesarean Delivery -- Malpresentation / Breech	Integer	{0, 1, 7, 9}	0=No (only if [DELMOD]=0), 1=Yes (only if [DELMOD]=0), 7=N/A (only if [DELMOD]=1 or 2), 9=Unknown (only if [DELMOD]=9)
18	INDCESMG	Indication for Cesarean Delivery -- Multiple Gestation	Integer	{0, 1, 7, 9}	0=Mo (only if [DELMOD]=0 and [MULT]=1,0), 1=Yes (only if [MULT]=1, [DELMOD]=0), 7=N/A (only if [DELMOD]=1 or 2), 9=Unknown (only if [DELMOD]=9)
18	INDCESFD	Indication for Cesarean Delivery -- Fetal Distress	Integer	{0, 1, 7, 9}	0=No (only if [DELMOD]=0), 1=Yes (only if [DELMOD]=0), 7=N/A (only if [DELMOD]=1 or 2), 9=Unknown (only if [DELMOD]=9)
18	INDCESER	Indication for Cesarean Delivery -- Elective	Integer	{0, 1, 7, 9}	0=No (only if [DELMOD]=0); 1=Yes (only if [DELMOD]=0); 7=N/A (only if [DELMOD]=1 or 2); 9=Unknown (only if [DELMOD]=9)
18	INDCESDY	Indication for Cesarean Delivery -- Dystocia/Failure to Progress	Integer	{0, 1, 7, 9}	0=No (only if [DELMOD]=0); 1=Yes (only if [DELMOD]=0), 7=N/A (only if [DELMOD]=1 or 2), 9=Unknown (only if [DELMOD]=9)
18	INDCESPP	Indication for Cesarean Delivery -- Placental Problems	Integer	{0, 1, 7, 9}	0=No (only if [DELMOD]=0), 1=Yes (only if [DELMOD]=0), 7=N/A (only if [DELMOD]=1 or 2), 9=Unknown (only if [DELMOD]=9)
18	INDCESHTN	Indication for Cesarean Delivery -- Hypertension	Integer	{0, 1, 7, 9}	0=No (only if [DELMOD]=0); 1=Yes (only if [DELMOD]=0), 7=N/A (only if [DELMOD]=1 or 2), 9=Unknown (only if [DELMOD]=9)
18	INDCESOTH	Indication for Cesarean Delivery -- Other	Integer	{0, 1, 7, 9}	0=No (only if [DELMOD]=0), 1=Yes (only if [DELMOD]=0), 7=N/A (only if [DELMOD]=1 or 2), 9=Unknown (only if [DELMOD]=9)
18	INDCESDESC	Indication for Cesarean Delivery -- Other Description	Char50		Up to 50 alphanumeric characters characters (only if [DELMOD]=0 AND [INDCESOTH]=1); blank if Not Applicable
18	INDCESUNK	Indication for Cesarean Delivery Unknown	Integer	{0, 1}	0=No, 1=Yes

19	AP1	Apgar score - 1 minute	Integer	{0 - 10, 99}	99=Unknown
19	AP5	Apgar score - 5 minute	Integer	{0-10, 99}	99=Unknown
19	AP10	Apgar score - 10 minute	Integer	{0 - 10, 77, 99}	77=Not Done; 99=Unknown
20a	DROX	Initial Resuscitation -- Oxygen	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
20b	DRCPPAP	Initial Resuscitation -- Nasal CPAP	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
20c	DRBM	Initial Resuscitation -- Bag/Mask	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
20d	DRET	Initial Resuscitation -- Endotracheal Tube	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
20e	DREP	Initial Resuscitation -- Epinephrine	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
20f	DRCC	Initial Resuscitation -- Cardiac Compression	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
NOTE: If [ACUTETRS]=1, then T.13a [DRSURF] must = [DRSURF] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					
21	DRSURF	Surfactant in the DR	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
21	SURFX	Surfactant given at any time	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
21	SURF1DHR	Surfactant Age at First Dose, Hours	Integer	{0 - 6665, 7777, 9999}	7777 if [SURFX] = 0; 9999 if [SURFX] = 9 or [SURF1DMIN] = 99; 9999 if Unknown
21	SURF1DMIN	Surfactant Age at First Dose, Minutes	Integer	{0 - 59, 77, 99}	77 if [SURFX] = 0; 99 IF [SURFX] = 9 OR [SURF1DHR] = 9999; 99 if Unknown

Post-Delivery Diagnoses and Interventions -- Respiratory					
22a	ATEMPM	Temperature Measured within One Hour of Admission to Your NICU	Integer	{0, 1, 9}	0, 1, 9 if [DELDIE]=0 and [BYEAR] >= 2007; 0=No, 1=Yes, 9=Unknown
22b	ATEMP	Temperature at Admission to Your NICU (in degrees centigrade to nearest 10th of a degree)	Double	{20.0 - 45.0, 777.7, 999.9}	777.7 if [DELDIE]=1 or [ATEMPM]=0 or [BYEAR] < 2007, 20.0 to 45.0, 999.9 if [DELDIE]=0 and [ATEMPM]=1 and [BYEAR] >= 2007; 777.7=N/A, 999.9=Unknown
23a	OXY	Post DR Respiratory Support -- Oxygen	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
23b	VENT	Post DR Respiratory Support -- VENT	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
23c	HFV	Post DR Respiratory Support -- HIFI	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
23d	HFNC	High Flow Nasal Cannula	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
23e	NIMV	Nasal IMV or SIMV	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
24a	CPAP	Post DR Respiratory Support -- CPAP of any	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown; Note that for VON DB, this field applies to oxygen EITHER in DR or after leaving the DR
24b	CPAPES	Nasal CPAP before ETT Ventilation	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (if [DELDIE]=1 or [CPAP]=0), 9=Unknown (always Unknown if [CPAP]=9)
25a	DURVENT	Duration of Assisted Ventilation (in your NICU)	Integer	{0, 1, 2, 9}	0=None, 1= <=4 Hours, 2= >4 Hours, 9=Unknown
25b	VENTDAYS	Days Ventilated (in your NICU)	Long Integer	{1-366 OR 367, 7777, 9999}	0 to 366 (367 for leap years), 7777=N/A (if [DURVENT]<>2) 9999=Unknown (always if [DURVENT]=9)
25b	VENTHOURS	Hours Ventilated in your NICU	Integer	{0-23, 77, 99}	0 to 23, 77=N/A (if [DURVENT]<>2), 99=Unknown (always if [DURVENT]=9). Hours should always be rounded up, i.e., 4 hours and 1 minute should be coded as 5 hours, etc.
26	DIE12	Did Infant Die within first 12 hours of entering your	Integer	{0, 1}	0=No, 1=Yes
27	RDS	Respiratory Distress Syndrome	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
28	PNTX	Pneumothorax	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
29	MECONIUM	Meconium Aspiration Syndrome	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
30	NITRICO	Inhaled Nitric Oxide	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
31	ECMO	ECMO	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
32a	POSTSTER	Postnatal Steroids	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
32b	POSTERCLD	Postnatal Steroids for Indication Chronic Lung	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [POSTER] = 0, or 7), 9=Unknown, 9 only if [POSTSTER]=9
32b	POSTEREX	Postnatal Steroids for Indication Extubation	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A (only if [POSTER] = 0, or 7)
32b	POSTERBP	Postnatal Steroids for Indication Hypotension	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A (only if [POSTER] = 0, or 7)
32b	POSTEROTH	Postnatal Steroids for Indication Other	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A (only if [POSTER] = 0, or 7)

33	NEWOX28	Supplemental Oxygen on Day 28	Integer	{0, 2, 3, 7, 9}	0=No, 2=Intermittent, 3=Continuous, 7=N/A (only if infant not in hospital on Day 28 or if [DELDIE]=1), 9=Unknown
34	OX36	Supplemental Oxygen at 36 Weeks (adjusted gestational age)	Integer	{0, 2, 3, 7, 9}	0=No, 2=Intermittent, 3=Continuous, 7=N/A (only if infant not in hospital at 36 weeks AGA or if [DELDIE]=1), 9=Unknown
35a	OXFINAL	Respiratory Support at Discharge -- Oxygen	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
35b	ACFINAL	Respiratory Support at Discharge -- Apnea or Cardio-Respiratory Monitor	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
35c	SUCFINAL	Respiratory Support at Discharge -- Mechanical Ventilation	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
35d	OTHFINAL	Respiratory Support at Discharge -- Other	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
35d	OTHFINALDESC	Description of Other Respiratory Support at Discharge	Char50		Up to 50 alphanumeric characters (only if [OTHFINAL]=1)
Post-Delivery Diagnoses and Interventions -- Infections					
36	EBSEPS	Sepsis -- Early Bacterial (on or before Day 3)	Integer	{0, 2, 3, 4, 9}	0=No, 2=Other, 3=GBS, 4 = e.Coli, 9=Unknown
36	EBSEPSDESC	If other, organism	Char50		Up to 50 alphanumeric characters (only if [EBSEPS]=2)
37a	LBPATH	Sepsis -- Late - Bacterial Pathogen	Integer	{0, 2, 3, 4, 7, 9}	0=No, 2=Other, 3=GBS, 4=e.Coli, 7=N/A, 9=Unknown (only if [DELDIE]=1)
37a	LBPATHDESC	If other, organism	Char50		Up to 50 alphanumeric characters (only if [LBPATH]=2)
37b	CNEGSTAPH	Sepsis -- Late - Coag Neg Staph	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1, 9=Unknown)
37c	FUNGAL	Sepsis -- Late - Fungal	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1, 9=Unknown)
38	VIRAL	Congenital Viral Infection	Integer	{0, 1, 9}	0=Negative culture, 1=Yes, 9=Unknown
38	VIRALDESC	Specify Viral Pathogen	Char50		Up to 50 alphanumeric; only specify pathogen if [VIRAL] = 1; else leave blank

39a	PDA	Patent Ductus Arteriosus	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
39b	INDOMETH	Indomethacin	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
39c	SRGLIG	Surgery: PDA Ligation	Integer	{0, 1, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1 OR [PDA]=0), 9=Unknown
40a	NEC	Necrotizing Enterocolitis	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
40b	SRGNEC	Surgery: NEC Surgery	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1 or [NEC]=0), 9=Unknown
41	GIPERF	Gastro-Intestinal Perforation	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
42a	EYEX	Retinal Exam	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown (always if [EYEX]=9)
42b	ISTAGE	Worst Stage of ROP	Integer	{0 - 4, 7, 9}	0 (no ROP) to 4; 7=N/A (only if [DELDIE]=1 or [EYEX] = 0); 9=Unknown (always if [EYEX]=9)
42c	SRGROP	Surgery: ROP	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1 or [EYEX]=0 or [ISTAGE]=0), 9=Unknown
43	SRGOTH	Other Surgery	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
43	SRGCD1	First Other Surgery Code	Char6	{Surgery Codes, 77, 99} (NOTE: New Surgery codes are in Appendix B)	77=if [SRGOTH] = 0 OR [BYEAR] < 2007; if [BYEAR] >= 2007: 99 IF [SRGOTH]=9; Surgery Code if [SRGOTH]=1; 77=N/A, 99=Unknown
43	SRGCD2	Second Other Surgery Code	Char6	{Surgery Codes, 77, 99} (NOTE: New Surgery codes are in Appendix B)	77=if [SRGOTH] = 0 OR [BYEAR] < 2007; if [BYEAR] >= 2007: 99 IF [SRGOTH]=9; Surgery Code if [SRGOTH]=1 and 2nd other surgery; 77=N/A, 99=Unknown
43	SRGCD3	Third Other Surgery Code	Char6	{Surgery Codes, 77, 99} (NOTE: New Surgery codes are in Appendix B)	77=if [SRGOTH] = 0 OR [BYEAR] < 2007; if [BYEAR] >= 2007: 99 IF [SRGOTH]=9; Surgery Code if [SRGOTH]=1 and 3rd other surgery; 77=N/A, 99=Unknown
43	SRGCD4	Fourth Other Surgery Code	Char6	{Surgery Codes, 77, 99} (NOTE: New Surgery codes are in Appendix B)	77=if [SRGOTH] = 0 OR [BYEAR] < 2007; if [BYEAR] >= 2007: 99 IF [SRGOTH]=9; Surgery Code if [SRGOTH]=1 and 4th other surgery; 77=N/A, 99=Unknown
43	SRGCD5	Fifth Other Surgery Code	Char6	{Surgery Codes, 77, 99} (NOTE: New Surgery codes are in Appendix B)	77=if [SRGOTH] = 0 OR [BYEAR] < 2007; if [BYEAR] >= 2007: 99 IF [SRGOTH]=9; Surgery Code if [SRGOTH]=1 and 5th other surgery; 77=N/A, 99=Unknown
43	SRGCD6	Sixth Other Surgery Code	Char6	{Surgery Codes, 77, 99} (NOTE: New Surgery codes are in Appendix B)	77=if [SRGOTH] = 0 OR [BYEAR] < 2007; if [BYEAR] >= 2007: 99 IF [SRGOTH]=9; Surgery Code if [SRGOTH]=1 and 6th other surgery; 77=N/A, 99=Unknown
43	SRGCD7	Seventh Other Surgery Code	Char6	{Surgery Codes, 77, 99} (NOTE: New Surgery codes are in Appendix B)	77=if [SRGOTH] = 0 OR [BYEAR] < 2007; if [BYEAR] >= 2007: 99 IF [SRGOTH]=9; Surgery Code if [SRGOTH]=1 and 7th other surgery; 77=N/A, 99=Unknown
43	SRGCD8	Eighth Other Surgery Code	Char6	{Surgery Codes, 77, 99} (NOTE: New Surgery codes are in Appendix B)	77=if [SRGOTH] = 0 OR [BYEAR] < 2007; if [BYEAR] >= 2007: 99 IF [SRGOTH]=9; Surgery Code if [SRGOTH]=1 and 8th other surgery; 77=N/A, 99=Unknown
43	SRGCD9	Ninth Other Surgery Code	Char6	{Surgery Codes, 77, 99} (NOTE: New Surgery codes are in Appendix B)	77=if [SRGOTH] = 0 OR [BYEAR] < 2007; if [BYEAR] >= 2007: 99 IF [SRGOTH]=9; Surgery Code if [SRGOTH]=1 and 9th other surgery; 77=N/A, 99=Unknown
43	SRGCD10	Tenth Other Surgery Code	Char6	{Surgery Codes, 77, 99} (NOTE: New Surgery codes are in Appendix B)	77=if [SRGOTH] = 0 OR [BYEAR] < 2007; if [BYEAR] >= 2007: 99 IF [SRGOTH]=9; Surgery Code if [SRGOTH]=1 and 10th other surgery; 77=N/A, 99=Unknown
43	SRGOTHDESC	Other Surgery Description	Char255		77 if [SRGOTH] = 0 or [BYEAR] < 2007 or if the surgery code(s) in Appendix do not require a description; if [BYEAR] >= 2007: 99 IF [SRGOTH]=9; description of surgical procedure(s) if [SRGOTH]=1 and code for type of surgery in Appendix requires a description. 77=N/A, 99=Unknown
44	SURGCOMP	Complications of Surgery	Integer	{0, 1, 7, 9}	See Manual for list of qualifying complications. 0=No, 1=Yes, 7=N/A (only if [DELDIE]=1 or all surgeries are checked as No), 9=Unknown
44	SURGCOMPDESC	Describe surgical complications	Char50		Up to 50 alphanumeric characters (only describe if [SURGCOMP]=1)

Post-Delivery Diagnoses and Interventions -- Neurological					
45a	IMAGE28	Imaging done on or before Day 28 and during this admission	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
45b	IGRADE	Worst Grade of Hemorrhage	Integer	{0-4, 7, 9}	0 (no peri IVH) to 4, 7=N/A (only if [DELDIE]=1 or if [IMAGE28]=0,7), 9=Unknown (always if [IMAGE28]=9)
45c	SHUNT	Shunt placed for bleed	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1 or if [IGRADE]=0,7), 9=unknown (always if [IMAGE28]=9 OR [IGRADE]=9)
45d	OTHHHEM	Other Intracranial hemorrhage present	Integer	{0,1,7,9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1 or if [IMAGE28]=0,7), 9=Unknown
45d	OTHHHEMDESC	Other Intracranial hemorrhage Description	Char50		Up to 50 alphanumeric characters (only if [OTHHHEM]=1)
46a	PVLIMAG	Cystic PVL Imaging performed during this	Integer	{0, 1, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1); 9=Unknown. Should always be 1 if [IMAGE28] is 1
46b	PVL	Cystic Periventricular Leukomalacia	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1 or if PVLIMAG=0), 9=Unknown
47	SEIZURE	Seizures, EEG or Clinical	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
48	HIE	Hypoxic-Ischemic Encephalopathy	Integer	{0, 3, 4, 5, 7, 9}	0=No; 3=Mild, 4=Moderate, 5=Severe, 7=N/A (only if [DELDIE]=1 or if gestational age at birth < 36 weeks), 9=Unknown
Post-Delivery Diagnoses and Interventions -- Congenital Malformations					
49	CMAL	Major Birth Defect	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
NOTE: If [ACUTETRS]=1, then T.10b [T_BDCD1 to T_BDCD5] must = [BDCD1 to BDCD5] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section. For each record, there is a limit of only 5 birth defect codes regardless if prenatally or post-natally diagnosed.					
49	BDCD1	Birth Defect Code 1	Integer	Birth Defects Table, 7777, 9999	7777=N/A (only if [T_CMAL]=0 AND [CMAL]=0), 9999=Unknown
	BDCD1FLAG	Birth Defect Time of Diagnosis	Integer	{1, 2, 7, 9}	1=Birth Defect Prenatal Diagnosis, 2=Birth Defect Post-natal Diagnosis, 7=N/A (only if [T_CMAL]=0 AND [CMAL]=0) OR (if [BDCD1]=7777), 9=Unknown
49	BDCD2	Birth Defect Code 2	Integer	Birth Defects Table, 7777, 9999	7777=N/A (only if [T_CMAL]=0 AND [CMAL]=0), 9999=Unknown
	BDCD2FLAG	Birth Defect Time of Diagnosis	Integer	{1, 2, 7, 9}	1=Birth Defect Prenatal Diagnosis, 2=Birth Defect Post-natal Diagnosis, 7=N/A (only if [T_CMAL]=0 AND [CMAL]=0) OR (if x>1 for [BDCDx]=7777), 9=Unknown
49	BDCD3	Birth Defect Code 3	Integer	Birth Defects Table, 7777, 9999	7777=N/A (only if [T_CMAL]=0 AND [CMAL]=0), 9999=Unknown
	BDCD3FLAG	Birth Defect Time of Diagnosis	Integer	{1, 2, 7, 9}	1=Birth Defect Prenatal Diagnosis, 2=Birth Defect Post-natal Diagnosis, 7=N/A (only if [T_CMAL]=0 AND [CMAL]=0) OR (if x>1 for [BDCDx]=7777), 9=Unknown
49	BDCD4	Birth Defect Code 4	Integer	Birth Defects Table, 7777, 9999	7777=N/A (only if [T_CMAL]=0 AND [CMAL]=0), 9999=Unknown
	BDCD4FLAG	Birth Defect Time of Diagnosis	Integer	{1, 2, 7, 9}	1=Birth Defect Prenatal Diagnosis, 2=Birth Defect Post-natal Diagnosis, 7=N/A (only if [T_CMAL]=0 AND [CMAL]=0) OR (if x>1 for [BDCDx]=7777), 9=Unknown
49	BDCD5	Birth Defect Code 5	Integer	Birth Defects Table, 7777, 9999	7777=N/A (only if [T_CMAL]=0 AND [CMAL]=0), 9999=Unknown
	BDCD5FLAG	Birth Defect Time of Diagnosis	Integer	{1, 2, 7, 9}	1=Birth Defect Prenatal Diagnosis, 2=Birth Defect Post-natal Diagnosis, 7=N/A (only if [T_CMAL]=0 AND [CMAL]=0) OR (if x>1 for [BDCDx]=7777), 9=Unknown
NOTE: If [ACUTETRS]=1, then T.10b [T_BDEFECT] must = [BDEFECT] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					
49	BDEFECT	Birth Defect Description	Char255		NOTE: This variable applies to any description regardless if diagnosed prenatally or post-natally. Up to 255 alphanumeric characters (necessary if codes 100, 150, 200, 300, 400, 504, 601, 605, 800, 900 were filled in for one or more of the 5 codes); 77=N/A (only if [T_CMAL]=0 AND [CMAL]=0)

Post-Delivery Diagnoses and Interventions -- Hyperbilirubinemia					
NOTE: Answer only for Outborn Infants Previously Discharged Home [PDH]=1					
50	BILILEVEL	TSB Level (15 to 45)	Integer	{1, 2, 3, 7, 9}	1=less than 25, 2=25 to less than 30, 3=greater than or equal to 30, 7=N/A (only if [DELDIE]=1 or [LOCATE]=0 or [PDH]=0), 9=Unknown
51	EXCHANGE	Exchange Transfusion	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1 or [LOCATE]=0 or [PDH]=0), 999=Unknown
52	LASTHOSPITAL	Last hospital prior to discharge	Char6	{OSHPD ID number, 777777, 999999}	Valid OSHPD ID number (see list), 777777=N/A (only if [DELDIE]=1 or [LOCATE]=0 or [PDH]=0), 999=Unknown
Initial Disposition					
53	ENTFEED	Enteral Feeding at Discharge	Integer	{0, 1, 2, 3, 9}	0=None, 1=Human Milk Only, 2=Formula Only, 3=Human Milk Fortified with Formula, 9=Unknown
54	FDISP	Initial Disposition from your hospital	Integer	{1, 2, 3, 5, 9}	1=Home, 2=Transported, 3=Died, 5=Still hospitalized as of first birthday, 9=Unknown
55	DWGT	Initial Disposition Weight (in grams)	Long Integer	{201-66665, 99999}	201-66665, 99999=Unknown
56	HEADCIRC	Head circumference at Initial Disposition (in cm)	Double	{10.0-70.0, 999.9}	10.0 TO 70.0, 999.9=Unknown
57	LOS1	Initial Length of Stay	Integer	{1-366 or 367, 999}	367 for leap years, 999=Unknown
Transfer					
58	TRANSCODE	Reason for Transport	Integer	{1, 2, 3, 4, 5, 6, 7, 9}	1=Growth/Discharge planning, 2=Medical/Diagnostic services, 3=Surgery, 4=Chronic care, 5=Other Reason, 6=Insurance, 7=N/A (only if [DELDIE]=1 or if [FDISP]<>2), 9=Unknown (always if [FDISP]=9)
59	XFER_OUT	Transferred to a CPQCC Center	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (if [FDISP] in (1 3 5 7)), 9=Unknown (always if [FDISP]=9)
60	F2DISP	Post-Transfer Disposition	Integer	{1, 2, 3, 4, 5, 7, 9}	1=Home, 2=Transferred again to another hospital, 3=Died, 4=Readmitted to your hospital, 5=Still hospitalized as of first birthday, 7=N/A (only if [DELDIE]=1 or if [FDISP] IN (1, 3, 5)); 9=Unknown (always if [FDISP]=9)
61	F3WGT	Weight at Disposition after Re-Admission	Long Integer	{201--66665, 77777, 99999}	201-66665 (if [F3DISP] in 1,2,3,5,9), 77777=N/A (if [F3DISP]=7), 99999=Unknown (if [F2DISP]=9 or [FDISP]=9)
62	F3DISP	Disposition after Re-Admission	Integer	{1, 2, 3, 5, 7, 9}	1=Home, 2=Transferred again to another hospital, 3=Died, 5=Still hospitalized as of first birthday, 7=N/A (only if [DELDIE]=1 or if [F2DISP] IN (1, 2, 3, 5, 7)), 9=Unknown (always if [F2DISP]=9 OR [FDISP]=9)
63	UDISP	Ultimate Disposition of Infant	Integer	{1, 3, 5, 7, 9}	1=Home, 3=Died, 5=Still hospitalized as of first birthday, 7=N/A (only if [DELDIE]=1 or if [F2DISP]=(1, 3, 5, 7) or [F3DISP]=(1, 3, 5); 9 if [F2DISP]=9 OR [F3DISP]=9 or [FDISP]=9; 1,3,5,9 IF [F2DISP]=2 OR [F3DISP]=2)
64	LOSTOT	Total Length of Stay	Integer	{1-366 or 367,777, 999}	367 for leap years, 777=N/A (if [DELDIE]=1 or [FDISP] IN (1, 3, 5)), 999=Unknown (always if [FDISP]=9)