



CPQCC Network Database 2009 Member Instructions for Electronic Data Submission

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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 2009 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 2009. 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 2009 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 2009, 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 2009 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 2009, 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 E 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 2009, 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 “12/12/2009{space}12:00” instead of 12/12/2009{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 2009 EDS Specifications for the combined CPQCC Network – CPeTS Database lists all of the fields required for electronic submitted of data beginning in 2009. The table also specifies the ranges and coding rules for each field. (Refer to Appendix E. 2009 EDS Specifications).

Submission of Date/Time Variables

Microsoft Access.

NOTE: For 2009, 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 E for details.

Text Files.

NOTE: For 2009, Text file submitters **MUST** submit all Date/Time variables as string variable values enclosed in double quotes. In other words in a comma separated Ascii file, a date variable must be submitted as "12/12/2009{space}12:00" instead of 12/12/2009{space}12:00.

IV. Summary of EDS Procedures for 2009

- A. Data Center Procedures.** CPQCC will adhere to rigid specifications regarding file names, file types, file contents, and file submission procedures in 2009. 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 2009.

- B. How to submit EDS files for infants born in 2009.** Please send data files for infants born on or after January 1, 2009 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 2009 SHOULD NOT be submitted in the same file for any records of infants born BEFORE 2009, otherwise these files will be rejected.

- C. How to submit EDS files for infants born in 2008.** Records for infants born in 2008 MUST be submitted or updated in their original format in 2008. However, the files must comply with the 2008 All Baby EDS file specifications as described in the 2008 EDS Instructions. Send any new records or updates to records for infants born in 2008 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 2007.** Records for infants born in 2007 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 2007 EDS records, otherwise files will be rejected.

V. Summary of Changes to Data Elements and Procedures for 2009

- A. Combined CPQCC Network – California Perinatal Transport System (CPeTS) Database.** In 2007, CPQCC began managing the CPeTS Database. The 2009 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 2009 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 2009 MUST sequentially follow the last file number that was submitted in 2008. For example if the last file number submitted in 2008 was 999 then the first file number submitted for 2009 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 2009, 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: 2009 Starting ID Number. In 2009 all CPQCC members are advised NOT to skip 10 IDs between submission years UNLESS the user has not yet closed out for 2008. For example, if a user is still submitting IDs for infants born in 2008 AND is also submitting new IDs for infants born in 2009, 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 2008 was 490, then the 2009 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 2009

For Section II of the EDS specifications, refer to the CPeTS Manual of Definitions for Infants Born in 2009 for more specific data collection instructions.

For Section III of the EDS specifications, refer to the CPQCC Manual of Definitions for Infants Born in 2009 for more specific data collection instructions.

1. **Item Renumbering for 2009.**

- a. For the 2009 systems upgrades, we re-structured and re-numbered the CPeTS Acute Inter-facility on-line form and CPeTS paper core form. We will retain the C-code numbering. We have discontinued the T-code numbering used in 2007 & 2008.

- b. **Item C.26a Mean Airway Pressure (MAP) at Referral, at Initial Evaluation, and NICU Admission variables will be removed** from the CPeTS Core Form as well as the on-line form.

- c. **Item C.26b Inspired Oxygen Concentration (FiO2) at Referral, at Initial Evaluation, and at NICU Admission will be renumbered as C.26.**

- d. **Item C.26c Arterial Oxygen (PAO2) at Referral, at Initial**

Evaluation, and at NICU Admission will be removed from the CPeTS Core Form as well as the on-line form.

e. Item C.30 Blood Glucose at Referral, at Initial Evaluation, and at NICU Admission variable will be removed from the CPeTS Core Form as well as the on-line form.

f. Item C.31 Referring Hospital will be renumbered from Item C.31 to Item C.30.

g. Item C.32a Previous Transfer will be renumbered from Item C.32a to Item C.31a.

h. Item C.32b FROM will be renumbered from Item C.32b to Item C.31b.

i. Item C.32b Location of Birth will be renumbered from Item C.32b to Item C.32.

j. Item C.34 Transport Team On-Site Leader will be renumbered from Item C.34 to Item C.33.

k. Item C.35a Team Baser will be renumbered from Item C.35a to Item C.34a.

l. Item C.35b Contract Services used will be renumbered from C.35b to Item C.34b.

m. Item C.36 Mode of Transport will be renumbered from Item C.36 to Item C.35.

n. Item C.36 User Comment will be renumbered from Item C.36 to Item C.35

2. Coding Rules

a. We have clarified the Coding Rules in the 2009 EDS Specifications for (Item C.26) Inspired Oxygen Concentration (FiO2) at Referral, at Initial Evaluation, and at NICU Admission as follows: T_FIO21: 777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS1]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown; T_FIO22: 777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS2]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown; T_FIO23: 777=N/A (only if [ACUTETRS]=0) OR

(only if [T_RESPSTATUS3]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown.

- b. For Admission History, Previously Discharged Home (for Outborn infants) (**Item 8a. PDH**), we have clarified that an infant that was previously discharged home (PDH=1) and not hospitalized at 36 weeks AGA (Item 3a. GAWEEKS, Item 3b. GADAYS) should be coded as Not Applicable. The Coding Rules in the EDS Specifications have been updated to read: 0=No, 1=Yes, 7=N/A {if [DELDIE] = 1 or [LOCATE]=0 or ([PDH] = 1 and not hospitalized at 36 weeks AGA)}.

In 2009, CPQCC has improved the assignment of Quality Metrics to the NICU of Occurrence. The changes are detailed in Appendix A. Revisions to the coding rules will be implemented to better track where an event occurred for the following conditions:

- c. Inhaled Nitric Oxide (**Item 30. NITRICO** coding **11=Yes Here, 12=Yes Elsewhere, and 13=Here and Elsewhere**).
- d. Surgical Complication (**Item 44. SURGCOMP** coding **11=Yes Here, Yes Elsewhere, 13=Here and Elsewhere**)
- e. Surgical Complication Description (**Item 44. SURGCOMPDESC** coding added **13 Here and Elsewhere**).
- f. Reason for Transfer (**Item 59. TRANSCODE**) coding has changed, 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 or 9), 9=Unknown (**always if [FDISP]=9**)
- g. Select the Hospital the infant was transferred from (**Item 60. XFERLOCATION**) coding has changed, Valid OSHPD ID number (see list); 777777=N/A (only if [DELDIE]=1 or [FDISP]< > 2 or 9), 9=Unknown (**always if [FDISP]=9**)

3. Discontinued Fields. (There are no fields that are discontinued for 2009)

4. Revised Fields.

- 1. In 2009, the coding rules for Inhaled Nitric Oxide (**Item 30. NITRICO**) will be revised to (**11=Yes Here, 12=Yes Elsewhere, and 13=Here and Elsewhere**) in order to better track where the event occurred.

2. In 2009, the coding rules for ECMO (**Item 31. ECMO**) will be revised to (**11=Yes Here, 12=Yes Elsewhere, and 13=Yes Here and Elsewhere**) in order to better track where the event occurred.
3. In 2009, the coding rules for Gastro-Intestinal Perforation (**Item 41. GIPERF**) will be revised to (**11=Yes Here, 12=Yes Elsewhere, and 13=Here and Elsewhere**) in order to better track where the event occurred.
4. In 2009, the coding rules for Necrotizing enterocolitis (**Item 40a. NEC**) will be revised to (0=No, 7=N/A, 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, **13=Yes Here AND Elsewhere**) in order to better track the where the event occurred.
5. In 2009, the coding rules for Surgical Complications (**Item 44. SURGCOMP**) will be revised to (**11=Yes Here, 12=Yes Elsewhere, and 13=Here and Elsewhere**) in order to better track where the event occurred.
6. In 2009, Surgical Complication Description (**Item 44. SURGCOMPDESC**) revised instructions will be as follows: If there were multiple complications at multiple locations (code **13=Yes Here and Elsewhere**), explain in the description field where the complication occurred. For example, "Complication A (Here), Complication B (Elsewhere)".
7. The definition of Reason for Transfer (**Item 58. TRANSCODE**) has been changed for infants born in 2009 to add ECMO as a reason for transfer. Revised coding rules will be as follows: **0=ECMO**, 1=Growth/Discharge Planning, 2=Medical/Diagnostic Services, 3=Surgery, 4=Chronic Care, 5=Other, 6=Insurance, 7=N/A, 9=Unknown.

5. New Fields and Field Descriptions.

1. A new item and **Periventricular-Intraventricular Hemorrhage Where first occurred (Item 45c. PIHHEMLOC)** has been added to the VON and CPQCC datasets. This is a new item in the 2009 CPQCC dataset. It will be located in the Post Delivery and Intervention section: 45a) Image Done, 45b) Worst Grade Hemorrhage, **45c) Periventricular-Intraventricular Hemorrhage Where first occurred**, 45d) Shunt, 45e) Other Intracranial Hemorrhage Present, 45e) Other Intracranial Hemorrhage Description.

- a. Shunt is renumbered as Item 45d in 2009. Previously Item 45c.
- b. Other Intracranial Hemorrhage Present is renumbered as Item 45e in 2009. Previously Item 45d.
- c. Other Intracranial Hemorrhage Description is renumbered as Item 45e in 2009. Previously Item 45d.

E. 2009 Acute Transport Records.

NOTE: Data definitions developed by CPQCC are consistent with the CPeTS definitions. Please use the 2009 CPeTS Manual of Operations for instructions in completing the 2009 Acute Transport data items.

1. Selection Criteria. An infant is eligible for inclusion in the 2009 CPeTS database if:
 - a. The infant is an acute transport-in from one in-patient facility to another.AND
 - b. The infant fulfills the CPQCC selection criteria as specified in the next section.

F. 2009 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 2009 CPQCC Manual of Operations for instructions in completing the 2009 Admission/Discharge data items. Also, please note that for 2009, all data must be recorded using the new 2009 CPQCC EDS Specifications. Any EDS specifications released by VON or CPQCC before 2009 are not compatible with the 2009 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 2009 CPQCC Database if **any** of the following three conditions apply:
 - a. Any infant who is born at your hospital and whose birth weight is between 401 and 1500 grams OR whose gestational age is between 22 weeks 0 days and 29 weeks 6 days (inclusive) is eligible, regardless of where in your hospital the infant receives care.

- b. Any outborn infant who is admitted to any location in your hospital within 28 days of birth, without first having gone home, and whose birth weight is between 401 and 1500 grams OR whose gestational age is between 22 weeks 0 days and 29 weeks 6 days (inclusive) is eligible, regardless of where in your hospital the infant receives care.
 - c. The infant is born or admitted to your hospital within 28 days of birth, with 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 hospital by Day 28 for Total Serum Bilirubin of \Rightarrow 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 2009, which should be used on all infants that are eligible for inclusion in the 2009 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 2009 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 2009.

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 2009.

- G. 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.

- H. 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 2009

- I. **Introduction.** This Appendix describes the changes in procedures or instructions for 2009 electronic data submissions, as compared to 2008.
- II. **CPQCC Network Database Eligibility.** We would like to encourage our members to utilize the on-line 2009 CCS Supplemental Forms as an added data validation tool. Completing the on-line form immediately after adding a record in the CPQCC database allows for real-time comparison to your CPQCC data.

NOTE: We are reiterating the eligibility rules for the Small Babies (401-1500 grams or 22 0/7 to 29 6/7 weeks gestation) for both the CPQCC and VON databases. It is as follows:

1. Any infant who is born at your hospital and whose birth weight is between 401 and 1500 grams OR whose gestational age is between 22 weeks 0 days and 29 weeks 6 days (inclusive) is eligible, regardless of where in your hospital the infant receives care.
2. Any outborn infant who is admitted to any location in your hospital within 28 days of birth, without first having gone home, and whose birth weight is between 401 and 1500 grams OR whose gestational age is between 22 weeks 0 days and 29 weeks 6 days (inclusive) is eligible, regardless of where in your hospital the infant receives care.

In summary, any Small Baby infant is automatically eligible into the CPQCC database. The infant does NOT have to be admitted to the NICU. In the CCS Supplemental Form, the Total Live Births in your Center (Table A) for birth weight categories 501-1500 grams MUST equal your CCS Inborn NICU Admissions (Table B data entered in cells) and your CPQCC submissions (Table B data displayed in green font directly below each cell).

- III. **Combined CPQCC Network – CPeTS Database Record Structure.**
 - A. **Combined CPQCC Network – CPeTS Database.** Since 2007, CPQCC started managing the CPeTS Database. The 2009 EDS file is divided into three sections: 1) ID section, 2) CPeTS section, and 3) CPQCC section.

- B. Acute Transfer-In Eligibility (ACUTETRS).** Since 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.

IV. New and Revised Items to the CPeTS Transport Form

- A.** The Following items have been added for 2009: (There are no new items added to the CPeTS Transport Form)
- B.** The following items have been revised for 2009:
- 1.** A new instruction has been added for Temperature (20 to 45°C or 68 to 113°F) at Referral, at Initial Evaluation, and NICU Admission (**Item C.21 T_TEMP1, T_TEMP2, T_TEMP2**), if the infant was undergoing intentional body/head cooling for therapeutic purposes, enter 20°C/68°F.
 - 2.** **Item C.26a Mean Airway Pressure (MAP) at Referral, at Initial Evaluation, and NICU Admission variables will be removed** from the CPeTS Core Form as well as the on-line form.
 - 3.** **Item C.26b Inspired Oxygen Concentration (FiO2) at Referral, at Initial Evaluation, and at NICU Admission will be renumbered as C.26.**
 - 4.** **Item C.26c Arterial Oxygen (PAO2) at Referral, at Initial Evaluation, and at NICU Admission will be removed from the CPeTS Core Form as well as the on-line form.**
 - 5.** **Item C.30 Blood Glucose at Referral, at Initial Evaluation, and at NICU Admission variable will be removed** from the CPeTS Core Form as well as the on-line form.
 - 6.** **Item C.31 Referring Hospital will be renumbered from Item C.31 to Item C.30.**
 - 7.** **Item C.32a Previous Transfer will be renumbered from Item C.32a to Item C.31a and C.31b.**

8. **Item C.32b Location of Birth will be renumbered from Item C.32b to Item C.32.**
9. **Item C.34 Transport Team On-Site Leader will be renumbered from Item C.34 to Item C.33.**
10. **Item C.35a Team Baser will be renumbered from Item C.35a to Item C.34a.**
11. **Item C.35b Contract Services used will be renumbered from Item C.35b to Item C.34b.**
12. **Item C.36 Mode of Transport will be renumbered from Item C.36 to Item C.35.**
13. **Item C.36 User Comment will be renumbered from Item C.36 to Item C.35.**

V. New and Revised Items to the CPQCC Admission/Discharge Form

- A. The CPQCC Data System builds upon Vermont Oxford Network's (VON) neonatal system for very low birth weight babies (VLBW). As a result of recent changes made by VON to their dataset, the following new data items have been added for infants born in 2009:

1. For Admission History, Previously Discharged Home (for Outborn infants) (**Item 8a. PDH**), we have clarified that an infant that was previously discharged home (PDH=1) and not hospitalized at 36 weeks AGA (Item 3a. GAWEEKS, Item 3b. GADAYS) should be coded as Not Applicable. The Coding Rules in the EDS Specifications have been updated to read: 0=No, 1=Yes, 7=N/A {if [DELDIE] = 1 or [LOCATE]=0 or ([PDH] = 1 and not hospitalized at 36 weeks AGA)}.
2. A new instruction has been added for Temperature (20 to 45°C or 68 to 113°F) at Admission to your NICU (**Item 22b. ATEMP**), if the infant was undergoing intentional body/head cooling for therapeutic purposes, enter 20°C/68°F.
3. In 2009, the coding rules for Inhaled Nitric Oxide (**Item 30. NITRICO**) will be revised to (11=Yes Here, 12=Yes Elsewhere, and 13=Here and Elsewhere) in order to

better track where the event occurred.

4. In 2009, the coding rules for ECMO (**Item 31. ECMO**) will be revised to (**11=Yes Here, 12=Yes Elsewhere, and 13=Here and Elsewhere**) in order to better track where the event occurred.
5. In 2009, the coding rules for Gastro-Intestinal Perforation (**Item 41. GIPERF**) will be revised to (**11=Yes Here, 12=Yes Elsewhere, and 13=Here and Elsewhere**) in order to better track where the event occurred.
6. In 2009, the coding rules for Necrotizing enterocolitis (**Item 40a. NEC**) will be revised to (0=No, 7=N/A, 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, **13=Yes Here AND Elsewhere**) in order to better track the where the event occurred.
7. In 2009, the coding rules for Surgical Complications (**Item 44. SURGCOMP**) will be revised to (**11=Yes Here, 12=Yes Elsewhere, and 13=Here and Elsewhere**) in order to better track where the event occurred.
8. Surgical Complications Descriptions (**Item 44. SURGCOMPDESC**) revised instructions will be as follows: If there were multiple complications at multiple locations (**code 13=Here and Elsewhere**), explain in the description field where the complication occurred. For example "Complication A (Here), Complication B (Elsewhere)".
9. A new item and **Periventricular-Intraventricular Hemorrhage Where first occurred (Item 45c. PIHHEMLOC)** has been added to the VON and CPQCC datasets. This is a new item in the 2009 CPQCC dataset. It will be located in the Post Delivery and Intervention section: 45a) Image Done, 45b) Worst Grade Hemorrhage, **45c) Periventricular-Intraventricular Hemorrhage Where first occurred**, 45c) Worst Grade Hemorrhage, 45d) Shunt, 45e) Other Intracranial Hemorrhage Present, 45e) Other Intracranial Hemorrhage Description.
10. Shunt is renumbered as Item 45d in 2009. Previously Item 45c.
11. Other Intracranial Hemorrhage Present is renumbered as

Item 45e in 2009. Previously Item 45d.

12. Other Intracranial Hemorrhage Description is renumbered as Item 45e in 2009. Previously Item 45d.

13. The definition of Reason for Transfer (**Item 58. TRANSCODE**) has been changed for infants born in 2009 to add ECMO as a reason for transfer. Revised coding rules will be as follows: **0=ECMO**, 1=Growth/Discharge Planning, 2=Medical/Diagnostic Services, 3=Surgery, 4=Chronic Care, 5=Other, 6=Insurance, 7=N/A, 9=Unknown

Appendix B

Bacterial Pathogens, Infants Born in 2009

1. *Achromobacter* species [including *Achromobacter xylosoxidans* (also known as *Alcaligenes xylosoxidans*) and others]
2. *Acinetobacter* species
3. *Aeromonas* species
4. *Alcaligenes* species [*Alcaligenes xylosoxidans* and others]
5. *Bacteroides* species
6. *Burkholderia* species [*Burkholderia capeczia* and others]
7. *Campylobacter* species [*Campylobacter fetus*, *C. jejuni* and others]
8. *Chryseobacterium* species
9. *Citrobacter* species [*Citrobacter diversus*, *C. freundii*, *C. koseri* and others]
10. *Clostridium* species
11. *Enterobacter* species [*Enterobacter aerogenes*, *E. cloacae*, and others]
12. *Enterococcus* species [*Enterococcus faecalis* (also known as *Streptococcus faecalis*), *E. faecium*, and other *Enterococcus* species]
13. *Escherichia coli*
14. *Flavobacterium* species
15. *Haemophilus* species [*Haemophilus influenzae* and others]
16. *Klebsiella* species [*Klebsiella oxytoca*, *K. pneumoniae* and others]
17. *Listeria monocytogenes*
18. *Moraxella* species [*Moraxella catarrhalis* (also known as *Branhamella catarrhalis*) and others]
19. *Neisseria* species [*Neisseria meningitidis*, *N. gonorrhoeae* and others]
20. *Pasteurella* species
21. *Prevotella* species
22. *Proteus* species [*Proteus mirabilis*, *P. vulgaris* and others]
23. *Providencia* species [*Providencia rettgeri*, and others]
24. *Pseudomonas* species [*Pseudomonas aeruginosa* and others]
25. *Ralstonia* species
26. *Salmonella* species
27. *Serratia* species [*Serratia liquefaciens*, *S. marcescens* and others]
28. *Staphylococcus coagulase positive* [*aureus*]
29. *Stenotrophomonas maltophilia*
30. *Streptococcus* species [including *Streptococcus* Group A, *Streptococcus* Group B, *Streptococcus* Group D, *Streptococcus pneumoniae*, *Streptococcus Milleri* and others]

Appendix C Surgery Codes for Item 43, Infants Born in 2009

Head and Neck Surgery

- 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 in Item 43. 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
- S108 Mandibular (jaw) distraction
- S100 Other head and neck surgery requiring general or spinal Anesthesia
(Description required)

Thoracic Surgery

- 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)
- S212 Surgery for Congenital Cystic Adenomatoid Malformation of the Lung
- S213 Lung transplant
- S200 Other thoracic surgery requiring general or spinal anesthesia
(Description required)

Abdominal and Gastro-Intestinal Surgery

- S301 Rectal biopsy with or without anoscopy
- S302 Laparoscopy (diagnostic, with/without biopsy)
Note: If the infant has NEC surgery, record all applicable codes in Item 43. Other Surgery even if Item 40b. NEC surgery, has already been checked, "Yes".
- 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 S 333).
- 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 bowel)
- 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.)
- S334 Anoplasty
- S335 Kasai procedure
- S336 Open liver biopsy
- S300 Other abdominal surgery requiring general or spinal anesthesia
(Description required)

Genito-Urinary Surgery

- 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)
- S416 Pyeloplasty
- S417 Renal transplant
- S400 Other genitourinary surgery requiring general or spinal anesthesia
(Description required)

Open Heart or Vascular 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
- S505 Heart transplant
- 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 Surgery

- S700 Skin or soft tissue surgery requiring general or spinal anesthesia
(Description required)

Musculo-Skeletal System Surgery

- S800 Other musculoskeletal surgery requiring general or spinal anesthesia
(Description required)

Central Nervous System Surgery

- 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 anesthesia
(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)

Conjoined Twins Surgery

- S1101 Separation of conjoined twins

Appendix D

Birth Defect Codes for Item 49, Infants Born in 2009

The following Birth Defect Codes require a detailed description in the space provided for Item 49 on the Admission / Discharge Form:

Code 150 - Other Central Nervous System Defects
Code 200 - Other Cardiac Defects
Code 300 - Other Gastro-Intestinal Defects
Code 400 - Other Genito-Urinary Defects
Code 504 - Other Chromosomal Anomaly
Code 601 - Skeletal Dysplasia
Code 605 - Inborn Error of Metabolism
Code 800 - Other Pulmonary Defects
Code 900 - Other Vascular or Lymphatic Defects

The following conditions should NOT be coded as Major Birth Defects:

1. Cleft Lip without Cleft Palate
2. Club Feet
3. Congenital Dislocation of the Hips
4. Extreme Prematurity
5. Fetal Alcohol Syndrome
6. Hypospadias
7. Hypothyroidism
8. Intrauterine Growth Retardation
9. Intrauterine Infection
10. Limb Abnormalities
11. Patent Ductus Arteriosus
12. Persistent Pulmonary Hypertension (PPHN)
13. Polydactyly
14. Pulmonary Hypoplasia (use code 401 for bilateral renal agenesis or 604 for oligohydramnios sequence, if applicable)
15. Small Size for Gestational Age
16. Syndactyly

Other Lethal or Life Threatening Birth Defects

- 100 Other lethal or life threatening birth defects, which are not listed below (for instructions, see definition of Item 49 in the 2009 Manual of Operations).

Central Nervous System Defects

- 101 Anencephaly
102 Meningocele
103 Hydranencephaly
104 Congenital Hydrocephalus
105 Holoprosencephaly
106 Microcephaly
107 Hypopituitary

- 108 Septic Optic Dyplasia
- 109 Encephalocele

- 150 Other lethal or life threatening CNS Defect not listed above (DESCRIBE)

Congenital Heart Defects

200 Other lethal or life threatening Congenital Heart Defects not listed below (DESCRIBE)

- 201 Truncus Arteriosus
- 202 Transposition of the Great Vessels
- 203 Tetralogy of Fallot
- 204 Single Ventricle
- 205 Double Outlet Right Ventricle
- 206 Complete Atrio-Ventricular Canal
- 207 Pulmonary Atresia
- 208 Tricuspid Atresia
- 209 Hypoplastic Left Heart Syndrome
- 210 Interrupted Aortic Arch
- 211 Total Anomalous Pulmonary Venous Return
- 212 Coarctation of the Aorta
- 213 Atrial septal defect (ASD)
- 214 Ventricular septal defect (VSD)
- 215 Arrhythmias
- 216 Ebsteins Anomaly
- 217 Pericardial Effusion
- 218 Pulmonary Stenosis
- 219 Hypertrophic Cardiomyopathy
- 220 Penatology of Cantrell (Thoraco-Abdominal Ectopia Cordis)

Gastro-Intestinal Defects

300 Other lethal or life-threatening GI Defects not listed below (DESCRIBE)

- 301 Cleft Palate
- 302 Tracheo-Esophageal Fistula
- 303 Esophageal Atresia
- 304 Duodenal Atresia
- 305 Jejunal Atresia
- 306 Ileal Atresia
- 307 Atresia of Large Bowel or Rectum
- 308 Imperforate Anus
- 309 Omphalocele
- 310 Gastroschisis
- 311 Pyloric Stenosis
- 312 Annular Pancreas
- 313 Biliary Atresia
- 314 Meconium Ilius
- 315 Malrotation Volvulus
- 316 Hirschsprung's Disease

Genito-Urinary Defects

- 400 Other lethal or life-threatening Genito-Urinary Defects not listed below(DESCRIBE)
- 401 Bilateral Renal Agenesis
- 402 Bilateral Polycystic, Multicystic, or Dysplastic Kidneys
- 403 Obstructive Uropathy with Congenital Hydronephrosis
- 404 Exstrophy of the Urinary Bladder

Chromosomal Abnormalities

- 501 Trisomy 13
- 502 Trisomy 18
- 503 Trisomy 21
- 504 Other Chromosomal Anomaly (Description Required)
- 505 Triploidy

Other Birth Defects

- 601 Skeletal Dysplasia (Description Required)
- 602 Congenital Diaphragmatic Hernia
- 603 Hydrops Fetalis with anasarca and one or more of the following: ascites, pleural effusion, pericardial effusion
- 604 Oligohydramnios sequence including all 3 of the following: (1) Oligohydramnios documented by antenatal ultrasound 5 or more days prior to delivery, (2) evidence of fetal constraint on postnatal physical exam (such as Potter's facies, contractures, or positional deformities of limbs), and (3) postnatal respiratory failure requiring endotracheal intubation and assisted ventilation.
- 605 Inborn Error of Metabolism (Description Required)
- 606 Myotonic Dystrophy requiring endotracheal intubation and assisted ventilation
- 607 Conjoined Twins
- 608 Tracheal Agenesis or Atresia
- 609 Thanatophoric Dysplasia Types 1 and 2
- 610 Hemoglobin Barts

Pulmonary Abnormalities

- 800 Other lethal or life-threatening Pulmonary Defects not listed below (DESCRIBE)
- 801 Congenital Lobar Emphysema
- 802 Congenital Cystic Adenomatoid Malformation of the Lung
- 803 Sequestered Lung
- 804 Avelolar Capillary Dysplasia

Vascular and Lymphatic Defects

- 900 Other Vascular or Lymphatic not listed below (DESCRIBE)
- 901 Cystic Hygroma
- 902 Hemangioma
- 903 Sacrococcygeal Teratoma
- 904 Cerebral AV Malformation

Other Diagnoses

- 120 Persistent Pulmonary Hypertension (Dx criteria – Echo or TA/UA gradients)
- 121 Hematologic
- 122 Hemolytic Disease of the Newborn (Not ABO)

Appendix E. 2009 CPQCC EDS Specifications

2009 EDS Specifications for the combined CPQCC Network - CPeTS Database

(Version 01.11 January 21,2011)

Summary of FIELDS for 2009

Section I. Tracking Fields

NOTE: ITEMS REMOVED FROM 2009 CPeTS are highlighted in Gray.

NOTE: NEW & REVISED FIELDS FOR 2009 ARE HIGHLIGHTED IN Yellow for CPeTS

Tracking Fields

2009 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	01/01/2009-06/30/2009	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	{2009}	For infants born on 2005 to 2008, EDS Specifications for 2005 through 2008 must be used respectively. Submit these files separately from any files with 2009 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. 2009 EDS Specifications for the CPeTS Database

Referral					
Transport Type					
2009 Item	Field Name	Description	Field Type	Range of Possible Values	Coding Rules
None	T_SPECIALSITUATION	Transport Special Situation	Char4	{0000}	0000=N/A, Record does NOT require a Transport Special Situation Override;
				{1000}	1000=Situation A. Delivery Room Attendance: N/A=SNAP Referral section first column Items C.15 through C.25 (T_RESP1, T_RESPRATE1, T_SAO21, T_RESPSTATUS1, T_MAP1 , T_FIO21, T_PAO21 , T_HEARTRATE1, T_BPSYS1, T_BPDIA1, T_BPMEAN1, T_PRESSOR1, T_TEMP1, T_GLUOSE1 , T_VENTMODE1); NOTE: Situation A CANNOT occur with any of the other three Special Situations.
				{0100, 0110, 0101, 0111}	0100= Situation B. Transport by Referring Center (Self-Transport): N/A=T_EVALINITDATETIME, SNAP Referral section second column Items C.15 through C.25 (T_RESP2, T_RESPRATE2, T_SAO22, T_RESPSTATUS2, T_MAP2 , T_FIO22, T_PAO22 , T_HEARTRATE2, T_BPSYS2, T_BPDIA2, T_BPMEAN2, T_PRESSOR2, T_TEMP2, T_GLUOSE2 , T_VENTMODE2), T_TTDEPDATETIME, T_TTARRDATETIME, and T_TEAMBASE must equal 3=Referring Hospital; 0110= Situation B and Situation C; 0101= Situation B and Situation D; 0111= Situation B, Situation C, and Situation D.
				{0010, 0110, 0011, 0111}	0010= Situation C. Transport from Emergency Department or other non-perinatal setting: N/A=T_MADMDATETIME, T_CMAL, T_GRAVIDA, T_ASTERDATETIME; T_BDATETIME= Must submit Date of Birth, then enter N/A=Time of Birth ONLY, T_BGWT= Must enter current birth weight; 0110= Situation B and Situation C; 0011= Situation C and Situation D; 0111= Situation B, Situation C, and Situation D.
				{0001, 0101, 0011, 0111}	0001= Situation D. Safe Surrender: N/A=T_MADMDATETIME, T_CMAL, T_GRAVIDA, T_ASTERDATETIME, DRSURF, T_SURFX; T_BDATETIME= Must submit Date of Birth, then enter N/A=Time of Birth ONLY, T_BGWT= Must enter current birth weight, BIRTHLOCATION= Must equal 900099=Safe Surrender; 0101= Situation B and Situation D; 0011= Situation C and Situation D; 0111= Situation B, Situation C, and Situation D.
C.1	T_TYPE	Transport Type	Integer	{1 - 5, 7}	1=Requested Delivery Attendance, 2= Emergent, 3=Scheduled Neonatal, 4=Other (Describe), 5=Urgent , 7=N/A (only if [ACUTETRS]=0); Only if [T_TYPE]=1, then C.15-C.25=7 or N/A
C.1	T_TYPEDESC	Type Describe	Char50	{Description, 77}	Up to 50 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.					
C.2	T_TRANSCODE	Indication for Transport	Integer	{2, 3, 6, 7, 8}	(Only if [ACUTETRS]=1): 2=Medical DX/RX Services, 3=Surgery, 6=Insurance; 7=N/A (only if [ACUTETRS]=0), 8=Bed Availability
Referral Date and Time (Time Sequence CPeTS)					
NOTE: This is the same as Referral Date/Time in Item C.14. Submit this variable only once using this field.					
C.14	T_REFDATETIME	Date/Time of Referral (and Referring Hospital Evaluation)	Char16	{01 - 12}/{01 - 31}/{2009}[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 "12/12/2009[space]12:00" instead of 12/12/2009[space]12:00.

Date/Time of Acceptance (Time Sequence CPeTS)					
C.15	T_ACCDATETIME	Date/Time of Acceptance	Char16	{01 - 12}/{01 - 31}/{2009}{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 "12/12/2009{space}12:00" instead of 12/12/2009{space}12:00.
History and Demographics					
Date & Time of Maternal Admission to Labor & Delivery					
C.10	T_MADMDATETIME	Date/Time of Mother's Admission to Perinatal Unit or L&D	Char16	{01 - 12}/{01 - 31}/{2009}{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 "12/12/2009{space}12:00" instead of 12/12/2009{space}12:00.
Infant Birth Date and Time					
NOTE: If [ACUTETRS]=1, then C.12 [T_BDATETIME] must = [BDATE] in the CPQCC Section. Submit this variable twice.					
C.12	T_BDATETIME	Date/Time of Birth	Char16	{01 - 12}/{01 - 31}/{2009}{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 "12/12/2009{space}12:00" instead of 12/12/2009{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 C.3 [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 C.4 [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 C.5 [SEX] must = [SEX] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					
Congenital Anomalies					
C.6a	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 C.6b [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)					
C.7	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 C.8 [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					
C.11	T_ASTERDATETIME	Date/Time of ANS Administration	Char16	{01 - 12}/{01 - 31}/{2009}{space}{00}:{00}; {07}/{07}/{1907}{space}{07}:{07}; {09}/{09}/{1909}{space}{09}:{09}	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); 09/09/1909 09:09=Unknown . 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 "12/12/2009{space}12:00" instead of 12/12/2009{space}12:00.
Surfactant Use					
NOTE: If [ACUTETRS]=1, then C.9a [DRSURF] must = [DRSURF] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.					
C.9	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
C.13	T_SURFXDATETIME	Date/Time of Surfactant Administration	Char16	{01 - 12}/{01 - 31}/{2009}{space}{00}:{00}; {07}/{07}/{1907}{space}{07}:{07}; {09}/{09}/{1909}{space}{09}:{09}	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); 09/09/1909 09:09=Unknown . 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 "12/12/2009{space}12:00" instead of 12/12/2009{space}12:00.
Infant Conditions					
Date/Time at which infant condition was evaluated					
NOTE: This is the same as Referral Date/Time in Item C.14. Submit this variable only once.					
Date/Time of Initial Evaluation by Transport Team within 15 minutes of Arrival at Referring Hospital					
C.18	T_EVALINITDATETIME	Date/Time of Arrival of Transport Team at Referring Hospital/Patient Bedside and Initial Transport Evaluation	Char16	{01 - 12}/{01 - 31}/{2009}{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 "12/12/2009{space}12:00" instead of 12/12/2009{space}12:00.
Date/Time of Initial Evaluation by Transport Team within 15 minutes of Arrival at Referring Hospital					
C.19	T_EVALNICUDATETIME	Date/Time of Arrival at Receiving NICU and Initial NICU Evaluation	Char16	{01 - 12}/{01 - 31}/{2009}{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 "12/12/2009{space}12:00" instead of 12/12/2009{space}12:00.
Responsiveness					
C.20	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 400)					
C.23	T_RESPRATE1	at Referral	Integer	{0 - 400, 777}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1)
	T_RESPRATE2	at Initial Evaluation	Integer	{0 - 400, 777}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1)
	T_RESPRATE3	at NICU Admission	Integer	{0 - 400, 777}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1)
Oxygen Saturation (SaO2) (0 to 100)					
C.24	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					
C.25	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)					
G.26a-	Mean Airway Pressure (MAP) (0 to 40) Removed from 2009 CPeTS				
	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_RESPSTATUS1]=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_RESPSTATUS1]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown-
G.26b/ C.26 (item # changed)	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_RESPSTATUS1]=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_RESPSTATUS1]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown
F.19e/-G.26c	Arterial Oxygen (PAO2) (0 to 500) Removed from 2009 CPeTS				
	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_RESPSTATUS1]=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_RESPSTATUS1]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown-

Heart Rate (0 to 400)					
C.22	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					
C.28a	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
C.28b	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
C.28c	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					
C.29	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)					
C.21	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). NOTE: If the infant was undergoing intentional body/head cooling for therapeutic purposes, enter actual temperature. If actual temperature is < 20°C/82.4°F enter 20°C/68°F
	T_TEMP2	at Initial Evaluation	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). NOTE: If the infant was undergoing intentional body/head cooling for therapeutic purposes, enter actual temperature. If actual temperature is < 20°C/82.4°F enter 20°C/68°F
NOTE: if [ACUTETRS]=1, then C.21 [T_TEMP3] must = 22b [ATEMP] in the CPQCC Section.					
	T_TEMP3	at NICU Admission	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). NOTE: If the infant was undergoing intentional body/head cooling for therapeutic purposes, enter actual temperature. If actual temperature is < 20°C/82.4°F enter 20°C/68°F
Blood Glucose (0 to 500) Removed from 2009 CPeTS					
C.30	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					
C.27	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					
Referring Hospital					
C.31 / C.30 (Item # change)	T_REFERRINGHOSPITAL	Referring Hospital	Char6	{OSHPD ID, 777777}	Valid OSHPD ID number (see list); 777777=N/A (only if [ACUTETRS]=0)
Previous Transfer?					
C.32a- / C.31a (Item # change)	T_FIRSTTRANS	Is This The First Transfer for This Infant?	Integer	{0, 1, 7}	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)
C.32b / C.31b (Item # change)	T_PREVHOSPITAL	Previously Transfer Referring Hospital	Char6	{OSHPD ID, 777777}	Valid OSHPD ID number (see list); 777777=N/A (if [T_firstTrans] = 0) OR (only if [ACUTETRS]=0)

Location of Birth					
NOTE: If [ACUTETRS]=1, then C.32 [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					
C.34 / C.33 (Item # change)	T_TEAMLEADER	Team Leader	Integer	{1, 2, 3, 4, 5, 6, 7}	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)
Team Baser					
C.35a / C.34a (Item # change)	T_TEAMBASE	Team Base	Integer	{1, 2, 3, 7}	1=Receiving Hospital, 2=Contract Service, 3=Referring Hospital, 7=N/A (only if [ACUTETRS]=0)
C.35b / C.34b (Item # change)	T_TEAMBASECS	Contract Service used	Char6	{Contract Service ID Number, 777777}	If [T_teamBase]=2, valid contract service ID number (see list); 777777 if [T_teamBase] IN (1,3) or if N/A (only if [ACUTETRS]=0)
Mode of Transport					
C.36 / C.35 (Item # change)	T_TRANSMODE	Mode of Transport	Integer	{1, 2, 3, 7}	1=Ground, 2=Helicopter, 3=Fixed Wing, 7=N/A (only if [ACUTETRS]=0)
Date/Time of Transport Team Departure for Referring Hospital					
C.16	T_TTDEPDATETIME	Date/Time of Transport Team Departure from Transport Team Office/NICU for Referring Hospital	Char16	{01 - 12}/{01 - 31}/{2009}{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 "12/12/2009{space}12:00" instead of 12/12/2009{space}12:00.
Date/Time of Arrival of Transport Team at Referring Hospital					
C.17	T_TTARRDATETIME	Date/Time of Transport Team Arrival at Referring Hospital/Patient Bedside and Initial Transport Evaluation	Char16	{01 - 12}/{01 - 31}/{2009}{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.
User Comment Box					
C.36 / C.35 (Item # change)	T_USERCOMMENT	User Comment Box	Char256	{Description, 77}	Up to 256 alphanumeric characters; 77=N/A (only if [ACUTETRS]=0)

Section II. 2009 EDS Specifications for the CPeTS Database

NOTE: NEW & REVISED FIELDS FOR 2009 ARE HIGHLIGHTED IN Yellow for CPQCC.

Tracking Fields (See Section I for Tracking Fields)

Identification and Demographics

2009 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 C.3 [T_BWGT] must = [BWGT] in the CPQCC Section.					
1	BWGT	Birth Weight (in Grams)	Long Integer	{1 - 7000}	For infants born in 2009, 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 10th of a cm)	Double	{10.0 - 70.0, 999.9}	777.7 if [BYEAR] <2006; 10.0 to 70.0, 999.9 if [BYEAR] >= 2006; Codes:777.7 = N/A, 999.9 = Unknown
NOTE: If [ACUTETRS]=1, then C.4 [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 C.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 C.8 [GADAYS] must = [GADAYS] in CPQCC Section; 99=Unknown
NOTE: If [ACUTETRS]=1, then C.12 [T_BDATE] must = [BDATE] in the CPQCC Section. Submit this variable twice.					
4	BDATE	Birth Date	Date	01/01/2008 - 12/31/2008	Date format mm/dd/yyyy
NOTE: If [ACUTETRS]=1, then C.5 [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 C.9 [SEX] must = [SEX] in CPQCC Section; 0=Female, 1=Male, 9=Unknown
6	DELDIE	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 [DELDIE]=1
7b	DAYADMISS	Day of Admission (for gt 1500 Grams or Outborn Infants)	Integer	{1 - 28, 77}	77 if [LOCATE]=0; 1 to 28 if [LOCATE]=1
NOTE: If [ACUTETRS]=1, then C.32 [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}	777777 if [BYEAR]<2008 or [LOCATE]=0; valid OSHPD ID number (see list)
8a	PDH	Previously Discharged Home (for Outborn Infants)	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A {if [DELDIE] = 1 or [LOCATE]=0 or ([PDH] = 1 and not hospitalized at 36 weeks AGA)}
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 [DELDIE]=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 C.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]<2009; 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]<2009; 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	ANCMCHORIO	Maternal: Chorioamionitis	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 Cesaeam	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	{Description, 77, 99}	Up to 50 alphanumeric characters; 77=N/A if [ANCMOTH]=0, 99=Unknown if [ANCMOTH]=9
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	{Description, 77, 99}	Up to 50 alphanumeric characters; 77=N/A if [ANCFOTH]=0, 99=Unknown if [ANCFOTH]=9
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 / Abruption / 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	{Description, 77, 99}	Up to 50 alphanumeric characters; 77=N/A if [ANCOOTH]=0, 99=Unknown if [ANCOOTH]=9
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. Mandatory for all CPQCC-eligible infants.					
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=No (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	{Description, 77, 99}	Up to 50 alphanumeric characters characters (only if [DELMOD]=0 AND [INDCESOTH]=1); 77=N/A if [INDCESOTH]=0,7; 99=Unknown if [INDCESOTH]=9
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 Ventilation	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 C.9a [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, 7=N/A Only if [DELDIE]=1
21	SURFX	Surfactant Given at Any Time	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown, 7=N/A Only if [DELDIE]=1
21	SURF1DHR	Surfactant Age at First Dose, Hours	Integer	{0 - 6665, 7777, 9999}	7777 if [SURFX] = 0 or if [DELDIE]=1; 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 or if [DELDIE]=1; 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, 7, 9}	7 Only if [DELDIE]=1 or [BYEAR]<2009; 0, 1, 9 if [DELDIE]=0 and [BYEAR] >= 2009; 0=No, 1=Yes, 7=N/A, 9=Unknown

NOTE: If [ACUTETRS]=1, then C.21 [T_TEMP3] must = 22b [ATEMP] in the CPQCC Section.					
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] < 2009, 20.0 to 45.0, 999.9 if [DELDIE]=0 and [ATEMPM]=1 and [BYEAR] >= 2009; 777.7=N/A, 999.9=Unknown. NOTE: If the infant was undergoing intentional body/head cooling for therapeutic purposes, enter actual temperature. If actual temperature is < 20°C/82.4°F at the time of obtaining the first temperature within 1 hour of NICU admission, enter 20°C/68°F!
23a	OXY	Post DR Respiratory Support -- Oxygen	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
23b	VENT	Post DR Respiratory Support -- VENT	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
23c	HFV	Post DR Respiratory Support -- HIFI	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
23d	HFNC	High Flow Nasal Cannula	Integer	{0, 1, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
23e	NIMV	Nasal IMV or SIMV	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
24a	CPAP	Post DR Respiratory Support -- CPAP of any type	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
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, 7, 9}	0=None, 1= <=4 Hours, 2= >4 Hours, 7=N/A Only if [DELDIE]=1, 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) or [DELDIE]=1, 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) or [DELDIE]=1, 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 NICU?	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1
27	RDS	Respiratory Distress Syndrome	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
28	PNTX	Pneumothorax	Integer	{0, 7, 9, 11, 12, 13}	0=No, 7=N/A Only if [DELDIE]=1, 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, 13=Yes Here AND Elsewhere
29	MECONIUM	Meconium Aspiration Syndrome	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
30	NITRICO	Inhaled Nitric Oxide	Integer	{0, 1, 7, 9, 11, 12, 13}	0=No, 7=N/A Only if [DELDIE]=1, 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, 13=Yes Here AND Elsewhere
31	ECMO	ECMO	Integer	{0, 1, 7, 9, 11, 12, 13}	0=No, 7=N/A Only if [DELDIE]=1, 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, 13=Yes Here AND Elsewhere

32a	POSTSTER	Postnatal Steroids	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
32b	POSTERCLD	Postnatal Steroids for Indication Chronic Lung Disease	Integer	{0, 7, 9, 11, 12, 13}	0=No, 7=N/A (only if [POSTER] = 0, or 7) OR ([DELDIE]=1), 9=Unknown, 9 only if [POSTSTER]=9, 11=Yes Here, 12=Yes Elsewhere, 13=Yes Here AND Elsewhere,
32b	POSTEREX	Postnatal Steroids for Indication Extubation	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A (only if [POSTER] = 0, or 7) or [DELDIE]=1
32b	POSTERBP	Postnatal Steroids for Indication Hypotension	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A (only if [POSTER] = 0, or 7) or [DELDIE]=1
32b	POSTEROTH	Postnatal Steroids for Indication Other	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A (only if [POSTER] = 0, or 7) or [DELDIE]=1
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, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
35b	ACFINAL	Respiratory Support at Discharge -- Apnea or Cardio-Respiratory Monitor	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
35c	SUCFINAL	Respiratory Support at Discharge -- Mechanical Ventilation	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
35d	OTHFINAL	Respiratory Support at Discharge -- Other	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
35d	OTHFINALDESC	Description of Other Respiratory Support at Discharge	Char50	{Description, 77, 99}	Up to 50 alphanumeric characters (only if [OTHFINAL]=1); 77=N/A if [OTHFINAL]=0,7 or [DELDIE]=1; 99=Unknown if [OTHFINAL]=9
Post-Delivery Diagnoses and Interventions -- Infections					
36	EBSEPS	Sepsis -- Early Bacterial (On or Before Day 3)	Integer	{0, 2, 3, 4, 7, 9}	0=No, 2=Other, 3=GBS, 4 = e.Coli, 7=N/A Only if [DELDIE]=1, 9=Unknown
36	EBSEPSDESC	If Other, Organism	Char50	{Description, 77, 99}	Up to 50 alphanumeric characters (only if [EBSEPS]=2); 77=N/A if [EPSEPS]=0,7 or if [DELDIE]=1; 99=Unknown if [EPSEPS]=9
37a	LBPATH	Sepsis -- Late - Bacterial Pathogen	Integer	{0, 7, 9, 21, 22, 23, 31, 32, 33, 41, 42, 43}	0=No, 7=N/A, 9=Unknown (only if [DELDIE]=1, 21=Other Here, 22=Other Elsewhere, 23=Other Here AND Elsewhere, 31=GBS Here, 32=GBS Elsewhere, 33=GBS Here AND Elsewhere, 41=e.Coli Here, 42=e.Coli Elsewhere, 43=e.Coli Here AND Elsewhere
37a	LBPATHDESC	If Other, Organism	Char50	{Description, 77, 99}	Up to 50 alphanumeric characters (only if [LBPATH]=2); 77=N/A if [LBPATH]=0,7 or if [DELDIE]=1; 99=Unknown if [LBPATH]=9
37b	CNEGSTAPH	Sepsis -- Late - Coag Neg Staph	Integer	{0, 7, 9, 11, 12, 13}	0=No, 7=N/A (only if [DELDIE]=1), 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, 13=Yes Here AND Elsewhere
37c	FUNGAL	Sepsis -- Late - Fungal	Integer	{0, 7, 9, 11, 12, 13}	0=No, 7=N/A (only if [DELDIE]=1), 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, 13=Yes Here AND Elsewhere
38	VIRAL	Congenital Viral Infection	Integer	{0, 1, 7, 9}	0=Negative culture, 7=N/A (only if [DELDIE]=1), 1=Yes, 9=Unknown
38	VIRALDESC	Specify Viral Pathogen	Char50	{Description, 77, 99}	Up to 50 alphanumeric; only specify pathogen if [VIRAL] = 1; 77=N/A if [VIRAL]=0,7 or if [DELDIE]=1; 99=Unknown if [VIRAL]=9
39a	PDA	Patent Ductus Arteriosus	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1), 9=Unknown
39b	INDOMETH	Indomethacin For Any Reason	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1), 9=Unknown
39c	IBUPROFEN	Ibuprofen for PDA	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1 OR [PDA]=0), 9=Unknown.
39d	SRGLIG	Surgery: PDA Ligation	Integer	{0, 7, 9, 11, 12, 13}	0=No, 7=N/A (only if [DELDIE]=1 OR [PDA]=0), 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, 13=Yes Here AND Elsewhere
40a	NEC	Necrotizing Enterocolitis	Integer	{0, 7, 9, 11, 12, 13}	0=No, 7=N/A (only if [DELDIE]=1), 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, 13=Yes Here AND Elsewhere
40b	SRGNEC	Surgery: NEC Surgery	Integer	{0, 7, 9, 11, 12, 13}	0=No, 7=N/A (only if [DELDIE]=1 or [NEC]=0), 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, 13=Yes Here AND Elsewhere
41	GIPERF	Gastro-Intestinal Perforation	Integer	{0, 1, 7, 9, 11, 12, 13}	0=No, 7=N/A (only if [DELDIE]=1), 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, 13=Yes Here AND Elsewhere

42a	EYEX	Retinal Exam	Integer	{0, 1, 7, 9}	0=No,1=Yes, 7=N/A (only if [DELDIE]=1), 9=Unknown (always if [EYEX]=9)
42b	ISTAGE	Worst Stage of ROP	Integer	{0 - 5, 7, 9}	0=No evidence of ROP, 1=Presence of demarcation line (+/- abnormal vascularization), 2=Presence of intraretinal ridge, 3=Presence of a ridge with extraretinal fibrovascular proliferation, 4=Partial retinal detachment, 5=Total retinal detachment; 7=N/A (only if [DELDIE]=1 or [EYEX] = 0); 9=Unknown (always if [EYEX]=9)
42c	SRGROP	Surgery: ROP	Integer	{0, 7, 9, 11, 12, 13}	0=No, 7=N/A (only if [DELDIE]=1 or [EYEX]=0 or [ISTAGE]=0), 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, 13=Yes Here AND Elsewhere
43	SRGOTH	Other Surgery	Integer	{0, 1, 7, 9}	0=No,7=N/A (only if [DELDIE]=1), 1=Yes, 9=Unknown
43	SRGCD1	First Other Surgery Code	Char6	{{(Surgery Codes)B, (Surgery Codes)E, (Surgery Codes)H, 77, 99}}	xxxxB=(Four-alphanumeric Surgery Code) Both Here AND Elsewhere; xxxxE=(Four-alphanumeric Surgery Code) Elsewhere; xxxxH=(Four-alphanumeric Surgery code) Here; 77 = if [SRGOTH] = 0 OR [BYEAR] < 2008 OR [DELDIE] = 1; 99 = if [SRGOTH]=9; Surgery Code if [SRGOTH]=1; 77=N/A, 99=Unknown
43	SRGCD2	Second Other Surgery Code	Char6	{{(Surgery Codes)B, (Surgery Codes)E, (Surgery Codes)H, 77, 99}}	xxxxB=(Four-alphanumeric Surgery Code) Both Here AND Elsewhere; xxxxE=(Four-alphanumeric Surgery Code) Elsewhere; xxxxH=(Four-alphanumeric Surgery code) Here; 77 = if [SRGOTH] = 0 OR [BYEAR] < 2008 OR [DELDIE] = 1; 99 = if [SRGOTH]=9; Surgery Code if [SRGOTH]=1: 77=N/A, 99=Unknown
43	SRGCD3	Third Other Surgery Code	Char6	{{(Surgery Codes)B, (Surgery Codes)E, (Surgery Codes)H, 77, 99}}	xxxxB=(Four-alphanumeric Surgery Code) Both Here AND Elsewhere; xxxxE=(Four-alphanumeric Surgery Code) Elsewhere; xxxxH=(Four-alphanumeric Surgery code) Here; 77 = if [SRGOTH] = 0 OR [BYEAR] < 2008 OR [DELDIE] = 1; 99 = if [SRGOTH]=9; Surgery Code if [SRGOTH]=1: 77=N/A, 99=Unknown
43	SRGCD4	Fourth Other Surgery Code	Char6	{{(Surgery Codes)B, (Surgery Codes)E, (Surgery Codes)H, 77, 99}}	xxxxB=(Four-alphanumeric Surgery Code) Both Here AND Elsewhere; xxxxE=(Four-alphanumeric Surgery Code) Elsewhere; xxxxH=(Four-alphanumeric Surgery code) Here; 77 = if [SRGOTH] = 0 OR [BYEAR] < 2008 OR [DELDIE] = 1; 99 = if [SRGOTH]=9; Surgery Code if [SRGOTH]=1: 77=N/A, 99=Unknown
43	SRGCD5	Fifth Other Surgery Code	Char6	{{(Surgery Codes)B, (Surgery Codes)E, (Surgery Codes)H, 77, 99}}	xxxxB=(Four-alphanumeric Surgery Code) Both Here AND Elsewhere; xxxxE=(Four-alphanumeric Surgery Code) Elsewhere; xxxxH=(Four-alphanumeric Surgery code) Here; 77 = if [SRGOTH] = 0 OR [BYEAR] < 2008 OR [DELDIE] = 1; 99 = if [SRGOTH]=9; Surgery Code if [SRGOTH]=1: 77=N/A, 99=Unknown
43	SRGCD6	Sixth Other Surgery Code	Char6	{{(Surgery Codes)B, (Surgery Codes)E, (Surgery Codes)H, 77, 99}}	xxxxB=(Four-alphanumeric Surgery Code) Both Here AND Elsewhere; xxxxE=(Four-alphanumeric Surgery Code) Elsewhere; xxxxH=(Four-alphanumeric Surgery code) Here; 77 = if [SRGOTH] = 0 OR [BYEAR] < 2008 OR [DELDIE] = 1; 99 = if [SRGOTH]=9; Surgery Code if [SRGOTH]=1: 77=N/A, 99=Unknown
43	SRGCD7	Seventh Other Surgery Code	Char6	{{(Surgery Codes)B, (Surgery Codes)E, (Surgery Codes)H, 77, 99}}	xxxxB=(Four-alphanumeric Surgery Code) Both Here AND Elsewhere; xxxxE=(Four-alphanumeric Surgery Code) Elsewhere; xxxxH=(Four-alphanumeric Surgery code) Here; 77 = if [SRGOTH] = 0 OR [BYEAR] < 2008 OR [DELDIE] = 1; 99 = if [SRGOTH]=9; Surgery Code if [SRGOTH]=1: 77=N/A, 99=Unknown
43	SRGCD8	Eighth Other Surgery Code	Char6	{{(Surgery Codes)B, (Surgery Codes)E, (Surgery Codes)H, 77, 99}}	xxxxB=(Four-alphanumeric Surgery Code) Both Here AND Elsewhere; xxxxE=(Four-alphanumeric Surgery Code) Elsewhere; xxxxH=(Four-alphanumeric Surgery code) Here; 77 = if [SRGOTH] = 0 OR [BYEAR] < 2008 OR [DELDIE] = 1; 99 = if [SRGOTH]=9; Surgery Code if [SRGOTH]=1: 77=N/A, 99=Unknown
43	SRGCD9	Ninth Other Surgery Code	Char6	{{(Surgery Codes)B, (Surgery Codes)E, (Surgery Codes)H, 77, 99}}	xxxxB=(Four-alphanumeric Surgery Code) Both Here AND Elsewhere; xxxxE=(Four-alphanumeric Surgery Code) Elsewhere; xxxxH=(Four-alphanumeric Surgery code) Here; 77 = if [SRGOTH] = 0 OR [BYEAR] < 2008 OR [DELDIE] = 1; 99 = if [SRGOTH]=9; Surgery Code if [SRGOTH]=1: 77=N/A, 99=Unknown
43	SRGCD10	Tenth Other Surgery Code	Char6	{{(Surgery Codes)B, (Surgery Codes)E, (Surgery Codes)H, 77, 99}}	xxxxB=(Four-alphanumeric Surgery Code) Both Here AND Elsewhere; xxxxE=(Four-alphanumeric Surgery Code) Elsewhere; xxxxH=(Four-alphanumeric Surgery code) Here; 77 = if [SRGOTH] = 0 OR [BYEAR] < 2008 OR [DELDIE] = 1; 99 = if [SRGOTH]=9; Surgery Code if [SRGOTH]=1: 77=N/A, 99=Unknown
43	SRGOTHDESC	Other Surgery Description	Char255	{Description, 77, 99}	77 if [SRGOTH]=0,7 or [BYEAR] < 2008 OR [DELDIE] = 1 or if the surgery code(s) in Appendix do not require a description; if [BYEAR] < 2008: 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, 11, 12, 13}	See Manual for list of qualifying complications. 0=No, 7=N/A if [DELDIE]=1 (or all surgeries are checked as No), 9=Unknown, 11=Yes, Here, 12=Yes, Elsewhere, 13=Yes, Here AND Elsewhere
44	SURGCOMPDESC	Describe Surgical Complications	Char50	{Description, 77, 99}	Up to 50 alphanumeric characters (only describe if [SURGCOMP]=1), 77=N/A if [SURGCOMP]=0,7 or if [DELDIE]=1; 99=Unknown if [SURGCOMP]=9; if there were multiple complications at multiple locations (code 13=Yes Here AND Elsewhere), explain in the description field where the complication occurred. For example, "Complication A (Here), Complication B (Elsewhere)".
Post-Delivery Diagnoses and Interventions – Neurological					
45a	IMAGE28	Imaging Done On or Before Day 28 and During This Admission	Integer	{0, 1, 7, 9}	0=No, 7=N/A (only if [DELDIE]=1), 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) Grade 0: No subependymal or intraventricular hemorrhage. Grade 1: Subependymal germinal matrix hemorrhage only; Grade 2: Intraventricular blood, no ventricular dilation; Grade 3: Intraventricular blood, ventricular dilation; Grade 4: Intraparenchymal hemorrhage
45c	PIHHEMLOC	Periventricular-Intraventricular Hemorrhage (PIH), where first occurred	Integer	{7, 9, 11, 12}	11=Yes and First Here, 12=Yes and First Elsewhere, 7=N/A, 9=Unknown. New variable added to CPQCC Data Collection for 2009
45e-/ 45d (Item # change)	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-/ 45e (Item # change)	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-/ 45e (Item # change)	OTHHHEMDESC	Other Intracranial Hemorrhage Description	Char50	{Description, 77, 99}	Up to 50 alphanumeric characters (only if [OTHHHEM]=1); 7=N/A if [OTHHHEM]=0,7 or if [DELDIE]=1, 99=Unknown if [OTHHHEM]=9
46a	PVLIMAG	Cystic PVL Imaging Performed During this admission?	Integer	{0, 1, 7, 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, 7, 9}	0=No, 7=N/A (only if [DELDIE]=1), 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 C.6b [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 C.6b [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	{Description, 77, 99}	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); 99=Unknown if [CMAL]=9

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=Not Done/ 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), 999999=Unknown
Initial Disposition					
53	ENTFEED	Enteral Feeding at Discharge	Integer	{0, 1, 2, 3, 7, 9}	0=None, 1=Human Milk Only, 2=Formula Only, 3=Human Milk Fortified with Formula, 7=N/A (only if [DELDIE]=1), 9=Unknown
54	FDISP	Initial Disposition From Your Hospital	Integer	{1, 2, 3, 5, 7, 9}	1=Home, 2=Transported, 3=Died, 5=Still hospitalized as of first birthday, 7=N/A (only if [DELDIE]=1), 9=Unknown
55	DWGT	Initial Disposition Weight	Long Integer	{201-66665, 99999}	201-66665, 99999=Unknown
56	HEADCIRC	Head Circumference at Initial Disposition (in cm to nearest 10th of a cm)	Double	{10.0-70.0, 999.9}	10.0 TO 70.0, 777.7=N/A (only if [DELDIE]=1) 999.9=Unknown
57	LOS1	Initial Length of Stay	Integer	{1-366 or 367, 999}	367 for leap years, 777=N/A (only if [DELDIE]=1), 999=Unknown
Transfer					
58	TRANSCODE	Reason for Transport	Integer	{0,1, 2, 3, 4, 5, 6, 7, 9}	0=ECMO, 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 or 9), 9=Unknown (always if [FDISP]=9)
59	XFERLOCATION	Transferred to a CPQCC Center	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); [FDISP]<>2 or 9)999999=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) or ([DELDIE]=1), 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)

**Appendix F. Section II. 2009 EDS Specifications for the CPeTS Database:
Summary of Codes for Transport Special Situations**

2009 Item	Field Name	Description	Situation A: Requested Delivery Attendance	Situation B: Transport by Referring Center (Self- Transport)	Situation C: Transport from Emergency Department or other non- perinatal setting	Situation D: Safe Surrender
None	T_SPECIALSITUATION	Transport Special Situation	1000=Situation A; NOTE: Situation A CANNOT occur with any of the other three Special Situations	0100= Situation B only; 0110= Situation B and Situation C; 0101= Situation B and Situation D; 0111= Situation B, Situation C, and Situation D	0010= Situation C only; 0110= Situation B and Situation C; 0011= Situation C and Situation D; 0111= Situation B, Situation C, and Situation D	0001= Situation D only; 0101= Situation B and Situation D; 0011= Situation C and Situation D; 0111= Situation B, Situation C, and Situation D
C.1	T_TYPE	Transport Type	1=DR-Attendance-Requested-Requested-Delivery-Attendance	enter data	enter data	enter data
C.1	T_TYPEDESC	Type Describe	enter data	enter data	enter data	enter data
C.2	T_TRANSCODE	Indication for Transport	enter data	enter data	enter data	enter data
C.14	T_REFDATETIME	Date/Time of Referral	enter data	enter data	enter data	enter data
C.15	T_ACCDATETIME	Date/Time of Acceptance	enter data	enter data	enter data	enter data
C.10	T_MADMDATETIME	Date/Time of mother's admission to L&D	enter data	enter data	N/A	N/A
C.12	T_BDATETIME	Date/Time of birth	enter data	enter data	Submit Date of Birth; N/A=Time of Birth ONLY	Submit Date of Birth; N/A=Time of Birth ONLY
C.3	T_BWGT	Birthweight	enter data	enter data	Enter current weight	Enter current weight
C.4/ (AD3a, 3b)	GAWEEKS, GADAYS	Best estimate of gestational age -- weeks, days	enter data	enter data	enter data	enter data
C.5/ (AD5)	SEX	Sex of infant	enter data	enter data	enter data	enter data
C.6a	T_CMAL	Major Birth Defect Diagnosed Prenatally	enter data	enter data	N/A	N/A
C.7	T_GRAVIDA	Gravida	enter data	enter data	N/A	N/A
C.11	T_ASTERDATETIME	Date/Time of ANS administration	enter data	enter data	N/A	N/A
C.9a	DRSURF	Surfactant in the Delivery Room	enter data	enter data	enter data	N/A
C.9b	T_SURFX	Surfactant Given at any time	enter data	enter data	enter data	N/A
C.13	T_SURFXDATETIME	Date/Time of Surfactant administration	enter data	enter data	enter data	enter data
C.18	T_EVALINITDATETIME	Date/Time of Initial Evaluation by Transfer Team	enter data	N/A	enter data	enter data
C.19	T_EVALNICUDATETIME	Date/Time of NICU Admission	enter data	enter data	enter data	enter data
C.20	T_RESP1	at Referral	N/A	enter data	enter data	enter data
	T_RESP2	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_RESP3	at NICU Admission	enter data	enter data	enter data	enter data

C.23	T_RESPRATE1	at Referral	N/A	enter data	enter data	enter data
	T_RESPRATE2	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_RESPRATE3	at NICU Admission	enter data	enter data	enter data	enter data
C.24	T_SAO21	at Referral	N/A	enter data	enter data	enter data
	T_SAO22	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_SAO23	at NICU Admission	enter data	enter data	enter data	enter data
C.25	T_RESPSTATUS1	at Referral	N/A	enter data	enter data	enter data
	T_RESPSTATUS2	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_RESPSTATUS3	at NICU Admission	enter data	enter data	enter data	enter data
C.26a Removed from 2009 CPeTS	T_MAP1	at Referral	N/A	enter data	enter data	enter data
	T_MAP2	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_MAP3	at NICU Admission	enter data	enter data	enter data	enter data
C.26b/ C.26 (Item # changed)	T_FIO21	at Referral	N/A	enter data	enter data	enter data
	T_FIO22	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_FIO23	at NICU Admission	enter data	enter data	enter data	enter data
C.26c Removed from 2009 CPeTS	T_PAO21	at Referral	N/A	enter data	enter data	enter data
	T_PAO22	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_PAO23	at NICU Admission	enter data	enter data	enter data	enter data
C.22	T_HEARTRATE1	at Referral	N/A	enter data	enter data	enter data
	T_HEARTRATE2	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_HEARTRATE3	at NICU Admission	enter data	enter data	enter data	enter data
C.28a	T_BPSYS1	at Referral	N/A	enter data	enter data	enter data
	T_BPSYS2	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_BPSYS3	at NICU Admission	enter data	enter data	enter data	enter data
C.28b	T_BPDIA1	at Referral	N/A	enter data	enter data	enter data
	T_BPDIA2	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_BPDIA3	at NICU Admission	enter data	enter data	enter data	enter data
C.28c	T_BPMEAN1	at Referral	N/A	enter data	enter data	enter data
	T_BPMEAN2	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_BPMEAN3	at NICU Admission	enter data	enter data	enter data	enter data
C.29	T_PRESSOR1	at Referral	N/A	enter data	enter data	enter data
	T_PRESSOR2	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_PRESSOR3	at NICU Admission	enter data	enter data	enter data	enter data
C.21	T_TEMP1	at Referral	N/A	enter data	enter data	enter data
	T_TEMP2	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_TEMP3	at NICU Admission	enter data	enter data	enter data	enter data
C.30 Removed from 2009 CPeTS	T_GLUCOSE1	at Referral	N/A	enter data	enter data	enter data
	T_GLUCOSE2	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_GLUCOSE3	at NICU Admission	enter data	enter data	enter data	enter data
C.27	T_VENTMODE1	at Referral	N/A	enter data	enter data	enter data
	T_VENTMODE2	at Initial Evaluation	enter data	N/A	enter data	enter data
	T_VENTMODE3	at NICU Admission	enter data	enter data	enter data	enter data
	T_REFERRINGHOSPITAL	Referring Hospital	enter data	enter data	enter data	enter data
C.32a / C.31a (Item # changed)	T_FIRSTTRANS	Is this the first transfer for this infant?	enter data	enter data	enter data	enter data
C.32b / C.31b (Item # changed)	T_PREVHOSPITAL	Previously Transfer Referring Hospital	enter data	enter data	enter data	enter data

C.33 / C.32 (Item # changed)	BIRTHLOCATION	Hospital of Birth	enter data	enter data	enter data	900099= Safe Surrender
C.34 / C.33 (Item # changed)	T_TEAMLEADER	Team Leader	enter data	enter data	enter data	enter data
C.35a / C.34a (Item # changed)	T_TEAMBASE	Team Base	enter data	3= Referring Hospital	enter data	enter data
C.35b / C.34b (Item # changed)	T_TEAMBASECS	Contract Service used	enter data	enter data	enter data	enter data
C.36 / C.35 (Item # changed)	T_TRANSMODE	Mode of Transport	enter data	enter data	enter data	enter data
C.16	T_TTDEPDATETIME	Date/Time of transport team departure for referring hospital	enter data	N/A	enter data	enter data
C.17	T_TTARRDATETIME	Date/Time of transport team arrival at referring hospital	enter data	N/A	enter data	enter data
C.36/ C.35 (Item # changed)	T_USERCOMMENT	User Comment Box	enter data	enter data	enter data	enter data

Appendix G. 2009 CPeTS Acute Inter-facility Transport: Systems Upgrade/ Item Re-order -- C to T codes

2008 Item Number	2008 Item Number	2009 Item Number	Field Name	Description
T.1	C.1	C.1	T_TYPE	Transport Type
T.1	C.1 Description	C.1 Description	T_TYPEDESC	Type Describe
T.2	C.2	C.2	T_TRANSCODE	Indication for Transport
T.3	C.14	C.14	T_REFDATETIME	Date/Time of Referral
T.4	C.15	C.15	T_ACCDATETIME	Date/Time of Acceptance
T.5	C.10	C.10	T_MADMDATETIME	Date/Time of mother's admission to L&D
T.6	C.12	C.12	T_BDATETIME	Date/Time of birth
T.7	C.3	C.3	T_BWGT	Birthweight
T.8/ AD.3a, 3b	C.4	C.4	GAWEEKS, GADAYS	Best estimate of gestational age -- weeks, days
T.9/ AD.5	C.5	C.5	SEX	Sex of infant
T.10a	C.6a	C.6a	T_CMAL	Major Birth Defect Diagnosed Prenatally
T.11	C.7	C.7	T_GRAVIDA	Gravida
T.12b	C.11	C.11	T_ASTERDATETIME	Date/Time of ANS administration
T.13a/ AD.21	C.9a	C.9a	DRSURF	Surfactant in the Delivery Room
T.13b	C.9b	C.9b	T_SURFX	Surfactant Given at any time
T.13c	C.13	C.13	T_SURFXDATETIME	Date/Time of Surfactant administration
T.14b	C.18	C.18	T_EVALINITDATETIME	Date/Time of Initial Evaluation by Transfer Team
T.14c	C.19	C.19	T_EVALNICUDATETIME	Date/Time of NICU Admission
T.15	C.20 Referral	C.20 Referral	T_RESP1	at Referral
	C.20 Initial Eval TT	C.20 Initial Eval TT	T_RESP2	at Initial Evaluation
	C.20 Eval NICU	C.20 Eval NICU	T_RESP3	at NICU Admission
T.16	C.23 Referral	C.23 Referral	T_RESPRATE1	at Referral
	C.23 Initial Eval TT	C.23 Initial Eval TT	T_RESPRATE2	at Initial Evaluation
	C.23 Eval NICU	C.23 Eval NICU	T_RESPRATE3	at NICU Admission
T.17	C.24 Referral	C.24 Referral	T_SAO21	at Referral
	C.24 Initial Eval TT	C.24 Initial Eval TT	T_SAO22	at Initial Evaluation
	C.24 Eval NICU	C.24 Eval NICU	T_SAO23	at NICU Admission
T.18	C.25 Referral	C.25 Referral	T_RESPSTATUS1	at Referral
	C.25 Initial Eval TT	C.25 Initial Eval TT	T_RESPSTATUS2	at Initial Evaluation
	C.25 Eval NICU	C.25 Eval NICU	T_RESPSTATUS3	at NICU Admission
T.19a	C.26a Referral	C.26a Referral	T_MAP1	at Referral

	C.26a Initial Eval TT C.26a Eval NICU	C.26a Initial Eval TT C.26a Eval NICU	T_MAP2 T_MAP3	at Initial Evaluation at NICU Admission
T.19b	C.26b Referral C.26b Initial Eval TT C.26b Eval NICU	C.26 Referral C.26 Initial Eval TT C.26 Eval NICU	T_FIO21 T_FIO22 T_FIO23	at Referral at Initial Evaluation at NICU Admission
T.19c	C.26c Referral C.26c Initial Eval TT C.26c Eval NICU	C.26c Referral C.26c Initial Eval TT C.26c Eval NICU	T_PAO21 T_PAO22 T_PAO23	at Referral at Initial Evaluation at NICU Admission
T.20	C.22 Referral C.22 Initial Eval TT C.22 Eval NICU	C.22 Referral C.22 Initial Eval TT C.22 Eval NICU	T_HEARTRATE1 T_HEARTRATE2 T_HEARTRATE3	at Referral at Initial Evaluation at NICU Admission
T.21a	C.28a Referral C.28a Initial Eval TT C.28a Eval NICU	C.28a Referral C.28a Initial Eval TT C.28a Eval NICU	T_BPSYS1 T_BPSYS2 T_BPSYS3	at Referral at Initial Evaluation at NICU Admission
T.21b	C.28b Referral C.28b Initial Eval TT C.28b Eval NICU	C.28b Referral C.28b Initial Eval TT C.28b Eval NICU	T_BPDIA1 T_BPDIA2 T_BPDIA3	at Referral at Initial Evaluation at NICU Admission
T.21c	C.28c Referral C.28c Initial Eval TT C.28c Eval NICU	C.28c Referral C.28c Initial Eval TT C.28c Eval NICU	T_BPMEAN1 T_BPMEAN2 T_BPMEAN3	at Referral at Initial Evaluation at NICU Admission
T.22	C.29 Referral C.29 Initial Eval TT C.29 Eval NICU	C.29 Referral C.29 Initial Eval TT C.29 Eval NICU	T_PRESSOR1 T_PRESSOR2 T_PRESSOR3	at Referral at Initial Evaluation at NICU Admission
T.23	C.21 Referral C.21 Initial Eval TT C.21 Eval NICU	C.21 Referral C.21 Initial Eval TT C.21 Eval NICU	T_TEMP1 T_TEMP2 T_TEMP3	at Referral at Initial Evaluation at NICU Admission
T.24	C.30 Referral C.30 Initial Eval TT C.30 Eval NICU	C.30 Referral C.30 Initial Eval TT C.30 Eval NICU	T_GLUCOSE1 T_GLUCOSE2 T_GLUCOSE3	at Referral at Initial Evaluation at NICU Admission
T.25	C.27 Referral C.27 Initial Eval TT C.27 Eval NICU	C.27 Referral C.27 Initial Eval TT C.27 Eval NICU	T_VENTMODE1 T_VENTMODE2 T_VENTMODE3	at Referral at Initial Evaluation at NICU Admission
T.26	C.31	C.30	T_REFERRINGHOSPITAL	Referring Hospital
T.27a	C.32a	C.31a	T_FIRSTTRANS	Is this the first transfer for this infant?

T.27b	C.32b	C.31b	T_PREVHOSPITAL	Previously Transfer Referring Hospital
T.28	C.33	C.32	BIRTHLOCATION	Hospital of Birth
T.29	C.34	C.33	T_TEAMLEADER	Team Leader
T.30a	C.35a	C.34a	T_TEAMBASE	Team Base
T.30b	C.35b	C.34b	T_TEAMBASECS	Contract Service used
T.31	C.36	C.35	T_TRANSMODE	Mode of Transport
T.31	C.36	C.35	T_USERCOMMENT	User Comments
T.32	C.16	C.16	T_TTDEPDATETIME	Date/Time of transport team departure for referring hospital
T.33	C.17	C.17	T_TTARRDATETIME	Date/Time of transport team arrival at referring hospital