



**CPQCC Network Database  
2017 Member Instructions for Electronic Data Submission  
Version 10.0  
December 9, 2016**

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## **Acknowledgments**

The CPQCC Data Center staff would like to thank 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 individually submitting each infant record to the on-line database. There are some notable differences in the data submission procedures and data elements for the 2017 CPQCC Database.

All centers are welcome to participate and take advantage of the benefits that 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, 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 can read existing hospital data and 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 updates to procedures and data elements being introduced for 2017. Please read through these instructions and contact the CPQCC Data Center by submitting a help ticket at the CPQCC Help Desk (<https://cpqccsupport.org/>) 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 submit a help ticket at the CPQCC Help Desk (<https://cpqccsupport.org/>) to discuss your center's capacities and to make specific plans for submitting 2017 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.** CPQCC adheres 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). Since 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 2017 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 **HnnnnEDSxxxx** and use the \*.mdb extension.

- **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. Refer to Appendix E for details. Please note that since 2013, we have reached the variables limit for Microsoft Access files. Therefore, if there are any more additions to the CPQCC DB, we will need to discontinue the support of the Microsoft Access files for future years.

**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 2017, 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 “12/12/2017{space}12:00” instead of 12/12/2017{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 is re-submitted, that has been updated since its previous 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 that 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 2017 EDS Specifications for the combined CPQCC Network – CPeTS Database lists all of the fields required for electronic submitted of data beginning in 2017. The table also specifies the ranges and coding rules for each field. (Refer to Appendix E. 2017 EDS Specifications).

### **Submission of Date/Time Variables**

#### **Microsoft Access.**

- **NOTE:** For 2017, 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. Please note that since 2013, we have reached the variables limit for Microsoft Access files. Therefore, if there are any more additions to the CPQCC DB, we will need to discontinue the support of the Microsoft Access files for future years.

#### **Text Files.**

- **NOTE:** For 2017, 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 "12/12/2017{space}12:00" instead of 12/12/2017{space}12:00.

## **IV. Summary of EDS Procedures for 2017**

- A. Data Center Procedures.** CPQCC will adhere to rigid specifications regarding file names, file types, file contents, and file submission procedures in 2017. 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 2017.
- B. How to submit EDS files for infants born in 2017.** Please send data files for infants born on or after January 1, 2017 in an e-mail attachment to [eds@cpqcc.org](mailto:eds@cpqcc.org). As the subject line for your 2017 EDS file please use "2017 EDS file for center nnnn," with nnnn replaced by your center's CPQCC membership number. 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 2017 SHOULD NOT be submitted in the same file for any records of infants born BEFORE 2017, otherwise these files will be rejected.

**C. How to submit EDS files for infants born in 2016.**

Records for infants born in 2016 MUST be submitted or updated in their original format in 2016. However, the files must comply with the 2016 All Baby EDS file specifications as described in the 2016 EDS Instructions. Send any new records or updates to records for infants born in 2016 as an e-mail attachment, zipped and password protected, to [eds@cpqcc.org](mailto:eds@cpqcc.org). As the subject line for your 2016 EDS file please use "2016 EDS file for center nnnn," with nnnn replaced by your center's CPQCC membership number.

**D. How to update records for Still In House Babies born in 2016.**

Records for infants born in 2016 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 2016 EDS records, otherwise files will be rejected.

**E. How the EDS Error Check within the CPQCC Data Management System issues errors for EDS file uploads**

The EDS Error Check issues errors for any of the following conditions:

1. File name does not begin with the letter H.
2. File name does not have EDS in positions 6 through 8.
3. File does not have the .zip extension.
4. Center is not approved for EDS submissions (based on characters 2 through 5 of the EDS file name).
5. File number is not in sequence (still allows addition of EDS file, but issues a user warning).
6. Password is incorrect.
7. Either ZIP file could not be unzipped successfully (pw incorrect) or file in ZIP archive is not named correctly.
8. File number already present in master DB.
9. Incorrect extension (not one of mdb, txt, or csv).
10. Data fields required are not present or not in the correct order in submitted data (CSV files).
11. Data fields not as required in mdb file.
12. The submitted Access DB includes all the required variables.

- However, at least one is not of the correct data type.
13. The submitted DB does not have the same file number and center number for ALL records.
  14. The length of the filename including the extension and period is not equal to 16.
  15. Not approved for EDS submissions based on NICU settings information in cpqcc.cpqccnicus (this means that the center was approved for the prior year, but has not yet undergone testing for the current year).
  16. ZIP file is corrupted! Cannot use this file! (Recommendation: Use the Test archive feature of your archiving software to ensure that the archive is not corrupt.)

## V. Summary of Changes to Data Elements and Procedures for 2017

- A. **Combined CPQCC Network – California Perinatal Transport System (CPeTS) Database.** Since 2007, CPQCC began managing the CPeTS Database. The 2017 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 2017 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 2017 MUST sequentially follow the last file number that was submitted in 2016. For example if the last file number submitted in 2016 was 999 then the first file number submitted for 2017 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. Since in 2012, we removed this variable from the MDB files due to the current variable constraints for Microsoft Access.
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. Since in 2012, we have removed this variable from the MDB files due to the current variable constraints for Microsoft Access.
6. **Acute Transfer-In Eligibility (ACUTETRS).** In 2017, 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: 2017 Starting ID Number.** In 2017 all CPQCC members are advised NOT to skip 10 IDs between submission years UNLESS the user has not yet closed out for 2016. For example, if a user is still submitting IDs for infants born in 2016 AND is also submitting new IDs for infants born in 2017, 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 2016 was 490, then the 2017 Starting ID Number should be 491. If you are unsure about your Starting ID Number please submit a help ticket through the CPQCC Help Desk at <https://cpqccsupport.org/>.

#### **D. Data Field Changes for 2017**

For Section II of the EDS specifications, refer to the CPeTS Manual of Definitions for Infants Born in 2017 for more specific data collection instructions.

For Section III of the EDS specifications, refer to the CPQCC Manual of Definitions for Infants Born in 2017 for more specific data collection instructions.

#### **E. 2017 Acute Transport Records.**

- **NOTE:** Data definitions developed by CPQCC are consistent with the CPeTS definitions. Please use the 2017 CPeTS Manual of Operations for instructions in completing the 2017 Acute Transport data items.

1. Selection Criteria. An infant is eligible for inclusion in the 2017 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. 2017 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 2017 CPQCC Manual of Operations for instructions in completing the 2017 Admission/Discharge data items. Also, please note that for 2017, all data must be recorded using the new 2017 CPQCC EDS Specifications. Any EDS specifications released by VON or CPQCC before 2017 are not compatible with the 2017 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 2017 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 **31 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 **31 weeks 6 days (inclusive)** is eligible, regardless of where in your hospital the infant receives care.
- c. Any infant who is born at or admitted to your hospital within 28 days of birth, with a birth weight that is greater than 1500 grams **MUST** also meet one of the following 10 criteria:
  - 1) Death,

- 2) Acute Transport-In,
- 3) Nasal IMV/SIMV (or any other form of non-intubated assisted ventilation) for greater than four continuous hours (for 2009 and later),
- 4) Intubated Assisted Ventilation for greater than four continuous hours,
- 5) Early Bacterial Sepsis,
- 6) Major surgery requiring anesthesia,
- 7) Acute Transport-Out of your NICU,
- 8) Previously Discharged Home and Readmitted to your hospital for Total Serum Bilirubin => 25mg/dL (427 micromols/Liter) and/or exchange transfusion,
- 9) Suspected Encephalopathy or suspected perinatal asphyxia.
- 10) Active therapeutic hypothermia.

➤ **NOTE:** Any Big Baby infant is eligible into the CPQCC database if the infant is admitted to your NICU within 28 days of birth, and then fulfills one of the 10 above criteria during the episode of care in your NICU. For criteria 8 (hyperbilirubinemia/ exchange transfusion), the infant may or may not be admitted to your NICU.

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 2017, which should be used on all infants that are eligible for inclusion in the 2017 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 2017 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 2017.*

- **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 2017.

- 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 2017

I. **Introduction.** This Appendix describes the changes in procedures or instructions for 2017 electronic data submissions, as compared to 2016.

**A. CPQCC Network Database Eligibility.** We would like to encourage our members to utilize the on-line 2017 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.

There will be no mandated changes to the CPQCC Eligibility Criteria for the 2017 CPQCC Network Database.

II. **Combined CPQCC Network – CPeTS Database Record Structure.**

**A. Combined CPQCC Network – CPeTS Database.** Since 2007, CPQCC started managing the CPeTS Database. The 2017 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.

**C. New and Revised Items to the On-Line CPeTS Transport Form**

**Starting in 2017 CPeTS has mandated the following changes:**

1. Changed “**Referral**” to “**Patient Diagnosis**” this change will be on the paper form and online form.
2. Changed “**Patient Identification/History**” to “**Critical Background Information**” this change will be on the paper form ONLY.
3. ~~Item C.2 Indication for Transport [T\_TRANSCODE]  
“Convalescent” added as an answer choice to the online and paper form.~~

2 = Medical Services

3 = Surgery

4 = Convalescent

6 = Insurance

8 = Bed Availability

Select Medical services if the infant was transported for medical problems that require acute resolution.

Select Surgery if the infant was transported primarily for major invasive surgery (requiring general anesthesia or its equivalent).

Select Convalescent if the infant was transported for convalescent or hospice care.

Select Insurance if the infant was transported for insurance purposes.

Select Bed Availability if the infant was transported due to bed availability issues at the referring facility.

4. Moved **Item C3b. Birth Head Circumference [BHEADCIR]** next to **Item C.3a Birth Weight [T\_BWGT]** this change will be on the paper form ONLY
5. **Item C.7a Maternal Gravida [T\_GRAVIDA]**, will be removed from the paper and online form. "**Prolonged Rupture of Membranes (> 18 hours)**" will replace this item on the paper form ONLY.

Select **Yes** if the rupture of the membranes is more than 18 hours prior to birth of the infant.

Select **No** if the rupture of the membranes is not more than 18 hours prior to birth of the infant.

Select **Unknown** if this information cannot be obtained.

6. **Item C.7b Labor Type** will be replaced by **Item C.7b Delivery Mode [DELMOD]**. This will be added to the paper form ONLY.

Select **Spontaneous Vaginal** for a Normal Vaginal delivery. This is any vaginal delivery for which instruments were not used. This includes cases where manual rotations or other head or shoulder maneuvers were used, provided instruments were not also used. Select **Operative Vaginal** for any vaginal delivery for which any instrumentation (forceps, vacuum) was used. Episiotomies are not considered operative deliveries.

Select **Cesarean** for any abdominal delivery.  
Select **Unknown** if this information cannot be obtained.

7. **Item C.8b Steroids [ASTER]**, changed to “**Antenatal Steroids**”. This change will be on the paper form ONLY.

Select **Yes** if corticosteroids were administered IM or IV to the mother during pregnancy at any time prior to delivery. Corticosteroids include betamethasone, dexamethasone, and hydrocortisone.

Select **No** if antenatal corticosteroids were not administered to the mother during pregnancy at any time prior to delivery or if there is no documentation in the medical record that antenatal steroid therapy was initiated before delivery.

Select **Unknown** if this information cannot be obtained (e.g. missing records from a referring hospital).

8. **Item C.9 Surfactant Given [T\_SURFX]**, removed from the paper form ONLY. This information will be collected in **Item C.13 Surfactant First Dose [T\_SURFXDATETIME]** on the paper form.

9. **Item C.11 Last Antenatal Steroid Administration (last dose) [T\_ASTERDATETIME]** has been removed from the paper form, this is greyed out on the online form.

10. **Item C.21c Method of Cooling for HIE [T\_COOLING1], [T\_COOLING2], [T\_COOLING3]**, definition changed from “**Selective Body**” to “**Whole Body**” for the paper form ONLY.

1=Passive  
2=Selective Head  
3=Whole Body  
4=Other  
9=Unknown

Select **Passive** if cooling was intentionally withholding standard temperature maintenance strategies for the purpose of achieving low temperature. If passive cooling is only used until head or body cooling is started, please select either head or body cooling.

Select **Selective Head** if active cooling was restricted to the head and brain as an intervention to reduce the temperature by exposing the head to lower than environmental temperature. Specially designed head cooling devices, other



cooling devices and ice packs applied to the head would be considered active cooling of the head and brain. Passive exposure to environmental temperature or cooling of the face for the treatment of supraventricular tachycardia is not considered active cooling of the head and brain.

Select **Whole Body** if active cooling of the body that is not restricted to the head and brain as an intervention to reduce the core body temperature and temperature of the brain by exposing the body to lower than environmental temperature. Whole body cooling may include cooling of the head in addition to the rest of the body. Cooling blankets, other cooling devices and ice packs applied to the body would be considered active cooling of the whole body. Passive exposure to environmental temperature is not considered active cooling of the whole body.

Select **Other** if cooling is actively administered in some other way that is not provided as an option.

11. **Item C.23 Respiratory Rate [T\_RESPRATE1], [T\_RESPRATE2], [T\_RESPRATE3]:** for clarification High Frequency Oscillatory Ventilation equal to 400 "HFOV = 400" has been added to the definition on the paper form ONLY.

12. **Item C.27 Respiratory Support [T\_VENTMODE1], [T\_VENTMODE2], [T\_VENTMODE3],** added "**Blowby**" to "**Hood/Nasal Cannula**". This change will be applied to the online and paper form.

0 = None

1 = Hood/Nasal Cannula, Blowby

2 = Nasal Continuous Positive Airway Pressure

3 = Endotracheal Tube

Select **None** if none of the methods of respiratory support listed below were used.

Select **Hood/Nasal Cannula (NC), Blowby** if the infant had spontaneous breathing and was supported using an oxygen hood, nasal cannula, or blowby.

Select **Nasal CPAP (NCPAP)** if the infant was provided with continuous positive airway pressure (CPAP) using nasal CPAP.

Select **Endotracheal Tube (ETT)** if the infant was ventilated using an endotracheal tube (ETT). Do not enter ETT if an endotracheal tube was placed only for suctioning and assisted ventilation was not given through the tube.

13. The following items have been renumbered (for the paper form ONLY):

- **Item C.21a. Temperature [T\_TEMP1], [T\_TEMP2], [T\_TEMP2]:** Too Low to register
- **Item C.21b. Temperature [T\_COOLING1], [T\_COOLING2], [T\_COOLING3]:** Was the infant cooled?
- **Item C.21c. Temperature [T\_COOLINGMETHOD1], [T\_COOLINGMETHOD2], [T\_COOLINGMETHOD3]:** Method of cooling
- **Item C.28a. Blood Pressure [T\_BPSYS1], [T\_BPSYS2], [T\_BPSYS3]:** Too low to register

14. Under “**Referral Process**” the following fields have been added/updated on the paper form only:

- Sending Hospital rsing Contact Information Name/Telephone
- Transport Information Names/Telephone Numbers
- Extra line for “Comments”

#### **D. New and Revised Items to the CPQCC Admission/Discharge Form**

In 2017, Item 22 Temperature and Cooling will include “for Hypoxic-Ischemic Encephalopathy (HIE)” so that it is clear that the cooling was for Hypoxic-Ischemic Encephalopathy (HIE).

#### **15. Item 22 Temperature and Cooling for Hypoxic-Ischemic Encephalopathy (HIE):**

(a) Was the Temperature Measured within the First Hour after Admission to Your NICU **[ATEMPM]**

1=Yes  
0=No  
7=N/A  
9=Unknown

Select **Yes** if the infant's core body temperature was measured and recorded within the first hour after admission to your NICU. Core body temperature may be measured by taking a rectal,

esophageal, tympanic or axillary temperature.

Select **No** if the infant's core body temperature was not measured and recorded within the first hour after admission to your NICU.

Select **Not Applicable** if the infant is eligible but was never admitted to your NICU.

- Notes: This item applies to the temperature of the infant during the first hour after admission to your NICU. For out born infants, do not record temperature measurements taken at the transporting center.

If an attempt was made to measure temperature during the first hour after admission to your NICU, and the temperature of the infant was lower than what the thermometer could measure, Select 'Yes' and check 'Too low to register' in item 22b. If the infant's core body temperature was not measured within the first hour after admission to your NICU, item 22b. is not applicable.

For infants not undergoing cooling during the transport process, this item propagates the same variable in the CPeTS on-line form (Item C.21c at NICU admission).

(b) First Temperature at Admission to Your NICU **[ATEMP]**

0, 20.0 to 45.0, 999.9 = ATEMP

777.7=N/A

888.8=Too Low to Register

999.9=Unknown

If the infant's core body temperature was measured and recorded within the first hour of the initial admission to your NICU, enter the infant's temperature in degrees centigrade to the nearest tenth of a degree. If the infant's temperature is measured multiple times within the first hour after admission to your NICU, enter the value of the first temperature measurement. Use rectal temperature or, if not available, esophageal temperature, tympanic temperature or axillary temperature, in that order. Check the option Too Low to Register for situations in which the infant's temperature is too low to register on the thermometer used. Temperatures may be entered in degrees Celsius or Fahrenheit. Item 22b. applies to the first temperature measured within an hour of the initial

admission to your NICU, even if the baby is being readmitted.

(c) Cooling for HIE [**ACooling**]

0=No Cooling for HIE

1=Cooling Started for HIE

2=Cooling Continued for Transfer-In for HIE

7=N/A

9=Unknown

Select **No Cooling for HIE** if no attempt for cooling / administration of hypothermic therapy was done at any time during the first admission to your NICU.

Select **Cooling Started for HIE** if the first attempt for cooling / administration of hypothermic therapy was started during the first admission to your NICU.

Select **Cooling Continued for Transport-in for HIE** if the first attempt for cooling / administration of hypothermic therapy was started at another hospital prior to admission to your NICU, and then continued during the first admission to your NICU. The option Cooling Continued for Transport-in is not applicable for inborn infants and will not be displayed on the on-line form for inborn infants.

Select **Unknown** if this information cannot be obtained.

- Notes: Item 22c applies only to the first admission to your NICU. If the infant is transported out and re-admitted to your NICU, do not update this item.

(d) Cooling Method for HIE [**ACoolingMethod**]

1=Passive,

2>Selective Head

3=Whole Body

4=Other

7=N/A

9=Unknown

If an infant was cooled for Hypoxic-Ischemic Encephalopathy (HIE) at any time during the initial admission to your NICU, record the last type of hypothermic therapy administered during the initial NICU admission.

Select **Passive** if cooling was intentionally withholding standard

temperature maintenance strategies for the purpose of achieving low temperature. If passive cooling is only used until head or body cooling is started, please select either head or body cooling.

Select **Selective Head** if active cooling was restricted to the head and brain as an intervention to reduce the temperature by exposing the head to lower than environmental temperature. Specially designed head cooling devices, other cooling devices and ice packs applied to the head would be considered active cooling of the head and brain. Passive exposure to environmental temperature or cooling of the face for the treatment of supraventricular tachycardia is not considered active cooling of the head and brain.

Select **Whole Body** if active cooling of the body that is not restricted to the head and brain as an intervention to reduce the core body temperature and temperature of the brain by exposing the body to lower than environmental temperature. Whole body cooling may include cooling of the head in addition to the rest of the body. Cooling blankets, other cooling devices and ice packs applied to the body would be considered active cooling of the whole body. Passive exposure to environmental temperature is not considered active cooling of the whole body.

Select **Other** if cooling is actively administered in some other way that is not provided as an option.

Select **Unknown** if this information cannot be obtained.

- **Notes:** If an infant is administered several methods of hypothermic therapy during the NICU admission, record the last type of hypothermic therapy administered during the first admission to your NICU. Item 22d applies only to the first admission to your NICU. If the infant is transported out and re-admitted to your NICU, do not update this item. This item is Not Applicable if the infant was not cooled.

16. Starting in 2016, we will add a note to Item 40b. Necrotizing Enterocolitis [NEC] to clarify when to select "Yes Here and Elsewhere".

Determine whether an infant has (a) Necrotizing Enterocolitis

(NEC) diagnosed at surgery, or (b) NEC diagnosed at postmortem examination, or (c) NEC diagnosed clinically and radiographically using the following criteria:

1) One or more of the following clinical signs present:

- Bilious gastric aspirate or emesis;
- Abdominal distension;
- Occult or gross blood in stool with no apparent rectal fissure.

AND

2) One or more of the following radiographic findings present:

- Pneumatosis intestinalis;
- Hepato-biliary gas;
- Pneumoperitoneum.

Select **Yes, Here** if NEC occurred at your hospital prior to initial disposition or following readmission after initial transport.

Select **Yes, Elsewhere** if NEC occurred at another hospital.

Select **Yes, Here and Elsewhere** if NEC occurred BOTH at your hospital AND at another hospital as defined above.

➤ **Note:**

Only select "Yes Here and Elsewhere" if NEC happened elsewhere prior to your hospital and then at your hospital, after a week of full feedings, NEC happened again.

Select No if the infant did not satisfy the above definition of NEC.

Select Unknown if this information cannot be obtained.

➤ **Notes:**

- Infants who satisfy the definition of Necrotizing Enterocolitis below but are found at surgery or post-mortem examination for that episode to have a "Focal Gastrointestinal Perforation" should be coded as having "focal gastrointestinal perforation," not as having NEC. There may also be infants who have an isolated perforation unassociated with clinical NEC; these cases should not be classified as having NEC.
- When infants transport to your hospital or are

readmitted to your hospital after initial transport, NEC will be considered to have occurred at another hospital in the following situations: 1. NEC was diagnosed at the other hospital prior to admission to your hospital or prior to readmission following initial transport. 2. NEC was diagnosed within 4 hours of admission to your hospital.

- Recurrence or recrudescence of NEC that had previously occurred at another hospital will not be considered to be NEC that occurred at your hospital unless the original case of NEC had resolved and the infant had been on full feedings for 1 week or more.

## **Appendix B**

### **Bacterial Pathogens, Infants Born in 2017**

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 capecica* 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 other

## **Appendix C**

### **Surgery Codes for Item 43, Infants Born in 2017**

#### **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
- S109 Craniotomy
- 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 pleuridesis/pleurectomy)
- S205 Thoracotomy (with or without pleural or lung biopsy)
- S206 Pneumonectomy, 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
- S214 Sternal closure
- 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 Ostomy creation (with or without fistula creation)
- S308 Small bowel resection
- S309 Large bowel resection
- S310 Duodenal Atresia/Stenosis/Web 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 Partial/complete splenectomy or splenorrhaphy
- S323 Resection of retroperitoneal tumor
- S324 Resection of sacrococcygeal tumor
- S325 Repair of diaphragmatic hernia
- S326 Plication of the diaphragm
- S327 Gastrostomy tube/jejunostomy tube
- S328 Upper endoscopy (stomach or duodenum, with or without biopsy)

- S329 Colonoscopy/sigmoidoscopy
- 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 Liver biopsy done during laparotomy or laparoscopy (includes wedge or needle techniques)
- S337 Umbilical hernia repair
- 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 or removal 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
- S506 Implanted pacemaker (permanent-do not use code for temporary pacemaker)

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 placement or removal

S904 Meningocele or myelomeningocele repair

S905 Encephalocele 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 2017**

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 2017 Manual of Definitions).

**Central Nervous System Defects**

- 101 Anencephaly  
102 Meningomyelocele  
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 Alveolar 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**

- 121 Hematologic
- 122 Hemolytic Disease of the Newborn (Not ABO)

**Appendix E. 2017 CPQCC EDS Specifications**

**2017 EDS Specifications for the combined CPQCC Network - CPeTS Database  
(Version 10.2, 2.06.18)**

**Summary of FIELDS for 2017**

**Section I. Tracking Fields**

**Tracking Fields**

2017 Item	Field Name	Description	Field Type	Range of Possible Values	Coding Rules
None	<b>FILENUM</b>	File Submission Number	Integer	{1 - 9999}	Sequentially assigned file number, incremented with each submission
None	<b>FILEDATE</b>	File Submission Date	Date	01/01/2017-06/30/2017	Date on which data is exported to file for submission to CPQCC. Valid date, format
None	<b>DELETED</b>	Record deleted	Integer	{BLANK, 1}	BLANK=No, 1=Yes record deleted (but unique network ID number preserved)
None	<b>APPLICATION</b>	Application Submitting the Data File	Char25		Up to 25 alphanumeric characters. <b>Starting in 2012, we removed this variable from the MDB files due to the current variable constraints for Microsoft Access.</b>
None	<b>VERSION</b>	Version of Application Submitting Data File	Char15		Up to 15 alphanumeric characters. <b>Starting in 2012, we removed this variable from the MDB files due to the current variable constraints for Microsoft Access.</b>
None	<b>HOSPNO</b>	Center ID Number	Integer		Center ID Number as assigned by CPQCC
None	<b>ID</b>	Network ID Number	Integer	{00001 - 99998}	Each ID number is to be sequentially assigned by hospital
None	<b>BYEAR</b>	Birth Year	Integer	{2017}	For infants born on 2005 to 2013, EDS Specifications for 2005 through 2013 must be used respectively. Submit these files separately from any files with 2013 records.



None	<b>ACUTETRS</b>	Acute Transport-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.
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**Section II. 2017 EDS Specifications for the CPeTS Database**

**NOTE: Title of specific sub-section of CPeTS Form in light GREEN.**

**NOTE: Notations are highlighted in GREEN.**

**NOTE: ITEMS DISCONTINUED in CPeTS are highlighted in Gray with strikethrough. Items discontinued in 2010 will remain discontinued in 2017.**

**NOTE: NEW & REVISED FIELDS FOR 2017 ARE HIGHLIGHTED IN Yellow for CPeTS**

**Patient Diagnosis**

**Transport Type**

2017 Item	Field Name	Description	Field Type	Range of Possible Values	Coding Rules
None	<b>T_SPECIALSITUATION</b>	Transport Special Situation	Char4	{0000}	0000=N/A, Record does NOT require a Transport Special Situation Override;
				{1000}	1000=Situation A. Delivery Room Attendance: 7777=N/A TRIP Referral section first column Items C.20 through C.29 (T_COOLING1, T_COOLINGMETHOD1, T_RESP1, T_RESPRATE1, T_SA021, T_RESPSTATUS1, T_FIO21, T_HEARTRATE1, T_BPSYS1, T_BPDIA1, T_BPMEAN1, T_PRESSOR1, T_TEMP1, T_VENTMODE1): NOTE: Situation A

		{0100, 0110, 0101, 0111}	<p>0100= Situation B. Transport by Referring Center (Self-Transport): 7777=N/A  T_EVALINITDATETIME, TRIP Referral section second column Items C.20 through C.29 (T_COOLING2, T_COOLINGMETHOD2, T_RESP2, T_RESPRATE2, T_SA022, T_RESPSTATUS2, T_FIO22, T_HEARTRATE2, T_BPSYS2, T_BPDIA2, T_BPMEAN2, T_PRESSOR2, T_TEMP2, 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.</p>
		{0010, 0110, 0011, 0111}	<p>0010= Situation C. Transport from Emergency Department or other non-perinatal setting: N/A=T_MADMDATETIME, T_CMAL, T_BDC1 to T_BDC5, T_GRAVIDA, T_ASTERDATETIME; T_BDATETIME= Must submit Date of Birth, then enter N/A=Time of Birth ONLY, T_BWGT= enter current weight (if current weight is missing, enter 9999); 0110= Situation B and Situation C; 0011= Situation C and Situation D; 0111= Situation B, Situation C, and Situation D.</p>

				{0001, 0101, 0011, 0111}	0001= Situation D. Safe Surrender: N/A=T_MADMDATETIME, T_CMAL, T_BDC1 to T_BDC5, T_GRAVIDA, T_ASTERDATETIME, DRSURF, T_SURFX; T_BDATETIME= Must submit Date of Birth, then enter N/A=Time of Birth ONLY, T_BWGT= enter current weight (if current weight is missing, enter 9999); 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.1	T_TYPEDESC	Type Describe	Char50	{Description, 77}	Up to 50 alphanumeric characters; 77=N/A (only if [ACUTETRS]=0)
<b>Indication for Transport</b>					
<b>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.</b>					
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
<b>Referral Date and Time (Time Sequence CPeTS)</b>					
<b>NOTE: This is the same as Referral Date/Time in Item C.14. Submit this variable only once using this field.</b>					

C.14	T_REFDATETIME	Date/Time of Referral (and Referring Hospital Evaluation)	Char16	{01 - 12}/{01 - 31}/{2017}{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 "12/12/2017{space}12:00" instead of 12/12/2017{space}12:00.
<b>Date/Time of Acceptance (Time Sequence CPeTS)</b>					
C.15	T_ACCDATETIME	Date/Time of Acceptance	Char16	{01 - 12}/{01 - 31}/{2017}{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
<b>History and Demographics</b>					
<b>Date &amp; Time of Maternal Admission to Labor &amp; Delivery</b>					

<b>C.10</b>	<b>T_MADMDATETI ME</b>	Date/Time of Mother's Admission to Perinatal Unit or L&D	Char16	{01 - 12}/{01 - 31}/{2017}{space}{00}:{00}; {07}/{07}/{1907}{space}{07}:{07}; {01 - 12}/{01 - 31}/{2017}{space}{99}:{99}	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); mm/dd/yyyy 99:99=Known Maternal Date of Birth but Unknown Time; {01 - 12}/{01 - 31}/{2017}{space}{99}:{99}; 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
<b>Infant Birth Date and Time</b>					
<b>NOTE: If [ACUTETRS]=1, then C.12 [T_BDATETIME] must = [BDATE] in the CPQCC Section. Submit this</b>					

C.12	T_BDATETIME	Date/Time of Birth	Char16	{01 - 12}/{01 - 31}/{2017}{space}{00}:{00}; {07}/{07}/{1907}{space}{07}:{07}; {01 - 12}/{01 - 31}/{2017}{space}{99}:{99}	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); mm/dd/yyyy 99:99=Known Date of Birth but Unknown Time; {01 - 12}/{01 - 31}/{2017}{space}{99}:{99}. 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 "12/12/2017{space}12:00" instead of 12/12/2017{space}12:00. NOTE: If [ACUTETRS]=1, then T.6 [T_BDATE] must = [BDATE] in the CPQCC Section. Submit this variable twice.
<b>Birth Weight</b>					
<b>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.</b>					
<b>Best estimate of gestational age</b>					
<b>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.</b>					
<b>Infant Sex</b>					
<b>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.</b>					
<b>Congenital Anomalies</b>					
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.**

**Mother's Date of Birth**

<b>NOTE: If [ACUTETRS]=1, then C.7a [MDATE] must = [MDATE] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.</b>					
<b>Number of Mother's Pregnancies Including the Current Pregnancies (Gravida)</b>					
C.7b	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
<b>Antenatal Steroids</b>					
<b>NOTE: If [ACUTETRS]=1, then C.8a [ASTER] must = [ASTER] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.</b>					
<b>Antenatal Conditions, Magnesium - Antenatal Magnesium Sulfate</b>					
<b>NOTE: If [ACUTETRS]=1, then C.8b [ANCMAMAGSULF] must = [ANCMAMAGSULF] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.</b>					
<b>Date &amp; Time of Last Antenatal Steroid Administration</b>					
C.11	T_ASTERDATETI ME	Date/Time of ANS- Administration	Char16	{01-12}/{01-31}/{2013}{space}{00-00}	<del>Item C.11 was discontinued in 2010. However, Item C.11 will appear on the Core CPeTS Acute Inter-facility paper form for 2013. But Item C.11 will be grayed-out and will not be available on the On-Line CPeTS form.</del>
<b>Surfactant Use</b>					
<b>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.</b>					
C.9b	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_SURFXDATE TIME	Date/Time of Surfactant Administration	Char16	{01 - 12}/{01 - 31}/{2013}{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
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**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_EVALINITDATE TIME	Date/Time of Arrival of Initial Evaluation by Transport Team within 15 Minutes of Arrival at Referring Hospital	Char16	{01 - 12}/{01 - 31}/{2017}{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
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**Date/Time of Initial Evaluation by Transport Team within 15 minutes of Arrival at Referring Hospital**

C.19	T_EVALNICUDAT ETIME	Date/Time of Arrival at Receiving NICU and Initial NICU Evaluation	Char16	{01 - 12}/{01 - 31}/{2017}{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); <b>09/09/1909 09:09=Unknown</b> . 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 "12/12/2013{space}12:00" instead of 12/12/2013{space}12:00.
<b>Responsiveness</b>					
C.20	T_RESP1	Responsiveness at	Integer	{0, 1, 2, 3, 7, 9}	0=Death; 1=None, Seizures, Muscle
	T_RESP2	Responsiveness at Initial Evaluation	Integer	{0, 1, 2, 3, 7, 9}	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); <b>9=Unknown</b>
	T_RESP3	Responsiveness at NICU Admission	Integer	{0, 1, 2, 3, 7, 9}	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); <b>9=Unknown</b>
<b>Respiratory Rate (0 to 400)</b>					
C.23	T_RESPRATE1	Respiratory Rate at Referral	Integer	{0 - 400, 777, 999}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1), <b>999=Unknown</b>
	T_RESPRATE2	Respiratory Rate at Initial Evaluation	Integer	{0 - 400, 777, 999}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1), <b>999=Unknown</b>

	<b>T_RESPRATE3</b>	Respiratory Rate at NICU Admission	Integer	{0 - 400, 777, 999}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1), 999=Unknown
<b>Oxygen Saturation (SaO2) (0 to 100)</b>					
<b>C.24</b>	<b>T_SAO21</b>	Oxygen Saturation (SaO2) at Referral	Integer	{0 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1), 999=Unknown
	<b>T_SAO22</b>	Oxygen Saturation (SaO2) at Initial Evaluation	Integer	{0 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1), 999=Unknown
	<b>T_SAO23</b>	Oxygen Saturation (SaO2) at NICU Admission	Integer	{0 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0 OR (only if [T_TYPE]=1), 999=Unknown
<b>Respiratory Status</b>					
<b>C.25</b>	<b>T_RESPSTATUS1</b>	Respiratory Status at Referral	Integer	{1 , 2, 3, 7, 9}	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); 9=Unknown
	<b>T_RESPSTATUS2</b>	Respiratory Status at Initial Evaluation	Integer	{1 , 2, 3, 7, 9}	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); 9=Unknown
	<b>T_RESPSTATUS3</b>	Respiratory Status at NICU Admission	Integer	{1 , 2, 3, 7, 9}	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); 9=Unknown
<b>Oxygen Index (for infants on respirator only)</b>					
<b>C.26</b>	<b>Inspired Oxygen Concentration (FiO2) (21 to 100)</b>				
	<b>T_FIO21</b>	Inspired Oxygen Concentration (FIO2) 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
	<b>T_FIO22</b>	Inspired Oxygen Concentration (FIO2) at Initial Evaluation	Integer	{21 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS2]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown
	<b>T_FIO23</b>	Inspired Oxygen Concentration (FIO2) at NICU Admission	Integer	{21 - 100, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS3]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown

<b>Heart Rate (0 to 400)</b>					
C.22	<b>T_HEARTRATE1</b>	Heart Rate at Referral	Integer	{0 - 400, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 999=Unknown
	<b>T_HEARTRATE2</b>	Heart Rate at Initial Evaluation	Integer	{0 - 400, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 999=Unknown
	<b>T_HEARTRATE3</b>	Heart Rate at NICU Admission	Integer	{0 - 400, 777, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 999=Unknown
<b>Blood Pressure</b>					
C.28a	<b>Systolic (0 to 140)</b>				
	<b>T_BPSYS1</b>	Systolic Blood Pressure at Referral	Integer	{0 - 140, 777, 888, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 888=Too Low to Register, 999=Unknown
	<b>T_BPSYS2</b>	Systolic Blood Pressure at Initial Evaluation	Integer	{0 - 140, 777, 888, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 888=Too Low to Register, 999=Unknown
	<b>T_BPSYS3</b>	Systolic Blood Pressure at NICU Admission	Integer	{0 - 140, 777, 888, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 888=Too Low to Register, 999=Unknown
C.28b	<b>Diastolic (0 to 100)</b>				
	<b>T_BPDIA1</b>	Diastolic Blood Pressure at Referral	Integer	{0 - 100, 777, 888, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 888=Too Low to Register, 999=Unknown
	<b>T_BPDIA2</b>	Diastolic Blood Pressure at Initial Evaluation	Integer	{0 - 100, 777, 888, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 888=Too Low to Register, 999=Unknown
	<b>T_BPDIA3</b>	Diastolic Blood Pressure at NICU Admission	Integer	{0 - 100, 777, 888, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 888=Too Low to Register, 999=Unknown
C.28c	<b>Mean (0 to 100)</b>				
	<b>T_BPMEAN1</b>	Mean Blood Pressure at Referral	Integer	{0 - 100, 777, 888, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 888=Too Low to Register, 999=Unknown
	<b>T_BPMEAN2</b>	Mean Blood Pressure at Initial Evaluation	Integer	{0 - 100, 777, 888, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 888=Too Low to Register, 999=Unknown

	<b>T_BPMEAN3</b>	Mean Blood Pressure at NICU Admission	Integer	{0 - 100, 777, 888, 999}	777=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 888=Too Low to Register, 999=Unknown
<b>Use of Pressors</b>					
C.29	<b>T_PRESSOR1</b>	Use of Pressors at Referral	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 9=Unknown
	<b>T_PRESSOR2</b>	Use of Pressors at Initial Evaluation	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 9=Unknown
	<b>T_PRESSOR3</b>	Use of Pressors at NICU Admission	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 9=Unknown
<b>Temperature (20 to 45 Celsius)</b>					
C.21a	<b>T_TEMP1</b>	Temperature (20 to 45 Celsius) at Referral	Double	{20.0 - 45.0, 777.7, 888.8, 999.9}	20.0 -45.0 degrees Celcius, 777.7=N/A (Only if [ACUTETRS]=0 OR [T_TYPE]=1 OR [DELDIE]=1), 999.9=Unknown, 888.8=Too Low to Register - Note: Enter if the attempted reading is lower than the thermometer could
C.21a	<b>T_TEMP2</b>	Temperature (20 to 45 Celsius) at Referral at Initial Evaluation	Double	{20.0 - 45.0, 777.7, 888.8, 999.9}	20.0 -45.0 degrees Celcius, 777.7=N/A (Only if [ACUTETRS]=0 OR [T_TYPE]=1 OR [DELDIE]=1), 999.9=Unknown, 888.8=Too Low to Register - Note: Enter if the attempted reading is lower than the thermometer could
<b>NOTE: If [ACUTETRS]=1, then C.21a [T_TEMP3] must = 22b [ATEMP] in the CPQCC Section.</b>					
C.21a	<b>T_TEMP3</b>	Temperature (20 to 45 Celsius) at Referral at NICU Admission	Double	{20.0 - 45.0, 777.7, 888.8, 999.9}	20.0 -45.0 degrees Celcius, 777.7=N/A (Only if [ACUTETRS]=0 OR [T_TYPE]=1 OR [DELDIE]=1), 999.9=Unknown, 888.8=Too Low to Register - Note: Enter if the attempted reading is lower than the thermometer could
<b>COOLING</b>					
C.21b	<b>T_COOLING1</b>	Cooling <b>for HIE</b> at Referral	Integer	{0,1,7, 9}	0=No, 1=Yes, 7=N/A (Only if [ACUTETRS]=0 OR [T_SPECIALSITUATION]=1000 OR [T_TYPE]=1 OR [DELDIE]=1), 9=Unknown
C.21b	<b>T_COOLING2</b>	Cooling <b>for HIE</b> at Initial Evaluation	Integer	{0,1,7, 9}	0=No, 1=Yes, 7=N/A (Only if [ACUTETRS]=0 OR [T_SPECIALSITUATION]=1000 OR [T_TYPE]=1 OR [DELDIE]=1), 9=Unknown

C.21b	T_COOLING3	Cooling for HIE at NICU Admission	Integer	{0,1,7, 9}	0=No, 1=Yes, 7=N/A (Only if [ACUTETRS]=0 OR [T_SPECIALSITUATION]=1000 OR [T_TYPE]=1 OR [DELDIE]=1), 9=Unknown
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C.21c	T_COOLINGMET HOD1	Type of Hypothermic Therapy <b>for HIE</b> at Referral (Check the last method used)	Integer	{1,2,3,4,7, 9}	1=Passive, 2=Selective Head, 3=Whole Body, 4=Other (Only if [T_COOLING1]=1, 7=N/A (Only if [T_COOLING1]=0 OR [ACUTETRS]=0 OR [T_SPECIALSITUATION]=1000 OR [T_TYPE]=1 OR [DELDIE]=1), 9=Unknown
C.21c	T_COOLINGMET HOD2	Type of Hypothermic Therapy <b>for HIE</b> at Initial Evaluation (Check the last method used)	Integer	{1,2,3,4,7, 9}	1=Passive, 2=Selective Head, 3=Whole Body, 4=Other (Only if [T_COOLING1]=1, 7=N/A (Only if [T_COOLING1]=0 OR [ACUTETRS]=0 OR [T_SPECIALSITUATION]=1000 OR [T_TYPE]=1 OR [DELDIE]=1), 9=Unknown
C.21c	T_COOLINGMET HOD3	Type of Hypothermic Therapy <b>for HIE</b> at NICU Admission (Check the last method used)	Integer	{1,2,3,4,7, 9}	1=Passive, 2=Selective Head, 3=Whole Body, 4=Other (Only if [T_COOLING1]=1, 7=N/A (Only if [T_COOLING1]=0 OR [ACUTETRS]=0 OR [T_SPECIALSITUATION]=1000 OR [T_TYPE]=1 OR [DELDIE]=1), 9=Unknown
<b>Respiratory Support</b>					
C.27	T_VENTMODE1	Respiratory Support at Referral	Integer	{0, 1, 2, 3, 7, 9}	0=None, <b>1=Hood/NC,Blowby</b> , 2=Nasal CPAP, 3=ETT, 7=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 9=Unknown
C.27	T_VENTMODE2	Respiratory Support at Initial Evaluation	Integer	{0, 1, 2, 3, 7, 9}	0=None, <b>1=Hood/NC,Blowby</b> , 2=Nasal CPAP, 3=ETT, 7=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 9=Unknown
C.27	T_VENTMODE3	Respiratory Support at NICU Admission	Integer	{0, 1, 2, 3, 7, 9}	0=None, <b>1=Hood/NC,Blowby</b> , 2=Nasal CPAP, 3=ETT, 7=N/A (only if [ACUTETRS]=0) OR (only if [T_TYPE]=1), 9=Unknown
<b>Referral Process</b>					
<b>Referring Hospital</b>					
C.30	T_REFERRINGH OSPITAL	Referring Hospital	Char6	{OSHPD ID, 777777}	Valid OSHPD ID number (see list); 777777=N/A (only if [ACUTETRS]=0)
<b>Previous Transfer?</b>					

C.31a	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.31b	T_PREVHOSPITAL	Previously Transfer Referring Hospital	Char6	{OSHPD ID, 777777}	Valid OSHPD ID number (see list); 777777=N/A (if [T_firstTrans] =1) OR (only if [ACUTETRS]=0)
<b>Location of Birth</b>					
<b>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.</b>					
<b>Transport Team On-Site Leader</b>					
C.33	T_TEAMLEADER	Team Leader	Integer	{1, 2, 3, 4, 5, 6, 7}	1=Sub-Specialist, 2=Pediatician, 3=Other MD/Resident, 4=Neonatal Nurse Practitioner, 5=Transport Specialist, 6=Nurse, 7=N/A (only if [ACUTETRS]=0)
<b>Team Baser</b>					
C.34a	T_TEAMBASE	Team Base	Integer	{1, 2, 3, 7}	1=Receiving Hospital, 2=Contract Service, 3=Referring Hospital, 7=N/A (only if
C.34b	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)
<b>Mode of Transport</b>					
C.35	T_TRANSMODE	Mode of Transport	Integer	{1, 2, 3, 7}	1=Ground, 2=Helicopter, 3=Fixed Wing, 7=N/A (only if [ACUTETRS]=0)
<b>Date/Time of Transport Team Departure for Referring Hospital</b>					



C.16	T_TDEPDATE ME	Date/Time of Transport Team Departure from Transport Team Office/NICU for Referring Hospital	Char16	{01 - 12}/{01 - 31}/{2017}{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 "12/12/2017{space}12:00" instead of 12/12/2017{space}12:00.
<b>Date/Time of Arrival of Transport Team at Referring Hospital</b>					
C.17	T_TARRDATE ME	Date/Time of Transport Team Arrival at Referring Hospital/Patient Bedside	Char16	{01 - 12}/{01 - 31}/{2017}{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 "12/12/2013{space}12:00" instead of 12/12/2013{space}12:00.

<b>User Comment Box</b>					
C.35	<b>T_USERCOMMENT</b>	User Comment Box	Char256	{Description, 77}	Up to 256 alphanumeric characters; 77=N/A (only if [ACUTETRS]=0)

**Section III. 2017 EDS Specifications for the CPQCC Database**

**NOTE: Title of specific sub-section of A/D, Transport, and DRD Forms in light GREEN.**

**NOTE: Notations are highlighted in GREEN.**

**NOTE: ITEMS DISCONTINUED in CPQCC are highlighted in Gray with strikethrough. These will remain**

**NOTE: NEW & REVISED FIELDS FOR 2017 ARE HIGHLIGHTED IN Yellow for CPQCC**

**Tracking Fields (See Section I for Tracking Fields)**

**Identification and Demographics**

2014 Item	Field Name	Description	Field Type	Range of Possible Values	Coding Rules
<b>NOTE: If [ACUTETRS]=1 AND [T_BWGT] is not equal to 9999, then C.3 [T_BWGT] must = [BWGT] in the</b>					
1	<b>BWGT</b>	Birth Weight (in Grams)	Long Integer	{1 - 7000}	For infants born in <b>2014</b> , birth weight can be 400 grams or less <b>ONLY IF</b> [GAWEEKS] is between 22 and <b>31 completed</b> weeks
2	<b>BHEADCIR</b>	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	<b>GAWEEKS</b>	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	<b>GADAYS</b>	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\_BDATETIME] must = [BDATE] in the CPQCC Section. Submit this**

4a.	<b>BDATETIME</b>	Birth Date/Time	Char16	{01 - 12}/{01 - 31}/{2017}{space}{00-23}:{00-59}; {01 - 12}/{01 - 31}/{2017}{space}{99}:{99}	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;  {01-12}/{01-31}/{2017} {00-23}:{00-59}= Date & Time of Birth if time of birth is known {01-12}/{01-31}/{2017} {99:99} = Date & Time of birth if time of birth is 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 "12/12/2017{space}12:00" instead of 12/12/2017{space}12:00. NOTE: If [ACUTETRS]=1, then T.6 [T_BDATE] must = [BDATE] in the CPQCC Section. Submit this variable twice.
<b>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.</b>					
5	<b>SEX</b>	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	<b>DELDIE</b>	Delivery Room Death	Integer	{0, 1}	0=No, 1=Yes
7a	<b>LOCATE</b>	Location of Birth	Integer	{0, 1, 2}	0=Inborn; 1=Outborn; 2=Born at Co-Located Hospital (Satellite NICU ONLY). Always 0 if

7b	<b>DAYADMISS</b>	Age in days at admission	Integer	{1 - 28, 77}	1 to 28 for outborn infants or inborn infants not meeting small baby criteria. DAYADMISS for inborn infants 401 to 1,500 grams or 22 to 29 <b>completed</b> weeks gestation should be 1. Note: Currently a value of 77 is accepted for inborn infants 401 to 1,500 grams or 22 to 29 <b>completed</b> weeks gestation and mapped to 1 by the EDS intake routine.
<b>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.</b>					
7c	<b>BIRTHLOCATION</b>	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	<b>PDH</b>	Was Previously Discharged Home after Birth (Outborn Infants). NOTE: A home birth does NOT qualify for checking "Previously Discharged Home From	Integer	{0, 1, 7}	0=Never Discharged Home from a Hospital after Birth (Only if [LOCATE]=1), 1=Was Previously Discharged Home after Birth (Only if [LOCATE]=1), 7=N/A (If [DELDIE]=1 OR [LOCATE]=0)
8b	<b>READMIT</b>	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)
<b>Maternal History, Delivery Room Care, and Surfactant Use</b>					
<b>NOTE: If [ACUTETRS]=1, then C.7a [MDATE] must = [MDATE] in the CPQCC Section. Submit this variable</b>					

9	<b>MDATE</b>	Mother's Date of Birth	Date	{Range depends on mother's age on infant's birth date, 09/09/1909}	Date format mm/dd/yyyy; 09/09/1909=Unknown
	<b>MAGE</b>	Mother's Age at Infant's Birth (Age Last Birthday)	Integer	{10 - 60, 99}	99=Unknown
10a	<b>HISP</b>	Is Mother of Hispanic Origin?	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
10b	<b>MATRACE</b> <i>(variable name changed from NEWRACE to MATRACE)</i>	Maternal Race	Integer	{1, 3, 4, 5, 6, 7, 99}	1=Black, 3=White, 4=Asian, 5=American Indian or Alaska Native, 6=Native Hawaiian or Pacific Islander, 7=Other identified race, 99=Unknown
11	<b>PCARE</b>	Prenatal Care	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
12	<b>GROUPBSTREP</b>	Group B Strep Positive	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A, 9=Unknown
<b>NOTE: If [ACUTETRS]=1, then C.8a [ASTER] must = [ASTER] in the CPQCC Section. Submit this variable once by only entering the data in the CPQCC Section.</b>					
13a	<b>ASTER</b>	Antenatal Steroids Received Prior to Delivery	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
<b>NOTE: Starting from 2013, this item [ASTERDOCUMENT] is only applicable and OPTIONAL for inborn infants who are &lt;32 weeks gestational age.</b>					
13b	<b>ASTERDOCUMENT</b>	Documentation in the medical record for reasons for NOT initiating antenatal steroid therapy before delivery.	Integer	{0,1, 7, 9}	0=No, 1=Yes, 7=N/A, 9=Unknown
<b>NOTE: Starting from 2013, this item [ASTERREASON] is only applicable and OPTIONAL for inborn infants who are &lt;32 weeks gestational age.</b>					

13c	<b>ASTERREASON</b>	If Yes, what was the documented reason for NOT administering antenatal steroids?	Integer	{0, 1, 2, 3, 4, 5, 6, 7, 77, 99}	1=Chorioamnionitis, 2=Other active infection, 3=Immediate delivery, 4=Fetus has anomalies incompatible with life, 5=History of adverse reaction to corticosteroids, 6=Comfort Care, 7=Other, 77=N/A, 99=Unknown
14	<b>SPLABOR</b>	Spontaneous Labor. Did the Mother Go into Labor on Her Own?	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
15a	<b>MULT</b>	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	<b>NBIRTHS</b>	Number of Infants Delivered	Integer	{1 - 10, 77, 99}	77 if [MULT]=0 or [BYEAR]<2013; 1 TO 10 if [MULT]=1; 77=N/A; 99=Unknown
15c	<b>BIRTHORDER</b>	Birth Order for Multiple Births	Integer	{1- 10 [NBIRTHS], 77, 99}	77 if [MULT]=0 or [BYEAR]<2013; 1 TO 10 [NBIRTHS] if [MULT]=1 and [NBIRTHS]=77; 77=N/A; 99=Unknown
16	<b>DELMOD</b>	Mode of Delivery	Integer	{0, 1, 2, 9}	0=Cesarean Section; 1=Normal or Spontaneous Vaginal; 2=Operative Vaginal, 9=Unknown
<b>Antenatal Conditions: Events that may affect the pregnancy and/or delivery of the infant.</b>					
<b>Maternal</b>					
17	<b>ANCMNONE</b>	No Maternal Complications	Integer	{0, 1}	0=No, 1=Yes; <del>Item discontinued in 2013.</del>
17	<b>ANCMHYP</b>	Maternal: Hypertension	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCMCHORIO</b>	Maternal: Chorioamnionitis	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCMOINF</b>	Maternal: Other Infection	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCMDIA</b>	Maternal: Diabetes	Integer	{0,1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCMAMAGSULF</b>	Maternal: Antenatal Magnesium Sulfate	Integer	{0,1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCMCES</b>	Maternal: Previous Cesarean	Integer	{0,1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCMOTH</b>	Maternal: Other	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown

17	<b>ANCMDESC</b>	Description of 'Other'	Char50	{Description, 77, 99}	Up to 50 alphanumeric characters; 77=N/A if [ANCMOTH]=0, 99=Unknown if [ANCMOTH]=9
17	<b>ANCMUNK</b>	Unknown Maternal-Complications	Integer	{0, 1}	0=No, 1=Yes; <b>Item discontinued in 2013.</b>
<b>Fetal</b>					
17	<b>ANCFNONE</b>	No Fetal Complications	Integer	{0, 1}	0=No, 1=Yes; <b>Item discontinued in 2013.</b>
17	<b>ANCFIUGR</b>	Fetal: IUGR	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCFDIS</b>	Fetal: Distress	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCFANO</b>	Fetal: Anomaly	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCFOTH</b>	Fetal: Other	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCFDESC</b>	Description of 'Other'	Char50	{Description, 77, 99}	Up to 50 alphanumeric characters; 77=N/A if [ANCFOTH]=0, 99=Unknown if [ANCFOTH]=9
17	<b>ANCFUNK</b>	Unknown Fetal-Complications	Integer	{0, 1}	0=No, 1=Yes; <b>Item discontinued in 2013.</b>
<b>Obstetrical</b>					
17	<b>ANCONONE</b>	No Obstetrical-Complications	Integer	{0, 1}	0=No, 1=Yes; <b>Item discontinued in 2013.</b>
17	<b>ANCOLABOR</b>	Obstetrical: Preterm Labor (regular contractions in the context of cervical change at >37 wks)	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCOPREPROM</b>	Obstetrical: Preterm Premature ROM (<37 wks)	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCOPREROM</b>	Obstetrical: Term Premature ROM (rupture BEFORE the onset of labor, not premature gestation)	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A if [GAWEEKS]<37, 9=Unknown
17	<b>ANCOPROM</b>	Obstetrical: Prolonged ROM (>18 hour)	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown

17	<b>ANCOMAL</b>	Obstetrical: Malpresentation / Breech	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCOBLEED</b>	Obstetrical: Bleeding / Abruptio / Previa	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCOOTH</b>	Obstetrical: Other	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
17	<b>ANCODESC</b>	Description of 'Other'	Char50	{Description, 77, 99}	Up to 50 alphanumeric characters; 77=N/A if [ANCOOTH]=0, 99=Unknown if [ANCOOTH]=9
17	<b>ANCOUNK</b>	Unknown Obstetrical- Complications	Integer	{0, 1}	0=No, 1=Yes; <b>Item discontinued in 2013.</b>
<b>Indication for Cesarean Delivery. What are the indications? All applicable indications may be recorded. Mandatory for all CPQCC-eligible infants.</b>					
<b>NOTE: These indications only apply if the birth was cesarean. For Vaginal Births all of these must be coded 7 = N/A</b>					
18	<b>INDCESNA</b>	Indication for Cesarean- Delivery Not Applicable	Integer	{0, 1}	0=No (only if [DELMOD]=0), 1=Yes (only if [DELMOD]=1,2,9)
18	<b>INDCESBR</b>	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	<b>INDCESMG</b>	Indication for Cesarean Delivery -- Multiple Gestation	Integer	{0, 1, 7, 9}	0=Mo (only if [DELMOD]=0 and [MULT]=1,0), 1=Yes (only if [MULT]=1, [DELMOD]=0), 7=N/A (only if [DELMOD]=1 or 2), 9=Unknown (only if [DELMOD]=9)
18	<b>INDCESFD</b>	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	<b>INDCESER</b>	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	<b>INDCESDY</b>	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)



<b>18</b>	<b>INDCESPP</b>	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)
<b>18</b>	<b>INDCESHTN</b>	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	<b>INDCESOTH</b>	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	<b>INDCESDESC</b>	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
18	<b>INDCESUNK</b>	Indication for Cesarean Delivery Unknown	Integer	{0, 1}	0=No, 1=Yes; <b>Item discontinued in 2013.</b>
19a	<b>AP1</b>	Apgar Score - 1 minute	Integer	{0 - 10, 99}	99=Unknown
19a	<b>AP5</b>	Apgar Score - 5 minute	Integer	{0-10, 99}	99=Unknown
19a	<b>AP10</b>	Apgar Score - 10 minute	Integer	{0 - 10, 77, 99}	77=Not Done; 99=Unknown
19b	<b>PA</b>	Suspected Encephalopathy or Suspected Perinatal Asphyxia	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (if [BWGT]<=1500 OR [DELDIE]=1), 9=Unknown
19c	<b>GAS</b>	Umbilical cord blood gas or baby blood gas in the first hour of life available	Integer	{0, 1, 7, 9}	0=No (if [BWGT]>1500 AND [DELDIE]=0 AND [[PA]=1 OR [HIE]=3, 4, 5 OR [ACCOOLINGMETHOD]=2, 3), 1=Yes (if [BWGT]>1500 AND [DELDIE]=0 AND [[PA]=1 OR [HIE]=3, 4, 5 OR [ACCOOLINGMETHOD]=2, 3), 7=N/A (if [BWGT]<=1500 OR [DELDIE]=1 OR [[PA]=0, 7 and [HIE]=0, 7 and [ACCOOLINGMETHOD]=0, 1, 4, 7), 9=Unknown (if [BWGT]>1500 AND [DELDIE]=0 AND [PA]=9 AND [HIE]=7, 9 AND [ACCOOLINGMETHOD]=7, 9)
19d	<b>GASSOURCE</b>	Source of blood gas	Integer	{1, 2, 3, 4, 5, 7, 9}	1=Cord umbilical arterial (UA) (only if [GAS]=1), 2=Cord umbilical venous (UV) (only if [GAS]=1), 3=Arterial baby gas (only if [GAS]=1), 4=Venous baby gas (only if [GAS]=1), 5=Capillary baby gas (only if [GAS]=1), 7=N/A (only if [GAS]=0,7), 9=Unknown (only if [GAS]=9)

19e	<b>GASPH</b>	pH within 1 hour of life	Double	{6.00-8.00, 77.7, 99.9}	77.7=N/A (if [GAS]=0,7), 99.9=Unknown (if [GAS]=0)
19f	<b>GASBD</b>	Base deficit in umbilical cord blood / baby blood gas within first hour of life	Double	{0.0-50.0, 77.7, 99.9}	77.7=N/A (if [GAS]=0,7), 99.9=Unknown (if [GAS]=0)
20a	<b>DROX</b>	Initial Resuscitation -- Supplemental Oxygen	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
20b	<b>DRCPAP</b>	Initial Resuscitation -- Nasal CPAP	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
20c	<b>DRBM</b>	Initial Resuscitation -- Face Mask Ventilation	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
20d	<b>DRET</b>	Initial Resuscitation -- Endotracheal Tube Ventilation	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
20e	<b>DREP</b>	Initial Resuscitation -- Epinephrine	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
20f	<b>DRCC</b>	Initial Resuscitation -- Cardiac Compression	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
20g	<b>DRNIPPV</b>	Initial Resuscitation -- Nasal Intermittent Positive Pressure Ventilation	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown
<b>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.</b>					
21	<b>DRSURF</b>	Surfactant in the DR	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown, 7=N/A Only if
21	<b>SURFX</b>	Surfactant Given at Any Time	Integer	{0, 1, 9}	1=Yes, 0=No, 9=Unknown, 7=N/A Only if [DELDIE]=1
21	<b>SURF1DHR</b>	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	<b>SURF1DMIN</b>	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]<2012; 0, 1, 9 if [DELDIE]=0 and [BYEAR] >= 2012; 0=No, 1=Yes, 7=N/A, 9=Unknown
<b>NOTE: If [ACUTETRS]=1, then C.21a [T_TEMP3] must = 22b [ATEMP] in the CPQCC Section.</b>					
22b	ATEMP	Temperature at Admission to Your NICU (in Degrees Centigrade to Nearest 10th of a Degree)	Double	{20.0 - 45.0, 777.7, 888.8, 999.9}	777.7 if [DELDIE]=1 or [ATEMPM]=0, 20.0 to 45.0, 999.9 if [DELDIE]=0 and [ATEMPM]=1 and [BYEAR] >= 2012; 777.7=N/A, 888.8=Too Low to Register, 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!
22c	ACOOLING	Infant Cooling during NICU Admission	Integer	{0, 1, 2, 7, 9}	0=No Cooling for HIE, 1=Cooling Started for HIE, 2=Cooling Continued for Transfer-In for HIE (only if [LOCATE]=1), 7=N/A (Only if [DELDIE]=1), 9=Unknown
22d	ACOOLINGMETHOD	Type of LAST Hypothermic Therapy for HIE during NICU Admission	Integer	{1, 2, 3, 4, 7, 9}	1=Passive, 2=Selective Head, 3=Whole Body, 4=Other, 7=N/A (Only if [ACOOLING]=0 OR [DELDIE]=1), 9=Unknown (Only if [ACOOLING]=9)
23a	OXY	Post DR Respiratory Support -- Supplemental 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 -- Intubated Conventional Ventilation	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
23c	HFV	Post DR Respiratory Support -- Intubated HIFI Ventilation	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, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown

23e	<b>NIMV</b>	Nasal IMV or SIMV (or any other form of non-intubated assisted	Integer	{0, 1, 2, 7, 9}	0=None, 1= ≤4 hours, 2= >4 hours, 7=N/A [DELDIE]=1, 9=Unknown
24a	<b>CPAP</b>	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	<b>CPAPES</b>	<b>Nasal CPAP before or without ever having received ETT Ventilation</b>	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A, 9=Unknown. 7=N/A (if [DELDIE]=1 or ([BYEAR] ≥ 2013 and [DRCPAP] in (0,7) and [CPAP] in (0, 7)) or ([BYEAR] < 2013 and [CPAP] in (0, 7)); 9=Unknown (if {[BYEAR] ≥ 2013 and ([DRCPAP]=9 and [CPAP] in (0,9)) or ([DRCPAP] in (0,9) and [CPAP]=9)} or ([BYEAR] < 2013 and [CPAP]=9); 0, 1, 9 if {[BYEAR] ≥ 2013 and ([DRCPAP]=1 or [CPAP]=1)} or ([BYEAR] < 2013 and [CPAP]=1)
25a	<b>DURVENT</b>	Duration of Intubated 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	<b>VENTDAYS</b>	Days Intubated Ventilated (in Your NICU)	Long Integer	{1-366 OR 367, 7777, 9999}	1 - 366 (367 for leap years), 1=Less than 24 Hours , 2= 24 Hours to under 48 Hours, ETC. 7777=N/A (Only if [DURVENT]=1 OR DELDIE=1), 9999=Unknown
25b	<b>VENTHOURS</b>	<del>Hours Intubated Ventilated (in Your</del>	Integer	<del>{0-23, 77, 99}</del>	<del>Item was discontinued in 2010. We will not require ventilation time in hours for</del>
26	<b>DIE12</b>	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	<b>RDS</b>	Respiratory Distress Syndrome	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown

28	<b>PNTX</b>	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	<b>MECONIUM</b>	Meconium Aspiration Syndrome	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
30	<b>NITRICO</b>	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
31	<b>ECMO</b>	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	<b>POSTSTER</b>	Postnatal Steroids	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
32b	<b>POSTERCLD</b>	Postnatal Steroids for Indication Chronic Lung Disease	Integer	{0, 7, 9, 11, 12, 13}	0=No, 7=N/A (only if [POSTSTER] = 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	<b>POSTEREX</b>	Postnatal Steroids for Indication Extubation	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A (only if [POSTSTER] = 0, or 7) or [DELDIE]=1, 9=Unknown (always if [POSTSTER]=9)
32b	<b>POSTERBP</b>	Postnatal Steroids for Indication Hypotension	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A (only if [POSTSTER] = 0, or 7) or [DELDIE]=1, 9=Unknown (always if [POSTSTER]=9)
32b	<b>POSTEROTH</b>	Postnatal Steroids for Indication Other	Integer	{0, 1, 7}	0=No, 1=Yes, 7=N/A (only if [POSTSTER] = 0, or 7) or [DELDIE]=1, 9=Unknown (always if [POSTSTER]=9)
33	<b>NEWOX28</b>	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
34a	<b>OX36</b>	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

34b	VENT36	Conventional Ventilation at 36 Weeks	Integer	{0, 1, 7, 9}	7=N/A if [BYEAR] < 2012 or [DELDIE]=1 OR if infant was not hospitalized at 36 Weeks; 0, 1, 9 if [BYEAR] ≥ 2012 and [DELDIE]=0 and infant hospitalized at 36 Weeks; 0=No, 1=Yes, 7=N/A, 9=Unknown
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34c	<b>HFV36</b>	High Frequency Ventilation at 36 Weeks	Integer	{0, 1, 7, 9}	7=N/A if [BYEAR] < 2012 or [DELDIE]=1 OR if infant was not hospitalized at 36 Weeks; 0, 1, 9 if [BYEAR] ≥ 2012 and [DELDIE]=0 and infant hospitalized at 36 Weeks; 0=No, 1=Yes, 7=N/A, 9=Unknown
34d	<b>HFNC36</b>	High Flow Nasal Cannula at 36 Weeks	Integer	{0, 1, 7, 9}	7=N/A if [BYEAR] < 2012 or [DELDIE]=1 OR if infant was not hospitalized at 36 Weeks; 0, 1, 9 if [BYEAR] ≥ 2012 and [DELDIE]=0 and infant hospitalized at 36 Weeks; 0=No, 1=Yes, 7=N/A, 9=Unknown
34e	<b>NIMV36</b>	Nasal IMV or SIMV at 36 Weeks	Integer	{0, 1, 7, 9}	7=N/A if [BYEAR] < 2012 or [DELDIE]=1 OR if infant was not hospitalized at 36 Weeks; 0, 1, 9 if [BYEAR] ≥ 2012 and [DELDIE]=0 and infant hospitalized at 36 Weeks; 0=No, 1=Yes, 7=N/A, 9=Unknown
34f	<b>CPAP36</b>	Nasal CPAP at 36 Weeks	Integer	{0, 1, 7, 9}	7=N/A if [BYEAR] < 2012 or [DELDIE]=1 OR if infant was not hospitalized at 36 Weeks; 0, 1, 9 if [BYEAR] ≥ 2012 and [DELDIE]=0 and infant hospitalized at 36 Weeks; 0=No, 1=Yes, 7=N/A, 9=Unknown
35a	<b>ACFINAL</b>	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
35b	<b>OXFINAL</b>	Respiratory Support at Discharge -- Oxygen	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
35c	<b>SUCFINAL</b>	Respiratory Support at Discharge -- Intubated Mechanical Ventilation	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
35d	<b>OTHFINAL</b>	Respiratory Support at Discharge -- Other	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A Only if [DELDIE]=1, 9=Unknown
35d	<b>OTHFINALDESC</b>	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**

**NOTE: We have clarified the difference in the definition used for the CPQCC Network Database & for the Perinatal Quality Care Collaborative (PQIP) initiatives.**

**NOTE: Each of the late infection items is based on whether the infant had the infection after Day 3 of life. In determining the date of Day 3, the date of birth counts as Day 1 regardless of the time of birth. For an infant born at 11:59 PM on September 1, Day 3 will be September**

36	<b>EBSEPS</b>	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	<b>EBSEPSDESC</b>	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	<b>LBPATH</b>	Sepsis -- Late - Bacterial Pathogen	Integer	{0, 7, 9, 21, 22, 23, 31, 32, 33, 41, 42, 43}	0=No, 7=N/A (only if [DELDIE]=1), 9=Unknown , 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	<b>LBPATHDESC</b>	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	<b>CNEGSTAPH</b>	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	<b>FUNGAL</b>	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	<b>VIRAL</b>	Congenital Viral Infection	Integer	{0, 1, 7, 9}	0=Negative culture, 7=N/A (only if [DELDIE]=1), 1=Yes, 9=Unknown
38	<b>VIRALDESC</b>	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	<b>PDA</b>	Patent Ductus Arteriosus	Integer	{0, 1, 7, 9} => {0, 1, 2, 7, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1), 9=Unknown => 0=No, 1=PDA meeting revised 2011 VON definition, 2=PDA diagnosis based on echo and/or clinical evidence or was treated for PDA, but not meeting all 2011 VON criteria, 7=N/A (only if [DELDIE]=1), 9=Unknown
39b	<b>INDOMETH</b>	Indomethacin For Any Reason	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1), 9=Unknown
39c	<b>IBUPROFEN</b>	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	<b>SRGLIG</b>	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
39e	<b>PDACLOSE</b>	PDA Closure by Catheterization	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; Note: For the purposes of the VON database, PDA Closure by Catheterization is considered a form of PDA Ligation and requires a documentation of a description in Other Surgery S600 code. Therefore, for the purpose of the VON submission, a response of Yes to the item PDA Closure by Catheterization will result in reporting Other Surgery S600 code description = PDA Closure by Catheterization, and will also be counted as a VON PDA Ligation. In summary, if [PDACLOSE] = {11, 12, 13} then to result in and [SRGOTH]=1, [SRGCD1-10]={S600H E B} and [SRGOTHDES]=PDA Closure by
40a	<b>PROBIOTICS</b>	Probiotics	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A [DELDIE]=1, 9=Unknown
40b	<b>NEC</b>	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

40c	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	Focal 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
<b>NOTE: Starting from 2013, the Retinopathy of Prematurity section (Items 42a. To 42d.) is only applicable for infants 401-1500 grams or 22 to 31 completed weeks of gestation.</b>					
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);
42c	VEGF	Treatment of ROP with Anti-VEGF Drug	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A [DELDIE]=1, 9=Unknown
42d	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	<b>SRGCD2</b>	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	<b>SRGCD3</b>	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	<b>SRGCD4</b>	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	<b>SRGCD5</b>	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	<b>SRGCD10</b>	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	<b>SRGOTHDESC</b>	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	<b>SURGCOMP</b>	Complications of Surgery	Integer	{0, 7, 9, 11, 12, 13}	<del>Item was discontinued in 2013. 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</del>
44	<b>SURGCOMPDESC</b>	Describe Surgical Complications	Char50	{Description, 77, 99}	<del>Item was discontinued in 2013. 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)".</del>
<b>Post-Delivery Diagnoses and Interventions -- Neurological</b>					

45a	<b>IMAGE28</b>	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	<b>IGRADE</b>	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:

45bc	PIHHEMLOC	Periventricular-Intraventricular Hemorrhage (PIH)	Integer	{7, 9, 11, 12}	11=Yes and First Here, 12=Yes and First Elsewhere, 7=N/A, 9=Unknown
45d	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)
45e	OTHHEM	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
45e	OTHHEMDESC	Other Intracranial Hemorrhage Description	Char50	{Description, 77, 99}	Up to 50 alphanumeric characters (only if [OTHHEM]=1); 7=N/A if [OTHHEM]=0,7 or if [DELDIE]=1, 99=Unknown if [OTHHEM]=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
<b>Post-Delivery Diagnoses and Interventions -- Congenital Malformations</b>					
49	CMAL	Major Birth Defect	Integer	{0, 1, 9}	0=No, 1=Yes, 9=Unknown
<b>NOTE: If [ACUTETRS]=1, then C.6b [T_BCD1 to T_BCD5] 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.</b>					
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



	<b>BDCD2FLAG</b>	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	<b>BDCD3</b>	Birth Defect Code 3	Integer	{Birth Defects Table, 7777, 9999}	7777=N/A (only if [T_CMAL]=0 AND [CMAL]=0), 9999=Unknown
	<b>BDCD3FLAG</b>	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	<b>BDCD4</b>	Birth Defect Code 4	Integer	{Birth Defects Table, 7777, 9999}	7777=N/A (only if [T_CMAL]=0 AND [CMAL]=0), 9999=Unknown
	<b>BDCD4FLAG</b>	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	<b>BDCD5</b>	Birth Defect Code 5	Integer	{Birth Defects Table, 7777, 9999}	7777=N/A (only if [T_CMAL]=0 AND [CMAL]=0), 9999=Unknown
	<b>BDCD5FLAG</b>	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
<b>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.</b>					
49	<b>BDEFECT</b>	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
<b>Post-Delivery Diagnoses and Interventions -- Hyperbilirubinemia</b>					
<b>NOTE: Answer only for Outborn Infants Previously Discharged Home [PDH]=1</b>					

50	<b>BILILEVEL</b>	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	<b>EXCHANGE</b>	Exchange Transfusion	Integer	{0, 1, 7, 9}	0=No, 1=Yes, 7=N/A (only if [DELDIE]=1 or [LOCATE]=0 or [PDH]=0), 9=Unknown
52	<b>LASTHOSPITAL</b>	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
<b>Initial Disposition</b>					
53	<b>ENTFEED</b>	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	<b>FDISP</b>	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	<b>DWGT</b>	Initial Disposition Weight (in Grams)	Long Integer	{201-66665, 99999}	201-66665, 99999=Unknown
56	<b>HEADCIRC</b>	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	<b>LOS1</b>	Initial Length of Stay	Integer	{1-366 or 367, 999}	1 if [DELDIE]=1; 1 to 366 (367 if leap day must be added), 999 if DELDIE=1; Codes: 999=Unknown.
<b>Transfer</b>					
58	<b>TRANSCODE</b>	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	<b>XFERLOCATION</b>	Transferred to a CPQCC Center	Char6	{OSHPD ID number, 777777, 999999}	Valid OSHPD ID number (see list); 777777=N/A (only if [DELDIE]=1, [FDISP]<>2 or 9)999999=Unknown (always if [FDISP]=9)

<b>60</b>	<b>F2DISP</b>	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)
<b>61</b>	<b>F3WGT</b>	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)
<b>62</b>	<b>F3DISP</b>	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)