Table of Contents

Introduction

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

Objectives of SHDD:

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

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

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

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

SHDD second version team:

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

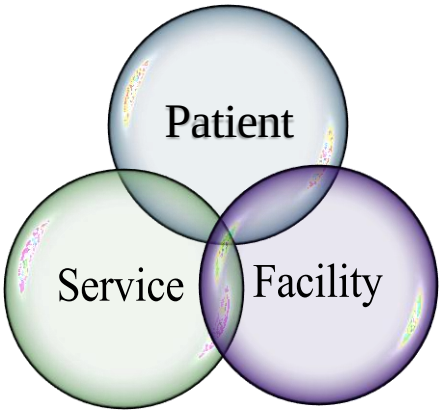
- Mr. Mohammad Ben Belkasem Al-Shehri – Chairman of the Technical Committee
- Mr. Ihab Abu Hamdeh – Consultant
- Ms. Honida Al-Mansori – Project Manager
- Eng. Hanan Al-Dosari – Project Member
- Eng. Hessa Al-Abbad
- Eng. Mohammad Al-Anizi
- Mr. Tariq Hakeem

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

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

Overview of the Dictionary:

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



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

Contents of the Dictionary

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

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

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

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

6. Health insurance information: such as an insurance company, insurance policy number and other.

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

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

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

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

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

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

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

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

1. Emergency Medical Services:

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

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

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

2. Maternity Information:

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

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

3. Ambulatory medical services information: It includes information such as date and time of the presence of the patient, the main complaint.
4. Vital signs: Information includes heart rate, heart rhythm pattern, and respiratory rate.
5. Admission Information: Such as the status of acceptance, the date and time of admission.
6. Discharge from hospital: Such as the date and time of the discharge, final diagnosis
7. When you enter service information for hospital treatment:

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

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

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

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

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

Part VI (Tumors): The number of elements 21

Tumors is considered one of the only health data information that was standardized among the health facility under what is known as the "National Cancer Registry", But SHDD in its second version have exceeded the registry data elements by adding treatment monitors to its content.
SHDD introduced elements of the information of this part all the registry information and added the waiting time for chemotherapy and radiotherapy as a monitor on treatment activities.

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

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

1. CVD
    - High blood pressure: a disease such as high blood pressure and classification of hypertension.
    - Ischemic heart disease.
2. Diabetes: such as the classification of diabetes and complications of diabetes mellitus.
3. Obesity.

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

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

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

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

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

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

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

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

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

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

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

Sources of data elements.

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

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

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

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

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

Chapter 01

Patient Information

Basic Information

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

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

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

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

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

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

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

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

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

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

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

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

Demographic Information

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

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

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

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

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

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

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

Social Information

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

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

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

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

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

Physical Characteristics

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

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

Health and Lifestyle Information

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

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

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

Code Description and Permissible Values	Codes used are 1=Restaurant diet 2 = Home diet 3 = Soft diet 4 = Partial Vegetarian diet 5 = Vegan diet 8 = Others 9 = Unknown

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

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

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

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

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

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

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

	06 = Substance abuse treatment service 07 = Other community/Healthcare service 08 = Correctional service 09 = Police diversion 10 = Court diversion 88 = Other 99 = Not stated/inadequately described

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

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

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

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

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

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

	Code 0 is used when the impairment is present in more than one body location (but not bilaterally see code 3); for example, when burn scars affect many areas of skin. **Code 1** is used when the impairment is present to the right of the midline of the person's body. **Code 2** is used when the impairment is present to the left of the midline of the person's body. **Code 3** is used when the impairment is two-sided and disposed on opposite sides of the midline axis of the body, for example bilateral joint deformities. **Code 4** is used when the impairment is present in front of a line passing through the midline of the body when viewed from the side. **Code 5** is used when the impairment is present behind a line passing through the midline of the body when viewed from the side. **Code 6** is used when the impairment is situated towards the point of origin or attachment, as of a limb or bone (opposed to distal), for example the end of the structure that is closer to the center of the body. **Code 7** is used when the impairment is situated away from the point of origin or attachment, as of a limb or bone (opposed to proximal), for example the end of structure that is further away from the center of the body. **Code 8** is used when there is an impairment of body structure but the location of the impairment is not recorded. **Code 9** is used when it is not appropriate to code the location of an impairment of body structure.

Code Description and Permissible Values	Codes used are: 0 = More than one region (except both sides) 1 = Right 2 = Left 3 = Both sides (bilateral). 4 = Front 5 = Back 6 = Proximal 7 = Distal 8 = Non specified 9 = Not applicable

Insurance Information

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

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

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

Chapter 02

Healthcare Facility **Information**

Healthcare / Hospital/ Clinic name

Healthcare Facility Information

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

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

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

Code Description and Permissible Values	**Codes used are**: Government Sectors D = MOD Ministry of Defense Healthcare Facility E = MOE Ministry of Education Healthcare Facility H = MOH Ministry of Health Care Facility I = MOI Ministry of Interior Healthcare Facility N = NGHA Ministry of National Guard Health Care Facility L= Ministry of Labor and Social Development P = Public Organizations Healthcare Facility R= Royal commission for Jubail & Yanbu S= Saudi Red Crescent X = Other Sectors Healthcare Facility Non-Government Sector C = Charity Healthcare Facility V = Private Healthcare Facility Y = Other Non-Government Health Care Facility

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

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

	allied medical services like radiology centers, medical laboratories, optician, pharmacies, regardless if they are private or governmental services CODE H1 = General Hospital = Code used to describe a general hospital facility that can handle most people and does not limit itself to a specified type of medical specialty or a higher level of medical care regardless if they are private or governmental services. CODE H2 = Specialist Hospital = Code used to describe all hospital facilities that has more than 300 operational hospital beds and recruits fully 30 medical consultants out of which 8 are subspecialties. This is applicable to all hospitals except Eye hospitals regardless if they are private or governmental services. CODE H3 = Medical City = Code used to describe the health facilities that are characterized by having more than one hospital under direct operation and physically in one Location regardless of the type of service provided whether general care or specialized care. It is also applicable regardless if the facility is private or governmental services. CODE H4 = Field Hospital = Code used to describe a mobile health facility that provides full hospitalization services that are used in disaster management or abnormal situations regardless if the facility is private or governmental services.
Code Description and Permissible Values	**Codes used are:** **Ambulatory & Allied Medical Health Care Facilities** A1 = Ambulatory Primary Health Care Facility A2 = Allied Medical services **Hospital Care Facilities** H1 = General Hospital H2 = Specialist Hospital H3 = Medical City H4 = Field Hospital

Healthcare Facility type of care	
Definition	A code that categorizes facilities into particular medical service or function
Metadata Type	Data Element
Data Concept	Healthcare Facility Information, Facility Type of Care Identifier
Reference ID	BA005
Synonyms	Not Applicable
Representation Class	Code
Data Type	Alphanumeric
	NNA
Format	
Maximum Field Size	3
Date Created	19/52016
Date Updated	To be defined
Source	Saudi Health Council
Usage	Use codes in accordance with the following: Big city Location is any city where the population is = or > 500,000 Small City Location is any city where population is < 500,000 Specialized Hospital is any hospital that is operating 300 beds or higher with full time 30 consultants at least 8 of them in subspecialties. General Hospital is any hospital that is operating less than 300 beds and does not have full time 30 consultants. Important Note: Eye hospitals are exempted from this definition. Note: These definition of city size and specialized

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

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

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

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

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

Available Emergency Beds	
Definition	The average number of beds which are immediately available for use by an emergency patient. A bed is immediately available for use if it is located in a suitable place for care with nursing and auxiliary staff available within a reasonable period
Metadata Type	Data Element
Data Concept	Healthcare Facility information - Number of available hospital Beds for Emergency patients
Reference ID	BA010
Synonyms	Not Applicable
Representation Class	Average
Data Type	Numeric
Format	NNNN
Maximum Field Size	4
Date Created	19/52016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	The average bed is to be calculated from monthly figures rounded to the nearest whole number
Code Description and Permissible Values	Not Applicable
Usage	The average bed is to be calculated from monthly figures rounded to the nearest whole number
Code Description and Permissible Values	Not Applicable

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

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

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

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

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

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

	hours
Code Description and Permissible Values	Not Applicable

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

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

	care. 10 = Charity organization 88 = Others 99 = Unknown

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

Usage	This field must— • Be a valid date; • Be less than or equal to the Organization end date.
Code Description and Permissible Values	Codes used are DDMMYYYY Century digits are considered essential

Postal Address	
Definition	Type of postal delivery service for a person, as represented by a code.
Data Concept	Healthcare Facility Information - Postal delivery service type - abbreviation
Reference ID	BA019
Synonyms	Not Applicable
Representation Class	Code
Data Type	Alphab
Format	
Maximum Field Size	
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	Use Saudi post standard
Code Description and Permissible Values	Codes used are **Saudi Post address code** -Building Number: Consists of four numbers, the number represents either a commercial or residential building; the numbers are unique and not repeated on the street. -Street Name: Represents the exact location of a certain building, entrance or shop that exists between several of buildings. -Neighborhood: Represents the area that consists of all these buildings. City: Represents all the areas as a whole with its different neighborhoods, street names and building numbers. -Postal Code/Zip Code: Consists of five digits, each digit

	has a significant location. This code covers a specific geographical area such as a neighborhood or any residential community. -Additional Numbers: It is similar to the building number and also consists of four numbers.

Facility Operation status	
Definition	It is the indicator of the facility status in reference to being operational on temporary or permanent bases
Metadata Type	Data Element
Data Concept	Healthcare Facility Information—Facility Operational Status
Reference ID	BA020
Synonyms	Not Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Health Council
Usage	This element is used to describe the facility in reference to its operational status. Code 1 is used for all facilities that are physically present and operational all year round Code 2 is used for all facilities that operate only during special seasons regardless of their facility physical presence, as example it is applicable on facilities serving during pilgrimage (Hajj) and facilities used in disaster situations like field hospitals.
Code Description and Permissible Values	Codes used are: 1=Permanent Facility 2 = Temporary Facility

Mental Medical Facility Information

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

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

Medical Facility Teaching Information

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

Chapter 03

Health Provision Information

Healthcare Provision Information

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

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

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

Emergency Medical Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ED Disposition	
Definition	Non-Admitted Patient Ed Service Episode-Episode End Status: The status of the patient at the end of the non-admitted patient emergency department service episode, as represented by a code
Metadata type	Data element
Data concept	Emergency department service episode
Reference ID	CB014
Synonyms	Not applicable
Represented class	Code
Data type	Numeric
Format	N
Maximum field size	1
Date created	01/04/2019
Date updated	To be decided
Source	National Health Data Dictionary - Australia
Usage	
Code description and permissible values	1. Admitted to this hospital 2. Non-admitted patient ED episode completed-departed without being admitted or referred to another hospital 3. non admitted patient ED episode completed -referred to another hospital for admission 4. did not wait to be attended by a health care professional 5 left at own risk after being attended by a health care professional, but before the non-admitted patient ED service episode was completed 6. Died in ED 7. Dead on arrival 8. Registered, advised of another health care service, and left the ED without being attended by a health care professional

Cardiovascular Diseases

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

	prolonged, usually lasting more than 10 minutes **4 Unstable chest pain patterns:** New and severe Use this code for new-onset chest pain that could be described as at least Canadian Cardiovascular Society (CCS) classification III severity. **5 Unstable chest pain pattern:** Accelerated and severe Use this code for recent acceleration of chest pain pattern that could be described by an increase in severity of at least 1 CCS class to at least CCS class III.
Code Description and Permissible Values	Codes used are: 1 = Atypical chest pain 2 = Stable chest pain pattern 3 = Unstable chest pain pattern: rest &/or prolonged 4 = Unstable chest pain pattern: new & severe 5 = Unstable chest pain pattern: accelerated and severe 8 = No chest pain/discomfort 9 = Not stated/inadequately described

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

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

Coronary artery procedure waiting time	
Definition	Time required for the patient with coronary artery disease to receive the intervention required for his/her management.
Metadata Type	Data Element
Data Concept	Cardiovascular Diseases—Coronary artery disease waiting time
Reference ID	CC004
Synonyms	Not Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Benchmark values from Quality Based Procedures report for Coronary Artery diseases Ministry of Health Ontario Canada 2014
Usage	The waiting time is calculated from the diagnosis date till the date of procedure completion, procedures included are Catheterization, PCI & CABG. **The indicated Catheterization procedure waiting time should be:** • Urgent Cath. < 7 days • Semi urgent Cath. < 28 days • Elective < 84 days – **The indicated PCI procedure waiting time should be:** • Urgent PCI < 7 days • Semi urgent PCI < 14 days • Elective PCI < 28 days **The indicated CABG procedure waiting time should be:** • Urgent CABG < 14 days • Semi urgent CABG < 42 days • Elective < 90 days
Code Description and Permissible Values	Codes used are: 1 = Procedure done according to waiting time benchmark 2 = Procedure done not according to waiting time benchmark

Maternity Information

First Day of the Last Menstrual Period	
Definition	Date of the first day of the mother's last menstrual period (LMP).
Metadata Type	Data Element
Data Concept	Antenatal First day last menstrual period
Reference ID	CD001
Synonyms	Not Applicable
Representation Class	Date
Data Type	Date/Time
Format	DDMMYYYY
Maximum Field Size	8
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	This element is used to describe the first day of the LMP which is essential for calculation of gestational age, If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999). The first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.
Code Description and Permissible Values	Codes used are: – DDMMYYYY Century digits are considered essential – 99999999 = Unknown

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

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

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

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

Spontaneous Abortion	
Definition	The total number of previous pregnancies of a female resulting in spontaneous abortion (less than 20 weeks' gestational age, or less than 400 g birth weight if gestational age is unknown)
Metadata Type	Data Element
Data Concept	Maternity, Antenatal, Abortion
Reference ID	CD006
Synonyms	Not Applicable
Representation Class	Total
Data Type	Numeric
Format	NN
Maximum Field Size	2
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	A pregnancy resulting in multiple births should be counted as once pregnancy. In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order: • All live births • Stillbirth • Spontaneous abortion • Induced abortion • Ectopic pregnancy Where the outcome was one stillbirth and one live birth, count as stillbirth. If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.
Code Description and Permissible Values	Codes used are: NN = Number of abortions, unit is pregnancy 99 = Not stated

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

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

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

Method of Delivery	
Definition	The method of complete expulsion or extraction from its mother of a product of conception in a birth event, as represented by a code.
Metadata Type	Data Element
Data Concept	Maternity Antenatal Intended Method of delivery
Reference ID	CD010
Synonyms	Not Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	The followings are guidelines to consider when coding this element: - In a vaginal breech with forceps to the after coming head, code as vaginal - forceps. - In a vaginal breech that has been manually rotated, code as vaginal - non-instrumental. - Where forceps/vacuum extraction are used to assist the extraction of the baby at caesarean section, code as caesarean section. - Where a hysterectomy is performed to extract the baby, code as caesarean section. - In the case of multiple births, method of birth should be recorded for each baby born.
Code Description and Permissible Values	Codes used are: 1 = Vaginal - non-instrumental 2 = Vaginal - with instruments 3 = Vaginal - vacuum extraction 4 = Caesarean section 9 = Not stated/inadequately described

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

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

Maternity: Labor Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Maternity: Postnatal

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

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

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

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

Maternity: Immunization

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

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

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

Apgar score	
Definition	Numerical score to evaluate the baby's condition at 1, 5 or 10 minute after birth.
Metadata Type	Data Concept
Data Concept	Maternity Newborn Apgar Score
Reference ID	CD036
Synonyms	Not Applicable
Representation Class	Concept
Data Type	
Format	
Maximum Field Size	
Date Created	
Date Updated	
Source	Palestinian Health Data Dictionary Second edition, 2005
Usage	The score introduced for use in 1953 and since then it is a reliable indicator of newborn status. It evaluates the newborn in 5 areas: 1- Color 2- Heart rate 3- Muscle tone 4- Reflexes and 5- Respiratory effort. Each of these areas are Code from 0 to 2. The maximum score or best response of newborn will be equal to score 10
Code Description and Permissible Values	Not Applicable

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

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

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

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

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

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

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

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

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

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

Number of qualified days for newborns	
Definition	The number of qualified newborn days occurring within a newborn episode of care.
Metadata Type	Data Element
Data Concept	Maternity: Newborn - Number of qualified days for newborns
Reference ID	CD047
Synonyms	Non Applicable
Representation Class	Total
Data Type	Numeric
Format	5N
Maximum Field Size	5
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	The rules for calculating the number of qualified newborn days are outlined below. The number of qualified days is calculated with reference to the Episode of admitted patient care— admission date, DDMMYYYY, Episode of admitted patient care—separation date, DDMMYYYY and any Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY: • The date of admission is counted if the patient was qualified at the end of the day • The date of change to qualification status is counted if the patient was qualified at the end of the day • The date of separation is not counted, even if the patient was qualified on that day • The normal rules for calculation of patient days apply, for example in relation to leave and same day patients The length of stay for a newborn episode of care is equal to the sum of the qualified and unqualified days.
Code Description and Permissible Values	Codes used are: 5N = Number of qualified newborn days

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

Ambulatory Care Information

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

Date Patient Presents	
Definition	The Date on which the patient/client presents for the delivery of a service.
Metadata Type	Data Element
Data Concept	Health service event—Date patient presents
Reference ID	CE002
Synonyms	Non Applicable
Representation Class	Date
Data Type	Date/Time
Format	DDMMYYYY
Maximum Field Size	8
Date Created	19/05/2016
Date Updated	To be defined
Source	Palestinian Health Data Dictionary Second edition, 2005
Usage	For community Healthcare, outreach services and services provided via telephone or telehealth, this may be the date on which the service provider presents to the patient or the telephone/telehealth session commences. The date of patient presentation at the Emergency department is the earliest occasion of being registered clerically or triaged. The date that the patient presents is not necessarily: • The listing date for care (see listing date for care), nor • The date on which care is scheduled to be provided, nor • The date on which commencement of care actually occurs (for admitted patients see admission date, for hospital non- admitted patient care and community Healthcare see service commencement date).
Code Description and Permissible Values	Codes used are: DDMMYYYY Century digits are considered essential

Time Patient Presents	
Definition	The time at which the patient presents for the delivery of a service. The service is defined as commencing when a Healthcare professional first takes responsibility for the patient/client's care.
Metadata Type	Data Element
Data Concept	Health service event—Time patient presents
Reference ID	CE003
Synonyms	Non Applicable
Representation Class	Time
Data Type	Date/Time
Format	HH:MM
Maximum Field Size	5
Date Created	19/05/2016
Date Updated	To be defined
Source	Palestinian Health Data Dictionary Second edition, 2005
Usage	For community Healthcare, outreach services and services provided via telephone or telehealth, this may be the date on which the service provider presents to the patient or the telephone/telehealth session commences. The date of patient presentation at the Emergency department is the earliest occasion of being registered clerically or triaged. The date that the patient presents is not necessarily: • The listing date for care (see listing date for care), nor • The date on which care is Scheduled to be provided, nor • The date on which commencement of care actually occurs (for admitted patients see admission date, for hospital non-admitted patient care and community Healthcare see service commencement date).
Code Description and Permissible Values	Codes used are: State the admission time based on 24 hours' time format HH:MM. HH = Ranges from 00 to 23 MM = Ranges from 00 to 59. 99 = Unknown values for HH or MM Use leading zeros to assure 2-character field widths for HH and MM. 0000 = Midnight Code, and begins the new day.

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

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

	The user will select the code that most closely summarizes, in terms of duration, frequency, manner or outcome, the level of difficulty of the person for whom the data is recorded. CODE 0 = No difficulty in this life area, is used when there is no difficulty in performing this activity. This scale has a margin of error of 5%. [0-4%] CODE 1 = Mild difficulty, is recorded for example, when the level of difficulty is below the threshold for medical intervention, the difficulty is experienced less than 25% of the time, and/or with a low alteration in functioning which may happen occasionally over the last 30 days. [5-24%]. CODE 2 = Moderate difficulty, is used for example when the level of difficulty is experienced less than 50% of the time and/or with a significant, but moderate effect on functioning (Up to half the scale of total performance) which may happen regularly over the last 30 days. [25-49%] CODE 3 = Severe difficulty, is used for example when performance in this life area can be achieved, but with only extreme difficulty, and/or with an extreme effect on functioning which may happen often over the last 30 days. [50-95%] CODE 4 = Complete difficulty, is used when the person cannot perform in this life area due of the difficulty in doing so. This scale has a margin of error of 5%. [96-100%] CODE 8 = Not specified, is used where a person has difficulty with activities in a life area but there is insufficient information to use codes 0-4. CODE 9 = Not applicable, is used where a life area is not applicable to this person, e.g. domestic life for a child under 5. This data element, in conjunction with Person—activities and participation life area, code (ICF 2001) ANNNN, indicates the presence and extent of activity limitation in a given domain of activity.

Code Description and Permissible Values	Codes used are: 0 = No difficulty 1 = Mild difficulty 2 = Moderate difficulty 3 = Severe difficulty 4 = Complete difficulty 8 = Not specified 9 = Not applicable

External cause (non-admitted patient)	
Definition	Environmental event, circumstance or condition as the cause of injury, poisoning or other adverse effect to a non-admitted patient.
Metadata Type	Data Element
Data Concept	Ambulatory Care Information - External cause (non-admitted patient)
Reference ID	CE006
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	NN
Maximum Field Size	2
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	This data item is used for injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. Non-admitted patients in emergency departments). Select the item which best characterizes the circumstances of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate select the one that comes first in the code list. The external cause - non-admitted patient group must always be accompanied by an external cause - human intent code (see metadata item Injury event—external cause, non-admitted patient human intent code NN)
Code Description and Permissible Values	Codes used are: 01 = Motor vehicle - driver 02 = Motor vehicle - passenger or unspecified occupant 03 = Motorcycle - driver 04 = Motorcycle - passenger or unspecified 05 = Pedal cyclist or pedal cycle passenger 06 = Pedestrian 07 = Other or unspecified transport-related circumstance 08 = Horse-related (includes fall from, struck or bitten by) 09 = Fall - low (on same level or 10 = Fall - high (drop of 1 meter or more) 11 = Drowning, submersion - swimming pool 12 = Drowning, submersion - other than swimming pool

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

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

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

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

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

Number of service events (non-admitted patient)	
Definition	The total number of service events provided to non-admitted patients in the reference period, for each of the clinical service types in the hospital.
Metadata Type	Data Element
Data Concept	Ambulatory Care Information -Number of service events (non-admitted patient)
Reference ID	CE010
Synonyms	Non Applicable
Representation Class	Total
Data Type	Numeric
Format	7N
Maximum Field Size	7
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	Count of non-admitted patient service events for each of the clinical service types listed in the value domain of the metadata item Non-admitted patient service event—service event type (clinical), code NN. For each Non-admitted patient service event count, specify the • Non-admitted patient service event—service event type (clinical), code NN • Non-admitted patient service event—multidisciplinary team status, code N • Service contact—group session status, individual/group session indicator code ANN.N • Non-admitted patient service event—patient present status, code N • Non-admitted patient service event— service mode, hospital code N{N}
Code Description and Permissible Values	Not Applicable

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

Service mode (non-admitted patient)	
Definition	Relative physical location of the patient, provider and the hospital campus of the provider of a non-admitted patient service event, as represented by a code.
Metadata Type	Data Element
Data Concept	Ambulatory Care Information -Service mode (non-admitted patient)
Reference ID	CE012
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	NN
Maximum Field Size	2
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	This element is used as follows: CODE 1.1 On the hospital campus of the provider, Patient and provider in the same physical location refers to face to face contacts. If this occurs at the hospital campus of the provider, use code 1.1 CODE 1.2 Not on the hospital campus of the provider, If the service event does not occur on the hospital campus of the provider (hospital-based outreach services), use code 1.2. Hospital-based outreach service events occur when the patient is treated by hospital staff in a location that is not part of the hospital campus (such as in the patient's home or place of work). Patient and provider not in the same physical location refers to service events delivered via a telephone call or video link (telemedicine). The provider may or may not be physically present on their hospital campus. A service event delivered via a telephone call is included if: • it is a substitute for a face-to-face service event, and • it is prearranged, and • a record of the service event is included in the patient's medical record A service event can be counted at each site participating via a video link.
Code Description and Permissible Values	Codes used are: 1 = Patient and provider in the same physical location 1.1 = On the hospital campus of the provider 1.2 = Not on the hospital campus of the provider 2 = Patient and provider not in the same physical location, and communicating via: 2.1 = Telephone 2.2 = Telemedicine

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

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

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

Place of occurrence of external cause of injury (Non-admitted patient)	
Definition	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.
Metadata Type	Data Element
Data Concept	Ambulatory Care Information-Place of occurrence of external cause of injury (non-admitted patient)
Reference ID	CE016
Synonyms	Non Applicable
Representation Class	Code
Date Type	Numeric
Format	NN
Maximum Field Size	2
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	To be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterizes the type of place where the person was situated when the injury occurred on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.
Code Description and Permissible Values	Codes used are: 00 = Home 01 = Residential Institution 02 = School, other institution and public administration area 03 = School 04 = Health service area 05 = Building used by general public or public group 06 = Sports and athletics area 07 = Street and highway 08 = Trade and service area 09 = Industrial and construction area 10 = Farm 88 = Other specified places 99 = Unspecified place

Vital Signs

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

Heart Rhythm Type	
Definition	The type of rhythm associated with the beating of the heart as determined from the electrocardiogram (ECG), as represented by a code.
Metadata Type	Data Element
Data Concept	Vital Signs - Heart Rhythm Type
Reference ID	CF002
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	NN
Maximum Field Size	2
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	This data element is used to collect data for Acute Coronary Syndrome (ACS) patient reporting, the data should be collected at time of presentation. If heart rhythm type is not recorded at the exact time of presentation, record the first heart rate measured closest to the time of presentation. This element has a medico-legal importance
Code Description and Permissible Values	Codes used are: 01 = Sinus rhythm 02 = Atrial fibrillation 03 = Atrial flutter 04 = Second degree heart block 05 = Complete heart block 06 = Supraventricular tachycardia 07 = Idioventricular rhythm 08 = Ventricular tachycardia 09 = Ventricular fibrillation 10 = Paced 88 = Other rhythm 99 = Not stated/inadequately described

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

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

Diastolic Blood Pressure	
Definition	The person's diastolic blood pressure, measured in millimetres of mercury (mmHg).
Metadata Type	Data Element
Data Concept	Vital Signs - Diastolic Blood Pressure
Reference ID	CF005
Synonyms	Non Applicable
Representation Class	Total
Data Type	Numeric
Format	NNN
Maximum Field Size	3
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	If the blood pressure was assessed by palpation or with a Doppler device, then this field should be Code as '888', as the diastolic blood pressure was, in fact, not measured. If this vital sign was not obtained, the field should be Code as '888', and if this vital sign was obtained but is unknown at the time of data entry, the field should be Code as '999'.
Code Description and Permissible Values	Codes used are: – Measuring unit mm. HG (Millimetre of Mercury) – NNN = Actual reading (3-digit field) – 888 = Not measurable – 999 = Unknown

Body Temperature	
Definition	Core body temperature measured at the beginning of health incident that mandates its recording
Metadata Type	Data Element
Data Concept	Vital Signs - Body Temperature
Reference ID	CF006
Synonyms	Non Applicable
Representation Class	Total
Data Type	Numeric
Format	NN
	2
Maximum Field Size	
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Health Council
Usage	This element is crucial when handling patients that suffer environmental injuries as the core body temperature is a main indicator of patient condition. Use Code 88 for unmeasured core temperature Use Code 99 when it is not known at the time of data entry
Code Description and Permissible Values	Codes used are: – Measuring unit is The Celsius scale (°C) – NN = Actual reading (2 digit field) – 88 = Not obtained – 99 = Unknown

Admission Information

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

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

Admission Time	
Definition	Time at which an admitted patient commences an episode of care.
Metadata Type	Data Element
Data Concept	Admission, Admission time
Reference ID	CG003
Synonyms	Non Applicable
Representation Class	Time
Data Type	Date/Time
Format	HH:MM
Maximum Field Size	5
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	Required to identify the time of commencement of the episode or hospital stay, for calculation of waiting times and length of stay.
Code Description and Permissible Values	Codes used are: This information is used to describe the admission time based on 24 hours' time format HHMM. – HH = Ranges from 00 to 23; – MM = Ranges from 00 to 59. – 0000 = Midnight is Code, and begins the new day. – 99 = Unknown values should be for HH or MM. – Use leading zeros to assure 2-character field widths for HH and MM.

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

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

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

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

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

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

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

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

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

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

Patient Clinical Complexity Level	
Definition	A measure of the cumulative effect of a patient's complications and comorbidities (CCs) that is calculated for each episode of admitted patient care. Each diagnosis is assigned CCL (Clinical Complexity Level)
Metadata type	Data element
Data concept	Patient clinical complexity
Reference ID	CG014
Synonyms	Not applicable
Represented class	Code
Data type	Numeric
Format	N
Maximum field size	1
Date created	01/04/2019
Date updated	To be decided
Source	AR-DRG v6.0 Definitions Manual
Usage	
Code description and permissible values	Codes used are: – 0 No CC effect – 1 Minor CC – 2 Moderate CC – 3 Severe CC – 4 Catastrophic CC

Encounter Type	
Definition	The type of encounter/visit designated as Inpatient, day case, emergency, outpatient clinic, home health care or Primary Health Care, as represented by a code.
Metadata type	Data element
Data concept	The type of encounter/visit
Reference ID	CG014
Synonyms	Not applicable
Represented class	Code
Data type	Numeric
Format	N
Maximum field size	1
Date created	01/04/2019
Date updated	To be decided
Source	1. Abu Dhabi Health Authority (HAAD) -Claims Schema - Encounter Type. 2. SHDD concepts of Health Service Event (ID CA001) 3. SHDD Admission Episode (ID CG001)
Usage	
Code description and permissible values	1. Hospital Inpatient - patient occupies inpatient bed and stays overnight. 2. Day Case - patient occupies bed and is discharged on the same day. 3. Emergency - patient is seen in. Emergency Department and is not admitted to Inpatient Bed. 4. Outpatient - patient not admitted and not seen in Emergency Department. 5. Home Health Care - patient is seen in the Home. 6. Primary Health Care - patient is seen in Primary health care setting , outside of the hospital.

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

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

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

Discharge Information

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

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

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

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

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

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

Hospital Care Information

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

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

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

Inter-hospital contracted patient	
Definition	An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals, as represented by a code.
Metadata Type	Data Element
Data Concept	Hospital Care Information—Inter-hospital contracted patient
Reference ID	CI004
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	All services provided at both the originating and destination hospitals should be recorded and reported by the originating hospital. The destination hospital should record the admission as an 'Inter-hospital contracted patient' so that these services can be identified in the various statistics produced about hospital activity.
Code Description and Permissible Values	Codes used are: 1 = Inter-hospital contracted patient from public sector hospital 2 = Inter-hospital contracted patient from private sector hospital 3 = Not contracted 9 = Not reported

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

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

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

Number of days of hospital-in-the-home care	
Definition	The number of hospital-in-the-home days occurring within an episode of care for an admitted patient.
Metadata Type	Data Element
Data Concept	Hospital Care Information—Number of days of hospital-in-the-home care
Reference ID	CI008
Synonyms	Non Applicable
Representation Class	Total
Data Type	Numeric
Format	NNN
Maximum Field Size	3
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	Number of days of hospital-in-the-home care data will be collected from all regions. The rules for calculating the number of hospital-in-the-home days are outlined below: • The number of hospital-in-the-home days is calculated with reference to the date of admission, date of separation, leave days and any date(s) of change between hospital and home accommodation; • The date of admission is counted if the patient was at home at the end of the day; • The date of change between hospital and home accommodation is counted if the patient was at home at the end of the day; • The date of separation is not counted, even if the patient was at home at the end of the day • The normal rules for calculation of patient days apply, for example in relation to leave and same day patients.
Code Description and Permissible Values	Codes used are: NNN = Number of days

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

Number of occasions of service	
Definition	The total number of occasions of examination, consultation, treatment or other service provided to a patient.
Metadata Type	Data Element
Data Concept	Hospital Care Information—Number of occasions of service
Reference ID	CI010
Synonyms	Non Applicable
Representation Class	Total
Data Type	Numeric
Format	7N
Maximum Field Size	7
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	The following guides for use apply: • An occasion of service is counted for each person attending in the capacity of a patient in their own right, even if other non-patient persons are present for the service. • Spouses, parents or carers attending the session are only counted if they are also participating in the service as a patient. • In the instance of a dependent child presenting to a clinic, the session is counted as a single Occasion of Service provided to the individual child for whom an event history is being recorded. Where parents/carers also attend in the capacity of patients themselves within a booked appointment, and receive the same services at the same time, the child and parent/carer can be counted as a group. In this instance a Group Session count would be recorded. • An occasion of service is counted for staff attending clinics of public hospitals only if they are attending as patients in their own right. Staff education and training is excluded. • Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or dialysis clinics are counted as group sessions, if two or more people receiving the same services at the same time.
Code Description and Permissible Values	Codes used are: 7N = Number of occasions.

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

Patient days	
Definition	The total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period.
Metadata Type	Data Element
Data Concept	Hospital Care Information—Patient days
Reference ID	CI012
Synonyms	Non Applicable
Representation Class	Total
Data Type	Numeric
Format	8N
Maximum Field Size	8
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	A day is measured from midnight to 23:59 hours. The following basic rules are used to calculate the number of patient days for overnight stay patients: • The day the patient is admitted is a patient day • If the patient remains in hospital from midnight to 23:59 hours count as a patient day. • The day a patient goes on leave is counted as a leave day • If the patient is on leave from midnight to 23:59 hours count as a leave day. • The day the patient returns from leave is counted as a patient day The day the patient is separated is not counted as a patient day. The following additional rules cover special circumstances and in such cases, override the basic rules: • Patients admitted and separated on the same date (same- day patients) are to be given a count of one patient day. • If the patient is admitted and goes on leave on the same day, count as a patient day. • If the patient returns from leave and goes on leave on the same date, count as a leave day. • If the patient returns from leave and is separated, it is not counted as either a patient day or a leave day. • If a patient goes on leave the day they are admitted and does not return from leave until the day they are discharged, count as one patient day (the day of admission is counted as a patient day, the day of separation is not counted as a patient day). When calculating total patient days for a specified period:

	• Count the total patient days of those patients separated during the specified period including those admitted before the specified period • Do not count the patient days of those patients admitted during the specified period who did not separate until the following reference period • Contact patient days are included in the count of total patient days. If it is a requirement to distinguish contact patient days from other patient days, they can be calculated by using the rules contained in the data element: total contact patient days
Code Description and Permissible Values	Codes used are: Total number of patient days calculated in days unit 8N

Procedure	
Definition	A clinical intervention represented by a code that: • Is surgical in nature, and/or • Carries a procedural risk, and/or • Carries an aesthetic risk, and/or • Requires specialized training, and/or • Requires special facilities or equipment only available in an acute care setting.
Metadata Type	Data Element
Data Concept	Hospital Care Information—Procedure
Reference ID	CI013
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	NNNNN-NN
Maximum Field Size	7
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	Record and code all procedures undertaken during the episode of care. Procedures are derived from and must be substantiated by clinical documentation.
Code Description and Permissible Values	Not Applicable

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

	their participation in this life situation, in terms of duration, frequency, manner and outcome. CODE 4 Moderate dissatisfaction with participation, used if two or three criteria (duration, frequency, manner or outcome) are not fulfilled, but are not so badly affected, in relation to the person's goals in that life area, that the person is extremely dissatisfied. For example, a person is able to participate in work, but is placed in supported employment rather than employment in the open labour market. This is not in line with the person's goals, so that the manner and outcome of the participation are not fulfilled. CODE 5 Extreme dissatisfaction with participation, used when all criteria (duration, frequency, manner and outcome) are not fulfilled for the specified life situation, or where any of the criteria are so badly affected in relation to the person's goals that they consider themselves to be extremely dissatisfied with this life area. An example of the latter would arise when a person is extremely dissatisfied with participation in interpersonal activities because his/her goal in terms of duration of social visits is never fulfilled, although other criteria (frequency and manner) may be fulfilled. CODE 6 Complete restriction and dissatisfaction, used when the person does not participate in this life situation in line with his or her own goals, i.e. in an area where they wish to participate and is completely dissatisfied with not participating in this life situation. CODE 9 Not applicable, used when participation in a life situation is not relevant, such as employment of an infant or where there is no participation and the person has no desire to participate in this area. For example, a personal preference not to participate in specified areas of community, social and civic life such as sport or hobbies. The area may not be applicable to the person's current life goals.
Code Description and Permissible Values	Codes used are: 1 = High satisfaction with participation 2 = Moderate satisfaction with participation 3 = Neither satisfied nor dissatisfied with participation 4 = Moderate dissatisfaction with participation 5 = Extreme dissatisfaction with participation 6 = Complete restriction and dissatisfaction 8 = Not specified 9 = Not applicable

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

Total leave days	
Definition	Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.
Metadata Type	Data Element
Data Concept	Hospital Care Information—Total leave days
Reference ID	CI016
Synonyms	Non Applicable
Representation Class	Total
Data Type	Numeric
Format	NNN
Maximum Field Size	3
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	A day is measured from midnight to midnight. The following rules apply in the calculation of leave days for both overnight and same-day patients: • The day the patient goes on leave is counted as a leave day. • The day the patient is on leave is counted as a leave day. • The day the patient returns from leave is counted as a patient day. • If the patient is admitted and goes on leave on the same day, this is counted as a patient day, not a leave day. • If the patient returns from leave and then goes on leave again on the same day, this is counted as a leave day. • If the patient returns from leave and is separated on the same day, the day should not be counted as either a patient day or a leave day.
Code Description and Permissible Values	Not Applicable

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

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

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

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

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

Chapter 04

Mortality

Mortality Basic Information

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

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

Time of Death	
Definition	Time of the person's Death
Metadata Type	Data Element
Data Concept	Mortality(—time of death
Reference ID	DA003
Synonyms	Non Applicable
Representation Class	Time
Data Type	Date/Time
Format	HH:MM
Maximum Field Size	5
Date Created	19/05/2016
Date Updated	To be defined
Source	Palestinian Health Data Dictionary Second edition, 2005
Usage	This element is the standard time format used to document the death time of patients, it is based on 24 hours' time format..
Code Description and Permissible Values	Codes used are: – Time = HH:MM – HH = Ranges from 00 to 23; – MM = Ranges from 00 to 59. – 00:00 = Midnight, and begins the new day – 99 = Unknown values for HH or MM. – Use leading zeros to assure 2-character field widths for HH and MM.

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

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

Mortality Statistical Information

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

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

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

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

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

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

+

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

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

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

Chapter 05

Communicable **Diseases**

Communicable Diseases

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

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

	CODING STRUCTURE : The structure created for the communicable diseases is a Local code created for each communicable disease composed of: 1 - First Letter denotes urgency in reporting: A = Immediate B = Intermediate C = Delayed 2 - Second Letter describes the causative organism / agent A = Adverse Events B = Bacteria C = Chlamydia F = Fungus I = Bite M = Metazoal P = Parasitic S= Sexual T= Tuberculosis V= Viral 3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease
Code Description and Permissible Values	Codes used are: **Groups A Group A (Immediate)**

Local l	**ICD 10**	**Disease**
AB01	A22	Anthrax
AB02	A00-A09	Cholera
AB03	A36	Diphtheria
AB04	A05	Food poisoning (Bacterial)
AB05	A39	Meningitis Meningococcal
AB06	A20	Plague
AB07	A34, A35	Tetanus Adult
AB08	A33	Tetanus neonatal

B Group B (Intermediate)

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

C Group C (Delayed)

Local I	ICD 10	Disease
CB01	N01	Glomerulonephritis
CB02	J12-12	Pneumonia
CB03	I00-I02	Rheumatic
CB04	A71	Trachoma

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

	CODING STRUCTURE: The structure created for the communicable diseases is a Local code created for each communicable disease composed of: 1 - First Letter that denotes urgency in reporting: A = Immediate, B = Intermediate, C = Delayed 2 - Second Letter describes the causative organism / agent A = Adverse Events B = Bacteria C = Chlamydia F = Fungus I = Bite M = Metazoal P = Parasitic S= Sexual T= Tuberculosis V= Viral 3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease
Code Description and Permissible Values	Codes used are: Local Code Icd10 Code Groups

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

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

	CODING STRUCTURE The structure created for the communicable diseases is a Local code created for each communicable disease composed of 1 - First Letter is that denotes urgency in reporting: A = Immediate B = Intermediate, C = Delayed 2 - Second Letter describes the causative organism / agent A = Adverse Events B = Bacteria C = Chlamydia F = Fungus I = Bite M = Metazoal P = Parasitic S= Sexual T= Tuberculosis V= Viral 3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease
Code Description and Permissible Values	Codes used are: Group A Especially in immunocompromised patient Local Code ICD 10 Code AF01 B45.1 Cryptococcus Meningitis AF02 B39 Histoplasmosis

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

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

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

	CODING STRUCTURE The structure created for the communicable diseases is a Local code created for each communicable disease composed of 1 - First Letter is that denotes urgency in reporting: A = Immediate, B = Intermediate , C = Delayed 2 - Second Letter describes the causative organism / agent A = Adverse Events B = Bacteria C = Chlamydia F = Fungus I = Bite M = Metazoal P = Parasitic S= Sexual T= Tuberculosis V= Viral 3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease
Code Description and Permissible Values	Codes used are: Local Code Icd10 Code: Groups B BP01 B55.1 Leishmania skin BP02 B55.0 Leishmania visceral BP03 B50-54 Malaria. Group C CP01 A06 Amebiasis CP02 B80 Enterobiasis CP03 A07.1 Giardiasis CP04 B67 HydatidDiseas CP05 B71 Hymenolepiasis CP06 B85 Pediculosis CP07 B86 Scabies CP08 B78 Strongyloidiasis CP09 B58 Toxoplasmosis CP10 B79 Trichuriasis

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

	CATEGORY C: Delayed These are diseases of urgent public health importance and shall be reported in Five working days. They are categorised as DELAYED urgency for reporting to health authorities upon identification or suspicion of a case. Such cases may require public health intervention. CODING STRUCTURE: The structure created for the communicable diseases is a Local code created for each communicable disease composed of 1 - First Letter is that denotes urgency in reporting: A = Immediate, B = Intermediate , C = Delayed 2 - Second Letter describes the causative organism / agent A = Adverse Events B = Bacteria C = Chlamydia F = Fungus I = Bite M = Metazoal P = Parasitic S= Sexual T= Tuberculosis V= Viral 3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease
Code Description and Permissible Values	Codes used are: Local Code Icd10 Code Groups Group B BR01 A75 Typhus

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

	authorities upon identification or suspicion of a case. Such cases may require public health intervention. CODING STRUCTURE The structure created for the communicable diseases is a Local code created for each communicable disease composed of 1 - First Letter is that denotes urgency in reporting: A = Immediate, B = Intermediate , C = Delayed 2 - Second Letter describes the causative organism / agent A = Adverse Events B = Bacteria C = Chlamydia F = Fungus I = Bite M = Metazoal P = Parasitic S= Sexual T= Tuberculosis V= Viral 3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease
Code Description and Permissible Values	Codes used are: Local Code Icd10 Code Groups Group B BS01 A50-A64 STD* BC02 A70 Chlamydial sexual diseases

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

	CATEGORY C: Delayed These are diseases of urgent public health importance and shall be reported in Five working days. They are categorised as DELAYED urgency for reporting to health authorities upon identification or suspicion of a case. Such cases may require public health intervention. CODING STRUCTURE: The structure created for the communicable diseases is a Local code created for each communicable disease composed of 1- First Letter is that denotes urgency in reporting: A = Immediate, B = Intermediate , C = Delayed 2 - Second Letter describes the causative organism / agent A = Adverse Events B = Bacteria C = Chlamydia F = Fungus I = Bite M = Metazoal P = Parasitic S= Sexual T= Tuberculosis V= Viral 3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease.
Code Description and Permissible Values	Codes used are: Local Code Icd10 Code Groups Group B BT01 A15,A16 TB pulmonary BT02 A17,A18 TB extra pulmonary

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

	CODING STRUCTURE: The structure created for the communicable diseases is a Local code created for each communicable disease composed of 1 - First Letter is that denotes urgency in reporting: A = Immediate, B = Intermediate , C = Delayed 2 - Second Letter describes the causative organism / agent A = Adverse Events B = Bacteria C = Chlamydia F = Fungus I = Bite M = Metazoal P = Parasitic S= Sexual T= Tuberculosis V= Viral 3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease
Code Description and Permissible Values	Codes used are: Local Code Icd10 Code Groups Group A AX01 G82 AFP (Unspecified Cerebral) A05.1 AFP (Botulism) A80 AFP (Polio related) AX02 J80 ARDS AX03 G61 Guillain Barr AX04 G37.3 Transverse Myelitis

Toxic Venom Incidents

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

	CODING STRUCTURE The structure created for the communicable diseases is a Local code created for each communicable disease composed of 1 - First Letter is that denotes urgency in reporting: A = Immediate, B = Intermediate, C = Delayed 2 - Second Letter describes the causative organism / agent A = Adverse Events B = Bacteria C = Chlamydia F = Fungus I = Bite M = Metazoal P = Parasitic S= Sexual T= Tuberculosis V= Viral 3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease
Code Description and Permissible Values	Codes used are Local Code Icd10 Code Groups Group A CI01 T63.4 Tick paralysis Group C CI01 W55.8 Bite Animal (Other mammals) CI02 W54 Bite Dog CI03 T63.2 Bite Scorpion CI04 T63 Bite Snake (Toxic Venom unspecified)

Non Micro-biological Communicable Incidents

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

	CODING STRUCTURE The structure created for the communicable diseases is a Local code created for each communicable disease composed of: 1. First Letter is that denotes urgency in reporting: A = Immediate, B = Intermediate , C = Delayed 2 - Second Letter describes the causative organism / agent A = Adverse Events B = Bacteria C = Chlamydia F = Fungus I = Bite M = Metazoal P = Parasitic S= Sexual T= Tuberculosis V= Viral 3- Local Serial Number with maximum permissible value 2 Characters NN Followed by the ICD 10 Code of the disease
Code Description and Permissible Values	Codes used are: Local Code Icd10 Code Groups Group A AK01 Y38,7 Terrorism involving Chemical weapons Group B BK01 T30 Chemical Burn

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

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

Chapter 06

Tumors

Tumor description and diagnosis

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

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

Tumor Morphology	
Definition	The histological classification of the cancer tissue (histopathological type) and a description of the course of development that a tumor is likely to take: benign or malignant (behavior), as represented by a code.
Metadata Type	Data Element
Data Concept	Tumors - Tumor Morphology
Reference ID	FA003
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	NNNN/N
Maximum Field Size	5
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi health council / Saudi Cancer Registry form
Usage	Morphology in Saudi Cancer Registry is based on International Classification of Diseases for Oncology ICDO3.1, it describes histology and behavior as separate variables, recognizing that there are a large number of possible combinations. Morphology is a 4-digit number ranging from 8000 to 9989, and behavior is a single digit which can be 0, 1, 2, 3, 6 or 9. Record morphology codes in accordance with ICDO coding standards. Use the 5th-digit to record behavior. The 5th digit behavior code numbers used in ICDO are listed below: 0 = Benign 1 = Uncertain whether benign or malignant: - Borderline malignancy - Low malignant potential 2 = Carcinoma in situ - Intraepithelial – Non infiltrating - Non-invasive 3 = Malignant, primary site 6 = Malignant, metastatic site - Malignant, secondary site 9 = Malignant, uncertain whether primary or metastatic site
Code Description and Permissible Values	Codes used are: As outlined in latest 2011 - ICDO3.1

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

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

Degree of spread of cancer	
Definition	Degree of spread of cancer is a measure of the progression/extent of cancer at a particular point in time, as represented by a code.
Metadata Type	Data Element
Data Concept	Tumor Grade—Degree of spread of cancer
Reference ID	FA006
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	The following examples will help understanding which code should be used Examples for Code 1 : 1) For colon cancer, the cancer has not progressed into the adventitia (peritoneal layer) surrounding the colon. 2) For breast cancer, the cancer has not progressed into the underlying muscle layer (pectoral) or externally to the skin. 3) For lung cancer, the cancer has not invaded the pleura. Examples for code 2 : 1) For colon cancer, the cancer has progressed into the adventitia (peritoneal layer) surrounding the colon. 2) For breast cancer, the degree of spread has progressed into the underlying muscle layer (pectoral) or externally into the skin. 3) For lung cancer, the cancer has invaded the pleura or tissues of the mediastinum. Example for code 3 : The regional lymph nodes by site of primary cancer (International Union Against Cancer's definition). 1) Head and neck: Cervical nodes 2) Larynx: Cervical nodes 3) Thyroid: Cervical and upper mediastinal nodes Stomach 4) Per gastric nodes along the lesser and greater curvatures 5) Colon & Rectum: Pericolic, perirectal, those located along the ileocolic, right colic, middle colic, left colic, inferior mesenteric and superior rectal 6) Anal: Perirectal, internal iliac, and inguinal lymph nodes Liver 7) Hilar nodes, e.g. the hepatoduodenal ligament Pancreas 8) Peripancreatic nodes - Lung: Intrathoracic, scalene and supraclavicular

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

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

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

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

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

Tumor Treatment

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

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

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

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

Radiotherapy Treatment Type	
Definition	The type of radiation therapy used in initial treatment of the cancer, as represented by a code.
Metadata Type	Data Element
Data Concept	Tumor Treatment—Radiation Therapy Treatment Type
Reference ID	FB005
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	More than one radiotherapy treatment type may be delivered during the course of treatment; select the appropriate code value. Most external beam radiotherapy is delivered on an outpatient basis. CODE 2 Brach therapy (radioactive implants) This code is likely to be listed as a procedure for admitted patients. The difference between the types of radiotherapy relates to the position of the radiation source: • External beam radiotherapy (EBRT) is delivered by directing the radiation at the tumor from outside the body. • Brach therapy or sealed source radiotherapy is delivered by placing the radiation source in close proximity to the tumor site. • Unsealed radioisotopes or systemic radioisotope therapy is delivered by infusion into the bloodstream or by ingestion and is a form of targeted therapy.
Code Description and Permissible Values:	Codes Used are: 0 = No radiotherapy treatment given 1 = External radiotherapy treatment given 2 = Brach therapy (radioactive implants) 3 = Unsealed radioisotopes 9 = Radiotherapy was administered but method was not stated

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

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

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

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

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

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

Chapter 07

Burden of Disease Information

Cardiovascular Diseases CVD

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

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

Hypertension Classification	
Definition	Identifies a person with or at risk of hypertension
Metadata type	Data Element
Data concept	Burden of Disease CVD ,Hypertension classification
Reference ID	GA003
Synonyms	Non applicable
Representation Class	Code
Data type	numeric
Format	N
Maximum field size	1
Data created	19/05/2016
Data Updated	To be defined
Source	Palestinian health data dictionary second edition,2005
Usage	This element is used in public health, health care and clinic settings to report data related to one of the chronic illnesses that are considered a high burden on the Saudi health system. The Staging of the severity of hypertension and treating plan with pharmacological or non-pharmacological or both, According to the stage. Confirming the diagnosis of HTN is based on the latest guidelines issued by the USA JNC 8 report 2014 which confirms Hypertension at a subsequent visit one to four weeks after the first.2 If blood pressure is very high (e.g., systolic 180 mmHg or higher), or timely follow-up unrealistic, treatment can be started after just one set of measurements. Hypertension classification is based on the following JNC 7 Classification of Blood Pressure: Normal = Systolic <120 and Diastolic <80 Prehypertension = Systolic 120–139 or Diastolic 80–89 Hypertension, Stage 1 = Systolic 140–159 or Diastolic 90–99 Hypertension, Stage 2 = Systolic ≥160 or Diastolic ≥100
Code Description and Permissible Values:	Codes used are: 0 = Normal 1 = Pre- Hypertension 2 = Stage 1 Hypertension 3 = Stage 2 Hypertension

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

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

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

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

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

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

Diabetes Mellitus

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

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

	Code 8 = Other Specific Types: Diabetes caused by other identifiable etiologies • Genetic defects of beta cell function (e.g., MODY* 1, 2, 3) • Genetic defects in insulin action • Diseases of the exocrine pancreas (e.g., cancer of the pancreas, cystic fibrosis, pancreatitis) • Endocrinopathies (e.g., Cushing's disease) • Drug or chemical induced (e.g., steroids) • Infection (e.g., rubella, Coxsackie, CMV) • Uncommon forms of immune- related diabetes • Other genetic syndromes.
Code Description and Permissible Values	Codes used are: 1 = Type 1 2 = Type 2 3 = Impaired Glucose Homeostasis 4 = Gestational Diabetes 8 = Other

Diabetes Mellitus Complications	
Definition	Diabetic complications can be classified as: - Acute complications: Complication which arise within a short time Frame due to poor metabolic control. – Chronic complications: Chronic diabetic complications contribute significantly to morbidity and mortality in diabetes mellitus, they are insidious in onset but may be present in up to 30% of type 2 diabetes at diagnosis and good metabolic control Can prevent/delay progression of these complications.
Metadata Type	Data Element
Data Concept	Burden of Disease Information, Diabetes Mellitus Complications
Reference ID	GB003
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	NNN
Maximum Field Size	3
Date Created	19/05/2016
Date Updated	To be defined
Source	Palestinian Health Data Dictionary Second edition, 2005
Usage	
Code Description and Permissible Values	Codes used are: **1.0 Acute complications:** 1.1 Hypoglycemia 1.2 Diabetic ketoacidosis (DKA) 1.3 Hyperglycemic hyperosmolar state (HHS) **2.0 Chronic complications:** 2.1 Microvascular 2.1.1 Coronary artery disease 2.1.2 Cerebrovascular disease 2.1.3 Peripheral vascular disease 2.2 Microvascular 2.2.1 Retinopathy, 2.2.2 Nephropathy 2.2.3 Neuropathy 2.3 Combination of microvascular and microvascular 2.3.1 diabetic foot 2.3.2 diabetic dermopathy 2.4 Others

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

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

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

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

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

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

Obesity

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

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

Renal Disease Therapy

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

Chapter 8

Pharmaceuticals

Storing

Pharmaceutical Storage Compliance	
Definition	The compliance of the drugs storing activities at any health facility with the best practices standards and in accordance with the Guidelines for Stability Testing of Active Pharmaceutical Ingredients (APIs) and Finished Pharmaceutical Products (FPPs) published on the official Saudi Food and Drug Authority website.
Metadata Type	Data Element
Data Concept	Pharmaceuticals, Storing, Storing compliance
Reference ID	HA001
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Food and Drug Authority
Usage	This data element is used to report on conditions of storage of the pharmaceuticals at a health facility in accordance with the best approved Saudi Food and Drug Authority (SFDA) national standards and manufacturer recommendations. The report should be generated and collected by INDEPENDENT supervising administration at the facility at Least quarterly. Code1 = Equivalent to optimum conditions for all types of Storing conditions and compliance with policies. Code 2 = Equivalent to conditions when less than optimal adherence to policies but no serious malpractice behavior noted. Code 3 = Equivalent to conditions where one major element of storing activity is missing and an evidence of neglect is observed but not fatal to patient health Code 4 = Equivalent to conditions when more than one major element is missing and/or at least one observation that is fatal to patient care Code 5 = Failure to assess the facility
Code Description and Permissible Values	Code used are: 1 = Complete compliance 2 = Partial compliance 3 = Poor compliance 4 = Non compliance 9 = No assessment

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

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

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

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

Prescribing and Preparation

Unauthorized Drug Error	
Definition	Patient prescribed a pharmaceutical product by an unauthorized health practitioner.
Metadata Type	Data Element
Data Concept	Pharmaceuticals, Unauthorized Drug Error
Reference ID	HB001
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Food and Drug Authority
Usage	This is a data element that is used to describe conditions related to prescribing a pharmaceutical product by a no authorized Practitioner. This element is applicable in the following conditions: 1- When a treating physician who is not specialized in the branch of medicine for which the pharmaceutical products is used (e.g. NON neurologist prescribing Antiepileptic) 2- When a health practitioner whose medical rank is not privileged to prescribe certain Pharmaceutical product (e.g. A narcotic drug prescribed by Nurse or Intern)
Code Description and Permissible Values	Codes used are: Code 1 = Error due to wrong specialty Code 2 = Error due to wrong medical ranking

Improper frequency Error	
Definition	Patient is prescribed or receiving an inappropriate frequency of a pharmaceutical product.
Metadata Type	Data Element
Data Concept	Pharmaceuticals, Improper frequency error
Reference ID	HB002
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Food and Drug Authority
Usage	This is a data element that is used to describe conditions related to prescribing or giving a wrong frequency of pharmaceutical product by an authorized practitioner. This element is applicable for inpatient care services in accordance with the following conditions: 1- When a treating physician have ordered a wrong frequency 2- When a health practitioner who is involved in giving the pharmaceutical product has given a wrong frequency
Code Description and Permissible Values	Codes used are: Code 1 = Error due to wrong prescription Code 2 = Error due to wrong Administration

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

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

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

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

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

Pharmacovigilance

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

Adverse Effect/Reaction	
Definition	An adverse reaction is a response to a medicinal product which is noxious and unintended.
Metadata Type	Data Element
Data Concept	Pharmaceuticals, Pharmacovigilance, adverse effect
Reference ID	HC002
Synonyms	Non Applicable
Representation Class	Code
Data Type	Alphanumeric ANN.NN
Format	
Maximum Field Size	6
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Food and drug Authority / ICD 10-AM coding guidelines.
Usage	Use this data element to report any medication adverse effect that may be noted during patient treatment, the following ICD 10 AM guidelines are important for good coding results Codes categories T36-T65 are combination codes that include the substance that was taken as well as the intent. No additional external cause code is required for poisonings, toxic effects, adverse effects and under dosing codes. • Do not code directly from the Table of Drugs and Chemicals. Always refer back to the Tabular List. • Use as many codes as necessary to describe completely all drugs, medicinal or biological substances. • If the same code would describe the causative agent for more than one adverse reaction, poisoning, toxic effect or under dosing, assign the code only once. • If two or more drugs, medicinal or biological substances are reported, code each individually unless a combination code is listed in the Table of drugs and Chemicals. When coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug (T36-T50). The code for the drug should have a 5th or 6th character “5” (for example T36.0X5-). Examples of the nature of an adverse effect are tachycardia,delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure.
Code Description and Permissible Values	Codes used are : ICD10- AM codes for Adverse Drug Reactions (ADR).

Poisoning by drugs and chemicals (Unintentional & Intentional)	
Definition	Overdose of a drug or chemical substance that caused an illness to a patient.
Metadata Type	Data Element
Data Concept	Pharmaceuticals, Pharmacovigilance, Poisoning by drugs & chemicals.
Reference ID	HC003
Synonyms	Non Applicable
Representation Class	Code
Data Type	Alphanumeric
Format	ANN.NN
Maximum Field Size	6
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Food and drug Authority / ICD 10-AM Coding guidelines
Usage	Use this data element to report any unintentional drug over dose by following these ICD 10 AM guidelines: When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), first assign the appropriate code from categories T36-T50. The poisoning codes have an associated intent as their 5th or 6th character (accidental, intentional self-harm, assault and undetermined. Use additional code(s) for all Manifestations of poisonings. If there is also a diagnosis of abuse or dependence of the substance, the abuse or dependence is assigned as an Additional code. Examples of poisoning include: • Errors made in drug prescription or in the administration of the drug by provider, nurse, patient, or other person. • If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be code as a poisoning. • If a non-prescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning. • When a reaction results from the interaction of a drugs) and alcohol, this would be classified as poisoning
Code Description and Permissible Values	Codes used are: ICD10- AM codes for Adverse Drug Reactions (ADR).

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

Utilization

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

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

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

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

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

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

	B) Injectable 1) Ampules Can be stored and used up to THREE months from opening date with proper storage conditions or as indicated by manufacturer. 2) Remainder of Single Dose Injectable that is Preservative Free should be discarded immediately after use. 3) Remainder of Multiple dose Injectable vials that Contain Preservatives should be discarded immediately after use 4) Insulin once opened discard after 4 weeks from date of opening unless manufacturer specified otherwise. 5) BCG Vaccine should be discarded 4 weeks from opening date with proper storage conditions, unless manufacturer specified otherwise. 6) Reconstituted Injectable (Multiple Dose Vials) should discarded 4 HOURS after reconstitution at refrigerator.
Code Description and Permissible Values	

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

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

Chapter 09

Health Facility Human Resources

Medical Human Resources

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

KSA Individual Provider Type	
Definition	The code used to describe the type of the individual health provider practicing in Saudi healthcare system.
Metadata Type	Data Element
Data Concept	Medical Human Resources, KSA Individual Provider Type
Reference ID	IA002
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	N
Maximum Field Size	1
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Commission for Health Specialties
Usage	The element is used to determine the individual provider type as per the set of standards issued by the Saudi Commission for Health Specialties.
Code Description and Permissible Values	Codes used are: 1 = Physician 2 = Dentist 3 = Pharmacist 4 = Nurse 5 = Applied Medical

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

	N07 = Non Practicing Nurse **Allied Medical Codes** L01 = Consultant Specialist (Non Physician) L02 = Senior Specialist (Non Physician) L03 = Specialist (Non Physician) L04 = Technician Allied Medical L05 = Health Assistant Allied Medical L07 = Non Practicing Allied Medical Practitioner

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

Non-Medical Staff	
Definition	It includes the non-medical staff providing all the support for the Healthcare Facility required for daily operation, maintenance and management.
Metadata Type	Data Element
Data Concept	Health facility HR, Non-Medical HR, Healthcare Management
Reference ID	IB001
Synonyms	Non Applicable
Representation Class	Code
Data Type	Numeric
Format	NN
Maximum Field Size	2
Date Created	19/05/2016
Date Updated	To be defined
Source	Saudi Health Council
Usage	Usage of this element is as follows: Code 1 is to report all non-medical senior staff who are working in the capacity of: - CEO, CFO or COO - General manager - Assistant Manager - Head of section or sub department Code 3 is to report all staff working on supporting the hospital cleaning process and waste management both inside and outside hospital facility. Code 11 is used to report all other administrative staff that are not in code 1
Code Description and Permissible Values	Codes used are: 01 = Administrative Senior Management 02 = Engineering Staff 03 = Environmental Services staff 04 = Finance and Human Resources Staff 05 = General Admin staff 06 = Information Management Staff 07 = Logistics Support staff 08 = Maintenance Staff 09 = Patient relations staff 10 = Purchase Management staff 11 = Safety and Security support staff 12 = Secretarial services staff 13 = Training Administration 14 = Transportation 15 = Ware house staff

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

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

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

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

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

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

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

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

Chapter 10

Hajj (Pilgrimage) Information

Hajj Season Medical Services

Hajj (Pilgrimage) Information

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

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

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

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

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

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

Daily census of invasive cardiac Procedures during Hajj season

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

Daily census of laboratory Investigations performed for Hajj patients

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

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

Chapter 11

Facility Financial **Information**

Health Facility Assets

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health Facility Revenue

Organization revenues	
Definition	Revenues of an organization relating to patient fees, recoveries, and other revenue in Saudi currency.
Metadata Type	Data Element
Data Concept	Facility Financial Information-Organization revenues
Reference ID	KB001
Synonyms	Non Applicable
Representation Class	Total
Data Type	Currency
Format	9N
Maximum Field Size	9
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	Revenues are to be reported in millions to the nearest 100,000 e.g. SAR 4,064,000 should be reported as SAR 4.1 Million. Revenue arises from: • The sale of goods, • The rendering of services • The use by others of entity assets yielding interest, Royalties and dividends. Goods include goods produced by the entity for the purpose of sale and goods purchased for resale, such as merchandise purchased by a retailer or land and other property held for Resale. The rendering of services typically involves the performance by the entity of a contractually agreed task over an agreed period of time. The services may be rendered within a single period or over more than one period. Some contracts for the rendering of services are directly related to construction contracts, for example, Those for the services of project managers and architects. Revenue arising from these contracts is not dealt within this Standard but is dealt with in accordance with the Requirements for construction contracts. The use by others of entity assets gives rise to revenue in the form of: A- Interest – charges for the use of cash or cash equivalents or amounts due to the entity; B- Royalties -charges for the use of long-term assets of the entity, for example, patents, trademarks, copyrights and computer software C-Dividends-distributions of profits to holders of equity investments in proportion to their holdings of a particular class of capital.
Code Description and Permissible Values	Not Applicable

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

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

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

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

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

Health Facility Expenditure

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

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

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

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

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

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

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

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

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

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

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

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

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

Recurrent expenditure (salaries and wages), other diagnostic and health professionals	
Definition	Salary and wage payments in Saudi Riyals to other diagnostic and health professionals of an establishment, for a financial year.
Metadata Type	Data Element
Data Concept	Facility Financial Information-Recurrent expenditure (salaries and wages)—other diagnostic and health professionals.
Reference ID	KC014
Synonyms	Non Applicable
Representation Class	Total
Data Type	Currency
Format	9N
Maximum Field Size	9
Date Created	19/05/2016
Date Updated	To be defined
Source	Australian National Health Data Dictionary Version 14, 2008
Usage	As per definition This data element should be derived from the salaries and wages paid to Occupational therapists, social workers, psychologists and other diagnostic and health professionals. Obligation conditions: 1: reporting of this data element is optional for nongovernment residential mental health services and specialized mental health services provided by private hospitals that receive state or government funding. 2: If this data element cannot be supplied, the total salaries and wages for diagnostic and health professionals must be.
Code Description and Permissible Values	Codes used are: 9N = Record values up to hundreds of millions of Saudi Riyals, rounded to the nearest whole Saudi Riyal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendices

Appendix 1- Sample for Unique Facility Identifier

APPENDIX 1
SAMPLE FOR
UNIQUE FACILITYIDENTIFIER

1-ChoosetheREGION&CITYCODEASPertheSaudiPostCityCode

2- ChoosethecorrectcodeforGOVERNMENTHEALTHSECTORIDENTIFIERfromListbelow

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

For NON GOVERNMENT HEALTH SECTOR IDENTIFIER

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

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

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

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

AP1	AP2	AP3	AP4	AP5	AP6	AP7	AM1	AM2	AM3	AM4	AM5	AM6	AM8	GH1	GH2	SH1	SH2	SH3	SH4	SH5	SH6	SH7	MC1	FH1	FH2
Ambulance (Hospital /Prehospital / Centre)	Clinic	Mobile clinic	Polyclinic	Primary Health Care	Dental Service	Smoking Cession Clinic	X Ray	Laboratory	Optician	Pharmacy	Artificial limb	Rehabilitation	AM8 = Others	General Hospital in Big City	General Hospital in Small City	Cancer Hospital	Day Surgery	Long Stay	SH4 = Maternity Children	Ophthalmology Hospital	Physic iatric Hospital	Rehabilitation Hospital	MC1 = Medical City	FH1 = Disaster response	H2 = Seasonal Response

5-AddtheSerialNumberofFacilityaccordingtoyoursector

Maximumcharactersare:NNNN

Appendix No. 2

"Facility Medical Units and Departments Identifier" Code Values

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

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

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

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

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

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

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

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

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

Appendix No. 3

Non-Medical Department & Units Identifier Code Values

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

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

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

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

	Transportation Administration	NE5
	Maintenance & Projects Administration	NE6
	Warehouse Administration	NE7

Appendix No. 4- Healthcare Specialty Identifier Code Values

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

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

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

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

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

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

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

Appendix No. 5- Retired/Frozen Subspecialty\Units

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

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

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

Appendix 6- Saudi Health Data Dictionary Change Request Form

Type of change Request		
◉ **Update**	○ **Add**	○ **Delete**
Date:		
Organization of Requester:		
Name of Requester:		
Title of Request:		
Requester contact information:	Email: Mobile:	

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

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

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