NACRS Data Elements, 2021–2022

The following table is a comparative list of NACRS mandatory and optional data elements for all data submission options, along with a brief description of the data element.

For a full description of each data element, please refer to the *NACRS Abstracting Manual, 2021–2022 Edition*.

### NACRS Data Elements, 2021–2022

**Legend**

M — mandatory; O — optional; M* — conditional mandatory; NA — not applicable

**Note:** The status of a data element as mandatory, optional or conditional mandatory may vary due to service type and/or jurisdiction. A shaded text cell with a dagger symbol (†) indicates a jurisdictional variation to the data element reporting status. The *NACRS Abstracting Manual* should be referenced for details.

<table>
<thead>
<tr>
<th>NACRS Data Elements</th>
<th>Data Element Name</th>
<th>Data Element Number</th>
<th>Description</th>
<th>ED (Level 1)</th>
<th>ED (Level 2)</th>
<th>ED (Level 3)</th>
<th>Day Surgery</th>
<th>Clinic Lite</th>
<th>Other Amb. Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submission Data</td>
<td>Reporting Facility’s Province/Territory</td>
<td>00A</td>
<td>A code used to identify provinces and territories of the submitting facility.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Submission Data</td>
<td>Reporting Facility’s Ambulatory Care Number</td>
<td>00B</td>
<td>A code assigned to a facility by the provincial/territorial Ministry or Department of Health which identifies the facility and the level of care submitted.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Submission Data</td>
<td>Submission Fiscal Year</td>
<td>00C</td>
<td>The reporting fiscal year (April 1 to March 31) when the patient’s visit occurred.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>NACRS Data Elements</td>
<td>Data Element Name</td>
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<td></td>
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</tr>
<tr>
<td>Submission Data</td>
<td>Submission Period</td>
<td>00D</td>
<td>The date interval when the patient's visit occurred.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>(continued)</td>
<td>Abstract Identification Number</td>
<td>00E</td>
<td>Unique identification number assigned to each record submitted to NACRS.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coder Number</td>
<td>00F</td>
<td>Facility-assigned number that identifies the person responsible for completing the abstract.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>O</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>Chart Number</td>
<td>01</td>
<td>Facility-assigned unique identification number for the patient.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>Ambulatory</td>
<td>11</td>
<td>Facility-assigned number to associate the patient with a particular visit.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Registration Number</td>
<td>Ambulatory</td>
<td>12</td>
<td>A link for encounters with the same Ambulatory Registration Number where services are provided on a recurring basis.</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td>Registration/</td>
<td>Complete Record</td>
<td>108</td>
<td>A flag identifying where data collection is finished but the abstract is incomplete or information needed for comprehensive data collection is incomplete.</td>
<td>NA</td>
<td>NA</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Encounter Sequence</td>
<td>Submission Level</td>
<td>128</td>
<td>Identifies the data submission level of the record.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Number</td>
<td>Level Code</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Patient/Client Demographic Data</td>
<td>Health Care Number</td>
<td>02</td>
<td>Patient's unique health care coverage number.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Province/Territory Issuing Health Care Number</td>
<td>03</td>
<td>Province/territory or federal government from which the health care number was issued.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Responsibility for Payment</td>
<td>04</td>
<td>Identifies the primary source responsible for payment of service(s) rendered.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>O</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Postal Code</td>
<td>05</td>
<td>A code assigned by Canada Post to identify the geographic location of the patient's place of residence.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Residence Code</td>
<td>06</td>
<td>Jurisdiction defined code that identifies the area in which the patient resides.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Gender</td>
<td>07</td>
<td>Alpha character describing the sex of the patient.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Birth Date</td>
<td>08</td>
<td>The date the patient was born.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Birth Date Is Estimated</td>
<td>09</td>
<td>A flag that indicates the Birth Date has unknown day/month/year or an estimated year of birth.</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
</tr>
<tr>
<td>Highest Level of Education</td>
<td>21</td>
<td>Highest level of education completed by the patient.</td>
<td>NA</td>
<td>NA</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>NACRS Data Elements</td>
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<td>----------------</td>
</tr>
<tr>
<td>Patient/Client Demographic Data (continued)</td>
<td>Access to Primary Health Care Code</td>
<td>129</td>
<td>Identifies whether a patient has access to primary health care through a family physician, family health team, walk-in clinic or in other settings.</td>
<td>O</td>
<td>O</td>
<td>M</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Ambulance Data</td>
<td>Admit via Ambulance</td>
<td>14</td>
<td>Identifies whether a patient arrives at the reporting facility via ambulance and the type of ambulance that was used.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>O</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>Ambulance Arrival Date/Time</td>
<td>118/119</td>
<td>Date and time when the ambulance pulls into the hospital driveway and arrives at the hospital.</td>
<td>O†</td>
<td>O†</td>
<td>O†</td>
<td>NA</td>
<td>O</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Ambulance Transfer of Care Process Date/Time</td>
<td>120/121</td>
<td>Date and time when the ambulance personnel turn over care of the patient to ED/hospital staff.</td>
<td>O†</td>
<td>O†</td>
<td>O†</td>
<td>NA</td>
<td>O</td>
<td>NA</td>
</tr>
<tr>
<td>Triage Data</td>
<td>Triage Date and Time</td>
<td>24/25</td>
<td>Date and time when the patient is triaged in the ED.</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Triage Level (CTAS)</td>
<td>26</td>
<td>Categorizes the patient according to the type and severity of the patient’s initial presenting signs and symptoms using the CTAS scale.</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>NACRS Data Elements</td>
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</tr>
<tr>
<td><strong>Triage Data (continued)</strong></td>
<td>Status After Triage</td>
<td>138</td>
<td>Records the placement of the client on a stretcher at any point during the emergency department visit commencing with triage.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Arrival and Visit Type Data</strong></td>
<td>Mode of Visit/ Contact</td>
<td>20</td>
<td>The method of contact between the provider and the patient.</td>
<td>O</td>
<td>O</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>Arrival Date and Time</td>
<td>22/23</td>
<td>Date and time the patient arrives at the emergency department for services.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Date of Registration/Visit</td>
<td>27</td>
<td>Date when the patient is officially registered for emergency or ambulatory care services.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Registration/Visit Time</td>
<td>28</td>
<td>Time when the patient is officially registered for emergency or ambulatory care services.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Referral Source Prior to Ambulatory Care Visit</td>
<td>31</td>
<td>Identifies the person/agency that referred the patient for emergency or ambulatory care service in the reporting facility.</td>
<td>O</td>
<td>O</td>
<td>M</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>Institution From</td>
<td>32</td>
<td>Identifies another health care facility or another level of care within the reporting facility from which the patient was transferred for further care.</td>
<td>NA</td>
<td>NA</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>NACRS Data Elements</td>
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<td>Data Element Number</td>
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<td></td>
<td></td>
<td></td>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrival and Visit Type Data (continued)</td>
<td>Referral Date</td>
<td>104</td>
<td>Date the patient was referred to an ambulatory care service.</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>Presenting Complaint List</td>
<td>136</td>
<td>The symptom, complaint, problem or reason for seeking emergency medical care as identified by the patient.</td>
<td>O</td>
<td>M*</td>
<td>O</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>ED Visit Indicator</td>
<td>139</td>
<td>Indicates whether a visit reported under the emergency MIS functional centre account code is an arranged day surgery or clinic visit taking place in the ED or an ED visit.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Provider Data</td>
<td>Provider Type</td>
<td>40</td>
<td>Identifies the role played by the health care providers in association with the patient’s visit.</td>
<td>O</td>
<td>O</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Provider Service</td>
<td>41</td>
<td>Identifies the service(s) of the health professional(s) responsible for provision of services to the patient during the visit.</td>
<td>O</td>
<td>O</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Provider Number</td>
<td>42</td>
<td>Identification number associated with the provider responsible for provision of services to the patient during the visit.</td>
<td>O</td>
<td>O</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Provider Data (continued)</td>
<td>Program Area</td>
<td>98</td>
<td>Identifies the program area providing service.</td>
<td>NA</td>
<td>NA</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td>Assessment and Consultation Data</td>
<td>Date and Time of Physician Initial Assessment</td>
<td>29/30</td>
<td>Date and time when patient was first assessed by a physician in the ED.</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Main and Other Problem Prefix</td>
<td>43</td>
<td>A code that provides additional information relating to the ICD-10-CA code to which it is assigned.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>Main Problem</td>
<td>44</td>
<td>ICD-10-CA code that describes the most clinically significant diagnosis, condition, problem or circumstance for the client's visit.</td>
<td>O</td>
<td>O</td>
<td>M</td>
<td>M</td>
<td>O</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>Other Problem</td>
<td>45</td>
<td>ICD-10-CA code that describes other diagnosis, condition, problem or circumstance for the patient's visit.</td>
<td>O</td>
<td>O</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Main and Other Problem Cluster</td>
<td>127</td>
<td>Identifies when more than one ICD-10-CA diagnosis code is required to describe a circumstance or condition.</td>
<td>NA</td>
<td>NA</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Consult Request Date and Time</td>
<td>130/131</td>
<td>Date and time when the initial request for a provider consultation was made.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>NACRS Data Elements</td>
<td>Data Element Name</td>
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<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Assessment and Consultation Data (continued)</td>
<td>Consult Request Service</td>
<td>132</td>
<td>Identifies the service of the provider requested for consultation.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>Date and Time of Non-Physician Initial Assessment</td>
<td>133/134</td>
<td>Date and time when a patient is first assessed or evaluated by a non-physician provider.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Non-Physician Initial Assessment Provider Service</td>
<td>135</td>
<td>The specialty of the non-physician provider who performed the initial assessment of the patient.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>ED Discharge Diagnosis</td>
<td>137</td>
<td>The patient's diagnosis at the time of discharge from the emergency department.</td>
<td>O</td>
<td>M*</td>
<td>O</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Consult Arrival Date and Time</td>
<td>143/144</td>
<td>Date and time when the consultant's service begins.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Intervention Data</td>
<td>Main Intervention</td>
<td>46</td>
<td>The intervention performed and considered the most clinically significant.</td>
<td>NA</td>
<td>NA</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Other Intervention(s)</td>
<td>47</td>
<td>Other intervention(s) performed to consolidate treatment and diagnosis in addition to the Main Intervention.</td>
<td>NA</td>
<td>NA</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Main and Other Attributes — Status/Location/Extent</td>
<td>48–50</td>
<td>Characters which provide additional details not present within the generic structure of the CCI codes.</td>
<td>NA</td>
<td>NA</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td>NACRS Data Elements</td>
<td>Data Element Name</td>
<td>Data Element Number</td>
<td>Description</td>
<td>ED Level 1</td>
<td>ED Level 2</td>
<td>ED Level 3</td>
<td>Day Surgery</td>
<td>Clinic Lite</td>
<td>Other Amb. Care</td>
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<td>----------------</td>
</tr>
<tr>
<td>Intervention Data (continued)</td>
<td>Duration of Ambulatory Care Intervention for Main and Other Intervention(s)</td>
<td>51</td>
<td>The length of time it took to complete the intervention.</td>
<td>NA</td>
<td>NA</td>
<td>O</td>
<td>O †</td>
<td>O</td>
<td>O †</td>
</tr>
<tr>
<td></td>
<td>Intervention Location Code for Main and Other Intervention(s)</td>
<td>52</td>
<td>The location in a facility where an intervention took place.</td>
<td>NA</td>
<td>NA</td>
<td>O</td>
<td>M* †</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Anaesthetic Technique</td>
<td>53</td>
<td>Denotes the method of anaesthesia administered to the patient during the intervention.</td>
<td>O</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Out of Hospital Indicator</td>
<td>55</td>
<td>Indicates that an intervention was performed in the day surgery or other ambulatory care setting outside of the reporting facility during the current emergency or ambulatory care visit.</td>
<td>NA</td>
<td>NA</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Out of Hospital Institution Number</td>
<td>56</td>
<td>Indicates the ambulatory setting of another facility where the out of hospital service (intervention) was performed.</td>
<td>NA</td>
<td>NA</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Main Intervention Start Date/Time</td>
<td>109/110</td>
<td>Date and time when the main intervention started.</td>
<td>NA</td>
<td>NA</td>
<td>O</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Other Intervention Start Date/Time</td>
<td>111/112</td>
<td>Date and time when other interventions started.</td>
<td>NA</td>
<td>NA</td>
<td>O</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td>NACRS Data Elements</td>
<td>Data Element Name</td>
<td>Data Element Number</td>
<td>Description</td>
<td>ED Level 1</td>
<td>ED Level 2</td>
<td>ED Level 3</td>
<td>Day Surgery</td>
<td>Clinic Lite</td>
<td>Other Amb. Care</td>
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<td>----------------</td>
</tr>
<tr>
<td>Intervention Data (continued)</td>
<td>Legal Status Upon Arrival to ED</td>
<td>170</td>
<td>Identifies the status of the patient at the time of arrival to the ED of the reporting facility.</td>
<td>O</td>
<td>O</td>
<td>M*</td>
<td>NA</td>
<td>O</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Type of Restraint</td>
<td>171</td>
<td>Identifies the use of control interventions to restrain a patient during their stay in the ED. Chemical restraints are excluded from data collection.</td>
<td>O</td>
<td>O</td>
<td>M*</td>
<td>NA</td>
<td>O</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Frequency of Restraint Use</td>
<td>172</td>
<td>Identifies the amount of time restraints were used during a patient’s stay in the ED.</td>
<td>O</td>
<td>O</td>
<td>M*</td>
<td>NA</td>
<td>O</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Emergency Department Intervention Pick List</td>
<td>173</td>
<td>This list provides twenty-eight intervention “codes/categories” that are used in the grouping methodology to determine the CACS cell assignment.</td>
<td>O</td>
<td>M*</td>
<td>O</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Emergency Department Investigative Technology</td>
<td>174</td>
<td>This list provides “codes/categories” for similar investigative technology types such as CT scan. Where variation in cost is significant, anatomical site is also included.</td>
<td>O</td>
<td>M*</td>
<td>O</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>NACRS Data Elements</td>
<td>Data Element Name</td>
<td>Data Element Number</td>
<td>Description</td>
<td>ED Level 1</td>
<td>ED Level 2</td>
<td>ED Level 3</td>
<td>Day Surgery</td>
<td>Clinic Lite</td>
<td>Other Amb. Care</td>
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</tr>
<tr>
<td>Intervention Data (continued)</td>
<td>Number of Emergency Department Investigative Technologies Performed</td>
<td>175</td>
<td>Indicates the number of times an investigative technology intervention from the Emergency Department Investigative Technology types (data element 174a-c) is performed.</td>
<td>O</td>
<td>M*</td>
<td>O</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Clinical Decision Unit Data</td>
<td>Clinical Decision Unit Flag</td>
<td>122</td>
<td>Indicates if the patient was placed in a clinical decision unit during the emergency visit.</td>
<td>O†</td>
<td>O†</td>
<td>O†</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Clinical Decision Unit Date In/ Time In</td>
<td>123/124</td>
<td>Date and time when the patient arrived in the clinical decision unit.</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Clinical Decision Unit Date Out/ Time Out</td>
<td>125/126</td>
<td>Date and time when the patient leaves the clinical decision unit.</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Separation Data</td>
<td>Visit Disposition</td>
<td>35</td>
<td>Patient's type of separation from the ambulatory care service after registration.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>Referred To — After Completion of Ambulatory Care Visit</td>
<td>38</td>
<td>Describes a person or agency to which the patient was referred after discharge from the reporting facility.</td>
<td>NA</td>
<td>NA</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>Institution To</td>
<td>39</td>
<td>Identifies the institution number of another health care facility or another level of care within the reporting facility where the patient was transferred to for further care.</td>
<td>NA</td>
<td>NA</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>NACRS Data Elements</td>
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<td>Data Element Number</td>
<td>Description</td>
<td>ED Level 1</td>
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<td>----------------</td>
</tr>
<tr>
<td>Separation Data (continued)</td>
<td>Disposition Date/Time</td>
<td>114/115</td>
<td>Date and time the decision was made about the patient’s disposition.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>O</td>
<td>M*</td>
</tr>
<tr>
<td></td>
<td>Date and Time Patient Left Emergency Department (ED)</td>
<td>116/117</td>
<td>Date and time the patient physically leaves the ED.</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>MIS Information</td>
<td>Visit MIS Functional Centre Account Code</td>
<td>13</td>
<td>Account number for statistical and financial reporting related to the service provided.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>MIS Functional Centre Account Code</td>
<td>75</td>
<td>A list of MIS Standards Functional Centre Account codes related to the services provided during an ambulatory care visit.</td>
<td>NA</td>
<td>NA</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>CACS Grouper Output</td>
<td>Vendor MAC/CACS/RIW</td>
<td>105–107</td>
<td>Vendor-assigned MAC/CACS/RIW values populated by the vendor software (grouping methodology).</td>
<td>NA</td>
<td>NA</td>
<td>O</td>
<td>O</td>
<td>NA</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>Vendor Age and Vendor Anaesthetic Category</td>
<td>140/141</td>
<td>Vendor-assigned CACS category codes. This value is populated by the vendor software.</td>
<td>NA</td>
<td>NA</td>
<td>O</td>
<td>O</td>
<td>NA</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>Vendor IT Total Count</td>
<td>142</td>
<td>A distinct count of the total number of Investigative Technology categories found on the abstract.</td>
<td>NA</td>
<td>NA</td>
<td>O</td>
<td>O</td>
<td>NA</td>
<td>O</td>
</tr>
<tr>
<td>Data Element Name</td>
<td>Data Element Number</td>
<td>Description</td>
<td>ED</td>
<td>Day Surgery</td>
<td>Clinic Lite</td>
<td>Other Amb. Care</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blood Information</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Transfusion Indicator</td>
<td>57</td>
<td>Identifies whether or not a patient received a blood transfusion during the episode of care.</td>
<td>NA</td>
<td>M †</td>
<td>M †</td>
<td>O M †</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Products/ Components</td>
<td>58–63, 177–185</td>
<td>Blood products or components transfused and received during the episode of care.</td>
<td>NA</td>
<td>M †</td>
<td>M †</td>
<td>O M †</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Therapeutic Abortion Information</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Previous Term Deliveries</td>
<td>69</td>
<td>The number of previous full-term deliveries (37 or more completed weeks) for the patient.</td>
<td>NA</td>
<td>M* †</td>
<td>M* †</td>
<td>O M* †</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Previous Pre-Term Deliveries</td>
<td>70</td>
<td>The number of previous pre-term deliveries (20 to 36 completed weeks) for the patient.</td>
<td>NA</td>
<td>M* †</td>
<td>M* †</td>
<td>O M* †</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Previous Spontaneous Abortions</td>
<td>71</td>
<td>The number of previous spontaneous abortions (miscarriages) for the patient.</td>
<td>NA</td>
<td>M* †</td>
<td>M* †</td>
<td>O M* †</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Previous Therapeutic Abortions</td>
<td>72</td>
<td>The number of previous therapeutic abortions for the patient.</td>
<td>NA</td>
<td>M* †</td>
<td>M* †</td>
<td>O M* †</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestational Age — Therapeutic Abortion</td>
<td>73</td>
<td>Records the duration of gestation.</td>
<td>NA</td>
<td>M* †</td>
<td>M* †</td>
<td>O M* †</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Last Menses</td>
<td>74</td>
<td>Calendar date of the patient's last menses.</td>
<td>NA</td>
<td>M* †</td>
<td>M* †</td>
<td>O M* †</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NACRS Data Elements</td>
<td>Data Element Name</td>
<td>Data Element Number</td>
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<td></td>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Projects Fields</td>
<td>Special Projects</td>
<td>145–169</td>
<td>Used to collect supplemental data required to meet the information needs of CIHI, the provinces/territories and health care facilities.</td>
<td>M*</td>
<td>M*</td>
<td>M*</td>
<td>O</td>
<td>M*</td>
<td></td>
</tr>
<tr>
<td>Injury Information</td>
<td>Glasgow Coma Scale</td>
<td>100</td>
<td>A clinical scoring system to assess the response of neurologically impaired patients.</td>
<td>NA</td>
<td>NA</td>
<td>M*</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seatbelt Indicator</td>
<td>101</td>
<td>Denotes whether a patient was wearing a seatbelt at the time of the motor vehicle accident.</td>
<td>NA</td>
<td>NA</td>
<td>M*</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Helmet Indicator</td>
<td>102</td>
<td>Denotes whether a patient was wearing a helmet at the time of the accident where helmet use would be warranted.</td>
<td>NA</td>
<td>NA</td>
<td>M*</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>