Ontario Trauma Registry Comprehensive Data Set
Data Dictionary, May 2014

Canadian Institute
for Health Information

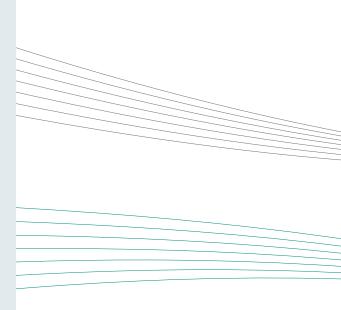Institut canadien
d'information sur la santé

Our Vision
Better data. Better decisions.
Healthier Canadians.

Our Mandate
To lead the development and
maintenance of comprehensive
and integrated health information
that enables sound policy and
effective health system management
that improve health and health care.

Our Values
Respect, Integrity, Collaboration,
Excellence, Innovation

Important Notice

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Introduction

The Ontario Trauma Registry Comprehensive Data Set (OTR CDS) consists of detailed information on patients hospitalized with major trauma in 11 participating facilities across 14 sites in the province.

Case Inclusion/Trauma Definition

A trauma case is included in the OTR CDS if it:

- Has an ISS greater than or equal to 12 in the 2005 version of AIS, and ;

- Has an ICD external cause of injury code that meets the definition of trauma in the OTR as outlined in Appendix B and;

- Meets one of the following criteria:

  - Admitted to a participating facility; or

  - Treated in the emergency department of a participating facility but not admitted; or

  - Died in the emergency department of a participating facility after treatment was initiated but prior to admission.

- Regardless of the above, if the Trauma Team was activated (as of April 1, 2011).

Use of Inappropriate, Unknown and Blanks

The Collector software contains additional data elements beyond those required for the OTR. Completion of these data elements are left to the discretion of the individual hospital. To ensure consistency and accurate reporting, all data elements are considered to be mandatory with some exceptions as listed in the data dictionary. All non-mandatory (referred to as "excluded") data elements have been removed from the data dictionary and placed in Appendix D.

Inappropriate (I) and unknown (U) may be used as necessary and are included as choices on some menus. Inappropriate means that the data element does not apply to the patient. Unknown means that the information cannot be found in the documentation.

As of April 1, 1995, data elements should not be left blank except in cases where the data elements are skipped by Collector. In the case of non-mandatory (excluded) fields, it is up to the institution to decide whether these fields should be completed, remain blank or be defaulted to other values. All mandatory fields must be completed and submitted to the Ontario Trauma Registry.

Provincially Required Data Elements

All data elements whose submission to the OTR is mandatory are included in section 1 to section 9. All data elements that are not mandatory to be submitted to the OTR are included in Appendix D. Non-mandatory data elements may still be completed as required by the individual institutions.

Hospital-Defined Menus

There are several data elements where it is possible for each participating hospital to create customized menus to facilitate the data entry process. Examples are Police Force and Trauma Team Leader. Instructions for creating a hospital defined menu can be found in the "Edit Popup Menus" section of the "Customization Options" chapter of the Collector documentation.

General Coding Guidelines

1. Every mandatory data element in the Comprehensive Data Set should be documented. As of April 1, 1995 blanks are not acceptable except in cases where data elements are skipped by Collector, or have been excluded. Some menus (where applicable) include unknown and inappropriate menu selections.

   Unknown should be used in cases where the information is not documented. Unknown should also be used if there are two conflicting sources of information that cannot be verified or for data elements where the information expected to be made available but has not arrived at the time the record is closed. In cases where there are conflicting sources of information, the Medical Director should be consulted.

   Inappropriate is used when the information would not be meaningful or appropriate for a specific case. An example is the primary hospital number in cases that are transported directly admitted to the lead/trauma hospital from the scene.

2. Dates and times should be documented whenever they are known. A best guess should not be used in order to maintain the integrity of the data. In cases where the time the ambulance was called and dispatched are documented as the same time, document the second time as one minute later as Collector will only accept sequential times.

   Unknown may be entered in a portion of date and time data elements if specific details are not known or if information is vague.

3. Old injuries such as healing fractures should not be included. Only injuries that are related to the cause of admission should be documented.

4. When patients are readmitted to a lead/trauma hospital with a missed injury, the missed injury should be added to the original list of injuries in the initial admission. No new record should be created for this missed injury. If the patient is admitted for the first time to the lead/trauma hospital with a missed injury, all injuries relating to the ISS≥12 incident should be documented.

5. At lead trauma facilities, the acute care master number should be used regardless of the status of the patient. This includes those who died in the emergency department, and those who were treated in emergency but not admitted to the hospital.

Skips

Skips have been incorporated into the Ontario version of Collector to facilitate the data entry. In many cases, data elements that are inappropriate based on a particular response to an earlier data element are skipped. These skips have been documented in the data dictionary. An example is for the secondary and tertiary Place of Injury data elements, which are skipped if secondary and tertiary External Cause Codes are not entered.

Defaults

Defaulted menu choices have been included for some data elements. Data elements can be set to a default menu option by individual hospitals whenever appropriate. Default menu options should facilitate data collection. Instructions for setting data element defaults can be found in the "Edit Data Entry Defaults" section of the "Customization Options" chapter of the Collector documentation and in the "Help" section of the Collector software.

Dates and Times

Many calculations are done in Collector including pre-hospital time, scene time and length of stay. It is important that all dates and times are entered sequentially for these calculations to be done. Data checks have been built in to alert the user to times that are not sequential. For example, the time the ambulance call is received and the time the ambulance is dispatched must be sequential. If these times are documented as the same on the Ambulance Call Report, the second time should be documented as one minute later.

It is possible to enter "U" in portions of the date and time data elements in Collector when all the information is not available. A best guess should not be used for dates and times.

Data Submission Procedures

The central site (CIHI) receives data by the 30th of each month.

- A record of the data that are transmitted is documented on the OTR Transmission Data Control Record Form, and is submitted to the OTR via email. This form is used to identify the total number of records sent broken down by transmission and retransmission data.
- The guideline for data submission for the Comprehensive Data Set is no later than 60 days post discharge. Records that are retransmitted reflect updated information and/or corrections. Hospitals are encouraged to close records when waiting for information from external sources (i.e. post mortems) and retransmit when information is received.

The central site (CIHI) system is available for data submission 24 hours a day. A user ID, password and internet access are required for transmissions.

Transmissions are done using the Electronic Data Submission Services (eDSS) tool, as per the procedure outlined in "*Electronic Data Submission Services (eDSS): User's Manual*" document.

The eDSS tool is found on the CIHI web site, www.cihi.ca, under Applications, and by selecting eDSS.

Transmission problems/questions should be directed to helpdesk@cihi.ca.

How to transmit:

- Open the Collector for Windows software;
- From the REPORT menu, select CVW BATCH;
- Select TRANSFER.CBR;
- Click OK;
- Follow on-screen instructions;
- TRANSFER.ZIP is created in the root folder of Collector;
- Rename zip file using the following naming convention: OTRYYYYPP5FFFFnnn.zip (see below);
- Send Transmission Record to OTR;
- Transmit cases using eDSS

Naming convention: OTRYYYYPP5FFFFnnn.zip

Where:

OTR	Database name
YYYY	Fiscal year
PP	Reporting Period (01 = April, 02 = May, 03 = June, 04 = July, 05 = August, 06 = September, 07 = October, 08 = November, 09 = December, 10 = January, 11 = February, 12 = March)
5FFFF	5 plus the 4-digit facility number
nnn	Monthly transmission number. Start with 001

Data Elements

The data elements are divided into the following sections:

For a complete list of data elements, including their page number and Collector screen number, refer to Appendix C.

Data Dictionary Layout

The data elements are grouped according to the type of data they cover. Each data element will have the following specifications:

Name in Database	The actual name of the field in the OTR CDS.
Definition	The OTR definition of the data element.
Data Type	The type of data that can be entered into the field, Data type is generated from Collector by Digital Innovation, Inc.
Data Element Length	The number of characters required for that data element. For example, "21" cannot be entered into a field with a data element length of 1. When decimal places are accepted for a data element, they are denoted by a number following a comma. For example, "5, 2" denotes a total field length of five, including two decimal places.
Field Values	A list of the possible values that may be entered into the field for the data element, either the format of the field or a range of accepted values.
Constraints	Any constraints on the values that can be input.
Source	Indicates whether the data is calculated or directly input.
Hierarchy	Source hierarchy for finding data elements in the patient's chart.
Additional Information	Any additional directives for entering data into the data element will be written in this box. It also contains any other information that would be useful for someone who is either documenting the data or analyzing the information.
History	Historical changes to the data elements, with effective dates of changes.

Section 1: Demographic Data

Institution Number

Name in Database	INST_NUM
Definition	Institution number is a 4-digit number assigned to each hospital by the Ministry of Health according to the Master Numbering System.
Data Type	Integer
Data Element Length	4
Field Values	Institution numbers as assigned by the Ministry of Health
Constraints	0000–9999
Source	Your institution number will be displayed on the screen
Hierarchy	Ministry of Health Master Numbering System
Additional Information	If a patient dies in the emergency room, inpatient code for the lead/trauma hospital should be used. The following is a link to the April 1, 2012 Ministry of Health and Long-Term Care Master Numbering System. http://www.health.gov.on.ca/en/common/ministry/publications/reports/master_numsys/master_numsys.aspx
History	

Trauma Number: TRAUMA_NUM, FRACTION

Name in Database	TRAUMA_NUM, FRACTION
Definition	A trauma number is a unique 7-digit trauma patient identifying number assigned by the lead/trauma hospital. A fraction is an optional seventh digit of trauma number following the decimal displayed on the screen.
Data Type	Integer
Data Element Length	6,1
Field Values	000000.0–999999.9
Constraints	000000.0–999999.9
Source	Direct data entry or auto-generated by software
Hierarchy	
Additional Information	If the decimal is not required, fraction field will be defaulted to zero.
History	

Is This a Readmission?

Name in Database	READMIT
Definition	Indicates if the case is a readmission.
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No I—Inappropriate
Constraints	1, 2, I
Source	Direct data entry
Hierarchy	
Additional Information	This field should be defaulted to "no" or "inappropriate," as a readmission would be captured in the readmission screen. Readmissions related to the initial injury should be captured in section 12, in field "NUM_READ". A readmission is not assigned a new trauma number or entered as a new record in the database.
History	

Patient—Ontario Health Number

Name in Database	PAT_ACT
Definition	Patient's 10 digit Ontario health number.
Data Type	Al/Num
Data Element Length	10
Field Values	As per Ontario health insurance lists U—Unknown I—Inappropriate
Constraints	Within the ranges of the Ontario health insurance, U, I
Source	Direct data entry
Hierarchy	Face sheet
Additional Information	Zeroes and text should not be entered in this data element. If the health number is unknown, enter 10 "U"s. An example of a case where the health number may be unknown is a patient that is DIE. If the patient is not eligible for an Ontario health number, enter 10 "I"s. Because this field is alphanumeric 10 "U"s or "I"s must be entered so that Collector's statistical calculations can correctly recognize the data. The forward slash key "/" will automatically enter 10 "I"s in Collector, similarly the "*" key will insert 10 "U"s. Inappropriate should be documented if the patient does not have a health number due to religious reasons. Unknown should be documented if the patient has newly arrived in Ontario and is eligible for but has not yet received a health number. In this case, the out of province health number should be entered in the Other Health Number data element. If patient has Federal Health Number only, enter element in Other Health Number.
History	

Patient—Ontario Health Number—Version

Name in Database	PAT_ACT_V
Definition	Version code as it appears on the patient's new Ontario health card.
Data Type	Al/Num
Data Element Length	2
Field Values	As per Ontario health insurance lists U—Unknown I—Inappropriate
Constraints	Valid Ontario Health Care Number version code, U, I
Source	Direct data entry
Hierarchy	
Additional Information	
History	Effective April 2005

Other Health Number

Name in Database	PAT_ACT_O
Definition	Non-Ontario Health Care Number or other identifying number.
Data Type	Text
Data Element Length	12
Field Values	As per provincial health insurance lists U—Unknown I—Inappropriate
Constraints	Within the ranges of provincial health insurance, U, I
Source	Direct data entry
Hierarchy	Face sheet
Additional Information	This field will be skipped if an Ontario health number is entered. This field will not be skipped if "unknown" or "inappropriate" is entered in the Ontario Health Number field. However, if "unknown" or "inappropriate" is entered in the Ontario Health Number field and the out of province health number is unknown or not available, enter "unknown" or "inappropriate."
History	

Campus Number

Name in Database	CAMPUS_NUM
Definition	A hospital defined field potentially used to distinguish hospital sites within the same institution.
Data Type	Integer
Data Element Length	1
Field Values	Valid campus number I—Inappropriate
Constraints	1–4, I
Source	Direct data entry or auto-generated by software
Hierarchy	
Additional Information	This field has a hospital defined menu. If your institution only has one site default this field to "I."
History	

Chart Number

Name in Database	CHART_NUM
Definition	Patient's hospital chart number.
Data Type	Text
Data Element Length	10
Field Values	As per number assigned by the Admitting Department
Constraints	Within the range of assigned number
Source	Direct data entry
Hierarchy	
Additional Information	The chart number is usually assigned by the Admitting Department. A patient will be assigned the same chart number when readmitted to the same institution.
History	

Patient—Residence (If Not Ontario)

Name in Database	RESID
Definition	Province of residence if other than Ontario or if the patient is a resident of the United States.
Data Type	Integer
Data Element Length	2
Field Values	01—Ontario (Note: cannot be selected from menu) 02—Manitoba 03—Saskatchewan 04—British Columbia 05—Alberta 06—Quebec 07—New Brunswick 08—Newfoundland 09—Prince Edward Island 10—Nova Scotia 11—Northwest Territories 12—Yukon Territory 13—United States 14—Other U—Unknown I—Inappropriate (for homeless)
Constraints	1–14, U, I
Source	Direct data entry or auto-generated by software
Hierarchy	1. Face sheet 2. ED physician record 3. ED nursing record
Additional Information	This field will be skipped if an Ontario health number was entered. Although Ontario is on the menu, it cannot be selected. Enter "I" if the patient is homeless and does not spend the majority of time in one province. If the homeless patient spends the majority of time in one province, enter that province.
History	

Patient—Residence—If Other

Name in Database	RESID_O
Definition	Specify if "other" was entered in the previous field.
Data Type	Text
Data Element Length	30
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	This field will be skipped if "other" was not selected.
History	

Date of Birth

Name in Database	DOB_M, DOB_D, DOB_Y
Definition	The patient's date of birth.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY U—Unknown
Constraints	01 01 1900—Present, U
Source	Direct data entry
Hierarchy	1. Face sheet 2. ED physician record 3. ED nursing record
Additional Information	"U" may be entered in any of the data components if the information is not available. For example, if only the month and year of birth is known, enter 05UU1974.
History	

Raw Age

Name in Database	RAW_AGE
Definition	The patient's age at the time of admission in the units defined by the next data element.
Data Type	Integer
Data Element Length	3
Field Values	Age in year, month or day U—Unknown
Constraints	000–120
Source	Calculated using 1. Date of birth And 2. Date of Admission (when patient is not admitted use Date of Arrival)
Hierarchy	Date of birth: 1. ED physician record 2. ED nursing record 3. Face sheet Date of Admission or Date of Arrival
Additional Information	For pediatric patients less than 2 years of age enter the age in months, selecting months from the AGE_TYPE data element. Collector converts ages entered in months to fractions for TRISS calculations.
History	

Age Type

Name in Database	AGE_TYPE
Definition	The units of the patient's age.
Data Type	Integer
Data Element Length	1
Field Values	1—Years 2—Months 3—Days 4—Estimated in Years U—Unknown
Constraints	1–4, U
Source	Direct data entry
Hierarchy	1. ED physician record 2. ED nursing record 3. Face sheet
Additional Information	
History	

Patient—Sex

Name in Database	Sex
Definition	The patient's sex.
Data Type	Integer
Data Element Length	1
Field Values	1—Male 2—Female U—Unknown
Constraints	1, 2, U
Source	Direct data entry
Hierarchy	1. ED physician record 2. ED nursing record 3. Face sheet
Additional Information	
History	

Patient—Weight

Name in Database	Weight
Definition	For patients under the age of 16, enter the patient's weight in kilograms.
Data Type	Fixed—1
Data Element Length	5
Field Values	000.0–999.0 U—Unknown I—Inappropriate
Constraints	Valid weight values, U, I
Source	Direct data entry
Hierarchy	
Additional Information	Hospitals may document weight for adult patients as appropriate for their specific institution. Hospitals may wish to default this data element to inappropriate if they do not treat patients <16 years of age.
History	As of April 1st, 1995 hospitals will be required to collect weight for pediatric patients only (i.e. <16 years of age).

Occupation

Name in Database	OCCUP
Definition	The type of industry that the patient was working in at the time of injury.
Data Type	Integer
Data Element Length	2
Field Values	01—Recreation, Sports, Performing Arts (Athletes, Dancers, Physical Fitness Instructors, Actors) 02—Medicine, Health (MD's, Nurses, Therapists, Ambulance Attendants, Dental Assistants, Veterinarians, Mental Health Workers) 03—Other Professional, Administrative, and Artistic (Clerks, Teachers, Engineers, Writers, Literary Agents, Artists, Accountants, Data Processors, Office Workers; Not in category 1 or 2) 04—Sales (Insurance Agents, Sales Clerks, Retail Store Workers, Service Station Attendants) 05—Protective Services (Firefighters, Police, Security Guards, Soldiers) 06—Other Services (Janitors, Food Services, Personal Services; Examples are hairstylists, cooks, day care workers, florists, butchers, Public Utility workers, landscapers) 07—Mining or Quarrying (Drilling, Blasting) 08—Forestry, Logging

Occupation (cont'd)

Field Values (cont'd)	09—Farming (general or specialist farms such as horse farms), Fishing, Hunting 10—Manufacturing—Processing or Machinery (Packaging Food, Inspecting, Knitting, Metal Plating, Mixing Chemicals, Sheet Metal, Sawing, Shaping Clay, Pulp and Paper Mills, Grain Elevators) 11—Other Manufacturing—Assembly, Repairing, or Fabricating (Mechanic, Shoe Maker, Vehicle Assembler, Upholsterer) 12—Construction Trades (Plumber, Carpentry, Electrician, General Contractor, Bulldozer Operator) 13—Transport Equipment Operators (Drivers of cars, vans, trucks, buses, ambulances and taxis) 14—Other Drivers (Fast Food Delivery, Streetcars, Railways, Ships, Aircraft) 15—Materials Handling and Related Equipment Operation (Freight Handler, Forklift Operator, Crane Operator, Hoist Operator) 16—Other Crafts and Stationary Equipment Operators (Printers, Photo Processing, Audio/Video Equipment Operators) 17—Student (full time, all ages) 18—Retired 19—Homemaker 20—Unemployed 21—Other U—Unknown I—Inappropriate
Constraints	1–21, U, I
Source	Direct data entry
Hierarchy	
Additional Information	Occupation must be documented for work-related injury. Hospitals wishing to document occupation for non–work related injury may do so. If the injury is not work related, document occupation as "I." If the incident is work-related but occupation is unknown, document occupation as Unknown. **(Working Group 03/95)** Labourers may fall into a number of categories depending on the type of industry they are employed in. For example, a labourer working on road construction would be documented as menu item 12 while a labourer working in a warehouse as a shipper and receiver in a manufacturing industry would be documented as menu item 10. For self-employed patients, document the industry the patient is employed in. For example, an owner of a retail store would be documented as menu item 4. Menu item 17 would be selected for children over the age of 3 if the injury occurred at school, and "I" would be entered for those under the age of 3.
History	April 1, 2014: Clarification for use of menu item 17 if injury occurs at school.

Patient—Occupation—If Other

Name in Database	OCCUP_O
Definition	Specify if "other" was entered in the previous field.
Data Type	Text
Data Element Length	20
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	This field will be skipped if "other" was not selected in the previous field. This data element should only be used for occupations that do not fall into any of the categories listed in the previous data element.
History	

Patient—City

Name in Database	PAT_ADR_CI
Definition	Patient's city of residence.
Data Type	Text
Data Element Length	20
Field Values	City name I—Inappropriate
Constraints	
Source	Direct data entry
Hierarchy	1. ED physician record 2. ED nursing record 3. Face sheet
Additional Information	This field has a hospital defined menu. Enter "I" if the patient is homeless and does not spend the majority of time in one city. If the patient spends the majority of time in one city, enter that city.
History	

Patient—Province

Name in Database	PAT_ADR_ST
Definition	The patient's province of residence.
Data Type	Integer
Data Element Length	2
Field Values	01—Ontario 02—Manitoba 03—Saskatchewan 04—British Columbia 05—Alberta 06—Quebec 07—New Brunswick 08—Newfoundland 09—Prince Edward Island 10—Nova Scotia 11—Northwest Territories 12—Yukon Territory 13—United States 14—Other U—Unknown I—Inappropriate (for homeless)
Constraints	1–14, U, I
Source	Direct data entry
Hierarchy	1. ED physician record 2. ED nursing record 3. Face sheet
Additional Information	For permanent residents of other jurisdictions, e.g. non-Ontario residents attending school in Ontario, it is acceptable to include Ontario contact information rather than the patient's permanent address/home address. Enter "I" if the patient is homeless and does not spend the majority of time in one province. If the homeless patient spends the majority of time in one province, enter that province. Hospitals may wish to default this field to Ontario.
History	

Patient—Province—Other

Name in Database	PAT_ADR_SO
Definition	Specify the patient's province or country of residence if "other" was entered in the previous field.
Data Type	Text
Data Element Length	30
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	This field will be skipped if "other" was not selected in the previous field.
History	

Home Address—Country

Name in Database	CNTRY
Definition	Patient's country of residence.
Data Type	Integer
Data Element Length	1
Field Values	1—Canada 2—United States 3—Other I—Inappropriate (for homeless)
Constraints	1–3, I
Source	Direct data entry
Hierarchy	1. Face sheet 2. ED physician record 3. ED nursing record
Additional Information	Enter "I" if the patient is homeless and does not spend the majority of time in one country. If the homeless patient spends the majority of time in one country, enter that country. Hospitals may wish to default this field to Canada.
History	

Patient—Country—If Other

Name in Database	CNTRY_O
Definition	Specify if "other" was entered in the previous field.
Data Type	Text
Data Element Length	30
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	This field will be skipped if "other" was not selected in the previous field.
History	

Patient—Postal Code

Name in Database	PAT_ADR_PC
Definition	Patient's residential postal code (in ANA NAN format).
Data Type	Text
Data Element Length	7
Field Values	Format: ANA NAN, XX if homeless U—Unknown
Constraints	7 bytes, alphanumeric
Source	Direct data entry
Hierarchy	1. Face sheet 2. ED physician record 3. ED nursing record
Additional Information	A space will be entered by the system. Postal Code letters must be entered in upper case. This field will be skipped if "other" was selected for Country.
History	Effective April 1, 2012, change in field values to identify homeless patients

Patient—Other Country Postal Code

Name in Database	PAT_ADR_ZC
Definition	Patient's residential zip code or other postal code information for residents of the United States and other countries.
Data Type	Integer
Data Element Length	5
Field Values	Valid postal code U—Unknown
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	This field will be skipped if Postal Code is entered.
History	

Patient—Residence Code

Name in Database	RESID_CODE
Definition	Patient's residence code from the Ministry of Health and Long-Term Care Residence Coding Manual.
Data Type	Integer
Data Element Length	4
Field Values	Coding numbers as assigned by the Ontario Ministry of Health
Constraints	0000–9999
Source	Direct data entry
Hierarchy	
Additional Information	The Residence Codes manual is available by registering on the MOHLTC website: https://hsimi.on.ca/hdbportal/user/register The first two digits represent the county, district or regional municipality in which the place is located. Digits three and four identify municipalities within the county, or areas of the county if the area is not municipally organized, or Indian Reserves and Settlements.
History	Prior to 2004, the Residence Coding Manual was available in paper copy.

Section 2: Injury Data

Incident Date

Name in Database	INJ_DATE_M, INJ_DATE_D, INJ_DATE_Y
Definition	The date the patient was injured.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY U—Unknown
Constraints	01 01 1900—Present
Source	Direct data entry
Hierarchy	1. EMS run sheet 2. Police Crash Report 3. ED physician record 4. ED nursing record 5. Trauma nurse flow sheet 6. Trauma physician record
Additional Information	"U" may be entered in the month and/or date portion if the incident date is unknown, vague (i.e. occurred sometime last night) or if the injury occurred over time (i.e. child abuse). An estimate should not be used. In the case of a baby that suffers injury before birth in a motor vehicle collision and subsequently requires delivery by C-Section the following day, the date of injury should be entered as the day before birth.
History	

Incident Time

Name in Database	INJ_TIME_H, INJ_TIME_M
Definition	The time the patient was injured using the 24 hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM U—Unknown HHUU—If a value can be estimated to the hour only
Constraints	0000–2359, U
Source	Direct data entry
Hierarchy	1. EMS run sheet 2. Police Crash Report 3. ED physician record 4. ED nursing record 5. Trauma nurse flow sheet 6. Trauma physician record
Additional Information	An estimate should not be used in order to maintain the integrity of the data. Incident time should be taken from the Ambulance Call Report, Police Crash Report, or from the history notes on the hospital chart. It is important to document an incident time when possible because calculations for elapsed times are based on this data element. Collector has built in date and time checks that will alert you if the time is incomplete, i.e. field includes "UU"s. These checks should be validated if the complete time is unavailable.
History	

Incident Date and Time—Approximation

Name in Database	APPROX_INJ
Definition	The patient's approximation injury time.
Data Type	Integer
Data Element Length	1
Field Values	1—Within 1 week 2—Within 1 month 3—Within 3 months 4—Within 1 year U—Unknown
Constraints	1–4, U
Source	Direct data entry
Hierarchy	1. EMS run sheet 2. ED physician record 3. ED nursing record 4. Trauma nurse flow sheet 5. Trauma physician record
Additional Information	This field will be skipped unless unknown is entered in any portion of the Incident Date data element. Unknown should only be used for this data element when there is no information available about the date of the incident, the injury date is uncertain or the injuries cannot be dated.
History	

ICD-10 Primary External Cause Code

Name in Database	ICD10EXT_1
Definition	External Cause of Injury Codes (V01–Y98) are a classification within the International Classification of Diseases (ICD-10-CA) that describe the nature of injury.
Data Type	Al/Num
Data Element Length	7
Field Values	ICD-10-CA code most closely related to the patient's most serious injuries
Constraints	Valid ICD-10-CA code
Source	Direct data entry
Hierarchy	
Additional Information	External Cause of Injury Codes (V01–Y98) are a classification within the International Classification of Diseases (ICD-10-CA) that describe the nature of injury. Similar to E-Codes, three External Cause Codes can be documented in Collector (primary, secondary, tertiary). Enter an ICD-10-CA External Cause of Injury code for the etiology that is most closely related to the patient's most serious injuries. External Cause Codes may be selected from a menu system as follows. The first menu presented lists 35 broad categories of injury corresponding to sections in the ICD manual. After selecting a category from this menu a second menu listing specific Secondary External Cause Codes will be displayed. After selecting a specific External Cause Code from the second menu, a third menu listing tertiary External Cause Codes will be displayed. Cause of injury codes may also be selected from the ICD-10 folio.
History	

ICD-10 Secondary External Cause Code

Name in Database	ICD10EXT_2
Definition	An additional ICD-10-CA External Cause of Injury code for an additional secondary etiology that is more closely related to the circumstances causing the injury. Enter "inappropriate" if a secondary external cause is not involved.
Data Type	Al/Num
Data Element Length	7
Field Values	An additional ICD-10-CA code for secondary etiology I—Inappropriate
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	
History	

ICD-10 Tertiary External Cause Code

Name in Database	ICD10EXT_3
Definition	An additional ICD-10-CA External Cause of Injury code for an additional tertiary etiology that is more closely related to the circumstances causing the injury. Enter "inappropriate" if a tertiary external cause is not involved.
Data Type	Al/Num
Data Element Length	7
Field Values	An additional ICD-10-CA code for tertiary etiology I—Inappropriate
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	
History	

Cause of Injury—Specify

Name in Database	CAUSE_INJ
Definition	Describes the cause of the injury.
Data Type	Text
Data Element Length	59
Field Values	Free text description
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	
History	

Sports and Recreational Activity Code

Name in Database	E917_X
Definition	If the patient is injured while participating or observing in any sports or recreational activity regardless of whether the person is being paid to participate, select the appropriate activity from the menu.
Data Type	Al/Num
Data Element Length	2
Field Values	See Appendix K for the list of Sports and Recreational Activity codes. I—Inappropriate
Constraints	
Source	
Hierarchy	
Additional Information	Hospitals may wish to default this field to inappropriate which should be documented for all patients who are not injured in a sports or recreational activity.
History	

Sports and Recreational Activity Code—Specify

Name in Database	CAUSE_917
Definition	Description of sports/recreational activity injury.
Data Type	Text
Data Element Length	59
Field Values	Free text description if Other is selected. Leave blank if not applicable.
Constraints	
Source	
Hierarchy	
Additional Information	
History	

ICD-10 Primary Place of Injury

Name in Database	U98_X_1
Definition	The place of injury that corresponds to the ICD-10-CA primary U Code to denote the place where the injury occurred for the patient.
Data Type	Integer
Data Element Length	1
Field Values	0—Home 1—Residential Institution 2—School/Other Institute/Public Area 3—Sports/Athletics Area 4—Street/Highway 5—Trade/Service Area 6—Industrial/Construction area 7—Farm 8—Other Specified Place of Occurrence 9—Unspecified Place of Occurrence
Constraints	0–9
Source	Direct data entry
Hierarchy	
Additional Information	If a patient is injured on a regular ski hill, the place of injury should be documented as "other specified place of occurrence" (menu item 8), whereas if the place of injury is a ski resort and is monitored by ski patrol, "sport/athletics area" (menu item 3) should be selected.
History	

Place of Injury—Specify

Name in Database	PLACE_INJ
Definition	Description of the place of injury.
Data Type	Text
Data Element Length	40
Field Values	Free text description if Other is selected. Leave blank if not applicable.
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	
History	

Primary Injury Type

Name in Database	INJ_TYPE
Definition	Indicates whether the most serious injury is a blunt, penetrating, burn or drowning/asphyxia injury.
Data Type	Integer
Data Element Length	1
Field Values	1—Blunt 2—Penetrating 3—Burns 4—Drowning/Asphyxia
Constraints	1–4
Source	Direct data entry
Hierarchy	

Primary Injury Type (cont'd)

Additional Information	To document injury type, consider only the cause of injury. For patients with more than one type of injury (i.e. a combination of blunt, penetrating and burn) consider the most severe injury to determine the injury type.
	
	Penetrating is used only if the patient is impaled by an object or if a missile enters or strikes the body. Missiles include bullets and pieces of glass or metal. Impaling objects may include, but are not limited to, knives, nails and fence posts.
	
	Drowning/Asphyxia should be documented for cases of drowning, near drowning or asphyxiation, including suffocation and hanging, etc.
	
	Examples of coding of the injury type:
	• Blast injuries should be coded as blunt.
	• A patient struck by a motor vehicle is documented as a blunt injury even if their injuries include deep lacerations.
	• A burn should be used for cases with inhalation where there is corrosion (i.e. batteries).
	• In an assault where injuries are the result of both stabbing and beating:
	  – If the injuries include a head injury and a stab to the arm, the injury type would be documented as blunt because of the more severe head injury.
	  – If the injuries include a laceration to an organ as a result of the stabbing and minimal injury from the blunt object assault, the injury type would be penetrating.
	• Isolated burns with an ISS>12 or burns with another injury with an AIS = 1 should be documented as a burn injury type.
	• Animal bites should most commonly be documented as penetrating injury from a clinical perspective. If, on the other hand, the tissue damage is mainly due to crushing, the injury type should be documented as blunt.
	
	If in doubt as to the type of injury, it is recommended your Medical Director be consulted. **(Working Group 03/97)**

History	Effective April 1, 2012, change in allowable field values: addition of field value 4 (Drowning/Asphyxia).

Work-Related Injury

Name in Database	WORK_RELAT
Definition	Indicates if the injury was work related.
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No
Constraints	1, 2
Source	Direct data entry
Hierarchy	
Additional Information	Note that occupation on Screen 1.2 must be documented if the injury is work related. Work-related injuries include only those injuries that occur while the patient is being paid for services. Trades people who are injured while voluntarily working at their trade at their own home or at a friend's home or as a hobby are not considered as work-related injury. Work-related injuries **include**: 01—Injuries resulting from an event in the work environment where people are present as a condition of their employment including: 02—Employer's premises 03—Other locations where employees are engaged in work-related activities or are present as a condition of their employment 04—Not only the primary facility, but also such areas as company storage facilities 05—Equipment or materials used in the course of an employee's work 06—Incidents that occur while people work at home if the incident occurs while conducting business tasks 07—Injuries to full or part time employees 08—Injuries that occur outside normal working hours 09—Injuries that occur during travel for company business (all the time spent in the interest of the company including, but not limited to, travel to and from customer contacts, and entertaining or being entertained for the purpose of transacting, discussing or promoting business etc.) Work-related injuries **exclude**: • Travel to and from work • Incidents that occur in company parking lots on the way to and from work.
History	

Intentional Injury

Name in Database	INTENT_INJ
Definition	Indicates whether the injury was intentional.
Data Type	Integer
Data Element Length	1
Field Values	1—No (Not Indicated) 2—Self-Inflicted Injury 3—Homicide/Assault U—Unknown
Constraints	1–3, U
Source	Direct data entry
Hierarchy	
Additional Information	Was the injury intentional? Use "U" if the hospital chart questions whether the injury was intentional or does not specify intentional injury. External Cause of Injury codes that apply to intentional injury are Self-Inflicted, E950-958 (ICD-9-CM or X60-84 (ICD-10-CA) and Purposefully Inflicted, Homicide/assault, E960-969 (ICD-9-CM) or X85-Y09 (ICD-10-CA). Cases with Undetermined Intentionality, External Cause of Injury codes between E980-988 (ICD-9-CM) and Y20-34 (ICD-10-CA), should be entered as "U."
History	

Extrication Required

Name in Database	EXTRICATE
Definition	Indicates if extrication was required at the scene of the injury.
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No I—Inappropriate
Constraints	1, 2, I
Source	Direct data entry
Hierarchy	
Additional Information	Extrication is documented if the patient was trapped and required release from the scene of the incident. Examples include extrication from motor vehicles, dwellings on fire and falls where extrication is required. For some cases, extrication is not a consideration, i.e. fall from high chair. Use Inappropriate if this is the case.
History	

Extrication Time Required (in Minutes)

Name in Database	EXTRIC_TIM
Definition	Time of extrication in minutes.
Data Type	Integer
Data Element Length	3
Field Values	Valid extrication time
Constraints	0–999
Source	Ambulance Call Report
Hierarchy	
Additional Information	Enter the time of extrication in minutes. Extrication time is from the time of arrival of the rescue team to the time of successful extrication. Extrication time can be found on the Ambulance Call Report. This field will be skipped if "no" was entered in the previous field.
History	

Accident Number

Name in Database	ACC_NUM_1
Definition	Accident number from the Police Motor Vehicle Accident Report.
Data Type	Al/Num
Data Element Length	12
Field Values	Accident number I—Inappropriate U—Unknown
Constraints	
Source	Motor Vehicle Accident Report
Hierarchy	If the Police Motor Vehicle Accident Report (MVAR) is not available, record the information from other documented sources. Other sources of information can be used to document motor vehicle crash information in addition to the MVAR when it is available. The scene and MVAR information are the earliest and most reliable data and should be considered as the primary source of information (04/01/95). The accident number is a unique number assigned by the investigating police department used to identify a specific car crash. Left align if the number is not in the format shown on the screen. In cases where MVARs are not completed by police due to their policies (i.e. assaults with motor vehicles), inappropriate should be entered.
Additional Information	Because it is not always clear whether police forces are involved in transport related incidents such as snowmobile incidents occurring off the highway, hospitals should attempt to get MVARs for all transport incidents. **(Working Group 03/97)** It is important to note when recording information from the MVAR that the patient may be in Vehicle One (V1) or Vehicle Two (V2). Information for the vehicle the patient was in should be documented.
History	

Police Force

Name in Database	POL_FORCE
Definition	Name of police force investigating the incident.
Data Type	Text
Data Element Length	20
Field Values	Name I—Inappropriate U—Unknown
Constraints	
Source	Motor Vehicle Accident Report
Hierarchy	
Additional Information	Enter the name of the Police Force investigating the crash. This is a hospital defined menu. Police Force is identified on the Motor Vehicle Accident Report and is typically OPP or city police departments.
History	

Police Force Division

Name in Database	POL_DIV
Definition	Police Force Division investigating the incident.
Data Type	Text
Data Element Length	20
Field Values	Police Force Division I—Inappropriate U–Unknown
Constraints	
Source	Motor Vehicle Accident Report
Hierarchy	
Additional Information	The Police Force Division is specified on the Motor Vehicle Accident Report and is a subset of the Police Force that identifies the detachment of OPP or municipality of the force. If the Police Force involved is not organized in divisions enter "I." This is a hospital defined menu.
History	

Vehicle Type

Name in Database	VEH_TYPE
Definition	Type of vehicle the patient was in or on for transport incidents.
Data Type	Integer
Data Element Length	2
Field Values	01—Bus (14–19) 02—Passenger Vehicle (01 04) 03—Light Truck (vans, pickup trucks) (06) 04—Heavy Truck (> half ton) (07–13 98 99) 05—Recreational Vehicle (20) 06—Motorcycle (02 03) 07—Snowmobile (25) 08—ATV (21–24) 09—Boat 10—Bicycle (36) 11—Transport Truck 12—Logging Truck 13—Plane 14—Train (29) 15—Other (26–28 30–35) 16—Pedestrian
Constraints	01–16
Source	Direct data entry
Hierarchy	
Additional Information	Select the type of vehicle that the patient was in or on for transport incidents. The menu used in Collector has been modified from the selections seen on the Motor Vehicle Accident Report (MVAR) form based on lead/trauma hospital input. The field values above also list the corresponding MVAR codes in brackets. This information is found in box 21 for Vehicle One and box 22 for Vehicle Two on the MVAR. Use pedestrian (menu item 16) if the injured person is a pedestrian struck by a vehicle including a bicycle. Use 10 for injured cyclists.
History	**As of April 1st, 1997 (Working Group 03/97):** • Inappropriate should never be documented for vehicle type for transport incidents. • If the patient is injured falling from a vehicle, the vehicle type data element should reflect the type of vehicle the patient fell from. • Vehicle type should be documented as a pedestrian for patients injured when struck by a train whether the patient was walking or laying on the train tracks at the time of the injury. • Vehicle type should be documented as "other" when the incident involves an animal or animal drawn vehicle. **As of April 3, 2002 (Working Group 04/02):** • Vehicle type should be documented as "other" when incident involves a motorized scooter, golf cart, jet ski/sea doo and construction vehicles.

Vehicle Type—If Other

Name in Database	VEH_TYPE_O
Definition	Type of vehicle if Other was entered in the previous field.
Data Type	Text
Data Element Length	20
Field Values	Free text description
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	This field will be skipped if Other was not selected in the previous field.
History	

Protective Device

Name in Database	PROT_DEV_1, PROT_DEV_2, PROT_DEV_3, PROT_DEV_4
Definition	All protective devices in use by the patient. This field repeats 4 times.
Data Type	Integer
Data Element Length	2
Field Values	00—None 01—Lap and shoulder belt 02—Lap belt only 03—Lap belt only of combined assembly 04—Child safety seat used incorrectly 05—Child safety seat used correctly 06—Air bag deployed 07—Other passive restraint device 08—Helmet 09—Equipment available but not used 10—No equipment available 11—Use unknown 12—Other safety equipment used 13—Infant seat (less than 20 pounds) 14—Child seat (between 20—40 pounds) 15—Booster seat (greater than 40 pounds) 16—Seatbelt NFS 17—Helmet flew off 18—Child safety seat unspecified as to type 19—Eye protection/visor (sports/recreational) 20—Lifejacket/personal floatation device 21—Sports specific pads 22—Hard hat (work related) 23—Safety Harness/restraining bar (work related) 24—Safety/protective clothing (work related) 25—Goggles/Eye protection (work related) U—Unknown I—Inappropriate
Constraints	1–25, U, I
Source	Direct data entry
Hierarchy	1. EMS run sheet 2. Hospital notes (nursing, medical, social work, etc.)

Protective Device (cont'd)

Additional Information	Select all of the protective devices in use by the patient. Up to four menu items may be selected. Use menu item #16 (Seatbelt NFS) if seatbelt is specified, but if lap or shoulder usage is not specified. • Protective devices are any devices in use or not in use by the injured patient at the time of the incident. • Use menu item 9 (Equipment Available, But Not Used) for cyclists injured while not wearing a helmet. • Use menu item 12 (Other Safety Equipment Used) for pedestrians or cyclists injured while wearing fluorescent clothing specifically designed to promote visibility. • The options listed in the Collector menu are identical to Safety Equipment Used on the MVAR (Box 77) with the exceptions of menu items 0, 11 and 13.17. Collector Menu item 0 (None) is not to be used. Menu item 11 (Use Unknown) is coded as 00 on the MVAR.
History	Effective April 1, 2012, addition of allowable field values 18 through 25

Protective Devices—If Other

Name in Database	PROT_DEV_O
Definition	Description if Other Safety Equipment Used was selected in previous element.
Data Type	Text
Data Element Length	20
Field Values	Free text description
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	Specify if "Other Safety Equipment Used" was selected in the previous menu. This field will be skipped unless "Other Safety Equipment Used" (#12) was selected from the previous menu.
History	

Ejected From Vehicle

Name in Database	EJECTED
Definition	Indicates whether the patient was ejected from a vehicle.
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No 3—Partial U—Unknown
Constraints	1–3, U
Source	Direct data entry
Hierarchy	
Additional Information	Enter "No" if ejection is not documented on the patient's chart of the Motor Vehicle Police Report. Because some police forces document the distance ejected for cyclists and pedestrians, this field and the following distance ejected field may be used to document this information for cyclists and pedestrians as appropriate at your institution. As of April 1st, 1997, "unknown" should be documented if it is unclear whether the patient was ejected. **(Working Group 03/97)** Box 76 on the MVAR documents ejection from vehicle for up to five involved persons. Names are recorded on the MVAR which will help identify information for the patient. Please note that although the menu items are the same for this data element in Collector and on the MVAR they are not in the same order.
History	

Ejected From Vehicle—Distance Ejected (in Metres)

Name in Database	EJECTED_D
Definition	Distance in metres patient was ejected from the vehicle.
Data Type	Integer
Data Element Length	3
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	Ambulance Call Report
Additional Information	A decimal point is not allowed. This field will be skipped if "No" was selected from the previous menu. This information is not found in a specific box on the MVAR. This information may potentially be found in the text of the Investigating Officer's Description of Accident and Diagram section of the MVAR or the Ambulance Call Report.
History	

Location of Primary Vehicle Impact

Name in Database	PRI_IMPACT
Definition	Type of impact for the primary vehicle.
Data Type	Integer
Data Element Length	2
Field Values	01—Right-Front Corner 02—Right-Front 03—Right Centre 04—Right-Rear 05—Right-Rear Corner 06—Back Centre 07—Left-Rear Corner 08—Left-Rear 09—Left Centre 10—Left Front 11—Left Front Corner 12—Front Centre 13—Front Complete 14—Right Complete 15—Back Complete 16—Left Complete 17—Top 18—Undercarriage 19—No Contact I—Inappropriate U—Unknown
Constraints	01–19, I, U
Source	
Hierarchy	
Additional Information	Vehicle impact describes the location of the initial impact on a vehicle for those patients injured in motor vehicle crashes. Impact may be with a vehicle or fixed object. The primary vehicle for the purposes of Collector is the one that the patient is travelling in or on and may be Vehicle One or Vehicle Two. The primary vehicle impact describes the location of impact for the vehicle the patient was travelling in or on. As of April 1st, 1997, the primary vehicle impact data element should be documented as "inappropriate" for injured cyclists. **(Working Group 03/97)** A diagram of the vehicle damage or area of impact is found on the Motor Vehicle Accident Report. The information to be documented in this data element differs slightly from what is recorded on the MVAR in that the patient may be in Vehicle One (Box 62) or Vehicle Two (Box 64). If only "driver's side" is specified in the chart, record "Left Complete." If "head on" is specified in the chart, record "Front Complete."
History	

Location of Secondary Vehicle Impact

Name in Database	SEC_IMPACT
Definition	Type of impact for secondary vehicle.
Data Type	Integer
Data Element Length	2
Field Values	01—Right-Front Corner 02—Right-Front 03—Right Centre 04—Right-Rear 05—Right-Rear Corner 06—Back Centre 07—Left-Rear Corner 08—Left-Rear 09—Left Centre 10—Left Front 11—Left Front Corner 12—Front Centre 13—Front Complete 14—Right Complete 15—Back Complete 16—Left Complete 17—Top 18—Undercarriage 19—No Contact I—Inappropriate U—Unknown
Constraints	01–19, I, U
Source	Direct data entry
Hierarchy	
Additional Information	The secondary vehicle is another vehicle involved in the collision which the patient was not travelling in or on and may be any type of vehicle. The secondary vehicle impact describes the location of the initial impact for a second vehicle involved in the crash which the patient was not travelling in or on (may be Vehicle One or Vehicle Two). This data element differs from the MVAR which defines secondary impact as "damage sustained in subsequent impacts." As of April 1st, 1997, the secondary vehicle impact data element should be documented as "inappropriate" for injured cyclists or pedestrians. **(Working Group 03/97)** If only "driver's side" is specified in the chart, record "Left Complete." If "head on" is specified in the chart, record "Front Complete."
History	

Impact Type

Name in Database	IMP_TYPE
Definition	Type of Impact
Data Type	Integer
Data Element Length	1
Field Values	1—Approaching 2—Angle 3—Rear end 4—Sideswipe 5—Turning 6—Single motor vehicle strikes unattended vehicle 7—Single motor vehicle other 8—Other U—Unknown
Constraints	1–8, U
Source	Direct data entry
Hierarchy	Motor Vehicle Accident Report
Additional Information	Impact type is a description as defined by the Ministry of Transportation for the vehicle in which the patient was travelling in or on. This information is found on the MVAR (Box 45). A diagram of initial impact type is found on the reverse side of the MVAR template. Please see the MVAR Section in Appendix G for Ministry of Transport definitions for impact type. The menu below is identical to the MVAR menu with the exception of #8 (Other), which is coded as 99 on the MVAR. Impact type should be documented as "Single motor vehicle other" (menu item 7) when the incident involves a pedal cyclist or a pedestrian injured by a motor vehicle.
History	

Collision Detail 1

Name in Database	COL_DET_1
Definition	Collision detail code for the primary impact.
Data Type	Integer
Data Element Length	1
Field Values	1—Impact with moving object (Moveable Objects 01–09, 97) 2—Impact with fixed object (Fixed Objects 50–66, 99) 3—Submersion (Other Events 25) 4—Vehicle fire (Other Events 24) 5—Vehicle roll over (Other Events 26) U—Unknown I—Inappropriate
Constraints	1–5, U, I
Source	Direct data entry
Hierarchy	Motor Vehicle Accident Report
Additional Information	The primary impact is the impact that results in the patient's most serious injuries, not necessarily the first injury recorded. Collision detail is the description of the collision the patient was injured in as defined by the Ministry of Transportation. This information is found in the Sequence of Events section of the MVAR which includes moveable objects, other events, fixed objects and fixed object offset.
History	

Collision Detail 2

Name in Database	COL_DET_2
Definition	Collision detail code for the secondary impact.
Data Type	Integer
Data Element Length	1
Field Values	1—Impact with moving object 2—Impact with fixed object 3—Submersion 4—Vehicle fire 5—Vehicle roll over U—Unknown I—Inappropriate
Constraints	1–5, U, I
Source	Direct data entry
Hierarchy	Motor Vehicle Accident Report
Additional Information	Enter the appropriate code for collision detail for the secondary impact. The secondary impact is the impact that relates to the secondary External Cause Code. This information is not found on the MVAR.
History	

Position in Vehicle

Name in Database	POS_IN_VEH
Definition	Position in Vehicle is a numbering system designed by the Ministry of Transportation to indicate the position of the patient when injured in, on or by a vehicle in the case of pedestrians.
Data Type	Integer
Data Element Length	2
Field Values	01—Driver 02—Middle-front 03—Right-front 04—Left-rear 05—Middle-rear 06—Right-rear 07—Behind middle-rear 08—Hanger-on 09—Pedestrian 10—Front seat NFS 11—Rear seat NFS I—Inappropriate U—Unknown
Constraints	01–11, U, I
Source	Direct data entry
Hierarchy	Motor Vehicle Accident Report (MVAR)

Position in Vehicle (cont'd)

Additional Information	Enter the appropriate code for the patient's position in the vehicle. This data element should be used to indicate the position of the patient when injured in, on or by a vehicle in the case of pedestrians. Select menu item #9 (pedestrians) if the patient is a pedestrian.
	Position in Vehicle is a numbering system designed by the Ministry of Transportation to designate where the injured person was seated in a vehicle. This information can be found in box 74 on the MVAR for all involved persons. Enter L as the first digit if the patient was sitting on someone's lap in the vehicle. If the patient was not sitting on a lap, enter "inappropriate" (a space cannot be entered in this field).
	Menu items 10 and 11 were added at the request of lead/trauma hospitals. It should be noted that Position in Vehicle is interpreted differently by different police departments (i.e. motorcycle passengers may be coded as menu items #4 (left-rear) or #2 (middle-front). Please use your best judgement to document this data element based on the information available on the MVAR.
	All occupants of the third bench in a minivan and passengers on multi-service vehicles such as buses or trains should be coded as menu item #7 (behind middle-rear). Cyclists, like motorcycle drivers, should be coded as menu item #1 (driver).
	Riders in a box of a pickup truck should be coded as menu item #8 (hanger-on). Motorcycle and bicycle passengers should be coded as menu item #4 (left-rear) if the passenger was sitting behind the driver. Passengers sitting in front of the driver may be coded as menu item #8 (hanger-on) depending on the police force.

Position in Vehicle—LAP

Name in Database	LAP
Definition	Indicates whether the patient was sitting on a lap.
Data Type	Al/Num
Data Element Length	1
Field Values	L—Patient was sitting on someone's lap in the vehicle. I—Inappropriate
Constraints	L, I
Source	Direct data entry
Hierarchy	Motor Vehicle Accident Report (MVAR)
Additional Information	
History	

Section 3: Scene Data

Primary Institution Transferred To

Name in Database	INST_NUM_1
Definition	The primary institution number to which the patient was transferred to from the scene if other than a lead/trauma hospital.
Data Type	Integer
Data Element Length	4
Field Values	Institution number I—Inappropriate
Constraints	Valid institution number, I
Source	Direct data entry
Hierarchy	
Additional Information	If the patient was admitted, enter the AT or AP number. If the patient was seen in the emergency department only, enter AM number. Enter "I" to skip the primary institution screens if the patient was transferred directly to a lead/trauma hospital. Please refer to the current version of the Ministry of Health and Long-Term Care Master Numbering System. The following is a link to the April 1, 2012 version: http://www.health.gov.on.ca/en/common/ministry/publications/reports/master_numsys/master_numsys.aspx
History	

Secondary Institution Transferred To

Name in Database	INST_NUM_2, INST_NUM_3
Definition	The first and second secondary institution number (the second and third hospital) to which the patient was transferred to from the scene if other than a lead/trauma hospital.
Data Type	Integer
Data Element Length	4
Field Values	Institution number I—Inappropriate
Constraints	Valid institution number, I
Source	Direct data entry
Hierarchy	
Additional Information	If the patient was admitted, enter the AT or AP number. If the patient was seen in the emergency department only, enter AM number.
History	

Lead Trauma Institution Transferred To

Name in Database	INST_NUM_4
Definition	Your institution number will be defaulted into this field on this screen.
Data Type	Integer
Data Element Length	4
Field Values	Institution number
Constraints	Valid institution number
Source	Direct data entry
Hierarchy	
Additional Information	At lead trauma facilities, the acute care master number should be used regardless of the status of the patient.
History	

Geocode of Incident Location

Name in Database	GEOCODE
Definition	Seven-digit numeric classification code to document the location of the injury incident for all patients who arrive by ambulance.
Data Type	Al/Num
Data Element Length	8
Field Values	Code U—Unknown I—Inappropriate
Constraints	Valid code, U, I
Source	Direct data entry
Hierarchy	Ambulance Call Report and may be recorded as the UTM on the pre-hospital D form or F8 form.
Additional Information	Unknown: Includes patients for which the geocode is not available in the documentation or cannot be obtained through reasonable effort. Inappropriate: Includes injuries occurring outside of Ontario or arriving by private vehicle. If the patient was transferred by a self-dispatched area which does not document geocodes, enter an "S" before the 5- or 7-digit code from the self-dispatched area. In cases where the geocode received from the ambulance dispatch service is identified by OTR edit checks as incorrect, hospitals may enter the geocode found in the Metro geocode book rather than documenting unknown. For those individuals obtaining geocode information from UTM maps please note that the first three digits of a geocode represent the three most significant of the Easting and the last four digits of the geocode represent the four most significant digits of the Northing. Geocodes are based on UTMs (Universal Transverse Mercator) which is a mapping projection similar to latitude and longitude. However, a map is required to determine geocodes and may not be available to ambulance dispatch staff for some areas.
History	

Incident Location (If Out of Province)

Name in Database	LOC_STATE
Definition	Location of the incident if it occurred outside of Ontario.
Data Type	Integer
Data Element Length	2
Field Values	01—Ontario (Do not use.) 02—Manitoba 03—Saskatchewan 04—British Columbia 05—Alberta 06—Quebec 07—New Brunswick 08—Newfoundland 09—Prince Edward Island 10—Nova Scotia 11—Northwest Territories 12—Yukon Territory 13—United States 14—Other U—Unknown I—Inappropriate
Constraints	1–14, U, I
Source	Direct data entry
Hierarchy	Ambulance Call Report
Additional Information	Although Ontario can be selected from this menu, it is not an appropriate choice as this data element is for those injuries occurring outside of Ontario. Enter "I" if the injury occurred in Ontario.
History	

Incident Location—If Other

Name in Database	LOC_ST_O
Definition	Specify location of incident if "14. Other" was selected for previous field (LOC_STATE).
Data Type	Text
Data Element Length	30
Field Values	Free Text Description
Constraints	
Source	Direct data entry
Hierarchy	Ambulance Call Report
Additional Information	This field will be skipped if "other" was not selected in the previous field.
History	

Transport Mode

Name in Database	MODE_1_S MODE_2_S MODE_3_S
Definition	The mode of transport (vehicle/provider) used during patient transport from the scene to hospital and between hospitals.
	Up to three patient transfers in different vehicles between hospitals may be documented in Collector.
Data Type	Integer
Data Element Length	1
Field Values	1—Land ambulance
	2—Helicopter ambulance
	3—Fixed-wing ambulance
	4—Blank
	5—Blank
	6—Private vehicle
	7—Walk-in
	8—Other
	I—Inappropriate
	U—Unknown
Constraints	1–3, 6–8, U, I
Source	Direct data entry
Hierarchy	
Additional Information	Up to three modes of transport (land or air vehicles) can be documented for each run. A run is a pre-hospital transfer which may be from the scene to a hospital or between hospitals.
	The modes of transport should be captured sequentially. For each Mode of Transport, if "I" is entered, data elements for that run will be skipped. If "U" is entered, the cursor will move to the remaining data elements for that run. If there is only one transport, 2nd and 3rd mode of transport should be entered as "I." If menu items 6 or 7 are entered, Collector skips to the next provider and all related data elements are not accessible. If the patient went directly to a lead/trauma hospital, the first mode of transport from the scene will pertain to the run from the scene to the lead/trauma hospital.
	A "Walk-in" must be a direct admission from the scene (patient walks in off the street) for purposes of the OTR and may differ from hospital chart documentation.
	If an ambulance is a charter fixed-wing, indicate fixed-wing as the term "charter" has been discontinued.
History	As of April 1, 2012, menu items 4 and 5 are retired.

Transport Service

Name in Database	SERV_1_S SERV_2_S SERV_3_S
Definition	Three-digit ambulance service number from ACR for land ambulances only.
Data Type	Integer
Data Element Length	3
Field Values	Ambulance service number I—Inappropriate U—Unknown
Constraints	Ambulance service number, I, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	Data element repeats 3 times. For cases that did not use land ambulance services, inappropriate would be selected. Use unknown if ambulance service number is unknown.
History	

Run Sheet Available

Name in Database	RUNSHT_1_S, RUNSHT_2_S, RUNSHT_3_S
Definition	Is the pre-hospital run sheet available for the applicable provider (land or air vehicle) from the scene electronically or on the patient chart prior to discharge?
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No I—Inappropriate U—Unknown
Constraints	1, 2, I, U
Source	Direct data entry
Hierarchy	1. Electronic pre-hospital reporting system 2. Patient chart
Additional Information	Data element repeats 3 times For cases that did not use ambulance services, inappropriate would be selected.
History	

Pre-Hospital Number

Name in Database	PHTN_1_S, PHTN_2_S, PHTN_3_S
Definition	The pre-hospital transport number for applicable provider (land or air vehicle) at the scene.
Data Type	Text
Data Element Length	12
Field Values	Valid transport number
Constraints	
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	Data element repeats 3 times Pre-hospital number includes flight number for air ambulance or fixed-wing transport and an OASIS or ARIS number for land ambulance
History	

Number of Qualified Personnel

Name in Database	For 1st Provider at Scene: BLS_1_S, ALS_1_S, RN_1_S, RT_1_S, MD_1_S, CCT_1_S, OTH_1_S, UNK_1_S For 2nd Provider at Scene: BLS_2_S, ALS_2_S, RN_2_S, RT_2_S, MD_2_S, CCT_2_S, OTH_2_S, UNK_2_S For 3rd Provider at Scene: BLS_3_S, ALS_3_S, RN_3_S, RT_3_S, MD_3_S, CCT_3_S, OTH_3_S, UNK_3_S
Definition	The number of personnel from each category accompanying the patient during the transport for the applicable provider (land or vehicle) at the scene. Categories includes: BLS: Basic Life Support ALS: Advance Life Support RN: Registered Nurse RT: Respiratory Therapist MD: Medical Doctor Critical Care Transport Team (Note: Enter yes or no to designate use of CCTT) Other Unknown
Data Type	Integer

Number of Qualified Personnel (cont'd)

Data Element Length	2, 2, 2, 2, 2, 1, 2, 2
Field Values	Valid number of personnel, U
Constraints	
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	Data elements repeats 3 times
	If a Critical Care Transport Team is used, select "Yes" from the menu.
	Qualified personnel include Basic Life Support (EMA ambulance crew graduates from community college), Advanced Life Support (CMA Level 3, paramedics), Registered Nurse, Medical Doctor, and Critical Care Transport Team (CCTT must be a recognized team that leaves the lead/trauma hospital to pick up a patient at the referring centre and returns to the lead/trauma hospital).
	Check your local base hospital program to determine the types of qualified personnel available in your region.
	If unclear as to the ambulance qualifications (i.e. there are no crew qualifications provided), none should be recorded. However, if there is clear evidence that the crew, or a member of the crew, are either ALS or BLS then it should be coded as such. For example, if there are procedures documented that can only be performed by those with an ALS qualification then it seems reasonable to assume that the qualification level should be documented as an ALS for at least one crew member. Other crew members may still need to be documented as unknown if there is no statement or evidence of the qualification level.
History	

Date Call Received

Name in Database	PREDATE_CM, PREDATE_CD, PREDATE_CY
Definition	The date the ambulance call was received if different from the date of the incident.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY U—Unknown
Constraints	01 01 1900—Present, U
Source	Direct data entry
Hierarchy	
Additional Information	For all ambulance dates, the default is the date of the incident. Enter a different date if necessary or press Enter to accept the dates displayed. If dates are unknown, "U" should be documented in all or a portion of the date data elements.
History	

Time Call Received

Name in Database	PRETIME_CH, PRETIME_CM
Definition	The time the ambulance call was received using the 24 hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM U—Unknown
Constraints	0000–2359, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	If times are unknown, "U" should be documented in all or a portion of the time data elements.
History	

Date Dispatched

Name in Database	PREDATE_DM, PREDATE_DD, PREDATE_DY
Definition	The date the ambulance was dispatched if different from the date of the incident.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY U—Unknown
Constraints	01 01 1900—Present, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	For all ambulance dates, the default is the date of the incident. Enter a different date if necessary or press Enter to accept the dates displayed. If dates are unknown, "U" should be documented in all or a portion of the date data elements.
History	

Time Dispatched

Name in Database	PRETIME_DH, PRETIME_DM
Definition	The time the ambulance was dispatched using the 24 hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM U—Unknown
Constraints	0000–2359, U, I
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	If times are unknown, "U" should be documented in all or a portion of time data elements.
History	

Date Arrived at Scene

Name in Database	PREDATE_AM, PREDATE_AD, PREDATE_AY
Definition	The date the ambulance arrived at the scene if different from the date of the incident (MMDDYYYY).
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY U—Unknown
Constraints	01 01 1900—Present, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	For all ambulance dates, the default is the date of the incident. Enter a different date if necessary or press Enter to accept the dates displayed. If dates are unknown, "U" should be documented in all or a portion of the date data elements.
History	

Time Arrived at Scene

Name in Database	PRETIME_AH, PRETIME_AM
Definition	The time the ambulance arrived at the scene using the 24 hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM U—Unknown
Constraints	0000–2359, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	If times are unknown, "U" should be documented in all or a portion of time data elements.
History	

Date Arrived at Patient

Name in Database	PREDATE_PM, PREDATE_PD, PREDATE_PY
Definition	The date the ambulance arrived at the patient if different from the date of the incident (MMDDYYYY).
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY U—Unknown
Constraints	01 01 1900—Present, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	For all ambulance dates, the default is the date of the incident. Enter a different date if necessary or press Enter to accept the dates displayed. If dates are unknown, "U" should be documented in all or a portion of the date data elements.
History	

Time Arrived at Patient

Name in Database	PRETIME_PH, PRETIME_PM
Definition	The time the ambulance arrived at the patient using the 24 hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM U—Unknown
Constraints	0000–2359, U, I
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	If times are unknown, "U" should be documented in all or a portion of time data elements.
History	

Date Departed From Scene

Name in Database	PREDATE_LM, PREDATE_LD, PREDATE_LY
Definition	The date the ambulance departed from the scene if different from the date of the incident.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY U—Unknown
Constraints	01 01 1900—Present, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	This screen will only appear if the mode of transport selected is ambulance.
History	

Time Departed From Scene

Name in Database	PRETIME_LH, PRETIME_LM
Definition	The time the ambulance departed from the scene using the 24 hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM U—Unknown
Constraints	0000–2359, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	This screen will only appear if the mode of transport selected is ambulance.
History	

Total Scene Time

Name in Database	TOTAL_SH, TOTAL_SM
Definition	Total scene time is a calculated field based on the time ambulance arrived at the scene to the time the ambulance left the scene.
Data Type	Integer
Data Element Length	2, 2
Field Values	Valid scene time
Constraints	
Source	
Hierarchy	
Additional Information	Scene time will be displayed on the screen in hours and minutes when all times on this screen have been entered.
History	

Total Pre-Hospital Time

Name in Database	TOTAL_PH, TOTAL_PM
Definition	Total pre-hospital time is a calculated field based on the incident time to the time the ambulance arrived at the first hospital.
Data Type	Integer
Data Element Length	2, 2
Field Values	Valid pre-hospital time
Constraints	
Source	
Hierarchy	
Additional Information	Pre-hospital time will be displayed on the screen in hours and minutes when the time of arrival at the primary hospital has been entered.
History	

Heart Rate (Scene)

Name in Database	PULSE_S
Definition	Patient's first recorded heart rate per minute at the scene.
Data Type	Integer
Data Element Length	3
Field Values	0–200 U—Unknown
Constraints	Valid HR values, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	Defined as the patient's first recorded HR upon arrival of EMS personnel at the scene. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the HR is not documented, enter *unknown*.
History	

Unassisted Respiration Rate (Scene)

Name in Database	RESP_RAT_S
Definition	Patient's first recorded unassisted respiratory rate at the scene.
Data Type	Integer
Data Element Length	2
Field Values	0–99 U—Unknown I—Inappropriate
Constraints	Valid RR, U, I
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	Defined as the patient's first recorded unassisted RR upon arrival of EMS personnel at the scene. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the RR is not documented, enter unknown. Enter inappropriate if patient respirations are assisted, that is, patient is intubated or being bagged.
History	

Systolic Blood Pressure (Scene)

Name in Database	SBP_S
Definition	Patient's first recorded systolic blood pressure (SBP) at the scene.
Data Type	Integer
Data Element Length	3
Field Values	000–250 U—Unknown
Constraints	Valid SBP, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	Defined as the patient's first recorded SBP upon arrival of EMS personnel at the scene. If the SBP is not taken or not documented, document as *unknown*.
History	

Pediatric Trauma Score (Scene)

Name in Database	PTS_S
Definition	Patient's Pediatric Trauma Score at the scene for patients <16 years of age.
Data Type	SgdInt
Data Element Length	2
Field Values	-6 to 12 U—Unknown I—Inappropriate
Constraints	-6 to12, U, I
Source	Direct data entry
Hierarchy	1. Ambulance report 2. ED physician record 3. ED nursing record 4. Medical progress notes 5. Radiology reports 6. Operative reports
Additional Information	Pediatric Trauma Score can range from -6 to 12. Pediatric Trauma Score should be calculated by the lead/trauma hospital if the components are documented. The weight at the lead/trauma hospital may be used. If any components are missing, enter unknown. Although a negative sign can be entered when necessary, a positive sign cannot be entered.
History	

Additional Information table:

Component	Score		
	+2	+1	-1
Size	>20 kg	10–20 kg	<10 kg
Airway	Normal	Maintainable (oral or nasal)	Unmaintainable (intubated)
Systolic BP	>90 mm Hg	90–50 mm Hg	<50 mm Hg
CNS	Awake	Obtunded/LOC	Coma ecerebrate
Open Wound	None	Minor	Major/penetrating
Skeletal	None	Closed fracture open	Multiple fractures
SUM (PTS)—range is 6 to =12			

Was Patient Intubated? (Scene)

Name in Database	INTUBAT_S
Definition	Was the patient intubated at the time the GCS at the scene was calculated?
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No U—Unknown
Constraints	1, 2, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	
History	

Paralytic Agents in Effect (Scene)

Name in Database	PAR_AGNT_S
Definition	Were paralytic agents in effect when the GCS at the scene was calculated?
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No U—Unknown
Constraints	1, 2, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	Paralytic agents stop muscular activity e.g. posturing, tremors, rigidity, restlessness. For patients who are intubated and mechanically ventilated, these agents reduce the patient's tendency to fight the ventilator. Paralytic agents also help preserve or increase the cerebral venous draining in severe head injury patients helping to reduce or keep intracranial pressure to normal range. Common paralytic agents include rocuronium (Zemuron), vecuronium, cisatracurium (Nimbex), succinylcholine, pancuronium (Pavulon) and atracurium. Succinylcholine/Anectine produces complete skeletal muscle relaxation and is used in trauma patients prior to intubation or induction of anesthesia. Morphine, Demerol, Ativan/lorazepam and Thiopental/Pentothal have pain killing and sedating actions, which are used in combination with a paralyzing agent. The intent of collecting whether or not paralytic agents were administered is to evaluate the number of times that the GCS cannot be completed due to paralytic agents rather than the number of paralytic agents administered. **(Working Group 3/99)**
History	

GCS Eye Opening (Scene)

Name in Database	EYE_OPNG_S
Definition	Patient's first eye-opening response for the Glasgow Coma Scale (GCS) taken at the scene.
Data Type	Integer
Data Element Length	1
Field Values	1—None 2—To pain 3—To voice 4—Spontaneous U—Unknown
Constraints	1–4, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	Enter "I" if the patient's eyes are swollen shut.
History	New data element for the NTR CDS as of April 1, 2012 and defined as the patient's first eye-opening response for the GCS documented upon arrival of EMS personnel. If the eye-opening response is not documented or if the patient's eyes are swollen shut, enter *not known*. The value items "U" and "I" for this data element in OTRCDS are to be mapped to "U" in NTR CDS.

GCS Verbal Response (Scene)

Name in Database	VER_RESP_S
Definition	Patient's first verbal response for the Glasgow Coma Scale (GCS) taken at the scene.
Data Type	Integer
Data Element Length	1
Field Values	1—None 2—Incomprehensible sounds 3—Inappropriate words 4—Confused 5—Oriented U—Unknown I—Inappropriate
Constraints	1–5, U, I
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	If the patient is intubated, this field will default to "I."
History	New data element for the NTR CDS as of April 1, 2012 and defined as the patient's first verbal response for the GCS documented upon arrival of EMS personnel at the scene. The value items "U" and "I" for this data element in OTRCDS are to be mapped to "U" in NTR CDS.

GCS Motor Response (Scene)

Name in Database	MOT_RESP_S
Definition	Patient's first motor response for the Glasgow Coma Scale (GCS) taken at the scene.
Data Type	Integer
Data Element Length	2
Field Values	1—None 2—Extension 3—Flexion 4—Withdraws 5—Localizes 6—Obeys U—Unknown I—Inappropriate
Constraints	1–6, U, I
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	If paralytic agents are in effect, this field will default to "I."
History	New data element for the NTR CDS as of April 1, 2012 and defined as the patient's first motor response for the GCS documented upon arrival of EMS personnel at the scene. The value items "U" and "I" for this data element in OTRCDS are to be mapped to "U" in NTR CDS.

Total GCS (Scene)

Name in Database	DISP_GCS_S
Definition	Patient's first total Glasgow Coma Scale (GCS) at the scene.
Data Type	Integer
Data Element Length	2
Field Values	3–15 U—Unknown I—Inappropriate
Constraints	3–15, U, I
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	Total Glasgow Coma Scale at the scene is a calculated field based on eye-opening, verbal and motor responses at the scene. The total GCS (range 3–5) will be displayed on the screen. If any of these fields are not valued, GCS is not calculated and will be displayed as "I" on the screen. Press Enter to move to the next field if "I" is displayed. Do not anticipate what the expected GCS component score would be if the patient were not intubated, paralytic agents were not in effect or their eyes were not swollen shut. GCS as documented from pre-hospital forms only. Although there is value in documenting the component scores when they are available, hospitals may document only the total GCS in cases where only the total score is documented. **(Working Group 03/96)**
History	

Total RTS (Scene)

Name in Database	DISP_RTS_S
Definition	Patient's Revised Trauma Score at the scene.
Data Type	Fixed—2
Data Element Length	4
Field Values	Formula: Coded Value x Weight = Score
Constraints	
Source	Software calculated
Hierarchy	
Additional Information	Revised Trauma Score at the scene is a calculated field based on Glasgow Coma Scale, systolic blood pressure and respiratory rate. The total RTS will be displayed on the screen. If any of the fields needed for the calculation of RTS are not valued, total RTS will not be calculated and "U" should be entered. **Respiratory Rate (breaths/min)** 10-29 4 >29 3 6-9 2 x 0.2908 = _____ 1-5 1 0 0 (Use 0 if patient arrived intubated) **Systolic Blood Pressure (mm Hg)** >89 4 76-89 3 50-75 2 x 0.7326 = _____ 1-49 1 0 0 **Glasgow Coma Scale** 13-15 4 9-12 3 6-8 2 x 0.9368 = _____ 4-5 1 3 0 **Total RTS = _____**
History	

Non-Operative Procedures (Scene)—(1–5)

Name in Database	NONOP_S_01, NONOP_S_02, NONOP_S_03, NONOP_S_04, NONOP_S_05
Definition	Non-operative procedures performed at the scene or en route to the first hospital. This element repeats 5 times.
Data Type	Integer
Data Element Length	2
Field Values	01—Oral intubation 02—Nasal intubation 03—Tracheotomy 04—Cricothyrotomy 05—Ventilation 06—IV 07—CPR 08—C-Spine immobilization 09—Backboards 10—KED 11—Oxygen administered 12—Other U—Unknown
Constraints	01–12, U
Source	Direct data entry
Hierarchy	1. Ambulance run sheet 2. Emergency notes at referring hospital
Additional Information	Please note bagging should be considered as ventilation whether it occurs in emergency or at the scene and whether it is manual or mechanical. **(Working Group 08/00)**
History	

Other Non-Operative Procedures (Scene)

Name in Database	NONOP_S_O
Definition	Description of non-operative procedure if Other was entered in the previous field.
Data Type	Text
Data Element Length	15
Field Values	Free text description
Constraints	
Source	Direct data entry
Hierarchy	Ambulance run sheet, emergency notes at referring hospital
Additional Information	This field will be skipped unless "other" was selected from the previous menu. This field is available to identify other non-operative procedures performed at the scene (not included in the previous list of values) that the LTH is interested in capturing.
History	

Section 4: Primary Hospital

Date of Arrival at Primary Hospital

Name in Database	REF_AR_D_M, REF_AR_D_D, REF_AR_D_Y
Definition	The patient's date of arrival at the primary hospital if different from the date of the incident.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY U—Unknown
Constraints	01 01 1900—Present, U
Source	
Hierarchy	1. ED physician record 2. ED nursing record 3. Face sheet
Additional Information	
History	

Time of Arrival at Primary Hospital

Name in Database	REF_AR_T_H, REF_AR_T_M
Definition	The patient's time of arrival at the primary hospital using the 24 hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM U—Unknown
Constraints	0000–2359, U
Source	Direct data entry
Hierarchy	1. ED physician record 2. ED nursing record 3. Face sheet
Additional Information	Choose the earliest time documented to reflect time patient arrived.
History	

Date of Departure From Primary Hospital

Name in Database	REF_DP_D_M, REF_DP_D_D, REF_DP_D_Y
Definition	The date of departure from the primary hospital for all patients (including admitted patients) if different from the date of incident.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY U—Unknown
Constraints	01 01 1900—Present, U
Source	Direct data entry
Hierarchy	1. ED physician record 2. ED nursing record 3. Face sheet
Additional Information	
History	

Time of Departure From Primary Hospital

Name in Database	REF_DP_T_H, REF_DP_T_M
Definition	The time of departure from the primary hospital for all patients (including admitted patients) using the 24 hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM U—Unknown
Constraints	0000–2359, U
Source	Direct data entry
Hierarchy	1. EMS sheet 2. ED physician record 3. ED nursing record 4. Face sheet
Additional Information	If the time is not documented, enter "U." Choose the earliest time documented to reflect time patient departed.
History	

Temperature (Primary Hospital)

Name in Database	TEMP_P
Definition	Patient's first recorded temperature in Celsius degrees within 15 minutes of arrival at the primary hospital.
Data Type	Fixed—1
Data Element Length	4
Field Values	Temperature number U—Unknown
Constraints	Valid temperature values, U
Source	Direct data entry
Hierarchy	1. ED nursing record 2. ED physician record
Additional Information	Because a decimal point is allowed, 3 digits must be entered (includes the digit after the decimal point). Enter U if temperature is not documented or not taken within first 15 minutes.
History	Effective April 1, 2014, change in data element definition: The observation interval is within 15 minutes of patient arrival.

Heart Rate (Primary Hospital)

Name in Database	PULSE_P
Definition	The patient's first recorded heart rate per minute within 15 minutes of arrival at the primary hospital.
Data Type	Integer
Data Element Length	3
Field Values	0–200 U—Unknown
Constraints	Valid HR values, U
Source	Direct data entry
Hierarchy	1. ED nursing record 2. ED physician record
Additional Information	If the patient is documented as VSA, enter zero. Enter 'U" if heart rate is not documented or not taken within first 15 minutes.
History	Effective April 1, 2014, change in data element definition: The observation interval is within 15 minutes of patient arrival.

Unassisted Respiration Rate (Primary Hospital)

Name in Database	RESP_RAT_P
Definition	The patient's first recorded unassisted respiratory rate per minute within 15 minutes of arrival at the primary hospital.
Data Type	Integer
Data Element Length	2
Field Values	0–99 U—Unknown I—Inappropriate
Constraints	Valid RR values, U, I
Source	Direct data entry
Hierarchy	1. ED nursing record 2. ED physician record
Additional Information	If the patient arrives ventilated or bagged enter "I." If the patient is documented as VSA before assistance is initiated, enter zero. Enter "U" if respiratory rate is not documented or not taken within first 15 minutes.
History	Effective April 1, 2014, change in data element definition: The observation interval is within 15 minutes of patient arrival.

Systolic Blood Pressure (Primary Hospital)

Name in Database	SBP_P
Definition	The patient's first recorded systolic blood pressure within 15 minutes of arrival at the primary hospital.
Data Type	Integer
Data Element Length	3
Field Values	000–250 U—Unknown
Constraints	Valid SBP, U
Source	Direct data entry
Hierarchy	1. ED nursing record 2. ED physician record
Additional Information	If the patient is documented as VSA, enter zero. Enter "U" if SBP is not documented or not taken within first 15 minutes.
History	Effective April 1, 2014, change in data element definition: The observation interval is within 15 minutes of patient arrival.

Pediatric Trauma Score (Primary Hospital)

Name in Database	PTS_P
Definition	The patient's Pediatric Trauma Score at the primary hospital for patients <16 years of age.
Data Type	StdInt
Data Element Length	2
Field Values	-6 to 12 U—Unknown I—Inappropriate
Constraints	-6 to 12, U, I
Source	Direct data entry
Hierarchy	1. ED physician record 2. ED nursing record 3. Medical progress notes 4. Radiology reports 5. Operative reports
Additional Information	Pediatric Trauma Score can range from -6 to +12. Although a negative sign can be entered when necessary, a positive sign cannot be entered. Please see Pediatric Trauma Score at scene for more detail.
History	

Was Patient Intubated at Primary Hospital? (Primary Hospital)

Name in Database	INTUBAT_P
Definition	Was the patient intubated at the time the GCS was calculated at the primary hospital?
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No U—Unknown
Constraints	1, 2, U
Source	Direct data entry
Hierarchy	1. ED nursing record 2. ED physician record
Additional Information	
History	

Paralytic Agents in Effect (Primary Hospital)

Name in Database	PAR_AGNT_P
Definition	Were paralytic agents administered when the GCS was calculated at the primary hospital?
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No U—Unknown
Constraints	1, 2, U
Source	Direct data entry
Hierarchy	1. ED nursing record 2. ED physician record
Additional Information	Please see Paralytic Agents in Effect at Scene for more detail.
History	Change in definition as of April 1, 2012

Eye Opening (Primary Hospital)

Name in Database	EYE_OPNG_P
Definition	The patient's first eye-opening response for the Glasgow Coma Scale within 15 minutes of arrival at the primary hospital.
Data Type	Integer
Data Element Length	1
Field Values	1—None 2—To pain 3—To voice 4—Spontaneous U—Unknown I—Inappropriate
Constraints	1–4, U, I
Source	Direct data entry
Hierarchy	1. ED nursing record 2. ED physician record
Additional Information	Enter "I" if the patient's eyes are swollen shut. Enter "U" if not taken within first 15 minutes.
History	Effective April 1, 2014, change in data element definition: The observation interval is within 15 minutes of patient arrival.

GCS Verbal Response (Primary Hospital)

Name in Database	VER_RESP_P
Definition	The patient's first verbal response for the Glasgow Coma Scale within 15 minutes of arrival at the primary hospital.
Data Type	Integer
Data Element Length	1
Field Values	1—None 2—Incomprehensible sounds 3—Inappropriate words 4—Confused 5—Oriented U—Unknown I—Inappropriate
Constraints	1–5, U, I
Source	Direct data entry
Hierarchy	1. ED nursing record 2. ED physician record
Additional Information	If the patient is intubated, this field will default to "I." Press Enter to move to the next field if "I" is displayed. Enter "U" if not taken within first 15 minutes.
History	Effective April 1, 2014, change in data element definition: The observation interval is within 15 minutes of patient arrival.

Motor Response (Primary Hospital)

Name in Database	MOT_RESP_P
Definition	The patient's first motor response for the Glasgow Coma Scale within 15 minutes of arrival at the primary hospital.
Data Type	Integer
Data Element Length	1
Field Values	1—None 2—Extension 3—Flexion 4—Withdraws 5—Localizes 6—Obeys U—Unknown I—Inappropriate
Constraints	1–6, U, I
Source	Direct data entry
Hierarchy	1. ED nursing record 2. ED physician record
Additional Information	If paralytic agents are in effect, this field will default to "I." Press Enter to move to the next field if "I" is displayed. Enter "U" if not taken within first 15 minutes.
History	Effective April 1, 2014, change in data element definition: The observation interval is within 15 minutes of patient arrival.

Total GCS (Primary Hospital)

Name in Database	DISP_GCS_P
Definition	Patient's first total Glasgow Coma Scale (GCS) within 15 minutes of arrival at the primary hospital.
Data Type	Integer
Data Element Length	3
Field Values	3–15 U—Unknown I—Inappropriate
Constraints	3–15, U, I
Source	Direct data entry
Hierarchy	1. ED nursing record 2. ED physician record
Additional Information	Total Glasgow Coma Score at the primary hospital is a calculated field based on eye-opening, verbal and motor responses. The total GCS (range 3-15) will be displayed on the screen. If any of these fields are not valued, GCS is not calculated and will be displayed as "I" on the screen. Press Enter to move to the next field if "I" is displayed. Enter "U" if not taken within first 15 minutes. Do not anticipate what the expected GCS component score would be if the patient were not intubated, paralytic agents were not in effect or their eyes were not swollen shut. The intent of collecting whether or not paralytic agents were administered is to evaluate the number of times that the GCS cannot be completed due to paralytic agents rather than the number of paralytic agents administered. **(Working Group 3/99)** Although there is value in documenting the component scores when they are available, hospitals may document only the total GCS in cases where only the total score is documented. **(Working Group 03/96)**
History	Effective April 1, 2014, change in data element definition: The observation interval is within 15 minutes of patient arrival.

Total RTS (Primary Hospital)

Name in Database	DISP_RTS_P
Definition	Patient's Revised Trauma Score at the primary hospital.
Data Type	Fixed—2
Data Element Length	4
Field Values	Formula: Coded Value x Weight = Score I—Inappropriate
Constraints	Valid RTS score, I
Source	Software calculated
Hierarchy	
Additional Information	Revised Trauma Score at the primary hospital is a calculated field based on Glasgow Coma Scale, systolic blood pressure and respiratory rate. The total RTS will be displayed on the screen. If any of the fields needed for the calculation of RTS are not valued, total RTS will not be calculated and "U" should be entered
History	

Blood Alcohol Concentration (BAC) (mmol/L) (Primary Hospital)

Name in Database	ETOH_BAC_P
Definition	The patient's blood alcohol concentration in SI units at the primary hospital.
Data Type	Fixed—1
Data Element Length	5
Field Values	Format: ####.# U—Unknown
Constraints	Valid BAC, U
Source	Direct data entry
Hierarchy	1. Lab results 2. ED physician notes
Additional Information	• Enter "U" if the patient was not tested or the results are not available. • If the lab results state <2 or trace document zero as of April 1, 1995.
History	Please refer to Appendix D for historical changes to this element.

Transport Mode (Primary Hospital)

Name in Database	For 1st Provider from Primary Hospital: MODE_1_P For 2nd Provider from Primary Hospital: MODE_2_P
Definition	The mode of transport for the first or second provider (land or air vehicle) from the primary hospital to the secondary or lead/trauma hospital.
Data Type	Integer
Data Element Length	1
Field Values	1—Land ambulance 2—Helicopter ambulance 3—Fixed-wing ambulance 4—Blank 5—Blank 6—Private vehicle 7—Walk-in 8—Other U—Unknown
Constraints	1–3, 6–8, U
Source	Direct data entry
Hierarchy	1. EMS run sheet 2. ED nursing notes 3. ED physician notes
Additional Information	Mode of transport refers to the vehicle/provider used during patient transport from the scene to hospital and between hospitals. Three patient transfers in different vehicles between hospitals may be documented in Collector. A "Walk-in" must be a direct admission from the scene (patient walks in off the street) for purposes of the OTR and may differ from hospital chart documentation.
History	• Effective April 1, 2012, values 4 and 5 have been retired. • The modes of transport should be captured sequentially. • If an ambulance is a charter fixed-wing, indicate fixed-wing as the term "charter" has been discontinued.

Transport Service (Primary Hospital)

Name in Database	For 1st Provider from Primary Hospital SERV_1_P For 2nd Provider from Primary Hospital SERV_2_P
Definition	The three-digit ambulance service number from the ACR for land ambulances only.
Data Type	Integer
Data Element Length	3
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	
History	

Run Sheet Available (1st Provider From Primary Hospital)

Name in Database	RUNSHT_1_P
Definition	Is the pre-hospital run sheet available for the first provider?
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No U—Unknown I—Inappropriate
Constraints	1, 2, U, I
Source	Direct data entry
Hierarchy	1. Electronic ambulance reporting system 2. Patient chart
Additional Information	
History	

Primary Pre-Hospital Number (1st Provider From Primary Hospital)

Name in Database	PHTN_1_P
Definition	the pre-hospital transport number for the first provider (land or air vehicle) from the primary hospital to the secondary or lead/trauma hospital.
Data Type	Text
Data Element Length	12
Field Values	Valid pre-hospital number U—Unknown
Constraints	Pre-hospital number, U
Source	Direct data entry
Hierarchy	EMS run sheet
Additional Information	Pre-hospital number includes flight number for air ambulance or fixed-wing transport and an OASIS or ARIS number for land ambulance.
History	

Non-Operative Procedures (Primary Hospital)

Name in Database	NONOP_P_01, NONOP_P_02, NONOP_P_03, NONOP_P_04, NONOP_P_05, NONOP_P_06, NONOP_P_07, NONOP_P_08, NONOP_P_09, NONOP_P_10, NONOP_P_11, NONOP_P_12, NONOP_P_13, NONOP_P_14, NONOP_P_15, NONOP_P_16, NONOP_P_17, NONOP_P_18, NONOP_P_19, NONOP_P_20
Definition	Non-operative procedures initiated in the primary hospital emergency department only.
Data Type	Integer
Data Element Length	2
Field Values	01—Oral Intubation 02—Nasal Intubation 03—Tracheotomy 04—Cricothyrotomy 05—Ventilation 06—Chest tubes 07—IV therapy 08—Central line 09—Arterial line 10—Cutdown 11—ED thoracotomy 12—CPR 13—ICP 14—Burr holes 16—Traction/pins 17—Peg tubes 18—Foley 19—Gastric tube 20—Angiography 21—Diagnostic peritoneal lavage (DPL) 22—CT scan 23—Other 24—MRI 25—Focused Assessment with Sonography for Trauma (FAST) 26—Reduction 27—Ultrasound 28—Sutures 29—Transfusion 30—Intraosseous lines U—Unknown
Constraints	1–30, U
Source	Direct data entry
Hierarchy	1. Emergency progress notes 2. Doctor notes 3. Nursing notes

Non-Operative Procedures (Primary Hospital) (cont'd)

Additional Information	Select up to 20 non-operative procedures initiated in the primary hospital emergency department only. Procedures already established which are being maintained should not be selected. Please see Appendix F for definitions of the procedures.
History	Menu items 24 and 29 are collected as of April 2005. Addition of 30—Intraosseous lines, April 1, 2014

Other Non-Operative Procedure (Primary Hospital)

Name in Database	NONOP_P_O1 NONOP_P_ O 2 NONOP_P_ O 3 NONOP_P_O4 NONOP_P_O5
Definition	Other non-operative procedures not included in the previous menu initiated in the primary hospital emergency department only.
Data Type	Text
Data Element Length	15
Field Values	Free text description
Constraints	
Source	Direct data entry
Hierarchy	1. Emergency Progress notes 2. ED physician record 3. ED Nursing record
Additional Information	These fields will be skipped if "other" was not selected in the previous field. This field is available to identify other non-operative procedures performed at the scene (not included in the previous list of values) that the LTH is interested in capturing.
History	

IV Lines (Primary Hospital)

Name in Database	IV_LINE_P
Definition	The total number of IV sites in place when leaving the primary hospital including IV sites established at the scene or during transport.
Data Type	Integer
Data Element Length	1
Field Values	Number of IV site I—No IV site U—Unknown
Constraints	Valid IV site number, I, U
Source	Direct data entry
Hierarchy	1. Primary hospital notes 2. Ambulance transfer document 3. Emergency notes from arrival hospital
Additional Information	Enter "I" rather than zero if there are no IV sites in situ at the primary hospital. Central lines should be included in the number of IV lines (not arterial lines).
History	

Ventilator Days (Primary Hospital)

Name in Database	VENT_DAY_P
Definition	The number of days the patient was intubated and mechanically ventilated intermittently or continuously excluding non-intubated patients on BIPAP and intubated patients on CPAP at the primary hospital.
Data Type	Integer
Data Element Length	3
Field Values	> = 1 I—Inappropriate (not ventilated)
Constraints	1–999, I
Source	Direct data entry
Hierarchy	1. Respiratory therapy flow sheet 2. Special care unit flow sheet
Additional Information	Ventilator days include any part of 1 day up to midnight including the day the ventilator is discontinued (excluding the day ventilator is begun) for cases where there is more than one ventilator day. A ventilator day is counted if a ventilated patient is admitted and discharged in the same day or if ventilation is started and discontinued in the same day. Routine intubation for OR is not included. Ventilator days from referring hospitals should be documented even if patient was not admitted. Enter "I" rather than zero if the patient was not ventilated. Hospitals may wish to default this field to inappropriate.
History	

Primary Hospital—Number of OR Visits

Name in Database	NUM_OR_P
Definition	The number of OR visits (not procedures) at the primary hospital.
Data Type	Integer
Data Element Length	2
Field Values	> = 1 I—No OR
Constraints	
Source	Direct data entry
Hierarchy	1. Operative records 2. Medical progress notes
Additional Information	Only OR visits related to the injury or complications arising from the injury should be documented. Enter "I" if there were no OR visits. Although any two digit number can be entered in the Number of OR Visits field, detail will be collected for five OR visits only. OR visits related to comorbidities should not be included. **(Working Group 05/95)**
History	

Date of 1st OR Visit (Primary Hospital)

Name in Database	OP_01_P_M, OP_01_P_D, OP_01_P_Y
Definition	The date of the first OR visit at the primary hospital.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY U—Unknown
Constraints	01 01 1900—Present, U
Source	Direct data entry
Hierarchy	Operative record
Additional Information	
History	

Start Time of 1st OR Visit (Primary Hospital)

Name in Database	OP_01_P_SH, OP_01_P_SM
Definition	The start time of the first OR visit at the primary hospital using the 24 hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM U—Unknown
Constraints	0000–2359, U
Source	Direct data entry
Hierarchy	Operative record
Additional Information	Start time is defined as the time of entry to the operating room theatre.
History	

Finish Time of 1st OR Visit (Primary Hospital)

Name in Database	OP_01_P_FH, OP_01_P_FM
Definition	The finish time of the first OR visit at the primary hospital using the 24 hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM U—Unknown
Constraints	0000–2359, U
Source	Direct data entry
Hierarchy	Operative record
Additional Information	Finish time is defined as the time of exit from the operating room theatre.
History	

Elapsed Time of 1st OR Visit (Primary Hospital)

Name in Database	OP_01_P_ET
Definition	Calculated field based on the time of entry and exit to the operating room theatre.
Data Type	Integer
Data Element Length	3
Field Values	Time in minute U—Not known
Constraints	Valid time, U
Source	Calculated field from time left operative theatre and time arrived operative theatre
Hierarchy	Operative record
Additional Information	Total elapsed time will be displayed on the screen in minutes.
History	

Operation #1 CCI Procedures (Primary Hospital)—ICD-10

Name in Database	OP_01_P_T1, OP_01_P_T2, OP_01_P_T3, OP_01_P_T4, OP_01_P_T5, OP_01_P_T6, OP_01_P_T7, OP_01_P_T8
Definition	The ICD-10-CA procedure codes for up to eight procedures for the first OR visit at the primary hospital (field repeats 8 times).
Data Type	Al/Num
Data Element Length	10
Field Values	ICD-10-CA/CCI code U—Unknown
Constraints	Valid ICD-10 CCI code, U
Source	Direct data entry
Hierarchy	1. Operative record 2. Physician notes
Additional Information	This field is mandatory. At least one procedure is required. Other procedures may be left blank.
History	CCI codes were mandated as of April 1, 2002.

Operation #1 Procedures (Primary Hospital)—Status

Name in Database	OP_01_P_A1, OP_01_P_A2, OP_01_P_A3, OP_01_P_A4, OP_01_P_A5, OP_01_P_A6, OP_01_P_A7, OP_01_P_A8
Definition	CCI intervention attribute designed to allow users to identify additional circumstances or conditions which may impact on the resources required to perform the intervention or the outcome expected (field repeats 8 times).
Data Type	Al/Num
Data Element Length	2
Field Values	ICD-10-CA/CCI code
Constraints	Valid CCI code
Source	
Hierarchy	1. Operative record 2. Physician notes
Additional Information	This field may not be required to complete for certain procedures. In this case, the filed may be left blank.
History	

Operation #1 Procedures (Primary Hospital)—Location

Name in Database	OP_01_P_L1, OP_01_P_L2, OP_01_P_L3, OP_01_P_L4, OP_01_P_L5, OP_01_P_L6, OP_01_P_L7, OP_01_P_L8
Definition	CCI intervention attribute designed to allow users to identify additional circumstances or conditions which may impact on the resources required to perform the intervention or the outcome expected (field repeats 8 times).
Data Type	Al/Num
Data Element Length	2
Field Values	
Constraints	Valid CCI code
Source	Direct data entry
Hierarchy	1. Operative record 2. Physician notes
Additional Information	This field may not be required to complete for certain procedures.
History	

Operation #1 Procedures (Primary Hospital)—Extent

Name in Database	OP_01_P_X1, OP_01_P_X2, OP_01_P_X3, OP_01_P_X4, OP_01_P_X5, OP_01_P_X6, OP_01_P_X7, OP_01_P_X8
Definition	CCI intervention attribute designed to allow users to identify additional circumstances or conditions which may impact on the resources required to perform the intervention or the outcome expected (field repeats 8 times).
Data Type	Al/Num
Data Element Length	2
Field Values	ICD-10-CA/CCI code
Constraints	Valid CCI code
Source	Direct data entry
Hierarchy	1. Operative record 2. Physician notes
Additional Information	This field may not be required to complete for certain procedures.
History	

Operation #1 Procedures (Primary Hospital)—Mode of Delivery

Name in Database	OP_01_P_M1, OP_01_P_M2, OP_01_P_M3, OP_01_P_M4, OP_01_P_M5, OP_01_P_M6, OP_01_P_M7, OP_01_P_M8
Definition	CCI intervention attribute designed to allow users to identify additional circumstances or conditions which may impact on the resources required to perform the intervention or the outcome expected (field repeats 8 times).
Data Type	Al/Num
Data Element Length	2
Field Values	
Constraints	Valid CCI code
Source	Direct data entry
Hierarchy	1. Operative record 2. Physician notes
Additional Information	This field may not be required to complete for certain procedures.
History	

Section 5: Lead/Trauma Hospital

Direct Admission to Service (Bypass ED)

Name in Database	DIRECT_ADM
Definition	If the patient admitted directly to the ICU, the OR, or a ward bypassing the emergency department.
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No U—Unknown
Constraints	1, 2, U
Source	Direct data entry
Hierarchy	1. Nursing progress notes 2. Medical progress notes 3. EMS run sheet
Additional Information	
History	

Date of Arrival at Lead/Trauma Hospital

Name in Database	AMB_AR_D_M, AMB_AR_D_D, AMB_AR_D_Y
Definition	The date of arrival at the lead/trauma hospital.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: DD MM YYYY
Constraints	01 01 1900—Present
Source	Direct data entry
Hierarchy	1. ED physician notes 2. ED nursing notes 3. EMS run sheet 4. Inpatient unit nursing notes (apply only to patients bypassing the ED)
Additional Information	This date must be entered for all cases including DIE's, in-hospital deaths, direct admission to service and transfers to ensure accurate reporting.
History	

Time of Arrival at Lead/Trauma Hospital

Name in Database	AMB_AR_T_H, AMB_AR_T_M
Definition	The time of arrival at the lead/trauma hospital using the 24 hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM
Constraints	0000–2359
Source	Direct data entry
Hierarchy	1. ED physician notes 2. ED nursing notes 3. EMS run sheet 4. Inpatient unit nursing notes (apply only to patients bypassing the ED)
Additional Information	
History	

Temperature in Celsius (Lead/Trauma Hospital)

Name in Database	TEMP_A
Definition	The patient's first recorded temperature in Celsius degrees within 15 minutes of arrival at the lead/trauma hospital.
Data Type	Fixed—1
Data Element Length	4
Field Values	25–50 U—Unknown
Constraints	Valid temperature values, U
Source	Direct data entry
Hierarchy	1. ED nursing notes 2. Inpatient nursing flow sheet 3. ED physician notes 4. Trauma resuscitation record
Additional Information	Because a decimal point is allowed, 3 digits must be entered (includes the digit after the decimal point). Enter "U" if temperature is not documented or not taken within first 15 minutes.
History	Effective April 1, 2012, change in data element definition: the observation interval is within 15 minutes of patient arrival.

Heart Rate (Lead/Trauma Hospital)

Name in Database	PULSE_A
Definition	The patient's first recorded heart rate per minute within 15 minutes of arrival at the lead/trauma hospital.
Data Type	Integer
Data Element Length	3
Field Values	0–200 U—Unknown
Constraints	Valid HR, U
Source	Direct data entry
Hierarchy	1. ED nursing notes 2. Inpatient nursing flow sheet 3. Trauma resuscitation record 4. ED physician notes
Additional Information	If the patient is documented as VSA, enter zero. Enter "U" if heart rate is not documented or not taken within the first 15 minutes of arrival.
History	Effective April 1, 2012, change in data element definition: the observation interval is within 15 minutes of patient arrival.

Unassisted Respiration Rate (Lead/Trauma Hospital)

Name in Database	RESP_RAT_A
Definition	The patient's first recorded unassisted respiratory rate per minute within 15 minutes of arrival at the lead/trauma hospital.
Data Type	Integer
Data Element Length	2
Field Values	0–99 U—Unknown I—Inappropriate
Constraints	Valid RR values, U, I
Source	Direct data entry
Hierarchy	1. ED nursing notes 2. Inpatient nursing flow sheet 3. Trauma resuscitation record 4. ED physician notes
Additional Information	If the patient arrives ventilated or bagged enter "I." If the patient is documented as VSA before assistance is initiated, enter zero. Enter "U" if respiratory rate is not documented or not taken within first 15 minutes.
History	Effective April 1, 2012, change in data element definition: the observation interval is within 15 minutes or patient arrival.

Systolic Blood Pressure (Lead/Trauma Hospital)

Name in Database	SBP_A
Definition	The patient's first recorded systolic blood pressure within 15 minutes of arrival at the lead/trauma hospital.
Data Type	Integer
Data Element Length	3
Field Values	000–250 U—Unknown
Constraints	Valid SBP values, U
Source	Direct data entry
Hierarchy	1. ED nursing notes 2. Inpatient nursing flow sheet 3. Trauma resuscitation record 4. ED physician notes
Additional Information	If the patient is document as VSA, enter zero. Enter "U" if SBP is not documented or not taken within first 15 minutes.
History	Effective April 1, 2012, change in data element definition: the observation interval is within 15 minutes of patient arrival.

Pediatric Trauma Score (Lead/Trauma Hospital)

Name in Database	PTS_A
Definition	The patient's Pediatric Trauma Score at the lead/trauma hospital for patients < 16 years of age.
Data Type	SgdInt
Data Element Length	2
Field Values	-6 to 12 U—Unknown I—Inappropriate
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	Pediatric Trauma Score can range from -6 to 12. Although a negative sign can be entered when necessary, a positive sign cannot be entered. Please see Pediatric Trauma Score at scene for more detail.
History	

Was Patient Intubated? (Lead/Trauma Hospital)

Name in Database	INTUBAT_A
Definition	Was the patient intubated at the time the GCS was calculated at the lead/trauma hospital?
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No U—Unknown
Constraints	1, 2, U
Source	Direct data entry
Hierarchy	1. EMS run sheet 2. Transferring hospital ED notes 3. ED nursing notes (trauma centre) 4. Transfer referral form
Additional Information	
History	

Paralytic Agents in Effect (Lead/Trauma Hospital)

Name in Database	PAR_AGNT_A
Definition	Paralytic agents administered when the Glasgow Coma Scale (GCS) was calculated at the trauma centre.
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No U—Unknown
Constraints	1, 2, U
Source	Direct data entry
Hierarchy	1. EMS run sheet 2. Transferring hospital ED notes 3. ED nursing notes (trauma centre) 4. Transfer referral form
Additional Information	Please see Paralytic Agents in Effect at Scene for more detail.
History	

GCS—Eye (Lead/Trauma Hospital)

Name in Database	EYE_OPNG_A
Definition	Patient's first eye-opening response for the Glasgow Coma Scale (GCS) taken within the first 15 minutes of arrival at the trauma centre.
Data Type	Integer
Data Element Length	1
Field Values	1—None 2—To pain 3—To voice 4—Spontaneous U—Unknown
Constraints	1–4, U
Source	Direct data entry
Hierarchy	1. ED nursing notes 2. Inpatient nursing flow sheet 3. Trauma resuscitation record 4. ED physician notes
Additional Information	Defined as the patient's first eye-opening response for the GCS, documented within 15 minutes of arrival at the trauma centre. Enter not known if not documented or if patient's eyes are swollen shut.
History	Effective April 1, 2012, change in data element definition: the observation interval is within 15 minutes of patient arrival.

GCS—Verbal (Lead/Trauma Hospital)

Name in Database	VER_RESP_A
Definition	Patient's first verbal response for the Glasgow Coma Scale (GCS), taken within 15 minutes of arrival at the trauma centre.
Data Type	Integer
Data Element Length	1
Field Values	1—None 2—Incomprehensible sounds 3—Inappropriate words 4—Confused 5—Oriented U—Unknown I—Inappropriate
Constraints	1–5, U, I
Source	Direct data entry
Hierarchy	1. ED nursing notes 2. Inpatient nursing flow sheet 3. Trauma resuscitation record 4. ED physician notes
Additional Information	If the patient is intubated, this field will default to "I" Press Enter to move to the next field if "I" is displayed.
History	Effective April 1, 2012, change in data element definition: the observation interval is within 15 minutes of patient arrival.

GCS—Motor (Lead/Trauma Hospital)

Name in Database	MOT_RESP_A
Definition	Patient's first motor response for the Glasgow Coma Scale (GCS), taken within 15 minutes of arrival at the trauma centre.
Data Type	Integer
Data Element Length	1
Field Values	1—None 2—Extension 3—Flexion 4—Withdraws 5—Localizes 6—Obeys U—Unknown I—Inappropriate
Constraints	1–6, U, I
Source	Direct data entry
Hierarchy	1. ED nursing notes 2. Inpatient nursing flow sheet 3. Trauma resuscitation record 4. ED physician notes
Additional Information	If paralytic agents are in effect, this field will default to "I." Press Enter to move to the next field if "I" is displayed.
History	Effective April 1, 2012, change in data element definition: the observation interval is within 15 minutes of patient arrival.

Total GCS (Lead/Trauma Hospital)

Name in Database	DISP_GCS_A
Definition	Patient's total Glasgow Coma Scale (GCS), within 15 minutes of arrival at trauma centre.
Data Type	Integer
Data Element Length	2
Field Values	3–15 U—Unknown I—Inappropriate
Constraints	3–15, U, I
Source	Calculated score from EYE_OPNG_A, VERB_RESP_A and MOT_RESP_A or Direct data entry
Hierarchy	1. ED nursing notes 2. Inpatient nursing flow sheet 3. Trauma resuscitation record 4. ED physician notes
Additional Information	The total GCS (range 3-15) will be auto calculated and displayed on the screen. If any of these fields are entered as *not appropriate*, GCS will be displayed as "I" if any of the components are entered as unknown the total GCS will be blank, enter unknown. If the components are not known but the total GCS is known, enter the total GCS. Do not anticipate what the expected GCS component score would be if the patient were not intubated, paralytic agents were not in effect or their eyes were not swollen shut. The intent of collecting whether or not paralytic agents were administered is to evaluate the number of times that the GCS cannot be completed due to paralytic agents rather than the number of paralytic agents administered. **(Working Group 3/99)** Although there is value in documenting the component scores when they are available, hospitals may document only the total GCS in cases where only the total score is documented. **(Working Group 03/96)** Defined as the total GCS, documented within 15 minutes of patient arrival at the trauma centre. If the GCS or any component of the GCS is not documented or if the patient is intubated within 15 minutes of the arrival at the trauma centre, enter not known. If the individual components are not documented but the total GCS is documented within 15 minutes of arrival at the trauma centre, this value may be used. If the documentation reflects the patient is awake, alert and oriented, the total GCS may be assumed to be 15.
History	Effective April 1, 2012, change in data element definition: the observation interval is within 15 minutes of patient arrival.

Total RTS (Lead/Trauma Hospital)

Name in Database	DISP_RTS_A
Definition	Calculated field based on Glasgow Coma Scale, systolic blood pressure and unassisted respiratory rate.
Data Type	Fixed—2
Data Element Length	4
Field Values	Formula: Coded Value × Weight = Score I—Inappropriate
Constraints	
Source	Calculated using 1. Glasgow Coma Scale And 2. Systolic blood pressure And 3. Unassisted respiratory rate
Hierarchy	1. ED nursing notes 2. Inpatient nursing flow sheet 3. ED physician notes 4. Trauma resuscitation record
Additional Information	If any of the fields needed for the calculation of RTS are not applicable, total RTS will need to be entered as "I." If the fields required for calculation are unknown enter unknown in the RTS field. Please see Total RTS at Scene for more detail.
History	

Blood Alcohol Concentration (mmol/L) (Lead/Trauma Hospital)

Name in Database	ETOH_BAC_A
Definition	The patient's blood alcohol concentration (BAC) in SI units at the trauma centre.
Data Type	Fixed—1
Data Element Length	5
Field Values	Format: ####.# U—Unknown
Constraints	Valid BAC, U,
Source	Direct data entry
Hierarchy	1. Lab results 2. ED physician notes
Additional Information	• Enter "U" if the patient was not tested or the results are not available. • If the lab results state <2 or trace document zero as of April 1, 1995.
History	• At the March 21, 1995 TRAC meeting, it was recommended that BAC should be routinely collected at lead/trauma hospitals on all trauma patients >10 years of age. • At the January 31st 1996 Subcommittee meeting, the BAC recommendation was updated to the following: BAC should be routinely collected at lead/trauma hospitals on all trauma patients >10 years of age with an ISS >12 when the patient is admitted within 12 hours of the incident. • The legal alcohol limit is 17 mmol/L. • The ISS component of the January 31st subcommittee recommendation should be removed given that the staff in the emergency department do not know the ISS at the time of treatment. **(Working Group 03/97)** • To comply with the NTR the age <10 years has been removed.

ED Arrival Date

Name in Database	EDA_DATE_M, EDA_DATE_D, EDA_DATE_Y
Definition	Date of arrival at the lead/trauma hospital emergency department.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY
Constraints	01 01 1900—Present
Source	Direct data entry
Hierarchy	1. ED nursing notes 2. ED physician notes 3. EMS run sheet
Additional Information	This date will default to the date of arrival at the lead/trauma hospital. This field will be skipped if Direct Admission to Service (Bypass ED) is "Yes." Note: Can be different from Date of Admission.
History	

ED Arrival Time

Name in Database	EDA_TIME_H, EDA_TIME_M
Definition	Time of the arrival at the lead/trauma hospital emergency department using the 24 hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM
Constraints	0000–2359
Source	Direct data entry
Hierarchy	1. ED nursing notes 2. ED physician notes 3. EMS run sheet
Additional Information	This field will be skipped if Direct Admission to Service (Bypass ED) is "Yes." Note: Can be different from time of admission.
History	

ED Departure Date

Name in Database	EDD_DATE_M, EDD_DATE_D, EDD_DATE_Y
Definition	The date of departure from the lead/trauma hospital emergency department.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY
Constraints	01 01 1900—Present
Source	Direct data entry
Hierarchy	1. EMS run sheet 2. ED nursing notes 3. ED physician notes
Additional Information	This field will be skipped if Direct Admission to Service (Bypass ED) is "Yes."
History	

ED Departure Time

Name in Database	EDD_TIME_H, EDD_TIME_M
Definition	The time of departure from the lead/trauma hospital emergency department using the 24-hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM
Constraints	0000–2359
Source	Direct Data Entry
Hierarchy	1. ED nursing notes 2. ED physician notes 3. EMS run sheet
Additional Information	This field will be skipped if Direct Admission to Service (Bypass ED) on Screen 6.1 is "Yes." Departure time is considered the final time the patient left the department. I.e. if a patient leaves the department and goes to Radiology for a CT scan and then back to emergency and then leaves again to go to the floor, the last time should be used. ED departure time may also be the same as the ED separation or death time. **(Working Group 04/05)**
History	

Admission Date

Name in Database	ADM_DATE_M, ADM_DATE_D, ADM_DATE_Y
Definition	The date of admission to the lead/trauma hospital.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY
Constraints	01 01 1900—Present
Source	Direct Data Entry
Hierarchy	
Additional Information	Admission date should not be documented for patients transferred or discharged from the lead/trauma emergency department or for DIE's. For DIE's, "II" should be entered for "inappropriate." For non-trauma patients who are injured in hospital, the date of admission should be documented as the date of injury so the LOS will relate to the injury.
History	

Trauma Team Activated

Name in Database	TRAUMA_TM
Definition	Indicates whether the trauma team was activated.
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No U—Unknown I—Not applicable
Constraints	1, 2, U, I
Source	Direct Data Entry
Hierarchy	
Additional Information	The trauma team is a multidisciplinary team headed by a Trauma Team Leader (who is an active staff member or fellow) and can include various other members, which will vary from hospital to hospital Indicate *Not applicable* if patient bypasses the ED.
History	

Date of Arrival of Trauma Team Leader

Name in Database	TTA_DATE_M, TTA_DATE_D, TTA_DATE_Y
Definition	Date of arrival of the Trauma Team Leader at the patient's bedside
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	MMDDYYYY
Constraints	01 01 1900—Present
Source	Direct data entry
Hierarchy	1. ED nursing notes 2. ED physician notes
Additional Information	Indicate the Trauma Team Leader's arrival date, regardless of whether or not the patient has arrived.
History	New data element as of April 1, 2014

Time of Arrival of Trauma Team Leader

Name in Database	TTA_TIME_H, TTA_TIME_M
Definition	Time of arrival of the Trauma Team Leader at the patient's bedside
Data Type	Integer
Data Element Length	2, 2
Field Values	HHMM
Constraints	0000–2359
Source	Direct data entry
Hierarchy	1. ED nursing notes 2. ED physician notes
Additional Information	Indicate the Trauma Team Leader's exact time of arrival, regardless of whether or not the patient has arrived.
History	New data element as of April 1, 2014

Admitting Physician Service

Name in Database	ADMIT_SRV
Definition	Select the physician service to which the patient was admitted.
Data Type	Integer
Data Element Length	2
Field Values	Valid physician service code, I
Constraints	
Source	Direct Data Entry
Hierarchy	
Additional Information	For patients who are DIE or who are discharged directly from the emergency, "inappropriate" should be entered. This menu lists the CIHI Admitting Services under the broad categories of General and Pediatric. A complete list of CIHI Admitting Services can be found in Appendix E. For patients admitted to a SCU, the recommendation for using the critical care doctor service is to follow the individual institutions admitting pattern, i.e. if a patient is admitted to ICU under neurosurgery, the admission service should be neurosurgery, if the patient is admitted to ICU under the critical care specialist, the admission service should be critical care specialist. **(Working Group 08/00)**
History	

Non-Operative Procedures (Lead/Trauma Hospital)

Name in Database	NONOP_A_01, NONOP_A_02, NONOP_A_03, NONOP_A_04, NONOP_A_05, NONOP_A-06, NONOP_A_07, NONOP_A_08, NONOP_A_09, NONOP_A_10, NONOP_A_11, NONOP_A_12, NONOP_A_13, NONOP_A_14, NONOP_A_15, NONOP_A_16, NONOP_A_17, NONOP_A_18, NONOP_A_19, NONOP_A_20
Definition	Up to 20 non-operative procedures performed in the lead/trauma hospital emergency department only (field repeats 20 times).
Data Type	Integer
Data Element Length	2

Non-Operative Procedures (Lead/Trauma Hospital) (cont'd)

Field Values	01—Oral Intubation 02—Nasal Intubation 03—Tracheotomy 04—Cricothyrotomy 05—Ventilation 06—Chest tubes 07—IV therapy 08—Central line 09—Arterial line 10—Cutdown 11—ED thoracotomy 12—CPR 13—ICP 14—Burr holes 15—Halo traction or tongs 16—Traction/pins 17—Peg tubes 18—Foley 19—Gastric tube 20—Angiography 21—Diagnostic peritoneal lavage (DPL) 22—CT scan 23—Other 24—MRI 25—FAST 26—Reduction 27—Ultrasound 28—Sutures 29—Transfusion 30—Intraosseous lines
Constraints	1–30, U, I
Source	Direct data entry
Hierarchy	1. Trauma resuscitation record 2. ED physician record 3. ED nursing notes 4. Medical progress notes
Additional Information	Procedures already established which are being maintained should not be selected. Non-operative procedures done in transit at other hospitals as part of the resuscitation process under the direction of the lead/trauma hospital should be included in the non-operative procedures at the lead/trauma hospital. Enter "u" if documentation is lacking and "I" if patient is admitted directly bypassing the ED.
History	Addition of 30—Intraosseous lines, April 1, 2014

Other Non-Operative Procedure (Lead/Trauma Hospital)

Name in Database	NONOP_A_O1, NONOP_A_O2, NONOP_A_O3, NONOP_A_O4, NONOP_A_O5
Definition	Up to five other non-operative procedures not included in the previous menu completed at the lead/trauma hospital emergency department (field repeats 5 times).
Data Type	Text
Data Element Length	15
Field Values	Text
Constraints	
Source	Direct data entry
Hierarchy	1. Trauma resuscitation record 2. ED physician record 3. ED nursing record
Additional Information	This field will be skipped if "other" was not selected in the previous menu. This field is available to identify other non-operative procedures performed at the scene (not included in the previous list of values) that the LTH is interested in capturing.
History	

CT Scan Location (Lead/Trauma Hospital)

Name in Database	CT_SCAN_A1, CT_SCAN_A2, CT_SCAN_A3, CT_SCAN_A4, CT_SCAN_A5
Definition	Select up to five locations of CT scans done at the lead/trauma hospital (emergency department only).
Data Type	Integer
Data Element Length	1
Field Values	1—Head 2—Spine 3—Face 4—Chest 5—Abdomen 6—Pelvis 7—Other
Constraints	1–7
Source	Direct Data Entry
Hierarchy	
Additional Information	
History	

IV Sites (Lead/Trauma Hospital)

Name in Database	IV_LINE_A
Definition	The total number of IV sites in place at the lead/trauma hospital including IV sites established prior to arrival.
Data Type	Integer
Data Element Length	1
Field Values	
Constraints	
Source	Direct Data Entry
Hierarchy	
Additional Information	Enter "I" rather than zero if there are no IV sites in situ prior to arrival. Central lines should be included in the number of IV lines (not arterial lines).
History	

Ventilator Days (Lead/Trauma Hospital)

Name in Database	VENT_DAY_A
Definition	Enter the number of days the patient was intubated and mechanically ventilated intermittently or continuously.
Data Type	Integer
Data Element Length	3
Field Values	Numeric value, U, I
Constraints	Numeric value, U, I
Source	Direct Data Entry
Hierarchy	
Additional Information	Excludes non-intubated patients on BIPAP and intubated patients on CPAP at the **lead/trauma** hospital. Ventilator days include any part of 1 day up to midnight including the day the ventilator is discontinued (excluding the day ventilator is begun) for cases where there is more than one ventilator day. A ventilator day is counted if a ventilated patient is admitted and discharged in the same day or if ventilation is started and discontinued in the same day. Routine intubation for OR is not included. Enter "I" rather than zero if the patient was not ventilated. Hospitals may wish to default this field to inappropriate.
History	

ICP Day (Lead/Trauma Hospital)

Name in Database	ICP_DAY_A
Definition	The number of ICP days at the lead/trauma hospital.
Data Type	Integer
Data Element Length	3
Field Values	Numeric value, U, I
Constraints	Numeric value, U, I
Source	Direct Data Entry
Hierarchy	
Additional Information	ICP days include any part of one day up to midnight including the day the ICP is discontinued (excluding the day the ICP is begun). Enter "I" rather than zero if ICP monitoring was not done. Hospitals may wish to default this field to inappropriate. Intracranial pressure is volume measurement of blood, brain tissue and cerebrospinal fluid within the skull. Each of the components has a relatively constant volume and each volume contributes to the overall ICP. ICP will increase whenever one or more of the contributing volume pressures increase. The normal range is 0–15 mm Hg (millimetres of Mercury). ICP monitoring is used to evaluate a head injury patient's response to therapy and may also be used as a treatment modality to vent CSF. ICP is measured by one of two major types of devices: • subarachnoid bolt or screw, referred to as a Richmond bolt or screw, which is placed through the skull onto the surface of the brain, • intraventricular or Camino catheter, which may have a fibre optic sensor in the catheter tip that is placed into the lateral ventricle of the brain on the patient's non-dominant side. Both types of measuring devices are connected to transducers and recorders, which will display both numerical values of ICP and corresponding waveforms.
History	

Number of OR Visits (Lead/Trauma Hospital)

Name in Database	NUM_OR_A
Definition	The number of OR visits (not procedures) at the lead/trauma hospital.
Data Type	Integer
Data Element Length	2
Field Values	Numeric value, I
Constraints	Numeric Value, I
Source	Direct Data Entry
Hierarchy	
Additional Information	This field should capture the actual number of OR visits, even though hospitals may collect up to 25 OR visits and only 10 can be submitted to the OTR. OR visits related to comorbidities should not be included. **(Working Group 05/95)**
History	

Section 6: Lead/Trauma Hospital Care

Physician Service—1 to 3

Name in Database	For 1st Physician Service: XFER_1_SRV For 2nd Physician Service: XFER_2_SRV For 3rd Physician Service: XFER_3_SRV
Definition	The first physician service to which the patient was transferred.
Data Type	Integer
Data Element Length	2
Field Values	See Appendix E for valid values, I
Constraints	Valid Physician service number, I
Source	Direct data entry
Hierarchy	
Additional Information	The first service may be intensivist but should not be traumatologist (use specific service). The menus for Service Transfers include CIHI Admitting Services and are divided into broader categories of General and Pediatric. A service transfer is defined as a transfer from the admission service to another service within the hospital. Transfer from the Emergency Department physician to an admitting service is not considered a service transfer. Length of stay for each service is calculated based on admission and discharge dates from each service. Enter "I" if the patient is not transferred to another service from the admitting service. For patients admitted to a SCU, the critical care physician service should follow the individual institution's admitting pattern, i.e. if a patient is admitted to ICU under Neurosurgery, the admission service should be neurosurgery; if a patient is admitted to ICU under the critical care specialist, the admission service should be critical care specialist.
History	

Physician Service—Date Admitted 1 to 3

Name in Database	For 1st Physician Service: XFER_1_A_M, XFER_1_A_D, XFER_1_A_Y For 2nd Physician Service: XFER_2_A_M, XFER_2_A_D, XFER_2_A_Y For 3rd Physician Service: XFER_3_A_M, XFER_3_A_D, XFER_3_A_Y
Definition	The date of admission for the first service to which the patient was transferred.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY
Constraints	01 01 1900—Present
Source	Direct data entry
Hierarchy	
Additional Information	Enter the date the patient was transferred to this service. This field will be skipped if the physician service transfer field is "I."
History	

Physician Service—Date Discharged 1 to 3

Name in Database	For 1st Physician Service: XFER_1_D_M, XFER_1_D_D, XFER_1_D_Y For 2nd Physician Service: XFER_2_D_M, XFER_2_D_D, XFER_2_D_Y For 3rd Physician Service: XFER_3_D_M, XFER_3_D_D, XFER_3_D_Y
Definition	The data of discharge for the first service to which the patient was transferred.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY
Constraints	01 01 1900—Present
Source	Direct data entry
Hierarchy	
Additional Information	Enter the date the patient was transferred to another service or discharged from hospital. This field will be skipped if the physician service transfer field is "I."
History	

Physician Service—Length of Stay (in Days) 1 to 3

Name in Database	For 1st Physician Service: XFER_1_LOS For 2nd Physician Service: XFER_2_LOS For 3rd Physician Service: XFER_3_LOS
Definition	The length of stay for the first physician service.
Data Type	Integer
Data Element Length	3
Field Values	> = 1
Constraints	1–999
Source	This is a calculated field based on transfer service admission and discharge dates.
Hierarchy	
Additional Information	Length of stay will be displayed on the screen when admission and discharge dates are entered for each service.
History	

See Appendix D for history (all patient service elements and numbers 4 through 6 patient and physician elements are excluded from the OTR CDS).

Post-ED/Arrival Destination

Name in Database	POST_ED
Definition	The post-ED or post arrival destination for patients who are treated in emergency department as well as those patients who are admitted directly to a service bypassing ED.
Data Type	Integer
Data Element Length	1
Field Values	1—Acute Care Hospital (not Lead/Trauma Hospital) 2—Another Lead/Trauma Hospital 3—OR 4—Special Care Unit (2:1 is normal patient: nurse ratio) 5—Ward 6—DIE 7—Discharged Home 8—Other
Constraints	1–8
Source	Direct data entry
Hierarchy	

Post-ED/Arrival Destination (cont'd)

Additional Information	The post-ED/arrival destination of the patient is the destination of the patient after leaving the emergency department or arriving at the hospital for those patients who are admitted directly to a patient unit. A DIE (Died in Emergency) is a patient who dies in the emergency department after any active treatment or resuscitation by the trauma team or emergency department physician after the patients enters the emergency department. DIEs may include patients who arrive VSA if treatment or resuscitation is initiated. Patients who are admitted to hospital and die in the emergency department while waiting for transfer are considered to be an in-hospital death rather than a DIE. These patients should be coded as 'DIE' with an admission date. For true DIEs, admission date should be entered as "inappropriate" **(Working Group 04/05).** A patient who has not had active treatment and is pronounced dead by the trauma team leader or emergency physician in the emergency department is considered to be DOA (Dead on Arrival). If only the pre-hospital crew conduct active treatment (e.g. CPR) in the hospital emergency department and treatment is not initiated by the trauma team or emergency department physician the patient is considered as DOA. DIEs and DOAs must be identified according to the above definition regardless of what is documented in the hospital chart. The definition of DIE and DOA may differ from those used for hospital purposes. For DIEs, select menu item 6 (DIE) from the menu above and menu item 7 (dead) from the separation status data element. Do not enter an admission date unless the patient was admitted and waiting for an inpatient bed and died in the ED.
History	

Post-ED/Arrival Destination—If Other

Name in Database	POST_ED_O
Definition	Post-ED destination for the patient if Other was selected from the previous menu.
Data Type	Text
Data Element Length	20
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	
History	

Post-OR Destination

Name in Database	POST_OR
Definition	A post OR destination if the patient was transferred to the OR from the ED.
Data Type	Integer
Data Element Length	2
Field Values	1—Special Care Unit (2:1 is normal patient: nurse ratio) 2—Ward 3—Morgue 4—Other I—Inappropriate U—Unknown
Constraints	1–4, I, U
Source	Direct data entry
Hierarchy	
Additional Information	This field will be skipped unless OR (menu item #3) was selected from the Post-ED Destination menu.
History	

Post-OR Destination—If Other

Name in Database	POST_OR_O
Definition	A post OR destination for the patient if "Other" was selected in the previous field.
Data Type	Text
Data Element Length	20
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	
History	

Special Care Unit

Name in Database	SCU_A
Definition	The type of Special Care Unit the patient was transferred to post-ED.
Data Type	Integer
Data Element Length	1
Field Values	1—Surgical ICU 2—Pediatric ICU 3—Neuro ICU 4—Burn ICU 5—Stepdown/Observation Unit 6—ICU 7—Other U—Unknown I—Inappropriate
Constraints	1–7, U, I
Source	Direct data entry
Hierarchy	

Special Care Unit (cont'd)

Additional Information	This field will be skipped unless Special Care Unit (#4) was selected from the Post-ED Destination menu. Special care units include intensive care and observation units with a normal patient: nurse ratio of at least 2:1. Special care units documented in Collector include surgical ICU, pediatric ICU, neuro ICU, burn ICU, stepdown/observation unit, general ICU and other. Use hospital specific terminology for reporting ICU. For the purposes of the Comprehensive Data Set, a stepdown/observation unit is defined as a designated area, which provides interim patient care between the ICU and the ward. The maximum patient: nurse ratio is 4:1. All menu options are available, however CIHI will only report on Stepdown/Observation Unit, Other and ICU (specific ICUs will be grouped under ICU). Institutions with multiple ICUs may use specific ICU options for their own purposes. **(TRAC 05/05)**
History	

Special Care Unit—If Other

Name in Database	SCU_A_O
Definition	Type of special care unit if "other" was selected from the previous menu.
Data Type	Text
Data Element Length	20
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	
History	

Note

All operation fields repeat 10 times, with up to 10 procedures per operation.

Operation 1–10—Date

Name in Database	OP_01_A_M, OP_01_A_D, OP_01_A_Y, OP_02_A_M, OP_02_A_D, OP_02_A_Y, OP_03_A_M, OP_03_A_D, OP_03_A_Y, OP_04_A_M, OP_04_A_D, OP_04_A_Y, OP_05_A_M, OP_05_A_D, OP_05_A_Y, OP_06_A_M, OP_06_A_D, OP_06_A_Y, OP_07_A_M, OP_07_A_D, OP_07_A_Y, OP_08_A_M, OP_08_A_D, OP_08_A_Y, OP_09_A_M, OP_09_A_D, OP_09_A_Y, OP_10_A_M, OP_10_A_D,OP_10_A_Y
Definition	The dates of the procedures performed in the OR or, in certain instances, in the ICU at the lead/trauma hospital.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY
Constraints	01 01 1900—Present
Source	Direct data entry
Hierarchy	1. Operative record 2. Medial physician notes 3. ICU nursing notes
Additional Information	See Appendix J for a list of acceptable procedures performed in the ICU. Hospitals may collect up to 25 OR visits, but only 10 can be submitted to the OTR. As such, the ones associated with the trauma should be prioritized. If there are more than 10 visits related to the injury, prioritize according to resource intensity of procedure. The duration of OR time may serve as a guideline.
History	Specific procedures performed while the patient was in ICU are also included

Operation 1–10—Start Time

Name in Database	OP_01_A_SH, OP_01_A_SM, OP_02_A_SH, OP_02_A_SM, OP_03_A_SH, OP_03_A_SM, OP_04_A_SH, OP_04_A_SM, OP_05_A_SH, OP_05_A_SM, OP_06_A_SH, OP_06_A_SM, OP_07_A_SH, OP_07_A_SM, OP_08_A_SH, OP_08_A_SM, OP_09_A_SH, OP_09_A_SM, OP_10_A_SH, OP_10_A_SM
Definition	The start time of the entry into the operating theatre or in the ICU in the lead/trauma hospital.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM
Constraints	0000–2359
Source	Direct data entry
Hierarchy	1. Operative record 2. Medial physician notes 3. ICU nursing notes
Additional Information	See Appendix J for a list of acceptable procedures performed in the ICU.
History	As of April 1, 2012, specific procedures performed while the patient was in ICU are also included.

Operation 1–10—Finish Time

Name in Database	OP_01_A_FH, OP_01_A_FM, OP_02_A_FH, OP_02_A_FM, OP_03_A_FH, OP_03_A_FM, OP_04_A_FH, OP_04_A_FM, OP_05_A_FH, OP_05_A_FM, OP_06_A_FH, OP_06_A_FM, OP_07_A_FH, OP_07_A_FM, OP_08_A_FH, OP_08_A_FM, OP_09_A_FH, OP_01_A_FM, OP_10_A_FH, OP_10_A_FM
Definition	The time the patient left the operating theatre or, in certain instances, the ICU at the lead/trauma hospital.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM
Constraints	0000–2359
Source	Direct data entry
Hierarchy	1. Operative record 2. Medial physician notes 3. ICU nursing notes
Additional Information	See Appendix J for a list of acceptable procedures performed in the ICU.
History	As of April 1, 2012, specific procedures performed while the patient was in ICU are also included.

Operation 1–10—Elapsed Time

Name in Database	OP_01_A_ET, OP_02_A_ET, OP_03_A_ET, OP_04_A_ET, OP_05_A_ET, OP_06_A_ET, OP_07_A_ET, OP_08_A_ET, OP_09_A_ET, OP_10_A_ET
Definition	Elapsed time of the procedures performed in the OR or, in certain instances, in the ICU at the lead/trauma hospital.
Data Type	Integer
Data Element Length	2
Field Values	Format: HHMM
Constraints	0000–2359
Source	Auto calculated time based on the operative start and finish times (OP_01_A_SH, OP_01_A_SM and OP_01_A_FH, OP_01_A_FM through OP_10_A_SH, OP_10_A_SM and OP_10_A_FH, OP_10_A_FM
Hierarchy	
Additional Information	This is a calculated field based on the times of entry and exit to the operating room theatre. Total elapsed time will be displayed on the screen in minutes. See Appendix J for a list of acceptable procedures performed in the ICU.
History	Specific procedures performed while the patient was in ICU are also included

Operation 1–10—Procedure 1–10—ICD-10 Code

Name in Database	OP_01_A_T1, OP_01_A_T2, OP_01_A_T3, OP_01_A_T4, OP_01_A_T5, OP_01_A_T6, OP_01_A_T7, OP_01_A_T8, OP_01_A_T9, OP_10_A_T0
	OP_02_A_T1, OP_02_A_T2, OP_02_A_T3, OP_01_A_T4, OP_02_A_T5, OP_02_A_T6, OP_02_A_T7, OP_02_A_T8, OP_02_A_T9, OP_02_A_T0
	OP_03_A_T1, OP_03_A_T2, OP_03_A_T3, OP_03_A_T4, OP_03_A_T5, OP_03_A_T6, OP_03_A_T7, OP_03_A_T8, OP_03_A_T9, OP_03_A_T0
	OP_04_A_T1, OP_04_A_T2, OP_04_A_T3, OP_04_A_T4, OP_04_A_T5, OP_04_A_T6, OP_04_A_T7, OP_04_A_T8, OP_04_A_T9, OP_04_A_T0
	OP_05_A_T1, OP_05_A_T2, OP_05_A_T3, OP_05_A_T4, OP_05_A_T5, OP_05_A_T6, OP_05_A_T7, OP_05_A_T8, OP_05_A_T9, OP_05_A_T0
	OP_06_A_T1, OP_06_A_T2, OP_06_A_T3, OP_06_A_T4, OP_06_A_T5, OP_06_A_T6, OP_06_A_T7, OP_06_A_T8, OP_06_A_T9, OP_06_A_T0
	OP_07_A_T1, OP_07_A_T2, OP_07_A_T3, OP_07_A_T4, OP_07_A_T5, OP_07_A_T6, OP_07_A_T7, OP_07_A_T8, OP_07_A_T9, OP_07_A_T0
	OP_08_A_T1, OP_08_A_T2, OP_08_A_T3, OP_08_A_T4, OP_08_A_T5, OP_08_A_T6, OP_08_A_T7, OP_08_A_T8, OP_08_A_T9, OP_08_A_T0
	OP_09_A_T1, OP_09_A_T2, OP_09_A_T3, OP_09_A_T4, OP_09_A_T5, OP_09_A_T6, OP_09_A_T7, OP_09_A_T8, OP_09_A_T9, OP_09_A_T0
	OP_10_A_T1, OP_10_A_T2, OP_10_A_T3, OP_10_A_T4, OP_10_A_T5, OP_10_A_T6, OP_10_A_T7, OP_10_A_T8, OP_10_A_T9, OP_10_A_T0
Definition	The ICD-10-CA procedure codes for up to 10 procedures performed in up to 10 OR visits or, in certain instances, in the ICU at the lead/ trauma hospital. Note: Hospitals may collect up to 25 OR visits, but only 10 can be submitted to the OTR. As such, the ones associated with the trauma should be prioritized. If there are more than 10 visits related to the injury, prioritize according to resource intensity of procedure. The duration of OR time may serve as a guideline.

Operation 1–10—Procedure 1–10—ICD-10 Code (cont'd)

Data Type	Al/Num
Data Element Length	10
Field Values	Valid CCI procedure codes
Constraints	CCI procedure codes
Source	Direct data entry
Hierarchy	
Additional Information	At least one procedure is required, others may be left blank. See Appendix J for a list of acceptable procedures performed in the ICU.
History	

Operation 1–10—Status

Name in Database	OP_01_A_A1, OP_01_A_A2, OP_01_A_A3, OP_01_A_A4, OP_01_A_A5, OP_01_A_A6, OP_01_A_A7, OP_01_A_A8, OP_01_A_A9, OP_10_A_A0
	OP_02_A_A1, OP_02_A_A2, OP_02_A_A3, OP_01_A_A4, OP_02_A_A5, OP_02_A_A6, OP_02_A_A7, OP_02_A_A8, OP_02_A_A9, OP_02_A_A0
	OP_03_A_A1, OP_03_A_A2, OP_03_A_A3, OP_03_A_A4, OP_03_A_A5, OP_03_A_A6, OP_03_A_A7, OP_03_A_A8, OP_03_A_A9, OP_03_A_A0
	OP_04_A_A1, OP_04_A_A2, OP_04_A_A3, OP_04_A_A4, OP_04_A_A5, OP_04_A_A6, OP_04_A_A7, OP_04_A_A8, OP_04_A_A9, OP_04_A_A0
	OP_05_A_A1, OP_05_A_A2, OP_05_A_A3, OP_05_A_A4, OP_05_A_A5, OP_05_A_A6, OP_05_A_A7, OP_05_A_A8, OP_05_A_A9, OP_05_A_A0
	OP_06_A_A1, OP_06_A_A2, OP_06_A_A3, OP_06_A_A4, OP_06_A_A5, OP_06_A_A6, OP_06_A_A7, OP_06_A_A8, OP_06_A_A9, OP_06_A_A0
	OP_07_A_A1, OP_07_A_A2, OP_07_A_A3, OP_07_A_A4, OP_07_A_A5, OP_07_A_A6, OP_07_A_A7, OP_07_A_A8, OP_07_A_A9, OP_07_A_A0
	OP_08_A_A1, OP_08_A_A2, OP_08_A_A3, OP_08_A_A4, OP_08_A_A5, OP_08_A_A6, OP_08_A_A7, OP_08_A_A8, OP_08_A_A9, OP_08_A_A0
	OP_09_A_A1, OP_09_A_A2, OP_09_A_A3, OP_09_A_A4, OP_09_A_A5, OP_09_A_A6, OP_09_A_A7, OP_09_A_A8, OP_09_A_A9, OP_09_A_A0
	OP_10_A_A1, OP_10_A_A2, OP_10_A_A3, OP_10_A_A4, OP_10_A_A5, OP_10_A_A6, OP_10_A_A7, OP_10_A_A8, OP_10_A_A9, OP_10_A_A0

Operation 1–10—Status (cont'd)

Definition	CCI intervention attribute designed to allow users to identify additional circumstances or conditions which may impact on the resources required to perform the intervention or the outcome expected (field repeats 10 times).
Data Type	Al/Num
Data Element Length	2
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	This field may not be required for certain procedures
History	

Operation 1–10—Procedure 1–10—Location

Name in Database	OP_01_A_L1, OP_01_A_L2, OP_01_A_L3, OP_01_A_L4, OP_01_A_L5, OP_01_A_L6, OP_01_A_L7, OP_01_A_L8, OP_01_A_L9, OP_10_A_L0
	OP_02_A_L1, OP_02_A_L2, OP_02_A_L3, OP_01_A_L4, OP_02_A_L5, OP_02_A_L6, OP_02_A_L7, OP_02_A_L8, OP_02_A_L9, OP_02_A_L0
	OP_03_A_L1, OP_03_A_L2, OP_03_A_L3, OP_03_A_L4, OP_03_A_L5, OP_03_A_L6, OP_03_A_L7, OP_03_A_L8, OP_03_A_A9, OP_03_A_L0
	OP_04_A_L1, OP_04_A_L2, OP_04_A_L3, OP_04_A_L4, OP_04_A_L5, OP_04_A_L6, OP_04_A_L7, OP_04_A_L8, OP_04_A_A9, OP_04_A_L0
	OP_05_A_L1, OP_05_A_L2, OP_05_A_L3, OP_05_A_L4, OP_05_A_L5, OP_05_A_L6, OP_05_A_L7, OP_05_A_L8, OP_05_A_L9, OP_05_A_L0
	OP_06_A_L1, OP_06_A_L2, OP_06_A_L3, OP_06_A_L4, OP_06_A_L5, OP_06_A_L6, OP_06_A_L7, OP_06_A_L8, OP_06_A_A9, OP_06_A_L0
	OP_07_A_L1, OP_07_A_L2, OP_07_A_L3, OP_07_A_L4, OP_07_A_L5, OP_07_A_L6, OP_07_A_L7, OP_07_A_L8, OP_07_A_L9, OP_07_A_L0
	OP_08_A_L1, OP_08_A_L2, OP_08_A_L3, OP_08_A_L4, OP_08_A_L5, OP_08_A_L6, OP_08_A_L7, OP_08_A_L8, OP_08_A_L9, OP_08_A_L0
	OP_09_A_L1, OP_09_A_L2, OP_09_A_L3, OP_09_A_L4, OP_09_A_L5, OP_09_A_L6, OP_09_A_L7, OP_09_A_L8, OP_09_A_L9, OP_09_A_L0
	OP_10_A_L1, OP_10_A_L2, OP_10_A_L3, OP_10_A_L4, OP_10_A_L5, OP_10_A_L6, OP_10_A_L7, OP_10_A_L8, OP_10_A_L9, OP_10_A_L0

Operation 1–10—Procedure 1–10—Location (cont'd)

Definition	CCI intervention attribute designed to allow users to identify additional circumstances or conditions which may impact on the resources required to perform the intervention or the outcome expected (field repeats 10 times).
Data Type	Al/Num
Data Element Length	2
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	This field may not be required for certain procedures.
History	

Operation 1–10—Procedure 1–10—Extent

Name in Database	OP_01_A_X1, OP_01_A_X2, OP_01_A_X3, OP_01_A_X4, OP_01_A_X5, OP_01_A_X6, OP_01_A_X7, OP_01_A_X8, OP_01_A_X9, OP_10_A_X0 OP_02_A_X1, OP_02_A_X2, OP_02_A_X3, OP_01_A_X4, OP_02_A_X5, OP_02_A_X6, OP_02_A_X7, OP_02_A_X8, OP_02_A_X9, OP_02_A_X0 OP_03_A_X1, OP_03_A_X2, OP_03_A_X3, OP_03_A_X4, OP_03_A_X5, OP_03_A_X6, OP_03_A_X7, OP_03_A_X8, OP_03_A_A9, OP_03_A_X0 OP_04_A_X1, OP_04_A_X2, OP_04_A_X3, OP_04_A_X4, OP_04_A_X5, OP_04_A_X6, OP_04_A_X7, OP_04_A_X8, OP_04_A_A9, OP_04_A_X0 OP_05_A_X1, OP_05_A_X2, OP_05_A_X3, OP_05_A_X4, OP_05_A_X5, OP_05_A_X6, OP_05_A_X7, OP_05_A_X8, OP_05_A_X9, OP_05_A_X0 OP_06_A_X1, OP_06_A_X2, OP_06_A_X3, OP_06_A_X4, OP_06_A_X5, OP_06_A_X6, OP_06_A_X7, OP_06_A_X8, OP_06_A_A9, OP_06_A_X0 OP_07_A_X1, OP_07_A_X2, OP_07_A_X3, OP_07_A_X4, OP_07_A_X5, OP_07_A_X6, OP_07_A_X7, OP_07_A_X8, OP_07_A_X9, OP_07_A_X0 OP_08_A_X1, OP_08_A_X2, OP_08_A_X3, OP_08_A_X4, OP_08_A_X5, OP_08_A_X6, OP_08_A_X7, OP_08_A_X8, OP_08_A_X9, OP_08_A_X0 OP_09_A_X1, OP_09_A_X2, OP_09_A_X3, OP_09_A_X4, OP_09_A_X5, OP_09_A_X6, OP_09_A_X7, OP_09_A_X8, OP_09_A_X9, OP_09_A_X0 OP_10_A_X1, OP_10_A_X2, OP_10_A_X3, OP_10_A_X4, OP_10_A_X5, OP_10_A_X6, OP_10_A_X7, OP_10_A_X8, OP_10_A_X9, OP_10_A_X0
Definition	CCI intervention attribute designed to allow users to identify additional circumstances or conditions which may impact on the resources required to perform the intervention or the outcome expected (field repeats 10 times).
Data Type	Al/Num
Data Element Length	2
Field Values	
Constraints	

Operation 1–10—Procedure 1–10—Extent (cont'd)

Source	Direct data entry
Hierarchy	
Additional Information	This field may not be required for certain procedures.
History	

Operation 1–10—Procedure 1–10—Mode of Delivery

Name in Database	OP_01_A_M1, OP_01_A_M2, OP_01_A_M3, OP_01_A_M4, OP_01_A_M5, OP_01_A_M6, OP_01_A_M7, OP_01_A_M8, OP_01_A_M9, OP_10_A_M0
	OP_02_A_M1, OP_02_A_M2, OP_02_A_M3, OP_01_A_M4, OP_02_A_M5, OP_02_A_M6, OP_02_A_M7, OP_02_A_M8, OP_02_A_M9, OP_02_A_M0
	OP_03_A_M1, OP_03_A_M2, OP_03_A_M3, OP_03_A_M4, OP_03_A_M5, OP_03_A_M6, OP_03_A_M7, OP_03_A_M8, OP_03_A_A9, OP_03_A_M0
	OP_04_A_M1, OP_04_A_M2, OP_04_A_M3, OP_04_A_M4, OP_04_A_M5, OP_04_A_M6, OP_04_A_M7, OP_04_A_M8, OP_04_A_A9, OP_04_A_M0
	OP_05_A_M1, OP_05_A_M2, OP_05_A_M3, OP_05_A_M4, OP_05_A_M5, OP_05_A_M6, OP_05_A_M7, OP_05_A_M8, OP_05_A_M9, OP_05_A_M0
	OP_06_A_M1, OP_06_A_M2, OP_06_A_M3, OP_06_A_M4, OP_06_A_M5, OP_06_A_M6, OP_06_A_M7, OP_06_A_M8, OP_06_A_A9, OP_06_A_M0
	OP_07_A_M1, OP_07_A_M2, OP_07_A_M3, OP_07_A_M4, OP_07_A_M5, OP_07_A_M6, OP_07_A_M7, OP_07_A_M8, OP_07_A_M9, OP_07_A_M0
	OP_08_A_M1, OP_08_A_M2, OP_08_A_M3, OP_08_A_M4, OP_08_A_M5, OP_08_A_M6, OP_08_A_M7, OP_08_A_M8, OP_08_A_M9, OP_08_A_M0
	OP_09_A_M1, OP_09_A_M2, OP_09_A_M3, OP_09_A_M4, OP_09_A_M5, OP_09_A_M6, OP_09_A_M7, OP_09_A_M8, OP_09_A_M9, OP_09_A_M0
	OP_10_A_M1, OP_10_A_M2, OP_10_A_M3, OP_10_A_M4, OP_10_A_M5, OP_10_A_M6, OP_10_A_M7, OP_10_A_M8, OP_10_A_M9, OP_10_A_M0

Operation 1–10—Procedure 1–10—Mode of Delivery (cont'd)

Definition	CCI intervention attribute designed to allow users to identify additional circumstances or conditions which may impact on the resources required to perform the intervention or the outcome expected (field repeats 10 times).
Data Type	Al/Num
Data Element Length	2
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	This field may not be required for certain procedures.
History	

1st and 2nd Special Care Unit

Name in Database	SCU_1, SCU_2
Definition	Special Care Units to which the patient was admitted (field repeats 5 times).
Data Type	Integer
Data Element Length	1
Field Values	1—Surgical ICU 2—Pediatric ICU 3—Neuro ICU 4—Burn ICU 5—Stepdown/Observation Unit 6—ICU 7—Other I—Inappropriate
Constraints	1–7, I
Source	Direct data entry
Hierarchy	
Additional Information	Enter "I" if patient was not admitted to a special care unit. Although the field repeats five times, only the first two are mandatory and should be transmitted to the OTR.
History	

Special Care Unit 1–2—Date Admitted

Name in Database	SCU_1A_D_M, SCU_1A_D_D, SCU_1A_D_Y—SCU_2A_D_M, SCU_2A_D_D, SCU_2A_D_Y
Definition	Dates of admission to the special care units (field repeats 5 times).
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	Enter the date the patient was admitted to the Special Care Unit. This field will be skipped if the Special Care Unit field (SCU_1-SCU_5) is "I."
History	

Special Care Unit 1–2—Date Discharged

Name in Database	SCU_1D_D_M, SCU_1D_D_D, SCU_1D_D_Y—SCU_5D_D_M, SCU_5D_D_D, SCU_5D_D_Y
Definition	Dates of discharge from the special care units.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	Enter the date the patient was discharged from the Special Care Unit. This field will be skipped if the Special Care Unit field (SCU_1-SCU_2) is "I."
History	

Special Care Unit 1–2—Length of Stay (in Days)

Name in Database	SCU_LOS_1, SCU_LOS_2
Definition	Length of stay for the special care unit is a calculated field based on the dates of admission and discharge from that unit.
Data Type	Integer
Data Element Length	3
Field Values	> = 1 I—Inappropriate
Constraints	1–999, I
Source	software-generated
Hierarchy	
Additional Information	Length of stay will be displayed on the screen when admission and discharge dates are entered for each service.
History	

As of April 1, 1998 hospitals are no longer required to collect 3rd, 4th, and 5th Special Care Unit information, but may do so as required by their institution.

See Appendix D for history.

Section 7: Anatomical Diagnoses

AIS 2005—Anatomical Diagnosis—Injury Text

Name in Database	I_INJ_TXT
Definition	Free text of anatomical diagnosis.
Data Type	Memo
Data Element Length	1750
Field Values	Text
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	Tri-Code software uses this text to generate AIS codes and calculate the Injury Severity Score (ISS).
History	

2005 AIS—Version Number

Name in Database	I_AIS_VER
Definition	Version of AIS
Data Type	Integer
Data Element Length	2
Field Values	05
Constraints	05
Source	software-generated
Hierarchy	
Additional Information	This field only comes up when manual coding is done, and is auto-generated by the software to reflect the version of AIS associated with the accompanying codes.
History	

AIS 2005—ICD-10 Injury Code

Name in Database	I_ICD9_01 I_ICD9_02 I_ICD9_03 I_ICD9_04 I_ICD9_05 I_ICD9_06 I_ICD9_07 I_ICD9_08 I_ICD9_09 I_ICD9_10 I_ICD9_11 I_ICD9_12 I_ICD9_13 I_ICD9_14 I_ICD9_15 I_ICD9_16 I_ICD9_17 I_ICD9_18 I_ICD9_19 I_ICD9_20 I_ICD9_21 I_ICD9_21 I_ICD9_22 I_ICD9_23 I_ICD9_24 I_ICD9_25 I_ICD9_26 I_ICD9_27
Definition	ICD-10-CA diagnosis codes that reflect the patient's injuries.
Data Type	Al/Num
Data Element Length	6
Field Values	All ICD-10-CA codes in the range S to T
Constraints	Limited to S and T codes in the appropriate ICD-10-CA manual or folio
Source	Direct data entry or software-generated

Hierarchy	1. Composite of
	  a. Medical progress reports
	  b. Radiology reports
	  c. Operative reports
	  d. Autopsy reports
	 2. Discharge summary
	 3. ED physician notes

Additional Information	The decimal point should not be included. Up to 27 codes can be reported per patient record; field therefore recurs 27 times.
History	

AIS 2005—AIS Code

Name in Database	I_AIS_01 I_AIS_02 I_AIS_03 I_AIS_04 I_AIS_05 I_AIS_06 I_AIS_07 I_AIS_08 I_AIS_09 I_AIS_10 I_AIS_11 I_AIS_12 I_AIS_13 I_AIS_14 I_AIS_15 I_AIS_16 I_AIS_17 I_AIS_18 I_AIS_19 I_AIS_20 I_AIS_21 I_AIS_22 I_AIS_23 I_AIS_24 I_AIS_25 I_AIS_26 I_AIS_27
Definition	Abbreviated Injury Scale (AIS) 2005 (update 2008) AIS code and body region assigned for each injury description.
Data Type	Integer
Data Element Length	2
Field Values	1st digit: severity 2nd digit: body region
Constraints	11–99
Source	Direct data entry or software-generated from injury text or ICD codes.
Hierarchy	Injuries as described in the medical record and supporting documentation: 1. Trauma physician notes 2. Operative notes 3. Radiology reports 4. Autopsy reports 5. Medical progress notes
Additional Information	The first digit of the AIS code represents severity ranging from 1 (minor) to 6 (maximum) with 9 representing unknown severity. The second digit designates body region. A complete description of body regions can be found in the AIS Dictionary.
History	The AIS was originally developed to be used by crash investigators to standardize data on the frequency and severity of motor vehicle related injuries.

AIS 2005—AIS Predot Code Field

Name in Database	I_PDOT_01 I_PDOT_02 I_PDOT_03 I_PDOT_04 I_PDOT_05 I_PDOT_06 I_PDOT_07 I_PDOT_08 I_PDOT_09 I_PDOT_10 I_PDOT_11 I_PDOT_12 I_PDOT_13 I_PDOT_14 I_PDOT_15 I_PDOT_16 I_PDOT_17 I_PDOT_18 I_PDOT_19 I_PDOT_20 I_PDOT_21 I_PDOT_22 I_PDOT_23 I_PDOT_24 I_PDOT_25 I_PDOT_26 I_PDOT_27
Definition	Abbreviated Injury Scale (AIS) 2005 (update 2008) predot codes that describe all injuries.
Data Type	Integer
Data Element Length	6
Field Values	Valid AIS code
Constraints	010000–916000
Source	Direct data entry or software-generated coding from injury text or ICD codes.
Hierarchy	Injuries as described in the medical record and supporting documentation: 1. Trauma physician notes 2. Operative notes 3. Radiology reports 4. Autopsy reports 5. Medical progress notes
Additional Information	Refer to AIS dictionary for the detailed descriptions of the AIS predot codes.
History	

AIS 2005—ISS

Name in Database	DISP_ISS_2005
Definition	The ISS is a calculated field based on the injury descriptions entered above. The ISS is the sum of the squares of the highest AIS code in each of the three most severely injured ISS body regions. ISS ranges from 1 to 75.
Data Type	Integer
Data Element Length	2
Field Values	1–75
Constraints	1–75
Source	software-generated
Hierarchy	
Additional Information	The six body regions of injuries used in the ISS are: 1. Head or neck 2. Face 3. Chest 4. Abdominal or pelvic contents 5. Extremities or pelvic girdle 6. External
History	

AIS 2005—TRISS

Name in Database	DISP_TRISS_2005
Definition	TRISS is a calculated field based on the first recorded set of vital signs at the lead/trauma hospital.
Data Type	Float
Data Element Length	5
Field Values	
Constraints	
Source	software-generated
Hierarchy	
Additional Information	Because of the nature of this calculation in Collector, if TRISS cannot be calculated due to missing data the data element will appear blank on the screen.

TRISS combines both physiologic and anatomic indices to characterize severity of injury and estimate patient survival probability (Ps). The physiologic index is the RTS as assessed at emergency department admission. The RTS is a weighted sum of coded values (0-4) of the Glasgow Coma Scale (GCS), systolic blood pressure (SBP) and respiratory rate (RR).

TRISS combines these physiologic and anatomic measures to estimate survival probability as follows:

PS=1/(1+e to the minus b) where b=b0 + b1(RTS) + b2(ISS) + b3(age) Age=0 for age <55 years and age=1 for age >=55 years.

The "b"s are regression weights that differ for blunt and penetrating injury. |
| **History** | |

AIS 2005—MAIS

Name in Database	MAX_AIS_2005_BR_1 MAX_AIS_2005_BR_2 MAX_AIS_2005_BR_3 MAX_AIS_2005_BR_4 MAX_AIS_2005_BR_5 MAX_AIS_2005_BR_6 MAX_SEV_AIS_2005_BR1 MAX_ SEV_AIS_2005_BR2 MAX_ SEV_AIS_2005_BR3 MAX_SEV_AIS_2005_BR4 MAX_ SEV_AIS_2005_BR5 MAX_ SEV_AIS_2005_BR6
Definition	MAIS (Maximum Abbreviated Injury Score) is a calculated field based on the highest AIS recorded for each body region.
Data Type	Integer
Data Element Length	11
Field Values	
Constraints	
Source	software-generated
Hierarchy	
Additional Information	
History	

Comorbid Diagnosis

Name in Database	CO_MORB_01 CO_MORB_02 CO_MORB_03 CO_MORB_04 CO_MORB_05 CO_MORB_06 CO_MORB_07 CO_MORB_08 CO_MORB_09 CO_MORB_10
Definition	A condition present at the beginning of hospital observation and/or treatment that may or may not have a significant influence on the patient's hospitalization (LOS) and/or significantly influence the management or treatment of the patient.
Data Type	Float
Data Element Length	7
Field Values	Valid ICD-10 codes for comorbidities
Constraints	Valid ICD-10 codes for comorbidities
Source	Direct data entry
Hierarchy	
Additional Information	Enter any comorbid conditions from the list, regardless of condition influence on LOS or treatment. Up to 10 comorbidities can be accepted per patient record; field therefore recurs 10 times. See Appendix H for definitions of comorbid conditions. Provinces have the ability to collect additional comorbid conditions but must collect those listed in Appendix H at a minimum. Comorbidity data may be captured using data element, which has comorbidities listed in a drop-down menu, as an alternative to this data element, which captures comorbidities as ICD-10 codes. External Cause of Morbidity and Mortality may be entered as comorbidities. Z Codes are also valid entries for comorbidities provided they meet the OTR CDS definition of a comorbidity.
History	

Comorbid Diagnosis (NTR Codes)

Name in Database	CMB_NTR_01 CMB_NTR_02 CMB_NTR_03 CMB_NTR_04 CMB_NTR_05 CMB_NTR_06 CMB_NTR_07 CMB_NTR_08 CMB_NTR_09 CMB_NTR_10
Definition	A condition present at the beginning of hospital observation and/or treatment that may or may not have a significant influence on the patient's hospitalization (LOS) and/or significantly influence the management or treatment of the patient.
Data Type	Integer
Data Element Length	2
Field Values	01—No NTR/OTR comorbidities are present 02—Alcoholism 03—Ascites within 30 days 04—Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder 05—Autism/Asperger's 06—Bleeding disorder 07—Chemotherapy for cancer within 30 days 08—Cirrhosis 09—Congenital anomalies 10—Congestive heart failure 11—Current smoker 12—Currently requiring or on dialysis 13—CVA/residual neurological deficit 14—Diabetes mellitus 15—Disseminated cancer 16—Do not resuscitate (DNR) status 17—Drug use 18—Esophageal varices 19—Functionally dependent health status 20—History of angina within past one month 21—History of myocardial infarction within past six months 22—History of revascularization/amputation for PVD 23—Hypertension requiring medication 24—Impaired sensorium 25—Obesity 26—Prematurity 27—Respiratory disease 28—Steroid use
Constraints	01–28
Source	Direct data entry
Hierarchy	1. Patient history and physical 2. Medical progress notes 3. Medical consultation notes 4. Discharge summary

Comorbid Diagnosis (NTR Codes) (cont'd)

Additional Information	Enter any comorbid conditions from the approved list, regardless of condition influence on LOS or treatment. Up to 10 comorbidities can be accepted per patient record; field therefore recurs 10 times. See Appendix H for definitions of comorbid conditions.
History	

Complications

Name in Database	COMPLIC_01 COMPLIC_02 COMPLIC_03 COMPLIC_04 COMPLIC_05 COMPLIC_06 COMPLIC_07 COMPLIC_08 COMPLIC_09 COMPLIC_10
Definition	A condition arising after the beginning of hospital observation and/or treatment that usually has a significant influence on the patient's hospitalization (LOS) and/or significantly influences the management or treatment of the patient.
Data Type	Float
Data Element Length	7
Field Values	Valid ICD-10-CA codes for complications
Constraints	Valid ICD-10-CA codes for complications
Source	Direct data entry
Hierarchy	1. Medical progress notes 2. Medical consultation notes 3. Discharge summary
Additional Information	External Cause of Morbidity and Mortality may be entered as complications. Z Codes are also valid entries for complications provided they meet the OTR CDS definition of a complication.
History	

Complications (NTR Codes)

Name in Database	CMP_NTR_01 CMP_NTR_02 CMP_NTR_03 CMP_NTR_04 CMP_NTR_05 CMP_NTR_06 CMP_NTR_07 CMP_NTR_08 CMP_NTR_09 CMP_NTR_10
Definition	A condition arising after the beginning of hospital observation and/or treatment that usually has a significant influence on the patient's hospitalization (LOS) and/or significantly influences the management or treatment of the patient.
Data Type	Integer
Data Element Length	2

Complications (NTR Codes) (cont'd)

Field Values	01—No NTR/OTR-listed medical complications occurred 02—Abdominal compartment syndrome 03—Abdominal fascia left open 04—Acute renal failure 05—Acute respiratory distress syndrome (ARDS) 06—Bleeding 07—Cardiac arrest with CPR 08—Coagulopathy 09—Decubitus ulcer 10—Deep surgical site infection 11—Drug or alcohol withdrawal syndrome 12—Deep vein thrombosis (DVT)/thrombophlebitis 13—Extremity compartment syndrome 14—Graft/prosthesis/flap failure 15—Intracranial pressure elevation 16—Myocardial infarction 17—Organ space surgical site infection 18—Osteomyelitis 19—Pneumonia 20—Pulmonary embolism 21—Stroke/CVA 22—Superficial surgical site infection 23—Systemic sepsis 24—Unplanned intubation 25—Unplanned return to the ICU 26—Unplanned return to the OR 27—Urinary tract infection 28—Wound disruption
Constraints	1–28
Source	Direct data entry
Hierarchy	1. Medical progress notes 2. Medical consultation notes 3. Discharge summary
Additional Information	Up to 10 complications can be accepted per patient record; field therefore recurs 10 times. See Appendix I for definitions of complications. Provinces have the ability to collect more complications but must collect those listed in Appendix I at a minimum.
History	

Section 8: Outcome

Date of Separation

Name in Database	D_DEATH_M, D_DEATH_D, D_DEATH_Y
Definition	The date the patient was discharged from hospital or the emergency department or the date the patient died in hospital.
Data Type	Integer
Data Element Length	2, 2, 4
Field Values	Format: MMDDYYYY
Constraints	01 01 1900—Present
Source	Direct data entry
Hierarchy	Inpatient discharge and death: 1. Face sheet 2. Physician discharge order 3. Inpatient nursing notes 4. Death certificate ED visit only (alive or dead): 1. ED nursing notes 2. ED physician notes 3. Death certificate
Additional Information	The date of death should be documented as the date the patient was pronounced dead for patients who are pronounced dead and remain in an SCU or OR for some time during the day after being pronounced for the purposes of organ harvesting. The length of stay in the hospital and the SCU should also reflect the date the patient was pronounced dead. **(Working Group 03/97)**
History	

Time of Separation

Name in Database	T_DEATH_H, T_DEATH_M
Definition	The patient's time of death or discharge using the 24 hour clock.
Data Type	Integer
Data Element Length	2, 2
Field Values	Format: HHMM
Constraints	0000–2359, U
Source	Direct data entry
Hierarchy	Inpatient discharge and death: 1. Face sheet 2. Physician discharge order 3. Inpatient nursing notes 4. Death certificate ED visit only (alive or dead): 1. ED nursing notes 2. ED physician notes 3. Death certificate
Additional Information	While this field is mandatory for death cases, hospitals also have the option of completing it for patients discharged alive. Hospitals may wish to default this field to Unknown. The time of death should be documented as the time the patient was pronounced dead for patients who are pronounced dead and remain in an SCU or OR for some time during the day after being pronounced for the purposes of organ harvesting. **(Working Group 03/97)**
History	

Separation Status

Name in Database	SEP_STATUS
Definition	The status of the patient at discharge from the trauma centre.
Data Type	Integer
Data Element Length	2
Field Values	06—Discharged alive 07—Died in hospital after admission 08—Died in emergency, other than failed resuscitation attempt 09—Died after failed resuscitation attempt lasting between 5 and 15 minutes 10—DOA (declared dead on arrival) less than 5 minutes after presentation/resuscitation efforts or no resuscitation attempt
Constraints	6–10
Source	Direct data entry
Hierarchy	Inpatient discharge and death: 1. Face sheet 2. Physician discharge order 3. Inpatient nursing notes 4. Death certificate ED visit only (alive or dead): 1. ED nursing notes 2. ED physician notes 3. Trauma flow sheet 4. Death certificate
Additional Information	Enter *6* if the patient is discharged alive. Enter *7* if the patient dies after admission to the hospital. Enter *8* if the patient dies in the ED but resuscitation attempts take longer than 15 minutes or patient decompensates after arrival and expires. Enter *9* if the patient presents vital signs absent (VSA) and is pronounced after resuscitation attempts lasting between 5 and 15 minutes. Enter *10* if the patient presents VSA and has less than 5 minutes of resuscitation attempts or no resuscitation efforts.
History	As of April 1, 2012, valid values have been expanded to include 10

Live Die Status

Name in Database	DIS_STATUS
Definition	The status of the patient at discharge from the trauma centre.
Data Type	Integer
Data Element Length	1
Field Values	6—Alive 7—Dead
Constraints	6, 7
Source	Default from Sep_status
Hierarchy	Inpatient discharge and death: 1. Face sheet 2. Physician discharge order 3. Inpatient nursing notes 4. Death certificate ED visit only (alive or dead): 1. ED nursing notes 2. ED physician notes 3. Trauma flow sheet 4. Death certificate
Additional Information	This field will be defaulted from Sep_status field: If Sep_status is entered as "6," Dis_status will be defaulted to "6"; If Sep_status is entered as either "7", "8", "9" or "10", dos_status will default to "7."
History	

Length of Stay at Lead/Trauma Hospital

Name in Database	LTR_LOS
Definition	Length of stay at the lead/trauma hospital is a calculated field which will be displayed on the screen and is based on admission and separation dates at the lead/trauma hospital.
Data Type	Integer
Data Element Length	3
Field Values	Valid LOS number
Constraints	1–999
Source	software-generated
Hierarchy	1. Inpatient nursing notes 2. Medical progress notes 3. Physician orders 4. Discharge summary
Additional Information	The date of admission is not counted in the calculation. The discharge date should be from your lead/trauma hospital only. A patient who is admitted and discharged on the same day will have a LOS of 1 day. A patient who is admitted on one day and discharged the next day will have a LOS of 1 day.
History	

Disposition

Name in Database	DSCHG_TO
Definition	The location to which the patient is discharged or the service arranged for the patient immediately upon discharge from hospital.
Data Type	Integer
Data Element Length	2
Field Values	01—Home 02—Home with Support Services 03—Another Acute Care Facility 04—General Rehabilitation Facility 05—Chronic Care Facility 06—Nursing Home 07—Special Rehabilitation Facility 08—Foster Care/Children's Aid 09—Other 10—Died
Constraints	1–10
Source	Direct data entry
Hierarchy	1. Inpatient nursing notes 2. Medical progress notes 3. Physician orders 4. Discharge summary

Disposition (cont'd)

Additional Information	Definitions of Discharge Disposition Institutions:
	
	1. Home—no support service from an external agency required; patient functions independently; use for patients leaving against medical advice
	
	2. Home with support services—senior's lodge, attendant care, home care, meals on wheels, homemaking, supportive housing, etc.
	
	Examples:
	
	   a. A facility where supervisory care is not required on a continuing basis. The patient is discharged and able to function independently within a group setting. Community services would be brought in to provide support, when necessary.
	
	   b. The patient is discharged home with the support of home care workers who are providing daily dressing changes and wound care.
	
	3. Another acute care facility: patient is transferred to an acute care inpatient institution (includes other acute, subacute, acute psychiatric, acute rehabilitation, acute cancer, acute pediatric, etc.)
	
	4. General rehabilitation facility—a rehabilitation unit or collection of beds designated for rehabilitation purposes that is part of a general hospital offering multiple levels or types of care
	
	5. Chronic care facility—patient is discharged to a reporting facility that provides continuing medical care by medical and allied medical staff
	
	6. Nursing home—patient receives support services at some level
	
	7. Special rehabilitation facility—a facility that may provide extensive and specialized inpatient rehabilitation services; commonly a free-standing facility or a specialized unit within a hospital
	
	8. Foster care and/or children's aid
	
	9. Other
	
	10. Died

History	Effective April 1, 2012, change in data element allowable field values April 1, 2014: Clarification that Home should be used for patients leaving against medical advice.

Disposition—If Other

Name in Database	DSCHG_TO_O
Definition	Specify if "other" was entered in the previous menu.
Data Type	Text
Data Element Length	39
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	This field will be skipped unless "other was selected in the previous menu.
History	

If Home With Support Services

Name in Database	DIS_HSS_1 DIS_HSS_2 DIS_HSS_3 DIS_HSS_4 DIS_HSS_5
Definition	Support services are additional care offered in the patient's home following discharge from the lead/trauma hospital.
Data Type	Integer
Data Element Length	1
Field Values	1—Home Care 2—Outpatient Rehabilitation 3—Community Services 4—Special Education 5—Other I—Inappropriate
Constraints	1–5, I
Source	Direct data entry
Hierarchy	1. Inpatient nursing notes 2. Medical progress notes 3. Physician orders 4. Discharge summary
Additional Information	Outpatient rehabilitation includes clinic visits but not treatment in the patient's home. Community services include WheelTrans, Meals on Wheels and associations or support groups. Special education would include tutors at home or school.
History	

If Home With Support Services—If Other

Name in Database	DIS_HSS_O
Definition	Specify if "other" entered in the previous menu.
Data Type	Text
Data Element Length	20
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	This field will be skipped unless "other" was selected in the previous menu.
History	

Institution Number

Name in Database	DIS_INST
Definition	The institution number of a facility to which the patient was discharged.
Data Type	Integer
Data Element Length	4
Field Values	Institution numbers as assigned by the Ministry of Health
Constraints	0000–9999
Source	This field has a hospital defined menu.
Hierarchy	
Additional Information	The following is a link to the April 1, 2012 Ministry of Health and Long-Term Care Master Numbering System. http://www.health.gov.on.ca/en/common/ministry/publications/reports/master_numsys/master_numsys.aspx This field is only entered for patients who are transferred to another facility (i.e. menu items 03-07 in the Disposition field).
History	

Outside of Ontario

Name in Database	DIS_NO_ONT
Definition	Enter the name of the institution in a province other than Ontario to which the patient was transferred.
Data Type	Text
Data Element Length	40
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	
History	

Outside of Canada

Name in Database	DIS_NO_CAN
Definition	Enter the name of the institution outside of Canada to which the patient was transferred.
Data Type	Text
Data Element Length	40
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	Hospitals should document the receiving institution number as 9991. (World Remainder, All Health Facilities) when the patient is transferred to a hospital outside of Canada. **(Working Group 03/97, 07/99)**
History	

Glasgow Outcome Scale

Name in Database	GOS
Definition	Glasgow Outcome Scale at time of discharge
Data Type	Integer
Data Element Length	1
Field Values	1—Death 2—Persistent vegetative state 3—Severe disability (conscious but disabled) 4—Moderate disability (disabled but independent) 5—Good recovery I—Inappropriate U—Unknown
Constraints	1–5, U, I
Source	Direct data entry
Hierarchy	
Additional Information	The Glasgow Outcome Scale is an outcome measure to be calculated within 72 hours of discharge (regardless of the date ready for discharge) from the hospital on patients with a head injury AIS>2. The FIM® team or neurosurgeons should calculate the Glasgow Outcome Scale. GOS should not be calculated from documentation available on the chart. Enter "I" if the patient is not a head injured patient AIS>2 or if patient is <6 months of age. Descriptions of each field value: **Death**—As a direct result of brain trauma patient regained consciousness, died thereafter from secondary complications or other causes. **Persistent Vegetative**—Patient remains unresponsive and speechless for an extended period of time. He may open his eyes and show sleep/wake cycles, but shows an absence of function in the cerebral cortex as judged behaviourally, no evidence of psychologically meaningful responsiveness. **Severe Disability**—Patient needs assistance for some activities of daily living every day. May range from continuous total dependency to need for assistance with any one major activity. More often dependency is due to combination of physical and mental disability, but severe mental disability may occasionally justify this classification in a patient with little or no physical disability.

Glasgow Outcome Scale (cont'd)

Additional Information (cont'd)	**Moderate Disability—**Some previous activities, either work or social life are no longer possible by reason of either mental or physical deficits. Can travel by public transport and work in a sheltered environment and can therefore be independent insofar as daily life is concerned. The disabilities found include varying degrees of dysphasia, hemiparesis, or ataxia, as well as intellectual and memory deficits and personality change. Independence is greater than simple ability to maintain self-care within the patient's home. **Good Recovery—**Capacity to resume normal occupational and social activities, although there may be minor physical or mental deficits. May not have resumed all previous activities.
History	

RANCHOS at Discharge

Name in Database	RANCHOS_D
Definition	The RANCHOS at time of discharge
Data Type	Integer
Data Element Length	1
Field Values	1—No Response 2—Generalized Response 3—Localized Response 4—Confused, Agitated 5—Confused, Inappropriate, Non-agitated 6—Confused, Appropriate 7—Automatic, Appropriate 8—Purposeful and Appropriate U—Unknown I—Inappropriate
Constraints	1–8, U, I
Source	Direct data entry
Hierarchy	

(cont'd on next page)

RANCHOS at Discharge (cont'd)

Additional Information	RANCHOS is an outcome measure to be calculated within 72 hours of discharge (regardless of the date ready for discharge) from the hospital on patients who sustain a head injury AIS>2. RANCHOS should not be calculated from documentation available on the chart. Enter "I" if the patient has died or is not a head injured patient AIS>2 or if the patient is <6 months of age. Descriptions of each field value: **No Response**—The patient appears to be in a very deep sleep or coma and does not respond to voices, sounds, light or touch. Generalized—The patient demonstrates vague, generalized reactions, moves around, but movement does not seem to have a purpose or consistency. Patients may open their eyes but do not seem to focus on anything in particular, may make some sounds, or react with grimaces or generalized discomfort to pain. **Localized**—Patients begin to move their eyes and look at specific people and objects. They turn their heads in the direction of loud voices or noise. Patients at Level 3 may follow a simple command, such as "squeeze my hand." If pain is inflicted, only the affected arm or leg is pulled away. Restraints, NG tubes or catheters may be pulled at or out as a reaction to moving a source of discomfort. How patients respond is predictable, but they do not respond every time. **Confused/Agitated**—The patient is very confused and agitated about where he or she is and what is happening in the surroundings. At the slightest provocation, the patient may become very restless, aggressive, or verbally abusive. The patient may scream, cry out, hit, flail around in bed, remove restraints or tubes and crawl out of bed. The patient may enter into incoherent conversation. **Confused/Inappropriate**/**Non-agitated**—The patient is confused and does not make sense in conversations but may be able to follow simple directions. Stressful situations may provoke some upset, but agitation is no longer a major problem. Patients may experience some frustration as elements of memory return. **Confused/Appropriate**—The patient's speech makes sense, and he or she is able to do simple things such as getting dressed, eating and teeth brushing. Although patients know how to perform a specific activity, they need help in discerning when to start and stop. Learning new things may also be difficult. Memory begins to improve, but is usually patchy.

RANCHOS at Discharge (cont'd)

Additional Information (cont'd)	**Automatic/Appropriate—**Patients can perform all self-care activities and are usually coherent. They have difficulty remembering recent events and discussions. Rational judgements, calculations and solving multi-step problems present difficulties, yet patients may not seem to realize this. Understanding or rapid social interchanges or jokes may be significantly limited, with misinterpretation of others behaviour and conversation. **Purposeful and Appropriate—**At this level, patients are independent and can process new appropriate information. They remember distant and recent events and can figure out complex and simple problems.
History	

Was ALC Form Completed?

Name in Database	ALC_FORM_Y
Definition	Was Alternate Level of Care (ALC) form completed?
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No
Constraints	1, 2
Source	Direct Data Entry
Hierarchy	
Additional Information	An ALC form is typically completed indicating that a patient is awaiting discharge in an acute care facility. A patient may be designated as Alternative Level of Care (ALC) while remaining in acute care hospital awaiting discharge to an appropriate facility or services such as Home Care. ALC requires a form or physician order be completed to indicate that the patient is awaiting discharge to a non-acute care bed.
History	

Date Ready for ALC

Name in Database	ALC_DATE_M, ALC_DATE_D, ALC_DATE_Y
Definition	The date the patient was ready for an Alternate Level of Care.
Data Type	Integer
Data Element Length	2 ,2, 4
Field Values	Format: MMDDYYYY, I, U
Constraints	01 01 1900—Present, I, U
Source	Direct Data Entry
Hierarchy	
Additional Information	Enter "I" if an ALC form was not completed. Hospitals may wish to default this field to inappropriate. Note: If the patient was ready for discharge on two different dates, enter the latest one (i.e. the one which gives the greatest number of ALC days).
History	

Reasons for ALC Days 1–3

Name in Database	ALC_REAS_1 ALC_REAS_2 ALC_REAS_3
Definition	The reason for Alternate Level of Care (ALC) days.
Data Type	Integer
Data Element Length	1
Field Values	1—Lack of available beds 2—Lack of available services (i.e. lack of home care, equipment etc.) 3—Other I—Inappropriate
Constraints	1–3, I
Source	Direct Data Entry
Hierarchy	
Additional Information	Enter "I" if ALC was not ordered. Hospitals may wish to default this field to inappropriate.
History	

Reasons for ALC Days—Other

Name in Database	ALC_REAS_O
Definition	If "other" entered in the previous field.
Data Type	Text
Data Element Length	15
Field Values	
Constraints	
Source	Direct Data Entry
Hierarchy	
Additional Information	This field will be skipped if "other" was not selected in the previous field.
History	

Number of ALC Days

Name in Database	ALC_DAYS
Definition	The number of Alternate Level of Care (ALC) days is calculated based on the date the patient is ready for ALC and the date of discharge.
Data Type	Integer
Data Element Length	3
Field Values	0–999
Constraints	Valid ALC days
Source	Direct Data Entry
Hierarchy	
Additional Information	This field will be skipped if "other" was not selected in the previous field.
History	

Place of Death

Name in Database	LOC_DEATH
Definition	The location of the patient's death.
Data Type	Integer
Data Element Length	1
Field Values	1—ED 2—OR/Recovery Room 3—Special Care Unit (Nurse: Patient ratio is 1:2) 4—Ward 5—Other
Constraints	1–5
Source	Direct Data Entry
Hierarchy	
Additional Information	Enter the location of the patient when he/she died.
History	

Place of Death—If Other

Name in Database	LOC_DEATHO
Definition	If "other" entered in the previous field.
Data Type	Text
Data Element Length	20
Field Values	
Constraints	
Source	Direct Data Entry
Hierarchy	
Additional Information	This field will be skipped unless "other" was entered in the previous field.
History	

If SCU, Specify

Name in Database	SCU
Definition	The special care unit (normal patient: nurse ratio is 2:1) where death occurred.
Data Type	Integer
Data Element Length	1
Field Values	1—Surgical ICU 2—Pediatric ICU 3—Neuro ICU 4—Burn ICU 5—Stepdown Unit/Observation Unit 6—ICU 7—Other
Constraints	1–7
Source	Direct data entry
Hierarchy	
Additional Information	All menu options are available, however CIHI will only report on Stepdown/Observation Unit, Other and ICU (specific ICUs will be grouped under ICU). Institutions with multiple ICUs may use specific ICU options for their own purposes. **(TRAC 05/05)**
History	

If SCU—Other

Name in Database	SCU_O
Definition	If "other" entered in the previous field.
Data Type	Text
Data Element Length	20
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	This field will be skipped unless "other" was entered in the previous field.
History	

Was Post-Mortem Report Received?

Name in Database	AUTOPSY_R
Definition	Was a Post-Mortem report received (if post-mortem done)?
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No
Constraints	1, 2
Source	Direct Data Entry
Hierarchy	
Additional Information	
History	

Was Patient/Patient's Family Approached About Organ or Tissue Donation?

Name in Database	ORGAN_ASK
Definition	Was the patient or patient's family asked about organ or tissue donation?
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No U—Unknown
Constraints	1, 2, U
Source	Direct Data Entry
Hierarchy	
Additional Information	
History	

Were Organs or Tissue Donated?

Name in Database	ORGAN_DNR
Definition	Was the patient an organ or tissue donor?
Data Type	Integer
Data Element Length	1
Field Values	1—Yes 2—No U—Unknown
Constraints	1, 2, U
Source	Direct Data Entry
Hierarchy	
Additional Information	This field will be skipped unless "yes" was entered in the previous field.
History	

Section 9: Readmission Related to Original Admission

Number of Readmissions

Name in Database	NUM_READ
Definition	The number of times the patient has been admitted to the institution for reasons related to the original incident.
Data Type	Integer
Data Element Length	2
Field Values	
Constraints	
Source	Direct data entry
Hierarchy	
Additional Information	For patients who have died, enter "I" to skip. Hospitals may wish to default this field to inappropriate. Lead/trauma hospitals should only document the number of readmissions as of April 1, 1995. Readmission data will be reported on centrally using the Minimal Data Set. A readmission is an inpatient admission of a patient previously admitted with an ISS>=12 or trauma team activation who has a subsequent unplanned or unscheduled urgent/emergent admission to the same lead/trauma hospital related to the original trauma admission.
History	As of April 1, 2014, addition of urgent/emergency clarification to definition.

Appendices

Appendix A: Abbreviations

Abbreviation	Full name
AIS	Abbreviated Injury Scale
ALC	Alternative Level of Care
BAC	Blood Alcohol Concentration
CAS	Children's Aid Society
CDS	Comprehensive Data Set
CIHI	Canadian Institute for Health Information
CPAP	Continuous Positive Airway Pressure
CPR	Cardio-Pulmonary Resuscitation
CSF	Cerebrospinal Fluid
CT	Computerized Tomography
DAD	Discharge Abstract Database
DIE	Died in Emergency Department
DOA	Dead on Arrival at Hospital
ED	Emergency Department
EMS	Emergency Medical Service
FIM®®	Functional Independence Measure
GCS	Glasgow Coma Scale
GOS	Glasgow Outcome Scale
ICD	International Classification of Diseases
ICP	Intracranial Pressure
ICU	Intensive Care Unit
ISS	Injury Severity Score
LOS	Length of Stay
MAIS	Maximum Abbreviated Injury Scale
MVAR	Motor Vehicle Accident Report
OR	Operating Room
OTR	Ontario Trauma Registry
PTS	Pediatric Trauma Score
RANCHOS	Rancho Los Amigos Scale
RTS	Revised Trauma Score
SCU	Special Care Unit
TRISS	Trauma Injury Severity Score
TTA	Trauma Team Activation
TTL	Trauma Team Leader
UTM	Universal Transverse Mercator
VSA	Vital Signs Absent

Appendix B: Definition of Trauma

External Cause of Injury Codes—Inclusions

ICD-10-CA Code	Definition
V01–V99	Transport incidents
V01–V06, V09–V90	Land transport incidents
V91–V94	Water transport incidents
V95–V97	Air and space transport incidents
V98, V99	Other and unspecified transport incidents
W00–W19	Unintentional falls
W20–W44, W45.09, W46, W49	Exposure to inanimate mechanical forces
W50–W60, W64	Exposure to animate mechanical forces
W65–W70, W73, W74	Unintentional drowning and submersion
W75–W77, W81, W83, W84	Other unintentional threats to breathing except due to inhalation of gastric contents, food or other objects
W85–W94, W99	Exposure to electric current, radiation and extreme ambient air temperature and pressure
X00–X06, X08, X09	Exposure to smoke, fire and flames
X10–X19	Contact with heat and hot substances
X30–X39	Exposure to forces of nature
X50	Overexertion and strenuous or repetitive movements
X52	Prolonged stay in weightless environment
X58, X59	Unintentional exposure to other and unspecified factors
X70–X84	Intentional self-harm, excluding poisoning
X86, X91–X99, Y00–Y05, Y07–Y09	Assault, excluding poisoning
Y20–Y34	Event of undetermined intent, excluding poisoning
Y35, Y36	Legal intervention and operations of war

Historical changes due to updates to ICD-10-CA:

- Addition of W46: Contact with hypodermic needle (this was added in the 2009 version of ICD-10-CA)
- W45.00 (previous definition was Foreign body or object entering through skin. This was split into 2 codes in the 2012 version:
    - W45.00 Voluntary body piercing: **Excluded** from trauma definition
    - W45.09 Foreign body or object entering through skin: **Included** in trauma definition

External Cause of Injury Codes—Exclusions

ICD-10-CA Code	Definition
W45.00	Voluntary body piercing
W78–W80	W78 Inhalation of gastric contents; W79 Inhalation and ingestion of food causing obstruction of respiratory tract; W80 Inhalation and ingestion of other objects causing obstruction of respiratory tract
X20–X29	Contact with venomous animals and plants
X40–X49	Unintentional poisoning and exposure to noxious substances
X51	Travel and motion
X53, X54, X57, Y06	X53 Lack of food; X54 Lack of water; X57 Unspecified privation; Y06 Neglect and abandonment
X60–X69	Intentional self-harm by poisoning
X85, X87–X90	Assault by poisoning
Y10–Y19	Poisoning of undetermined intent
Y40–Y59	Drugs, medicaments and biological substances causing adverse effects in therapeutic use
Y60–Y69	Misadventures to patients during surgical and medical care
Y70–Y82	Medical devices associated with adverse incidents in diagnostic and therapeutic use
Y83, Y84	Surgical and other medical procedures as the cause of abnormal reaction of the patient; or of later complication, without mention of misadventure at the time of the procedures
Y85–Y89	Sequelae of external causes of morbidity and mortality
Y90–Y98	Supplementary factors related to causes of morbidity and mortality classified elsewhere

Appendix C: List of Data Elements by Screen

Below is a list of data elements by screen, as of April 1, 2012.

Mandatory elements are those to be submitted to the OTR CDS. Excluded data elements may have been part of the OTR CDS at some point, but are no longer part of the data to be submitted. Facilities may choose to continue collecting them for their own purposes. These are optional and are referred to as "excluded" in the data dictionary.

Section 1: Demographic Data

Screen F1.1

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable/ if Known)
Institution Number		6	M	
Trauma Number		6	M	
Trauma Number	Fraction	6	M	
Is this a readmission?		7	M	
Demographic Data	Overflow	215	E	
Health Number	Ontario Health Number	8	M	
	Ontario Health Number—Version	9	M	
	Other Health Number	9	M	
Campus Number		10	M	
Chart Number		10	M	
Patient—Residence	If Not Ontario	11	M	
	If Other	12	M	
Patient	Last Name	215	E	
	First Name	215	E	
	Middle Name	215	E	
Date of Birth	Month	12	M	
	Day	12	M	
	Year	12	M	
Age Type	(Raw)	13	M	
	(Type)	14	M	
Patient	Sex	14	M	
Height		215	E	
Weight		15	M	

Screen F1.2

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Occupation		15	M	
Patient	Occupation—If Other	17	E	
	Language Spoken	216	E	
	Language Spoken— Other	216	E	
	Province	18	E	
	City	17	M	
	Province	18	M	
	Province—Other	19	M	
Home Address	Country	19	M	
Patient	Country—If Other	20	M	
	Postal Code	20	M	
	Other Country Postal Code	21	M	
Home	Phone 1	216	E	
	Phone 2	216	E	
	Phone 3	216	E	
Patient	Residence Code	21	M	

Screen F1.3

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Relative	Last Name	216	E	
	First Name	217	E	
	Middle Initial	217	E	
	Relationship to Patient	217	E	
	Other Relationship to Patient	217	E	
	Language Spoken	217	E	
	Language Spoken— If Other	218	E	
	Province	218	E	
	City	218	E	
	State	218	E	
	Province—If Other	218	E	
	Country	219	E	
	Country—If Other	219	E	
	Postal Code	219	E	
	Other Country Postal Code	219	E	

Screen F1.4

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Demographic Memo	Memo Field	219	E	

Screen F1.5

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Field 1-9	220	E	

Screen F1.6

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Field 10-18	220	E	

Section 2: Injury Data

Screen F2.1

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Injury Date	Month	22	M	
	Day	22	M	
	Year	22	M	
	Hour	23	M	
	Minute	23	M	
Incident Date and Time	Approximation	24	M	
ICD-9 Primary Cause of Injury		220	E	
ICD-10 Primary Cause of Injury		25	M	
ICD-9 Secondary Cause of Injury		220	E	
ICD-10 Secondary Cause of Injury		221	E	
ICD-9 Tertiary Cause of Injury		221	E	
ICD-10 Tertiary Cause of Injury		221	M	
Causes of Injury	Specify	27	M	
Sports and Recreational Activity Code		27	M	
	Specify	28	M	
ICD-10 Primary Place of Injury		28	M	
ICD-10 Secondary Place of Injury		221	E	
ICD-10 Tertiary Place of Injury		221	E	
Place of Injury	Specify	29	M	
Primary Injury Type		29	M	
Work-Related Injury		31	M	
Intentional Injury		32	M	
Extrication Required		33	M	
Extrication Time Required in Minutes		33	M	

Screen F2.2

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Accident Number		34	M	
Police Force		35	M	
Police Force Division		35	M	
Vehicle Type		36	M	
Vehicle Type	If Other	39	M	
Protective Device	1	38	M	
	2	38	M	
	3	38	M	
	4	38	M	
	If Other	39	M	
Ejected from Vehicle		40	M	
	Distance Ejected (Metres)	41	M	

Screen F2.3

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Location of Vehicle Impact	Primary	42	M	
	Secondary	43	M	
Impact Type		44	M	
Collision Detail	1	45	M	
	2	46	M	

Screen F2.4

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Position in Vehicle	LAP	48	M	
Position in Vehicle		47	M	

Screen F2.5

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Injury Memo—Memo Field		221	E	

Section 3: Scene Data

Screen F3.1

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Institution Number—Primary		49	M	
Institution Number	1st Secondary	50	M	
	2nd Secondary	50	M	
Institution Number— Lead Trauma		50	M	
Geocode of Incident Location		51	M	
Incident Location	If Out of Province	52	M	
	If Other	53	M	

Screen F3.2

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Scene Transport Mode/ Service 1 through 3	Transport Mode 1-3	54	M	
	Transport Service 1-3	55	M	
	Run Sheet Available 1-3	55	M	
	Scene Pre-hospital Number 1-3	56	M	
	Basic Life Support 1-3	56	M	
	Advanced Life Support 1-3	56	M	
	Qualified Personnel—RN 1-3	56	M	
	Qualified Personnel—RT 1-3	56	M	
	MD—1-3	56	M	
	Critical Care Transport team 1-3	56	M	
	Transport Mode/ Service—Unknown 1-3	56	M	
	Qualified Personnel Unknown 1-3	56	M	

Screen F3.3

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Date Call Received	Month	58	M	
	Day	58	M	
	Year	58	M	
Time Call Received	Hour	58	M	
	Minute	58	M	
Date Dispatched	Month	59	M	
	Day	59	M	
	Year	59	M	
Time Dispatched	Hour	59	M	
	Minute	59	M	
Date Arrived at Scene	Month	60	M	
	Day	60	M	
	Year	60	M	
Time Arrived at Scene	Hour	60	M	
	Minute	60	M	
Date Arrived at Patient	Month	61	M	
	Day	61	M	
	Year	61	M	
Time Arrived at Patient	Hour	61	M	
	Minute	61	M	
Date Departed from Scene	Month	62	M	
	Day	62	M	
	Year	62	M	
Time Departed from Scene	Hour	62	M	
	Minute	62	M	
Scene Transport	Heart Rate	64	M	
	Unassisted Respiration	64	M	
	Systolic Blood Pressure	65	M	
	Pediatric Trauma Score	66	M	
Was Patient Intubated at Scene		67	M	
Scene Transport— Paralytic Agents in Effect		68	M	

Screen F3.3 (cont'd)

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Scene GCS	Eye	69	M	
	Verbal	70	M	
	Motor	71	M	
Total GCS at Scene		72	M	
Total RTS at Scene		73	M	
Non-Operative Procedures—Scene	1	74	M	
	2	74	M	
	3	74	M	
	4	74	M	
	5	74	M	
	If Other	75	M	

Screen F3.4

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Scene Memo		222	E	September 1, 2004

Screen F3.5

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Fields 1-9	222	E	n/a

Screen F3.6

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Fields 10-18	222	E	n/a

Section 4: Primary Hospital

Screen F4.1

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Date of Arrival—Primary Hospital	Month	76	M	
	Day	76	M	
	Year	76	M	
	Hour	76	M	
	Minute	76	M	
Date of Departure— Primary Hospital	Month	77	M	
	Day	77	M	
	Year	77	M	
	Hour	77	M	
	Minute	77	M	
Referring Physician— Primary Hospital		230	E	
Primary Hospital	Temperature	78	M	
	Heart Rate	78	M	
	Unassisted Respiration	79	M	
	Systolic Blood Pressure	79	M	
	Pediatric Trauma Score	80	M	
Was Patient Intubated at Primary Hospital		80	M	
Primary Hospital— Paralytic Agents in Effect		81	M	
Primary GCS	Eye	81	M	
	Verbal	82	M	
	Motor	83	M	
Primary—Total GCS on Admission		84	M	
Primary—Total RTS on Admission		85	M	
Blood Alcohol—Primary		85	M	

Screen 4.2

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Primary Hospital Transport Mode/Service 1 through 3	Transport Mode 1-2	86	M	
	Transport Mode 3	223	E	April 1, 1998
	Transport Service 1-2	87	M	
	Transport Service 3	223	E	April 1, 1998
	Run Sheet Available 1	87	M	
	Run Sheet Available 2–3	223	E	April 1, 1998
	Primary Pre-hospital Number 1	88	M	
	Primary Pre-hospital Number 2-3	223	E	April 1, 1998
	Basic Life Support 1-3	222	E	April 1, 1998
	Advanced life support 1-3	222	E	April 1, 1998
	Qualified Personnel— RN 1-3	222	E	April 1, 1998
	Qualified Personnel— RT 1-3	222	E	April 1, 1998
	MD—1-3	222	E	April 1, 1998
	Critical Care Transport Team 1-3	222	E	April 1, 1998
	Transport Mode/Service— Unknown 1-3	222	E	April 1, 1998
	Qualified Personnel— Unknown 1-3	222	E	April 1, 1998

Screen 4.3

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Non-operative Procedures—Primary	1 through 20	89	M	
Other Non-Hospital Procedures—Primary	1 through 5	90	M	
CT Scan Locations— Primary	1 through 5	223	E	April 1, 1998
IV Lines at Primary Hospital		91	M	
Ventilator Days at Primary Hospital		91	M	
ICP Days—Primary Hospital		224	E	April 1, 1998
Number of OR Visits— Primary Hospital		92	M	

Screen 4.4

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Primary Hospital First OR Visit	Elapsed Minutes	94	M	
	Month	94	M	
	Day	94	M	
	Year	94	M	
	Start-Hour	94	M	
	Start-Minute	94	M	
	Finish-Hour	94	M	
	Finish-Minute	94	M	
Operation #1 Procedures (Primary Hospital)— Procedure 1	ICD-9	226	E	September 1, 2004
	ICD-10	94	M	
	Status	95	M	
	Location	95	M	
	Extent	96	M	
	Mode of Delivery	96	M	
	Service	229	E	April 1, 1998
Operation 1 on Adm to Primary Hosp— Procedures 2 through 8	ICD-9 2-8	226	E	September 1, 2004
	ICD-10 2-8	226	E	September 1, 2004
	Status 2-8	227	E	September 1, 2004
	Location 2-8	227	E	September 1, 2004
	Extent 2-8	228	E	September 1, 2004
	Mode of Delivery 2-8	228	E	September 1, 2004
	Service 2-8	229	E	April 1, 1998

Screen F4.5

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Operation 2 on Adm to Primary Hosp	Elapsed Minutes	224	E	April 1, 1998
	Day	224	E	April 1, 1998
	Year	224	E	April 1, 1998
	Start-Hour	225	E	April 1, 1998
	Start-Minute	225	E	April 1, 1998
	Finish-Hour	225	E	April 1, 1998
	Finish-Minute	225	E	April 1, 1998
Operation 2 on Adm to Primary Hosp— Procedures 1–8	ICD-9 1-8	226	E	April 1, 1998
	ICD-10 1-8	226	E	September 1, 2004
	Status 1-8	227	E	September 1, 2004
	Location 1-8	227	E	September 1, 2004
	Extent 1-8	228	E	September 1, 2004
	Mode of Delivery 1-8	228	E	September 1, 2004
	Service 1-8	229	E	April 1, 1998

Screen 4.6

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Operation 3 on Adm to Primary Hosp	Elapsed Minutes	224	E	April 1, 1998
	Day	224	E	April 1, 1998
	Year	224	E	April 1, 1998
	Start-Hour	225	E	April 1, 1998
	Start-Minute	225	E	April 1, 1998
	Finish-Hour	225	E	April 1, 1998
	Finish-Minute	225	E	April 1, 1998
Operation 3 on Adm to Primary Hosp— Procedures 1–8	ICD-9 1-8	226	E	April 1, 1998
	ICD-10 1-8	226	E	September 1, 2004
	Status 1-8	227	E	September 1, 2004
	Location 1-8	227	E	September 1, 2004
	Extent 1-8	228	E	September 1, 2004
	Mode of Delivery 1-8	228	E	September 1, 2004
	Service 1-8	229	E	April 1, 1998

Screen 4.7

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Operation 4 on Adm to Primary Hosp	Elapsed Minutes	224	E	April 1, 1998
	Day	224	E	April 1, 1998
	Year	224	E	April 1, 1998
	Start-Hour	225	E	April 1, 1998
	Start-Minute	225	E	April 1, 1998
	Finish-Hour	225	E	April 1, 1998
	Finish-Minute	225	E	April 1, 1998
Operation 4 on Adm to Primary Hosp— Procedures 1–8	ICD-9 1-8	226	E	April 1, 1998
	ICD-10 1-8	226	E	September 1, 2004
	Status 1-8	227	E	September 1, 2004
	Location 1-8	227	E	September 1, 2004
	Extent 1-8	228	E	September 1, 2004
	Mode of Delivery 1-8	228	E	September 1, 2004
	Service 1-8	229	E	April 1, 1998

Screen 4.8

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Operation 5 on Adm to Primary Hosp	Elapsed Minutes	224	E	April 1, 1998
	Day	224	E	April 1, 1998
	Year	224	E	April 1, 1998
	Start-Hour	225	E	April 1, 1998
	Start-Minute	225	E	April 1, 1998
	Finish-Hour	225	E	April 1, 1998
	Finish-Minute	225	E	April 1, 1998
Operation 5 on Adm to Primary Hosp— Procedures 1–8	ICD-9 1-8	226	E	April 1, 1998
	ICD-10 1-8	226	E	September 1, 2004
	Status 1-8	227	E	September 1, 2004
	Location 1-8	227	E	September 1, 2004
	Extent 1-8	228	E	September 1, 2004
	Mode of Delivery 1-8	228	E	September 1, 2004
	Service 1-8	229	E	April 1, 1998

Screen 4.9

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Primary Hospital Memo— Memo Field		229	E	September 1, 2004

Section 5: Secondary Hospital

Screen F5.1

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Date of Arrival at Secondary Hospital	Day	230	E	April 1, 1998
	Month	230	E	April 1, 1998
	Year	230	E	April 1, 1998
Time of Arrival at Secondary Hospital	Hour	230	E	April 1, 1998
	Minute	230	E	April 1, 1998
Date of Departure from Secondary Hospital	Day	230	E	April 1, 1998
	Month	230	E	April 1, 1998
	Year	230	E	April 1, 1998
Time of Departure from Secondary Hospital	Hour	230	E	April 1, 1998
	Minute	230	E	April 1, 1998
Referring Physician		230	E	April 1, 1998
Secondary Hospital	Temperature	231	E	April 1, 1998
	Heart Rate	231	E	April 1, 1998
	Unassisted Respiration	231	E	April 1, 1998
	Systolic Blood Pressure	231	E	April 1, 1998
	Pediatric Trauma Score	231	E	April 1, 1998
Was Patient Intubated at Secondary Hospital		232	E	April 1, 1998
Secondary Hospital— Paralytic Agents in Effect		232	E	April 1, 1998
Eye Opening—Secondary		232	E	April 1, 1998
Secondary Hospital—GCS Verbal Response		232	E	April 1, 1998
Motor Response— Secondary Hospital		233	E	April 1, 1998
GCS on Admission— Secondary		233	E	April 1, 1998
RTS on Admission— Secondary		233	E	April 1, 1998
Blood Alcohol—Secondary		233	E	April 1, 1998

Screen F5.2

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Secondary Hospital Transport Mode/Service 1 through 3	Transport Mode 1-3	234	E	April 1, 1998
	Transport Service 1-3	234	E	April 1, 1998
	Run Sheet Available 1-3	234	E	April 1, 1998
	Secondary Pre-hospital Number 1-3	234	E	April 1, 1998
	Basic Life Support 1-3	235	E	April 1, 1998
	Advanced life support 1-3	235	E	April 1, 1998
	Qualified Personnel—RN 1-3	235	E	April 1, 1998
	Qualified Personnel—RT 1-3	235	E	April 1, 1998
	MD—1-3	235	E	April 1, 1998
	Critical Care Transport Team 1-3	235	E	April 1, 1998
	Transport Mode/Service—Unknown 1-3	235	E	April 1, 1998
	Qualified Personnel—Unknown 1-3	235	E	April 1, 1998

Screen F5.3

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Secondary Hospital-Non-operative Procedures	Non-operative Procedures 1-20	235	E	April 1, 1998
Secondary Hospital— Other Non-operative Procedure	Other Non-operative Procedure 1-5	235	E	April 1, 1998
CT Scan Locations— Secondary Hospital	CT Scan Locations 1-5	236	E	April 1, 1998
IV Lines at Secondary Hospital		236	E	April 1, 1998
Ventilator Days— Secondary Hospital		236	E	April 1, 1998
ICP DAY Secondary Hospital		236	E	April 1, 1998
Number of OR Visits— Secondary Hospital		236	E	April 1, 1998

Screen F5.4

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Operation 1 on Adm to Sec Hosp	Elapsed Minutes	238	E	April 1, 1998
	Day	237	E	April 1, 1998
	Year	237	E	April 1, 1998
	Start—Hour	237	E	April 1, 1998
	Start—Minute	237	E	April 1, 1998
	Finish—Hour	238	E	April 1, 1998
	Finish—Minute	238	E	April 1, 1998
Operation 1 on Adm to Sec Hosp—Procedure 1 through 8	ICD-9 1-8	239	E	April 1, 1998
Operation 1 on Adm to Sec Hosp—Procedure 1 through 8	ICD-10 1-8	240	E	
	Status 1-8	241	E	April 1, 1998
	Location 1-8	242	E	April 1, 1998
	Extent 1-8	243	E	April 1, 1998
	Mode of Delivery 1-8	244	E	April 1, 1998
	Service 1-8	245	E	April 1, 1998

Screen F5.5

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Operation 2 on Adm to Sec Hosp	Elapsed Minutes	238	E	April 1, 1998
	Day	237	E	April 1, 1998
	Year	237	E	April 1, 1998
	Start—Hour	237	E	April 1, 1998
	Start—Minute	237	E	April 1, 1998
	Finish—Hour	238	E	April 1, 1998
	Finish—Minute	238	E	April 1, 1998
Operation 2 on Adm to Sec Hosp—Procedure 1 through 8	ICD-9 1-8	239	E	April 1, 1998
	ICD-10 1-8	240	E	
	Status 1-8	241	E	April 1, 1998
	Location 1-8	242	E	April 1, 1998
	Extent 1-8	243	E	April 1, 1998
	Mode of Delivery 1-8	244	E	April 1, 1998
	Service 1-8	245	E	April 1, 1998

Screen F5.6

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Operation 3 on Adm to Sec Hosp	Elapsed Minutes	238	E	April 1, 1998
	Day	237	E	April 1, 1998
	Year	237	E	April 1, 1998
	Start—Hour	237	E	April 1, 1998
	Start—Minute	237	E	April 1, 1998
	Finish—Hour	238	E	April 1, 1998
	Finish—Minute	238	E	April 1, 1998
Operation 3 on Adm to Sec Hosp—Procedure 1 through 8	ICD-9 1-8	239	E	April 1, 1998
	ICD-10 1-8	240	E	
	Status 1-8	241	E	April 1, 1998
	Location 1-8	242	E	April 1, 1998
	Extent 1-8	243	E	April 1, 1998
	Mode of Delivery 1-8	244	E	April 1, 1998
	Service 1-8	245	E	April 1, 1998

Screen F5.7

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Operation 4 on Adm to Sec Hosp	Elapsed Minutes	238	E	April 1, 1998
	Day	237	E	April 1, 1998
	Year	237	E	April 1, 1998
	Start—Hour	237	E	April 1, 1998
	Start—Minute	237	E	April 1, 1998
	Finish—Hour	238	E	April 1, 1998
	Finish—Minute	238	E	April 1, 1998
Operation 4 on Adm to Sec Hosp—Procedure 1 through 8	ICD-9 1-8	239	E	April 1, 1998
	ICD-10 1-8	240	E	
	Status 1-8	241	E	April 1, 1998
	Location 1-8	242	E	April 1, 1998
	Extent 1-8	243	E	April 1, 1998
	Mode of Delivery 1-8	244	E	April 1, 1998
	Service 1-8	245	E	April 1, 1998

Screen F5.8

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Operation 5 on Adm to Sec Hosp	Elapsed Minutes	238	E	April 1, 1998
	Day	237	E	April 1, 1998
	Year	237	E	April 1, 1998
	Start—Hour	237	E	April 1, 1998
	Start—Minute	237	E	April 1, 1998
	Finish—Hour	238	E	April 1, 1998
	Finish—Minute	238	E	April 1, 1998
Operation 5 on Adm to Sec Hosp—Procedure 1 through 8	ICD-9 1-8	239	E	April 1, 1998
	ICD-10 1-8	240	E	
	Status 1-8	241	E	April 1, 1998
	Location 1-8	242	E	April 1, 1998
	Extent 1-8	243	E	April 1, 1998
	Mode of Delivery 1-8	244	E	April 1, 1998
	Service 1-8	245	E	April 1, 1998

Screen F5.9

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Secondary Hospital Memo– Memo Field		245	E	April 1, 1998

Section 6: Lead/Trauma Hospital

Screen F6.1

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Direct Admission to Service (Bypass ED)		97	M	
Ambulance Arrival Date	Month	97	M	
	Day	97	M	
	Year	97	M	
	Hour	97	M	
	Minute	97	M	
Lead Trauma Hospital	Temperature	98	M	
	Heart Rate	99	M	
	Unassisted Respiration	99	M	
	Systolic Blood Pressure	100	M	
	Pediatric Trauma Score	100	M	
Was Patient Intubated on Admission to Lead/ Trauma Hospital		101	M	
Lead Trauma Hospital— Paralytic Agents in Effect		101	M	
Lead—Eye Opening		102	M	
Lead—GCS Verbal Response		103	M	
Lead—Motor Response on Admission		104	M	
Lead—GCS on Admission		105	M	
Lead—RTS on Admission		106	M	
Lead—Blood Alcohol		107	M	

Screen F6.2

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Lead/Trauma Hospital— ED Arrival Date	Month	108	M	
	Day	108	M	
	Year	108	M	
	Hour	108	M	
	Minute	108	M	
Date of ED Discharge	Month	109	M	
	Day	109	M	
	Year	109	M	
	Hour	109	M	
	Minute	109	M	
ED MD		246	E	
Lead Trauma Admission Date	Month	110	M	
	Day	110	M	
	Year	110	M	
Lead Trauma Hospital— Trauma Team Activated		110	M	
Trauma Team Leader		246	E	
Admitting Physician Service		112	M	
Admitting Patient Service		246	E	

Screen F6.3

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Lead—Non-operative Procedures 1 through 20	Non-operative Procedures 1-20	112	M	
Lead—Other Non- operative Procedure	Other Non-operative Procedure 1-5	114	M	
Lead—CT Scan Location	CT Scan Location 1-5	114	M	
IV Lines—Lead Hospital		115	M	
Ventilator Days— Lead Hospital		115	M	
ICP DAY—Lead Hospital		116	M	
Number of OR Visits— Lead Hospital		117	M	

Screen F6.4

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Lead/Trauma Hospital Memo—Memo Field		246	E	

Screen F6.5

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Field 1-9	247	E	

Screen F6.6

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Field 10-18	247	E	

Screen F6.7

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Field 19-27	247	E	

Section 7: Lead/Trauma Hospital Care

Screen F7.1

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Physician Service Transfer 1 through 3	Service	118	M	
	Admitted—Month	119	M	
	Admitted—Day	119	M	
	Admitted—Year	119	M	
	Discharged—Month	119	M	
	Discharged—Day	119	M	
	Discharged—Year	119	M	
	Length of Stay (in Days)	120	M	
Physician Service Transfer 4 through 6	Service	248	E	
	Admitted—Month	248	E	
	Admitted—Day	248	E	
	Admitted—Year	248	E	
	Discharged—Month	249	E	
	Discharged—Day	249	E	
	Discharged—Year	249	E	
	Length of Stay (in Days)	249	E	
Patient Service Transfer 1 through 6	Service	247	E	
	Admitted—Month	247	E	
	Admitted—Day	247	E	
	Admitted—Year	247	E	
	Discharged—Month	248	E	
	Discharged—Day	248	E	
	Discharged—Year	248	E	
	Length of Stay (in Days)	248	E	
Lead Trauma Hospital—Post-ED/Arrival Destination		120	M	
Post-ED/Arrival Destination—If other		122	M	

(cont'd on next page)

Screen F7.1 (cont'd)

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Lead Trauma Hospital— Post OR Destination		122	M	
Post OR Destination— If Other		123	M	
Lead Trauma—Special Care Unit		123	M	
Special Care Unit— If other		125	M	

Screen F7.2—F7.11*

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Operation 1 through 10	Month	126	M	
	Day	126	M	
	Year	126	M	
	Start—Hour	127	M	
	Start—Minute	127	M	
	Finish—Hour	128	M	
	Finish—Minute	128	M	
	Procedure 1 through 10—ICD-10 Code	130	M	
	Procedure 1 through 10—Status	132	M	
	Procedure 1 through 10—Location	133	M	
	Procedure 1 through 10—Extent	135	M	
	Procedure 1 through 10—Mode of Delivery	136	M	
	Procedure 1 through 10—Service	136	M	

Note

*   Hospitals may choose to collect up to 15 additional operations, with up to 10 procedures each. These would be seen on screens F7.12–F7.26 and may be collected at hospitals but are not collected by the OTR.

Screen F7.27

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Special Care Unit 1 through 2		137	M	
Date of Special 1 through 2	Arrival—Lead Trauma—Month	138	M	
	Arrival—Lead Trauma—Day	138	M	
	Arrival—Lead Trauma—Year	138	M	
	Discharge—Lead Trauma—Month	138	M	
	Discharge—Lead Trauma—Day	138	M	
	Discharge—Lead Trauma—Year	138	M	
	Length of Stay (in Days)	139	M	
Special Care Unit 3 through 5		252	E	
Date of Special 3 through 5	Arrival—Lead Trauma—Month	252	E	
	Arrival—Lead Trauma—Day	252	E	
	Arrival—Lead Trauma—Year	252	E	
	Discharge—Lead Trauma—Month	252	E	
	Discharge—Lead Trauma—Day	252	E	
	Discharge—Lead Trauma—Year	252	E	

Screen F7.28

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Lead/Trauma Hospital Care Memo—Memo Field		253	E	

Screen F7.29

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Nursing Memo— Memo Field		253	E	September 1, 2004

Screen F7.30

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Quality Assurance Memo—Memo Field		253	E	

Screen F7.31

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
System Memo— Memo Field		253	E	

Screen F7.32

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Field 1-9	254	E	

Screen F7.33

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Field 10-18	254	E	

Screen F7.34

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Field 19-27	254	E	

Section 8: Anatomical Diagnosis

Screen F8.1

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
AIS 2005—Anatomical Diagnosis		140	M	
AIS 2005—Anatomical Diagnosis—Injury Text— Memo Field		140	M	
ISS (AIS 2005)		144	M	
AIS 90—Anatomical Diagnosis		254	E	April 1, 2012
AIS 90—Anatomical Diagnosis—Injury Text— Memo Field		254	E	April 1, 2012
ISS (AIS 1990)		256	E	April 1, 2012

Screen F8.2

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
AIS Version Number		140	M	
ICD-10 Injury Code 1–27		141	M	
AIS 2005—AIS Code 1–27		142	M	
AIS 2005—AIS PreDot Code 1–27		143	M	

Screen F8.4

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
AIS Version Number		254	E	April 01, 2012
AIS 90—ICD-10 Injury Code 1–27		255	E	April 01, 2012
AIS 90—AIS Code 1–27		255	E	April 01, 2012
AIS 90—AIS PreDot Code 1–27		255	E	April 01, 2012

Screen F8.5

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if applicable)
TRISS		145	M	
MAIS		146	M	
Comorbid Diagnosis 1–10		147	M	
Comorbid NTR Diagnosis 1–10		148	M	
Complications 1–10		149	M	
Complications NTR 1–10		149	M	

Section 9: Outcome

Screen F9.1

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Outcome—Date of Separation	Month	151	M	
	Day	151	M	
	Year	151	M	
Time of Separation	Hour	152	M	
	Minute	152	M	
Disposition	Separation Status	153	M	
	Live Die Status	154	M	
	Discharge To	155	M	
	If Other	157	M	
	Home with Support Services 1–5	157	M	
If Home with Support Services	If Other	158	M	
Disposition	Institution Number	158	M	
Institution Number	Outside of Ontario	159	M	
	Outside of Canada	159	M	
Disposition	Transport Mode to Discharge Care Facility	257	E	September 1, 2004

Screen 9.2

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Discharge FIM® Self-Care	Eating	257	E	April 01, 2008
	Grooming	257	E	April 01, 2008
	Bathing	257	E	April 01, 2008
	Dressing Upper	257	E	April 01, 2008
	Dressing Lower	257	E	April 01, 2008
Discharge FIM®	FIM® Total	257	E	April 01, 2008
Discharge FIM®— Sphincter Control	Bladder	258	E	April 01, 2008
	Bowel	258	E	April 01, 2008
Discharge FIM®— Mobility—Transfer	Bed	258	E	April 01, 2008
	Toilet	258	E	April 01, 2008
	Tub/Shower	258	E	April 01, 2008
Discharge FIM®	Walk/Wheelchair	258	E	April 01, 2008
Discharge FIM®— Locomotion	Walk/Wheelchair	258	E	April 01, 2008
	Stairs	258	E	April 01, 2008
Discharge FIM®	Type of Comprehension	258	E	April 01, 2008
Discharge FIM®— Communication	Comprehension	259	E	April 01, 2008
Discharge FIM®	Type of Expression	259	E	April 01, 2008
Discharge FIM®— Communication	Expression	270	E	April 01, 2008
Discharge FIM®— Social Cognition	Social Interaction	260	E	April 01, 2008
	Problem Solving	260	E	April 01, 2008
	Memory	260	E	April 01, 2008
Discharge FIM®	FIM® Type	260	E	April 01, 2008
	From Chart	260	E	April 01, 2008

Screen F9.3

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Glasgow Outcome Scale		160	M	
RANCHOS at Discharge		161	M	
Was ALC Form Completed		163	M	
ALC Date	Month	164	M	
	Day	164	M	
	Year	164	M	
Reasons for ALC Days	1	164	M	
	2	164	M	
	3	164	M	
	Other	165	M	

Screen 9.4

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Death Info	Place of Death	166	M	
Place of Death	If Other	166	M	
Death Info	If SCU, Specify	167	M	
Place of Death	If SCU, Other	167	M	
Was coroner notified?		261	E	April 1, 1998
Was post-mortem done?		261	E	April 1, 1998
Was post-mortem report received?		168	M	
Was patient/patient's family approached about organ or tissue donation?		168	M	
Were organs or tissue donated?		169	M	
	Trillium Gift of Life Involvement	261	E	September 1, 2004
Organs Donated	1	261	E	
	2	262	E	
	3	262	E	
	4	262	E	

Screen 9.5

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Outcome Memo	Memo Field	261	E	September 1, 2004

Screen 9.6

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Outcome 1– Outcome 9	262	E	

Screen F9.7

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Outcome 10– Outcome18	262	E	

Screen F9.8

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Outcome 19– Outcome 27	262	E	

Section 10: ACS Filter

Screen F10.1

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Patient seen in ED and admitted to the hospital within 72 hours of initial evaluation?		262	E	.
Ambulance report on medical record if transported by pre-hospital EMS personnel?		262	E	
Was hourly chart documentation present for patient?		263	E	
Dx at discharge of cervical spine injury not indicated in admission dx?		263	E	

Screen F10.2

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Did patient have epidural/subdural brain hematoma, did they receive a craniotomy >4 hours after EDA?		263	E	
Did adult trauma patient have transfusion of platelets or fresh frozen plasma within 24 hours EDA after having received <8 units packed RBC or whole blood?		264	E	
Did comatose trauma patient leave ED before mechanical airway was established?		264	E	
Did patient require reintubation within 48 hours of extubation?		264	E	
Was there an unplanned return to the OR within 48 hours of the initial procedure?		264	E	

Screen F10.3

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Was a CT Scan of Head obtained within 2 hours of hospital arrival?		264	E	
Did patient require a laparotomy that was not performed within 2 hours of EDA?		265	E	
Was there a nonfixation of femoral diaphyseal fracture in adult trauma patient?		265	E	
If patient sustained a GSW to the abdomen, was he/she managed non-operatively?		265	E	
Was there an interval of > 8 hours between arrival and treatment of blunt compound tibial fx/open laceration of joint?		265	E	
Was abdominal/thoracic/ vascular/cranial surgery done > 24 hrs after EDA?		265	E	
Were HIV results available?		266	E	

Section 11: Follow-Up

Screen F11.1

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Follow-Up FIM®— Contact [I]		266	E	April 1, 2008
Follow-Up Date	Month	266	E	April 1, 2008
	Day	266	E	April 1, 2008
	Year	266	E	April 1, 2008
FOLLOW-UP FIM®— SELF-CARE	Eating	266	E	April 1, 2008
	Grooming	266	E	April 1, 2008
	Bathing	267	E	April 1, 2008
	Dressing Upper	267	E	April 1, 2008
	Dressing Lower	267	E	April 1, 2008
Follow-Up FIM®—FIM® Toileting		267	E	April 1, 2008
FOLLOW-UP FIM®— SPHINCTER CONTROL	Bladder	267	E	April 1, 2008
	Bowel	268	E	April 1, 2008
FOLLOW-UP FIM®— MOBILITY—Transfer	Bed	268	E	April 1, 2008
	Toilet	268	E	April 1, 2008
	Tub/Shower	268	E	April 1, 2008
Follow-Up FIM®— Walk/Wheelchair [I]		269	E	April 1, 2008
FOLLOW-UP FIM®— LOCOMOTION	Walk/Wheelchair	269	E	April 1, 2008
	Stairs	269	E	April 1, 2008
Follow-Up FIM®— Comprehension		269	E	April 1, 2008
FOLLOW-UP FIM®— COMMUNICATION— Comprehension		270	E	April 1, 2008
Follow-Up FIM®— Expression		270	E	April 1, 2008
FOLLOW-UP FIM®— COMMUNICATION— Expression		270	E	April 1, 2008
FOLLOW-UP FIM®— SOCIAL COGNITION	Social Interaction	270	E	April 1, 2008
	Problem Solving	271	E	April 1, 2008
	Memory	271	E	April 1, 2008
FOLLOW-UP FIM®— FIM® Type		273	E	April 1, 2008

Screen F11.2

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Level of Employment		273	E	
Income Level—If Less, Percent of Previous Income		273	E	
If Student, Level of Study (Post Injury)		273	E	
Related Admission to Hospital Following Discharge		274	E	
Related Admission to Hospital Following Discharge— Specify Hospital		274	E	
Therapy Received After Discharge		274	E	
Specify Therapy Type	Therapy Type 1-8	274	E	
Therapy Received After Discharge—If Other		275	E	
Date of Death	Month	275	E	
	Day	275	E	
	Year	275	E	
Time of Death	Hour	275	E	
	Minute	275	E	
Cause of Death		275	E	
Related to Injury		275	E	

Screen F11.3

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Follow-Up Memo— Memo Field		276	E	N/A

Section 12: Readmission

Screen F12.1 to Screen F12.5

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Readmission—Date of Readmission 1 through 5	Month	276	E	April 1, 1995
	Day	276	E	April 1, 1995
	Year	276	E	April 1, 1995
Readmission—Category 1 through 5		276	E	April 1, 1995
Readmission—Diagnosis Code 1 through 5	Diagnosis Code 1-5	277	E	April 1, 1995
Readmission—Most Responsible Physician Service 1 through 5		278	E	April 1, 1995
Readmission—Most Responsible Patient Service 1 through 5		278	E	April 1, 1995
Readmission—Number of OR Visits 1 through 5		278	E	April 1, 1995
Readmission—Total OR Time (Min) 1 through 5		278	E	April 1, 1995
Readmission—Principal Procedure 1 through 5		279	E	April 1, 1995
Readmission—CCI Code 1 through 5		279	E	April 1, 1995
Readmission—Attributes 1 through 5	Status	279	E	April 1, 1995
	Location	279	E	April 1, 1995
	Extent	279	E	April 1, 1995
	Mode of Delivery	280	E	April 1, 1995
Readmission—Date of Separation 1 through 5	Month	280	E	April 1, 1995
Readmission—Date of Separation 1 through 5	Day	280	E	April 1, 1995
Readmission—Date of Separation 1 through 5	Year	280	E	April 1, 1995
Readmission—Separation Status 1 through 5		280	E	April 1, 1995
Readmission—Disposition 1 through 5		280	E	April 1, 1995
Readmission— Disposition—If other 1 through 5		280	E	April 1, 1995

Screen F12.6

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
Readmission Memo— Memo Field		281	E	April 1, 1995

Screen F12.7

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Field 1-9	281	E	

Screen F12.8

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Field 10-18	281	E	

Screen F12.9

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Field 19-27	281	E	N/A

Screen F12.10

Data Element Single/Group	Data Element Single	Page Number	Mandatory/ Excluded	Exclusion Date (if Applicable)
User Defined Field	Field 28-36	281	E	

Appendix D: Historical Information

Below are data elements which may be present in Collector at the Lead Trauma Hospitals, but which are not part of the OTR CDS data set. These data elements are optional and collection varies from hospital to hospital; some have continued to collect them for their own purposes.

Exclusion dates of these non-mandatory data elements are provided where available. Updates for some data elements on ICD-10-CA in Collector were implemented although they were not mandatory. As such, changes are applied even though the data are excluded from the OTR CDS.

Section 1: Demographic Data

Demographic Data—Overflow

Name in Database	Overflow (formerly: PREV_TRNUM)
Definition	This is a numeric field that can be used for special studies as determined by the lead/trauma hospitals or the Registry Office.
Additional Information	
History	Excluded as of April 1, 1998

Patient Name (Last, First, Middle)

Name in Database	PAT_NAM_L, PAT_NAM_F, PAT_NAM_M
Definition	The patient's first name, last name and middle name.
Additional Information	
History	Excluded as of September 1, 2004

Height

Name in Database	HEIGHT
Definition	The patient's height in centimetres.
Additional Information	Because a decimal is allowed, 4 digits must be entered (including the digit after the decimal point). As of April 1st, 1995 hospitals will no longer be required to collect height information but may do so as required by their institution.
History	Excluded as of September 1, 2004

Patient—Language

Name in Database	PAT_LANG
Definition	Select the language spoken by the patient.
Additional Information	Select English if the patient is reasonably conversant in English. Specify another language if an interpreter is required.
History	Excluded as of September 1, 2004

Patient—Language—Other

Name in Database	PAT_LANG_O
Definition	Specified language spoken of patient if "other" was indicated in the previous field.
Additional Information	Specify if "other" was entered in the previous field. This field will be skipped if "other" was not selected in the previous field.
History	Excluded as of April 1, 1998

Patient—Province

Name in Database	PAT_ADR_S
Definition	The patient's residential street address.
Additional Information	Enter "I" if the patient is homeless.
History	Excluded as of September 1, 2004

Home Phone 1, 2, 3

Name in Database	H_PHONE_1, H_PHONE_2, H_PHONE_3
Definition	The patient's home telephone number including the area code.
Additional Information	Enter unknown if not known, or inappropriate if patient does not have a phone.
History	Excluded as of September 1, 2004

Relative—Last Name

Name in Database	REL_NAM_L
Definition	The surname of the patient's legal next of kin if different from the patient's.
Additional Information	
History	Excluded as of April 1, 1998

Relative—First Name

Name in Database	REL_NAM_F
Definition	The first name of the patient's legal next of kin if different from the patient's.
Additional Information	
History	Excluded as of April 1, 1998

Relative—Middle Initial

Name in Database	REL_NAM_M
Definition	The middle name of the patient's legal next of kin if different from the patient's.
Additional Information	An initial may be entered if the middle name is unknown. A period should not be entered after the initial.
History	Excluded as of April 1, 1998

Relative—Relationship to Patient

Name in Database	RELATION
Definition	The relationship of the legal next of kin to the patient.
Additional Information	
History	Excluded as of April 1, 1998

Relative—Other Relationship to Patient

Name in Database	REL_RELAT
Definition	Specify the relationship of the legal next of kin if "other" was indicated in the previous field.
Additional Information	This field will be skipped if "other" was not selected in the previous field.
History	Excluded as of April 1, 1998

Relative—Language Spoken

Name in Database	REL_LANG
Definition	Enter the language spoken by the patient's legal next of kin.
Additional Information	Select English if the patient's legal next of kin is reasonably conversant in English. Specify another language if an interpreter is required.
History	Excluded as of April 1, 1998

Relative—Language Spoken—If Other

Name in Database	REL_LANG_O
Definition	Specify if "other" was entered in the previous field and if different from the information entered for the patient.
Additional Information	This field will be skipped if "other" was not selected in the previous field.
History	Excluded as of April 1, 1998

Relative—Street

Name in Database	REL_ADR_S
Definition	Enter the street address of the patient's legal next of kin if different from the patient's.
Additional Information	
History	Excluded as of April 1, 1998

Relative—City

Name in Database	REL_ADR_CI
Definition	Enter the city of residence for the patient's legal next of kin if different from the patient's.
Additional Information	This field has a hospital defined menu.
History	Excluded as of April 1, 1998

Relative—Province

Name in Database	REL_ADR_ST
Definition	Enter the province of residence for the patient's legal next of kin if different from the patient's.
Additional Information	Select United States for residents of the US.
History	Excluded as of April 1, 1998

Relative—Province—If Other

Name in Database	REL_ADR_SO
Definition	Enter the province of the legal next of kin if "other" was entered in the previous field and if the information is different from the patient's.
Additional Information	This field will be skipped if "other" was not selected in the previous field.
History	Excluded as of April 1, 1998

Relative—Country

Name in Database	REL_CNTRY
Definition	Enter the country of residence for the patient's legal next of kin if different from the patient's.
Additional Information	
History	Excluded as of April 1, 1998

Relative—Country—If Other

Name in Database	REL_OCNTRY
Definition	Specify if "other" was entered in the previous field.
Additional Information	This field will be skipped if "other" was not selected in the previous field.
History	Excluded as of April 1, 1998

Relative—Postal Code

Name in Database	REL_ADR_PC
Definition	Enter the postal code for the patient's legal next of kin if different from the patient's (in ANA NAN format).
Additional Information	A space will be added by the system. Postal Code letters must be entered in upper case. This field will be skipped if "other" was selected for Country.
History	Excluded as of April 1, 1998

Relative—Other Country Postal Code

Name in Database	REL_ADR_ZC
Definition	Enter the zip code or other postal code information for the patient's legal next of kin for residents of the United States and other countries if different from the patient's.
Additional Information	
History	Excluded as of April 1, 1998

Demographic Memo—Memo Field

Name in Database	NOTES_PAT
Definition	
Additional Information	
History	Excluded as of September 1, 2004

User Defined Field 1–18

Name in Database	DEMOGRAF1, DEMOGRAF2, DEMOGRAF3, DEMOGRAF4, DEMOGRAF5, DEMOGRAF6, DEMOGRAF7, DEMOGRAF8, DEMOGRAF9, DEMOGRAF10, DEMOGRAF11, DEMOGRAF12, DEMOGRAF13, DEMOGRAF14, DEMOGRAF15, DEMOGRAF16, DEMOGRAF17, DEMOGRAF18
Definition	
Additional Information	
History	

Section 2: Injury Data

ICD-9 Primary Cause of Injury

Name in Database	E_CODE
Definition	E-Codes (E800.999) are a classification within the International Classification of Diseases (ICD-9-CM) that describe the nature of injury.
Additional Information	E-Codes may be selected from a menu system as follows. The first menu presented lists 23 broad categories of injury corresponding to sections in the ICD manual. This menu is listed below. After selecting a category from this menu a second menu listing specific E-Codes will be displayed. After selecting a specific E Code from the second menu, a third menu listing appropriate fourth digits will be displayed. The second and third menus can be found in Appendix C of the Collector Trauma Registry manual. The cause of injury codes may also be retrieved form the ICD-9 coding manual
History	This data element is no longer mandatory as of April 2012

ICD-9 Secondary Cause of Injury

Name in Database	E_CODE_2
Definition	An additional four digit ICD-9-CM External Cause of Injury code (E Code) for an additional secondary etiology that is more closely related to the circumstances causing the injury.
Additional Information	
History	This data element is no longer mandatory as of April 1, 2012

ICD-10 Secondary Place of Injury

Name in Database	U98_X_2
Definition	The place of injury that corresponds to the ICD-10-CA secondary U Code to denote the place where the injury occurred for the patient
Additional Information	If a patient is injured on a regular ski hill, the place of injury should be documented as "other specified place of occurrence" (menu item 8), whereas if the place of injury is a ski resort and is monitored by ski patrol, "sport/athletics area" (menu item 3) should be selected.
History	

ICD-9 Tertiary Cause of Injury

Name in Database	E_CODE_3
Definition	An additional four digit ICD-9-CM External Cause of Injury code (E Code) for an additional tertiary etiology that is more closely related to the circumstances causing the injury.
Additional Information	
History	This data element is no longer mandatory as of April 2012

ICD-10 Tertiary Place of Injury

Name in Database	U98_X_3
Definition	The place of injury that corresponds to the ICD-10-CA tertiary U Code to denote the place where the injury occurred for the patient
Additional Information	If a patient is injured on a regular ski hill, the place of injury should be documented as "other specified place of occurrence" (menu item 8), whereas if the place of injury is a ski resort and is monitored by ski patrol, "sport/athletics area" (menu item 3) should be selected.
History	

Injury Memo—Memo Field

Name in Database	NOTES_INJ
Definition	Memos are hospital defined fields for notes that are not transferred to the Registry Office. This field is to be used for injury notes.
Additional Information	
History	

Section 3: Scene Data

Scene Memo

Name in Database	NoteS_PRE
Definition	Memo field for scene information
Additional Information	Memos are hospital defined fields for notes that are not transferred to the Registry Office. This field is to be used for scene notes.
History	Excluded as of September 1, 2004

User Defined Fields (Prehosp 1 through 18)

Name in Database	PREHOSP1 PREHOSP2 PREHOSP3 PREHOSP4 PREHOSP5 PREHOS PREHOSP7 PREHOSP8 PREHOSP9 PREHOSP10 PREHOSP11 PREHOSP12 PREHOSP13 PREHOSP14 PREHOSP15 PREHOSP16 PREHOSP17 PREHOSP18
Definition	User defined fields
Additional Information	18 fields for hospital's own use, not transmitted to the OTR.
History	

Section 4: Primary Hospital

Number of Qualified Personnel (1st, 2nd and 3rd Providers from Primary Hospital)

Name in Database	BLS_1_P, ALS_1_P, RN_1_P, RT_1_P, MD_1_P, CCT_1_P, OTH_1_P,UNK_1_P, BLS_2_P, ALS_2_P, RN_2_P, RT_2_P, MD_2_P, CCT_2_P,OTH_2_P,UNK_2_P, BLS_3_P, ALS_3_P, RN_3_P, RT_3_P, MD_3_P, CCT_3_P,OTH_3_P,UNK_3_P
Definition	Number of personnel from the following groups: Basic life support, advanced life support, nursing, respiratory therapy, MD, critical care transport, other and unknown, accompanying the patient during transport for the first, second and third providers from the primary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Run Sheet Available (2nd and 3rd Providers from Primary Hospital)

Name in Database	RUNSHT_2_P, RNSHT_3_P
Definition	Availability of the run sheet for the second provider from the primary hospital to the secondary or lead trauma hospital.
Additional Information	
History	Excluded as of April 1, 1998

Pre-Hospital Number (2nd and 3rd Providers from Primary Hospital)

Name in Database	PHTN_2_P, PHTN_3_P
Definition	Pre-hospital number for the second and third provider from the primary hospital to the secondary or lead trauma hospital.
Additional Information	
History	Excluded as of April 1, 1998

Mode of Transport (3rd Provider from Primary Hospital)

Name in Database	MODE_3_P
Definition	Mode of transport for the third provider from the primary hospital to the second or lead/trauma hospital.
Additional Information	
History	Excluded as of April 1, 1998

Transport Service (3rd provider from Primary Hospital)

Name in Database	SERV_3_P
Definition	The three-digit ambulance service number from the ACR for land ambulances only.
Additional Information	
History	Excluded as of April 1, 1998

CT Scan Locations 1-5—Primary Hospital

Name in Database	CT_SCAN_P1, CT_SCAN_P2, CT_SCAN_P3, CT_SCAN_P4, CT_SCAN_P5
Definition	CT Scan Locations at the Primary Hospital
Additional Information	
History	Excluded as of April 1, 1998

ICP Days

Name in Database	ICP_DAY_P
Definition	The number of ICP days at the primary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Operation 2–5, Elapsed Time

Name in Database	For operation 2: OP_02_P_ET For operation 3: OP_03_P_ET For operation 4: OP_04_P_ET For operation 5: OP_05_P_ET
Definition	Elapsed time of the OR visit at the primary hospital is a calculated field based on the time of entry and exit to the operating room theatre. Total elapsed time will be displayed on the screen in minutes.
Additional Information	
History	Excluded as of April 1, 1998.

Operation 2–5, Date of OR Visit

Name in Database	For operation 2: OP_02_P_M, OP_02_P_D, OP_02_P_Y For operation 3: OP_03_P_M, OP_03_P_D, OP_03_P_Y For operation 4: OP_04_P_M, OP_04_P_D, OP_04_P_Y For operation 5; OP_05_P_M, OP_05_P_D, OP_05_P_Y
Definition	The date of the OR visit at the primary hospital (MM DD YYYY).
Additional Information	
History	Excluded as of April 1, 1998.

Operation 2–5, Start Time of OR Visit

Name in Database	For operation 2: OP_02_P_SH, OP_02_P_SM For operation 3: OP_03_P_SH, OP_03_P_SM For operation 4: OP_04_P_SH, OP_04_P_SM For operation 5; OP_05_P_SH, OP_05_P_SM
Definition	The start time of the OR visit at the primary hospital using the 24 hour clock. Start time is defined as the time of entry to the operating room theatre.
Additional Information	
History	Excluded as of April 1, 1998.

Operation 2–5, Finish Time of OR Visit

Name in Database	For operation 2: OP_02_P_FH, OP_02_P_FM For operation 3: OP_03_P_FH, OP_03_P_FM For operation 4: OP_04_P_FH, OP_04_P_FM For operation 5; OP_05_P_FH, OP_05_P_FM
Definition	The finish time of the OR visit at the primary hospital using the 24 hour clock. Finish time is defined as the time of exit from the operating room theatre.
Additional Information	
History	Excluded as of April 1, 1998.

Operation 1–5, Procedures 1–8 on Admission to Primary Hospital—ICD-9

Name in Database	For operation 1: OP_01_P_P1, OP_01_P_P2, OP_01_P_P3, OP_01_P_P4, OP_01_P_P5, OP_01_P_P6, OP_01_P_P7, OP_01_P_P8 For operation 2: OP_02_P_P1, OP_02_P_P2, OP_02_P_P3, OP_02_P_P4, OP_02_P_P5, OP_02_P_P6, OP_02_P_P7, OP_02_P_P8 For operation 3: OP_03_P_P1, OP_03_P_P2, OP_03_P_P3, OP_03_P_P4, OP_03_P_P5, OP_03_P_P6, OP_03_P_P7, OP_03_P_P8 For operation 4: OP_04_P_P1, OP_04_P_P2, OP_04_P_P3, OP_04_P_P4, OP_04_P_P5, OP_04_P_P6, OP_04_P_P7, OP_04_P_P8 For operation 5; OP_05_P_P1, OP_05_P_P2, OP_05_P_P3, OP_05_P_P4, OP_05_P_P5, OP_05_P_P6, OP_05_P_P7, OP_05_P_P8
Definition	The ICD-9-CM codes for up to eight procedures for each of the five OR visits at the primary hospital.
Additional Information	Field repeats 8 times for each operation (1 to 5).
History	OP_01_P_P1—P8: excluded as of September 1, 2004. All other fields are excluded as of April 1, 1998.

Operation 2–5, Procedures 1–8 on Admission to Primary Hospital—ICD-10

Name in Database	For operation 2: OP_02_A_T1, OP_02_A_T2, OP_02_A_T3, OP_02_A_T4, OP_02_A_T5, OP_02_A_T6, OP_02_A_T7, OP_02_A_T8 For operation 3: OP_03_A_T1, OP_03_A_T2, OP_03_A_T3, OP_03_A_T4, OP_03_A_T5, OP_03_A_T6, OP_03_A_T7, OP_03_A_T8 For operation 4: OP_04_A_T1, OP_04_A_T2, OP_04_A_T3, OP_04_A_T4, OP_04_A_T5, OP_04_A_T6, OP_04_A_T7, OP_04_A_T8 For operation 5; OP_05_A_T1, OP_05_A_T2, OP_05_A_T3, OP_05_A_T4, OP_05_A_T5, OP_05_A_T6, OP_05_A_T7, OP_05_A_T8
Definition	The ICD-10 codes for up to eight procedures for each of the OR visits at the primary hospital.
Additional Information	Field repeats 8 times for each operation (2 to 5).
History	Excluded as of September 1, 2004.

Operation 2–5, Procedures 1–8—Status

Name in Database	For operation 2: OP_02_P_A1, OP_02_P_A2, OP_02_P_A3, OP_02_P_A4, OP_02_P_A5, OP_02_P_A6, OP_02_P_A7, OP_02_P_A8, For operation 3: OP_03_P_A1, OP_03_P_A2, OP_03_P_A3, OP_03_P_A4, OP_03_P_A5, OP_03_P_A6, OP_03_P_A7, OP_03_P_A8, For operation 4: OP_04_P_A1, OP_04_P_A2, OP_04_P_A3, OP_04_P_A4, OP_04_P_A5, OP_04_P_A6, OP_04_P_A7, OP_04_P_A8, For operation 5; OP_05_P_A1, OP_05_P_A2, OP_05_P_A3, OP_05_P_A4, OP_05_P_A5, OP_05_P_A6, OP_05_P_A7, OP_05_P_A8,
Definition	The code as found in the Mandatory Attributes for DAD chart that corresponds to each of the 4OR operative procedure.
Additional Information	Field repeats 8 times per operation. This field may not be required to complete for certain procedures.
History	Excluded as of September 1, 2004

Operation 2–5, Procedures 1–8—Location

Name in Database	For operation 2: OP_02_P_L1, OP_02_P_L2, OP_02_P_L3, OP_02_P_L4, OP_02_P_L5, OP_02_P_L6, OP_02_P_L7, OP_02_P_L8 For operation 3: OP_03_P_L1, OP_03_P_L2, OP_03_P_L3, OP_03_P_L4, OP_03_P_L5, OP_03_P_L6, OP_03_P_L7, OP_03_P_L8 For operation 4: OP_04_P_L1, OP_04_P_L2, OP_04_P_L3, OP_04_P_L4, OP_04_P_L5, OP_04_P_L6, OP_04_P_L7, OP_04_P_L8 For operation 5: OP_05_P_L1, OP_05_P_L2, OP_05_P_L3, OP_05_P_L4, OP_05_P_L5, OP_05_P_L6, OP_05_P_L7, OP_05_P_L8
Definition	The code as found in the Mandatory Attributes for DAD chart that corresponds to each of the four operative procedures.
Additional Information	Field repeats eight times per operation. This field may not be required to complete for certain procedures.
History	Excluded as of September 1, 2004.

Operation 1–5, Procedures 1–8—Extent

Name in Database	For operation 2: OP_02_P_X1, OP_02_P_X2, OP_02_P_X3, OP_02_P_X4, OP_02_P_X5, OP_02_P_X6, OP_02_P_X7, OP_02_P_X8 For operation 3: OP_03_P_X1, OP_03_P_X2, OP_03_P_X3, OP_03_P_X4, OP_03_P_X5, OP_03_P_X6, OP_03_P_X7, OP_03_P_X8 For operation 4: OP_04_P_X1, OP_04_P_X2, OP_04_P_X3, OP_04_P_X4, OP_04_P_X5, OP_04_P_X6, OP_04_P_X7, OP_04_P_X8 For operation 5: OP_05_P_X1, OP_05_P_X2, OP_05_P_X3, OP_05_P_X4, OP_05_P_X5, OP_05_P_X6, OP_05_P_X7, OP_05_P_X8
Definition	The code as found in the Mandatory Attributes for DAD chart that corresponds to each of the four operative procedures.
Additional Information	Field repeats eight times per operation. This field may not be required to complete for certain procedures.
History	Excluded as of September 1, 2004.

Operation 1–5, Procedures 1–8—Mode of Delivery

Name in Database	For operation 2: OP_02_P_M1, OP_02_P_M2, OP_02_P_M3, OP_02_P_M4, OP_02_P_M5, OP_02_P_M6, OP_02_P_M7, OP_02_P_M8 For operation 3: OP_03_P_M1, OP_03_P_M2, OP_03_P_M3, OP_03_P_M4, OP_03_P_M5, OP_03_P_M6, OP_03_P_M7, OP_03_P_M8 For operation 4: OP_04_P_M1, OP_04_P_M2, OP_04_P_M3, OP_04_P_M4, OP_04_P_M5, OP_04_P_M6, OP_04_P_M7, OP_04_P_M8 For operation 5: OP_05_P_M1, OP_05_P_M2, OP_05_P_M3, OP_05_P_M4, OP_05_P_M5, OP_05_P_M6, OP_05_P_M7, OP_05_P_M8
Definition	The code as found in the Mandatory Attributes for DAD chart that corresponds to each of the four operative procedures.
Additional Information	Field repeats eight times per operation. This field may not be required to complete for certain procedures.
History	Excluded as of September 1, 2004.

Operation 1–5, Procedures 1–8—Service

Name in Database	For operation 1: OP_01_P_S1, OP_01_P_S2, OP_01_P_S3, OP_01_P_S4, OP_01_P_S5, OP_01_P_S6, OP_01_P_S7, OP_01_P_S8 For operation 2: OP_02_P_S1, OP_02_P_S2, OP_02_P_S3, OP_02_P_S4, OP_02_P_S5, OP_02_P_S6, OP_02_P_S7, OP_02_P_S8 For operation 3: OP_03_P_S1, OP_03_P_S2, OP_03_P_S3, OP_03_P_S4, OP_03_P_S5, OP_03_P_S6, OP_03_P_S7, OP_03_P_S8 For operation 4: OP_04_P_S1, OP_04_P_S2, OP_04_P_S3, OP_04_P_S4, OP_04_P_S5, OP_04_P_S6, OP_04_P_S7, OP_04_P_S8 For operation 5: OP_05_P_S1, OP_05_P_S2, OP_05_P_S3, OP_05_P_S4, OP_05_P_S5, OP_05_P_S6, OP_05_P_S7, OP_05_P_S8
Definition	Physician service for the procedures performed during each of the 5 OR visits at the primary hospital.
Additional Information	This field may not be required to complete for certain procedures.
History	Excluded as of April 1, 1998.

Referring Physician (Primary Hospital)

Name in Database	REFER_PHYS
Definition	The name of the referring physician at the primary hospital
Additional Information	This field has a hospital defined menu. Format should be Surname, First Name or Initial (no period).
History	

Primary Hospital Memo

Name in Database	NoteS_REF1
Definition	Memo field for primary hospital notes
Additional Information	
History	Excluded as of September 1, 2004.

Section 5: Secondary Hospital

Date of Arrival at Secondary Hospital

Name in Database	SEC_AR_D_M, SEC_AR_D_D, SEC_AR_D_Y
Definition	The patient's date of arrival at the secondary institution (MMDDYYYY)
Additional Information	
History	Excluded as of April 1, 1998

Time of Arrival at Secondary Hospital

Name in Database	SEC_AR_T_H, SEC_AR_T_M
Definition	The patient's time of arrival at the secondary hospital using the 24 hour clock.
Additional Information	
History	Excluded as of April 1, 1998

Date of Departure at Secondary Hospital

Name in Database	SEC_DP_D_M, SEC_DP_D_D, SEC_DP_D_Y
Definition	The date of departure from the secondary hospital (MMDDYYYY).
Additional Information	
History	Excluded as of April 1, 1998

Time of Departure at Secondary Hospital

Name in Database	SEC_DP_T_H, SEC_DP_T_M
Definition	The patient's time of arrival at the secondary hospital using the 24 hour clock.
Additional Information	
History	Excluded as of April 1, 1998

Referring Physician (Secondary Hospital)

Name in Database	SEC_REF_MD
Definition	The name of the referring physician at the secondary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Temperature (Secondary Hospital)

Name in Database	TEMP_L
Definition	The patient's first recorded temperature in Celsius degrees at the secondary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Heart Rate (Secondary Hospital)

Name in Database	PULSE_L
Definition	The patient's first recorded heart rate per minute at the secondary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Unassisted Respiration Rate (Secondary Hospital)

Name in Database	RESP_RAT_L
Definition	The patient's first recorded unassisted respiratory rate per minute at the secondary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Systolic Blood Pressure (Secondary Hospital)

Name in Database	RESP_RAT_L
Definition	The patient's first recorded unassisted respiratory rate per minute at the secondary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Pediatric Trauma Score (Secondary Hospital)

Name in Database	PTS_L
Definition	The Pediatric Trauma Score at the secondary hospital for patients <16 years of age.
Additional Information	
History	Excluded as of April 1, 1998

Was the patient intubated? (Secondary Hospital)

Name in Database	INTUBAT_L
Definition	Was the patient intubated at the time the GCS was calculated at the secondary hospital?
Additional Information	
History	Excluded as of April 1, 1998

Paralytic Agents in Effect (Secondary Hospital)

Name in Database	PAR_AGNT_L
Definition	Were paralytic agents in effect at the time the GCS was calculated at the secondary hospital?
Additional Information	
History	Excluded as of April 1, 1998

Eye (Secondary Hospital)

Name in Database	EYE_OPNG_L
Definition	The patient's best eye-opening response for the Glasgow Coma Scale at the secondary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Verbal (Secondary Hospital)

Name in Database	VER_RESP_L
Definition	The patient's best verbal response for the Glasgow Coma Scale at the secondary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Motor (Secondary Hospital)

Name in Database	MOT_RESP_L
Definition	The patient's best motor response score for the Glasgow Coma Scale at the secondary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Total GCS (Secondary Hospital)

Name in Database	DISP_GCS_L
Definition	Total Glasgow Coma Scale at the secondary hospital is a calculated field based on eye-opening, verbal and motor responses.
Additional Information	
History	Excluded as of April 1, 1998

Total RTS (Secondary Hospital)

Name in Database	DISP_RTS_L
Definition	Revised Trauma Score at the secondary hospital is a calculated field based on Glasgow Coma Scale, systolic blood pressure and respiratory rate.
Additional Information	
History	Excluded as of April 1, 1998

BAC (mmol/L) (Secondary Hospital)

Name in Database	ETOH_BAC_L
Definition	The patient's blood alcohol concentration in SI units at the secondary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Mode of Transport (1st, 2nd and 3rd Provider from Secondary Hospital)

Name in Database	MODE_1_L, Mode_2_L, Mode_3_L
Definition	The mode of transport for the first, second, and third provider (land or air vehicle) from the secondary hospital to a lead/trauma hospital.
Additional Information	
History	Excluded as of April 1, 1998

Transport Service (1st, 2nd, 3rd Provider from Secondary Hospital)

Name in Database	SERV_1_L, SERV_2_L, SERV_3_L
Definition	The three-digit ambulance service number from the ACR for land ambulances only.
Additional Information	
History	Excluded as of April 1, 1998

Runsheet Available (1st, 2nd, 3rd Provider from Secondary Hospital)

Name in Database	RUNSHT_1_L, RUNSHT_2_L, RUNSHT_3_L
Definition	Is the pre-hospital run sheet available for the first, second, and third providers (land or air vehicle) from the secondary hospital to the lead/trauma hospital prior to discharge?
Additional Information	
History	Excluded as of April 1, 1998

Pre-hospital Number (1st, 2nd, 3rd Provider from Secondary Hospital)

Name in Database	PHTN_1_L, PHTN_2_L, PHTN_3_L
Definition	The pre-hospital transport number for the first, second, and third provider (land or air vehicle) from the first secondary hospital to the lead/trauma hospital.
Additional Information	
History	Excluded as of April 1, 1998

Number of Qualified Personnel (1st, 2nd, 3rd Provider from Secondary Hospital)

Name in Database	First Provider: BLS_1_L, ALS_1_L, RN_1_L, RT_1_L, MD_1_L, CCT_1_L, OTH_1_L, UNK_1_L Second Provider: BLS_2_L, ALS_2_L, RN_2_L, RT_2_L MD_2_L, CCT_2_L, OTH_2_L, UNK_2_L Third Provider: BLS_3_L, ALS_3_L, RN_3_L, RT_3_L MD_3_L, CCT_3_L, OTH_3_L, UNK_3_L
Definition	The number of personnel from each category accompanying the patient during the transport for the first, second, and third provider (land or air vehicle) from the secondary hospital to the lead/trauma hospital.
Additional Information	
History	Excluded as of April 1, 1998

Non-operative Procedures (Secondary Hospital)

Name in Database	NONOP_L_01, NONOP_L_02, NONOP_L_03, NONOP_L_04, NONOP_L_05, NONOP_L_06, NONOP_L_07, NONOP_L_08, NONOP_L_09, NONOP_L_10, NONOP_L_11, NONOP_L_12, NONOP_L_13, NONOP_L_14, NONOP_L_15, NONOP_L_16, NONOP_L_17, NONOP_L_18, NONOP_L_19, NONOP_L_20
Definition	Up to 20 non-operative procedures performed in the secondary hospital emergency department only.
Additional Information	
History	Excluded as of April 1, 1998

Other Non-operative Procedures (Secondary Hospital)

Name in Database	NONOP_L_O1, NONOP_L_O2, NONOP_L_O3, NONOP_L_O4, NONOP_L_O5
Definition	Up to five other non-operative procedures not included in the previous menu completed in the secondary hospital emergency department only.
Additional Information	
History	Excluded as of April 1, 1998

CT Scan Location (Secondary Hospital)

Name in Database	CT_SCAN_L1, CT_SCAN_L2, CT_SCAN_L3, CT_SCAN_L4,CT_SCAN_L5
Definition	Up to five locations of CT scans done at the secondary hospital emergency department.
Additional Information	
History	Excluded as of April 1, 1998

IV Sites (Secondary Hospital) (Excluded)

Name in Database	IV_LINE_L
Definition	The total number of IV sites in place at the secondary hospital including IV sites established during transport.
Additional Information	
History	Excluded as of April 1, 1998

Ventilator Days (Secondary Hospital)

Name in Database	VENT_DAY_L
Definition	The number of days the patient was intubated and mechanically ventilated intermittently or continuously excluding non-intubated patients on BIPAP and intubated patients on CPAP at the **secondary** hospital.
Additional Information	
History	Excluded as of April 1, 1998

ICP Days (Secondary Hospital)

Name in Database	ICP_DAY_L
Definition	Number of ICP days at the secondary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Number of OR Visits (Secondary Hospital)

Name in Database	NUM_OR_L
Definition	The number of OR visits (not procedures) at the secondary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Date of 1st-5th OR Visit (Secondary Hospital)

Name in Database	First Visit: OP_01_L_M, OP_01_L_D, OP_01_L_Y Second Visit: OP_02_L_M, OP_02_L_D, OP_02_L_Y Third Visit: OP_03_L_M, OP_03_L_D, OP_03_L_Y Fourth Visit: OP_04_L_M, OP_04_L_D, OP_04_L_Y Fifth Visit: OP_05_L_M, OP_05_L_D, OP_05_L_Y
Definition	The date of the first through fifth OR visits at the secondary hospital (MMDDYYYY).
Additional Information	
History	Excluded as of April 1, 1998

Start Time of 1st-5th OR Visit (Secondary Hospital)

Name in Database	First Visit: OP_01_L_SH, OP_01_L_SM Second Visit: OP_02_L_SH, OP_02_L_SM Third Visit: OP_03_L_SH, OP_03_L_SM Fourth Visit: OP_04_L_SH, OP_04_L_SM Fifth Visit: OP_05_L_SH, OP_05_L_SM
Definition	The start time of the first through fifth OR visits at the secondary hospital using the 24 hour clock.
Additional Information	
History	Excluded as of April 1, 1998

Finish Time of 1st-5th OR Visit (Secondary Hospital)

Name in Database	First Visit: OP_01_L_FH, OP_01_L_FM Second Visit: OP_02_L_FH, OP_02_L_FM Third Visit: OP_03_L_FH, OP_03_L_FM Fourth Visit: OP_04_L_FH, OP_04_L_FM Fifth Visit: OP_05_L_FH, OP_05_L_FM
Definition	The finish time of the first through fifth OR visits at the secondary hospital using the 24 hour clock.
Additional Information	
History	Excluded as of April 1, 1998

Elapsed Time of 1st-5th OR Visit (Secondary Hospital)

Name in Database	First Visit: OP_01_L_ET Second Visit: OP_02_L_ET Third Visit: OP_03_L_ET Fourth Visit: OP_04_L_ET Fifth Visit: OP_05_L_ET
Definition	Elapsed time of the first through fifth OR visits at the secondary hospital is a calculated field based on the time of entry and exit to the operating room theatre.
Additional Information	
History	Excluded as of April 1, 1998

Operation #1-#5 Procedures 1-8 (Secondary Hospital)—ICD-9

Name in Database	First Operation: OP_01_L_P1, OP_01_L_P2, OP-01_L_P3, OP_01_L_P4, OP_01_L_P5, OP_01_L_P6, OP_01_L_P7, OP_01_L_P8 Second Operation: OP_02_L_P1, OP_02_L_P2, OP_02_L_P3, OP_02_L_P4, OP_02_L_P5, OP_02_L_P6, OP_02_L_P7, OP_02_L_P8 Third Operation: OP_03_L_P1, OP_03_L_P2, OP_03_L_P3, OP_03_L_P4, OP_03_L_P5, OP_03_L_P6, OP_03_L_P7, OP_03_L_P8 Fourth Operation: OP_04_L_P1, OP_04_L_P2, OP_04_L_P3, OP_04_L_P4, OP_04_L_P5, OP_04_L_P6, OP_04_L_P7, OP_04_L_P8 Fifth Operation: OP_05_L_P1, OP_05_L_P2, OP_05_L_P3, OP_05_L_P4, OP_05_L_P5, OP_05_L_P6, OP_05_L_P7, OP_05_L_P8
Definition	The ICD-9-CM procedure codes for up to eight procedures for the first five OR visits at the secondary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Operation #1-#5 CCI Procedures 1-8 (Secondary Hospital)—ICD-10

Name in Database	First Operation: OP_01_L_T1, OP_01_L_T2, OP_01_L_T3, OP_01_L_T4, OP_01_L_T5, OP_01_L_T6, OP_01_L_T7, OP_01_L_T8 Second Operation: OP_02_L_T1, OP_02_L_T2, OP_02_L_T3, OP_02_L_T4, OP_02_L_T5, OP_02_L_T6, OP_02_L_T7, OP_02_L_T8 Third Operation: OP_03_L_T1, OP_03_L_T2, OP_03_L_T3, OP_03_L_T4, OP_03_L_T5, OP_03_L_T6, OP_03_L_T7, OP_03_L_T8 Fourth Operation: OP_04_L_T1, OP_04_L_T2, OP_04_L_T3, OP_04_L_T4, OP_04_L_T5, OP_04_L_T6, OP_04_L_T7, OP_04_L_T8 Fifth Operation: OP_05_L_T1, OP_05_L_T2, OP_05_L_T3, OP_05_L_T4, OP_05_L_T5, OP_05_L_T6, OP_05_L_T7, OP_05_L_T8
Definition	The ICD-10-CA procedure codes for up to eight procedures for the first five OR visits at the secondary hospital.
Additional Information	
History	Excluded as of April 1, 1998

Operation #1-#5 Procedures 1-8 (Secondary Hospital)—Status

Name in Database	First Operation: OP_01_L_A1, OP_01_L_A2, OP_01_L_A3, OP_01_L_A4, OP_01_L_A5, OP_01_L_A6, OP_01_L_A7, OP_01_L_A8 Second Operation: OP_02_L_A1, OP_02_L_A2, OP_02_L_A3, OP_02_L_A4,OP_02_L_A5, OP_02_L_A6, OP_02_L_A7, OP_02_L_A8 Third Operation: OP_03_L_A1, OP_03_L_A2, OP_03_L_A3, OP_03_L_A4, OP_03_L_A5, OP_03_L_A6, OP_03_L_A7, OP_03_L_A8 Fourth Operation: 04_L_A1, OP_04_L_A2, OP_04_L_A3, OP_04_L_A4, OP_04_L_A5, OP_04_L_A6, OP_04_L_A7, OP_04_L_A8 Fifth Operation: 05_L_A1, OP_05_L_A2, OP_05_L_A3, OP_05_L_A4, OP_05_L_A5, OP_05_L_A6, OP_05_L_A7, OP_05_L_A8
Definition	The code as found in the Mandatory Attributes for DAD chart that corresponds to each of the five operative procedures.
Additional Information	
History	Excluded as of April 1, 1998

Operation #1-#5 Procedures 1–8 (Secondary Hospital)—Location

Name in Database	First Operation: OP_01_L_L1, OP_01_L_L2, OP_01_L_L3, OP_01_L_L4, OP_01_L_L5, OP_01_L_L6, OP_01_L_L7, OP_01_L_L8 Second Operation: OP_02_L_L1, OP_02_L_L2, OP_02_L_L3, OP_02_L_L4, OP_02_L_L5, OP_02_L_L6, OP_02_L_L7, OP_02_L_L8 Third Operation: OP_03_L_L1, OP_03_L_L2, OP_03_L_L3, OP_03_L_L4, OP_03_L_L5, OP_03_L_L6, OP_03_L_L7, OP_03_L_L8 Fourth Operation: OP_04_L_L1, OP_04_L_L2, OP_04_L_L3, OP_04_L_L4, OP_04_L_L5, OP_04_L_L6, OP_04_L_L7, OP_04_L_L8 Fifth Operation: OP_05_L_L1, OP_05_L_L2, OP_05_L_L3, OP_05_L_L4, OP_05_L_L5, OP_05_L_L6, OP_05_L_L7, OP_05_L_L8
Definition	The code as found in the Mandatory Attributes for DAD chart that corresponds to each of the five operative procedures.
Additional Information	
History	Excluded as of April 1, 1998

Operation #1-#5 Procedures 1–8 (Secondary Hospital)—Extent

Name in Database	First Operation: OP_01_L_X1, OP_01_L_X2, OP_01_L_X3, OP_01_L_X4, OP_01_L_X5, OP_01_L_X6, OP_01_L_X7, OP_01_L_X8 Second Operation: OP_02_L_X1, OP_02_L_X2, OP_02_L_X3, OP_02_L_X4, OP_02_L_X5, OP_02_L_X6, OP_02_L_X7, OP_02_L_X8 Third Operation: OP_03_L_X1, OP_03_L_X2, OP_03_L_X3, OP_03_L_X4, OP_03_L_X5, OP_03_L_X6, OP_03_L_X7, OP_03_L_X8 Fourth Operation: OP_04_L_X1, OP_04_L_X2, OP_04_L_X3, OP_04_L_X4, OP_04_L_X5, OP_04_L_X6, OP_04_L_X7, OP_04_L_X8 Fifth Operation: OP_05_L_X1, OP_05_L_X2, OP_05_L_X3, OP_05_L_X4, OP_05_L_X5, OP_05_L_X6, OP_05_L_X7, OP_05_L_X8
Definition	The code as found in the Mandatory Attributes for DAD chart that corresponds to each of the five operative procedures.
Additional Information	
History	Excluded as of April 1, 1998

Operation 1–5 Procedures 1–8 (Secondary Hospital)—Mode of Delivery

Name in Database	First Operation: OP_01_L_M1, OP_01_L_M2, OP_01_L_M3, OP_01_L_M4, OP_01_L_M5, OP_01_L_M6, OP_01_L_M7, OP_01_L_M8 Second Operation: OP_02_L_M1, OP_02_L_M2, OP_02_L_M3, OP_02_L_M4, OP_02_L_M5, OP_02_L_M6, OP_02_L_M7, OP_02_L_M8 Third Operation: OP_03_L_M1, OP_03_L_M2, OP_03_L_M3, OP_03_L_M4, OP_03_L_M5, OP_03_L_M6, OP_03_L_M7, OP_03_L_M8 Fourth Operation: OP_04_L_M1, OP_04_L_M2, OP_04_L_M3, OP_04_L_M4, OP_04_L_M5, OP_04_L_M6, OP_04_L_M7, OP_04_L_M8 Fifth Operation: OP_05_L_M1, OP_05_L_M2, OP_05_L_M3, OP_05_L_M4, OP_05_L_M5, OP_05_L_M6, OP_05_L_M7, OP_05_L_M8
Definition	The code as found in the Mandatory Attributes for DAD chart that corresponds to each of the five operative procedures.
Additional Information	
History	Excluded as of April 1, 1998

Services Performing Operation 1–5 Procedures 1–8 (Secondary Hospital)

Name in Database	First Operation: OP_01_L_S1, OP_01_L_S2, OP_01_L_S3, OP_01_L_S4, OP_01_L_S5, OP_01_L_S6, OP_01_L_S7, OP_01_L_S8
	Second Operation: OP_02_L_S1, OP_02_L_S2, OP_02_L_S3, OP_02_L_S4, OP_02_L_S5, OP_02_L_S6, OP_02_L_S7, OP_02_L_S8
	Third Operation: OP_03_L_S1, OP_03_L_S2, OP_03_L_S3, OP_03_L_S4, OP_03_L_S5, OP_03_L_S6, OP_03_L_S7, OP_03_L_S8
	Fourth Operation: OP_04_L_S1, OP_04_L_S2, OP_04_L_S3, OP_04_L_S4, OP_04_L_S5, OP_04_L_S6, OP_04_L_S7, OP_04_L_S8
	Fifth Operation: OP_05_L_S1, OP_05_L_S2, OP_05_L_S3, OP_05_L_S4, OP_05_L_S5, OP_05_L_S6, OP_05_L_S7, OP_05_L_S8
Definition	The code as found in the Mandatory Attributes for DAD chart that corresponds to each of the five operative procedures.
Additional Information	
History	Excluded as of April 1, 1998

Secondary Hospital Memo

Name in Database	NoteS_REF2
Definition	Memos are hospital defined fields for notes that are not transferred to the Registry Office.
Additional Information	This field is to be used for secondary hospital notes.
History	Excluded as of September 1, 2004

Section 6: Lead/Trauma Hospital

Admitting Patient Service

Name in Database	ADMIT_ZRV
Definition	Select the admitting patient service to which the patient was admitted.
Additional Information	This menu lists the CIHI patient services under the broad categories of General and Pediatric. A complete list of CIHI patient services can be found in Appendix E. This field is optional and is intended for institutions that have a trauma service. Hospitals without a trauma service are not required to complete this field. Hospitals that have a trauma service should complete this field in order to distinguish between physician and patient service in situations where the patient is admitted to a trauma service but the admitting physician is not a traumatologist. **(Working Group 04/05)**
History	

ED MD

Name in Database	ED_MD
Definition	The name of the emergency physician or attending physician as appropriate at the hospital.
Additional Information	This field has a hospital defined menu. This data element will not be transmitted to the Ontario Trauma Registry (CIHI). This field will be skipped if Direct Admission to Service (Bypass ED) is "Yes."
History	

Trauma Team Leader

Name in Database	TRAUMA_LDR
Definition	The name of the Trauma Team Leader at the lead/trauma hospital.
Additional Information	This field has a hospital defined menu and can be used as appropriate at your hospital. This data element will not be transmitted to the Ontario Trauma Registry (CIHI).
History	

Lead/Trauma Hospital Memo

Name in Database	NoteS_ED
Definition	Memos are hospital defined fields for notes that are not transferred to the Registry Office.
Additional Information	This field is to be used for lead/trauma hospital notes.
History	

User Defined Field

Name in Database	EDCARE1 EDCARE2 EDCARE3 EDCARE4 EDCARE5 EDCARE6 EDCARE7 EDCARE8 EDCARE9 EDCARE10 EDCARE11 EDCARE12 EDCARE13 EDCARE14 EDCARE15 EDCARE16 EDCARE17 EDCARE18 EDCARE19 EDCARE20 EDCARE21 EDCARE22 EDCARE23 EDCARE24 EDCARE25 EDCARE26 EDCARE27
Definition	
Additional Information	
History	

Section 7: Lead/Trauma Hospital Care

Patient Service Transfer 1–3—Service

Name in Database	XFEZ_1_SRV, XFEZ_2_SRV, XFEZ_3_SRV
Definition	The first, second, and third patient service to which the patient was transferred.
Additional Information	Note that Patient Service fields are Optional, and use is at the discretion of the individual trauma hospital.
History	Patient Service fields are optional and use is at the discretion of the individual trauma hospital (Effective April 1, 2005).

Patient Service Transfer 1-3—Admitted Date

Name in Database	XFEZ_1_A_M, XFEZ_1_A_D, XFEZ_1_A_Y XFEZ_2_A_M, XFEZ_2_A_D, XFEZ_2_A_Y XFEZ_3_A_M, XFEZ_3_A_D, XFEZ_3_A_Y
Definition	The date of admission for the first, second, and third patient service to which the patient was transferred.
Additional Information	Note that Patient Service fields are Optional, and use is at the discretion of the individual trauma hospital.
History	Patient Service fields are optional and use is at the discretion of the individual trauma hospital.

Patient Service Transfer 1–3—Discharged Date

Name in Database	XFEZ_1_D_M, XFEZ_1_D_D, XFEZ_1_D_Y XFEZ_2_D_M, XFEZ_2_D_D, XFEZ_2_D_Y XFEZ_3_D_M, XFEZ_3_D_D, XFEZ_3_D_Y
Definition	The date of discharge for the first, second, and third patient service to which the patient was transferred.
Additional Information	Note that Patient Service fields are Optional, and use is at the discretion of the individual trauma hospital.
History	

Patient Service Transfer 1–3—Length of Stay

Name in Database	XFEZ_1_LOS, XFEZ_2_LOS, XFEZ_3_LOS
Definition	The date of discharge for the first, second, and third patient service to which the patient was transferred.
Additional Information	Note that Patient Service fields are Optional, and use is at the discretion of the individual trauma hospital.
History	

Physician Service Transfer 4-6—Service

Name in Database	XFER_4_SRV, XFER_5_SRV, XFER_6_SRV
Definition	The fourth, fifth, and sixth physician service to which the patient was transferred.
Additional Information	
History	Excluded as of April 1, 1998

Physician Service Transfer 4-6—Admitted Date

Name in Database	XFER_4_A_M, XFER_4_A_D, XFER_4_A_Y XFER_5_A_M, XFER_5_A_D, XFER_5_A_Y XFER_6_A_M, XFER_6_A_D, XFER_6_A_Y
Definition	The date of admission for the fourth, fifth, and sixth physician service to which the patient was transferred.
Additional Information	
History	Excluded as of April 1, 1998

Physician Service Transfer 4–6—Discharged Date

Name in Database	XFER_4_D_M, XFER_4_D_D, XFER_4_D_Y XFER_5_D_M, XFER_5_D_D, XFER_5_D_Y XFER_6_D_M, XFER_6_D_D, XFER_6_D_Y
Definition	The date of discharge for the fourth, fifth, and sixth physician service to which the patient was transferred.
Additional Information	
History	Excluded as of April 1, 1998

Physician Service Transfer 4–6—Length of Stay

Name in Database	XFER_4_LOS, XFER_5_LOS, XFER_6_LOS
Definition	The date of discharge for the fourth, fifth, and sixth physician service to which the patient was transferred.
Additional Information	
History	Excluded as of April 1, 1998

Patient Service Transfer 4-6—Service

Name in Database	XFEZ_4_SRV, XFEZ_5_SRV, XFEZ_6_SRV
Definition	The fourth, fifth, and sixth patient service to which the patient was transferred.
Additional Information	Note that Patient Service fields are Optional, and use is at the discretion of the individual trauma hospital.
History	Excluded as of September 1, 2004

Patient Service Transfer 4-6—Admitted Date

Name in Database	XFEZ_4_A_M, XFEZ_4_A_D, XFEZ_4_A_Y XFEZ_5_A_M, XFEZ_5_A_D, XFEZ_5_A_Y XFEZ_6_A_M, XFEZ_6_A_D, XFEZ_6_A_Y
Definition	The date of admission for the fourth, fifth, and sixth patient service to which the patient was transferred.
Additional Information	Note that Patient Service fields are Optional, and use is at the discretion of the individual trauma hospital.
History	Excluded as of September 1, 2004

Patient Service Transfer 4–6—Discharged Date

Name in Database	XFEZ_4_D_M, XFEZ_4_D_D, XFEZ_4_D_Y XFEZ_5_D_M, XFEZ_5_D_D, XFEZ_5_D_Y XFEZ_6_D_M, XFEZ_6_D_D, XFEZ_6_D_Y
Definition	The date of discharge for the fourth, fifth, and sixth patient service to which the patient was transferred.
Additional Information	Note that Patient Service fields are Optional, and use is at the discretion of the individual trauma hospital.
History	Excluded as of September 1, 2004

Patient Service Transfer 4–6—Length of Stay

Name in Database	XFEZ_4_LOS, XFEZ_5_LOS, XFEZ_6_LOS
Definition	The date of discharge for the fourth, fifth, and sixth patient service to which the patient was transferred.
Additional Information	Note that Patient Service fields are Optional, and use is at the discretion of the individual trauma hospital.
History	Excluded as of September 1, 2004

Operation 1–10—Procedure 1–10—Service

Name in Database	OP_01_A_S1, OP_01_A_S2, OP_01_A_S3, OP_01_A_S4, OP_01_A_S5, OP_01_A_S6, OP_01_A_S7, OP_01_A_S8, OP_01_A_S9, OP_01_A_S0
	OP_02_A_S1, OP_02_A_S2, OP_02_A_S3, OP_02_A_S4, OP_02_A_S5, OP_02_A_S6, OP_02_A_S7, OP_02_A_S8, OP_02_A_S9, OP_02_A_S0
	OP_03_A_S1, OP_03_A_S2, OP_03_A_S3, OP_03_A_S4, OP_03_A_S5, OP_03_A_S6, OP_03_A_S7, OP_03_A_S8, OP_03_A_S9, OP_03_A_S0
	OP_04_A_S1, OP_04_A_S2, OP_04_A_S3, OP_04_A_S4, OP_04_A_S5, OP_04_A_S6, OP_04_A_S7, OP_04_A_S8, OP_04_A_S9, OP_04_A_S0
	OP_05_A_S1, OP_05_A_S2, OP_05_A_S3, OP_05_A_S4, OP_05_A_S5, OP_05_A_S6, OP_05_A_S7, OP_05_A_S8, OP_05_A_S9, OP_05_A_S0
	OP_01_A_S1, OP_01_A_S2, OP_01_A_S3, OP_01_A_S4, OP_01_A_S5, OP_01_A_S6, OP_01_A_S7, OP_01_A_S8, OP_01_A_S9, OP_01_A_S0
	OP_01_A_S1, OP_01_A_S2, OP_01_A_S3, OP_01_A_S4, OP_01_A_S5, OP_01_A_S6, OP_01_A_S7, OP_01_A_S8, OP_01_A_S9, OP_01_A_S0
	OP_01_A_S1, OP_01_A_S2, OP_01_A_S3, OP_01_A_S4, OP_01_A_S5, OP_01_A_S6, OP_01_A_S7, OP_01_A_S8, OP_01_A_S9, OP_01_A_S0
	OP_01_A_S1, OP_01_A_S2, OP_01_A_S3, OP_01_A_S4, OP_01_A_S5, OP_01_A_S6, OP_01_A_S7, OP_01_A_S8, OP_01_A_S9, OP_01_A_S0
	OP_01_A_S1, OP_01_A_S2, OP_01_A_S3, OP_01_A_S4, OP_01_A_S5, OP_01_A_S6, OP_01_A_S7, OP_01_A_S8, OP_01_A_S9, OP_01_A_S0
Definition	The physician service of the physician performing the operation or procedure.
Additional Information	
History	Operation and Procedure "Services" have been excluded from the OTR as of April 1, 1998.

Special Care Unit 3–5

Name in Database	SCU_3, SCU_4, SCU_5
Definition	Select the third, fourth, and fifth Special Care Unit to which the patient was admitted.
Additional Information	
History	Excluded as of April 1, 1998

Date of Special 3–5 Arrival—Lead Trauma—Date

Name in Database	SCU_3A_D_M, SCU_3A_D_D, SCU_3A_D_Y SCU_4A_D_M, SCU_4A_D_D, SCU_4A_D_Y SCU_5A_D_M, SCU_5A_D_D, SCU_5A_D_Y
Definition	The date of admission to the third, fourth, and fifth Special Care Unit.
Additional Information	The date of admission will default to the date of discharge from the second Special Care Unit.
History	Excluded as of April 1, 1998

Date of Special 3–5 Discharge—Lead Trauma—Date

Name in Database	SCU_3D_D_M, SCU_3D_D_D, SCU_3D_D_Y SCU_4D_D_M, SCU_4D_D_D, SCU_4D_D_Y SCU_5D_D_M, SCU_5D_D_D, SCU_5D_D_Y
Definition	The date of discharge from the third, fourth, and fifth Special Care Unit.
Additional Information	
History	Excluded as of April 1, 1998

3rd, 4th and 5th Special Care Unit—Length of Stay (in Days)

Name in Database	SCU_LOS_3, SCU_LOS_4, SCU_LOS_5
Definition	Length of stay for the third, fourth, and fifth special care unit is a calculated field based on the dates of admission and discharge from that unit.
Additional Information	Length of stay will be displayed on the screen when admission and discharge dates are entered for each service.
History	Excluded as of April 1, 1998

Lead/Trauma Hospital Care Memo—Memo Field

Name in Database	NoteS_INH
Definition	Memos are hospital defined fields for notes that are not transmitted to the Registry Office.
Additional Information	This field is used for lead/trauma hospital care notes.
History	Excluded as of September 1, 2004

Nursing Memo—Memo Field

Name in Database	NoteS_NURS
Definition	Memos are hospital defined fields for notes that are not transmitted to the Registry Office.
Additional Information	This field is used for nursing notes.
History	Excluded as of September 1, 2004

Quality Assurance Memo—Memo Field

Name in Database	NoteS_QA
Definition	Memos are hospital defined fields for notes that are not transmitted to the Registry Office.
Additional Information	This field is for quality assurance notes.
History	Excluded as of September 1, 2004

System Memo—Memo Field

Name in Database	NoteS_SYS
Definition	Memos are hospital defined fields for notes that are not transmitted to the Registry Office.
Additional Information	This field is for system notes.
History	Excluded as of September 1, 2004

User Defined Field—Clinical (1–27)

Name in Database	CLINICAL1, CLINICAL2, CLINICAL3, CLINICAL4, CLINICAL5, CLINICAL6, CLINICAL7, CLINICAL8, CLINICAL9, CLINICAL10, CLINICAL11, CLINICAL12, CLINICAL13, CLINICAL14, CLINICAL15, CLINICAL16, CLINICAL17, CLINICAL18, CLINICAL19, CLINICAL20, CLINICAL21, CLINICAL22, CLINICAL23, CLINICAL24, CLINICAL25, CLINICAL26, CLINICAL27
Definition	
Additional Information	
History	Excluded as of September 1, 2004

Section 8: Anatomical Diagnosis

AIS 90 Version Number

Name in Database	AIS_VER
Definition	AIS 90 Version Number
Additional Information	
History	As of April 1 2012, AIS 1990 codes are no longer being collected by the OTR

AIS 90—Anatomical Diagnosis—Injury Text

Name in Database	INJ_TXT
Definition	Free text of anatomical diagnosis.
Additional Information	When all injury descriptions have been entered, press the CODE button at the bottom of the screen to begin coding. Tri-Code will display ICD-9-CM codes, AIS severity, body region and the predot code on the screen and will indicate to which injury the codes refer. ISS and MAIS will be displayed on the screen. Please see the Tri-Code documentation from Tri-Analytics for further information.

Please see the Tri-Code documentation for further information. Please note that AIS severity and body regions must be entered with the ICD-9-CM code and the predot code to allow the calculation of TRISS and ISS.

Injury coding can also be done by entering ICD-9-CM nature of injury. After entering the required codes, press the CODE button at the bottom of the screen to begin coding. ISS and MAIS will be displayed 04/02. |
| **Additional Information** | |
| **History** | As of April 1 2012, AIS 1990 codes are no longer being collected by the OTR. |

AIS 90 ICD-9 Injury Codes 1–27

Name in Database	ICD9_01, ICD9_02, ICD9_03, ICD9_04, ICD9_05, ICD9_06, ICD9_07, ICD9_08, ICD9_09, ICD9_10, ICD9_11, ICD9_12, ICD9_13, ICD9_14, ICD9_15, ICD9_16, ICD9_17, ICD9_18, ICD9_19, ICD9_20, ICD9_21, ICD9_22, ICD9_23, ICD9_24, ICD9_25, ICD9_26, ICD9_27
Definition	ICD-9-CM diagnosis codes (N Codes) from 800.999 can be entered for up to 27 injuries.
Additional Information	
History	As of April 1 2012, AIS 1990 codes are no longer being collected by the OTR.

AIS 90 ICD-9 AIS Severity Codes 1–27

Name in Database	AIS_01, AIS_02, AIS_03, AIS_04, AIS_05, AIS_06, AIS_07, AIS_08, AIS_09, AIS_10, AIS_11, AIS_12, AIS_13, AIS_14, AIS_15, AIS_16, AIS_17, AIS_18, AIS_19, AIS_20, AIS_21, AIS_22, AIS_23, AIS_24, AIS_25, AIS_26, AIS_27
Definition	AIS 90 Severity Code
Additional Information	AIS is calculated for each injury description. The first digit of the AIS code represents severity ranging from 1 (minor) to 6 (maximum) with 9 representing unknown severity. The second digit designates body region. A complete description of body regions can be found in the AIS Dictionary.
History	As of April 1 2012, AIS 1990 codes are no longer being collected by the OTR.

AIS 90 ICD-9 Predot Codes 1–27

Name in Database	PREDOT_01, PREDOT_02, PREDOT_03, PREDOT_04, PREDOT_05, PREDOT_06, PREDOT_07, PREDOT_08, PREDOT_09, PREDOT_10, PREDOT_11, PREDOT_12, PREDOT_13, PREDOT_14, PREDOT_15, PREDOT_16, PREDOT_17, PREDOT_18, PREDOT_19, PREDOT_20, PREDOT_21, PREDOT_22, PREDOT_23, PREDOT_24, PREDOT_25, PREDOT_26, PREDOT_27
Definition	AIS 90 Predot Code
Additional Information	The Predot code is composed of body region, type of anatomic structure, specific anatomic structure and level.
History	As of April 1 2012, AIS 1990 codes are no longer being collected by the OTR.

AIS 90—ISS

Name in Database	DISP_ISS
Definition	The ISS is a calculated field based on the injury descriptions entered above. The ISS is the sum of the squares of the highest AIS code in each of the three most severely injured ISS body regions. ISS ranges from 1 to 75.
Additional Information	The six body regions of injuries used in the ISS are: 1. Head or neck 2. Face 3. Chest 4. Abdominal or pelvic contents 5. Extremities or pelvic girdle 6. External
History	As of April 1 2012, AIS 1990 codes are no longer being collected by the OTR.

AIS 90—TRISS

Name in Database	DISP_TRISS
Definition	TRISS is a calculated field based on the first recorded set of vital signs at the lead/trauma hospital.
Additional Information	Because of the nature of this calculation in Collector, if TRISS cannot be calculated due to missing data the data element will appear blank on the screen. TRISS combines both physiologic and anatomic indices to characterize severity of injury and estimate patient survival probability (Ps). The physiologic index is the RTS as assessed at emergency department admission. The RTS is a weighted sum of coded values (0-4) of the Glasgow Coma Scale (GCS), systolic blood pressure (SBP) and respiratory rate (RR). TRISS combines these physiologic and anatomic measures to estimate survival probability as follows: $PS = 1/(1 + e$ to the minus $b)$ where $b = b_0 + b_1(RTS) + b_2(ISS) + b_3(age)$ Age=0 for age <55 years and age=1 for age >=55 years. The "b"s are regression weights that differ for blunt and penetrating injury.
History	As of April 1 2012, AIS 1990 codes are no longer being collected by the OTR.

AIS 90—MAIS

Name in Database	MAIS_BR_1, MAIS_BR_2, MAIS_BR_3, MAIS_BR_4, MAIS_BR_5, MAIS_BR_6
Definition	MAIS (Maximum Abbreviated Injury Score) is a calculated field based on the highest AIS recorded for each body region.
Additional Information	
History	As of April 1 2012, AIS 1990 codes are no longer being collected by the OTR.

Section 9: Outcome

Disposition: Transport Mode to Discharge Care Facility

Name in Database	DIS_MODE
Definition	Mode of transport to the discharge facility
Additional Information	
History	Excluded as of September 1, 2004

Discharge FIM®—Self-Care

Name in Database	DF_EAT, DF_GROOM, DF_BATH, DF_DRESS_U, DF_DRESS_L
Definition	Discharge FIM®—self-care elements eating, grooming, bathing, dressing upper and lower
Additional Information	
History	Excluded as of April 1, 2008

Discharge FIM®—FIM® Total

Name in Database	DF_SC_TOIL
Definition	Discharge FIM®—total
Additional Information	
History	Excluded as of April 1, 2008

Discharge FIM®—Sphincter Control

Name in Database	DF_BLADDER, DF_BOWEL
Definition	Bowel and bladder sphincter control
Additional Information	
History	Excluded as of April 1, 2008

Discharge FIM®—Mobility Transfer

Name in Database	DF_BED, DF_TOILET, DF_TUB
Definition	Mobility of transfers to/from bed, toilet and tub/shower
Additional Information	
History	Excluded as of April 1, 2008

Discharge FIM®—Walk/Wheelchair

Name in Database	DF_W_C
Definition	Discharge FIM®—walk/wheelchair
Additional Information	
History	Excluded as of April 1, 2008

Discharge FIM®—Locomotion

Name in Database	DF_WALK, DF_STAIRS
Definition	Locomotion status—walk/wheelchair, stairs
Additional Information	
History	Excluded as of April 1, 2008

Discharge FIM®—Type of Comprehension

Name in Database	DF_A_V
Definition	The most usual mode of comprehension.
Additional Information	
History	Excluded as of April 1, 2008

Discharge FIM®—Comprehension

Name in Database	DF_COMP
Definition	The appropriate level for comprehension based on the FIM scale from 1-7.
Additional Information	
History	Excluded as of April 1, 2008

Discharge FIM®—Type of Expression

Name in Database	DF_V_N
Definition	The most usual mode of expression.
Additional Information	
History	Excluded as of April 1, 2008

Discharge FIM®— Expression

Name in Database	DF_EXPRESS
Definition	The appropriate level for expression based on the FIM scale from 1-7.
Additional Information	
History	Excluded as of April 1, 2008

Discharge FIM®—Social Cognition

Name in Database	DF_SOCIAL, DF_SOLVING, DF_MEMORY
Definition	The appropriate level for social interaction, problem solving and memory based on the FIM scale from 1–7.
Additional Information	
History	Excluded as of April 1, 2008

Discharge FIM®—FIM® Type

Name in Database	DF_TYPE
Definition	
Additional Information	
History	Excluded as of April 1, 2008

Discharge Type—From Chart

Name in Database	FROM_CHART
Definition	
Additional Information	
History	Excluded as of April 1, 2008

Was the coroner notified?

Name in Database	CORONER
Definition	Was the coroner notified of the patient's death?
Additional Information	
History	Excluded as of April 1, 1998

Was a post-mortem done?

Name in Database	AUTOPSY
Definition	Was a post-mortem examination done?
Additional Information	
History	Excluded as of April 1, 1998

Trillium Gift of Life Involvement

Name in Database	MORE_INV
Definition	Was the Trillium Gift of Life involved?
Additional Information	
History	Excluded as of September 1, 2004

Organs Donated

Name in Database	ORG_DNR_1, ORG_DNR_2, ORG_DNR_3, ORG_DNR_4
Definition	Specify up to 4 organs or tissue harvested from the patient.
Additional Information	
History	

Outcome Memo

Name in Database	NoteS_AUT
Definition	Outcome memo field
Additional Information	
History	Excluded as of September 1, 2004

User Defined Fields (Outcome 1 through 18)

Name in Database	OUTCOME_1 OUTCOME_2 OUTCOME_3 OUTCOME_4 OUTCOME_5 OUTCOME_6 OUTCOME_7 OUTCOME_8 OUTCOME_9 OUTCOME_10 OUTCOME_11 OUTCOME_12 OUTCOME_13 OUTCOME_14 OUTCOME_15 OUTCOME_16 OUTCOME_17 OUTCOME_18
Definition	User defined fields
Additional Information	18 fields for hospital's own use, not transmitted to the OTR.
History	Excluded as of September 1, 2004

Section 10: ACS Audit Filters

Patient seen in ED and admitted to the hospital within 72 hrs of initial evaluation?

Name in Database	SEEN_PREV
Definition	Was the patient seen in ED and admitted to the hospital within 72 hours of initial evaluation?
Additional Information	
History	Excluded as of 1995

Ambulance report on medical record if transported by pre-hospital EMS personnel?

Name in Database	RUN_FORM
Definition	Was there an ambulance report on the medical record while the patient was still in hospital if patient was transported by pre-hospital EMS personnel?
Additional Information	
History	Excluded as of 1995

Hourly chart doc beginning with EDA, including time spent in radiology, up to admission to the OR or ICU, death, transfer?

Name in Database	NURS_DOC_S
Definition	Was there hourly chart documentation present for the patient beginning with EDA, including time spent in radiology, up to admission to the OR or ICU, death, or transfer to another hospital?
Additional Information	
History	Excluded as of 1995

Sequential neuro doc on ED record if dx of skull fx, intracranial or spinal injury?

Name in Database	NURS_N_DOC
Definition	Was there sequential neurological documentation present on ED record if the patient had a diagnosis of skull fracture, intracranial injury or spinal cord injury?
Additional Information	
History	Excluded as of 1995

Dx at discharge of cervical spine injury not indicated in admission dx?

Name in Database	MISSED_CS
Definition	Was there a diagnosis at discharge of cervical spine injury not indicated in admission diagnosis?
Additional Information	
History	Excluded as of 1995

If epidural or subdural brain hematoma, craniotomy received > 4 hours after EDA?

Name in Database	CRANIOT
Definition	If a patient had an epidural or subdural brain hematoma, did he/she receive a craniotomy >4 hours after EDA, excluding one performed for ICP monitoring?
Additional Information	
History	Excluded as of 1995

Platelets or FFP transfused w/in 24 hrs of EDA after < 8 units packed RBC.

Name in Database	TFUSION_24
Definition	Did adult patient receive transfusion of platelets or fresh frozen plasma within 24 hours of EDA after receiving < 8 units of packed red blood cells or whole blood?
Additional Information	
History	Excluded as of 1995

Was patient comatose upon leaving ED before mechanical airway was established?

Name in Database	ART_AIRWAY
Definition	Did comatose trauma patient leave ED before mechanical airway was established?
Additional Information	
History	Excluded as of 1995

Did patient require reintubation within 48 hours of extubation?

Name in Database	REINTUBAT
Definition	Did the patient require reintubation within 48 hours of extubation?
Additional Information	
History	Excluded as of 1995

Was there an unplanned return to the OR within 48 hours of the initial procedure?

Name in Database	UNPLAND_OR
Definition	Was there an unplanned return to the OR within 48 hours of the initial procedure?
Additional Information	
History	Excluded as of 1995

Was a CT Scan of Head obtained within 2 hours of hospital arrival?

Name in Database	CT_SCAN
Definition	Was a CT Scan of the head obtained within 2 hours of hospital arrival if GCS <13?
Additional Information	
History	Excluded as of 1995

Did patient require a laparotomy that was not performed within 2 hours of EDA?

Name in Database	LAPAROT
Definition	Did patient require a laparotomy that was not performed within 2 hours of ED admission?
Additional Information	
History	Excluded as of 1995

Was there a nonfixation of femoral diaphyseal fracture in adult trauma patient?

Name in Database	NONFIX_FEM
Definition	Was there a nonfixation of a femoral diaphyseal fracture in adult trauma patient?
Additional Information	
History	Excluded as of 1995

If patient sustained a GSW to the abdomen, was he/she managed non-operatively?

Name in Database	NONOP_GSWA
Definition	If patient sustained a gunshot wound to the abdomen, was he/she managed non-operatively?
Additional Information	
History	Excluded as of 1995

Interval > 8 hours between EDA/treatment blunt compound tib fx/open lac joint?

Name in Database	TIB_FX_LAC
Definition	Was there an interval of > 8 hours between arrival and treatment of blunt compound tibial fracture or open laceration of joint?
Additional Information	
History	Excluded as of 1995

Abdominal, thoracic, vascular or cranial surgery performed > 24 after EDA?

Name in Database	UNP_SRG_24
Definition	Was there an abdominal, thoracic, vascular or cranial surgery performed more than 24 hours after ED arrival?
Additional Information	
History	Excluded as of 1995

Were HIV results available?

Name in Database	HIV
Definition	Were HIV results available?
Additional Information	
History	Excluded as of 1995

Section 11: Follow-Up

Follow-Up FIM®—Contact

Name in Database	CONTACT
Definition	Was patient contacted for 6 month phone follow-up?
Additional Information	
History	Excluded as of April 1, 2008

Follow-Up Date

Name in Database	FOLLOW_D_M, FOLLOW_D_D, FOLLOW_D_Y
Definition	Enter the date of follow-up (MMDDYYYY).
Additional Information	
History	Excluded as of April 1, 2008

Follow-Up FIM®—Eating

Name in Database	FOLLOW_D_M, FOLLOW_D_D, FOLLOW_D_Y
Definition	The appropriate level for eating
Additional Information	Eating includes the use of suitable utensils to bring food to the mouth, chewing and swallowing, once the meal is appropriately prepared. Enter "I" if the patient died during hospitalization.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Grooming

Name in Database	FF_GROOM
Definition	The appropriate level for grooming based on the FIM® scale from 1–7.
Additional Information	Grooming includes oral care, hair grooming, washing hands and face, and either shaving or applying makeup. If there is no preference for shaving or applying makeup, then disregard.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Bathing

Name in Database	FF_BATH
Definition	The appropriate level for bathing based on the FIM® scale from 1–7.
Additional Information	Bathing includes bathing the body from the neck down (excluding the back), either tub, shower or sponge/bed bath.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Dressing Upper Body

Name in Database	FF_DRESS_U
Definition	The appropriate level for dressing upper body based on the FIM® scale from 1–7.
Additional Information	Dressing upper body includes dressing above the waist as well as donning and removing prosthesis or orthosis when applicable.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Dressing Lower Body

Name in Database	FF_DRESS_L
Definition	The appropriate level for dressing lower body based on the FIM® scale from 1–7.
Additional Information	Dressing lower body includes dressing from the waist down as well as donning or removing prosthesis or orthosis when applicable.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Toileting

Name in Database	FF_SC_TOIL
Definition	The appropriate level for toileting based on the FIM® scale from 1–7.
Additional Information	Toileting includes maintaining perineal hygiene and adjusting clothing before and after toilet or bed pan use.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Bladder Management

Name in Database	FF_BLADDER
Definition	The appropriate level for bladder management based on the FIM® scale from 1–7.
Additional Information	Bladder management includes complete intentional control of urinary bladder and use of equipment or agents necessary for bladder control.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Bowel Management

Name in Database	FF_BOWEL
Definition	The appropriate level for bowel management based on the FIM® scale from 1–7.
Additional Information	Bowel management includes complete intentional control of bowel movement and use of equipment or agents necessary for bowel control.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Bed/Wheelchair

Name in Database	FF_BED
Definition	The appropriate level for transfer to bed, chair, wheelchair based on the FIM® scale from 1–7.
Additional Information	Transfers bed, chair, wheelchair includes all aspects of transferring to and from bed, chair and wheelchair, and coming to a standing position, if walking is the typical mode of locomotion.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Toilet

Name in Database	FF_TOILET
Definition	The appropriate level for transfer to the toilet based on the FIM® scale from 1–7.
Additional Information	Transfer toilet includes getting on and off a toilet.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Tub/Shower

Name in Database	FF_TUB
Definition	The appropriate level for transfer to the tub/shower based on the FIM® scale from 1–7.
Additional Information	Transfers tub or shower includes getting into and out of a tub or shower stall.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Type of Locomotion

Name in Database	FF_W_C
Definition	The most frequent mode of locomotion
Additional Information	If both modes of locomotion are used about equally, enter, B (Both). (See FIM®/WeeFIM® Version 4.0 Manual). • W Walking • C Wheelchair • B Both For children, the modes of locomotion are as follows: • W Walking • C Wheelchair • L Crawling For a child that is held, enter inappropriate.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Walk/Wheelchair

Name in Database	FF_WALK
Definition	The appropriate level for walking or mobility using a wheelchair based on the FIM® scale from 1–7.
Additional Information	Locomotion includes walking, once in a standing position, or using a wheelchair, once in a seated position, on a level surface.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Stairs

Name in Database	FF_STAIRS
Definition	The appropriate level for walking up and down stairs based on the FIM® scale from 1–7.
Additional Information	Stairs are defined as going up and down 12 to 14 stairs (one flight) indoors.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Type of Comprehension

Name in Database	FF_A_V
Definition	The most usual mode of comprehension.
Additional Information	
History	Excluded as of April 1, 2008

Follow-Up FIM®—Comprehension

Name in Database	FF_COMP
Definition	the appropriate level for comprehension based on the FIM® scale from 1–7.
Additional Information	Comprehension includes understanding of either auditory or visual communication (e.g. writing, sign language, gestures).
History	Excluded as of April 1, 2008

Follow-Up FIM®—Type of Expression

Name in Database	FF_V_N
Definition	The most usual mode of expression.
Additional Information	
History	Excluded as of April 1, 2008

Follow-Up FIM®—Expression

Name in Database	FF_EXPRESS
Definition	The appropriate level for expression based on the FIM® scale from 1–7.
Additional Information	Expression includes clear vocal or non-vocal expression of language. This item includes both intelligible speech and clear expression of language using writing or a communication device.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Social Interaction

Name in Database	FF_SOCIAL
Definition	The appropriate level for social interaction based on the FIM® scale from 1–7.
Additional Information	Social interaction includes skills related to getting along and participating with others in therapeutic and social situations. It represents how one deals with one's own needs together with the needs of others.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Problem Solving

Name in Database	FF_SOLVING
Definition	the appropriate level for problem solving based on the FIM® scale from 1–7.
Additional Information	Problem solving includes skills related to solving problems of daily living. This means making reasonable, safe and timely decisions regarding financial, social and personal affairs and initiating, sequencing and self-correcting tasks and activities to solve the problem.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Memory

Name in Database	FF_MEMORY
Definition	the appropriate level for memory based on the FIM® scale from 1–7.
Additional Information	Memory includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting. It includes ability to store and retrieve information, particularly verbal and visual. A deficit in memory impairs learning as well as performance of tasks.
History	Excluded as of April 1, 2008

Follow-Up FIM®—Self-Care Component Score

Name in Database	FF_SELF
Definition	A calculated field based on eating, grooming, bathing, dressing upper and lower body and toileting scores.
Additional Information	
History	Excluded as of April 1, 2008

Follow-Up FIM®—Sphincter Control Component Score

Name in Database	FF_SPHINCT
Definition	A calculated field based on bladder and bowel management scores.
Additional Information	
History	Excluded as of April 1, 2008

Follow-Up FIM®—Mobility Component Score

Name in Database	FF_MOBILE
Definition	A calculated field based on transfers to bed, chair, wheelchair, toilet and tub, shower scores.
Additional Information	
History	Excluded as of April 1, 2008

Follow-Up FIM®—Locomotion Component Score

Name in Database	FF_LOC
Definition	A calculated field based on walk/wheelchair and stair scores.
Additional Information	
History	Excluded as of April 1, 2008

Follow-Up FIM®—Communication Component Score

Name in Database	FF_COMM
Definition	A calculated field based on comprehension and expression scores.
Additional Information	
History	Excluded as of April 1, 2008

Follow-Up FIM®—Social Cognition Component Score

Name in Database	FF_SOC_COG
Definition	A calculated field based on social interaction, problem solving and memory scores.
Additional Information	
History	Excluded as of April 1, 2008

Follow-Up FIM®—Total Score

Name in Database	FF_TOTAL
Definition	A calculated field that totals all 18 FIM® scores.
Additional Information	The total score may range from 18 to 126.
History	Excluded as of April 1, 2008

Follow-Up FIM®—FIM® Type

Name in Database	FF_TYPE
Definition	the appropriate FIM® type
Additional Information	As of April 1, 1995 WeeFIM® can be done on the pediatric population as defined by individual hospitals. This is a UDS guideline. Reports can be created for specific age groups using Collector's query feature. Hospitals may wish to default this field to the most common FIM® type used in their institution.
History	Excluded as of April 1, 2008

Level of Employment

Name in Database	EMPLOY_LVL
Definition	the patient's level of employment compared to his level of employment at the time of injury.
Additional Information	"Unemployed' is defined as being unable to work due to an injury. Enter "I" for students, children and those who were retired or on some type of disability or unemployment insurance at the time of injury.
History	Excluded as of April 1, 2008

Percent of Previous Income

Name in Database	INCOME_LVL
Definition	the percentage of income **regardless of the source of the income (Working Group 03/96)** if patient's level of employment is "less" as reported in the previous field.
Additional Information	This field will be skipped unless menu item #2 (less) was selected in the previous menu.
History	Excluded as of April 1, 2008

Level of Study

Name in Database	STUDY_LVL
Definition	the patient's level of study post injury if a student reported in the previous field.
Additional Information	**Full and part time students should be included (Working Group 03/96).** Enter "I" if patient is not a student.
History	Excluded as of April 1, 2008

Related Admission to Hospital

Name in Database	RA_RELATED
Definition	Has the patient had an inpatient admission to any hospital related to the original trauma in the six months following discharge?
Additional Information	The hospital would include any hospital admissions but would not include the discharge disposition from the lead/trauma hospital unless the patient was discharged home and readmitted to the discharge disposition.
History	Excluded as of April 1, 2008

Hospital Admitted To

Name in Database	RA_INST
Definition	The institution number of the first hospital to which the patient was admitted for a related admission to hospital in the six months following discharge.
Additional Information	This field has the lead/trauma hospital menu defined earlier in this document.
History	Excluded as of April 1, 2008

Therapy Received After Discharge

Name in Database	THERAPY
Definition	Did the patient receive therapy from any institution in the six months following discharge?
Additional Information	Therapy is defined as traditional therapy including occupational therapy, physiotherapy, speech language pathology, neuropsychology, Social Work and nutritional therapy that is received as a result of the original injury.
History	Excluded as of April 1, 2008

Therapy Type

Name in Database	THERAPY_1, THERAPY_2, THERAPY_3, THERAPY_4, THERAPY_5, THERAPY_6, THERAPY_7, THERAPY_8
Definition	Types of therapy received
Additional Information	Select up to eight types of therapy received
History	Excluded as of April 1, 2008

Other Therapy Type

Name in Database	THERAPY_O
Definition	The type of therapy received if "other" was selected in the previous field.
Additional Information	This field will be skipped unless "other" selected in the previous field.
History	Excluded as of April 1, 2008

Date of Death

Name in Database	F_DEATH_DM, F_DEATH_DD, F_DEATH_DY
Definition	
Additional Information	
History	Excluded as of April 18, 2005

Time of Death

Name in Database	F_DEATH_TH, F_DEATH_TM
Definition	
Additional Information	
History	Excluded as of April 18, 2005

Cause of Death

Name in Database	F_DEATH_CS
Definition	
Additional Information	
History	Excluded as of April 18, 2005

Related to Injury

Name in Database	INJ_RELATE
Definition	
Additional Information	
History	Excluded as of April 18, 2005

Follow-Up Memo

Name in Database	NoteS_FOL
Definition	
Additional Information	
History	Excluded as of September 1, 2004

Section 12: Readmission Related to Original Admission

Number of Readmissions

Name in Database	NUM_READ
Definition	The number of times the patient has been admitted to the institution for reasons related to the original incident.
Additional Information	For patients who have died, enter "I" to skip section XII. Hospitals may wish to default this field to inappropriate. Lead/trauma hospitals should only document the number of readmissions as of April 1, 1995. Readmission data will be reported on centrally using the Minimal Data Set.
History	

Readmission 1 through 5—Date of Readmission

Name in Database	RA_1_A_D_M RA_1_A_D_D RA_1_A_D_Y RA_2_A_D_M RA_2_A_D_D RA_2_A_D_Y RA_3_A_D_M RA_3_A_D_D RA_3_A_D_Y RA_4_A_D_M RA_4_A_D_D RA_4_A_D_Y RA_5_A_D_M RA_5_A_D_D RA_5_A_D_Y
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1 through 5—Category

Name in Database	RA_1_A_CAT RA_2_A_CAT RA_3_A_CAT RA_4_A_CAT RA_5_A_CAT
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1—Diagnosis Code 1 to 5

Name in Database	RA_1_DX_1 RA_1_DX_2 RA_1_DX_3 RA_1_DX_4 RA_1_DX_5
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 2—Diagnosis Code 1 to 5

Name in Database	RA_2_DX_1 RA_1_DX_2 RA_1_DX_3 RA_1_DX_4 RA_1_DX_5
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 3—Diagnosis Code 1 to 5

Name in Database	RA_3_DX_1 RA_3_DX_2 RA_3_DX_3 RA_3_DX_4 RA_3_DX_5
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 4—Diagnosis Code 1 to 5

Name in Database	RA_4_DX_1 RA_4_DX_2 RA_4_DX_3 RA_4_DX_4 RA_4_DX_5
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission—Most Responsible Physician Service

Name in Database	RA_1_SERV RA_2_SERV RA_3_SERV RA_4_SERV RA_5_SERV
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 5—Diagnosis Code 1 to 5

Name in Database	RA_5_DX_1 RA_5_DX_2 RA_5_DX_3 RA_5_DX_4 RA_5_DX_5
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1 through 5—Most Responsible Physician Service

Name in Database	RA_1_SERV RA_2_SERV RA_3_SERV RA_4_SERV RA_5_SERV
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1 through 5—Most Responsible Patient Service

Name in Database	RA_1_ZERV RA_2_ZERV RA_3_ZERV RA_4_ZERV RA_5_ZERV
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1 through 5–Number of OR Visits

Name in Database	RA_1_ZERV RA_2_ZERV RA_3_ZERV RA_4_ZERV RA_5_ZERV
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1 through 5—Total OR Time (Min)

Name in Database	RA_1_OR_T RA_2_OR_T RA_3_OR_T RA_4_OR_T RA_5_OR_T
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1 through 5—Principal Procedure

Name in Database	RA_1_PROC RA_2_PROC RA_3_PROC RA_4_PROC RA_5_PROC
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1 through 5—CCI Code

Name in Database	RA_1_CCI RA_2_CCI RA_3_CCI RA_4_CCI RA_5_CCI
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1 through 5–Attributes—Status

Name in Database	RA_1_CCI_A RA_2_CCI_A RA_3_CCI_A RA_4_CCI_A RA_5_CCI_A
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1 through 5—Attributes—Location

Name in Database	RA_1_CCI_L RA_2_CCI_L RA_3_CCI_L RA_4_CCI_L RA_5_CCI_L
Definition	
Additional Information	
History	

Readmission 1 through 5—Attributes—Extent

Name in Database	RA_1_CCI_X RA_2_CCI_X RA_3_CCI_X RA_4_CCI_X RA_5_CCI_X
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1 through 5—Attributes—Mode of Delivery

Name in Database	RA_1_CCI_M RA_2_CCI_M RA_3_CCI_M RA_4_CCI_M RA_5_CCI_M
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1 through 5—Date of Separation

Name in Database	RA_1_S_D_M RA_1_S_D_D RA_1_S_D_Y RA_2_S_D_M RA_2_S_D_D RA_2_S_D_Y RA_3_S_D_M RA_3_S_D_D RA_3_S_D_Y RA_4_S_D_M RA_4_S_D_D RA_4_S_D_Y RA_5_S_D_M RA_5_S_D_D RA_5_S_D_Y
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1 through 5—Separation Status

Name in Database	RA_1_STAT RA_2_STAT RA_3_STAT RA_4_STAT RA_5_STAT
Definition	
Additional Information	
History	

Readmission 1 through 5—Disposition

Name in Database	RA_1_DISP RA_2_DISP RA_3_DISP RA_4_DISP RA_5_DISP
Definition	
Additional Information	
History	Excluded as of April 1, 1995

Readmission 1 through 5—Disposition—If Other

Name in Database	RA_1_ODISP RA_2_ODISP RA_3_ODISP RA_4_ODISP RA_5_ODISP
Definition	
Additional Information	
History	

Readmission Memo

Name in Database	NoteS_RA
Definition	Memos are hospital defined fields to be used for notes that are not transmitted to the Registry Office.
Additional Information	This field is to be used for readmission notes.
History	Excluded as of April 1, 1995

User Defined Field

Name in Database	MISC1, MISC2, MISC3, MISC4, MISC5, MISC6, MISC7, MISC8, MISC9, MISC10, MISC11, MISC12, MISC13, MISC14, MISC15, MISC16, MISC17, MISC18, MISC19, MISC20, MISC21, MISC22, MISC23, MISC24, MISC25, MISC26, MISC27, MISC28, MISC29, MISC30, MISC31, MISC32, MISC33, MISC34, MISC35, MISC36
Definition	
Additional Information	
History	

Appendix E: Physician and Patient Services

Admitting Physician Services

Code	Description
01	Family Practice/General Practice Medicine
11	Clinical Immunology and Allergy
12	Cardiology
13	Dermatology
14	Endocrinology and Metabolism
15	Gastroenterology
16	Nephrology
17	Neurology
18	Respirology
19	Rheumatology
20	Pediatrics
21	Pediatric Immunology and Allergy
22	Pediatric Cardiology
23	Pediatric Dermatology
24	Pediatric Endocrinology and Metabolism
25	Pediatric Gastroenterology
26	Pediatric Nephrology
27	Pediatric Neurology
28	Pediatric Respirology
29	Pediatric Rheumatology
30	General Surgeon
31	Cardiovascular Surgeon
32	Neurosurgeon
33	Oral Surgeon
34	Orthopedic Surgery
35	Plastic Surgery
36	Thoracic Surgery
37	Transplant Surgery
38	Traumatology
39	Urology
40	Pediatric General Surgery
41	Pediatric Cardiac Surgery

Code	Description
42	Pediatric Neurosurgery
43	Pediatric Oral Surgeon
44	Pediatric Orthopedic Surgery
45	Pediatric Plastic Surgery
46	Pediatric Thoracic Surgery
47	Pediatric Vascular Surgery
48	Pediatric Cardiothoracic Surgery
49	Pediatric Urology
50	Obstetrics and Gynecology
57	Anesthesiology
60	Otolaryngology
61	Pediatric Otolaryngology
62	Ophthalmology
63	Pediatric Ophthalmology
64	Psychiatry
65	Pediatric Psychiatry
66	Hematology
67	Pediatric Hematology
68	Immunologist
69	Pediatric Immunologist
70	Physiatrist
71	Pediatric Physiatrist
72	Geriatric Medicine
74	Medical Oncology
77	General Pathology
78	Medical Microbiology
79	Parasitologist
80	Diagnostic Radiology
81	Radiotherapist
82	Medical Genetics
83	Anatomical Pathology
84	Toxicologist
87	Dentist
88	Pediatric Dentist
89	Nuclear Medicine

Code	Description
91	Podiatrist
95	Vascular Surgeon
96	Infectious Diseases
97	Neonatal—Perinatal Medicine
98	Pediatric Critical Care
99	Intensivist

Admitting Patient Services

Code	Description
01	Family Practitioner
10	Internal Medicine
11	Allergy
12	Cardiology
13	Dermatology
14	Endocrinology
15	Gastroenterology
16	Nephrology
17	Neurology
18	Respirology
19	Rheumatology
20	PEDIATRIC MEDICINE
21	Pediatric Allergy
22	Pediatric Cardiology
23	Pediatric Dermatology
24	Pediatric Endocrinology
25	Pediatric Gastroenterology
26	Pediatric Nephrology
27	Pediatric Neurology
28	Pediatric Respirology
29	Pediatric Rheumatology
30	GENERAL SURGERY
31	Cardiovascular Surgery
32	Neurosurgery
33	Oral Surgery
34	Orthopedic Surgery

Code	Description
35	Plastic Surgery
36	Thoracic Surgery
37	Transplant Surgery
38	Traumatology
39	Urology
40	PEDIATRIC SURGERY
41	Pediatric Cardiovascular Surgery
42	Pediatric Neurosurgery
43	Pediatric Oral Surgery
44	Pediatric Orthopedic Surgery
45	Pediatric Plastic Surgery
46	Pediatric Thoracic Surgery
47	Pediatric Transplant Surgery
48	Pediatric Traumatology
49	Pediatric Urology
57	Anesthesiology
60	Otolaryngology and ORL
61	Pediatric Otolaryngology and ORL
62	Ophthalmology
63	Pediatric Ophthalmology
64	PSYCHIATRY
65	Pediatric Psychiatry
66	Hematology
67	Pediatric Hematology
68	Immunology
69	Pediatric Immunology
70	Physical Medicine and Rehabilitation (Physiatry)
71	Pediatric Physical Medicine and Rehabilitation (Physiatry)
72	Geriatrics
74	Oncology
77	Pathology
78	Microbiology
79	Parasitology
80	Radiology
81	Radiotherapy

Code	Description
82	Genetics
84	Toxicology
87	Dentistry
88	Pediatric Dentistry
91	Podiatry
95	Vascular Surgery
96	Infectious Disease
97	Neonatology
99	Intensivist

Appendix F: Definitions of Non-Operative Procedures

Code	Description	Definition
1	Oral Intubation	The insertion of an oral endotracheal tube
2	Nasal Intubation	The insertion of a nasal endotracheal tube
3	Tracheotomy	The creation of a surgical opening through the trachea with insertion of a tracheostomy tube
4	Cricothyrotomy	The creation of a surgical opening through the cricothyroid membrane with insertion of a tracheostomy tube
5	Ventilation	Ventilation is assisted by an external medical device
6	Chest tubes	Tubes inserted into the chest cavity between the ribs to allow the drainage of fluids or trapped air
7	IV therapy	The insertion of a peripheral IV catheter into a vein
8	Central line	The percutaneous insertion of an IV needle or catheter into the internal jugular or subclavian vein for the purposes of monitoring venous pressure, delivering large amounts of fluids or delivering TPN (Total Parenteral Nutrition) solutions
9	Arterial line	The percutaneous insertion of an IV needle or catheter into an artery for the purposes of monitoring arterial pressure and for arterial blood sampling when this is done frequently
10	Cutdown	The insertion of an intravenous catheter through a surgical incision into a peripheral vein
11	ED thoracotomy	An incision of the chest wall done in the emergency department
12	CPR	Cardio-pulmonary resuscitation is a combination of chest compressions and ventilation
13	ICP Catheter/Bolt Insertion	The insertion of a catheter or bolt through the skull to monitor intracranial pressure
14	Burr holes	Openings created in the skull in order to relieve pressure. They are usually done as an emergent procedure in the OR, but can also be done in the ER/Trauma room
15	Halo traction or tongs	Applications of devices to the skull to apply C-spine traction and stabilization
16	Traction/pins	Pins are surgically inserted to facilitate applying traction directly to the bone
17	PEG tubes	A Percutaneous Endoscopic Gastrostomy Tube is a flexible Silastic tube placed into the stomach/duodenum through a puncture wound in the abdominal wall, with the assistance of an endoscope to visualize the puncture site and to help anchor the tube in the stomach
18	Foley	A type of flexible catheter inserted into the urinary bladder via the urethra

Code	Description	Definition
19	Gastric tube	A soft flexible tube that is inserted through a nostril or the mouth into the stomach
20	Angiography	An X-ray examination of the vessels of the body following injection of a contrast medium
21	Diagnostic Peritoneal Lavage (DPL)	Insertion of a small diameter flexible Silastic tube through the abdominal wall and infusion of lavage fluid into the peritoneal space
22	CT scan	A computerized (x-ray) tomography examination
23	Other	
24	MRI	(Magnetic Resonance Imaging) A special imaging technique used to image internal structures of the body, particularly the soft tissues
25	FAST	(Focused Assessment with Sonography for Trauma) A rapid, bedside, ultrasound examination performed to identify intra-peritoneal hemorrhage or pericardial tamponade
26	Reduction	The correction of a fracture, dislocation or hernia
27	Ultrasound	A type of imaging technique, which uses high-frequency sound waves
28	Sutures	Materials used in closing a surgical or traumatic wound
29	Transfusion	The introduction of whole blood or blood component directly into the blood stream
30	Intraosseous lines	The insertion of a needle into the bone marrow, used when IV access is not feasible or successful

Appendix G: Motor Vehicle Accident Report Information

Motor Vehicle Collision Report Information

Note: Definitions are taken from the Ministry of Transportation Motor Vehicle Collision Report manual (March 1989). The word 'accident' used in definitions has been replaced with "collision."

Ministry of Transportation Definitions for Impact Type (Box 45 on MVAR)

Approaching

Initial direction of travel of each vehicle is opposite to the other and at least one vehicle was impacted on the front. One vehicle may be stopped but not disabled or parked.

Angle

Included are collisions which occur at intersections and/or private drives, where the initial directions of travel are approximately 90 degrees to one another and neither vehicle is in the act of turning. Normally a vehicle entering a roadway from a private drive is in the act of turning and this is not considered an angle impact.

Rear End

Vehicles are travelling in the same direction and the lead vehicle is struck in the rear.

Sideswipe

Collisions involving side impacts where vehicles are travelling in the same or opposite direction.

Vehicles which sideswipe while approaching, i.e. no frontal impacts are coded as sideswipes.

Turning Movement

Collisions in which vehicles are turning and impact location on one of the vehicles is on the side (lane changes are excluded on some roadways).

SMV Unattended Vehicle

Single motor vehicle (SMV) collisions occur when a vehicle strikes a vehicle unattended by its driver. Included parked, stopped, disabled, abandoned and runaway vehicles, provided it was not under the care and control of a driver. Does not include vehicles stopped for traffic or standing while loading or unloading passengers or cargo.

SMV Other

SMV initially collides with a fixed object, pedestrian, pedal cyclist or animal. Includes occurrences of Other Events provided in the Sequence of Events section.

Ministry of Transportation Definitions for Safety Equipment Used (protective devices) (Box 77 on MVAR)

Use Unknown

Where the driver or passenger has left the scene of the collision and usage has not been determined.

Lap And Shoulder Belt

Both lap and shoulder belt were worn. In most vehicles unit is one assembly, however older models may have separate assemblies. Includes child in approved booster seat.

Lap Belt Only

Only a lap belt exists and was worn. Older vehicles or trucks may be fitted with this equipment only. In newer vehicles rear seat or centre seat positions frequently have lap belts only. This includes child in approved booster seat.

Lap Belt Only of Combined Assembly

Passenger altered the position of the shoulder harness so that only the lap portion was used or lap belt only was used in older vehicle with separate assemblies.

Child Safety Seat Used Incorrectly

Child safety seat did not conform to one or more of the following:

- Properly anchored
- Approved equipment
- Facing proper direction
- Using restraint straps.

Note: Approved equipment safety standards label on the rear of the seat, written as CMVSS213. Car beds are not approved safety equipment. Approved booster seats are coded under the type of restraint in use, if any. Infants should face backwards.

Child Safety Seat Used Correctly

Child safety seat was all of the following:

- Anchored properly
- Approved equipment
- Facing proper direction
- Using restraint straps

Note: See notes for Child Safety Used Incorrectly.

Air Bags Deployed

The vehicles were equipped with air bags, which were deployed on impact. Air bags are a passive restraint device.

Other Passive Restraint Device

The vehicle was equipped with a passive restraint device other than an air bag.

Helmet

For use when helmet was worn. In Ontario, C.S.A. approved helmets are required by operators and passengers of motorcycles, snowmobiles and off-road vehicles.

Equipment Not Used But Available

Seating position was fitted with safety equipment in good repair but equipment was not used. Include equipment, which has been intentionally disabled.

No Equipment Available

Seat position was not fitted with safety equipment, i.e. belts, helmets or approved child seats. Includes equipment, which has been inadvertently damaged and is not functional.

Other Safety Equipment Used

Approved safety equipment in use is not detailed above. Detailed information is entered in the Description of Code(s) 97, 98, 99 field (found at bottom of Investigating Officer's Description of Collision and Diagram section of MVAR).

Guidelines for Entering MVAR Information for Injured Cyclists and Pedestrians

The following guidelines are provided for documenting motor vehicle collision data elements for cyclists and pedestrians.

Data Element	Cyclist	Pedestrian
Vehicle type **Describes the type of vehicle (including pedestrian) that the patient was in, on or fell from.** **Vehicle type should never be documented as inappropriate for transport incidents (i.e. V01-V99) and should reflect the vehicle the patient was in, on or fell from. (Working Group 03/97)**	• Menu item 10 (bicycle)	• Menu item 16 (pedestrian) • Vehicle type should be documented as pedestrian for patients struck by a train whether the patient was walking or laying on the train tracks. Working Group 03/97)
Protective devices	• If wearing a helmet, menu item 8 (helmet) or 17 (helmet flew off) • If not wearing a helmet, menu item 9 (equipment available but not used) The Working Group agreed that helmets are theoretically available to all cyclists and therefore menu item 10 (no equipment available) should not be documented for cyclists. (03/97)	• If wearing specifically designed clothing for visibility, menu item 12 (other safety equipment used) • If documentation does not indicate that the patient was wearing any fluorescent clothing or any other type of safety device designed for increased visibility, inappropriate should be documented
Ejected **Distance Ejected**	Because some police forces document the distance ejected for cyclists and pedestrians and because some hospitals use this information for research purposes, these fields may be used as appropriate at your institution.	
Primary vehicle impact **Describes the location of the initial impact on the vehicle the patient was travelling in or on.**	• Inappropriate **(Working Group 03/97)**	• Inappropriate

Data Element	Cyclist	Pedestrian
Secondary vehicle impact **Describes the location of the initial impact for a second vehicle involved the collision in which the patient not travelling in or on.**	• May be menu items 1-19 depending on area of damage to vehicle striking cyclist	• May be menu items 1-19 depending on area of damage to vehicle striking pedestrian
Impact type **Ministry of Transportation description for the vehicle the patient was travelling in or on.**	• Menu item 07 (single motor vehicle other)	• Menu item 07 (single motor vehicle other)
Collision detail—primary impact **Ministry of Transportation description of the collision in which the patient was injured.**	• Menu item 01 (impact with moving object) if cyclist struck by moving vehicle • May also be other menu items depending on the circumstances of the collision	• Menu item 01 (impact with moving object) if pedestrian struck by moving vehicle • May also be other menu items depending on the circumstances of the collision
Collision detail—secondary impact **The secondary impact collision detail describes the impact that relates to the secondary External Cause Code when applicable.**	• Should be documented as inappropriate unless a secondary External Cause Code is documented	• Should be documented as inappropriate unless a secondary External Cause Code is documented
Position in vehicle	• Cyclists (and motorcycle) drivers, should be coded as drivers (menu item #01) • Cyclist (and motorcycle) passengers should be coded as left-rear if the passenger was sitting behind the driver (menu item #04) or hanger-on (menu item #08) for a position other than behind the driver	• Menu item 09

Appendix H: Comorbidities

Alcoholism: To be determined based upon the brief screening tool used at your institution.

ICD-10-CA codes: F10.0–F10.9, F19.0, F19.2, Z13.3

Attention Deficit Disorder (ADD)/Attention deficit hyperactivity disorder (ADHD):

ICD-10-CA code: F90.0, F98.8 (for ADD only)

Ascites within 30 days: The presence of fluid accumulation (other than blood) in the peritoneal cavity noted on physical examination, abdominal ultrasound or abdominal CT/MRI.

ICD-10-CA code: R18

Autism/Asperger's

ICD-10-CA codes: F84.0, F84.1, F84.5

Bleeding disorder: Any condition that places the patient at risk for excessive bleeding due to a deficiency of blood clotting elements (such as vitamin K deficiency, hemophilia, thrombocytopenia or chronic anticoagulation therapy with Coumadin, Plavix or similar medications). Do not include patients on chronic aspirin therapy.

ICD-10-CA codes: D68.4, D66, D68.1, D67.1, D68.0, D68.3, D69.1, D69.4, D69.5, D69.6, D69.8, D69.9

Chemotherapy for cancer within 30 days: A patient who had any chemotherapy treatment for cancer in the 30 days prior to admission. Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies, such as colon, breast, lung, head and neck, and gastrointestinal solid tumors, as well as lymphatic and hematopoietic malignancies, such as lymphoma, leukemia and multiple myeloma.

ICD-10-CA code: Z51.1

Cirrhosis: Documentation in the medical record of cirrhosis, which might also be referred to as end-stage liver disease. If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy or ascites with notation of liver disease, then cirrhosis should be considered present. Cirrhosis should also be considered present if documented by diagnostic imaging studies or at laparotomy/laparoscopy.

ICD-10-CA codes: K74.0–K74.6, K70.3, K70.4, K71.7

Congenital anomalies: Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic or metabolic congenital anomaly.

ICD-10-CA codes: Q00.0–Q99.9

Congestive heart failure: The inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or the ability of the heart to do so only at an increased ventricular filling pressure. To be included, this condition must be noted in the medical record as CHF, congestive heart failure or pulmonary edema with onset or increasing symptoms within 30 days prior to injury. Common manifestations are

1. Abnormal limitation in exercise tolerance due to dyspnea or fatigue;

2. Orthopnea (dyspnea on lying supine);

3. Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea);

4. Increased jugular venous pressure;

5. Pulmonary rales on physical examination;

6. Cardiomegaly; and

7. Pulmonary vascular engorgement.

ICD-10-CA codes: I50.0, I50.1, I11, I13, I42.0–I42.9, I43.0–I43.8, I09.8

Current smoker: A patient who has smoked cigarettes in the year prior to admission. Do not include patients who smoke cigars or pipes or use chewing tobacco.

Currently requiring or on dialysis: Acute or chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration or hemodiafiltration.

ICD-10-CA code: Z99.2

CVA/residual neurological deficit: A history prior to injury of a cerebrovascular accident (embolic, thrombotic or hemorrhagic) with persistent residual motor, sensory or cognitive dysfunction (such as hemiplegia, hemiparesis, aphasia, sensory deficit or impaired memory).

ICD-10-CA codes: I60.0–I69.8

Diabetes mellitus: Diabetes mellitus prior to injury that required exogenous parenteral insulin or an oral hypoglycemic agent.

ICD-10-CA codes: E10.0–E11.9, E13.0–E14.9

Disseminated cancer: Patients who have cancer

1. That has spread to one or more sites in addition to the primary site; AND

2. In whom the presence of multiple metastases indicates the cancer is widespread, fulminant or near terminal. Other terms describing disseminated cancer include "diffuse," "widely metastatic," "widespread" or "carcinomatosis." Common sites of metastases include major organs (such as the brain, lung, liver, meninges, abdomen, peritoneum, pleura and bone).

ICD-10-CA codes: C77.0–C80.9

Do not resuscitate (DNR) status: The patient had a do not resuscitate (DNR) document or similar advance directive recorded prior to injury.

Drug use: Mental and behavioural disorders due to the use of drugs.

ICD-10-CA codes: F11.0–F16.9, F19.0–F19.9, Z13.3

Esophageal varices: Engorged collateral veins in the esophagus that bypass a scarred liver to carry portal blood to the superior vena cava. A sustained increase in portal pressure results in esophageal varices, which are most frequently demonstrated by direct visualization at esophagoscopy.

ICD-10-CA code: I86.4

Functionally dependent health status: Pre-injury functional status may be represented by the ability of the patient to complete activities of daily living (ADLs), including bathing, feeding, dressing, toileting and walking. This item is marked *yes* if the patient, prior to injury, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all ADLs. Formal definitions of dependency are listed below:

1. Partially dependent: The patient requires the use of equipment or devices coupled with assistance from another person for some ADLs. Any patient coming from a nursing home setting who is not totally dependent would fall into this category, as would any patient who requires kidney dialysis, home ventilator support or chronic oxygen therapy yet maintains some independent functions.

2. Totally dependent: The patient cannot perform any ADLs for himself or herself. This would include a patient who is totally dependent upon nursing care or a dependent nursing home patient. All patients with psychiatric illnesses should be evaluated for their ability to function with or without assistance with ADLs, just as non-psychiatric patients are.

History of angina within past one month: Pain or discomfort between the diaphragm and the mandible resulting from myocardial ischemia. Typically, angina is a dull, diffuse (fist-sized or larger) substernal chest discomfort precipitated by exertion or emotion and relieved by rest or nitroglycerin. Radiation often occurs to the arms and shoulders and occasionally to the neck, jaw (mandible, not maxilla) or interscapular region. For patients on anti-anginal medications, enter *yes* only if the patient has had angina within one month prior to admission.

ICD-10-CA codes: I20.0–I20.9

History of myocardial infarction within past six months: The history of a non–Q wave or a Q-wave infarction in the six months prior to injury, as diagnosed in the patient's medical record.

ICD-10-CA code: I25.2

History of revascularization/amputation for peripheral vascular disease: Any type of angioplasty or revascularization procedure for atherosclerotic peripheral vascular disease (PVD) (for example, aorta–femoral, femoral–femoral and femoral–popliteal) or a patient who has had any type of amputation procedure for PVD (for example, toe amputations, transmetatarsal amputations and below-knee or above-knee amputations). Patients who have had an amputation for trauma or resection of abdominal aortic aneurysms would not be included.

Hypertension requiring medication: History of a persistent elevation of systolic blood pressure greater than 140 mm Hg and a diastolic blood pressure greater than 90 mm Hg requiring an antihypertensive treatment (such as diuretics, beta blockers, ACE inhibitors or calcium channel blockers).

ICD-10-CA codes: I10.0–I10.9, I11–I15

Impaired sensorium: Patients should be noted to have an impaired sensorium if they had mental status changes and/or delirium in the context of a current illness prior to injury. Patients with chronic or long-standing mental status changes secondary to chronic mental illness (such as schizophrenia) or chronic dementing illnesses (such as multi-infarct dementia or senile dementia of the Alzheimer's type) should also be included. Mental retardation would qualify as impaired sensorium. For pediatric populations, patients with documented behaviour disturbances, delayed learning or delayed development should be included.

ICD-10-CA codes: F00.0–F09, F70.0–F79.9, G30.0–G30.9, F91.8, F91.9, F81.9, F80.0, F80.1, F80.8, F80.9, F81.3, F81.8

Obesity: A body mass index of 30 or greater.

ICD-10-CA codes: E66.0–E66.9

Prematurity: Documentation of premature birth, a history of bronchopulmonary dysplasia, ventilator support for longer than seven days after birth or the diagnosis of cerebral palsy. Premature birth is defined as infants delivered before 37 weeks from the first day of the last menstrual period.

ICD-10-CA codes: G80.0–G80.9, P07.0–P07.3, P27.0–P27.9
CCI code: 1.GZ.31

Respiratory disease: Severe chronic lung disease, chronic asthma, cystic fibrosis or chronic obstructive pulmonary disease (COPD) (such as emphysema and/or chronic bronchitis) resulting in any one or more of the following:

1. Functional disability from COPD (such as dyspnea or inability to perform ADLs);

2. Hospitalization in the past for treatment of COPD;

3. Requirement for chronic bronchodilator therapy with oral or inhaled agents; and/or

4. An FEV1 of less than 75% of predicted on pulmonary function testing.

Do not include patients whose only pulmonary disease is *acute* asthma. Do not include patients with diffuse interstitial fibrosis or sarcoidosis.

ICD-10-CA codes: E84.0–E84.9, J40–J45.91

Steroid use: Patients who required the regular administration of oral or parenteral corticosteroid medications (such as prednisone or Decadron) in the 30 days prior to injury for a chronic medical condition (such as COPD, asthma, rheumatologic disease, rheumatoid arthritis or inflammatory bowel disease). Do not include topical corticosteroids applied to the skin or corticosteroids administered by inhalation or rectally.

Appendix I: Complications

Abdominal compartment syndrome: The sudden increase in intra-abdominal pressure resulting in alteration in the respiratory mechanism, hemodynamic parameters and renal perfusion. Typically, patients with this syndrome are critically ill and require ventilator support and/or reoperation.

ICD-10-CA code: T79.6

Abdominal fascia left open: No primary surgical closure of the fascia, or intra-abdominal packs left at conclusion of primary laparotomy (damage control).

Acute renal failure: A patient who did not require dialysis prior to injury, who has worsening renal dysfunction after injury requiring hemodialysis, ultrafiltration or peritoneal dialysis. If the patient refuses treatment (such as dialysis), the condition is still considered present.

ICD-10-CA codes: N17.0–N19, N25.0, N03.0–N05.9, I12, I13, T79.5

ARDS: Adult (acute) respiratory distress syndrome occurs in conjunction with catastrophic medical conditions, such as pneumonia, shock, sepsis (or severe infection throughout the body, sometimes also referred to as systemic infection, and possibly including or also called a blood or blood-borne infection) and trauma. It is a form of sudden and often severe lung failure characterized by PaO2/FiO2 of 200 or less, decreased compliance and diffuse bilateral pulmonary infiltrates without associated clinical evidence of CHF. The process must persist beyond 36 hours and require mechanical ventilation.

ICD-10-CA code: J80
CCI code: 1.GZ.31

Bleeding: Any transfusion (including autologous) of five or more units of packed red blood cells or whole blood given from the time the patient is injured up to and including 72 hours later. The blood may be given for any reason.

CCI code: 1.LZ.19

Cardiac arrest with CPR: The absence of a cardiac rhythm or presence of chaotic cardiac rhythm that results in loss of consciousness requiring the initiation of any component of basic and/or advanced cardiac life support. Excludes patients who arrive at the hospital in full arrest.

ICD-10-CA codes: I46.0–I46.9

Coagulopathy: Twice the upper limit of the normal range for PT or PTT in a patient without a pre-injury bleeding disorder of this magnitude.

ICD-10-CA codes: D65–D68.2, D69.1, D69.30–D69.4

Decubitus ulcer: A pressure sore resulting from pressure exerted on the skin, soft tissue, muscle or bone by the weight of an individual against a surface beneath. Individuals unable to avoid long periods of uninterrupted pressure over bony prominences are at increased risk for the developing necrosis and ulceration.

ICD-10-CA codes: L89.0–L89.9

Deep surgical site infection: An infection that occurs within 30 days after an operation and that appears to be related to the operation. The infection should involve deep soft tissues (such as the fascial and muscle layers) at the site of incision and at least one of the following:

1. There is purulent drainage from the deep incision but not from the organ/space component of the surgical site.

2. A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (greater than 38°C), localized pain or tenderness, unless site is culture-negative.

3. An abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation or by histopathologic or radiologic examination.

4. A deep incision infection is diagnosed by a surgeon or attending physician.

Note: Report infections that involve both superficial and deep incision sites as deep surgical site infection. If a wound spontaneously opens as a result of infection, code for deep surgical site infection and wound disruption.

ICD-10-CA code: T81.4

Drug or alcohol withdrawal syndrome: A set of symptoms that may occur when a person who has been drinking too much alcohol or habitually using certain drugs suddenly stops. Symptoms may include activation syndrome (that is, tremulousness, agitation, rapid heartbeat and high blood pressure), seizures, hallucinations or delirium tremens.

ICD-10-CA codes: F10.3–F10.5, F19.3, 19.4

Deep vein thrombosis (DVT)/thrombophlebitis: The formation, development or existence of a blood clot or thrombus within the vascular system, which may be coupled with inflammation. This diagnosis may be confirmed by a venogram, ultrasound or CT scan. The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.

ICD-10-CA code: I80.2

Extremity compartment syndrome: A condition in which there is swelling and an increase in pressure within a limited space (a fascial compartment) that presses on and compromises blood vessels, nerves and/or tendons that run through that compartment. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh and shoulder.

ICD-10-CA codes: M62.20–M62.29

Graft/prosthesis/flap failure: Mechanical failure of an extracardiac vascular graft or prosthesis, including myocutaneous flaps and skin grafts, requiring return to the operating room or a balloon angioplasty.

ICD-10-CA codes: T82.0–T82.9

Intracranial pressure elevation: Intracranial pressure greater than 25 torr for longer than 30 minutes.

ICD-10-CA code: G93.2

Myocardial infarction: A new acute myocardial infarction occurring during hospitalization (within 30 days of injury).

ICD-10-CA codes: I21.0–I21.9

Organ/space surgical site infection: An infection that occurs within 30 days after an operation and which involves any part of the anatomy (organs or spaces) other than the incision, which was opened or manipulated during a procedure. The infection must also involve at least one of the following:

1. There is purulent drainage from a drain that is placed through a stab wound or puncture into the organ/space.

2. Organisms are isolated from an aseptically obtained culture of fluid or tissue in the organ/space.

3. An abscess or other evidence of infection involving the organ/space is found on direct examination, during reoperation or by histopathologic or radiologic examination.

4. An organ/space SSI is diagnosed by a surgeon or attending physician.

ICD-10-CA codes: T81.4, T82.6, T82.7, T83.5, T83.6, T84.50–T84.58, T84.60–T84.69, T85.7, T87.40–T87.49, Y83.0–Y83.9, Y88.3

Osteomyelitis: A condition that meets at least one of the following criteria:

1. Organisms are cultured from bone.

2. There is evidence of osteomyelitis on direct examination of the bone during a surgical operation or histopathologic examination.

3. At least two of the following signs or symptoms with no other recognized cause are present: fever (38°C), localized swelling, tenderness, heat or drainage at the suspected site of bone infection and at least one of the following:

   a. Organisms are cultured from blood;

   b. There is a positive blood antigen test (such as H. influenzae or S. pneumoniae); and/or

   c. There is radiographic evidence of infection, such as abnormal findings on X-ray, CT scan, MRI scan or radiolabel scan (gallium, technetium, etc.).

ICD-10-CA codes: H05.0, M86.00–M86.19

Pneumonia: Patients with evidence of pneumonia that develops during the hospitalization. Patients with pneumonia must meet at least one of the following two criteria:

Criterion 1. Rales or dullness to percussion on physical examination of chest AND any of the following:

a. New onset of purulent sputum or change in character of sputum;

b. Organism isolated from blood culture; and/or

c. Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing or biopsy.

Criterion 2. Chest radiographic examination shows new or progressive infiltrate, consolidation, cavitation or pleural effusion AND any of the following:

a. New onset of purulent sputum or change in character of sputum;

b. Organism isolated from the blood;

c. Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing or biopsy;

d. Isolation of virus or detection of viral antigen in respiratory secretions;

e. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen; and/or

f. Histopathologic evidence of pneumonia.

ICD-10-CA codes: J12.0–J18.9, J95.88

Pulmonary embolism: A lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system. Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram.

ICD-10-CA codes: I26.0–I26.9

Stroke/CVA: Following injury, patient develops an embolic, thrombotic or hemorrhagic vascular accident or stroke with motor, sensory or cognitive dysfunction (such as hemiplegia, hemiparesis, aphasia, sensory deficit or impaired memory) that persists for 24 or more hours.

ICD-10-CA codes: I63.1–I63.9, I64

Superficial surgical site infection: Defined as an infection that occurs within 30 days after an operation and that involves only skin or subcutaneous tissue of the incision and at least one of the following:

1. There is purulent drainage, with or without laboratory confirmation, from the superficial incision.

2. Organisms are isolated from an aseptically obtained culture of fluid or tissue from the superficial incision.

3. At least one of the following signs or symptoms of infection is present: pain or tenderness, localized swelling, redness or heat; and the superficial incision is deliberately opened by the surgeon, unless incision is culture-negative.

4. Superficial incisional surgical site infection is diagnosed by the surgeon or attending physician.

Do not report the following conditions as superficial surgical site infection:

1. Stitch abscess (minimal inflammation and discharge confined to the points of suture penetration).

2. Infected burn wound.

3. Incisional SSI that extends into the facial and muscle layers (see **deep surgical site infection**).

ICD-10-CA code: T81.4

Systemic sepsis: Definitive evidence of infection, plus evidence of a systemic response to infection. This systemic response is manifested by the presence of infection and TWO or more of the following conditions:

1. Temperature higher than 38°C or lower than 36°C;

2. Sepsis with hypotension despite adequate fluid resuscitation combined with perfusion abnormalities that may include, but are not limited to, lactic acidosis, oliguria or an acute alteration in mental status. Patients who are on inotropic or vasopressor agents may not be hypotensive at the time that perfusion abnormalities are measured;

3. HR higher than 90 BPM;

4. RR greater than 20 breaths/minute or PaCO2 lower than 32 mm Hg (less than 4.3 kPa); and

5. WBC greater than 12,000 cells/mm^3, less than 4,000 cells/mm^3 or greater than 10% immature (band) forms.

ICD-10-CA codes: A40.0–A41.9, A49.9

Unplanned intubation: Patient requires placement of an endotracheal tube and mechanical or assisted ventilation because of the onset of respiratory or cardiac failure manifested by severe respiratory distress, hypoxia, hypercarbia or respiratory acidosis. In patients who were intubated in the field or emergency department, or those intubated for surgery, unplanned intubation occurs if they require reintubation after being extubated.

Unplanned return to the ICU: Unplanned return to the intensive care unit after initial ICU discharge. Does not apply if ICU care is required for post-operative care of a planned surgical procedure.

Unplanned return to the OR: Unplanned return to the operating room after initial operation management for a similar or related previous procedure.

Urinary tract infection: An infection anywhere along the urinary tract with clinical evidence of infection, which includes at least one of

1. Fever higher than 38.5°C;

2. WBC higher than 100,000 or less than 3,000 per cubic millimetre;

3. Urgency;

4. Dysuria; or

5. Suprapubic tenderness.

ICD-10-CA code: N39.0

Wound disruption: Separation of the layers of a surgical wound, which may be partial or complete, with disruption of the fascia.

ICD-10-CA code: T81.3

Appendix J: Procedures Performed in the ICU

Cardiovascular

Open cardiac massage
CCI Codes: 1.HZ.09.LA-CJ
Angio-embolization
CCI Codes: Specific CCI code related to the vessel of the site being embolized
IVC filter
CCI Code: 1.IS.51.GR-KA

CNS

Insertion of ICP monitor
CCI Codes: 1.AA.53.SE-PL, 1.AA.53.SZ-PL, 1.AC.53.DA-PL, 1.AC.53.SZ-PL, 1.AN.53.SE-PL, 1.AN.53.SZ-PL
Ventriculostomy
CCI Codes: 1.AC.52.^^
Cerebral oxygen monitoring
CCI Code: 1.AA.53.SE-PL

Musculoskeletal

Fasciotomy
CCI Codes: 1.EP.72.WK, 1.SG.72.WK, 1.SY.72.WK, 1.TF.72.WK, 1.TQ.72.WK, 1.UY.72.WK, 1.VD.72.WK, 1.VR.72.WK, 1.WV.72.WK

Genitourinary

Ureteric catheterization (ureteric stent)
CCI Codes: 1.PG.50.^^
Suprapubic cystostomy
CCI Codes: 1.PM.52.HH-TS

Respiratory

Chest tube
CCI Codes: 1.GV.52.DA-TS, 1.GV.52.HA-HE, 1.GV.52.LA-TS
Tracheostomy
CCI Codes: 1.GJ.77.^^

Gastrointestinal

Gastrostomy/jejunostomy (percutaneous or endoscopic)
CCI Codes: 1.NF.53.^^, 1.NK.53.^^

Appendix K: Sports and Recreational Activity Codes

Code	Description
01	Aerobics
02	Aircraft—Recreational motorized (e.g. fixed wing)
03	Aircraft—Recreational non-motorized (e.g. glider)
04	All-Terrain Vehicle (ATV)
05	Amusement Rides
06	Auto Racing
07	Badminton
08	Baseball (Hard Ball, Soft Ball, T-Ball, Slo-Pitch)
09	Basketball
10	Billiards/Pool/Shuffleboard
11	Boating—Motorized
12	Boating—Canoe
13	Boating—Kayak
14	Boating—Rowboat
15	Boating—Sailing
16	Boating—Windsurf/Sail Board
17	Boating—Pedal Boat
18	Boating—Waverunners, SeaDoos etc.
19	Boating—Other, unspecified
20	Boxing (Organized, would not include children at play)
21	Bowling (5 or 10 Pin)
22	Cricket
23	Croquet/Lawn Bowling
24	Curling
25	Cycling—Driver (If unspecified, assume driver)
26	Cycling—Passenger
27	Cycling—Unicycles
28	Dancing
29	Darts
30	Dirt Biking/Mini Bikes/Motocross
31	Diving
32	Fencing

Code	Description
33	Fire (Open flames outdoors—e.g. charcoal and gas barbecues, camp fires)
34	Fireworks—User
35	Fireworks—Observer
36	Fishing
37	Football
38	Go Carting
39	Golf
40	Gymnastics (Organized—would not include children at play)
41	Handball
42	Hang Gliding/Para Sailing
43	Hiking
44	Horse Back Riding
45	Hockey—Ice (If type of hockey is unspecified, assume ice or street depending on season)
46	Hockey—Street/Ball
47	Hockey—Field/Floor
48	Hockey—Inline
49	Horseshoes
50	Hunting—Bow and Arrow
51	Hunting—Gun
52	Hunting—Knives (Main activity is hunting, injury caused by knife)
53	Jogging/Running
54	Lacrosse
55	Lawn Darts
56	Luge/Bobsled
57	Martial Arts (Judo, Kendo, Karate, Tae Kwon-Do, Jiu-Jitsu etc.)
58	Mountaineering/Rock Climbing
59	Playground Equipment (Swings, Slides, Monkey Bars, Teeter Totter in any location)
60	Play not further specified (i.e. running, jumping, skipping, general play activities)
61	Racquetball
62	Ringette
63	Rugby
64	Scuba Diving
65	Shooting—Bow and Arrow (i.e. targets)
66	Shooting—Gun (i.e. non-hunting use of firearm, targets, rifle range, skeet)

Code	Description
67	Skate Boarding
68	Skating—Ice (use in winter seasons if type of skating is not specified)
69	Skating—Inline
70	Skating—Roller
71	Skiing—Downhill—Recreational (use if type of skiing is not specified)
72	Skiing—Downhill—Racing
73	Skiing—Cross Country
74	Ski Jumping (includes moguls and aerial stunts)
75	Sky Diving/Parachuting
76	Snowboarding
77	Snowmobiling—Driver (assume driver if not specified)
78	Snowmobiling—Passenger
79	Snowmobiling—Towed Behind on Toboggan, Tube, Sleigh
80	Soccer
81	Squash
82	Swimming—Pool
83	Swimming—Open Water
84	Swimming—Wading Pool, Location Unspecified
85	Tennis
86	Tobogganing/Sledding/Snow Tubing (Not Towed)
87	Track and Field (organized)
88	Trampoline
89	Volleyball
90	Walking (For Exercise)
91	Water polo
92	Water-skiing/tubing
93	Weightlifting (recreational or organized, includes exercise equipment)
94	Wrestling (organized, does not include children at play)
95	Observer of Sporting Event
96	Other
97	Scooter—Non-Motorized
98	Rodeo Sports
99	Scooter—Motorized

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