

# *Section 3— Data Definitions*



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# *Data Definition Structure*

The table below details the attributes common to every data item located in Section 3 – Data Definitions.

## **Specification**

<i>Definition</i>	A statement that expresses the essential nature of a data item and its differentiation from all other data items.
<i>Datatype</i>	<p>The type of symbol, character or other designation used to represent a data item. For example:</p> <ul style="list-style-type: none"><li>• <b>Alpha/Numeric</b> - a field on which calculations are not performed</li><li>• <b>Numeric</b> - a field on which calculations are performed</li><li>• <b>Date</b> - a field which indicates a date entry</li><li>• <b>Time</b> - a field which indicates a time entry</li></ul>
<i>Form</i>	<p>Name or description of the form of representation for the data item, such as: Date, Code (code set), and Quantitative value.</p> <p>For example, the representational form for <i>Country of Birth</i> is 'Code' because individual codes drawn from the codeset represent a different country.</p>
<i>Field size</i>	The <b>maximum</b> number of characters accommodated by this field.
<i>Layout</i>	<p>The layout of characters in the data item, expressed by a character string representation (see also Field size). For example:</p> <ul style="list-style-type: none"><li>• 'DDMMCCYY' for dates</li><li>• 'NNN' for a numeric value of 3 digits</li></ul>
<i>Reported for</i>	The specified circumstances when this data item must be reported.
<i>Code set</i>	The set of valid values for the data item, according to the form, layout, datatype and field size.
<i>Reporting guide</i>	Additional comments or assistance on interpreting, applying and reporting the data item and code set.
<i>Edits</i>	A list of edits (edit numbers and titles) that relate to this data item.
<i>Related items</i>	Other data items that relate to this particular data item.

## Administration

<i>Purpose</i>	The main reason/s for the collection of this data item.
<i>Principal data users</i>	Identifies the key/primary users of this information.
<i>Collection start</i>	The year the collection of this data item commenced.
<i>Version</i>	Provides information regarding modifications made to the data item. Listed are a version number, beginning with 1 and incremented by 1 for each subsequent revision as well as an effective date, describing the date the modification came into effect.
<i>Definition source</i>	Identifies the authority that defined this data item.
<i>Code set source</i>	Identifies the authority that developed the code set for this data item.

# Data Items (Alphabetical Order)

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## Activity When Injured

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### Specification

**Definition** The type of activity being undertaken by the person, at the moment the injury occurred.

**Datatype** Alpha/numeric      **Form** Code

**Field size** One      **Layout** A

**Reported for** Presentations where any other Injury Surveillance items are completed or if an injury code from the Nature of Main Injury and Body Region Matrix is in the Primary Diagnosis field (Conditional mandatory).

Injury Surveillance Items:

- Activity when Injured
- Body Region
- Description of Main Injury
- Human Intent
- Injury Cause
- Nature of Main Injury
- Place Where Injury Occurred.

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>	<b>Includes</b>	<b>Excludes</b>
	S	Sports (includes sport as a means of income)	Physical exercise with a described functional element such as: golf, riding, jogging, skiing, school athletics, swimming, trekking, water-skiing.	

<i>Code set</i>	Code	Descriptor	Includes	Excludes
	L	Leisure	Hobby activities; leisure-time activities with an entertainment element such as being at a cinema, a dance or party; participating in activities of a voluntary organisation.	Sports (S).
	W	Working for income	Paid work for salary (manual) (professional), bonus and other types of income; transportation (time) to and from such activities.	Voluntary work (L) Sports (S).
	E	Education	Formal education, learning activities, such as: attending school session or lesson, university, undergoing education.	
	C	Other work	Unpaid domestic duties, such as: caring for children and relatives, cleaning, gardening, household maintenance, cooking. Other duties for which income is not gained, such as: unpaid work in family business.	Voluntary work (L).
	N	Being nursed, cared for	Care of infant by parent, patient by nurse.	
	V	Vital activity, resting, sleeping, eating	Personal hygiene, other personal activity.	
	O	Other specified activity		
	U	Unspecified activity		

**Reporting guide** Report the first appropriate code listed in the table which best characterises the type of activity being undertaken by the person at the time when the injury occurred, on the basis of the information available at the time it is recorded.

If two or more categories are judged to be equally appropriate, select the code, which is sequenced first in the code list.

**Examples:**

Refer to Section 4 - Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised.

**VEMD – VAED Mapping**

**E - Education**

This code can be mapped to the ICD-10-AM External Cause code 'While engaged in other types of work'.

**N - Being nursed, cared for**

This code can be mapped to the ICD-10-AM External Cause code 'While resting, sleeping, eating or engaging in other vital activities'.

**Edits**  
E310 Activity When Injured Code Invalid  
E311 Activity When Injured Code Blank

**Related items** Primary Diagnosis, Nature of Main Injury, Body Region, Description of Injury Event, Injury Cause, Human Intent, Place where Injury Occurred.

**Administration**

**Purpose** To facilitate injury research.

**Principal data users** Monash University Accident Research Centre; Hospital Demand Management, DHS.

**Collection start** 1 July 1995                      **Version** 1 (Effective 01.07.95)

**Definition source** DHS                              **Code set source** DHS

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# Ambulance Case Number

---

## Specification

<i>Definition</i>	Unique identifier issued by either MAS or RAV for each ambulance transport occasion.		
<i>Datatype</i>	Alpha/numeric	<i>Form</i>	Identification Number
<i>Field size</i>	Four	<i>Layout</i>	NNNN, A, or blank
<i>Reported for</i>	Arrival Transport Mode 1, 2, 3 or 10, indicating arrival by ambulance, other than hospital contracted private ambulance car.		
<i>Reporting guide</i>	All case number ranges recommence each day at midnight (based on dispatch time) and depend on geographic area of ambulance dispatch.		

### Alternate Codes

Ambulance Case Number not available due to:

B	Industrial action (for example: bans, strikes)
U	Ambulance Officer not providing it

### Valid combinations

<i>Arrival Transport Mode</i>	<i>Ambulance Case Number</i>
1, 2	NNNN B, U
3, 10	NNNN (within ranges, see following page) B, U
6, 8, 9, 11, 99	Blank

*Reporting guide  
(Cont)*

**Metropolitan Ambulance Service**

**Valid Ambulance Case Number ranges**

If Arrival Transport Mode equals

- 1 - Air Ambulance; OR
- 2 - Helicopter

Ambulance Case Number should be between:

1001 to 9999

- 3 – Road Ambulance Service

Ambulance Case Number should be between:

1001 to 2999

- 10 – Ambulance Service - private ambulance car - MAS/RAV contracted

Ambulance Case Number should be between:

3000 to 3499  
4000 to 5499  
6000 to 6499  
8000 to 8499

**Rural Ambulance Victoria**

**Valid Ambulance Case Number ranges**

If Arrival Transport Mode equals

	3- Road Ambulance Service	10 - Ambulance Service - private ambulance car - MAS/RAV Contracted
<b>Ballarat</b>	1001 to 1500	1501 to 2000
<b>Bendigo</b>	2001 to 2500	2501 to 3000
<b>Wangaratta</b>	3001 to 3500	3501 to 4000
<b>Morwell</b>	4001 to 4500	4501 to 5000
<b>Geelong</b>	5001 to 5500	5501 to 6000

***Edits***

E150 Ambulance Case Number Invalid

E151 Ambulance Case Number & Arrival Transport Mode Combination Invalid

***Related items***

Arrival Transport Mode.

## Administration

<i>Purpose</i>	Analysis of ambulance service delivery.		
<i>Principal data users</i>	Metropolitan Ambulance Service; Rural Ambulance Victoria; Monash University Accident Research Centre; Hospital Demand Management, DHS.		
<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95) 2 (Effective 01.07.02) 3 (Effective 01.07.03)
<i>Definition source</i>	DHS	<i>Code set source</i>	DHS

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# Arrival Date

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## Specification

*Definition* Date patient was first registered or triaged (whichever comes first), by clerical officer, triage nurse or doctor in the Emergency Department.

*Datatype* Date *Form* Date

*Field size* Eight *Layout* DDMMCCYY

*Reported for* Every Emergency Department presentation.

**Valid Format:**

DDMMCCYY

**Invalid Format:**

Zero-filled

See Section 2 – Concept and Derived Data Item Definitions (Age, Date / Time Fields, Length of Stay, Time to Treatment).

<i>Edits</i>	E025	Duplicate Attendance
	E086	Medicare Code and Date of Birth Combination Invalid
	E089	Medicare Code and DOB Combination Invalid
	E092	Sex Indeterminate with Age Greater Than or Equal To 90 Days
	E093	Sex Indeterminate and Age Less Than 90 Days
	E095	Date of Birth Invalid
	E103	Born Overseas and Treated Same Day
	E155	Arrival Date/Time Invalid
	E167	Triage Date/Time Before Arrival Date/Time
	E219	Length Of Stay Greater Than 10 Days
	E263	Diagnosis Code and Age Incompatible
	E265	Diagnosis Code and Age – Check
	E297	Injury Cause Code and Age Incompatible
	E302	Human Intent Code and Age Incompatible
	E336	Inpatient Bed Request Date/Time Before Arrival Date/Time
	E340	Departure Date/Time Less Than or Equal To Arrival Date/Time
	E350	Length Of Stay Greater Than 4 and Less Than 10 Days
	E351	Waiting Time Potentially Excessive for Triage Category
	E355	Type of Usual Accommodation and Age Combination Invalid

*Related items*      Arrival Time.

## Administration

*Purpose*      Used in the calculation of various derived items:

- Age at admission: with Arrival Date/Time and Date of Birth
- Length of Stay: with Arrival Date/Time and Departure Date/Time
- Time to Treatment: with Arrival Date/Time, Triage Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.

*Principal data users*      Monash University Accident Research Centre; Hospital Demand Management, DHS.

<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95)
			2 (Effective 01.07.02)

<i>Definition source</i>	DHS	<i>Code set source</i>	DHS
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# Arrival Time

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## Specification

*Definition* Time the patient was first registered or triaged (whichever comes first), by clerical officer, triage nurse or doctor in the Emergency Department.

*Datatype* Time *Form* Quantitative Value

*Field size* Four *Layout* HHMM

*Reported for* Every Emergency Department presentation.

*Reporting guide* **Valid Format:**  
HHMM (Must be in 24-hour format)

**Invalid Format:**  
0000 or 2400

Following international convention midnight is reported as either 2359 of preceding date or 0001 of the following date.

See Section 2 – Concept and Derived Item Definitions (Age, Date / Time Fields, Length of Stay, Time to Treatment).

<i>Edits</i>	E025	Duplicate Attendance
	E086	Medicare Code and Date of Birth Combination Invalid
	E089	Medicare Code and DOB Combination Invalid
	E092	Sex Indeterminate with Age Greater Than or Equal To 90 Days
	E093	Sex Indeterminate and Age Less Than 90 Days
	E095	Date of Birth Invalid
	E103	Born Overseas and Treated Same Day
	E155	Arrival Date/Time Invalid
	E167	Triage Date/Time Before Arrival Date/Time
	E219	Length Of Stay Greater Than 10 Days
	E263	Diagnosis Code and Age Incompatible
	E265	Diagnosis Code and Age – Check
	E297	Injury Cause Code and Age Incompatible
	E302	Human Intent Code and Age Incompatible
	E336	Inpatient Bed Request Date/Time Before Arrival Date/Time
	E340	Departure Date/Time Less Than or Equal To Arrival Date/Time.
	E350	Length Of Stay Greater Than 4 and Less Than 10 Days
	E351	Waiting Time Potentially Excessive for Triage Category
	E355	Type of Usual Accommodation and Age Combination Invalid

*Related items*      Arrival Date.

## Administration

*Purpose*      Used in the calculation of various derived items:

- Age at admission: with Arrival Date/Time and Date of Birth
- Length of Stay: with Arrival Date/Time and Departure Date/Time
- Time to Treatment: with Arrival Date/Time, Triage Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.

*Principal data users*      Monash University Accident Research Centre; Hospital Demand Management, DHS.

<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95)
			2 (Effective 01.07.02)

<i>Definition source</i>	DHS	<i>Code set source</i>	DHS
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# Arrival Transport Mode

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## Specification

**Definition** The type of transport the patient utilised to arrive at the Emergency Department.

**Datatype** Numeric **Form** Code

**Field size** Two **Layout** NN

**Reported for** Every Emergency Department presentation.

**Code set**

Code	Descriptor
1	Air ambulance - fixed wing aircraft for all or any part of journey. Excludes helicopter (Code 2)
2	Helicopter
3	Road Ambulance service
6	Community/public transport (includes council / philanthropic services)
8	Police vehicle
9	Undertaker
10	Ambulance service - private ambulance car - MAS / RAV contracted
11	Ambulance service - private ambulance car - hospital contracted
99	Other

**Reporting guide** For journeys involving more than one transport mode, select the mode of transport in which the greater distance of the journey was undertaken.

For example:

It is acknowledged that most patients transported by air require road transportation to and/or from the transferring hospital. Where the air transport involves the greater distance, select code 1 or 2 as appropriate.

<i>Edits</i>	E125	Arrival Transport Mode Invalid
	E151	Ambulance Case Number and Arrival Transport Mode Combination Invalid
	E352	Arrival Transport Mode '9 - Undertaker' but not DOA
	E353	Diagnosis Code Equals 'R961 - Dead on Arrival' but Patient not DOA

*Related items*      Ambulance Case Number.

## **Administration**

*Purpose*                      Analysis of transport service utilisation and co-ordination.

*Principal data users*    Metropolitan Ambulance Service; Rural Ambulance Victoria; Monash University Accident Research Centre; Hospital Demand Management, DHS.

<i>Collection start</i>	1 July 1995	<i>Version</i>	1	(Effective 01.07.95)
			2	(Effective 01.07.97)
			3	(Effective 01.07.99)
			4	(Effective 01.07.03)

<i>Definition source</i>	DHS	<i>Code set source</i>	DHS
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# Body Region

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## Specification

<i>Definition</i>	The region of the body where the injury was sustained.		
<i>Datatype</i>	Alpha/numeric	<i>Form</i>	Code
<i>Field size</i>	Two	<i>Layout</i>	NN or AN
<i>Reported for</i>	<p>Presentations where any other Injury Surveillance items are completed or if an injury code from the Nature of Main Injury and Body Region Matrix is in the Primary Diagnosis field (Conditional mandatory).</p> <p>Injury Surveillance Items:</p> <ul style="list-style-type: none"><li>• Activity when Injured</li><li>• Body Region</li><li>• Description of Main Injury</li><li>• Human Intent</li><li>• Injury Cause</li><li>• Nature of Main Injury</li><li>• Place Where Injury Occurred</li></ul>		
<i>Code set</i>	<p>See the following separate code sets:</p> <ul style="list-style-type: none"><li>• Body Region - Foreign Body injury</li><li>• Body Region - Non-foreign body injury</li></ul>		
<i>Reporting guide</i>	<p>There are two sets of Body Region codes (see following tables) based on whether or not the Nature of Main Injury code indicates that the injury is due to a foreign body.</p> <p>In cases where the primary diagnosis is an injury code (any diagnosis codes beginning with S or T), check with the matrix and ensure that the corresponding injury ICD-10-AM code for the Nature of Main Injury and Body Region combination is in Primary Diagnosis.</p>		

**Reporting guide  
(Cont)**

**How to use the NoMI/Body Region Matrix:**

1. Select the NoMI code appropriate
2. Scroll across row to appropriate body region for injury or poisoning
3. Select the ICD-10-AM code in the intersecting cell of the matrix
4. Ensure remainder of the Injury Surveillance fields are completed.

**Examples:**

Refer to Section 4 – Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised.

Software suppliers should note the ideal implementation would restrict the look-up screens to present only the Body Region screen that is valid for the Nature of Main Injury code.

See Section 8 – Supplementary Code Lists (Nature of Main Injury/Body Region and ICD-10-AM Matrix) and Section 7 – Editing.

**Edits**

- E260 Primary Diagnosis Blank
- E285 Body Region Blank
- E286 Body Region Code Invalid
- E287 Nature of Main Injury and Body Region Combination Invalid
- E320 Nature of Main Injury, Body Region and Primary Diagnosis Combination Invalid
- E321 Nature of Main Injury, Body Region and Primary Diagnosis Combination Invalid

**Related items**

Primary Diagnosis, Nature of Main Injury, Description of Injury Event, Injury Cause, Human Intent, Place Where Injury Occurred, Activity When Injured.

**Administration**

**Purpose**

To facilitate injury research.

**Principal data users**

Monash University Accident Research Centre; Hospital Demand Management, DHS.

**Collection start**

1 July 1995

**Version**

- 1 (Effective 01.07.95)
- 2 (Effective 01.07.97)

**Definition source**

NHDD

**Code set source**

DHS;  
NHDD, modified

## ***Body region - foreign body injury***

***Definition***                    The region of the body where the injury (foreign body) was sustained.

<b><i>Code set</i></b>	<b><i>Code</i></b>	<b><i>Descriptor</i></b>
	F1	Eye
	F2	Ear
	F3	Nose
	F4	Respiratory tract (Excludes Nose - use code F3)
	F5	Digestive tract
	F6	Genitourinary tract
	F7	Soft tissue

***Reporting guide***            The foreign body codes listed above must only be reported if:

- Nature of Main Injury is 14 - Foreign Body.

See            Section 3 – Data Definitions (Nature of Main Injury).

**Definition of foreign body:**

“any object or substance found in an organ or tissue in which it does not belong under normal circumstances, such as a bolus of food in the trachea or a particle of dust in the eye” (Mosby’s Medical, Nursing & Allied Health Dictionary, 6<sup>th</sup> Edition, Mosby Inc, 2002, p. 699).

Select the first appropriate category.

(Non-foreign body injury table on following page)

## ***Body Region - Non-Foreign Body***

***Definition*** The region of the body where the injury (non-foreign body) was sustained.

<b><i>Code set</i></b>	<b><i>Code</i></b>	<b><i>Descriptor</i></b>
	1	Head (Includes ear; excludes face – use code 2)
	2	Face (Excludes eye, use code F1)
	3	Neck
	4	Thorax
	5	Abdomen
	6	Lower back (includes loin)
	7	Pelvis (includes ano-genital and perineum)
	8	Shoulder
	9	Upper arm
	10	Elbow
	11	Forearm
	12	Wrist
	13	Hand (includes fingers)
	14	Hip
	15	Thigh
	16	Knee
	17	Lower leg
	18	Ankle
	19	Foot (includes toes)
	20	Unspecified body region
	21	Multiple injuries involving more than one body region
	22	Body Region not applicable

***Reporting guide*** The Body Region codes listed above must only be reported if:  
Nature of Main Injury is **not** 14 - Foreign Body  
See Section 3 - Data Definitions (Nature of Main Injury).  
Select the first appropriate category.

(Foreign Body Injury table on previous page)

---

# Campus Code

---

## Specification

*Definition* Indicates the hospital campus in which the Emergency Department presentation occurred.

*Datatype* Numeric *Form* Code

*Field size* Four *Layout* NNNN

*Reported for* Every Emergency Department presentation.

### *Reporting guide*

#### **Campus Code format:**

- 1<sup>st</sup> digit: Indicates whether the hospital is Public (1-5) or Private (6-8)
- 2<sup>nd</sup> and 3<sup>rd</sup> digits: Identifies an individual hospital
- 4<sup>th</sup> digit: Indicates an individual hospital campus

Report a valid code from the list in Section 8 – Supplementary Code Lists (Campus Codes, Transfer Source/Destination Codes).

The codes contained in the Campus Code Table will be amended occasionally as new hospitals open and others close. These changes will be documented in the HDSS Bulletin.

The Campus Code Table is located on the internet and is periodically updated. Please contact the HDSS, see Section 1 – Introduction (Contact Details) if a Campus Code cannot be located.

See Section 8 – Supplementary Code Lists (Campus Codes, Transfer Source/Destination Codes).

### *Edits*

E010 Non VEMD Hospital  
E050 Campus Code Invalid  
E137 Transfer Destination / Source Equals Campus Code  
E233 Unregistered Short Stay Observation Unit

*Related items* Transfer Source, Transfer Destination.

## Administration

*Purpose* To identify the reporting hospital.

*Principal data users* Monash University Accident Research Centre; Hospital Demand Management, DHS.

<i>Collection start</i>	1 July 1995	<i>Version</i>	1	(Effective 01.07.95)
			2	(Effective 01.07.97)
			3	(Effective 01.07.99)

<i>Definition source</i>	DHS	<i>Code set source</i>	DHS
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# Compensable Status

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## Specification

**Definition** Funding source, where the patient is entitled to compensation as a result of the injury sustained.

**Datatype** Numeric **Form** Code

**Field size** One **Layout** N

**Reported for** Every Emergency Department presentation.

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	1	Transport Accident Commission
	2	Department of Veterans' Affairs
	3	Work Cover
	4	Common Law, Public liability, Other compensable, Service personnel
	5	Ineligible not compensable
	6	Medicare patient/Overseas eligible/Ineligible hospital exempt
	7	Compensable status unknown

**Reporting guide** Select the first appropriate category.

**Edits** E079 Compensable Status and DVA Number Combination Invalid  
E145 Compensable Status Invalid

**Related items** DVA Number, Medicare Number, Medicare Suffix.

## Administration

<i>Purpose</i>	Analysis and monitoring.		
<i>Principal data users</i>	Monash University Accident Research Centre; Hospital Demand Management, DHS; Department of Veterans' Affairs; Work Cover; Transport Accident Commission; Medicare.		
<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95)
<i>Definition source</i>	DHS; NHDD	<i>Code set source</i>	DHS

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## Country of Birth

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### Specification

*Definition*                      The country in which the patient was born.

*Datatype*                      Numeric                      *Form*                      Code

*Field size*                      Four                      *Layout*                      NNNN

*Reported for*                      Every Emergency Department presentation.

*Reporting guide*                      Select the code which describes the patient's Country of Birth as precisely as possible.

**Australian born:**

Patients born in Australia should be reported under the State in which they were born.

Please Note:

1100 - Australia not otherwise specified.

This code should only be used when no further details are available.

See              Section 8 - Supplementary Code Lists (Country of Birth Codes).

*Edits*                      E100      Country of Birth Invalid  
                                 E102      Unusual Country of Birth  
                                 E103      Born Overseas and Treated Same Day  
                                 E107      Indigenous But Not Australian Born

## Administration

*Purpose* Country of Birth is important in the study of access to services by different population sub-groups. This item is required for analysis of service utilisation, need for services and epidemiological studies.

*Principal data users* Monash University Accident Research Centre; Hospital Demand Management, DHS.

*Collection start* 1 July 1995      *Version* 1 (Effective 01.07.95)

*Definition source* DHS; NHDD      *Code set source* Australian Standard Classification of Countries for Social Statistics. (Australian Bureau of Statistics, catalogue no. 1269.0). NHDD

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# Date of Birth

---

## Specification

<i>Definition</i>	Patient's date of birth.		
<i>Datatype</i>	Date	<i>Form</i>	Date
<i>Field size</i>	Eight	<i>Layout</i>	DDMMCCYY
<i>Reported for</i>	Every Emergency Department presentation.		
<i>Reporting guide</i>	<b>Unknown Date of Birth:</b> Estimate the year of birth and enter 0000 (zeros) in DDMM and estimated year in CCYY.  <b>Valid Format:</b> DDMMCCYY <b>Invalid Format:</b> Zero-filled 00MMCCYY See Section 2- Concept and Derived Item Definitions (Age).		
<i>Edits</i>	E086	Medicare Code and Date of Birth Combination Invalid	
	E089	Medicare Code and DOB Combination Invalid	
	E092	Sex Indeterminate with Age Greater Than or Equal To 90 Days	
	E093	Sex Indeterminate and Age Less Than 90 Days	
	E095	Date of Birth Invalid	
	E103	Born Overseas and Treated Same Day	
	E263	Diagnosis Code and Age Incompatible	
	E265	Diagnosis Code and Age – Check	
	E297	Injury Cause Code and Age Incompatible	
	E302	Human Intent Code and Age Incompatible	
	E355	Type of Usual Accommodation and Age Combination Invalid	

## Administration

<i>Purpose</i>	Used in the calculation of derived item:		
	<ul style="list-style-type: none"><li>• Age at admission: with Arrival Date/Time and Date of Birth.</li></ul>		
<i>Principal data users</i>	Monash University Accident Research Centre; Hospital Demand Management, DHS.		
<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95)
<i>Definition source</i>	NHDD	<i>Code set source</i>	DHS

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# Departure Date

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## Specification

*Definition* Date the patient physically leaves the Emergency Department.

*Datatype* Date *Form* Date

*Field size* Eight *Layout* DDMMCCYY

*Reported for* Every Emergency Department presentation.

*Reporting guide* Record the date the patient:

- Leaves the Emergency Department (Departure Status is 0, 1, 4, 5, 9, 10, 11, 12); **OR**
- Leaves the Emergency Department to go to a ward (Departure Status is 2) or registered Short Stay Observation unit (Departure Status is 3); **OR**
- Dies within the Emergency Department (Departure Status is 7); **OR**
- Is dead on arrival (Departure Status is 8).

**Valid Format:**

DDMMCCYY

**Invalid Format:**

Zero-filled

See Section 2 – Concept and Derived Item Definitions (Date / Time Fields, Length of Stay, Time to Treatment).

<i>Edits</i>	E025	Duplicate Attendance
	E210	Departure Date Invalid
	E212	Departure Date/Time Before First Seen By Treating Nurse Date/Time
	E213	Departure Date/Time Before First Seen By Doctor Date/Time
	E217	Departure Date Conflicts with VEMD File Name
	E219	Length Of Stay Greater Than 10 Days
	E335	Departure Date/Time Before Inpatient Bed Request Date/Time
	E340	Departure Date/Time Less Than or Equal To Arrival Date/Time.
	E350	Length Of Stay Greater Than 4 and Less Than 10 Days

*Related items* Departure Time.

## **Administration**

*Purpose* Used in the calculation of various derived items:

- Length of Stay: with Arrival Date/Time and Departure Date/Time
- Length of Treatment: with Departure Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.

*Principal data users* Monash University Accident Research Centre; Hospital Demand Management, DHS.

<i>Collection start</i>	1 July 1995	<i>Version</i>	1	(Effective 01.07.95)
			2	(Effective 01.07.02)

*Definition source* NHDD

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# Departure Status

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## Specification

**Definition** Patient destination or status on departure from the Emergency Department.

**Datatype** Alpha/numeric      **Form** Code

**Field size** Two      **Layout** NN

**Reported for** Every Emergency Department presentation.

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	0	Residential care facility (includes nursing home, hostel, psychogeriatric nursing home, residential care respite bed)
	1	Home
	2	Ward (Includes HITH and Medical Assessment and Planning Unit; Excludes Emergency Medical Unit and Short Stay Observation Unit)
	3	Short Stay Observation Unit (Includes Chest Pain Evaluation Unit; Excludes Emergency Medical Unit and Medical Assessment and Planning Unit)
	4	Another hospital campus (also record Transfer Destination)
	5	Left at own risk, after treatment started
	7	Died within ED
	8	Dead on arrival
	9	Mental health residential facility (Excludes psychogeriatric nursing home, use 0)
	10	Left after clinical advice regarding treatment options
	11	Left at own risk, without treatment
	12	Correctional/Custodial Facility
	13	Emergency Medical Unit (Excludes Medical Assessment and Planning Unit and Short Stay Observation Unit)

## *Reporting guide*

Used to identify the **immediate** destination or departure status of the patient upon departure from the ED. This may not necessarily be to the patient's usual place of residence.

### **0 - Residential care facility (includes nursing home, hostel, psychogeriatric nursing home, residential care respite bed)**

Includes: nursing home, hostel, psychogeriatric nursing home, residential care respite bed and nursing home beds which are located within an acute or sub-acute hospital campus

### **1 - Home**

Includes:

- house,
- unit,
- boarding/rooming house,
- hotel,
- caravan,
- youth hostel accommodation,
- homeless person's shelters
- shelter/refuges
- armed forces hospitals and
- no fixed abode.

Excludes: accommodation described in remainder of codeset.

### **2 - Ward (Includes HITH and Medical Assessment and Planning Unit; Excludes Emergency Medical Unit and Short Stay Observation Unit)**

Includes patients who are admitted to the ward after attending the ED at the same hospital (and HITH), and those patients who attend the ED from an inpatient ward at the same hospital and then return to the ward. See also Section 2 - Concept and Derived Item Definitions.

Any change in 'Campus code' in multi-campus transfers is considered a transfer and requires a 'Transfer Destination' code.

### **3 -Short Stay Observation Unit (Includes Chest Pain Evaluation Unit; Excludes Emergency Medical Unit and Medical Assessment and Planning Unit)**

See also Section 2 - Concept and Derived Item Definitions.

### **4 - Another hospital campus (also record Transfer Destination)**

Excludes armed forces hospitals (use 1 - Home) and correction facility hospital (use 12 - Correctional/Custodial facility).

### **5 - Left at own risk, after treatment started**

Patient departs the Emergency Department after being seen by a definitive service provider despite being advised by clinical staff NOT to leave. The appropriate hospital forms must be completed and signed by the patient.

*Reporting guide  
(Cont)*

**7 - Died Within ED**

Patient died after commencement of ED presentation. Includes where there is an intention to resuscitate but the patient is later pronounced dead.

**8 - Dead on Arrival**

Patient is pronounced dead by a medical practitioner before (or without) being brought into the ED or where the patient is brought into the ED but there is no intention to resuscitate.

**9 -Mental health residential facility (Excludes psychogeriatric nursing home, use 0)**

Does not require a Transfer Destination code.

**10 - Left after clinical advice regarding treatment options**

At or subsequent to triage, the patient has received advice about Emergency Department and alternative treatment options. On consideration of this advice, the patient chooses to leave without being seen by a definitive service provider.

**11 - Left at own risk, without treatment**

Patient departs the Emergency Department before being seen by a definitive service provider:

- Without notifying staff; OR
- Despite being advised by clinical staff NOT to leave; OR
- Without receiving advice about alternatives to treatment in the Emergency Department

Common descriptions include: Did Not Wait, DNW, Failed To Answer, FTA.

**12 -Correctional/ Custodial Facility**

Does not require a Transfer Destination code. Refer to comments below.

**13 - Emergency Medical Unit (Excludes Medical Assessment and Planning Unit and Short Stay Observation Unit)**

See also Section 2 - Concept and Derived Item Definitions.

**Armed Forces and Prison Hospitals:**

These are not generally recognised as hospitals by the Commonwealth Department of Health and Aged Care and therefore admission from, or separation to, such facilities is not an inter-hospital transfer.

If a patient is transferred from the ED to an Armed Forces hospital, Departure Status equals 1- Home.

If a patient is transferred from the ED to a Prison hospital, Departure Status equals 12- Correctional/Custodial Facility.

**Edits**

- E142 Dead on Arrival Combination Invalid
- E181 First Seen By Treating Nurse Date/Time Before Triage Date/Time
- E182 First Seen By Treating Nurse / Doctor Date/Time and Departure Status Comb Invalid
- E196 First Seen By Doctor Date/Time Before Triage Date/Time
- E212 Departure Date/Time Before First Seen By Treating Nurse Date/Time
- E213 Departure Date/Time Before First Seen By Doctor Date/Time
- E230 Departure Status Invalid
- E232 Transfer Departure Status Code Combination Invalid
- E233 Unregistered Short Stay Observation Unit
- E242 Referred to on Departure and Departure Status Combination Invalid
- E260 Primary Diagnosis Blank
- E320 Nature of Main Injury, Body Region and Primary Diagnosis Combination Invalid
- E321 Nature of Main Injury, Body Region and Primary Diagnosis Combination Invalid
- E339 Inpatient Bed Request Date/Time and Departure Status Combination Invalid
- E342 Primary Diagnosis Recorded When Departure Status Is '10', '11' OR '8'.
- E352 Arrival Transport Mode '9 - Undertaker' but not DOA
- E353 Diagnosis Code Equals 'R961 - Dead on Arrival' but Patient not DOA
- E356 Type of Usual Accommodation and Departure Status Combination Invalid
- E366 Departure Status and Triage Category Combination Invalid
- E367 Unregistered Emergency Medical Unit

**Related items**

Escort Source, Transfer Destination, Referred to on Departure, Reason for Transfer, Departure Transport Mode.

## Administration

**Purpose** To identify and monitor the status and location of patients on departure from the ED. It is also used to define patients for whom performance measures including admission block, are calculated.

**Principal data users** Monash University Accident Research Centre; Hospital Demand Management, DHS.

<b>Collection start</b>	1 July 1995	<b>Version</b>	1	(Effective 01.07.95)
			2	(Effective 01.07.00)
			3	(Effective 01.07.01)
			4	(Effective 01.07.02)
			5	(Effective 01.07.03)

<b>Definition source</b>	NHDD	<b>Code set source</b>	DHS
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# Departure Time

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## Specification

*Definition* Time the patient physically leaves the Emergency Department.

*Datatype* Time *Form* Quantitative Value

*Field size* Four *Layout* HHMM

*Reported for* Every Emergency Department presentation.

*Reporting guide* Record the time the patient:

- Leaves the Emergency Department (Departure Status is 0, 1, 4, 5, 9, 10, 11, 12); **OR**
- Leaves the Emergency Department to go to a ward (Departure Status is 2), Short Stay Observation unit (Departure Status is 3) or Emergency Medical Unit (Departure Status is 13); **OR**
- Dies within the Emergency Department (Departure Status is 7); **OR**
- Is dead on arrival (Departure Status is 8).

**Valid Format:**

HHMM (Must be in 24-hour format)

**Invalid Format:**

0000 or 2400

Following international convention midnight is reported as either 2359 of preceding date or 0001 of the following date.

See Section 2 - Concept and Derived Item Definitions (Date / Time Fields, Length of Stay, Time to Treatment).

<i>Edits</i>	E025	Duplicate Attendance
	E210	Departure Date Invalid
	E212	Departure Date/Time Before First Seen By Treating Nurse Date/Time
	E213	Departure Date/Time Before First Seen By Doctor Date/Time
	E217	Departure Date Conflicts with VEMD File Name
	E219	Length Of Stay Greater Than 10 Days
	E335	Departure Date/Time Before Inpatient Bed Request Date/Time
	E340	Departure Date/Time Less Than or Equal To Arrival Date/Time.
	E350	Length Of Stay Greater Than 4 and Less Than 10 Days
<i>Related items</i>		Departure Date.

## Administration

<i>Purpose</i>	Used in the calculation of various derived items:		
	<ul style="list-style-type: none"> <li>• Length of Stay: with Arrival Date/Time and Departure Date/Time</li> <li>• Length of Treatment: with Departure Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.</li> </ul>		
<i>Principal data users</i>	Monash University Accident Research Centre; Hospital Demand Management, DHS.		
<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95) 2 (Effective 01.07.02)
<i>Definition source</i>	DHS		

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# Departure Transport Mode

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## Specification

**Definition** The type of transport used to transfer the patient from the Emergency Department to another hospital.

**Datatype** Alpha/numeric **Form** Code

**Field size** Two **Layout** NN

**Reported for** Presentations where Departure Status code is 4 - Another hospital campus.  
Must remain blank if Departure Status code is **not** 4 - Another hospital campus (Conditional mandatory).

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	1	Air ambulance - fixed wing aircraft other than helicopter (code 2)
	2	Helicopter
	3	Ambulance Service - MICA
	4	Ambulance Service - road car
	6	Community / philanthropic services (e.g. hospital volunteer drivers)
	7	Private car
	8	Police vehicle
	10	Ambulance Service - private ambulance car - MAS / RAV contracted
	11	Ambulance Service - private ambulance car - hospital contracted
	19	Other

**Reporting guide** Item should be blank if patient has not been transferred to another hospital.  
For journeys involving more than one transport mode, select the mode of transport in which the greater distance of the journey was undertaken.

*Edits* E232 Transfer Departure Status Code Combination Invalid  
E255 Departure Transport Mode Invalid

*Related items* Departure Status, Transfer Destination, Reason for Transfer, Escort Source.

## **Administration**

*Purpose* Analysis of transport utilisation.

*Principal data users* Monash University Accident Research Centre; Hospital Demand Management, DHS.

<i>Collection start</i>	1 July 1995	<i>Version</i>	1	(Effective 01.07.95)
			2	(Effective 01.07.97)
			3	(Effective 01.07.00)
			4	(Effective 01.07.02)

<i>Definition source</i>	DHS	<i>Code set source</i>	DHS
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## Description of Injury Event

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### Specification

<i>Definition</i>	Patient's personal account or description of injury event provided at triage.		
<i>Datatype</i>	Alpha/numeric	<i>Form</i>	Free text
<i>Field size</i>	Two hundred and fifty	<i>Layout</i>	
<i>Reported for</i>	Presentations where any other Injury Surveillance items are completed or if an injury code from the Nature of Main Injury and Body Region Matrix is in the Primary Diagnosis field (Conditional mandatory).  Injury Surveillance Items: <ul style="list-style-type: none"><li>• Activity when Injured</li><li>• Body Region</li><li>• Description of Main Injury</li><li>• Human Intent</li><li>• Injury Cause</li><li>• Nature of Main Injury</li><li>• Place Where Injury Occurred.</li></ul>		
<i>Reporting guide</i>	Data entry prompts must be installed to ensure the collection of the required components (see following list).  <b>Data entry prompts</b>  Briefly and concisely describe the injury event using the prompts. Information should be incorporated into a single description of the injury event for data transmission: <ul style="list-style-type: none"><li>• <b>Location</b> Specific location of the person at the time the injury occurred. For example: own home in the bathroom, workshop or local shops.</li><li>• <b>Activity</b> Specific activity the person was undertaking at the time the injury occurred. For example: playing, working on forklift pallet or playing competition Australian Rules football.</li></ul>		

**Reporting guide  
(Cont)**

- **Product**  
Specific product involved in the injury (where applicable).  
For example: 50mls brand name X medicine, wooden pallet or football.
- **Safety Equipment**  
Safety devices in use or absent at the time the injury occurred (where applicable).  
For example: wearing steel capped work boots, not wearing seatbelt, child resistant close was on bottle or mouthguard worn.
- **Additional**  
What the injuries actually were.  
Which (thing or person, non-identifying descriptions should be used wherever possible i.e. work-colleague or bar patron) caused the injuries (subject).  
Any other relevant information.

**Valid characters**

This field can contain any valid ASCII character for the VEMD as listed in the reference file (see Section 8 – Supplementary Code Lists).

**Examples:**

Refer to Section 4 – Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised.

**Edits**

- E290 Description of Injury Event Invalid
- E291 Description of Injury Event Blank

**Related items**

Diagnosis codes, Nature of Main Injury, Body Region, Injury Cause, Human Intent, Place Where Injury Occurred, Activity When Injured.

**Administration**

**Purpose**

To clarify the injury event (vital for identifying the interventions) and provide additional information relevant to the injury (product type, brand name, safety precautions, etc). The narrative is very important to identify injury event features not captured by the coded data.

**Principal data users**

Monash University Accident Research Centre; Hospital Demand Management, DHS.

**Collection start**

1 July 1995

**Version**

- 1 (Effective 01.07.95)
- 2 (Effective 01.07.02)

**Definition source**

DHS

**Code set source**

DHS

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## Diagnosis - Additional Diagnoses 1 and 2

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### Specification

#### *Definition*

Additional diagnoses are those which:

- Existed at the time of presentation
- Arose while patient was in the Emergency Department
- Are expected to affect treatment plan or length of stay in the Emergency Department.

#### *Datatype*

Alpha/numeric

#### *Form*

Code

#### *Field size*

Five

#### *Layout*

ANNNN

#### *Reported for*

Emergency Department presentations with more than one diagnosis code.

Mandatory if Primary Diagnosis is 'Z099 - Attendance for Follow-up (includes injections) / Review following earlier treatment'.

#### *Reporting guide*

Additional diagnoses give information on factors, which result in increased length of stay, more intensive treatment or the use of greater resources. Additional diagnosis can include diseases, conditions, injuries, poisoning, signs, symptoms, abnormal findings, complaints, or other factors influencing the patient's health status.

In cases requiring mandatory assignment due to Primary Diagnosis of 'Z099', the Additional Diagnosis 1 provides information regarding the specific condition under review during the Emergency Department presentation.

The Additional Diagnosis 1 code identifies the condition under review, and it must not be 'Z099'.

Additional Diagnoses should correlate with and must be substantiated by clinical documentation.

**Reporting guide  
(Cont)**

**Diagnosis code format:**

Diagnosis codes must be submitted in ICD-10-AM format. Ensure any punctuation (decimal points or obliques) is removed from ICD-10-AM codes before submission, as codes with punctuation will not be accepted.

Only codes detailed in the VEMD ICD-10-AM Diagnosis Code list in Section 8 – Supplementary Code Lists will be accepted. For diagnoses not detailed in this list please contact the VEMD Help Desk for assistance. Refer Section 1 – Introduction (Contact Details).

See Section 8 – Supplementary Code Lists (VEMD ICD-10-AM Diagnosis codes).

**Edits**

- E261 Diagnosis Code Invalid
- E262 Diagnosis Code and Sex Incompatible
- E263 Diagnosis Code and Age Incompatible
- E264 Diagnosis Code and Sex – Check
- E265 Diagnosis Code and Age – Check
- E271 Diagnosis Code Format Invalid
- E341 Primary Diagnosis Equals 'Z099' but Additional Diagnosis Blank

**Related items**

Primary Diagnosis.

**Administration**

**Purpose**

To facilitate epidemiological studies and other research.

**Principal data users**

Monash University Accident Research Centre; Hospital Demand Management, DHS.

**Collection start**

1 July 1995

**Version**

- 1 (Effective 01.07.95)
- 2 (Effective 01.07.98)
- 3 (Effective 01.07.99)
- 4 (Effective 01.07.01)
- 5 (Effective 01.07.02)

**Definition source**

DHS

**Code set source**

DHS

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# Diagnosis - Primary Diagnosis

---

## Specification

**Definition** The diagnosis primarily responsible for presentation to the Emergency Department.

**Datatype** Alpha/numeric      **Form** Code

**Field size** Five      **Layout** ANNNN

**Reported for** Primary Diagnosis is mandatory, except where Departure Status is 10 – Left after clinical advice regarding treatment options or 11 – Left at own risk, without treatment.

If the Departure Status is 8 – Dead on Arrival; the Primary Diagnosis must be R961 – Dead on Arrival or R95 Sudden Infant Death Syndrome (SIDS).

**Reporting guide** If the Primary Diagnosis code is an injury, poisoning or other consequence of an external cause (VEMD diagnosis codes beginning with S or T), ensure that the corresponding Nature of Main Injury and Body Region combination is correct (Section 8 – Supplementary Code Lists).

Further specify the injury by utilising the Injury Surveillance items.

If the Primary Diagnosis code is ‘Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment’, an Additional Diagnosis 1 code is mandatory.

The Additional Diagnosis 1 code must identify the condition under review, and therefore must not be ‘Z099’.

Primary Diagnosis must be substantiated by clinical documentation.

**Diagnosis code format:**

Diagnosis codes must be submitted in ICD-10-AM format. Ensure that any punctuation (decimal points or obliques) is removed from ICD-10-AM codes before submission, as codes with punctuation will not be accepted.

**Reporting guide** Only codes detailed in the VEMD ICD-10-AM Diagnosis Code list in

**(Cont)**

Section 8 – Supplementary Code Lists will be accepted. For diagnoses not detailed in this list please contact the VEMD Help Desk for assistance, see Section 1 – Introduction (Contact Details).

**How to use the NoMI/B.Region Matrix:**

1. Select the NoMI code appropriate
2. Scroll across row to body region the appropriate
3. Select the ICD-10-AM code in the intersecting cell of the matrix
4. Ensure that all of the Injury Surveillance fields are completed.

**Examples:**

Refer to Section 4 – Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised.

Software suppliers should note:

- That if a Primary Diagnosis of ‘Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment’ is entered the user should be prompted to enter the mandatory Additional Diagnosis 1 code.
- The Additional Diagnosis 1 code identifies the condition under review and it must not be ‘Z099’.

See Section 8 – Supplementary Code Lists (Nature of Main Injury/Body Region and ICD-10-AM Matrix, VEMD ICD-10-AM Diagnosis Codes).

<i>Edits</i>	E142	Dead on Arrival Combination Invalid
	E260	Primary Diagnosis Blank
	E261	Diagnosis Code Invalid
	E262	Diagnosis Code and Sex Incompatible
	E263	Diagnosis Code and Age Incompatible
	E264	Diagnosis Code and Sex – Check
	E265	Diagnosis Code and Age – Check
	E271	Diagnosis Code Format Invalid
	E320	Nature of Main Injury, Body Region and Primary Diagnosis Combination Invalid
	E321	Nature of Main Injury, Body Region and Primary Diagnosis Combination Invalid
	E341	Primary Diagnosis Equals ‘Z099’ but Additional Diagnosis Blank
	E342	Primary Diagnosis Recorded When Departure Status Is ‘10’, ‘11’ OR ‘8’.
	E353	Diagnosis Code Equals ‘R961 – Dead on Arrival’ but Patient not DOA

*Related items* Additional Diagnosis, Nature of Main Injury, Body Region, Description of Injury Event, Injury Cause, Human Intent, Place Where Injury Occurred, Activity When Injured.

## Administration

*Purpose* To facilitate epidemiological studies and other research.

*Principal data users* Monash University Accident Research Centre; Hospital Demand Management, DHS.

<i>Collection start</i>	1 July 1995	<i>Version</i>	1	(Effective 01.07.95)
			2	(Effective 01.07.98)
			3	(Effective 01.07.99)
			4	(Effective 01.07.02)

<i>Definition source</i>	DHS	<i>Code set source</i>	DHS
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# DVA Number

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## Specification

<i>Definition</i>	The Department of Veterans' Affairs file number applicable for the patient.		
<i>Datatype</i>	Alpha/numeric	<i>Form</i>	Identification Number
<i>Field size</i>	Nine	<i>Layout</i>	See below Reporting guide, Layout (characters 1 - 9)
<i>Reported for</i>	Presentations with Compensable Status of 2 - Department of Veterans' Affairs (Conditional mandatory).		

*Reporting guide* The DVA number is obtained from the patient.

**Layout:**

Character 1	State identifier. Valid codes: Q, N, V, T, S or W. ACT is included in N (NSW) and NT with S (SA).
Characters 2 - 4	Alphabetic characters may appear in these items, but no alphabetic characters may appear after any numeric in these positions
Characters 5 - 8	Numeric, except the last non-space character may be alphabetic
Character 9	space (veteran) alpha (dependent)

**Valid format** (see also above layout and following examples):

- Only alphabetic and numeric characters and spaces are permitted
- Alphabetic characters must be in uppercase
- A maximum of six numeric characters is permitted
- Trailing spaces (to the right) are permitted.

**Examples:**

N123456, VX123456, WXX123A or QXXX1B

*Edits* E078 DVA Number Invalid  
E079 Compensable Status and DVA Number Combination Invalid

*Related items* Compensable Status.

## **Administration**

*Purpose* Required for analysis of service utilisation by eligible veterans and war widow(er)s.

*Principal data users* Department of Veterans' Affairs; Financial Analysis & Purchasing Unit, Purchasing & Financial Policy Branch; Hospital Demand Management, DHS; Monash University Accident Research Centre.

*Collection start* 1 July 2000 *Version* 1 (Effective 01.07.00)

*Definition source* NHDD *Code set source* DVA

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# Escort Source

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## Specification

**Definition** The work location or source of the medical or nursing assistant(s) accompanying a patient being transferred to another hospital.

**Datatype** Alpha/numeric      **Form** Code

**Field size** One      **Layout** N

**Reported for** Departure Status is 4 - Another Hospital Campus (Optional).

**Code set**

<i>Code</i>	<i>Descriptor</i>
1	Emergency Department
2	ICU/CCU
3	Ward
4	Retrieval Service
5	Nil (no medical or nursing escort)
9	Other medical or nursing escort

**Reporting guide** Item should be left blank if Departure Status is not equal to 4.  
  
Report the first appropriate code, which best explains the escort source.

**Edits** E250 Escort Source Code Invalid

**Related items** Departure Status, Transfer Destination, Reason for Transfer, Departure Transport Mode.

## Administration

*Purpose* To monitor medical or nursing staff resource consumption for patient transfers.

*Principal data users* Monash University Accident Research Centre; Hospital Demand Management, Quality Branch, DHS.

<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95)
			2 (Effective 01.07.97)
			3 (Effective 01.07.01)

<i>Definition source</i>	DHS	<i>Code set source</i>	DHS
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# First Seen By Doctor Date

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## Specification

*Definition* Date that a medical officer first assessed the patient.

*Datatype* Date *Form* Date

*Field size* Eight *Layout* DDMMCCYY or blank.

*Reported for* All presentations where the doctor is the definitive service provider (Conditional mandatory).

*Reporting guide* First Seen By Doctor Date/Time must be completed if First Seen By Treating Nurse Date/Time is blank, except where Departure Status is 10 - Left after clinical advice, regarding treatment options, or 11 - Left at own risk, without treatment. In this instance the First Seen By Doctor Date/Time and First Seen By Treating Nurse Date/Time should be left blank.

Where a valid date has been entered in First Seen By Doctor Date, a valid time must be entered in First Seen By Doctor Time.

**Valid Format:**

DDMMCCYY

**Invalid Format:**

Zero-filled

See Section 2 - Concept and Derived Item Definitions (Date / Time Fields, Length of Stay, Time to Treatment).

<i>Edits</i>	E182	First Seen By Treating Nurse / Doctor Date/Time and Departure Status Comb Invalid
	E195	First Seen By Treating Doctor Date/Time Invalid
	E196	First Seen By Doctor Date/Time Before Triage Date/Time
	E213	Departure Date/Time Before First Seen By Doctor Date/Time
	E351	Waiting Time Potentially Excessive for Triage Category
	E366	Departure Status and Triage Category Combination Invalid

*Related items* First Seen By Doctor Time.

## Administration

*Purpose* Used in the calculation of various derived items:

- Length of Treatment: with Departure Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.
- Time to Treatment: with Arrival Date/Time, Triage Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.

*Principal data users* Monash University Accident Research Centre; Hospital Demand Management, DHS.

*Collection start* 1 July 1995                      *Version* 1 (Effective 01.07.95)

*Definition source* DHS                              *Code set source* DHS

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# First Seen By Doctor Time

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## Specification

*Definition* Time that a Medical Officer first assesses the patient.

*Datatype* Time *Form* Quantitative Value

*Field size* Four *Layout* HHMM or blank

*Reported for* All presentations where the doctor is the definitive service provider (Conditional mandatory).

*Reporting guide* First Seen By Doctor Date/Time must be completed if First Seen By Treating Nurse Date/Time is blank, except where Departure Status is 10 - Left after clinical advice, regarding treatment options, or 11 - Left at own risk, without treatment. In this instance First Seen By Doctor Date/Time and First Seen By Treating Nurse Date/Time items should be left blank.

Where a valid date has been entered in First Seen By Doctor Date, a valid time must be entered in First Seen By Doctor Time.

**Valid Format:**

HHMM (Must be in 24-hour format)

**Invalid Format:**

0000 or 2400

Following international convention midnight is reported as either 2359 of preceding date or 0001 of the following date.

See Section 2 - Concept and Derived Item Definitions (Date / Time Fields, Length of Stay, Time to Treatment).

<i>Edits</i>	E182	First Seen By Treating Nurse / Doctor Date/Time and Departure Status Comb Invalid
	E195	First Seen By Treating Doctor Date/Time Invalid
	E196	First Seen By Doctor Date/Time Before Triage Date/Time
	E213	Departure Date/Time Before First Seen By Doctor Date/Time
	E351	Waiting Time Potentially Excessive for Triage Category
	E366	Departure Status and Triage Category Combination Invalid

*Related items* First Seen By Doctor Date.

## Administration

*Purpose* Used in the calculation of various derived items:

- Length of Treatment: with Departure Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.
- Time to Treatment: with Arrival Date/Time, Triage Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.

*Principal data users* Monash University Accident Research Centre; Hospital Demand Management, DHS.

*Collection start* 1 July 1995      *Version* 1 (Effective 01.07.95)

*Definition source* DHS      *Code set source* DHS

---

# First Seen By Treating Nurse Date

---

## Specification

**Definition** Date that the Treating Nurse first saw the patient. This includes the taking of baseline observations after triage.

**Datatype** Date **Form** Date

**Field size** Eight **Layout** DDMMCCYY or blank

**Reported for** All presentations where the nurse is the definitive service provider (Conditional mandatory).

**Reporting guide** First Seen By Treating Nurse Date/Time must be completed if First Seen By Doctor Date/Time is blank, except where Departure Status is 10 - Left after clinical advice, regarding treatment options or 11 - Left at own risk, without treatment. In this instance the First Seen By Treating Nurse Date/Time and First Seen By Doctor Date/Time should be left blank.

Where a valid date has been entered in First Seen By Treating Nurse Date, a valid time must be entered in First Seen By Treating Nurse Time.

**Valid Format:**

DDMMCCYY

**Invalid Format:**

Zero-filled

See Section 2 - Concept and Derived Item Definitions (Date / Time Fields, Length of Stay, Time to Treatment).

<i>Edits</i>	E180	First Seen By Treating Nurse Date/Time Invalid
	E181	First Seen By Treating Nurse Date/Time Before Triage Date/Time
	E182	First Seen By Treating Nurse / Doctor Date/Time and Departure Status Comb Invalid
	E212	Departure Date/Time Before First Seen By Treating Nurse Date/Time
	E351	Waiting Time Potentially Excessive for Triage Category
	E366	Departure Status and Triage Category Combination Invalid

*Related items* First Seen By Treating Nurse Time.

## Administration

*Purpose* Used in the calculation of various derived items:

- Length of Treatment: with Departure Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.
- Time to Treatment: with Arrival Date/Time, Triage Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.

*Principal data users* Monash University Accident Research Centre; Hospital Demand Management, DHS.

*Collection start* 1 July 1995                      *Version* 1 (Effective 01.07.95)

*Definition source* DHS                      *Code set source* DHS

---

# First Seen By Treating Nurse Time

---

## Specification

**Definition** Time that the Treating Nurse first saw the patient. This includes the taking of baseline observations after triage.

**Datatype** Time **Form** Quantitative Value

**Field size** Four **Layout** HHMM or blank

**Reported for** All presentations where the nurse is the definitive service provider (Conditional mandatory).

**Reporting guide** First Seen By Treating Nurse Date/Time must be completed if First Seen By Doctor Date/Time is blank, except where Departure Status is 10 - Left after clinical advice, regarding treatment options or 11 - Left at own risk, without treatment. In this instance the First Seen By Treating Nurse Date/Time and First Seen By Doctor Date/Time items should be left blank.

Where a valid date has been entered in First Seen By Treating Nurse Date, a valid time must be entered in First Seen By Treating Nurse Time.

**Valid Format:**

HHMM (Must be in 24-hour format)

**Invalid Format:**

0000 or 2400

Following international convention midnight is reported as either 2359 of preceding date or 0001 of the following date.

See Section 2 - Concept and Derived Item Definitions (Date / Time Fields, Length of Stay, Time to Treatment).

<i>Edits</i>	E180	First Seen By Treating Nurse Date/Time Invalid
	E181	First Seen By Treating Nurse Date/Time Before Triage Date/Time
	E182	First Seen By Treating Nurse / Doctor Date/Time and Departure Status Comb Invalid
	E212	Departure Date/Time Before First Seen By Treating Nurse Date/Time
	E351	Waiting Time Potentially Excessive for Triage Category
	E366	Departure Status and Triage Category Combination Invalid

*Related items* First Seen By Treating Nurse Date.

## Administration

*Purpose* Used in the calculation of various derived items:

- Length of Treatment: with Departure Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.
- Time to Treatment: with Arrival Date/Time, Triage Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.

*Principal data users* Monash University Accident Research Centre; Hospital Demand Management, DHS.

*Collection start* 1 July 1995      *Version* 1 (Effective 01.07.95)

*Definition source* DHS      *Code set source* DHS

---

# Human Intent

---

## Specification

**Definition** Most likely human intent in the occurrence of the injury or poisoning as assessed by clinician.

**Datatype** Alpha/numeric      **Form** Code

**Field size** Two      **Layout** NN

**Reported for** Presentations where any other Injury Surveillance items are completed or if an injury code from the Nature of Main Injury and Body Region Matrix is in the Primary Diagnosis field (Conditional mandatory).

Injury Surveillance Items:

- Activity when Injured
- Body Region
- Description of Main Injury
- Human Intent
- Injury Cause
- Nature of Main Injury
- Place Where Injury Occurred.

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	1	NON-intentional harm
	2	Intentional self-harm
	3	Sexual assault
	4	Child neglect, maltreatment by parent, guardian
	5	Maltreatment, assault by domestic partner
	6	Police, legal intervention or operations of war
	7	Assault not otherwise specified
	8	Adverse effect or complication of medical or surgical care
	9	Intent cannot be determined
	10	Other specified intent
	11	Intent not specified

**Reporting guide** For this item, the issue is the intent to produce the injury, not the intent to undertake an activity, which happened to result in injury.

Select the first appropriate category, which best characterises the role of intent in the occurrence of the injury on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one listed first in the code set.

**Examples:**

Refer to Section 4 - Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised.

**Edits**

E300	Human Intent Code Invalid
E301	Human Intent Blank
E302	Human Intent Code and Age Incompatible

**Related items** Primary Diagnosis, Nature of Main Injury, Body Region, Description of Injury Event, Injury Cause, Place Where Injury Occurred, Activity When Injured.

## Administration

**Purpose** To facilitate injury / poisoning research.

**Principal data users** Monash University Accident Research Centre; Hospital Demand Management, DHS.

<b>Collection start</b>	1 July 1995	<b>Version</b>	1	(Effective 01.07.95)
			2	(Effective 01.07.03)

<b>Definition source</b>	NHDD	<b>Code set source</b>	NHDD, modified
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# Indigenous Status

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## Specification

*Definition* Indigenous Status of the patient as determined by self-identification.

*Datatype* Alpha/numeric      *Form* Code

*Field size* One      *Layout* N

*Reported for* Every Emergency Department presentation.

*Code set*

<i>Code</i>	<i>Descriptor</i>
2	Not indigenous - Not Aboriginal or Torres Strait Islander origin
5	Indigenous - Aboriginal but not Torres Strait Islander origin
6	Indigenous - Torres Strait Islander but not Aboriginal origin
7	Indigenous - Aboriginal and Torres Strait Islander origin

*Reporting guide* Select the first appropriate category.

An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community with which he/she lives (High Court of Australia in Commonwealth V Tasmania (1983) 46 ALR).

Given the gross inequalities in health status between Indigenous and non-Indigenous peoples in Australia, the size of the Aboriginal and Torres Strait Islander populations and their historical and political context, there is a strong case for ensuring that information on Indigenous Status is collected for planning and service delivery purposes and for monitoring Aboriginal and Torres Strait Islander health.

**Reporting guide  
(Cont)**

**How to obtain this information:**

Rather than asking the patient about their Indigenous Status, first ask the patient 'Were you born in Australia?':

- If 'No', the patient should be asked 'What country were you born in?'
- If 'Yes', the patient should be asked 'Are you of Aboriginal and/or Torres Strait Islander origin?'

Any response, which is not affirmative, must be coded to 2 - Not Aboriginal or Torres Strait Islander.

**Babies and children:**

When a baby or child attends the Emergency Department, the parent or guardian should be asked whether the child's mother or father is of Aboriginal or Torres Strait Islander origin.

- If either parent identifies as being of Aboriginal or Torres Strait Islander origin, then the baby or child should be recorded as being of Aboriginal or Torres Strait Islander origin.
- If the mother of a newborn baby identifies as not indigenous, staff must not assume that the baby is also not indigenous. The indigenous status of the father must also be established.

**Edits**

E105	Indigenous Status Invalid
E107	Aboriginal or Torres Strait Islander Origin But Not Australian Born
E360	Indigenous Status /Preferred Language Mismatch

**Administration**

**Purpose**

Required for analysis of service utilisation, needs and epidemiological studies. The information collected on the number and health status of Aboriginal and Torres Strait Islanders assists planning and service delivery to these populations.

**Principal data users**

Koori Health Unit; Monash University Accident Research Centre; Hospital Demand Management, DHS.

**Collection start**

1 July 1995

**Version**

- 1 (Effective 01.07.95)
- 2 (Effective 01.07.99)

**Definition source**

NHDD

**Code set source**

NHDD, modified

---

# Injury Cause

---

## Specification

**Definition** Event, circumstances or condition associated with the occurrence of injury, poisoning or adverse effect.

**Datatype** Alpha/numeric      **Form** Code

**Field size** Two      **Layout** NN

**Reported for** Presentations where any other Injury Surveillance items are completed or if an injury code from the Nature of Main Injury and Body Region Matrix is in the Primary Diagnosis field (Conditional mandatory).

Injury Surveillance Items:

- Activity when Injured
- Body Region
- Description of Main Injury
- Human Intent
- Injury Cause
- Nature of Main Injury
- Place Where Injury Occurred.

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	1	Motor vehicle - driver
	2	Motor vehicle - passenger
	3	Motorcycle - driver
	4	Motorcycle - passenger
	5	Pedal cyclist - rider or passenger
	6	Pedestrian
	7	Horse related (fall from, struck or bitten by)
	8	Other transport-related circumstance
	9	Fall - low (same level or less than 1 metre, or no information on height)
	10	Fall - high (greater than 1 metre)

- 11 Submersion or drowning - swimming pool
- 12 Submersion or drowning - other
- 13 Other threat to breathing (includes strangulation, asphyxiation)
- 14 Fire, flames, smoke
- 15 Scalds (hot drink, food, water, other fluid, steam, gas or vapour)
- 16 Contact burn (hot object or substance)
- 17 Poisoning - medication
- 18 Poisoning - other or unspecified substance
- 19 Firearm
- 20 Cutting, piercing object
- 21 Dog related
- 22 Other animal related (Excludes dog - use code 21; horse - use code 7)
- 23 Struck by or collision with person
- 24 Struck by or collision with object
- 25 Machinery
- 26 Electricity
- 27 Hot conditions (natural origin, includes sunlight)
- 28 Cold conditions (natural origin)
- 29 Other specified external cause
- 30 Unspecified external cause

***Reporting guide***

Select the first appropriate category.

**Examples:**

Refer to Section 4 – Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised.

***Edits***

- E295 Injury Cause Code Invalid
- E296 Injury Cause Blank
- E297 Injury Cause Code and Age Incompatible

***Related items***

Diagnosis codes, Nature of Main Injury, Body Region, Description of Injury Event, Human Intent, Place Where Injury Occurred, Activity When Injured.

## Administration

*Purpose* To facilitate injury / poisoning research.

*Principal data users* Monash University Accident Research Centre; Hospital Demand Management, DHS.

*Collection start* 1 July 1995                      *Version* 1 (Effective 01.07.95)  
2 (Effective 01.07.97)

*Definition source* DHS                      *Code set source* DHS

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# Inpatient Bed Request Date

---

## Specification

<i>Definition</i>	Date a request was made for the allocation of an inpatient bed.		
<i>Datatype</i>	Date	<i>Form</i>	Date
<i>Field size</i>	Eight	<i>Layout</i>	DDMMCCYY or blank
<i>Reported for</i>	Presentations where an inpatient bed has been requested.		
<i>Reporting guide</i>	To ensure accuracy, this item (and Inpatient Bed Request Time) should be completed as much as possible in real time.		

**Valid Format:**

DDMMCCYY

**Invalid Format:**

Zero-filled

<i>Edits</i>	E331	Inpatient Bed Request Date/Time Invalid
	E335	Departure Date/Time Before Inpatient Bed Request Date/Time
	E336	Inpatient Bed Request Date/Time Before Arrival Date/Time
	E339	Inpatient Bed Request Date/Time and Departure Status Combination Invalid

*Related items* Inpatient Bed Request Time.

## Administration

*Purpose* Used to calculate the waiting time of Emergency Department patients requiring admission to a ward.

*Principal data users* Hospital Demand Management, DHS.

*Collection start* 1 July 1999                      *Version* 1 (Effective 01.07.99)  
2 (Effective 01.07.02)

*Definition source* DHS                              *Code set source* DHS

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# Inpatient Bed Request Time

---

## Specification

**Definition** Time request was made for the allocation of an inpatient bed.

**Datatype** Time **Form** Quantitative Value

**Field size** Four **Layout** HHMM or blank

**Reported for** Presentations where an inpatient bed has been requested.

**Reporting guide** To ensure accuracy, this item (and Inpatient Bed Request Date) should be completed as much as possible in real time.

**Valid Format:**

HHMM (Must be in 24-hour format)

**Invalid Format:**

0000 or 2400

Following international convention midnight is reported as either 2359 of preceding date or 0001 of the following date.

**Edits**

- E331 Inpatient Bed Request Date/Time Invalid
- E335 Departure Date/Time Before Inpatient Bed Request Date/Time
- E336 Inpatient Bed Request Date/Time Before Arrival Date/Time
- E339 Inpatient Bed Request Date/Time and Departure Status Combination Invalid

**Related items** Inpatient Bed Request Date.

## Administration

*Purpose* Used to calculate the waiting time of Emergency Department patients requiring admission to a ward or Short Stay Observation unit.

*Principal data users* Hospital Demand Management, DHS.

<i>Collection start</i>	1 July 1999	<i>Version</i>	1 (Effective 01.07.99)
			2 (Effective 01.07.02)

<i>Definition source</i>	DHS	<i>Code set source</i>	DHS
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# Interpreter Required

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## Specification

*Definition* The patient's need for an interpreter, as perceived by the patient or person consenting for the patient.

*Datatype* Alpha/Numeric      *Form* Code

*Field size* One      *Layout* N

*Reported for* Every Emergency Department presentation.

*Code set*

<i>Code</i>	<i>Descriptor</i>
1	Yes
2	No
3	Not Stated

*Reporting guide* Preferred Language to be asked before Interpreter Required.  
If the Preferred language is English, Interpreter Required can be assumed to be '2 - No'.

This information must:

- Be checked for every admitted patient episode
- Not be set up to a default code on computer systems
- Be collected on, or as soon as possible after, admission.

The standard question is:

[Do you] [Does the person] [Does (name)] require an interpreter?

The question 'Do you require an interpreter?' is asked to determine patient need for an interpreter, not the capacity of the hospital to provide an interpreter.

**1      Yes**

Use code 1 if the patient indicates they need an interpreter.

**Reporting guide  
(Cont)**

**2 No**

Use code 2 if the patient indicates they do not need an interpreter.

*Includes:*

Where the Preferred Language is English.

**3 Not Stated**

Use code 3 if neither Yes nor No can be accurately ascertained.

*Includes:*

Where the Preferred Language is 98 *Not Stated*.

Some instances where the Preferred Language is 96 *Inadequately described*.

**Patient is unable to consent (eg baby, child or elderly):**

Where a person is not able to consent for themselves (eg baby, child or elderly) then the need for an interpreter is recorded for the person who is consenting. For example a guardian or someone with enduring power of attorney.

**Edits**

E358 Interpreter Required Invalid

E359 Preferred Language Equals English but Interpreter Required  
Not Equal to 'N - No'

E362 Preferred Language Not Stated but Interpreter Required Not  
Equal to '3 - Not Stated'

E363 Interpreter Required Equals '3 - Not Stated' but Preferred  
Language Not Equal to '96' or '98'

**Related items**

Country of Birth, Indigenous Status, Preferred Language.

## Administration

**Purpose**

For planning and to form the basis for future funding allocation for CALD hospital service provision.

**Principal data users**

Clinical Governance Section, DHS.

**Collection start**

1 July 2003

**Version**

1 (Effective 01.07.03)

**Definition source**

DHS

**Code set source**

DHS

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# Locality

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## Specification

<i>Definition</i>	Geographic location (suburb/town) of usual residence as stated by the patient at time of presentation (not a postal address).		
<i>Datatype</i>	Alpha/Numeric	<i>Form</i>	Code
<i>Field size</i>	Twenty-two	<i>Layout</i>	AAAAAAAAAAAAAAAAAAAA AAAA
<i>Reported for</i>	Every Emergency Department presentation.		
<i>Reporting guide</i>	<p>Do not include the street address (number, name of road).</p> <p>Do not use non-residential localities (such as mail delivery centres).</p> <p>The hospital may collect the patient's postal address for its own purposes. However, for transmission to DHS, the Postcode and Locality items must contain details of the patient's residential address.</p> <p><b>Interstate Locality:</b></p> <p>Interstate locality is edited on the first three letters of the Locality field. The postcode must correspond correctly to the locality.</p> <p><b>Reference file:</b></p> <p>The Locality and Postcode codes are used to assign a Statistical Local Area (SLA) code for DHS purposes.</p> <p>Statistical Local Area (SLA) Reference files can be obtained by:</p> <ul style="list-style-type: none"><li>• Contacting the HDSS Help Desk by phone or via e-mail to request a copy, see Section 1 - Introduction (Contact Details)</li><li>• Visiting the website at: <a href="http://hdss.health.vic.gov.au/globalref/index.htm">http://hdss.health.vic.gov.au/globalref/index.htm</a> Listed under Heading: Global Reference Files</li><li>• Accessing the Australia Post website, which provides an up to date postcode and localities listing at <a href="http://www.auspost.com.au">www.auspost.com.au</a></li></ul>		

**Reporting guide (Cont)** Note that the SLA Reference File is in line with the most recent version of the National Localities Index (NLI) and is reviewed annually.

In the event that there is a new locality and postcode that is not included in the current reference file please notify: [submit.vemd@dhs.vic.gov.au](mailto:submit.vemd@dhs.vic.gov.au)

The VEMD editing program excludes non-residential localities but includes common variations of locality spellings as used in Melway references and the Australian Bureau of Statistics Locality Index (Cat. No. 1252).

**Newborns:**

Use the guardian's residential locality.

**Edits** E115 Postcode/Locality Combination Invalid

**Related items** Postcode.

## Administration

**Purpose** Analysis of service utilisation and epidemiological studies.

**Principal data users** Monash University Accident Research Centre; Hospital Demand Management, DHS.

<b>Collection start</b>	1 July 1995	<b>Version</b>	1 (Effective 01.07.95)
			2 (Effective 01.07.99)

<b>Definition source</b>	DHS	<b>Code set source</b>	ABS National Locality Index (Cat. No. 1252)
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# Medicare Number

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## Specification

<i>Definition</i>	Personal identifier allocated by the Health Insurance Commission to eligible persons under the Medicare scheme.		
<i>Datatype</i>	Numeric	<i>Form</i>	Code
<i>Field size</i>	Eleven	<i>Layout</i>	NNNNNNNNNNNN or blank
<i>Reported for</i>	Every Emergency Department presentation, unless Medicare Suffix is C-U, N-E or P-N (Conditional mandatory).		

*Reporting guide* Under the Medicare Scheme, each eligible family in the Australian population is assigned a unique identifying number (see top left of following diagram). A single digit number to the left of the name denotes each individual family member.

It is important that hospitals ensure, as much as possible, that only eligible patients receive treatment under Medicare. This cannot be ensured if Medicare Numbers and codes are not sought.

<p><i>Medicare</i></p> <p>3256 11283 7</p> <p>1 Jane Citizen</p> <p>2 John Citizen</p> <p>Valid to 08/02</p>
--

**Example:**

If John Citizen attended the ED:

- family number is 3256112837,
- Medicare Code is 2

**Medicare Number** is 32561128372

- Medicare Suffix is JOH

Medicare Numbers provided must be numeric and have the appropriate check-digit (2<sup>nd</sup> last digit at top left of card) and Medicare Code (Number left of patient name). The card number is reported first with the Medicare code reported as the 11<sup>th</sup> digit (refer diagram and example above).

*Reporting guide  
(Cont)*

**Valid:**

- First character can only be a: 2, 3, 4, 5, or 6
- Numeric or all blanks
- Length of 11 characters
- Check digit (ninth character) is the remainder of the following equation:  
$$[(1^{\text{st}} \text{ digit} * 1) + (2^{\text{nd}} \text{ digit} * 3) + (3^{\text{rd}} \text{ digit} * 7) + (4^{\text{th}} \text{ digit} * 9) + (5^{\text{th}} \text{ digit} * 1) + (6^{\text{th}} \text{ digit} * 3) + (7^{\text{th}} \text{ digit} * 7) + (8^{\text{th}} \text{ digit} * 9)] / 10$$

**Invalid:**

- Special characters (for example, \$, #)
- Alphabetic characters
- Length not equal to 11 characters

**Medicare Number not available:**

Data field can be left blank however the Medicare Suffix must be entered as C-U, N-E or P-N.

**Unnamed neonates:**

Use the Medicare Number issued to the mother/family with a Medicare suffix of 'BAB' and a Medicare Code of '0' (zero).

**Prisoners:**

Medicare do not subsidise Emergency Department presentations for prisoners. Therefore it is important that the Medicare Suffix be entered as P-N and the hospital bill either the health service within the prison or the operator of the prison. (The reason for the differentiation is that, in some prisons (such as Port Phillip), the health service operator is not the same as the prison operator.) It is acceptable that hospitals negotiate ED presentation rates with prisons in their vicinity.

Hospitals must ensure that neither Medicare nor DHS are billed for ED services to prisoners.

See Section 3- Data Definitions (Medicare Suffix).

<i>Edits</i>	E080	Medicare Number Blank
	E081	Medicare Number Invalid
	E086	Medicare Code and Date of Birth Combination Invalid
	E087	Medicare Suffix Invalid
	E089	Medicare Code and DOB Combination Invalid
	E357	Type of Usual Accommodation and Medicare Suffix Combination Invalid
	E364	Medicare Last Digit Zero; Suffix Not 'Bab'
	E365	Medicare Suffix 'Bab'; Medicare Number Last Digit Not Zero
<i>Related items</i>	Compensable Status, Medicare Suffix.	

## Administration

*Purpose* To ensure the patient is an eligible Medicare patient.

*Principal data users* Monash University Accident Research Centre; Hospital Demand Management, DHS.

<i>Collection start</i>	1 July 1995	<i>Version</i>	1	(Effective 01.07.95)
			2	(Effective 01.07.99)

<i>Definition source</i>	NHDD	<i>Code set source</i>	Health Insurance Commission
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# Medicare Suffix

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## Specification

*Definition* First three characters of the patient's first given name (as it appears on the Medicare card).

*Datatype* Alpha/numeric                      Form                      Code

*Field size* Three                                      Layout                      AAA

*Reported for* Every Emergency Department presentation.

<i>Code set</i>	Alternative Codes	Descriptor
	C-U	Card unavailable
	N-E	Not eligible for Medicare
	P-N	Prisoner
	BAB	Unnamed neonate

*Reporting guide* The Medicare Suffix is the **first three** characters of the patient's first name and must be reported in capital letters to the VEMD.

**Valid:**

- upper case alphas
- first two or three characters of the patient's given name
- space as second and third characters
- space as third character
- hyphen or apostrophe as second character or third character

**Invalid:**

- blank
- lower case alphas
- hyphen or apostrophe as first character
- hyphen/apostrophe combination

**Reporting guide  
(Cont)**

**Medicare Number unavailable or patient not eligible:**

Leave the Medicare Number item blank and enter the appropriate alternative code suffix

**Unnamed neonate:**

Use the Medicare Number issued to the mother/family with a Medicare suffix of 'BAB' and a Medicare Code of '0' (zero).

**Prisoners:**

Medicare do not subsidise Emergency Department presentations for prisoners. Refer to Medicare Number for further details.

**Edits**

- E087 Medicare Suffix Invalid
- E357 Type of Usual Accommodation and Medicare Suffix Combination Invalid
- E364 Medicare Last Digit Zero; Suffix Not 'Bab'
- E365 Medicare Suffix 'Bab'; Medicare Number Last Digit Not Zero

**Related items**

Compensable Status, Medicare Number.

## **Administration**

**Purpose**

To ensure the patient is an eligible Medicare patient.

**Principal data users**

Monash University Accident Research Centre; Hospital Demand Management, DHS.

**Collection start**

1 July 1999

**Version**

1 (Effective 01.07.99)

**Definition source**

DHS

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## Nature of Main Injury

---

### Specification

**Definition** The patho-physical nature of the injury primarily responsible for the patient's presentation at the Emergency Department.

**Datatype** Alpha/numeric      **Form** Code

**Field size** Two      **Layout** NN

**Reported for** Presentations where any other Injury Surveillance items are completed or if an injury code from the Nature of Main Injury and Body Region Matrix is in the Primary Diagnosis field (Conditional mandatory).

Injury Surveillance Items:

- Activity when Injured
- Body Region
- Description of Main Injury
- Human Intent
- Injury Cause
- Nature of Main Injury
- Place Where Injury Occurred.

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>	<b>B.Region</b>
	1	Superficial (Includes abrasion, blister, contusion; Excludes eye - use code 13)	+
	2	Open wound (Excludes eye - use code 13)	+
	3	Fracture (Excludes tooth - use code 16)	+
	4	Dislocation	+
	5	Sprain or strain	+
	6	Injury to nerve (Includes spinal cord; Excludes Intracranial injury - use code 15)	+
	7	Injury to blood vessel (major or named vessel)	+
	8	Injury to muscle or tendon	+
	9	Crushing injury	+

10	Traumatic amputation	+
11	Injury to internal organ	+
12	Burn or corrosion	+
13	Eye injury (Includes burn; Excludes Foreign Body in external eye – use code 14)	22
14	Foreign body	#
15	Intracranial injury (Includes concussion)	22
16	Dental injury (Includes fractured tooth)	22
17	Drowning, immersion	22
18	Asphyxia or other threat to breathing	22
19	Electrical injury	22
20	Poisoning, toxic effect (Excludes Bite – use code 21)	22
21	Bite (venomous)	+
22	Other specified nature of injury	+
23	Injury of unspecified nature	+
24	Multiple injuries (more than one nature of injury)	+
25	No injury detected	22
26	Bite (non-venomous)	+

**KEY:**

- +** Non-foreign body injury requires ‘Body Region - Non-foreign body’ code, see Section 3 – Data Definitions (Body Region - Non-foreign body).
- #** Foreign body injury requires ‘Body Region - Foreign Body’ code, see Section 3 – Data Definitions (Body Region - Foreign Body).

**Reporting guide**

Select the first appropriate category.

Select the item, which best characterises the nature of the injury responsible for the patient’s presentation on the basis of the information available at the time it is recorded.

If two or more categories are judged to be equally appropriate, select the one that is sequenced first in the above code list. It is more significant to code a major injury, if present, rather than a minor injury.

If a major injury has been sustained (e.g. fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding ‘multiple injuries’.

**Reporting guide  
(Cont)**

As a general rule, any injury, which on its own would be unlikely to have led to the presentation, may be regarded as minor.

All diagnosis codes beginning with either a 'S' or 'T' are injury codes. Each injury code in the Primary Diagnosis field is matched in the Nature of Main Injury and Body Region matrix. The fields must be completed with the valid combinations (see Section 8 – Supplementary Code Lists).

**How to use the NoMI/Body Region Matrix:**

1. Select the NoMI code appropriate
2. Scroll across the row to the appropriate body region for the injury or poisoning
3. Select the ICD-10-AM code in the intersecting cell of the matrix.
4. Ensure that the remainder of the Injury Surveillance fields are completed.

**Examples:**

Refer to Section 4 – Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised.

**Edits**

- E260 Primary Diagnosis Blank
- E280 Nature of Main Injury Blank
- E281 Nature of Main Injury Invalid
- E287 Nature of Main Injury and Body Region Combination Invalid
- E320 Nature of Main Injury, Body Region and Primary Diagnosis Combination Invalid
- E321 Nature of Main Injury, Body Region and Primary Diagnosis Combination Invalid

**Related items**

Diagnosis code, Body Region, Description of Injury Event, Injury Cause, Human Intent, Place Where Injury Occurred, Activity When Injured.

**Administration**

**Purpose**

To facilitate injury research.

**Principal data users**

Monash University Accident Research Centre; Hospital Demand Management, DHS.

**Collection start**

1 July 1995

**Version**

- 1 (Effective 01.07.95)
- 2 (Effective 01.07.97)
- 3 (Effective 01.07.99)
- 4 (Effective 01.07.02)

**Definition source**

DHS

**Code set source**

DHS

---

# Patient Identifier

---

## Specification

**Definition** Patient identifier, unique to this hospital or campus. Often referred to as the unit record number.

**Datatype** Alpha/numeric      **Form** Identification Number

**Field size** Ten      **Layout** NNNNNNNNNN  
Right justified, Zero filled

**Reported for** Every Emergency Department presentation.

**Code Set** Hospital-generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.

**Reporting Guide** All newborns must have their own Patient Identifier. This cannot be the mother's Patient Identifier but could be the mother's Patient Identifier with a prefix or suffix.

**Edits**

E025	Duplicate Attendance
E030	Duplicate Unique Key
E065	Patient Identifier Invalid

## Administration

**Purpose** To ensure hospitals have the ability to identify specific patient presentations.

**Principal data users** Monash University Accident Research Centre; Hospital Demand Management, DHS.

**Collection start** 1 July 1995      **Version** 1 (Effective 01.07.95)

**Definition source** DHS      **Code set source** Hospitals

---

## Place Where Injury Occurred

---

### Specification

**Definition** The physical location of the person when the injury occurred.

**Datatype** Alpha/numeric **Form** Code

**Field size** One **Layout** A

**Reported for** Presentations where any other Injury Surveillance items are completed or if an injury code from the Nature of Main Injury and Body Region Matrix is in the Primary Diagnosis field (Conditional mandatory).

Injury Surveillance Items:

- Activity when Injured
- Body Region
- Description of Main Injury
- Human Intent
- Injury Cause
- Nature of Main Injury
- Place Where Injury Occurred.

<i>Code set</i>	<i>Code</i>	<i>Descriptor</i>	<i>Includes</i>	<i>Excludes</i>
	H	Home	House, home premises, farm house, non-institutional place of residence, apartment, boarding house, caravan park (resident), private: driveway to home, garage, garden/yard or home, path to home, swimming pool in private house, garden.	Institutional place of residence (I), Abandoned or derelict house (O), Home under construction and not yet occupied (C).
	I	Residential institution	Children's home, orphanage, home for the sick, nursing home, old people's home, hospice, military camp, reform school, prison, pensioners home, dormitory.	Hospital (M).
<i>Code set</i>	<i>Code</i>	<i>Descriptor</i>	<i>Includes</i>	<i>Excludes</i>

S	School, day care centre, public administration area	Building (including adjacent grounds) used by the general public or by a particular group of the public such as: assembly hall, public hall, church, clubhouse, courthouse, post office, day care centre, preschool, youth centre, gallery, library, museum, cinema, theatre, opera house, concert hall, dance hall, school (public or private), college, university, institution for higher education, movie house, kindergarten, campus.	Hospital (M), Recreation area (P), Athletics and sports area (A), Trade or service area (T), Building under construction (C), Residential institution (I).
M	Medical hospital	Hospital.	Hospice, nursing home (I).
A	Athletics and sports area	Cricket ground, football, hockey field, riding school, basketball court, golf course, stadium, skating rink, tennis, squash court, swimming pool.	
R	Road, street or highway	Freeway, footpath, motorway, pavement, road.	Private driveway (H).
T	Trade or service area	Bank, petrol station, supermarket, airport, cafe, casino, garage (commercial), gas station, hotel, market, office building, radio or television station, restaurant, service station, shop (commercial), shopping mall, station (bus/rail), warehouse.	Garage in private home (H).
C	Industrial or construction area	Any building under construction, industrial yard, workshop, dry dock, dock yard, factory building/premises, gasworks, oil rig & other offshore installation, power station (coal/nuclear/oil), shipyard.	Mine, quarry, tunnel under construction (Q).

*Code set*

*Code*

*Descriptor*

*Includes*

*Excludes*

Q	Mine or quarry	Mine or quarry tunnel under construction.	
F	Farm	Farm buildings and land, ranch.	Farm house, & home premises of farm (H).
P	Place for recreation	Public park, amusement park.	Athletics and sports area (A).
O	Other specified place	Forest, beach, pond, abandoned or derelict house, campsite, canal, caravan site NOS, desert, dock NOS, harbour, hill, lake, marsh, military training ground, mountain, parking lot & parking place, prairie, public place NOS, railway line, river, sea, seashore, stream, swamp, water reservoir, zoo.	
U	Unspecified place		

### *Reporting guide*

Report the code which best characterises the location where the patient was situated at the time the injury occurred, on the basis of the information available at the time it is recorded.

If two or more categories are equally appropriate, select the code sequenced first in above code list.

### **Examples:**

Refer to Section 4 – Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised.

### **VEMD – VAED Mapping**

#### **M – Medical hospital**

This code can be mapped to ICD-10-AM External Cause code 2 – School, other institution and public administrative area, which include the VEMD ‘M’ category.

#### **P – Place for recreation**

This code can be mapped to ICD-10-AM External Cause code 8 – Other specified places which includes the VEMD ‘P’ category.

### *Reporting guide (Cont)*

#### **Q – Mine or quarry**

Both this code and the VEMD code C – Industrial or construction area

can be mapped to the ICD-10-AM External Cause code 6 – Industrial and construction area, which includes the VEMD ‘C’ and ‘Q’ categories.

*Edits*

E305	Place Where Injury Occurred Invalid
E306	Place Where Injury Occurred Blank

*Related items* Primary Diagnosis, Body Region, Nature of Main Injury, Description of Injury Event, Injury Cause, Human Intent, Activity When Injured.

## **Administration**

*Purpose* To facilitate injury research.

*Principal data users* Monash University Accident Research Centre; Hospital Demand Management, DHS.

<i>Collection start</i>	1 July 1995	<i>Version</i>	2 (Effective 01.07.95)
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<i>Definition source</i>	DHS	<i>Code set source</i>	NHDD, modified
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# Postcode

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## Specification

<i>Definition</i>	Postcode of locality in which patient usually resides (not a postal address).		
<i>Datatype</i>	Numeric	<i>Form</i>	Code
<i>Field size</i>	Four	<i>Layout</i>	NNNN
<i>Reported for</i>	Every Emergency Department presentation.		
<i>Reporting guide</i>	The Locality and Postcode codes are used to assign a Statistical Local Area (SLA) code for DHS purposes.		

The hospital may collect the patient's postal address for its own purposes. However, for transmission to DHS, the Postcode and Locality items must contain details of the patient's residential address. The VEMD editing program will reject non-residential Postcodes (including mail delivery centres).

### **Statistical Local Area (SLA) Reference file can be obtained by:**

- Contacting the HDSS Help Desk by phone or via e-mail to request a copy, see Section 1 - Introduction (Contact Details).
- The website at <http://hdss.health.vic.gov.au/globalref/index.htm> and selecting the appropriate file under Global Reference Files.
- Accessing the Australia Post website which provides an up to date postcode and localities listing at [www.auspost.com.au](http://www.auspost.com.au)

Note: The SLA Reference File corresponds with the most recent version of the National Localities Index (NLI) and is reviewed annually.

In the event that there is a new locality and postcode that is not included in the current reference file please notify [vemd.submit@dhs.vic.gov.au](mailto:vemd.submit@dhs.vic.gov.au)

The VEMD editing excludes non-residential localities but includes common variations to locality spellings as used in Melway references and Australian Bureau of Statistics Locality Index (Cat. 1252).

**Reporting guide  
(Cont)**

**Newborns:**

Use the guardian's residential postcode.

**Interstate postcodes:**

Must correspond with interstate locality (edited to postcode and first three letters of the Locality).

**Pseudo Postcodes:**

- 1000 No fixed abode (leave Locality item blank)
- 8888 Overseas (Optional to complete the Locality item)
- 9988 Unknown Postcode (Leave Locality item blank)

Note: 'No fixed abode', and 'Unknown Postcode' must have a blank locality item. It is optional to have the suburb/town/locality entered in the Locality item for the pseudo code 8888 indicating 'Overseas'.

**Edits** E115 Postcode/Locality Combination Invalid

**Related items** Locality.

## Administration

**Purpose** Analysis of service utilisation and epidemiological studies.

**Principal data users** Monash University Accident Research Centre; Hospital Demand Management, DHS.

**Collection start** 1 July 1995      **Version** 1 (Effective 01.07.95)

**Definition source** DHS      **Code set source** Australia Post

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# Preferred Language

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## Specification

**Definition** The language (including sign language) most preferred by the patient for communication. This may be a language other than English even where the person can speak fluent English.

**Datatype** Alpha/numeric      **Form** Code

**Field size** Two      **Layout** NN

**Reported for** Every Emergency Department presentation.

**Reporting guide** Report valid codes as documented in Section 8 – Supplementary Code Lists (Preferred Language).

This information must:

- Be checked for every emergency presentation
- Not be set up to a default code on computer Emergency Department Information systems
- Be collected on, or as soon as possible after, admission.

The standard question to ask is:

What is [your] [the person's] preferred language?

### **Patient is unable to consent (eg baby, child or elderly):**

Where a person is not able to consent for themselves (eg baby, child or elderly) then the language of the person who is consenting will be recorded. For example a parent/guardian or someone with enduring power of attorney.

### **07 - Australian Indigenous languages, NEC**

Includes:

All Australian Indigenous languages not shown separately on the code list.

Reporting guide  
(Cont)

## 98 - Not Stated

Includes:

Patients who are not able to respond to this question during their admission (eg unconscious).

Unaccompanied child, who is too young to identify preferred language.

This question on the form was not completed or completed incorrectly and cannot be verified throughout the admission.

Further reference:

<http://babel.uoregon.edu/yamada/geoguides.html>

<http://www.ethnologue.com/>

### *Edits*

E110	Preferred Language Invalid
E359	Preferred Language Equals English but Interpreter Required
E360	Not Equal to 'N - No'
E361	ATSI Identification but Preferred Language Not Equal to English or ATSI
E362	Preferred Language is Unspecified
	Preferred Language Not Stated but Interpreter Required Not Equal to '3 - Not Stated'
E363	Interpreter Required Equals '3 - Not Stated' but Preferred Language Not Equal to '96' or '98'

## Administration

### *Purpose*

This item is an indicator of ethnicity and assists multilingual service planning and provision.

### *Principal data users*

Monash University Accident Research Centre; Hospital Demand Management, DHS.

### *Collection start*

1 July 1995

### *Version*

1 (Effective 01.07.95)  
2 (Effective 01.07.95)

### *Definition source*

NHDD

### *Code set source*

NHDD; ABS mod Aust. Stand. Classification

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# Procedures

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## Specification

<i>Definition</i>	Specific interventions/treatments performed in the Emergency Department for the diagnosis and/or treatment of patients.		
<i>Datatype</i>	Alpha/numeric	<i>Form</i>	Code
<i>Field size</i>	Eighty nine	<i>Layout</i>	NN (x 30) Separated by a left { curly bracket
<i>Reported for</i>	<b>Optional</b> if the Primary Diagnosis item is completed.		
<i>Reporting guide</i>	<b>Multiple procedure codes:</b> Up to thirty procedure codes will be accepted. Each procedure code must be separated by a left { curly bracket: For example 01{21{71{91 Procedures will count as one item, even though up to thirty codes can be entered. It is not necessary to have multiples of 'Other' and 'unspecified' procedure codes. For example: A procedure list such as - 42{91{91{91{43 would be better defined as 42{91{43  See      Section 8 – Supplementary Code Lists (Procedure Codes).		
<i>Edits</i>	E206	Procedure Code Invalid	
	E207	Procedure Code Format Invalid	

## Administration

<i>Purpose</i>	Analysis of Emergency Department activity.		
<i>Principal data users</i>	Monash University Accident Research Centre; Hospital Demand Management, DHS.		
<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95) 2 (Effective 01.07.01)
<i>Definition source</i>	DHS	<i>Code set source</i>	DHS

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# Reason for Transfer

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## Specification

**Definition** Reason for transfer of a patient to another hospital or health service.

**Datatype** Alpha/numeric      **Form** Code

**Field size** One      **Layout** N

**Reported for** Presentations with Departure Status of 4 - Another Hospital Campus (Conditional mandatory).

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	1	ICU bed not available
	2	CCU bed not available
	3	General bed not available
	4	Specialty not available
	5	Previous patient of destination hospital
	6	Insured/Compensable
	7	Patient preference
	9	Other reason

**Reporting guide** Item should be left blank if patient has not been transferred or if transfer is to a Nursing Home (Departure Status is 0 - Residential Care Facility).

Select the first appropriate category.

**Edits** E232 Transfer Departure Status Code Combination Invalid  
E245 Reason for Transfer Code Invalid

**Related items** Transfer Destination, Escort Source, Departure Status, Departure Transport Mode.

## Administration

<i>Purpose</i>	To monitor the reasons for patient transfer between hospitals.		
<i>Principal data users</i>	Critical Care Inter Hospital Transfer program; Monash University Accident Research Centre; Hospital Demand Management, DHS.		
<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95) 2 (Effective 01.07.97)
<i>Definition source</i>	DHS	<i>Code set source</i>	DHS

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# Referred By

---

## Specification

*Definition* Source from which patient was referred to this Emergency Department.

*Datatype* Alpha/numeric      *Form* Code

*Field size* Two      *Layout* NN

*Reported for* Every Emergency Department presentation.

<i>Code set</i>	<i>Code</i>	<i>Descriptor</i>
	0	Staff from this campus
	1	Self, family, friends
	2	Local medical officer, includes local GP/Doctor
	4	Private specialist
	6	Staff from another campus (includes both admitted and non-admitted transfers. Also record Transfer Source)
	8	Correctional Officer / Police
	9	Crisis Assessment Team
	10	Community Services Staff
	13	Nurse (Excluding those in categories 0 to 10)
	19	Other

*Reporting guide*      **13 Nurse:**  
Includes District Nurse, Nurse Practitioner and Nurses employed within Aged Care Residential Care Facility (both high and low level care), Hostel, Respite Care Facility, Nursing Home and Custodial Care Facility.

Excludes: Personal Care Attendants (PCA), and nurses within this hospital or other acute care facility.

Select the first appropriate category.

**Reporting guide  
(Cont)**

**Armed Forces and Prison Hospitals:**

Armed Forces and Prison Hospitals are not recognised by the Commonwealth Department of Health and Aged Care and therefore admission from, or separation to, such facilities is not an inter-hospital transfer.

- If a patient is transferred to the ED from an Armed Forces hospital, Referred By is 19 - Other
- If a patient is transferred to the ED from a Prison hospital,
- Referred By is 8 – Correctional Officer/Police.

**Edits**

E130 Referred By Invalid

E136 Referred By and Transfer Source Combination Invalid

**Related items**

Arrival Transport Mode.

## **Administration**

**Purpose**

Analysis of referral patterns.

**Principal data users**

Monash University Accident Research Centre; Hospital Demand Management, DHS.

**Collection start**

1 July 1995

**Version**

- 1 (Effective 01.07.95)
- 2 (Effective 01.07.97)
- 3 (Effective 01.07.01)
- 4 (Effective 01.07.02)
- 5 (Effective 01.07.03)

**Definition source**

DHS

**Code set source**

DHS

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## Referred to on Departure

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### Specification

*Definition* The agency to which the patient was referred for continuing care.

*Datatype* Alpha/numeric *Form* Code

*Field size* Two *Layout* NN

*Reported for* Every Emergency Department presentation.

<i>Code set</i>	<i>Code</i>	<i>Descriptor</i>	<i>Includes</i>
	1	Review in ED - scheduled	Planned return to ED
	2	Review in ED - as required	Return to ED if problems persist
	3	Outpatients	
	4	LMO	Referred to local doctor
	5	Medical Specialist	
	6	Other Specialist Health Practitioner	Physiotherapist, Dentist, etc.
	7	Home Nursing Services	RDNS
	8	Specialised Community Service	Detox Centre, Rape Crisis Centre, Crisis Assessment Team,
	9	Aged Care Assessment Service	Dedicated ACAS teams which are able to assess eligibility for community & residential aged care programs.
	16	No referral	Treatment complete
	17	Not known	
	18	Other	
	19	Not applicable	Admission to inpatient bed (Ward or MAPU), Emergency Medical Unit, Short Stay Observation Unit, Transferred, Died, Dead on Arrival, Left at own risk.

## **Reporting guide**

Select the first appropriate category.

### **9 – Aged Care Assessment Service (ACAS)**

Used where a patient is referred to an ACAS in order to assess eligibility for access to Community Aged Care Packages or residential aged care.

The core objective of ACAS is to comprehensively assess the needs of frail older people and to facilitate access to available services appropriate to their needs. In meeting this objective, ACAS also determine eligibility for Commonwealth subsidised residential aged care (including residential respite), Community Aged Care Packages and some flexible care services, including Extended Aged Care at Home (EACH).

Where a patient is referred to any other aged care specific service the appropriate code should be used (e.g. if a referral is made to a geriatrician then use code 5 medical specialist)

## **Edits**

E142	Dead on Arrival Combination Invalid
E240	Referred to on Departure Invalid
E242	Referred to on Departure and Departure Status Combination Invalid
E352	Arrival Transport Mode '9 – Undertaker' but not DOA
E353	Diagnosis Code Equals 'R961 – Dead on Arrival' but Patient not DOA

## **Administration**

### **Purpose**

To promote and monitor the coordination of patient care.

### **Principal data users**

Monash University Accident Research Centre; Hospital Demand Management, DHS.

### **Collection start**

1 July 1995

### **Version**

- 1 (Effective 01.07.95)
- 2 (Effective 01.07.97)
- 3 (Effective 01.07.03)

### **Definition source**

DHS

### **Code set source**

DHS

---

# Sex

---

## Specification

*Definition* The sex of the patient.

*Datatype* Alpha/numeric      *Form* Code

*Field size* One      *Layout* N

*Reported for* Every Emergency Department presentation.

<i>Code set</i>	<i>Code</i>	<i>Descriptor</i>
	1	Male
	2	Female
	3	Indeterminate

*Reporting guide* Sex should be inferred or accepted as reported by the respondent, as at the time of admission.

That is, it is usually unnecessary and may be inappropriate or even offensive to ask a person their sex. Sex may be inferred from other cues such as observation, relationship to respondent, or first name.

For infants with ambiguous sexual genitalia, the biological sex as determined at birth, possibly following genetic testing, is recorded. Only where this cannot be determined during the episode of care should 'Indeterminate' be assigned. It can only be used for infants aged less than 90 days.

<i>Edits</i>	E090	Sex Invalid
	E092	Sex Indeterminate with Age Greater Than or Equal To 90 Days
	E093	Sex Indeterminate and Age Less Than 90 Days
	E262	Diagnosis Code and Sex Incompatible
	E264	Diagnosis Code and Sex – Check

*Related items* Diagnosis code.

## Administration

<i>Purpose</i>	Analysis of service utilisation and epidemiological studies.		
<i>Principal data users</i>	Monash University Accident Research Centre; Hospital Demand Management, DHS.		
<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95) 2 (Effective 01.07.03)
<i>Definition source</i>	NHDD	<i>Code set source</i>	NHDD

---

## Transfer Destination

---

### Specification

<i>Definition</i>	The acute health care facility (hospital or campus) to which the patient was transferred.		
<i>Datatype</i>	Alpha/numeric	<i>Form</i>	Code
<i>Field size</i>	Four	<i>Layout</i>	NNNN
<i>Reported for</i>	Presentations where 'Departure Status' is 4 - Another Hospital Campus, irrespective of whether they were admitted or not admitted at the sending hospital (Conditional mandatory).		
<i>Reporting guide</i>	<p><b>Victorian hospital</b></p> <p>If a patient is transferred to a Victorian hospital, select a code from the code list in Section 8 - Supplementary Code Lists.</p> <p><b>Interstate/overseas hospital</b></p> <p>If a patient is transferred interstate or overseas, allocate a code according to the structure outlined in Section 8 - Supplementary Code Lists.</p> <p>Item should be left blank if patient has not been transferred or if transfer is to a Nursing Home.</p> <p><b>Prison Hospitals and Armed Forces Hospitals:</b></p> <p>These are not generally recognised as hospitals by the Commonwealth Department of Health and Aged Care and therefore admission from, or separation to, such facilities is not an inter-hospital transfer.</p>		

**Reporting guide  
(Cont)**

**Multiple campus hospital transfers:**

The VEMD is a 'campus' based collection.

Where the patient transfers to another campus of the same hospital (different site identifier):

- Departure Status is 4 – Another Hospital Campus
- Transfer Destination is Campus Code.

Where the patient moves between wards of the same campus (same site identifier):

- Departure Status is 2 - Ward (including HITH and MAPU)
- Departure Status is 3 – SOU
- Departure Status is 13 – EMU.

**Unknown Transfer Destination:**

It is expected that the sending hospital is aware of the specific receiving hospital to which the patient is being transferred. Unknown Transfer Destination of 9999 will result in a rejection.

See Section 3 – Data Definitions (Campus Code, Transfer Source).  
Section 8 – Supplementary Code Lists (Campus Codes and Transfer Source/Destination Codes).

**Edits**

- E137 Transfer Destination / Source Equals Campus Code
- E232 Transfer Departure Status Code Combination Invalid
- E235 Transfer Destination Code Invalid

**Related items**

Departure status.

## Administration

**Purpose**

Analysis of patient transfer patterns.

**Principal data users**

Monash University Accident Research Centre; Hospital Demand Management, DHS.

**Collection start**

1 July 1995

**Version**

- 1 (Effective 01.07.95)
- 2 (Effective 01.07.97)
- 3 (Effective 01.07.99)

**Definition source**

DHS

**Code set source**

DHS

---

# Transfer Source

---

## Specification

**Definition** The acute health care facility (hospital or campus) from which the patient was transferred to this Emergency Department.

**Datatype** Alpha/numeric      **Form** Code

**Field size** Four      **Layout** NNNN

**Reported for** Presentations where Referred By is 6 – Staff from Another Campus, except if from a nursing home within such a facility (Conditional mandatory).

**Reporting guide** This item includes all patients who were transferred, whether admitted or not admitted at the transferring hospital and identifies the precise acute health care facility from which the patient was transferred to your hospital.

Item should be blank if patient has not been transferred or if transfer is from a nursing home.

### **Victorian hospital**

If a patient is transferred to a Victorian hospital, select a code from the code listed in Section 8 – Supplementary Code Lists.

### **Interstate/overseas hospital**

If a patient is transferred interstate or overseas, allocate a code according to the structure outlined in Section 8 – Supplementary Code Lists.

### **Prison Hospitals and Armed Forces Hospitals:**

These are not generally recognised as hospitals by the Commonwealth Department of Health and Aged Care and therefore admission from, or separation to, such facilities is not an inter-hospital transfer.

**Reporting guide  
(Cont)**

**Multiple hospital campus transfers:**

The VEMD is a 'campus' based collection.

Where the patient is transferred from another campus of the same hospital (different site identifier):

- Referred By is 6 – Staff from Another Campus
- Transfer Source is Campus Code.

Where the patient moves between wards of the same campus (same site identifier):

- Referred By is 0 – Staff from this campus.

**Unknown Transfer Source:**

9999 - unknown.

This code will result in a warning message, as it is possible that a receiving hospital may not be aware of the health care facility that has transferred the patient. The assignment of this code by the receiving hospital should not occur frequently.

See Section 3 – Data Definitions (Campus Code, Transfer Source).

Section 8 – Supplementary Code Lists (Campus Codes, Transfer Source/Destination Codes).

**Edits**

E135 Transfer Source Code Invalid

E136 Referred By and Transfer Source Combination Invalid

E137 Transfer Destination / Source Equals Campus Code

**Related items**

Referred By.

## Administration

**Purpose**

Analysis of patient transfer patterns.

**Principal data users**

Monash University Accident Research Centre; Hospital Demand Management, DHS.

**Collection start**

1 July 1995

**Version**

1 (Effective 01.07.95)

2 (Effective 01.07.97)

3 (Effective 01.07.99)

**Definition source**

DHS

**Code set source**

DHS

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# Triage Category

---

## Specification

*Definition* Classification according to urgency of need for medical and nursing care, using the National Triage Scale.

*Datatype* Alpha/numeric      *Form* Code

*Field size* One      *Layout* N

*Reported for* Every Emergency Department presentation.

<i>Code set</i>	<i>Code</i>	<i>Descriptor</i>	<i>Recommended time to treatment</i>
	1	Resuscitation	Immediate: less than or equal to 1 minute
	2	Emergency	Less than or equal to 10 minutes
	3	Urgent	Less than or equal to 30 minutes
	4	Semi urgent	Less than or equal to 60 minutes
	5	Non urgent	Less than or equal to 120 minutes
	6	Dead on arrival	

*Reporting guide* The Triage Category is to be allocated by an experienced registered nurse or medical practitioner.

It is imperative that the VEMD accurately reflects the demand placed on Emergency Department services, therefore, once a patient is triaged, to one of the VEMD triage categories, the presentation must be recorded within the VEMD in all instances. This applies even when the patient did not wait for treatment to commence OR if registration was commenced but not completed.

### **Changes in triage category:**

It is recognised that triage categories may alter during a presentation.

The following guideline should be followed when a patient changes Triage Category during an emergency presentation:

**Reporting guide  
(Cont)**

- If the triage category of a patient is altered during their presentation, the original Triage Category is to be transmitted to the VEMD (regardless of whether the re-categorisation is higher or lower)
- Changes in Triage Categories may be recorded locally but should not be submitted to the VEMD; only the original Triage Category should be reported.

**6 - Dead on arrival:**

This item is collected for VEMD purposes. It is not included in the National Triage Scale.

Refer Section 4 – Business Rules (Dead On Arrival).

**Edits**

- E142 Dead on Arrival Combination Invalid
- E175 Triage Category Invalid
- E351 Waiting Time Potentially Excessive for Triage Category
- E352 Arrival Transport Mode '9 - Undertaker' but not DOA
- E353 Diagnosis Code Equals 'R961 - Dead on Arrival' but Patient not DOA
- E366 Departure Status and Triage Category Combination Invalid

**Related items**

Arrival Date, Arrival Time, First Seen By Doctor Date, First Seen By Doctor Time, First Seen By Treating Nurse Date, First Seen By Treating Nurse Time.

## **Administration**

**Purpose**

To identify and monitor the urgency of a patient's presentation and corresponding time to treatment.

**Principal data users**

Monash University Accident Research Centre; Hospital Demand Management, DHS.

**Collection start**

1 July 1995

**Version**

1 (Effective 01.07.95)

**Definition source**

Australasian College for  
Emergency Medicine

**Code set source**

Australasian College for  
Emergency Medicine;  
DHS; NHDD

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# Triage Date

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## Specification

*Definition* Date the patient was first seen by a Triage nurse/doctor.

*Datatype* Date *Form* Code

*Field size* Eight *Layout* DDMMCCYY

*Reported for* Every Emergency Department presentation.

*Reporting guide* If local work practices dictate that the Triage process occurs immediately upon arrival, then the Triage Date/Time will equal Arrival Date/Time.

**Valid Format:**

DDMMCCYY

**Invalid Format:**

Zero-filled

*Edits*

See	Section 2 - Concept and Derived Item Definitions (Date / Time Fields, Time to Treatment).
E165	Triage Date/Time Invalid
E167	Triage Date/Time Before Arrival Date/Time
E181	First Seen By Treating Nurse Date/Time Before Triage Date/Time
E196	First Seen By Doctor Date/Time Before Triage Date/Time
E366	Departure Status and Triage Category Combination Invalid

*Related items* Triage Time.

## Administration

<i>Purpose</i>	Used in the calculation of various derived items:		
	<ul style="list-style-type: none"><li>• Time to Treatment: with Arrival Date/Time, Triage Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.</li></ul>		
<i>Principal data users</i>	Monash University Accident Research Centre; Hospital Demand Management, DHS.		
<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95)
<i>Definition source</i>	NHDD	<i>Code set source</i>	NHDD

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# Triage Time

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## Specification

*Definition* Time the patient was first seen by a Triage nurse/doctor.

*Datatype* Time *Form* Code

*Field size* Four *Layout* HHMM

*Reported for* Every Emergency Department presentation.

*Reporting guide* **Valid Format:**  
HHMM (Must be in 24-hour format)

**Invalid Format:**  
0000 or 2400

Following international convention midnight is reported as either 2359 of preceding date or 0001 of the following date.

If local work practices dictate that the Triage process occurs immediately upon arrival, then the Triage Date/Time will equal Arrival Date/Time.

*Edits* See Section 2 – Concept and Derived Item Definitions (Date / Time Fields, Time to Treatment).

E165 Triage Date/Time Invalid

E167 Triage Date/Time Before Arrival Date/Time

E181 First Seen By Treating Nurse Date/Time Before Triage Date/Time

E196 First Seen By Doctor Date/Time Before Triage Date/Time

E366 Departure Status and Triage Category Combination Invalid

*Related items* Triage Date.

## Administration

<i>Purpose</i>	Used in the calculation of various derived items:		
	<ul style="list-style-type: none"><li>• Time to Treatment: with Arrival Date/Time, Triage Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time.</li></ul>		
<i>Principal data users</i>	Monash University Accident Research Centre; Hospital Demand Management, DHS.		
<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95)
<i>Definition source</i>	DHS	<i>Code set source</i>	DHS

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## Type of Usual Accommodation

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### Specification

*Definition* Type of accommodation in which the patient usually lives.

*Datatype* Alpha/Numeric *Form* Code

*Field size* Two *Layout* NN

*Reported for* Every Emergency Department presentation.

<i>Code Set</i>	<i>Code</i>	<i>Descriptor</i>
	1	Private Residence, living alone
	2	Private Residence, living with other(s)
	3	Residential aged care facility - includes both high care (nursing home) and low care (hostel)
	4	Boarding/rooming house/hostel or hostel type accommodation (not including aged care hostel)
	5	Community-based residential supported living facility or other supported accommodation (includes group home for people with disabilities, supported residential services, specialised alcohol/other drug treatment residence).
	6	Psychiatric Hospital
	7	Other Hospital Setting
	8	Homeless Person's Shelter
	9	Shelter/refuge (not including homeless person's shelter)
	10	Public place (homeless)
	11	Prison/Remand Centre/ Youth Training centre
	18	Unknown/unable to determine
	19	Other accommodation, not elsewhere classified

*Reporting guide* 'Usual' is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to presentation.

If a person stays in a particular place of accommodation for four or more days a week over the period, that place of accommodation would be the person's type of usual accommodation.

Reporting guide  
(Cont)

In practice, receiving an answer strictly in accordance with the above definition may be difficult to achieve. The place the person perceives, as their usual accommodation will often prove to be the best approximation.

**2 - Private Residence, living with other(s)**

Includes: family or friends. Intended to capture those who would provide support on discharge.

**3 - Residential aged care facility -includes both high care (nursing home) and low (hostel) care.**

Includes: nursing home beds in acute and sub/acute care hospitals.

**5 - Community-based residential supported living facility or other supported accommodation**

Includes:

- Community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provide 24-hour support/rehabilitation on a residential basis
- Group homes for people with disabilities, cluster apartments where a support worker lives on-site, community residential apartments, congregate care arrangements. Support is provided by staff on either a live-in or rostered basis, and they may or may not have 24-hour supervision and care
- Other supported accommodation facilities such as hostels for people with disabilities and Residential Services/Facilities. These facilities provide board and lodging and rostered care workers provide client support services.

The intent of code 5 is to capture accommodation where there is some support available. Where there is no support available i.e. the hostel or other facility provides accommodation only, code 4 should be allocated.

**6 - Psychiatric Hospital**

Includes alcohol/other drug treatment units in psychiatric hospitals

**7 - Other Hospital Setting**

Includes respite and palliative care facilities.

**Edits**

- E354 Type of Usual Accommodation Invalid
- E355 Type of Usual Accommodation and Age Combination Invalid
- E356 Type of Usual Accommodation and Departure Status Combination Invalid
- E357 Type of Usual Accommodation and Medicare Suffix Combination Invalid

**Related items**

Date of Birth, Locality, Postcode.

## Administration

*Purpose* To assist in the evaluation of acute / residential care interface issues and the implementation of strategies to address these issues.

*Principal data users* Metropolitan Health and Aged Care Services, DHS.

*Collection start* 1 July 2003      *Version* 1 (Effective 01.07.03)

*Definition source* DHS      *Code set source* DHS

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## Type of Visit

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### Specification

<i>Definition</i>	The reason the patient presented to the Emergency Department.		
<i>Datatype</i>	Alpha/numeric	<i>Form</i>	Code
<i>Field size</i>	Two	<i>Layout</i>	NN
<i>Reported for</i>	Every Emergency Department presentation.		
<i>Code set</i>	<i>Code</i>	<i>Descriptor</i>	<i>Includes</i>
	1	Emergency presentation	<p>Presentation due to a new clinical condition; <b>OR</b></p> <p>An Unplanned presentation for a continuing condition; <b>OR</b></p> <p>Privately referred or privately treated patient.</p>
	2	Return visit - planned	<p>Planned return to the ED as a result of a previous ED presentation or return visit. The return visit may be for planned follow-up treatment or as a consequence of test results indicating need for further treatment or as a result of a care plan initiated at discharge; <b>OR</b></p> <p>Outpatient appointment for a planned presentation.</p>
	8	Pre-arranged admission - clerical, nursing, clinical	<p>Presentation at the ED for clerical, nursing or medical processes to be undertaken. Admission has been arranged by the referring medical officer.</p>
	9	Patient in transit	<p>The ED is responsible for care and treatment of a patient awaiting transport to another institution.</p>

10	Dead on arrival	Patient is pronounced dead by a medical practitioner before (or without) being brought into the ED or where the patient is brought into the ED but there is no intent to resuscitate.
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**Reporting guide**      Select the first appropriate category.

**2 - Return Visit - Planned**

Includes the following:

Where a return visit has been scheduled (for example where a patient is told to return on a specific date for removal of sutures);

Where a return visit is required as a consequence of test results indicating need for further treatment;

Where a return visit becomes necessary as part of a conditional, documented discharge plan (for example: patient is given specific plaster care advice and returns with numbness in the affected limb);

Excludes:

Where a visit follows a general exhortation to return if feeling unwell, this should not be recorded as a planned visit.

<b>Edits</b>	E140    Type of Visit Invalid
	E142    Dead on Arrival Combination Invalid
	E352    Arrival Transport Mode '9 - Undertaker' but not DOA
	E353    Diagnosis Code Equals 'R961 - Dead on Arrival' but Patient not DOA

**Administration**

**Purpose**      Analysis of service utilisation.

**Principal data users**    Monash University Accident Research Centre; Hospital Demand Management, DHS.

<b>Collection start</b>	1 July 1995	<b>Version</b>	1    (Effective 01.07.95) 2    (Effective 01.07.03)
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<b>Definition source</b>	NHDD	<b>Code set source</b>	DHS; NHDD, modified
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# Unique Key

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## Specification

<i>Definition</i>	A unique identifier specific to an individual ED presentation.		
<i>Datatype</i>	Alpha/Numeric	<i>Form</i>	Code
<i>Field size</i>	Nine	<i>Layout</i>	NNNNNNNNNN Right justified, Zero filled
<i>Reported for</i>	Every Emergency Department presentation.		
<i>Code Set</i>	Hospital-generated.		
<i>Reporting guide</i>	<p>The hospital derives the unique identifier <b>specific</b> to the individual Emergency Department presentation.</p> <p>The Unique Key can be computer-generated or have specific relevance at the hospital.</p> <p>A Unique Key <i>cannot</i> be changed: the episode would need to be deleted and re-submitted with a new Unique Key.</p> <p>Do <i>not</i> re-use a Unique Key; a Unique Key must <i>not</i> be re-assigned to another presentation for the same patient or to another patient.</p>		
<i>Edits</i>	E025	Duplicate Attendance	
	E030	Duplicate Unique Key	
	E060	Unique Key Invalid	

## Administration

<i>Purpose</i>	To uniquely identify every ED presentation.		
<i>Principal data users</i>	Monash University Accident Research Centre; Hospital Demand Management, DHS.		
<i>Collection start</i>	1 July 1995	<i>Version</i>	1 (Effective 01.07.95) 2 (Effective 01.07.98) 3 (Effective 01.07.99)
<i>Definition source</i>	DHS	<i>Code set source</i>	Hospital-generated

