Department of Health

Appendix B

File Format and Validation Rules 2015 – 2016

Queensland Hospital Admitted Patient Data Collection (QHAPDC)

Contents

Public Hospital Services File Format 2015-2016 Collection Year

Introduction

This document specifies the file format for the electronic submission of data by facilities providing public hospital services to Health Statistics Branch, Queensland Department of Health for the Queensland Hospital Admitted Patient Data Collection.

A record must be provided for each admitted patient, including all newborn babies, from any facility permitted to admit patients.

All boarders and posthumous organ procurement donors are also included in the scope of the Collection.

There are 13 files specified in this document: Header, Patient, Admission, Activity, Morbidity, Mental Health, Elective Admissions, Sub and Non-Acute Patient, Palliative Care, Department of Veterans' Affairs, Workers' Compensation, Australasian Rehabilitation Outcomes Centre and Telehealth Inpatient Details.

The following standard should be used when naming the files:

fffffctyyctyynnn.filetype

fffff	five-digit facility number (zero filled from the left)	
ctyyctyy	collection year to which the data relates	
nnn	data extract number for collection year	
filetype	HDR	for the Header File
	PAT	for the Patient File
	ADM	for the Admission File
	ACT	for the Activity File
	MOR	for the Morbidity File
	MEN	for the Mental Health File
	EAS	for the Elective Admission File
	SNP	for the Sub and Non-Acute Patient File
	PAL	for the Palliative Care File
	DVA	for the Department of Veterans' Affairs File
	WCP	for the Workers' Compensation File
	ARC	for the Australasian Rehabilitation Outcomes Centre File
	TID	for the Telehealth Inpatient Details File

So the 1st admission file for ABC Hospital (facility number 99999) for collection year 2015-2016 would be named:

9999920152016001.ADM

You are able to supply data for multiple months or a partial month in the one extract file. The data extract number for a collection year must begin at '001' and be contiguous throughout the collection year.

Public File Format

Header file

The header file contains an extraction details record (the facility and period for which data has been extracted, and the date the extraction took place) and file details records (the number and type of records on each file).

The extraction details record is the first record on the Header File. There should be only one extraction details record in the Header File.

For each file extracted, there must be a file details record on the Header File.

EXTRACTION DETAILS RECORD			
Record Identifier	1 char	E, Extraction details	
Facility Number	5 num	Must be a valid facility number.	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
Extract Date	8 date	Date data extracted	ctyymmdd

FILE DETAILS RECORD			
Record Identifier	1 char	F, File details	
File Type	3 char	PAT = Patient ADM = Admission ACT = Activity MOR = Morbidity MEN = Mental Health EAS = Elective Admission SNP = Sub and Non-Acute Patient PAL = Palliative Care DVA = Department of Veterans' Affairs WCP = Workers' Compensation ARC = Australasian Rehabilitation Outcomes Centre TID = Telehealth Inpatient Details	
Record Type	1 char	N, New	
Number of Records	5 num	Number of new records	Right adjusted and zero filled from left; zero if null
Record Type	1 char	A, Amendment	
Number of Records	5 num	Number of amendment records	Right adjusted and zero filled from left; zero

			if null
Record Type	1 char	D, Deletion	
Number of Records	5 num	Number of deletion records	Right adjusted and zero filled from left; zero if null
Record Type	1 char	U, Up to Date	
Number of Records	5 num	Number of up to date records	Right adjusted and zero filled from left; zero if null
Filler	2	Blank	

An example of a header file is:

E999992015070120150731201508 20
FPATN00420A00020D00000U00007
FADMN00420A00124D00001U00007
FACTN00080A00000D00010U00008
FMORN01000A00000D00005U00009
FMENN00020A00000D00001U00001
FEASN00005A00000D00002U00002
FSNPN00010A00002D00001U00003
FPALN00008A00001D00002U00004
FDVAN00003A00001D00001U00005
FWCPN00002A00001D00001U00010
FARCN00004A00002D00001U00006
FTIDN00007A00002D00001U00001

The details provided in the above example are:

Extraction details

Facility 99999 - ABC Hospital
Extraction period 1 July 2015 to 31 July 2015
Extraction date 20 August 2015

File details

Patient file

420 New records
20 Amendments
0 Deletions
7 Up to Date

Admission file

420 New records
124 Amendments
1 Deletions
7 Up to Date

Activity file

80	New records
0	Amendments
10	Deletions
8	Up to Date

Morbidity file

1000	New records
0	Amendments
5	Deletions
9	Up to Date

Mental Health file

20	New records
0	Amendments
1	Deletions
1	Up to Date

Elective Admission file

5	New records
0	Amendments
2	Deletions
2	Up to Date

Sub and Non-Acute Patient file

10	New records
2	Amendments
1	Deletions
3	Up to Date

Palliative Care file

8	New records
1	Amendments
2	Deletions
4	Up to Date

Department of Veterans' Affairs file

3	New records
1	Amendments
1	Deletions
5	Up to Date

Workers' Compensation file

2	New records
1	Amendments
1	Deletions
10	Up to Date

Australasian Rehabilitation Outcomes Centre file

4	New records
2	Amendments
1	Deletions
6	Up to Date

Telehealth Inpatient Details

7	New records
2	Amendments
1	Deletions
1	Up to Date

Patient File

The header record is the first record on the file. There is only one header record, followed by the patient details records.

HEADER RECORD			
Facility Number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type PAT = Patient	
Number of Records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	238	Blank	

PATIENT DETAILS RECORDS			
Record Identifier	1 char	N = new A = amendment, U = up to date	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (eg. unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
Family Name	24 char	First 24 characters of surname of patient	Left adjusted
First Given Name	15 char	First 15 characters of first given name of patient	Left adjusted, blank if null
Second Given Name	15 char	First 15 characters of second given name of patient	Left adjusted, blank if null
Address of Usual Residence	40 char	Number and street of usual residential address of patient. Note: For HBCIS this data is captured from the 'Address Line' where the 'Address Type' value is equal to 'P' – Permanent.	Blank if null

Location (Suburb/Town) of Usual Residence	40 char	The location associated with the permanent address.	Left adjusted. Must not be null
Postcode of Usual Residence	4 num	Australian postcode associated with the permanent address. Supplementary codes as below (note that for Australian External Territory addresses, the actual postcode should be used). 9301 = Papua New Guinea 9302 = New Zealand 9399 = Overseas other (not PNG or NZ) 9799 = At sea 9989 = No fixed address 0989 = Not stated or unknown	Must not be null
State of Usual Residence	1 num	State associated with the permanent address (note that for Australian External Territory addresses, the actual state id should be used). 0 = Overseas 1 = New South Wales 2 = Victoria 3 = Queensland 4 = South Australia 5 = Western Australia 6 = Tasmania 7 = Northern Territory 8 = Australian Capital Territory 9 = Not stated/unknown/no fixed address/at sea	Must not be null
Filler	4	Blank	
Sex	1 num	1 = Male 2 = Female 3 = Intersex or indeterminate Note: Intersex refers to patients who, because of a genetic condition, have been born with reproductive organs or sex chromosomes that are not exclusively male or female or whose sex has not yet been determined for whatever reason.	Must not be null
Date of Birth	8 date	Full date of birth of patient Where dd is unknown use 15 Where mm is unknown use 06 Where yy is unknown estimate year	ctyymmdd
Estimated Date of Birth Indicator	1 char	A flag to indicate whether any component of a reported date of birth is estimated. 1 = Estimated	Blank if null

Marital Status	1 num	1 = Never married 2 = Married/de facto 3 = Widowed 4 = Divorced 5 = Separated 9 = Not stated/unknown	Must not be null
Country of Birth	4 num	Country of birth of patient	Right adjusted and zero filled from left
Indigenous Status	1 num	1 = Aboriginal but not Torres Strait Islander origin 2 = Torres Strait Islander but not Aboriginal origin 3 = Both Aboriginal and Torres Strait Islander origin 4 = Neither Aboriginal nor Torres Strait Islander origin 9 = Not stated/unknown	Must not be null
Filler	2	Currently not required	Blank if null
Occupation	4	Currently not required	Blank if null
Labour Force Status	1	Currently not required	Blank if null
Medicare Eligibility	1 num	1 = Eligible 2 = Not eligible 9 = Not stated/unknown	Must not be null
Medicare Number	11 num	Medicare number of patient. The eleventh digit is the number that precedes the patient's name on the card (the subnumerate). If a subnumerate cannot be supplied, the eleventh digit of the Medicare number should be provided as zero.	Blank if not available or if null
Australian South Sea Islander Status	1 char	Denotes whether the patient is of Australian South Sea Islander origin 1 = Yes 2 = No 9 = Not stated/unknown	Must not be null
Contact for Feedback Indicator	1 char	Indicates whether or not the patient consents to be contacted by Queensland Health, or its agent, to obtain feedback on the services provided at the facility. Y = Yes N = No U = Unable to obtain	Must not be null
Telephone Number – Home	20 char	The patient's home contact telephone number.	Left adjusted, blank if null
Telephone Number – Mobile	20 char	The patient's mobile contact telephone number.	Left adjusted, blank if null

Telephone Number – Business or Work	20 char	The patient's business or work contact telephone number.	Left adjusted, blank if null
Hospital Insurance health fund code	6 char	The health insurance fund of which the patient is currently a member for their hospital insurance.	Left adjusted, blank if null
Hospital Insurance health fund description	50 char	When health fund code is 'Other' - a description of the health insurance fund of which the patient is currently a member for their hospital insurance is required.	Left adjusted, blank if null

Admission File

The header record is the first record on the file. There is only one header record, followed by the admission details records.

HEADER RECORD			
Facility Number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type ADM = Admission	
Number of Records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	139	Blank	

ADMISSION DETAILS RECORDS			
Record Identifier	1 char	N = new, A = amendment, D = deletion, U = up to date	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (eg. unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
Admission Date	8 date	Date of admission to facility	ctyymmdd
Admission Time	4 num	Time of admission to facility (0000 to 2359)	hhmm (24 hour clock)
Account Class	12 char	Facility-specific account codes (HBCIS only)	Left adjusted, blank if null
Chargeable Status	1 num	1 = Standard 2 = Private share 3 = Private single	Must not be null

Care Type	2 num	01 = Acute 20 = Rehabilitation 30 = Palliative 05 = Newborn 09 = Geriatric Evaluation and Management 10 = Psychogeriatric 11 = Maintenance **12 = Mental Health** 06 = Other care 07 = Organ Procurement 08 = Boarder	Right adjusted zero filled from left
Compensable Status	1 num	1 = Workcover Queensland 2 = Workers' Compensation Board (Other) 6 = Motor Vehicle (Qld) 7 = Motor Vehicle (Other) 3 = Other Third Party 4 = Other Compensable 5 = Dept of Veterans' Affairs 9 = Department of Defence 8 = None of the above	Must not be null
Band	2 char	Classification to categorise same day procedures into the Commonwealth Bands 1A = Band 1A 1B = Band 1B 2 = Band 2 3 = Band 3 4 = Band 4	Left adjusted, blank if null.
Source of Referral/Transfer	2 num	01 = Private medical practitioner (not Psychiatrist) 02 = Emergency dept – this hospital 03 = Outpatient dept – this hospital 23 = Residential Aged Care Service 06 = Episode change 09 = Born in hospital 15 = Private psychiatrist 16 = Correctional facility 17 = Law enforcement agency (police/courts) 18 = Community service 19 = Routine readmission not requiring referral 14 = Other health care establishment 20 = Organ procurement 21 = Boarder 24 = Admitted patient transferred from another hospital 25 = Non-admitted patient referred from other hospital 29 = Other	Right adjusted and zero filled from left
Transferring from Facility	5 num	Facility number from which patient was transferred or referred. Code if Source of Referral/Transfer is 16, 23, 24 or 25	Right adjusted and zero filled from left; blank if null

Hospital Insurance	1 num	7 = Hospital insurance 8 = No hospital insurance 9 = Not stated/unknown	Must not be null
Separation Date	8 date	Date of separation from facility	ctyymmdd
Separation Time	4 num	Time of separation from facility (0000 to 2359)	hhmm (24 hour clock)
Mode of Separation	2 num	01 = Home/usual residence 16 = Transferred to another hospital 15 = Residential Aged Care Service 05 = Died in hospital 06 = Episode change 07 = Discharged at own risk 09 = Non return from leave 12 = Correctional facility 04 = Other health care establishment 13 = Organ Procurement 14 = Boarder 19 = Other 17 = Medi-Hotel	Right adjusted and zero filled from left
Transferring to Facility	5 num	Facility number to which patient was transferred. Code if Mode of Separation is 12, 15 or 16	Right adjusted and zero filled from left, blank if null
DRG (version 7.0)	5 char	Collected if available	Left adjusted, blank if null
MDC	3 char	Collected if available	Left adjusted, blank if null
Baby Admission Weight	4 num	Admission weight in grams for neonates 28 days of age or less, or where the admission weight is less than 2,500 grams	Right adjusted and zero filled from left, blank if null
Admitting Ward	6 char	Code to describe admitting ward	Left adjusted
Admitting Unit	4 char	Code to describe admitting unit	Blank if null
Standard Unit Code	4 char	Standard code to describe Treating Doctor Speciality/Unit	Left adjusted
Treating Doctor at admission of episode of care	**6 char**	**Code to identify the treating doctor at the admission of the episode of care.**	**Left adjusted, Must not be null**
Planned Same Day	1 char	Y = Yes N = No	Must not be null
Elective Patient Status	1 char	1 = Emergency admission 2 = Elective admission 3 = Not assigned	Must not be null
Qualification Status	1 char	A = Acute U = Unqualified	Blank if null

Standard Ward Code	4 char	Denotes whether the ward is assigned to a Standard Ward Code CCU4 = Coronary Care Unit Level 4 CCU5 = Coronary Care Unit Level 5 CCU6 = Coronary Care Unit Level 6 CHEM = Chemotherapy– Children's **CIC4 = Children's Intensive Care Service Level 4** **CIC5 = Children's Intensive Care Service Level 5** CIC6 = Intensive Care Service Level 6 DIAL = Renal Dialysis **EDSS = Emergency Department Short Stay Unit** EMER = Emergency HOME = Hospital in the Home ICU4 = Intensive Care Unit Level 4 ICU5 = Intensive Care Unit Level 5 ICU6 = Intensive Care Unit Level 6 MATY = Maternity MENA = Specialised Mental Health Acute Psychiatric MENN = Specialised Mental Health Non-acute Psychiatric MIXC = Mixed Wards Critical Care MIXG = Mixed Wards Non-Critical Care Service Types NORM = General Wards NSV4 = Neonatal Service Level 4 NSV5 = Neonatal Service Level 5 NSV6 = Neonatal Service Level 6 OBSV = Observation PAED = Paediatric Services SNAP = Designated SNAP Unit STKU = Stroke Unit	Blank if null
Contract Role	1 char	A = Hospital A (contracting hosp) B = Hospital B (contracted hosp) Identifies whether the hospital is 'Hospital A' – the purchaser of hospital care (contracting hospital) or 'Hospital B' - the provider of an admitted or non-admitted service (contracted hospital)	Blank if null

Contract Type	1 char	1 = B 2 = ABA 3 = AB 4 = (A)B 5 = BA Describes the contract arrangement between the contracting hospital ('Hospital A') and the contracted hospital ('Hospital B')	Blank if null

Funding Source	2 char	Expected principal source of funds for the episode. 01 = Health service budget (not covered elsewhere) 02 = Private health insurance 03 = Self-funded 04 = Worker's compensation 05 = Motor vehicle third party personal claim 06 = Other compensation (e.g.Public liability, common law and medical negligence) 07 = Department of Veterans' Affairs 08 = Department of Defence 09 = Correctional facility 10 = Other hospital or public authority (contracted care) 11 = Health service budget (due to eligibility for Reciprocal Health Care 12 = Other funding source 13 = Health service budget (no charge raised due to hospital decision) 99 = Not known	Right adjusted and zero filled from left
Incident Date	8 date	The date the patient was first aware of the symptoms or onset of illness; or had the accident for which hospital treatment as either an admitted or non-admitted patient is being administered. Where dd is unknown use 15. Where mm is unknown use 06. Where yy is unknown an estimate must be provided.	ctyymmdd Blank if null
Incident Date Flag	1 char	Flag to indicate whether the Patient's incident date is estimated 1 = Estimated	Blank if null
Workcover Queensland (Q-Comp) Consent	1 char	Indicates whether or not the patient consents to the release of their details to Workcover Queensland (Q-Comp). Y = Yes N = No U = Unable to obtain	Must not be null
Motor Accident Insurance Commission (MAIC) Consent	1 char	Indicates whether or not the patient consents to the release of their details to the Motor Accident Insurance Commission. Y = Yes N = No	Must not be null

		U = Unable to obtain	
Department of Veterans' Affairs (DVA) Consent	1 char	Indicates whether or not the patient consents to the release of their details to the Department of Veterans' Affairs. Y = Yes N = No U = Unable to obtain	Must not be null
Department of Defence Consent	1 char	Indicates whether or not a patient consents to the release of their details to the Department of Defence. Y = Yes N = No U = Unable to obtain	Must not be null
Filler	4	Filler	Blank
Interpreter Required	1 num	Indicates whether an interpreter service is required by or for the person. 1 = Yes 2 = No 9 = Unknown	Must not be null
Religion	4 num	Currently not required	Blank if null
QAS Patient Identification Number (eARF Number)	12 num	QAS patient identification number provided by the QAS Team when delivering a patient to this facility.	Left adjusted, blank if null
Purchaser/Provider Identifier	5 num	The identifier of the 'other' facility or purchaser involved in the contracted care. Record the Code of the other hospital if contract type = 2, 3, 4, 5. Record the Code of the Jurisdiction, HHS or other external purchaser that has purchased the public contracted hospital care if contract type = 1 and contract role = B (Hospital B).	Right adjusted and zero filled from left; blank if null
Preferred Language	6 num	Indicates the patient's preferred language for communicating when receiving health care services.	Left adjusted. Must not be null
Length of Stay in Intensive Care Unit	7 num	The total amount of time spent by an admitted patient in an approved intensive care unit (Adult Intensive Care Unit - ICU6 or Children's Intensive Care Service Level 6 - CIC6) Format HHHHHMM H = Hours, M = Minutes	Right adjusted and zero filled from left blank if null

Duration of continuous ventilatory support	7 num	The total amount of time an admitted patient has spent on continuous ventilatory support (ie invasive ventilation). Format HHHHHMM H = Hours, M = Minutes	Right adjusted and zero filled from left blank if null

Criteria Led Discharge Type	2 num	The discipline of the clinician who initiated the separation. 01 = Not CLD – Authorised (Admitting) Practitioner 02 = Junior Doctor – CLD 03 = Nurse – CLD 04 = Midwife – CLD 05 = Nurse Practitioner – CLD 06 = Physiotherapist – CLD 07 = Occupational Therapist – CLD 08 = Social Worker – CLD 09 = Psychologist – CLD 10 = Speech Pathologist – CLD 11 = Dietician – CLD 12 = Pharmacist – CLD 99 = Other – CLD	Right adjusted and zero filled from left. Must not be null
Smoking Status	**1 num**	**Indicates the smoking status of the patient.** **1 = Reported as a current smoker within the last 30 days** **2 = Reported not a smoker** **9 = Not reported**	**Blank if null**
Smoking Pathway Completed	**1 char**	**Indicates whether a Smoking Cessation Clinical Pathway has been completed.** **Y = Yes** **N = No**	**Must not be null if smoking status = 1**
Treating Doctor at Separation of Episode of Care	**6 char**	**Code to identify the treating doctor at separation of the episode of care.**	**Left adjusted, must not be null**

Activity File

The header record is the first record on the file. There is only one header record, followed by the activity details records.

HEADER RECORD			
Facility Number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type ACT = Activity	
Number of Records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	25	Blank	

ACTIVITY DETAILS RECORDS			
Record Identifier	1 char	N = new, D = deletion, U = up to date	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (eg. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
Activity Code	1 char	A = Account Class Variation L = Leave Episode W = Ward/Unit Transfer C = Contract Status N = Not Ready for Care E = Elective Surgery Items Q = Qualification Status S = Sub and Non-Acute Items T = Nursing Home Type D = Delayed Assessed Separation Event B = Mother's Patient Identifier of baby born in hospital R = Australasian Rehabilitation Outcomes Centre Items	

Activity Details		See below table/s for record details	

Activity Details if Activity Code = A (Account Class Variation)			
Account Class	12 char	Facility-specific account codes (HBCIS only)	Left adjusted, blank if null
Filler	2	Blank	
Chargeable Status	1 num	1 = Standard 2 = Private shared 3 = Private single	
Compensable Status	1 num	1 = Workcover Queensland 2 = Workers' Compensation Board (other) 6 = Motor Vehicle (Qld) 7 = Motor Vehicle (Other) 3 = Other Third Party 4 = Other Compensable 5 = Dept of Veterans' Affairs 9 = Department of Defence 8 = None of the above	
Filler	2	Blank	
Date of Change	8 date	Date that change to account class occurred	ctyymmdd
Time of Change	4 num	Not currently required	Blank if null

Activity Details if Activity Code = L (Leave Episode)			
Date of Starting Leave	8 date	Date patient went on leave	ctyymmdd
Time of Starting Leave	4 num	Not currently required	Blank if null
Date Returned from Leave	8 date	Date patient returned from leave	ctyymmdd
Time Returned from leave	4 num	Not currently required	Blank if null
Filler	6	Blank	

Activity Details if Activity Code = W (Ward/Unit Transfer)			
Ward	6 char	Ward that patient was transferred to	
Unit	4 char	Unit that patient was transferred to	Blank if null
Standard Unit Code	4 char	Standard unit that patient was transferred to	
Date of Transfer	8 date	Date patient transferred	ctyymmdd
Time of Transfer	4 num	Time patient transferred	hhmm (24 hour clock)

Standard Ward Code	4 char	Denotes whether the ward is assigned to a Standard Ward Code CCU4 = Coronary Care Unit Level 4 CCU5 = Coronary Care Unit Level 5 CCU6 = Coronary Care Unit Level 6 CHEM = Chemotherapy **CIC4 = Children's Intensive Care Service Level 4** **CIC5 = Children's Intensive Care Service Level 5** CIC6 = Children's Intensive Care Service Level 6 DIAL = Renal Dialysis **EDSS = Emergency Department Short Stay Unit** EMER = Emergency HOME = Hospital in the Home ICU4 = Intensive Care Unit Level 4 ICU5 = Intensive Care Unit Level 5 ICU6 = Intensive Care Unit Level 6 MATY = Maternity MENA = Specialised Mental Health Acute Psychiatric MENN = Specialised Mental Health Non-acute Psychiatric MIXC = Mixed Wards Critical Care MIXG = Mixed Wards Non-Critical Care Service Types NORM = General Wards NSV4 = Neonatal Service Level 4 NSV5 = Neonatal Service Level 5 NSV6 = Neonatal Service Level 6 OBSV = Observation PAED = Paediatric Services SNAP = Designated SNAP Unit STKU = Stroke Unit	Blank if null

Activity Details if Activity Code = C (Contract Status)			
Date Transferred for Contract	8 date	Date patient transferred for contract service	ctyymmdd
Date returned from Contract	8 date	Date patient returned from contract service	ctyymmdd
Facility Contracted to	5 num	Facility number for facility performing contracted service	
Filler	9	Blank	

Activity Details if Activity Code = N (Not Ready for Care)			
Entry Number	3 num	The unique Waiting List placement number	Right adjusted, zero filled from left
Date Not Ready For Care	8 date	Date patient was not ready for care	ctyymmdd
Time Not Ready For Care	4 num	Not currently required	Blank if null
Last Date Not Ready For Care	8 date	Last date patient not ready for care	ctyymmdd
Last Time Not Ready For Care	4 num	Not currently required	Blank if null
Filler	3	Blank	

Activity Details if Activity Code = E (Elective Surgery Items)			
Entry Number	3 num	The unique Waiting List placement number	Right adjusted, zero filled from left
Urgency Category	**1 num**	Clinical urgency classification from field 20 of the Waiting List Entry screen 1 = Elective Surgery – Category 1 2 = Elective Surgery – Category 2 3 = Elective Surgery – Category 3 4 = Other – Category 1 5 = Other – Category 2 6 = Other – Category 3 **9 = Gastrointestinal Endoscopy Surveillance**	
Accommodation (intended)	1 char	Currently not required	Blank if null
Site Procedure Indicator	3 char	Currently not required	Blank if null
National Procedure Indicator	2 num	Currently not required	Blank if null
Planned Length of Stay	3 char	Currently not required	Blank if null
Planned Admission Date	8 Date	Currently not required	Blank if null
Date of Change	8 date	Date that change to elective surgery item occurred.	ctyymmdd
Filler	1	Blank	

Activity Details if Activity Code = Q (Qualification status)			
Qualification Status	1 char	A = Acute U = Unqualified	
Date of Change	8 date	Date that change of qualification status occurred	ctyymmdd
Time of Change	4 num	Currently not required	Blank if null
Filler	17	Blank	
All changes of qualification status must be provided. If more than one change of qualification status occurs on a single day, then the final qualification status for that day should be provided.			

If Activity Code = S (Sub and Non-acute Items), then Activity Details =			
SNAP Episode Number	3 num	The unique SNAP episode number	Right adjusted, zero filled from left
ADL Type	3 char	Measure of physical, psychosocial, vocational and cognitive functions of an individual with a disability FIM = Functional independence measure HON = Health of the nation outcome scales RUG = Resource utilisation group	Must not be null
ADL Subtype	3 char	The HoNOS tool requires the collection of the total HoNOS score and the two individual items to allow for the assignment to a Psychogeriatric care type. If ADL Type = HON record 3 ADL Subtypes: BEH = Overactive behaviour ADL = Activity of Daily Living TOT = Total The FIM tool has a cognitive and a motor sub-scale used as an assignment variable when assigning to a Rehabilitation or Geriatric Evaluation and Management care type. If ADL Type = FIM record 2 ADL Subtypes: MOT = Motor COG = Cognitive The RUG tool requires the collection of the total RUG score when assigning to a Maintenance or Palliative care type. If ADL Type = RUG, record 1 ADL Subtype: TOT = Total	Must not be null
ADL Score	3 num	Numerical rating from the ADL tool used as a measurement of different components of functional ability.	Must not be null. Right adjusted, zero filled from left

ADL Date	8 date	Date the ADL score was recorded	ctyymmdd
ADL Time	4 num	Not currently required	Blank if null
Phase Type	2 num	A distinct period or stage of illness relating to palliative care patients. So, for SNAP Type = PAL or PAA record one phase type: 01 = Stable 02 = Unstable 03 = Deteriorating 04 = Terminal Care	Blank if null Must not be null if SNAP Type = PAL or PAA
Filler	4	Blank	
ADL scores for each SNAP episode are to be supplied. Do not provide more than one set of scores on the same date for the same ADL type and ADL sub type. *For all SNAP episodes:* • *A code of '999' is acceptable as a SNAP score when the actual ADL score is not known or cannot be determined at the time of entry.*			

If Activity Code = T (Nursing Home Type) then Activity Details =			
Nursing Home Flag	3 char	NHT = Nursing Home Flag	Not valid for patients with a care type of: 01 – Acute 05 – Newborn 07 – Organ Procurement 08 - Boarder
Date Commenced NHT Care	8 date	Date when patient commenced Nursing Home Type care	ctyymmdd
Date Ceased NHT Care	8 date	Date when patient ceased Nursing Home Type care	ctyymmdd
Filler	11	Blank	

If Activity Code = D (Delayed Assessed Separation Event), then Activity Details =			
Delayed Assessed Separation Event Number	2 num	The unique Delayed Assessed Transfer number	Right adjusted, zero fill from left
Delayed Assessed Separation Event – Start Date	8 date	Date that the treating clinician identifies that a patient is ready to be separated to another stage of care, but cannot be separated for one or more reasons.	ctyymmdd
Delayed Assessed Separation Event – End Date	8 date	Date that a patient is separated to another stage of care, or it is identified that the patient no longer requires separation.	ctyymmdd
Delayed Assessed Separation Event – Waiting Reason 1	2 num	The reason for the delay to separate a patient. Up to three waiting reasons can be provided. 13 = Awaiting decision by patient, patient's family, or patient's carer(s)	Must not be null

		14 = Awaiting decision by Guardianship and Administration Tribunal 15 = Awaiting formal assessment, re-assessment or review - Clinical 16 = Awaiting formal assessment, re-assessment or review – ACAT 23 = Awaiting modifications to residence 24 = Awaiting placement in a non-hospital setting 25 = Awaiting availability of hospital services or programs 26 = Awaiting availability of community-based services or programs 27 = Awaiting equipment 31 = Awaiting Transport 32 = Awaiting family/informal carer support 33 = Awaiting a dwelling 98 = Other reason 99 = Not stated/unknown reason	
Delayed Assessed Separation Event – Waiting Reason 2	2 num	The reason for the delay to separate a patient. Up to three waiting reasons can be provided. 13 = Awaiting decision by patient, patient's family, or patient's carer(s) 14 = Awaiting decision by Guardianship and Administration Tribunal 15 = Awaiting formal assessment, re-assessment or review - Clinical 16 = Awaiting formal assessment, re-assessment or review - ACAT 23 = Awaiting modifications to residence 24 = Awaiting placement in a non-hospital setting 25 = Awaiting availability of hospital services or programs 26 = Awaiting availability of community-based services or programs 27 = Awaiting equipment 31 = Awaiting Transport 32 = Awaiting family/informal carer support 33 = Awaiting a dwelling 98 = Other reason 99 = Not stated/unknown reason	Can be null
Delayed Assessed Separation Event – Waiting Reason 3	2 num	The reason for the delay to separate a patient. Up to three waiting reasons can be provided. 13 = Awaiting decision by patient, patient's family, or patient's carer(s) 14 = Awaiting decision by Guardianship and Administration Tribunal 15 = Awaiting formal assessment, re-assessment or review - Clinical 16 = Awaiting formal assessment, re-assessment or review - ACAT 23 = Awaiting modifications to residence 24 = Awaiting placement in a non-hospital setting	Can be null

		25 = Awaiting availability of hospital services or programs 26 = Awaiting availability of community-based services or programs 27 = Awaiting equipment 31 = Awaiting Transport 32 = Awaiting family/informal carer support 33 = Awaiting a dwelling 98 = Other reason 99 = Not stated/unknown reason	
Delayed Assessed Separation Event – Proposed Setting	3 num	The principal care setting proposed for a patient on separation. Only one proposed setting can be provided. If there is more than one proposed setting, provide the principal setting. 110 = Residential aged care, high level dementia specific care 111 = Residential aged care, high level of care - other 112 = Residential aged care, low level dementia specific care 113 = Residential aged care, low level of care - other 103 = Residential aged care, unknown or unspecified level of care 104 = Residential support institutions, hostels, or group homes for people with a disability 105 = Specialised residential mental health service 106 = Other non-hospital health care residential facilities 107 = Other non-health care supported accommodation 108 = Private residence of a service provider 109 = Private residence - other 198 = Other non-hospital care setting 201 = Admitted service, current treating hospital 202 = Admitted service, another hospital 203 = Non-admitted service, current treating hospital 204 = Non-admitted service, another hospital 298 = Other hospital care setting 999 = Not stated/unknown setting	Must not be null
Delayed Assessed Separation Event – Proposed Service	3 num	The principal type of service that is it proposed a patient will be separated to. Only one proposed service can be provided. If there is more than one proposed service, provide the principal service. 001 = No service is required 101 = Community/home based rehabilitation 102 = Community/home based palliative 103 = Community/home based geriatric	Must not be null

		evaluation and management 111 = Community/home based – nursing/domiciliary 104 = Community/home based respite 105 = Community/home based psychogeriatric 106 = Home and community care 107 = Community aged care package, extended aged care in the home 108 = Flexible care package 109 = Transition care program (includes intermittent care service) 110 = Outreach Service 198 = Community/home based - other 201 = Hospital based (admitted) - rehabilitation 202 = Hospital based (admitted) - maintenance 203 = Hospital based (admitted) - palliative 204 = Hospital based (admitted) - geriatric evaluation and management 205 = Hospital based (admitted) -respite 206 = Hospital based (admitted) – psychogeriatric 207 = Hospital based (admitted) - acute 208 = Hospital based - non-admitted services 298 = Hospital based - other 998 = Other service 999 = Not stated/unknown service	
Delayed Assessed Separation Event – Start Time	4 num	Time that the treating clinician identifies that a patient is ready to be separated to another stage of care, but cannot be separated for one or more reasons. (0000 to 2359)	hhmm (24 hour clock)
Delayed Assessed Separation Event – End Time	4 num	Time that the treating clinician identifies that a patient is ready to be separated to another stage of care, but cannot be separated for one or more reasons. (0000 to 2359)	hhmm (24 hour clock)

Activity Details if Activity Code = B (Mother's Patient Identifier of baby born in hospital)			
Mother's Patient Identifier	8 char	Mother's Patient Identifier of baby born in hospital	Right adjusted and zero filled from left
Filler	22	Blank	

Activity Details if Activity Code = R (Australasian Rehabilitation Outcomes Centre)

AROC Episode Number	3 num	The unique AROC episode number	Right adjust, zero filled from left
ADL Type	3 char	Measure of physical, psychosocial, vocational and cognitive functions of an individual with a disability FIM = Functional independence measure	Must not be null.
ADL Subtype	4 char	The FIM tool has a motor and a cognitive sub-scale used as an assignment variable when assigning to an AROC Rehabilitation care type. The Motor subtypes are: MEAT = Eat MGRM = Groom MBTH = Bath MDRU = Dress Upper MDRL = Dress Lower MTLT = Toilet MBWL = Bowel MBDR = Bladder MTBC = Transfer Bed/Chair MTTL = Transfer Toilet MTTU = Transfer Tub MWWL = Walk/Wheelchair MSTR = Stairs The Cognition subtypes are: CCMP = Comprehension CEXP = Expression CSNT = Social Interaction CPRS = Problem Solving CMEM = Memory	Must not be null.
ADL Score	3 num	Numerical rating from the ADL tool used as a measurement of different components of functional ability.	Must not be null.
ADL Date	8	Date the ADL score was recorded.	ctyymmdd
Filler	9	Blank	

Morbidity File

The header record is the first record on the file. There is only one header record, followed by the morbidity details records.

HEADER RECORD			
Facility Number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type MOR = Morbidity	
Number of Records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify the version of software used	Left adjusted, blank if null
Filler	66	Blank	

MORBIDITY DETAILS RECORDS			
Record Identifier	1 char	N = new, D = deletion, U = up to date	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (eg. unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
Diagnosis Code Identifier	3 char	PD = Principal diagnosis OD = Other diagnosis EX = External cause code PR = Procedure M = Morphology	Left adjusted
ICD-10-AM Code (**9th edition**)	7 char	Code assigned from The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, **9th edition**.	Left adjusted

Diagnosis Text	50 char	Textual description of diseases and procedures are optional	Left adjusted, blank if null
Procedure Date	8 date	Date that the procedure was performed. The date must be provided if the procedure is within the following block ranges: 1 to 59 67 to 559 561 to 737 739 to 1059 1062 to 1062 1064 to 1089 1091 to **1580** 1602 to 1759 1828 to 1828 1886 to 1886 1890 to 1891 1906 to **1907** 1909 to 1912 1920 to 1922	ctyymmdd, blank if null
Contract Flag	1 num	Recorded by Hospital A when a patient receives an admitted or non-admitted contracted service from the contracted hospital (Hospital B) 1 = Contracted admitted procedure 2 = Contracted non-admitted procedure	Blank if null
Diagnosis Onset Type	1 char	An indicator for each diagnosis to indicate the onset and/or significance of the diagnosis to the episode of care. 1 = Condition present on admission to the episode of care 2 = Condition arises during the current episode of care 9 = Unknown/Uncertain	Blank if null
Most Resource Intensive Condition Flag	1 char	1 = Most Resource Intensive Condition	Blank if null
Other Co-Morbidity of Interest Flag	1 char	1 = Other Co-Morbidity of Interest	Blank if null

Mental Health File

A record is to be provided on the mental health details file for each episode of care where the standard unit code (either at admission to the episode or through a ward transfer during the episode) is in the range PYAA to PYZZ.

No record is to be provided if there were no standard unit codes in this range during the episode of care.

The header record is the first record on the file. There is only one header record, followed by the mental health details records.

HEADER RECORD			
Facility Number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type MEN = Mental Health	
Number of Records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	2	Blank	

MENTAL HEALTH DETAILS RECORDS			
Record Identifier	1 char	N = new, A = amendment, D = deletion, U = up to date	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (eg. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left

Type of Usual Accommodation	1 char	1 = House or flat 2 = Independent unit as part of a retirement village or similar 3 = Hostel or hostel accommodation 4 = Psychiatric hospital 5 = Acute hospital 7 = Other accommodation 8 = No usual residence	
Employment Status	1 char	1 = Child not at school 2 = Student 3 = Employed 4 = Unemployed 5 = Home duties 6 = Pensioner 8 = Other	
Pension Status	1 char	1 = Aged 2 = Repatriation 3 = Invalid 4 = Unemployment benefit 5 = Sickness benefit 7 = Other 8 = No pension/benefit	
First Admission For Psychiatric Treatment	1 char	1 = No previous admission for psychiatric treatment 2 = Previous admission for psychiatric treatment	
Referral To Further Care	2 char	01 = Not referred 02 = Private psychiatrist 03 = Other private medical practitioner 04 = Mental health/alcohol and drug facility - admitted patient 05 = Mental health/alcohol and drug facility - non-admitted patient 06 = Acute hospital - admitted patient 07 = Acute hospital - non-admitted patient 08 = Community health program 29 = Other	Right adjusted and zero filled from left
Mental Health Legal Status Indicator	1 char	1 = Involuntary patient for any part of the episode 2 = Voluntary patient for all of the episode	
Previous Specialised Non-Admitted Treatment	1 char	1 = Patient has no previous non-admitted service contact(s) for psychiatric treatment 2 = Patient has previous non-admitted service contact(s) for psychiatric treatment	

Elective Admission File

A record is to be provided on the elective admissions details file for each episode of care where one or more completed EAS entries have been linked to the episode of care.

Each episode of care can have one or more EAS entry linked to it.

The header record is the first record on the file. There is only one header record, followed by the elective admission details records.

HEADER RECORD			
Facility Number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type EAS = Elective Admissions	
Number of Records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	57	Blank	

ELECTIVE ADMISSION DETAILS RECORDS			
Record Identifier	1 char	N = new, A = amendment, D = deletion, U = up to date	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (eg. unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
Entry Number	3 num	The unique waiting list placement number	Right adjusted and zero filled from left
Planned Unit	4 char	Currently not required	Blank if null

NMDS Specialty Grouping	2 num	Waiting List Speciality codes are derived from the mapping of units to one of the twelve speciality codes: 01 = Cardio Thoracic 02 = ENT Surgery 03 = General Surgery 04 = Gynaecology 05 = Neurosurgery 06 = Ophthalmology 07 = Orthopaedic Surgery 08 = Plastic and Reconstructive Surgery 09 = Urology 10 = Vascular Surgery 11 = Other – Surgical 90 = Other - Non-Surgical	Right adjusted and zero filled from left
Waiting List Status	2 num	Currently not required	Blank if null
Reason for Removal	2 num	Reason for removal codes are derived from the mapping of waiting list status codes to reason for removal codes: 01 = Admitted and treated as an elective patient for awaited procedure in this hospital 02 = Admitted and treated as an emergency patient for awaited procedure in this hospital 04 = Treated elsewhere for awaited procedure 05 = Surgery not required or declined 06 = Transferred to other hospital's waiting list 99 = Not stated/unknown	Right adjusted and zero filled from left, blank if null
Listing Date	8 Date	Date patient placed on waiting list	ctyymmdd
Pre-Admission Date (Planned)	8 Date	Currently not required	Blank if null
Urgency Category	**1 num**	Clinical urgency classification from field 20 of the Waiting List Entry screen 1 = Elective Surgery – Category 1 2 = Elective Surgery – Category 2 3 = Elective Surgery – Category 3 4 = Other – Category 1 5 = Other – Category 2 6 = Other – Category 3 **9 = Gastrointestinal Endoscopy Surveillance**	
Accommodation (intended)	1 char	Accommodation code from field 21 of the Waiting List Entry screen P = Public R = Private Single S = Private Shared	Left adjusted space filled from the right

Site Procedure Indicator	**3 Filler**	**Blank**	
National Procedure Indicator	2 num	Derived from the mapping of **primary planned procedure codes** to national procedure indicators 01 = Cataract extraction 02 = Cholecystectomy 03 = Coronary artery bypass graft 04 = Cystoscopy 05 = Haemorrhoidectomy 06 = Hysterectomy 07 = Inguinal herniorrhaphy 08 = Myringoplasty 09 = Myringotomy 10 = Prostatectomy 11 = Septoplasty 12 = Tonsillectomy 13 = Total hip replacement 14 = Total knee replacement 15 = Varicose veins 16 = Not applicable	Right adjusted zero filled from left
Planned Length of Stay	3 char	Estimated stay from field 22 of the WL Entry screen. Value to be converted to zero during HQI extraction if values of 'D' for Day Case encountered	Right adjusted zero filled from left
Planned Admission Date	8 Date	Not currently required	Blank
Pre-admission Clinic Attendance Date	8 Date	Not currently required	Blank
Planned Procedure Date	8 Date	The most recent planned procedure date for the patient prior to admission for each entry on the waiting list - from field 10 of the Booking Entry screen	ctyymmdd Blank if null
Filler (Facility Identifier of the hospital managing the waiting list).	**5 filler**	**Not currently required.**	**Blank**
Primary Planned Procedure Code	**7 char**	**Primary Planned Procedure Code from field 27 of the Waiting List Entry screen.** **Entries to be validated against the contents of the Primary Planned Procedure Code reference file.**	**Left adjusted. Must not be null**

Sub and Non-Acute Patient (SNAP) File

A record for each SNAP type is to be provided on the sub and non-acute patient details file for each episode of care where the care type is sub-acute or non-acute (ie Rehabilitation Care, Geriatric Evaluation and Management Care, Palliative Care, Psychogeriatric Care or Maintenance Care)

No record is to be provided if the care type is **mental health**, acute, newborn, boarder, organ procurement or other care.

The header record is the first record on the file. There is only one header record, followed by the sub and non-acute patient details records.

HEADER RECORD			
Facility Number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type SNP = Sub and Non-acute Patient	
Number of Records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	31	Blank	

SUB AND NON-ACUTE PATIENT DETAILS RECORDS			
Record Identifier	1 char	N = new, A = amendment, D = deletion, U = up to date	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted, zero filled from left
SNAP Episode Number	3 num	The unique SNAP episode number	Right adjusted, zero filled from left

SNAP Type	3 char	Classification of a patient's care type based on characteristics of the person, the primary treatment goal and evidence PAA = Palliative – assessment only PAL = Palliative care RAO = Rehabilitation – assessment only RCD = Rehabilitation – congenital deformities ROI = Rehabilitation - other disabling impairments RST = Rehabilitation – stroke RBD = Rehabilitation – brain dysfunction RNE = Rehabilitation – neurological RSC = Rehabilitation - spinal cord dysfunction RAL = Rehabilitation – amputation of limb RPS = Rehabilitation - pain syndromes ROF = Rehabilitation – orthopaedic conditions, fractures ROR = Rehabilitation – orthopaedic conditions, replacement ROA = Rehabilitation – orthopaedic, all other RCA = Rehabilitation – cardiac RMT = Rehabilitation - major multiple trauma RPU = Rehabilitation – pulmonary RDE = Rehabilitation – debility RDD = Rehabilitation – developmental disabilities RBU = Rehabilitation – burns RAR = Rehabilitation – arthritis GAO = Geriatric Evaluation and management - assessment only GEM = Geriatric evaluation and management GSD = Geriatric evaluation and management - planned same day MAO = Maintenance – assessment only MRE = Maintenance – respite MNH = Maintenance - nursing home type MCO = Maintenance – convalescent care MOT = Maintenance – other PSA = Pschogeriatric – assessment only PSG = Psychogeriatric care	Must not be null
Group Classification	3 num	Currently not required	Blank if null
Start Date	8 Date	The start date of each SNAP episode	ctyymmdd
End Date	8 Date	The end date of each SNAP episode	ctyymmdd

Multidisciplinary Care Plan Flag	1 char	There is documented evidence of an agreed multidisciplinary care plan. Y = Yes N = No U = Unknown	Required for patients with a Rehabilitation, Geriatric Evaluation and Management, Psychogeriatric or Palliative SNAP Type. Blank if null
Multidisciplinary Care Plan Date	8 Date	The date of establishment of the multidisciplinary care plan	Ctyymmdd Required for patients with a Rehabilitation , Geriatric Evaluation and Management , Psychogeriatric or Palliative SNAP Type and Multidisciplinary Care Plan Flag = 'Y' Blank if null
Proposed Principal Referral Service	3 num	The principal type of service proposed for a patient post discharge. Only one proposed service can be provided. If there is more than one proposed service, provide the principal service. 001 = No service is required 101 = Community/home based rehabilitation 102 = Community/home based palliative 103 = Community/home based geriatric evaluation and management 111 = Community/home based – nursing/domiciliary 104 = Community/home based respite 105 = Community/home based psychogeriatric 106 = Home and community care 107 = Community aged care package, extended aged care in the home 108 = Flexible care package 109 = Transition care program (includes intermittent care service) 110 = Outreach Service 198 = Community/home based - other 201 = Hospital based (admitted) - rehabilitation 202 = Hospital based (admitted) - maintenance 203 = Hospital based (admitted) - palliative 204 = Hospital based (admitted) - geriatric evaluation and management 205 = Hospital based (admitted) -respite	Required for patients with a Rehabilitation, Geriatric Evaluation and Management , Psychogeriatric or Palliative SNAP Type. Blank if null

		206 = Hospital based (admitted) - psychogeriatric 207 = Hospital based (admitted) - acute 208 = Hospital based - non-admitted services 298 = Hospital based - other 998 = Other service 999 = Not stated/unknown service	
Primary Impairment Type	7 char	The impairment which is the primary reason for admission to the episode.	Left adjusted, Blank if null. Only required for patients with a rehabilitation SNAP type

For Maintenance Care SNAP Episodes

- *At least one set of ADL scores must be provided for each SNAP episode.*
- *There must be at least one SNAP episode within a single non-acute episode of care.*
- *If there are more than one SNAP episode then these must be contiguous.*
- *The start date of the first SNAP episode must be the same as the start date of the episode of care.*
- *The end date of the last SNAP episode must be the same as the end date of the episode of care.*

For Rehabilitation Care, Geriatric Evaluation and Management Care, Palliative Care and Psychogeriatric Care SNAP Episodes

- *At least one set of ADL scores must be provided for each SNAP episode.*
- *There can only be one SNAP episode within a single sub-acute episode of care.*
- *The start date of the SNAP episode must be the same as the start date of the episode of care.*
- *The end date of the SNAP episode must be the same as the end date of the episode of care*

Palliative Care File

A record is to be provided on the palliative care details file for each episode of care where the care type is:

30 = Palliative care

No record is to be provided if the care type is NOT 30.

The header record is the first record on the file. There is only one header record, followed by the palliative care details records.

HEADER RECORD			
Facility Number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type PAL = Palliative Care	
Number of Records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify version of software used	Left adjusted, blank if null

PALLIATIVE CARE DETAILS RECORDS			
Record Identifier	1 char	N = new, A = amendment, D = deletion, U = up to date	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
First Admission For Palliative Care Treatment	1 char	1 = No previous admission for Palliative care treatment 2 = Previous admission for Palliative care treatment	
Previous Specialised Non-Admitted Palliative Care Treatment	1 char	1 = Patient has no previous non-admitted service contact(s) for Palliative care treatment 2 = Patient has previous non-admitted service contact(s) for Palliative care treatment	
Filler	4	Blank	

Department of Veterans' Affairs File

A record is to be provided on the Department of Veterans' Affairs patient details file where the charges for the episode of care are met by the Department of Veterans' Affairs.

A record is not to be provided if the charges for the episode of care are not met by the Department of Veterans' Affairs.

The header record is the first record on the file. There is only one header record, followed by the Department of Veterans' Affairs details records.

HEADER RECORD			
Facility Number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type DVA = Department of Veterans' Affairs	
Number of Records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	5	Blank	

DEPARTMENT OF VETERANS' AFFAIRS DETAILS RECORDS			
Record Identifier	1 char	N = new, A = amendment, D = deletion, U = up to date	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (eg. unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
DVA File Number	10 char	The patient's Department of Veterans' Affairs identification number	Left adjusted and space filled from the right
Card Type	1 char	G = Gold W = White Denotes whether the patient is a gold or white card holder.	

Workers' Compensation File

A record is to be provided on the Workers' Compensation file where the charges for the episode of care are eligible to be met by a Queensland workers' compensation insurer. This is currently defined as those episodes where the payment class is 'WCQ' or 'WCQI'.

A record is not to be provided if the charges for the episode of care are not eligible to be met by a Queensland workers' compensation insurer.

The header record is the first record on the file. There is only one header record, followed by the Workers' Compensation Details records.

HEADER RECORD			
Facility Number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type WCP = Workers' Compensation	
Number of Records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	682	Blank	

WORKERS' COMPENSATION DETAILS RECORDS			
Record Identifier	1 char	N = new, A = amendment, D = deletion, U = up to date	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (eg. unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
Workers' Compensation Record Number	8 num	The patient's Workers' Compensation record number. Populated on the workers' compensation screen from the admission screen	Right adjusted and space filled from left
Payment Class	6 char	The patient's payment class. Populated on the workers' compensation screen from the admission screen	Left adjusted and space filled from right

WC Incident Date	8 date	Date of accident recorded on the workers' compensation screen	ctyymmdd
WC Incident Time	4 num	Time of accident recorded on the workers' compensation screen (0000 to 2359) - will default to 0000 if not entered	hhmm (24 hour clock)
WC Incident Date Flag	1 char	Flag to indicate that if incident date is estimated – generated by HQI based on the use of '*' in the WC Incident Date field Y = Yes N = No	
WC Incident Location	55 char	Free text field used to record the location of the incident. Will have default value of 'UNKNOWN'.	Left adjusted
Nature of Injury	55 char	Free text field used to record the nature of the injury. Will have default value of 'UNKNOWN'.	Left adjusted
Employer Informed	1 char	Flag to indicate if the employer has been informed of the incident. The default value will be 'U' Y = Yes N = No U = Unknown	
Authority Name	30 char	Name of authority	Left adjusted, blank if null
Authority Address Line 1	30 char	First line of authority address details	Left adjusted, blank if null
Authority Address Line 2	30 char	Second line of authority address details	Left adjusted, blank if null
Authority Suburb	30 char	Suburb of authority address details	Left adjusted, blank if null
Authority Postcode	4 num	Postcode of authority address details	Blank if null
Employer Name	30 char	Name of employer	Left adjusted, blank if null
Employer Address Line 1	30 char	First line of employer address details	Left adjusted, blank if null
Employer Address Line 2	30 char	Second line of employer address details	Left adjusted, blank if null
Employer Suburb	30 char	Suburb of employer address details	Left adjusted, blank if null
Employer Postcode	4 num	Postcode of employer address details	Blank if null
Insurer Name	30 char	Name of insurer	Left adjusted, blank if null
Insurer Address Line 1	30 char	First line of insurer address details	Left adjusted, blank if null

Insurer Address Line 2	30 char	Second line of insurer address details	Left adjusted, blank if null
Insurer Suburb	30 char	Suburb of insurer address details	Left adjusted, blank if null
Insurer Postcode	4 num	Postcode of insurer address details	Blank if null
Solicitor Name	30 char	Name of solicitor	Left adjusted, blank if null
Solicitor Address Line 1	30 char	First line of solicitor address details	Left adjusted, blank if null
Solicitor Address Line 2	30 char	Second line of solicitor address details	Left adjusted, blank if null
Solicitor Suburb	30 char	Suburb of solicitor address details	Left adjusted, blank if null
Solicitor Postcode	4 num	Postcode of solicitor address details	Blank if null
Status 1	2 char	Identifies how the WC Incident occurred. Possible values are AW, TW, FW, or U.	Left adjusted and space filled from right
Status 2	2 char	Identifies the patient's role in the WC Incident if it was a road incident. Possible values are C, D, MC, PA, or PD.	Left adjusted and space filled from right, blank if null
Claim Number	20 char	Claim number entered on the workers' compensation screen.	Left adjusted and space filled from right
Occupation	30 char	Occupation when incident occurred. Will have default value of 'UNKNOWN'.	Left adjusted

Australian Rehabilitation Outcomes Centre File

The header record is the first record on the file. From 1 July 2013 AROC data will not be entered on HBCIS and only the header record will be provided in the AROC extract file.

HEADER RECORD			
Facility Number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type ARC = Australasian Rehabilitation Outcomes Centre	
Number of Records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	88	Blank	

AUSTRALASIAN REHABILITATION OUTCOMES CENTRE DETAILS RECORDS			
Record Identifier	1 char	N = new, A = amendment, D = deletion, U = up to date	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (eg. unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
AROC Episode Number	3 num	The unique AROC episode number	Right adjusted, zero filled from left
AROC Episode Begin Date	8 date	The start date of each AROC Episode of Care	ctyymmdd

Type of Usual Accommodation Prior to Admission	1 char	Type of accommodation lived in prior to hospitalisation. 1 = Private residence (inc unit in retirement village) 2 = Residential aged care, low level care (hostel) 3 = Residential aged care, high level care (nursing home) 4 = Community group home 5 = Boarding house 6 = Transitional Living Unit (TLU) 7 = Other	
Usual Living Status Prior to Admission	1 char	Level of support received prior to hospitalisation: 1 = Lives alone 2 = Lives with others	
Usual Level of Support Prior to Admission	1 char	Level of support received prior to hospitalisation 1 = No support/care provided 2 = Support/care provided by other than home residents 3 = Support/care provided by home residents 9 = Not stated	
Labour Force Status	1 char	Identifies the patient's employment status 1 = Employed 2 = Unemployed 3 = Not in Labour Force 9 = Not stated / inadequately defined	
Mode of AROC Episode Start	1 char	Identifies the patients status at the start of the AROC episode 1 = Admitted from usual accommodation. 2 = Admitted from other than usual accommodation (non-Hospital). 3 = Transferred from another hospital. 4 = Transferred from acute care in another ward. 5 = Change from acute care in same ward. 6 = Change of sub-acute care type 9 = Other.	
AROC Impairment Code	7 char	Primary reason for admission to the rehabilitation program	Left adjusted
First Admission for this Impairment	1 char	Identifies if this is the first AROC episode for this impairment at this hospital 1 = Yes 2 = No	
Current Impairment the Result of Trauma	1 char	Identifies if this impairment was the result of trauma 1 = Yes 2 = No	

Date of Relevant Preceding Acute Admission	8 date	The admission date of preceding episode of acute care relevant to the current AROC episode at this hospital with the last 3 months	ctyymmdd, blank if null
Time Since Onset of Impairment	1 char	The time since onset of the impairment not related to an acute admission 1 = less than 1 month 2 = 1 month to less than 3 months 3 = 3 months to less than 6 months 4 = 6 months to less than 1 year 5 = 1 year to less than 2 years 6 = 2 years to less than 5 years 7 = 5 years or greater 9 = Unknown	
Comorbidity	1 char	Identifies if the patient has any existing comorbidities that may interfere with the AROC episode 1 = Yes 2 = No	
Comorbidity Interfering with AROC Episode 1	2 char	Where Comorbidity = 1 (Yes) Code identifying a condition, in addition to the impairment, which may interfere with the AROC episode 01 = Ischaemic heart disease 02 = Cardiac failure 03 = Atrial fibrillation 04 = Osteoporosis 05 = Osteoarthritis 06 = Upper limb amputation 07 = Lower limb amputation 08 = Depression 09 = Bipolar Affective Disorder 10 = Drug and alcohol abuse 11 = Dementia 12 = Asthma 13 = Chronic Airways Disease/ Chronic Obstructive Pulmonary Disease (CAD/COPD) 14 = Renal failure 15 = Epilepsy 16 = Parkinson's Disease 17 = Cerebral Vascular Accident (CVA) 18 = Spinal cord injury/disease 19 = Visual impairment 20 = Hearing impairment 21 = Diabetes 22 = Delirium 23 = Morbid obesity 99 = Other	Right adjusted

Comorbidity Interfering with AROC Episode 2	2 char	Code identifying a condition, in addition to the impairment, which interferes with the AROC episode 01 = Ischaemic heart disease 02 = Cardiac failure 03 = Atrial fibrillation 04 = Osteoporosis 05 = Osteoarthritis 06 = Upper limb amputation 07 = Lower limb amputation 08 = Depression 09 = Bipolar Affective Disorder 10 = Drug and alcohol abuse 11 = Dementia 12 = Asthma 13 = Chronic Airways Disease/ Chronic Obstructive Pulmonary Disease (CAD/COPD) 14 = Renal failure 15 = Epilepsy 16 = Parkinson's Disease 17 = Cerebral Vascular Accident (CVA) 18 = Spinal cord injury/disease 19 = Visual impairment 20 = Hearing impairment 21 = Diabetes 22 = Delirium 23 = Morbid obesity 99 = Other	Right adjusted
Comorbidity Interfering with AROC Episode 3	2 char	Code identifying a condition, in addition to the impairment, which interferes with the AROC episode 01 = Ischaemic heart disease 02 = Cardiac failure 03 = Atrial fibrillation 04 = Osteoporosis 05 = Osteoarthritis 06 = Upper limb amputation 07 = Lower limb amputation 08 = Depression 09 = Bipolar Affective Disorder 10 = Drug and alcohol abuse 11 = Dementia 12 = Asthma 13 = Chronic Airways Disease/ Chronic Obstructive Pulmonary Disease (CAD/COPD) 14 = Renal failure 15 = Epilepsy	Right adjusted

		16 = Parkinson's Disease 17 = Cerebral Vascular Accident (CVA) 18 = Spinal cord injury/disease 19 = Visual impairment 20 = Hearing impairment 21 = Diabetes 22 = Delirium 23 = Morbid obesity 99 = Other	
Comorbidity Interfering with AROC Episode 4	2 char	Code identifying a condition, in addition to the impairment, which interferes with the AROC episode 01 = Ischaemic heart disease 02 = Cardiac failure 03 = Atrial fibrillation 04 = Osteoporosis 05 = Osteoarthritis 06 = Upper limb amputation 07 = Lower limb amputation 08 = Depression 09 = Bipolar Affective Disorder 10 = Drug and alcohol abuse 11 = Dementia 12 = Asthma 13 = Chronic Airways Disease/ Chronic Obstructive Pulmonary Disease (CAD/COPD) 14 = Renal failure 15 = Epilepsy 16 = Parkinson's Disease 17 = Cerebral Vascular Accident (CVA) 18 = Spinal cord injury/disease 19 = Visual impairment 20 = Hearing impairment 21 = Diabetes 22 = Delirium 23 = Morbid obesity 99 = Other	Right adjusted
AROC Episode End Date	8 date	The end date of each AROC episode	ctyymmdd
Assessment Only	1 char	Identifies whether the patient was admitted into the AROC episode for assessment only 1 = Yes 2 = No	

Complication	1 char	Identifies if the patient has a significant illness or impairment, in addition to the principal presenting condition, that may interfere with the AROC episode. Derived from field 04 on the (AROC) Rehabilitation Episode Completion Details screen 1 = Yes 2 = No	
Complication Interfering with AROC Episode 1	2 char	Where Complication = 1 Code identifying a significant illness or impairment, in addition to the principal presenting condition, that may interfere with the AROC episode 02 = Urinary tract infection (UTI) 03 = Pressure ulcer 04 = Wound infection 05 = Deep Venous Thrombosis / Pulmonary Embolism (DVT/PE) 06 = Chest infection 07 = Significant electrolyte imbalance 08 = Falls Risk 09 = Faecal impaction 99 = Other (not included above)	Right adjusted
Complication Interfering with AROC Episode 2	2 char	Code identifying a significant illness or impairment, in addition to the principal presenting condition, that may interfere with the AROC episode 02 = Urinary tract infection (UTI) 03 = Pressure ulcer 04 = Wound infection 05 = Deep Venous Thrombosis / Pulmonary Embolism (DVT/PE) 06 = Chest infection 07 = Significant electrolyte imbalance 08 = Falls Risk 09 = Faecal impaction 99 = Other (not included above)	Right adjusted
Complication Interfering with AROC Episode 3	2 char	Code identifying a significant illness or impairment, in addition to the principal presenting condition, that may interfere with the AROC episode 02 = Urinary tract infection (UTI) 03 = Pressure ulcer 04 = Wound infection 05 = Deep Venous Thrombosis / Pulmonary Embolism (DVT/PE) 06 = Chest infection 07 = Significant electrolyte imbalance 08 = Falls Risk 09 = Faecal impaction 99 = Other (not included above).	Right adjusted

Complication Interfering with AROC Episode 4	2 char	Code identifying a significant illness or impairment, in addition to the principal presenting condition, that may interfere with the AROC episode 02 = Urinary tract infection (UTI) 03 = Pressure ulcer 04 = Wound infection 05 = Deep Venous Thrombosis / Pulmonary Embolism (DVT/PE) 06 = Chest infection 07 = Significant electrolyte imbalance 08 = Falls Risk 09 = Faecal impaction 99 = Other (not included above)	Right adjusted
Mode of AROC Episode End	1 char	The mode or manner in which the AROC episode ended 1 = Discharged to usual accommodation. 2 = Discharged to interim accommodation (non-Hospital) 3 = Death. 4 = Discharge/transfer to another hospital. 5 = Change to acute care –different ward 6 = Change to acute care –same ward 7 = Change of care type within sub-acute care. 8 = Discharged at own risk 9 = Other	
Accommodation Post Discharge	1 char	Code identifying the type of accommodation that the patient intends to live in after discharge from the AROC episode 1 = Private residence (inc unit in retirement village) 2 = Residential aged care, low level care (hostel) 3 = Residential aged care, high level care (nursing home) 4 = Community group home 5 = Boarding house 6 = Transitional Living Unit (TLU) 7 = Other	
Usual Living Status Post Discharge	1 char	Whether the client intends to reside alone or with others post discharge from the AROC 1 = Live alone 2 = Live with others	
Usual Level of Support Post Discharge	1 char	The principal level of support/care intended post discharge from the AROC episode 1 = No support/care provided 2 = Support/care provided by other than home residents 3 = Support/care provided by home residents 9 = Not stated	

Date Discharge Plan Established	8 date	The date on which the patient's discharge plan was established by the Multi-Disciplinary Team	ctyymmdd
Unplanned Suspension of Treatment	1 char	Identifies if the patient's longest period of suspension during an AROC episode was unplanned 1 = Yes 2 = No	
Longest Suspension Period	3 num	Longest number of suspension days during the AROC episode	Zero if null
Total Leave Days	3 num	Total number of leave days during the AROC episode	Zero if null
Total Number of Suspension Days	3 num	Total number suspension days during the AROC episode	Zero if null
Number of Suspension Occurrences	3 num	Total number of suspension occurrences during the AROC episode	Zero if null
Multidisciplinary Care Plan Date	8 date	The date on which the Multi Disciplinary Care Plan was established by the Assessment Team	ctyymmdd
Country of Usual Residence	4 num	Country of usual residence of AROC patient	Right adjusted and zero filled from left
State of Usual Residence	1 num	State of usual residence of AROC patient as below (note that for Australian External Territory addresses, the actual state id should be used). 0 = Overseas 1 = New South Wales 2 = Victoria 3 = Queensland 4 = South Australia 5 = Western Australia 6 = Tasmania 7 = Northern Territory 8 = Australian Capital Territory 9 = Not stated/unknown/no fixed address/at sea	

Telehealth Inpatient Details File

A record is to be provided on the HQI Telehealth Inpatient Details file for each Telehealth event within an episode of care as recorded on the Telehealth Inpatient Details HBCIS screen.

A record should not be provided where a Telehealth service has not been provided to an admitted patient.

The header file is the first record on the file. There is only one header record, followed by the Telehealth Inpatient Details records.

HEADER RECORD			
Facility Number	5 num	Must be a valid facility number Must be same facility number in corresponding header file	Right adjusted and zero filled from the left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type TID= Telehealth Inpatient Details	
Number of Records	5 num	Total number of records in file	Right adjusted and zero filled from left zero if null
Extraction software identifier	10 char	Code to identify version of software used	Left adjusted blank if null
Filler	49	Blank	

TELEHEALTH INPATIENT DETAILS RECORDS			
Record identifier	1 char	N= New A= Amendment D= Deleted U= Up to date	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not be reused, regardless of deletions etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
Telehealth Event ID	8 num	A unique number that identifies each Telehealth event within an episode of care	Must not be null
RSQ	1 num	Indicates if Retrieval Service Queensland (RSQ) participated in an admitted patient Telehealth event 1= Yes 2= No	Must not be null

Provider Facility	5 num	A code that identifies the facility delivering clinical activity for an admitted patient Telehealth event	Right adjusted and zero filled from left If RSQ is 1 (Yes), then Provider Facility must be null Must be a valid facility number
Provider Unit	4 char	A code that identifies the clinical unit of the provider facility for an admitted patient Telehealth event	Left adjusted If RSQ is 1 (Yes), then Provider Unit must be null
Event Type	2 num	The type of clinical activity delivered by a provider facility during an admitted patient Telehealth event	Right adjusted and zero filled from left Cannot be null
Start Date	8 date	The date on which a Telehealth session commenced	Ctyymmdd
Start Time	4 num	The time when a Telehealth event commenced	hhmm (24 hour clock)
End Date	8 date	The date on which a Telehealth session was completed	Ctyymmdd
End Time	4 num	The time when a Telehealth session was completed	hhmm (24 hour clock)
Event Count	3 num	Count of Telehealth events within a Telehealth session	Must not be null
Total Duration	4 num	The total duration of a Telehealth session	hhmm (24 hour clock)
Average Duration	4 num	The average duration of a Telehealth event	hhmm (24 hour clock)

Public Validation Rules

These validation rules apply only to new 'N'; amendment 'A' and delete 'D' records. For up to date 'U' records, other validation rules apply.

Patient details records

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Family Name	Must not be null
Patient First name	No validation
Patient Second name	No validation
Address of Usual Residence	No validation
Location (Suburb/town) of Usual Residence	Must not be null Validated against Locality Data Set parts with the Postcode and Locality of Usual Residence
Postcode of Usual Residence	Must not be null Validated against Locality Data Set parts with the Postcode and Locality of Usual Residence
State of Usual Residence	Must not be null Validated against list of State codes
Sex	Must not be null Validated against list of valid sex codes
Date of Birth	Must not be null Must be a valid date Must not be in future (ie. past current date) Must not be after the admission date Must not be more than 124 years prior to admission date

Estimated Date of Birth Indicator	Can be null Validated against list of estimated date of birth indicator codes
Marital Status	Must not be null Validated against list of marital status codes
Country of Birth	Must not be null Validated against country codes
Indigenous Status	Validated against list of indigenous status codes Must not be null
Filler	Currently not required, no validation
Occupation	Currently not required, no validation
Labour Force Status	Currently not required, no validation
Medicare Eligibility	Must not be null Validated against a list of medicare eligibility codes
Medicare Number	Must be a valid medicare number, if not null 11 digit medicare number required The eleventh digit is the number that precedes the patient's name on the card (the subnumerate). If a subnumerate cannot be supplied, the eleventh digit of the medicare number should be provided as zero
Australian South Sea Islander Status	Must not be null Must be 1, 2 or 9
Contact for Feedback Indicator	Must not be null Must be Y, N or U
Telephone Number – Home	Can be null
Telephone Number – Mobile	Can be null
Telephone Number – Business or Work	Can be null
Hospital Insurance health fund code	Can be null Validated against a list of Hospital Insurance health fund codes
Hospital Insurance health fund description	Can be null Should contain description when health fund code is 'Other'

Admission details records

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each patient within facility
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Admission Date	Must not be null Must be a valid date Must not be in future (i.e. past current date) Must not be before the birth date of the patient Must be before or on separation date
Time of Admission	Must not be null Must be a valid time Must be before the separation time, if admitted the same day as separated
Account Class	No Validation
Chargeable Status	Validated against list of chargeable status codes Must not be null
Care Type	Validated against list of care type codes Must not be null
Compensable Status	Validated against list of compensable status codes Must not be null
Band	Validated against list of band codes, if not null Must be a same day patient
Source of Referral/Transfer	Validated against list of source of referral/transfer codes Must not be null
Transferring from Facility	Must not be null if Source of Referral/Transfer is 16, 23, 24 or 25 Only applicable if Source of Referral/Transfer is 16, 23, 24 or 25 Must be a valid facility number
Hospital Insurance	Validated against list of Hospital Insurance codes Must not be null

Separation Date	Must not be null Must be a valid date Must not be in future (ie. past current date) Must be on or after admission date
Separation Time	Must not be null Must be a valid time
Mode of Separation	Validated against list of Mode of Separation codes Must not be null
Transferring to Facility	Must not be null if Mode of Separation is 12, 15 or 16 Only applicable if Mode of Separation is 12, 15 or 16 Must be a valid facility number
DRG	No validation
MDC	No validation
Baby Admission Weight	Must not be null if patient aged 28 days or less, or admission weight is less than 2,500 grams
Admitting Ward	Must not be null No validation
Admitting Unit	No validation
Standard Unit Code	Must not be null Must be a valid standard unit code
Treating Doctor at Admission of Episode of Care	**Must not be null**
Planned Same Day	Must be Y or N
Elective Patient Status	Must not be null Must be a valid elective patient status code
Qualification Status	Can be null Validated against list of qualification status codes
Standard Ward Code	Can be null Must be a valid standard ward code
Contract Role	Can be null Must be a valid Contract Role code
Contract Type	Can be null Must be a valid Contract Type code
Funding Source	Must not be null Validated against a list of Funding Source codes If Funding Source = 10 then Contract Role and Contract Type cannot be null

Incident Date	Can be null Must be a valid date Must not be in future (ie. past current date) Must be on or before admission date
Incident Date Flag	Can be null Validated against list of incident date flag codes
Workcover Queensland (Q-Comp) Consent	Must not be null Must be Y, N or U
Motor Accident Insurance Commission (MAIC) Consent	Must not be null Must be Y, N or U
Department of Veterans' Affairs (DVA) Consent	Must not be null Must be Y, N or U
Department of Defence Consent	Must not be null Must be Y, N or U
Interpreter Required	Must not be null Must be 1 or 2 or 9
Religion	Not currently required, no validation
QAS Patient Identification Number (eARF Number)	Can be null Validated against Source of Referral/Transfer
Purchaser/Provider Identifier	Must be a valid establishment number Must not be null if contract role = 'A' or 'B' and contract type in (2, 3, 4, 5) Must not be null if contract role = 'B' and contract type = 1 and chargeable status is public
Preferred Language	Must not be null Validated against list of language codes
Length of Stay in Intensive Care Unit	Must not be null if the treatment was provided in an ICU6 or CIC6
Duration of Continuous Ventilatory Support	Must not be null if the patient received continuous ventilatory support
Criteria Led Discharge Type	Must not be null Validated against list of criteria led discharge type codes
Smoking Status	**Must not be null if the care type = 01 acute and patient days >= 2 and age of patient at admission is >= 18 years and mode of separation <> 05.**
Smoking Pathway Completed	**Must not be null if smoking status = 1**
Treating Doctor at Separation of Episode of Care	**Must not be null**

Activity details records

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Activity Code	Must be a valid code (A, L, W, C, E, N, Q, S, T, D, B, R)

Activity code = A	
Account Class Code	No Validation
Chargeable Status	Validated against list of chargeable status codes
Compensable Status	Validated against list of compensable status codes
Date of Change	Valid date format Must not be null Must not be before the admission date Must not be after separation date
Time of Change	Not currently required, no validation

Activity code = L	
Date of Starting Leave	Must be a valid date Must not be null Must not be before the admission date Must not be after separation date Must not fall within any other leave periods Same day leaves are not required
Time of Starting Leave	Not currently required, no validation
Date Returned from Leave	Must be a valid date Must not be null Must be after the date of starting leave Must not be after separation date Must not fall within any other leave periods Same day leaves are not required
Time Returned from Leave	Not currently collected, no validation

For activity code = W	
Ward	Must not be null No validation
Unit	No validation
Standard Unit Code	Must be valid standard unit code Must not be null
Date of Transfer	Must be a valid date Must not be in future Must not be before the admission date Must not be within any leave periods Must not be after the separation date Must not be null
Time of Transfer	Must be a valid time Must not be null
Standard Ward Code	Must be a valid standard ward code Can be null

For activity code = C	
Date Transferred for Contract	Must be a valid date Must not be within any leave periods Must not be before the admission date Must not be after separation date Must not be in future Must not be null Must not be after date returned from contract
Date Returned from Contract	Must be a valid date Must not be within any leave periods Must not be before the admission date Must not be after separation date Must not be in future Must not be null Must not be before the date transferred for contract
Facility Contracted to	If there is a date for transferred for contract, there must be a facility contract to. Must be a valid facility number Must not be null

For activity code = E	
Entry Number	Must not be null Must not be zero
Urgency Category	Must not be null Validate against Waiting List Category codes reference file
Accommodation	Not currently required, no validation
Site Procedure Indicator	Not currently required, no validation
National Procedure Indicator	Not currently required, no validation
Planned Length of Stay	Not currently required, no validation
Planned Admission Date	Not currently required, no validation
Date of Change	Must be a valid date Can be after the admission date Must not be null

For activity code = N	
Entry Number	Must not be null

	Must not be zero
Date Not Ready for Care	Must be a valid date Must not be after the admission date Must not be in future Must not be null Must not be after the last not ready for care date
Time Not Ready for Care	Not currently collected, no validation
Last Date Not Ready for Care	Must be a valid date Must not be after the admission date Must not be in future Must not be null Must not be before the date not ready for care
Last Time Not Ready for Care	Not currently collected, no validation

For activity code = Q	
Qualification Status	Must not be null Validated against list of qualification status codes
Date of Change	Must be a valid date Must not be before the admission date Must not be after separation date Must not be in future Must not be null
Time of Change	Not currently required, no validation

For activity code = S	
SNAP Episode Number	Must not be null Must not be zero
ADL Type	Must not be null Validated against list of ADL type codes
ADL Subtype	Must not be null Validated against list of ADL subtype codes
ADL Score	Must not be null ADL scores for each SNAP episode are to be supplied. Do not provide more than one set of scores on the same date for the same ADL type and ADL sub type. For all SNAP episodes: • A code of '999' is acceptable as a SNAP score when the actual ADL score is not known or cannot be determined at the time of entry. Where ADL type = FIM and • ADL sub type = MOT score must be between 13 and 91 • ADL sub type = COG score must be between 5 and 35 Where ADL type HON and • ADL sub type = BEH score must be between 0 and 4 • ADL sub type = ADL score must be between 0 and 4 • ADL sub type = TOT score must be between 0 and 48 Where ADL type = RUG and • ADL sub type = TOT score must be between 4 and 18
ADL Date	Must be a valid date Must not be before the admission date

	Must not be after the separation date Must not be in future Must not be null
ADL Time	Not currently collected, no validation
Phase Type	Can be null Must not be null if SNAP type = PAL or PAA Validated against list of phase type codes

For activity code = T	
Nursing Home Flag	Must not be null Must be a valid Nursing Home Flag code Not valid for patients with a care type of: 01 – Acute 05 – Newborn 07 – Organ Procurement 08 - Boarder
Date Commenced NHT Care	Must be a valid date Must not be before the admission date Must not be after separation date Must not be in future Must not be null Must be before the date ceased NHT care Must not fall within any other NHT periods
Date Ceased NHT Care	Must be a valid date Must not be before the admission date Must not be after separation date Must not be in future Must not be null Must be after the date commenced NHT care Must not fall within any other NHT periods

Activity code = D	
Delayed Assessed Separation Event Number	Must not be null Must not be zero
Delayed Assessed Separation Event – Start Date	Must be a valid date Must not be null Must not be before the admission date Must not be after the separation date Must not fall within any other delayed assessment separation event periods
Delayed Assessed Separation Event – End Date	Must be a valid date Must not be null Must not be before the admission date Must not be after the separation date Must not fall within any other delayed assessment separation event periods Must be equal to or greater than the delayed assessed separation event start date
Delayed Assessed Separation Event – Waiting Reason 1	Must not be null Validated against the list of waiting reason codes
Delayed Assessed Separation Event – Waiting Reason 2	Can be null Validated against the list of waiting reason codes
Delayed Assessed Separation Event – Waiting Reason 3	Can be null Validated against the list of waiting reason codes
Delayed Assessed Separation Event	Must not be null

– Proposed Setting	Validated against the list of proposed setting codes
Delayed Assessed Separation Event – Proposed Service	Must not be null Validated against the list of proposed service codes
Delayed Assessed Separation Event – Start Time	Must be a valid time Must not be null
Delayed Assessed Separation Event – End Time	Must be a valid time Must not be null

For activity code = B	
Mother's Patient Identifier	Must not be zero Must be unique for each patient within facility Must not be null for Source of Referral/Transfer = '09'

For activity code = R	
AROC Episode Number	Must not be null Must not be zero
ADL Type	Must not be null Validated against list of ADL type codes (=FIM)
ADL Subtype	Must not be null Validated against list of ADL subtype codes
ADL Score	Must not be null Score must be between 1 and 7
ADL Date	Must be a valid date Must not be before the AROC episode begin date Must not be after the AROC episode end date Must not be in future Must not be null

Morbidity details records

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Diagnosis Code Identifier	Must not be null Validated against list of diagnosis code types Every separation must have one and only one PD Cannot have an OD, EX, PR or M without a PD
ICD-10-AM Code **(9th edition**)	Must not be null Please refer to Queensland Hospital Admitted Patient Data Collection guidelines for the sequencing of ICD-10-AM codes.
Diagnosis Text	Text is optional, as ICD-10-AM codes must be supplied.
Procedure Date	Must be a valid date Must not be in the future Must not be null for procedures with block codes between: 1 to 59 67 to 559 561 to 737 739 to 1059 1062 to 1062 1064 to 1089 1091 to **1580** 1602 to 1759 1828 to 1828 1886 to 1886 1890 to 1891 1906 to **1907** 1909 to 1912 1920 to 1922
Contract Flag	Validated against list of contract flag codes
Diagnosis Onset Type	Validated against list of Diagnosis Onset Type codes Must not be null if Diagnosis Code Identifier = PD,OD, EX or M
Most Resource Intensive Condition Flag	Can be null Validated against list of Care Type codes

	Cannot have a Diagnosis Code Identifier = PR If Care Type code in (07, 08) and Diagnosis Code Identifier = PD must be 1
Other Co-Morbidity of Interest Flag	Can be null Validated against list of Care Type codes Cannot have a Diagnosis Code Identifier = PD, PR Cannot have a Most Resource Intensive Condition = 1 If Care Type code in (07, 08) must be null

Mental Health details records

A record is to be provided on the mental health details file for each episode of care where the standard unit code (either at admission to the episode or through a ward transfer during the episode) is in the range PYAA to PYZZ.

No record is to be provided if there were no standard unit codes in this range during the episode of care.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Type of Usual Accommodation	Must not be null Validated against type of usual accommodation codes
Employment Status	Must not be null Validated against employment status codes If 1 then age must be < 18 If 3, 4, or 6 then age must be > 14
Pension Status	Must not be null Validated against pension status codes If 1 then age must be > 59 if female and > 64 if male If 2 to 5 then age must be 14 < age < 65
First Admission For Psychiatric Treatment	Must not be null Validated against previous specialised non-admitted treatmen codes
Referral To Further Care	Must not be null Validated against referral to further care codes
Mental Health Legal Status Indicator	Must not be null Validated against legal status indicator codes
Previous Specialised Non-admitted Treatment	Must not be null Validated against previous specialised non-admitted treatment codes

Elective Admission details records

A record is to be provided on the elective admissions details file for each episode of care where one or more completed EAS entries have been linked to the episode of care.

Each episode of care can have one or more EAS entry linked to it.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Entry Number	Must not be null Must not be zero
Planned Unit	Not currently required, no validation
NMDS Speciality Grouping	Must not be null Validated against Waiting List Speciality codes
Waiting List Status	Not currently required, no validation
Reason for Removal	Can be null Validated against Waiting List Status reference file
Listing Date	Must be a valid date Must not be after the admission date Must not be in future Must not be null
Pre-admission Date (planned)	Not currently required, no validation
Urgency Category	Must not be null Validate against Waiting List Category codes reference file
Accommodation	Must not be null Validated against Waiting List Accommodation Codes reference file
Site Procedure Indicator	**Not currently required, no validation**
National Procedure Indicator	Must not be null Validated against National Procedure Indicator reference file
Planned Length of Stay	Must not be null Must be numeric Zero values accepted
Planned Admission Date	Not currently required, no validation
Pre-admission Clinic Attendance Date	Not currently required, no validation
Planned Procedure Date	Must be a valid date Can be after the admission date

	Can be null Must not be null if reason for removal = 01
Filler **(Facility Identifier of the hospital managing the waiting list).**	**Not currently required, no validation**
Primary Planned Procedure Code	**Validated against a list of Primary Planned Procedure Codes** **Must not be null**

Sub and Non-Acute Patient details records

A record for each SNAP type is to be provided on the sub and non-acute patient details file for each episode of care where the care type is sub-acute or non-acute (ie Rehabilitation Care, Geriatric Evaluation and Management Care, Palliative Care, Psychogeriatric Care or Maintenance Care)

No record is to be provided if the care type is **mental health**, acute, newborn, boarder, organ procurement or other care.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
SNAP Episode Number	Must not be null Must not be zero
SNAP Type	Must not be null Validated against list of SNAP type codes PAL, PAA is only valid for Palliative care RAO, RCD, ROI, RST, RBD, RNE, RSC, RAL, RPS, ROF, ROR, ROA, RCA, RMT, RPU, RDE, RDD, RBU, RAR are only valid for Rehabilitation care GAO, GEM, GSD are only valid for Geriatric Evaluation and Management care MRE, MNH, MCO, MOT, MAO are only valid for Maintenance care PSG, PSA is only valid for Psychogeriatric care
Group Classification	Not currently required, no validation
Start Date	Must not be null Must be a valid date Must not be in future (ie. past current date) Must not be before the birth date of the patient Must be on or after the admission date Must be before or on separation date

End Date	Must not be null Must be a valid date Must not be in future (ie. past current date) Must be on or after admission date Must be before or on separation date
Multidisciplinary Care Plan Flag	Must be a valid value Must not be null if a Rehabilitation, Geriatric Evaluation and Management, Palliative or Psychogeriatric SNAP Type
Multidisciplinary Care Plan Date	Must be a valid date Must not be in the future (ie. past current date) Must be before or on separation date Can be null
Proposed Principal Referral Service	Must not be null if a Rehabilitation, Geriatric Evaluation and Management, Palliative or Psychogeriatric SNAP Type Validated against the list of proposed service codes
Primary Impairment Type	Must not be null if a rehabilitation SNAP Type Validated against the list of Primary Impairment Type codes

For Maintenance Care SNAP Episodes

- At least one set of ADL scores must be provided for each SNAP episode.
- There must be at least one SNAP episode within a single non-acute episode of care.
- If there are more than one SNAP episode then these must be contiguous.
- The start date of the first SNAP episode must be the same as the start date of the episode of care.
- The end date of the last SNAP episode must be the same as the end date of the episode of care.

For Rehabilitation Care, Geriatric Evaluation and Management Care, Palliative Care and Psychogeriatric Care SNAP Episodes

- At least one set of ADL scores must be provided for each SNAP episode.
- There can only be one SNAP episode within a single sub-acute episode of care.
- The start date of the SNAP episode must be the same as the start date of the episode of care.
- The end date of the SNAP episode must be the same as the end date of the episode of care.

Palliative care details records

A record is to be provided on the palliative care details file for each episode of care where the care type is: 30 = Palliative care

No record is to be provided if the care type is NOT 30.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
First Admission For Palliative Care Treatment	Must not be null Validated against first admission for palliative care treatment codes
Previous Specialised Non-Admitted Palliative Care Treatment	Must not be null Validated against previous specialised non-admitted palliative care treatment codes

Department of Veterans' Affairs details records

A record is to be provided on the Department of Veterans' Affairs patient details file where the charges for the episode of care are met by the Department of Veterans' Affairs.

A record is not to be provided if the charges for the episode of care are not met by the Department of Veterans' Affairs.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
DVA File Number	Must not be null
Card Type	Must not be null Must be a valid Card Type code

Workers Compensation records

A record is to be provided on the Workers' Compensation details file where the charges for the episode of care are met by WorkCover Queensland. This is currently defined as those episodes where the payment class is 'WCQ' or 'WCQI'.

A record is not to be provided if the charges for the episode of care are not met by WorkCover Queensland.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Workers' Compensation Record Number	Must not be null
Payment Class	Must be WCQ or WCQI Must not be null
WC Incident Date	Valid date format Must not be null Must not be after separation date
WC Incident Time	Valid time format Must not be null Must be between 0000 and 2359
WC Incident Date Flag	Must be 'Y' or 'N' Must not be null
WC Incident Location	Default value will be 'UNKNOWN' Must not be null
Nature of Injury	Default value will be 'UNKNOWN' Must not be null
Employer Informed	Must be 'Y', or 'N', or 'U' Must not be null
Authority Name	No validation

Authority Address Line 1	No validation
Authority Address Line 2	No validation
Authority Suburb	Validated against locality data set parts with the Authority Postcode
Authority Postcode	Validated against locality data set parts with the Authority Suburb
Employer Name	No validation
Employer Address Line 1	No validation
Employer Address Line 2	No validation
Employer Suburb	Validated against locality data set parts with the Employer Postcode
Employer Postcode	Validated against locality data set parts with the Employer Suburb
Insurer Name	No validation
Insurer Address Line 1	No validation
Insurer Address Line 2	No validation
Insurer Suburb	Validated against locality data set parts with the Insurer Postcode
Insurer Postcode	Validated against locality data set parts with the Insurer Suburb
Solicitor Name	No validation
Solicitor Address Line 1	No validation
Solicitor Address Line 2	No validation
Solicitor Suburb	Validated against locality data set parts with the Solicitor Postcode
Solicitor Postcode	Validated against locality data set parts with the Solicitor Suburb
Status 1	Must be ‘AW’, ‘TW’, ‘FW’ or ‘U’ Must not be null
Status 2	Must be ‘C’, ‘D’, ‘MC’, ‘PA’, PD’ or null
Claim Number	Must not be null
Occupation	Default value will be ‘UNKNOWN’ Must not be null

Australian Rehabilitation Outcomes Centre records

A record is to be provided on the Australasian Rehabilitation Outcomes Centre file for each episode of care where one or more completed AROC entries have been linked to the episode of care.

Each episode of care can have one or more AROC entries linked to it.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
AROC Episode Number	Must not be null Must not be zero
AROC Episode Begin Date	Must not be null Must be a valid date Must not be in future (ie. past current date) Must not be before the birth date of the patient Must be before or on separation date Must be on or after episode admission date
Type of Usual Accommodation Prior to Admission	Must be a valid value Must not be null
Usual Living Status Prior to Admission	Must be a valid value Must not be null
Usual Level of Support Prior to Admission	Must be a valid value Must not be null
Labour Force Status	Must be a valid value Must not be null
Mode of AROC Episode Start	Must be a valid value Must not be null
AROC Impairment Code	Must be a valid value Must not be null

First Admission for this Impairment	Must not be null Must be 1 or 2
Current Impairment the Result of Trauma	Must not be null Must be 1 or 2
Date of Relevant Preceding Acute Admission	Can be null Must be a valid date Must not be in future (ie. past current date) Must not be before the birth date of the patient Must be before Rehabilitation Episode Begin Date
Time Since Onset of Impairment	Must be a valid value Must not be null
Comorbidity	Must not be null Must be 1 or 2
Comorbidity Interfering with AROC Episode 1	Must not be null if Comorbidity = 1 Must be a valid value
Comorbidity Interfering with AROC Episode 2	Can be null Must be a valid value
Comorbidity Interfering with AROC Episode 3	Can be null Must be a valid value
Comorbidity Interfering with AROC Episode 4	Can be null Must be a valid value
AROC Episode End Date	Must not be null Must be a valid date Must not be in future (ie. past current date) Must be on or after admission date Must be on or after AROC phase begin date
Assessment Only	Must not be null Must be 1 or 2
Complication	Must not be null Must be 1 or 2
Complications Interfering with AROC Episode 1	Must not be null if Complication = 1 Must be a valid value
Complications Interfering with AROC Episode 2	Can be null Must be a valid value
Complications Interfering with AROC Episode 3	Can be null Must be a valid value
Complications Interfering with AROC Episode 4	Can be null Must be a valid value

Mode of AROC Episode End	Must be a valid value Must not be null
Accommodation Post Discharge	Must be a valid value Can be null unless [1] discharged to usual accommodation or [2] discharged to interim accommodation (non-Hospital)
Usual Living Status Post Discharge	Must be a valid value Can be null unless [1] discharged to usual accommodation or [2] discharged to interim accommodation (non-Hospital)
Usual Level of Support Post Discharge	Must be a valid value Can be null unless [1] discharged to usual accommodation or [2] discharged to interim accommodation (non-Hospital)
Date Discharge Plan Established	Can be null unless [1] discharged to usual accommodation or [2] discharged to interim accommodation (non-Hospital) Must be a valid date Must not be in future (ie. past current date) Must be on or after phase start date Must be before or on phase end date Must be on or after Multidisciplinary Care Plan Date (MCPD)
Unplanned Suspension of Treatment	Must not be null Must be 1 or 2
Longest Suspension Period	Must not be null
Total Leave Days	Must not be null
Total Number of Suspension Days	Must not be null
Number of Suspension Occurrences	Must not be null
Multidisciplinary Care Plan Date	Must be a valid date Must not be in the future (ie. past current date) Must be on or after AROC phase Begin Date Must be before or on AROC phase End Date
Country of Usual Residence	Must not be null Validated against country codes
State of Usual Residence	Must not be null Validated against list of State codes

Telehealth Admission details records

A record is to be provided on the Telehealth admissions details file where a Telehealth service has been provided to an admitted patient.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Telehealth Event ID	Must not be null Must not be zero
RSQ	Must not be null Must be 1 or 2
Provider Facility	Must not be null Must be a valid facility code
Provider Unit	If RSQ is 1 (yes), then Provider Facility must be null
Event Type	Must not be null
Start Date	Must be a valid date Must not be after the end date Must not be in future Must not be null
Start Time	Must be a valid time Must not be null
End Date	Must be a valid date Must be after the start date Must not be in future Must not be null
End Time	Must be a valid time Must not be null
Event Count	Must not be null

Total Duration	Must not be null Must be numeric
Average Duration	Must not be null Must be numeric Zero values accepted

Public Processing Rules

The processing rules apply to new 'N'; amendment 'A'; delete 'D' and up to date 'U' records.

RECORD IDENTIFIER = N

Description **Patient separated in extract period or patient separated prior to extract period but not previously submitted (late insertion).**

Patient File

- A corresponding record must exist in the admission file.

Admission File

- Admission record must not already exist.
- A corresponding record must exist in the patient file.
- Patient must be separated in the extract period or patient separated prior to extract period but not previously submitted (late insertion).
- Late insertions for the current financial year can be received up to and including the extraction for August data of the next financial year (due in early October).

Activity File

- A corresponding record must exist in the admission file and in the patient file.
- All activities must occur within the admission and separation dates.

Account Class Variations

- Must not already exist.

Leave

- Must not already exist.
- Leave period must not overlap with any other leave periods for admission.

Ward Transfer

- Must not already exist for admission.

Contract Status

- Must not already exist for admission.

Not Ready For Care

- Must not already exist for admission.
- Not ready for care period must not overlap with any other not ready for care periods for admission.

Qualification Status

- Must not already exist for admission.

Elective Surgery Items

- Must not already exist for admission.

Sub and Non-acute Patient Items

- Must not already exist for admission.

Nursing Home Type Patient Items

- Must not already exist for admission.

Delayed Assessed Separation Event

- Must not already exist for admission.
- Event period must not overlap with any other event periods for admission.

Patient Identifier of mother of baby born in hospital

- Must not already exist for admission.

Morbidity File

- A corresponding record must exist in the admission file and in the patient file.
- The ICD-10-AM code must not already exist for this admission except for procedure, morphology and external cause codes.

Mental Health File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.
- Must exist if any standard ward/unit code in the activity or admission file is in the range PYAA to PYZZ.

Elective Admission File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Sub and Non-Acute Patient File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Palliative Care File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Department of Veterans' Affairs File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Workers' Compensation File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Australasian Rehabilitation Outcomes Centre File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Telehealth Inpatient Details File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

RECORD IDENTIFIER = A

Description **Amendment to records submitted prior to extract period. Amendment records for the current financial year can be received up to and including the extraction of August data of the next financial year (due in early October).**

These processing rules also apply to Up to Date records previously sent.

Patient File
- Patient record must exist.

Admission File
- Admission record must exist

Activity File
- Cannot be amended. Must instead be deleted and re-created.

Morbidity File
- Cannot be amended. Must instead be deleted and re-created.

Mental Health File
- Mental Health record must exist.

Elective Admissions File
- Elective Admissions record must exist.

Sub and Non-acute Patient File
- Sub and Non-acute Patient record must exist.

Palliative Care File
- Palliative Care patient record must exist.

Department of Veterans' Affairs File
- Department of Veterans' Affairs record must exist.

Workers' Compensation File
- Workers' Compensation record must exist.

Australasian Rehabilitation Outcomes Centre File
- Australasian Rehabilitation Outcomes Centre record must exist

Telehealth Inpatient Details File
- Telehealth Inpatient record must exist.

RECORD IDENTIFIER = D

Description **Deletion of any record previously sent. Deletion records for the current financial year can be received up to and including the extraction of August data of the next financial year (due in early October).**

These processing rules also apply to Up to Date records previously sent.

Patient File

- Deletion is not applicable to patient records.

Admission File

- The admission record must exist.

Activity File

- Only the one record matching the previously submitted record exactly will be deleted.

Account Class Variations
- The record must exist

Leave
- The record must exist

Ward Transfer
- The record must exist

Contract Status
- The record must exist

Not Ready For Care
- The record must exist

Qualification Status
- The record must exist

Elective Surgery Items
- The record must exist

Sub and Non-acute Items
- The record must exist

Nursing Home Type Patient Items
- The record must exist

Delayed Assessed Separation Event
- The record must exist

Patient Identifier of mother of baby born in hospital
- The record must exist

Morbidity File

- All morbidity records in relation to that admission will be deleted.
- The morbidity record must exist.

Mental Health File

- Mental health record must exist.

Elective Admission File

- Elective admissions record must exist.

Sub and Non-Acute Patient File

- Sub and non-acute patient record must exist.

Palliative Care File

- Palliative care patient record must exist.

Department of Veterans' Affairs File

- Department of Veterans' Affairs record must exist.

Workers' Compensation File

- Workers' Compensation record must exist.

Australasian Rehabilitation Outcomes Centre File

- Australasian Rehabilitation Outcomes Centre record must exist.

Telehealth Inpatient Details File

- **Telehealth Inpatient record must exist.**

RECORD IDENTIFIER = U

Description **Patient admitted during, or prior to, the extract period but who is not separated in the extract period.**

A 'U' Up to Date record identifier replaces a 'N' New record identifier when the Up to Date record is first supplied in the extract. All amendments to an up to date record should be provided using the processing rules applied to end dated records. Following the separation of a patient the end date of the record will be provided in the extract as an amendment record within the admission file.

Patient File

- A corresponding record must exist in the admission file.

Admission File

- Admission record must not already exist.
- A corresponding record must exist in the patient file.
- Patient admitted during or prior to extract period but who is not separated in extract period or separated prior to extract period but not previously submitted (late insertion).
- During each collection period there will be a 'refresh point' for U records. This will entail DCU deleting all existing U records. Therefore all records that meet the 'U' criteria, including those records that have been previously supplied, are required to be submitted in the first extract following the extract period for August data.

Activity File

- A corresponding record must exist in the admission file and in the patient file.
- All activities must occur within the admission and extract period to dates.

Account Class Variations
- Must not already exist**.**

Leave
- Must not already exist.
- Leave period must not overlap with any other leave periods for admission.

Ward Transfer
- Must not already exist for admission.

Contract Status
- Must not already exist for admission.

Not Ready For Care
- Must not already exist for admission.
- Not ready for care period must not overlap with any other not ready for care periods for admission.

Qualification Status
- Must not already exist for admission.

Elective Surgery Items
- Must not already exist for admission.

Sub and Non-acute Patient Items
- Must not already exist for admission.

Nursing Home Type Patient Items
- Must not already exist for admission.

Delayed Assessed Separation Event
- Must not already exist for admission.
- Event period must not overlap with any other event periods for admission.

Patient Identifier of mother of baby born in hospital

- Must not already exist for admission.

Morbidity File

- A corresponding record must exist in the admission file and in the patient file.
- The ICD-10-AM code must not already exist for this admission except for procedure, morphology and external cause codes.

Mental Health File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.
- Must exist if any standard ward/unit code in the activity or admission file is in the range PYAA to PYZZ.

Elective Admission File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Sub and Non-Acute Patient File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Palliative Care File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Department of Veterans' Affairs File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Workers' Compensation File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Australasian Rehabilitation Outcomes Centre File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Telehealth Inpatient Details File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Private Facility File Format 2015-2016 Collection Year

Introduction

This document specifies the file format for the electronic submission of data by private facilities to Health Statistics Branch (HSB), Queensland Department of Health for the Queensland Hospital Admitted Patient Data Collection.

A record must be provided for each admitted patient, including all newborn babies, separated from any facility permitted to admit patients. Separated is an inclusive term meaning discharged, died, transferred or statistically separated.

All boarders and posthumous organ procurement donors are also included in the scope of the Collection.

HSB is able to electronically process amendments if the facility's patient record system is capable of supplying amendment and deletion records. These records have a record identifier of 'A' or 'D' as detailed in the following file format. Please inform your HSB contact prior to your facility commencing the reporting of any amendments and deletion records electronically.

There are 9 files specified in this document: Header, Patient, Admission, Activity, Morbidity, Mental Health, Sub and Non-Acute Patient, Palliative Care and Department of Veterans' Affairs.

The following is our standard when naming the files:

fffffctyyctyynnn.filetype

fffff	five-digit facility number (zero filled from the left)	
ctyyctyy	collection year to which the data relates	
nnn	data extract number for collection year	
filetype	HDR	for the Header File
	PAT	for the Patient File
	ADM	for the Admission File
	ACT	for the Activity File
	MOR	for the Morbidity File
	MEN	for the Mental Health File
	SNP	for the Sub and Non-Acute Patient File
	PAL	for the Palliative Care file
	DVA	for the Department of Veterans' Affairs File

So the 4th admission file for ABC Hospital (facility number 99999) for collection year 2015-2016 would be named:

9999920152016004.ADM

You are able to supply data for multiple months or for a partial month in the one extract file. The data extract number for a collection year must begin at '001' and be contiguous throughout the collection year.

Private File Format

Header File

The header file contains an extraction details record (the facility and period for which data has been extracted, and the date the extraction took place) and file details records (the number the type of records on each file).

The extraction details record is the first record on the Header File. There should be only one extraction details record in the Header File.

For each file extracted, there must be a file details record on the Header File.

EXTRACTION DETAILS RECORD			
Record Identifier	1 char	E, Extraction details	
Facility Number	5 num	Must be a valid facility number.	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
Extract Date	8 date	Date data extracted	ctyymmdd

FILE DETAILS RECORD			
Record Identifier	1 char	F, File details	
File Type	3 char	PAT = Patient ADM = Admission ACT = Activity MOR = Morbidity MEN = Mental Health SNP = Sub and Non-Acute Patient PAL = Palliative Care DVA = Dept of Veterans' Affairs	
Record Type	1 char	N, New	
Number of Records	5 num	Number of new records	Right adjusted and zero filled from left; zero if null
Record Type	1 char	A, Amendment	
Number of Records	5 num	Number of amendment records	Right adjusted and zero filled from left; zero if null
Record Type	1 char	D, Deletion	
Number of Records	5 num	Number of deleted records	Right adjusted and zero filled from left; zero if null
Filler	8	Blank	

An example of a header file is:

E999992015070120150731201508 20
FPATN00420A00020D00000
FADMN00420A00124D00001
FACTN00080A00000D00010
FMORN01000A00000D00005
FMENN00020A00000D00001
FSNPN00010A00002D00001
FPALN00008A00001D00002
FDVAN00003A00001D00001

The details provided by the above example are:

Extraction details

Facility 99999 –	ABC Private Hospital
Extraction period	1 July 2015 to 31 July 2015
Extraction date	20 August 2015

File details

Patient file

420	New records
20	Amendments
0	Deletions

Admission details

420	New records
124	Amendments
1	Deletions

Activity

80	New records
0	Amendments
10	Deletions

Morbidity details

1000	New records
0	Amendments
5	Deletions

Mental Health details

20	New records
0	Amendments
1	Deletions

Sub and Non-Acute Patient file details

10	New records
2	Amendments
1	Deletions

Palliative Care details

8	New records
1	Amendments
2	Deletions

Department of Veterans' Affairs details

3	New records
1	Amendments
1	Deletions

Patient File

The header record is the first record on the file. There is only one header record, followed by the patient details records.

HEADER RECORD			
Facility number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract period	16 date	From date To date	ctyymmdd ctyymmdd
File type	3 char	Abbreviation to identify file type PAT = Patient	
Number of records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction software identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	234	Blank	

PATIENT DETAILS RECORDS			
Record Identifier	1 char	*N = new,* *A = amendment*	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
Family Name	24 char	First 24 characters of surname of patient	Left adjusted
First Given name	15 char	First 15 characters of first given name of patient	Left adjusted, blank if null
Second Given name	15 char	First 15 characters of second given name of patient	Left adjusted, blank if null
Address of Usual Residence	40 char	Number and street of usual residential address of patient. Note: Post office box numbers, property names (with no other details, eg include access road name with the property name), or mail service numbers should NOT be recorded.	Blank if null

Location of Usual Residence	40 char	Location associated with the permanent address.	
Postcode of Usual Residence	4 num	Australian postcode associated with the permanent address. Supplementary codes as below (note that for Australian External Territory addresses, the actual postcode should be used). 9301 = Papua New Guinea 9302 = New Zealand 9399 = Overseas other (not PNG or NZ) 9799 = At sea 9989 = No fixed address 0989 = Not stated or unknown	
State of Usual Residence	1 num	State associated with the permanent address (note that for Australian External Territory addresses, the actual state id should be used). 0 = Overseas 1 = New South Wales 2 = Victoria 3 = Queensland 4 = South Australia 5 = Western Australia 6 = Tasmania 7 = Northern Territory 8 = Australian Capital Territory 9 = Not stated/unknown/no fixed address/at sea	
Filler	4	Blank	
Sex	1 num	1 = Male 2 = Female 3 = Indeterminate/Intersex Code 3 Intersex or indeterminate, refers to a patient, who because of a genetic condition, was born with reproductive organs or sex chromosomes that are not exclusively male or female or whose sex has not yet been determined for whatever reason.	
Date of Birth	8 date	Full date of birth of patient Where dd is unknown use 15 Where mm is unknown use 06 Where yy is unknown estimate year	ctyymmdd
Estimated Date of Birth Indicator	1 char	A flag to indicate whether any component of a reported date of birth is estimated. 1 = Estimated	Blank if null

Marital Status	1 num	1 = Never married 2 = Married/de facto 3 = Widowed 4 = Divorced 5 = Separated 9 = Not stated/unknown	
Country of Birth	4 num	Country of birth of patient	Right adjusted and zero filled from left
Indigenous Status	1 num	1= Aboriginal but not Torres Strait Islander origin 2= Torres Strait Islander but not Aboriginal origin 3= Both Aboriginal and Torres Strait Islander origin 4= Neither Aboriginal nor Torres Strait Islander origin 9= Not stated/unknown	
Filler	2	Currently not required	Blank if null
Occupation	4	Currently not required	Blank if null
Employment Status	1	Currently not required	Blank if null
Medicare Eligibility	1 num	1 = Eligible 2 = Not eligible 9 = Not stated/unknown	
Medicare Number	11 num	Medicare number of patient. The eleventh digit is the number that precedes the patient's name on the card (the subnumerate). If a subnumerate cannot be supplied, the eleventh digit of the medicare number should be provided as zero.	Blank if not available or if null
Australian South Sea Islander Status	1 char	Denotes whether the patient is of Australian South Sea Islander origin 1 = Yes 2 = No 9 = Not stated/unknown	
Contact for Feedback Indicator	1 char	Currently not required	Blank if null
Telephone Number – Home	20 char	Currently not required	Blank if null
Telephone Number – Mobile	20 char	Currently not required	Blank if null
Telephone Number – Business or Work	20 char	Currently not required	Blank if null

Admission File

The header record is the first record on the file. There is only one header record, followed by the admission details records.

HEADER RECORD			
Facility number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract period	16 date	From date To date	ctyymmdd ctyymmdd
File type	3 char	Abbreviation to identify file type ADM = Admission	
Number of records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction software identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	133	Blank	

ADMISSION DETAILS RECORDS			
Record Identifier	1 char	N = new, A = amendment, D = deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
Admission Date	8 date	Date of admission to facility	Ctyymmdd
Admission Time	4 num	Time of admission to facility (0000 to 2359)	hhmm (24 hour clock)
Account Class	12 char	Currently not required	Blank if null
Chargeable Status	1 num	1 = Standard 2 = Private share 3 = Private single	

Care Type	2 num	01 = Acute 20 = Rehabilitation 30 = Palliative 05 = Newborn 09 = Geriatric Evaluation and Management 10 = Psychogeriatric 11 = Maintenance **12 = Mental Health** 06 = Other care 07 = Organ Procurement 08 = Boarder	Right adjusted zero filled from left
Compensable Status	1 num	1 = WorkCover Queensland 2 = Workers' Compensation Board (other) 6 = Motor Vehicle (Qld) 7 = Motor Vehicle (Other) 3 = Other Third Party 4 = Other Compensable 5 = Dept of Veterans' Affairs 9 = Department of Defence 8 = None of the above	
Band	2 char	Classification to categorise same day procedures into the Commonwealth Bands. 1A = Band 1A 1B = Band 1B 2 = Band 2 3 = Band 3 4 = Band 4	Blank if null, left adjusted
Source of Referral/Transfer	2 num	01 = Private medical practitioner (not Psychiatrist) 02 = Emergency dept – this hospital 03 = Outpatient dept – this hospital 24 = Admitted patient transferred from another hospital 25 = Non-admitted patient referred from other hospital 23 = Residential Aged Care Service 06 = Episode change 09 = Born in hospital 15 = Private psychiatrist 16 = Correctional facility 17 = Law enforcement agency (police/courts) 18 = Community service 19 = Routine readmission not requiring referral 14 = Other health care establishment 20 = Organ procurement 21 = Boarder 29 = Other	Right adjusted & zero filled from left
Transferring from Facility	5 num	Facility number from which patient was transferred or referred. Code if Source of Referral/Transfer is 16, 23, 24 or 25	Right adjusted & zero filled from left; blank if null

Hospital Insurance	1 num	7 = Hospital insurance 8 = No hospital insurance 9 = Not stated/unknown	
Separation Date	8 date	Date of separation from facility	ctyymmdd
Separation Time	4 num	Time of separation from facility (0000 to 2359)	hhmm (24 hour clock)
Mode of Separation	2 num	01 = Home/usual residence 16 = Transferred to another hospital 15 = Residential Aged Care Service 05 = Died in hospital 06 = Episode change 07 = Discharged at own risk 09 = Non return from leave 12 = Correctional facility 04 = Other health care establishment 13 = Organ Procurement 14 = Boarder 19 = Other 17 = Medi-Hotel	Right adjusted and zero filled from left
Transferring to Facility	5 num	Facility number to which patient was transferred. Code if Mode of Separation is 12, 15 or 16	Right adjusted & zero filled from left - blank if null
Filler	5 char	Blank	
Filler	3 char	Blank	
Baby Admission Weight	4 num	Admission weight in grams for neonates 28 days of age or less, or where the admission weight is less than 2,500 grams	Right adjusted & zero filled from left Blank if null
Admitting Ward	6 char	Code to describe admitting ward	Left justified
Admitting Unit	4 char	Code to describe admitting unit	Blank if null
Standard Unit Code	4 char	Standard code to describe Treating Doctor Speciality/Unit	Left justified
Treating Doctor at admission of episode of care	6 char	**Code to identify the treating doctor at the admission of the episode of care.**	Blank if null
Planned Same Day	1 char	Y = Yes N = No	
Elective Patient Status	1 char	1 = Emergency admission 2 = Elective admission 3 = Not assigned	
Qualification Status	1 char	A = Acute U = Unqualified	Blank if null

Standard Ward Code	4 char	Denotes whether the ward is assigned to a Designated SNAP Unit SNAP = Designated SNAP Unit Code	Blank if null
Contract Role	1 char	A = Hospital A (contracting hospital) B = Hospital B (contracted hospital) Identifies whether the hospital is the purchaser of hospital care (contracting hospital) or the provider of an admitted or non-admitted service (contracted hospital)	Blank if null
Contract Type	1 char	1 = B 2 = ABA 3 = AB 4 = (A)B 5 = BA Describes the contract arrangement between the contracting hospital (hospital A) and the contracted hospital (hospital B)	Blank if null
Funding Source	2char	Expected principal source of funds for the episode 01 = Health service budget (not covered elsewhere) 02 = Private health insurance 03 = Self-funded 04 = Worker's compensation 05 = Motor vehicle third party personal claim 06 = Other compensation (e.g. Public liability, common law and medical negligence) 07 = Department of Veterans' Affairs 08 = Department of Defence 09 = Correctional facility 10 = Other hospital or public authority (contracted care) 11 = Health service budget (due to eligibility for Reciprocal Health Care Agreement) 12 = Other funding source 13 = Health service budget (no charge raised due to hospital decision) 99 = Not known	Right adjusted & zero filled from left
Incident Date	8 date	Currently not required	ctyymmdd Blank if null
Incident Date Flag	1 char	Currently not required	Blank if null
WorkCover Queensland (Q-Comp) Consent	1 char	Currently not required	Blank if null
Motor Accident Insurance Commission (MAIC) Consent	1 char	Currently not required	Blank if null

Department of Veterans' Affairs (DVA) Consent	1 char	Currently not required	Blank if null
Department of Defence Consent	1 char	Currently not required	Blank if null
Preferred Language	4 num	Currently not required	Blank if null
Interpreter Required	1 num	Currently not required	Blank if null
Religion	4 num	Currently not required	Blank if null
QAS Patient Identification Number (eARF Number)	12 num	QAS patient identification number provided by the QAS Team when delivering a patient to this facility.	Left adjusted, blank if null
Purchaser/ Provider Identifier	5 num	The identifier of the 'other' facility or purchaser involved in the contracted care. Record the code of the other hospital if contract type = 2, 3, 4, 5. Record the code of the Jurisdiction, Hospital & Health Service or other external purchaser that has purchased the public contracted hospital care if contract type = 1 and contract role = B (Hospital B).	Right adjusted and zero filled from left; blank if null
Filler	6	Blank	
Length of Stay in Intensive care Unit	7 num	The total amount of time spent by an admitted patient in an approved intensive care unit ie Adult Intensive Care Unit - ICU Level 6, Clinical Services Capability Framework (CSCF) Version 3 (equivalent to ICU Level 3 CSCF version 2) or Children's Intensive Care Service Level 6 (equivalent to PICU CSCF version2). Format HHHHHMM H = Hours, M = Minutes	Right adjusted and zero filled from left, blank if null
Duration of continuous ventilatory support	7 num	The total amount of time an admitted patient has spent on continuous ventilatory support (ie invasive ventilation). Format HHHHHMM H = Hours, M = Minutes	Right adjusted and zero filled from left, blank if null

Activity File

The header record is the first record on the file. There is only one header record, followed by the activity details records.

HEADER RECORD			
Facility number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract period	16 date	From date To date	ctyymmdd ctyymmdd
File type	3 char	Abbreviation to identify file type ACT = Activity	
Number of records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction software identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	25	Blank	

ACTIVITY DETAILS RECORDS			
Record Identifier	1 char	N = new, D = deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
Activity Code	1 char	A = Account class variation L = Leave episode W = Ward/unit transfer C = Contract status Q = Qualification status T = Nursing Home Type S = Sub and Non-Acute Items B = Patient Identifier of mother of baby born in hospital	
Activity Details		See below for record details	

Activity Details if Activity code = A (Account Class Variation)			
Account Class	12 char	Currently not required	Left adjusted, blank if null
Filler	2	Blank	

Chargeable Status	1 num	1 = Standard 2 = Private shared 3 = Private single	
Compensable Status	1 num	1 = WorkCover Queensland 2 = Workers' Compensation Board (other) 6 = Motor Vehicle (Qld) 7 = Motor Vehicle (Other) 3 = Other Third Party 4 = Other Compensable 5 = Dept of Veterans' Affairs 9 = Department of Defence 8 = None of the above	
Filler	2	Blank	
Date of Change	8 date	Date that change to account class occurred	ctyymmdd
Time of Change	4 num	Currently not required	Blank if null

Activity Details if Activity Code = L (Leave Episode)			
Date of Starting Leave	8 date	Date patient went on leave	ctyymmdd
Time of Starting Leave	4 num	Currently not required	Blank if null
Date Returned from Leave	8 date	Date patient returned from leave	ctyymmdd
Time Returned from leave	4 num	Currently not required	Blank if null
Filler	6	Blank	

Activity Details if Activity Code = W (Ward/Unit Transfer)			
Ward	6 char	Ward that patient was transferred to	
Unit	4 char	Unit that patient was transferred to	Blank if null
Standard Unit Code	4 char	Standard unit that patient was transferred to	
Date of Transfer	8 date	Date patient transferred	ctyymmdd
Time of Transfer	4 num	Time patient transferred	hhmm (24 hour clock)
Standard Ward Code	4 char	Denotes whether the ward is assigned to a Designated SNAP unit SNAP = Designated SNAP Unit code	Blank if null

If Activity Code = C (Contract Status) then Activity Details =			
Date Transferred for Contract	8 date	Date patient transferred for contract service	ctyymmdd
Date returned from Contract	8 date	Date patient returned from contract service	ctyymmdd

Facility Contracted to	5 num	Facility number of the other facility involved in the contracted service	
Filler	9	Blank	
If Activity code = Q (Qualification status) then Activity Details =			
Qualification Status	1 char	A = Acute U = Unqualified	
Date of Change	8 date	Date that the change of qualification status occurred	ctyymmdd
Time of Change	4 num	Not currently required	Blank if null
Filler	17	Blank	
All changes of qualification status must be provided. If more than one change of qualification status occurs on a single day, then the final qualification status for that day should be provided.			

If Activity code = T (Nursing Home Type) then Activity Details =			
Nursing Home Flag	3 char	NHT = Nursing Home Flag	Not valid for patients with a care type of: 01 – Acute 05 – Newborn 07 – Organ Procurement 08 - Boarder
Date Commenced NHT Care	8 date	Date when patient commenced Nursing Home Type care	ctyymmdd
Date Ceased NHT Care	8 date	Date when patient ceased Nursing Home Type care	ctyymmdd
Filler	11	Blank	

SNAP information is required for all sub and non-acute patients with a public chargeable status.			
If Activity Code = S (Sub and Non-acute Items), then Activity Details =			
SNAP Episode Number	3 num	The unique SNAP episode number	Right adjusted, zero filled from left
ADL Type	3 char	Measure of physical, psychosocial, vocational and cognitive functions of an individual with a disability FIM = Functional independence measure HON = Health of the nation outcome scales RUG = Resource utilisation group	Must not be null

ADL Subtype	3 char	The HoNOS tool requires the collection of the total HoNOS score and the two individual items to allow for the assignment to a Psychogeriatric care type. If ADL Type = HON record 3 ADL Subtypes: BEH = Behaviour ADL = Activity of daily living TOT = Total The FIM tool has a cognitive and a motor sub-scale used as an assignment variable when assigning to a Rehabilitation or Geriatric Evaluation and Management care type. If ADL Type = FIM record 2 ADL Subtypes: MOT = Motor COG = Cognitive The RUG tool requires the collection of the total RUG score when assigning to a Maintenance or Palliative care type. If ADL Type = RUG, record 1 ADL Subtype: TOT = Total	Must not be null
ADL Score	3 num	Numerical rating from the ADL tool used as a measurement of different components of functional ability.	Must not be null. Right adjusted, zero filled from left
ADL Date	8 date	Date the ADL score was recorded	ctyymmdd
ADL Time	4 num	Not currently required	Blank if null
Phase Type	2 num	A distinct period or stage of illness relating to palliative care patients. So, for SNAP Type = PAL or PAA record one phase type: 01 = Stable 02 = Unstable 03 = Deteriorating 04 = Terminal Care	Blank if null Must not be null if SNAP Type = PAL or PAA
Filler	4	Blank	

ADL scores for each SNAP episode are to be supplied. Do not provide more than one set of scores on the same date for the same ADL type and ADL sub type.

For all SNAP episodes:

- *A code of '999' is acceptable as a SNAP score when the actual ADL score is not known or cannot be determined.*

Activity Details if Activity Code = B (Patient Identifier of mother of baby born in hospital)			
Mother's Patient Identifier	8 char	Patient Identifier of mother of baby born in hospital	Right adjusted and zero filled from left
Filler	22	Blank	

Morbidity File

The header record is the first record on the file. There is only one header record, followed by the morbidity details records.

HEADER RECORD			
Facility number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract period	16 date	From date To date	ctyymmdd ctyymmdd
File type	3 char	Abbreviation to identify file type MOR = Morbidity	
Number of records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction software identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	66	Blank	

MORBIDITY DETAILS RECORDS			
Record Identifier	1 char	N = new, D = deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
Diagnosis Code Identifier	3 char	PD = Principal diagnosis OD = Other diagnosis EX = External cause code PR = Procedure M = Morphology	Left adjusted
ICD-10-AM Code (**9th edition**)	7 char	Code assigned from the International Statistical Classification of Diseases and related Health Problems, 10th Revision, Australian Modification, **9th edition**	Left adjusted
Diagnosis Text	50 char	Textual description of diseases and procedures are optional	Left adjusted blank if null

Procedure Date	8 date	Date that the procedure was performed. The date must be provided if the procedure is within the following block ranges: 1 to 59 67 to 559 561 to 737 739 to 1059 1062 to 1062 1064 to 1089 1091 to **1580** 1602 to 1759 1828 to 1828 1886 to 1886 1890 to 1891 1906 to **1907** 1909 to 1912 1920 to 1922	ctyymmdd Blank if null
Contract Flag	1 num	Recorded by Hospital A when a patient receives an admitted or non-admitted contracted service from the contracted hospital (Hospital B) 1 = Contracted admitted procedure 2 = Contracted non-admitted procedure	Blank if null
Diagnosis Onset Type	1 char	An indicator for each diagnosis to indicate the onset and/or significance of the diagnosis to the episode of care. 1 = Condition present on admission to the episode of care 2 = Condition arises during the current episode of care 9 = Unknown/Uncertain	Blank if null
Most Resource Intensive Condition Flag	1 char	Currently not required	Blank if null
Other Co-Morbidity of Interest Flag	1 char	Currently not required	Blank if null

Mental Health File

A record is to be provided on the mental health details file for each episode of care where the standard unit code (either at admission to the episode or through a ward transfer during the episode) is in the range PYAA to PYZZ.

No record is to be provided if there were no standard unit codes in this range during the episode of care.

The header record is the first record on the file. There is only one header record, followed by the mental health details records.

HEADER RECORD			
Facility number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract period	16 date	From date To date	ctyymmdd ctyymmdd
File type	3 char	Abbreviation to identify file type MEN = Mental Health	
Number of records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction software identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	2	Blank	

MENTAL HEALTH DETAILS RECORDS			
Record Identifier	1 char	N = new, A = amendment, D = deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
Type of Usual Accommodation	1 char	1 = House or flat 2 = Independent unit as part of a retirement village or similar 3 = Hostel or hostel accommodation 4 = Psychiatric hospital 5 = Acute hospital 7 = Other accommodation 8 = No usual residence	

Employment Status	1 char	1 = Child not at school 2 = Student 3 = Employed 4 = Unemployed 5 = Home duties 6 = Pensioner 8 = Other	
Pension Status	1 char	1 = Aged 2 = Repatriation 3 = Invalid 4 = Unemployment benefit 5 = Sickness benefit 7 = Other 8 = No pension/benefit	
First Admission For Psychiatric Treatment	1 char	1 = No previous admission for psychiatric treatment 2 = Previous admission for psychiatric treatment	
Referral To Further Care	2 char	01 = Not referred 02 = Private psychiatrist 03 = Other private medical practitioner 04 = Mental health/alcohol and drug facility - admitted patient 05 = Mental health/alcohol and drug facility - non-admitted patient 06 = Acute hospital – admitted patient 07 = Acute hospital - non-admitted patient 08 = Community health program 29 = Other	Right adjusted & zero filled from left
Mental Health Legal Status Indicator	1 char	1 = Involuntary patient for any part of the episode 2 = Voluntary patient for all of the episode	
Previous Specialised Non-Admitted Treatment	1 char	1 = Patient has no previous non-admitted service contact(s) for psychiatric treatment 2 = Patient has previous non-admitted service contact(s) for psychiatric treatment	

Sub and Non-Acute Patient Details File

SNAP information is required for all sub and non-acute patients with a public chargeable status**.**

No record is to be provided if the care type is **mental health**, acute, newborn, boarder, organ procurement or other care.

The header record is the first record on the file. There is only one header record, followed by the sub and non-acute patient details records.

HEADER RECORD			
Facility Number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type SNP = Sub and Non-acute Patient	
Number of Records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	31	Blank	

SUB AND NON-ACUTE PATIENT DETAILS RECORDS			
Record Identifier	1 char	N = new, A = amendment, D = deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted, zero filled from left
SNAP Episode Number	3 num	The unique SNAP episode number	Right adjusted, zero filled from left

SNAP Type	3 char	Classification of a patient's care type based on characteristics of the person, the primary treatment goal and evidence PAA = Palliative – assessment only PAL = Palliative care RAO = Rehabilitation – assessment only RCD = Rehabilitation – congenital deformities ROI = Rehabilitation - other disabling impairments RST = Rehabilitation – stroke RBD = Rehabilitation – brain dysfunction RNE = Rehabilitation – neurological RSC = Rehabilitation - spinal cord dysfunction RAL = Rehabilitation – amputation of limb RPS = Rehabilitation - pain syndromes ROF = Rehabilitation – orthopaedic conditions, fractures ROR = Rehabilitation – orthopaedic conditions, replacement ROA = Rehabilitation – orthopaedic conditions, all other RCA = Rehabilitation – cardiac RMT = Rehabilitation - major multiple trauma RPU = Rehabilitation – pulmonary RDE = Rehabilitation – debility RDD = Rehabilitation – developmental disabilities RBU = Rehabilitation – burns RAR = Rehabilitation – arthritis GAO = Geriatric Evaluation and management - assessment only GEM = Geriatric evaluation and management GSD = Geriatric evaluation and management - planned same day MAO = Maintenance – assessment only MRE = Maintenance – respite MNH = Maintenance - nursing home type MCO = Maintenance – convalescent care MOT = Maintenance – other PSA = Pschogeriatric – assessment only PSG = Psychogeriatric care	Must not be null
Group Classification	3 num	Currently not required	Blank if null
Start Date	8 Date	The start date of each SNAP episode	ctyymmdd
End Date	8 Date	The end date of each SNAP episode	ctyymmdd

Multidisciplinary Care Plan Flag	1 char	There is documented evidence of an agreed multidisciplinary care plan. Y = Yes N = No U = Unknown	Required for patients with a Rehabilitation , Geriatric Evaluation and Management , Psychogeriatric or Palliative SNAP Type Blank if null
Multidisciplinary Care Plan Date	8 Date	The date of establishment of the multidisciplinary care plan	Ctyymmdd Required for patients with a Rehabilitation , Geriatric Evaluation and Management , Psychogeriatric or Palliative SNAP Type and Multidisciplinary Care Plan Flag = 'Y' Blank if null
Proposed Principal Referral Service	3 num	The principal type of service proposed for a patient post discharge. Only one proposed service can be provided. If there is more than one proposed service, provide the principal service. 001 = No service is required 101 = Community/home based rehabilitation 102 = Community/home based palliative 103 = Community/home based geriatric evaluation and management 111 = Community/home based – nursing/domiciliary 104 = Community/home based respite 105 = Community/home based psychogeriatric 106 = Home and community care 107 = Community aged care package, extended aged care in the home 108 = Flexible care package 109 = Transition care program (includes intermittent care service) 110 = Outreach Service 198 = Community/home based - other 201 = Hospital based (admitted) - rehabilitation 202 = Hospital based (admitted) - maintenance 203 = Hospital based (admitted) - palliative 204 = Hospital based (admitted) - geriatric evaluation and management 205 = Hospital based (admitted) -respite	Required for patients with a Rehabilitation, Geriatric Evaluation and Management , Psychogeriatric or Palliative SNAP Type. Blank if null

		206 = Hospital based (admitted) - psychogeriatric 207 = Hospital based (admitted) - acute 208 = Hospital based - non-admitted services 298 = Hospital based - other 998 = Other service 999 = Not stated/unknown service	
Primary Impairment Type	7 char	The impairment which is the primary reason for admission to the episode.	Left adjusted, Blank if null. Only required for patients with a rehabilitation SNAP type

For Maintenance Care SNAP Episodes

- *At least one set of ADL scores must be provided for each SNAP episode.*
- *There must be at least one SNAP Episode within a single non-acute episode of care.*
- *If there are more than one SNAP episode then these must be contiguous.*
- *The start date of the first SNAP episode must be the same as the start date of the episode of care.*
- *The end date of the last SNAP episode must be the same as the end date of the episode of care.*

For Rehabilitation Care, Geriatric Evaluation and Management Care, Palliative Care and Psychogeriatric Care SNAP Episodes

- *At least one set of ADL scores must be provided for each SNAP episode.*
- *There can only be one SNAP Episode within a single sub-acute episode of care.*
- *The start date of the SNAP episode must be the same as the start date of the episode of care.*
- *The end date of the SNAP episode must be the same as the end date of the episode of care.*

Palliative Care File

A record is to be provided on the palliative care details file for each episode of care where the care type is:

30 = Palliative care

No record is to be provided if the care type is NOT 30.

The header record is the first record on the file. There is only one header record, followed by the palliative care details records.

HEADER RECORD			
Facility number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract period	16 date	From date To date	ctyymmdd ctyymmdd
File type	3 char	Abbreviation to identify file type PAL = Palliative Care	
Number of records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction software identifier	10 char	Code to identify version of software used	Left adjusted, blank if null

PALLIATIVE CARE DETAILS RECORDS			
Record Identifier	1 char	N = new, A = amendment, D = deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
First Admission For Palliative Care Treatment	1 char	1 = No previous admission for palliative care treatment 2 = Previous admission for palliative care treatment	
Previous Specialised Non-Admitted Palliative Care Treatment	1 char	1 = Patient has no previous non-admitted service contact(s) for palliative care treatment 2 = Patient has previous non-admitted service contact(s) for palliative care treatment	
Filler	4	Blank	

Department of Veterans' Affairs File

A record is to be provided on the Department of Veterans' Affairs patient details file where the charges for the episode of care are met by the Department of Veterans' Affairs.

A record is not to be provided if the charges for the episode of care are not met by the Department of Veterans' Affairs.

The header record is the first record on the file. There is only one header record, followed by the Department of Veterans' Affairs details records.

HEADER RECORD			
Facility number	5 num	Must be same as facility number in corresponding header file	Right adjusted and zero filled from left
Extract period	16 date	From date To date	ctyymmdd ctyymmdd
File type	3 char	Abbreviation to identify file type DVA = Department Of Veterans' Affair	
Number of records	5 num	Total number of records in file	Right adjusted and zero filled from left; zero if null
Extraction software identifier	10 char	Code to identify version of software used	Left adjusted, blank if null
Filler	5	Blank	

DEPARTMENT OF VETERANS' AFFAIRS DETAILS RECORDS			
Record Identifier	1 char	N = new, A = amendment, D = deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
DVA File Number	10 char	The patient's Department of Veterans' Affairs identification number	Left adjusted space filled from the right
Card Type	1 char	G = Gold W = White Denotes whether the patient is a gold or white card holder	

Private Validation Rules

Patient details records

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Family Name	Must not be null
First Given name	No validation
Second Given name	No validation
Address of Usual Residence	No validation
Location of Usual Residence	Must not be null Validated against Locality Data Set parts with the Postcode and Locality of Usual Residence
Postcode of Usual Residence	Must not be null Validated against Locality Data Set parts with the Postcode and Locality of Usual Residence
State of Usual Residence	Must not be null Validated against list of State codes
Sex	Must not be null Validated against list of valid sex codes
Date of Birth	Must not be null Must be a valid date Must not be in future (ie. past current date) Must not be after the admission date Must not be more than 124 years prior to admission date
Estimated Date of Birth Indicator	Can be null Validated against list of estimate date of birth indicator codes

Marital Status	Must not be null Validated against list of marital status codes
Country of Birth	Must not be null Validated against country codes
Indigenous Status	Validated against list of indigenous status codes Must not be null
Filler	Currently not required, no validation
Occupation	Currently not required, no validation
Employment Status	Currently not required, no validation
Medicare Eligibility	Must not be null Validated against list of medicare eligibility codes
Medicare Number	Must be a valid medicare number, if not null 11 digit medicare number required The eleventh digit is the number that precedes the patient's name on the card (the subnumerate). If a subnumerate cannot be supplied, the eleventh digit of the medicare number should be provided as zero
Australian South Sea Islander Status	Must not be null Must be 1, 2 or 9
Contact for Feedback Indicator	Not currently required, no validation
Telephone Number – Home	Not currently required, no validation
Telephone Number – Personal Mobile	Not currently required, no validation
Telephone Number – Business or Work	Not currently required, no validation

Admission details records

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each patient within facility
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Admission Date	Must not be null Must be a valid date Must not be in future (i.e. past current date) Must not be before the birth date of the patient Must be before or on separation date
Time of Admission	Must not be null Must be a valid time Must be before the separation time, if admitted the same day as separated
Account Class	Not currently required, no validation
Chargeable Status	Validated against list of chargeable status codes Must not be null
Care Type	Validated against list of type of episode codes Must not be null
Compensable Status	Validated against list of compensable status codes Must not be null
Band	Validated against list of band codes, if not null Must be a same day patient
Source of Referral/Transfer	Validated against list of source of referral/transfer codes Must not be null
Transferring from Facility	Must not be null if Source of Referral/Transfer is 16, 23, 24 or 25 Only applicable if Source of Referral/Transfer is 16, 23, 24 or 25 Must be a valid facility number
Hospital Insurance	Validated against list of Hospital Insurance codes Must not be null

Separation Date	Must not be null Must be a valid date Must not be in future (ie. past current date) Must be on or after admission date
Separation Time	Must not be null Must be a valid time
Mode of Separation	Validated against list of Mode of Separation codes Must not be null
Transferring to Facility	Must not be null if Mode of Separation is 12, 15 or 16 Only applicable if Mode of Separation is 12, 15 or 16 Must be a valid facility number
DRG	No validation
MDC	No validation
Baby Admission Weight	Must not be null if patient aged 28 days or less, or admission weight is less than 2,500 grams
Admitting Ward	Must not be null No validation
Admitting Unit	No validation
Standard Unit Code	Must not be null Must be a valid standard unit code
Treating Doctor at admission of episode of care	No validation
Planned Same Day	Must be Y or N
Elective Patient Status	Must not be null Must be a valid elective patient status code
Qualification Status	Can be null Validated against list of qualification status codes
Standard Ward Code	Can be null Must be a valid standard ward code
Contract Role	Can be null Must be a valid Contract Role code
Contract Type	Can be null Must be a valid Contract Type code
Funding Source	Must not be null Validated against a list of Funding Source codes If Funding Source = 10 then Contract Role and Contract Type cannot be null
Incident Date	Not currently required, no validation
Incident Date Flag	Not currently required, no validation
WorkCover Queensland (Q-	Not currently required, no validation

Comp) Consent	
Motor Accident Insurance Commission (MAIC) Consent	Not currently required, no validation
Department of Veterans' Affairs (DVA) Consent	Not currently required, no validation
Department of Defence Consent	Not currently required, no validation
Interpreter Required	Not currently required, no validation
Religion	Not currently required, no validation
QAS Patient Identification Number (eARF Number)	Can be null Validated against Source of Referral/Transfer
Purchaser/Provider Identifier	Must be a valid establishment number Must not be null if Contract Role = 'A' or 'B' and Contract Type in (2, 3, 4, 5) Must not be null if Contract Role = 'B' and Contract Type = 1 and chargeable status is public
Length of Stay in Intensive Care Unit	Must not be null if treatment was provided in an ICU Level 6 or CIC Service Level 6
Duration of Continuous Ventilatory Support	Must not be null if the patient received continuous ventilatory support

Activity details records

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Activity Code	Must be a valid code (A, L, W, C, Q, T, S, B)

Activity code = A	
Account Class Code	Not currently required, no validation
Chargeable Status	Validated against list of chargeable status codes
Compensable Status	Validated against list of compensable status codes
Date of Change	Valid date format Must not be null Must not be before the admission date Must not be after separation date
Time of Change	Not currently required, no validation

Activity code = L	
Date of Starting Leave	Must be a valid date Must not be null Must not be before the admission date Must not be after separation date Must not fall within any other leave periods Same day leaves are not required
Time of Starting Leave	Not currently required, no validation
Date Returned from Leave	Must be a valid date Must not be null Must be after the date of starting leave Must not be after separation date Must not fall within any other leave periods Same day leaves are not required

Time Returned from Leave	Not currently collected, no validation

Activity code = W	
Ward	Must not be null No validation
Unit	No validation
Standard Unit Code	Must be valid standard unit code Must not be null
Date of Transfer	Must be a valid date Must not be in future Must not be before the admission date Must not be within any leave periods Must not be after the separation date Must not be null
Time of Transfer	Must be a valid time Must not be null
Standard Ward Code	Can be null Must be a valid standard ward code of 'SNAP'

Activity code = C	
Date Transferred for Contract	Must be a valid date Must not be within any leave periods Must not be before the admission date Must not be after separation date Must not be in future Must not be null Must not be after date returned from contract
Date Returned from Contract	Must be a valid date Must not be within any leave periods Must not be before the admission date Must not be after separation date Must not be in future Must not be null Must not be before the date transferred for contract
Facility Contracted to	If there is a date for transferred for contract, there must be a facility contract to. Must be a valid facility number Must not be null

Activity code = Q	
Qualification Status	Must not be null Validated against list of qualification status codes
Date of Change	Must be a valid date Must not be before the admission date Must not be after separation date Must not be in future

	Must not be null
Time of Change	Not currently required, no validation

Activity code = T	
Nursing Home Flag	Must not be null Must be a valid Nursing Home Flag code Not valid for patients with a care type of: 01 – Acute 05 – Newborn 07 – Organ Procurement 08 - Boarder
Date Commenced NHT Care	Must be a valid date Must not be before the admission date Must not be after separation date Must not be in future Must not be null Must be before the date ceased NHT care Must not fall within any other NHT periods Same day NHT periods are not required
Date Ceased NHT Care	Must be a valid date Must not be before the admission date Must not be after separation date Must not be in future Must not be null Must be after the date commenced NHT care Must not fall within any other NHT periods Same day NHT periods are not required

Activity code = S	
SNAP information is required for all sub and non-acute patients with a public chargeable status.	
SNAP Episode Number	Must not be null Must not be zero
ADL Type	Must not be null Validated against list of ADL type codes
ADL Subtype	Must not be null Validated against list of ADL subtype codes
ADL Score	Must not be null ADL scores for each SNAP episode are to be supplied. Do not provide more than one set of scores on the same date for the same ADL type and ADL sub type. For all SNAP episodes: • A code of '999' is acceptable as a SNAP score when the actual ADL score is not known or cannot be determined. Where ADL type = FIM and • ADL sub type = MOT score must be between 13 and 91 • ADL sub type = COG score must be between 5 and 35 Where ADL type HON and • ADL sub type = BEH score must be between 0 and 4

	• ADL sub type = ADL score must be between 0 and 4 • ADL sub type = TOT score must be between 0 and 48 Where ADL type RUG and • ADL sub type = TOT score must be between 4 and 18
ADL Date	Must be a valid date Must not be before the admission date Must not be after the separation date Must not be in future Must not be null
ADL Time	Not currently collected, no validation
Phase Type	Can be null Must not be null if SNAP type = PAL or PAA Validated against list of phase type codes

Activity code = B	
Mother's Patient Identifier	Must not be zero Must be unique for each patient within facility Must not be null for Source of Referral/Transfer = '09'

Morbidity details records

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Diagnosis Code Identifier	Must not be null Validated against list of diagnosis code types Every separation must have one and only one PD Cannot have an OD, EX, PR or M without a PD
ICD-10-AM Code (**9th edition**)	Must not be null Please refer to Queensland Hospital Admitted Patient Data Collection guidelines for the sequencing of ICD-10-AM codes.
Diagnosis Text	Text is optional as ICD-10-AM codes must be supplied.
Procedure Date	Must be a valid date Must not be in the future Must not be null for procedures with a block code between: 1 to 59 67 to 559 561 to 737 739 to 1059 1062 to 1062 1064 to 1089 1091 to **1580** 1602 to 1759 1828 to 1828 1886 to 1886 1890 to 1891 1906 to **1907** 1909 to 1912 1920 to 1922
Contract Flag	Validated against list of contract flag codes
Diagnosis Onset Type	Validated against list of Diagnosis Onset Type codes Must not be null if Diagnosis Code Identifier = PD,OD, EX or M

Most Resource Intensive Condition Flag	Not currently collected, no validation
Other Co-Morbidity of Interest Flag	Not currently collected, no validation

Mental Health details records

A record is to be provided on the mental health details file for each episode of care where the standard unit code (either at admission to the episode or through a ward transfer during the episode) is in the range PYAA to PYZZ.

No record is to be provided if there were no standard unit codes in this range during the episode of care.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Type of Usual Accommodation	Must not be null Validated against type of usual accommodation codes
Employment Status	Must not be null Validated against employment status codes If 1 then age must be < 18 If 3, 4 or 6 then age must be > 14
Pension Status	Must not be null Validated against pension status codes If 1 then age must be > 59 if female and > 64 if male If 2 to 5 then age must be 14 < age< 65
First Admission For Psychiatric Treatment	Must not be null Validated against previous specialised non-admitted treatment codes
Referral To Further Care	Must not be null Validated against referral to further care codes
Mental Health Legal Status Indicator	Must not be null Validated against legal status indicator codes
Previous Specialised Non-admitted Treatment	Must not be null Validated against previous specialised non-admitted treatment codes

Sub and Non-Acute Patient details records

A record for each SNAP type is to be provided on the sub and non-acute patient details file for each episode of care for public chargeable patients where the care type is sub-acute or non-acute (ie Rehabilitation Care, Geriatric Evaluation and Management Care, Palliative Care, Psychogeriatric Care or Maintenance care).

No record is to be provided if the care type is **mental health**, acute, newborn, boarder, organ procurement or other care.

The header record is the first record on the file. There is only one header record, followed by the sub and non-acute patient details records.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
SNAP Episode Number	Must not be null Must not be zero
SNAP Type	Must not be null Validated against list of SNAP type codes PAL, PAA is only valid for Palliative care RAO, RCD, ROI, RST, RBD, RNE, RSC, RAL, RPS, ROF, ROR, ROA**,** RCA, RMT, RPU, RDE, RDD, RBU, RAR are only valid for Rehabilitation care GAO, GEM, GSD are only valid for Geriatric Evaluation and Management care MRE, MNH, MCO, MOT, MAO are only valid for Maintenance care PSG, PSA is only valid for Psychogeriatric care
Group Classification	Not currently required, no validation
Start Date	Must not be null Must be a valid date Must not be in future (ie. past current date) Must not be before the birth date of the patient Must be on or after the admission date Must be before or on separation date

End Date	Must not be null Must be a valid date Must not be in future (ie. past current date) Must be on or after admission date Must be before or on separation date
Multidisciplinary Care Plan Flag	Must be a valid value Must not be null if a Rehabilitation, Geriatric Evaluation and Management, Palliative or Psychogeriatric SNAP Type
Multidisciplinary Care Plan Date	Must be a valid date Must not be in the future (ie. past current date) Must be before or on separation date Can be null
Proposed Principal Referral Service	Must not be null if a Rehabilitation, Geriatric Evaluation and Management, Palliative or Psychogeriatric SNAP Type Validated against the list of proposed service codes
Primary Impairment Type	Must not be null if a rehabilitation SNAP Type Validated against the list of Primary Impairment Type codes

For Maintenance Care SNAP Episodes

- At least one set of ADL scores must be provided for each SNAP Episode.
- There must be at least one SNAP Episode within a single non-acute episode of care.
- If there are more than one SNAP episode then these must be contiguous.
- The start date of the first SNAP episode must be the same as the start date of the episode of care.
- The end date of the last SNAP episode must be the same as the end date of the episode of care.

For Rehabilitation Care, Geriatric Evaluation and Management Care, Palliative Care and Psychogeriatric Care SNAP Episodes

- At least one set of ADL scores must be provided for each SNAP episode.
- There can only be one SNAP Episode within a single sub-acute episode of care.
- The start date of the SNAP episode must be the same as the start date of the episode of care.
- The end date of the SNAP episode must be the same as the end date of the episode of care.

Palliative Care details records

A record is to be provided on the palliative care details file for each episode of care where the care type is: 30 = Palliative care

No record is to be provided if the care type is NOT 30.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
First Admission For Palliative Care Treatment	Must not be null Validated against first admission for palliative care treatment codes
Previous Specialised Non-Admitted Palliative Care Treatment	Must not be null Validated against previous specialised non-admitted palliative care treatment codes

Department of Veterans' Affairs details records

A record is to be provided on the Department of Veterans' Affairs patient details file where the charges for the episode of care are met by the Department of Veterans' Affairs.

A record is not to be provided if the charges for the episode of care are not met by the Department of Veterans' Affairs.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
DVA File Number	Must not be null
Card Type	Must not be null Must be a valid Card Type code

Private Processing Rules

RECORD IDENTIFIER = N

Description Patient separated in extract period or patient separated prior to extract period but not previously submitted (late insertion).

Patient File
- A corresponding record must exist in the admission file.

Admission File
- Admission record must not already exist.
- A corresponding record must exist in patient file.
- Patient must be separated in the extract period or patient separated prior to extract period but not previously submitted (late insertion).
- Late insertions for the current financial year can be received up to and including the extraction for August data of the next financial year (due in early October).

Activity File
- A corresponding record must exist in the admission file and in the patient file.
- All activities must occur within the admission and separation dates.

  Account Class Variations
  - Must not already exist.

  Leave
  - Leave period must not overlap with any other leave periods for admission.

  Ward Transfer
  - Must not already exist for admission.

  Contract Status
  - Must not already exist for admission.

  Qualification Status
  - Must not already exist for admission.

  Nursing Home Type Patient Items
  - Must not already exist for admission.

  Sub and Non-acute Patient Items
  - Must not already exist for admission.

  Patient Identifier of mother of baby born in hospital
  - Must not already exist for admission**.**

Morbidity File
- A corresponding record must exist in admission file and in the patient file.
- The ICD-10-AM code must not already exist for this admission except for procedure, morphology and external cause codes.

Mental Health
- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.
- Must exist if any standard ward/unit code in the activity or admission file is in the range PYAA to PYZZ.

Sub and Non-Acute Patient File
- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission

Palliative Care

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Department of Veterans' Affairs

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

RECORD IDENTIFIER = A

Description Amendment to records submitted prior to extract period. Amendment records for the current financial year can be received up to and including the extraction of August data of the next financial year (due in early October).

Patient File
- Patient record must exist.

Admission File
- Admission record must exist

Activity File
- Cannot be amended. Must instead be deleted and re-created.

Morbidity File
- Cannot be amended. Must instead be deleted and re-created.

Mental Health File
- Mental Health record must exist.

Sub and Non-acute Patient File
- Sub and Non-acute Patient record must exist.

Palliative Care File
- Palliative Care patient record must exist.

Department of Veterans' Affairs File
- Department of Veterans' Affairs record must exist.

RECORD IDENTIFIER = D

Description Deletion of any record previously sent. Deletion records for the current financial year can be received up to and including the extraction of August data of the next financial year (due in early October).

Patient File

- Deletion is not applicable to patient records.

Admission File

- The admission record must exist.

Activity File

- Only the one record matching the previously submitted record exactly will be deleted.

  Account Class Variations
  - The record must exist

  Leave
  - The record must exist

  Ward Transfer
  - The record must exist

  Contract Status
  - The record must exist

  Qualification Status
  - The record must exist

  Nursing Home Type Patient Items
  - The record must exist

  Sub and Non-acute Items
  - The record must exist

  Patient Identifier of mother of baby born in hospital
  - The record must exist

Morbidity File

- All morbidity records in relation to that admission will be deleted.
- The morbidity record must exist.

Mental Health File

- Mental health record must exist.

Sub and Non-Acute Patient File

- Sub and non-acute patient record must exist.

Palliative Care File

- Palliative care record must exist.

Department of Veterans' Affairs File

- Department of Veterans' Affairs record must exist.