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AQCESS SYSTEM SPECIFICATION: PATIENT ADMINISTRATION SUBSYSTEMS

AND

AQCESS SYSTEM SPECIFICATION: QUALITY ASSURANCE SUBSYSTEM

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GUIDE FOR INSTALLING
AQCESS SOFTWARE



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Bethesda, Maryland 20816

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AQCESS IS A MICROCOMPUTER BASED, INTEGRATED, TERMINAL ORIENTED, INTERACTIVE, ON-LINE COMPUTER SYSTEM DESIGNED TO SUPPORT PATIENT ADMINISTRATION, CLINICAL RECORDS AND QUALITY OF CARE EVALUATION FUNCTIONS WITHIN A MILITARY MEDICAL TREATMENT FACILITY.

SYSTEM DOCUMENTATION INCLUDES:

(a) FUNCTIONAL DESCRIPTION - DESCRIBES THE FUNCTIONAL REQUIREMENTS USED AS A BASIS FOR SYSTEM DEVELOPMENT. PROVIDES INFORMATION ON PERFORMANCE REQUIREMENTS, PRELIMINARY DESIGN, USER IMPACT, DATA RELATIONSHIPS AND DATA FLOWS BETWEEN QUALITY ASSURANCE PROCESSES AND PATIENT ADMINISTRATION FUNCTIONS,

(b) SYSTEM SPECIFICATIONS - PROVIDES A DETAILED DEFINITION OF THE SYSTEM FUNCTIONS AS WELL AS INTERFACES WITH OTHER SYSTEMS AND SUB-SYSTEMS,

(c) USERS MANUAL - PROVIDES NON-ADP PERSONNEL WITH THE INFORMATION NECESSARY TO EFFECTIVELY USE THE SYSTEM, and

(d) INSTALLATION GUIDE - CONTAINS STEP-BY-STEP INSTRUCTIONS FOR INSTALLING AQCESS ON THE DEC PDP-11/84 COMPUTER.

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GUIDE FOR INSTALLING AQCESS ON THE PDP-11/84

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3. INSTALLING AQCESS SOFTWARE ON THE PDP-11/84

This section describes how to install the AQCESS software on the number three system, the PDP-11/84; and to verify its operational readiness. Be sure to review the instructions presented in this section before you actually begin software installation.

General instructions and statements about system actions are printed across the width of the page. System prompts that appear on the console are shown in the lefthand column. Defaults are shown between the symbols < and >. (To accept a default, press Return.) The righthand column, under the heading "Your Actions," gives specific instructions such as "Press Return"; it also shows in boldface the exact responses you type in.

Installing the software on the PDP-11/84 may take approximately a full day or longer. If you need any clarification, refer to your DEC Users Guide.

3.1 LOAD THE AQCESS DISTRIBUTION KIT (DSM-11 OPERATING SYSTEM)

If the system is not powered up, power it up and proceed to STEP 2. (Refer to Section 24 of the AQCESS System Management Training Aid).

STEP 1. SHUTDOWN THE SYSTEM.

Log on to the Manager database as shown in the first line under "Your Actions" in the box below--that is, type MGR:, then hold down the CTRL key while you type XXX. [Whenever you see (CTRL) in these instructions, this means that you hold down the CTRL key while typing whatever characters appear after (CTRL).]

System Prompts:	Your Actions:
DSM-11 VERSION 3.ØT Device #1 UCI:	**MGR:(CTRL)XXX**
>	**D ^SSD**
...Caretaker stopped	
NO JOBS ARE CURRENTLY LOGGED IN. LOGINS ARE NOW DISABLED.	
1. Display Logged-in Jobs 2. Perform Timed Shutdown 3. Terminate All Jobs, Perform Immediate Shutdown	
ENTER OPTION >	3
READY TO HALT	
Exit	

Mount the Distribution magnetic tape onto the TU80 Tape Drive. Press LOAD REWIND so that the light is on. The tape will begin spinning and when the BOT LIGHT comes on, press ON LINE.

STEP 2. PREVENT SYSTEM DISK BOOT.

Manual booting. Lift the S2 switch (behind the CPU) to the up position.

Halt the system by pressing the switch to the HALT position and replace it to the center position (RUN). Lift the switch to RESTART position, and the switch springs back to the center position (RUN).

System Prompts:	Your Actions:
ØØ576Ø @	(This number may vary.)
Testing in progress - Please wait Memory Size is 2Ø48 K Bytes 9 Step memory test STEP 1 2 3 4 5 6 7 8 9	
Message Ø4 Entering Dialog mode	
Commands are Help, Boot, List, Setup, Map and Test. Type a command then press the RETURN key:	B
Enter device name and unit number then press the RETURN key:	MSØ
Trying MSØ	
Starting ROM Boot	
DSM-11 Version 3.ØA Now running the baseline system	

Automatic booting. Return the S2 switch (behind the CPU) to the down position.

STEP 3. LOAD THE AQCESS DISTRIBUTION KIT (DSM-11 OPERATING SYSTEM) FROM TAPE.

System Prompts:	Your Actions:
Begin DSM-11 Version 3.ØA system installation	
Answer with a question mark (?) any time you wish more information.	
Please enter today's date [DD-MMM-YY] ? >	If the date shown is today's actual date, press Return. If not, enter today's date.
and time [HH:MM:SS] ? >	Enter the current time.
The only useable disk is DUØ DUØ now holds a DSM11 V3 system disk. With volume label: "TRIMIS" Do you wish to upgrade your DSM-11 Version 3 system to DSM-11 Version 3.0A ? [Y/N] >	N
Do you wish to proceed with installation, overwriting DUØ ? [Y/N] >	Y
Do you wish to run a comprehensive test for bad blocks on this disk ? [Y/N] >	Y
Test pattern 177777 octal ? [Y/N] >	Y
Test pattern 125252 octal ? [Y/N] >	Y
Test pattern Ø52525 octal ? [Y/N] >	Y
Test pattern ØØØØØØ octal ? [Y/N] >	Y
(You may hit the "ESC" key at any time to determine the number of blocks processed so far)	
1Ø:5Ø:42 Begin test pattern 177777	
11:Ø5:4Ø Begin test pattern 125252	
11:2Ø:35 Begin test pattern Ø52525	
11:4Ø:25 Begin test pattern ØØØØØØ	
12:27:Ø1 Testing complete	

This process takes approximately 30 minutes. If you hit the "ESC" key, press Return to proceed with testing.

While the test patterns are running, take this time to make sure line connections are secured to all terminals. Use the Setup Function Key (F3) on the CRT to set the default and baud rate on all CRT's; then save and exit.

System Prompts:	Your Actions:
RA8Ø Unit Ø Bad Block Table	
The Bad Block Table is empty.	
Do you know of any other bad blocks on this disk ? [Y/N] >	N
What would you like the new label of this disk to be ? (up to 22 characters enclosed in quotes)?>	"MASTER Ø"
What 3-character uppercase name do you wish to give this volume set ?	SYS

Now initializing DUØ for use as DSM-11 volume...
Loading the DSM-11 Version 3.ØA system utilities
onto the system disk:

%BN	%CRF	BSCPER
ATTACH	AUPAT	DPV2UPG
BSCQUE	BSCRCV	MUX1
FASTDBT	MUX	ALLOCAT
MUXDEF	SPL	DSKTRACK
SGSUB...	SPL...	SPLALL...

The above is a sampling of the system utilities that will be copied to disk.

System Prompts:	Your Actions:
Transferring the system globals: % %EDI %EDIHELP %MENU %Q SYS	
Now copying the system image onto your new disk, making it a bootable DSM-11 Version 3.ØA system disk...	
DUØ is now a bootable DSM-11 Version 3.ØA system disk. You may dismount the distribution magnetic tape now.	

System Prompts:			Your Actions:
The following utilities are no longer supported for Version 3 will be removed from the managers account.			
%DDP	%FIND	%GC...	
DPUPGMOR	DSKLOK	DSKPREP2...	
SG22	SG23	SG3...	
SUPHELP	SUPPAR	SUPPAR1...	
Do you wish to proceed directly to SYSGEN ? <Y>			Press Return.

Remove the Distribution Kit (DMS-11 Operating System) and mount/load the Backup Tape (DUØ) on the tape drive. Press the online button when ready.

STEP 4. PERFORM A SYSGEN.

System Prompts:	Your Actions:
System generation for DIGITAL Standard MUMPS Type ? for HELP at any time	
PART 1: SYSGEN	
1.1 Would you like extended help [Y OR N] ? <N>	Press Return.
1.2 Enter the configuration identifier <1>	Press Return.
1.3 Do you wish to Auto-configure the current system [Y OR N] ? <Y>	Press Return.

The system will begin to print the system configuration.

System Prompts:	Your Actions:
Configuring Host System...	
Processor Type: PDP-11/84	
Memory Size: 2048 KB	
Processor/Memory Options:	
Floating Point Unit Extended Instruction Set 22 Bit Addressing UNIBUS Mapping Support Cache Memory parity	

System Prompts:						Your Actions:
Name	Vector	CSR	Unit	Type	Description	
DUA	154	17215Ø	Ø	UDA5Ø RA8Ø	Disk Controller Disk Drive	
MSA	224	17252Ø		TU8Ø	Tape Controller	
YZA	3ØØ	16Ø1ØØ		DZ11	Asynch Multiplexor Controller	
YZB	31Ø	16Ø11Ø		DZ11	Asynch Multiplexor Controller	
YZC	32Ø	16Ø12Ø		DZ11	Asynch Multiplexor Controller	
YZD	33Ø	16Ø13Ø		DZ11	Asynch Multiplexor Controller	
YZE	34Ø	16Ø14Ø		DZ11	Asynch Multiplexor Controller	
YZF	35Ø	16Ø15Ø		DZ11	Asynch Multiplexor Controller	
YZG	36Ø	16Ø16Ø		DZ11	Asynch Multiplexor Controller	
YZH	37Ø	16Ø17Ø		DZ11	Asynch Multiplexor Controller	

Verify the system disk to determine its useable drive.

Example:	Unit	Type	Description
	Ø	RA8Ø	Disk Drive

Note: If the disk drive, unit Ø, is missing it may mean a problem with the system disk drive. Place a call first to NDC Customer Support to determine if a service call is required.

System Prompts:	Your Actions:
1.4 Do you wish to modify this configuration information [Y OR N] ? <N>	Press Return.
PART 2: DISK INFORMATION	
Disk information supplied by AUTOCONFIGURE	

System Prompts:		Your Actions:
PART 3: SYSTEM DEVICES		
System Device information supplied by AUTOCONFIGURE		
PART 4: CONFIGURE DMC-11's		
PART 5: SOFTWARE CONFIGURATION		
5.1 Do you wish to use the STANDARD SOFTWARE OPTIONS [Y OR N] ? <Y>		Press Return.
PART 6: ASSIGN DEVICE NUMBERS		
PART 7: SOFTWARE OPTIONS		
SEQUENTIAL DISK PROCESSOR support:	Included	
JOURNAL support: With 2 buffers	Included	
SPOOLING support:	Not Included	
INTERJOB COMMUNICATIONS support: With 16 communication channels and a 64 byte default ring buffer size	Included	
EBCDIC-ASCII TRANSLATION TABLES support:	Included	
LOADABLE or USER DRIVER SPACE support:	Not Included	
EXECUTIVE DEBUGGING TOOL support:	Not Included	
MAPPED ROUTINES support:	Not Included	
UCI TRANSLATION TABLES support:	Included	
MOUNTABLE DATABASE VOLUME SETS support:	Included	
Total System Exec size:	65.71 K Bytes	

System Prompts: Your Actions:

PART 8: MEMORY BUFFER ALLOCATION

Default terminal RING BUFFER size: 64 Bytes

Total space allocated to RING BUFFERS: 9344 Bytes

Total number of 1 K byte DISK-TAPE cache buffers: 377

PART 9: SYSTEM DATA STRUCTURES

Space allocated for DISK-MAP and BAD BLOCK TABLE: 256 Bytes
Space allocated to UCI TRANSLATION TABLE: 1024 Bytes

Space allocated to the LOCK TABLE: 512 Bytes

Number of mountable DATABASE VOLUME SETS: 3

PART 10: JOB PARTITION DEFINITION

PARTITIONs are allocated in 1024 byte increments.

The following PARTITIONs have been defined:

JOURNAL system job	1 KB
GARBAGE COLLECTOR system job	1 KB
Job #1 (to guarantee one 8 K byte PARTITION)	8 KB

Default partition size: 8 K Bytes

Space remaining for PARTITION allocation: 1580.00 K Bytes

The remainder of memory is assigned to the DYNAMIC PARTITION POOL

PART 11: DATABASE PARAMETERS

WRITE CHECK after WRITE on disks: Not Included

System default global characteristics are:

8 Bit Subscripts:	Yes
Journaling:	No
Collating sequence:	Numeric

System Prompts:	Your Actions:
PART 12: BASIC SYSTEM PARAMETERS	
Default UDA disks that are dual-ported: NONE	
View buffer device protection: Included	
ZUSE command protection: Included	
LOGIN SEQUENCE CHARACTERS: echoed	
Default APPLICATION INTERRUPT key: 3 (CTRL/C)	
Default PROGRAMMER ABORT key: 25 (CTRL/Y)	
Time delay for POWER FAIL RESTART: 40 seconds	
Time delay for TELEPHONE DISCONNECT: 15 seconds	
Number of significant DIGITS for DIVISION: 12	

Note: Before responding to the next question, if you are installing overseas, check with the System Manager to determine the line frequency for the country. Enter N if it is different from 60 HZ, and press Return to accept the new frequency. After you load the AQCESS software, do a SYSGEN (D SYSGEN) and reboot the system. Do NOT use system shutdown. Default through all responses except 12.9 (line frequency) to repeat the response shown here.

System Prompts:	Your Actions:
12.9 Is the LINE FREQUENCY 60 HZ [Y OR N] ? <Y>	Press Return.
12.10 Enter the 3-character Programmer Access Code (PAC) >	**(CTRL)XXX**
Please enter your initials >	Type in a 3-character initial.
Enter comment (max. 200 chars.) >	Type in site name.
The system global SYS has been built by SYSGEN. SYS is a reserved global and should not be altered.	

System Prompts:	Your Actions:
If you wish to customize your new configuration by modifying:	
- Terminal speed settings or other parameters - Magnetic tape default format - UCI's or database VOLUME SETS - TIED TERMINAL table - Default GLOBAL CHARACTERISTICS/PLACEMENT - Routine maps	
then login to the manager's UCI and type "D ^SYSDEF"	
You do not have a startup command file, Do you wish to remain in baseline mode ? <N>	Press Return.
Begin defining a new startup command file.	
Configuration ? <1>	Press Return.
Apply patches to memory [Y OR N] ? <N>	Press Return.
Start up the Journal [Y OR N] ? <N>	Press Return.
Enable the Spool device (device #2) [Y OR N] ? <N>	Press Return.
Start the Caretaker background job [Y OR N] ? <Y>	Press Return.
Enter the Printer Number for system error messages <1>	Press Return.
Automatic logging of DSM errors [Y OR N] ? <N>	Press Return.
Mount additional disk volumes [Y OR N] ? <N>	Press Return.
Make this the new startup file for configuration 1 [Y OR N] ? <Y>	Press Return.
Re-configuring memory... Memory re-configured	
Mounting SYS as Volume Set number SO Volume 1 on DUØ has 118400 blocks 116937 available. Total in volume set: 118400 blocks 116937 available.	
Building terminal control blocks...	
Caretaker is now running as job number 2.	
DSM-11 Version 3.ØA 1 is now up and running! Exit	Press Return.

Next, do a broadcast message to each terminal to verify line continuity and communications settings.

System Prompts:	Your Actions:
DSM-11 Version 3.ØA Device #1 UCI:	**MGR:(CTRL)XXX**
>	**D^BCS**
Enter message >	Enter **TEST PORT 64** Press Return.
Output to terminal(s) ? >	Enter **64** as a corresponding device number. Press Return.
Output to terminal(s) ? >	Press Return.
Enter Message >	

Repeat this process for all the ports. After all the ports numbers have been *entered, leave the "Enter message >" blank and press Return to display the* prompt(>).

3.2 VERIFY AND DOCUMENT DEVICE NUMBERS AND CORRESPONDING LINE NUMBERS

STEP 5. IDENTIFY TERMINAL NUMBERS WITH PORT/LINE CONFIGURATION ON CPU BOARD.

Note: Connect lines to the terminals left unconnected by the DEC Field Service Engineer.

Use the Initial Port/Line Verification chart to identify all the terminals corresponding to the CPU port/line configuration.

At each CRT, press Return to display the UCI prompt and device number. At each printer, look to see the device number that was broadcast.

Match the line of the terminal with the corresponding device number.

Use the Initial Port/Line Verification chart to complete the Device Schematic in the Port Configuration form in your System Management Handout Packet.

Note: It is important to complete this step before continuing to load the AQCESS software.

STEP 6. SHUTDOWN THE SYSTEM.

System Prompts:	Your Actions:
	D ^SSD
>	
...Caretaker stopped.	
NO JOBS ARE CURRENTLY LOGGED IN. LOGINS ARE NOW DISABLED.	
1. Display Logged-In Jobs 2. Perform Timed Shutdown 3. Terminate All Jobs, Perform Immediate Shutdowr.	
ENTER OPTION >	3
READY TO HALT	
Exit	

STEP 7. BOOT THE SYSTEM.

Boot the system. Halt the system by pressing the switch to HALT position and replace it to the center position (RUN). Lift the switch to RESTART position and the switch springs back to the center position (RUN).

System Prompts:	Your Actions:
Ø3662Ø @	(This number may vary.)
Testing in progress - Please wait Memory Size is 2Ø48 K Bytes 9 Step memory test Step 1 2 3 4 5 6 7 8 9 Starting automatic boot	
Starting system from DUØ	
Booting DSM-11...	
DSM-11 Version 3.ØA Now running the baseline system.	
Please enter today's date <25-OCT-85>	If the default is actually today's date, press Return. If not, enter today's date.
Is today Friday ? <Y>	Press Return.
Please enter time [HH:MM:SS] >	Enter the current time.
Is this 11:15 AM in the Morning ? <Y>	Press Return.

IMPORTANT (READ CAREFULLY): Press Return after answering N below, and then, as the box shows, immediately hold down the CTRL key and type TNB. Do not press Return after that. You only have 10 seconds to do this.

System Prompts:	Your Actions:
Start up the default system (1) [Y/N] ? <Y>	**N** Press Return.
	(CTRL)TNB
Remain in baseline mode [Y/N] ? <N>	**Y** Press Return.

STEP 8. RESTORE THE DRIVE.

System Prompts:	Your Actions:
>	D ^REST
Which drive will contain the disk to be restored *to* ? >	DUØ
What will this disk's Master Label be ? >	"MASTER Ø"
Will you be restoring this disk from another disk, or from magtape [D or M] ? <D>	M
Which Magtape Unit (Ø, 1, 2, or 3) ? >	Ø
Please mount the Backup tape to be restored *from*, on Magtape Unit# Ø then type <CR> >	Press Return.
Please mount the Master disk to be restored *TO*, label = "MASTER Ø" in drive DUØ, *WRITE-ENABLED* THEN TYPE <CR>	Press Return.
** 18:36:43 BEGIN RESTORE	

Note that it takes approximately 11 minutes to load this tape.

System Prompts:	Your Actions:
** 18:47:32 RESTORE COMPLETE	
Please re-mount the original system disk: "MASTER Ø" in drive DUØ *WRITE-ENABLED* THEN TYPE <CR>	Press Return.

Do not remove the tape.

The system will automatically rewind the tape; when tape is rewound the system will display a (>) prompt.

STEP 9. REBOOT THE SYSTEM.

Do NOT use the shutdown command. Simply halt the system by pressing the switch to HALT position and replace it to the upper position (RUN). Lift the switch to RESTART position and the switch springs back to the center position (RUN).

System Prompts:	Your Actions:
	(This number may vary.)
Ø3662Ø @	
Testing in progress - Please wait Memory Size is 2Ø48 K Bytes 9 Step memory test Step 1 2 3 4 5 6 7 8 9 Starting automatic boot	
Starting system from DUØ	
Booting DSM-11...	
DSM-11 Version 3.ØA Now running the baseline system.	
Please enter today's date <14-DEC-85>	If the default is actually today's date, press Return. If not, enter today's date.
Is today Friday ? <Y>	Press Return.
Please enter time [HH:MM:SS] >	Enter the current time.
Is this 1:ØØ PM in the Afternoon ? <Y>	Press Return.
Start up the default system (1) [Y/N] ? <Y>	Press Return.
Re-configuring memory... Memory re-configured	

System Prompts: Your Actions:

```
Mounting SYS as Volume Set number SØ
Volume 1 on DUØ has    118400 blocks  41375  available.
Total in volume set:   118400 blocks  41375  available.

Building terminal control blocks...

Caretaker is now running as job number 2.

Loading Mapped Routine set:  AQCESS

 AT         AT12      ATAP      ATC...
 ATFIL2     ATFILE    ATLOAD    ATLS...
 DS         P1        P1Ø       P13Ø...
 P182       P182A     P183      P183A...
 P186       P186A     P186B     P186C...
 P19ØB      P191      P193      P194...
 P197       P198      P198A     P199...
 P5ØB       P7        P8        P8A...
 PTESLK     PTLCK     PTLKP     PTSEL...
 RGC2       RGFILE    RGFMP     RGLOAD...
 SMMELP     SMRED     SO...

 17Ø688 Bytes used for Routine Set AQCESS
 5248 Bytes remain in Mapped Routine Space


 DSM-11 Version 3.ØA 1 is now up and running!
 Exit
```

The system now contains DSM-11 and the current version of AQCESS software. Remove the Backup Tape (DUØ) from the tape drive.

3.4 INSTALL SITE-SPECIFIC TABLES

STEP 10. CUSTOMIZE DIRECTORY FOR SERVICE.

Log on to the live database by typing what is shown on the first line under "Your Actions" below.

System Prompts:	Your Actions:
DSM-11 Version 3.ØA Device #1 UCI:	**AQC:(CTRL)XXX**
>	**D ^INSTALL**
SET UP FOR WHICH SERVICE? >	Enter the code for the site's service, e.g., **A** = Army, **N** = Navy, or **F** = Air Force.
REBUILDING SERVICE SPECIFIC TABLES...	

The cursor will hang until the table rebuilding process is completed. This process will take about 3 minutes.

System Prompts:	Your Actions:
STATE:	Enter the code for the MTF's state. If installing overseas, press Return when the system prompts for "STATE:" and the system will skip to "DELETE UNNECESSARY FILES?"
FACILITY: GROW MED CEN ANDREWS AFB KIMBROUGH AH FT. MEADE NAVHOSP BETHESDA NAVHOSP PATUXENT RIVER USTF BALTIMORE	**?**
FACILITY:	Enter the name of the MTF.
DELETE UNNECESSARY FILES?	**Y**
>	**H Press Return**
EXIT	Press Return

Log on to the Training database by typing what appears on the first line under "Your Actions" below.

System Prompts:	Your Actions:
DSM-11 Version 3.ØA Device #1 UCI:	**TRN:(CTRL)XXX**
>	**D ^INSTALL**
SET UP FOR WHICH SERVICE? >	Enter the code for the site's service, e.g., **A** = Army, **N** = Navy, or **F** = Air Force.
REBUILDING SERVICE SPECIFIC TABLES...	

The cursor will hang until the table rebuilding process is completed. This process will take about 15 minutes.

System Prompts:	Your Actions:
STATE:	Enter the code for the MTF's state. If installing overseas, press Return when the system prompts for "STATE:" and the system will skip to "DELETE UNNCESSARY FILES?"
FACILITY: GROW MED CEN ANDREWS AFB KIMBROUGH AH FT. MEADE NAVHOSP BETHESDA NAVHOSP PATUXENT RIVER USTF BALTIMORE	?
FACILITY:	Enter the name of the MTF.
DELETE UNNECESSARY FILES?	**Y**
>	**H** Press Return
EXIT	Press Return

Mount the System Manager Restore tape onto the TU8Ø Tape Drive. When it has rewound, press the online light.

3.5 LOAD THE SYSTEM MANAGER USER ID PROGRAM, AND RESTORE THE SYSTEM MANAGER USER ID/PASSWORD.

STEP 11. ESTABLISH THE SYSTEM MANAGER USER ID/PASSWORD.

Log onto the Manager database by typing what appears on the first line under "Your Actions" below.

System Prompts:	Your Actions:
DMS-11 Version 3.ØA Device #1 UCI:	**MGR:(CTRL)XXX**
>	**D ^MENU**
USER ID	Press Return.
PASSWORD	Press Return.
TYPE A '?' FOR OPTIONS	
OPTION:	**?**
U UPDATE OR VIEW SOFTWARE	
R RESTORE SYSTEM MANAGER	
OPTION:	**U**
8-Oct-85 9:45	
TYPE A '?' FOR UPDATE OPTIONS	
UPDATE OPTION:	**?**
R ROUTINE LOAD	
UPDATE OPTION:	**R**
TRAINING, LIVE OR MANAGER:	**L**
Routine Restore	
Input Device ? >	**47**
Magtape Mode ? <D>	Press Return.
Block size ? <1Ø24>	Press Return.
Routines were saved on 11-Sept-85 1Ø:49	
Header: SYSTEM MANAGER RESTORE VERSION 1.Ø4	
Restore all (A) or Selected (S) ? <A>	Press Return.
SMRC	
Input Device ? >	Press Return.
Exit	

This process loads the System Manager Restore program onto the live database.

Log on to the Manager database by typing what appears on the first line under "Your Actions" below.

System Prompts:	Your Actions:
DSM-11 Version 3.ØA Device #1 UCI:	**MGR:(CTRL)XXX**
>	**D ^MENU**
USER ID	Press Return.
PASSWORD	Press Return.
TYPE A '?' FOR OPTIONS	
OPTION:	?
U UPDATE OR VIEW SOFTWARE	
R RESTORE SYSTEM MANAGER	
OPTION:	**R**
TERMINAL NUMBER:	Enter the number of the terminal you want to restore SM capabilities to.
USER ID:	**NDC**
PASSWORD:	**LIVE**
Exit	

This process restores the System Manager User ID/Password by specifying the number of the terminal to be used to set up terminal capabilities.

3.6 CONSOLE DEVICE SET-UP

STEP 12. DISABLE THE CONSOLE BREAK KEY.

Make sure the console is idle before starting this process. At the console while holding down the CTRL key press SET-UP key. Simultaneously, (Set-up light blinks). Press the numberic key 8 (status).

```
 System Prompts:                                    Your Actions:
LA1ØØ V1.3 KSR
Ø.4K Buffer
DPS: ØØ5...ØØ9.....

***Keyboard Settings:

E-Local echo:Disabled
K-Keyboard:United States
L-Return key:<CR>
Q-Keyclick:Disabled
U-Break Key:Enabled
Y-Keypad mode:numeric

***Printer Settings:

B-Pitch Mode:All Pitches
C-GØ Character set:United States
D-G1 Character set:United States
  G2 Character set:United States
  G3 Character set:United States
F-Form Length:264
H-Horiz pitch (cpi):1Ø
J-End of line control:wrap mode
V-Vert pitch (lpi):6
W-NewLine request char.:none

***Communication Settings:

A-Auto-answerback:Disabled
N-Disconnect on EOT:Disabled
O-Paper fault processing:XOFF (if enabled)
P-Parity:7/S
R-Receiver error:Print error block
S-Speed (bps):12ØØ
X-Auto XON/XOFF:Enabled
Z-Modem Control:No Modem Control-Restraint Mode
                                                        U
U-Break Key
A:Disabled
B:Enabled
U=B
```

System Prompts:	Your Actions:
	U = A Press Return

This process displays the status and changes of the Break key menu.

System Prompts:	Your Actions:
	Hold down the **SHIFT** key simultaneously press numeric 9 (Store) key. The Set-up light stalls for few seconds and starts blinking when storing is completed.
U-Break Key A:Disabled B:Enabled U = A	**U** Press Return

This process displays the Break key menu to verify the change made to disabled. Press the Set-up function key to get out of the set-up mode.

3.7 COMPLETE THE INSTALLATION PART OF THE IMPLEMENTATION CHECKLIST

STEP 13. LOAD THE TRAINING DATABASE.

If you have to update the AQCESS software after installing it, it is important to load the Training Database before doing the update.

Log on to the Manager database by typing what appears on the first line under "Your Actions" below.

System Prompts:	Your Actions:
DSM-11 Version 3.ØA Device #1 UCI:	**MGR:(CTRL)XXX**
>	**D ^MENU**
USER ID	**NDC**
PASSWORD	**LIVE**
TYPE A '?' FOR OPTIONS	
OPTION:	**?**
S SYSTEM STATUS	
E ERRORS	
ED EDIT TERMINAL GLOBALS	
D DEVICE SETUP	
I INTEGRITY	
SA SAVE TRAINING DATABASE	
L LOAD TRAINING DATABASE	
B BROADCAST	
BA BACKUP SYSTEM	
C CLINICAL RECORDS BATCH PROCESSING	
T TALLY DISK BLOCKS	
CA CARETAKER UTILITIES	
DA DATE UPDATE	
TI TIME UPDATE	
SH SHUTDOWN SYSTEM	
U UPDATE OR VIEW SOFTWARE	
R RESTORE SYSTEM MANAGER	
OPTION:	**L**
LOAD TAPE TRAINING BACKUP 9/11/85 ? >	**Y**

This Training Database can be reloaded at any time to train new users.

You can also add to the database by entering more data and then backing it up onto another cassette.

STEP 14. SET UP USER IDS AND PASSWORDS FOR TRAINING.

Log on to the System Manager Terminal using the User ID/Password established in the Restore process (NDC/LIVE) to set up a User ID/Password for you and other NDC personnel to use on-site. See the chart below for the User IDs and Passwords that you should set up.

Date Last Changed	User ID Name	Password	Capabilities	Flags Train	Tutor	CR	SM	Initials
Today's Date	ADTRN A&D Clerk	ME	RADTIH1B	Y				NDC
Today's Date	CRTRN CR Clerk	ME	C2IH	Y				NDC
Today's Date	QATRN QA Coordinator	ME	QPIH2	Y				NDC
Today's Date	ADSUP A&D Supervisor	ME	RADTICHBE1	Y				NDC
Today's Date	CRSUP CR Supervisor	ME	CI2H1	Y		Y		NDC
Today's Date	SYS NDC Installer/ Trainer	ME	RADTH1PQCSEBI2	Y		Y	Y	NDC
Today's Date	TUTOR	ME		Y	Y			

STEP 15. SET UP TERMINAL CAPABILITIES.

Log off the System Manager terminal and sign on using the training User ID and Password SYS/ME.

Give all capabilities to all terminals in Training Database only.

Verify Training User IDs as follows:

User ID	Password
ADTRN	ME
CRTRN	ME
QATRN	ME
ADSUP	ME
CRSUP	ME
SYS	ME
TUTOR	ME

STEP 16. SET UP THE PRODUCT DEVICE TABLE IN TRAINING.

Use the worksheet.

Product	Description	Device
A&D		
A&D1	A&D Reports - plain paper	A&D printer
ATCOVER	A&D Cover Sheet - form	A&D printer
ATCRD	A&D Paper Cards (3x5 or 5x8) - cards	A&D printer
ATNIR (Navy only)	Navy Admission Form - form	A&D printer
CR		
CR1	CR Record Report - plain paper	CR printer
CRCES	Coded Episode Summary - plain paper	CR printer
CRDFT	Draft Cover Sheet - plain paper	CR printer
CRFIN	Final Cover Sheet - plain paper or form	CR printer
QA		
QA1	QA reports - plain paper	QA printer
CONSOLE		
RGFORM	Registration Form - form	Console
SYTLS	System Management Table Lists	Console
CONSOLE	Console Generated Logs	Console

Verify that printers are set up and working correctly in the training database ONLY. Do this using the following steps:

- Send the Admission Cover Sheet form to the device set up to print this form.
- Select patient (Lannon) with registration number 25 and process through disposition to generate a Clinical Record report on this patient and route it to the CR printer.
- Select Dr. Robins as a provider and send a QA report to the QA printer.

STEP 17. MISCELLANEOUS CHECKING.

Now check the following:

1. All terminals should be tied to AQCESS. To do this, type D ^MUX while at the > prompt in the MGR account. Change the RTN NUM to 2 for each terminal.

   Do not tie the console until you are ready to leave the site. When you do tie the console, enter 1 for RTN NUM for Device #1, and enter 2 for RTN NUM for Device #3.

2. Check the printer baud rate. To do this, at every printer, simply press the online and self-test buttons down at the same time. Check the speed (bps). If not 12ØØ, then the DIP switches must be reset inside the printer, under the ribbon cartridge. See the Letterwriter 100 manual, which is at the site.

3. Check the clinical service code AAE (for Air Force and Navy) or AAEA (for Army) to see whether a delete date was incorrectly entered for it. Do this by logging on to AQCESS using the User ID/Password SYS/ME. Then access the System Management process, Table Maintenance function. Select Table 2ØØ5 to change, and enter AAE if you are at an Air Force or Navy site; enter AAEA if you are at an Army site. If the screen shows that there is a delete date for this clinical service code, erase that date using the CLEAR DATA key.

4. Verify that all devices are set up to be VT22Øs. Do this by logging on the operator's menu and selecting option ED (EDIT TERMINAL GLOBALS). Enter 2 (TERMINAL PORTS). Enter each of the port numbers to see if it is a VT22Ø; if it is not, change to VT22Ø.

5. Make sure the software version displayed on the screen reflects the current version.

Note: It is important for the System Manager to run the Daily/ Weekly/Monthly reports (see the System Management Training Aid).

The system-generated Integrity Reports, Error Lists, and Disk Block Tallies should be mailed to:

NDC-FSI
Customer Support
1300 Piccard Drive, Suite 101
Rockville, MD 20850
Attn.: Dean Smith

SYSTEM NUMBER _____ PAGE _____

SITE NAME _____

INSTALLER _____

DATE _____

INITIAL PORT/LINE VERFICATION CHART

PORT #								
LINE #								
LOCATION								

NOTE: This chart is intended to assist in identifying the Initial Port/Line Configuration relative to the correct terminal location. Use this chart to complete the Port Configuration form in your System Management Handout Packet. The Port Configuration form should be returned to NDC along with the training evaluations and installation audit checklist.

AQCESS SYSTEM SPECIFICATION: PATIENT ADMINISTRATION SUBSYSTEMS



TRIMIS Program Office
5401 Westbard Avenue
Bethesda, Maryland 20816

CONTRACT NO:
MDA 903-85-C-0107

March 29, 1985



NDC Federal Systems, Inc.
1300 Piccard Drive
Rockville, Maryland 20850

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PART I - GENERAL

SECTION 1. GENERAL

1.1 Purpose. This System Specification (SS) for the Automated Quality of Care Evaluation Support System (AQCESS) is written to:

a. Provide a detailed definition of the system functions.

b. Communicate details of the ongoing analysis between the user's operational personnel and the appropriate development personnel.

c. Define in detail the interfaces with other systems and subsystems.

1.2 Project References. The TRIMIS Program was formally created on July 11, 1974, by the Department of Defense Assistant Secretaries of Defense (Comptroller, and Health and Environment). The program is now managed and administered by the TRIMIS Program Office (TPO) of the Office of the Assistant Secretary of Defense (Health Affairs) [OASD(HA)]. Its purpose is to consolidate previous Service efforts and to "improve the effectiveness and economy of health care delivery in the Army, Navy, and Air Force." As this original tasking assignment stated, "TRIMIS will include development of automated information systems for timely patient-centered health data, supporting medical services, clinical research, epidemiological, and health care information."

The TPO has developed a microcomputer-based Clinical Records and Patient Administration System using the MUMPS language and certain utilities from the Veterans Administration File Manager. The system has had extensive Tri-Service input and is designed for efficient use by current patient administration personnel, and incorporates extensive service-specific edits of data to ensure reliable and accurate data collection. The system is designed to be easy to learn, provides on-line assistance to users, and can operate without dedicated computer operators and special environmental conditions. Being written in ANSI MUMPS, it can operate on a wide variety of hardware and is capable of modification to correct problems and incorporate additional requirements. Development of this system was suspended following redirection of the TRIMIS program in March 1984. The Automated Quality of Care Evaluation Support System (AQCESS) will be developed from the existing PAD software. The software will be completed to include Military Department Clinical Records and QA requirements.

The overall objectives of the AQCESS are to:

a. Improve the quality and timeliness of the evaluation of health care.

b. Provide administrative support for inpatient episodes.

c. Support the identification of variations which would adversely affect the quality of health care.

The following references relate to the history of the TRIMIS Program and the development of the AQCESS.

a. DoD Standard 7935, Automated Data Systems (ADS) Documentation, February 15, 1983.

b. Functional Description for an Automated Quality of Care Evaluation Support System (AQCESS); TRIMIS Program Office (TPO); January 25, 1985.

c. MUMPS Patient Administration System Program Maintenance Manual (Draft); National Data Corporation/Federal Systems, Inc. (NDC/FSI); April 6, 1984.

d. MUMPS Patient Administration User Handbook (Draft); NDC/FSI; April 6, 1984.

e. Functional Description for Tri-Service Patient Administration System (Army Version); TPO; June 9, 1983.

f. Functional Description for Tri-Service Patient Administration System (Navy Version); Libra Technology; September 30, 1983.

g. Functional Description for Tri-Service Patient Administration System (Air Force Version); TPO; June 30, 1983.

h. Functional Description for CHCS Patient Administration (PAD) (Version 2.0); NDC/FSI; February 17, 1984.

i. NAVMEDCOM 6320.7; Quality Assurance Guide (Draft); September 1984.

j. NAVMEDCOM 6320.8; Credentialing Program (Draft); September 1984.

k. AR 40-66, (Change 2) Chapter 9; Medical Recorded Quality Assurance Administration; December 1, 1982.

l. AFR 168-13; Quality Assurance in the Air Force Medical Service; May 31, 1984.

m. AFR 168-4; Administration of Medical Activities; July 22, 1983.

n. AFR 168-695; Medical Administrative Management System (Vols. I & II), July 18, 1980.

o. AFR 205-16; Automatic Data Processing (ADP) Security Policy, Procedures, and Responsibilities; August 1, 1984.

p. DoDD 5200.28; Security Requirements for Automatic Data Processing (ADP) Systems; December 18, 1972.

q. DoDD 5200.28-M; ADP Security Manual; January 1973.

r. AR 380-380; Automated Systems Security; April 15, 1979.

s. AFR 300-13 (as amended); Safeguarding Personal Data in Automatic Data Processing Systems; March 14, 1976.

t. AFR 125-37; The Resources Protection Program [PA; May 6, 1982 (and change 1)].

1.3 Terms and Abbreviations.

A&D	Admissions and Dispositions
ACLS	Advanced Cardiac Life Support
ADP	Automatic Data Processing
ADT	Admission, Disposition, and Transfer
AMA	Against Medical Advice
AQCESS	Automated Quality of Care Evaluation Support System
ASMRO	Armed Services Medical Regulating Office
ATLS	Advanced Trauma Life Support
CHCS	Composite Health Care System
CPP	Credentialing/Privileges Process
CPU	Central Processing Unit
CR	Clinical Records (Inpatient Records)
CRID	Clinical Records Identification (Inpatient Record Identification)
CRT	Cathode Ray Tube
CT	Coding Transcript
CTT	Coding Transcript Tape
DEERS	Defense Enrollment Eligibility Reporting System
DoD	Department of Defense
ER	Emergency Room
ES	Emergency Service
FD	Functional Description
FMP	Family Member Prefix
ICD	International Classification of Diseases
ICP	International Classification of Procedures
ID	Identification
IR	Inpatient Records (Clinical Records)
IRID	Inpatient Records Identification (Clinical Records Identification)
ITRCS	Inpatient Treatment Record Cover Sheet
JAG	Judge Advocate General
JCAH	Joint Committee for Accreditation of Hospitals
MEB	Medical Evaluation Board
MTF	Medical Treatment Facility
MTRC	Medical Treatment Recording Card
MUMPS	Massachusetts Utility Multi Programming System
NDC/FSI	National Data Corporation/Federal Systems, Inc.
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
PAD	Patient Administration

PTID	Patient Identification
QA	Quality Assurance
QAC	Quality Assurance Coordinator
QAP	Quality Assurance Program
QAS	Quality Assurance System (Navy Use Only)
R/ADT	Registration/Admission, Disposition, and Transfer
RIPT	Record of Inpatient Treatment
SSN	Social Security Number
TPO	TRIMIS Program Office
TRIMIS	Tri-Service Medical Information Systems
TRIPAD	Tri-Service Patient Administration System
UCA	Uniform Chart of Accounts
VSI/SI/SC	Very Seriously Ill/Seriously Ill/Special Category

SECTION 2. SUMMARY OF REQUIREMENTS

2.1 System Description. The Automated Quality of Care Evaluation Support System is an interactive, terminal-oriented, on-line computer system designed to manage patient administration and quality of care information at MTFs.

AQCESS consists of several subsystems. This System Specification describes the patient administration subsystems: Access Control, R/ADT, and Clinical Records. The Quality Assurance subsystem is described in the Quality Assurance Subsystem Specification under separate cover.

The patient administration subsystems will collect registration data about military personnel, their eligible dependents, and other eligible beneficiaries admitted to the MTF. They also collect admission, disposition, and transfer data necessary to administer the MTF's inpatient population.

Each AQCESS subsystem consists of one or more processes. The following chart lists the subsystems of the entire Automated Quality of Care Evaluation Support System, and the processes that make up each subsystem.

Access Control Subsystem

- User Entry
- Patient Identification (PTID)

Quality Assurance Subsystem

- Quality Assurance
- Profiling

R/ADT Subsystem

- Registration
- Admission
- Transfer
- Disposition
- Correction Management
- Bed Management
- System Management
- Inpatient History
- Patient Inquiry
- R/ADT Reports

Clinical Records Subsystem

- Clinical Records
- Clinical Records Reports

This section summarizes the capabilities of the Access Control, R/ADT, and Clinical Records subsystems.

2.1.1 Access Control Subsystem.

2.1.1.1 User Entry. User Entry protects the system and its data from unauthorized users and restricts users to those processes they are authorized to perform. Specifically, User Entry:

a. Receives and verifies the user ID and password.

b. Controls which processes can be performed at each terminal.

c. Allows a user access to authorized processes only.

2.1.1.2 Patient Identification (PTID). AQCESS uses six items of information to identify each patient: register number, patient name, family member prefix, date of birth, sponsor's Social Security number, and sex. In PTID, users enter all of this data except register number to begin processing on new patients and to check their eligibility for care. Users can also conduct various searches to locate existing patient records by entering any of several combinations of the PTID data. Existing patient records must be located via the PTID process before those records can be processed in any of the patient-oriented functions (Registration, Admission, Disposition, Transfer, and Inpatient History).

2.1.2 R/ADT Subsystem.

2.1.2.1 Registration. The user registers individuals as patients by entering demographic data on them and their sponsors via the Registration process. Specifically, Registration:

a. Collects, edits, and validates registration data, including:

   1. patient's race, marital status, address, religion, and military ID card expiration date.

   2. rank, branch of service, and flying status of patient or patient's sponsor.

   3. patient's military occupation and unit ID, if active duty.

b. Automatically retrieves patient address data if any other family member's record is on file.

c. Allows the user to update registration information.

d. Indicates whether registration data has been reviewed and verified as correct by the patient or patient's agent.

e. Is used to print Registration Forms, which contain registration data on the patient.

f. Displays data on the patient's most recent previous inpatient episode.

2.1.2.2 Admission. The user enters information about the inpatient episode via the Admission process in order to admit persons to the MTF as inpatients. Specifically, Admission:

a. Ensures that inpatients are registered before admission proceeds.

b. Collects, edits, and validates admission information, such as:

1. date, time, and source of admission; admitting physician; and admitting diagnosis.

2. length of service, if active duty.

3. ward, physician, and clinical service assignments.

c. Collects, edits, and validates information on active-duty military who have Medical Evaluation Board (MEB) status, casualty status, or absent status.

d. Automatically generates a register number that identifies the patient's record if the MTF has chosen to have register numbers assigned by the system. (Through the System Management process, the MTF can choose to have register numbers assigned automatically or by the user; see section 2.1.2.7, below.)

e. Allows potential inpatients to be pre-admitted.

f. Is used to produce Admission Forms, Index Cards, and inpatient embossed cards, which contain admission information.

g. Allows users to admit newborns, by automatically retrieving applicable data from the mother's record, and forces the user to either disposition the newborn or change its status when the mother is put on convalescent leave.

h. Enables users to track patients who are the administrative responsibility of the MTF.

i. Allows users to cancel admissions or convert admissions to pre-admissions.

j. Allows user to enter projected disposition data.

2.1.2.3 Transfer. The Transfer process enables the user to update administrative data when an inpatient's ward, clinical service, or physician assignment is changed. This process also allows users to update data on the patient's emergency contact, MEB status, casualty status, and absent status, to view other admission data, and to request printing of inpatient products.

2.1.2.4 Disposition. Through the Disposition process, the user enters data about the patient's discharge from the MTF and begins final processing of records on the inpatient episode. Specifically, Disposition:

a. Collects, edits, and validates disposition data, such as date and type of disposition and physician ordering the disposition.

b. Removes the patient from active ward and clinical service records, which are used in system reports.

c. Allows users to cancel dispositions.

d. Allows users to either disposition newborns at the time of the mother's disposition, or to track them as pay patients.

e. Allows users to view admission data and request inpatient products.

2.1.2.5 Correction Management. Correction Management is used to correct data that cannot be corrected through the other AQCESS processes. Through this process, users can:

a. Correct the following data as it appears on the patient record: patient category, length of service, source of admission, date and time of admission, date and time of disposition, disposition type, absent statuses, clinical services, and inter-ward transfers.

b. Add appropriate absent status, clinical service, and inter-ward transfer data omitted from a patient's record during admission.

c. Add remarks to the Admission and Disposition (A&D) Report (1) to alert others that erroneous data was included on previous A&D Reports and (2) to explain changes or additions described in a and b.

2.1.2.6 Bed Management. This process maintains statistics on the numbers of beds that are occupied or available on each ward and enables users to monitor ward statuses in the MTF. Specifically, Bed Management:

a. Adjusts and computes bed availability figures for each ward.

b. Allows users to create new Ward Status records and to delete existing Ward Status records (except when there are occupied or reserved beds on the ward to be deleted).

c. Displays total figures on bed availability for the entire MTF.

d. Allows users to adjust the number of total beds and blocked beds on a ward.

2.1.2.7 System Management. The System Management process is used by the System Administrator to maintain data that regulates the operation of AQCESS. Specifically, this process allows the System Administrator to:

a. Maintain the list of all system tables, which can be displayed on a screen or printed in hard-copy form.

b. Maintain and update the system tables.

c. Maintain profile data that identifies the MTF, including its Military Department, and profile data that regulates certain system functions, such as dates for archiving files. The System Administrator also uses this process to indicate whether register numbers will be assigned automatically or manually, and to reserve or release blocks of register numbers for manual or automatic assignment to records.

d. Regulate system security by user ID and terminal ID, and to designate system capabilities authorized to individual users and terminals.

2.1.2.8 Inpatient History. Through this process, users can review information about inpatient episodes of active and dispositioned patients. Inpatient History keeps track of all inpatient episodes for an individual patient. It can display a list of episodes for a patient who has been admitted more than once, and allow users to choose an episode for review. Specifically, Inpatient History displays the following data on individual episodes:

a. Register numbers, admission dates, disposition dates, and admission diagnosis codes on patients with more than one inpatient episode.

b. PTID data, patient category, rank, branch of service, religion, source of admission, and admission date and time.

c. Disposition type, disposition date and time, clinical service, ward, type case, archive date, primary discharge diagnosis and principal procedure performed.

2.1.2.9 Patient Inquiry. This process identifies segments of the patient population according to categories specified by the MTF, and lists patients who fall into those categories. The MTF may specify categories such as ward, physician, diagnosis, etc. For example, through Patient Inquiry the user may view a list of all inpatients currently on a given ward.

2.1.2.10 R/ADT Reports. Through this function, users enter requests to print the reports listed below. These reports, which are generated from data entered via the R/ADT subsystem processes, are described in detail in Part III, Outputs.

a. Admission and Disposition Report.

b. Admission and Disposition Recapitulation and Patient Strength Report.

c. Alpha Roster of Hospital Patients.

d. Daily Admissions by Diagnosis.

e. Injury Report.

f. Invalid Sign-On Log.

g. List of Current Passwords.

h. Roster of VSI/SI/SC Patients.

i. Status Out Roster.

j. UCA Disposition Report.

k. UCA Inpatient Occupied Bed Days Report.

l. Ward Nursing Report.

2.1.3 Clinical Records Subsystem. Through Clinical Records, users perform the final processing on each inpatient episode and produce documentation on dispositioned patients for the patient chart as well as for reporting to higher commands. Specifically, Clinical Records:

a. Collects, edits, and validates data on each diagnosis made and each procedure (i.e., operation) performed during the hospital visit.

b. Collects and maintains data on previous inpatient episodes at other MTFs or civilian hospital from which the patient transferred to this MTF.

c. Computes and maintains data on the number of days a patient spent in various clinical services and absent statuses during this inpatient episode.

d. Allows the user to enter administrative data, and displays and collects codes for non-procedural physicians associated with this episode.

e. Tracks items missing from the record and posts them as delinquencies on the Provider Profile after a period of time (which is specified by the MTF).

f. Initiates final edits on the record and generates the Inpatient Treatment Record Cover Sheet (ITRCS) or Record of Inpatient Treatment (RIPT) and the Coded Episode Summary (CES).

g. Produces reports (printouts, report format tapes) including the coding transcript.

2.1.3.1 Clinical Records Reports. Through this process, users initiate month-end processing on records and enter requests to print the following Clinical Records reports, which are described in detail in Part III, Outputs.

a. Coded Transcript Tape.

b. Roster of Delinquent Records.

c. Roster of Records Currently Released to A&D.

2.2 System Functions.

2.2.1 Accuracy, Precision, and Validity. AQCESS ensures accuracy and validity of data by editing all input, update, and inquiry data from system users. Data transmitted between functions and/or logical segments of the system is subjected to the following error checks:

a. Validity edits - AQCESS performs alphanumeric and required field edits on input data. The system also ensures that coded, abbreviated, and other entry values for data items are acceptable, as defined in the MTF input/edit tables. AQCESS generates appropriate error messages for terminal display.

b. Consistency edits - AQCESS performs defined consistency edits against entered data before storing the data in a permanent file. The system notifies users of inconsistencies and allows rapid, easy correction of erroneous input.

Data transmitted between internal functions and interfacing systems is subject to error checks including:

a. Internal data element checking of telecommunications data.

b. Internal application checking and acknowledgment by the receiver of telecommunications data.

c. Integrity checking of the data base data before and after executing backup and failure recovery operations.

2.2.2 Timing. Fulfillment of the timing requirements set forth in sections 3.1.2 and 4.2.2 of the AQCESS Functional Description depends on the hardware used (reference 1.2.b). Further specification of the manner in which the AQCESS will meet these requirements awaits the award of the hardware contract.

2.3 Flexibility. Intersystem interfaces will be added to include specified automated PAD card embossers and ASMRO. Other system interfaces and requirements not heretofore stated will be processed as system change requests.

PART II - SCREENS

SECTION 3. USER ENTRY SCREENS

3.1 User Entry Function - Overview. User Entry controls system security. Users go through this function in order to access the system, and they return to it on completion of processing within a selected function.

The user identification (user ID) and password are entered via the User Entry function. The system checks whether that ID and password appear on a list of authorized users, and checks which terminal is being used. User Entry will lock a terminal and user ID if the ID or password is entered incorrectly more than the maximum number of times allowed by the MTF.

If the user ID and password are entered correctly, User Entry determines which functions the user is authorized to perform, and which functions can be performed at a given terminal. Based on these determinations, User Entry regulates access to the system's functions. User Entry indicates which functions are available to the user, and the user can select which type of processing he or she wants to perform.

User Entry consists of three screens: the Sign-On Screen, the Privacy Act Screen, and the User Entry Menu Screen.

3.1.1 Sign-On Screen (Figure 3-1). On this screen the user enters a user ID and password. The password does not appear on the screen as it is typed.

If the system finds the ID and password are not valid, it will display an error message. The user will be able to correct an ID and password that have been entered incorrectly. The user will not be able to use the system until he or she enters an ID and password that the system recognizes as valid. The number of attempts that the user can make to enter these correctly is limited. If the user exceeds this limit, the terminal and user ID will lock, and the system manager must be called to unlock it.

If the system finds that the user ID and password are valid, the user will be able to access the system's functions.

To emphasize the confidentiality of the AQCESS data, the next screen displays the Privacy Act statement, and the number of the Act (Figure 3-2). No data is entered on this screen.

Next, User Entry determines which functions are available to the user at that particular terminal and displays the User Entry Menu Screen.

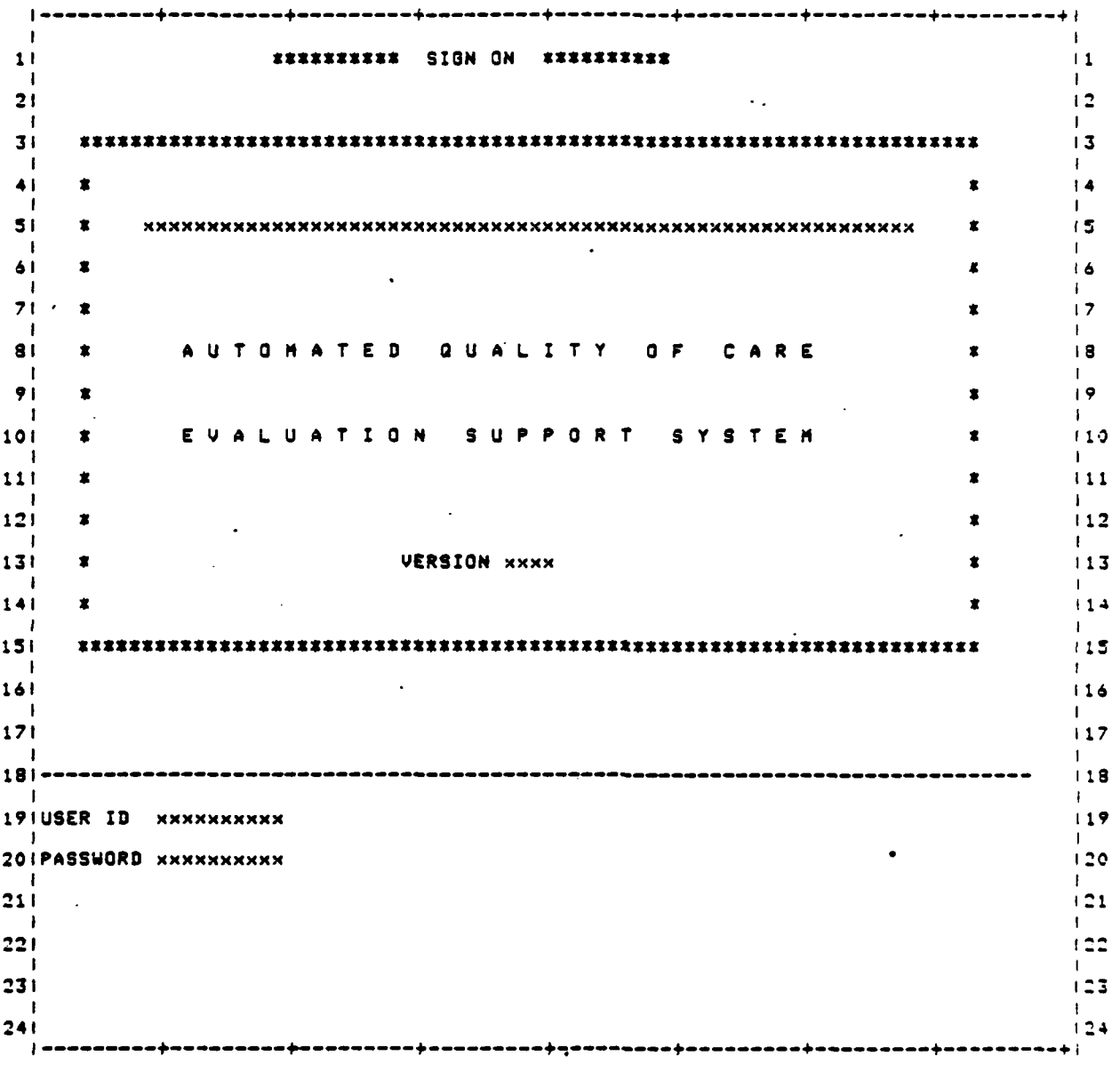


Figure 3-1. SIGN-ON SCREEN

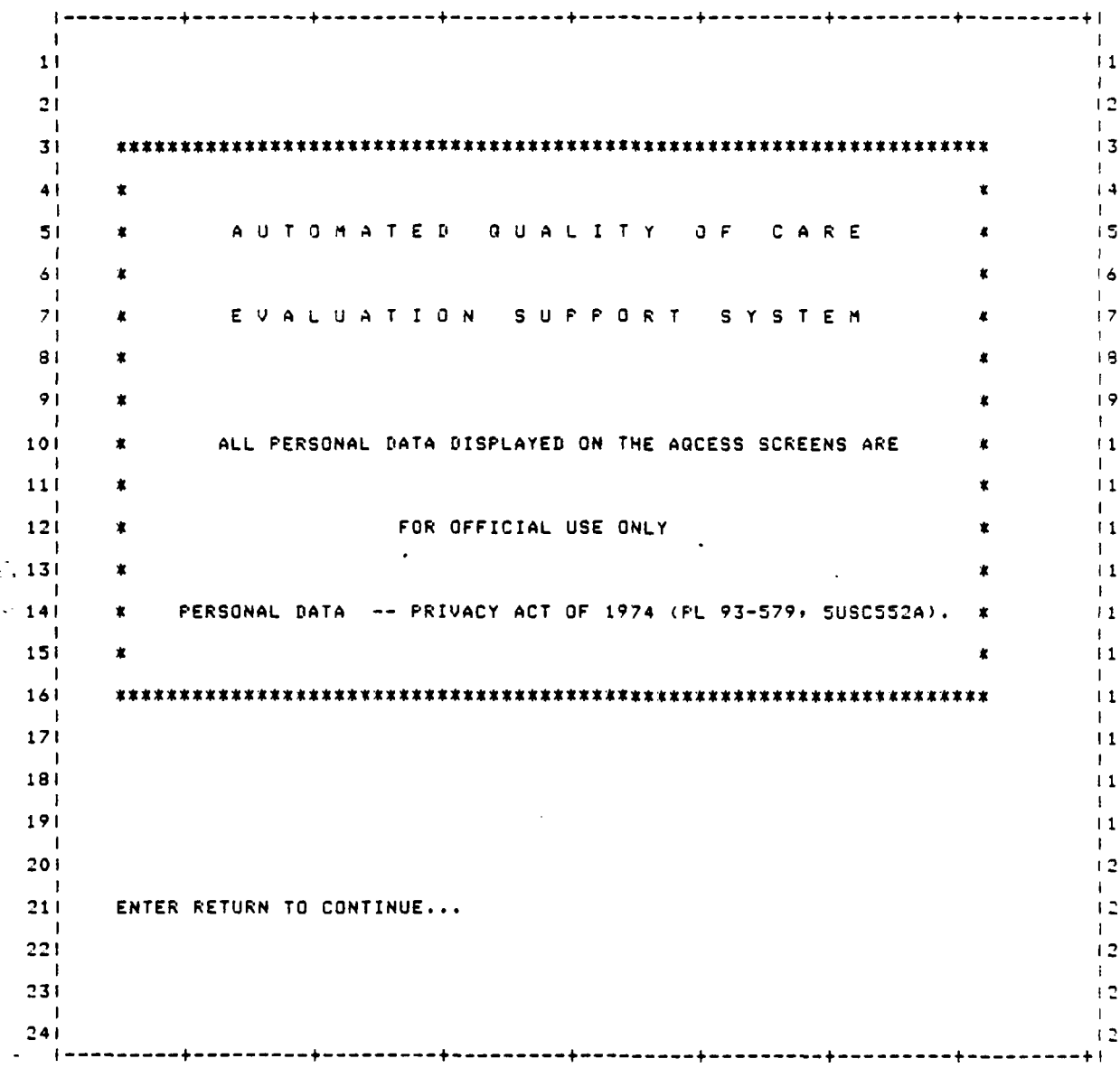


Figure 3-2. PRIVACY ACT SCREEN

3.1.2 User Entry Menu Screen (Figure 3-3). The User Entry Menu Screen lists all the functions that are available to a given user. Of these functions, those that are accessible from the particular terminal are marked with asterisks. The Menu Screen shown in Figure 3-3 is for a user who is authorized to use all the AQCESS functions, and for a terminal where all the functions are accessible.

The user indicates which function he or she wants by entering the letter or number preceding it after the words ENTER FUNCTION.

3.1.3 Function Selection. The screen that appears next is determined by what function the user has selected. The first screen of most system functions is displayed as soon as it is chosen from the User Entry Menu.

If the user has chosen either Registration, Admission, Disposition, Transfer, or Inpatient History, the first screen to appear will be the PTID Screen. Through PTID the user must either locate an existing patient record or begin a new patient record. Once this has been done, the first screen of the selected function is displayed. However, if the user chose Admission and the patient is not a current inpatient, the Registration Screen will appear next, and the user must register or update registration data on the new inpatient. The Admission Screen for a new inpatient is only displayed after the person has been registered. For an illustration of the sequence in which these functions are accessed, see Figure 3-4.

When the user has finished processing a record, the PTID Screen will be redisplayed. Then the user can identify another record and use that function again, or the user can cancel out of the function and return to the User Entry Menu. For example, if the user selected Disposition from the Menu Screen, the PTID Screen is displayed, and the user identifies a record to process. Then the Disposition Screen appears and the user dispositions that patient. After finishing the disposition, the PTID Screen is displayed again. Then the user locates another record and dispositions that patient. After this, the PTID Screen is displayed again, but the user has finished disposition processing. The user cancels out or otherwise leaves the PTID Screen, and the User Entry Menu again appears.

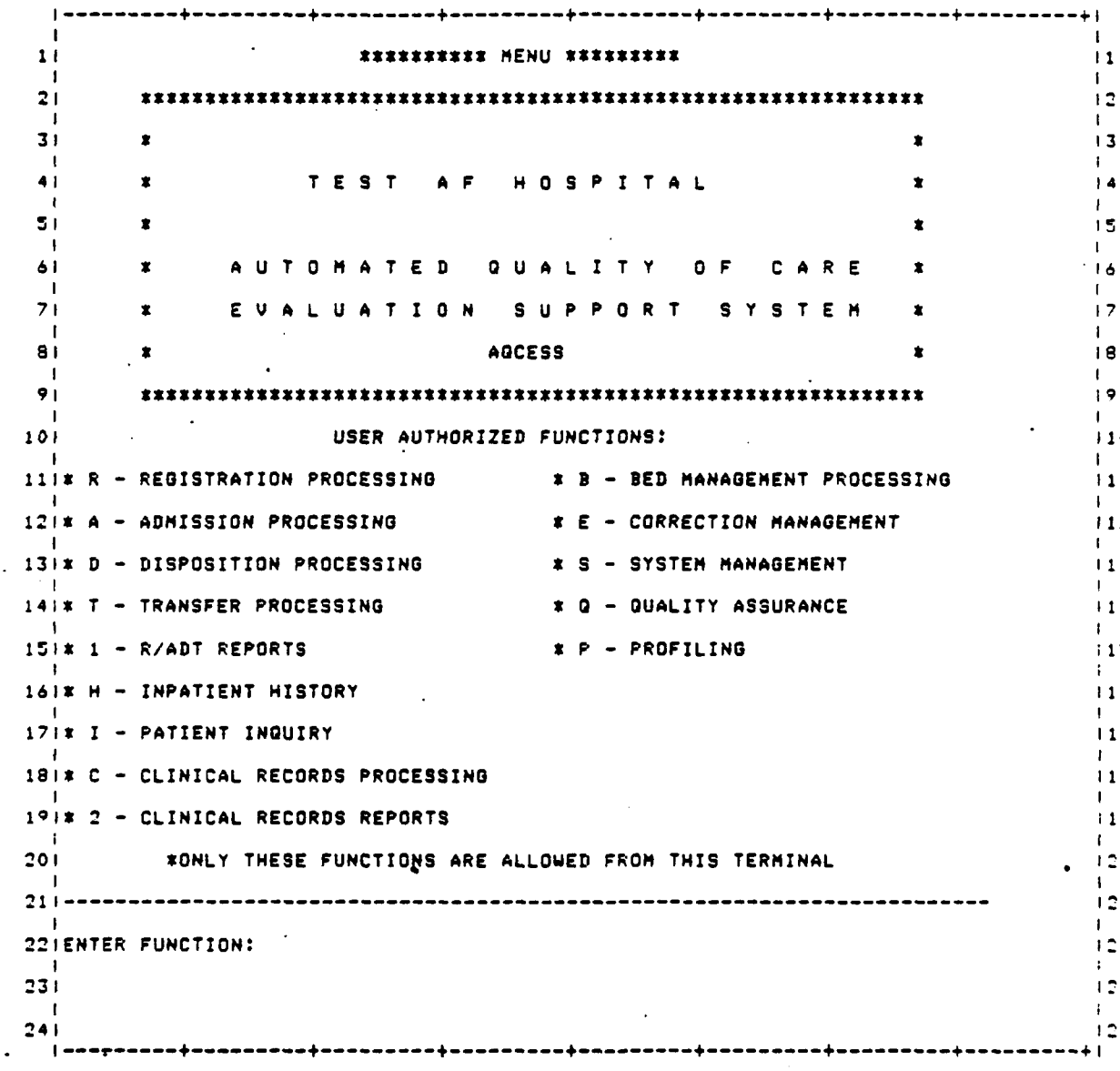


Figure 3-3. USER ENTRY MENU SCREEN

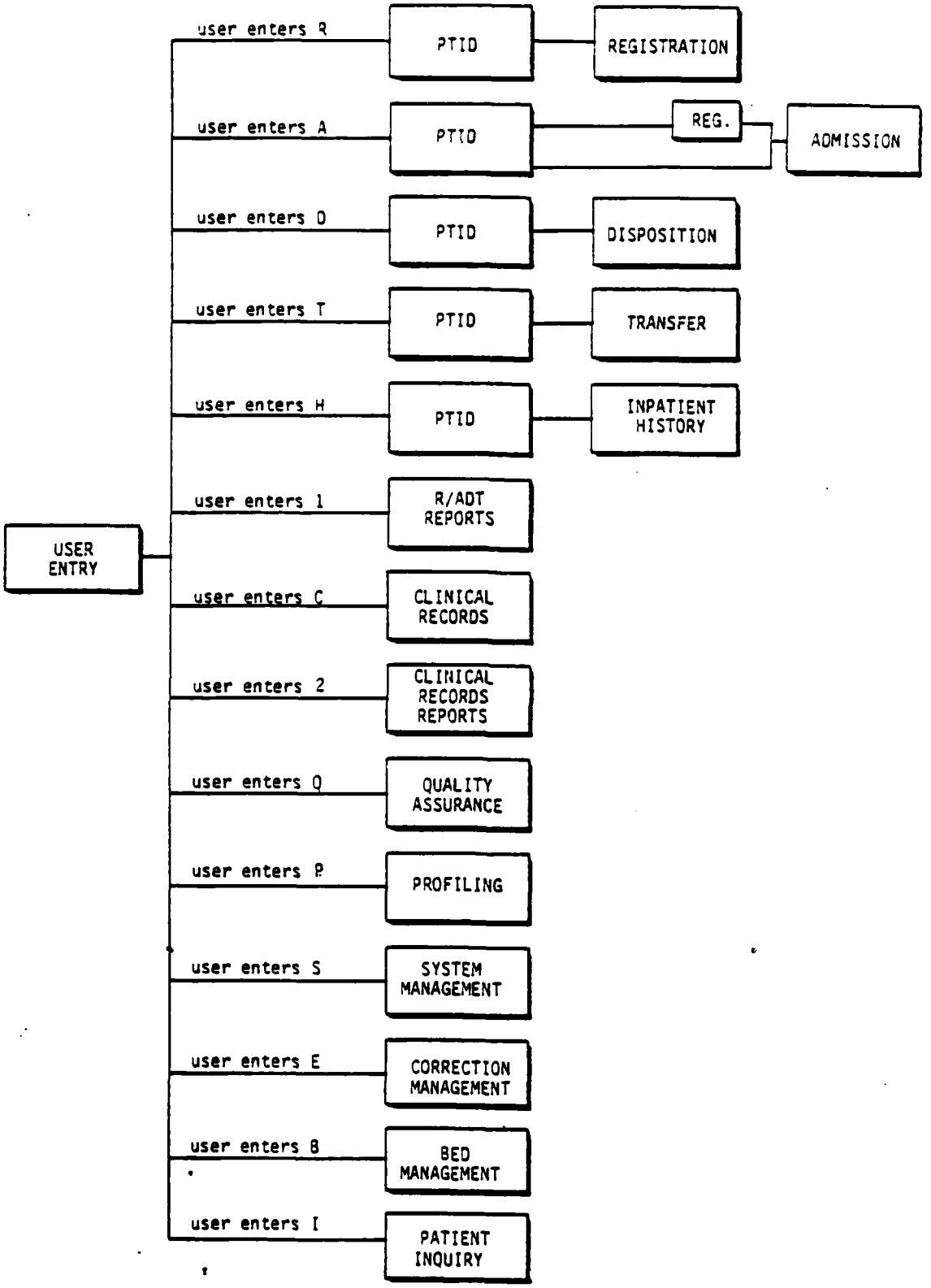


Figure 3-4. FUNCTION SELECTION THROUGH USER ENTRY

SECTION 4. PATIENT IDENTIFICATION (PTID) SCREENS

4.1 Patient Identification (PTID) Function - Overview. Through PTID the user can begin creation of a new patient record or locate an existing record. PTID collects six data items that identify the patient: register number, patient name, family member prefix (FMP), sponsor's Social Security number (SSN), patient's date of birth, and patient's sex. PTID allows the user to locate an existing record directly, or by using one of several searches, depending on what information the user has.

The user can locate a record directly by entering the register number associated with it. A unique register number is assigned to the record of each inpatient episode, and thus precisely identifies that record. The user can also locate a record directly by entering the patient's FMP and SSN.

Alternatively, the user can initiate any of the following searches:

a. Name fragment search, by entering part of the patient's last name, or part or all of the last name and part of the first name.

b. Soundex search, by entering an asterisk followed by all or part of the patient's last name.

c. Social Security number search, by entering the sponsor's SSN.

PTID functions are accomplished using two screens: the PTID Screen and the Candidate List Screen. On the PTID Screen, the user enters data to begin a new record or to locate an existing record. If the user employs a search, the Candidate List Screen appears, displaying names of patients who fit the search criteria, with additional information about the records of their inpatient episodes.

4.2 PTID Screen.

4.2.1 Creating New Records. Before a person can be registered or admitted to the MTF, the user must enter identifying data for that person on the PTID Screen (see Figure 4-1). The user must enter data in every field on the screen except REG NO, and enter "N" in the selection field to indicate that this is a new patient. As on the other AQCESS screens, the system edits this data to make sure it is valid. For more details on these data items, see Data Chart 4-1.

```
 1 xxxxxxxxxxxxxxx              xxxxxxxxxxxx          DATE xxxxxxxxxxx TIME xxxx
 2                      PERSONAL DATA - PRIVACY ACT OF 1974
 3
 4
 5            REG NO xxxxxxxx
 6
 7            PATIENT NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
 8
 9            FAMILY MEMBER PREFIX (FMP) xx
10
11            SPONSOR'S SOCIAL SECURITY NUMBER (SSN) xxxxxxxxxxx
12
13            DATE OF BIRTH xxxxxxxxxxx            SEX x
14
15
16            (N - NEW)   SELECTION
17
18 ------------------------------------------------------------------------------
19 REGISTER NUMBER SEARCH              ENTER REGISTER NUMBER
20 NAME FRAGMENT SEARCH                ENTER PATIENT'S NAME ONLY
21 SOUNDEX SEARCH                      ENTER ASTERISK(*) BEFORE LAST NAME
22 SOCIAL SECURITY NUMBER SEARCH       SSN IS REQUIRED/FMP IS OPTIONAL
23
24
```

Figure 4-1. PTID SCREEN

When identifying data has been entered for a new patient, the system will try to ensure that this is not a duplicate registration by searching for the record of any patient with the same SSN/FMP or any patient with the same last name, same first four characters of the first name, and the same sex. If any such records are found, they will be listed on the Candidate List Screen.

If the Candidate List shows a patient with the same SSN/FMP, the user must select that candidate from the list or return to the PTID Screen and correct the SSN/FMP just entered.

Or, if the Candidate List shows any patients with the same last name and similar first name or very similar SSN, the user can make sure that none of these is the patient that was just entered. If the new patient is on the list, the user can select that patient. If the new patient is not on the list, the user enters "R" to continue the new registration.

If no patient with the same SSN/FMP or a similar name already exists on the system, no Candidate List will appear. The Registration Screen will be displayed, and the user can register the patient. If the user cancels out before registering, the PTID data will not be stored in the system.

Any later changes to the PTID data must be made on the Registration Screen; the PTID Screen cannot be updated.

(1) REG NO. The number assigned to the inpatient episode during the Admission process.

(2) PATIENT NAME. Last name first, then first name and middle initial. Cannot include any punctuation.

(3) FAMILY MEMBER PREFIX (FMP). Indicates the relationship between the sponsor and the patient. Table 1012.

(4) SPONSOR'S SOCIAL SECURITY NUMBER (SSN). The Social Security number of the patient's sponsor (or of the patient if the patient is also the sponsor).

(5) DATE OF BIRTH (DOB). Patient's date of birth.

(6) SEX. Patient's sex.

Data Chart 4-1. PTID SCREEN

4.2.2 Locating Existing Records. There are two methods of locating patient records: the direct method and the candidate list search.

Records can be accessed directly when the user enters data that uniquely identifies that record. When a record is accessed directly, or by a "direct hit," the system displays the first screen of the function chosen by the user immediately after the PTID Screen.

The user can access a record directly by entering the register number associated with it. If the register number is valid, the first screen of the chosen function will be displayed for that record. If there is no such record, the PTID Screen will display an error message. The user can also access a current record directly by entering the patient's FMP and SSN.

When the user does not have the information to access a record directly, the record can be located through a candidate list search. To initiate a search, the user can enter one of a variety of data combinations, and the system will display a Candidate List Screen, showing the patient records that fit those criteria; then the user can choose the desired record, and the first screen of the chosen function will be displayed for that record. There are three types of candidate list searches: name fragment, soundex, and Social Security number. These searches are more expensive in terms of processing time than direct access.

a. Name fragment searches are used when the user only knows part of the patient's name. Part of the last name, or all or part of the last name and part of the first name can be entered. The Candidate List Screen will list all records for all patients or sponsors whose names begin with the letters entered.

b. Soundex searches are used when the user is not sure of the spelling of the patient's last name. The user enters an asterisk, followed by the phonetic spelling of the last name (the first character of the name entered must be the same as the actual first character of the name). The Candidate List Screen will list all records for all patients or sponsors whose names sound like the one entered.

c. Social Security number searches are used when the user only knows the SSN of the patient's sponsor. The Candidate List Screen will list all records for the sponsor and all patients with that sponsor's SSN--in other words, all members of that family.

The user can restrict any of these searches by entering any other identifying data that he or she has--FMP, date of birth (or part of DOB), or sex.

In some circumstances, the user may have entered a valid register number or other valid identifying data, but the system will not be able to display the desired screen. If the user chose Admission from the Menu Screen and the patient has been dispositioned, the Admission Screen for that inpatient episode will not be available. Or, if the record has been accessed via the

Clinical Records function, neither the Registration, Admission, Disposition, or Transfer screens for that record will be accessible.

4.2.3 Candidate List Screen (Figure 4-2). The Candidate List Screen lists patient records that were found either as the result of a candidate list search, or as a result of the system's automatic search for duplicates performed when the user has entered the data for a new patient.

The Candidate List Screen displays data on as many as 10 individuals at a time. If there are more than 10, this will be indicated, and the remainder of the list can be viewed on subsequent pages of the screen. The data displayed on this screen is described in Data Chart 4-2.

To select a record from the Candidate List Screen, the user enters its number in the selection field, and the first screen of the chosen function will be displayed for that record.

(1) LIST NUMBER. Shows the order in which the record is listed on this screen (from 0 to 9). The user enters this number at ENTER SELECTION to choose a record to process.

(2) NAME OF PATIENT. Last name, first name, and middle initial.

(3) FMP. Patient's family member prefix. Indicates the relationship between the sponsor and the patient. Table 1012.

(4) SSN. Social Security Number of patient's sponsor.

(5) DOB. Patient's date of birth.

(6) SEX of patient.

(7) CURRENT/PREVIOUS IND. Indicates whether the patient is a current inpatient or was an inpatient previously.

(8) REG NO. Register number of the patient's most recent hospital episode, or the code PREADM if the patient has been preadmitted.

Data Chart 4-2. CANDIDATE LIST SCREEN

```
1 xxxxxxxxxxxxxxx                    xxxxxxxxxxxxx    DATE xxxxxxxxxxx TIME xxxx
2                        PERSONAL DATA - PRIVACY ACT OF 1974
3                           xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
4 LIST  NAME OF PATIENT          FMP   SSN          DOB        SEX  CURRENT/   REG
5                                                                 PREVIOUS   NO
6                                                                   IND
7 0  xxxxxxxxxxxxxxxxxxxxxxxxxx  xx  xxxxxxxxx  xxxxxxxxxxx  x      x      xxxxxxxx
8 1  xxxxxxxxxxxxxxxxxxxxxxxxxx  xx  xxxxxxxxx  xxxxxxxxxxx  x      x      xxxxxxxx
9 2  xxxxxxxxxxxxxxxxxxxxxxxxxx  xx  xxxxxxxxx  xxxxxxxxxxx  x      x      xxxxxxxx
10 3 xxxxxxxxxxxxxxxxxxxxxxxxxx  xx  xxxxxxxxx  xxxxxxxxxxx  x      x      xxxxxxxx
11 4 xxxxxxxxxxxxxxxxxxxxxxxxxx  xx  xxxxxxxxx  xxxxxxxxxxx  x      x      xxxxxxxx
12 5 xxxxxxxxxxxxxxxxxxxxxxxxxx  xx  xxxxxxxxx  xxxxxxxxxxx  x      x      xxxxxxxx
13 6 xxxxxxxxxxxxxxxxxxxxxxxxxx  xx  xxxxxxxxx  xxxxxxxxxxx  x      x      xxxxxxxx
14 7 xxxxxxxxxxxxxxxxxxxxxxxxxx  xx  xxxxxxxxx  xxxxxxxxxxx  x      x      xxxxxxxx
15 8 xxxxxxxxxxxxxxxxxxxxxxxxxx  xx  xxxxxxxxx  xxxxxxxxxxx  x      x      xxxxxxxx
16 9 xxxxxxxxxxxxxxxxxxxxxxxxxx  xx  xxxxxxxxx  xxxxxxxxxxx  x      x      xxxxxxxx
17
18 ------------------------------------------------------------------------------
19 [ 0 - x ] PATIENT SELECTED      xxxxxxxxxxx                N - VIEW NEXT PAGE
20
21
22 ENTER SELECTION:
23
24
```

Figure 4-2. CANDIDATE LIST SCREEN

SECTION 5. REGISTRATION SCREENS

5.1 Registration Function - Overview. Registration collects identification and demographic information on all persons eligible for care at the MTF. Individuals must be registered before being admitted as inpatients.

The Registration function makes use of one primary Registration Screen, containing the Registration Data segment and the Sponsor Data segment. Two alternate segments can be displayed in place of Sponsor Data: Registration Products and History Data. The user accesses the Registration Products segment to request printing of the Registration Form. The History Data segment displays data on the most recent previous inpatient episode this patient had at this MTF, if any.

5.2 The Registration Screen (Figure 5-1). On the primary Registration Screen the user enters the basic demographic information needed to register the person as a patient at the MTF (see Data Chart 5-1). The user can also use this screen to indicate whether the registration data has been reviewed and verified by the patient or the patient's agent.

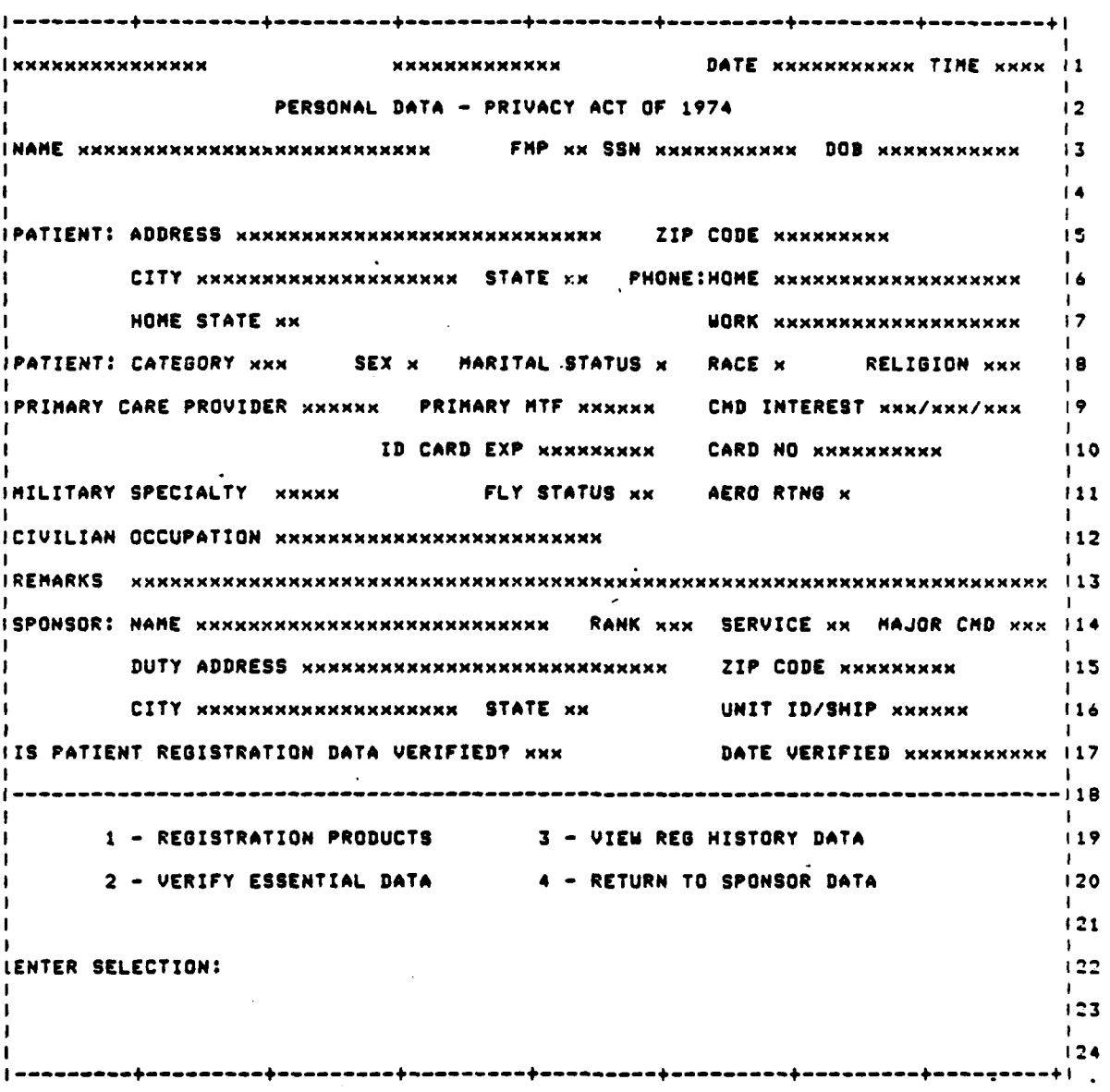
The primary Registration Screen is displayed after the PTID Screen (1) when the user chose Registration from the User Entry Menu, or (2) when the user chose the Admission function and is entering a new admission.

The Registration Screen on a new patient will display the identification data on that person that was entered in PTID. The user can enter the basic data necessary to register the person, and can call up the Registration Products segment to request Registration Forms on that patient, or the History Data segment, to review information on a previous admission the patient may have had.

For a new patient with family members who have already been registered on the system, the patient address fields and the sponsor data fields will default to the information stored on the existing relative's record.

When the user chooses to perform Registration processing on a patient who has already been registered, the screen will display the registration data that was previously entered and stored on the system. The user will be able to review or update this data, and can again request Registration products from the Registration Products segment or review information on the patient's previous admission.

When the user has finished Registration processing, the next screen to be displayed will be the PTID Screen if the user chose Registration from the main Menu, or the Admission Screen if the user chose Admission.


xxxxxxxxxxxxxxx xxxxxxxxxxxxx DATE xxxxxxxxxxx TIME xxxx
PERSONAL DATA - PRIVACY ACT OF 1974
NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxx FMP xx SSN xxxxxxxxxxx DOB xxxxxxxxxxx
PATIENT: ADDRESS xxxxxxxxxxxxxxxxxxxxxxxxxxxx ZIP CODE xxxxxxxxx
CITY xxxxxxxxxxxxxxxxxxx STATE xx PHONE:HOME xxxxxxxxxxxxxxxxxx
HOME STATE xx WORK xxxxxxxxxxxxxxxxxx
PATIENT: CATEGORY xxx SEX x MARITAL STATUS x RACE x RELIGION xxx
PRIMARY CARE PROVIDER xxxxxx PRIMARY MTF xxxxxx CMD INTEREST xxx/xxx/xxx
ID CARD EXP xxxxxxxxx CARD NO xxxxxxxxxx
MILITARY SPECIALTY xxxxx FLY STATUS xx AERO RTNG x
CIVILIAN OCCUPATION xxxxxxxxxxxxxxxxxxxxxxx
REMARKS xxxxxxxxxxxxxxxxxxxx

(1) PATIENT: ADDRESS. Street name and number, and apartment number, of patient's home.

(2) ZIP CODE. The patient's zip code. If user enters a zip code that is on the MTF's zip code table, the CITY and STATE fields will default to the city and state associated with that zip code on the table. Table 1025.

(3) CITY. The city in which the patient lives.

(4) STATE. 2-letter abbreviation for the state in which the patient lives (Table 1015).

(5) PHONE: HOME. Patient's home telephone number, area code first, followed by 7-digit number, with 4-digit extension, if any.

(6) HOME STATE. The state of residence for active-duty Army personnel.

(7) WORK. Patient's business or day telephone number. In the same format as for home phone number. Can include autovon number for military patients.

(8) PATIENT: CATEGORY. Code indicating the service affiliation and the authorization classification which authorizes care. (Table 1091, Air Force; Table 1090, Army; Table 1092, Navy.)

(9) SEX. Patient's sex. From data dictionary.

(10) MARITAL STATUS. Patient's marital status. From data dictionary.

(11) RACE. Patient's race. Table 1024.

(12) RELIGION. Patient's religious preference. Table 1000.

(13) PRIMARY CARE PROVIDER. The code of the patient's primary health care provider. From Table 1004.

(14) PRIMARY MTF. Code for the primary medical treatment facility that cares for the patient, as listed on Table 1005. Up to six characters.

(15) CMD INTEREST. Code indicating a special category or type of patient. Up to 3 3-character codes can be entered, each separated by a slash. From Table 1016.

Data Chart 5-1. PRIMARY REGISTRATION SCREEN

(16) ID CARD EXP. Date on which the patient's ID card expires.

(17) CARD NO. Patient's military identification card number. This field is only used by Navy and only for dependents.

(18) MILITARY SPECIALTY. Code indicating the service member's military specialty. Must be entered for all active-duty personnel.

(19) FLY STATUS. Flying status or aviation service code of patient.

(20) AERO RTNG. Patient's aeronautical rating code. Table 1009.

(21) CIVILIAN OCCUPATION. Occupation of patient if not active-duty military.

(22) REMARKS. User can enter up to 70 characters of free-text remarks about the registration in this field.

SPONSOR DATA SEGMENT

(23) SPONSOR: NAME. Name of the patient's military sponsor. If the patient is a sponsor (i.e., the FMP = 20) this field will default to the patient's name.

(24) RANK. Rank of sponsor. Table 1006.

(25) SERVICE. Service affiliation for Air Force, Navy, and foreign officers. Enter Army corps code for Army officers.

(26) MAJOR CMD. Identity of sponsor's major command. Table 1017. Air Force only.

(27) DUTY ADDRESS of sponsor. The unit to which the sponsor is assigned.

(28) ZIP CODE of the sponsor's military unit. If entry is from zip code table, the CITY and STATE fields will default to the city and state associated with the zip code on the table. Table 1025.

(29) CITY. The post, base, or military installation where the sponsor's unit is located.

(30) STATE. The state where sponsor's military unit is located. From Table 1015.

Data Chart 5-1 (continued). PRIMARY REGISTRATION SCREEN

(31) UNIT ID/SHIP. The unit's zip code except during deployment, when the unit ID code is entered.

(32) IS PATIENT REGISTRATION DATA VERIFIED? "YES" in this field means that the patient or the patient's agent has verified this registration data as correct, and that all the data that is required for verification has been filled in.

(33) DATE VERIFIED. Date on which the registration data was verified.

Data Chart 5-1 (continued). PRIMARY REGISTRATION SCREEN

To register any patient, the user must enter data in the PATIENT CATEGORY, MARITAL STATUS, RACE, SPONSOR NAME, and RANK fields. Additional fields may be required depending on the patient data entered (e.g., more fields are required if the patient is active duty).

5.2.1 Registration Sub-Menu. The Registration sub-menu consists of the options displayed on lines 19 and 20 of the screen. These options are available to the user when he or she has just entered a new registration but has not yet stored it, or when the user has chosen to perform Registration processing on a previously registered patient.

a. Registration Products. Choosing this option causes the Registration Products segment to replace the Sponsor Data segment (see Figure 5-2). On this segment, the user can request printing of the Registration Form, indicating the desired number (between 1 and 9). The Registration Form contains registration data on the patient. For examples of this product, see Part III, Outputs.

```
 1 xxxxxxxxxxxxxxx              xxxxxxxxxxxxx          DATE xxxxxxxxxxx TIME xxxx  1
 2                    PERSONAL DATA - PRIVACY ACT OF 1974                        2
 3 NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      FMP xx SSN xxxxxxxxxxx  DOB xxxxxxxxxxx  3
 4                                                                               4
 5 PATIENT: ADDRESS xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx    ZIP CODE xxxxxxxxx         5
 6          CITY xxxxxxxxxxxxxxxxxxx  STATE xx   PHONE:HOME xxxxxxxxxxxxxxxxxx  6
 7          HOME STATE xx                          WORK xxxxxxxxxxxxxxxxxx     7
 8 PATIENT: CATEGORY xxx     SEX x   MARITAL STATUS x   RACE x      RELIGION xxx  8
 9 PRIMARY CARE PROVIDER xxxxxx   PRIMARY MTF xxxxxx    CMD INTEREST xxx/xxx/xxx  9
10                             ID CARD EXP xxxxxxxxx    CARD NO xxxxxxxxxx       10
11                                                                              11
12                  xxx REGISTRATION PRODUCTS xxx                               12
13                                                                              13
14 NUMBER OF REG FORMS REQUESTED x                                              14
15                                                                              15
16                                                                              16
17                                                                              17
18 ---------------------------------------------------------------------------- 18
19        1 - REGISTRATION PRODUCTS          3 - VIEW REG HISTORY DATA          19
20        2 - VERIFY ESSENTIAL DATA          4 - RETURN TO SPONSOR DATA         20
21                                                                              21
22 ENTER SELECTION:                                                             22
23                                                                              23
24                                                                              24
```

Figure 5-2. REGISTRATION PRODUCTS SEGMENT

b. Verify Essential Data. This selection allows the user to indicate that the patient or the patient's agent has verified that the registration data is correct. To verify, the user must have entered data in several fields in addition to those that are normally required. Data required for verification varies depending on the Military Department, as illustrated by the following table (A = Army, F = Air Force, N = Navy).

Service	Required Field
A, F, N	Patient street address
A, F, N	Zip code
A, F, N	City
A, F, N	State
A, F, N	Patient category
A, F, N	Military specialty (if military patient category)
A, F, N	Sponsor rank
A, F, N	Sponsor branch of service
A, F, N	Duty address
A, F, N	Duty zip code
A, F, N	Duty city
A, F, N	Duty state
A, N	Sex
A, N	Race
A, N	ID card date
A, N	Unit ID/ship
A, F	Home phone
A, F	Work phone
A, F	Civilian occupation (if civilian patient category)
A	Home state
A	Marital status
A	Religion
A	Flying status
A	Primary care provider
F	Primary MTF

The registration data must be re-verified if it is later updated.

c. View Registration History Data. This selection causes the History Data segment to replace the Sponsor Data segment. The History Data segment displays information on the patient's most recent previous admission to the MTF, if any. See Figure 5-3 for an example Registration Screen with History Data segment, and Data Chart 5-2 for a description of its fields.

(1) LAST INPATIENT ADMISSION. Date on which the patient was last admitted to the MTF.

(2) LAST INPATIENT DISPOSITION. Date on which the patient was last dispositioned from the MTF.

(3) CURRENT REG NO. of the patient.

(4) PREVIOUS REG NO. Patient's register number for the last inpatient episode.

(5) DATE OF LAST REGISTRATION DATA UPDATE. Date on which the registration data was updated.

Data Chart 5-2. REGISTRATION - HISTORY DATA SEGMENT

d. Return to Sponsor Data. This selection allows the user to have the Sponsor Data segment redisplayed if one of the alternate segments is being displayed.

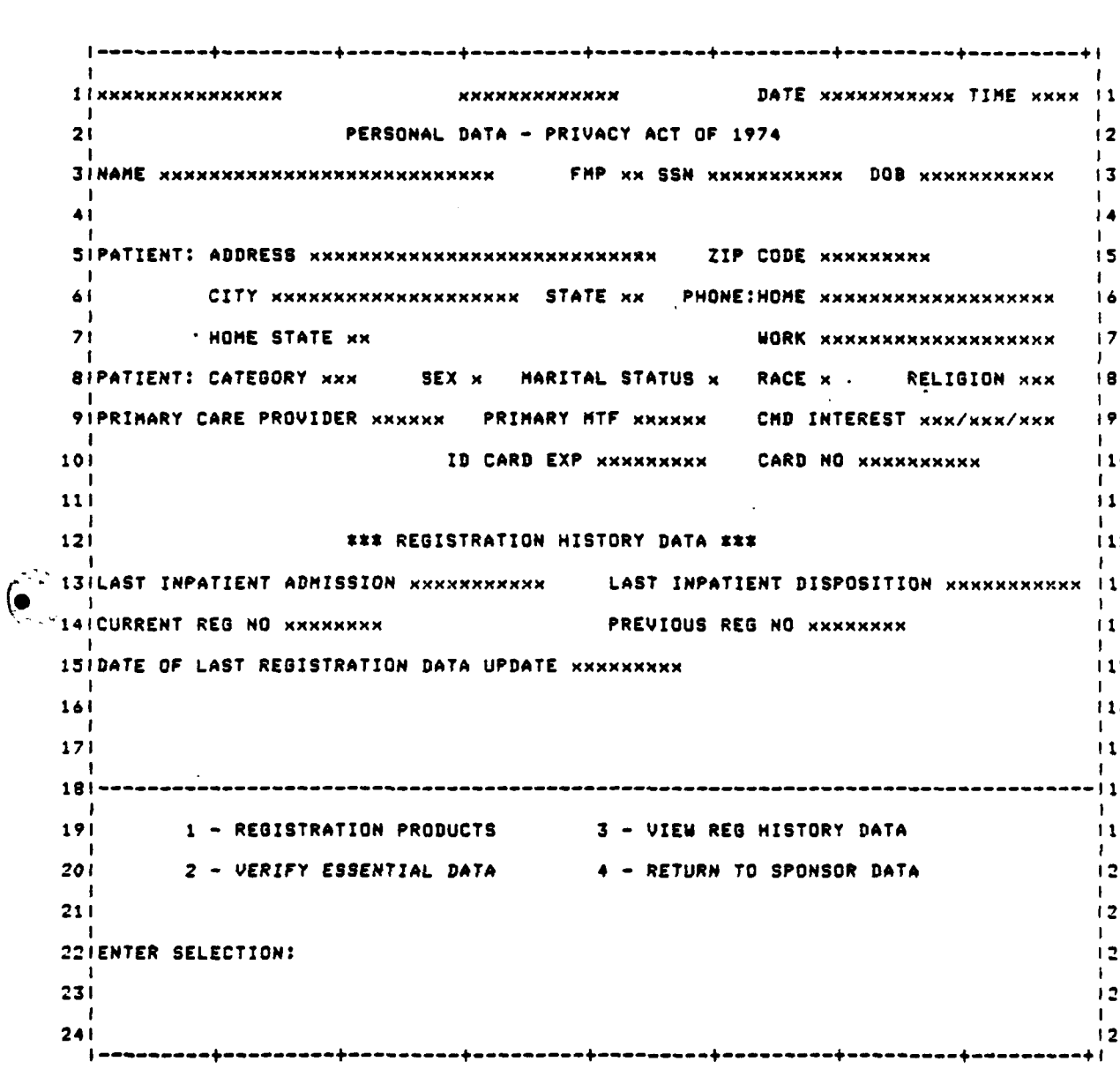


Figure 5-3. REGISTRATION - HISTORY DATA SEGMENT

SECTION 6. ADMISSION SCREENS

6.1 Admission Function - Overview. The Admission function collects data on the inpatient episode that is necessary to admit the person as an inpatient in the MTF. Patients can only be admitted using this function after they have been registered using the Registration function. Admission automatically generates a register number identifying the record of the inpatient episode, if the MTF has chosen to have register numbers assigned by the system rather than manually.

Through this function, users can enter or update data on transfers into the MTF, and data on Medical Evaluation Board status, casualty status, and absent status. Users can also cancel admissions, pre-admit potential inpatients, and convert admissions to pre-admissions. This function facilitates the admission of infants born in the MTF by retrieving data from the mother's record. And, through Admission users can request printing of the inpatient products--the Admission Form, Index Cards, and inpatient embossed cards.

The Admission function employs a primary Admission Screen, which consists of the Admission Data and Entrance Data segments. The Entrance Data segment can be replaced by the following series of segments:

a. Newborn Admission
b. Transfer-In
c. Emergency Data
d. Cause of Injury
e. Absent Status
f. Casualty Status
g. Medical Evaluation Board Status.

In addition to these segments, the user can request the Inpatient Products and Admission Cancellation segments..

6.2 Primary Admission Screen (Figure 6-1). See Data Chart 6-1 for a description of the data on the primary screen.

```
 1 xxxxxxxxxxxxxxx                xxxxxxxxxxxxx          DATE xxxxxxxxxxx TIME xxxx  1
 2                        PERSONAL DATA - PRIVACY ACT OF 1974                        2
 3 NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxx  FMP xx  SSN xxxxxxxxxxx  DOB xxxxxxxxxxx  3
 4 PATIENT CATEGORY xxx      SEX x     RELIGION xxx      CMD INTEREST xxx/xxx/xxx     4
 5                                                                                   5
 6 SOURCE ADM xxx       REG NO xxxxxxxx   ADM DATE/TIME xxxxxxxxxxxxxxxx            6
 7 ATTENDING PHY xxxxxx DATE xxxxxxxxxxx  CLIN SVC xxxx DATE/TIME xxxxxxxxxxxxxxxx  7
 8 WARD xxxx  ROOM xxxxxx  BED xxx  DATE/TIME xxxxxxxxxxxxxxxx       TYPE CASE xxx   8
 9 ADM DIAG: CODE xxxxxxx  TEXT xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx  9
10 STATUS:  ABSENT xx  CASUALTY xxx  MEB x   EAOS/ETS xxxxxxxxxxx  LENGTH SVC xxxx 10
11                                                                                  11
12                            *** ENTRANCE DATA ***                                 12
13 ADMITTING PHYSICIAN xxxxxx                                    CLERK xxx         13
14 PREVIOUS ADM xxx                  PROJECTED DISP:  TYPE xxxx  DATE xxxxxxxxxxx  14
15 ADM REMARKS xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx  15
16 MEAL CARD x                                                                      16
17 HR x   DR x   SR x   PR x   OR x   PE x                                         17
18 ---------------------------------------------------------------------------    18
19       1 - INPATIENT PRODUCTS                  3 - RETURN TO ENTRANCE            19
20       2 - VIEW NEXT SEGMENT                   4 - SELECTION TABLE               20
21                                                                                  21
22 ENTER SELECTION:                                                                 22
23                                                                                  23
24                                                                                  24
```

Figure 6-1. PRIMARY ADMISSION SCREEN

(1) SOURCE ADM. Code for the type of this inpatient admission (e.g., "DIR" for "direct," "TFR" for "transfer"). Table 2001.

(2) REG NO. The 7-digit number that uniquely identifies the record of this inpatient episode. Can be assigned automatically by the system or manually by the user, depending on the choice of the MTF as indicated through the System Management function. If numbers are being assigned by the system, this field will display a register number when the primary Admission Screen for the new admission is first displayed. If numbers are being entered manually, the user can enter it by typing over whatever number is displayed. An 8th digit is the newborn suffix (Air Force only).

(3) ADM DATE/TIME. Date and time of the admission.

(4) ATTENDING PHY. The code for the physician attending this patient. From Table 1004.

(5) DATE when the attending physician began treatment of the patient. Defaults to the date in the ADM DATE/TIME field for new admissions.

(6) CLIN SVC. Code designating the clinical service to which the patient was assigned. Table 2005.

(7) DATE/TIME when the clinical service assignment was made. Defaults to the admission date/time for new admissions.

(8) WARD. ID of ward to which was assigned. Table 8010.

(9) ROOM. Number of patient's room. Free text.

(10) BED. Number of the bed to which the patient is assigned.

(11) DATE/TIME when the patient was assigned to a ward, room, and bed. Defaults to the admission date/time for new admissions.

(12) TYPE CASE. Code indicating the type of medical case and its cause (e.g., disease, assault, battlefield injury, etc.). From Table 2004.

(13) ADM DIAG: CODE. The International Classification of Diseases code that indicates the diagnosis made at admission. From ICD code table.

(14) TEXT. The textual description of the diagnosis made at admission. 25 characters. Defaults to the text description of the ICD code as it appears in the table.

Data Chart 6-1. PRIMARY ADMISSION SCREEN

(15) STATUS: ABSENT. Code indicating the hospitalization status of the patient. Table 2002.

(16) CASUALTY. Patient's casualty status. Indicates the seriousness of the patient's condition. Table 2011.

(17) MEB. 1-character code indicating patient's Medical Evaluation Board (MEB) status. For active-duty patients only. Table 2010.

(18) EAOS/ETS. Expiration of term of service. The date on which the patient is to be released from service, if active duty.

(19) LENGTH SVC. Length of time the patient has been on active duty. Table 2014.

ENTRANCE DATA SEGMENT

(20) ADMITTING PHYSICIAN. The physician authorizing the admission. Table 1004.

(21) CLERK. Initials of the clerk entering the admission. 3 characters.

(22) PREVIOUS ADM. If the patient has been admitted to this MTF before, this field should contain "Y" for "yes," and the year of the admission. For example, "Y83" means that the patient was admitted in 1983. "N" in this field means the patient has not been admitted to this facility.

(23) PROJECTED DISP: TYPE. Code for the disposition type that is expected for this patient (e.g., returned to duty, transferred to another MTF, AWOL, deceased). Table 2007.

(24) DATE. The date on which this patient is expected to be dispositioned.

(25) ADM REMARKS. 65 spaces available for free-text remarks about the admission.

(26) MEAL CARD. A "Y" in this field indicates that the patient has a meal card (patient must be active duty). (Air Force only.)

(27) HR, DR, SR, PR, OR, PE. A "Y" after any of these fields indicates that a record, or orders, or personal effects have been received for this patient. The fields are: HR = health record, DR = dental record, SR = service record, PR = pay record, OR = orders, PE = personal effects. (Navy only.)

Data Chart 6-1 (continued). PRIMARY ADMISSION SCREEN

6.2.1 New Admissions. The Admission Screen appears after registration has been completed for a new patient, if the user chose Admission processing from the User Entry Menu Screen. At this point the Admission Screen displays only the patient data entered in PTID and Registration.

After data on the new admission has been entered on the primary Admission Screen, a series of screen segments are displayed in place of the Entrance Data segment. The user can enter data on each segment. When the user has gone through all the segments applicable to the particular patient, the new admission is complete.

For each new admission, the Emergency Data segment will be displayed. The remaining segments are displayed when the patient data indicates they are applicable. These segments, the order in which they appear, and the reason they are displayed are listed in the following chart.

1.	Newborn Admission	If patient is a newborn (as indicated by SOURCE ADM field; not used by Air Force).
2.	Transfer-In	If patient has transferred into this MTF (as indicated by SOURCE ADM).
3.	Emergency Data	For every admission.
4.	Cause of Injury	If the patient was admitted for treatment of an injury (as indicated by TYPE CASE field).
5.	Absent Status	If absent status is anything other than Bed Occupied.
6.	Casualty Status	If patient has casualty status (as indicated by CASUALTY STATUS field).
7.	Medical Evaluation Board (MEB) Status	If patient has MEB status (as indicated by MEB STATUS field).

The following paragraphs describe each segment.

a. Newborn Admission Segment (Figure 6-2). This segment is displayed if the user has indicated in the SOURCE OF ADM field that this patient is a newborn (i.e., a live birth in this MTF). It contains one field, MOTHER'S REG NO, which must be filled in by the user. (The baby's mother must have been admitted before the baby.) The system checks to make sure that the mother's record is on file, that she is a female, and that her status is currently Bed Occupied. When a valid register number for the mother is entered, the next segment is displayed.

```
 1|xxxxxxxxxxxxxxx              xxxxxxxxxxxxx          DATE xxxxxxxxxx TIME xxxx  1
 2|                       PERSONAL DATA - PRIVACY ACT OF 1974                     2
 3|NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxx  FMP xx  SSN xxxxxxxxxxx  DOB xxxxxxxxxxx  3
 4|PATIENT CATEGORY xxx      SEX x     RELIGION xxx      CMD INTEREST xxx/xxx/xxx  4
 5|                                                                               5
 6|SOURCE ADM xxx       REG NO xxxxxxxx   ADM DATE/TIME xxxxxxxxxxxxxxxx          6
 7|ATTENDING PHY xxxxxx DATE xxxxxxxxxxx  CLIN SVC xxxx DATE/TIME xxxxxxxxxxxxxxxx 7
 8|WARD xxxx  ROOM xxxxxx  BED xxx  DATE/TIME xxxxxxxxxxxxxxxx       TYPE CASE xxx  8
 9|ADM DIAG: CODE xxxxxxx  TEXT xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 9
10|STATUS:  ABSENT xx  CASUALTY xxx  MEB x   EAOS/ETS xxxxxxxxxx  LENGTH SVC xxxx 10
11|                                                                              11
12|                                                                              12
13|                        xxx  NEWBORN ADMISSION DATA xxx                       13
14|MOTHER'S REG NO xxxxxxx                                                       14
15|                                                                              15
16|                                                                              16
17|                                                                              17
18|------------------------------------------------------------------------------ 18
19|       1 - INPATIENT PRODUCTS                  3 - RETURN TO ENTRANCE        19
20|       2 - VIEW NEXT SEGMENT                   4 - SELECTION TABLE           20
21|                                                                              21
22|ENTER SELECTION:                                                             22
23|                                                                              23
24|                                                                              24
```

Figure 6-2. ADMISSION - NEWBORN ADMISSION SEGMENT

b. Transfer-In Segment (Figure 6-3). This segment is displayed if the user has indicated in the SOURCE OF ADM field that this patient has transferred into this MTF. Data Chart 6-2 describes the data on the Transfer-In segment.

(1) INITIAL ADMISSION MTF. Code of the facility where the initial hospitalization for this episode took place.

(2) ADMISSION DATE. Date when the patient was admitted to the previous MTF.

(3) COUNTRY OF INITIAL ADMISSION. Code of the country in which the previous MTF is located (Army only).

Data Chart 6-2. ADMISSION - TRANSFER-IN SEGMENT

```
 1 xxxxxxxxxxxxxxx              xxxxxxxxxxxxx          DATE xxxxxxxxxxx TIME xxxx
 2                       PERSONAL DATA - PRIVACY ACT OF 1974
 3 NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxx  FMP xx  SSN xxxxxxxxxxx  DOB xxxxxxxxxxx
 4 PATIENT CATEGORY xxx      SEX x     RELIGION xxx      CMD INTEREST xxx/xxx/xxx
 5
 6 SOURCE ADM xxx       REG NO xxxxxxxx   ADM DATE/TIME xxxxxxxxxxxxxxxx
 7 ATTENDING PHY xxxxxx DATE xxxxxxxxxxx  CLIN SVC xxxx DATE/TIME xxxxxxxxxxxxxxxx
 8 WARD xxxx  ROOM xxxxxx  BED xxx  DATE/TIME xxxxxxxxxxxxxxxx       TYPE CASE xxx
 9 ADM DIAG: CODE xxxxxxx  TEXT xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
10 STATUS:  ABSENT xx  CASUALTY xxx  MEB x   EAOS/ETS xxxxxxxxxxx  LENGTH SVC xxxx
11
12
13                         ***  TRANSFER-IN DATA ***
14 INITIAL ADMISSION MTF xxxx              ADMISSION DATE xxxxxxxxxxx
15 COUNTRY OF INITIAL ADMISSION xx
16
17
18 ------------------------------------------------------------------------------
19       1 - INPATIENT PRODUCTS                  3 - RETURN TO ENTRANCE
20       2 - VIEW NEXT SEGMENT                   4 - SELECTION TABLE
21
22 ENTER SELECTION:
23
24
```

Figure 6-3. ADMISSION - TRANSFER-IN SEGMENT

c. Emergency Data Segment (Figure 6-4). The Emergency Data segment is used to record data that would be needed in any emergency involving this patient (see Data Chart 6-3). It is displayed for every new admission, and is usually the first segment to appear after the user has filled out the primary Admission Screen.

When the emergency data for a patient already exists on the system, that data will be displayed when this segment first appears. A patient's emergency data may already be on the system if: (1) there is a record of a previous admission for the patient or for the patient's sponsor, or (2) a home address was entered for the patient on the Registration Screen. The user can change this defaulted data if necessary. After processing is complete on this segment, the next segment in the series is displayed.

(1) NEXT OF KIN: NAME. Name of the legal next-of-kin to be notified for all legal changes in the patient's statuses.

(2) RELATION. Relationship of the next-of-kin to the patient.

(3) ADDRESS. Street name and number and apartment number of next-of-kin.

(4) ZIP CODE of next-of-kin.

(5) CITY of next-of-kin.

(6) STATE of next-of-kin.

(7) PHONE number of next-of-kin.

(8) EMERGENCY: NAME. Name of the person to be contacted in case of emergency regarding this patient.

(9) RELATION. Relationship of the emergency contact to the patient.

(10) ADDRESS. Street name and number and apartment number of emergency contact.

(11) ZIP CODE of the emergency contact.

(12) CITY of the emergency contact.

(13) STATE of the emergency contact.

(14) PHONE number of the emergency contact.

Data Chart 6-3. ADMISSION - EMERGENCY DATA SEGMENT

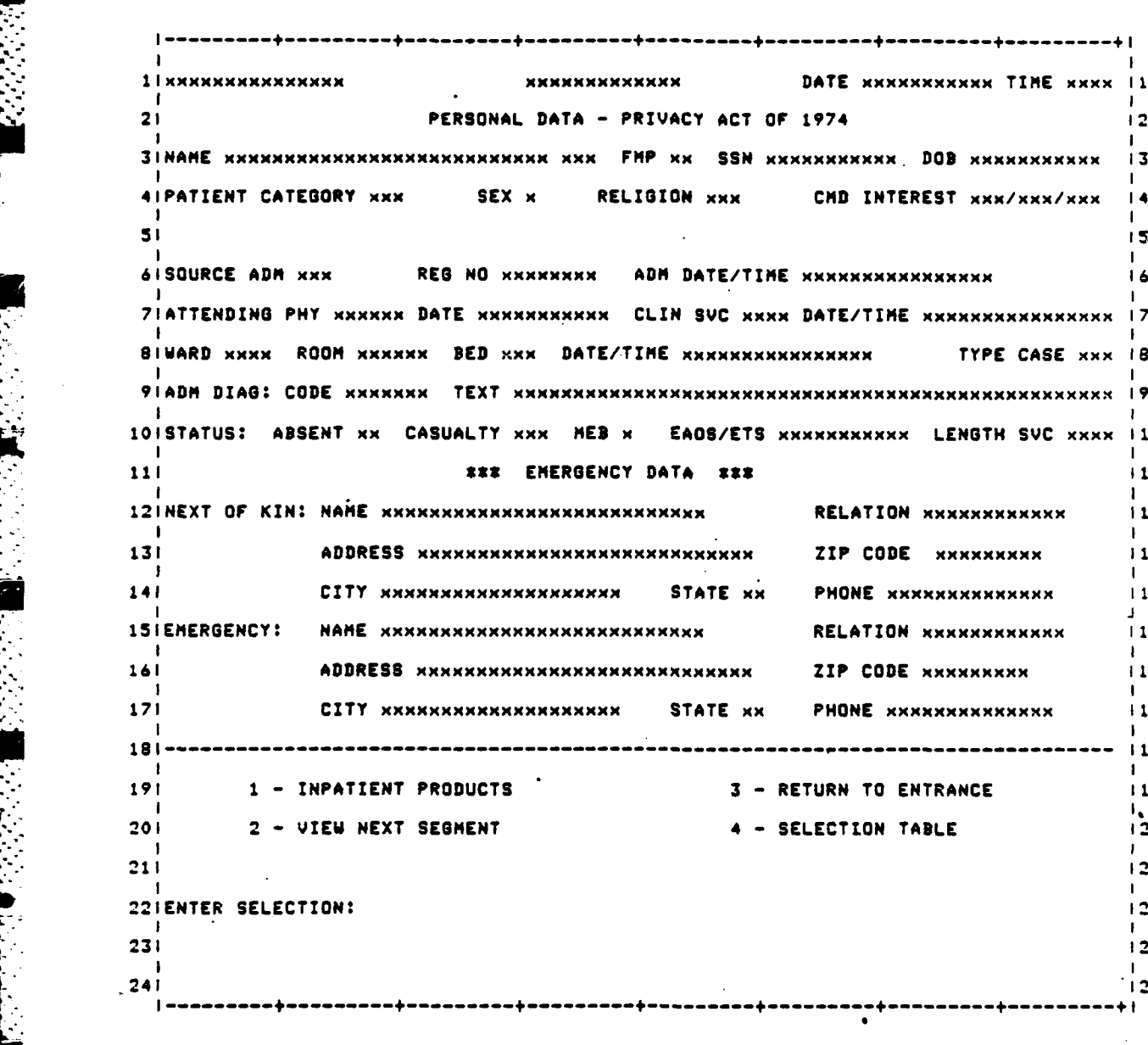


Figure 6-4. ADMISSION - EMERGENCY DATA SEGMENT

d. Cause of Injury Segment (Figure 6-5). This segment is displayed if the TYPE CASE field indicates that the patient's hospitalization is the result of an injury. On this segment the user enters data on that injury, after which the next segment in the series is displayed. See Data Chart 6-4 for data descriptions.

(1) MILITARY THEATER OF OPERATIONS. Code for the theater of operations in which the injury took place. Table 2008. (Navy only.)

(2) ON DUTY FLAG. Indicates whether the injury occurred when the patient was on duty.

(3) CAUSE OF INJURY (CODE). Codes indicating the class of trauma and the causative agent for the injury. Table 2009.

(4) (TEXT). Free text describing the injury and place injury occurred.

Data Chart 6-4. ADMISSION - CAUSE OF INJURY SEGMENT

```
 1|xxxxxxxxxxxxxxx                xxxxxxxxxxxxx          DATE xxxxxxxxxxx TIME xxxx  1
 2|                        PERSONAL DATA - PRIVACY ACT OF 1974                       2
 3|NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxx  FMP xx  SSN xxxxxxxxxxx  DOB xxxxxxxxxxx  3
 4|PATIENT CATEGORY xxx       SEX x      RELIGION xxx       CMD INTEREST xxx/xxx/xxx  4
 5|                                                                                 5
 6|SOURCE ADM xxx        REG NO xxxxxxxx    ADM DATE/TIME xxxxxxxxxxxxxxxx          6
 7|ATTENDING PHY xxxxxx DATE xxxxxxxxxxx  CLIN SVC xxxx DATE/TIME xxxxxxxxxxxxxxxx 7
 8|WARD xxxx  ROOM xxxxxx  BED xxx  DATE/TIME xxxxxxxxxxxxxxxx       TYPE CASE xxx  8
 9|ADM DIAG: CODE xxxxxxx  TEXT xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx  9
10|STATUS:  ABSENT xx  CASUALTY xxx  MEB x   EAOS/ETS xxxxxxxxxxx  LENGTH SVC xxxx 10
11|                                                                                11
12|                          ***  CAUSE OF INJURY DATA  ***                       12
13|                                                                                13
14|MILITARY THEATER OF OPERATIONS xx      ON DUTY FLAG x                           14
15|CAUSE OF INJURY: (CODE) x xxx  (TEXT) xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 15
16|xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 16
17|                                                                                17
18|--------------------------------------------------------------------------------18
19|       1 - INPATIENT PRODUCTS                  3 - RETURN TO ENTRANCE          19
20|       2 - VIEW NEXT SEGMENT                   4 - SELECTION TABLE             20
21|                                                                                21
22|ENTER SELECTION:                                                               22
23|                                                                                23
24|                                                                                24
```

Figure 6-5. ADMISSION - CAUSE OF INJURY SEGMENT

e. Absent Status Segment (Figure 6-6). The Absent Status segment is displayed on a new admission whenever the absent status is anything other than Bed Occupied, or whenever the absent status is changed. When this segment is first displayed for a new admission, it shows the absent status that was entered for this patient on the primary screen, and defaults its effective date and time to the admission date and time. (See Data Chart 6-5.)

If the initial absent status is not Bed Occupied, two A&D transactions will be generated--one for the admission event, and one for the change of status out.

An absent status change from an out to an in status must be entered on the primary Admission Screen so that the new ward can be entered. An absent status change from an in to an out status can be made directly on the absent status segment. The ward will automatically be cleared by the system.

(1) ABS STATUS. Indicates the patient's hospitalization status. Table 2002.

(2) EFF DATE/TIME. Date and time when this absent status became effective. Defaults to admission date and time on a new admission.

(3) RETURN DATE/TIME. Date and time when patient who is absent from the MTF is expected to return. Required for certain "out" statuses as specified in the absent status table (Table 2002).

(4) FACILITY TYPE. Code indicating the type of facility in which an absent sick patient is located. Table 2015.

(5) COORD MED OFFICER. Code for this facility's health care provider responsible for the absent sick patient. Table 1004.

(6) NON-MILITARY: NAME. Name of the hospital where the absent sick patient is located.

(7) ADDRESS. Street name and number of non-military hospital.

(8) ZIP CODE of the non-military hospital.

(9) CITY of non-military hospital.

(10) STATE of non-military hospital. Table 1015.

Data Chart 6-5. ADMISSION - ABSENT STATUS SEGMENT

```
 1|xxxxxxxxxxxxxxx                xxxxxxxxxxxxx          DATE xxxxxxxxxxx TIME xxxx  1
 2|                        PERSONAL DATA - PRIVACY ACT OF 1974                       2
 3|NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxx  FMP xx  SSN xxxxxxxxxxx  DOB xxxxxxxxxxx  3
 4|PATIENT CATEGORY xxx      SEX x     RELIGION xxx      CMD INTEREST xxx/xxx/xxx     4
 5|                                                                                 5
 6|SOURCE ADM xxx       REG NO xxxxxxxx   ADM DATE/TIME xxxxxxxxxxxxxxx             6
 7|ATTENDING PHY xxxxxx DATE xxxxxxxxxxx  CLIN SVC xxxx DATE/TIME xxxxxxxxxxxxxxxx 7
 8|WARD xxxx  ROOM xxxxxx  BED xxx  DATE/TIME xxxxxxxxxxxxxxx       TYPE CASE xxx    8
 9|ADM DIAG: CODE xxxxxxx  TEXT xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 9
10|STATUS:  ABSENT xx  CASUALTY xxx  MEB x   EAOS/ETS xxxxxxxxxx  LENGTH SVC xxxx 10
11|                         xxx  ABSENT STATUS DATA  xxx                           11
12|ABS STATUS xx  EFF DATE/TIME xxxxxxxxxxxxxxx RETURN DATE/TIME xxxxxxxxxxxxxxx  12
13|FACILITY TYPE xxx                COORD MED OFFICER xxxxxxxxxxxxxxxxxxxxxxxx     13
14|NON-MILITARY:       NAME xxxxxxxxxxxxxxxxxxxxxxxxxx                            14
15|                     ADDRESS xxxxxxxxxxxxxxxxxxxxxxxxxx   ZIP CODE xxxxxxxxx    15
16|                     CITY xxxxxxxxxxxxxxxxxx STATE xx     PHONE xxxxxxxxxxxxxx  16
17|CIVILIAN PHYSICIAN: NAME xxxxxxxxxxxxxxxxxxxxxxxxx       PHONE xxxxxxxxxxxxxx  17
18|--------------------------------------------------------------------------------18
19|       1 - INPATIENT PRODUCTS                3 - RETURN TO ENTRANCE           19
20|       2 - VIEW NEXT SEGMENT                 4 - SELECTION TABLE              20
21|                                                                                21
22|ENTER SELECTION:                                                               22
23|                                                                                23
24|                                                                                24
```

Figure 6-6. ADMISSION - ABSENT STATUS SEGMENT

(11) PHONE number of non-military hospital.

(12) CIVILIAN PHYSICIAN. Name of civilian physician attending the patient.

(13) PHONE number of civilian physician.

Data Chart 6-5 (continued). ADMISSION - ABSENT STATUS SEGMENT

f. Casualty Status Segment (Figure 6-7). This segment is displayed to collect data on casualty status (see Data Chart 6-6, below). If the status is Very Seriously Ill (VSI), Seriously Ill (SI), or Special Category (SC), data on this patient will be included on the Roster of VSI/SI/SC Patients (see Part III, Outputs).

(1) CASUALTY STATUS. Code indicating the seriousness of the patient's condition. Table 2011.

(2) PROGNOSIS. Code indicating patient's estimated recovery possibility.

(3) CASUALTY DIAGNOSIS. Free text.

(4) DATE NEXT OF KIN LAST NOTIFIED of the casualty status.

(5) DATE STATUS CHANGE. Date showing any change in the status. Filled in automatically by the system. Can be updated.

(6) DATE PLACED ON CASUALTY ROSTER. Filled in by the system. Can be updated.

(7) DATE REMOVED FROM ROSTER. Date when status changed to non-casualty. Filled in automatically by system, and can be updated.

(8) DATE NOTIFIED HIGHER COMMAND. Date on which higher command was notified of the casualty status. Air Force and Navy only.

Data Chart 6-6, ADMISSION - CASUALTY STATUS SEGMENT

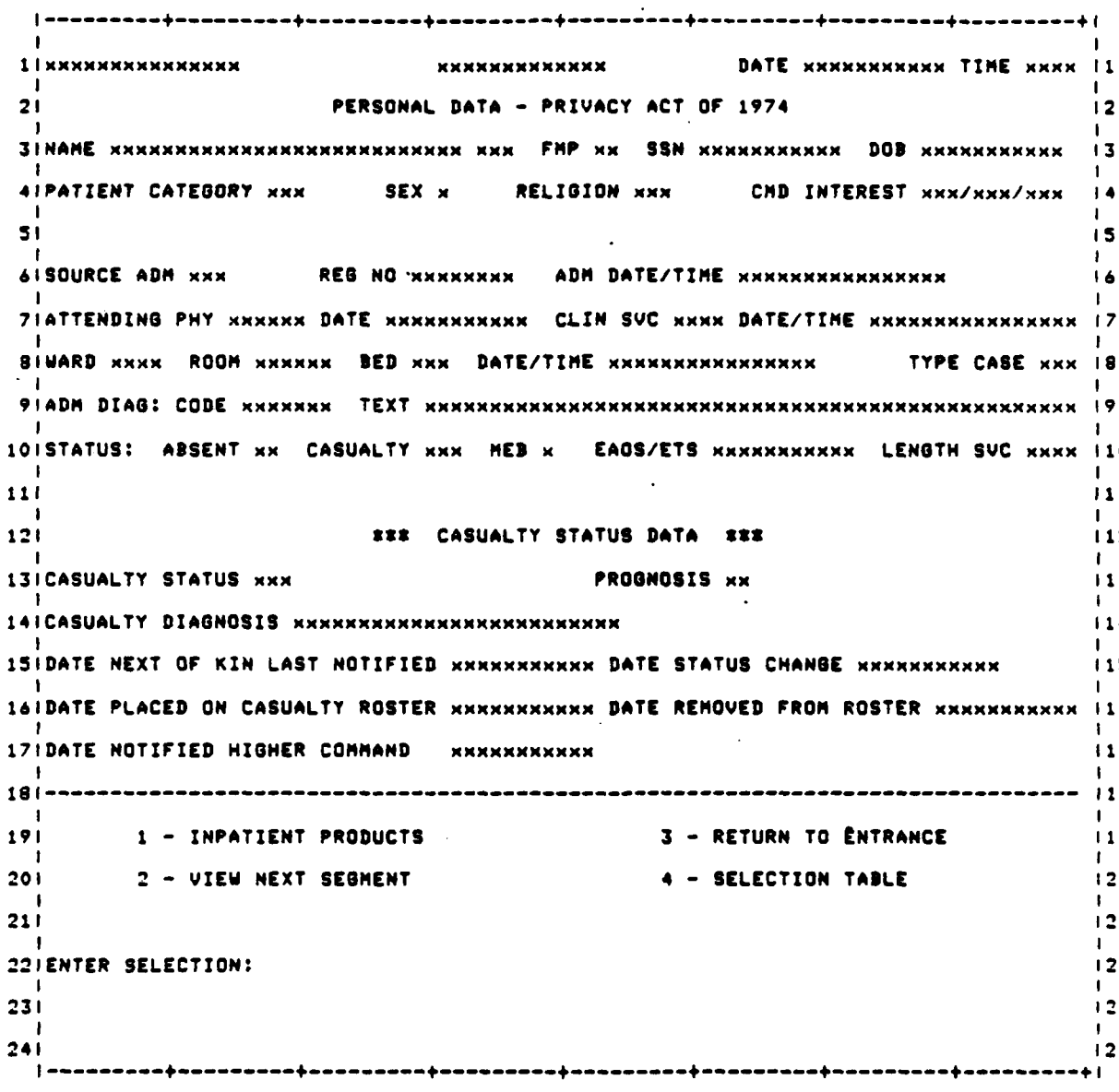


Figure 6-7. ADMISSION - CASUALTY STATUS SEGMENT

g. Medical Evaluation Board (MEB) Status Segment (Figure 6-8). This segment is displayed to collect data on MEB status (see Data Chart 6-7). The MEB Status segment is displayed if the MEB status is initially entered or changed on the primary Admission Screen, or if the user chooses the "update MEB segment" option from the selection table.

(1) MEB CANDIDATE. Single-character code indicating the Medical Evalua-Board status of the patient. If the user enters "P" ("potential candidate"), the DATE IDENTIFIED field will default to the current date. If the user enters "R" ("resolved"), the DATE RESOLVED field will default to the current date. For active-duty patients only. Table 2010.

(2) DATE IDENTIFIED. Date when an MEB status was first entered for this patient.

(3) DATE CONFIRMED. Date when an MEB status of "C" ("confirmed") was entered.

(4) DATE RESOLVED. Date when a status of "R" ("resolved") was entered.

(5) MEB REMARKS. Free text.

Data Chart 6-7. ADMISSION - MEB STATUS SEGMENT

```
1 xxxxxxxxxxxxxxx              xxxxxxxxxxxxx          DATE xxxxxxxxxxx TIME xxxx
2                      PERSONAL DATA - PRIVACY ACT OF 1974
3 NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxx  FMP xx  SSN xxxxxxxxxxx  DOB xxxxxxxxxxx
4 PATIENT CATEGORY xxx      SEX x     RELIGION xxx      CMD INTEREST xxx/xxx/xxx
5
6 SOURCE ADM xxx       REG NO xxxxxxxx   ADM DATE/TIME xxxxxxxxxxxxxxx
7 ATTENDING PHY xxxxxx DATE xxxxxxxxxxx  CLIN SVC xxxx DATE/TIME xxxxxxxxxxxxxxxx
8 WARD xxxx  ROOM xxxxxx  BED xxx  DATE/TIME xxxxxxxxxxxxxxxx       TYPE CASE xxx
9 ADM DIAG: CODE xxxxxxx  TEXT xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
10 STATUS:  ABSENT xx  CASUALTY xxx  MEB x   EAOS/ETS xxxxxxxxxx  LENGTH SVC xxxx
11
12
13                        ***  MEB STATUS DATA  ***
14 MEB CANDIDATE x                                   DATE IDENTIFIED xxxxxxxxxxx
15 DATE CONFIRMED xxxxxxxxxxx                        DATE RESOLVED xxxxxxxxxxx
16 MEB REMARKS xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
17
18 ------------------------------------------------------------------------------
19       1 - INPATIENT PRODUCTS                  3 - RETURN TO ENTRANCE
20       2 - VIEW NEXT SEGMENT                   4 - SELECTION TABLE
21
22 ENTER SELECTION:
23
24
```

Figure 6-8. ADMISSION - MEDICAL EVALUATION BOARD STATUS (MEB) SEGMENT

6.2.2 Special Admissions.

6.2.2.1 Preadmissions. Preadmitting a person means filling in the Registration and Admission Screens for that person before his or her actual admission date. The user can reserve a bed for that patient by entering a ward assignment. When the person actually arrives to be admitted, the user may need to make only minor adjustments to the record, thus speeding up the Admission function.

The Admission Screen is filled in for a preadmission the same way as for admissions except that a preadmission code is entered in the SOURCE ADM field. Although a register number will appear on the screen if register numbers are being assigned automatically, this number will not actually be assigned to the record if the source of admission indicates this is a preadmission.

To convert a preadmission to an admission, the user enters an appropriate source of admission code and the actual date and time of admission.

An admission can be changed to a preadmission, and preadmissions can be cancelled, just as admissions can, by using the Admission Cancellation segment. See section 6.2.3.

6.2.2.2 Carded for Record Only and Emergency Room Death Cases (Army and Air Force Only). "Carded for Record Only" usually refers to patients who were dead on arrival at the MTF. Emergency Room Death refers to someone who has died in the Emergency Room before admission to the MTF. To admit a CRO or ERD case, the user enters a source of admission of CRO or ERD, an absent status of CR, and a clinical service appropriate for CRO or ERD cases. The Emergency Data and Absent Status segments will be displayed next, and then the Disposition segment (see section 8.1). In other words, CRO and ERD patients are admitted and then immediately dispositioned. The system will treat either as dispositioned patients. If the CRO or ERD should be cancelled later, this is done via the Disposition function (section 8.4.1).

6.2.3 The Admission Sub-Menu. The user can use the options listed on the Admission sub-menu after processing the series of segments for a new admission, or when processing an already existing record. There are a total of 12 sub-menu options; the complete sub-menu is displayed when the user selects option 4, SELECTION TABLE.

a. Inpatient Products. This option displays the Inpatient Products segment (Figure 6-9), from which the user can request printing of Admission Forms (Army and Navy only), Index (3x5 or 5x8) Cards, and inpatient embossed cards, all of which contain information on the admission. Index cards are printed in sets; the number of cards in each set is specified on the MTF Profile in System Management (see section 11.4). The user can print as many sets as desired. On a new admission, one Admission Form and one set of Index Cards will be produced unless the user changes the default request on this segment. See Part III, Outputs, for details on the contents of these products.

b. View Next Segment. This option displays the next segment in the order discussed in section 6.2.1, even if it is not relevant to the patient record being accessed.

c. Return to Entrance. This option redisplays the Entrance Data segment when another segment is displayed. (However, neither this nor any other option can be selected when the series of segments is being displayed automatically for a new admission, as described in section 6.2.1.)

d. Selection Table. This option causes the Entrance Data area of the screen to be replaced by the rest of the Admission sub-menu (Figure 6-10).

Selections 5 through 11 (e through k, below) display the screen segment indicated and allow the user to update it.

e. Update Newborn Admission Data.

f. Update Transfer-In Data.

g. Update Emergency Data.

h. Update Cause of Injury Data.

i. Update Absent Status Data.

j. Update Casualty Status Data.

k. Update MEB Status Data.

```
 1 xxxxxxxxxxxxxxx                xxxxxxxxxxxxx          DATE xxxxxxxxxxx TIME xxxx
 2                        PERSONAL DATA - PRIVACY ACT OF 1974
 3 NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxx  FMP xx  SSN xxxxxxxxxxx  DOB xxxxxxxxxxx
 4 PATIENT CATEGORY xxx       SEX x      RELIGION xxx       CMD INTEREST xxx/xxx/xxx
 5
 6 SOURCE ADM xxx        REG NO xxxxxxxx    ADM DATE/TIME xxxxxxxxxxxxxxxx
 7 ATTENDING PHY xxxxxx DATE xxxxxxxxxxx  CLIN SVC xxxx DATE/TIME xxxxxxxxxxxxxxxx
 8 WARD xxxx  ROOM xxxxxx  BED xxx  DATE/TIME xxxxxxxxxxxxxxxx        TYPE CASE xxx
 9 ADM DIAG: CODE xxxxxxx  TEXT xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
10 STATUS:  ABSENT xx  CASUALTY xxx  MED x   EAOS/ETS xxxxxxxxxxx  LENGTH SVC xxxx
11
12                          *** INPATIENT PRODUCTS ***
13
14 NUMBER OF INDEX CARDS REQUESTED x
15 NUMBER OF EMBOSSED CARDS REQUESTED  x
16 NUMBER OF ADMISSION FORMS x
17
18 ------------------------------------------------------------------------------
19        1 - INPATIENT PRODUCTS                  3 - RETURN TO ENTRANCE
20        2 - VIEW NEXT SEGMENT                   4 - SELECTION TABLE
21
22 ENTER SELECTION:
23
24
```

Figure 6-9. ADMISSION - INPATIENT PRODUCTS SEGMENT

1. Admission Cancellation. This option displays the Admission Cancellation segment (Figure 6-11) and allows the user to:

(1) Cancel an admission, by entering a cancel admission code in the SOURCE ADM field.

(2) Cancel a preadmission, by entering a cancel preadmission code in SOURCE ADM.

(3) Change an admission to a preadmission, by entering a preadmission code in SOURCE ADM.

Admission cancellation cannot be used on a new admission that has just been entered but not yet stored. See Data Chart 6-8.

(1) SOURCE ADM. Code for the type of inpatient admission (e.g., direct admission, transfer, etc.). Table 2001.

(2) CLERK. Initials of clerk entering data in this segment.

(3) AUTHORIZING PHYSICIAN. Code for the physician authorizing the cancellation.

(4) DATE OF CANCELLATION.

(5) REASON FOR CANCELLATION. Free text.

Data Chart 6-8. ADMISSION - ADMISSION CANCELLATION SEGMENT

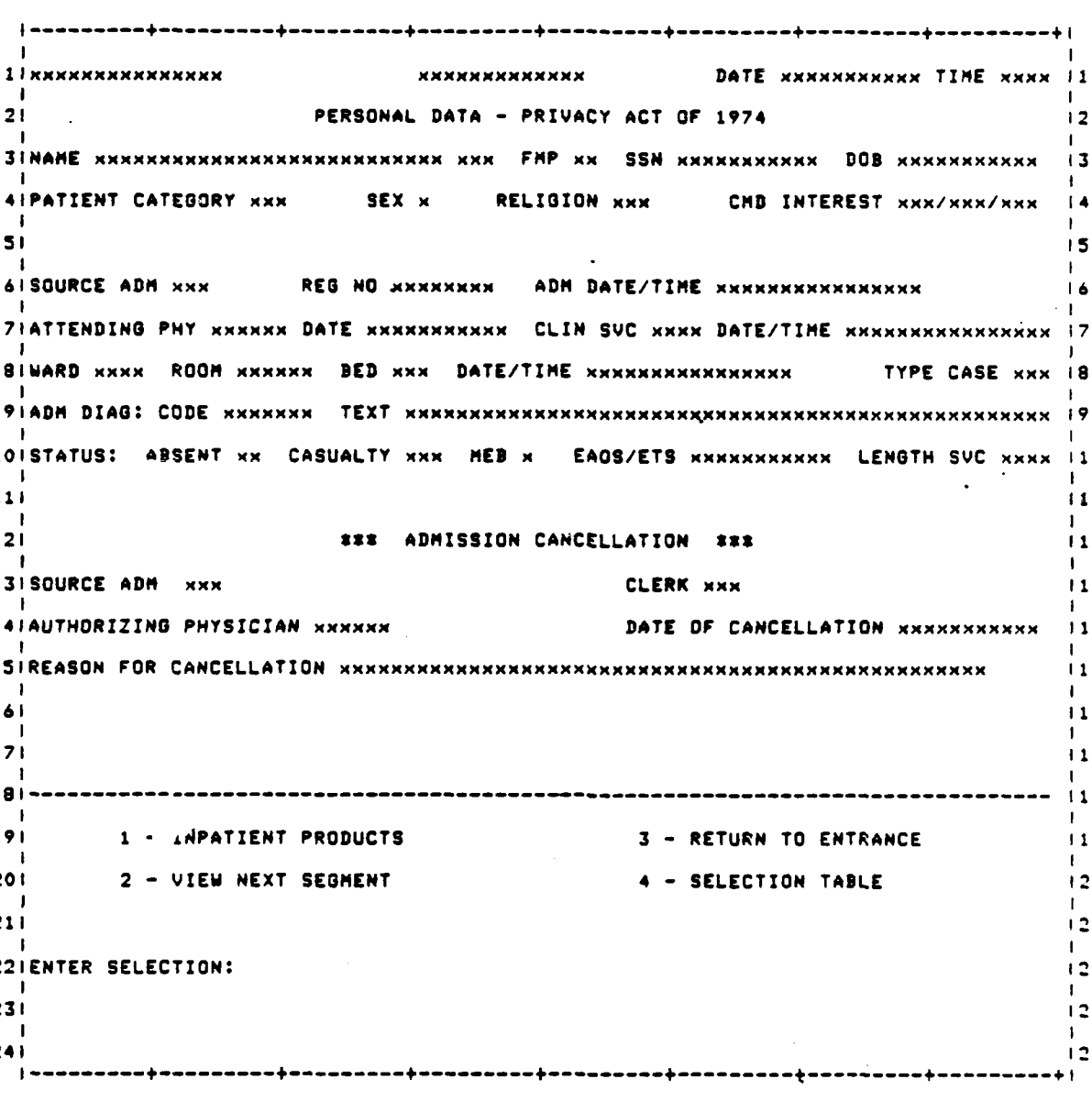


Figure 6-11. ADMISSION - ADMISSION CANCELLATION SEGMENT

SECTION 7. TRANSFER SCREENS

7.1 Transfer Function - Overview. Through this function the user keeps track of a patient's transfers within the hospital, such as changes in ward, clinical service, or physician assignments. (The Transfer function is not concerned with transfers into or out of the MTF.) Transfer consists of the same screens as Admission. Transfer can be used to perform all the functions available in Admission except admitting new patients, cancelling admissions and preadmissions, and changing preadmissions to admissions (and vice versa). The purpose of the Transfer function is to make most Admission processing available to many users, but to restrict the number of sites within an MTF where new admissions and admission cancellations can be performed.

Selecting Transfer on the User Entry Menu calls up the PTID Screen, through which the user locates the patient record to be processed. Only records of patients who have been registered and admitted are accessible. When the record is located, the primary Admission Screen is displayed. All the Admission screen segments are available except Admission Cancellation. See section 6 for examples and descriptions of these screens.

SECTION 8. DISPOSITION SCREENS

8.1 Disposition Function - Overview. Through Disposition the user enters data about the patient's discharge from the MTF. When dispositioning mothers of newborns, the Disposition function prompts the user to disposition the newborn or change it to pay status. This function is also used to cancel dispositions.

When Disposition is selected from the User Entry Menu, the PTID Screen is displayed, and the user can locate the patient record to be processed. If the patient has been dispositioned and Clinical Records processing has begun on that record, it will not be available in Disposition. If not, the system displays the primary Disposition Screen when the record is located (Figure 8-1 and Data Chart 8-1).

The primary Disposition Screen consists of two segments: Admission Summary and Disposition. The Admission Summary contains the same data as the Admission Data segment at the top of the Admission Screen. It is for review only and cannot be updated in Disposition. The Disposition segment contains data fields related to the disposition itself.

The Disposition segment can be overlaid by the Newborn Disposition, Disposition Cancellation, or Newborn Disposition Cancellation segments.

See Data Chart 6-1 for a description of the fields in the Admission Summary.

(1) DISPOSITION TYPE. Code indicating the patient's status at the end of hospitalization. Table 2007.

(2) DISPOSITION DATE/TIME. Date and time when the patient left the hospital's care.

(3) MTF TRANSFERRED. If the disposition type indicates that the patient is transferring to another MTF, the code for that MTF is entered here. Table 1005.

(4) CLERK. Initials of the clerk entering the disposition.

(5) PHYSICIAN ORDERING DISP. Code for the physician ordering the disposition. Table 1004.

(6) PHYSICIAN AUTHENTICATING DISP. Code for the physician who authenticates the disposition. Table 1004.

Data Chart 8-1. PRIMARY DISPOSITION SCREEN

```
 1|xxxxxxxxxxxxxxx              xxxxxxxxxxxxx         DATE xxxxxxxxx   TIME xxxx  | 1
 2|                      PERSONAL DATA - PRIVACY ACT OF 1974                      | 2
 3|NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxx  FMP xx  SSN xxxxxxxxxxx  DOB xxxxxxxxxxx | 3
 4|PATIENT CATEGORY xxx     SEX x     RELIGION xxxx      CMD INTEREST xxx/xxx/xxx   | 4
 5|                                                                               | 5
 6|SOURCE ADM xxx       REG NO xxxxxxxx   ADM DATE/TIME xxxxxxxxxxxxxxx          | 6
 7|ATTENDING PHY xxxxxx DATE xxxxxxxxxxx  CLIN SVC xxxx DATE/TIME xxxxxxxxxxxxxxx | 7
 8|WARD xxxx  ROOM xxxxxx  BED xxx  DATE/TIME xxxxxxxxxxxxxxx       TYPE CASE xxx | 8
 9|ADM DIAG: CODE xxxxx    TEXT xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx | 9
10|STATUS:  ABSENT xx  CASUALTY xxx  MEB x   EAOS/ETS xxxxxxxxxx  LENGTH SVC xxxx | 10
11|                                                                              | 11
12|                        ***  PATIENT DISPOSITION  ***                         | 12
13|                                                                              | 13
14|DISPOSITION TYPE xxxx                 DISPOSITION DATE/TIME xxxxxxxxxxxxxxx   | 14
15|MTF TRANSFERRED xxxxxx                CLERK xxx                               | 15
16|PHYSICIAN ORDERING DISP xxxxxx        PHYSICIAN AUTHENTICATING  DISP xxxxxx   | 16
17|                                                                              | 17
18|------------------------------------------------------------------------------ | 18
19|1 - CANCEL DISPOSITION                 2 - VIEW ADMISSION DATA                 | 19
20|                                                                              | 20
21|                                                                              | 21
22|ENTER SELECTION:                                                              | 22
23|                                                                              | 23
24|                                                                              | 24
```

Figure 8-1. PRIMARY DISPOSITION SCREEN

8.2 Dispositioning a Patient. If the record indicates that this is a current inpatient, the user can disposition the patient by entering a disposition type and filling out the other required fields on the Disposition segment. If the patient is active duty, the user must enter a disposition type that is valid for active-duty patients.

8.3 Newborn Disposition Segment. The Newborn Data segment is displayed automatically when the user has dispositioned a mother of a nondispositioned newborn (see Figure 8-2). This segment contains the same data fields as the Disposition segment, with the addition of the infant's register number, FMP, and SSN. A sub-menu is displayed with this segment, and the user must use one of the options listed: either disposition the baby (option 1), or change it to pay status (option 2). If the user chooses to change the baby's status, the screen will display a SOURCE ADM field in which the user enters the pay status code. A change to pay status can only be made as a result of the mother's disposition.

If a multiple birth is associated with the mother's record, the system will display a Newborn Disposition segment for each infant in turn.

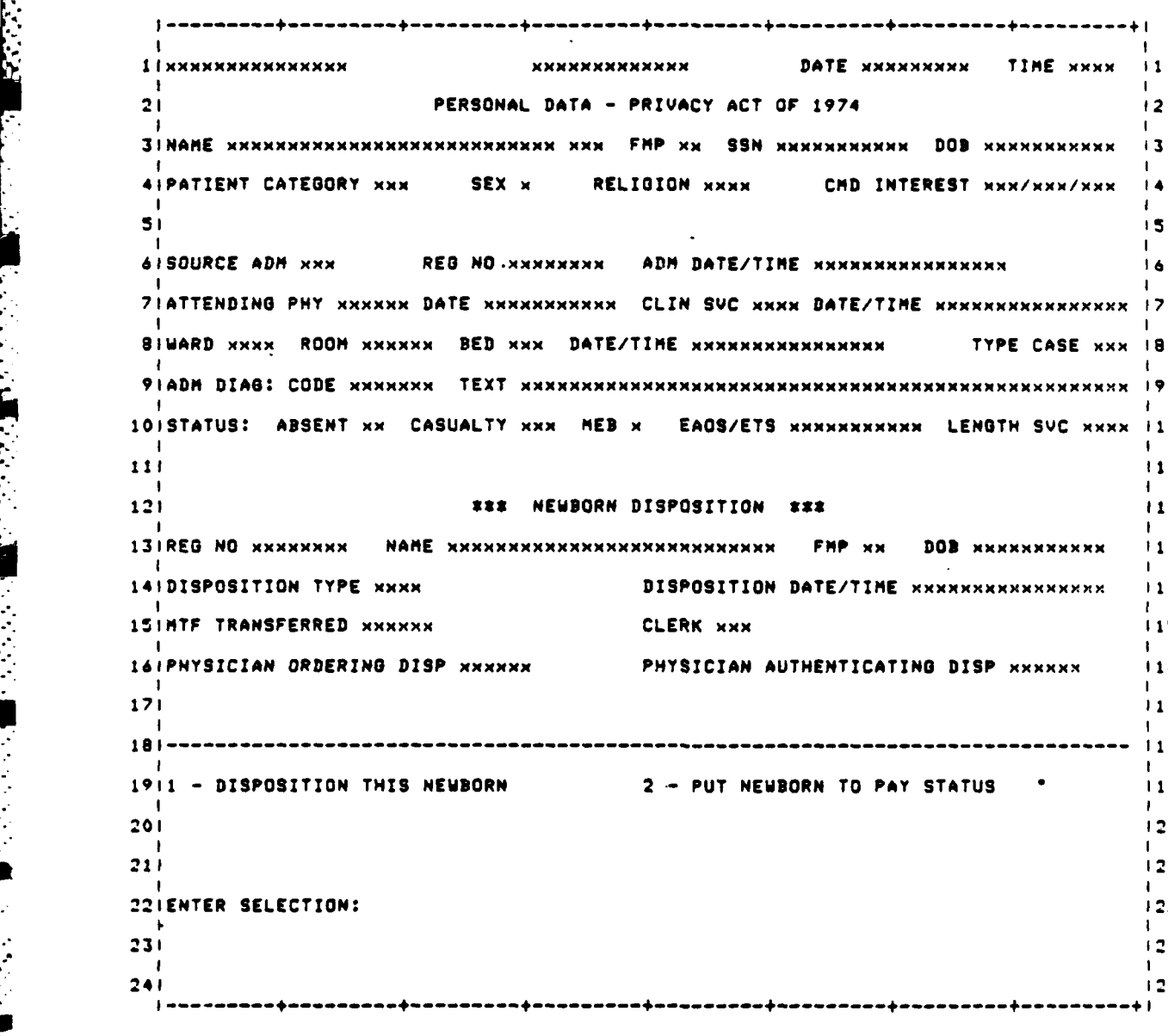


Figure 8-2. DISPOSITION - NEWBORN DISPOSITION SEGMENT

8.4 The Disposition Sub-Menu. The Disposition sub-menu is displayed when the user has just dispositioned a patient but has not yet left the screen, or when processing the record of a previously dispositioned patient. The paragraphs to follow describe the functions available.

8.4.1 Cancel Disposition. The user can cancel any disposition, except one that was just entered but has not yet been stored on the system. When this option is selected, the Disposition Cancellation segment is displayed (Figure 8-3 and Data Chart 8-2).

(1) WARD from which the patient was dispositioned or to which the patient will be reassigned if the disposition is cancelled.

(2) ROOM to which patient was assigned.

(3) BED to which patient was assigned.

(4) DATE/TIME when last ward assignment was made. Should be updated if the ward is changed.

(5) CANCEL DATE. Date on which the disposition is cancelled.

(6) AUTHORIZING PHYSICIAN. Code for the physician authorizing the cancellation. Table 1004.

(7) CLERK. Initials of the clerk entering the cancellation.

(8) REASON FOR CANCELLATION. Free text.

Data Chart 8-2. DISPOSITION - DISPOSITION CANCELLATION SEGMENT

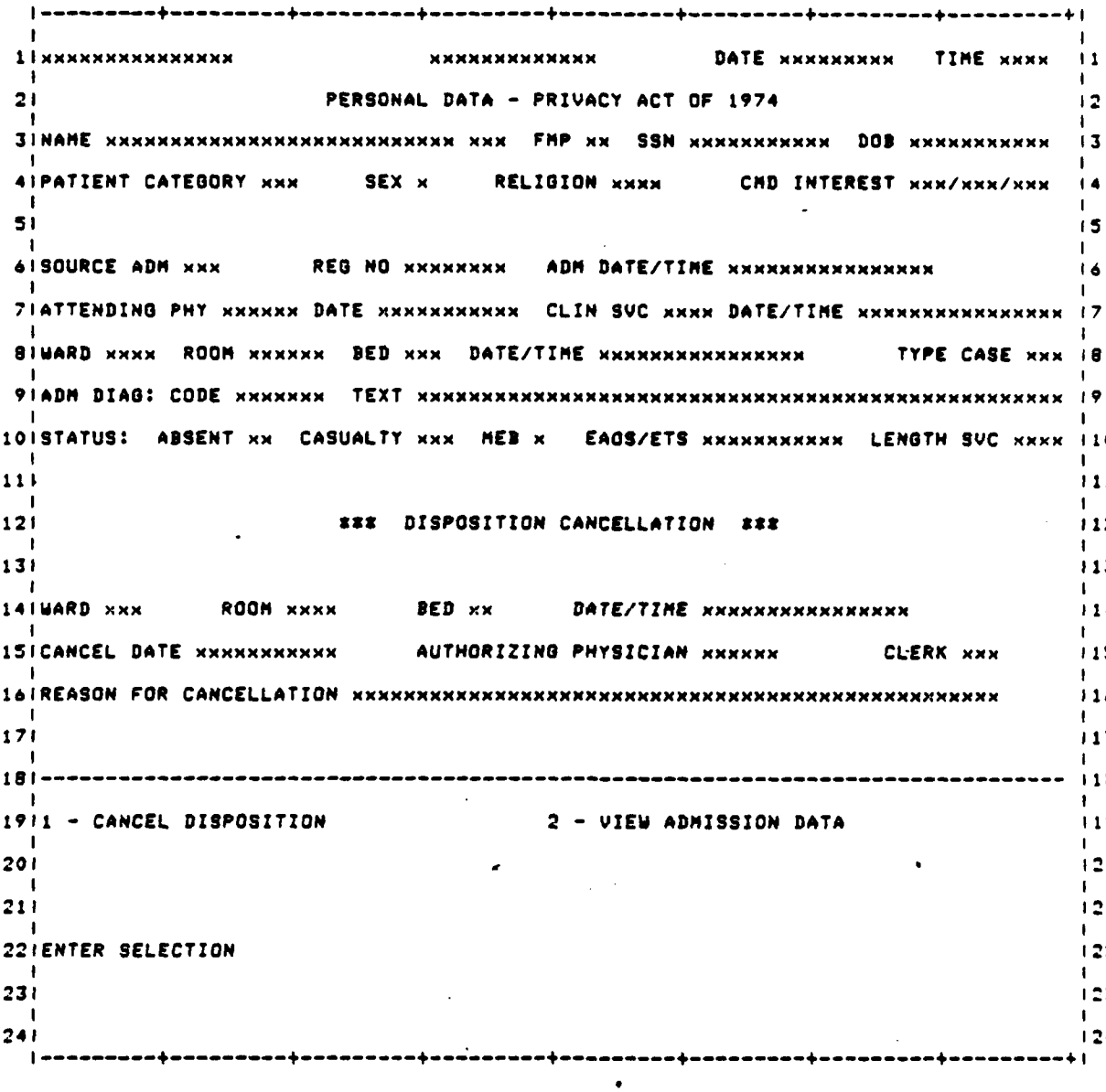


Figure 8-3. DISPOSITION - DISPOSITION CANCELLATION SEGMENT

The Disposition Cancellation segment can be used to cancel CRO and ERD cases (see section 6.2.2.2). An authorizing physician and a reason for the cancellation must be entered. Cancelling the disposition for either a CRO or ERD case automatically cancels its admission, but does not affect the patient's registration data.

If the user has cancelled a mother's disposition, the Newborn Disposition Cancellation segment will be displayed next for the dispositioned newborn (or newborns) associated with her inpatient episode. Figure 8-4 shows an example of the Newborn Disposition Cancellation screen segment. This segment displays the same data fields as the Disposition Cancellation segment, with additional fields for the infant's register number, name, FMP, and DOB, and with its own sub-menu. If the newborn was dispositioned, the user will be able to cancel that disposition, if appropriate, by selecting option 1 from this segment's sub-menu. If the newborn's disposition is to remain in effect, the user selects option 2.

8.4.2 View Admission Data. This option allows the user to view the admission data on a patient who has been dispositioned. After making this selection, the Entrance Data segment will be displayed in place of the Disposition segment, and the user will be able to view each segment in the Admission sequence, and to request inpatient products. None of the data on these segments can be updated in Disposition.

```
 1 xxxxxxxxxxxxxxx                xxxxxxxxxxxxx          DATE xxxxxxxxx   TIME xxxx
 2                        PERSONAL DATA - PRIVACY ACT OF 1974
 3 NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxx xxx  FMP xx  SSN xxxxxxxxxxx  DOB xxxxxxxxxxx
 4 PATIENT CATEGORY xxx      SEX x      RELIGION xxxx       CMD INTEREST xxx/xxx/xxx
 5
 6 SOURCE ADM xxx        REG NO xxxxxxxx    ADM DATE/TIME xxxxxxxxxxxxxxxx
 7 ATTENDING PHY xxxxxx DATE xxxxxxxxxxx  CLIN SVC xxxx DATE/TIME xxxxxxxxxxxxxxxx
 8 WARD xxxx  ROOM xxxxxx  BED xxx  DATE/TIME xxxxxxxxxxxxxxxx        TYPE CASE xxx
 9 ADM DIAG: CODE xxxxxxx  TEXT xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
10 STATUS:  ABSENT xx  CASUALTY xxx  MED x   EAOS/ETS xxxxxxxxxxx  LENGTH SVC xxxx
11
12                       ***  NEWBORN DISP CANCELLATION  ***
13 REG NO xxxxxxxx   NAME xxxxxxxxxxxxxxxxxxxxxxxxxx   FMP xx   DOB xxxxxxxxxxx
14 WARD xxxx       ROOM xxxxxx     BED xxxx     DATE/TIME xxxxxxxxxxxxxxxx
15 CANCEL DATE xxxxxxxxxxx        AUTHORIZING PHYSICIAN xxxxxx        CLERK xxx
16 REASON FOR CANCELLATION xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
17
18 ------------------------------------------------------------------------------
19 1 - CANCEL NEWBORN DISPOSITION          2 - LEAVE NEWBORN AS IS
20
21
22 ENTER SELECTION:
23
24
```

Figure 8-4. DISPOSITION - NEWBORN DISPOSITION CANCELLATION SEGMENT

SECTION 9. CORRECTION MANAGEMENT SCREENS

9.1 Correction Management Function - Overview. Correction Management allows the user to correct errors in the patient record that are not correctable through any other AQCESS function. Through this function, the user can correct absent status, clinical service, and ward assignment data. If an Admission and Disposition Report contains any incorrect data, the user can enter notes in Correction Management that will appear on the next A&D Report that is printed.

When this function is chosen from the User Entry Menu, the Register Number Identification Screen is displayed, on which the user enters the register number of the record to be corrected. If the record has been accessed by Clinical Records, it is not available to Correction Management or R/ADT users unless the record is released from Clinical Records.

If the record is available in Correction Management, the screen displays the register number, name, FMP, and SSN of the patient, and a sub-menu of functions the user can access (Figure 9-1). The user can edit certain Admission and Disposition data, edit text notes for the next A&D Report, or edit an event record, which contains absent status, clinical service, and ward change data. These selections are described in the paragraphs to follow.

9.2 Editing Admission and Disposition Data. This option displays the Admission and Disposition Data Screen, showing data that was entered in Admission and Disposition, and the user will be able to correct it (see Figure 9-2). Consistency edits will be performed on some of this data as it is entered, and on other data when the user has finished processing for this screen. When the user has completed processing on this screen, the system will ask the user to confirm that the correction should be filed.

The following conditions apply to data entry on the Admission and Disposition Data Screen:

a. The user cannot disposition a patient or cancel a disposition.

b. The user cannot enter a CRO or ERD or pay status code at SOURCE OF ADMISSION.

c. The user cannot change a source of admission if it is CRO, ERD, pay status, absent sick, or cancelled.

d. The system deletes related transfer-in data if the source of admission is changed from transfer-in to direct.

e. The user must enter related transfer-in data if he or she has changed the source of admission to transfer-in.

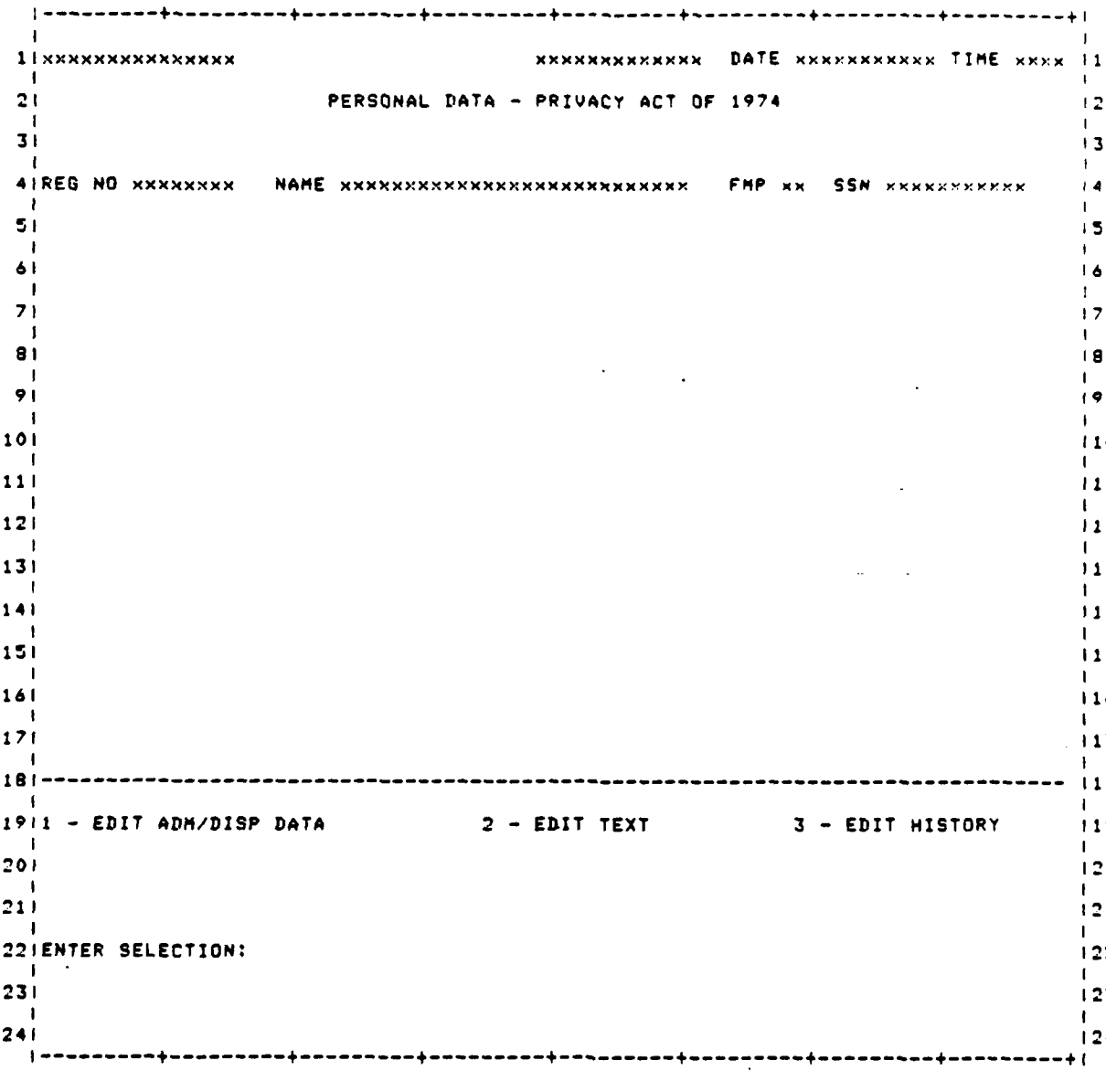


Figure 9-1. CORRECTION MANAGEMENT ID SCREEN, showing Patient Data and Sub-Menu

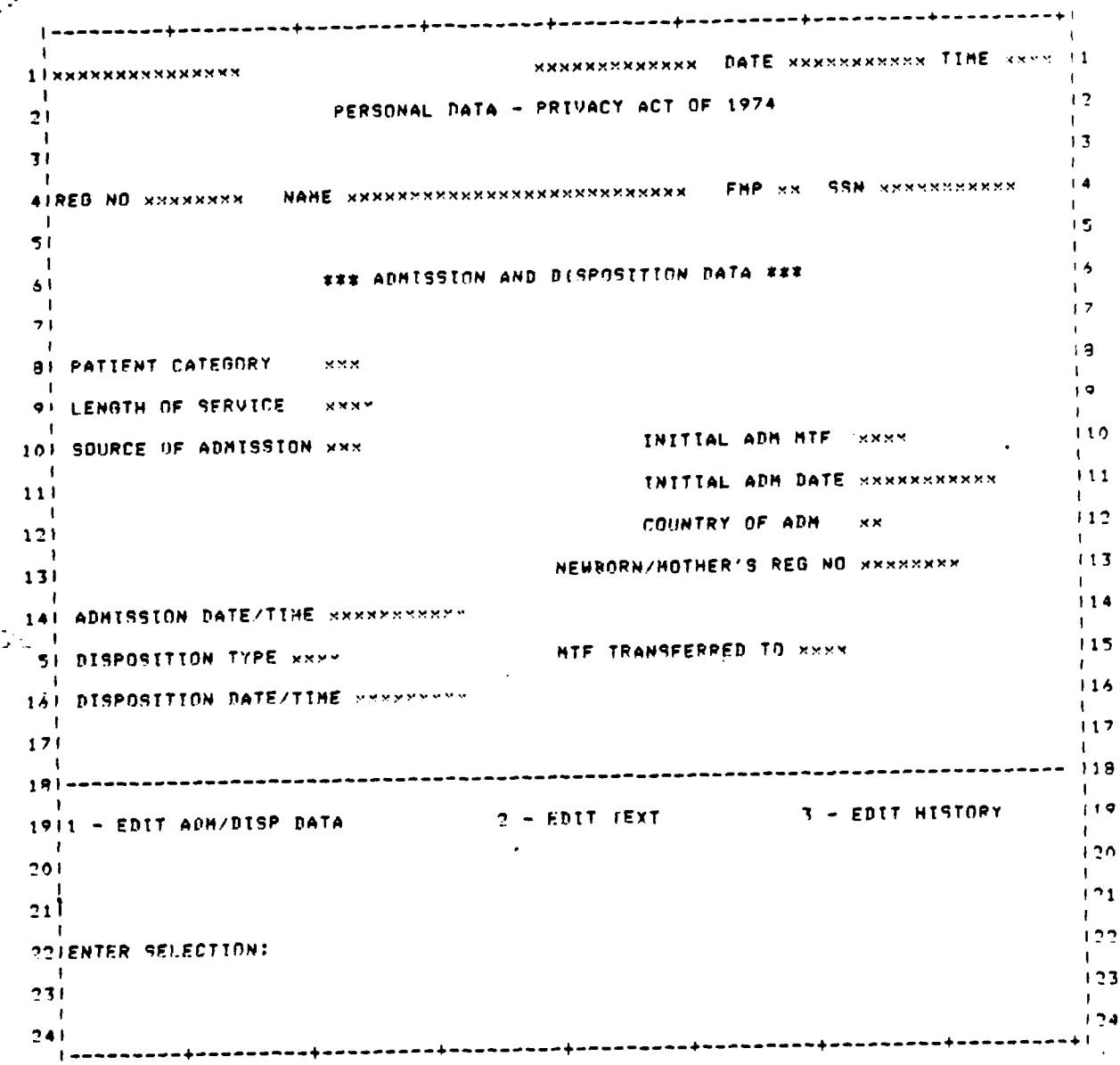


Figure 9-2. CORRECTION MANAGEMENT - ADMISSION & DISPOSITION DATA SCREEN

f. The user must enter mother's register number if the source of admission is changed to newborn.

g. The system automatically updates the effective dates and times for first absent status and clinical service entries if the user changes the date and time of the patient's admission.

h. The user must enter the code for the MTF transferred to, if the disposition code is changed to transfer-out.

i. The system will delete the code for MTF transferred to, if the user changes the disposition code from transfer-out to a non-transfer code.

9.3 Editing Text Notes for the A&D Report. This option enables the user to correct textual notes for a particular inpatient episode that will appear on the next A&D Report. The user will only be able to edit notes that will be printed on the next A&D Report, not notes that have appeared on previous reports. When the user makes this selection, the Text Notes Screen is displayed, showing any notes that the system has automatically generated for the next report (Figure 9-3). The REPORT DATE shows the date of the report on which the note will be printed.

The user will be able to change the notes displayed and to add, change, or delete new notes. When adding notes, the user will not be able to change the REPORT DATE, which will always be today's report. In the EFFECT DATE field, the user enters the date of the A&D Report to which the new note refers.

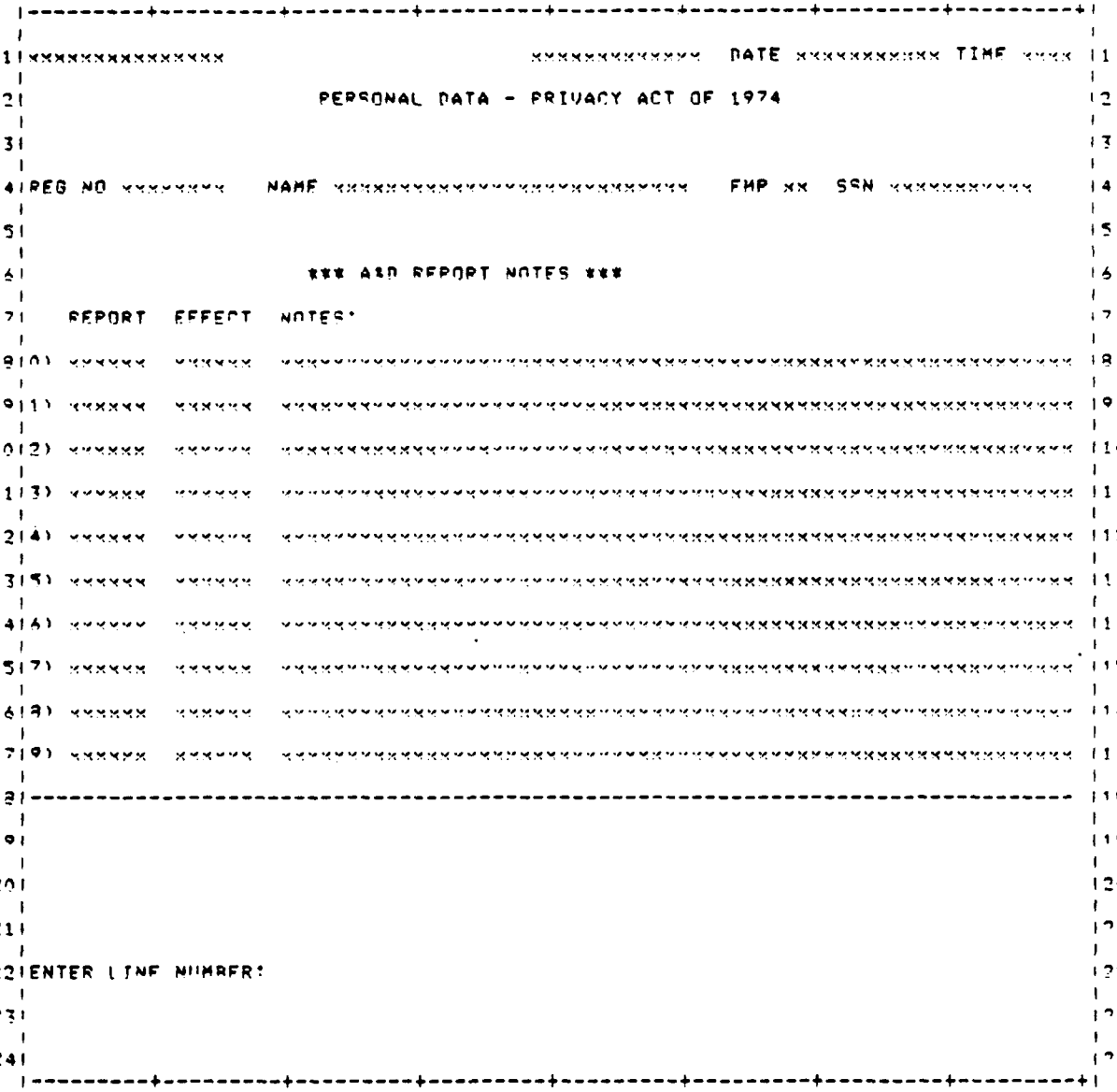


Figure 9-3. CORRECTION MANAGEMENT - TEXT NOTES SCREEN

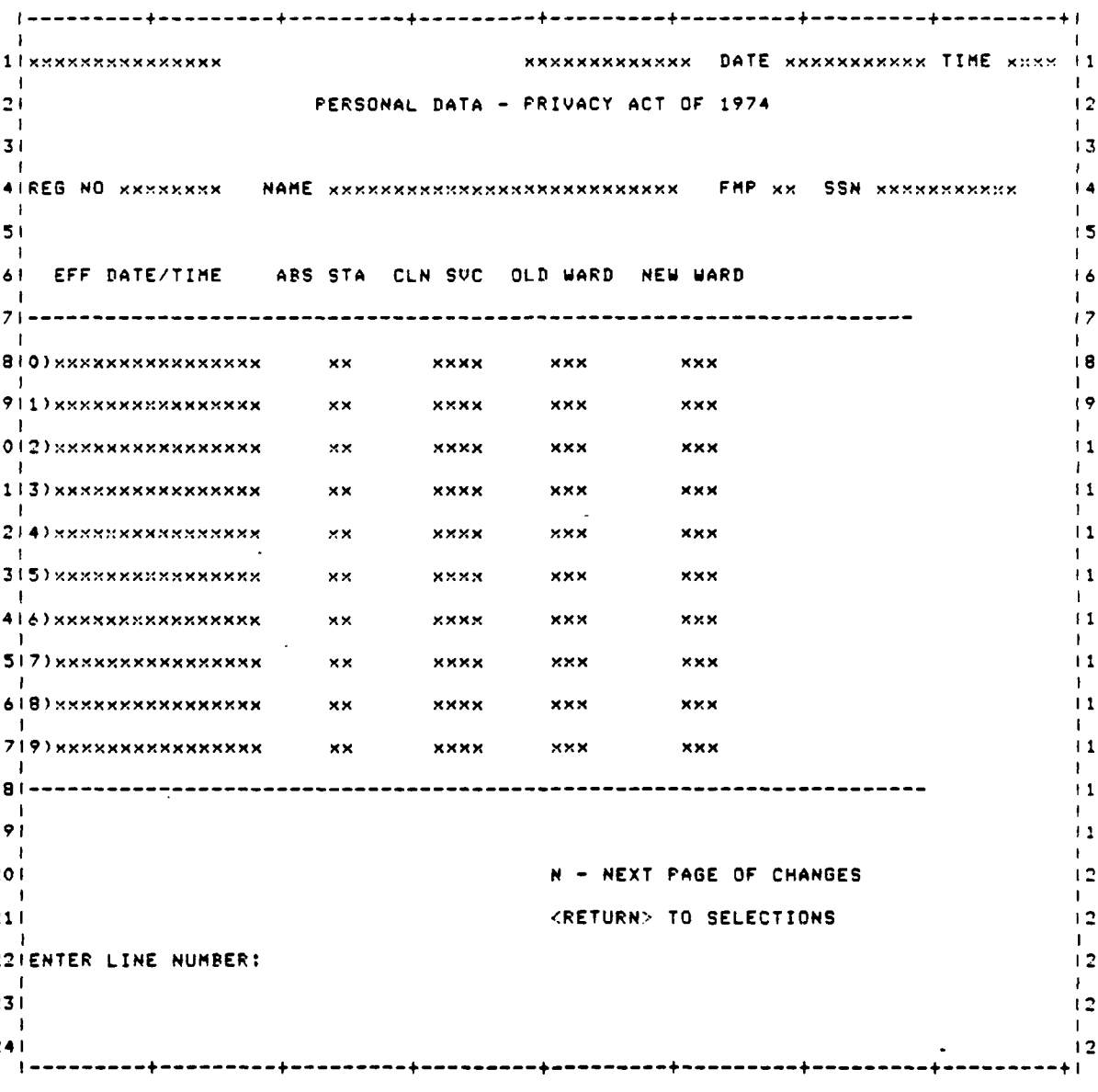


Figure 9-4. CORRECTION MANAGEMENT - EVENT RECORD SCREEN

9.4 Editing an Event Record. With this selection, the user is able to change records of A&D events. An A&D event is an admission, a disposition, or a change in the patient's ward, clinical service, or absent status that is reported on the A&D Report. The Event Record Screen displayed by this selection shows patient identification data, and one line of data for each change in ward, clinical service, or absent status that has already been entered on this patient. The patient's admission and disposition are also represented by one line of data each (Figure 9-4).

If the patient was admitted as "Bed Occupied," the first line of data will display the clinical service and ward assigned at admission. Any absent statuses other than Bed Occupied indicates that the patient is absent from the MTF and can be referred to as an "out" status. If the patient had an out status at the time of admission, the first line of data will show the clinical service and/or ward entered at admission, and the second line will show the absent status. This is tracked as an admission and change of status out.

The remaining lines of event record data will show any changes to ward, absent status, and clinical service that have already been entered. If the patient has been dispositioned, the last line of data will reflect the ward assignment in effect at disposition.

The following conditions govern how event record data is displayed on this screen:

a. Two "out" absent statuses will not appear consecutively.

b. If absent status changes to an "out" status, an OLD WARD will be displayed.

c. If absent status changes to Bed Occupied, a NEW WARD will be displayed.

d. Changes to and from an absent status of "On Pass" will not result in a NEW or OLD WARD displayed, since days spent On Pass are counted as bed days.

e. If the ward changes, the old ward and the new ward will be displayed.

Ten event records can be displayed on each page of this screen. The user can enter "N" to view the next page of event record data.

The user can insert a new line of data into the event record list. (Data cannot be added to the end of the list for current patients, since that would become the current data for the patient, and that kind of change can be can be entered through another R/ADT function.) Whether inserting or changing data, the user must observe the constraints described above (i.e., when the user enters a change to an "out" status, he or she must enter a ward ID under OLD WARD, etc.).

To insert data about an event record change, the user enters the number of the first blank event line and then the effective date and time of the change. The system prompts the user to specify which type of event is being created (absent status, clinical service, or ward). If the date/time is valid, the user will be able to enter the data.

To update an existing event record, the user enters its line number.

SECTION 10. BED MANAGEMENT SCREEN

10.1 Bed Management Function - Overview. Bed Management maintains figures on the number of beds that are occupied or available on each ward in the MTF. Through this function, the user can review bed availability statistics and can create or delete ward status records, which define the wards for the system.

When this function is chosen from the User Entry Menu Screen, the Bed Management ID Screen is displayed, on which the user enters the ID of a ward. (The user can enter "TOT" to review bed availability totals for all wards in the MTF.) After a valid ward ID (or "TOT") is entered, the Bed Management Screen appears (Figure 10-1).

10.2 Bed Management Screen. The Bed Management Screen displays current information on the ward selected, or total figures for the whole MTF (see Data Chart 10-1). This ward information is referred to as a "ward status record." The ward status record defines the ward to the system.

(1) WARD ID. ID number of the ward for which data is requested. Cannot be all numeric.

(2) AVAILABLE BEDS. Number of available beds on the ward. For display only.

(3) DESCIPTION. The type of ward this is (e.g., pediatrics). Free text.

(4) BLOCKED BEDS. Number of beds in use or temporarily marked as unavailable. This figure is the sum of the number of occupied beds, beds reserved for preadmits, and otherwise unavailable beds ("OTHER"). For display only.

(5) OCCUPIED BEDS. Number of beds currently in use. For display only.

(6) PREADMITS. Number of beds reserved for preadmits. For display only.

(7) OTHER. The number of beds that are unavailable for other reasons.

(8) TOTAL: BEDS. The number of beds physically assigned to the ward.

Data Chart 10-1. BED MANAGEMENT SCREEN

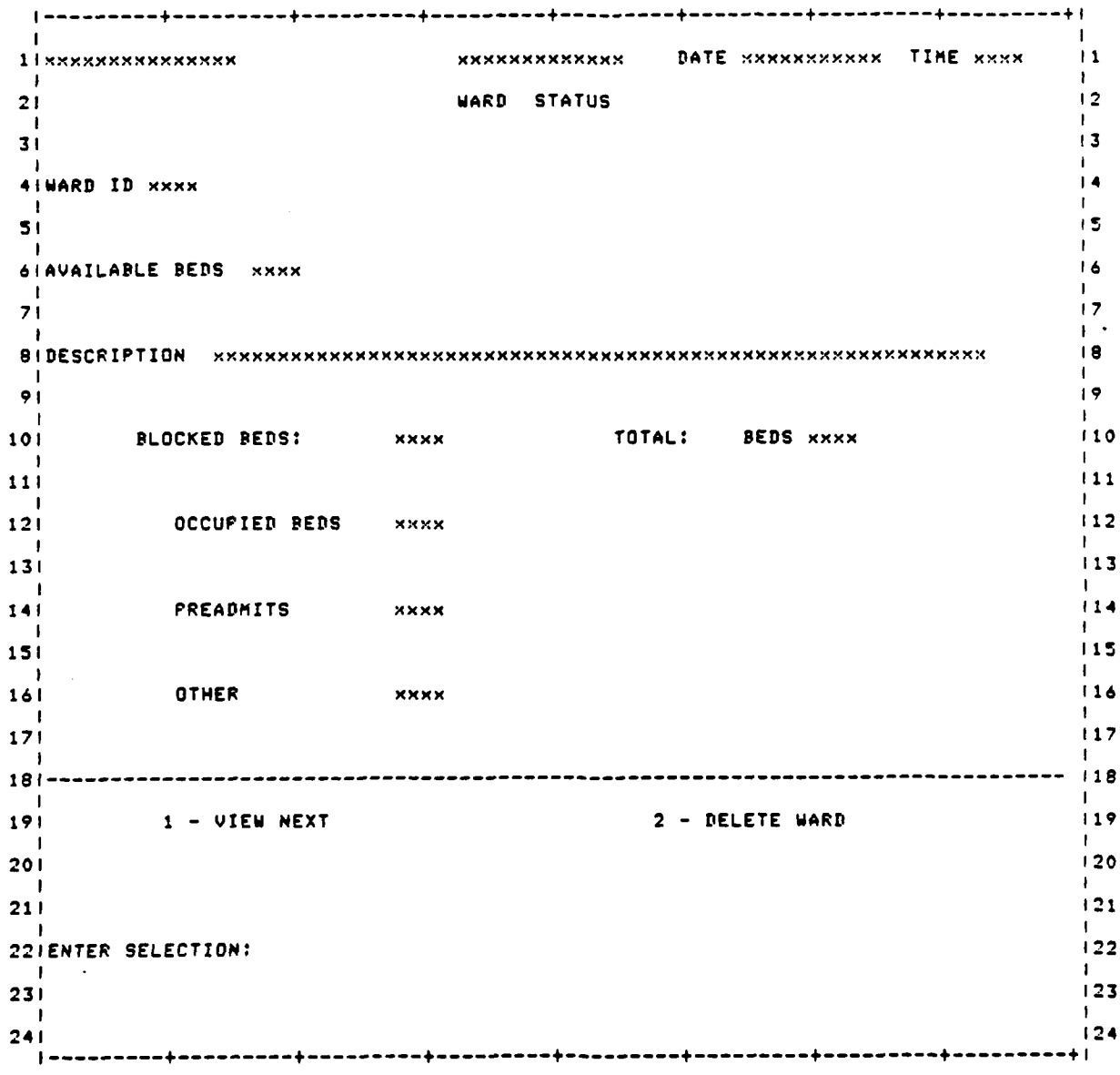


Figure 10-1. BED MANAGEMENT SCREEN

The user creates a ward status record by entering, on the ID Screen, the ID of a ward that does not currently exist on the system. The system edits the new ward ID entered to make sure that no ward with that ID already exists. Then on the Bed Management Screen, the user enters its description, the total number of beds assigned to it, and number of blocked beds, if any.

The Bed Management Screen lists the following sub-menu options.

a. View Next. With this option, the user can view information on each ward in the MTF in turn.

b. Delete Ward. With this option, the user can logically delete a ward status record. Deleting a record makes the ward inactive; the actual record is retained on the system with 0 beds, and can later be reactivated.

Only the ward status record of an empty ward can be deleted. If any of the beds on that ward are blocked, the ward status record cannot be deleted. When the user has entered a ward ID on the ID Screen, the Bed Management Screen displays data on that ward. If the user chooses this option, and the ward has no current blocked beds, the system will display a message prompting the user to confirm that this ward should be deleted. The ward status record will not be physically removed from the file. It will be flagged as deleted as of the date when it was deleted.

SECTION 11. SYSTEM MANAGEMENT SCREENS

11.1 System Management Function - Overview. This function is used by the system manager to regulate the operation of AQCESS and to ensure the security of the system. Only an authorized system manager has access to System Management, and only one person can use this function at any given time.

When the user selects this option from the User Entry Menu, the System Management Menu Screen is displayed (Figure 11-1), listing the actions that can be performed. Through System Management, the system manager can:

a. Modify system tables, which define the valid entries for specific data fields on the system's screens, and print table listings.

b. List system tables.

c. Maintain hospital profile data, including the MTF's name and code, the default service code, and whether the MTF has chosen to have register numbers assigned to records automatically or manually.

d. Reserve blocks of register numbers for manual assignment to records, or release reserved blocks of numbers for automatic assignment.

e. Generate user IDs and passwords, assign functional privileges to users and to terminals, and allow locked-out users to re-access the system.

This section describes the functions listed on the System Management Menu.

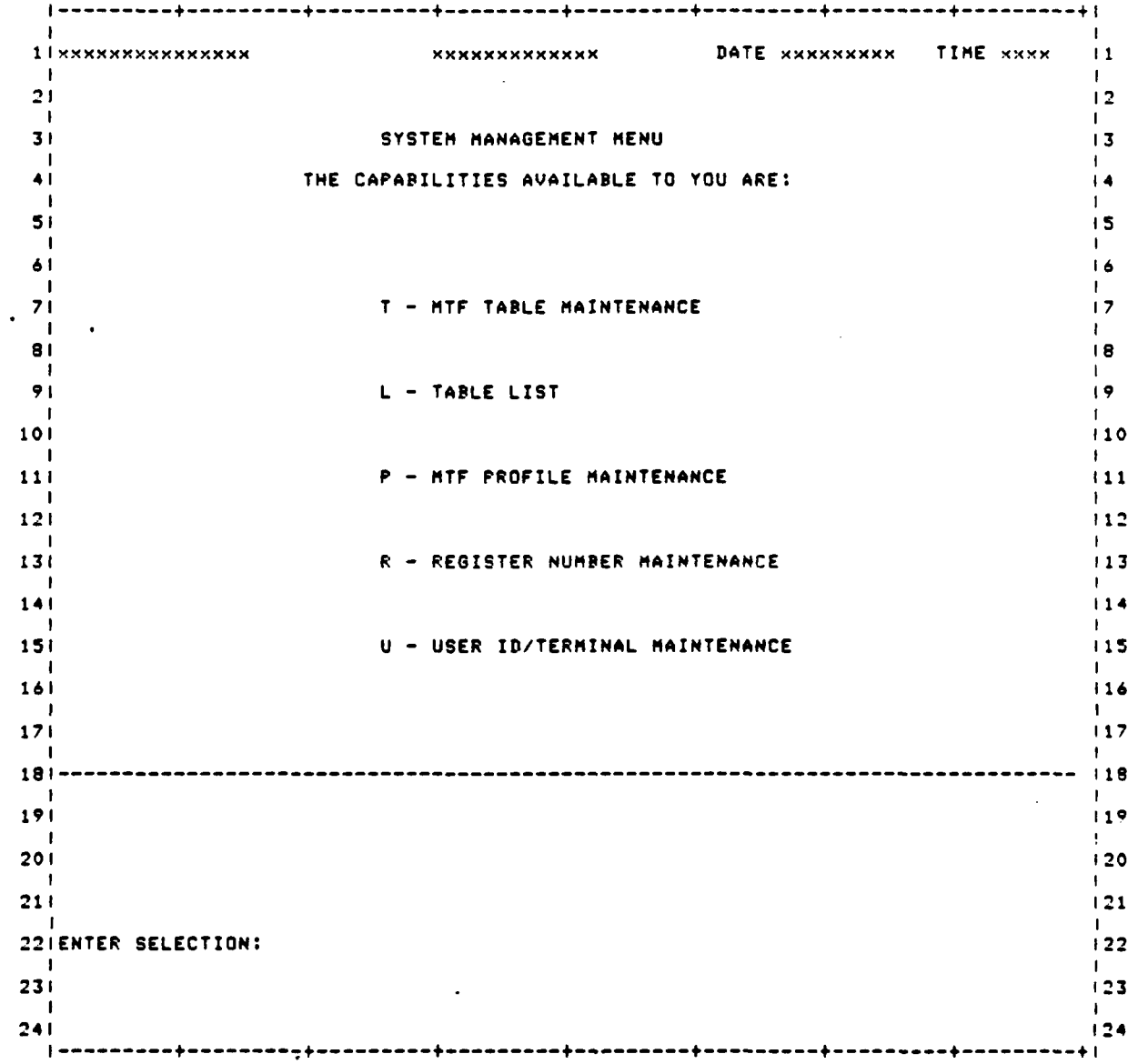


Figure 11-1. SYSTEM MANAGEMENT MENU SCREEN

11.2 MTF Table Maintenance. Figure 11-2 shows the Table Maintenance Screen as it appears when the Table Maintenance option is selected. Through Table Maintenance, the system manager can change, add, or delete individual table items, or view information on them. These options are listed on the Table Maintenance Screen's sub-menu.

Whether the user chooses to view, add, delete, or change table items, he or she must first identify the table in question. When the user chooses one of these options from the sub-menu, the screen displays a field in which to enter the ID number of the table. The user can query Help for a list of the tables and their IDs.

The user must then enter the code that he or she wishes to add, change, delete, or view. The code is the set of characters that is entered in a given data field, such as "A41" denoting an Army dependent, or "DIR" meaning a direct admission. The user may enter a ? to have the codes in the current table listed on the screen.

After the table and code are identified, the information that is displayed varies depending on which function the user selected.

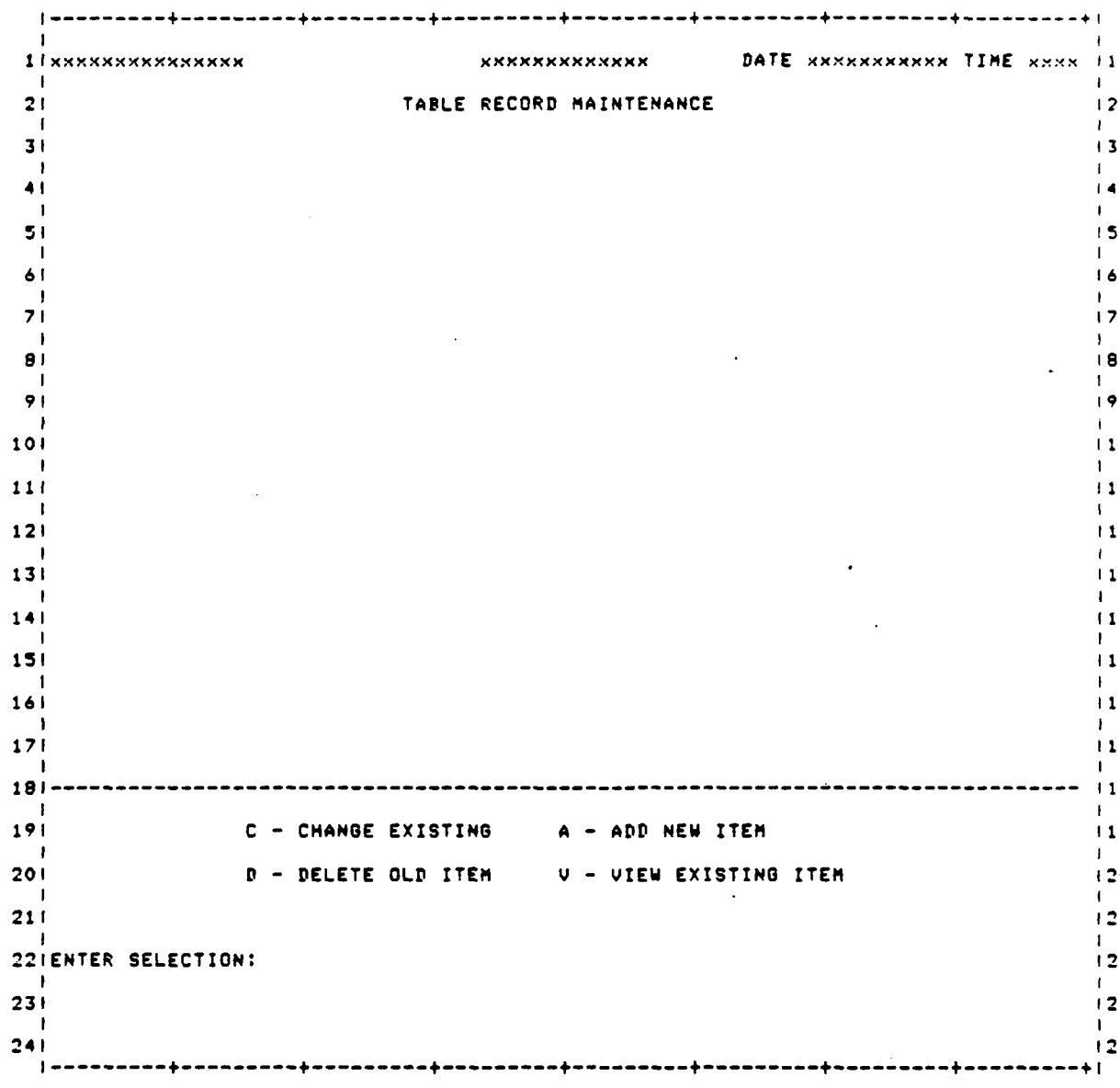


Figure 11-2. SYSTEM MGMT. - TABLE MAINTENANCE SCREEN

a. Changing an Existing Item. When the user chooses to change an individual table item, the screen displays the description of that item and any additional parameters applicable for the selected table. Different additional parameters are displayed for different tables. The user is able to change any or all of the information.

For many tables, the first piece of additional information to appear after the item's description, are the edit flags that may be associated with that item. An edit flag is a single-digit number that stands for an additional piece of information describing the data item. Edit flags are associated with the codes on some, but not all, system tables, and are important to system processing and consistency editing.

When the Table Maintenance Screen displays the data for a table item that is to be changed, it will list all of the edit flags for that item and display, in turn, the table that shows what each edit flag means. For example, for the code "TFR" on the Disposition Type Table, the flags are 3311. Below, that, the screen displays the following:

Flag 1

1 - Predisposition
2 - Death
3 - Transfer
4 - Same day (DSD)

This shows that the meaning of the first flag ("3") is "Transfer." The user can enter another number for the flag, or press the RETURN key and see the table for the next flag, which is:

Flag 2

1 - Military only
2 - Civilian only
3 - Both

Since the second flag is "3," this means that the disposition type of "transferred" can be entered for both military and civilian patients. Each of the subsequent edit flags supplies an additional piece of information about the data item. The number and kind of edits flags is different for each table.

After all of the edit flags have been displayed, more information on the item can be displayed. For the Disposition Type Table, service flags for the code are displayed. These flags indicate for which Military Departments this code is valid. Then, for this table, codes that represent the data item on the Coding Transcript Tape are displayed in the NAVY, AIR FORCE, and ARMY fields. Data Chart 11-1 describes the data that is displayed for the Disposition Type Table.

(1) TABLE ID. The ID number of the table on which an item is to be changed. Table IDs and names are displayed if Help is used.

(2) TITLE of the table.

(3) CODE. The code to be changed.

(4) DESCRIPTION. The meaning of the code. For example, the description of the source of admission code "ABS" is "direct, absent sick," and the description of the disposition type "TFR" is "transferred."

(5) FLAGS. The numerical edit flags associated with this item. Each flag is a one-digit number. (May not be displayed for all tables.)

(6) SERVICE FLAG. Indicates which services this code is valid for. (May not be displayed for all tables.)

(7) ARMY CODE. The Army code for this data item that is included in reports to higher commands. (May not be displayed for all tables.)

(8) AIR FORCE CODE. The Air Force code for this data item that is used in reports to higher commands. (May not be displayed for all tables.)

(9) NAVY CODE. The Navy code for this data item that is used on reports to higher commands. (May not be displayed for all tables.)

Data Chart 11-1. SYSTEM MGMT. - TABLE MAINTENANCE SCREEN - CHANGING AN EXISTING ITEM

When the user has finished entering changes, the screen displays a message asking the user to confirm that everything is now correct. The user's changes will be stored on the system only if the user confirms.

b. Deleting an Old Item. With this request, the user enters the ID of the table and enters the code to be deleted. Then a message is displayed asking the user to confirm that the deletion should be made. The item will be deleted from the table if the user confirms.

c. Adding a New Item. When the user has identified a table, he or she enters a code to be added and the description of the code. The user must enter any additional parameters defined for the selected table. If edit flags are applicable, the screen will display in turn the table for each edit flag associated with the particular system table, as it does when an existing item is being changed. The user must indicate the value of the flag for the new item, specify service codes (if applicable), and then confirm that the addition is correct.

d. Viewing an Existing Item. When the user has identified the table and the item to be viewed, the screen displays the item's description and lists the additional information associated with it. If edit flags are associated with the table, their meanings are not displayed. Figure 11-3 shows the data that would be displayed if the user chose to view the "TFR" item on the Disposition Type Table.

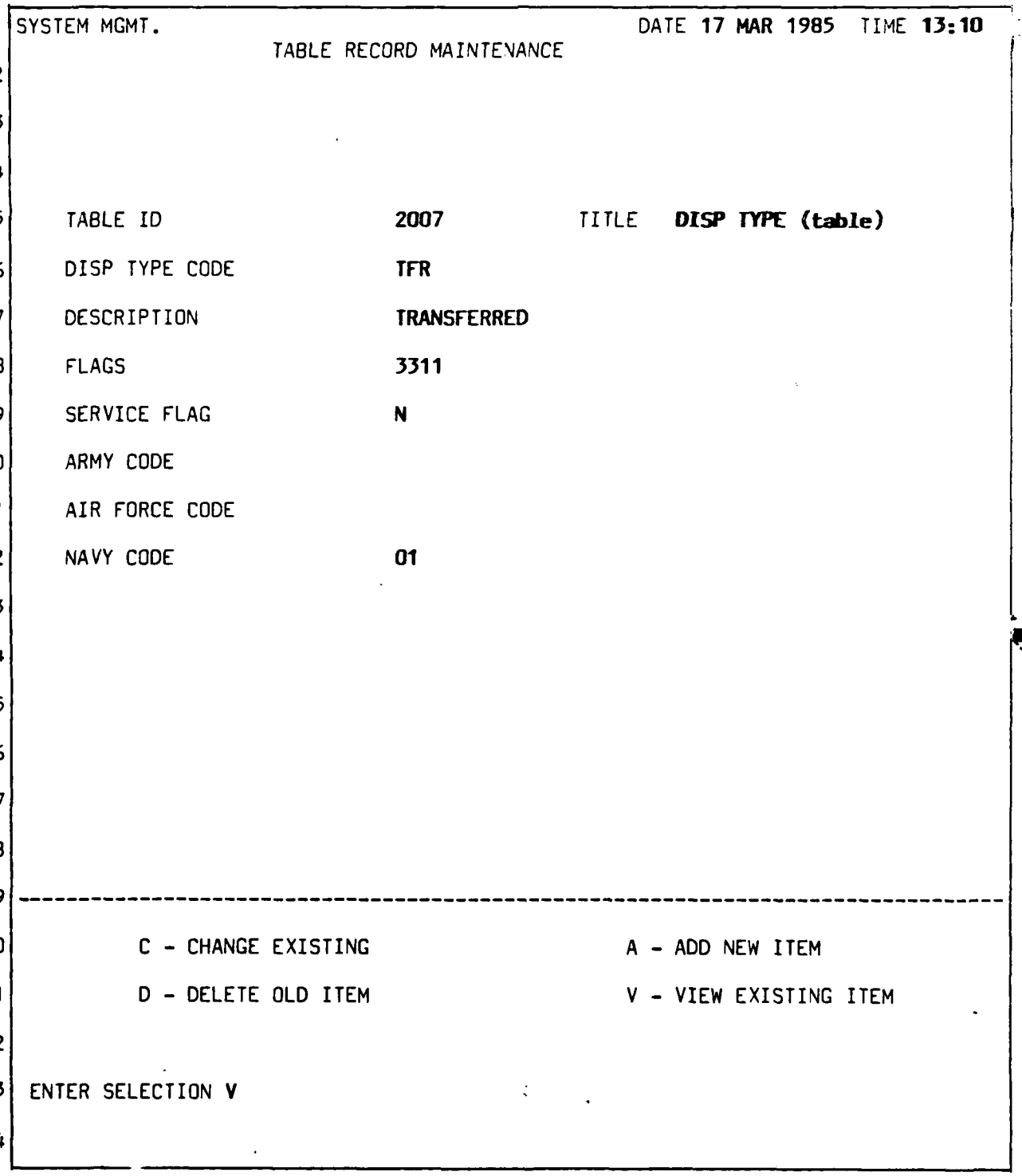


Figure 11-3. SYSTEM MGMT. - TABLE MAINTENANCE SCREEN, Viewing an Existing Item

11.3 Table List. The Table List option allows the user to view a list of the names and ID numbers of the system tables, and to print any or all of the tables. When this option is chosen, the Table List Screen is displayed (Figure 11-4).

This screen can display up to 20 tables per page. Selecting the "N" option on the Table List sub-menu will display the next and subsequent pages of the list. The "A" option requests printing of all the system tables, and option "S" requests printing of an individual table that the user specifies.

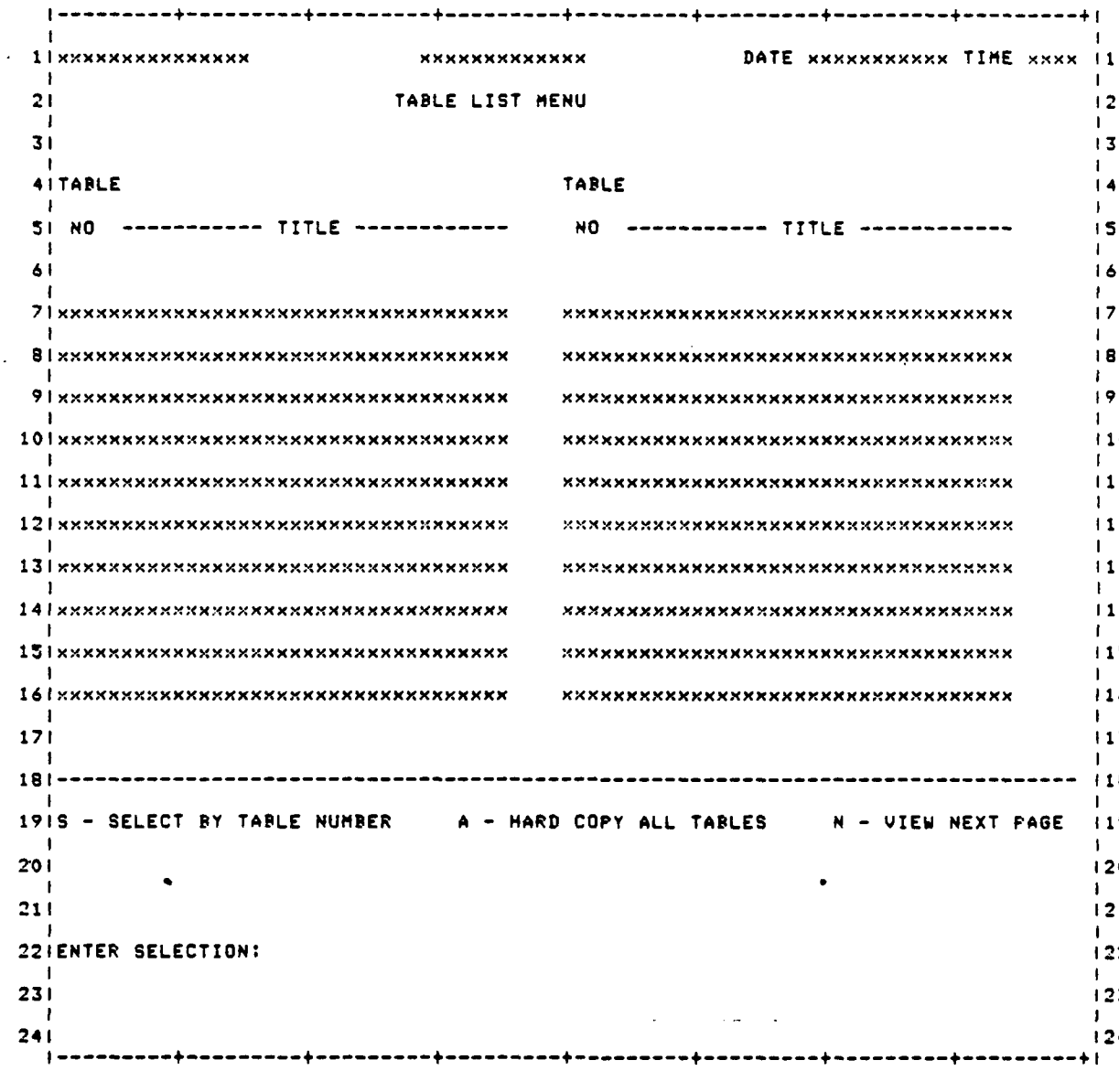


Figure 11-4. SYSTEM MGMT. - TABLE LIST SCREEN

11.4 MTF Profile Maintenance. The MTF Profile contains data that regulates some of the system's operations, and data that identifies the MTF and appears on system reports. The system manager will be able to review or update the MTF Profile data. (See Figure 11-5 and Data Chart 11-2.)

(1) MTF NAME.

(2) MTF CODE.

(3) DEFAULT SERVICE CODE. This MTF's branch of service.

(4) VERSION NUMBER of the AQCESS software.

(5) REGISTER NUMBER IND (Y/N). "Y" indicates the Admission function assigns register numbers automatically to new records; "N" indicates that register numbers are being entered manually by system users.

(6) INDEX CARDS (# PER SET). The number of 3X5 Cards or 5x8 Cards in each set requested in Admission.

(7) WAR (Y/N). Indicates whether a state of war exists.

(8) DELINQUENCY DAYS. Number of days after disposition by which a record must be completely processed in Clinical Records or be considered delinquent.

(9) TAPE TO ARCHIVE MONTHS. Number of months before a completely processed record should be archived.

(10) INVALID ATTEMPTS BEFORE LOCKOUT. The number of times in succession that an invalid user ID/password combination can be entered before the terminal or the user ID/password locks.

(11) STAND ALONE QA SYSTEM. Indicates whether this MTF is running the Quality Assurance function only, without the other AQCESS functions.

(12) DAYS TO DELINQUENCY FOR CHECKLIST. Number of days after disposition by which an incompleted Occurrence Screening Checklist is considered delinquent.

(13) DAYS TO DELINQUENCY FOR MED REC. Number of days after the start of Clinical Records processing by which the chart must be complete or be considered delinquent, which will cause a delinquency to be posted to the provider profile.

(14) AUTO ER LOG NO. "Y" indicates that log numbers are assigned automatically by the system to Emergency Room episodes. "N" indicates that they are assigned manually by the user.

Data Chart 11-2. SYSTEM MGMT. - MTF PROFILE MAINTENANCE SCREEN

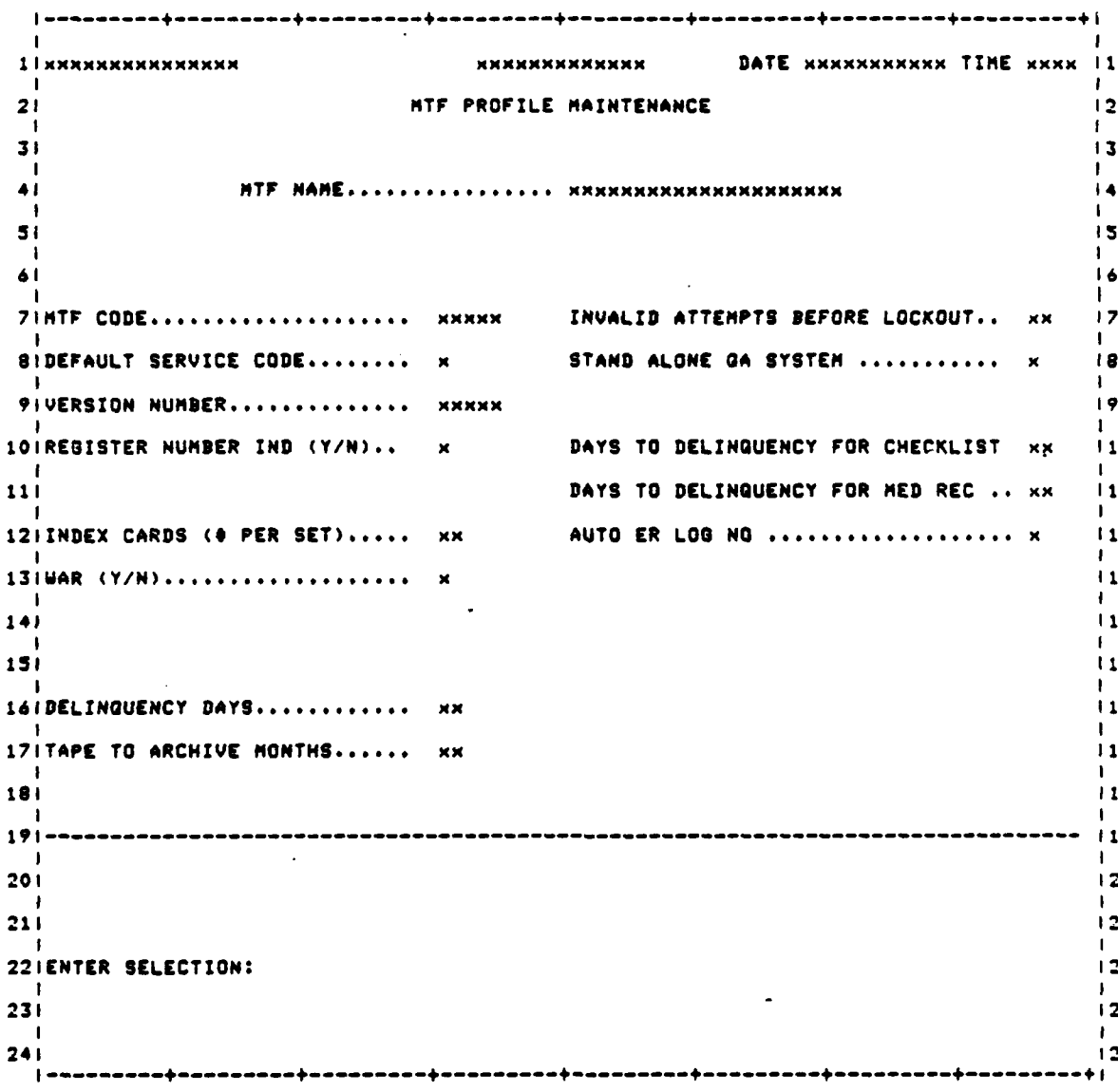


Figure 11-5. SYSTEM MGMT. - MTF PROFILE MAINTENANCE SCREEN

11.5 Register Number Maintenance. On the Register Number Maintenance Screen, the system manager can:

a. Specify a block of register numbers to be assigned manually to patient records.

b. Release blocked numbers to a cancel pool so that the system will assign them automatically to records (this cancel pool of numbers is displayed on the right side of the screen).

c. View a list of the numbers of a reserved block that have been assigned to records.

To use this function, the register number indicator on the MTF Profile must be set to "Y," meaning that register numbers are being assigned to records automatically in the Admission function (see section 11.4). The system manager should perform Register Number Maintenance only when no one else is using the system, since it affects the assignment of register numbers, which can be taking place constantly when other users are on the system.

Figure 11-6 shows the format of the Register Number Maintenance Screen, and Data Chart 11-3 describes its fields. The options on this screen's sub-menu operate as follows:

a. Reserve Block #. When the system is set to assign register numbers automatically, blocks of register numbers can be set aside to be assigned to records manually by users. After selecting this option, the system manager specifies how many register numbers to reserve. Then Register Number Maintenance calculates which register numbers will be set aside, based on the number in the NEXT SEQUENTIAL REGISTER NUMBER field. It also automatically decreases the number in the QUANTITY REMAINING field as these reserved numbers are actually assigned to records. Up to five blocks of register numbers can be reserved.

b. Release Block #. A block of register numbers that has been reserved can also be released to be assigned automatically by the system. The released numbers will go into the cancel pool, and be listed on the right side of the screen. The system will assign these numbers in sequence. Any reserved number that has already been assigned will not be affected, and will not go into the cancel pool.

c. View Used Blocks. When this option is chosen, the screen will list the numbers within a reserved block that have already been used. This list will appear in the cancel pool display area.

d. Return to Cancel Pool. If the cancel pool display area contains the list of used register numbers accessed by the View Used Blocks option, this option will redisplay the cancel pool.

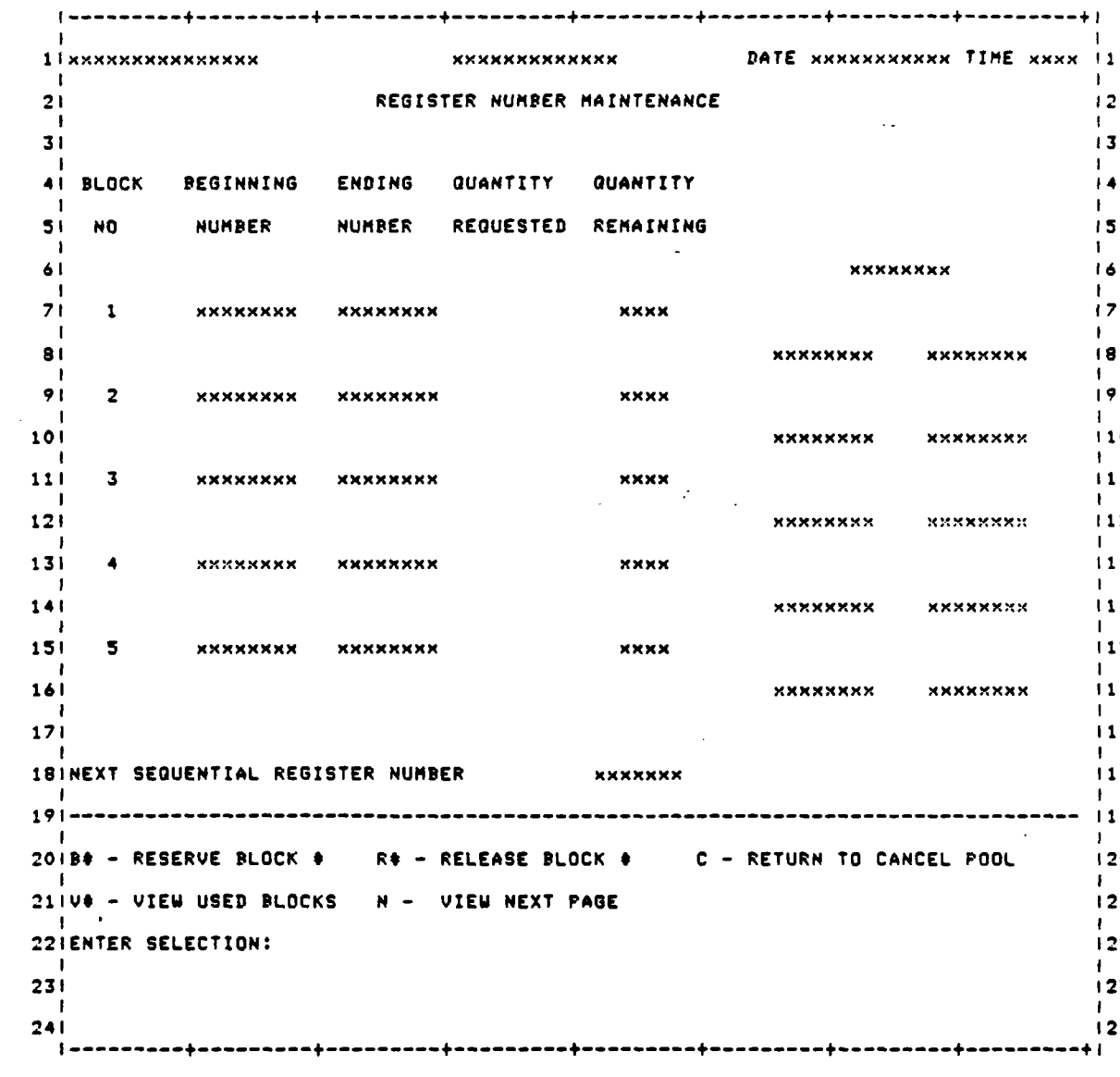


Figure 11-6. SYSTEM MGMT. - REGISTER NUMBER MAINTENANCE SCREEN

e. View Next Page. Each page of the screen displays up to 20 cancel pool numbers or 20 used numbers. This selection will display subsequent pages of either. The rest of the screen will continue to display the five blocks of reserved register numbers.

(1) BLOCK NO. The number identifying the block to be reserved or released.

(2) BEGINNING NUMBER. The first register number in the block. Calculated by the system from the number in the NEXT SEQUENTIAL REGISTER NUMBER field.

(3) ENDING NUMBER. The last register number in the block. Calculated by the system by adding the QUANTITY REQUESTED to the BEGINNING NUMBER.

(4) QUANTITY REQUESTED. The number of register numbers that the system manager wants to reserve.

(5) QUANTITY REMAINING. The number of register numbers in the reserved block that have not yet been assigned manually. Calculated by the system.

(6) CANCEL POOL. If a block of register numbers that has been reserved is released, to be assigned automatically, any numbers in that block that have not been used will go into the cancel pool. The cancel pool also contains any number applied to an admission that was later cancelled. The cancel pool is displayed on the right side of the screen; it can contain up to 20 register numbers.

(7) NEXT SEQUENTIAL REGISTER NUMBER. The next register number to be assigned to a record. Calculated by the system.

Data Chart 11-3. SYSTEM MGMT. - REGISTER NUMBER MAINTENANCE SCREEN

11.6 User ID/Terminal Maintenance. This function is used to generate user IDs and passwords, assign functional privileges to users and to terminals, and release locked-out users and terminals. When this option is selected from the System Management Menu Screen, the User ID/Terminal Maintenance Menu is displayed (Figure 11-7). The following paragraphs describe the options available from this menu.

11.6.1 User ID/Password Maintenance. This option is used to create new user IDs. It also enables the system manager to view or update information on each user ID, including what functions and other privileges are allowed to a particular user. The system manager can also use this function to release locked-out users.

When the User ID Maintenance Screen is displayed and the system manager enters a valid user ID, information on that user will be displayed, except the password, which can be viewed on request. The system manager can update any of this information. Figure 11-8 shows the User ID Maintenance Screen, and Data Chart 11-4 explains its fields.

The CAPABILITIES field lists the AQCESS functions available to this user, by the letter or number listed for each function on the User Entry Menu. The capabilities may be specified by entering a string of letters and numbers or by selecting a canned profile of capabilities. Rather than re-entering the capabilities string to change it or to modify a standard profile, the system manager uses the MODIFIED BY field to add or subtract capabilities from the existing string.

The user can also update the LOCKOUT FLAG. This field will be set to "1" if the person with this user ID and password has been locked out of the system. A user will be locked out if he or she enters a password incorrectly a number of times in succession. The number of chances the user has to enter the password correctly is specified by the MTF (via MTF Profile Maintenance; see section 11.4). By entering zero in the LOCKOUT FLAG field, the user will be unlocked. Conversely, the system manager can change zero to "1" to lock out a user.

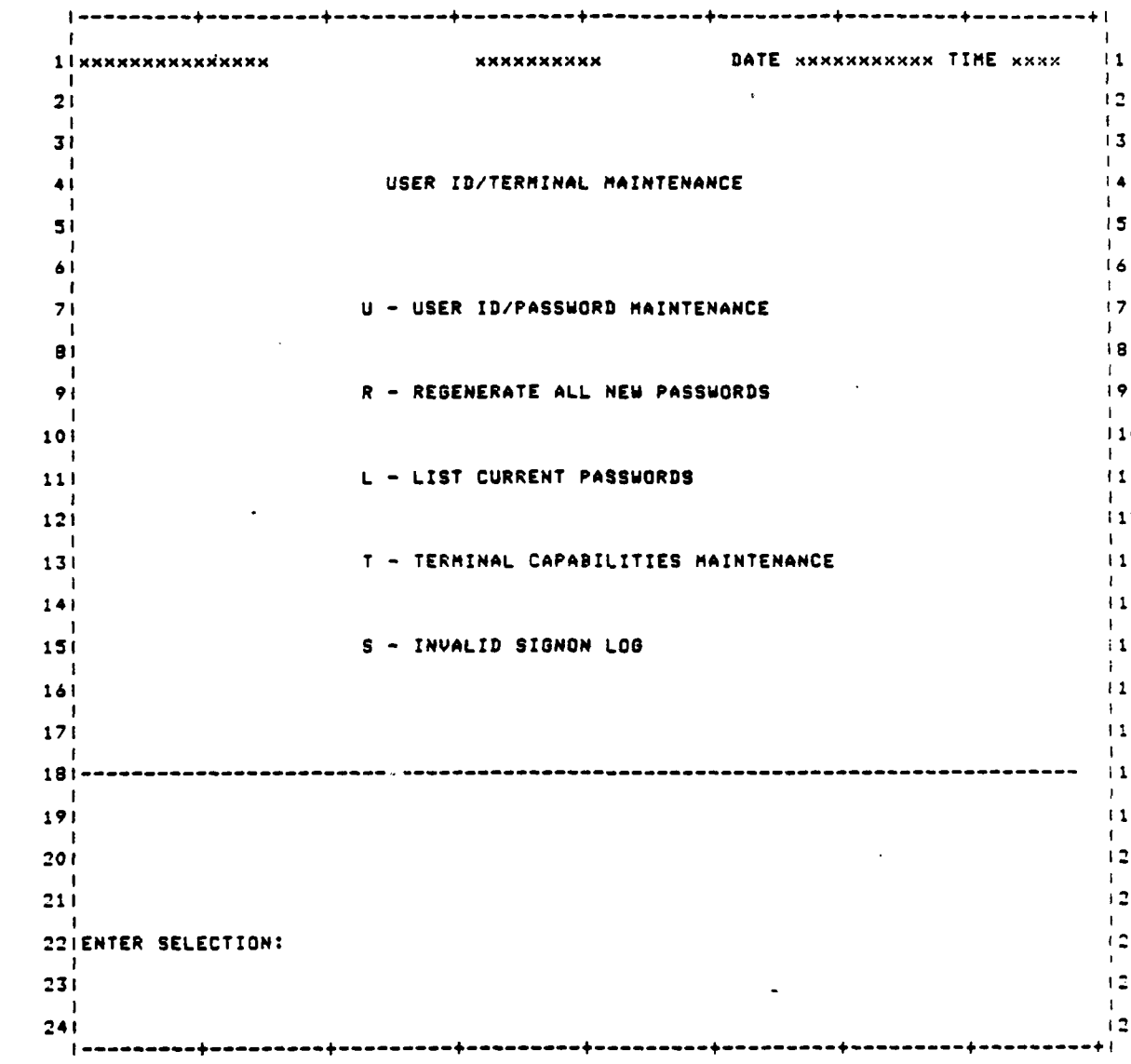


Figure 11-7. SYSTEM MGMT. - USER ID/TERMINAL MAINTENANCE MENU SCREEN

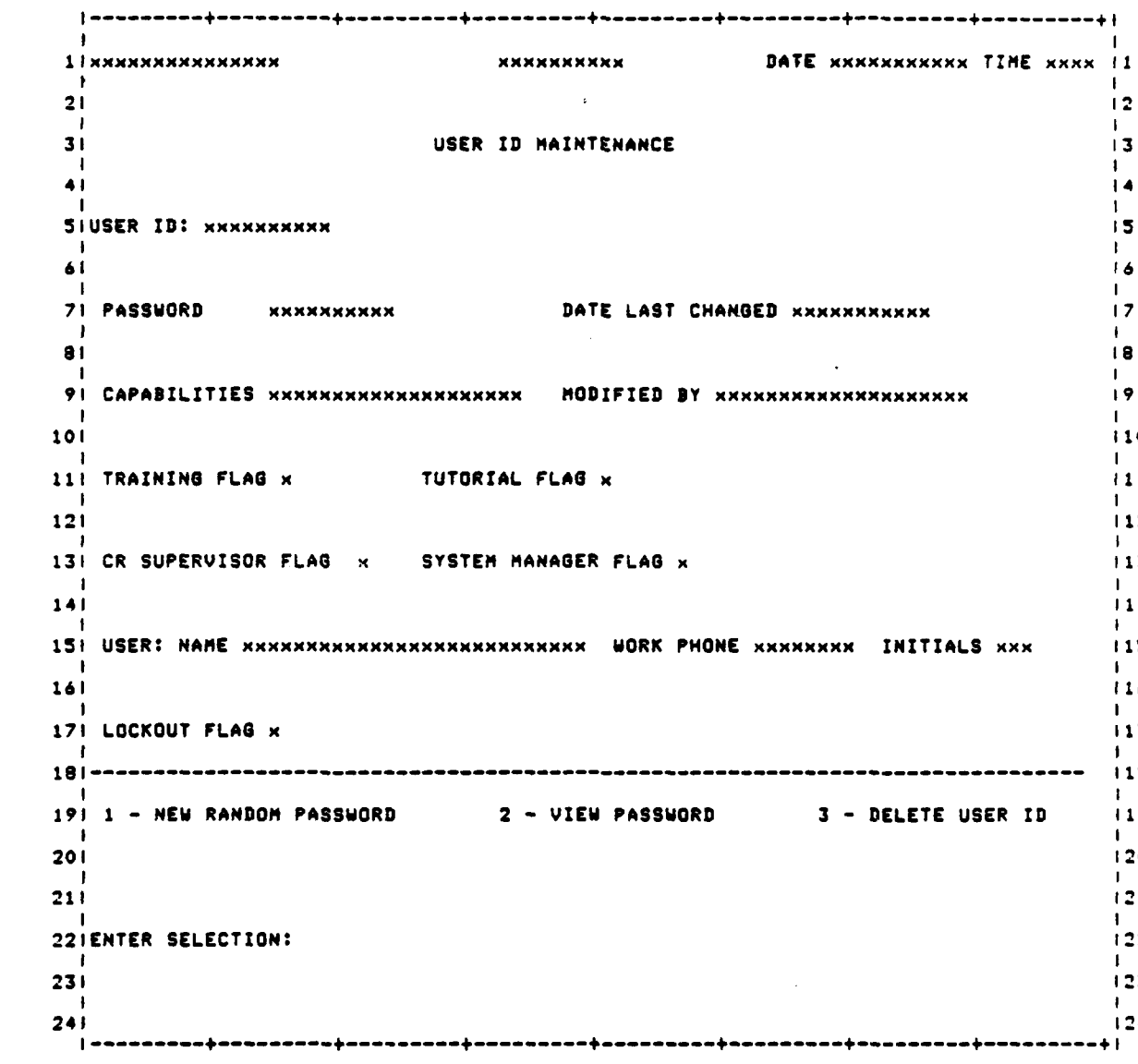


Figure 11-8. SYSTEM MGMT. - USER ID MAINTENANCE SCREEN

(1) USER ID.

(2) PASSWORD is displayed if the system manager selects option 2 on this screen.

(3) DATE LAST CHANGED. Date when the password was last changed.

(4) CAPABILITIES. The AQCESS functions allowed to this user ID/password are listed in this field. Each function is signified by the letter that appears to the left of it on the User Entry Menu.

(5) MODIFIED BY. To modify the user's capabilities without retyping the entire string, the system manager enters + or - and the letter of the function to be added or removed.

(6) TRAINING FLAG. A "Y" in this field indicates that the user has access only to the training data base.

(7) TUTORIAL FLAG. A "1" in this field indicates that the user has access to the tutorial lessons, and that the system will run in tutorial mode with automatic Super Help and expanded error explanations.

(8) CR SUPERVISOR FLAG. A "Y" in this field indicates that the user is authorized as the Clinical Records supervisor.

(9) SYSTEM MANAGER FLAG. A "Y" in this field indicates that the user is authorized as the System Manager.

(10) USER: NAME. Name of the user who has this user ID/password.

(11) WORK PHONE of this user.

(12) INITIALS of this user. Used to trace entries and updates of records.

(13) LOCKOUT FLAG. A "1" in this field indicates that this user is locked out of the system. "0" means that the user is able to use his or her assigned functions.

Data Chart 11-4. SYSTEM MGMT. - USER ID MAINTENANCE SCREEN

The functions listed on this screen's sub-menu operate as follows.

a. New Random Password. When the system manager makes this selection, the system will assign this user a new password. The new password is created from a random series of three letters and three numbers.

b. View Password. This option causes the password associated with this user ID to be displayed.

c. Delete User ID. This selection deletes this user ID from the system.

11.6.2 Regenerate All New Passwords. Selecting this option causes the system to create a new password for each user ID except the system manager's. The system creates new passwords by random selection of three letters and three numbers. The system manager will be prompted to confirm his request before new passwords are actually generated. No screen is displayed as a result of this selection.

11.6.3 List Current Passwords. The system manager chooses this option to view the list of user IDs and passwords on the screen and/or print it. With this option, the first screen to be displayed allows the system manager to choose to see the list on the screen or have it printed. For an example of this report and a description of its data, see Part III, Outputs.

11.6.4 Terminal Capabilities Maintenance. The system manager selects this option to specify the functions available at each terminal. When the Terminal ID Maintenance Screen is displayed, the system manager enters the ID number of the terminal, and information on the available functions is displayed. The system manager can view that information or update it. Figure 11-9 shows the Terminal ID Maintenance Screen, and Data Chart 11-5 describes its fields.

On this screen the system manager can also lock or unlock terminals. User IDs and terminals become locked if the user ID or password is entered incorrectly more than the maximum number of times allowed.

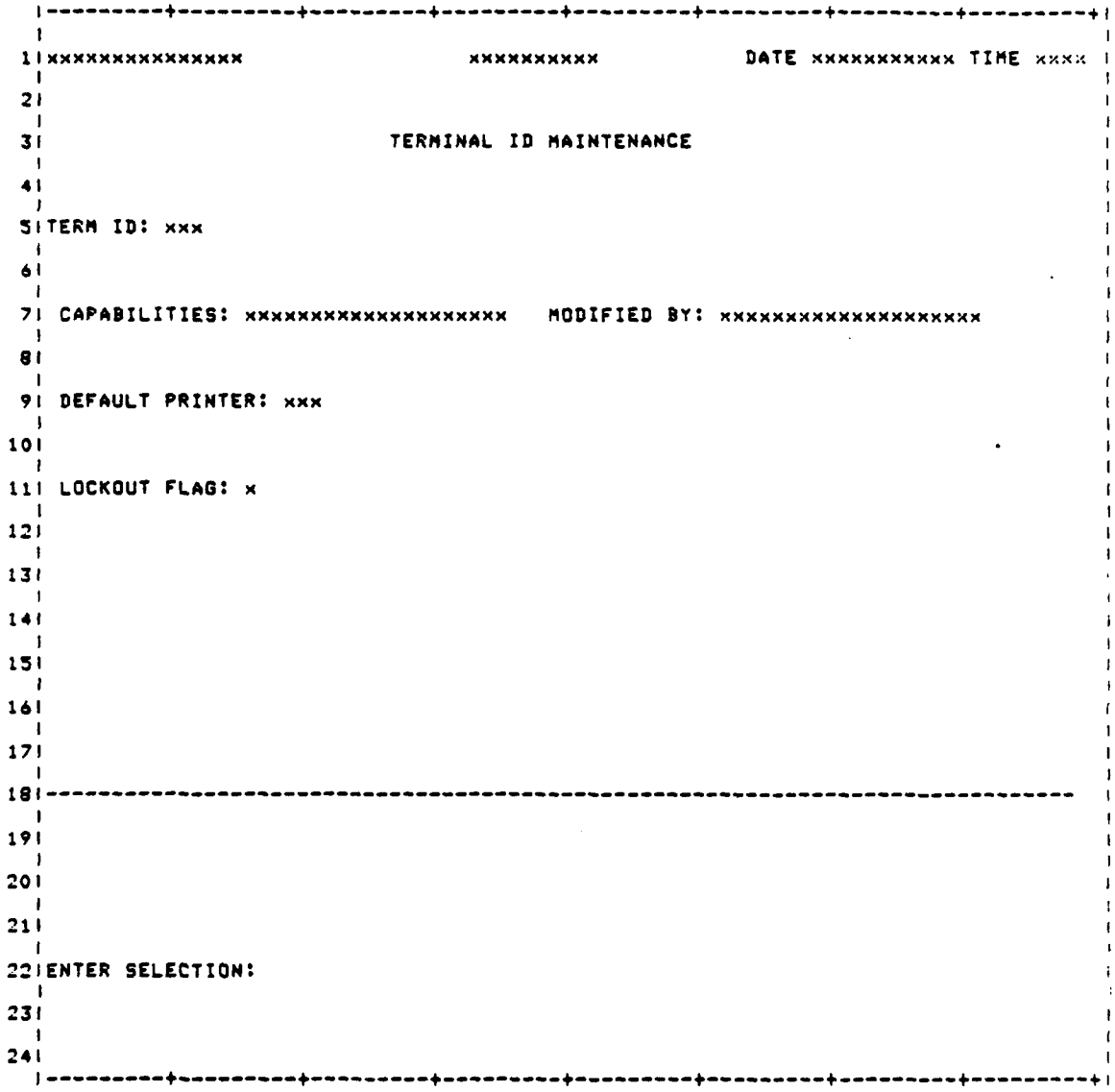


Figure 11-9. SYSTEM MGMT. - TERMINAL ID MAINTENANCE SCREEN

(1) TERM ID. ID number of the terminal.

(2) CAPABILITIES. The AQCESS functions available to users at this terminal.

(3) MODIFIED BY. To add or delete to the functions available from this terminal, the user enters + or - and the letter of the function to be added or deleted.

(4) DEFAULT PRINTER. The printer that all print requests from this terminal (indicated by pressing CTRL P) will go to.

(5) LOCKOUT FLAG. "1" in this field means that the terminal is locked. "0" means that it is functioning normally.

Data Chart 11-5. SYSTEM MGMT. - TERMINAL ID MAINTENANCE SCREEN

11.6.5 Invalid Signon Log. This option requests printing of the Invalid Sign-On Log, which gives information about occasions when incorrect user IDs and passwords were entered (i.e., date, user ID/password, and terminal ID, etc.). When this option is selected, a screen is displayed on which the system manager indicates the time period for which this information is requested by entering starting and ending dates. The report may be displayed on the screen or printed as hard copy.

SECTION 12. INPATIENT HISTORY SCREEN

12.1 Inpatient History Function - Overview. The Inpatient History function allows the user to review summary data on inpatient episodes of current and dispositioned patients. The patient must have been admitted to the MTF for a patient record to be reviewed through this function.

When Inpatient History is selected from the User Entry Menu, the PTID Screen is displayed so that the user can identify the patient record to be reviewed. The user can locate a record directly by entering its register number, and the Inpatient History Screen will appear, displaying data summarizing that inpatient episode. Or the user can initiate a name fragment, soundex, SSN or SSN/FMP search, and the resulting list of candidates will appear on a Candidate List Screen. If the user selects a patient who has had more than one admission, an Episode List Screen will display a list of inpatient episodes. The user can select any episode to review, and can page through all the episodes for that patient.

No data on the Inpatient History Candidate List Screen or the Inpatient History Screen can be updated.

See Figure 12-1 for an example of the Episode List Screen, and Figure 12-2 for the Inpatient History Screen. For a description of the Inpatient History data fields, see the Data Charts for the primary Registration, Admission, Disposition, and Clinical Records Screens. An additional field, ARCHIVE DATE, indicates when this record was archived.

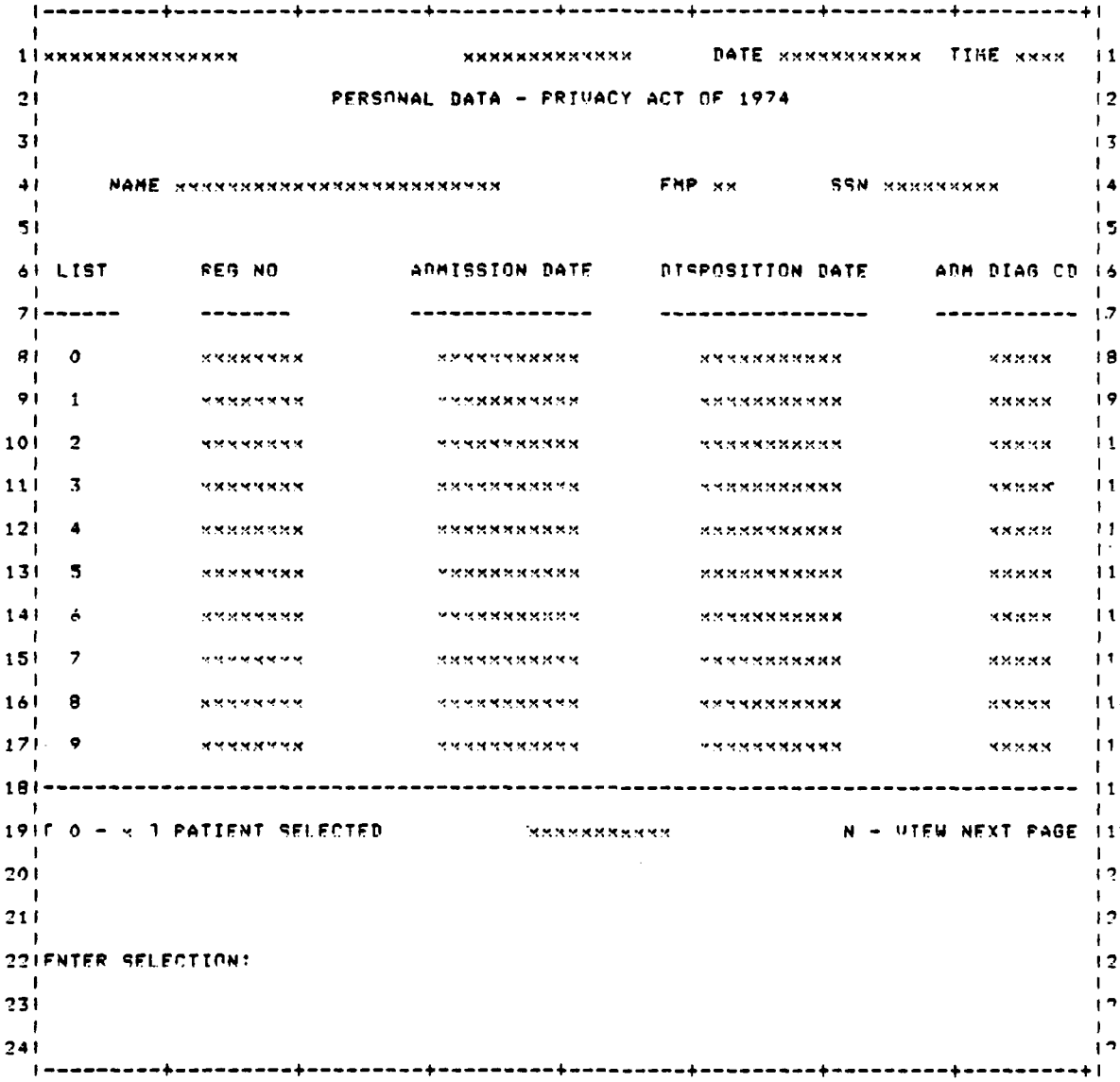


Figure 12-1. INPATIENT HISTORY - EPISODE LIST SCREEN

```
 1 xxxxxxxxxxxxxxx                      xxxxxxxxxxxxx  DATE xxxxxxxxxxx TIME xxxx
 2                      PERSONAL DATA - PRIVACY ACT OF 1974
 3
 4 NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxx   FMP xx     SSN xxxxxxxxxxx   DOB xxxxxxxxxxx
 5 PNT CAT xxx     BRANCH SVC xx        RANK xxx  SEX x   RELIGION xxx     RACE x
 6
 7                            REG NO xxxxxxxx
 8
 9 ADM DATE/TIME xxxxxxxxxxxxxxxx       CLINICAL SERVICE xxxx   WARD xxxx
10
11 SOURCE ADMISSION xxx                 ADMITTING DIAG CODE xxxxx  TYPE CASE xxx
12
13 DISP DATE/TIME xxxxxxxxxxxxxxxx      DISP TYPE xxxx  MTF xxxxxx
14
15 PRIMARY DISP DIAG xxxxx              ATTENDING PHYSICIAN xxxxxx
16
17 PRIMARY PROCEDURE xxxx               ARCHIVE DATE xxxxxxxxxxx
18 ------------------------------------------------------------------------------
19                N - NEXT                        P - PREVIOUS
20
21
22 ENTER SELECTION:
23
24
```

Figure 12-2. INPATIENT HISTORY SCREEN

SECTION 13. PATIENT INQUIRY SCREEN

13.1 Patient Inquiry Function - Overview. This function identifies segments of the patient population according to categories specified by the MTF, and lists patients who fall into those categories.

When this function is selected from the User Entry Menu, the Patient Inquiry Look-Up Screen is displayed (Figure 13-1). On this screen the user specifies the category of patients he or she is interested in. For example, the MTF may have designated the categories as ward, attending physician, and diagnosis. If the user enters "WARD" and then a ward ID number, a Candidate List Screen will display a list of all patients currently on that ward (with the same data on each patient as the PTID Candidate List; see Data Chart 4-2). If the user selects a patient from this Candidate List, an Inpatient History Screen for the patient will be displayed.

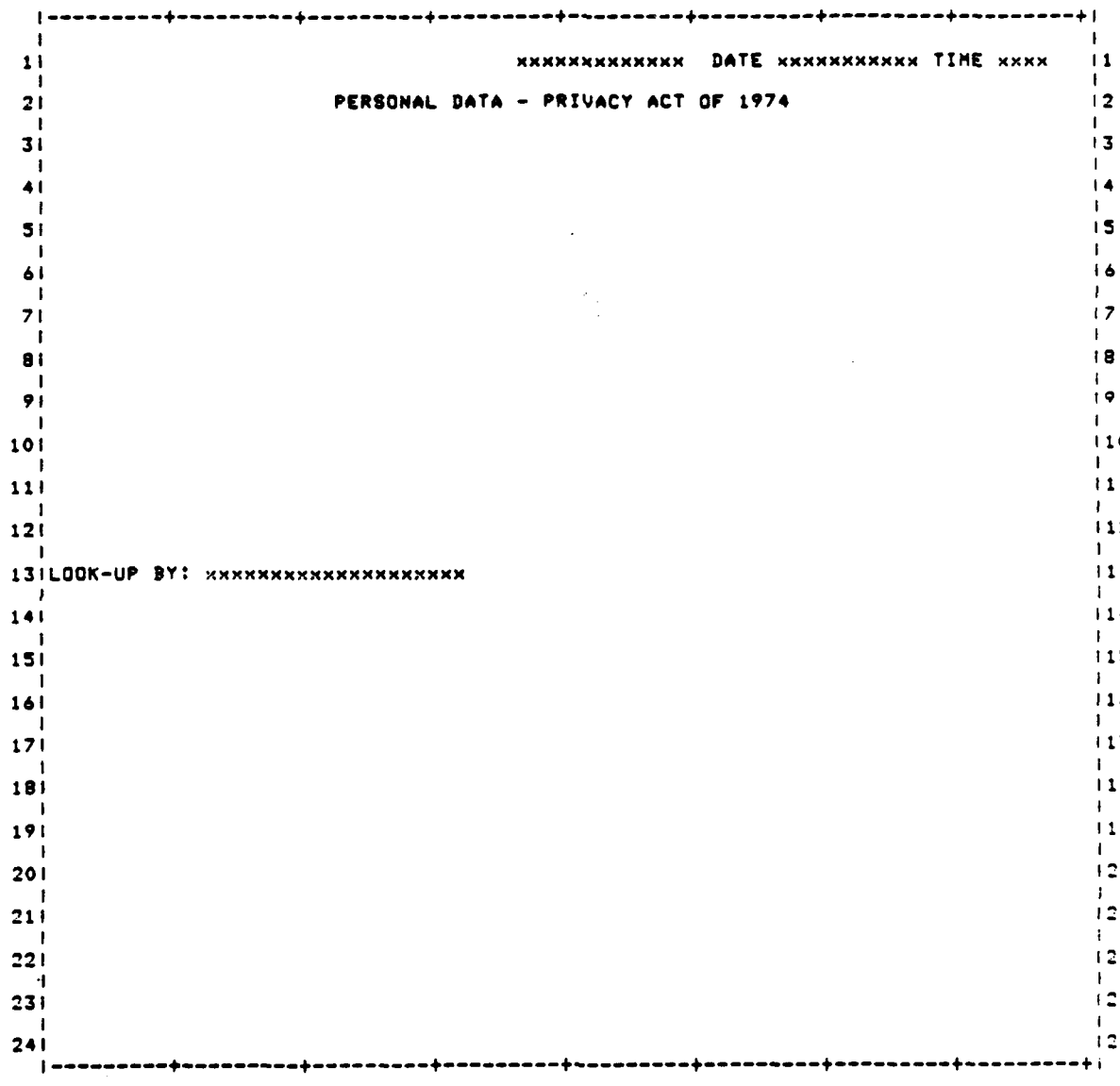


Figure 13-1. PATIENT INQUIRY LOOK-UP SCREEN

SECTION 14. R/ADT REPORTS SCREEN

14.1 R/ADT Reports Function - Overview. From the Reports Selection Screen, the user requests printing of R/ADT reports, and indicates the effective date of the report.

When the user selects the R/ADT Reports function from the User Entry Menu, the Reports Selection Screen is displayed (Figure 14-1). This screen contains a menu of available reports that is built at run time from the reports table. The menu is different for each service. It can include the following reports:

a. Admission and Disposition Report.
b. A&D Recap/Patient Strength Report.
c. Alpha Roster of Hospital Patients.
d. Daily Admissions by Diagnosis.
e. Injury Report.
f. Invalid Sign-On Log.
g. List of Current Passwords.
h. Roster of VSI/SI/SC Patients.
i. Status Out Roster.
j. UCA Disposition Report.
k. UCA Patient Occupied Bed Days Report.
l. Ward Nursing Report.

The options on the Reports Selection Screen allow the user to request all nightly or monthly reports, or any combination of reports listed on the menu. (The MTF specifies which reports should usually be run nightly, and which monthly.)

For each report a screen will be displayed on which the user specifies its run-time parameters. At a minimum, the user must specify if the report is to be printed (hard copy) or displayed on the terminal. Other run-time parameters may be specified--for example, report date or report month--depending on the report. Reports that are to be printed will run as a background job; after the run-time specifications are entered, the user may go on with other processing. Reports that are output to the terminal, obviously, run while the user waits.

Most of the AQCESS reports have been implemented using the Report Generator utility. Report definitions--sort specification selection criteria and format--are stored in the report definition file. Even reports that are implemented as programmer-written MUMPS programs have an entry in the report definition file.

Each report will print on the device specified for that report in the report definition. If the device is busy, the user may specify an alternate device.

For details on the contents of these reports, see Part III, Outputs.

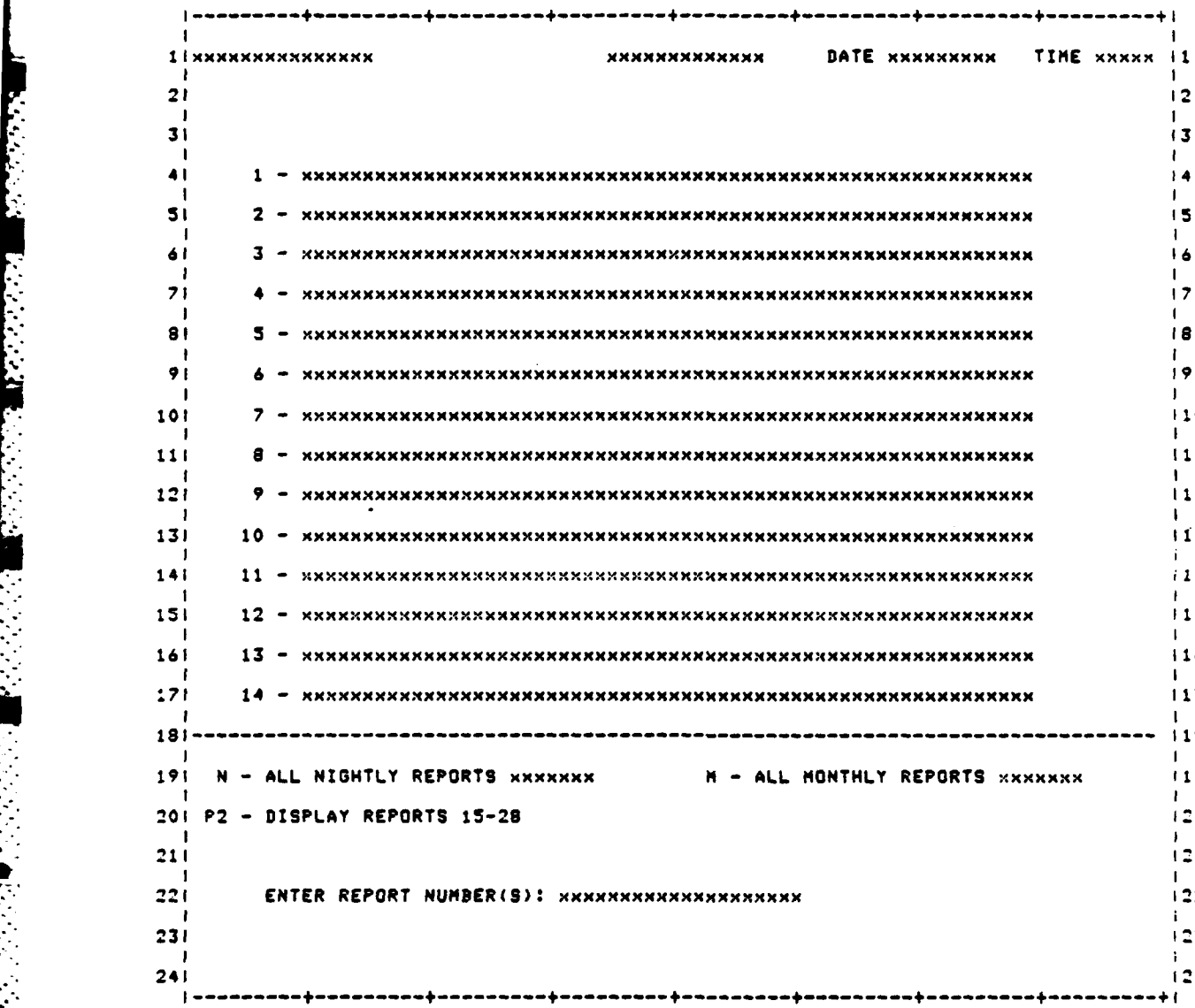


Figure 14-1. R/ADT REPORTS - SELECTION SCREEN

SECTION 15. CLINICAL RECORDS SCREENS

15.1 Clinical Records Function - Overview. The Clinical Records function assists the user in performing final processing on each inpatient episode. The CR screens display data that was entered in R/ADT, as well as summary statistics that are computed by the Clinical Records function.

Through Clinical Records, the user is able to enter or update data on the patient's diagnoses, on procedures performed during the inpatient episode, on care providers, and miscellaneous data on cause of injury, residual disability, blood transfused, etc. The CR user can review information on the number of days the patient spent in bed-day and non-bed-day absent statuses, and on milestones in the processing of a record. Also through this function, the user can mark the record as approved and final, and ready for inclusion on reports to higher commands, and can produce documentation on the episode for the patient chart.

A record can be accessed in Clinical Records when the patient has been dispositioned, has an absent status of "medical holding" (Navy only), or has been given a projected disposition date.

If the patient has a projected disposition, the user can perform any CR function except change the record's CR status or print out final reports on it. If the patient has been dispositioned or is on medical hold, any CR function can be performed.

When the record of a dispositioned patient is accessed in Clinical Records, it falls under the control of the CR function and cannot be accessed through any other function. Records of medical hold or projected-disposition patients can still be accessed by Disposition (and only in order to enter the final disposition).

The Clinical Records ID (CRID) Screen appears when Clinical Records is selected from the User Entry Menu (see Figure 15-1). When the user enters a the register number of a record available for CR processing (as defined above), data on that patient is displayed at the top of the screen, and the user is able to choose from the sub-menu options. The patient data appears on each Clinical Records Screen. Figure 15-2 shows the sub-menu and the common patient data, which is described in Data Chart 15-1. (Numbers of applicable system tables have been omitted from this section if they appear in other sections of this document.) None of this patient data can be updated in CR.

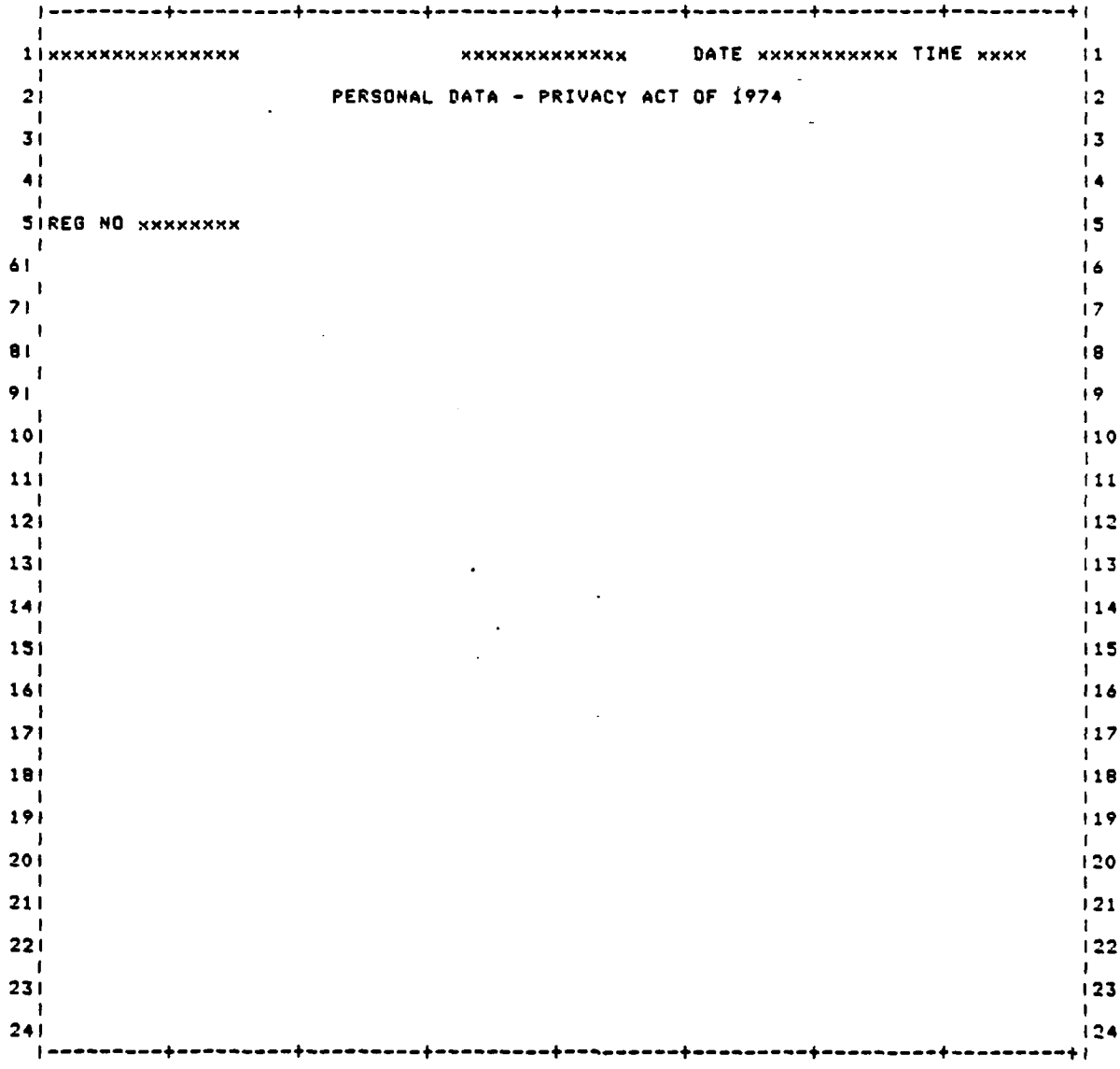


Figure 15-1. CLINICAL RECORDS IDENTIFICATION (CRID) SCREEN

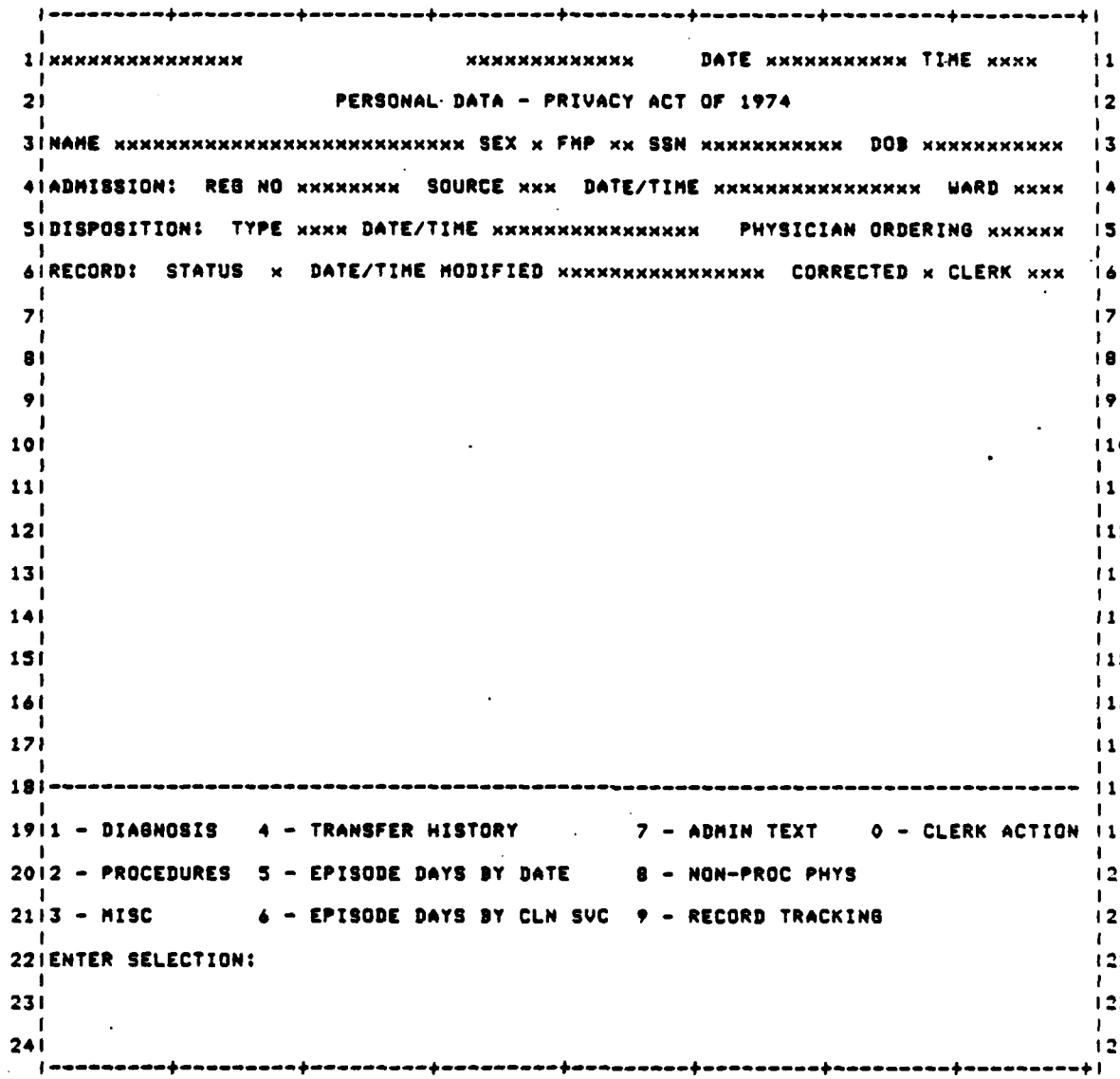


Figure 15-2. CRID SCREEN showing Common Data and Sub-Menu

Line 3 displays the NAME, SEX, FMP, SSN, and DOB of the patient.

(1) ADMISSION: REG NO. The patient's register number.

(2) SOURCE. Source of admission.

(3) DATE/TIME of admission.

(4) WARD. The patient's ward assignment at disposition.

(5) DISPOSITION: TYPE. Type of Disposition entered on Disposition Screen.

(6) DATE/TIME of disposition.

(7) PHYSICIAN ORDERING the disposition.

(8) RECORD: STATUS: A code indicating the stage of CR processing that this record is in. Actions taken by the CR clerk and supervisor change the record status. The code usually displayed here is "I" for "incomplete," meaning that CR processing has begun on this record but is not yet finished. See section 15-10 and Figures 15-13 and 15-14 for more details on record status.

(9) DATE/TIME MODIFIED. The date when this record was last updated in CR.

(10) CORRECTED. Code indicating whether the record was sent to higher commands and then returned for correction. The record is marked as corrected so that when it is approved again and re-transmitted to higher commands, it will not be processed as a new record.

(11) CLERK. The initials of the last clerk to update this record.

Data Chart 15-1. CLINICAL RECORDS - COMMON PATIENT DATA

Each option on the Clinical Records sub-menu displays a Clinical Records screen. When the user has completed processing on each screen, the Clinical Records sub-menu is redisplayed and the user can choose another option. The Clinical Records sub-menu options, and the screens displayed by them, are described in the following paragraphs.

15.2 Diagnosis. On the Diagnosis Screen the user can review, enter, or update data on diagnoses made during the inpatient episode (see Figure 15-3). Several data items can be entered for each diagnosis; this group of data is

```
 1 xxxxxxxxxxxxxxx                  xxxxxxxxxxxxx     DATE xxxxxxxxxxx TIME xxxx     1
 2                       PERSONAL DATA - PRIVACY ACT OF 1974                         2
 3 NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxx SEX x FMP xx SSN xxxxxxxxxxx  DOB xxxxxxxxxxx   3
 4 ADMISSION:  REG NO xxxxxxxx  SOURCE xxx  DATE/TIME xxxxxxxxxxxxxxxx  WARD xxxx   4
 5 DISPOSITION:  TYPE xxxx DATE/TIME xxxxxxxxxxxxxxxx   PHYSICIAN ORDERING xxxxxx   5
 6 RECORD:  STATUS  x  DATE/TIME MODIFIED xxxxxxxxxxxxxxx  CORRECTED x CLERK xxx    6
 7                                                                                 7
 8                            *** TOTAL DIAGNOSES xx ***                           8
 9  xx ICD CODE: xxxxx x x      CAUSE x xxx   OCC REL x   GROUP NBR xx               9
10     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx       10
11     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx       11
12  xx ICD CODE: xxxxx x x      CAUSE x xxx   OCC REL x   GROUP NBR xx               12
13     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx       13
14     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx       14
15  xx ICD CODE: xxxxx x        CAUSE x xxx   OCC REL x   GROUP NBR xx               15
16     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx       16
17     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx       17
18 ------------------------------------------------------------------------------ 18
19 N - NEXT PAGE      P - PREVIOUS PAGE      M - MOVE CODE      D - DELETE CODE     19
20                                                                                 20
21                                                                                 21
22 ENTER SELECTION:                                                               22
23                                                                                 23
24                                                                                 24
```

Figure 15-3. CR - DIAGNOSIS SCREEN

called a data set. Each data set consists of (1) the sequence number of the data set, (2) the International Classification of Diseases (ICD) code of the diagnosis, (3) cause-of-injury codes and a code indicating whether the condition was occupationally related (both for Navy users), (4) the group number of the diagnosis (Army use only), and (5) a free-text description of the diagnosis. This data is described in more detail in Data Chart 15-2.

The Diagnosis Screen can display three diagnosis data sets per page. To view subsequent pages of data, the user can select sub-menu option N-NEXT PAGE. Selection P redisplays previous pages. To enter or update data, the user enters the sequence number of the data set. Up to 99 diagnosis data sets can be entered.

The data sets are displayed in the order in which they are entered, but the user can change this order or delete data sets. With sub-menu option M-MOVE CODE, the screen displays the message "MOVE ENTRY #__ BEFORE ENTRY #__" and the user enters the appropriate sequence numbers to rearrange the order. Option D-DELETE CODE, allows the user to delete a data set from the record.

(1) TOTAL DIAGNOSES. The total number of diagnoses entered on this patient.

(2) (SEQUENCE NUMBER) of the diagnosis data set.

(3) ICD CODE. 5-digit code for the diagnosis, from the International Classification of Diseases (ICD). A 6th digit is an asterisk/secondary/dagger code, and a 7th digit indicates the place of the diagnosis or whether this was a pre-existing condition.

(4) CAUSE. Code indicating class of trauma and code indicating causative agent of the injury (Navy only).

(5) OCC REL. Code indicating whether this condition was occupationally related (Navy only).

(6) GROUP NBR. Logical group number of the diagnosis, for printing on the ITRCS (Army only).

(7) (TEXT). The description of the diagnosis that is associated with this ICD code. When the ICD code is entered, the first line of text defaults to the description from the ICD table. The description can be updated. When a CAUSE code is entered, the text describing the cause of injury is displayed on the second line of text (Navy only).

Data Chart 15-2. CR - DIAGNOSIS SCREEN

15.3 Procedure. On the Procedure Screen, the user can review, enter, or update data on procedures, or operations, performed during the inpatient episode (Figure 15-4). For the Air Force, this episode includes previous hospitals from which the patient has transferred. For the Navy, the episode includes only procedures performed since admission to this MTF.

Each page of the Procedure Screen can display three procedure data sets, consisting of (1) sequence number, (2) an International Classification of Procedures (ICP) code, (3) the date(s) when the procedure was performed, (4) the care providers associated with the procedure, and (5) a free-text description of the procedure.

Codes for up to three care providers can be entered in the PRVDR field. For a surgical procedure, the first provider is the principal surgeon, the second is the assistant, and the third is a teaching staff physician. For a medical procedure, the first provider is the attending or primary provider, the second is the resident, and the third is any other physician. The provider is not coded if the procedure was not performed in this MTF (sixth byte of procedure code "U").

This screen and its functions operate in the same way as the Diagnosis Screen. The user takes the same steps to view, enter, and update procedure data, as well as to re-order it or to delete data sets, as those described in section 15.2.

```
 1 xxxxxxxxxxxxxxx                  xxxxxxxxxxxxx     DATE xxxxxxxxxxx TIME xxxx     1
 2                        PERSONAL DATA - PRIVACY ACT OF 1974                        2
 3 NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxx SEX x FMP xx SSN xxxxxxxxxxx  DOB xxxxxxxxxxx  3
 4 ADMISSION:  REG NO xxxxxxxx  SOURCE xxx  DATE/TIME xxxxxxxxxxxxxxxx  WARD xxxx   4
 5 DISPOSITION:  TYPE xxxx DATE/TIME xxxxxxxxxxxxxxxx   PHYSICIAN ORDERING xxxxxx   5
 6 RECORD:  STATUS  x  DATE/TIME MODIFIED xxxxxxxxxxxxxxxx  CORRECTED x CLERK xxx   6
 7                                                                                 7
 8                              xxx TOTAL PROCEDURES xx xxx                        8
 9  xx PROCD: xxxx x xx  DATE xxxxxxxxxxx-xxxxxxxxxxx PRVDR  xxxxxx xxxxxx xxxxxx  9
10     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx    10
11     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx    11
12  xx PROCD: xxxx x xx  DATE xxxxxxxxxxx-xxxxxxxxxxx PRVDR  xxxxxx xxxxxx xxxxxx  12
13     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx    13
14     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx    14
15  xx PROCD: xxxx x xx  DATE xxxxxxxxxxx-xxxxxxxxxxx PRVDR  xxxxxx xxxxxx xxxxxx  15
16     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx    16
17     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx    17
18 ------------------------------------------------------------------------------ 18
19 N - NEXT PAGE      P - PREVIOUS PAGE      M - MOVE CODE        D - DELETE CODE   19
20                                                                                20
21                                                                                21
22 ENTER SELECTION:                                                               22
23                                                                                23
24                                                                                24
```

Figure 15-4. CR - PROCEDURE SCREEN

15.4 Miscellaneous. The Miscellaneous Screen displays data on transfers-out, cause of injury, and cause of death or separation, etc. (see Figure 15-5 and Data Chart 15-3). All data on this screen can be updated.

(1) ATTEND/PRIMARY PHY. The patient's primary attending physician. This is the responsible physician, who also signs the ITRCS or RIPT.

(2) TYPE CASE. Code indicating type of case.

(3) AGE of patient. Calculated from date of birth. This field can only be updated if the patient is a newborn.

(4) ANESTHETIC RISK CODE. The risk code assigned for surgical patients (a number between 1 and 5).

(5) CAUSE DEATH/SEPARATION. Code for the cause of death or separation.

(6) CC'S WHOLE BLOOD used during this inpatient episode.

(7) CC'S PACKED CELLS used during this inpatient episode.

(8) TFR OUT: MODE. Mode of transportation used if the patient transferred out of the hospital.

(9) MTF. Code of the MTF to which patient was transferred. Table 1005.

(10) CIV HOSP. Name of the civilian hospital transferred to, if any.

(11) TRANSFER VA HOSPITAL/AUTOPSY. Indicates whether the patient transferred to a VA Hospital, or whether an autopsy was performed.

(12) DATE INITIAL PROCEDURE. Date when the first procedure was performed during this inpatient episode.

(13) CAUSE OF INJURY. See Data Chart 15-2.

(14) RESIDUAL DISABILITY. Code indicating the level of the patient's disability if any.

(15) CAUSE OF INJURY DATA. Description of the cause of injury. Defaults to the description in the Cause of Injury Table if a cause-of-injury code was entered on line 12. This default can be overridden by the user.

(16) CONVALESCENT LEAVE DAYS RECOMMENDED. Number of days of convalescent leave recommended, if any.

(17) PRESENTATION OF FETUS. Code describing presentation of the fetus. Table 4005. Air Force only.

Data Chart 15-3. CR - MISCELLANEOUS SCREEN

```
 1|xxxxxxxxxxxxxxx                  xxxxxxxxxxxxx     DATE xxxxxxxxxxx TIME xxxx     |1
 2|                        PERSONAL DATA - PRIVACY ACT OF 1974                        |2
 3|NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxx SEX x FMP xx SSN xxxxxxxxxxx  DOB xxxxxxxxxxx   |3
 4|ADMISSION:  REG NO xxxxxxxx  SOURCE xxx  DATE/TIME xxxxxxxxxxxxxxxx  WARD xxxx   |4
 5|DISPOSITION:  TYPE xxxx DATE/TIME xxxxxxxxxxxxxxxx   PHYSICIAN ORDERING xxxxxx   |5
 6|RECORD:  STATUS  x  DATE/TIME MODIFIED xxxxxxxxxxxxxxxx  CORRECTED x CLERK xxx   |6
 7|                              *** MISCELLANEOUS ***                              |7
 8|ATTEND/PRIMARY PROVIDER xxxxxx              TYPE CASE xxx   AGE xxx              |8
 9|ANESTHETIC RISK CODE x                      CAUSE DEATH/SEPARATION x             |9
10|CC'S WHOLE BLOOD xxxx                       CC'S PACKED CELLS xxxx               |10
11|TFR OUT:  MODE x     MTF xxxxxx             CIV HOSP xxxxxxxxxxxxxxxxxxxxxxxxx   |11
12|TRANSFER VA HOSPITAL/AUTOPSY x              DATE INITIAL PROCEDURE xxxxxxxxxxx   |12
13|CAUSE OF INJURY x xxx                       RESIDUAL DISABILITY  xxx             |13
14|CAUSE OF INJURY DATA xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx   |14
15|    xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx   |15
16|    xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx   |16
17|CONVALESCENT LEAVE DAYS RECOMMENDED xxx   PRESENTATION OF FETUS xx xx xx xx     |17
18|-------------------------------------------------------------------------------|18
19|                                                                               |19
20|                                                                               |20
21|                                                                               |21
22|ENTER SELECTION:                                                               |22
23|                                                                               |23
24|                                                                               |24
```

Figure 15-5. CR - MISCELLANEOUS SCREEN

15.5 Transfer History. The Transfer History Screen collects information on the patient's transfers from other MTFs before transferring to this MTF (Figure 15-6 and Data Chart 15-4).

On the Transfer-In segment of the Admission Screen, users can only enter data about one previous admission before transfer to this MTF, and this does not include detailed information about the distribution of beds among absent statuses. The Transfer History Screen automatically displays the data entered on the Transfer-In segment, allowing the user to enter bed days data on that previous hospital stay. Also, if the patient transferred to that MTF from other hospitals, the user can enter data about those previous transfers on the Transfer History Screen. As many as seven lines of transfer data can be entered on each page of this screen, and the sub-menu options N-NEXT PAGE and P-PREVIOUS PAGE can be used to move back and forth among pages. To update a line of data, the user enters its sequence number in the selection field. The user can also delete a line by selecting option D-DELETE LINE.

(1) (SEQUENCE NO.) of the transfer data.

(2) MTF. Code of the MTF the patient was transferred from.

(3) ADMISSION DATE. Date of admission to the previous MTF.

(4) DISPOSITION DATE. Date of disposition from the previous MTF (i.e., the date when the patient transferred out).

(5) BED DAYS. The total number of days that the patient spent on an absent status for which bed days are counted during the previous episode.

(6) ABS SICK. The number of days that the patient spent with an absent status of "absent sick."

(7) CONV LV. The number of days that the patient spent with an absent status of "convalescent leave."

(8) COOP CARE. The number of days that the patient spent with an absent status of "cooperative care."

(9) SUPP CARE. The number of days that the patient spent with an absent status of "supplemental care."

(10) OTH DAYS. The number of days that the patient spent on another absent status for which bed days are not counted.

(11) MODE. The patient's mode of transportation when being transferred out of the previous MTF.

Data Chart 15-4. CR - TRANSFER HISTORY SCREEN

```
1 xxxxxxxxxxxxxxx                    xxxxxxxxxxxxx     DATE xxxxxxxxxxx TIME xxxx
2                          PERSONAL DATA - PRIVACY ACT OF 1974
3 NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxx SEX x FMP xx SSN xxxxxxxxxxx  DOB xxxxxxxxxxx
4 ADMISSION:  REG NO xxxxxxxx  SOURCE xxx  DATE/TIME xxxxxxxxxxxxxxxx  WARD xxxx
5 DISPOSITION:  TYPE xxxx DATE/TIME xxxxxxxxxxxxxxxx   PHYSICIAN ORDERING xxxxxx
6 RECORD:  STATUS  x  DATE/TIME MODIFIED xxxxxxxxxxxxxxxx  CORRECTED x CLERK xxx
7
8                               *** TRANSFER HISTORY ***
9     MTF   ADMISSION     DISPOSITION   BED   ABS   CONV  COOP  SUPP  OTH   MODE
10            DATE          DATE        DAYS  SICK  LV    CARE  CARE  DAYS
11  xx xxxx  xxxxxxxxxxx  xxxxxxxxxxx  xxxx  xxxx  xxxx  xxxx  xxxx  xxxx  x
12  xx xxxx  xxxxxxxxxxx  xxxxxxxxxxx  xxxx  xxxx  xxxx  xxxx  xxxx  xxxx  x
13  xx xxxx  xxxxxxxxxxx  xxxxxxxxxxx  xxxx  xxxx  xxxx  xxxx  xxxx  xxxx  x
14  xx xxxx  xxxxxxxxxxx  xxxxxxxxxxx  xxxx  xxxx  xxxx  xxxx  xxxx  xxxx  x
15  xx xxxx  xxxxxxxxxxx  xxxxxxxxxxx  xxxx  xxxx  xxxx  xxxx  xxxx  xxxx  x
16  xx xxxx  xxxxxxxxxxx  xxxxxxxxxxx  xxxx  xxxx  xxxx  xxxx  xxxx  xxxx  x
17  xx xxxx  xxxxxxxxxxx  xxxxxxxxxxx  xxxx  xxxx  xxxx  xxxx  xxxx  xxxx  x
18 ------------------------------------------------------------------------------
19 N - NEXT PAGE          P - PREVIOUS PAGE          D - DELETE LINE
20
21
22 ENTER SELECTION:
23
24
```

Figure 15-6. CR - TRANSFER HISTORY SCREEN

15.6 Episode Days by Date/Clinical Service. The Episode Days Screens display information on the number of days the patient spent on various absent statuses and clinical services during the inpatient episode. As the CR menu indicates, there are two versions of the Episode Days Screen. Selection 5 from the menu calls up the Episode Days by Date Screen, which displays days data in chronological order (Figure 15-7). Selection 6 displays the Episode Days by Clinical Service Screen, showing days data grouped according to clinical service, with total bed-day figures for each clinical service (Figure 15-8).

Each screen displays a line of data on each clinical service-absent status assignment; up to seven assignments can be displayed per page of these screens. Data Chart 15-5 describes the data for these screens.

Episode days data was calculated by the system from the admission date, the disposition date, and the dates associated with each of the patient's changes in clinical service and absent status. This data is for review only; it cannot be updated in Clinical Records.

(1) CLN SVC. The patient's clinical service assignment. On the Episode Days by Date Screen, clinical service/absent status assignments are listed in chronological order.

(2) ABS STATUS. The patient's absent status.

(3) DATE ASSIGNED. Date of the clinical service/absent status assignment.

(4) DAYS: TOTAL. The total number of days accumulated for this clinical service/absent status combination. On the Episode Days by Clinical Service Screen, this column also shows the total number of days the patient spent on this clinical service.

(5) BED. The number of days on this clinical service that the patient had a status for which bed days are counted. On the Episode Days by Clinical Service Screen, this column shows the total number of bed days for the clinical service.

(6) NON-BED. The number of days on this clinical service that the patient had an absent status for which non-bed days are counted. On the Episode Days by Clinical Service Screen, this column shows the total number of non-bed days for the clinical service.

(7) TOTALS FOR THIS MTF. This line displays the total number of days during the inpatient episode, and the total number of bed days and non-bed days accumulated.

Data Chart 15-5. CR - EPISODE DAYS SCREENS

```
1 xxxxxxxxxxxxxxx                    xxxxxxxxxxxxx     DATE xxxxxxxxxxx TIME xxxx
2                        PERSONAL DATA - PRIVACY ACT OF 1974
3 NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxx SEX x FMP xx SSN xxxxxxxxxxx  DOB xxxxxxxxxxx
4 ADMISSION:  REG NO xxxxxxxx  SOURCE xxx  DATE/TIME xxxxxxxxxxxxxxxx  WARD xxxx
5 DISPOSITION:  TYPE xxxx DATE/TIME xxxxxxxxxxxxxxxx   PHYSICIAN ORDERING xxxxxx
6 RECORD:  STATUS  x  DATE/TIME MODIFIED xxxxxxxxxxxxxxx  CORRECTED x CLERK xxx
7                          xxx EPISODE DAYS BY DATE xxx
8    CLN SVC    ABS STATUS    DATE ASSIGNED       DAYS:  TOTAL    BED    NON-BED
9     xxxx          xxx        xxxxxxx                    xxxx    xxxx     xxxx
10    xxxx          xxx        xxxxxxx                    xxxx    xxxx     xxxx
11    xxxx          xxx        xxxxxxx                    xxxx    xxxx     xxxx
12    xxxx          xxx        xxxxxxx                    xxxx    xxxx     xxxx
13    xxxx          xxx        xxxxxxx                    xxxx    xxxx     xxxx
14    xxxx          xxx        xxxxxxx                    xxxx    xxxx     xxxx
15    xxxx          xxx        xxxxxxx                    xxxx    xxxx     xxxx
16                                                      ==========================
17                     TOTALS FOR THIS MTF                xxxx    xxxx     xxxx
18 ------------------------------------------------------------------------------
19                     N - NEXT PAGE              P - PREVIOUS PAGE
20
21
22 ENTER SELECTION:
23
24
```

Figure 15-7. CR - EPISODE DAYS BY DATE SCREEN

```
1 xxxxxxxxxxxxxxx                xxxxxxxxxxxxx     DATE xxxxxxxxxxx TIME xxxx
2                          PERSONAL DATA - PRIVACY ACT OF 1974
3 NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxx SEX x FMP xx SSN xxxxxxxxxxx  DOB xxxxxxxxxxx
4 ADMISSION:  REG NO xxxxxxxx  SOURCE xxx  DATE/TIME xxxxxxxxxxxxxxxx  WARD xxxx
5 DISPOSITION:  TYPE xxxx DATE/TIME xxxxxxxxxxxxxxxx   PHYSICIAN ORDERING xxxxxx
6 RECORD:  STATUS  x  DATE/TIME MODIFIED xxxxxxxxxxxxxxxx  CORRECTED x CLERK xxx
7                      *** EPISODE DAYS BY CLINICAL SERVICE ***
8    CLN SVC    ABS STATUS    DATE ASSIGNED        DAYS:   TOTAL    BED    NON-BED
9     xxxx          xx         xxxxxxxxx          xxxxxx    xxx     xxx      xxx
10    xxxx          xx         xxxxxxxxx          xxxxxx    xxx     xxx      xxx
11    xxxx          xx         xxxxxxxxx          xxxxxx    xxx     xxx      xxx
12    xxxx          xx         xxxxxxxxx          xxxxxx    xxx     xxx      xxx
13    xxxx          xx         xxxxxxxxx          xxxxxx    xxx     xxx      xxx
14    xxxx          xx         xxxxxxxxx          xxxxxx    xxx     xxx      xxx
15    xxxx          xx         xxxxxxxxx          xxxxxx    xxx     xxx      xxx
16    xxxx          xx         xxxxxxxxx          xxxxxx    xxx     xxx      xxx
17    xxxx          xx         xxxxxxxxx          xxxxxx    xxx     xxx      xxx
18 ------------------------------------------------------------------------------
19                     N - NEXT PAGE              P - PREVIOUS PAGE
20
21
22 ENTER SELECTION:
23
24
```

Figure 15-8. CR - EPISODE DAYS BY CLINICAL SERVICE SCREEN

15.7 Administrative Text. On the Administrative Data Screen the user can enter up to seven lines of free-text remarks on the inpatient episode (Figure 15-9). Two pages of this screen are available.

15.8 Non-Procedural Providers. On the Non-Procedural Providers Screen the user can enter or update codes for physicians associated with the inpatient episode, but not associated with particular procedures performed during the episode. Up to 30 providers can be listed (Figure 15-10).

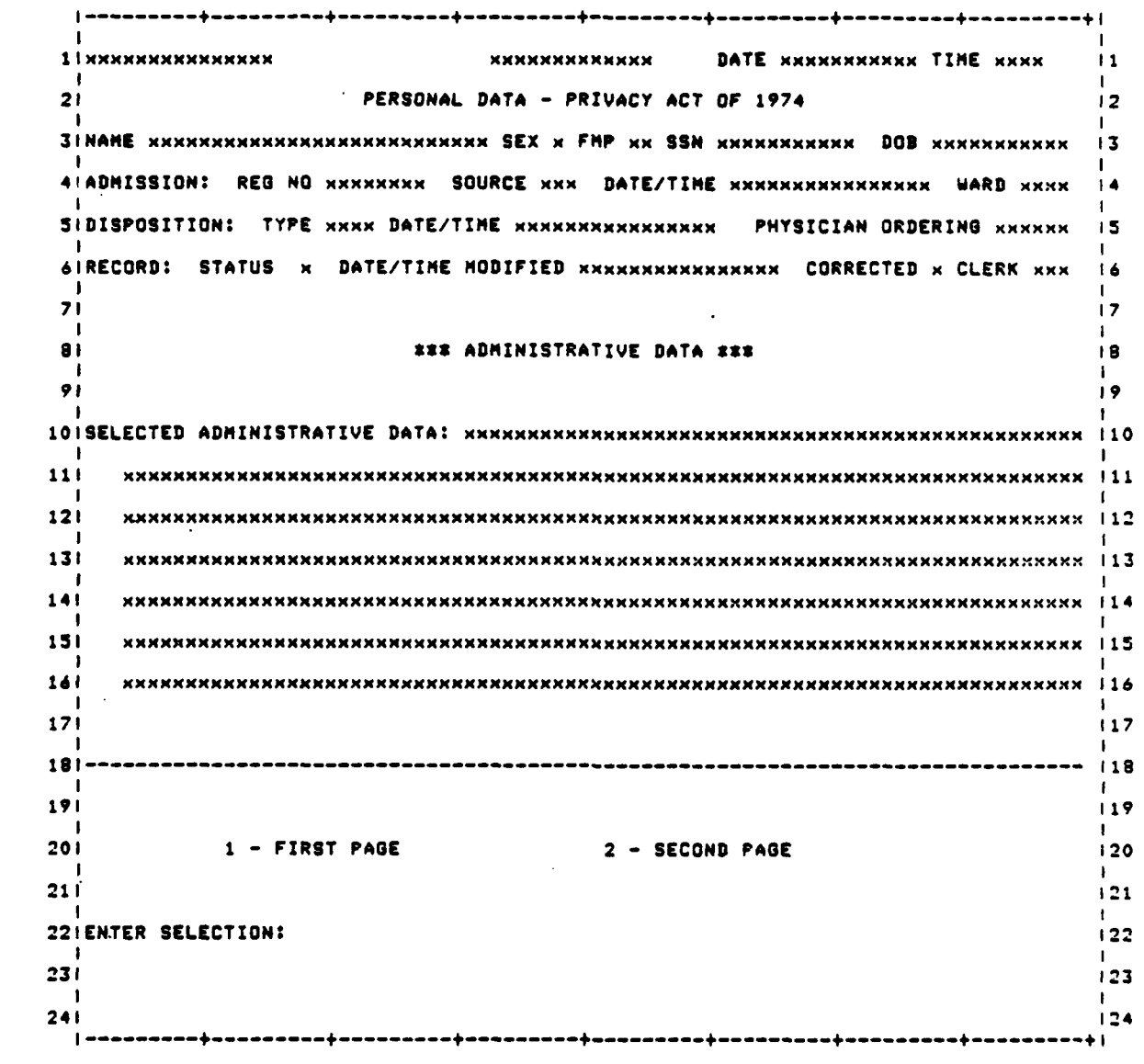


Figure 15-9. CR - ADMINISTRATIVE DATA SCREEN

```
 1|xxxxxxxxxxxxxxx                 xxxxxxxxxxxxx     DATE xxxxxxxxxxx TIME xxxx     | 1
 2|                        PERSONAL DATA - PRIVACY ACT OF 1974                       | 2
 3|NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxx SEX x FMP xx SSN xxxxxxxxxxx  DOB xxxxxxxxxxx  | 3
 4|ADMISSION:  REG NO xxxxxxxx  SOURCE xxx  DATE/TIME xxxxxxxxxxxxxxxx  WARD xxxx   | 4
 5|DISPOSITION:  TYPE xxxx DATE/TIME xxxxxxxxxxxxxxxx   PHYSICIAN ORDERING xxxxxx   | 5
 6|RECORD:  STATUS  x  DATE/TIME MODIFIED xxxxxxxxxxxxxxxx  CORRECTED x CLERK xxx   | 6
 7|                        *** NON-PROCEDURAL PROVIDERS ***                         | 7
 8|PROVIDER  xxxxxx              PROVIDER  xxxxxx              PROVIDER  xxxxxx     | 8
 9|PROVIDER  xxxxxx              PROVIDER  xxxxxx              PROVIDER  xxxxxx     | 9
10|PROVIDER  xxxxxx              PROVIDER  xxxxxx              PROVIDER  xxxxxx     |10
11|PROVIDER  xxxxxx              PROVIDER  xxxxxx              PROVIDER  xxxxxx     |11
12|PROVIDER  xxxxxx              PROVIDER  xxxxxx              PROVIDER  xxxxxx     |12
13|PROVIDER  xxxxxx              PROVIDER  xxxxxx              PROVIDER  xxxxxx     |13
14|PROVIDER  xxxxxx              PROVIDER  xxxxxx              PROVIDER  xxxxxx     |14
15|PROVIDER  xxxxxx              PROVIDER  xxxxxx              PROVIDER  xxxxxx     |15
16|PROVIDER  xxxxxx              PROVIDER  xxxxxx              PROVIDER  xxxxxx     |16
17|PROVIDER  xxxxxx              PROVIDER  xxxxxx              PROVIDER  xxxxxx     |17
18|-------------------------------------------------------------------------------- |18
19|                                                                                 |19
20|                                                                                 |20
21|                                                                                 |21
22|ENTER SELECTION:                                                                 |22
23|                                                                                 |23
24|                                                                                 |24
```

Figure 15-10. CR - NON-PROCEDURAL PROVIDERS SCREEN

15.9 Record Tracking. On the Record Tracking Screen the user can enter, update, or review information on items missing from the record, such as signatures and dictations. These items are tracked to determine deficiencies and delinquencies of the medical record. If the record is not complete after the suspense date, the delinquency will automatically be posted to the respective provider profile. See Figure 15-11 for an example of the screen, and Data Chart 15-6 for a description of its fields.

From this screen the user can choose option 1-OTHER MISSING SIGNATURES, which displays the Record Tracking Missing Signatures Screen. On this screen the user can enter codes for as many as eight providers whose signatures are missing from the record, and the date on which each signature was received (see Figure 15-12).

(1) STATUS.

(2) START DATE. The date when Clinical Records processing was initiated on this record. Calculated by the system but can be updated.

(3) SUSPENSE DATE. The date by which the record must be complete or it will be considered delinquent. Calculated by the system from the start date and the number of days until medical record deficiency (which is specified on the MTF Profile Screen in System Management).

This screen lists the following recordkeeping milestones:

(4) HISTORY PHY. The history physical.

(5) NARRATIVE.

(6) OP REPORT.

(7) DISC ORDER. Discharge order.

(8) DISC NOTE. Discharge notes.

(9) NURSING WARD.

For each of these milestones, data items 10 through 14 can be entered:

(10) PROVIDER. Code for the provider responsible for this part of the record.

(11) MISSING SIG. Indicates whether this part of the record is missing a signature.

(12) DATE COMP. Date on which the signature on this part of the record was received.

(13) MISSING DICT. Indicates whether dictation about this part of the record is missing.

(14) DATE COMP. Date on which the dictation for this part of the record was received.

(15) REMARKS. 140 spaces available for free-text remarks about the record.

Data Chart 15-6. CR - RECORD TRACKING SCREEN

```
 1|xxxxxxxxxxxxxxx                xxxxxxxxxxxxx     DATE xxxxxxxxxxx TIME xxxx     | 1
 2|                        PERSONAL DATA - PRIVACY ACT OF 1974                     | 2
 3|NAME xxxxxxxxxxxxxxxxxxxxxxxxxxx SEX x FMP xx SSN xxxxxxxxxxx  DOB xxxxxxxxxxx | 3
 4|ADMISSION:  REG NO xxxxxxxx  SOURCE xxx  DATE/TIME xxxxxxxxxxxxxxx  WARD xxxx | 4
 5|DISPOSITION:  TYPE xxxx DATE/TIME xxxxxxxxxxxxxxxx   PHYSICIAN ORDERING xxxxxx | 5
 6|RECORD:  STATUS  x  DATE/TIME MODIFIED xxxxxxxxxxxxxxxx  CORRECTED x CLERK xxx | 6
 7|                             ** RECORD TRACKING **                             | 7
 8|STATUS: x      START DATE: xxxxxxxxxxx      SUSPENSE DATE: xxxxxxxxxxx         | 8
 9|               PROVIDER       MISSING SIG   DATE COMP   MISSING DICT  DATE COMP | 9
10|HISTORY PHY:    xxxxxx            x         xxxxxxxxxxx        x       xxxxxxxxxxx | 10
11|NARRATIVE:      xxxxxx            x         xxxxxxxxxxx        x       xxxxxxxxxxx | 11
12|OP REPORT:      xxxxxx            x         xxxxxxxxxxx        x       xxxxxxxxxxx | 12
13|DISC ORDER:     xxxxxx            x         xxxxxxxxxxx        x       xxxxxxxxxxx | 13
14|DISC NOTE:      xxxxxx            x         xxxxxxxxxxx        x       xxxxxxxxxxx | 14
15|NURSING WARD:  xxxx/xxxx/xxxx                                                   | 15
16|REMARKS: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx | 16
17|         xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx | 17
18|-------------------------------------------------------------------------- | 18
19|                                                                           | 19
20|     1 - OTHER MISSING SIGNATURES                                          | 20
21|                                                                           | 21
22|ENTER SELECTION:                                                           | 22
23|                                                                           | 23
24|                                                                           | 24
```

Figure 15-11. CR - RECORD TRACKING SCREEN

```
 1|xxxxxxxxxxxxxxx                 xxxxxxxxxxxxx     DATE xxxxxxxxxxx TIME xxxx    | 1
 2|                        PERSONAL DATA - PRIVACY ACT OF 1974                      | 2
 3|NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxx SEX x FMP xx SSN xxxxxxxxxxx  DOB xxxxxxxxxxx  | 3
 4|ADMISSION:  REG NO xxxxxxxx  SOURCE xxx  DATE/TIME xxxxxxxxxxxxxxxx  WARD xxxx  | 4
 5|DISPOSITION:  TYPE xxxx DATE/TIME xxxxxxxxxxxxxxxx   PHYSICIAN ORDERING xxxxxx  | 5
 6|RECORD:  STATUS  x  DATE/TIME MODIFIED xxxxxxxxxxxxxxxx  CORRECTED x CLERK xxx  | 6
 7|                                                                               | 7
 8|OTHER MISSING SIGNATURES:                                                      | 8
 9|                    PROVIDER            DATE COMPLETE                          | 9
10|                     xxxxxx              xxxxxxxxxxx                           |10
11|                     xxxxxx              xxxxxxxxxxx                           |11
12|                     xxxxxx              xxxxxxxxxxx                           |12
13|                     xxxxxx              xxxxxxxxxxx                           |13
14|                     xxxxxx              xxxxxxxxxxx                           |14
15|                     xxxxxx              xxxxxxxxxxx                           |15
16|                     xxxxxx              xxxxxxxxxxx                           |16
17|                     xxxxxx              xxxxxxxxxxx                           |17
18|-------------------------------------------------------------------------------|18
19|                                                                               |19
20|     1 - RETURN TO PRIMARY RECORD TRACKING SCREEN                               |20
21|                                                                               |21
22|ENTER SELECTION:                                                               |22
23|                                                                               |23
24|                                                                               |24
```

Figure 15-12. CR - RECORD TRACKING MISSING SIGNATURE SCREEN

15.10 Clerk Actions. This screen lists the actions that the clerk and supervisor can take to complete processing on an inpatient episode record (Figure 15-13). For example, the clerk can enter a selection that indicates that the record is waiting for the supervisor's approval if it contains no errors. The supervisor can approve the record as final, or can override any errors to mark the record as final, among other functions. Most of the actions available from this screen also change record status, as displayed on line 6. Figure 15-14 summarizes the record statuses, and Figure 15-15 describes the clerk and supervisor actions appropriate for each.

The clerk can use this screen to request printing of the Inpatient Treatment Record Cover Sheet (ITRCS), the Record of Inpatient Treatment (RIPT), or the Coded Episode Summary. (The draft version of the RIPT is referred to as the "DRIPT.") These reports contain summary information on the inpatient episode.

Final Clinical Records processing of a patient record is considered complete when data on the record has been transmitted on tape to higher commands. This tape is called the Coding Transcript Tape (CTT). CR processing should be completed on each record within a certain length of time after the patient has been dispositioned; the length of time is specified by the MTF via the System Management function. Records that have not been completely processed in CR within this time limit are considered delinquent, and are listed on the Roster of Delinquent Records. After transmittal, the record is later removed from the system onto an archive tape. The MTF also specifies, through System Management, the length of time between tape transmittal and archiving.

The following paragraphs describe the clerk and supervisor actions available on this screen.

15.10.1 Clerk's Actions.

a. Print Draft Report. Through this option the clerk requests printing of the ITRCS or the DRIPT (see Part III, Outputs for further description of these reports). The clerk can request printing at any time except when the record has a status of D, meaning that it has been deleted from CR processing.

The ITRCS or the RIPT are also printed automatically when the clerk makes selection W, indicating that the record is waiting for the supervisor's approval. Both of these selections initiate an extensive set of final edits on the record. If any errors are discovered, they will be listed on the report, and they must be corrected before the record status will actually change to W.

```
xxxxxxxxxxxxxxx                    xxxxxxxxxxxxx      DATE xxxxxxxxxxx TIME xxxx
                        PERSONAL DATA - PRIVACY ACT OF 1974
NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx SEX x FMP xx SSN xxxxxxxxxxx  DOB xxxxxxxxxxx
ADMISSION:  REG NO xxxxxxxx  SOURCE xxx  DATE/TIME xxxxxxxxxxxxxxxx  WARD xxxx
DISPOSITION:  TYPE xxxx DATE/TIME xxxxxxxxxxxxxxxx   PHYSICIAN ORDERING xxxxxx
RECORD:  STATUS  x  DATE/TIME MODIFIED xxxxxxxxxxxxxxxx  CORRECTED x CLERK xxx
 CLERK:                                          SUPERVISOR:
   P - PRINT DRAFT ITRCS/COVER SHEET                A - APPROVE
   S - PRINT CODED EPISODE SUMMARY                  D - DELETE
   W - WAITING SUPERVISOR APPROVAL                  O - OVERRIDE
   R - RELEASE TO A & D                             X - REJECT
                                                    C - CLERK LIST

SELECT ACTION:  x

AUTHORIZED SIGNER FOR REPORT: xxx
REASON FOR RELEASE:  xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
-------------------------------------------------------------------------------
1 - DIAGNOSIS    4 - TRANSFER HISTORY          7 - ADMIN TEXT    0 - CLERK ACTION
2 - PROCEDURES   5 - EPISODE DAYS BY DATE      8 - NON-PROC PHYS
3 - MISC         6 - EPISODE DAYS BY CLN SVC   9 - RECORD TRACKING
ENTER SELECTION:
```

Figure 15-13. CR - CLERK ACTIONS SCREEN

b. Waiting Supervisor Approval. When the clerk believes the record is complete and error-free, he or she can make this selection to mark the record as waiting for the supervisor's approval. As mentioned, this selection causes final edits to be run on the record and the ITRCS or RIPT to be printed. If errors are found, they will be printed on the report, and the record status will remain I. If no errors are found, the record status changes to W, and the record cannot be updated again unless the supervisor changes its status.

c. Release to A&D. When a record is accessed through Clinical Records, it is not available to any other AQCESS function. If the record needs to be corrected through another function, the clerk can release the record from CR control by making this selection. The only records that cannot be released to A&D are those with a status of T, meaning that they have already been included on tape to higher commands. A reason for the release can be entered on line 17 of this screen. A released record acquires a record status of R, but this status never appears on a CR screen. When the record is accessed again in Clinical Records, its status will again be I. The Roster of Records Released to A&D lists the records and the reason for their release, enabling A&D to make sure the appropriate changes are made.

d. Print Coded Episode Summary. The clerk can request printing of the Coded Episode Summary (CES) at any time except when the record has a status of D, meaning that it has been deleted from CR processing.

15.10.2 Supervisor's Actions. After selecting each of the following actions, the supervisor must enter his or her user ID and password in the appropriate field.

a. Approve. With this option the supervisor can approve a W status record for inclusion on the Coding Transcript Tape. The supervisor must enter the initials of the person who will sign the patient's report in the AUTHORIZED SIGNER FOR REPORT field. This selection also causes a final version of the ITRCS or the RIPT to print out.

b. Delete. A deleted record, or D status record, cannot be accessed in CR and does not appear on system reports. The supervisor can delete a record if it is incomplete, waiting for approval, or rejected (statuses I, W, or X, respectively). To be able to access a deleted record again, the supervisor must reject it (see paragraph d, below).

c. Override. When a record contains errors, the supervisor can override those errors and mark the record as waiting (status W) using this selection.

d. Reject. Rejecting a record returns it for further processing or correction in Clinical Records. The supervisor can reject records that have been approved, deleted, marked as waiting, or included on the Coding Transcript (statuses A, D, W, or T, respectively). A rejected record takes on a status of X. As soon as it is updated again, the status changes to I.

If a T status record is rejected, the corrected record field in the common data section of the CR screens will be automatically set to C. For the Army, this record may be approved again and will be retransmitted with the corrected flag set. For the Navy, a correction transaction will be generated.

e. Clerk List. This screen displays the Clerk List (Figure 15-16), which lists the last 20 clerks who updated this record, and the date of each update.

15.10.3 Submitting the Record to Higher Commands. After the record is included on the Coding Transcript Tape, it acquires a record status of T. When a record has this status, the clerk will be able to use the Print Draft Report option. If this report reveals any errors on the record, the supervisor will be able to reject the record so that the errors can be corrected.

Record Status

P = This patient has a projected disposition.

I = CR processing has begun on this record but is incomplete.

W = The record is waiting for the supervisor's approval.

A = The record has been approved for inclusion on the Coding Transcript Tape (CTT).

D = The record has been deleted from CR processing; it cannot be accessed in CR and does not appear on reports.

X = The record contains errors and has been rejected so that it can be corrected in CR.

R = The record has been released from CR control so that it can be accessed by an R/ADT function.

Figure 15-14. SUMMARY OF CR RECORD STATUSES

When Record Status Is:	Clerk Can Select:	Supervisor Can Select:
I	P - PRINT DRAFT REPORT W - WAITING SUPERVISOR APPROVAL R - RELEASE TO A&D	D - DELETE O - OVERRIDE C - CLERK LIST
W	P - PRINT DRAFT REPORT R - RELEASE TO A&D	X - REJECT A - APPROVE D - DELETE C - CLERK LIST
X	P - PRINT DRAFT REPORT W - WAITING SUPERVISOR APPROVAL R - RELEASE TO A&D	C - CLERK LIST D - DELETE
A	P - PRINT DRAFT REPORT R - RELEASE TO A&D	X - REJECT C - CLERK LIST
D	R - RELEASE TO A&D	X - REJECT D - DELETE
T	P - PRINT DRAFT REPORT	X - REJECT D - DELETE
P (projected disposition)	P - PRINT DRAFT REPORT	C - CLERK LIST

Figure 15-15. SUMMARY OF CLERK AND SUPERVISOR ACTIONS APPROPRIATE FOR EACH CR RECORD STATUS

```
xxxxxxxxxxxxxxx                    xxxxxxxxxxxxx     DATE xxxxxxxxxx TIME xxxx
                        PERSONAL DATA - PRIVACY ACT OF 1974
NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxxx SEX x EMP xx SSN xxxxxxxxxxx  DOB xxxxxxxxxxx
ADMISSION:  REG NO xxxxxxxx  SOURCE xxx  DATE/TIME xxxxxxxxxxxxxxxx  WARD xxxx
DISPOSITION:  TYPE xxxx DATE/TIME xxxxxxxxxxxxxxxx   PHYSICIAN ORDERING xxxxxx
RECORD:  STATUS  x  DATE/TIME MODIFIED xxxxxxxxxxxxxxxx  CORRECTED x CLERK xxx
                        ** CLERK UPDATE LIST **
    CLERK: xxx  DATE: xxxxxxxxxxxxxxxx   CLERK: xxx  DATE: xxxxxxxxxxxxxxxx
    CLERK: xxx  DATE: xxxxxxxxxxxxxxxx   CLERK: xxx  DATE: xxxxxxxxxxxxxxxx
    CLERK: xxx  DATE: xxxxxxxxxxxxxxxx   CLERK: xxx  DATE: xxxxxxxxxxxxxxxx
    CLERK: xxx  DATE: xxxxxxxxxxxxxxxx   CLERK: xxx  DATE: xxxxxxxxxxxxxxxx
    CLERK: xxx  DATE: xxxxxxxxxxxxxxxx   CLERK: xxx  DATE: xxxxxxxxxxxxxxxx
    CLERK: xxx  DATE: xxxxxxxxxxxxxxxx   CLERK: xxx  DATE: xxxxxxxxxxxxxxxx
    CLERK: xxx  DATE: xxxxxxxxxxxxxxxx   CLERK: xxx  DATE: xxxxxxxxxxxxxxxx
    CLERK: xxx  DATE: xxxxxxxxxxxxxxxx   CLERK: xxx  DATE: xxxxxxxxxxxxxxxx
    CLERK: xxx  DATE: xxxxxxxxxxxxxxxx   CLERK: xxx  DATE: xxxxxxxxxxxxxxxx
    CLERK: xxx  DATE: xxxxxxxxxxxxxxxx   CLERK: xxx  DATE: xxxxxxxxxxxxxxxx
1 - DIAGNOSIS   4 - TRANSFER HISTORY          7 - ADMIN TEXT    0 - CLERK ACTION
2 - PROCEDURES  5 - EPISODE DAYS BY DATE      8 - NON-PROC PHYS
3 - MISC        6 - EPISODE DAYS BY CLN SUC   9 - RECORD TRACKING
ENTER SELECTION:
```

Figure 15-16. CR - CLERK LIST SCREEN

SECTION 16. CLINICAL RECORDS REPORTS SCREEN

16.1 Clinical Records Reports Function - Overview. Through this function the user is able to request printing of Clinical Records reports such as:

a. Dispositions without Clinical Records Report.

b. Roster of Delinquent Records.

c. Roster of Records Currently Released to A&D.

Through the Clinical Records Reports function, users also initiate end-of-month processing of records.

When this selection is entered on the User Entry Menu Screen, the Clinical Records Reports Selection Screen is displayed (Figure 16-1). This screen displays the list of reports from which the user can choose. For each report a screen will appear on which the user specifies run-time parameters, as for the R/ADT reports. The user must specify whether the report is to be displayed on the screen or printed. Other report parameters may be specified, depending on the report. Reports that are to be printed will run as a background job; after the run-time specifications are entered, the user may go on with other processing. Reports that are output to the terminal, obviously, run while the user waits.

For details on the contents of these reports, see Part III, Outputs.

NOT AVAILABLE AT THIS TIME

Figure 16-1. CLINICAL RECORDS REPORTS SELECTION SCREEN

PART III - OUTPUTS

SECTION 17. OUTPUTS

17.1 Overview. Two types of outputs are produced by AQCESS: products and reports.

The system's products, which are listed below, are described in section 17.2.

a. Registration product: Registration Form.

b. Inpatient products.

(1) Admission Form.
(2) Embossed Cards.
(3) Index Cards.

c. Clinical Records products.

(1) Coded Episode Summary (CES).
(2) Inpatient Treatment Record Cover Sheet (ITRCS) or Record of Inpatient Treatment (RIPT).
(3) Error List.

The system's reports are:

a. R/ADT Reports (described in section 17.3).

(1) Admission and Disposition Report.
(2) A&D Recapitulation and Patient Strength Report.
(3) Alpha Roster of Hospital Patients.
(4) Daily Admissions by Diagnosis.
(5) Injury Report.
(6) Invalid Sign-On Log.
(7) List of Current Passwords.
(8) Roster of VSI/SI/SC Patients.
(9) Status Out Roster.
(10) UCA Disposition Report.
(11) UCA Inpatient Occupied Bed Days Report.
(12) Ward Nursing Report.

b. Clinical Records Reports (described in section 17.4).

(1) Coded Transcript Tape (CTT).
(2) Roster of Delinquent Records.
(3) Roster of Records Released to A & D.

Most figures in this section show formats of the reports, without data in them. On these formats, the letter "h" indicates that this field contains header information, the letter "p" represents the page number, the letter "x" represents data, and the letter "t" indicates that trailer or footer information is displayed.

All the AQCESS reports display the same header data, except where indicated otherwise. (The top line shown on formats of reports, giving the report number, is not actually displayed on reports as printed for the user.) After the line showing the report number, the first line shows TRIMIS PAD version number, the Privacy Act statement, and the run date. The second line contains the MTF's name and code and the page number. The third line shows the name of the report.

17.2 Products.

17.2.1 Registration Products.

a. Registration Form. These forms contain data entered during registration and are requested from the Registration Products segment of the Registration process. Figure 17-1 shows a sample form. The data on this form is described in section 5, Registration (see Data Chart 5-1).

17.2.2 Inpatient Products.

a. Admission Form. This form containing patient information is sent to the ward with the patient and used to record treatment information. It is requested from Admission's Inpatient Products segment. See Figure 17-2 for an example of the Admission Form used by the Army, and Figure 17-3 for an example of the Form used by the Navy.

b. Embossed Cards. This product also displays registration and admission information; it can be requested via Admission's Inpatient Products segment. See Figure 17-4 for an example.

c. Index Card. These cards also display admission data and are requested from Admission's Inpatient Products segment. Index Cards, which are 3x5 or 5x8 cards, are printed in sets. The number of cards in each set is specified by the MTF on the MTF Profile (see section 11). The user requests the number of sets desired. Figure 17-5 shows an example of the 3 x 5 card used by the Army and Air Force, and Data Chart 17-1 describes its fields. Figure 17-6 is an example of the 5 x 8 card used by the Navy, and Data Chart 17-2 describes its fields.

```
AQCESS VERSION 100      **** PERSONAL DATA ****      LAST UPDATE 20 FEB 1985
TEST AF HOSPITAL        * PRIVACY ACT OF 1974 *      RUN DATE    21 FEB 1985
                      PATIENT REGISTRATION FORM

NAME:                       JOHNSTON ALBERT

DATE OF BIRTH:              04 DEC 1944

SEX:                        M

RACE:                       1

FAMILY MEMBER PREFIX:       20

SPONSOR NAME:

SPONSOR SSN:                125125125

PATIENT CATEGORY:           A11

SPONSOR RANK:               COL

PATIENT OCCUPATION:

DUTY TELEPHONE:             2174338990

HOME TELEPHONE:             2175557645

SPONSOR MIL DUTY STAT ADDR:
                            FT MEADE
                            FT MEADE          MD          20045

PATIENT MAILING ADDRESS:
                            1014 FIRST STREET
                            MONROE            NY          10879

PRIMARY CARE MTF:

REG NO LAST ADM THIS MTF:  NONE

DATE LAST ADM THIS MTF:

REGISTRATION REMARKS:

DATE VERIFIED W/PNT:

FLYING STATUS
```

Figure 17-1. REGISTRATION FORM

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40 - 400; the proponent agency is the Office of The Surgeon General.

1. REGISTER NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. EMP	12. SSN		13. ORGANIZATION			14. WARD	
15. FLYING STATUS	16. RATING/OSG	17. DEPT/BEN	18. BRANCH/CORPS.	19. MOS/SIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION				22. HOUR OF ADMISSION	23 CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION	26. DATE OF DISPOSITION		ADMITTING OFFICER
27. ADDRESS OF EMERGENCY ADDRESSEE (INCLUDE ZIP CODE)				TELEPHONE NO.	28. DATE OF THIS ADMISSION		32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INITIAL ADMISSION		

31. SELECTED ADMINISTRATIVE DATA

Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSIS/OPERATIONS AND SPECIAL PROCEDURES

☐ Check If Continued on Reverse

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORD OFFICER

Figure 17-2. ADMISSION FORM (ARMY)

NAVMED 6300/5M (FRONT)

NPATIENT ADMISSION/DISPOSITION RECORD

1 PATIENT'S NAME (LAST, FIRST, MIDDLE)	2 TIME ADMITTED	3 ADMISSION DATE	4 REPORTING MEDICAL TREATMENT FACILITY (UIC)	5 LOC CODE	6 REGISTER NUMBER

7 DUTY STATION (ACCD NAVY & MARINE CORPS ONLY)	8 FAMILY PREFIX	9 SOCIAL SECURITY NUMBER	10 SEX CODE	11 RACE	12 RELIGION
SHIP/STATION CODE				CODE	

13 HOME ADDRESS (OTHER THAN ACTIVE DUTY) OR 7 DUTY STATION (ACCD U.S. ARMY AND AIR FORCE ONLY)	14 MARITAL STATUS	15 BIRTH DATE	16 LENGTH OF SERVICE	17 PAY GRADE CODE	18 DES. MOS NEC	19 RECORDS RECEIVED

20 DEPENDENTS ID CARD NUMBER EXP DATE	21 PATIENT CATEGORY	CODE	22 TYPE OF ADMISSION	CODE	23 MIL TM OR CODE

24 NEXT OF KIN SPONSOR, GIVE NAME, ADDRESS, RELATIONSHIP AND PHONE NO	25 CLINIC SERVICE CODE	26 NOTIFY IN CASE OF EMERGENCY (OTHER THAN NEXT OF KIN) GIVE NAME, ADDRESS, RELATIONSHIP AND PHONE NO
	REMARKS	

27 ADMISSION DIAGNOSIS (INCLUDE BODY PART ANATOMIC SITE IF APPLICABLE)	28 MEDICAL TREATMENT FACILITY TRANSFERRED FROM	29 ORIGINAL ADMISSION DATE
DIAGNOSIS CODE	CODE	

30 CIRCUMSTANCES OF ACCIDENT, VIOLENCE, POISONING (ACTIVE DUTY U.S. UNIFORMED SERVICES ON DUTY INDICATE Y OR N) CAUSE CODE	2 RECORD BRIEFLY - WHAT, WHEN, WHERE, HOW

31 DISPOSITION TO

32 PATIENT'S NAME (LAST, FIRST, MIDDLE)	33 GRADE/RATE	34 WARD	35 REPORTING MEDICAL TREATMENT FACILITY

Figure 17-3. ADMISSION FORM (NAVY)

Q008 AQCESS - PAD

NOT AVAILABLE AT THIS TIME

Figure 17-4. EMBOSSED CARD

PERSONAL DATA/PRIV ACT 1974

0000158 JONES BABY

01 121514567 31 61

4E DIS F BAPT C 01AUG 84 DIR

JONES JANE M (301) 777-8898

12 OLIVE ST

BETHESDA MD 20910

A51 31MAR85 1045 LEWIS, STERLING F., MAJ AAAA

Figure 17-5. 3 X 5 CARD

Line 1 contains	PRIVACY ACT STATEMENT.
Line 2 contains:	PATIENT'S REGISTER NUMBER, PATIENT'S NAME, RANK, if active duty.
Line 3 contains:	PATIENT'S FMP, SPONSOR'S SSN, AUTHORITY FOR HOSPITALIZATION.
Line 4 contains:	WARD ID, TYPE CASE, PATIENT' SEX, RELIGION, RACE, ARMY BRANC' OF SERVICE, DOB, SOURCE OF ADMISSION
Line 5 contains:	NAME OF NEXT OF KIN, RELATIONSHIP, PHONE NUMBER
Line 6 contains:	NEXT OF KIN'S STREET ADDRESS, PATIENT'S EXPIRATION OF TERM OF SERVICE, if active duty
Line 7 contains:	NEXT OF KIN'S CITY, STATE, and ZIP CODE; PATIENT'S DATE and COUNTRY of initial admission
Line 8 contains:	PATIENT'S PATIENT CATEGORY, DATE/TIME OF ADMISSION, ADMITTING PHYSICIAN, and UCA CLINICAL SERVICE CODE, if dependent.

Data Chart 17-1. 3 X 5 CARD

NOT AVAILABLE AT THIS TIME

Figure 17-6. 5 x 8 CARD

NOT AVAILABLE AT THIS TIME

Data Chart 17-2. 5 x 8 CARD

17.2.3 Clinical Records Products.

17.2.3.1 Coded Episode Summary (CES). The Coded Episode Summary is a printout of the data on the Coding Transcript Tape (see section 17.4.1). The CES is different for each military department. It is printed on request or when the clerk sets the record's status to W.

See Figure 17-7 for an example of the format of the Air Force CES. (This is an example of the format only; the data is not correct.)

17.2.3.2 Inpatient Record Cover Sheet (ITRCS) and Record of Inpatient Treatment (RIPT). The RIPT for the Navy and the Air Force is printed on request or when the user sets the record status to W. The formats are similar. See Figure 17-8 for an example of of the Air Force form, and Figure 17-9 for an example of the Navy form.

17.2.3.3 Error List. The Error List is printed following each draft ITRCS or RIPT. The heading is standard for all military departments. Any errors will be listed. The edit logic and, therefore, the error messages are different for each military department. See Figure 17-10 for an example of the Error List.

```
                    *** CLINICAL RECORDS CODED EPISODE SUMMARY ***
                         PERSONAL DATA PRIVACY ACT OF 1974          27 MAR 1985 0644

REG # 00000636 NAME: JOHNS BARRY                          SEX: M FMP/SSN: 20 888-77-7666
PNT CAT: F11                    DOB: 03 MAR 1933          RECORD CLERK: HKK
ADM DATE: 22 MAR 1985 1400                                DISP DATE: 27 MAR 1985 0626
SRC ADM: DIR                    DISP TYPE: DUTY           CAUSE:       CLN SVC:
-------------------------------------------------------------------------------

------------------------------------ CARD A -----------------------------------
REGISTER    MTF      FMP      SSN      BEN/CMD GRADE  AFSC AV-SV A-RAT L-SVC  AGE
  1-8       9-14    15-16    17-25      26-28  29-30 31-33 34-35  36   37-38 39-40
--------  ------    --   ---------     ---    --    ---   --    -    --    --
00000636  000251    20  888777666      F11    03    45                 11

SEX MSTAT RACE DUTYZ INIT-MTF IN-AD-DT DISP-D DISP-TP TO-DY-DT BD-DT BD-FAC   A
41   42    43  44-50  51-56     57-61   62-66    67      68-70  71-73 74-76 77-80
-    -     -  -------  ------    -----   -----    -       ---    ---   ---   ----
M    S     C  9998700           2850322 2850327  A         5      2     2     A

------------------------------------ CARD B -----------------------------------
REGISTER    MTF  DIS-CLIN <BED-DA CAUSE-INJ CAUSE-D/S PRI-DIAG <INF 2ND-DIAG <INF
  1-8       9-14   15-17   18-20    21-24      25      26-31     32   33-38     39
--------  ------   ---     ---      ----       -       ------    -    ------    -
00000636  000251           0                          53000     0    53010     0
3RD-DIAG <INF  PRI-PROVDR  2ND-PROVDR  3RD-PROVDR  CONV-TAKEN CONV-REC        B
40-45     46   47-52   53  54-59   60  61-66   67    68-69      70-71      72-80
------    -    ------  -   ------  -   ------  -     --         --     ---------
               A                                                          B

------------------------------------ CARD C -----------------------------------
REGISTER    MTF  OTH-CLIN <BED-DA OTH-CLIN <BED-DA (1ST-OP D POCT)(2ND-OP D POCR)
  1-8       9-14   15-17   18-20   21-23     24-26  27-30 31 32-34 35-38 39 40-42
--------  ------   ---     ---     ---       ---    ----  -  ---  ----  -  ---
00000636  000251   AAA     002     AAA       000
(3RD-OP D POCT) PRE-OP POST-OP VL-WHOL CC-PACK FETUS1 FETUS2 FETUS3 FETUS4     C
43-46 47  48-50  51-53  54-56   57-61   62-66   67-68  69-70  71-72  73-74 75-80
----    -  ---    ---    ---     -----   -----   --     --     --     --  ------
                                                                          LC
```

Figure 17-7. CODED EPISODE SUMMARY (AIR FORCE)

```
RUN DATE: 27 MAR 1985    **** RECORD OF INPATIENT TREATMENT ****    PAGE: 1
    TIME: 657            PERSONAL DATA - PRIVACY ACT OF 1974
                                  MTF: 0251
  *****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****
REGISTER: 0000636       NAME: JOHNS BARRY                FMP/SSN: 20 888-77-7666
--------------------------------------------------------------------------------
ADMISSION:   DATE/TIME: 22 MAR 1985 1400  SOURCE: DIR  WARD: 4E  TYPE CASE: DIS
PNT CATEGORY: ACT-DUTY USAF            BRANCH OF SERVICE: F
GRADE: 03  LENGTH OF SVC: YRS: 11 MOS: 00   MILITARY OCC: 22345  FLY STATUS:
MARITAL STATUS: S     SEX: M    RACE: C       DOB: 03 MAR 1933
RELIGION: ROMAN CATHOLIC
AERO RATING:                                 AVIATION SERVICE CODE:
--------------------------------------------------------------------------------
DISPOSITION:  DATE/TIME: 27 MAR 1985 0626     TYPE: DUTY
              UNDERLYING CAUSE:               FACILITY TFR TO:
--------------------------------------------------------------------------------
SELECTED ADMINISTRATIVE DATA:
--------------------------------------------------------------------------------
CAUSE OF INJURY:
--------------------------------------------------------------------------------
SPONSOR NAME: JOHNS BARRY
DUTY ADDRESS: KEESLER AFB
              BILOXI  MS  99987

NXT OF KIN RELATIONSHIP: WIFE            EMERGENCY RELATIONSHIP:
NAME:   JOHNS MILDRED                    NAME:
ADDRESS: 123 4TH SOUTH                   ADDRESS:
         CARMEL VALLEY  CA 93924

PATIENT
ADDRESS: 123 4TH SOUTH                   HOME PHONE:
         CARMEL VALLEY  CA 93924         WORK PHONE:
PRIMARY MTF:
--------------------------------------------------------------------------------
============================== D I A G N O S E S ==============================
ICD: 5300       INF: 0
     ACHALASIA AND CARDIOSPASM
--------------------------------------------------------------------------------
ICD: 5301       INF: 0
     ESOPHAGITIS
--------------------------------------------------------------------------------
============================== P R O C E D U R E S ============================
***** NONE PERFORMED
--------------------------------------------------------------------------------
============== N O N - P R O C E D U R A L  P R O V I D E R S ================
PRIMARY PROVIDER:









--------------------------------------------------------------------------------
REGISTER: 0000636       NAME: JOHNS BARRY                FMP/SSN: 20 888-77-7666
                                                          CONTINUED ON PAGE 2
** REPLACES AF FORM 565 **
```

Figure 17-8. RECORD OF INPATIENT TREATMENT (AIR FORCE)

```
RUN DATE: 27 MAR 1985    **** RECORD OF INPATIENT TREATMENT ****    PAGE: 2
    TIME: 657            PERSONAL DATA - PRIVACY ACT OF 1974
                                  MTF: 0251
  *****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****
REGISTER: 0000636       NAME: JOHNS BARRY                FMP/SSN: 20 888-77-7666
--------------------------------------------------------------------------------
********************** E P I S O D E  D A Y  S U M M A R Y **********************
*TOT   BED  NON-BED*
*DAYS  DAYS  DAYS  *
                    THIS MTF: USAF CLINIC, EIELSON AFB, AK 99702
                    ADMIT DATE: 22 MAR 1985 1400 DISP DATE: 27 MAR 1985 0626

    5               INTERNAL MEDICINE
          2     0         BED OCCUPANT THIS MTF
                            DATE ASSIGNED: 22 MAR 1985
          0     3         CONVALESCENT LEAVE
                            DATE ASSIGNED: 24 MAR 1985
 ****  ****  ****
    5     2     3    *TOTAL DAYS THIS MTF
    0     0     0    *TOTAL PRIOR MTFS, NON-MILITARY FACILITIES AND TRANSIT
    5     2     3    *TOTAL DAYS TO DATE
--------------------------------------------------------------------------------
CONVALESCENT LEAVE TAKEN: 3        RECOMMENDED: 2
--------------------------------------------------------------------------------
************************ O T H E R  R E S O U R C E S ************************
CC-WHOLE  CC-PACKED  PRE-OP POST-OP COOPERATIVE CARE DAYS     SUPP CARE DAYS
 BLOOD      CELLS     DAYS   DAYS    THIS MTF  PRIOR MTFS  THIS MTF  PRIOR MTFS
                                        0          0          0          0
--------------------------------------------------------------------------------
--------------------------------------------------------------------------------
REGISTER: 0000636       NAME: JOHNS BARRY                FMP/SSN: 20 888-77-7666
                                                      >>>>>>>> END OF REPORT <<<<<<<<
** REPLACES AF FORM 565 **
```

Figure 17-8 (continued). RECORD OF INPATIENT TREATMENT (AIR FORCE)

```
RUN DATE: 27 MAR 1985    **** RECORD OF INPATIENT TREATMENT ****    PAGE: 1
    TIME: 703            PERSONAL DATA - PRIVACY ACT OF 1974
                                  MTF: 0251
  *****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****
REGISTER: 0000613       NAME: WILLIAMS AMY                FMP/SSN: 30 123-45-6789
--------------------------------------------------------------------------------
ADMISSION:   DATE/TIME: 21 MAR 1985 1514  SOURCE: DIR  WARD: 4E  TYPE CASE: DIS
PNT CATEGORY: DEPN USN ACTIVE DUTY    BRANCH OF SERVICE: N
CIV OCC: DOMESTIC ENGINEER
MARITAL STATUS: M     SEX: F     RACE: C        DOB: 30 DEC 1955
RELIGION: NO PREFERENCE
RECORDS RECEIVED:   HR-        DR-        SR-        PR-        ORD-      PE-
--------------------------------------------------------------------------------
DISPOSITION:  DATE/TIME: 22 MAR 1985 1142      TYPE: HOME
              UNDERLYING CAUSE:                FACILITY TFR TO:
--------------------------------------------------------------------------------
SELECTED ADMINISTRATIVE DATA:
--------------------------------------------------------------------------------
CAUSE OF INJURY:
--------------------------------------------------------------------------------
NXT OF KIN RELATIONSHIP: WIFE              EMERGENCY RELATIONSHIP:
NAME:   WILLIAMS AMY                       NAME:
ADDRESS: 125 W BROAD ST                    ADDRESS:
         PAWCATUCK  CT 02345

PATIENT
ADDRESS: 125 W BROAD ST                    HOME PHONE: 123456789
         PAWCATUCK  CT 02345               WORK PHONE:
PRIMARY MTF: N015
--------------------------------------------------------------------------------
============================== D I A G N O S E S ==============================
OCCUPATION RELATED:       EPTE:     ICD: 65001     CAUSE:
      NORMAL DELIVERY
--------------------------------------------------------------------------------
============================= P R O C E D U R E S ==============================
PROCEDURE: 9263- -          DATES: 21 MAR 1985
      ROUTINE EPISIOTOMY
      PROVIDER TEAM: STAFF DOCTOR
--------------------------------------------------------------------------------
============== N O N - P R O C E D U R A L  P R O V I D E R S ================
PRIMARY PROVIDER:




--------------------------------------------------------------------------------
REGISTER: 0000613       NAME: WILLIAMS AMY                FMP/SSN: 30 123-45-6789
                                                    CONTINUED ON PAGE 2
```

Figure 17-9. RECORD OF INPATIENT TREATMENT (NAVY)

```
RUN DATE: 27 MAR 1985    **** RECORD OF INPATIENT TREATMENT ****    PAGE: 2
    TIME: 703            PERSONAL DATA - PRIVACY ACT OF 1974
                                  MTF: 0251
  *****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****
REGISTER: 0000613       NAME: WILLIAMS AMY                FMP/SSN: 30 123-45-6789
-------------------------------------------------------------------------------
********************** E P I S O D E  D A Y  S U M M A R Y ********************
*TOT    BED  NON-BED*
*DAYS   DAYS  DAYS  *
                     THIS MTF: USAF CLINIC, EIELSON AFB, AK 99702
                     ADMIT DATE: 21 MAR 1985 1514 DISP DATE: 22 MAR 1985 1142

    1                INTERNAL MEDICINE
          1      0         BED OCCUPANT THIS MTF
                             DATE ASSIGNED: 21 MAR 1985
 ====   ====   =-==
    1      1      0    *TOTAL DAYS THIS MTF
    0      0      0    *TOTAL PRIOR MTFS, NON-MILITARY FACILITIES AND TRANSIT
    1      1      0    *TOTAL DAYS TO DATE
-------------------------------------------------------------------------------
CONVALESCENT LEAVE TAKEN: 0          RECOMMENDED:
-------------------------------------------------------------------------------
********************** O T H E R  R E S O U R C E S ************************
CC-WHOLE   CC-PACKED   PRE-OP  POST-OP  COOPERATIVE CARE DAYS      SUPP CARE DAYS
 BLOOD       CELLS      DAYS    DAYS     THIS MTF  PRIOR MTFS  THIS MTF  PRIOR MTFS
                                             0          0          0          0
-------------------------------------------------------------------------------
-------------------------------------------------------------------------------
REGISTER: 0000613       NAME: WILLIAMS AMY                FMP/SSN: 30 123-45-6789
                                                  >>>>>>> END OF REPORT <<<<<<<
```

Figure 17-9 (continued). RECORD OF INPATIENT TREATMENT (NAVY)

```
                        *** CLINICAL RECORDS ERROR LIST ***                PAGE 2
                         PERSONAL DATA PRIVACY ACT OF 1974        27 MAR 1985 0613

REG # 0000613  NAME: WILLIAMS AMY                  SEX: F FMP/SSN: 30 123-45-6789
PNT CAT: N41                    DOB: 30 DEC 1955     RECORD CLERK:
ADM DATE: 21 MAR 1985 1514                           DISP DATE: 22 MAR 1985 1142
SRC ADM: DIR                    DISP TYPE: HOME      CAUSE:       CLN SUC: AAA
-------------------------------------------------------------------------------

NO ERRORS FOUND
```

Figure 17-10. CLINICAL RECORDS ERROR LIST

17.3 R/ADT Reports.

17.3.1 Admission and Disposition Report. The A&D Report describes all corrections to data on admissions, dispositions, changes of absent status, and newborn activity. The report is run daily, usually at midnight, but a partial report can be run at anytime. Figure 17-11 shows an example of the A&D Report.

In addition to the standard heading data, an inserted third line shows the period ending date for this report.

The body of the A&D report is divided into sections depending on the type of activity being reported. These sections are: Admission, Disposition, Absent Status, Interward Transfer, Newborn, and Text Corrections. Each section lists the patient record affected by the activity, and gives the following information on that record (as indicated by the report's column headings):

(1) REG. NO., PATIENT NAME, DUTY ADDRESS, TYPE CASE, TIME, WARD

(2) FMP, SPONSOR SSN, RANK, PNT CAT., RELATIONSHIP, MTF DAYS, FS (flying status)

a. Admission Section Content. The Admission Section is divided into subsections that contain the admission activity for each source of admission as collected on the Admission Screen. The actual subsections are different for each service. Admissions that are "Transfer-In" are grouped by the code of the MTF from which the patient transferred. There is a two-line entry for each patient who falls under the various admission subsections.

b. Disposition Section Content. The Disposition Section is divided into subsections that contain the disposition activity for each disposition type (see the appropriate table) as specified on the Disposition Screen. Dispositions that are "Transfer-Out" are grouped by the MTF code to which the patient was transferred. There is a two-line entry for each patient who falls under the various disposition subsections.

c. Absent Status Section Content. The Absent Status Section is divided into subsections that reflect the change of absent status activity for each absent status collected and modified in Admission/Transfer processing. There is a two-line entry for each patient who falls under the various change of absent status subsections.

d. Interward Transfer Section Content. The Interward Transfer Section contains a line entry for each patient who has been transferred from one ward to another.

e. Newborn Section Content. The Newborn Section contains subsections that reflect births, deaths, and discharges of newborns.

f. Text Corrections. Text corrections are memoranda entered via the Correction Management subsystem that are used to communicate corrections to previous A&D Reports or unusual circumstances to MTF personnel.

```
                    PERSONAL DATA - PRIVACY ACT 1974  RUN DATE 25 MAR 1985 1355
TEST NAVY HOSPITAL                                                      PAGE 1
                       PERIOD ENDING 1355 HOURS  25 MAR 1985            * 85084 *

              * * * * * ADMISSION AND DISPOSITION REPORT * * * * *

REG NO.    PATIENT NAME              DUTY ADDRESS/          TYPE CASE TIME WARD
  FMP SPONSOR SSN  RANK  PNT-CAT     RELATIONSHIP            MTF DAYS FS

*********** DIRECT ADMISSIONS - ACTIVE DUTY U.S. UNIFORMED SERVICES ***********

 0000625  CARTER WILLIAM                                     DIS  1340 FAB
   20  000-00-0001   SN   N11                                0

********************************** WARD TRANSFERS **********************************

 0000625  CARTER WILLIAM                                     DIS  1342 6S
   20  000-00-0001   SN   N11                                0         FAB
 0000609  MATTIA ALAN               939-A LKJFI              INJ  1317 5S
   20  093-98-4329   1LT   A11     SAN ANTONIO  TX  90320   4         4E

******************** CORRECTIONS FOR DISPOSITION CANCELLATIONS ******************

CHANGES TO REPORT OF 22 MAR 1985

DISPOSITION CANCELLED ON DATE OTHER THAN DISPOSITION DATE
 0000609  MATTIA ALAN               939-A LKJFI              INJ  1107 *PO
   20  093-98-4329   1LT   A11     SAN ANTONIO  TX  90320   4
```

Figure 17-11. ADMISSION AND DISPOSITION REPORT

17.3.2 A&D Recap and Patient Strength Report. The A&D Recap is a list of all patients sorted by their patient category. It includes the following data:

(1) PNT CAT
(2) DESCRIPTION
(3) PREVIOUS REPORT
(4) GAINS
(5) LOSSES
(6) PRESENT REPORT
(7) SUB ELSE
(8) ABSENT SICK
(9) OTHER ABSENT
(10) TOTAL ABSENT
(11) ON PASS
(12) NON-PAY NEWBORN
(13) BEDS TOTAL

See Figure 17-12 for an example of the Army version of this report. Information on the Patient Strength Report will be available at a later date.

PERSONAL DATA - PRIVACY ACT 1974 RUN DATE 25 MAR 1985 1401

TEST NAVY HOSPITAL PAGE 1

PERIOD ENDING 2400 HOURS 25 MAR 1985 1401

ADMISSION AND DISPOSITION REPORT

PMT CAT	DESCRIPTION	PREVIOUS REPORT	GAINS	LOSSES	PRESENT REPORT	SUB ELSE	ABSENT SICK	OTHER ABSENT	TOTAL ABSENT	ON PASS	NON-PAY NEWBORN	BEDS TOTAL
* * * * * * * * * * * * * * * * * * *	ADMISSION AND DISPOSITION RECAPITULATION											
A11	USAR ACTIVE DUTY	4	0	0	4	1	0	0	1	0	0	3
F11	USAF ACTIVE DUTY	1	0	0	1	0	0	0	0	0	0	1
F22	USAF RET AD TRAINING	1	0	0	1	0	0	0	0	0	0	
N11	USN ACTIVE DUTY	1	1	0	2	0	0	0	0	0	0	
N41	DEPN USN ACTIVE DUTY	1	0	0	1	0	0	0	0	0	0	
TOTAL:		8	1	0	9	1	0	0	1	0	0	9

Figure 17-12. A&D RECAP REPORT (ARMY)

17.3.3 Alpha Roster of Hospital Patients. The Alpha Roster of Hospital Patients is a listing of all current inpatients. It is used as a reference document by the Admissions and Dispositions desk. This report lists, in alphabetical order, all patients who are physically in the MTF, on pass, or otherwise absent from the MTF. Figure 17-13 shows an example of the Alpha Roster.

In addition to the standard heading information, the time at which the reporting period ends appears on line 3.

The body of the report contains an entry of three or more lines for each patient physically in the MTF, on pass, or on another absent status. For each patient, the following information can be given:

(1) PATIENT NAME
(2) RANK
(3) MED HLD
(4) REG NO
(5) WARD
(6) SEX
(7) CLN SVC
(8) SSN
(9) TYPE CASE
(10) ABS STA
(11) FMP
(12) DOB
(13) BR OF SVC
(14) RELIGION
(15) ADMISSION DATE/TIME
(16) PNT CAT

```
                    REPORT NUMBER    2  ALPHA ROSTER OF INPATIENTS

hfffffffffffffffffff
h                    PERSONAL DATA - PRIVACY ACT OF 1974      RUN DATE: ffffffffffff
hPERIOD ENDING 2400 HOURS ffffffffffff                            PAGE: ppp

h          * * * * *  ALPHA ROSTER OF HOSPITAL INPATIENTS  * * * * *

h-------------------------------------------------------------------------------
h  PATIENT NAME                        SSN          FMP         DOB       PNT CAT
h  RANK    MED HLD    SEX        TYPE CASE     BR OF SVC     RELIGION
h  REG NO     WARD    CLN SVC   ABS STA          ADMISSION DATE/TIME
h-------------------------------------------------------------------------------

 xxxxxxxxxxxxxxxxxxxxxxxxxxx  xxxxxxxxxxx     xx     xxxxxxxxxxx     xxx
   xxxx       x         x          xxxx           xx           xxxx
   xxxxxxxx   xxxx      xxxx       xx             xxxxxxxxxxxxxxxx
```

Figure 17-13. ALPHA ROSTER OF HOSPITAL PATIENTS

17.3.4 Daily Admissions by Diagnosis. This report lists the number of admissions for a given day for each diagnosis, and gives the following data for each admission:

(1) DIAG: CODE
(2) DESC
(3) REG NO
(4) PNT NAME
(5) FMP
(6) ADMITTING PHYSICIAN
(7) SSN
(8) RANK
(9) WARD
(10) CLN SVC

See Figure 17-14 for an example of this report.

```
                    REPORT NUMBER    9  DAILY ADM BY DIAGNOSIS

h                      PERSONAL DATA - PRIVACY ACT          RUN DATE: fffffffffff
hfffffffffffffffffffffffffff

h      * * * *  DAILY ADMISSIONS BY DIAGNOSIS FOR fffffffffff * * * *
hDIAG: CODE    DESC                                  ADMITTING PHYSICIAN
h    REG NO    PNT NAME                      FMP     SSN       RANK  WARD  CLN SVC
h-------------------------------------------------------------------------------

 xxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx    xxxxxxxxxxxxxxxxxxxxxxxxx
     xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx  xx xxxxxxxxxxx    xxx    xxx    xxxx
```

Figure 17-14. DAILY ADMISSIONS BY DIAGNOSIS

17.3.5 Injury Report. This report lists each patient whose type case indicates injury, and gives the following information on each patient:

(1) PATIENT NAME
(2) ADDRESS
(3) UNIT ADDRESS
(4) CAUSE INJ: CODE
(5) TEXT
(6) FMP/SSN
(7) REG NO
(8) RANK ADM: DATE
(9) DIAG
(10) HOME PHONE
(11) WORK PHONE

See Figure 17-15 for an example of this report.

```
                        REPORT NUMBER  500  INJURY REPORT

hfffffffffffffffffff                                    RUN DATE: fffffffffff
h                     PERSONAL DATA - PRIVACY ACT 1974

h                               INJURY REPORT

h*************************************************************************************
h*PATIENT NAME                  FMP SSN          REG NO     RANK ADM: DATE     DIAG*
h* ADDRESS                                                        HOME PHONE      *
h* UNIT ADDRESS                                                   WORK PHONE      *
h*CAUSE INJ: CODE   TEXT:                                                         *
h*-*************************************************************************************

                                   xxx

 xxxxxxxxxxxxxxxxxxxxxxxxxxx  xx xxxxxxxxxxx  xxxxxxxx  xxx  xxxxxxxxxxx  xxxxx
  xxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xx  xxxxxxxxx xxxxxxxxxxxxx
  xxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xx  xxxxxxxxx xxxxxxxxxxxxx
 x xxxx              xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
 xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
```

Figure 17-15. INJURY REPORT

17.3.6 Invalid Sign-On Log. This report gives information about any incorrect entry of user IDs and passwords. It is requested through the System Management function, and the system manager specifies the time period of the report. The following information is displayed:

(1) DATE/TIME
(2) USER CODE
(3) PASSWORD
(4) TERMINAL NO
(5) ATTEMPT COUNT

See Figure 17-16 for an example of this report.

```
                    REPORT NUMBER    7  INVALID SIGN ON LOG

h                        USERCODE / PASSWORD ERROR LOG              PAGE: ppp
h                      FROM fffffffffff  THRU fffffffffff

hDATE     / TIME       USERCODE     PASSWORD      TERMINAL NO    ATTEMPT COUNT
h-------------------------------------------------------------------------------

 xxxxxxxxxxxxxxxxx     xxxxxxxxxx   xxxxxxxxxx        xxx             x
```

Figure 17-16. INVALID SIGN-ON LOG

17.3.7 List of Current Passwords. This report lists the current user IDs and passwords. It includes the following information:

(1) DATE LAST CHANGED
(2) USER ID
(3) PASSWORD
(4) CAPABILITIES
(5) TRAIN
(6) FLAGS
(7) TUTOR
(8) CR
(9) SM
(10) INITIALS

See Figure 17-17 for an example of this report.

```
                    REPORT NUMBER   11  LIST CURRENT PASSWORDS

h                              LIST OF CURRENT PASSWORDS     RUN DATE: ffffffffff

h DATE LAST     USERID     PASSWORD  CAPABILITIES          FLAGS:        INITIALS
h  CHANGED                                              TRAIN TUTOR CR SM
h-------------------------------------------------------------------------------

  xxxxxxxxxxx  xxxxxxxxxx  xxxxxx  xxxxxxxxxxxxxx     x      x    x  x      xxx
```

Figure 17-17. LIST OF CURRENT PASSWORDS

17.3.8 Roster of VSI/SI/SC Patients. The Roster of VSI/SI/SC patients is a listing by ward and clinical service of all inpatients whose casualty code is VSI (very seriously ill), SI (seriously ill), SC (special category), or TI (terminally ill). Figure 17-18 shows an example of this report.

This report contains the heading data that is standard on R/ADT reports.

The body of the report contains an entry of three or more lines for each VSI, SI, SC, or TI patient. The information for each patient is grouped under the following column headings:

(1) WARD
(2) CLINICAL SERVICE
(3) PATIENT'S NAME, RANK
(4) RELIGION
(5) REG. NO.
(6) EMERGENCY NAME
(7) CASUALTY STATUS
(8) DIAGNOSIS
(9) DATE (casualty status acquired)
(10) RECOVERY POSSIBILITY

```
                        REPORT NUMBER    6  VSI/SI/SC REPORT

h                   PERSONAL DATA - PRIVACY ACT 1974          RUN DATE: fffffffffff
h                                                                PAGE: pppp

h* * * * * ROSTER OF VSI/SI/SC PATIENTS BY WARD AND CLINICAL SERVICE * * * * *
h-------------------------------------------------------------------------------
hWARD   CLN SVC    PATIENT NAME          CASUALTY: STA       DATE      REC POS
h   RANK    RELIGION      REG NBR         DIAGNOSIS
h   EMERGENCY NAME                       PATIENT CATEGORY
h-------------------------------------------------------------------------------

 xxxx    xxxx     xxxxxxxxxxxxxxxxxxxxxxxxxxxx     xxx    xxxxxxxxxxx   xxxx
    xxx      xxxx          xxxxxxxx       xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
    xxxxxxxxxxxxxxxxxxxxxxxxxxxxx              xxx
```

Figure 17-18. ROSTER OF VSI/SI/SC PATIENTS

17.3.9 Status Out Roster. This report lists patients currently out of the hospital, giving their expected return date and indicating whether the return is overdue. Patients are listed alphabetically and sorted by return date. The following information is included:

(1) RTN DATE
(2) PATIENTS: NAME
(3) SEX
(4) CLINICAL SVC
(5) CAT
(6) REG NO
(7) STAT: DAYS ON
(8) OVERDUE

See Figure 17-19 for an example of this report.

```
                    REPORT NUMBER   10  STATUS OUT ROSTER

h                   PERSONAL DATA - PRIVACY ACT 1974    RUN DATE: ffffffffffff
hfffffffffffffffffff

h               * * * * *  STATUS OUT ROSTER  * * * * *
hRTN DATE       PATIENTS: NAME              REG NBR  STAT: DAYS ON  OVERDUE
h                SEX    CLINICAL SVC   CAT
h-------------------------------------------------------------------------------

 xxxxxxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxx  xxx     xxx       xxx
                x         xxxx         xxx
```

Figure 17-19. STATUS OUT ROSTER

17.3.10 UCA Disposition Report. The UCA Disposition Report is a monthly report that gives you the number of patients that have been dispositioned for the specified month by UCA Clinical Service code. Figure 17-20 is an example of the UCA Disposition Report.

In addition to the standard heading data, the UCA Disposition Report contains the name of the month for which data is being reported.

Each line of data in the body of this report contains the following information:

(1) CLINICAL SERVICE CODE
(2) TITLE (name of the service)
(3) NUMBER OF PATIENTS

The last line of the report gives the total number of patients dispositioned.

PERSONAL DATA - PRIVACY ACT 1974 RUN DATE: 25 MAR 1985 1355

TEST NAVY HOSPITAL REPORT MONTH: MAR 1985 PAGE 1

* * * * * UCA DISPOSITION REPORT * * * * *

CLINICAL SERVICE CODE	TITLE	# OF PATIENTS
AAA	INTERNAL MEDICINE	9
AAB	CARDIOLOGY	1
AAC	CORONARY CARE UNIT	1
AAG	HEMATOLOGY	1
ABB	THORACIC/CARDIOVASC SURG	2
ABC	INTERSIVE CARE (SURGICAL)	2
ACB	OBSTETRICS	1
ADA	PEDIATRICS	1
ADB	NURSERY	2
AEA	ORTHOPEDICS	1
	TOTAL PATIENTS:	21

Figure 17-20. UCA DISPOSITION REPORT

17.3.11 UCA Inpatient Occupied Bed Days Report. The UCA Inpatient Occupied Bed Days Report shows the number of bed days accumulated for each clinical service and ward for the month. It also gives the total bed days per clinical service, total bed days per ward, and the grand total of all bed days for the month. Figure 17-21 shows an example of this report.

In addition to the standard heading data, this report contains the name of the month for which data is being reported.

Each line of the report contains the UCA code and the name of the clinical service. For each ward in the hospital, the report shows the number of bed days accumulated. Each line of data ends with the total number of bed days accumulated for the clinical service. The last line of the report contains the total bed days by ward.

PERSONAL DATA - PRIVACY ACT 1974 RUN DATE 25 MAR 1985 1355

TEST NAVY HOSPITAL REPORT MONTH: MAR 1985 PAGE 1

* * * * * MONTHLY RECAP - INPATIENT OCCUPIED BED DAYS * * * * *

CODE	TITLE	2D	2R	30N	4E	40A	4R	4S	4W	5E	5S	5W	66N	66S	66W	60A	6S	6SP	6W	7SW	7W
AAA	INTERNAL MEDIC	21	0	0	48	0	0	11	2	0	0	2	0	0	0	0	7	0	0	0	0
AAB	CARDIOLOGY	0	0	24	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AAC	CORONARY CARE	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AAL	PULMONARY UPPE	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ABB	THORACIC/CARDI	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ABC	INTERSIVE CARE	3	0	0	16	0	0	1	0	0	0	0	0	0	0	0	2	0	0	0	0
ABF	ORAL SURGERY	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0	0	0	0	0	0
ABG	OTORHINOLARYNG	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ACB	OBSTETRICS	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0
ADA	PEDIATRICS	0	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	5	0	0	0
ADB	NURSERY	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ADC	NEONATAL ICU	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AEA	ORTHOPEDICS	0	0	0	21	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL		24	0	47	95	0	0	18	2	3	7	2	0	0	0	0	9	5	0	0	0

Figure 17-21. UCA INPATIENT OCCUPIED BED DAYS REPORT

17.3.12 Ward Nursing Report. The Ward Nursing Report is a listing of all inpatients assigned to a specific ward at the time the report is run. The patients are listed alphabetically by ward. The report is run daily, usually at midnight. See Figure 17-22 for the format of this report.

This report contains the standard R/ADT heading data.

For each patient on the ward there is an entry of three or more lines, containing the following data:

(1) PATIENT NAME
(2) REG NBR
(3) ATTENDING PHYS
(4) DAYS THIS MTF
(5) SSN
(6) ADMITTING DIAGNOSIS
(7) ADMISSION REMARKS
(8) FMP
(9) DOB
(10) CAT
(11) RANK
(12) CLN SVC

The final page of the report shows the following summary statistics for each ward:

(1) BEDS IN WARD
(2) PATIENTS IN WARD
(3) BLOCKED BEDS IN WARD
(4) PREADMITS IN WARD
(5) BEDS AVAILABLE

```
                    REPORT NUMBER    3  WARD NURSING REPORT

h                   PERSONAL DATA - PRIVACY ACT 1974  RUN DATE ffffffffff ffff
hfffffffffffffffffff                                          PAGE ffff

h           * * * * *  WARD NURSING REPORT FOR xxxx  * * * * *

h-------------------------------------------------------------------------------
h  PATIENT NAME                    SSN        FMP      DOB       CAT  RANK  CLN SVC
h  REG NBR    ATTEND PHYS  ADMIT DIAG
h  DAYS THIS MTF           ADMISSION REMARKS
h-------------------------------------------------------------------------------
  xxxxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxx  xx  xxxxxxxxxx  xxx  xxxx   xxxx
   xxxxxxxx      xxxxxx     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
        xxx                 xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
```

Figure 17-22. WARD NURSING REPORT

17.4 Clinical Records Reports.

17.4.1 Coded Transcript Tape (CTT). The CTT is different for each military department. For the Army, it will consist of two tapes, the first tape containing X and Y card data and the second containing A, B, and C card data, as per regulation. For the Navy, the CTT will contain A, B, C, D, H, and M cards, as per regulation. For the Air Force, the CTT will contain A, B, C, D, E, and F cards, as per to regulation.

17.4.2 Roster of Delinquent Records. This report lists records that have not been completely processed in Clinical Records within the time limit set by the MTF, and which are therefore delinquent. An example of this report will be submitted at a later date.

17.4.3 Roster of Records Released to A & D. This report lists records that have been returned to A & D for processing. It will contain the following data:

(1) REG NO
(2) PATIENT NAME
(3) FMP
(4) SSN
(5) REASON RELEASED
(6) DATE: DISP
(7) RELEASED

See Figure 17-23 for an example of this report.

```
                    REPORT NUMBER  501  CLINICAL RECORD RETURNED A&D

h'''''''''''''''''''''''                                    RUN DATE: ''''''''''''
h                          PERSONAL DATA - PRIVACY ACT 1974

h                         CLINICAL RECORDS RETURNED TO A & D

h*************************************************************************************
h*REG NO    PATIENT NAME                  FMP    SSN        DATE: DISP     RELEASED *
h*                                          REASON RELEASED                          *
h*************************************************************************************

 xxxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxx xx xxxxxxxxxxx  xxxxxxxxxxx  xxxxxxxxxxx
                                          xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
```

Figure 17-23. ROSTER OF RECORDS RETURNED TO A & D

PART IV - TECHNICAL APPENDIX

SECTION 18. ENVIRONMENT

18.1 Equipment Environment. This information will not be available until award of the hardware contract.

18.2 Support Software. The AQCESS software is written in ANSI standard MUMPS. It currently runs under the ISM M/11+ operating system. The code for all machine-dependent functions is stored in a file, MACH, and is not embedded in the source code. The application software for screen management will support multiple brands and models of terminals, but the CAI tutorial software requires reverse video. Function keys are currently not implemented.

The AQCESS software uses the Veterans Administration File Manager as a data base tool. All data dictionary definitions are specified using the File Manager.

18.3 Interfaces. Interfaces will be specified at a later date.

18.4 Security and Privacy. The AQCESS meets the privacy requirements set forth in the Privacy Act of 1974, Public Law 93-579, and complies with all applicable provisions of this Act and of subsequent laws and directives which amend and amplify it, as described in section 5.6 of the AQCESS Functional Description (reference 1.2.b).

18.5 Controls. No specific controls have been established within the AQCESS.

SECTION 19. DESIGN DETAILS

19.1 System Logical Flow. Figure 19-1 illustrates the system logical flow for AQCESS.

19.2 Data Base Description. Please refer to the Data Base Specification for the Automated Quality of Care Evaluation Support System accompanying this document.

19.3 Program Descriptions. For descriptions of the AQCESS system's PAD programs, see Appendix A.

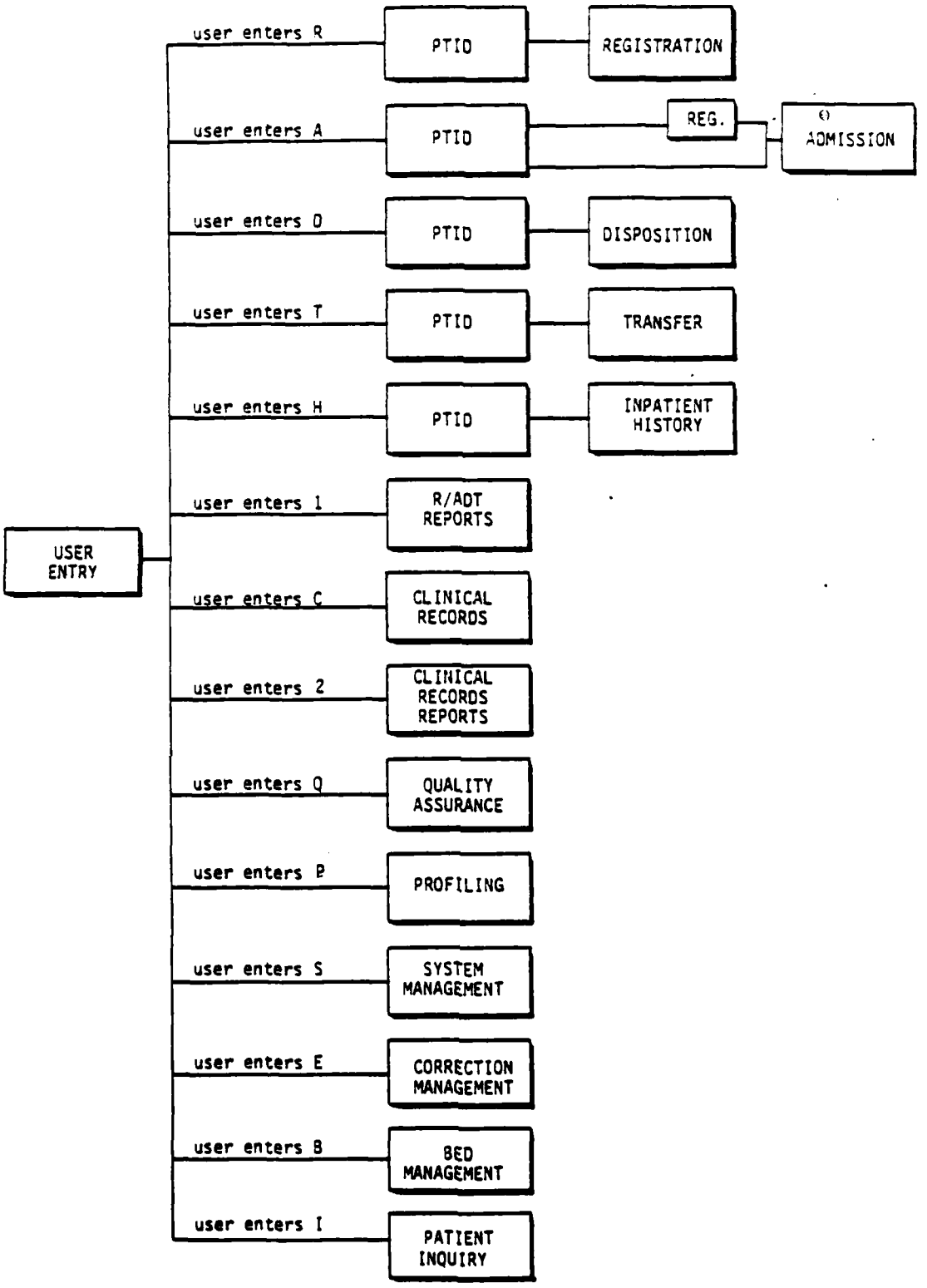


Figure 19-1. AQCESS SYSTEM LOGICAL FLOW

APPENDIXES

Appendix A

PAD PROGRAM DESCRIPTIONS

APPENDIX A. PAD PROGRAM DESCRIPTIONS

1.1 Program Descriptions. As an introduction to descriptions of the PAD programs themselves, this section discusses basic system concepts. (For descriptions of Quality Assurance and Profiling programs, see section 7 of the QA Subsystem Specification.)

AQCESS is implemented using ANSI standard MUMPS and the Veterans Administration File Manager. In the MUMPS environment each user who signs on is assigned a memory partition that is at least 4K. The current AQCESS implementation is assuming a minimum 6K partition. A job number is associated with this partition. This job number (variable PADJ) is used by the AQCESS software as an index into the scratch data file (^SMSCR) so that each user has a unique disk work area. Unlike transaction processing, each user has a copy of the currently running routine in his partition. Local memory is specific to the user and remains defined until the application routine explicitly kills each variable.

This section discusses the following general system concepts and their implementation:

a. The File Manager, as it relates to the AQCESS system
b. Screen implementation
c. Terminal independence
d. Editing and error processing
e. System security--timed reads
f. Recovery
g. Locking
h. The generic application
i. Products
j. Reports
k. System tables
l. Function table
m. Machine dependence.

a. The File Manager is a collection of many routines used to access collections of data on disk. The AQCESS system is actually only using the File Manager to 1) define the data base (build and maintain the data dictionary) and 2) define and produce hard copy reports. Concepts and logic were extracted from the File Manager to build the screen handling capability that is briefly described below. The term data base refers to any "file"; in the AQCESS system each system table, the registration/admission data, the ward data, the register number maintenance data, the clinical record data, etc., are all separate arrays of data maintained on disk. Each has a data dictionary or schema that is maintained using interactive File Manager routines. The AQCESS system is not generally using standard File Manager routines for "lookup"--retrieving data from disk--or "filing"--storing data to disk.

b. Screen Implementation. One of the "files" used by the AQCESS system is the screen definition file ^SMDEF. It is a standard File Manager file, but it is not maintained in the File Manager global DIC. Each screen or part of a screen is defined in ^SMDEF. Each screen contains data such as name of screen, clear screen flag, screen brightness, etc.; data describing the screen as a whole; and data describing each field like the text label, cursor coordinates for the text, entry length, cursor coordinates for the entry, etc. See the data dictionary of ^SMDEF for a complete description of a screen definition. Each screen is defined by a programmer using the interactive enter/edit option of File Manager. The programmer then executes either or both of two programs, ^SMP and/or ^SME, for each screen defined. ^SMP will generate a routine, or series of routines, of standard MUMPS code that will, when invoked from an application program, paint the defined screen. ^SMP generates a unique program (named by the programmer) for each screen. ^SME will generate a routine, or series of routines, of standard MUMPS code that will, when invoked by an application program, control data entry on a specific screen, one unique program for screen. As stated above, concepts and some actual code were taken from File Manager routines and incorporated into the painter and entry programs. However, at run time no actual calls are made to the File Manager routines to retrieve, validate, or store data. Although there are many painter and entry programs in the AQCESS system, they are generated programs and not individually maintained. If the screen definition changes, the respective painter and/or entry program must be regenerated. Every entry program will call a screen utility ^SMHELP in response to the user's entry of a "?" character. This program will read the DD file in the data dictionary for canned executable on-line documentation. This program will also show the user a list of valid responses for data items with valid responses contained in "tables." ^SMHELP erases the screen from the line below the line on which the "?" was entered. This blank area of the screen is used to display the entries in the table file. ^SMHELP will also process partial matches--if the user enters part of a data field that is not unique for the table, ^SMHELP will display a partial list of valid responses. For both "?" and partial matches, the entry screen is repainted when the user moves to the next prompt. The routine (or routines) used to repaint are specified in the screen definition for the respective entry screen.

Selection processing is a concept related to screen definition and screen processing that is very important in understanding the AQCESS design. It became evident that the user often is presented with a screen with a menu and an "enter selection" field in which to enter his selected option. The selection usually indicates a desire to enter data on this screen or a subsequent screen segment or to view another screen or both. The selection logic can be easily set to 1 if this screen has a selection table defined that is to be used in processing the selection field. Additionally, each screen defines where the selection field occurs on the screen (X and Y coordinate) and defines the selection table. The selection processing actually accomplishes 2 tasks: 1) it validates the selection (if the selection is not in the table, an error is returned); and 2) it initiates the next processing if defined for this selection (for certain selections control must return to the application). Also, if the next program is an entry program for a different screen segment, it is necessary to execute a painter program. Therefore, in the selection table the programmer may define the painter program to be executed

prior to data entry and this painting may be based on the user's previous selection. The selection table is a powerful tool for controlling flow from screen to screen. There is a PAD utility to read the user's selection and to do selection processing using the screen specific selection table. This program is ^PADSEL.

c. Terminal Independence. The screen implementation supporting the AQCESS software was designed so that a variety of terminals could be used in the hardware configuration. The terminal attributes utility allows the user to associate each physical port with a device type, and each device type with a file entry that specifies the actual terminal specific codes associated with a given attribute. The highest level application program, User Entry, is responsible for loading the terminal attributes for the device specified for the given line into local memory. This array of terminal attributes (ZTA) is used during execution by all the application programs, as well as the screen painter and entry programs, to perform terminal I/O.

d. Editing and Error Processing. There are two types of editing done on each segment of data entry, validity editing and consistency editing. Validity editing--editing to check that an individual field entry is valid--is done as the user enters each data item. The validity editing logic is generated for each field as part of the screen entry program. The logic is based on the data dictionary definition of the field. If it is free text, a pattern match is performed if defined in the schema. If it is a date or date/time field, date/time validity is checked. If the field is defined as a set, the set of codes are "compiled" into the entry program for validity checking at entry time. It is important to understand that codes for a data item defined as a set cannot be changed at a site since the actual codes become part of the screen entry program when ^SME is run. However, validity editing for a "set" variable is fast since it involves no disk accesses. If a field is defined as a pointer, validity editing is performed by accessing the respective pointer table and determining if the entered code is valid. Additionally, if a field is defined as "required" in the data base definition, the user will be forced to enter data. Because of service differences, not many fields are always required. Service-specific required fields and data- dependent required fields are handled by the consistency editing (see below).

In addition to the standard validity editing based on the data base field definition, each field on each screen may have a line of special MUMPS code defined in the screen definition. This code is compiled into the entry program and executed after standard validity editing for that field. This special MUMPS code may be extended editing (e.g., the TRIMIS standard name edit) or may be a "hook" for some special case processing not necessarily strictly related to editing (e.g., a new SSN on the registration screen; see program RGSSN).

Consistency edits are performed after data entry is complete for a given screen or screen segment. The consistency edit program defined in the screen definition is performed by the entry program. Each consistency edit routine

performs application-dependent checks on the consistency between the data fields. Whereas validity errors are always errors that must be corrected before proceeding, a consistency edit can result in an error or a warning. Errors must be corrected; warnings may be overridden by the user (a warning that is not overridden is processed as an error). All error checks are made before warning type checks within the consistency edit program. If any errors are detected, the consistency program sets the system variable SMERR, displays the error message and returns to the entry program. The entry program checks SMERR. If it is set, it re-executes itself. If there were no errors detected, the nodes of the local array SMZ are stored in the respective nodes of ^SMSCR by the consistency edit program.

e. System Security. In addition to user code/password identification, the AQCESS software has implemented the screen timeout feature. If a user fails to enter data on a screen within a specified period of time, the read will time out. The system variable HALT specifies the number of seconds to timeout. After any read timeouts, control is passed to the utility HALT, which will unlock any locked records and log the user off the system. In the AQCESS system timed reads are done from every entry program, by ^PADSEL (to read the enter selection), by ^PTSEL (to read the candidate selection for PTID), by ^SMHELP (to read the user page response) and by any consistency edit program that implements warning errors and the user option to override the error. Any read to the terminal must be timed; any application code that reads from the terminal must support this security feature.

f. Recovery. The objective of recovery for the AQCESS system is to ensure integrity of the data base without sacrificing response. With the implemented recovery scheme, the user should lose no more than the transaction in progress due to system failure, including power failure, software failure or hardware failure--except where hardware failure includes physical damage to the disk (this failure must be protected against by backup procedures).

To ensure data base integrity, each application is responsible for preparing for recovery. Just before "filing" data, it must store a recovery record in ^SMSCR(PADJ,1) that includes, in piece 1, the name of the recovery program for this function (for example, RCRG is the recovery program for registration). The application must store in subsequent pieces of this node any local variables used during filing, including any SMDE array items necessary for processing cross references. Each "filer" program must be written so that it may be re-executed after being interrupted at any point. Immediately after filing, the application program kills the recovery node in ^SMSCR. The recovery program specific for each function has only 2 steps: (1) Load the local variables stored in piece 2 through piece n of the recovery node back into local and (2) do the filer routine.

The system recovery program ^RC must be run from the operator's console after system failure before anyone can sign on. The RC program will $N(ext) through ^SMSCR(I,1) and execute each function specific recovery program to reinitiate filing that was in progress. After function-specific recovery is complete (at a given failure time, few if any applications will be "caught" in

filing), ^RC will read through all inpatient episode records and recalculate the ward counts for beds occupied and preadmits. The users are then free to sign on to the system.

g. Locking. In the MUMPS environment there is no such concept as physical locking of an entity. Rather, MUMPS keeps track of a user's logical locks in a system table. Additionally, when a user locks one entity, that lock implicitly unlocks all other entities. Therefore, to handle locking in the AQCESS application, three lock files have been set up to be used in addition to standard logical locking. Entries are made in these files to logically lock from an application point of view a patient, and/or a patient's mother, a family, and a Clinical Records register number and to maintain these entities as "locked" until the application processing is complete. When these lock files are accessed each is logically locked while an entry is being stored and then unlocked. The ^PTLCK lock file is used to lock individual patients and patient's mother if the patient is a newborn (subscript is the patient file entry number or mother's file entry number). The ^RGLCK lock file is used to lock a family of patients (subscript is the SSN). The ^CRLCK lock file is used to lock record's register number (subscript is register number). There are two other logical entities defined to protect against multiple users attempting to update the ward or register number maintenance records at the same time. The entity ^BMLCK subscripted by ward and the entity ^RGN are logically locked just for the duration of the update to these respective records. If an application program finds these entities locked, it will wait.

Since so many functions use PTID to identify the patient and each is then required to lock the patient before processing, a utility program ^PTLCK is used to do patient locking (and mother locking for newborns). However, each application program is responsible for any other necessary locking and is responsible for unlocking the patient and the mother in the lock file ^PTLCK.

h. PAD Generic Application. Using the screen programs generated by ^SMP and ^SME and the selection processing capability, a generic PAD application would be structured as depicted in Figure 19-2.

The top level module is application specific and controls the execution of the other modules. The application module is responsible for ensuring that any input from a terminal is implemented using timed read, for logically locking files and patient data as appropriate to the application, and for setting up for recovery. The "loader," "consistency editor," and "filer" programs are application code written specifically for the function. The loader is responsible for retrieving data from ^DIC and loading it into the job-specific elements of ^SMSCR (the user's scratch file). The screen painter programs load data from ^SMSCR into the local array SMZ (based on the system variable SMLD); the entry programs store the entered data in the local array SMZ; and the consistency edit programs store data into ^SMSCR from SMZ when there are no errors. The filer moves data from the scratch file (^SMSCR) into the data base (^DIC).

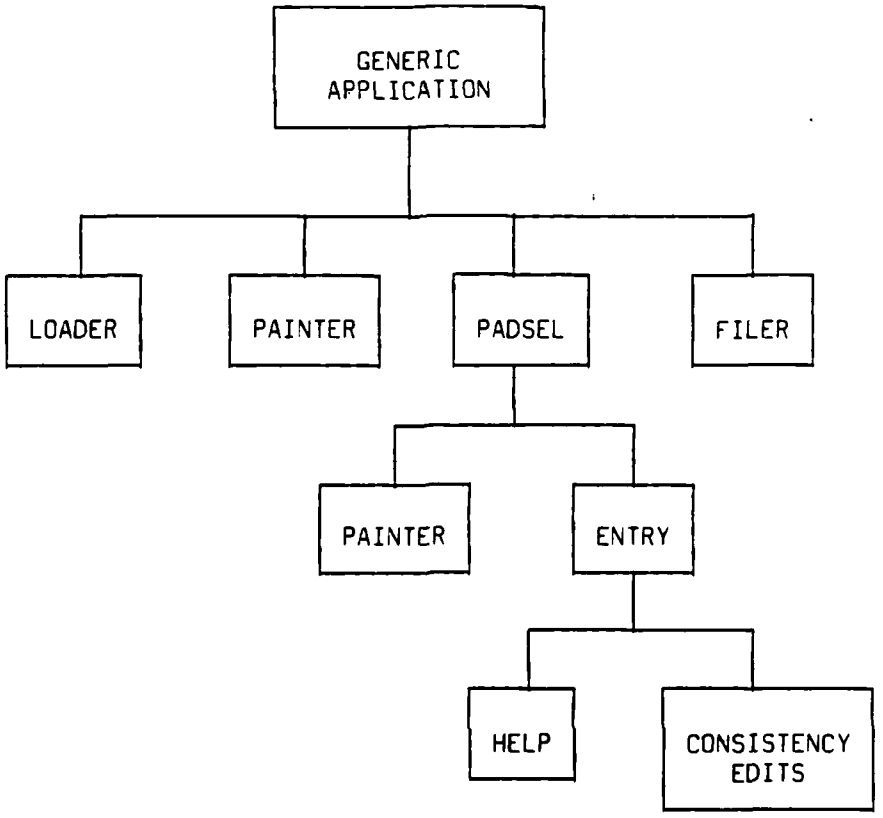


Figure 19-2. GENERIC PAD APPLICATION

i. Products. The products package ^PRD runs in a partition not associated with any user. The package contains one control routine and multiple specific product programs, one for each type of product. Any application program wishing to produce products must store an entry in file ^PRD. This file functions like a spool of product requests. The request must specify the program name to produce the product, the quantity requested, and appropriate patient identification information. The application must then check to see if the products program ^PRD is running in background. In order to determine if a program is running in background, a non-existent device is defined in the machine-dependent file ^MACH (see paragraph m, below, for a description of the implementation of machine-dependent features). The Products program executes by indirection the code associated with

^MACH("PRD"). In the AQCESS implementation this code opens a non-existent device. An application program can test to see if the Products program is running by opening the same device. If the device is available, the job is not running and it must be started. After opening the mythical device, the products program takes an entry off the spool. Based on the type of products request, it opens the first available device defined for that product (the list of devices by product maintained in the product device file), and initiates the program to produce the product. It produces all the products requested in the spool file, killing each entry as it is processed, and quits when the file is empty (closing the mythical device). The next application program requesting a product will find the mythical device available and will need to restart the products program.

j. Reports. Reports, like products, are initated by an on-line request but actually produced by a background job. The file ^MACH, containing machine-dependent code, defines the ^MACH("BACK2") and ^MACH("BACK2OFF") entities to control the execution of the background reports program ^RPRJ. As with products, each report has an entry in the device file specifying the ordered list of output devices for the given report. Program ^RPR will create an entry in the report request file, ^RPRJ, indicating the name of the program associated with the requested report, the number of copies requested, and the service of the hospital. If the background job, RPRJ, is not running, it will initiate it. The background job will process each request from the request file, and then kill itself.

k. System Tables. System tables are defined to specify the valid codes for a given data item. The tables (called pointer files in the File Manager documentation) are used for validity editing and for Help processing. The table code is defined in node 0, piece 1 of the file entry. In addition to the code, each table entry has a desc ption in node 0, piece 2. Pieces 3 through n and other nodes may contai other information specific to the table. See below for a detailed exp anation of the use of piece 3. There are four types of tables in the AQCESS system. They are hospital-specific tables, service specific tables, tri-service master tables (which are modified at installation time by deleting codes not applicable to the particular service), and standard tri-service tables. Master tri-service tables include a mode 3 entry that specifies the applicable service (A,F or N) or combination of services for which each code is valid. At installation time a service table generation program (^RBTBL) is run that will first rebuild the full cross reference, and then delete the cross-reference entries for codes not applicable to the specified service. In this manner the master tri-service set of codes still exist in the table, but the cross-reference pointers for codes not applicable to the specified service do not exist, preventing the user from accessing invalid codes for his or her service. The R/ADT tables are categorized as follows:

1) Hospital-Specific Tables:
   - Doctor
   - User code/password
   - Terminal capabilities
   - Product device table

These tables have not been categorized at this time:
Aeronautical rating,
Aviation service codes.

2) Service-Specific Tables:
Patient Category (file 1006)
Rank/pay Grade
MTF codes

3) Master Tri-Service Tables, to be subsetted by service:
Source of admission
Absent status
Disposition type
FMP
Type Case
Religion

4) Standard Tri-Service Tables:
Casualty Status
MEB Status
State/County Codes
Command Interest
Major Command
Flying Status
Clinical Service
Military Theatre of Operations
Relationship
Cause of Injury

For certain tables, node 0, piece 3 is used to define flags to aid in consistency editing. A flag field is set up for each code of each of the following tables. Each flag field is a free-text string of bytes that are extracted as needed by the application software.

TABLE	FLAG
Source of admission	byte 1 : 0 = absent sick 1 = direct 2 = newborn 3 = transfer 4 = NB retained 5 = CRO/ERD 6 = preadmit 7 = cancel 8 = quarters byte 2 : 1 = military only

TABLE	FLAG
Source of admission (cont'd.)	byte 3 : 1 = absent sick 2 = CRO 3 = ERD 4 = quarters 5 = transfer-in
FMP	byte 1 : 1 = dependent 3 = sponsor
Absent status	byte 1 : 1 = status is in 2 = status is out
	byte 2 : 1 = military only 2 = military only, conv. leave
	byte 3 : 1 = absent sick 2 = CRO 3 = ERD 4 = quarters
	byte 4 : 1 = bed day
	byte 5 : 1 = return date not required
	byte 6 : 1 = absent status cannot be changed
	byte 7 : 1 = can disposition from this absent status
	byte 8 : 1 = medical hold
Clinical service	byte 1 : 1 = nursery 2 = pediatrics 3 = OB/GYN
	byte 2 : 1 = military only
	byte 3 : 1-4 same as absent status
Disposition type	byte 1 : 1 = predisposition 2 = death 3 = transfer 4 = same day disp (DSD)
	byte 2 : 1 = military only 2 = civilian only 3 = both

TABLE	FLAG
Disposition.type (cont'd.)	byte 3 : 1 = valid for CRO
	byte 4 : 1 = newborn
Type case	byte 1 : 1 = injury
	byte 2 : 1 = military only
	byte 3 : 1 = valid only during war
Patient category	byte 1 : 1 = active duty 2 = retired 3 = dependent 9 = other
	byte 2 : 1 = sponsor
	byte 3 : 1 = dependent
	byte 4 : 1 = civilian emergency
	byte 5 : 1 = extended active duty/training
	byte 6 : 1 = military
	byte 7 : 1 = army officer who requires branch of service
FMP	byte 1 : 1 = dependent 3 = sponsor
	byte 2 : 1 = civilian emergency

Node 1 of many tables is used to define Clinical Records codes for the respective table entry.

1. Function Table. There is one specific system table that is used by the User Sign-On function to control the execution of logical application components necessary for a specified function. The multi-function components that are used in the AQCESS system are patient identification and patient locking. The function table specifies for each function the ordered list of programs (the multi-function components and application programs) that User Sign-On executes to complete a function. This function table is defined in DIC(1020). Figure 19-3 shows the top level hierarchy of AQCESS programs executed to supported a user-selected function.

m. Machine Dependence. Every effort has been made to design the AQCESS system so that the software is portable. However, there are certain machine-dependent capabilities that are necessary to support the AQCESS design. To isolate these features from the actual application code,

machine-dependent capabilities are defined in the ^MACH file. Each capability is subscripted by a string containing its name. The application code needed to perform a machine-dependent function must execute the machine-dependent code indirectly through this file.

The following machine-dependent functions are currently defined for AQCESS:

^MACH("BACK")	opens a non-existent device to control the background products job
^MACH("BACKOFF")	closes the products "background" device
^MACH("BREAKOFF")	machine-specific code to disable break
^MACH("BREAKON")	machine-specific code to enable break
^MACH("ECHOON")	machine-specific code to turn echo on
^MACH("ECHOOFF")	machine-specific code to turn echo off
^MACH("JOBNUM")	sets variable %J to the current job number
^MACH("LINNUM")	sets variable %I to the current line number
^MACH("BACK2")	opens a non-existent device to control the background reports job
^MACH("BACKOFF2")	closes the reports "background" device
^MACH("BACK3")	opens a non-existent device to control the Clinical Records on-line printing and editing background job
^MACH("BACKOFF3")	closes the CR background device.

If selection =

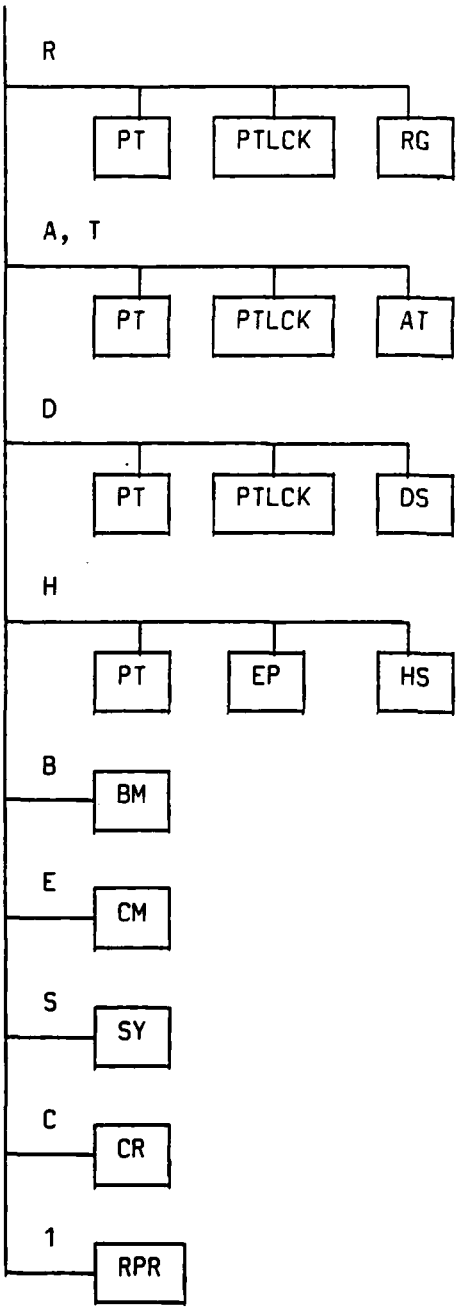
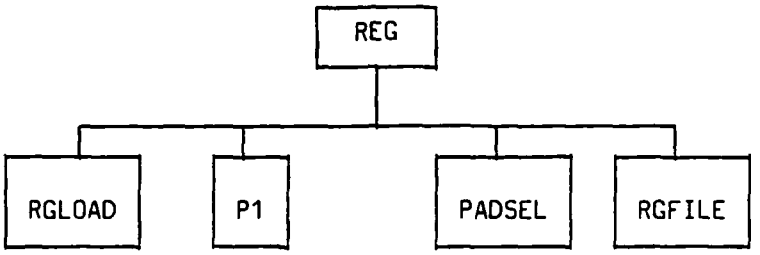


Figure 19-3. HIERARCHY OF AQCESS (PAD) PROGRAMS

1.2 PAD Program Descriptions.

1.2.1 Registration (RG). The following figure shows the hierarchy chart for this function.



a. Purpose. The Registration package (RG*) is executed to perform new registrations and to modify existing registration data after a patient has been identified by the patient identification process.

Invoked by: SO
Globals referenced: ^DIC(8000,)

b. Input Variables:

SMPT	set to the internal file entry number for the patient
SMSP	set to the internal file entry number for the sponsor
PADNEW	set to 0 for old patient, old sponsor 1 for new patient, old sponsor 2 for old patient, new sponsor 3 for new patient, new sponsor

c. Processing Logic. The RG program assumes the patient has been locked (^PTLCK). Since the sponsor data for each "family" is stored only in the sponsor's data entry, the RG routine is responsible for logically locking the entire family while an individual entry is being processed. The family is released at the end of the RG processing regardless of function; the individual patient is unlocked only if the function is registration (PADTAB="R").

(1) Lock family lock file (^RGLCK). If unavailable for 5 seconds, error set and return.
(2) If this family is in use, set error and return.

(3) If a new patient is indicated, RG checks if the SSN/FMP already exists. If they do, an error is returned. This check must be made again, (^PTLKP did it once), in case a new registration has been filed since the first look- up.

(6) The SMUPD flag is set to 0. The entry programs will set SMUPD to 1 if any data is entered or changed.

(7) The RG program paints the initial registration screen. If the "edit flag" (node 0, piece 2) is set, the data on file is incomplete; set DQ to I. For a normal new patient, set DQ to 5. DQ specifies in which field on the screen to begin entry. In this case, entry would start at either PATIENT NAME (field 1) or STREET ADDRESS (field 5).

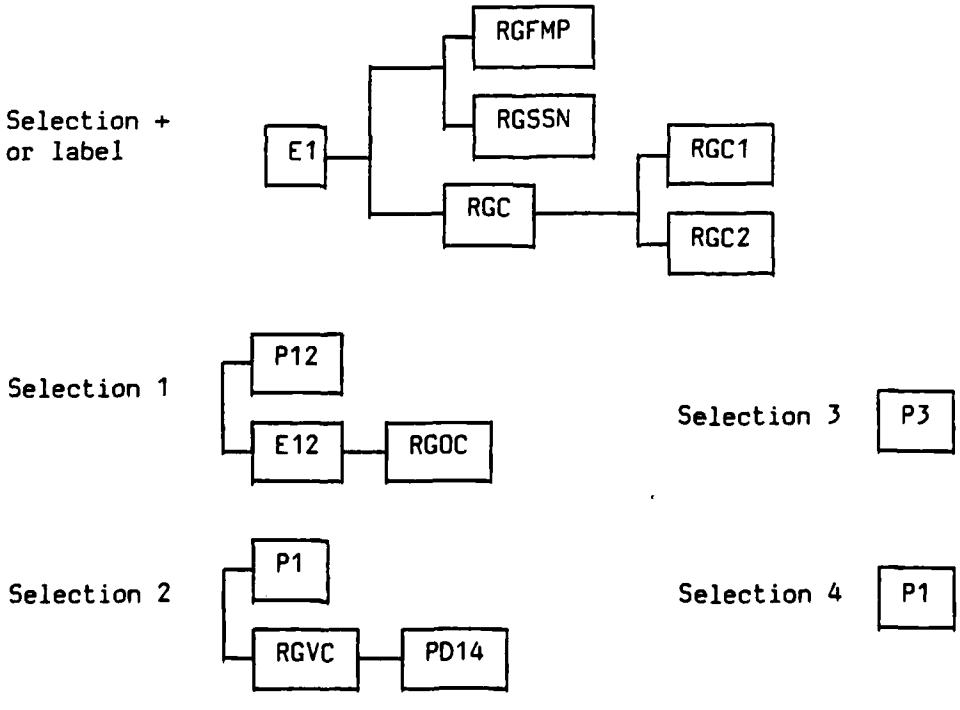
(8) If SMUPD is 1, RG saves the necessary variables for recovery if the system crashes during filing. It then executes the filer, ^RGFILE.

(9) Kill the recovery data when filing is complete. Unlock the family. If function is registration, unlock the patient and kill all of ^SMSCR. Return.

d. Output Variables.

Local variables:
If function is registration: SMCAN
If function is admission: SMCAN, SMPT, SMSP
Globals updated: ^SMSCR
^RGLCK
^PTLCK

e. PADSEL for Registration (SMEN = 1).



f. Compiled Painter Programs.

Program	Source
P3	History Display Screen
P12	OP Products
P1	Registration Display Screen
PD14	Verify

g. Compiled Entry Programs.

Program Name	Source	Refresh Screen Routines	Special Edit Routines
E1	Update PTID data	P1	RGFMP, RGSSN
E12	OP Products	P12	

1.2.1.1 Registration Loader (RGLOAD).

a. Purpose. The RGLOAD program sets up the SMSCR file with patient and sponsor registration data.

Invoked by: RG
Globals referenced: ^DIC

b. Input Variables. PADNEW, PADJ, SMPT, SMSP

c. Processing Logic.

(1) For new patients ^SMSCR(PADJ,8000,0) is set to ^SMSCR(PADJ,1010,0) (the temporary disk area for new PTID data).
(2) If the patient is a sponsor, default the sponsor name to the patientname. If there is an existing dependent record for thi s new sponsor, default the patient address and home telephone data from the dependent record (node 1, pieces 1-6).
(3) If the new patient is not a sponsor and the sponsor record exists, default patient address and home telephone in the same way.
(4) For old patients load corresponding nodes of ^DIC into ^SMSCR. If node 1 does not exist, attempt to default address and home telephone data from another family record.
(5) For new or old dependents, set ^SMSCR node 3 from sponsor record.

d. Output Variables.

Local variables: None
Globals updated: ^SMSCR

1.2.1.2 Registration Filer (RGFILE).

a. Purpose. The ^RGFILE program is called to store data collected in ^SMSCR in the data base ^DIC(8000) in both the patient and sponsor file entries and to update the registration data cross references as required.

Invoked by: RG
Globals referenced: ^SMSCR
^DIC
^MACH
^PRD

b. Input Variables.

DT
PADNEW
SMDE
SMPT
SMSP
SMUPD

c. Processing Logic.

(1) Extract products requested quantities: C = Registration Forms requested, D = outpatient embossed cards requested. Store entry in products request file (^PRD) and initiate background job if it is not running. Null out products request pieces in ^SMSCR.
(2) Loop through ^DD and extract set and kill statements for each defined cross reference. Sets are stored in DE(IDX,M,1) and kills in DE(IDX,M,2) where IDX is the node; piece of the cross-reference variable.
(3) Wipe out Edit Flag--node 0,piece 2 (indicating this is a partial record) and concatenate in DT as date registration data last updated (piece 19).
(4) File nodes of ^SMSCR. Only file node 3 if this patient is also a sponsor.
(5) Loop through the DE array of sets and kills executing each: Killing the old cross reference based on SMDE and setting the new based on ^SMSCR for each cross-reference field for the patient.
(6) If patient is a sponsor:
- if sponsor record already exists (PADNEW <2), set sponsor name from ^SMSCR into node 0 of sponsor data in DIC and set node 3 of DIC to node 3 of ^SMSCR.
- if sponsor does not already exist, build a skeletal sponsor record: node 0 with edit flag set to 1 and FMP; node 3 from ^SMSCR.
- Process name cross reference for sponsor. Use cross-reference sets and kills for "0;1" but use sponsor name data from "3;1".

1.2.1.3 Registration FMP Special Edit (RGFMP).

a. Purpose. The ^RGFMP program is called whenever the user changes a patient's FMP on the Registration Screen. If a patient changes from a sponsor to a dependent or vice versa, the patient, sponsor file entry numbers are updated and sponsor data redisplayed where appropriate.

Invoked by: E1 (entry program with special MUMPS code for FMP edit)
Globals referenced: ^DD
^SMDEF

b. Input Variables:

X (new FMP)
SMPT
SMSP
SMZ

c. Processing Logic.

(1) If SSN field is blank (user changed the FMP, then backed up from the SSN field), skip the SSN-FMP check (go to step 3).
(2) Loop through SSN cross reference. If an entry exists with this FMP/SSN, delete the SSN in SMZ and on the screen. (User will now be forced to enter a non-duplicate SSN or go back and enter a different FMP).
(3) If patient is now a sponsor, set SMSP to SMPT, recalculate PADNEW and set the sponsor name to the patient name.
(4) If the patient is now a dependent and was a sponsor, set PADNEW to indicate new sponsor, get a new file entry number for sponsor in SMSP and blank out sponsor name.
(5) Redisplay sponsor name.

d. Output Variables:

Local: SMSP
PADNEW
SMZ(8000, ...)

Globals updated: ^RGLCK
^DIC

1.2.1.4 Registration SSN Special Edit (RGSSN).

a. Purpose. The RGSSN routine is called whenever the user changes the SSN on the registration screen. RGSSN validates the change and, if no error exists, redisplays sponsor data as appropriate.

Invoked by: E1 (entry program with special MUMPS code for SSN edit)
Globals referenced: ^DD
^SMDEF

b. Input Variables:

X (new SSN)
SMPT
SMSP
SMZ

c. Processing Logic.

(1) Lock the family lock file. If unavailable for 5 seconds, set an error and return. If available but new family is locked, set an error and return.
(2) Loop through the SSN cross reference for this whole family. Save sponsor file entry number. If this FMP/SSN already exists, set error and return.
(3) Unlock old family; lock new family.
(4) If new sponsor does not exist, get new file entry number; set SMSP.
(5) For each sponsor field, replace the old sponsor field in SMZ with the new sponsor's field. Write new field on screen.

d. Output Variables:

Local: SMSP
SMZ(8000,
Globals updated: ^DIC
^RGLCK

1.2.1.5 Registration Consistency Editor (RGC).

a. Purpose. The Registration consistency edit program ensures that the registration data is consistent. If it is not, an error is displayed.

Invoked by: E1
Globals referenced: ^DIC(1011), ^DIC(1012), ^DIC(1002), ^DIC(1006)

b. Input Variables:

SMZ

c. Processing Logic.

(1) Clear line 24 of possible previous error messages.
(2) Get the patient category flag in FCAT and the actual category code (rather than the pointer number) in CAT. Get the FMP flag in FFMP.
(3) Do edits 2-12 (see section H below).
(4) Do sponsor edits (edits 13-21) (routine RGC1).
(5) If the service is Navy, do edits 22-32 (routine RGC2).
(6) If any errors have been detected, return.
(7) If updates had been made (SMUPD flag set by the entry programs), set verification to "NO" and clear the verification date.
(8) Store SMZ in ^SMSCR. After ^SMSCR is updated, repaint verification line if updates had been made. Return.

d. Output Variables:

Local: SMERR
Globals updated: ^SMSCR

e. PADSEL. Not applicable.

f. Compiled Painter Program:

PD14 VERIFY screen definition 14

g. Compiled Entry Programs: None.

h. Editing Logic. The following edits are performed based on the branch of service in profile record.

Applicable Service	Edits
1. A,F,N	SSN cannot be all null.
2. A,F,N	Sponsor (FFMP byte 1 = 3) must have a sponsor type of patient category (the 2nd digit of FCAT is 1). (Error 1001).

	Applicable Service	Edits
3.	A,F,N	Dependent (FFMP byte 1 = 1) must have a dependent type of patient category (the 3rd digit of FCAT is 1) and vice versa. (Error 1001).
4.	A,F,N	Civilian emergency (FFMP byte 1 = 2) must have a civilian emergency type of category (the 4th digit of FCAT is 1). (Error 1001).
5.	A,F,N	Active duty or retired member of the uniformed services must be at least 16 years old for Air Force and 17 years old for Navy and Army. (If the 2nd digit of FCAT is 1 then check DOB against current date). (Error 1002).
6.	A,F,N	Mother and mother-in-law of sponsor (FMP is 40 or 50) must be female. (Error 1003).
7.	A,F,N	Father and father-in-law of sponsor (FMP is 45 or 55) must be male. (Error 1003).
8.	A,F,N	Children (FMP is 01 through 19) cannot have marital status of married (M), interlocatory (I) or separated (L). (Error 1004).
9.	A,F,N	A spouse (FMP is 30) cannot have a marital status of annulled (A), divorced (D) or single (S). (Error 1004).
10.	A,F,N	Spouse of deceased sponsor (FMP is 30 and the 2nd and 3rd digits of CAT is 43 or 44) must have marital status of widowed (W) or unknown (U). (Error 1004).
11.	F	AFSC must be entered for all active-duty Air Force. (If 1st digit of CAT is "F" and the 1st digit of FCAT is 1, then the 4th through 6th digits of military occupation must be numeric.) (Error 1005).
12.	F	Aviation service code is entered only for active duty personnel. (If aviation service code is not null, then the 1st character of FCAT must be 1 and the 1st character of CAT must be "F".) (Error 1006).
13.	A,F,N	If sponsor (first byte of FFMP = 3) and the sponsor name is entered, then the sponsor name must be the same as the patient name. If sponsor, and the sponsor name is blank, default the sponsor name to the patient name. (Error 1007).

Applicable Service	Edits
14. A,F,N	Rank must be entered for active duty or retired member of the uniformed services. (If 1st digit of FCAT is 1 or 2, the rank cannot be blank or "CIV".) (Error 1008, 1018). Rank must be consistent with patient category (Error 1018).
15a. A	If Army officer (A11, A21, A23, A26, A31, A33, A41), Army branch of service must be entered (Error 1023). If foreign military (patient category "S..."), service must be entered (Error 1025). If not Army officer or foreign military, field should be blank (Error 1024).
15b. F,N	Service must be entered (Error 1026).
16. F	The major command must be entered for all AF extended active-duty and training personnel (the 5th digit of FCAT is 1) (Error 1009).
17. A,F,N	If the permanent active flag is changed to "N", default the date in which patient placed on inactive status to the current date.
18. A,F,N	If the permanent active flag is "Y", blank out the date in which patient placed on inactive status.
19. A,F	If FMP is 20, the UNIT ID/SHIP is defaulted to the sponsor's duty zip code. If FMP is not 20, the UNIT ID/SHIP is defaulted to the patient's zip code. If UNIT ID/SHIP is blank after default, then it is an error (Error 1103, 1111).
20a. A	Flying status indicator must be entered (Error 1144).
20b. N	If the flying status indicator is not blank, then the patient category must be active Navy or Marine personnel (the first digit of FCAT is 1 and the first character of CAT is "N" or "M", and CAT is not = N13) (Error 1010.)
21. A	If patient is active-duty Army, Navy, Air Force, or Marine personnel, then aeronautical rating must be entered (Error 1011.)
22. N	If FMP is 20 and the sponsor's pay grade is 07-11, then one of the command interest fields must be VIP (Error 1012).
23. N	If FMP is 20 and the 1st 5 characters of UIC equals the MTF code, then one of the command interest fields must be STF (Error 1022).

Applicable Service	Edits
24. N	If patient is an active duty Navy or Marine personnel (the 1st digit of FCAT is 1 and the 1st character of CAT is "N" or "M"), then the UIC cannot be null (Error 1013.)
25. N	If patient is an active duty Navy or active duty enlisted Marine personnel (the 1st digit of FCAT is 1 and the 1st digit of CAT is "N" or "M" and CAT is not = N13, N14, M14 or M22), then the military occupation cannot be blank (Error 1014).
26. N	If patient is an active-duty Marine (the 1st digit of FCAT is 1 and the 1st digit of CAT is "M" and CAT is not = M14 or M15), or patient is an active-duty Navy officer (the 1st digit of FCAT is 1 and the 1st digit of CAT is "N" and CAT is not = N13 or N14 and the pay grade is 01-11 or 21-24), then the military occupation must be numeric (Error 1015).
27. N	If patient is an active duty Navy enlisted personnel (the 1st digit of FCAT is 1 and the 1st digit of CAT is "N" and CAT is not = N13 or N14 and the pay grade is 31-39), then the military occupation must not be numeric (Error 1016).
28. N	All non-active-duty military patients (the 1st digit of FCAT is not = 1 or the 1st digit of FCAT is = 1, but 1st digit of CAT is not = "N", "M", "A", or "F") must have a patient address. (The alphanumeric fields of the patient address cannot be null and the zip code cannot be null or zeroes.) (Error 1020, 1100, 1101, 1102, 1103.)
29. N	If this is an active-duty or retired uniformed services patient (the 1st digit of FCAT is 1 or 2), the ID card number must be blank (Error 1017).
30. N	Active-duty Air Force or Army patient (the 1st digit of FCAT is 1 and the 1st digit of CAT is "A" or "F") must have a military address. (The alphanumeric fields of the duty address cannot be null and the zip code cannot be null or zeroes.) (Error 1021, 1108, 1109, 1110, 1111.)
31. N	If sponsor's rank is "M1" (Air Cadets), the patient category must be "A13", "F13", "M13", "N13" or "P13" (Error 1018).
32. N	If sponsor's rank is "C1" (Academy Cadets), the patient category must be "M14" or "N14" (Error 1018).

1.2.1.6 Registration Products Consistency Editor (RGOC).

a. Purpose. The RGOC routine stores the SMZ node containing the products request in ^SMSCR.

Invoked by: RGOE

b. Input Variables: None.

c. Processing Logic.

(1) If SMZ node 2 exists, store it in ^SMSCR node 2 for file 8000.

d. Output Variables:

Local: None
Globals updated: ^SMSCR

1.2.1.7 Registration Verification (RGVC)

a. Purpose. The RGVC program performs the verification checks on registration data. If the service-specific required data is present, the verified indicator and date verified are set and displayed.

Invoked by: PADSEL

b. Input Variables:

SMZ

c. Processing Logic.

(1) Clear error flag; set base error number (variable MN).
(2) Check Tri-service fields. If any error, display error and return (display error based on specific field).
(3) If the service is "Army", perform the common Army/Navy edits, the common Army/Air Force edits, and the Army-only edits. If the service is Air Force, perform the common Army/Air Force edits and the Air Force-only edits. If the service is Navy, perform the common Army/Navy edits.
(4) If no verification errors exists, set verification indicator to YES and verification date to the current date, repaint the verification screen line.

Common edits: The list of node;piece strings that specify the fields to be edited contains a third piece if the edit is based on a civilian/military categorization. This is true for the occupation fields. If the third piece exists, the patient category table flag is tested to perform the edit.

d. Output Variables: None.

e. PADSEL. Not applicable.

f. Compiled Painter Programs:

P1 - VERIFY screen definition 14

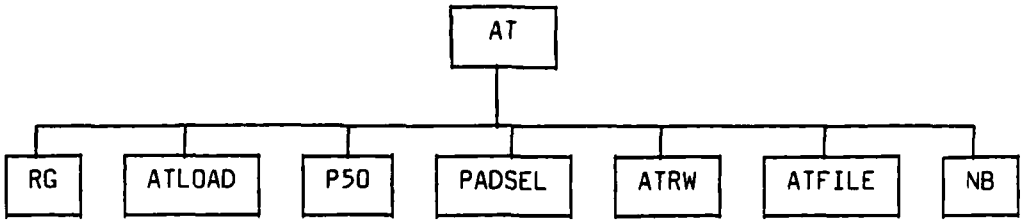
g. Compiled Entry Programs: Not applicable.

h. Editing Logic.

Applicable Service	Edits
1. A,F,N	Patient Street Address
2. A,F,N	City
3. A,F,N	State
4. A,F,N	Zip

Applicable Service	Edits
5. A,F,N	Patient Category
6. A,F,N	Military Occupation (if military patient category)
7. A,F,N	Sponsor Rank
8. A,F,N	Sponsor Service
9. A,F,N	Duty Address
10. A,F,N	Duty City
11. A,F,N	Duty State
12. A,F,N	Duty Zip Code
13. A,N	Sex
14. A,N	Race
15. A,N	ID Card Date
16. A,N	Unit ID Ship
17. A,F	Home Phone
18. A,F	Work Phone
19. A.F	Civilian occupation (if civilian patient category
20. A	Home State
21. A	Marital status
22. A	Religion
23. A	Flying status
24. A	Primary care provider
25. F	Primary MTF

1.2.2 Admission and Transfer (AT). The following figure shows the hierarchy chart of Admission/Transfer programs.



a. Purpose. Admission and Transfer are two functions that are used to maintain a patient's inpatient episode data. Transfer allows the user to perform a subset of those options provided in admission (the user is unable to perform an initial admission or to cancel an admission). Therefore, both these functions will be performed by the package AT*, with those few differences between the functions being controlled by PADTAB, a variable set up when the user identifies which "function" is to be performed on the user entry menu screen (see the figure above).

Two separate "functions" exist so that the system manager is able to limit users' capabilities in certain areas of the hospital by only assigning access to the Transfer function.

Invoked by: SO
Global referenced: ^DIC(8000,)

b. Input Variables. By the time control gets to the Admission and Transfer program (AT), several things have been accomplished.

(1) The user has identified a patient on the Patient Identification screen - this patient may or may not already exist on the data base.
(2) SMPT has been set to the file entry number of the patient identified. If the patient did not already exist, a new number has been assigned.
(3) SMSP has been set to the sponsor's file entry number and if a sponsor record does not exist, a new number has been assigned.
(4) PADNEW has been set to identify whether a patient was previously registered:

0 = Old patient, Old Sponsor
1 = New patient, Old Sponsor
2 = Old patient, New Sponsor
3 = New patient, New Sponsor

(5) The patient's record has been locked. An entry has been placed in ^PTLCK.
(6) PADTAB has been set to indicate which function has been selected:

A = Admission
T = Transfer

With this information, AT begins processing.

c. Processing Logic. First, determine if the patient is a current inpatient. The flag ATFLG is used to keep this information (0 = current inpatient, 1 not current inpatient). If the user identified a new patient (PADNEW = 1 or 3), then he or she is not a current inpatient; set ATRGN = "". However, this could be an old patient without being a current inpatient; set ATRGN equal to the current register number field (0,17) of the registration file (8000). If the current register number field is null, then the patient is not a current inpatient.

Initial processing based on inpatient status:

(1) When function is transfer (PADTAB="T") the user is not allowed to perform an initial admission. Therefore if the patient is not an inpatient (ATFLG=1), set SMERR=1995 "Patient not currently admitted". Set SMCAN = 1 and go to UNLCK which will unlock the patient and quit the program. Control will return to the User Entry Menu Program which will loop back to ^PT and display the error message.
(2) In admission (PADTAB="A") whenever the user is about to perform an initial admission, (ATFLG=1), the user is forced to go thru registration in the hope that he/she will review the Registration data and make sure that it is current.
Upon returning from registration, check SMCAN and SMERR; if either is set, go to UNLCK. If it is not set, kill all except node 0 of ^SMSCR, (the other nodes of scratch pertain only to Registration).
(3) If the patient is an inpatient, load node 0 of the registration file into ^SMSCR, and go directly into admission.

Do ^ATLOAD to load admission data (see Section 1.2.2.1). This routine loads ^SMSCR from ^DIC. It either loads existing admission data or, if none exists, it defaults the emergency data portion of the admission file from other records and, if necessary, generates a new register number.

Display the initial Admission/Transfer Screen. Do ^P50.

For an initial admission, the user starts by entering data on the Admission Screen line 6; for all subsequent updating of that information either through Admission or Transfer, the cursor is initially set at the ENTER SELECTION field. Selection processing is handled through ^PADSEL, which does the Entry and Painter programs. By setting PADCHN to + for a new admission, ^PADSEL will do the Admission Entry program without any selection entry by the user.

If this is not an initial admission, the user is not allowed access to source of admission, register number, and date/time of admission fields. Set SMST for screen 50 to 4 (starting field number for entry program). The flow from screen to screen will stay under ^PADSEL until the user either chooses to cancel or store the data. To understand this flow see section E, below.

Upon returning from ^PADSEL, check if the user has chosen to cancel (SMCAN=1). If so and if the register number was automatically assigned (ATFLG = 1, ATAUTO = 1,) then return the register number and go to UNLCK. If the user did not cancel, it is time to prepare the data for filing. Before filing, some additional checking of data must be done to make sure that before a new ward assignment is stored, there is room for a patient on that ward. Also if the user has entered a register number (in manual mode or an override number in auto register number mode), check that it is unique and its assignment is valid. If it is valid and automatic register number assignment is in use, return the old number. Also, if this is a preadmission and auto reg number is on, return the assigned number. For a cancel admission, the assigned number must be returned and a cancel number retrieved. All these functions are performed in ^ATRW (see section 1.2.2.2).

If an error was discovered in ^ATRW, AT must display an error message and return control to ^PADSEL allowing the user to correct the error and update any other data, or to cancel out. If no error was found, save all variables needed for recovery. This is done immediately before filing so that should the system crash during filing, there will be a mechanism for recovering the data base (see section 1.1.e for a discussion of recovery).

Finally, file the data. Do ^ATFILE (see Section 1.2.2.3). The filer must file the admission data and make any necessary entries in the event file. If the patient was a mother who went on convalescent leave, then her baby(s) must either be dispositioned or put on pay status. The user will be prompted to collect that data for each child. Do ^NB.

UNLCK - unlocks the patient number by killing ^PTLCK(SMPT), and if the patient is a baby, must unlock the mother ^PTLCK(SMOM). UNLCK must also kill all local variables PADSEL, ATFLG, ATAUTO, PADCHN, ^SMSCR(PADJ), SMDE, ATRGN, X, Y, DY, DX, SMZ, SMST, SMSK, NBDSDT, HCAS, HAS, HSA, HMEB, HTC, SMNXT, ATPRE, CANPRE.

d. Output Variables:

Local variables:

(1) SMCAN is set when Admission or Tranfer processing has been cancelled.

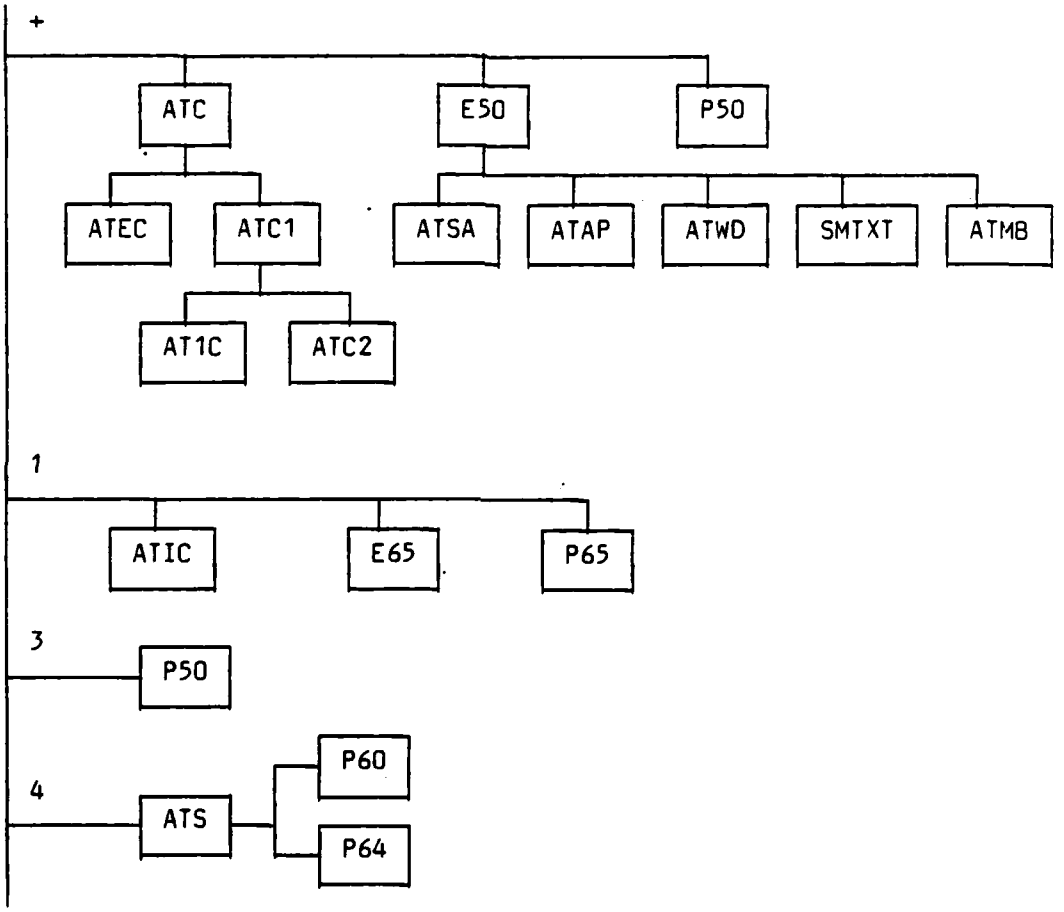
(2) SMERR is set to an error message number if an error is found during Admission or Transfer processing that prevents further processing. This will be used by PT to display an error message.

Global variables:

^DIC(8000,SMPT)
^DIC(1008) register number file
^DIC(8010) ward
^DIC(8020) event file

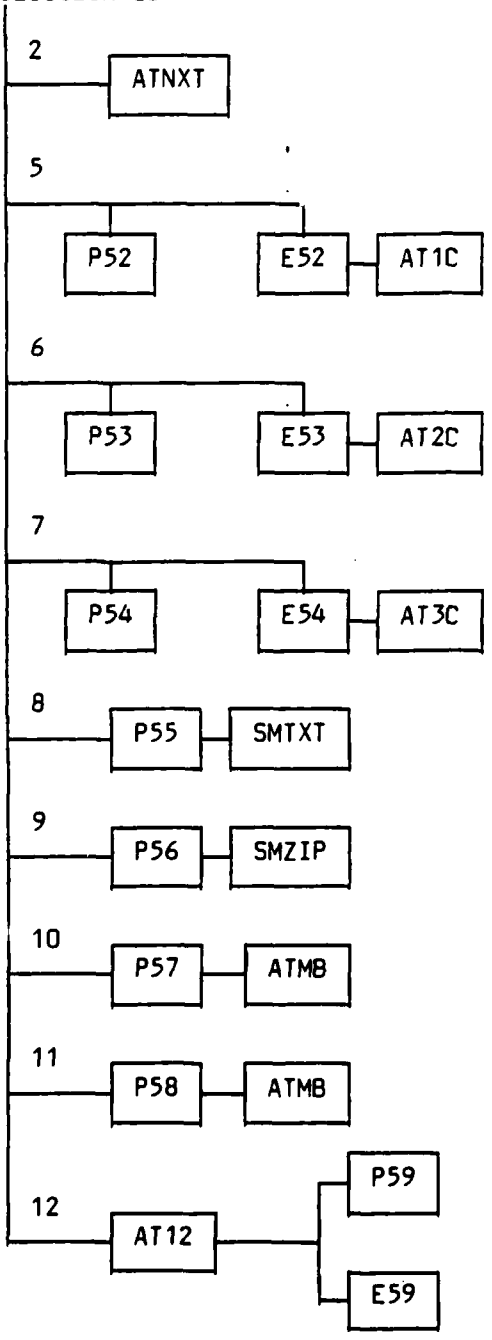
e. PADSEL.

If selection is:



e. PADSEL (continued).

If selection is:



f. Compiled Painter Programs:

Program	Source
P50	Admission/Transfer display screen
P52	AT Mother's register number
P53	AT Transfer-in data
P54	AT Emergency data
P55	AT Cause of injury screen
P56	AT Absent status screen
P57	AT Casualty status screen
P58	AT MEB status screen
P59	Admission cancellation screen
P60	Admission selection screen
P61	AT Menu painter
P64	Transfer selection screen
P65P	AT Inpatient products

g. Compiled Entry Programs:

Program	Source	Refresh Screen Routines	Special Edit Routines
E50	Admission/Transfer Main Screen	P50	SMTXT, ATAP, ATSA, ATWD, ATLS,* ATMB
E52	AT Mother's Register Number	P52, P61	
E53	AT Transfer-in Screen	P53, P61	
E54	AT Emergency Data	P54, P61	SMZIP
E55	AT Cause of Injury Screen	P55, P61	SMTXT
E56	AT Absent Status Screen	P56, P61	SMZIP
E57	AT Casualty Status Screen	P57, P61	ATMB
E58	AT MEB Status Screen	P58, P61	ATMB
E59	Admission Cancellation Screen	P59, P61	
E65E	AT Inpatient Products	P65, P61	

* ATLS is a special input transform edit called on all length of service input (also see E81).

1.2.2.1 A/T Loader (ATLOAD).

a. Purpose. The Admission and Transfer loader sets up ^SMSCR(PADJ,8000.01) with any available admission data from the admission file. For a current inpatient or a preadmission, load all existing data. If no previous admission data exists, default the emergency data from either a previous admission record, sponsor's admission record, or patient's registration data. If automatic register number generation is requested by the site, and the patient is not a current inpatient, then ATLOAD must assign a register number.

Invoked by: ^AT
Globals referenced: ^DIC(8000)

b. Input Variables:

(1) SMPT has been set to the file entry number of the patient identified.
(2) SMSP has been set to the sponsor's file entry number identifying the sponsors location in the registration file.
(3) PADNEW identifies whether a patient was previously registered.

0 = Old patient, Old Sponsor
1 = New patient, Old Sponsor
2 = Old patient, New Sponsor
3 = New patient, New Sponsor

(4) ATFLG has been set to 1 if the patient is not a current inpatient.
(5) ^SMSCR(PADJ,8000,0) contains all registration data that will be needed for admission and transfer processing.
(6) ATRGN contains the patient's current register number if one exists.

c. Processing Logic. This routine must first determine if the patient is a current inpatient. The routine will check the ATFLG. If it is zero, then:

(1) Simply load all existing admission data into ^SMSCR(PADJ,8000.01).

(2) Variables HMEB, HAS, HCAS, HTC and HSA are used to track changes to the MEB, absent status, casualty status, type case, and source of admission fields respectively. ATLOAD sets the original value from the respective data base node. The admission consistency edit programs use these variables to detect changes and therefore force screen chaining to collect data associated with these fields. The consistency edit programs update these fields each time they change.

If ATFLG=1 then one of two situations could exist.

(1) If it is a preadmit patient, some admission data already exists; if so, load that data. All preadmits have the same register number, 9999999, so ATLOAD loads this data.

(2) If it is not a preadmit, then default the emergency data part of their admission data from their own previous admission record if one exists, or the sponsor's admission data (if it exists), or from the patient registration record.
   (a) If this is an old patient (PADNEW = 0,2), then he/she could potentially have been previously admitted and if so, the emergency data is defaulted from the previous admission record. This is done by checking if the previous register number field exists in ^SMSCR (Node 0, 18th piece). Use that number to get the admission data ^DIC(8000, SMPT,5), then load the Emergency data (Node 3) into scratch. If successful, go to step 3.
   (b) If this is an existing sponsor (PADNEW = 0,1), then use SMSP to look up the registration record. Check the current register number field in the registration file (0;17) and if it exists, use that number to get the admission data; otherwise use the previous register number (0;18) and load the Emergency data into scratch. If successful go to step 3. If neither register number exists, the sponsor was never an inpatient.
   (c) As a last resort, take the patient's address and phone number from their registration record (1;1 - 1;6) and move them into the emergency address and phone number in ^SMSCR (3;3 - 3;7)

(3) In either case, if the patient is not a current inpatient (ATFLG=1), two more things must be done.
   (a) Determine if automatic register number generation is requested. In the MTF profile record (1011) of each site, the user can specify if they want register numbers automatically assigned (0;4), or if they will be handled manually. Set ATAUTO to the auto register number flag.
   (b) If automatic register number assignment is requested:
      - Lock the register number maintenance record (RGN). If unavailable for 5 seconds, display a message and try again (see section 1.1.g on locking).
      - Look in the cancelled number pool (DIC(1008 1,1,REG NUMBER) and see if any numbers exist. If one exists, set ATRGN equal to that number In addition save it in the recovery node (see 4) then remove it from the cancel pool.

- If no cancel pool numbers exist, set ATRGN equal to the current register number field (^DIC(1008,1,0)), save it in the recovery node (see 4) and add 1 to the current register number field.
- Any automatically assigned register number must be saved in the recovery node because they must not be lost. If the system were to crash after a number was assigned but before the data was stored, there must be a way of retrieving that number. This is done by saving that number in ^SMSCR(PADJ,1) along with the name of the recovery program (^RCATRN) that must be run to return the number. When the system is brought back up, before doing anything else, recovery must be run (see Section 1.1.f).

(5) Unlock the register number file.

(6) Set the newly assigned register number into ^SMSCR(PADJ,8000.01) node 0, piece 1.

(4) If this is an initial admit, default products, form, and index cards, to 1.

d. Output Variables:

Local variables:

(1) ATAUTO has been set to 1 if automatic register number generation was requested, 0 if manual register number assignment is being used.

(2) ATPRE identifies whether the patient was a preadmission or not

1 = preadmission
2 = not preadmission

(3) HMEB, HAS, HCAS, HTC, HSA contain the current values of the MEB, absent, casualty statuses, the type of case and source of admission.

(4) ATRGN previously contained any existing register number. It was then updated to contain any new register number assignment.

Global variables:

^SMSCR(PADJ,8000.01)
^DIC(1008)

1.2.2.2 A/T Register Number and Ward Verification (ATRW).

a. Purpose. This program in the Admission and Transfer package ensures that the data entered can be filed. It makes sure that before the new ward assignment is stored, there is room for a patient on that ward. Also, if the user has entered a register number, ATRW checks that it is unique and its assignment is valid. If it is valid and automatic register number assignment is in use, it returns the old number. Also, if this is a preadmission and automatic register number is on, it returns the assigned number. For a cancel admission, the assigned number is returned and a cancel number retrieved. Also, for a new admission, it assigns a number in the event file to be used when building any event records for this admission episode.

Globals referenced:

DIC(2001)
DIC(8000)
SMSCR
DIC(1011)
DIC(1008)
DIC(8010)
DIC(8020)
DIC(1001)

b. Input Variables:

(1) ATAUTO has been set to 1 if auto register number generation is on for this site.
(2) ATRGN contains the register number originally assigned.

c. Processing Logic.

(1) Retrieve the source of admission of this patient and the flags associated with that value (variables SA,FSA). These variables will be used throughout ATRW.
(2) Determine if the user has entered his or her own register number. (This can only be done at the time of initial admission.) This is done by checking SMDE(8000.01, "0;1"). If it exists, then the number has been changed. If it has been changed, check the register number cross reference (^DIC(8000,"F")) to determine if the new number already exists. If it does, set SMERR-2022 "REGISTER NUMBER IN USE", replace the new number with the number initially assigned (ATRGN) in ^SMSCR and SMZ, redisplay the field on the screen and quit the program. This will return control to ^AT which will allow the user to reenter data. If the number does not already exist and ATAUTO=0, quit. If automatic register number generation is on (ATAUTO=1), then the program must check if the user overrode the register number with a valid number. In order for the number to be valid it must be from a block.
(a) Lock the register number maintenance file (^RGN). If unavailable for 5 seconds display a message and try again.

(b) Once the file is locked, loop through, checking each block of numbers to see if the new register number is within the range of the block. If it is in the range of block, then add 1 to the number used from the block and add it to the list of used numbers for that block, and stop checking. If it is not in the range of any of the blocks, then set SMERR=2019 "REGISTER NUMBER NOT BLOCKED", reset the register number field in ^SMSCR and SMZ to ATRGN, redisplay the field on the screen and quit the program.

(c) Return the original number assigned to the Register number cancel pool and unlock the file.

(3) Next this program must determine if any updating of the ward records must be done. These records contain the total number of beds on the ward, the number of beds reserved for preadmissions, the number of blocked or unavailable beds and the number of inpatient occupied beds. A ward record may need to be updated for two reasons: 1) the patient's ward has changed from one ward to another, or from a ward to no ward or from no ward to a ward, 2) the patient's source of admission may have changed from a preadmission to an admission or cancelled from an admission to a preadmission. This processing is done as follows:

(a) Determine if either a ward change or a source of admission change has occurred.

(b) Initialize the preadmission (PCT) and inpatient (ICT) adjustment counters to zero.

(c) If the source of admission changed but the ward did not change then if the old source of admission was preadmission, set the preadmission counter to -1; otherwise, set the inpatient counter to -1,

(d) Set WARD equal to the new value of ward in SMSCR. If this is not null then check the new source of admission flag; if it is a preadmission set PCT=1, if it is an inpatient set ICT=1 and go update the ward record (see f).

(e) If the ward has changed, set WARD equal to the value of SMDE of the old ward. If the ward is not null then check the old source of admission flag; if it's a a preadmission, set PCT=-1, ICT=0 or for an inpatient, set PCT=0, ICT=-1 and update the ward record. Then quit.

(f) Updating the ward records involves:

- Lock the ward record BMLCK(WARD). If it is unavailable for 5 seconds display a message and try again.
- If the value of ICT is not equal PCT and ICT or PCT is greater than zero then this is adding a new patient to a ward to which he/she was not already assigned. Make sure that there is an available bed by comparing the total number of beds to the sum of the preadmit beds, unavailable beds and inpatient beds. If they are equal, set SMERR=2020, unlock the ward record and quit the program.

- Increment the ward count by adding PCT to the number of preadmit beds and adding ICT to the number of inpatient beds in use on that ward.
- Unlock the ward file.

(4) Now, if an event file number has not been assigned for patient, one must be assigned:
   (a) Lock node zero of the event file.
   (b) Get the last number used (node 0, piece 3) and add 1 to it. Then make sure it doesn't already exist in the file. If it does, increment the number and try again.
   (c) Once a unique number is found, update the number used field in node 0, and set it into SMSCR (PADJ,8000.01) node 1, piece 9. This number will be used anytime an event record is built for this inpatient episode.

(5) Finally, if the source of admission is preadmission or cancel admission, more updating of the register number file must be done. ATRW must return the original number ATRGN to the file so that it can be reassigned. This is done as follows:
   (a) For a cancel admission, assign a cancel number (RGN) from ^DIC(1008,1,0) piece 2 and increment that field.
   (b) If there is no automatic register number assignment or if ATRGN has a suffix, then nothing else must be done, so quit the program.
   (c) Set the recovery node with the register number that is going to be returned, so that if the system crashes after returning the number but before the data under that number is removed, this number must be removed from the cancel pool or available block numbers because it is still in use.
   (d) Lock the register number file ^RGN. If unavailable for 5 seconds, display a message and try again.
   (e) Once the file is locked, check to see if the number being returned (ATRGN) was from a block. If it was, decrement the numbers used count and increment the number remaining and remove that number from the list of used blocked numbers.
   (f) If it was not in a block, then add it to the cancel pool and increment the counter of the number of entries in the cancel pool.

d. Output Variables:

Local variables:
(1) SMERR is set to an error number if any error condition is found.
(2) RGN is set to cancel number for cancelled admissions.

Global variables:
^DIC(1008) register number file
^DIC(8010) ward file
^DIC(8020) event file

1.2.2.3 A/T Filer (ATFILE, ATFIL2).

a. Purpose. The Admission and Transfer Filer must accomplish several tasks. It must file all admission data and set up all cross references to that data. The admission data is cross-referenced by register number ("F") and record status flag ("E"). For an initial admission it must update the current register number field in the Registration record. Based on the admission data, it may or may not have to build a new entry(s) in the event file.

Invoked by: AT
Globals referenced:
DIC(2001)
DIC(2004)
SMSCR
DIC(8000)
PRD
MACH
DIC(8020)
DIC(1002)
DIC(2002)
DIC(1001)

b. Input Variables:

(1) ATRGN is set to the patient's register number. For an initial admission, if auto register number is on, it will contain the number assigned; otherwise it will be null.
(2) ATFLG is set to 1 if this is a new admission.
(3) RGN is set to the cancel register number for a cancel admission.

c. Processing Logic.

(1) Set FSA to the source of admission flags. These are used to determine if an special handling is required for this patient's records.
(2) If not a cancel admission, set RGN equal to the register number in ^SMSCR. If the patient has overwritten the register number that was assigned, RGN will contain the new number.
(3) There are several fields that commonly need to be updated before filing. These fields are: the current and previous register number in the Registration file, and register number and record status in the admission file. This routine will define fields in local memory to contain the values of these fields. These variables must be initialized to the values most often used, and they will be updated later for any special cases. Set PRGN equal to the previous register number in ^SMSCR (PADJ,8000) node 0, piece 18. Set CRGN equal to RGN, and set RS equal to "I" which is the record status for a current inpatient.

(4) Now this program must check the value of FSA to see what special handling is required:

(a) If the patient is a preadmit (FSA=6):
- Set RGN=9999999. All preadmissions have the same register number regardless of what number may have been entered.
- Check to see if this patient was an admission cancelled to a preadmission. This would be true if there was a source of admission change, SMDE was defined, and the old value of the source of admission was not null. If it was a cancel admission then ATFILE must kill off all old cross references to the old admission data and set CANPRE=1. CANPRE is a flag used to indicate that this was a cancel admission to a preadmission.
- Set RS, CRGN="".

(b) If this a cancel admission (FSA=7):
- ATFILE must check the old value of the source of admission (FOSA). The source of admission has to have just been changed to cancel because once cancelled, the user no longer has access to the patient's records in Admission or Transfer.
- If FOSA is not equal to 6, then the patient was an inpatient, so kill the record status ("E") cross-reference.
- If FOSA equal to 6, then preadmission has been cancelled, so set ATRGN=9999999.
- In both cases kill the register number ("F") cross reference to ATRGN.
- Set RS="C", CRGN="".

(c) If the patient is carded for record only or an emergency room death (FSA=5), then he/she is dispositioned at the time of admission. Set RS="D" to indicate that the patient is dispositioned. Set PRGN=RGN and CRGN="".

(d) If this is an initial admission but it is not one of the above, then:
- Remove any disposition information that may have been entered into ^SMSCR during this user session.
- Check if the source of admission was a preadmission. If so set ATRGN=9999999.
- If the patient is a newborn (FSA=2) then store the baby's register number in the mother's record in the first null register number slot. In the mother's record there is space for 8 babies' register numbers allowing for a maximum of a multiple birth of 8 babies. If there are more than 8 babies (which has never happened) then simply don't store the number.

(5) Now all special cases have been dealt with so everything should be set to file. The filing is as follows:

(a) Finish cleaning up ^SMSCR. If the type of case is not injury then there should be no cause of injury data. If there is no casualty status then kill node 6 of the admission file. If the source of admission is not transfer-in then there should be no transfer-in data, and if this is not an MEB candidate then kill node 5.
(b) Set CRGN and PRGN into the registration file node 0.
(c) Set RGN and RS into ^SMSCR for the admission file node 0.
(d) If not a preadmission, set up the record status cross reference.
(e) If not a cancel admission, set the register number cross reference.
(f) Kill any data that may have existed under ATRGN.
(g) File all data from ^SMSCR into ^DIC(8000,SMPT,5,+RGN).
(h) If any products were requested, put request on queue and start background job.

(6) Now do a continuation program ^ATFIL2 which will handle the building of any event records. The event records track a history of changes during an inpatient episode. Event records are built for an initial admission but not a preadmission, for an absent status change, for a clinical service change, and for an interward transfer. Through the admission and transfer process the user is only able to create a new event record, never able to change an existing one. These event records appear on a report that is run each night. They are selected for the report if their effective date matches the report date. Whenever an event record is built and the effective date is less than the current date, the report for the day may have been run. To handle this situation, a text record is automatically generated that notes that a correction has been made to a prior day's report and gives the effective date of the change and the type of change that has occurred. This text record will appear on the current day's report. The event records are stored in file 8020 and are formatted as follows:
(a) The event file is indexed by event number.
(b) Node 0 contains the patient's register number and SMPT.
(c) Under node 0 is a subfile containing all patient event records for a given inpatient episode. This subfile is indexed by a date/time key (EFDK). This date/time key is cross-referenced by the effective date/time of a particular record. The subfile layout is as follows:
    Effective date/time (EFD).
    - Indicator which consists of up to three pieces separated by semicolons. The indicator specifies the type of event being created and some pertinent information about the event. These are very important when running the A&D report.
    - Absent status pointer.
    - Clinical service pointer.
    - Old ward pointer.
    - New ward pointer.

- Text.
- Current date/time.

(d) Not all items will be filled in for all records. The procedure for building the various types of records will be described below.

(7) Before any event records can be built, ATFIL2 must get the event number EVT from node 1, piece 9 of the admission data. It then determines what type of event record needs to be built.

(a) For a cancel admission to a preadmission (CANPRE=1) or a cancel admission (FSA=7), do CADM1 (see 14 below). If a text record needs to be built, set the indicator to "5;6" and set SMERR=1507 if CANPRE=1, or SMERR=1504 if FSA=7 (see 9 below) and quit.

(b) If this is an initial admission (ATFLG=1), one or two event records may need to be built (see 10 below). If the patient is admitted to an "in" absent status, only an admission event needs to be built. However, if the patient is admitted to an "out" absent status, two records will be built: 1) the admission event reflecting a gain, and 2) an absent status event reflecting a change out. For each event record built, a corresponding text record may need to be built. If an admission text is to be built, set the indicator to "5;1" and SMERR=1501. If an out status text is to be built, set the indicator to "5;4" and SMERR=1506.

(c) For an absent status change (SMDE(8000.01,"4;1") exists), an absent status event record must be built (see 10 below). If a corresponding text record needs to be built, set the indicator to "5;3" and SMERR=1502 for a change in and "5;4" and SMERR= 1506 for a change out.

(d) For a clinical service change (SMDE(8000.01,"0;8") exists), build a clinical service event record (see 12 below). No text record needs to be built.

(e) For an interward transfer (SMDE(8001.01,"0;9") exists and is not null and the new ward in SMSCR is not null), build an interward transfer event record (see 13 below). If a text record needs to be built set the indicator to "5;5" and SMERR=1503.

(8) All event records are cross-referenced by effective date/time. As each event record is built, this must also build the corresponding cross-reference (^DIC(8020, "DT",EFD,EVT,EFDK)).

(9) A text record needs to be built whenever the effective date/time of the record is less then the current date/time. Text records consists of:

(a) The effective date/time, which is the current date.

(b) The indicator which depends upon the type of event record this is correcting.

(c) The text.

(d) The current date field, which contains the effective date of the event.

(10) At the time of initial admission, since this is the first record built for this inpatient episode, this routine must first build node 0 with the patient's register number and SMPT. One event record must always be built and a second event record may be necessary.
   (a) The first contains the following:
      - An effective date/time which is the admission date/time.
      - An indicator that consists of:
         - Part 1 is 1;
         - Part 2 is the source of admission;
         - Part 3 is the first byte of the patient category flag (the patient category flag is found in the patient category table 1002 node 0, piece 3).
      - The absent status pointer at the time of admission if this is an "in" status (this information is contained in the absent status flag first character).
      - The clinical service pointer at the time of admission.
      - The new ward pointer, if one exists.
      - The current date and time.
   (b) A second event record will need to be built if the admission absent status is an "out" status. The second record will be an absent status change type record, and it will contain:
      - The effective date/time will equal the admission date/time.
      - The indicator consists of:
         - Part 1 is 3;
         - Part 2 is 2; for an absent status change out;
         - Part 3 is the current absent status.
      - The absent status pointer.

(11) An absent status change event record contains:
   (a) The effective date/time of the absent status change.
   (b) The indicator that consists of:
      - Part 1 is a 3;
      - Part 2 is a 1 if this is a change in or a 2 if it is a change out (this information is contained in the first character of the absent status flag);
      - Part 3 is the old absent status if it is a change in or the new absent status for a change out.
   (c) The pointer to the current absent status.
   (d) The old ward pointer if it is a change from a bed to non-bed absent status. This test is based on the fourth character of the absent status flag.
   (e) The new ward pointer if it is change from non-bed to bed absent status.
   (f) Current date/time.

(12) A clinical service change event record contains:
   (a) The effective date/time of the clinical service change.
   (b) The indicator of 0. These records do not appear on the A&D report.

(c) The pointer to the current clinical service.
(d) The current date/time.

(13) An interward transfer record contains:
(a) The effective date/time of the ward change.
(b) The indicator of 4.
(c) The old ward pointer.
(d) The new ward pointer.
(e) The current date/time.

(14) For a cancel admission to a preadmission or a cancel admission all event records must be deleted and node 0 is updated to contain either the preadmission register number (9999999) or the cancel number.

d. Output Variables:

Local variables: None.

Global variables:
^DIC(8000) registration and admission file.
^DIC(8020) event file.

1.2.2.4 Admission Consistency Program-Primary Admission Data (ATC).

a. Purpose. The ATC routines check the consistency of admission data for a new admission and each time this data is updated. If an error is detected, the user is required to correct it. If a warning is detected, the user may override it and continue. After all the edits are done and no errors exist, the ATC program sets the ATCHN variable to control the automatic screen sequence based on new data or data changes. ATC then stores the local SMZ nodes in the corresponding nodes of ^SMSCR.

Invoked by: E5O
Global referenced: ^DIC

b. Input Variables:

SMZ
SMDE

c. Processing Logic. The ATC program is made up of four routines: ATC, ATCO, ATC1, ATC2. With few exceptions, all Tri-Service edits are in the first routine. Newborn edits are performed from the mother's segment entry program, except for the Air Force, where the newborn's edits are performed by a DO of the AT1C edit program from ATC1. As in all consistency programs, all "error" edits are performed before "warning" edits. There is one admission edit that is an error for one service and a warning for others.

(1) Clear SMCB of previous error number.
(2) Get patient category flag (FCAT), clinical service flag (FCS), source of admission flag (FSA), type case flag (FTC), and absent status flag (FAS).
(3) Clear the error line.
(4) Do edit 1.
(5) If patient is non-military, then do edits 2-6.
(6) If patient is military, then do edit 7.
(7) Do edits 8, 9.
(8) If patient is MEB candidate, then do edits 10, 11.
(9) Do edits 12, 13.
(10) If source of admission is not preadmit, then do edits 14-19.
(11) Do edits 20-22.
(12) If source of admission is not preadmit, then do edits 23-28.
(13) If source of admission is not preadmit, and this is a bed day (absent status); then do edits 23-34.
(14) If the service is Army, then do edits 35-37, 42-47.
(15) If the service is Air Force, then do edits 38-40, 42-48.
(16) If the service is Navy, then do edits 41, 44-46.
(17) Set PADCHN to a string of screen selections for automatic screen chaining. For a new admission concatenate PADCHN as follows:
    (a) if source of admission is newborn
    (b) if source of admission is transfer
    (c) all new admissions (emergency data)
    (d) if type case is injury

(e) all new admissions except Preadmits with no Absent Status (absent status data)
(f) if casualty status was entered
(g) if MEB status was entered.
For old admissions or updates of initial admission concatenate PADCHN as follows:
(a) if source of admission changed to newborn
(b) if source of admission changed to transfer
(c) if type case is changed to injury
(d) if absent status was changed
(e) if casualty status was changed
(f) if MEB status was changed.
Note: Source of admission can only be changed during the initial admission process, or on the Cancel Screen.

For changes to Source of Admission and Type Case, set HSA and HTC to the updated value.

(18) Set existing nodes of SMZ into the respective node of ^SMSCR.

d. Output Variables:

SMERR
HSA, HTC

e. PADSEL. Not applicable.

f. Compiled Painter Programs: Not applicable.

g. Compiled Entry Programs: Not applicable.

h. Editing Logic. The following edits are performed based on the branch of service in the profile record:

Applicable Service	Edits
1. A,F,N	The Source of Admission can't be changed to Retained and can't be changed unless it was Preadmit. (Error 1400, 1402).
2. A,F,N	Non-military personnel can only have a Type Case of Disease or Injury. (Error 1403).
3. A,F,N	Non-military personnel must have a non-military Source of Admission. (Error 1407).
4. A,F,N	Non-military personnel must have a non-military Clinical Service. (Error 1408).
5. A,F,N	Non-military personnel can't have a Length of Service. (Error 1404).

	Applicable Service	Edits
6.	A,F,N	Non-military personnel can't have a military Absent Status. (Error 1406).
7.	A,F,N	Military personnel must have a Length of Service. (Error 1409).
8.	A,F,N	If the Source of Admission is Absent Sick, CRO, ERD or quarters; then the Clinical Service must be the same. (Error 1410).
9.	A,F,N	If the Clinical Service is military, then the Patient Category must be military. (Error 1426).
10.	A,F,N	MEB Candidate can't be entered if not active duty. (Error 1405).
11.	A,F,N	The initial MEB Status can't be removed. (Error 1452).
12.	A,F,N	If the Clinical Service is ACA or ACB , then the Patient Sex must be female. (Error 1427).
13.	A,F,N	If the Absent Status is Absent Sick, CRO, ERD or Quarters; then the Clinical Service must be the same. (Error 1411).
14.	A,F,N	If Source of Admission is not Preadmit, Absent Status must be entered. (Error 1443).
15.	A,F,N	Initial Clinical Service Date/Time must be the same as Date/Time Admission. (Error 1474).
16.	A,F,N	Initial Absent Status Date/Time must be the same as Date/Time Admission. (Error 1475).
17.	A,F,N	Ward Date/Time must be after previous Absent Status Date/Time. (Error 1457).
18.	A,F,N	If Absent Status is changed, it must be changed from status in to status out or vice versa. (Error 1448).
19.	A,F,N	Must enter date and time when Ward changes. (Error 1471).
20.	A,F,N	If and only if the Source of Admission is Newborn or Retained, the Clinical Service is Nursery. (Error 1419).

Applicable Service	Edits
21. A,F,N	If the Source of Admission is Newborn or Retained, then the Patient Category must be Dependent or Civilian Emergency. (Error 1432).
22. A,F,N	If the Casualty Status is SC, III, SI or VSI; then the Absent Status must be BO. (Error 1418).
23. A,F,N	Must enter time for Admission Date/ Time, unless Source of Admission is Preadmit. (Error 1478).
24. A,F,N	Can't use future Admission Dates/ Times, unless Source of Admission is Preadmit. (Error 1477).
25. A,F,N	Can't use future Attending Physician Date Assigned, unless Source of Admission is Preadmit. (Error 1479).
26. A,F,N	Must enter time for Clinical Service Date/Time, unless Source of Admission is Preadmit. (Error 1482).
27. A,F,N	Can't enter future Clinical Service Date/Time, unless Source of Admission is Preadmit. (Error 1480).
28. A,F,N	Can't enter future Ward Date, unless Source of Admission is Preadmit. (Error 1481).
29. A,F,N	If this is a bed day (Absent Status), and Source of Admission is not Preadmit, then the Ward must be entered. (Error 1425).
30. A,F,N,	If this is a bed day (Absent Status), and Source of Admission is not Preadmit, then the Ward Date/Time must be entered. (Error 1471).
31. A,F,N	If this is a bed day (Absent Status) and Source of Admission is not Preadmit, then the time must be entered for Ward Date/Time. (Error 1488).
32. A,F,N	If this is a bed day (Absent Status), and Source of Admission is not Preadmit, then the Attending Physician must be entered. (Error 1425).
33. A,F,N	Must enter Attending Physician Date with Attending Physician. (Error 1473).
34. A,F,N	Initial Ward Date/Time must be the same as Date/Time Admission. (Error 1476).
35. A	Absent Status of PV can't be changed. (Error 1449).

Applicable Service	Edits
36. A	If the Clinical Service is Pediatrics, then the Patient age can't be over 17 years old. (Error 1421).
37. A	If not at war, then Casualty Status can't be Battlefield Casualty. (Error 1423).
38. F	If not active duty military, then the Meal Card can't be entered. (Error 1417).
39. F	If enlisted active duty military, then the Meal Card must be entered. (Error 1420).
40. F	If and only if the Source of Admission is Newborn or Retained, then the Registration Number Suffix is entered. (Error 1430, 1431).
41. N	If the Clinical Service is Pediatrics, then the age can't be over 21. (Error 1422).
42. A,F	If and only if the Patient Category is Active Duty, then the Expired Term of Service is entered. (Error 1414, 1415).
43. A,F	If Med Hold is entered then Patient Category must be Active Duty Military. (Error 1412).
44. A,N	Register Number must be all numeric characters. (Error 1413).
45. A,F,N	Expired Term of Service Date indicates patient is ineligible for treatment. (Error 1416).
46. A,F,N	Ward is not consistent with Clinical Service. (Warning 1441)
47. A	Age minus Length of Service less than 18 years. (Warning 1442).
48. A,F,N	Patient may not be readmitted the same day as the last disposition date. (Warning 1489).
49. F	Mother is unavailable. (Error 19 96).

1.2.2.5 Admission Consistency Editor-Entrance Data Segment (ATEC).

a. Purpose. The ATEC routine performs consistency edits on the admission entrance data. If no errors are detected, node 2 of SMZ is stored in node 2 of SMSCR.

Invoked by: ATCO

b. Input Variables: SMZ

c. Processing Logic.

(1) Perform Edit Logic
(2) If no errors, store respective node of SMZ in SMSCR.

d. Output Variables:

Local: SMERR
Global updated: SMSCR

e. PADSEL. Not applicable.

f. Compiled Printer Programs: Not applicable.

g. Compiled Entry Programs: Not applicable.

h. Editing Logic. The following edit is performed based on the branch of service in the profile record:

Applicable Service	Edit
1. A,F,N	If the Projected Disposition date is entered, then it cannot be less than the Admission Date. (Error 1424).

1.2.2.6 Special Edit Routines.

1.2.2.6.1 A/T MEB Status (ATMB).

a. Purpose. This routine defaults the Date Identified, Date Confirmed or Date Resolved when the MEB Candidate status is entered or changed for MEB data or the date identified, changed, or removed for casualty date. The date is also corrected on the screen.

Invoked by: E57, E58
Globals referenced: ^DIC, ^SMDEF

b. Input Variables:

DT	: Current date in File Manager format.
PADDT	: Current date in printable military format.
SMDE	: Array of old values for all tracked fields.
SMZ	: Array of current values for all fields on screen currently being used.
X	: Value of field just entered (MEB Candidate).

c. Processing Logic.

(1) If MEB or casualty status hasn't changed, exit.
For each of the fields to be defaulted to the current date, set NO = the node, J = the piece number, and K = the piece number of the DD number in piece 17 of the screen field definition node for the MEB or casualty status field.
(2) If MEB:
(a) Get MEB flags.
- If MEB is resolved (B=2), default Date Resolved.
- If MEB is confirmed, default Date Confirmed.
- If MEB status is entered for the first time, default Date Identified.

(b) Print defaulted date.
If casualty:
(a) Check flags. If casualty status has changed to removed, default Date Removed.
(b) If casualty status is entered for the first time, default Date Placed on Casualty Roster.
(c) Otherwise, default Date Status changed.
(3) Default date:
(a) Set up new SMDE.
(b) Set current date (DT) in SMZ.
(c) Get screen field definition node of status field.
(d) Get field information specifying fields to default (screen number in piece 14 and DD numbers in piece 17).
(e) Using SMDEF "C" cross-reference, get screen field numbers of field to default.
(f) Position cursor to field coordinates. Print current date.

d: Output Variables:

Local: SMDE, SMZ
Globals updated: None

1.2.2.6.2 A/T Attending Physician (ATAP).

a. Purpose. This routine puts the admission date in the attending physician date field when the Source of Admission has changed, or is Preadmit and the Attending Physician has just been entered. The display on the screen is also updated.

Invoked by: E50
Global referenced: ^SMDEF

b. Input Variables:

SMDE : Array of old values for all tracked fields.

SMZ : Array of current values for all fields on screen currently being used.

c. Processing Logic.

(1) Checks SMDE to see if Source of Admission has changed, or is Preadmit. If not, the Attending Physician Date is not Defaulted to the Admission Date.
(2) Put the Admission Date (/1 strips out time) in the first piece of admission node 1.
(3) Gets the information from the screen file to display the Attending Physician Date.
(4) Positions the cursor to print the attending Physician Date. Print attending Physician Date. (Omit time)
(5) Kills variables and exits system.

d. Output Variables:

Local: SMZ
Globals updated: None

1.2.2.6.3 A/T Source of Admission (ATSA)

a. Purpose. This routine defaults the Clinical Service and Absent Status Dates to the Admission Date when the Source of Admission is entered.

Invoked by: E50
Global referenced: ^SMDEF

b. Input Variables:

SMZ : Array of current values for all tracked fields on the screen currently being used.

X : Value of field just entered. (Admission Date and Time)

c. Processing Logic.

(1) For Clinical Service Date and time (I=1) and Absent Status Effective Date and Time (I=4), default to the Admission Date and Time when the Source of Admission and Admission Date and Time have been entered. This is done right after the Admission Date is entered. For each date, it corrects the old value of the date field in SMDE to reflect defaulting of the current date.
(2) Gets screen information to print the Clinical Service Date and time. Wipe out existing date on the screen. Print the Clinical Service Date and Time.

d. Output Variables:

Local:
SMZ : Array of current values for all fields on the screen SMZ

Globals updated: None.

1.2.2.6.4 A/T Ward Date (ATWD).

a. Purpose. This routine defaults the Ward Date and Time to the Admission Date and Time if the Source of Admission has changed or is Preadmit. The display on the screen is also updated.

Invoked by: E50
Globals referenced: ^DIC, ^SMDEF

b. Input Variables:

SMDE : Array of old values for all tracked fields.
SMZ : Array of current values for all fields on the screen currently currently being used.

c. Processing Logic:

(1) Checks SMDE to see if Source of Admission has changed or it is Preadmit. If not, the Ward Date and Time is not defaulted to the Admission Date and Time.
(2) Pulls out node with Ward Date and Time. Corrects the old value of the Ward Date and Time in SMDE to reflect defaulting of current date.
(3) Defaults Ward Date and Time to Admission Date and Time.
(4) Gets screen information to print Ward Date and Time.
(5) Positions cursor to print defaulted date. Wipes out existing date on screen. Prints defaulted date.

d. Outputs Variables:

Local: SMDE, SMZ
Globals updated: None.

1.2.2.6.5 Mother's Consistency Editor (ATIC).

a. Purpose. The Mother's Consistency Edit Program ensures that the mother is identified properly for a newborn admission. If she is not, an error is displayed. This program is called from the main admission consistency program (^ATC) for the Air Force.

Invoked by: E51, ATC
Global referenced: ^DIC

b. Input Variables:

ATCHN
PADCHN
HALT
SMZ(
ZTA(

c. Processing Logic.

(1) Get MTF service from the profile record.
(2) Exit if the Source of Admission is not Newborn.
(3) Find mother and load data (edits 1, 2).
(4) Check mother's data (edits 3,4).
(5) If service is Army or Air Force, do edit 5.
(6) If service is Navy, do edit 6.
(7) If service is Army or Navy, do edit 7 (same edit done for Air Force in ^ATC2). Put mother's file number in SMOM.
(8) If any errors have been detected, return.
(9) Store SMZ in ^SMSCR. Exit.

d. Output Variables:

Local: MAPT, SMERR, SMOM
Globals updated: ^PTLCK, ^SMSCR

e. PADSEL. Not applicable.

f. Compiled Painter Program. Not applicable.

g. Compiled Entry Program. Not applicable.

h. Editing Logic. The following edits are performed based on the branch of service in profile record.

	Applicable Service	Edits
1.	A,F,N	Mother's Register Number required. (Error 1434).
2.	A,F,N	No patient on file with Mother's Register Number. (Error 1435).

	Applicable Service	Edits
3.	A,F,N	Newborn's mother must not be dispositioned. (Error 1433).
4.	A,F,N	Mother must be female. (Error 1436) .
5.	A,F,N	Newborn's mother must have IN Absent Status.
6.	A,F	Mother's SSN must be the same as baby's SSN. (Warning 1437).
7.	N	Mother's SSN must be the same as baby's SSN. (Error 1437).
8.	A,N	Mother's file in use (Error 1996).

1.2.2.6.6 Transfer-in Consistency Editor (AT2C).

a. Purpose. The Transfer-in Consistency Edit Program ensures that the Transfer-in data is consistent. If it is not, an error is displayed.

Invoked by: E53
Global referenced: ^DIC

b. Input Variables:

SMZ(
ZTA(

c. Processing Logic.

(1) Get MTF service from profile record.
(2) Get Source of Admission and Clinical Service from scratch.
(3) Clear line 24 of previous error messages.
(4) Exit if Source of Admission is not Transfer-In.
(5) Do edits 1-4.
(6) If the service is Air Force, do edit 5.
(7) If any errors have been detected, return.
(8) Store SMZ in ^SMSCR. Exit.

d. Output Variables:

Local: SMERR
Global updated: ^SMSCR

e. PADSEL. Not applicable.

f. Compiled Painter Programs. Not applicable.

g. Compiled Entry Programs. Not applicable.

h. Editing Logic. The following edits are performed based on the branch of service in profile record.

Applicable Service	Edits
1. A,F,N	Source of Admission must be transfer-in to enter transfer-in data. (Error 1486).
2. A,F,N	Initial Admission MTF must be entered on a transfer. (Error 1459).
3. A,F,N	Date of Initial Admission must be entered on a transfer. (Error 1460).
4. A,F,N	Military Transfer-In Date can't be greater than Date of Admission. (Error 1461).
5. F	Clinical Service must be CRO if Initial Admission MTF is CRO. (Error 1462).

1.2.2.6.7 Emergency Consistency Editor (AT3C).

a. Purpose. The Emergency Consistency Edit Program ensures that the emergency data is consistent. If it is not, an error is displayed.

Invoked by: E54
Globals referenced: None

b. Input Variables: None.

c. Processing Logic.

(1) Store SMZ in ^SMSCR. Exit.

d. Output Variables:

Local: None
Global updated: SMSCR

e. PADSEL. Not applicable.

f. Compiled Painter Programs. Not applicable.

g. Compiled Entry Programs. Not applicable.

h. Editing Logic. The following edits are performed based on the branch of service in profile record:

Applicable Service	Edits
No	Edits Currently Performed

1.2.2.6.8 Injury Consistency Editor (AT4C).

a. Purpose. The Injury Consistency Edit Program ensures that the injury data is consistent. If it is not, an error is displayed.

Invoked by: E55
Global referenced: ^DIC

b. Input Variables:

SMZ(
ZTA(

c. Processing Logic.

(1) Get the MTF service from the profile record.
(2) Get the Type Case. (HTC)
(3) Skip edit and filing if no injury data entered.
(4) Clear line 24 of previous error messages.
(5) If service is Navy, do edits 1,2.
(6) If any errors have been detected, return.
(7) Store SMZ in ^SMSCR. Exit.

d. Output Variables:

Local: SMERR, HTC
Global updated: ^SMSCR

e. PADSEL. Not applicable.

f. Compiled Painter Programs. Not applicable.

g. Compiled Entry Programs. Not applicable.

h. Editing Logic. The following edits are performed based on the branch of service record.

Applicable Service	Edits
1. N	If Cause of Injury Text and Code are blank, On-Duty Flag must be blank. (Error 1469).
2. N	If Cause of Injury Code and Text are entered, On-Duty Flag must be entered. (Error 1470).

1.2.2.6.9 Absent Status Consistency Editor (AT5C).

a. Purpose. The Absent Status Consistency Edit Program ensures that the absent status data is consistent. If it is not, an error is displayed.

Invoked by: E56
Global referenced: ^DIC

b. Input Variables:

SMZ(
ZTA(

c. Processing Logic.

(1) Get MTF service from the profile record.
(2) Get Source of Admission flags from DIC (2001,...) using SMZ.
(3) Clear line 24 of previous error messages.
(4) Get absent status if entered (set HAS).
(5) Do edits 1-6 for all services.
(6) Skip to edit 16 if Source of Admission is Preadmit.
(7) Do edits 7 and 8 if Absent Status is bed day.
(8) If Source of Admission has not changed do edits 9-13.
(9) Do edits 14-17.
(10) If any errors have been detected, return.
(11) Store SMZ in SMSCR. Set PADCHN to next screen from ATCHN. Exit.

d. Output Variables:

Local: HAS, SMERR
Global updated: ^SMSCR

e. PADSEL. Not applicable.

f. Compiled Painter Programs. Not applicable.

g. Compiled Entry Programs. Not applicable.

h. Editing Logic. The following edits are performed based on the branch of service in the profile record:

Applicable Service	Edits
1. A,F,N	Absent Status required for other than Preadmit. (Error 1443).
2. A.F.N	If Absent Status entered, Effective Date/Time must be entered. (Error 1450).

	Applicable Service	Edits
3.	A,F,N	Must enter both date and time for Absent Status Effective Date and Time. (Error 1483).
4.	A,F,N	Can't enter future date and time for Absent Status Effective Date and Time, unless the Source of Admission is Preadmit. (Error 1484).
5.	A,F,N	Clinical Service doesn't agree with Absent Status. (Error 1411).
6.	A,F,N	Absent Status must be BO for Casualty Status of SC, III, SI or VSI. (Error 1418).
7.	A,F,N	Ward and Attending Physician must be entered for active inpatient. (Error 1425).
8.	A,F,N	Absent Status Date/Time must agree with Ward Date/Time. (Error 1472).
9.	A,F,N	Can't change Effective Date and Time without changing Absent Status. (Error 1438).
10.	A	Absent Status of PV can't be changed (Error 1449).
11.	A,F,N	*Absent status can only be changed from IN to OUT or* OUT to IN. (Error 1448).
12.	A,F,N	Can't change Absent Status without changing Effective Date and Time. (Error 1439).
13.	A,F,N	New Effective Date and Time must be after previous Effective Date and Time. (Error 1440).
14.	A,F,N	Return Date and Time must be entered unless the Absent Status is Bed Occupant, Carded-for-Record Only, PCS VA Hospital Pending Separation/Retirement, or Absent Sick Non-military MTF. (Error 1444).
15.	A,F,N	For Absent Status of Absent Sick, Non-military Hospital Data must be entered. (Error 1447).
16.	A,F,N	Return Date and Time not allowed for Bed Occupant. (Error 1445).
17.	A,F,N	Return Date and Time can't be less than Effective Date and Time. (Error 1446).

1.2.2.6.10 Casualty Status Consistency Editor (AT6C).

a. Purpose. The Casualty Status Consistency Edit Program ensures that the Casualty Status data is consistent. If it is not, an error is displayed.

Invoked by: E57
Global referenced: ^DIC

b. Input Variables:

SMZ(
ZTA(

c. Processing Logic.

(1) Exit if no casualty data entered.
(2) Load Casualty Status from SMZ (HCAS).
(3) Load Absent Status, if entered, from SMZ.
(4) Clear line 24 of previous error messages.
(5) Do edits 1-3.
(6) If Date Removed from Casualty Status entered, do edits 4,5.
(7) Do edit 6.
(8) If any errors have been detected, return.
(9) Store SMZ in ^SMSCR. Exit.

d. Output Variables:

Local: SMERR, SMLD, HCAS
Global updated: ^SMSCR

e. PADSEL. Not applicable.

f. Compiled Painter Programs. Not applicable.

g. Compiled Entry Programs. Not applicable.

h. Editing Logic (Admission Consistency Edits - Casualty Status Data). The following edits are performed based on the branch of service in profile record.

Applicable Service	Edits
1. A,F,N	Must enter Casualty Status to enter casualty data. (Error 1463).
2. A,F,N	Must enter Casualty Diagnosis and Prognosis when entering casualty data. (Error 1465).
3. A,F,N	Must have prior Casualty Status to be Removed from Roster. (Error 1464).

Applicable Service	Edits
4. A,F,N	Casualty Status must be removed if Date Removed from Casualty Status is entered (Error 1466).
5. A,F,N	Date Removed From Casualty Status must be after Date Placed On Casualty Status (Error 1467).
6. A,F,N	Absent Status must be 80 for Casualty Status of SC, III, SI or VSI. (Error 1418).

1.2.2.6.11 MEB Consistency Editor (AT7C).

a. Purpose. The MEB Consistency Edit Program ensures that the MEB data is consistent. If it is not, an error is displayed.

Invoked by: E58
Global referenced: ^DIC

b. Input Variables:

SMZ(
ZTA(

c. Processing Logic.

(1) Exit if no MEB data entered.
(2) Clear line 24 of previous error messages.
(3) Get Source of Admission flags from DIC using SMZ.
(4) Get MEB Candidate from scratch (HMEB).
(5) Get Patient Category flags from DIC using scratch and MEB candidate flags.
(6) Do edits 1-3.
(7) If MEB Candidate is confirmed or removed, do edits 4, 8-10.
(8) Else do edits 5-7.
(9) If any errors have been detected, return.
(10) Store SMZ in ^SMSCR. Exit.

d. Output Variables:

Local: SMERR, SMLD, HMEB
Global updated: ^SMSCR

e. PADSEL. Not applicable.

f. Compiled Painter Programs. Not applicable.

g. Compiled Entry Programs. Not applicable.

h. Editing Logic. The following edits are performed based on the branch of service in profile record:

	Applicable Service	Edits
1.	A,F,N	MEB data can't be entered unless MEB Status is entered. (Error 1451).
2.	A,F,N	MEB Candidate can't be entered if not active duty. (Error 1405).
3.	A,F,N	Must have prior MEB Status to be Resolved. (Error 1452).

	Applicable Service	Edits
4.	A,F,N	Date MEB Candidate Confirmed must be entered if MEB Status is Confirmed or Resolved. (Error 1453).
5.	A,F,N	Date MEB Candidate Confirmed can't be entered if MEB Status is not Confirmed or Resolved. (Error 1454).
6.	A,F,N	Can't enter Date Resolved if MEB Candidate is not Resolved. (Error 1487).
7.	A,F,N	Can't enter future date for Date Identified, unless Source of Admission is Preadmit. (Error 1485).
8.	A,F,N	Date MEB Candidate Confirmed must be after Date MEB Candidate Identified. (Error 1455).
9.	A,F,N	Date MEB Candidate Resolved must be entered if MEB Status is Resolved. (Error 1456).
10.	A,F,N	Date MEB Candidate Resolved must be after Date MEB Candidate Confirmed. (Error 1458).

1.2.2.6.12 Cancel Consistency Editor (AT8C).

a. Purpose. The Cancel Consistency Edit Program ensures that the Cancel data is consistent. If it is not, an error is displayed.

Invoked by: E59
Global referenced: ^DIC

b. Input Variables:

SMZ(
ZTA(

c. Processing Logic.

(1) Get Source of Admission flags from DIC using scratch.
(2) Exit if Source of Admission has not been changed.
(3) Clear line 24 of previous error messages.
(4) Do edits 1,2.
(5) If any errors have been detected, return.
(6) Store SMZ in ^SMSCR. Exit.

d. Output Variables:

Local: SMERR
Global updated: SMSCR

e. PADSEL. Not applicable.

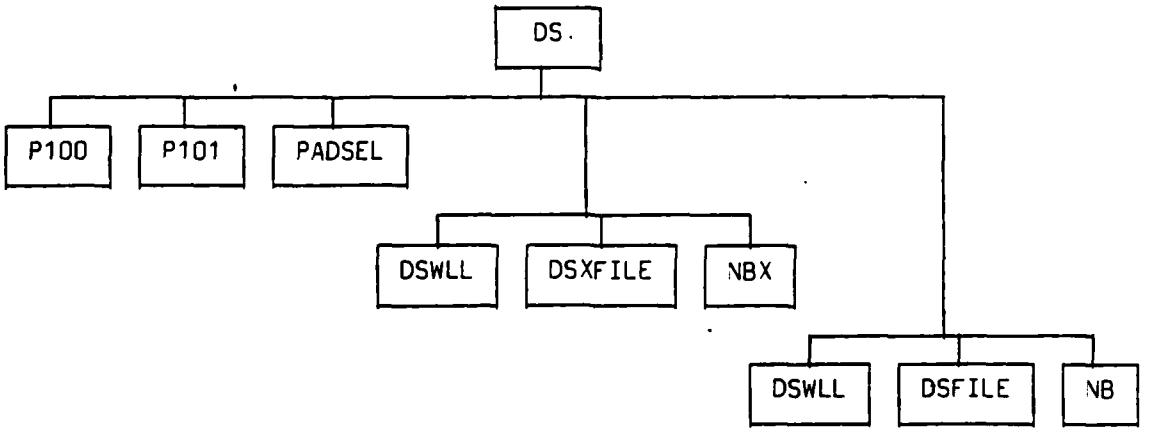
f. Compiled Painter Programs. Not applicable.

g. Compiled Entry Programs. Not applicable.

h. Editing Logic. The following edits are performed based on the branch of service in the profile record.

Applicable Service	Edits
1. A,F,N	Source of Admission can only be changed to Preadmit or Cancel on Cancel Screen. (Error 1402).
2. A,F,N	Authorizing Physician and Reason must be entered to cancel admission. (Error 1468).

1.2.3 Disposition (DS). The following chart shows the hierarchy of Disposition programs.



a. Purpose. The Disposition package (DS*) is executed to perform new dispositions, update existing disposition data, and cancel dispositions (see Figure 2-7).

Invoked by: SO
Globals referenced: ^DIC(8000), ^DIC(2002), ^DIC(2007)

b. Input Variables:

(1) SMPT Set to internal file entry number for the patient
(2) PADNEW Set to 0 or 2 for old patient
1 or 3 for new patient

c. Processing Logic. It is assumed that all locking of patient records is done before entering the DS program.

(1) If PADNEW is set for a new patient, set error and return.
(2) Attempt to locate a register number in the patient's record. First, try the "Current Register Number" (Node 0, piece 17). If there is no current register number, then try the "Previous Register Number" (Node 0, piece 18).
(3) If no register number can be located, set error and return.
(4) Load node 0 of the patient's episode record into scratch.
(5) Save the "Record Status Flag" (Episode record, node 0, piece 12) in DSFLG. If DSFLG equals "C" (Cancelled Admission), "A" (Archived), or "P" (sent to Clinical Records), set error and return.
(6) Set FAS to the seventh byte of the flag for the patient's current absent status (Episode Record, Node 4, piece 1). If

FAS is zero, indicating that the patient can not be dispositioned from this absent status, set error and return.

(7) This patient is valid for disposition, so load the patient's record into scratch and set DSUPF and DSPMF to 0. DSUPF will be set to 1 by the consistency edit program (^DSC) if any disposition data is changed. DSPMF will be set to 1 at file time if the patient is not a mother with newborn(s).

(8) Paint the initial disposition screen. If DSFLG is not set to "D" (Dispositioned), then this is a new disposition; set PADCHN to +. This will cause ^PADSEL to skip reading the selection and go straight to the full six-field entry program.

(9) Do ^PADSEL to process data entry.

(10) If DSCAN = 1, the user has cancelled a disposition. To complete the process several steps must be taken:
   (a) Set WCNT to 1 to add to the occupied bed count for the ward specified, and do ^DSWU. If SMERR is set (the ward was full), display an error message, set PADCHN to "1" so that cancellation data entry will automatically start again, and go back to Step 9.
   (b) Get the disposition type flags in FDT. If the patient is a CRO/ERD (FSA=5) do ^DSXCRO to return the register number.
   (c) Do steps 17-20 to see if this is a mother. Save all the variables needed for recovery, set DSPIN to SMPT and do ^DSXFILE.
   (d) Filing is complete, so kill the recovery information saved. If this is a mother with newborns (DSPMF=0), save the mother's cancellation date/time in *NBDXDT* and do ^*NBX*.

(11) If DSCAN = 1, or DSUPF = 0 (nothing changed during a normal disposition sequence), there is no more to do, so return.

(12) If this is a new disposition, set WCNT to -1 to subtract from the occupied bed count and do ^DSWU.

(13) Do steps 17-20 to see if this is a mother with newborns. Save all the variables needed for recovery, set DSPIN to SMPT, and do ^DSFILE.

(14) If this is a new disposition (DSFLG not = "D") and this is a mother (DSPMF=0), DS needs to make sure that all associated newborn records, up to 8, are resolved. For this processing, it first saves the mother's disposition date/time in NBDSDT, then does ^NB.

(15) Unlock the patient, kill all of ^SMSCR and all unnecessary local variables, and return. The following are special steps taken to determine whether the patient is a mother.

(16) If this a predisposition (first byte of FDT = 1), set DSPMF = 1 and return.

(17) If the first newborn register number field (episode record, node 7, piece 6) is null, set DSPMF = 1 and return.

(18) The field has some value, but if this is a newborn's record, the value will be the mother's register number. Therefore, we must now check the source of admission flag (FSA). If FSA equals 2 or 4 (newborn or retained), set DSPMF = 1 and return.

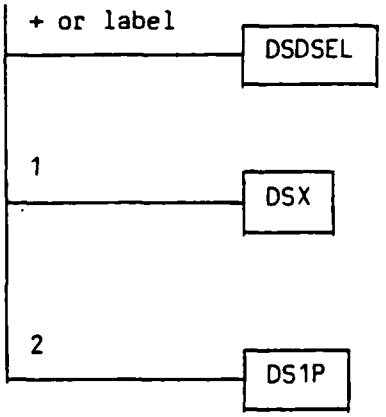
(19) Return.

d. Output Variables:

Local: SMCAN, SMERR
Globals updated: ^SMSCR, ^PTLCK

e. PADSEL.

if selection is:



f. Compiled Painter Programs:

Program	Source
P100	Dispoistion at Data Screen
P101	Disposition Initial Entry Screen
P106	Disposition Cancel Screen
P110	Disposition Menu Painter
P50	DS at Entrance Data Screen
P52	DS Mother's Data
P53	DS Transfer-In
P54	DS Emergency Data
P55	DS Cause of Injury
P56	DS Absent Status Data
P57	DS Casualty Status Data
P58	DS MEB Status Data
P65	DS Inpatient Products

g. Compiled Entry Programs:

Program	Source	Refresh Screen Routine
E101	Disposition Initial Entry Screen	P101
E106	Disposition Cancel Screen	P106
E107	DS Cancel Pay Srce Adm Screen	P132
E65	DS Inpatient Products	P65

1.2.3.1 Disposition Ward Update (DSWU).

a. Purpose. The Disposition Ward Update Program updates the occupied bed count for the ward the patient was in by the value in WCNT.

Invoked by: DS, NB, NBX
Globals referenced: ^BMLCK, ^DIC(8010), ^DIC(1001)

b. Input Variables:

WCNT is set to -1 for a disposition and +1 for a disposition cancellation.

c. Processing Logic:

(1) Get the ward pointer number in WARD. If WARD is null (no pointer in the patient record, as in an absent sick disposition) then return.
(2) Attempt for five seconds to lock the ward. If it can not be locked, display a busy message and try again.
(3) Get the ward record in W.
(4) If WCNT is +1 (Disposition Cancellation) and the total of preadmit beds, blocked beds, and occupied beds is not less than the total beds for the ward, set "WARD FULL" error, unlock the ward, and return.
(5) Update the occupied bed count in W by adding WCNT. For a disposition, this actually results in subtraction since WCNT is -1.
(6) Store W back as the updated ward record, kill off local variables that are no longer needed, unlock the ward, and return.

d. Output Variables:

Local: SMERR will be set to an error number if the ward was full.
Global updated: ^DIC(8010)

1.2.3.2 Disposition Cancellation (DSX).

a. Purpose. The Disposition Cancellation Program allows the user to cancel a previously entered patient disposition.

Invoked by: PADSEL
Globals referenced: ^DIC(8020), ^DIC(1001)

b. Input Variables:

DSFLG contains the patient's record status flag.
SMZ contains the patient's record.

c. Processing Logic.

(1) If this is an inpatient (DSFLG="I"), then there is no actual disposition to cancel. Display an error message and return.
(2) Get the patient's internal event number in EVT, then loop through the associated event file records, looking for the disposition event record (IND="2;..." or "6;..."). When the correct record is found, take the ward pointer number from the event record (node 0, piece 5) and store it into the patient's record in SMZ (Node 0, Piece 9).
(3) Paint the cancellation screen segment and do the entry program. If the user cancels (SMCAN=1), return.
(4) Kill MDSDT to ensure it will exist only for a newborn. If this is not a newborn (FSA not=2), return.
(5) Get the mother's register number from the newborn's record (node 7, piece 6) and save it in MR, then look up the mother's "F" cross-reference record and save her patient episode number in MP.
(6) Look in the mother's episode record at the record status flag (node 0, piece 12). If she is an inpatient (Flag ="I"), return.
Since the mother is not an inpatient, the newborn's source of admission must be changed to a retained/pay status.
(7) Get the mother's disposition date/time in MDSDT. Display a message explaining the mother is not an inpatient, paint the source of admission prompt, and do the entry program to get the new source of admission. If the user cancels (SMCAN=1), return.
(8) Store the pointer value for the source of admission code just entered into newborn's episode record in ^SMSCR (node 0, piece 5). Return.

d. Output Variables:

Local: SMCAN is set if the user cancelled.
MDSDT contains the mother's disposition date.
Global updated: ^SMSCR

1.2.3.3 Disposition Consistency Editor (DSC).

a. Purpose. The Disposition Consistency Edit Program ensures that the disposition data is consistent. If it is not, an error is displayed.

Invoked by: E101, NBDC
Globals referenced: ^DIC(1002), ^DIC(2001), ^DIC(8020), ^DIC(2007), ^DIC(1001)

b. Input Variables: SMZ

c. Processing Logic.

(1) Get the first patient category flag in FCAT. Get the disposition date/time in DSDT, and the admission date/time in ADDT. Get the first source of admission flag in FSA. Get the latest absent status date/time in ASDT, the latest clinical service date/time in CSDT, and set RTDT to null. Get patient's internal file entry number in EVT.
(2) Clear line 24 of possible previous error messages.
(3) If this is being done from NBDC, it is possible an error has already been found. If this is so, write the error and return.
(4) Do edits 1&2 (see Section H). If an error is detected, write message and return.
(5) Get the disposition type flags in FDT. If this is a retained newborn (FSA=4), get the effective date/time retained in RTDT.
(6) Do edits 3-19 (see Section H).
(7) If any errors are detected, write message and return.
(8) Store SMZ in ^SMSCR. Set DSUPF to 1. Return.

d. Output Variables: LOCAL: SMERR, SMSK, FSA, FCAT, FDT

e. PADSEL. Not applicable.

f. Compiled Painter Programs. None.

g. Compiled Entry Programs: None.

h. Editing Logic. The following edits are performed on all patients, regardless of the branch of service.

Edits

1. Type of disposition must be entered. (Error 1702).

2. Disposition date/time must be entered. (Error 1703).

3. If this is not a "TRANSFER" disposition type, then the disposition MTF can not be entered. (Error 1706).

Edits

4. If this is a "TRANSFER" disposition type, then the disposition MTF must be entered. (Error 1707).

5. If this is a "MILITARY ONLY" disposition type, then the patient must have an "ACTIVE DUTY" patient category. (Error 1704).

6. If this is a "CIVILIAN ONLY" disposition type, then the patient must not have an "ACTIVE DUTY" patient category.

7. If this is not a "NEWBORN" source of admission, then the disposition type must not be for a newborn.

8. If this is a "NEWBORN" source of admission, then the disposition type must be flagged valid for newborns. (Error 1713).

9. Disposition time must be entered. (Error 1708).

10. Disposition date/time can not be less than admission date/time. (Error 1710).

11. If this is a "DEATH" disposition type, the disposition date can not be greater than the current date. (Error 1705).

12. If this is not a predisposition, the disposition date/time can not be greater than the current date/time. (Error 1711).

13. If this is a "CRO" or "ERD" source of admission, the disposition date/time must be equal to the admission date/time. (Error 1712).

14. If this is a "RETAINED" source of admission, the disposition date/time cannot be less than the retained effective date/time. (Error 1714).

15. If this is a same day admission/ disposition, the disposition date must equal the admission date. (Error 1715).

16. If this is not a "CRO" or "ERD" source of admission, the disposition date/time cannot equal the admission date/time. (Error 1716).

17. The disposition date/time cannot be less than the current absent status date/time. (Error 1717).

18. The disposition date/time cannot be less than the current clinical service assigned date/time. (Error 1718).

19. Physician ordering disposition must be entered. (Error 1709).

1.2.3.4 Disposition Cancellation Consistency Editor (DSXC).

a. Purpose. The Disposition Cancellation Consistency Edit Program ensures that the cancellation data is consistent. If it is not, an error is displayed.

Invoked by: E106, E135
Globals referenced: ^DIC(2001), ^DIC(2002), ^DIC(1001)

b. Input Variables: SMDE, SMZ

c. Processing Logic.

(1) If SMDE(8000.01,"0;9") exists, the patient's ward has been changed; set CHWF=1. If it doesn't exist, set CHWF=0.
(2) If SMDE(8000,01,"1;3") exists, the ward date/time has been changed; set CHDF=1. If it doesn't exist, set CHDF=0.
(3) Get the first flag for the patient's source of admission in FSA, clear line 24 of possible previous error messages, and do edits 1-3 (see Section H below).
(4) If any errors have been detected, return.
(5) Get the first flag for the patient's current absent status in FAS and do edits 4 and 5.
(6) If any errors have been detected, return.
(7) Store SMZ in ^SMSCR. Set DSCAN to 1. Return.

d. Output Variables:

Local: SMERR, CHWF, FSA, DSCAN, SMSK
Globals updated: ^SMSCR

e. PADSEL. Not applicable.

f. Compiled Painter Programs. None.

g. Compiled Entry Programs. None.

h. Editing Logic. The following edits are performed regardless of the branch of service.

Edits

1. If the ward has been changed (CHDF=1), the ward date/time must also have been changed (CHWF=1), and vice versa. (Error 1722).

2. If the ward date/time is changed, the ward time must be entered. (Error 1471).

Edits

3. Physician authorizing cancellation and reason for cancellation must both be entered. (Error 1723).

4. Ward can be entered only for an "IN" absent status (FAS= 1). (Error 1724).

5. The ward cannot be entered for an "OUT" absent status (FAS=2). (Error 1725).

1.2.3.5 Disposition Filer (DSFILE).

a. Purpose. The Disposition Filer Program does the actual updating of the patient's records for a disposition.

Invoked by: DS, NB
Globals referenced: ^DIC(8000), ^DIC(1011), ^DIC(2007), ^DIC(2002), ^DIC(1001), ^DIC(8020), ^PRD, ^DD, ^MACH

b. Input Variables:

FSA, FCAT, FDT, DSPMF, DSFLG, DSRGN, DSPIN

c. Processing Logic.

(1) Get node 0 of the episode record in AR0 and node 7 in AR7.
(2) If requests for any inpatient products were made (pieces 16, 17, and 18 of AR7), write the quantity of each requested into PRD, execute a background to print it all, clear the product fields in SMSCR, and kill AR7.
(3) If this a predisposition (first byte of FDT=1) or a disposition update (DSFLG="D"), go to step 16.
(4) Look through DD and extract kill statements for each defined cross-reference. These are stored in DE(IDX,M,2), where IDX is the node;piece of the cross-reference variable.
(5) Loop through the DE array of kills, executing each.
(6) Kill the inpatient (E) cross-reference for status I and create a disposition (E) cross-reference for status D.
(7) Set NBF to 0. If this is a newborn (DSPMF=1 and FSA=2 or 4), set NBF to 1.
(8) Get the patient's internal file entry number in EVT, the current date in CUD, and put the disposition date/time in EFD and EFDK to be used as the effective date/time.
(9) Get the actual disposition type (rather than the pointer value) in DTYPE and the actual absent status in AS.
(10) Build the event record indicator in IND. The indicator is made up of three parts. The first part is a "6" if the patient is a newborn (NBF=1); otherwise, it is a "2". The second part is always DTYPE. The third part is AS if this is an Air Force hospital (PADSVC="F"); otherwise, it is FCAT. The three parts are separated by semicolons.
(11) If this an Air Force hospital, and this is an active duty patient, there is actually a fourth part to the indicator. This is a "1", separated from the rest by a semicolon. It is added strictly for reporting purposes.
(12) Build the event record in ER. ER will be made up of EFD in the first piece, IND in the second piece, the ward pointer value in the fifth piece, the disposition MTF in the seventh piece, and CUD in the eighth piece.

(13) Do steps 20-23 to write the event record.
(14) If the effective date (EFD) is less than the current date (CUD), set IND to "5;2" and do steps 18-23 to write a text record stating that the disposition was not today.
(15) Now rebuild the patient's record to reflect a disposition. First, move the register number (DSRGN) from current (Node 0, Piece 17) to previous (Node 0, Piece 18). Next, remove the ward pointer (Episode Record, Node 0, Piece 9) and change the record status flag (Episode Record, Node 0, Piece 12) to "D". Finally, remove any disposition cancellation data that might exist (Episode Record, Node 7, Pieces 2 through 5).
(16) Store ^SMSCR in ^DIC, kill all unnecessary local variables, and return.
(17) The following are special steps taken to write text and event records and their cross-references.
(18) Get the error message in TEXT and set SMERR to 0. Swap the values of CUD and EFD (EFDK is also set to CUD).
(19) Build the event record in ER. ER will be made up of EFD in the first piece, IND in the second piece, the ward pointer value in the fifth piece, TEXT in the seventh piece, and CUD in the eighth piece. Then set CUD back to the current date (DT).
(20) Set DUP to 0 and do CHT to ensure that this is not a duplicate record. DUP will be set to 1 if an exact match is found. If DUP=1, we do not want to write this event record, so return.
(21) Write the "DT" event record cross-reference, then the event record itself (ER).
(22) Get the zero node subfile record, if it exists, in DO. If it does not exist, create a new one in DO.
(23) Add 1 to the event record count (piece 4) in DO, and store DO back as the zero node subfile record. Return.

d. Output Variables:

Local: None
Globals updated: ^DIC(8020), ^DIC(8000), ^PRD

1.2.3.6 Disposition Cancellation Filer (DSXFILE).

a. Purpose. The Disposition Cancellation Filer Program does the actual updating of the patient's records for a disposition cancellation.

Invoked by: DS, NBX
Globals referenced: ^DIC(8000), ^DIC(8020), ^DIC(1001), ^DIC(2001), ^DIC(1002)

b. Input Variables:

FSA, RGN, DSRGN, DSPIN, CHWF, SMDE, MDSDT

c. Processing Logic.

(1) If the patient is a CRO or ERD (FSA=5), set RS="C". If the patient is not a CRO or ERD, set RS="I" and RGN=DSRGN. RGN was previously set for a CRO/ERD patient. RS will be the new event record status (cancelled admission or inpatient).
(2) Get node 0 of the patient's episode record in ARO, then get the disposition date/time in DSDT.
(3) Rebuild node 0 of the episode record in ARO. The first piece is replaced by the value of RGN, piece 12 is replaced by the value of RS, and pieces, 3, 10, and 11 (disposition data no longer valid) are removed. Store ARO back in SMSCR.
(4) Rebuild node 7 of the episode record in ^SMSCR. Simply remove the no longer valid disposition data in pieces 1, 14, and 15.
(5) Set PRGN to null and loop through the patient's episode records to see if there were any previous to the episode of the disposition cancellation. If there are previous episodes, take the register number from the episode just previous to the one being worked on and store it in PRGN.
(6) If this is a CRO/ERD patient, set CRGN to null. If not, set CRGN to DSRGN.
(7) Rebuild node 0 of the patient's registration data in SMSCR. Replace piece 17 with CRGN and piece 18 with PRGN.
(8) Kill the record status ("E") cross-reference for the disposition ("D"), and create a new cross-reference based on the value of RS.
(9) If this is a CRO/ERD patient (RS="C"), kill the register number ("F") cross-reference so that the episode can no longer be referenced.
(10) Get the patient's internal file entry number in EVT and loop through all of the patient's event records. For a CRO/ERD patient, kill all event records and their associated cross-references. For all other patients, kill only event records whose indicators begin with "2;", "6;", or "5;2", as well as and their associated cross-references.
(11) Get the current date in CUD, and put the ward date/time in EFD and EFDK.

(12) If the ward was changed (CHWF=1), set C=1, and build a ward transfer event record in ER. ER will be made up of EFD in the first piece, a "4" (record indicator) in the second piece, the old ward in the fifth piece, the new ward in the sixth, and CUD in the eighth piece. With ER built, do steps 22-25 to write the event record.
(13) Set both EFD and EFDK equal to DSDT.
(14) If the current date (CUD) is not equal to the date portion of EFD, set IND="5;7", SMERR=1791, and do steps 20-25 to write a text record stating that the disposition was cancelled on a date other than the one the patient was dispositioned on.
(15) If MDSDT does not exist, then this is not a newborn disposition cancellation. Go to step 19.
(16) Mother is not in hospital; newborn disposition cancellation must be to pay status. Get the current absent status pointer value in ABS and the patient category flags in FCAT. Set EFD and EFDK equal to MDSDT (mother's disposition date will be the effective date for the event records being created) and build the event record indicator in IND. IND will be made up of three pieces, separated by semicolons. The first piece will be a 1, indicating an admission event; the second piece will be the actual source of admission code; the third piece will be the first byte of FCAT.
(17) Now build the event record in ER. ER will be made up of EFD in the first piece, IND in the second piece, ABS in the third, the current clinical service pointer value in the fourth, the current ward pointer value in the sixth, and CUD in the eighth piece.
(18) Do steps 22-25 to write the event record. If the current date (CUD) is not equal to the effective date (EFD), set IND="5;1", SMERR=1501, and do steps 20-25 to write a record stating that the patient was admitted on a date other than the current date.
(19) Store ^SMSCR in DIC, kill all unnecessary variables, and return.

The following are special steps taken to write text and event records and their cross-references.

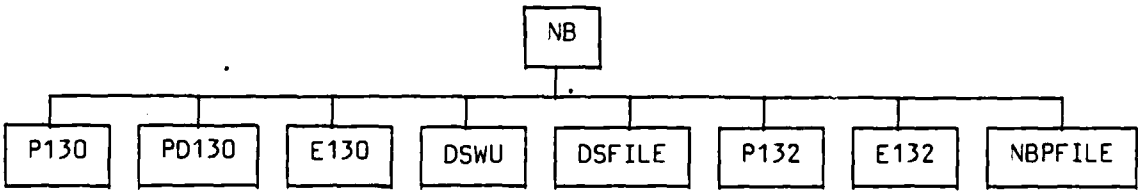
(20) Get the message in TEXT and set SMERR to 0. Swap the values of CUD and EFD (EFDK is also set to CUD).
(21) Build the event record in ER. ER will be made up of EFD in the first piece, IND in the second piece, TEXT in the seventh piece, and CUD in the eighth piece. Then set CUD back to the actual current date.
(22) Set DUP=0 and do CHT to ensure that this is not a duplicate record. DUP will be set to 1 if an exact match is found. If DUP=1 upon return, we do not want to write this event record, so return.
(23) Write the "DT" event record cross-reference, then the event record itself (ER).

(24) Get the zero node subfile record, if it exists, in DO. If it does not exist, create a new one in DO.
(25) Add 1 to the event record count (piece 4) in DO, and store DO back as the zero node subfile record. Return.

d. Output Variables:

Local: None
Globals updated: ^DIC(8000), ^DIC(8020)

1.2.4 Newborn Disposition (NB). The following chart shows the hierarchy of newborn disposition programs.



a. Purpose. The NB package of routines sequences through all the newborns for one mother requiring that each be dispositioned or put on pay status. This processing is initiated as a result of a mother's disposition or an active duty mother's change of status to convalescent leave.

Invoked by: AT, DS
Globals referenced: ^SMSCR(PADJ,8000.01,7) (mother's data)

b. Input Variables:

NBDSDT: newborn disposition date/time (set to mother's disposition date/time by DS or to mother's date/time of status change to CL by AT).

c. Processing Logic.

(1) Set variable NBDCLK to clerk of mother's disposition.
(2) Concatenate a string of baby(s) register numbers in variable NBREGS (from node 7 of mother's data). Set piece number variable NBCNT to 1.
(3) For each of up to 8 babies:
  (a) Get the register number in NBRGN from the NBREGS string. Get file entry number in NBPNT from register number cross-reference (^DIC(8000,"F",...)).
  (b) Set SMZ node 0 to node 0 of baby episode data.
  (c) Check disposition type field; if baby is already dispositioned or retained increment piece number in baby chain and go to step (a) to process next baby.
  (d) Load node 0 of baby's registration data in ^SMSCR and SMZ.
  (e) Convert baby's disposition date/time (NBDSDT; set by AT or DS) to display format in variable DD. Variable DD is the local variable displayed by painter ^P130.
  (f) Paint baby's initial disposition segment-baby's ID data and text of disposition screen - painter ^P130.
  (g) Read the user's selection (PAD utility ^PADSEL is not used in order to force the user to properly disposition or put each baby on pay status).

1.2.4.1 Newborn Disposition Consistency Editor (NBDC).

a. Purpose. The routine ^NBDC controls the editing of newborn disposition data to ensure that it is consistent.

Invoked by: E130

b. Input Variables: SMZ

c. Processing Logic.

(1) If disposition type is null, set error 1702.
(2) Load disposition type flag; if type is predisposition, set error 1713.
(3) Do standard disposition consistency edits (^DSC).

d. Output Variables:

Local: SMERR,
FCAT, FSA (from ^DSC)
FDT disposition flag, byte 1

1.2.4.2 Newborn Pay Status Consistency Editor (NBPC).

a. Purpose. The NBPC routine ensures that the new source of admission is a "pay status" source of admission.

Invoked by: E132
E107E

b. Input Variables: SMZ

c. Processing Logic.

(1) Set NBSAP to new source of admission (this value is subsequently used in ^NB and ^NBPFILE).
(2) If byte 1 of the flag for this source of admission does not indicate a pay status code, set error 1720. Display the error message and quit back to the entry program.

d. Output Variables:

NBSAP - newborn source of admission
SMERR

1.2.4:2 Newborn Pay Filer (NBPFILE).

a. Purpose. The NBPFILE routine stores the updated source of admission and creates the associated event(s) records for a newborn change to pay status.

Invoked by: ^NB

b. Input Variables:

NBRGN
NBPNT
NBSAP
NBDSDT
DT
PADJ

c. Processing Logic.

(1) Set local variable ARO to episode node 0. Concatenate in pay status source of admission. Restore node 0 to ^DIC.
(2) Store event record(s):
    (a) Build change to pay status event record. If an event record with this effective date key exists, compare events. If they are identical, system is in recovery, proceed with text record processing (step b). If the events are not identical, increment the effective date/time key by 1 minute and recheck to determine if this key exists and, if so, if the evets are identical. If and when a unique key is found, store the event record, the date/time cross-reference to it, and update the subfile node 0 fields.
    (b) If the effective date of this event is not today, build a text correction record. If an event record with this effective date exists, compare events. If they are identical, system is in recovery (this text record was already stored) and processing is complete--quit. If they are not identical, increment effective date/time key by 1 minute and loop to check if this key exists and, if so, if the events are identical . . . . If and when a unique key is found, store the text record, store the date/time cross-reference to it, and update the subfile node 0 fields.
(3) Exit.

d. Output Variables:

Local: None
Globlas: ^DIC(8000), ^DIC(8020)

1.2.4.4 Newborn Disposition Cancellation (NBX).

a. Purpose. The NBX routine sequences through all the newborns for one mother, allowing the user to cancel the disposition of any or all that were dispositioned.

Invoked by: DS
Globals referenced: ^SMSCR(PADJ,8000.01,7), ^DIC(8000), ^DIC(8020) (mother's data)

b. Input Variables:

NBDXDT: newborn cancellation date/time (set to mother's cancellation date/time)

c. Processing Logic.

(1) Set NBXCLK to clerk of mother's disposition cancellation.
(2) Concatenate a string of baby(s) register numbers in variable NBREGS (from node 7 of mother's data). Set piece number variable NBCNT to 1.
(3) For each of up to 8 babies:
(a) Get the baby's register number in NBRGN from the NBREGS string. Get the file entry number in NB PNT from register number cross-reference (^DIC(8000,"F"....)).
(b) Set SMZ *node 0 to node 0* of baby episode data.
(c) Check the record status flag. If the baby was not dispositioned, it must have been changed to retained/pay status, so the following steps must be taken:
1. Get the actual Source of Admission Code for the newborn in NBSA.
2. Search through the event records for this newborn to find the one for the retained/pay status admission (1 in piece 1 of indicator, NBSA in piece 2). If one can not be found, go to step 6.
3. Get the effective date/time for the event record in EFD and EFDK. If the date portion is not the same as today's date, write a text event record stating that the retained/pay status was cancelled due to the mother's disposition being cancelled. This is to note the change as a correction on the nightly A&D Report, and so is not necessary if it is the same day.
4. Kill the retained/pay status admission event record and cross-reference, and update the event record count. Look at the next event record to see if it is a text record that was associated with the just-killed admission record (a "5;1" indicator). If it is, kill it and the cross-reference, and update the event record count.

5. Get the Source of Admission code from the indicator of the newborn's first event record, which is the initial admission record, in IND. Use IND to look up the pointer value for the code, and save the pointer value in NBSAP. Replace the Source of Admission pointer in SMZ (Episode Record, Node, piece 5) with NBSAP and store the record.
6. Increment the piece number in the baby chain and go to step (a) to process the next baby.

(d) Kill nodes 1 and 7 in SMZ to clear out the mother's cancellation data. Load node 0 of baby's registration data in ^SMSCR and SMZ. Set SMLD so painter will not load SMZ (SMLD=1).

(e) Paint initial cancellation segment - baby's ID data and literals of cancellation screen - painter ^P135.

(f) Read the user's selection (PAD utility ^PADSEL is not used in order to force the user to make a decision whether or not to cancel this disposition).

(g) If the user enters "L" to leave the newborn dispositioned, increment NBCNT and go to step (a) to process the next newborn.

(h) Load baby's node 1 into SMZ. Load baby's node 7 into SMZ if it exists. Concatenate clerk's initials (NBXCLK) into node 7 of SMZ.

(i) Get the baby's internal event file number in EVT. Loop through the baby's event records until the disposition event record is found. Get the ward pointer value in W and concatenate W into node 0 of SMZ.

(j) Paint the cancellation segment (^PD135) to show ward information.

(k) Set ^PADCHN = "+" and do ^PADSEL to collect cancellation data.

(l) If the user cancels, clear the cancel flag and go to step (a).

(m) Do ^DSWU to add baby to bed occupied total in ward record. If the ward chosen is full, display error message and go to step (k).

(n) Set up recovery node ^SMSCR(PADJ,1)="RCDSX"_DT NBPNT_NBRGN CHWF SMDE(8000.01,"0;9") (if ward changed).

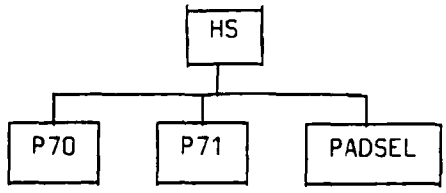
(o) Set variables DSPIN - baby's file entry number, DSRGN - register number and do standard cancellation filer ^DSXFILE.

(p) Kill recovery node, increment NBCNT to point to next baby, and go to step (a).

d. Output Variables:

Local: None
Globals updated: DIC(8020)

1.2.5 Inpatient History (HS). The following chart shows the hierarchy of Inpatient History programs.



a. Purpose. The History routines (HS*) are executed to review past and present summary admission data.

Invoked by: SO
Globals referenced: None

b. Input Variables: None.

c. Processing Logic.

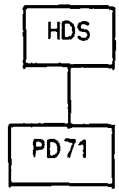
(1) Do program to paint fixed part of history screen.
(2) Do program to paint admission information on history screen.
(3) Do selection program (^PADSEL) for additional processing.

d. Output Variables:

Local: None
Global updated: ^SMSCR

e. PADSEL for History ($MEN=71):

If selection N or P



f. Compiled Painter Programs:

Program	Source
P70	Patient Header (History Screen)
P71	History Information Screen
PE71P	History Information Screen - data only

g. Compiled Entry Programs: Not applicable.

1.2.5.1 Inpatient History Next Episode (HSNX).

a. Purpose. The HSND routine finds the next or previous inpatient history episode. It loads the information to display into ^SMSCR and calls a painter program to display it.

Invoked by: PADSEL
Globals referenced: ^DIC

b. Input Variables:

EPNM
PADJ
SMPT
ZTA(

c. Processing Logic.

(1) Erase error message if previous selection caused error message to be printed
(2) If selection = "N" find next episode ($N from EPNM).
(3) If selection = "P" start at first episode, saving each number in X. When next episode number (Y) equals EPNM (current episode displayed), use last saved episode number (X).
(4) Print error message if there is no next or previous episode.
(5) Set EPNM and load episode data into ^SMSCR.
(6) Do PD71 to repaint data on screen.

d. Output Variables:

Local: EPNM, SMLD
Global updated: SMSCR

e. PADSEL. Not applicable.

f. Compiled Painter Program:

Program	Source
PD71	History Information Screen

g. Compiled Entry Program. Not applicable.

1.2.6 Utilities.

1.2.6.1 Selection Processing (PADSEL).

a. Purpose. The routine ^PADSEL reads the selection field, validates it and, of selection table processing is defined for the current screen, initiates the defined processing.

Invoked by: any application program
Global referenced: ^SMDEF

b. Input Variables:

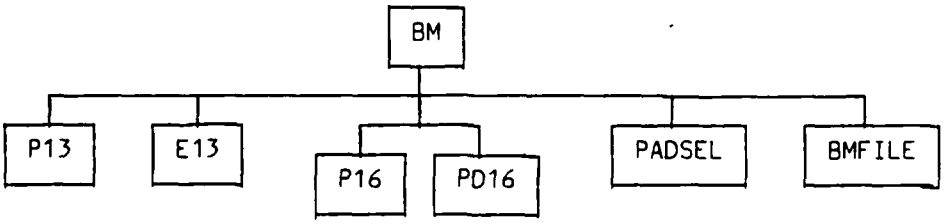
PADCHN	user has passed a selection to PADSEL to be selection processed; read will not be performed
PADSEL	user's previous selection
SMEN	screen entry number for current selection table

c. Processing Logic.

(1) Set SMST - default field number to start entry (conditionally, may be reset later).
(2) Load top level node of selection screen.
(3) If PADCHN exists and is not null, use first ;piece as selection and piece it out of PADCHN. Otherwise, get X and Y coordinates for selection field, clear the line, and read the selection. If the selection is CTRL P to print screen, do SMSPR and reread selection. If selection is !, set cancel (SMCAN) and exit. If selection is ?, display canned help message. If user entered "1" (bar - used for program selection), display error and reread.
(4) If selection is not alphanumeric, display error message and reread.
(5) If selection contains "1" or this is a menu screen, process with selection table (7 below).
(6) If selection starts with an alphabetic character:
    (a) If it is not "+" set selection in SMLB to restrict entry. If not a display-only screen, set up entry parameters, DQ, NDQ, SMST (if passed by application), and NOW. Do entry program. On return from entry, if user has cancelled, exit. If error, display. Go to reread selection.
(7) If selection not in selection table, display error and reread.
(8) Get selection node.
(9) If there is a painter defined and current screen is not that screen, paint. Set up parameters for entry.
(10) Save selection in PADSEL.
(11) If piece 2 is not the current screen, do it. Reset SMST. Reread selection.

d. Output Variables: SMCAN, PADSEL

1.2.7 Bed Management (BM). The following chart shows the hierarchy of Bed Management programs.



a. Purpose. The Bed Management routines (BM*) are executed to maintain figures on the number of beds that are occupied or available on each ward. Bed Management is used to create, update or delete ward status records.

Invoked by: SO
Globals referenced: ^SMSCR, ^DIC(8010)

b. Input Variables: PADJ, PADFNC, PADTRN, PADI

c. Processing Logic.

(1) Clear line 23.
(2) Paint BMID Screen (D P13, E13).
(3) Quit if user cancels or nothing is entered.
(4) If "TOT" is entered for ward ID, calculate the number of total blocked beds and available beds.
(5) If ward entered does not exist (adding a new ward), set PADCHN, lock the ward record.
(6) If ward entered exists, load data into SMSCR and SMZ; calculate the number of total blocked beds and available beds; lock the ward record.
(7) Display ward/TOT data (D P16 or PD16).
(8) D PADSEL.
(9) Quit if user cancels.
(10) If user chooses to view next record (selection 1), unlock the previous ward record, nexting through cross-reference to get next record; quit if next record does not exist; else go back to step 6.
(11) If user chooses to delete the record (selection 2), calculate the number of total blocked beds. If total blocked beds does not equal to 0, ask for confirmation to delete; if not confirmed, go to step 8.
(12) Set up ^SMSCR(PADJ,1) for recovery.
(13) D BMFILE.

d. Output Variables:

Local: PADCAN
Globals updated: ^DIC(8010.0)

e. PADSEL. Not applicable.

f. Compiled Painter Programs:

Program	Source
P13	Ward ID screen
P16	Ward record display screen
PD16	Data display for ward record

g. Compiled Entry Programs:

Program	Source
E13	Ward ID
E16	Ward record

1.2.7.1 Bed Management Consistency Editor (BMC).

a. Purpose. This BMC routine is to edit ward status data and do the filing.

Invoked by: E16
Global referenced: ^DIC(8010)

b. Input Variables: PADSEL, SMCAN

c. Processing Logic.

(1) Clear line 23.
(2) If no data entered, quit.
(3) If the calculated total available beds is less than 0, set SMERR, display error message, and quit.
(4) Display data, set ^SMSCR, and quit.

d. Output Variables:

Local: BMLB, BMAUB
Global updated: ^DIC(8010)

1.2.7.2 Bed Management Filer (BMFILE).

a. Purpose. The BMFILE routine will file the ward status record.

Invoked by: BM
Global referenced: ^DIC(8010)

b. Input Variables: PADSEL, WARD, PTR

c. Processing Logic.

(1) If PADSEL = 2, delete ward record and its cross-reference, update DIC (8010,0), and quit.
(2) If ward record does not exist (adding a ward), set pointer (PTR) to the next available entry from DIC(8010,0); lock DIC(8010,0), increment pieces 3 and 4 of DIC(8010,0) by 1.
(3) Load SMSCR into data base, set up cross-reference, and quit.

d. Output Variables:

Local: None
Global updated: ^DIC(8010)

Appendix B

CONSISTENCY EDITS

1.1 Registration Consistency Editor (RGC). The following edits are performed based on the branch of service in profile record.

Applicable Service	Edits
1. A,F,N	SSN cannot be all null.
2. A,F,N	Sponsor (FFMP byte 1 = 3) must have a sponsor type of patient category (the 2nd digit of FCAT is 1). (Error 1001).
3. A,F,N	Dependent (FFMP byte 1 = 1) must have a dependent type of patient category (the 3rd digit of FCAT is 1) and vice versa. (Error 1001).
4. A,F,N	Civilian emergency (FFMP byte 1 = 2) must have a civilian emergency type of category (the 4th digit of FCAT is 1). (Error 1001).
5. A,F,N	Active duty or retired member of the uniformed services must be at least 16 years old for Air Force and 17 years old for Navy and Army. (If the 2nd digit of FCAT is 1 then check DOB against current date). (Error 1002).
6. A,F,N	Mother and mother-in-law of sponsor (FMP is 40 or 50) must be female. (Error 1003).
7. A,F,N	Father and father-in-law of sponsor (FMP is 45 or 55) must be male. (Error 1003).
8. A,F,N	Children (FMP is 01 through 19) cannot have marital status of married (M), interlocatory (I) or separated (L). (Error 1004).
9. A,F,N	A spouse (FMP is 30) cannot have a marital status of annulled (A), divorced (D) or single (S). (Error 1004).
10. A,F,N	Spouse of deceased sponsor (FMP is 30 and the 2nd and 3rd digits of CAT is 43 or 44) must have marital status of widowed (W) or unknown (U). (Error 1004).
11. F	AFSC must be entered for all active-duty Air Force. (If 1st digit of CAT is "F" and the 1st digit of FCAT is 1, then the 4th through 6th digits of military occupation must be numeric.) (Error 1005).
12. F	Aviation service code is entered only for active duty personnel. (If aviation service code is not null, then the 1st character of FCAT must be 1 and the 1st character of CAT must be "F".) (Error 1006).

Applicable Service	Edits
13. A,F,N	If sponsor (first byte of FFMP = 3) and the sponsor name is entered, then the sponsor name must be the same as the patient name. If sponsor, and the sponsor name is blank, default the sponsor name to the patient name. (Error 1007).
14. A,F,N	Rank must be entered for active duty or retired member of the uniformed services. (If 1st digit of FCAT is 1 or 2, the rank cannot be blank or "CIV".) (Error 1008, 1018). Rank must be consistent with patient category (Error 1018).
15a. A	If Army officer (A11, A21, A23, A26, A31, A33, A41), Army branch of service must be entered (Error 1023). If foreign military (patient category "S..."), service must be entered (Error 1025). If not Army officer or foreign military, field should be blank (Error 1024).
15b. F,N	Service must be entered (Error 1026).
16. F	The major command must be entered for all AF extended active-duty and training personnel (the 5th digit of FCAT is 1) (Error 1009).
17. A,F,N	If the permanent active flag is changed to "N", default the date in which patient placed on inactive status to the current date.
18. A,F,N	If the permanent active flag is "Y", blank out the date in which patient placed on inactive status.
19. A,F	If FMP is 20, the UNIT ID/SHIP is defaulted to the sponsor's duty zip code. If FMP is not 20, the UNIT ID/SHIP is defaulted to the patient's zip code. If UNIT ID/SHIP is blank after default, then it is an error (Error 1103, 1111).
20a. A	Flying status indicator must be entered (Error 1144).
20b. N	If the flying status indicator is not blank, then the patient category must be active Navy or Marine personnel (the first digit of FCAT is 1 and the first character of CAT is "N" or "M", and CAT is not = N13) (Error 1010.)
21. A	If patient is active-duty Army, Navy, Air Force, or Marine personnel, then aeronautical rating must be entered (Error 1011.)

Applicable Service	Edits
22. N	If FMP is 20 and the sponsor's pay grade is 07-11, then one of the command interest fields must be VIP (Error 1012).
23. N	If FMP is 20 and the 1st 5 characters of UIC equals the MTF code, then one of the command interest fields must be STF (Error 1022).
24. N	If patient is an active duty Navy or Marine personnel (the 1st digit of FCAT is 1 and the 1st character of CAT is "N" or "M"), then the UIC cannot be null (Error 1013.)
25. N	If patient is an active duty Navy or active duty enlisted Marine personnel (the 1st digit of FCAT is 1 and the 1st digit of CAT is "N" or "M" and CAT is not = N13, N14, M14 or M22), then the military occupation cannot be blank (Error 1014).
26. N	If patient is an active-duty Marine (the 1st digit of FCAT is 1 and the 1st digit of CAT is "M" and CAT is not = M14 or M15), or patient is an active-duty Navy officer (the 1st digit of FCAT is 1 and the 1st digit of CAT is "N" and CAT is not = N13 or N14 and the pay grade is 01-11 or 21-24), then the military occupation must be numeric (Error 1015).
27. N	If patient is an active duty Navy enlisted personnel (the 1st digit of FCAT is 1 and the 1st digit of CAT is "N" and CAT is not = N13 or N14 and the pay grade is 31-39), then the military occupation must not be numeric (Error 1016).
28. N	All non-active-duty military patients (the 1st digit of FCAT is not = 1 or the 1st digit of FCAT is = 1, but 1st digit of CAT is not = "N", "M", "A", or "F") must have a patient address. (The alphanumeric fields of the patient address cannot be null and the zip code cannot be null or zeroes.) (Error 1020, 1100, 1101, 1102, 1103.)
29. N	If this is an active-duty or retired uniformed services patient (the 1st digit of FCAT is 1 or 2), the ID card number must be blank (Error 1017).

Applicable Service	Edits
30. N	Active-duty Air Force or Army patient (the 1st digit of FCAT is 1 and the 1st digit of CAT is "A" or "F") must have a military address. (The alphanumeric fields of the duty address cannot be null and the zip code cannot be null or zeroes.) (Error 1021, 1108, 1109, 1110, 1111.)
31. N	If sponsor's rank is "M1" (Air Cadets), the patient category must be "A13", "F13", "M13", "N13" or "P13" (Error 1018).
32. N	If sponsor's rank is "C1" (Academy Cadets), the patient category must be "M14" or "N14" (Error 1018).

1.2 Admission Consistency Program - Primary Admission Data (ATC).

Applicable Service	Edits
1. A,F,N	The Source of Admission can't be changed to Retained and can't be changed unless it was Preadmit. (Error 1400, 1402).
2. A,F,N	Non-military personnel can only have a Type Case of Disease or Injury. (Error 1403).
3. A,F,N	Non-military personnel must have a non-military Source of Admission. (Error 1407).
4. A,F,N	Non-military personnel must have a non-military Clinical Service. (Error 1408).
5. A,F,N	Non-military personnel can't have a Length of Service. (Error 1404).
6. A,F,N	Non-military personnel can't have a military Absent Status. (Error 1406).
7. A,F,N	Military personnel must have a Length of Service. (Error 1409).
8. A,F,N	If the Source of Admission is Absent Sick, CRO, ERD or quarters; then the Clinical Service must be the same. (Error 1410).
9. A,F,N	If the Clinical Service is military, then the Patient Category must be military. (Error 1426).
10. A,F,N	MEB Candidate can't be entered if not active duty. (Error 1405).
11. A,F,N	The initial MEB Status can't be removed. (Error 1452).
12. A,F,N	If the Clinical Service is ACA or ACB , then the Patient Sex must be female. (Error 1427).
13. A,F,N	If the Absent Status is Absent Sick, CRO, ERD or Quarters; then the Clinical Service must be the same. (Error 1411).
14. A,F,N	If Source of Admission is not Preadmit, Absent Status must be entered. (Error 1443).
15. A,F,N	Initial Clinical Service Date/Time must be the same as Date/Time Admission. (Error 1474).

Applicable Service	Edits
16. A,F,N	Initial Absent Status Date/Time must be the same as Date/Time Admission. (Error 1475).
17. A,F,N	Ward Date/Time must be after previous Absent Status Date/Time. (Error 1457).
18. A,F,N	If Absent Status is changed, it must be changed from status in to status out or vice versa. (Error 1448).
19. A,F,N	Must enter date and time when Ward changes. (Error 1471).
20. A,F,N	If and only if the Source of Admission is Newborn or Retained, the Clinical Service is Nursery. (Error 1419).
21. A,F,N	If the Source of Admission is Newborn or Retained, then the Patient Category must be Dependent or Civilian Emergency. (Error 1432).
22. A,F,N	If the Casualty Status is SC, III, SI or VSI; then the Absent Status must be BO. (Error 1418).
23. A,F,N	Must enter time for Admission Date/ Time, unless Source of Admission is Preadmit. (Error 1478).
24. A,F,N	Can't use future Admission Dates/Times, unless Source of Admission is Preadmit. (Error 1477).
25. A,F,N	Can't use future Attending Physician Date Assigned, unless Source of Admission is Preadmit. (Error 1479).
26. A,F,N	Must enter time for Clinical Service Date/Time, unless Source of Admission is Preadmit. (Error 1482).
27. A,F,N	Can't enter future Clinical Service Date/Time, unless Source of Admission is Preadmit. (Error 1480).
28. A,F,N	Can't enter future Ward Date, unless Source of Admission is Preadmit. (Error 1481).
29. A,F,N	If this is a bed day (Absent Status), and Source of Admission is not Preadmit, then the Ward must be entered. (Error 1425).
30. A,F,N,	If this is a bed day (Absent Status), and Source of Admission is not Preadmit, then the Ward Date/Time must be entered. (Error 1471).

Applicable Service	Edits
31. A,F,N	If this is a bed day (Absent Status) and Source of Admission is not Preadmit, then the time must be entered for Ward Date/Time. (Error 1488).
32. A,F,N	If this is a bed day (Absent Status), and Source of Admission is not Preadmit, then the Attending Physician must be entered. (Error 1425).
33. A,F,N	Must enter Attending Physician Date with Attending Physician. (Error 1473).
34. A,F,N	Initial Ward Date/Time must be the same as Date/Time Admission. (Error 1476).
35. A	Absent Status of PV can't be changed. (Error 1449).
36. A	If the Clinical Service is Pediatrics, then the Patient age can't be over 17 years old. (Error 1421).
37. A	If not at war, then Casualty Status can't be Battlefield Casualty. (Error 1423).
38. F	If not active duty military, then the Meal Card can't be entered. (Error 1417).
39. F	If enlisted active duty military, then the Meal Card must be entered. (Error 1420).
40. F	If and only if the Source of Admission is Newborn or Retained, then the Registration Number Suffix is entered. (Error 1430, 1431).
41. N	If the Clinical Service is Pediatrics, then the age can't be over 21. (Error 1422).
42. A,F	If and only if the Patient Category is Active Duty, then the Expired Term of Service is entered. (Error 1414, 1415).
43. A,F	If Med Hold is entered then Patient Category must be Active Duty Military. (Error 1412).
44. A,N	Register Number must be all numeric characters. (Error 1413).
45. A,F,N	Expired Term of Service Date indicates patient is ineligible for treatment. (Error 1416).
46. A,F,N	Ward is not consistent with Clinical Service. (Warning 1441)

Applicable Service	Edits
47. A	Age minus Length of Service less than 18 years. (Warning 1442).
48. A,F,N	Patient may not be readmitted the same day as the last disposition date. (Warning 1489).
49. F	Mother is unavailable. (Error 19 96).

1.2.1 Entrance Data Segment (ATEC).

Applicable Service	Edit
1. A,F,N	If the Projected Disposition date is entered, then it cannot be less than the Admission Date. (Error 1424).

1.2.2 Mother's Consistency Editor (ATIC).

	Applicable Service	Edits
1.	A,F,N	Mother's Register Number required. (Error 1434).
2.	A,F,N	No patient on file with Mother's Register Number. (Error 1435).
3.	A,F,N	Newborn's mother must not be dispositioned. (Error 1433).
4.	A,F,N	Mother must be female. (Error 1436) .
5.	A,F,N	Newborn's mother must have IN Absent Status.
6.	A,F	Mother's SSN must be the same as baby's SSN. (Warning 1437).
7.	N	Mother's SSN must be the same as baby's SSN. (Error 1437).
8.	A,N	Mother's file in use (Error 1996).

1.2.3 Transfer-in Consistency Editor (AT2C).

Applicable Service	Edits
1. A,F,N	Source of Admission must be transfer-in to enter transfer-in data. (Error 1486).
2. A,F,N	Initial Admission MTF must be entered on a transfer. (Error 1459).
3. A,F,N	Date of Initial Admission must be entered on a transfer. (Error 1460).
4. A,F,N	Military Transfer-In Date can't be greater than Date of Admission. (Error 1461).
5. F	Clinical Service must be CRO if Initial Admission MTF is CRO. (Error 1462).

1.2.4 Emergency Consistency Editor (AT3C).

Applicable Service	Edits
No Edits Currently Performed	

1.2.5 Injury Consistency Editor (AT4C).

Applicable Service	Edits
1. N	If Cause of Injury Text and Code are blank, On-Duty Flag must be blank. (Error 1469).
2. N	If Cause of Injury Code and Text are entered, On-Duty Flag must be entered. (Error 1470).

1.2.6 Absent Status Consistency Editor (AT5C).

	Applicable Service	Edits
1.	A,F,N	Absent Status required for other than Preadmit. (Error 1443).
2.	A.F.N	If Absent Status entered, Effective Date/Time must be entered. (Error 1450).
3.	A,F,N	Must enter both date and time for Absent Status Effective Date and Time. (Error 1483).
4.	A,F,N	Can't enter future date and time for Absent Status Effective Date and Time, unless the Source of Admission is Preadmit. (Error 1484).
5.	A,F,N	Clinical Service doesn't agree with Absent Status. (Error 1411).
6.	A,F,N	Absent Status must be BO for Casualty Status of SC, III, SI or VSI. (Error 1418).
7.	A,F,N	Ward and Attending Physician must be entered for active inpatient. (Error 1425).
8.	A,F,N	Absent Status Date/Time must agree with Ward Date/Time. (Error 1472).
9.	A,F,N	Can't change Effective Date and Time without changing Absent Status. (Error 1438).
10.	A	Absent Status of PV can't be changed (Error 1449).
11.	A,F,N	Absent status can only be changed from IN to OUT or OUT to IN. (Error 1448).
12.	A,F,N	Can't change Absent Status without changing Effective Date and Time. (Error 1439).
13.	A,F,N	New Effective Date and Time must be after previous Effective Date and Time. (Error 1440).
14.	A,F,N	Return Date and Time must be entered unless the Absent Status is Bed Occupant, Carded-for-Record Only, PCS VA Hospital Pending Separation/Retirement, or Absent Sick Non-Military MTF. (Error 1444).

Applicable Service	Edits
15. A,F,N	For Absent Status of Absent Sick, Non-military Hospital Data must be entered. (Error 1447).
16. A,F,N	Return Date and Time not allowed for Bed Occupant. (Error 1445).
17. A,F,N	Return Date and Time can't be less than Effective Date and Time. (Error 1446).

1.2.7 Casualty Status Consistency Editor (AT6C).

Applicable Service	Edits
1. A,F,N	Must enter Casualty Status to enter casualty data. (Error 1463).
2. A,F,N	Must enter Casualty Diagnosis and Prognosis when entering casualty data. (Error 1465).
3. A,F,N	Must have prior Casualty Status to be Removed from Roster. (Error 1464).
4. A,F,N	Casualty Status must be removed if Date Removed from Casualty Status is entered (Error 1466).
5. A,F,N	Date Removed From Casualty Status must be after Date Placed On Casualty Status (Error 1467).
6. A,F,N	Absent Status must be BO for Casualty Status of SC, III, SI or VSI. (Error 1418).

1.2.8 MEB Consistency Editor (AT7C).

Applicable Service	Edits
1. A,F,N	MEB data can't be entered unless MEB Status is entered. (Error 1451).
2. A,F,N	MEB Candidate can't be entered if not active duty. (Error 1405).
3. A,F,N	Must have prior MEB Status to be Resolved. (Error 1452).
4. A,F,N	Date MEB Candidate Confirmed must be entered if MEB Status is Confirmed or Resolved. (Error 1453).
5. A,F,N	Date MEB Candidate Confirmed can't be entered if MEB Status is not Confirmed or Resolved. (Error 1454).
6. A,F,N	Can't enter Date Resolved if MEB Candidate is not Resolved. (Error 1487).
7. A,F,N	Can't enter future date for Date Identified, unless Source of Admission is Preadmit. (Error 1485).
8. A,F,N	Date MEB Candidate Confirmed must be after Date MEB Candidate Identified. (Error 1455).
9. A,F,N	Date MEB Candidate Resolved must be entered if MEB Status is Resolved. (Error 1456).
10. A,F,N	Date MEB Candidate Resolved must be after Date MEB Candidate Confirmed. (Error 1458).

1.2.9 Cancel Consistency Editor (AT8C).

Applicable Service	Edits
1. A,F,N	Source of Admission can only be changed to Preadmit or Cancel on Cancel Screen. (Error 1402).
2. A,F,N	Authorizing Physician and Reason must be entered to cancel admission. (Error 1468).

1.3 Disposition Consistency Editor (DSC). The following edits are performed for all military departments.

Edits

1. Type of disposition must be entered. (Error 1702).

2. Disposition date/time must be entered. (Error 1703).

3. If this is not a "TRANSFER" disposition type, then the disposition MTF can not be entered. (Error 1706).

4. If this is a "TRANSFER" disposition type, then the disposition MTF must be entered. (Error 1707).

5. If this is a "MILITARY ONLY" disposition type, then the patient must have an "ACTIVE DUTY" patient category. (Error 1704).

6. If this is a "CIVILIAN ONLY" disposition type, then the patient must not have an "ACTIVE DUTY" patient category.

7. If this is not a "NEWBORN" source of admission, then the disposition type must not be for a newborn.

8. If this is a "NEWBORN" source of admission, then the disposition type must be flagged valid for newborns. (Error 1713).

9. Disposition time must be entered. (Error 1708).

10. Disposition date/time can not be less than admission date/time. (Error 1710).

11. If this is a "DEATH" disposition type, the disposition date can not be greater than the current date. (Error 1705).

12. If this is not a predisposition, the disposition date/time can not be greater than the current date/time. (Error 1711).

13. If this is a "CRO" or "ERD" source of admission, the disposition date/time must be equal to the admission date/time. (Error 1712).

14. If this is a "RETAINED" source of admission, the disposition date/time cannot be less than the retained effective date/time. (Error 1714).

15. If this is a same day admission/disposition, the disposition date must equal the admission date. (Error 1715).

Edits

16. If this is not a "CRO" or "ERD" source of admission, the disposition date/time cannot equal the admission date/time. (Error 1716).

17. The disposition date/time cannot be less than the current absent status date/time. (Error 1717).

18. The disposition date/time cannot be less than the current clinical service assigned date/time. (Error 1718).

19. Physician ordering disposition must be entered. (Error 1709).

1.3.1 Disposition Cancellation Consistency Editor (DSXC).

Edits

1. If the ward has been changed (CHDF=1), the ward date/time must also have been changed (CHWF=1), and vice versa. (Error 1722).

2. If the ward date/time is changed, the ward time must be entered. (Error 1471).

3. Physician authorizing cancellation and reason for cancellation must both be entered. (Error 1723).

4. Ward can be entered only for an "IN" absent status (FAS= 1). (Error 1724).

5. The ward cannot be entered for an "OUT" absent status (FAS=2). (Error 1725).

1.3.1.1 Newborn Disposition Consistency Editor (NBDC).

Edits

1. Disposition type cannot be null. (Error 1702.)
2. Disposition type cannot be predisposition. (Error 1713.)
3. All other disposition edits apply (see section 1.3.1).

1.3.1.2 Newborn Pay Status Consistency Editor (NBPC).

Edits

1. Source of admission must indicate pay status. (Error 1720.)

Appendix C

SYSTEM TABLES

LIST OF SYSTEM TABLES

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RELIGION (table) LIST

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RELIGION CODE	DESCRIPTION	SVC FLAG
ABC	AMERICAN BAPTIST CHURCH	AFN
AGC	ASSOCIATED GOSPEL CHURCHES	AFN
AGN	AGNOSTIC	AFN
AOG	ASSEMBLY OF GOD	AFN
ATH	ATHEIST	AFN
BAP	BAPTIST CHURCHES, OTHER	AFN
BCD	BRETHREN CHURCH - DUNKERS	AFN
BIC	BRETHREN IN CHRIST	AFN
BUD	BUDDHISM	AFN
CAT	ROMAN CATHOLIC	AFN
CND	CHRISTIAN NON-DENOMINATIONAL	AFN
COC	CHURCH OF CHRIST	AFN
COG	CHURCH OF GOD	AFN
CSC	CHRISTIAN SCIENCE	AFN
DOC	DISCIPLES OF CHRIST	AFN
EPI	EPISCOPAL CHURCH	AFN
EVC	EVANGELICAL CHURCH	AFN
FRN	FRIENDS - QUAKERS	AFN
FWB	FREEWILL BAPTIST CHURCH	AFN
GOC	GRACE GOSPEL CHURCH	AFN
HIN	HINDU	AFN
JEW	JEWISH	AFN
JWI	JEHOVAH WITNESS	AFN
LDS	JESUS CHRIST OF LATTER DAY SAINTS (MORMONS)	AFN
LMS	LUTHERN, MISSOURI SYNOD	AFN
LUT	LUTHERN	AFN
MET	METHODIST	AFN
MUS	MUSLIN	AFN
NAZ	NAZARENE	AFN
NRP	NO PREFERENCE	AFN
ORT	ORTHODOX	AFN
OTH	OTHER	AFN
PBT	PRESBYTERIAN	AFN
PEN	PENTOCOSTAL	AFN
PND	PROTESTANT NON-DENOMINATIONAL	AFN
POC	PROTESTANT OTHER CHURCHES	AFN
REF	REFORMED CHURCH	AFN
SBP	SOUTHERN BAPTIST	AFN
SDA	SEVENTH DAY ADVENTIST	AFN
SVC	SALVATION ARMY	AFN
UMO	UNITED METHODIST	AFN
UNI	UNITED CHURCH	AFN
UNK	UNKNOWN	AFN
UNU	UNITARIAN UNIVERSALIST	AFN

MTF (MEDICAL TREATMENT FACILITY) LIST — MAR 26,1985 09:58 — PAGE 1

PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
1001	WALTER REED AMC, WASHINGTON DC 20301		A
1011	PROV RES HOSP, FT DRUM, NY		A
1021	DEWITT ACH, FT BELVOIR, VA		A
1031	WOMACK ACH, FT BRAGG, NC		A
1041	CUTLER ACH, FT DEVENS, MA		A
1051	USAF HOSPITAL, DOVER AFB, DE		F
1051	WALSON ACH, FT DIX, NJ		A
1061	MCDONALD ACH, FT EUSTIS, VA		A
1071	IRELAND ACH, FT KNOX, KY		A
1081	KENNER ACH, FT LEE, VA		A
1091	KIMBROUGH ACH, FT MEADE, MD		A
1111	PATTERSON ACH, FT MONMOUTH, NJ		A
1121	KELLER ACH, WEST POINT, NY		A
1131	HAWLEY ACH, FT BENJAMIN HARRISON, IN		A
1201	FITZSIMONS AMC, DENVER, CO		A
1211	USACH, FT CARSON, CO		A
1221	MUNSON ACH, FT LEAVENWORTH, KS		A
1231	GEN LEONARD WOOD ACH, FT LEONARD WOOD, MO		A
1241	IRWIN ACH, FT RILEY, KS		A
1251	USACH, FT SHERIDAN, IL		A
1252	USAF RGN HOSP, EGLIN AFB, FL 32542		F
1253	AF RGN HOSP, MACDILL AFB, FL 33608		F
1256	USAF HOSP, PATRICK AFB, 32925		F
1258	USAF HOSP, TYNDALL AFB, FL 32403		F
1261	PROV RES HOSP, FT MCCOY, WI		A
1263	USAF HOSP, HOMESTEAD AFB, FL 33039		F
1301	EISENHOWER AMC, FT GORDON, GA		A
1311	MARTIN ACH, FT BENNING, GA		A
1321	BLANCHFIELD ACH, FT CAMPBELL, KY		A
1331	MONCRIEF ACH, FT JACKSON, SC		A
1341	NOBEL ACH, FT MCCLELLAN, AL		A
1351	FOX ACH, REDSTONE ARSENAL, AL		A
1355	USAF HOSPITAL, MOODY AFB, GA 31601		F
1356	USAF HOSPITAL, ROBINS AFB, GA 31098		F
1361	LYSTER ACH, FT RUCKER, AL		A
1371	USACH, FT STEWART, GA		A
1401	BROOKE AMC, FT SM HOUSTON, TX		A
1411	DARNALL ACH, FT HOOD, TX		A
1421	USACH, FT POLK, LA		A
1431	REYNOLDS ACH, FT SILL, OK		A
1501	WM BEAUMONT AMC, BT BLISS, TX		A
1511	BLISS USACH, FT HUACHUCA, AZ		A
1551	USAF CLINIC, HICKMAN AFB, HI 96853		F
1601	LETTERMAN AMC, SF, CA		A
1611	SILAS B HAYS ACH, FT ORD, CA		A
1631	WEED ACH, FT IRWIN, CA		A
1651	AF HSP, MOUNTAIN HOME AFB, ID 83648		F
1701	MADIGAN AMC, FT LEWIS, WA		A
1752	USAF HOSP, CHANUTE AFB, IL 61868		F
1756	USAF MED CTR, SCOTT AFB, IL 62225		F
1854	USAF CLINIC, GRISSOM AFB, IN 46971		F
2057	USAF HOSP, MCCONNEL AFB, KS 67221		F
2251	USAF HOSP, ENGLAND AFB, LA 71301		F
2252	USAF HOSP, BARKSDALE AFB, LA 71110		F
	ENGLAND AFB, LA (IAC) 71301		F

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PRIMARY CARE MTF	DESCRIPTION*	FLAGS	SERVICE FLAG
2451	MALCOLM GROW MED CTR, ANDREWS AFB, WASH DC 20331		F
2551	USAF CLINIC, HANSCOM AFB, MA 01731		F
2652	USAF HOSP, WURTSMITH AFB, MI 48753		F
2656	USAF HOSP, K I SAWYER AFB, MI 49843		F
2851	USAF HOSP, COLUMBUS AFB, MS 39701		F
2853	USAF MED CTR, KEESLER AFB, MS 39534		F
2954	USAF HOSP, WHITEMAN AFB, MO 65305		F
3051	USAF HOSP, MALSTROM AFB, MT 59402		F
3151	EHRLING BERQUIST USAF RGN HOSP, OFFUTT AFB, NE 68113		F
3251	USAF HOSP, NELLIS AFB, NV 89191		F
3352	USAF HOSP, PEASE AFB, NH 03801		F
3453	USAF CLINIC, MCGUIRE AFB, NJ 08641		F
3551	USAF HOSP, HOLLOMAN AFB, NM 88330		F
3552	USAF HOSP, KIRTLAND AFB, NM 87117		F
3554	UASF HOSPITAL, CANNON AFB, NM 88101		F
3557	49 TAC HOSP, HOLLOMAN AFB, NM (TAC) 88330		F
3653	USAF HOSP, GRIFFISS AFB, NY 13441		F
3663	USAF HOSP, PLATTSBURGH AFB, NY 12903		F
3752	USAF CLINIC, POPE AFB, NC 28308		F
3753	USAF HOSP, SEYMOUR JOHNSON AFB, NC 27531		F
3851	USAF HOSP, GRAND FORKS AFB, ND 58205		F
3852	USAF RGN HOSP, MINOT AFB, ND 58701		F
3954	USAF MED CEN, WRIGHT-PATTERSON, WPAFB, OH 45433		F
4052	USAF HOSP, TINKER AFB, OK 73145		F
4053	USAF CLINIC, VANCE AFB, OK 73701		F
4057	USAF HOSPITAL, ALTUS AFB, OK 73521		F
4552	USAF RGN HOSP, SHAW AFB, SC 29152		F
4553	AF CLINIC, CHARLESTON AFB, SC 29404		F
4554	AF HOSP, MYRTLE BEACH AFB, SC 29577		F
4555	354 TAC HOSP, MYRTLE BEACH AFB, SC (TAC) 29152		F
4651	USAF HOSP, ELLSWORTH AFB, SD 57706		F
4852	USAF HOSP, BERGSTROM AFB, TX 78743		F
4855	USAF CLINIC, BROOKS AFB, TX 78235		F
4857	AF RGN HOSP, CARSWELL AFB, TX 76127		F
4860	AF CLINIC, GOODFELLOW AFB, TX 76908		F
4864	USAF CLINIC, KELLY AFB, TX 78241		F
4865	WILFORD HALL MED CTR, LACKLAND AFB, TX 78236		F
4868	AF CLINIC, RANDOLPH AFB, TX 78148		F
4869	USAF HOSP, REESE AFB, TX 79489		F
4871	AF RGN HOSP, SHEPPARD AFB, TX 76311		F
4877	USAF HOSP, LAUGHLIN AFB, TX 78840		F
4879	USAF HOSPITAL, DYESS AFB, TX 79607		F
4951	USAF HOSPITAL, HILL AFB, UT 84406		F
5151	USAF HOSP, LANGLEY AFB, VA 23665		F
5152	1ST TAC HOSP, LANGLEY AFB, CA (TAC) 23655		F
5351	USAF HOSP, FAIRCHILD AFB, WA 99011		F
5354	USAF CLINIC, MCCHORD AFB, WA 98438		F
5652	USAF HOSP, F E WARREN AFB, WY 82001		F
0055	VETERANS HOSPITAL (CONUS)		F
0066	ALL OTHER NON-MILITARY HOSPITALS (CONUS)		F
0071	WALTER REED AMC, WASHINGTON, DC 20301		F
0072	BROOKE AMC, FT SAM HOUSTON, TX 78234		F
0073	WILLIAM BEAUMONT AMC, FT BLISS, TX 79920		F
0074	FITZSIMONS AMC, DENVER, CO 80045		F
	[illegible] AMC, SAN FRANCISCO, CA 94129		F

MTF (MEDICAL TREATMENT FACILITY) LIST

PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
0077	ALL OTHER ARMY FACILITIES		F
0081	US NAVAL HOSP, ST ALBANS		F
0082	US NAVAL HOSP, PHILADELPHIA, PA 19112		F
0083	US NAVAL HOSP, GREAT LAKES, IL 60088		F
0084	US NAVAL HOSP, SAN DIEGO, CA 92133		F
0085	US NAVAL HOSP, CHELSA		F
0086	US NAVAL HOSP, PORTSMOUTH, VA 23708		F
0087	US NAVAL HOSP, CHARLESTON, SC 29408		F
0088	ALL OTHER NAVY FACILITIES (CONUS)		F
0099	CARDED FOR RECORD ONLY (CRO)(CONUS)	1	F
0101	TRIPLER AMC, OAHU, HI		A
0111	BASSETT ACH, FT WAINWRIGHT, AK		A
0121	GORGAS ACH, REP OF PANAMA		A
0155	USAF RGN HSP, MAXWELL AFB, AL 36112		F
0211	USACH, SHAPE, BELGUIM		A
0251	USAF CLINIC, EIELSON AFB, AK 99702		F
0252	USAF HOSP, ELMENDORF AFB, AK 99506		F
0311	USACH, BERLIN, GE		A
0321	USACH, BREMERHAVEN, GE		A
0331	ARMC FRANKFURT, GE		A
0341	USACH, HEIDELBERG, GE		A
0351	ARMC LANDSTUHL, GE		A
0361	USACH, NUERNBERG, GE		A
0371	USACH, BAD CANNSTATT, GY		A
0381	USACH, WUERZBERG, GE		A
0391	USACH, AUGSBURG, GE		A
0411	USACH, LEGHORN, ITALY		A
0421	USACH, VICENZA, ITALY		A
0451	AF HSP, DAVIS-MONTHAN AFB, AZ 85707		F
0452	USAF HOSPITAL, LUKE AFB, AZ 85309		F
0454	USAF HOSP, WILLIAMS AFB, AZ 85224		F
0456	59 TAC HOSP, LUKE AFB, AZ (TAC) 85309		F
0551	AF HOSP, BLYTHEVILLE AFB, AR 72315		F
0553	AF HOSP, LITTLE ROCK AFB, AR 72076		F
0611	121ST EVAC HOSP, SOEUL, KOREA		A
0652	USAF HOSPITAL, BEALE AFB, CA 95903		F
0653	USAF HOSPITAL, CASTLE AFB, CA 95342		F
0654	USAF HOSP, EDWARDS AFB, CA 93523		F
0655	USAF HOSP, GEORGE AFB, CA 92392		F
0658	USAF HOSPITAL, MARCH AFB, CA 92518		F
0659	USAF HOSP, MATHER AFB, CA 95655		F
0661	AF CLINIC, MCCLELLAN AFB, CA 95652		F
0662	USAF CLINIC, NORTON AFB, CA 92409		F
0664	DAVID GRANT USAF MED CEN, TRAVIS AFB, CA 94535		F
0670	USAF HOSP, VANDENBERG AFB, CA 93437		F
0671	AF CLINIC, LOS ANGELES AFB, CA 90009		F
0855	USAF HOSP, LOWRY AFB, CO 80230		F
0857	USAF ACADEMY HOSP, ACADEMY USAF, CO 80840		F
0860	USAF CLINIC, PETERSON AFB, CO 80914		F
A201	AMC FITZSIMMONS, DENVER, CO		N
A202	AMC WM BEAUMONT, EL PASO, TX		N
A203	AH DEWITT, FT BELVOIR, VA		N
A204	AH MARTIN, FT BENNING, GA		N
A205	AH WOMACK, FT BRAGG, NC		N
A206	USAH FT CAMPBELL, KY		N
	[illegible], CO		N

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PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
A208	AH CUTLER, FT DEVENS, MA		N
A209	AH WALSON, FT DIX, NJ		N
A210	AH MCDONALD, FT EUSTIS, VA		N
A211	AH KIMBROUGH, FT GEORGE G MEADE, MD		N
A212	AMC D D EISENHOWER, FT GORDON, GA		N
A213	AH DARNALL, FT HOOD, TX		N
A214	AH RAYMOND W BLISS, FT HUACHUCA, AR		N
A215	AH MONCRIEF, FT JACKSON, SC		N
A216	AH BASSETT, FT JONATHAN M WAINWRIGHT, AK		N
A217	AH IRELAND, FT KNOX, KY		N
A218	AH MUNSON, FT LEAVENWORTH, KS		N
A219	AH KENNER, FT LEE, VA		N
A220	AH DEN L WOOD, FT LEONARD WOOD, MO		N
A221	AH NOBLE, FT MCCLELLAN, AL		N
A222	AH PATTERSON, FT MONMOUTH, NJ		N
A223	AH SILAS B HAYES, FT ORD, CA		N
A224	USAH FT POLK, LA		N
A225	AH FOX, REDSTONE ARSENAL, AL		N
A226	AH IRWIN, FT RILEY, KS		N
A227	AH LYSTER, FT RUCKER, AL		N
A228	AHC BROOKE, FT SAM HOUSTON, TX		N
A229	AH REYNOLDS, FT SILL, OK		N
A230	USAH FT STEWART, GA		N
A231	AMC TRIPLER, HONOLULU, HI		N
A232	AMC LETTERMAN, SAN FRANCISCO, CA		N
A233	AMC MADIGAN, TACOMA, WA		N
A234	AMC WALTER REED, WASHINGTON, DC		N
A235	AH KELLER, WEST POINT, NY		N
A299	ALL OTHER ARMY UNITED STATES		N
A301	USAH AUGSBURG, GERMANY		N
A302	USAH BAD CANNSTATT, GERMANY		N
A303	USAH BERLIN, GERMANY		N
A304	USAH BREMERHAVEN, GERMANY		N
A305	USAH FRANKFURT, GERMANY		N
A306	USAH HEIDELBERG, GERMANY		N
A307	USAH LANDSTUHL, GERMANY		N
A308	USAH LEGHORN, ITALY		N
A309	USAH NURNBERG, GERMANY		N
A310	USAH SEOUL, KOREA		N
A311	USAH SHAPE, BELGIUM		N
A312	USAH VICENZA, ITALY		N
A313	USAH WURZBURG, GERMANY		N
A399	ALL OTHER ARMY OUTSIDE US		N
C699	CIVILAN INPATIENT MED TREATMENT FAC U S		N
C799	CIVILIAN INPATIENT MED TREATMENT FAC OUTSIDE U S		N
F401	USAF ACADEMY HOSP, CO		N
F402	USAF HOSP, ALTUS, OK		N
F403	MALCOLM GROW USAF MED CEN, WASHINGTON, DC		N
F404	USAF HOSP, BARKSDALE, LA		N
F405	USAF HOSP, BEALE, CA		N
F406	USAF HOSP, BERGSTROM, TX		N
F407	USAF HOSP, BLYTHVILLE, AR		N
F408	USAF HOSP, CANNON, NM		N
F409	USAF REGIONAL HOSP, CARSWELL, TX		N
	USAF HOSP, CASTLE, CA		N

PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
F412	USAF HOSP, COLUMBUS, MS		N
F413	USAF HOSP, DAVIS-MONTHAN, AZ		N
F414	USAF HOSP, DOVER, DE		N
F415	USAF HOSP, DYESS, TX		N
F416	USAF HOSP, EDWARDS, CA		N
F417	USAF REGIONAL HOSPITAL, EGLIN, FL		N
F418	USAF HOSP, ELLSWORTH, SD		N
F419	USAF HOSP, ELMENDORF, AK		N
F420	USAF HOSP, ENGLAND, LA		N
F421	USAF HOSP, FAIRCHILD, WA		N
F422	USAF HOSP, F E WARREN, WY		N
F423	USAF HOSP, GEORGE, CA		N
F424	USAF HOSP, GRAND FORKS, ND		N
F425	USAF HOSP, GRIFFISS, NY		N
F426	USAF HOSP, HILL, UT		N
F427	USAF HOSP, HOLLOMAN, NM		N
F428	USAF HOSP, HOMESTEAD, FL		N
F429	USAF MEDICAL CENTER, KEESLER, MS		N
F430	USAF HOSP, KIRTLAND, NM		N
F431	USAF HOSP, K I SAWYER, MI		N
F432	WILFORD HALL USAF MED CEN (LACKLAND AFB), TX		N
F433	USAF HOSP, LANGLEY AFB, VA		N
F434	USAF HOSP, LAUGHLIN, TX		N
F435	USAF HOSP, LITTLE ROCK, AR		N
F436	USAF HOSP, LORING, ME		N
F437	USAF HOSP, LUKE, AZ		N
F438	USAF REGIONAL HOSP, MACDILL, FL		N
F439	USAF HOSP, MALSTROM, MT		N
F440	USAF REGIONAL HOSP, MARCH, CA		N
F441	USAF HOSP, MATHER, CA		N
F442	USAF REGIONAL HOSP, MAXWELL, AL		N
F443	USAF HOSP, MCCONNELL, KS		N
F444	USAF REGIONAL HOSP, MINOT, ND		N
F445	USAF HOSP, MOODY, GA		N
F446	USAF HOSP, MOUNTAIN HOME, ID		N
F447	USAF HOSP, MYRTLE BEACH, SC		N
F448	USAF HOSP, NELLIS, NV		N
F449	EHRLING BERGQUIST USAF REG HOSP (OFFUTT AFB), NE		N
F450	USAF HOSP, PATRICK, FL		N
F451	USAF HOSP, PEASE, NH		N
F452	USAF HOSP, PLATTSBURG, NY		N
F453	USAF HOSP, REESE, TX		N
F454	USAF HOSP, ROBINS, GA		N
F455	USAF MED CEN, SCOTT, IL		N
F456	USAF HOSP, SEYMOUR JOHNSON, NC		N
F457	USAF REGIONAL HOSP, SHAW, SC		N
F458	USAF REGIONAL HOSP, SHEPPARD, TX		N
F459	USAF HOSP, TINKER, OK		N
F460	DAVID GRANT USAF MED CEN (TRAVIS AFB), CA		N
F461	USAF HOSP, TYNDALL, FL		N
F462	USAF HOSP, VANDENBURG, CA		N
F463	USAF HOSP, WHITEMAN, MO		N
F464	USAF HOSP, WILLIAMS, AZ		N
F465	USAF MED CEN, WRIGHT-PATTERSON AFB, OH		N

MTF (MEDICAL TREATMENT FACILITY) LIST

PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
F501	USAF HOSP, BITBURG, GE, APO NY 09132		N
F502	USAF HOSP, CLARK, PHILIPPINES, APO SF 96432		N
F503	USAF HOSP, HAHN, GE, APO NY 09109		N
F504	USAF HOSP, ATHENS, GREECE, APO NY 09223		N
F505	TUSLOG DET 47 - TURKEY, APO NY 09289		N
F506	USAF HOSP, IRAKLION, CRETE, APO NY 09291		N
F507	USAF HOSP, KUNSAN, KOREA, APO SF 96264		N
F508	USAF HOSP, LAJES, AZORES, APO NY 09406		N
F509	USAF HOSP, MISAWA, JAPAN, APO SF 96519		N
F510	USAF HOSPI, OSAN, KOREA, APO SF 96570		N
F511	USAF HOSP, LAKENHEATH, ENGLAND, APO NY 09179		N
F512	USAF HOSP, UPPER HEYFORD, ENGLAND, APO NY 09194		N
F513	USAF HOSP, TORREJON, SPAIN, APO NY 09283		N
F514	USAF REGIONAL MED CEN, WIESBADEN, GE, APO NY 09220		N
F515	USAF HOSP, YOKOTA, JAPAN, APO SF 96328		N
F599	ALL OTHER AIR FORCE OUTSIDE U S		N
GE50	OTHER EUROPE		F
GE55	AF CLINIC RHEIN-MAIN, APO NY 09057		F
GE56	USAF HOSP WIESBADEN, APO NY 09220		F
GE59	USAF HOSP BITBURG, APO NY 09132		F
GE60	USAF HOSPITAL HAHN, APO NY 09109		F
GE61	USAF CLINIC SEMBACH, APO NY 09130		F
GE62	AF CLINIC SPANDAHLEM, APO NY 09123		F
GE64	USAF CLINIC RAMSTEIN, APO NY 09012		F
GE73	AF CLIN ZWEIBRUCKEN, APO NY 09860		F
GE74	50 TAC HOSP (HAHN), APO NY 09109		F
GE75	86 TAC HOSP (RAMSTEIN), APO NY 09012		F
GE76	36 TAC HOSP (BITBURG), APO NY 09132		F
GQ51	USAF CLINIC ANDERSON, APO SF 96334		F
GR51	USAF HOSP HELLENIKON, APO NY 09223		F
GR53	USAF HOSP IRAKLION, APO NY 09291		F
IT52	USAF CLINIC AVIANO, APO NY 09293		F
IT54	SAN VITO DEI NORMANNI USAF CLINIC, APO NY 09240		F
JA50	OTHER JAPAN AND OKINAWA		F
JA56	USAF HOSPITAL MISAWA, APO SF 96519		F
JA63	USAF HOSPITAL YOKOTA, APO SF 96328		F
JA71	655 TAC HOSP (YOKOTA), APO SF 09328		F
JA73	USAF CLINIC KADENA, APO SF 96239		F
KS54	USAF HOSPITAL KUNSAN, APO SF 96264		F
KS55	USAF HOSPITAL OSAN, APO SF 96570		F
N001	NS ADAK, AK		N
N002	NH BEAUFORT, SC		N
N003	NH BETHESDA, MD		N
N004	NAVHOSP BREMERTON, WA		N
N005	NAVHOSP CAMP LEJEUNE, NC		N
N006	NAVHOSP CAMP PENDLETON, CA		N
N007	NAVHOSP CHARLESTON, SC		N
N008	NH CHERRY POINT, NC		N
N009	NAVHOSP CORPUS CHRISTI, TX		N
N010	NAVHOSP GREAT LAKES, IL		N
N011	NAVHOSP JACKSONVILLE, FL		N
N012	NAVHOSP LEMOORE, CA		N
N013	NAVHOSP LONGBEACH, CA		N
N014	NAVHOSP MILLINGTON, MEMPHIS, TN		N
	NAVHOSP GROTON, NEW LONDON, CT		N

PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
N017	NAVHOSP OAKLAND, CA		N
N018	NH ORLANDO, FL		N
N019	NTC ORLANDO, FL		N
N020	NAVHOSP PATUXENT RIVER, MD		N
N021	NARMC PENSACOLA, FL		N
N022	NH PHILADELPHIA, PA		N
N023	NH PORTSMOUTH, VA		N
N024	NH SAN DIEGO, CA		N
N026	BR HOSP 29 PALMS, CA		N
N027	NH WHIDBEY ISLAND, WA		N
N099	ALL OTHER US		N
N101	USNAVHOSP GUAM, MARIANA ISLANDS		N
N102	USNAVHOSP GUANTANAMO BAY, CUBA		N
N103	USNCAS IWAKUNI, JAPAN		N
N104	USNAVHOSP KEFLAVIK, ICELAND		N
N105	USNS MIDWAY ISLAND		N
N106	USNAVHOSP NAPLES, ITALY		N
N107	USNAVHOSP, OKINAWA, JAPAN		N
N108	USNAVHOSP ROOSEVELT ROADS, PUERTO RICO		N
N109	USNAVHOSP ROTA, SPAIN		N
N110	USNAF, SIGONELLA, ITALY		N
N111	USNAVHOSP SUBIC BAY, PHILIPPINE ISLANDS		N
N112	USNAVHOSP YOKOSUKA, JAPAN		N
N198	ALL US NAVAL SHIPS		N
N199	ALL OTHERS OUTSIDE US		N
NL51	CAMP NEW AMSTERDAM USAF CLINIC APO NY 09292		F
P050	OTHER CANAL ZONE		F
P051	USAF HOSPITAL LAJES, APO NY 09406		F
P899	PUBLIC HEALTH SERVICE MED TREATMENT FACILITY		N
P051	USAF CLINIC HOWARD, APO MIAMI 34001		F
RP35	657 TAC HOSP (CLARK), APO SF 96432		F
RP50	OTHER PHILLIPINES		F
RP51	AF RGN MED CTR CLARK, APO SF 96432		F
RP54	656 TAC HOSP (CLARK), APO SF 96432		F
SP51	USAF HOSP TORREJON, APO NY 09283		F
SP53	USAF CLINIC ZARAGOZA, APO NY 09286		F
SP74	401 TAC HOSP (TORREJON), APO NY 09283		F
UK53	AF CLINIC BENTWATERS, APO NY 09755		F
UK59	AF HOSP LAKENHEATH, APO NY 09179		F
UK63	AF HOSP UPPER HEYFORD, APO NY 09194		F
UK65	AF CLINIC CHICKSANDS, APO NY 09193		F
UK73	AF CLINIC ALCONBURY, APO NY 09238		F
UK81	48 TAC HOSP (LAKENEATH), APO NY 09179		F
UK82	20 TAC HOSP (UPPER HEDFORD), APO NY 09194		F
V899	VETERANS ADMINISTRATION MED TREATMENT FAC		N
XX55	VETERANS ADMINISTRATION HOSPITAL		F
XX66	ALL OTHER NON-MILITARY HOSPITALS		F
XX67	GORGAS AH, CANAL ZONE		F
XX77	ARMY FACILITIES		F
XX88	NAVY FACILITIES		F
XX99	CARDED FOR RECORD ONLY (OVERSEAS)	1	F
Z799	ALL OTHER NON-MILITARY OUTSIDE U S		N
ZB99	ALL OTHER NON-MILITARY U S		N

RANK CODES LIST

RANK CODE	DESCRIPTION	COAST GUARD PAYGRADE	AIR FORCE PAYGRADE	MARINE PAYGRADE	NAVY PAYGRADE	OCEANAGRAPHIC PAYGRADE	PHS PAYGRADE	ARMY PAYGRADE
1LT	FIRST LIEUTENANT		O2	O2				O2
1SG	FIRST SERGEANT			E8				E8
2LT	SECOND LIEUTENANT		O1	O1				O1
A1C	AIRMAN FIRST CLASS		E3					
AB	AIRMAN BASIC		E1					
ADM	ADMIRAL	O4,10			O4,10	O4,10	O4,10	
AMN	AIRMAN		E2					
BG	BRIGADIER GENERAL		O1,07	O1,07				O1,07
CDR	COMMANDER	O5			O5	O5	O5	
CDT	CADET	CD	CD	CD	C1,M1			CD
CIV	RANK FOR CIVILIAN EMERGENCY							
CMS	CHIEF MASTER SERGENT		E9					
COL	COLONEL		O6	O6				O6
COM	COMMODORE	O1,07			O1,07	O1,07	O1,07	
CPL	CORPORAL			E4				E4
CPO	CHIEF PETTY OFFICER	E7			E7			
CPT	CAPTAIN	O6	O3	O3	O6	O6	O6	O3
CSM	COMMAND SARGEANT MAJOR							E9
CW2	CHIEF WARRANT OFFICER	W2	W2	W2	W2			W2
CW3	CHIEF WARRANT OFFICER	W3	W3	W3	W3			W3
CW4	CHIEF WARRANT OFFICER	W4	W4	W4	W4			W4
ENS	ENSIGN	O1			O1	O1	O1	
FA	FLEET ADMIRAL	O5,10			O5,10	O5,10	O5,10	
GA	GENERAL OF THE ARMY							O5,10
GAF	GENERAL OF THE AIR FORCE		O5,10					
GEN	GENERAL		O4,10	O4,10				O4,10
GSG	GUNNERY SERGEANT			E7				
LCM	LIEUTENANT COMMANDER	O4			O4	O4	O4	
LCP	LANCE CORPORAL			E3				
LT	LIEUTENANT	O3			O3	O3	O3	
LTC	LIEUTENANT COLONEL		O5	O5				O5
LTG	LIEUTENANT GENERAL		O3,09	O3,09				O3,09
LTJ	LIEUTENANT JUNIOR GRADE	O2			O2	O2	O2	
MAJ	MAJOR		O4	O4				O4
MCP	MASTER CHIEF PETTY OFFICER	E9			E9			
MG	MAJOR GENERAL		O2,08	O2,08				O2,08
MGS	MASTER GUNNERY SGT			E9				
MSG	MASTER SERGEANT		E7	E8				E8
PFC	PRIVATE FIRST CLASS			E2				E3
PO1	PETTY OFFICER FIRST CLASS	E6			E6			
PO2	PETTY OFFICER SECOND CLASS	E5			E5			
PO3	PETTY OFFICER THIRD CLASS	E4			E4			
PSG	PLATOON SARGEANT							E7
PV1	PRIVATE							E1
PV2	PRIVATE							E2
PVT	PRIVATE			E1				
RAD	REAR ADMIRAL	O2,08			O2,08	O2,08	O2,08	
SA	SEAMAN APPRENTICE	E2			E2			
SCP	SENIOR CHIEF PETTY OFFICER	E8			E8			
SFC	SERGEANT FIRST CLASS							E7
SGM	[illegible] SERGEANT MAJOR			E9				E9
SGT	[illegible]EANT		E4	E5				E5
SMA	[illegible]ANT MAJOR OF THE ARMY							E9
SMS	SE[illegible]OR MASTER SERGEANT		E8					
SN	SEAMAN	E3			E3			
								E4

RANK CODE LIST

RANK CODE	DESCRIPTION	COAST GUARD PAYGRADE	AIR FORCE PAYGRADE	MARINE PAYGRADE	NAVY PAYGRADE	OCEANOGRAPHIC PAYGRADE	PHS PAYGRADE	ARMY PAYGRADE
SP5	SPECIALIST 5							E5
SP6	SPECIALIST 6							E6
SP7	SPECIALIST 7							E7
SR	SEAMAN RECRUIT	E1			E1			
SRA	SENIOR AIRMAN		E4					
SSG	STAFF SERGEANT		E5	E6				E6
SSM	STAFF SERGEANT MAJOR							E9
TSG	TECHNICAL SERGEANT		E6					
VAD	VICE ADMIRAL	O3,O9			O3,O9	O3,O9	O3,O9	
WO1	WARRANT OFFICER	W1	W1	W1	W1			W1

AERONAUTICAL RATING LIST

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AERONAUTICAL RATING CODE	DESCRIPTION	SERVICE FLAG
0	NO DESIGNATION	F
2	FLIGHT NURSE	AF
3	SENIOR FLIGHT NURSE	AF
4	CHIEF FLIGHT NURSE	AF
9	UNKNOWN DESIGNATOR	F
A	MASTER ARMY AVIATOR OR COMMAND PILOT	AF
B	SENIOR ARMY AVIATOR OR SENIOR PILOT	AF
C	ARMY AVIATOR OR PILOT	AF
D	MASTER AIRCRAFT OBSERVER	AF
E	SENIOR AIRCRAFT OBSERVER	AF
F	AIRCRAFT OBSERVER	AF
J	MASTER NAVIGATOR	AF
K	SENIOR NAVIGATOR	AF
L	NAVIGATOR	AF
P	CHIEF FLIGHT SURGEON	AF
Q	SENIOR FLIGHT SURGEON	AF
R	FLIGHT SURGEON	AF
S	COMMAND PILOT ASTRONAUT	AF
T	SENIOR PILOT ASTRONAUT	AF
U	PILOT ASTRONAUT	AF
X	OTHER RATING OR DESIGNATION (CREW MEMBER)	AF
Y	FLYING PERSONNEL, NO RATING OR DESIGNATION	AF
Z	UNKNOWN RATING	AF

FMP (FAMILY MEMBER PREFIX) LIST

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FMP CODE	DESCRIPTION	SERVICE FLAG	FLAGS
10	TENTH OLDEST DEP CHILD	AFN	1
11	ELEVENTH OLDEST DEP CHILD	AFN	1
12	TWELFTH OLDEST DEP CHILD	AFN	1
13	THIRTEENTH OLDEST DEP CHILD	AFN	1
14	FOURTEENTH OLDEST DEP CHILD	AFN	1
15	FIFTEENTH OLDEST DEP CHILD	AFN	1
16	SIXTEENTH OLDEST DEP CHILD	AFN	1
17	SEVENTEENTH OLDEST DEP CHILD	AFN	1
18	EIGHTEENTH OLDEST DEP CHILD	AFN	1
19	NINETEENTH OLDEST DEP CHILD	AFN	1
20	SPONSOR	AFN	3
30	SPOUSE/FORMER SPOUSE	AFN	1
31	SPOUSE/FORMER SPOUSE	AFN	1
32	SPOUSE/FORMER SPOUSE	AFN	10
33	SPOUSE/FORMER SPOUSE	AFN	10
34	SPOUSE/FORMER SPOUSE	AFN	10
35	SPOUSE/FORMER SPOUSE	AFN	10
36	SPOUSE/FORMER SPOUSE	AFN	10
37	SPOUSE/FORMER SPOUSE	AFN	10
38	SPOUSE/FORMER SPOUSE	AFN	10
39	SPOUSE/FORMER SPOUSE	AFN	10
40	MOTHER/STEP-MOTHER	AFN	1
45	FATHER/STEP-FATHER	AFN	1
50	MOTHER-IN-LAW OF SPONSOR	AFN	1
55	FATHER-IN-LAW OF SPONSOR	AFN	1
60	1ST AUTH SPON DEP	AFN	1
61	2ND AUTH SPON DEP	AFN	1
62	3RD AUTH SPON DEP	AFN	10
63	4TH AUTH SPON DEP	AFN	10
64	5TH AUTH SPON DEP	AFN	10
65	6TH AUTH SPON DEP	AFN	10
66	7TH AUTH SPON DEP	AFN	10
67	8TH AUTH SPON DEP	AFN	10
68	9TH AUTH SPON DEP	AFN	10
69	10TH AUTH SPON DEP	AFN	10
98	CIVILIAN EMERGENCY	FN	31
99	OTHERS	AFN	31
00	CIVILIAN EMERGENCY	A	31
01	OLDEST DEP CHILD	AFN	1
02	SECOND OLDEST DEP CHILD	AFN	1
03	THIRD OLDEST DEP CHILD	AFN	1
04	FOURTH OLDEST DEP CHILD	AFN	1
05	FIFTH OLDEST DEP CHILD	AFN	1
06	SIXTH OLDEST DEP CHILD	AFN	1
07	SEVENTH OLDEST DEP CHILD	AFN	1
08	EIGHTH OLDEST DEP CHILD	AFN	1
09	NINTH OLDEST DEP CHILD	AFN	1

FLYING STATUS LIST

FLYING STATUS CODE	DESCRIPTION	SERVICE FLAG
1	DESIGNATED & ON FLYING STATUS	A
2	DESIGNATED & NOT ON FLY STATUS	A
00	DISQ: ADMIN REASON	F
01	DISQ: FEAR OF FLYING	F
02	DISQ: REASON PENDING	F
03	DISQ: MEDICAL (INDEF)	F
04	DISQ: HUMANITARIAN	F
05	DISQ: FLYING EVAL/OTHER	F
06	DISQ: FLYING/JUMP TERMINATED	F
07	DISQ: DAF MISCELLANEOUS	F
08	DISQ: VOLUNTARY	F
1A	ACIP(0-12): ACTIVE/OP FLYING	F
1B	ACIP(0-12): ACTIVE/PROF FLYING	F
1E	ACIP(0-12): ACTIVE/PARACHUTIST	F
1J	ACIP(0-12): INACT/RESTRICTED	F
1K	ACIP(0-12): INACT/NO SUPPORT	F
1L	ACIP(0-12): INACT/SCHOOL	F
1S	ACIP(0-12): INACT/NONPERFORM	F
1U	ACIP(0-12): ACT/FLY TRAINING	F
2A	ACIP(12-18): ACT/OP FLYING	F
2B	ACIP(12-18): ACT/PROF FLYING	F
2E	ACIP(12-18): ACT/PARACHUTIST	F
2J	ACIP(12-18): INACT/RESTRICTED	F
2K	ACIP(12-18): INACT/NO SUPPORT	F
2L	ACIP(12-18): INACT/SCHOOL	F
2S	ACIP(12-18): INACT/NONPERFORM	F
2U	ACIP(12-18): ACT/STUDENT	F
3A	ACIP(18-25): ACT/OP FLYING	F
3B	ACIP(18-25): ACT/PROF FLYING	F
3E	ACIP(18-25): ACT/PARACHUTIST	F
3J	ACIP(18-25): INACT/RESTRICTED	F
3K	ACIP(18-25): INACT/NO SUPPORT	F
3L	ACIP(18-25): INACT/SCHOOL	F
3S	ACIP(18-25): INACT/NONPERFORM	F
3U	ACIP(18-25): ACT/STUDENT	F
4A	COND(0-12): ACT/OP FLYING	F
4B	COND(0-12): ACT/PROF FLYING	F
4E	COND(0-12): ACT/PARACHUTIST	F
4J	COND(0-12): INACT/RESTRICTED	F
4K	COND(0-12): INACT/NO SUPPORT	F
4L	COND(0-12): INACT/SCHOOL	F
4S	COND(0-12): INACT/NONPERFORM	F
4U	COND(0-12): ACT/STUDENT	F
5A	COND(12-18): ACT/OP FLYING	F
5B	COND(12-18): ACT/PROF FLYING	F
5E	COND(12-18): ACT/PARACHUTIST	F
5J	COND(12-18): INACT/RESTRICTED	F
5K	COND(12-18): INACT/NO SUPPORT	F
5L	COND(12-18): INACT/SCHOOL	F
5S	COND(12-18): INACT/NONPERFORM	F
5U	COND(12-18): ACT/STUDENT	F
6A	COND(18-25): ACT/OP FLYING	F
6B	COND(18-25): ACT/PROF FLYING	F
6E	COND(18-25): ACT/PARACHUTIST	F
[illegible]	COND(18-25): INACT/RESTRICTED	F
[illegible]	[illegible]	F

FLYING STATUS LIST

FLYING STATUS CODE	DESCRIPTION	SERVICE FLAG
6L	COND(18-25): INACT/SCHOOL	F
6S	COND(18-25): INACT/NONPERFORM	F
6U	COND(18-25): ACT/STUDENT	F
7A	ACIP TERMINATED: ACT/OP FLYING	F
7B	ACIP TERM: ACT/PROF FLYING	F
7E	ACIP TERM: ACT/PARACHUTIST	F
7J	ACIP TERM: INACT/RESTRICTED	F
7K	ACIP TERM: INACT/NO SUPPORT	F
7L	ACIP TERM: INACT/SCHOOL	F
7S	ACIP TERM: INACT/NONPERFORM	F
7U	ACIP TERM: ACT/STUDENT	F
8P	COND ACIP MED: INACT SEPARATED	F
9C	COND HDIP: ACT/NON-CREW MEMB	F
9D	COND HDIP: ACT/NON-RATED CREW	F
9E	COND HDIP: ACT/PARACHUTIST	F
9G	COND HDIP: ACT/GROUNDED TEMP	F
9J	COND HDIP: INACT/RESTRICTED	F
9L	COND HDIP: INACT/SCHOOL	F
N	NOT APPLICABLE	AN
Y	YES	N

STATE CODE LIST

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STATE ABBREVIATION	STATE NAME
AB	ALBANIA
AC	ANTIGUA
AE	ARGENTINA
AF	AFGHANISTAN
AG	ALGERIA
AK	ALASKA
AL	ALABAMA
AN	ANDORRA
AO	ANGOLA
AQ	AMERICAN SAMOA
AR	ARKANSAS
AS	AUSTRALIA
AT	ASHMORE AND CARTIER ISLANDS
AU	AUSTRIA
AV	ANGUILLA
AY	ANTARCTICA
AZ	ARIZONA
BA	BAHRAIN
BB	BARBADOS
BC	BOTSWANA
BD	BERMUDA
BE	BELGIUM
BF	BAHAMA ISLANDS
BG	BANGLADESH
BH	BELIZE
BL	BOLIVIA
BM	BURMA
BP	BRITISH SOLOMON ISLANDS
BQ	UNITED STATES MISC. CARRIBEAN ISLANDS
BR	BRAZIL
BT	BHUTAN
BU	BULGARIA
BV	BOUVET ISLAND
BX	BRUNEI
BY	BURUNDI
BZ	NAVASSA ISLAND
CA	CALIFORNIA
CB	CAMBODIA
CC	CANADA
CD	CHAD
CE	SRI LANKA (CEYLON)
CF	CONGO (BRAZZAVILLE)
CG	ZAIRE, REPUBLIC OF
CH	CHINA, PEOPLES REPUBLIC OF
CI	CHILE
CJ	CAYMAN ISLANDS
CK	COCOS ISLAND (INDIAN OCEAN)
CM	CAMEROON
CN	COMORO ISLAND
CO	COLORADO
CP	CENTRAL AFRICAN REPUBLIC
CQ	COLUMBIA
CR	CORAL SEA ISLANDS TERRITORY
CS	COSTA RICA
CT	CONNECTICUT

STATE ABBREVIATION	STATE NAME
CW	COOK ISLAND
CY	CYPRUS
CZ	CZECHOSLOVAKIA
DA	DENMARK
DC	DISTRICT OF COLUMBIA
DE	DELAWARE
DI	INDONESIA
DM	DAHOMEY
DO	DOMINICA
DR	DOMINICAN REPUBLIC
EC	ECUADOR
EG	EGYPT
EI	IRELAND
EK	EQUATORIAL GUINEA
EQ	CANTON AND ENDERBURY ISLANDS
ES	EL SALVADOR
ET	ETHIOPIA
FA	FALKLAND ISLAND
FG	FRENCH GUIANA
FI	FINLAND
FJ	FIJI
FL	FLORIDA
FO	FAEROES ISLAND
FP	FRENCH POLYNESIA
FR	FRANCE
FS	FRENCH SOUTHERN AND ANTARCTIC LANDS
FT	FRENCH TERRITORY OF THE AFARS AND ISSAS
GA	GEORGIA
GB	GABON
GC	GERMANY, EAST
GE	GERMANY, FEDERAL REPUBLIC OF
GH	GHANA
GI	GIBRALTAR
GJ	GRENADA
GL	GREENLAND
GM	GAMBIA
GN	GOLBERT AND ELLICE ISLANDS (INCLUDES CENTRAL AND SOUTHERN LI
GP	GUADELOUPE
GQ	GUAM
GR	GREECE
GT	GUATEMALA
GV	GUINEA
GY	GUYANA
GZ	GAZA STRIP
HA	HAITI
HI	HAWAII
HK	HONG KONG
HM	HEARD AND MCDONALD ISLANDS
HO	HONDURAN (INCLUDES SWAN ISLANDS)
HU	HUNGARY
IA	IOWA
IC	ICELAND
ID	IDAHO
II	INDIA

STATE ABBREVIATION	STATE NAME
IQ	UNITED STATES MISC. PACIFIC ISLANDS
IR	IRAN
IS	ISRAEL
IT	ITALY
IU	ISRAEL-SYRIA DEMILITARIZED ZONES
IV	IVORY COAST
IW	ISRAEL-JORDAN DEMILITARIZED ZONES
IY	IRAQ-SAUDI ARABIA NEUTRAL ZONE
IZ	IRAQ
JA	JAPAN (INCLUDES RYUKYU ISLAND)
JM	JAMAICA
JN	JAN MAYEN
JO	JORDAN
JQ	JOHNSTON ATOLL
KE	KENYA
KN	KOREA, NORTH
KR	KOREA, REPUBLIC OF
KS	KANSAS
KT	CHRISTMAS ISLAND (INDIAN OCEAN)
KU	KUWAIT
KY	KENTUCKY
LA	LOUISIANA
LE	LEBANON
LI	LIBERIA
LO	LAOS
LS	LIECHTENSTEIN
LT	LESOTHO
LU	LUXEMBOURG
LY	LIBYA
MA	MASSACHUSETTS
MB	MARTINIQUE
MC	MACAO
MD	MARYLAND
ME	MAINE
MF	MALTA
MG	MONGOLIA
MH	MONSERRAT
MI	MICHIGAN
MJ	MADAGASCAR
MK	MONACO
ML	MALI
MM	MORROCO
MN	MINNESOTA
MO	MISSOURI
MP	MAURITIUS
MQ	MIDWAY ISLAND
MR	MAURITANIA
MS	MISSISSIPPI
MT	MONTANA
MU	OMAN
MV	MALDIVES
MW	MALAWI
MX	MEXICO
MY	MALAYSIA
MZ	MOZAMBIQUE

STATE ABBREVIATION	STATE NAME
ND	NORTH DAKOTA
NE	NEBRASKA
NF	NORFOLK ISLANDS
NG	NIGER
NH	NEW HAMPSHIRE
NI	NIGERIA
NJ	NEW JERSEY
NK	NIUE
NL	NETHERLANDS
NM	NEW MEXICO
NN	NEW CALEDONIA
NO	NORWAY
NP	NEPAL
NR	NAURU
NS	SURINAM
NU	NICARAGUA
NV	NEVADA
NW	NEW HERRIDES
NY	NEW YORK
NZ	NEW ZEALAND
OH	OHIO
OK	OKLAHOMA
OR	OREGON
PA	PENNSYLVANIA
PC	PITCAIRN
PE	PERU
PF	PARACEL ISLANDS
PG	SPRATLY ISLANDS
PK	PAKISTAN
PL	POLAND
PN	PANAMA
PO	PORTUGAL
PP	PAPUA NEW GUINEA
PQ	CANAL ZONE
PR	PURETO RICO
PT	PORTUGESE TIMOR
PU	PORTUGESE GUINEA
PY	PARAGUAY
QA	QATAR
RE	REUNION
RH	SOUTHERN RHODESIA
RI	RHODE ISLAND
RO	ROMANIA
RP	PHILIPPINES
RW	RWANDA
SA	SAUDI ARARIA
SB	ST. PIERRE AND MIQUELLON
SC	SOUTH CAROLINA
SD	SOUTH DAKOTA
SE	SEYCHELLES
SF	SOUTH AFRICA
SG	SENEGAL
SH	ST. HELENA
SI	SPANISH TERRITORY OF NORTHERN MOROCCO
SJ	ST. CHRISTOPHER-NEVIS

STATE CODE LIST

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STATE-ABBREVIATION	STATE NAME
SM	SAN MARINO
SN	SINGAPORE
SO	SOMALIA
SP	SPAIN
SS	SPANISH SAHARA
ST	ST. LUCIA
SU	SUDAN
SV	SVALBARDSW
SW	SWEDEN
SY	SYRIA
SZ	SWITZERLAND
TC	UNITED ARAB EMIRATES
TD	TRINIDAD AND TOBAGO
TG	TONGA
TH	THAILAND
TK	TURKS AND CAICOS ISLANDS
TL	TOKELAU ISLANDS
TN	TENNESSEE
TO	TOGO
TP	SAO TOME E PRINCIPE
TQ	TRUST TERRITORY OF THE PACIFIC ISLANDS
TS	TUNISIA
TU	TURKEY
TW	CHINA, REPUBLIC OF
TX	TEXAS
TZ	TANZANIA
UG	UGANDA
UK	UNITED KINGDOM
UR	SOVIET UNION
US	UNITED STATES
UT	UTAH
UV	UPPER VOLTA
UY	URUGUAY
VA	VIRGINIA
VC	ST. VINCENT
VE	VENEZUELA
VI	VIRGIN ISLANDS
VK	VIRGIN ISLANDS (U.S.)
VT	VERMONT
WA	WASHINGTON
WI	WISCONSIN
WV	WEST VIRGINIA
WY	WYOMING

COMMAND INTEREST LIST

COMMAND INTEREST CODE	DESCRIPTION
CON	NOTIFY COMMANDER
CON	CONGRESSIONAL
COP	NOTIFY CHIEF OF OUTPATIENT SERVICES
ENV	CALL ENVIRONMENTAL HEALTH
FLA	FLAG ADMISSION
FOR	FOREIGN DIGNITARY
LEG	CALL LEGAL OFFICER
LOD	POTENTIAL LINE OF DUTY INJURY
PAY	PAY PATIENT
PDP	POTENTIAL DANGEROUS PERSON
PRP	PERSONNEL RELIABILITY PROGRAM
PTA	CALL PATIENT AFFAIRS
STF	STAFF MEMBER
TPL	POTENTIAL THIRD PARTY LIABILITY
VIP	VIP

MAJOR COMMAND LIST MAR 24,1985 10:04 PAGE 1

MAJOR COMMAND CODE	DESCRIPTION
AAC	ALASKAN AIR COMMAND
AAB	AIR FORCE AUDIT AGENCY
AAO	AIR FORCE AUDIT AGENCY (OVERSEAS)
AAZ	ALASKAN AIR COMMAND (Z/I)
ACC	AERONAUTICAL CHART AND INFORMATION CENTER (HISTORICAL)
ADC	AEROSPACE DEFENSE COMMAND
ADO	AEROSPACE DEFENSE COMMAND (OVERSEAS)
AFA	US AIR FORCE ACADEMY
AFC	AIR FORCE ACCOUNTING AND FINANCE CENTER
AFE	US AIR FORCE IN EUROPE
AFO	HQ AIR FORCE RESERVE (OVERSEAS)
AFR	HQ AIR FORCE RESERVE
AFZ	US AIR FORCE IN EUROPE (Z/I)
ANC	AIR FORCE INTELLIGENCE CENTER
ASG	1947 ADMIN SUPP GROUP HQ, ALBERT F. SIMPSON HIST RESEARCH CENTER
ATC	AIR TRAINING COMMAND
ATO	AIR TRAINING COMMAND (OVERSEAS)
AUM	AIR UNIVERSITY (HISTORICAL)
AUO	AIR UNIVERSITY (OVERSEAS)(HISTORICAL)
CRT	AIR FORCE COMBAT OPERATIONS STAFF
CMC	AIR FORCE COMMUNICATIONS SERVICE
CMO	AF COMMUNICATIONS COMMAND (OVERSEAS)
CMS	AIR FORCE COMMISARY SERVICE
CSO	AIRFORCE COMMUNICATIONS SERVICE (OVERSEAS)
DAA	AIR FORCE DATA AUTOMATION AGENCY (HISTORICAL)
DAO	AIR FORCE DATA AUTOMATION AGENCY (OVERSEAS) (HISTORICAL)
ELC	ELECTRONIC SECURITY COMMAND
ESA	AIR FORCE ENGINEERING AND SERVICES AGENCY (HISTORICAL)
ESC	AIR FORCE ENGINEERING & SERVICES CENTER
F12	NAT GUARD OR RESERVE ACTIVE DUTY FOR TRAINING
F21	NAT GUARD OR RESERVE INACTIVE DUTY FOR TRAINING
HAF	HEADQUARTERS USAF
HAO	HEADQUARTERS USAF (OVERSEAS)
HQC	HEADQUARTERS COMMAND, USAF (SEE NOTE 1) (HISTORICAL)
HQO	HEADQUARTERS COMMAND, USAF (OVERSEAS) (SEE NOTE 1) (HISTORICAL)
HRS	USAF HISTORICAL RESEARCH CTR
ICT	AIR FORCE SERVICE INFORMATION & NEWS CENTER
IGC	AIR FORCE INSPECTOR GENERAL ACTIVITIES CENTER
INO	AIR FORCE INTELLIGENCE SERVICE (OVERSEAS) (HISTORICAL)
INT	AIR FORCE INTELLIGENCE SERVICE (HISTORICAL)
ISC	AIR FORCE INSPECTION AND SAFETY CENTER (HISTORICAL)
ISO	AIR FORCE INSPECTION AND SAFETY CENTER (OVERSEAS) (HISTORICAL)
KDA	AIR FORCE COMMUNICATIONS SERVICE (OLD)
LCT	AIR FORCE LEGAL SERVICES CENTER
LOG	AIR FORCE LOGISTICS COMMAND
LOO	AIR FORCE LOGISTIC COMMAND (OVERSEAS)
MAC	MILITARY AIRLIFT COMMAND
MAO	MILITARY AIRLIFT COMMAND (OVERSEAS)
MCT	AF MEDICAL SERVICE CENTER
MEA	AIR FORCE MANAGEMENT ENGINEERING AGENCY (HISTORICAL)
MPC	AIR FORCE MANPOWER & PERSONNEL CENTER
NGS	HEADQUARTERS, AIR NATIONAL GUARD SUPPORT CENTER
OAR	OFFICE OF AEROSPACE RESEARCH (HISTORICAL)
OMS	OFFICE OF MEDICAL SUPPORT
	AIR FORCE OFFICE OF SPECIAL INVESTIGATION (HISTORICA
	INVESTIGATION (OVERSEAS) (HISTORICAL)

MAJOR COMM .ST

MAJOR COMMAND CODE	DESCRIPTION
OSP	AF OFFICE OF SECURITY POLICE
PAF	PACIFIC AIR FORCE
PAZ	PACIFIC AIR FORCE (Z/I)
RPC	AIR RESERVE PERSONNEL CENTER (HISTORICAL)
SAC	STRATEGIC AIR COMMAND
SAO	STRATEGIC AIR COMMAND (OVERSEAS)
SCO	SPACE COMMAND OPERATIONS
SDZ	USAF SOUTHERN COMMAND (Z/I) (HISTORICAL)
SPC	SPACE COMMAND
SPO	SPACE COMMAND (OVERSEAS)
SUO	USAF SOUTHERN COMMAND (HISTORICAL)
SYD	AIR FORCE SYSTEMS COMMAND (OVERSEAS)
SYS	AIR FORCE SYSTEM COMMAND
TAC	TACTICAL AIR COMMAND
TAO	TACTICAL AIR COMMAND (OVERSEAS)
TEC	AIR FORCE TEST AND EVALUATION CENTER
USO	USAF SECURITY SERVICE (OVERSEAS) (HISTORICAL)
USS	USAF SECURITY SERVICE (HISTORICAL)
ZXZ	BAD CODE
ZZZ	MAJOR COMMAND UNKNOWN

BRANCH OF SERVICE LIST

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BRANCH OF SERVICE	DESCRIPTION	FLAG	SERVICE FLAGS
A	ARMY	1	AFN
AD	AIR DEFENSE ARTILLERY	2	A
AG	ADJ GENERAL	2	A
AN	ARMY NURSE CORP	2	A
AR	ARMOR	2	A
CH	CHAPLAIN	2	A
CM	CHEMICAL CORP	2	A
DE	DENTAL CORP	2	A
EN	ENGINEER CORP	2	A
F	AIR FORCE	1	AFN
FA	FIELD ARTILLERY	2	A
FI	FINANCE CORP	2	A
FN	UNKNOWN	2	A
GO	GENERAL OFFICER	2	A
IG	INSPECTOR GENERAL	2	A
IN	INFANTRY	2	A
JA	JUDGE ADVOCATE GEN CORP	2	A
M	MARINE CORPS	1	AFN
MC	MEDICAL CORP	2	A
MI	MILITARY INTELLIGENCE	2	A
MP	MILITARY POLICE	2	A
MS	MEDICAL SERVICE	2	A
N	NAVY	1	AFN
O	NOAA	1	AFN
OR	ORDNANCE CORP	2	A
P	USCG COAST GUARD	1	AFN
PR	PROFESSOR USMA	2	A
QM	QUARTERMASTER CORP	2	A
SC	SIGNAL CORP	2	A
SP	MED SPECIALITY CORP	2	A
TC	TRANSPORTATION CORP	2	A
U	UNKNOWN	1	FN
VC	VETERINARY CORP	2	A
W	PHS(PUBLIC HEALTH SVC)	1	AFN
X	CIVILIAN	1	FN

RACE CODE

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RACE CODE	DESCRIPTION	SERVICE FLAG
1	AMER INDIAN/ALSK NATIVE(AAN)	A
2	ASIAN/PAC ISLANDER(API)	A
3	BLACK OF NON-HISP ORIG(BNH)	A
4	BLACK OF HISP ORIGIN(BHO)	A
5	WHITE NOT OF HISP ORIG(WNH)	A
6	WHITE OF HISP ORIGIN(WHO)	A
7	UNKNOWN	A
C	CAUCASIAN	FN
G	MONGOLIAN	N
I	INDIAN	N
M	MALAYAN	N
N	NEGROID	FN
U	UNKNOWN	N
X	OTHER	F
Z	UNKNOWN	F

ZIP CODE	CITY,STATE
22312	ALEXANDRIA,VA
93426	BRADLEY,CA
93446	PASO ROBLES,CA
93901	SALINAS,CA
93902	SALINAS,CA
93905	SALINAS,CA
93907	SALINAS,CA
93921	CARMEL,CA
93922	CARMEL,CA
93924	CARMEL VALLEY,CA
93927	GREENFIELD,CA
93928	FORT HUNTER LIGGETT JDL
93930	KING CITY,CA
93933	MARINA,CA
93940	MONTEREY,CA
93941	FORT ORD,CA
93942	MONTEREY,CA
93950	PACIFIC GROVE,CA
93953	PEBBLE BEACH,CA
93955	SEASIDE,CA
93960	SOLEDAD,CA
93962	SPRECKELS,CA
94590	VALLEJO,CA
95003	APTOS,CA
95005	BEN LOMOND,CA
95010	CAPITOLA,CA
95012	CASTROVILLE,CA
95018	FELTON,CA
95019	FREEDOM,CA
95020	GILROY,CA
95023	HOLLISTER,CA
95035	MILPITAS,CA
95039	MOSS LANDING,CA
95045	SAN JUAN BAUTISTA,CA
95061	SANTA CRUZ,CA
95064	SANTA CRUZ,CA
95066	SCOTTS VALLEY,CA
95073	SOQUEL,CA
95076	WATSONVILLE,CA
95121	SAN JOSE,CA
95123	SAN JOSE,CA
99999	UNKNOWN CITY,CA

NAME	DESCRIPTION	[illegible]VICE AGS
11XX	NAVY LINE OFFICER SUR/SUB/SPEC	N
13XX	NAVY LINE OFFICER AVIATION	N
14XX	NAVY LINE OFFICER ENGINEERING	N
15XX	NAVY LINE OFFICER AERO ENG	N
16XX	NAVY LINE OFFICER SPECIAL DUTY	N
17XX	NAVY LINE OFFICER ORD ENG	N
18XX	NAVY LINE OFFICER SPEC DUTY	N
19XX	NAVY LINE OFFICER PROS STAFF	N
21XX	NAVY MEDICAL CORPS OFFICER	N
22XX	NAVY DENTAL CORPS OFFICER	N
23XX	NAVY MEDICAL SERVICE CORPS OFF	N
25XX	NAVY JAG CORPS OFFICER	N
29XX	NAVY NURSE CORPS OFFICER	N
31XX	NAVY SUPPLY CORPS OFFICER	N
41XX	NAVY CHAPLAIN CORPS OFFICER	N
51XX	NAVY CIV ENG CORPS OFFICER	N
61XX	NAVY LIMDU OFFICER SURFACE	N
62XX	NAVY LIMDU OFFICER SUB	N
63XX	NAVY LIMDU OFFICER AVIATION	N
64XX	NAVY LIMDU OFFICER OTHER	N
65XX	NAVY LIMDU OFFICER SUP/CEC/JAG	N
71XX	NAVY WARRANT OFFICER SURFACE	N
72XX	NAVY WARRANT OFFICER SUBMARINE	N
73XX	NAVY WARRANT OFFICER AVIATION	N
74XX	NAVY WARRANT OFFICER OTHER	N
75XX	NAVY WARRANT OFFICER SUP/CE/PA	N
AB	AVIATION BOATSWAIN'S MATE	N
AC	AIR TRAFFIC CONTROLLER	N
AD	AVIATION MACHINIST'S MATE	N
AE	AVIATION ELECTRICIAN'S MATE	N
AG	AEROGRAPHER'S MATE	N
AK	AVIATION STOREKEEPER	N
AM	AVIATION STRUCTURAL MECH	N
AO	AVIATION ORDNANCEMAN	N
AQ	AVIATION FIRE CONTROL TECH	N
AS	AVIATION SUPPORT EQUIP TECH	N
AT	AVIATION ELECTRONICS TECH	N
AW	AVIATION ANTISUB WARFARE OP	N
AX	AVIATION ANTISUB WARFARE TECH	N
AZ	AVIATION MAINTENANCE ADMIN	N
BM	BOATSWAINS MATE	N
BT	BOILER TECHNICIAN	N
BU	BUILDER	N
CE	CONSTRUCTION ELECTRICIAN	N
CM	CONSTRUCTION MECHANIC	N
CT	CRYPTOLOGIC TECHNICIAN	N
DK	DISBURSING CLERK	N
DM	ILLUSTRATOR DRAFTSMAN	N
DP	DATA PROCESSING TECHNICIAN	N
DS	DATA SYSTEMS TECHNICIAN	N
DT	DENTAL TECHNICIAN	N
EA	ENGINEERING AID	N
EM	ELECTRICIAN'S MATE	N
EN	ENGINEMAN	N
EO	EQUIPMENT OPERATOR	N
ET	ELECTRONICS TECHNICIAN	N
[illegible]	ELECTRONICS WARFARE TECHNICIAN	N

MILITARY SPECIALTY LIST

NAME	DESCRIPTION	SERVICE FLAGS
FT	FIRE CONTROL TECHNICIAN	N
GM	GUNNER'S MATE	N
GS	GAS TURBINE SYSTEMS TECHNICIAN	N
HM	HOSPITAL CORPSMAN	N
HT	HULL MAINTENANCE TECHNICIAN	N
IC	INTERIOR COMM ELECTRICIAN	N
IM	INSTRUMENTMAN	N
IS	INTELLIGENCE SPECIALIST	N
JO	JOURNALIST	N
LI	LITHOGRAPHER	N
LN	LEGALMAN	N
M01	USMC PERS/ADM	N
M02	USMC INTELLIGENCE	N
M03	USMC INFANTRY	N
M04	USMC LOGISTICS	N
M08	USMC FIELD ARTILLERY	N
M11	USMC UTILITIES	N
M13	USMC ENGINEER, CON/EQUIP	N
M14	USMC DRAFTING, SURVEY, MAPPING	N
M15	USMC PRINTING AND REPRODUCTION	N
M18	USMC TANK/AMPHIBIAN TRACTOR	N
M21	USMC ORDINANCE	N
M23	USMC AMMO/EXPL ORD DISPOSAL	N
M25	USMC OPERATIONAL COMM	N
M26	USMC SIG INT/GRND ELEC WARFARE	N
M28	USMC DATA/COMM MAINTENANCE	N
M30	USMC SUPPLY ADM/OPS	N
M31	USMC TRANSPORTATION	N
M33	USMC FOOD SERVICE	N
M34	USMC AUDIT, FINANCE/ACCT	N
M35	USMC MOTOR TRANSPORT	N
M40	USMC DATA SYSTEMS	N
M41	USMC EXCHANGE	N
M43	USMC PUBLIC AFFAIRS	N
M44	USMC LEGAL SERVICES	N
M46	USMC TRAINING/AUDIOVISUAL SUPP	N
M55	USMC BAND	N
M57	USMC NBC DEFENSE	N
M58	USMC MP/CORRECTIONS	N
M59	USMC ELECTRONICS MAINTENANCE	N
M60	USMC AIRCRAFT MAINTENANCE	N
M61	USMC AIRCRAFT MAINTENANCE	N
M63	USMC AVIONICS	N
M64	USMC AVIONICS	N
M65	USMC AVIATION ORDNANCE	N
M68	USMC WEATHER SERVICE	N
M70	USMC AIRFIELD SERVICES	N
M72	USMC AIR CONT/SUPP/ANTI-AIR	N
M73	USMC AIR TRF CONT/ENL FLT CREW	N
M75	USMC PILOTS/NAVEL FLT OFFICER	N
M80	USMC QUALITY ASSURANCE(SUBS)	N
M81	USMC BAUKD	N
M82	USMC EDUCATION ASSISTANT	N
M84	USMC RECRUITER/CAREER PLANNER	N
M85	USMC DI/INST/COUNS	N
M86	USMC RECON/INTERP	N
M87	USMC INFANTRY OPS SPEC	N

NAME	DESCRIPTION	...ICE ...S
M88	USMC FIREFIGHTER	N
M89	USMC FERS SUPP SPEC	N
M90	USMC GRAVES REGISTRATION SPEC	N
M96	USMC SPECIAL EDUCATION PROG	N
MA	MASTER AT ARMS	N
ML	MOLDER	N
MM	MACHINIST'S MATE	N
MN	MINEMAN	N
MR	MACHINE REPAIR	N
MS	MESS MANAGMENT SPECIALIST	N
MT	MISSILE TECHNICIAN	N
MU	MUSICIAN	N
NC	NAVY COUNSELOR	N
NS	SPECIAL NON-IDENTIFIED STRIKER	N
OM	OPTICALMAN	N
OS	OPERATIONS SPECIALIST	N
OT	OCEAN SYSTEMS TECHNICIAN	N
PC	POSTAL CLERK	N
PH	PHOTOGRAPHER'S MATE	N
PM	PATTERNMAKER	N
PN	PERSONNELMAN	N
PR	AIRCREW SURVIVAL EQUIP-MAN	N
QM	QUARTERMASTER	N
RM	RADIOMAN	N
RP	RELIGIOUS PROGRAM SPECIALIST	N
SH	SHIP'S SERVICEMAN	N
SK	STOREKEEPER	N
SM	SIGNALMAN	N
ST	SONAR TECHNICIAN	N
SW	STEELWORKER	N
TD	TRADEVMAN	N
TM	TORPEDOMAN'S MATE	N
UT	UTILITIESMAN	N
WP	WOMEN PETTY OFFICERS	N
YN	YEOMAN	N

PATIENT CATEGORY ARMY LIST — MAR 24,1985 10:07 — PAGE 1

PATIENT CATEGORY CODE	DESCRIPTION	FLAGS	BENEF SHORT DESC ARMY	AUTH FOR ADM
A11	USA AD OFFICE	1100011	ARMY	4-1
A12	USA AD ENLISTED	110001	ARMY	4-1
A21	USAR INITL ACDUTRA (REP 63) RESERVE	110011	IADT USAR	4-2
A22	USAR RES (<31 DAYS) ENLISTED	110001	USART	4-2
A23	USAR RES (<31 DAYS) OFFICER	1100011	USART	4-2
A24	USAR INITL ACDUTRA (REP 63) ARNGUS	110001	IADT ARNGUS	4-2
A25	USA NG (<31) ENLISTED	110001	ARNGUS	4-2
A26	USA NG (<31) OFFICE	1100011	ARNGUS	4-2
A27	USA NG ENL PROG ACDUTRA	110001	ARNGUS	4-2
A28	USAR RES ENL PROG ACDUTRA	110001	USAR	4-2
A29	USAR NON-AD/ACDUTRA, RES/ARNG OFF	910001	ARNGUS/USAR	4-2
A31	USA RET LOS OFFICE	2100011	RET/A	4-11
A32	USA RET LOS ENLISTED	210001	RET/A	4-11
A33	USA PDRL OFFICER	2100011	PDRL/A	4-11
A34	USA PDRL ENLISTED	210001	PDRL/A	4-11
A41	USA TDRL OFFICER	2100011	TDRL/A	4-11
A42	USA TDRL ENLISTED	210001	TDRL/A	4-11
A51	DEPN AD US ARMY SPONSOR	301000	DEP/ADA	4-12
A52	PREADOPT CHILD AD USA SPONSOR	301000	PREADP/ADA	4-58
A61	DEPN RET USA SPONSOR	301000	DEP/RET/A	4-12
A62	DEPN DECEASED USA SPONSOR	301000	DEP/DEC/A	4-12
A63	PREADOPT CHILD RET USA SPONSOR	301000	PREADP/RET/A	4-58
A71	US MILITARY ACAD CADETS	110001	USMA	4-1
A81	USA ROTC CADETS (OWN PAY)	910001	ROTC	4-4
A82	UNITED STATES ARMY ROTC CADET APPLICANTS	910001	ROTC	4-4,5 & 6
A91	SEC OF ARMY DESIGNEE (NO PAY)	910000	DOD DESG	4-26,55,57,59,60,63 & 67
A92	ARMY SEC DES (SB PAY)/RECORDS	910000	DOD DESG	4-26,47,55,57,59 & 60
A93	ARMY SEC DES (FULL PAY) /EVAC	910000	DOD DESG	4-26,55,57,59 & 60
A94	ARMY SEC DES (DEPN RATE)	201000	DOD DESG	4-26,55,57 & 59
A95	ARMY SEC DES (ISR RATE)	910000	DOD DESG	4-26,55,57 & 59
C11	USCG ACTIVE DUTY OFFICER	110001	USCG	4-1
C12	USCG ACTIVE DUTY ENLISTED	110001	USCG	4-1
C22	USCG RES (<31 DAYS) ENLISTED	110001	USCGT	4-2
C23	USCG RES (<31 DAYS) OFFICER	110001	USCGT	4-2
C28	USCG NON-AD/ACDUTRA RES ENLISTED	910001	USCGI	4-2
C29	USCG NON-AD/ACDUTRA RES OFFICER	910001	USCGI	4-2
C31	USCG RET LOS OFFICER	210001	RET/USCG	4-11
C32	USCG RET LOS ENLISTED	210001	RET/USCG	4-11
C33	USCG PDRL OFFICER	210001	PDRL/USCG	4-11
C34	USCG PDRL ENLISTED	210001	PDRL/USCG	4-11
C41	USCG TDRL OFFICER	210001	TDRL/USCG	4-11
C42	USCG TDRL ENLISTED	210001	TDRL/USCG	4-11
C51	DEPN USCG AD SPONSOR	301000	DEP/ADUSCG	4-12
C52	PREADOPT CHILD USCG AD SPONSOR	301000	PREADOP/ADCG	4-58
C61	DEPN USCG RET SPONSOR	301000	DEP/RET/USCG	4-12
C62	DEPN USCG DECEASED SPONSOR	301000	DEP/DEC/USCG	4-12
C63	PREADOPT CHILD USCG RET SPONSOR	301000	PREADP/RETCG	4-58
C71	USCG ACADEMY CADETS	110001	CAD/USCGA	4-1
F11	USAF AD OFFICER	110001	USAF	4-1
F12	USAF AD ENLISTED	110001	USAF	4-1
F21	USAF INITL ACDUTRA (REP 63) RES	110001	USAFT	4-2
F22	USAF RES (<31 DAYS) ENLISTED	110001	USAFT	4-2
F23	USAF RES (<31 DAYS) OFFICER	110001	USAFT	4-2
F24	USAF INITL ACDUTRA (REP 63) AFNG	110001	USAFT	4-2
F25	USAF NG (<31 DAYS) ENLISTED	110001	AFNGT	4-2
		110001	AFNGT	4-2

PATIENT CATEGORY CODE	DESCRIPTION	FLAGS	BENEF SHORT DESC ARMY	AUTH FOR ADM
F27	USAF NON-AD/ACDUTRA AFNG ENL	910001	AFNGI	4-2
F28	USAF NON-AD/ACDUTRA RES ENL	910001	AFNGI	4-2
F29	USAF NON-AD/ACDUTRA RES OFF	910001	AFNGI	4-2
F31	USAF RET LOS OFFICER	210001	RET/AF	4-11
F32	USAF RET LOS ENLISTED	210001	RET/AF	4-11
F33	USAF PDRL OFFICER	210001	PDRL/AF	4-11
F34	USAF PDRL ENLISTED	210001	PDRL/AF	4-11
F41	USAF TDRL OFFICER	210001	TDRL/AF	4-11
F42	USAF TDRL ENLISTED	210001	TDRL/AF	4-11
F51	DEPN USAF AD SPONSOR	301000	DEP/ADAF	4-12
F52	PREADOPT CHILD USAF AD SPON	301000	PREADP/AF	4-58
F61	DEPN USAF RET SPONSOR	301000	DEP/RET/AF	4-12
F62	DEPN USAF DECEASED SPONSOR	301000	DEP/DEC/AF	4-12
F63	PREADOPT CHILD USAF RET SPON	301000	PREADP/RETAF	4-58
F71	USAF ACADEMY CADETS	110001	USAFA	4-1
F81	USAF ACAD ROTC CADETS (PAY)	110001	ROTC	4-4
F82	USAF ACAD ROTC CADET APPLIC	110001	ROTC	4-4,5 & 6
H11	STATE DEPT EMPLOYEES	910000	ST DEPT EMP	4-34
H12	AID EMPLOYEES	910000	AID EMP	4-34
H13	COMMERCE DEPT EMPLOYEES	910000	COM DEPT EMP	4-34
H14	DRUG ENF ADMIN EMPLOYEES	910000	DEA EMP	4-34
H15	FAA EMPLOY/AIR TRF EMPLOYS	910000	FAA EMP	4-39
H16	FRGN CLAIMS SETTLMNT COMM EMPLOYS	91000	COMM EMP	4-34
H17	USIA EMPLOYEES	910000	USIA EMP	4-34
H18	AGRICULTHRAL DEPT EMPLOYEES	910000	USDA EMP	4-34
H19	FGN NATL STATE DPT/AID EMPLOYS	910000	FN STDEP EMP	4-34
H21	INT DEPT EMPLOYEES (SAMOA)	910000	INT DEP EMP	4-23 & 66
H22	TRANS DEPT EMPLOYEES	910000	TRAN DEP EMP	4-22 & 34
H23	JUSTICE DEPT EMPLOYEES	910000	JUST DEP EMP	4-22,34 & 37
H24	TREAS DEPT EMPLYS (SEC SVC)	910000	TRES DEP EMP	4-22 & 34
H25	HEW DEPT EMPLOYEES	910000	HEW EMP	4-22 & 34
H26	CIV EMPL DOD AUTH OCC HEALTH	910000	DOD EMP	4-21
H31	SECURITY EXC COMM EMPLOYEES	910000	SEC EMP	4-22
H32	LIBR OF CONGREE EMPLOYEES	910000	LIB OF CONG	4-22
H33	ENVIRONMENTAL PROT AGENCY EMP	910000	EPA EMP	4-22
H34	SOC SECY ADMIN EMPLOYEES	910000	SSA EMP	4-22
H35	GSA EMPLOYEES	910000	GSA EMP	4-22
H36	US CIV FED EMPLOYEES CONUS	910000	CIV FED EMP	4-22
H37	US CIV FED EMPL AUTH OCC HLTH SVC	910000	CIV FED EMP	4-21
H38	CIV EMPL US GOVT DIS RET EXAM	910000	CIV EMP RET	4-20
H39	US CUSTOMS SERVICE AGENT	910000	CUST AGENTS	4-38
H41	CIV FACULTY U OF HLTH SCIENCES	910000	FAC USUHS	4-70
H42	SECRET SERVICE PROTECTEES	910000	PROT OF SS	4-44
H43	CIV EMPL ARMY NATL GUARD	910000	ARNGUS EMP	4-61
H44	SEC SVC SPECIAL AGENTS	910000	SPEC AGENT	4-38 & 44
H45	FGN NATL EMPL US CONGRESS OCONUS	910000	US CONG EMP	4-61
H46	CIV EMPL DOD ALCH TRTMNT PROG	910000	DOD EMP ATP	4-21
H51	FED CIV EMPLOYEE IN REMOTE AREAS	910000	US GOVT EMP	4-22
J11	DEPN STATE DEPT EMPLOYEE	901000	DEP ST DEPT	4-34
J12	DEPN US CITY AID EMPL (FULL PAY)	901000	DEP AID EMP	4-34
J13	DEPN COMM DEPT EMPL (HUR OF PUB RDS)	901000	DEP COM DEP	4-34
J14	DEPN FAA EMPL	901000	DEP FAA EMP	4-34
J15	DEPN FGN CLAIMS SETTLMNT COMM EMPL	901000	DEP CLMS SET	4-34
J16	DEPN USIA EMPLOYEE	901000	DEP USIA EMP	4-34
[illegible]	DEPN DRUG ENFCMNT AGNCY EMPL	901000	DEP DEA EMP	4-23
		901000	D/CIV SAMOA	4-23

PATIENT CATEGORY ARMY LIST

PATIENT CATEGORY CODE	DESCRIPTION	FLAGS	BENEF SHORT DESC ARMY	AUTH FOR ADM
J19	DEPN AG DEPT EMPLOYEE	901000	DEP USDA EMP	4-34
J21	DEPN OF FED EMPL OCONUS & RMT CONUS	901000	DEP DOD EMP	4-22
J31	DEPN, EMPLOYEE FED AGENCY NEC	901000	DEP FED AG	4-22
K11	VETERANS ADMIN BENEFICIARIES	910000	VA BENE	4-30
K21	BENEFICIARIES OF OWCP	910000	OWCP	4-31
K31	MBR US SOLDIERS/ARMEN'S HOME	910000	MBR SVC HOME	4-36
K41	SOC SECY BENEFICIARY MEDICARE	910000	BENE SSA	4-41
K42	USPHS BENEFIT (INC AMER IND,ESK,ALEUT)	910000	BENE USPHS	4-32
K43	TRUST TERR CIT (MICRONESIA,SAMOA)	910000	CIT MICRO	4-42
K44	TRUST TERR CIT (AMER SAMOA,NEC)	910000	CIT AM SAMOA	4-43
K45	PEACE CORPS EMPL, MBR, APPL, DEPN	910000	PEACE CORP	4-35
K46	MERCHANT MARINE ACAD APPL	910000	MER MAR ACA	4-6
K47	USPHS STUDENT APPL	910000	USPHS STU	4-6
K48	SECRET SVC PROTECTOR/EE	910000	PROT SS	4-44
K49	BENE US CIVILIAN NEC	910000	BENE US CIV	4-61
K51	US CIV SEAMEN, NOT MSTS/MSC	910000	SEAMAN	4-48
K52	US CIV EMPL OF US GOV CONTRTRS	910000	CREW US SHIP	4-48 & 51
K53	US CIV EMPL OF CONTRTRS PHY EX	910000	DOD CONT EMP	4-52
K61	US CIV BENEF OF PRIV RLF ACTS OF CONG	910000	BENE PRI REL	4-54
K71	JOB CORPS BENEF, VISTA PERS	910000	BENE JOB C	4-40
K72	PEACE CORPS,VISTA,JOB CORPS NON BENEF	910000	PEC CP EMP	4-35 & 40
K73	JOB CORPS/VISTA APPLICANT	910000	APPL JC/VIST	4-40
M11	USMC AD OFFICER	110001	USMC	4-1
M12	USMC AD ENLISTED	110001	USMC	4-1
M21	USMC INITL ACDUTRA (REF 63) RES	110010	USMCT	4-2
M22	USMC RES (<31 DAYS) ENLISTED	110001	USMCT	4-2
M23	USMC RES (<31 DAYS) OFFICER	110001	USMCT	4-2
M28	USMC NON-ACDUTRA RES ENLISTED	910001	USMCI	4-2
M29	USMC NON-ACDUTRA RES OFFICER	910001	USMCI	4-2
M31	USMC RET LOS OFFICER	210001	RET/USMC	4-11
M32	USMC RET LOS ENLISTED	210001	RET/USMC	4-11
M33	USMC PDRL OFFICER	210001	PDRL/USMC	4-11
M34	USMC PDRL ENLISTED	210001	PDRL/USMC	4-11
M41	USMC TDRL OFFICER	210001	TDRL/USMC	4-11
M42	USMC TDRL ENLISTED	210001	TDRL/USMC	4-11
M51	DEPN USMC AD SPONSOR	301000	DEP/ADUSMC	4-12
M52	PREADOPT CHILD USMC AD SPONSOR	301000	PREADOP/USMC	4-58
M61	DEPN USMC RET SPONSOR	301000	DEP/RET USMC	4-12
M62	DEPN USMC DECEASED SPONSOR	301000	DEP/DEC/USMC	4-12
M63	PREADOPT CHILD USMC RET SPON	301000	PREAD/R/USMC	4-58
N11	USN AD OFFICER	110001	USN	4-1
N12	USN AD ENLISTED	110001	USN	4-1
N21	USN INITL ACDUTRA (REF 63) RES	110001	USNT	4-2
N22	USN RES (<31 DAYS) ENL	110001	USNT	4-2
N23	USN RES (<31 DAYS) OFFICER	110001	USNT	4-2
N28	USN NON-AD/ACDUTRA RES ENLISTED	910001	USNI	4-2
N29	USN NON-AD/ACDUTRA RES OFFICER	910001	USNI	4-2
N31	USN RET LOS OFFICER	210001	RET/N	4-11
N32	USN RET LOS ENLISTED	210001	RET/N	4-11
N33	USN PDRL OFFICER	210001	PDRL/N	4-11
N34	USN PDRL ENLISTED	210001	PDRL/N	4-11
N41	USN TDRL OFFICER	210001	TDRL/N	4-11
N42	USN TDRL ENLISTED	210001	TDRL/N	4-11
N51	DEPN USN AD SPONSOR	301000	DEP/ADN	4-12
N52	PREADOPT CHILD USN AD SPONSOR	301000	PREADP/ADN	4-58
N61	DEPN USN RET SPONSOR	301000	DEP/RET N	4-12

PATIENT CATEGORY CODE	DESCRIPTION	FLAGS	BENEF SHORT DESC ARMY	AUTH FOR ADM
N62	DEPN USN DEC SPONSOR	301000	DEP/DEC N	4-12
N63	PREADOPT CHILD USN RET SPONSOR	301000	PREAD/RET N	4-58
N71	USN ACAD MIDSHIPMEN	110001	USNA	4-1
N81	USN ROTC CADETS (OWN PAY)	110001	ROTC	4-4
N82	USN ROTC CADET APPL	110010	ROTC	4-4,586
O11	US NOAA ACT DUTY OFFICER	110001	NOAA	4-1
O12	US NOAA ACT DUTY ENLISTED	110001	NOAA	4-1
O21	US NOAA RES (<31 DAYS) OFFICER	110001	NOAAT	4-2
O29	US NOAA NON-AD/ACDUTRA RES	910001	NOAAI	4-2
O31	US NOAA RET LOS OFFICER	110001	RET/NOAA	031
O33	US NOAA PDRL OFFICER	210001	PDRL/NOAA	4-11
O41	US NOAA TDRL OFFICER	210001	TDRL/NOAA	4-11
O51	DEPN USNOA AD SPONSOR	301000	DEP/AD NOAA	4-12
O52	PREADOPT CHILD USNOA AD SPONSOR	301000	PREADP/ADNOA	4-58
O61	DEPN USNOA RET SPONSOR	301000	DEP/RET NOAA	4-12
O62	DEPN USNOA DEC SPONSOR	301000	DEP/DEC NOAA	4-12
O63	PREADOPT CHILD USNOA RET SPON	301000	PREADP/R/NOA	4-58
P11	PHS AD OFFICER	110001	PHS	4-1
P21	USPHS RES (<31 DAYS) OFFICER	110001	PHST	4-2
P25	USPHS INACTIVE RES OFFICER	110001	PHSI	4-32
P29	USPHS NON-AD/ACDUTRA RES OFF	910001	PHSI	4-2
P31	USPHS RET LOS OFFICER	210001	RET/USPHS	4-11
P33	USPHS PDRL OFFICER	210001	TDRL/USPHS	4-11
P41	USPHS TDRL OFFICER	210001	TDRL/USPHS	4-11
P51	DEPN USPHS AD SPONSOR	301000	DEP/AD/PHS	4-12
P52	PREADOPT CHILD USPHS AD SPON	301000	PREADP/A/PHS	4-58
P61	DEPN USPHS RET SPONSOR	301000	DEP/RET/PHS	4-12
P62	DEPN USPHS DEC SPONSOR	301000	DEP/DEC/PHS	4-12
P63	PREADOPT CHILD USPHS RET SPON	301000	PREADP/R/PHS	4-58
Q11	PRISONERS OF WAR	910000	POW	4-45
Q12	INTERNEES	910000	INTERNEE	4-45
Q13	RETAINED PERSONNEL	910000	RET PERS	4-45
R11	OTH-PRIS HOSP > SENTENCE EXP	910000	PRIS > ETS	4-45
R12	OTH PRIS-PNTIVE DISCHG-EXEC SENT NOT EXP	910000	PRISONER	4-45
R13	NON-MIL FED PRISONERS	910000	NON-MIL PRIS	4-38 & 45
R14	PERSONS IN MIL CUSTODY	910000	CUST OF MIL	4-45
S11	IMET TRAINEES, MIL, ENL	910000	IMET TRN	4-24 & 27
S12	IMET TRAINEES, MIL, OFF	910000	IMET TRN	4-24 & 27
S13	IMET TRAINEES, CIV	910000	IMET TRN	4-24 & 27
S14	IMET TRAINEES OVERSEAS NEC	910000	IMET TRN	4-24 & 27
S15	IMET ORIENTATION TOUR MEMBER	910000	IMET TOUR	4-27
S16	FGN MIL SALES TRAINEES	910000	MIL SALE TRN	4-24 & 27
S21	FGN MIL DIPL,ENL	910000	MIL DIPL	4-24
S22	FGN MIL DIPL,OFF	910000	MIL DIPL	4-24
S23	NATO MIL PERS, ENL	910000	NATO MIL	4-24
S24	NATO MIL PERS FGN NTL OFF	910000	NATO MIL	4-24
S25	MIL PERS,ALLIED/NEUT,TRN US ARM FORC,ENL	910000	NON-NATO MIL	4-24
S26	MIL PERS,ALLIED/NEUT,TRN US ARM FORC,OFF	910000	NON-NATO MIL	4-24
S27	MIL PER,ALLIED/NEUT,NOT TRN ARM FORC,ENL	910000	NON-NATO MIL	4-24
S28	MIL PER,ALLIED/NEUT,NOT TRN ARM FORC,OFF	910000	NON-NATO MIL	4-24
S31	FGN NON-MIL DIPL, NEC	910000	NON-MIL DIPL	4-24
S32	FOR NATL NATO CIV PER NEC	910000	NATO CIV PER	4-24
S33	FGN MIL KUWAIT STUDENT	910000	KUWAITI STU	4-24
S34	FOR NATL MEXICAN MIGRANT WORKER	910000	MEX WORKER	4-32
S35	SPEC FOR NATL OUTSIDE US	910000	SPEC FOR NAT	4-38
		910000	EMP US UNIF	4-31

PATIENT CATEGORY ARMY LIST

PATIENT CATEGORY CODE	DESCRIPTION	FLAGS	BENEF SHORT DESC ARMY	AUTH FOR ARM
S37	FGN NTL AUTH CARE PER AGREEMENT	910000	FGN NATL	4-24
S38	FGN NTL CIV PERS-LIAISON NATO/NATO/CENTO	910000	LIA NATO	4-26
S39	FGN NTL EMPL/DEPN US GOVT OCONUS, NEC	901000	FR NTL DEP	4-26
S41	FGN NATL DEP MIL DIPLOMAT NEC	910000	DEP MIL DIP	4-24
S42	DEPN NATO MIL PERS TRAIN W/US ARM FORC	901000	DEP FGN MIL	4-24
S43	DEPN OTH NATO MIL PERS NOT TRAIN	901000	DEP FGN MIL	4-24
S44	FGN NATL DEP OF NON NATO TNG W/US	901000	DEP NON-NATO	4-24
S45	FGN NATL DEPN NON-NATO MILITARY NEC	901000	DEP NON-NATO	4-24
S46	DEPN FGN NTL MIL SALES TRAINEES	901000	DEP MIL SALE	4-24 & 27
S47	DEPN FGN NTL MIL IN US FOR IMET, NEC	901000	DEP IMET	4-24 & 26
S48	DEPN OTH FGN MIL PERS,NEC	901000	OTH FGN MIL	4-24
S51	DEPN FGN NTL NON-MIL DIPL,NEC	901000	DEP DIPLO	4-24
S52	DEPN FGN NATO CIV PERS	901000	DEP NATO CIV	4-24
S53	DEPN FGN NTL NON-NATO CIV, NEC	901000	DEP NON-NATO	4-24
S54	DEPN AUTH FGN NTL IN US,NEC	901000	DEP FGN NATL	4-24
S55	DEPN AUTH FGN NTL, NEC	901000	DEP FGN NATL	4-24
S61	FGN NTL BENEF OF DISASTER RELIEF AGEN	910000	BENE DRA	4-71
S62	FGN NTL CRW/PAX NATO/CENTO ACRAFT	910000	FGN NATL CRW	4-27
S63	FGN NTL DOD DOM ACT PROG PARTIC	910000	FGN NATL DOD	4-45
S64	FGN NTL/PROV DIR SVC TO US FORC & DEPN	910000	FGN NATL	4-24
S65	FGN NTL DOMESTIC SERV OCONUS	910000	DOM SER	4-64
X11	APPL FOR CADET IN USMA	910000	APPL USMA	4-6
X12	APPL FOR CADET IN USNA	910000	APPL USNA	4-6
X13	APPL FOR CADET IN USAFA	910000	APPL USAF	4-6
X14	APPL FOR CADET IN USCGA	910000	APPL USCGA	4-6
X15	APPL/ENL, REENL IN ARM FORC, SELEC SERV	910000	APPL SEL SVC	4-7
X16	APPL APPOINT/WARRANT/COMMISION NEC	910000	APPL DOD APT	4-8
X17	NON-SELEC SVC REG FOR REENL IN NTL GRD	910000	APPL IN USNG	4-7
X18	NON-SELEC SVC REG FOR REENL IN RSV	910000	APPL IN USAR	4-7
X19	APPL FOR APPT OCONUS BENE	910000	APPL FOR BEN	4-34
X21	US CIV POW RELEAS FROM AD, OFF	910000	REFRAD OFF	4-68
X22	US CIV POW RELEAS FROM AD, ENL	910000	REFRAD ENL	4-68
X23	DEPN US CIV RETURN POW-FORMER SVC MBR	901000	DEP RNT POW	4-68
X31	US CIV CLAIMANT DOD	910000	CLAIM DOD	4-54
X32	USA CIV CLAIMANT	910000	CLAIM ARMY	4-54
X33	USN CIV CLAIMANT	910000	CLAIM NAVY	4-54
X34	USMC CIV CLAIMANT	910000	CLAIM USMC	4-54
X35	USAF CIV CLAIMANT	910000	CLAIM USAF	4-54
X36	CIV EMPL/OTH FED AGENC/NON-DOD, NEC	910000	CLAIM N-DOD	4-32 & 54
X41	REDD CROSS EMPLOYEE	910000	EMP RED CR	4-49
X42	RED CROSS VOLUNTEERS	910000	VOL WRKER	4-49
X43	CIV STUDENT EMPL-RED CROSS	910000	EMP R.C. STU	4-50
X44	ND OF HONOR DSCHG FEMALE	901000	ND/DSCHG SM	4-46
X45	CIV SEAMAN IN SVC OF MSTS/MSC	910000	MSC SEAMAN	4-48
X46	US CIV AUTH CARE PER AGRMNT	910000	PER AGREEM.	4-55
X47	FORMER MBR CITIZEN MIL TRAIN CORP	910000	CIT MIL TRNG	4-3
X48	US CIV-MIL SPONSOR ACTIV	910000	DOD ACTIV	4-53
X49	MISC CIV AUTH/DC GOVT/JROTC/CAP/CGAUX	910000	JR ROTC	4-53
X51	DEPN USO/RED CROSS	901000	DEP USO/RC	4-49 & 55
X52	DIVORC SPOUSE/RET MILITARY	901000	FORM SPOUSE	4-12
X61	HONOR DSCHG FEMALE-MATERN CARE	910000	DSCHG MAT	4-46
X71	NON-INDIGENT CIVILIAN	910100	NON-INDIGENT	4-54 & 61
X72	INDIGENT CIVILIAN	910000	DOD INDIGENT	4-61
X73	AB INF DEPN DAUGHTER	901000	AB DEP DAU	4-61
X74	VOLUN DONOR ORGAN/BLOOD NO CHG	910000	CIV DONOR	4-69,23-3 & 23-4
[illegible]	[illegible] RESEARCH PROJ	910000	JOE SUBJ	4-62

PATIENT CATEGORY ARMY LIST

PATIENT CATEGORY CODE	DESCRIPTION	FLAGS	BENEF SHORT DESC ARMY	AUTH FOR ADM
X76			NON-DOD BENE	4-34
X77	JOINT ORIENTATION CIV CONF GUEST	910000	CIV CONF GUE	4-61

PATIENT CATEGORY AIR FORCE LIST

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PATIENT CATEGORY CODE	DESCRIPTION	FLAGS	SHORT DESCRIPTION
A11	ACT-DUTY ARMY	110001	
A12	ARMY NAT GUARD	110001	
A13	CADET ARMY ACADEMY	110001	
A14	FEMALE FORMER MILITARY ARMY	11000100	
A21	ARMY RESERVE	110001	
A31	RET (LOS) ARMY	210001	
A32	RET (PDRL) ARMY	210001	
A33	RET (TDRL) ARMY	210001	
A41	DEPN AD ARMY	301000	
A42	DEPN RET ARMY	301000	
A43	DEP AD/DEC ARMY	301000	
A44	DEP RET/DEC ARMY	301000	
A45	NEWBORN OF FEMALE FORMER ARMY	90100000	
A51	AD NATO ARMY	91000	
A52	DEPN NATO ARMY	901000	
F11	ACT-DUTY USAF	110011	
F12	AF NAT GUARD	110011	
F13	CADET USAF ACAD	110001	
F14	FEMALE FORMER MILITARY USAF	11000100	
F21	AF RESERVE	110011	
F31	RET (LOS) USAF	210001	
F32	RET (PDRL) USAF	210001	
F33	RET (TDRL) USAF	210001	
F41	DEPN AD USAF	301000	
F42	DEPN RET USAF	301000	
F43	DEPN AD/DEC USAF	301000	
F44	DEPN RET/DEC USAF	301000	
F45	NEWBORN OF FEMALE FORMER USAF	90100000	
F51	AD NATO AF	910000	
F52	DEPN NATO AF	901000	
M11	ACT-DUTY MARINE	110001	
M12	USMC NAT GUARD	110001	
M14	FEMALE FORMER MILITARY USMC	11000100	
M21	USMC RESERVE	110001	
M31	RET (LOS) USMC	210001	
M32	RET (PDRL) USMC	210001	
M33	RET (TDRL) USMC	210001	
M41	DEPN AD USMC	301000	
M42	DEPN RET USMC	301000	
M43	DEPN AD/DEC USMC	301000	
M44	DEPN RET/DEC USMC	301000	
M45	NEWBORN OF FEMALE FORMER USMC	90100000	
M51	AD NATO MARINE	910000	
M52	DEPN NATO MARINE	901000	
N11	ACT-DUTY NAVY	110001	
N12	NAVY NAT GUARD	110001	
N13	MIDSHIPMAN NAVY	110001	
N14	FEMALE FORMER MILITARY NAVY	11000100	
N21	NAVY RESERVE	110001	
N31	RET (LOS) NAVY	210001	
N32	RET (PDRL) NAVY	210001	
N33	RET (TDRL) NAVY	210001	
N41	DEPN AD NAVY	301000	
N42	DEPN RET NAVY	301000	
N43	DEPN AD/DEC NAVY	301000	
[illegible]	DEPN RET/DEC NAVY	301000	

PATIENT CATEGORY CODE	DESCRIPTION	FLAGS	SHORT DESCRIPTION
N45	NEWBORN OF FEMALE FORMER NAVY	90100000	
N51	AD NATO NAVY	910000	
N52	DEPN NATO NAVY	901000	
011	ACT-DUTY NOAA	11000100	
012	NOAA NAT GUARD	11000100	
021	NOAA RESERVE	11000100	
031	RET (LOS) NOAA	21000100	
032	RET (PDRL) NOAA	21000100	
033	RET (TDRL) NOAA	21000100	
041	DEPN AD NOAA	30100000	
042	DEPN RET NOAA	30100000	
043	DEPN AD/DEC NOAA	30100000	
044	DEPN RET/DEC NOAA	30100000	
P11	ACT-DUTY USCG	11000100	
P12	CG NAT GUARD	11000100	
P13	CADET USCG ACADEMY	11000100	
P21	USCG RESERVE	11000100	
P31	RET (LOS) USCG	21000100	
P32	RET (PDRL) USCG	21000100	
P33	RET (TDRL) USCG	21000100	
P41	DEPN AD USCG	30100000	
P42	DEPN RET USCG	30100000	
P43	DEPN AD/DEC USCG	30100000	
P44	DEPN RET/DEC USCG	30100000	
W11	ACT-DUTY USPHS	11000100	
W12	USPHS NAT GUARD	11000100	
W21	USPHS RESERVE	11000100	
W31	RET (LOS) USPHS	21000100	
W32	RET (PDRL) USPHS	21000100	
W33	RET (TDRL) USPHS	21000100	
W41	DEPN AD USPHS	30100000	
W42	DEPN RET USPHS	30100000	
W43	DEPN AD/DEC USPHS	30100000	
W44	DEPN RET/DEC USPHS	30100000	
X19	FORMER POW/HOSTAGE	91000000	
X53	ACT-DUTY NON-NATO	91000000	
X54	DEPN AD NON-NATO	90100000	
X55	CIV IN SATP	91000000	
X56	DEPN CIV IN SATP	90100000	
X57	FOREIGN NATL IN US	91000000	
X58	FOREIGN NATL - US EMPL	91000000	
X59	FOREIGN NATL - OTHER BENE	91000000	
X61	CIV EMPL OVERSEA	91010000	
X62	DEPN CIV EMPL OVERSEA	90110000	
X63	STATE DEPT EMPL OVERSEA	91010000	
X64	DEPN STATE DEPT EMPL OVERSEA	90110000	
X65	CIV EMPL EXECUTIVE	91010000	
X69	OTHER CIV EMPL	90010000	
X71	CIV VA BENE	910100	
X72	CIV WORKMAN COMP PROGRAM	91010000	
X73	CIV SOC SEC ADMIN	91010000	
X74	CIV SPECIAL BENE	91010000	
X75	AMERICAN INDIAN	91010000	
X76	FED PRISONER	91010000	
X[illegible]	RED CROSS	91010000	

PATIENT CATEGORY AIR FORCE LIST

PATIENT CATEGORY CODE	DESCRIPTION	FLAGS	SHORT DESCRIPTION
		91010000	
X83	POW	91010000	
X84	INTERNEES	91010000	
X91	CIV ER	91010000	
X98	OTHER CIV	91010000	
X99	OTHERS		

PATIEN
CATEGORY

CODE	DESCRIPTION	FLAGS	SHORT DESCRIPTION
A11	USAR ACTIVE DUTY	11000101	ACDU-A
A12	USAR ACDUTRA	11000101	ACDUTRA-A
A13	USAR ACTIVE DUTY CADET	11000101	ACAD-CAD-A
A21	USAR INACDUTRA	91000101	INACDUTRA-A
A22	USAR RETAINED BEYOND ACDUTRA	11000101	RETACDUTRA-A
A31	USAR RETIRED - LENGTH OF SERVICE	210001	RET-A-LOS
A32	USAR RETIRED - PDRL	210001	RET-A-PDRL
A33	USAR RETIRED - TDRL	210001	RET-A-TDRL
A41	USAR AD DEPN	301000	DEP-ACDU-A
A42	USAR DEPN RETIRED	301000	DEP-RET-A
A43	USAR DEPN DECEASED AD	301000	DEP-D-ACDU-A
A44	USAR DEPN DECEASED RETIRED	301000	DEP-D-RET-A
F11	USAF ACTIVE DUTY	11000101	ACDU-F
F12	USAF ACTIVE DUTY TRAINING	11000101	ACDUTRA-F
F13	USAF ACTIVE DUTY CADET	11000101	ACAD-CAD-F
F21	USAF INACTIVE DUTY TRAINING	91000101	INACDUTRA-F
F22	USAF RET AD TRAINING	11000101	RETACDUTRA-F
F31	USAF RETIRED LOS	210001	RET-F-LOS
F32	USAF RETIRED PDRL	210001	RET-F-PDRL
F33	USAF RETIRED TDRL	210001	RET-F-TDRL
F41	DEPN USAF ACTIVE DUTY	301000	DEP-ACDU-F
F42	DEPN USAF RETIRED	301000	DEP-RET-F
F43	DEPN USAF DECEASED AD	301000	DEP-D-ACDU-F
F44	DEPN USAF DECEASED RETIRED	301000	DEP-D-RET-F
H61	US CIVILIAN EMPLOYEE NEC	910000	CIVEMP-NEC
H62	DEPN US CIVILIAN EMPLOYEE NEC	301000	D-CIVEMP-NEC
H63	FBI AGENTS FOR CLS AGAINST USG	910000	FBI-CLAIMANT
H64	STATE DEPT-FSO FOR EMPLOYEE	910000	STDEPT-FSO
H65	DEPN STATE DEPARTMENT	301000	STDEPT-DEP
K71	VETERANS ADMIN BENEFICIARY	910000	VAB
K72	OFFICE OF WORKERS COMP PROG	910000	OWCP
K73	SECRETARY OF NAVY DESIGNEE	910000	SECNAVDESG
K74	BENEFICIARIES OF SOC SECY ADMIN	910000	BENSOCSECADM
K75	OTHER BENEFICIARIES PHS	910000	BENPHS
K76	BENEFICIARIES OF THE NAVAL HOME	910000	BENNAVHOME
K77	ALL OTHER BENEFICIARIES	910000	AOB-NEC
M11	USMC ACTIVE DUTY	1100011	ACDU-MC
M12	USMC ACTIVE DUTY TRAINING	11000101	ACDUTRA-M
M14	USMC AD AVIATION CADET	1100011	AVIA-CAD-M
M15	USMC AD RECRUIT TRAINING	1100011	ACDU-MC-URT
M21	USMC INACTIVE DUTY TRAINING	91000101	INACDUTRA-M
M22	USMC RET AD TRAINING	11000101	RETACDUTRA-M
M31	USMC RETIRED LOS	210001	RET-M-LOS
M32	USMC RETIRED PDRL	210001	RET-M-PDRL
M33	USMC RETIRED TDRL	210001	RET-M-TDRL
M41	DEPN USMC ACTIVE DUTY	301000	DEP-ACDU-M
M42	DEPN USMC RETIRED	301000	DEP-RET-M
M43	DEPN USMC DECEASED AD	301000	DEP-D-ACDU-M
M44	DEPN USMC DECEASED RET	301000	DEP-D-RET-M
N11	USN ACTIVE DUTY	11000101	ACDU-N
N12	USN ACTIVE DUTY TRAINING	11000101	ACDUTRA-N
N13	USN ACTIVE DUTY ACAD CADET	11000101	ACAD-CAD-N
N14	USN ACTIVE DUTY AVIATION CADET	11000101	AVIA-CAD-N
N15	USN AD RECRUIT TRAINING	11000101	ACDU-N-URT
N21	USN INACTIVE DUTY TRAINING	91000101	INACDUTRA-N
N22	USN RETAINED AD TRAINING	11000101	RETACDUTRA-A

PATIENT CATEGORY CODE	DESCRIPTION	FLAGS	SHORT DESCRIPTION
N31	USN RETIRED LOS	210001	RET-NAV-LOS
N32	USN RETIRED PDRL	210001	RET-NAV-PDRL
N33	USN RETIRED TDRL	210001	RET-NAV-TDRL
N41	DEPN USN ACTIVE DUTY	301000	DEP-ACDU-N
N42	DEPN USN RETIRED	301000	DEP-RET-N
N43	DEPN USN DECEASED AD	301000	DEP-D-ACDU-N
N44	DEPN USN DECEASED RETIRED	301000	DEP-D-RET-N
011	USNOA ACTIVE DUTY	110001	ACDU-NOAA
031	USNOA RETIRED LOS	210001	RET-NOAA-LOS
032	USNOA RETIRED PDRL	210001	RET-NOAA-PDR
033	USNOA RETIRED TDRL	210001	RET-NOAA-TDR
041	DEPN USNOA ACTIVE DUTY	301000	DEP-ACDU-NOA
042	DEPN USNOA RETIRED	301000	DEP-RET-NOA
043	DEPN USNOA DECEASED AD	301000	DEP-D-AC-NOA
044	DEPN USNOA DECEASED RETIRED	301000	DEP-D-RE-NOA
P11	USCG ACTIVE DUTY	110001	ACDU-C
P12	USCG ACTIVE DUTY TRAINING	110001	ACDUTRA-C
P13	USCG ACTIVE DUTY ACAD CADET	110001	ACAD-CAD-C
P21	USCG INACTIVE DUTY TRAINING	910001	INACDUTRA-C
P22	USCG RETAINED AD TRAINING	110001	RETACDUTRA-C
P31	USCG RETIRED LOS	210001	RET-C-LOS
P32	USCG RETIRED PDRL	210001	RET-C-PDRL
P33	USCG RETIRED TDRL	210001	RET-C-TDRL
P41	DEPN USCG ACTIVE DUTY	301000	DEP-ACDU-C
P42	DEPN USCG RETIRED	301000	DEP-RET-C
P43	DEPN USCG DECEASED AD	301000	DEP-D-ACDU-C
P44	DEPN USCG DECEASED RETIRED	301000	DEP-D-RET-C
081	PRISONER OF WAR	910000	POW
S51	NATO ACTIVE DUTY	910000	NATO-AD
S52	DEPN NATO ACTIVE DUTY	301000	DEP-NATO-AD
S53	NON-NATO ACTIVE DUTY	910000	ACDU-N-NATO
S54	DEPN NON-NATO	301000	NON-NATO-DEP
S58			
W11	USPHS ACTIVE DUTY	110001	ACDU-PHS
W31	USPHS RETIRED LOS	210001	RET-PHS-LOS
W32	USPHS RETIRED PDRL	210001	RET-PHS-PDRL
W33	USPHS RETIRED TDRL	210001	RET-PHS-TDRL
W41	DEPN USPHS ACTIVE DUTY	301000	DEP-ACDU-P
W42	DEPN USPHS RETIRED	301000	DEP-RET-P
W43	DEPN USPHS DECEASED AD	301000	DEP-D-ACDU-P
W44	DEPN USPHS DECEASED RETIRED	301000	DEP-D-RET-P
X82	MERCHANT MARINE MIL SEALIFT CMMND	910000	MM-MIL-S-CMD
X83	MERCHANT MARINE PRIVATE PARTY	910000	MM-PRIV-PRTY
X84	SELEC SVC REG/APPL ENL/REENL	910000	
X85	EX SERVICE MATERNITY	910000	EXSVC-MATRNY
X86	AMERICAN RED CROSS	910000	AMER-RED-X
X87	NON INDIGENT CIVILIAN	910000	NON-IND-CIV
X88	INDIGENT CIVILIAN	910000	IND-CIV
X89	ALL OTHER NEC	910000	ALL-OTH-NEC

SOURCE OF ADM (Table) LIST MAR 26,1985 10:21 PAGE 1

SOURCE OF ADM CODE	DESCRIPTION	FLAGS	SERVICE FLAG	ARMY CODE	AIRFORCE CODE	NAVY CODE
ABS	DIRECT,ABSENT SICK	011	AF	0	20	
CAN	CANCEL ADMISSION	7	AFN			
CAS	DIRECT, CASUAL	1	F		01	
CBC	BATTLE CASUALTY, CRO	502	A	C		
CDA	DEAD ON ARRIVAL, AD MILITARY CRO	512	A	C		
CDO	DEAD ON ARRIVAL, NON AD, CRO	502	A	C		
CDS	DISABILITY SEPARATION, CRO	512	A	C		
COT	OTHER CARDED FOR RECORD ONLY	502	A	C		
CRO	CARDED FOR RECORD ONLY	502	F		21	
DIR	DIRECT ADMISSION	1	AFN	1	00	00
ERD	EMERGENCY ROOM DEATH	503	F		23	
FTM	TRANSFER FROM ANOTHER MILITARY MTF	305	N			10
FTO	TRANSFER FROM OTHER MEDICAL FACILITIES	3	N			11
LB	LIVE BIRTH	2	N			31
NB	NEWBORN THIS MTF	2	A	L		
NBD	NEWBORN WITH MOTHER DIRECT	2	N			32
NBR	NEWBORN RETAINED	4	N			34
NBT	NEWBORN WITH MOTHER FROM TRANSFER	2	N			33
NEW	LIVEBORN INFANTS (NEWBORN), THIS MTF	2	F		30	
P/S	NEWBORN TO PAY	4	A	L		
PRE	PREADMIT	600	AFN			
QTR	ADMITTED TO QUARTERS	814	F		22	
RET	NEWBORN RETAINED	4	F		34	
TAF	TRANSFER FROM USAF HOSPITAL	3	A	8		
TAR	TRANSFER FROM US ARMY HOSPITAL	3	A	6		
TDP	TRANSFER FROM USN,USAF DISPENSARY	3	A	5		
TFM	TRANSFER FROM FOREIGN MILITARY MTF	3	A	9		
TFR	TRANSFER FROM ANOTHER MILITARY MTF	305	F		10	
TNV	TRANSFER FROM USN HOSP/HOSP SHIP	3	A	7		

ABSENT STATUS (table) LIST

MAR 27,1985 10:23 PAGE 1

ABSENT STATUS CODE	DESCRIPTION	FLAGS	SERVICE FLAG	ARMY BUCKET NBR	AIR FORCE BUCKET NBR	NAVY BUCKET NBR	NAVY TRANS CODE
AC	ABSENT IN CUSTODY OF CIVILIAN AUTHORITIES	21001	FN			4	81
AG	AWOL(MORE THAN 10 DAYS) DFR	21001	FA	2			
AM	ABSENT IN CUSTODY OF MILITARY AUTHORITIES	21001	FAN	2		4	81
AS	ABSENT SICK NON-MILITARY MTF	2110101	FA	1			
AW	AWOL(LESS THAN 10 DAYS)	21001	FAN	2		4	83
BO	BED OCCUPANT THIS MTF	10011010	FAN	5	5	5	80
CC	COOPERATIVE CARE	2	AN	3	1	1	80
CL	CONVALESCENT LEAVE	22000000	FAN	3	3	3	82
CR	CARDED FOR RECORD ONLY	2020101	FA				
ER	EMER ROOM DEATH	10301010	F				
MH	MEDICAL HOLDING	21001111	AN				30
OL	EMERGENCY LEAVE	21001	FAN	2		4	82
OR	ORDINARY LEAVE	21001	A				
OT	OTHER AUTHORIZED ABSENCE	21001	A				
PH	PCS HOME PENDING SEPARATION/RETIREMENT	2100001	FA	2			
PS	ON PASS	2001101	FA	5	5		
PV	PCS VA HOSPITAL PENDING SEPARATION/RETIREMENT	2100011	AF	2			
QT	ABSENT IN QUARTERS	210000	F				
SC	SUPPLEMENTAL CARE	20001000	FAN	4	2	2	81
SE	SUBSISTING ELSEWHERE	21000	FAN	2		4	81
TD	TEMPORARY DUTY/SPECIAL DUTY	21000	A	2	2		

TYPE CASE (table) LIST

TYPE CASE CODE	DESCRIPTION	FLAGS	ARMY CODE	ARMY/AF ITRCS MNEMONIC	AF CODES	SERVICE FLAG
AST	ASSAULT OR INTENTIONALLY INFLICTED BY ANOTHER PERSON	1	3	INJ		A
BC	OTHER BATTLE*CASUALTIES CLASSIFIABLE BY DEPARTMENTAL REGULATIONS	11	1	BC	1	AF
DIS	DISEASE CASES AND ALL OTHER CASES NOT COVERED ELSEWHERE		0	DIS	D	AFN
EXR	INJURY SCHEMES AND EXERCISES	1	6	INJ		A
HST	DIRECT RESULT OF ACTION BY/AGAINST ORGANIZED ENEMY	01	0	BC		A
INJ	INJURY, NOT CLASSIFIABLE AS BATTLE CASUALTY	10		INJ	C	NF
LEG	RESULT OF INTERVENTION OF LEGAL AUTHORITY	11	2	INJ		A
OFF	OFF DUTY INJURY (INC LEAVE,PASS,AWOL)	1	5	INJ		A
OND	OCCURING WHILE ON DUTY	11	8	INJ		A
SLF	INJURY - INTENTIONALLY SELF-INFLICTED	1	4	INJ		A
TRN	INJURY - ALL OTHER TRAINING	11	7	INJ		A
UNK	INJURY UNK ON/OFF DUTY OR NON-MILITARY	1	9	INJ		

CLINICAL SVC (table) LIST — MAR 28,1985 13:22 — PAGE 1

CLINICAL SVC/MTF CODE	DESCRIPTION	FLAGS	VALID WARDS	ARMY CODE	TRICS SHORT DESC	SERVICE FLAG
AAA	INTERNAL MEDICINE	000				FN
AAAA	INTERNAL MEDICINE		6S14E	AA	INT MED	A
AAAB	INFECTIOUS DISEASE			AU	INF DIS	A
AAAC	ALLERGY			AN	ALGY/IMM	A
AAAF	FP INTERNAL MEDICINE			EA	FP MED	A
AAB	CARDIOLOGY	000				FN
AABA	CARDIOLOGY			AR	CARDIO	A
AABF	FP CARDIOLOGY			EA	FP MED	A
AAC	CORONARY CARE UNIT	000			CCU	FN
AACA	CORONARY CARE UNIT		16S1		CARDIO	A
AACF	CORONARY CARE FP			EA	FP MED	A
AAD	DERMATOLOGY	000				FN
AADA	DERMATOLOGY			AD	DERM	A
AADF	DERMATOLOGY			EA	FP MED	A
AAE	ENDOCRINOLOGY	000				FN
AAEA	ENDOCRINOLOGY			AE	ENDOCN	A
AAEF	ENDO FAM PRAC			EA	FP MED	A
AAF	GASTROENTEROLOGY	000				FN
AAFA	GASTROENTEROLOGY			AF	GASTRO	A
AAFF	FP GASTROENTEROLOGY			EA	FP MED	A
AAG	HEMATOLOGY	000				FN
AAGA	HEMATOLOGY			AG	HEMAT	A
AAGF	HEMA FAM PRACT			EA	FP MED	A
AAH	INTENSIVE CARE (MEDICINE)	000			ICU	FN
AAHA	INTENSIVE CARE UNIT (MEDICAL)		14S1	AH	ICU'	A
AAHF	FP MED ICU			EA	FP MED	A
AAI	NEPHROLOGY	000				FN
AAIA	NEPHROLOGY			AI	NEPHRO	A
AAJ	NEUROLOGY	000				FN
AAJA	NEUROLOGY			AJ	NEURO	A
AAJF	FP NEUROLOGY			EA		A
AAK	ONCOLOGY	000				FN
AAKA	ONCOLOGY			AK	ONCOL	A
AAL	PULMONARY UPPER RESPIR(NON-TB)	000				FN
AALA	PULMONARY/UPPER RESPIRATORY			AL	PUL DIS	A
AAM	RHEUMATOLOGY	000				FN
AAMA	RHEUMATOLOGY			AM	RHEUMAT	A
AAMF	RHEUM FAM PRAC			EA	FP MED	A
AAN	INTERMEDIATE CARE	000				FN
AAP	FAMILY PRACTICE					FN
AAR	ALLERGY	000				FN
AAS	PULMONARY UPPER RESPIR(TBC)	000				FN
AAZ	MEDICAL CARE N.E.C.					FN
ABA	GENERAL SURGERY	000				FN
ABAA	GENERAL SURGERY			BA	GEN SURG	A
ABB	THORACIC/CARDIOVASC SURG	000				FN
ABBA	CARD VAS THOR SURG			BB	THORAC SURG	A
ABBB	PERIPHERAL VASC			BN	PV SURG	A
ABC	INTERSIVE CARE (SURGICAL)	000				FN
ABCA	INTENSIVE CARE UNIT (SURGICAL)		14S1	BA	GEN SURG	A
ABCB	TRAUMA			AA	INT MED	A
ABCF	FP SURG ICU			EB	FP SURG	A
ABD	NEUROSURGERY	000				N
ABDA	NEUROSURGERY			BD	NEUROSURG	
		000				N

CLINICAL SVC (Table) LIST — MAR 26,1985 13:22 — PAGE 2

CLINICAL SVC/MTF CODE	DESCRIPTION	FLAGS	VALID WARDS	ARMY CODE	TRICS SHORT DESC	SERVICE FLAG
ABF	ORAL SURGERY	000				FN
ABFA	ORAL SURGERY			BE	ORAL SURG	A
ABG	OTORHINOLARYNGOLOGY	000			ENT	FN
ABGA	OTORHINOLARYNGOLOGY			HB	ENT	A
ABGF	FP OTORHINOLARYNGOLOGY			EB	FP SURG	A
ABH	PEDIATRIC SURGERY	200				FN
ABHA	PEDIATRIC SURGERY	2		BF	PED SURG	A
ABHF	PED SURG FAM PRAC			EF	FP PED	A
ABI	PLASTIC SURGERY	000				FN
ABIA	PLASTIC SURGERY			BG	PLAS SURG	A
ABJ	PROCTOLOGY	000				FN
ABJA	PROCTOLOGY			BH	PROCTO	A
ABJF	PROC FAM PRAC			BH	PROCTO	A
ABK	UROLOGY	000				FN
ABKA	UROLOGY			BI	UROLOGY	A
ABKF	FP UROLOGY			EB	FP SURG	A
ABL	HAND SURGERY			BJ	HAND SURG	FN
ABSK	ABSENT SICK IN NON-MILITARY HOSP	011		92	ABSK	A
ABZ	SURGICAL CARE (SERVICE NEC)	000				FN
ABZA	ORGAN TRANSPLANT			BL	ORG TRANS	A
ABZB	SURGICAL CARE N.E.C					A
ACA	GYNECOLOGY	300				FN
ACAA	GYNECOLOGY	3	15E1	CA	GYN	A
ACAF	FP GYNECOLOGY			ED	FP GYN	A
ACB	OBSTETRICS	300				FN
ACBA	LABOR/DELIVERY	3	5E	CB	OB	A
ACBF	FP LABOR/DELIVERY			EC	FP OB	A
ADA	PEDIATRICS	200				FN
ADAA	PEDIATRICS	2	14E1	DA	PED	A
ADAF	FP PEDIATRICS	2		EF	FP PED	A
ADB	NURSERY	100				FN
ADBA	NURSERY	10	5S	DB	NB	A
ADBF	FP NURSERY	1		EF	FP PED	A
ADC	NEONATAL ICU	100				FN
ADCA	NURSERY (NEONATAL)	10	4E	DE	PED	A
ADCF	NEONATAL ICU FAM PR			EF	FP PED	A
ADZ	PEDIATRIC CARE NEC	200				FN
ADZA	ADOLESCENT PEDIATRICS	2	14E1	DC	ADOL PED	A
AEA	ORTHOPEDICS	000				FN
AEAA	ORTHOPEDICS			FA	ORTHO	A
AEAF	FP ORTHOPEDICS			EG	FP ORTHO	A
AEB	PODIATRY	000				FN
AEBA	PODIATRY			FB	PODIA	A
AEBF	FP PODIATRY			EG	FP ORTHO	A
AFA	PSYCHIATRIC CARE			GA	PSY	FN
AFAF	FP PSYCHIATRIC CARE			EH	FP PSY	A
AJA	QUARTERS	014				FN
AJB	CARDED FOR RECORD ONLY	002				FN
AJC	IN NON-FEDERAL HOSPITAL	011				FN
AJD	PREGNANT IN QUARTERS	314				FN
AJE	EMERGENCY ROOM DEATH	003		92		FN
CRO	CARDED FOR RECORD ONLY	002		ZZ	CRO	A

DISP TYPE (Table) LIST

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DISP TYPE CODE	DESCRIPTION	FLAGS	SERVICE FLAG	ARMY CODE	AIR FORCE CODE	NAVY CODE
ARS	DISCHARGED TO ALCOHOL REHABILITATION SERVICE	0100	N			12
AWOL	ABSENT WITHOUT LEAVE OVER 10 DAYS	010	FA	D	S	
CL	DISCHARGED, CONVALSCENT LEAVE RECOMMENED	010	N			11
CROO	CRO - OTHER	231	A	Y		
DAAP	NONDISABILITY SEPN FOR DRUG & ALCOHOL ABUSE PROG	01	A	I		
DAMA	DISCHARGED AGAINST MEDICAL ADVICE	0201	AF	P	P	
DANP	DEATH, AUTOPSY NOT PERFORMED	2311	F		8	
DAP	DEATH, AUTOPSY PERFORMED	2311	F		7	
DETS	SEPN UP AR 635-200 ETS	01	A	L		
DFT	DISCHARGE FROM TREATMENT (NON-MILITARY PATIENTS ONLY)	0201	FA	O	U	
DIED	DIED	2311	N			20
DISN	NEWBORN - DISCHARGED	0201	A	O		
DMPS	SEPN UP AR 635-200 MEDICAL PROCUREMENT STDS	011	A	J		
DMT	DEATH, MATERNAL	231	A	V		
DNEW	NEWBORN DIED - MOTHER REMAINING	2201	A	W		
DNFS	SEPN UP AR 635-200 UNFIT/UNSUITABLE	01	A	K		
DNN	DEATH, NEO-NATAL (LESS THAN 27 DAYS)	2211	A	Q		
DNSA	DEATH, NO STATEMENT AS TO AUTOPSY	2311	F		9	
DOA	CRO - DEAD ON ARRIVAL	231	A	X		
DOTH	DEATH, ALL OTHER	2311	A	W		
DSD	DISCHARGE FROM HOSPITAL SAME DAY	431	F		X	
DUTY	RETURNED TO DUTY	0100	AF	A	A	
EPTS	DISCHARGE UNDER PROVISION OF ATCR 39-6	0100	F		B	
EUS	EVACUATED TO US	3301	F		M	
HOME	DISCHARGED TO DUTY/HOME	0301	N			10
OTH	OTHER DISPOSITION (MILITARY PATIENTS ONLY)	010	F		T	
PDRL	PERMANENT RETIREMENT FOR PHYSICAL DISABILITY	011	FA	E	C	
PRED	PRE-DISPOSITIONED	1301	N			
SEP	OTHER SEPARATIONS	011	A	M		
SWOP	SEPARATION WITHOUT SEVERANCE PAY (PER)	011	FA	H	F	
SWPL	SEPARATION WITH SEVERANCE PAY (PFB)	011	FA	G	E	
TAF	TRANSFER TO ARMY FACILITY	3301	FA	S	K	
TDRL	TEMPORARY RETIREMENT FOR PHYSICAL DISABILITY	011	FA	F	D	
TDUT	TO DUTY FROM TDRL	011	A	R		
TFF	TRANSFER TO AIR FORCE FACILITY	3301	FA	U	J	
TFR	TRANSFERED	3311	N			01
TNF	TRANSFER TO NAVY FACILITY	3301	FA	T	L	
TPDR	TO PDRL FROM TDRL	011	A	C		

MILITARY THEATRE OF OPERATIONS LIST

NAME	DESCRIPTION
99	NOT APPLICABLE
A1	LEBANON, HOSTILE
A2	LEBANON, NON-HOSTILE
B1	GRENADA, HOSTILE
B2	GRENADA, NON-HOSTILE

CAUSE OF INJURY (table) LIST MAR 24,1985 10:39 PAGE 1.

CAUSE OF INJURY CODE	DESCRIPTION
0	AIR ACCIDENT, FIXED-WING MILITARY, BOARDING OR ALIGHTING
1	AIR ACCIDENT, FIXED-WING MILITARY, TAXIIN,TAKEOFF,LANDING ON CARRIER
2	AIR ACCIDENT, FIXED-WING MILITARY, TAKEOFF,OTHER (INC CRASH ON TAKEOFF)
3	AIR ACCIDENT, FIXED-WING MILITARY, TAKEOFF,OTHER (INC TAXI COLLISION)
4	AIR ACCIDENT, FIXED-WING MILITARY, LANDING (INC CRASH ON LANDING)
5	AIR ACCIDENT, FIXED-WING MILITARY, TERM OF FLIGHT NOT AT AIRFIELD
6	AIR ACCIDENT, FIXED-WING MILITARY, RADIATION INJURY & OTHER NUC
9	AIR ACCIDENT, FIXED-WING MILITARY, OTHER INJURY
10	AIR ACCIDENT, ROTARY-WING MILITARY, BOARDING OR ALIGHTING
11	AIR ACCIDENT, ROTARY-WING MILITARY, TAXIING,TAKEOFF,LANDING ON CARRIER
12	AIR ACCIDENT, ROTARY-WING MILITARY, TAXIING (INC COLLISION) & HOVERING
13	AIR ACCIDENT, ROTARY-WING MILITARY, TAKEOFF
14	AIR ACCIDENT, ROTARY-WING MILITARY, LANDING
15	AIR ACCIDENT, ROTARY-WING MILITARY, TERMINATION OF FLIGHT
16	AIR ACCIDENT, ROTARY-WING MILITARY, OTHER
17	AIR ACCIDENT, OTHER MILITARY AIRCRAFT, GLIDER
18	AIR ACCIDENT, OTHER MILITARY AIRCRAFT, LIGHTER-THAN-AIR CRAFT
19	AIR ACCIDENT, OTHER MILITARY AIRCRAFT, PLATFORM OR LIKE AIRCRAFT
20	AIR ACCIDENT, PARACHUTING FROM DAMAGED OR FAILED MILITARY AIRCRAFT
21	AIR ACCIDENT, PARACHUTING FROM OK MIL CRAFT, INJ BY JET BLAST,FLANE PART
22	AIR ACCIDENT, PARACHUTING FROM OK MIL CRAFT, INJ BY CHUTE OPEN FAILURE
23	AIR ACCIDENT, PARACHUTING FROM OK MIL CRAFT, INJ BY OPENING SHOCK
24	AIR ACCIDENT, PARACHUTING FROM OK MIL CRAFT, INJ BY INITIAL GROUND IMPACT
25	AIR ACCIDENT, PARACHUTING FROM OK MIL CRAFT, INJ BY DRAGGED AFTER LANDING
26	AIR ACCIDENT, PARACHUTING FROM OK MIL CRAFT, INJ BY OTHER CIRCUMSTANCES
28	MILITARY AIRCRAFT ACCIDENT NOT IN FLIGHT, ON AIRCRAFT CARRIER
29	MILITARY AIRCRAFT ACCIDENT NOT IN FLIGHT, NOT SPEC TO BE ON CARRIER
30	AIR ACCIDENT, FLIGHT IN COMMERCIAL TRANSPORT FIXED-WING OR UNSPEC WING
31	AIR ACCIDENT, FLIGHT IN COMMERCIAL OTHER WING (INC ROTARY)
32	AIR ACCIDENT, FLIGHT IN OTHER & UNSPEC NON-MIL FIXED WING AND UNSPEC WING
33	AIR ACCIDENT, FLIGHT IN OTHER & UNSPEC NON-MIL CRAFT (INC ROTARY WING)
34	AIR ACCIDENT, BOARDING/ALIGHTING FROM COMMERCIAL CRAFT (FIXED-WING/OTHER)
35	AIR ACCIDENT, BOARDING/ALIGHTING FROM OTH NON-MIL CRAFT(FIXED-WING/OTHER)
36	ACCIDENT NOT IN FLIGHT INVOLVING COMMERCIAL AIRCRAFT (FIXED-WING/OTHER)
37	ACCIDENT NOT IN FLIGHT INVOLVING NON-MIL AIRCRAFT (FIXED-WING/OTHER)
39	ACCIDENT NOT IN FLIGHT INVOLVING UNSPECIFIED NON MILITARY AIRCRAFT
40	ASTRONAUT IN SPACECRAFT INJURED BY BLAST-OFF ACCIDENT - NO ESCAPE
41	ASTRONAUT IN SPACECRAFT INJURED BY BLAST-OFF ACCIDENT - EJECTED
42	ASTRONAUT IN SPACECRAFT INJURED DURING ASCENT
43	ASTRONAUT IN SPACECRAFT INJURED WHILE IN ORBIT
44	ASTRONAUT IN SPACECRAFT INJURED DURING RE-ENTRY
45	ASTRONAUT IN SPACECRAFT INJURED ON IMPACT AFTER RE-ENTRY - NO ESCAPE
46	ASTRONAUT IN SPACECRAFT INJURED ON IMPACT AFTER RE-ENTRY - DID ESCAPE
47	SPACECRAFT ACCIDENT NOT IN FLIGHT - FUEL HANDLING INVOLVING GROUND CREW
48	SPACECRAFT ACCIDENT NOT IN FLIGHT - EXPLOSION INVOLVING GROUND CREW
49	SPACECRAFT ACCIDENT NOT IN FLIGHT - OTHER OR UNSPECIFIED ACCIDENT
51	ESCAPE INJURY, AIR OR SPACECRAFT CREW, FROM ACCELERATIVE FORCES ON FIRING
52	ESCAPE INJURY, AIR OR SPACECRAFT CREW, FROM IMPACT WITH PARTS OF CRAFT
53	ESCAPE INJURY, AIR OR SPACECRAFT CREW, FROM WINDBLAST
54	ESCAPE INJURY, AIR OR SPACECRAFT CREW, FROM FALL
55	ESCAPE INJURY, AIR OR SPACECRAFT CREW, IMPACT ON LAND (LAND OR WATER)
56	ESCAPE INJURY, AIR OR SPACECRAFT CREW, FROM UNDERWATER EJECTION
[illegible]	[illegible] OR SPACECRAFT CREW, FROM OTHER UNSPEC CIRCUMSTANCES

CAUSE OF INJURY (table) LIST MAR 26,1985 10:39

CAUSE OF INJURY CODE	DESCRIPTION
102	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJURY TO UNSPECIFIED OCCUPANT
103	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJURY IN BOARDING/ALIGHTING
104	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJURY TO PEDESTRIAN
105	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJURY TO PEDAL CYCLIST (DRIVER/RIDER)
106	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJURY TO MOTORCYCLIST (DRIVER/RIDER)
107	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJ OCCUPANT TRACKED/SEMI-TRACKED VEH
109	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJ TO OTHER/UNSPECIFIED PERSON
110	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO DRIVER (EXCEPT 116,117)
111	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO PASSENGER (EXCEPT 116,117)
112	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO UNSPECIFIED OCCUPANT
113	MOTOR VEH ACCIDENT, MIL OWNED, INJURY BOARDING/ALIGHTING VEHICLE
114	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO PEDESTRIAN
115	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO PEDAL CYCLIST (DRIVER/RIDER)
116	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO MOTORCYCLIST (DRIVER/RIDER)
117	MOTOR VEH ACCIDENT, MIL OWNED, INJ OCCUPANT TRACKED/SEMI-TRACKED VEHICLE
119	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO OTHER UNSPECIFIED PERSON
120	MOTOR VEH ACCIDENT, INVOLVING NON MILITARY OWNED VEHICLE
130	MOTOR VEH ACCIDENT, NON TRAFFIC, INVOLVING MILITARY OWNED VEHICLE
140	LAND TRANSPORT ACCIDENT - RAILWAY ACCIDENT
149	LAND TRANSPORT ACCIDENT - OTHER SPECIFIED ACCIDENT
150	WATER ACCIDENT, SUBMERSION IN BOARDING AND ALIGHTING
151	WATER ACCIDENT, SUBMERSION OF OCCUPANT OF SMALL BOAT
159	WATER ACCIDENT, OTHER SUBMERSION
160	WATER ACCIDENT, FALL IN BOARDING OR ALIGHTING
161	WATER ACCIDENT, TWIST,TURN,SLIP,RUN (NO FALL) IN BOARDING/ALIGHTING
162	WATER ACCIDENT, FALL ONE LEVEL TO ANOTHER, NOT IN BOARDING/ALIGHTING
163	WATER ACCIDENT, FALL SAME LEVEL, NOT BOARDING/ALIGHTING
164	WATER ACCIDENT, TWIST,TURN,SLIP,RUN (NO FALL) NOT BOARDING/ALIGHTING
170	WATER ACCIDENT INV MACHINERY, BOILERS AND GAUGES IN ENGINE ROOM
171	WATER ACCIDENT INVOLVING OTHER MACHINERY IN ENGINE ROOM
172	WATER ACCIDENT INVOLVING OTHER MACHINERY
190	OTHER WATER ACCIDENT, BOARDING/ALIGHTING EXCLUDES SUBMERSION & FALLS
191	OTHER WATER ACCIDENT, NOXIOUS FUMES (INCLUDES CARBON MONOXIDE)
192	OTHER WATER ACCIDENT, EXCESSIVE HEAT IN ENGINE ROOM, BOILER ROOM, ETC.
193	OTHER WATER ACCIDENT, INADEQUATE VENTILATION INCLUDES OXYGEN DEFICIENCY
194	OTHER WATER ACCIDENT, EFFECTS OF ROUGH WEATHER NEC (EXC SEASICKNESS-871)
195	OTHER WATER ACCIDENT, DIVING ACCIDENT
196	OTHER WATER ACCIDENT, WATERTIGHT DOORS AND HATCH COVERS
197	OTHER WATER ACCIDENT, RADIATION INJURY OR OTHER NUCLEAR
199	OTHER WATER ACCIDENT, OTHER NAUTICAL HAZARD
201	ATHLETIC ACCIDENT ON BOARD SHIP, BASKETBALL
203	ATHLETIC ACCIDENT ON BOARD SHIP, BOXING
204	ATHLETIC ACCIDENT ON BOARD SHIP, CALISTHENICS/GYMNASTICS ('PT')
207	ATHLETIC ACCIDENT ON BOARD SHIP, HANDBALL, FIVES, SQUASH, JAI ALAI
212	ATHLETIC ACCIDENT ON BOARD SHIP, SOFTBALL AND ROUNDERS
213	ATHLETIC ACCIDENT ON BOARD SHIP, SWIMMING AND DIVING
214	ATHLETIC ACCIDENT ON BOARD SHIP, TENNIS AND BADMINTON
216	ATHLETIC ACCIDENT ON BOARD SHIP, WRESTLING, JUDO
219	ATHLETIC ACCIDENT ON BOARD SHIP, OTHER ATHLETICS AND SPORTS
220	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, BASEBALL
221	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, BASKETBALL
222	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, BOATING (SAIL,POWER & OTHER SMALL)
223	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, BOXING
	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, CALISTHENICS/GYMNASTICS ('PT')

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CAUSE OF INJURY CODE	DESCRIPTION
226	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, FOOTBALL (AMERICAN)
227	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, HANDBALL,FIVES,SQUASH,JAI ALAI
228	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, HOCKEY
229	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, MOUNTAINEERING, SKIING, TOBAGGANING
230	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, RUGGER
231	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, SOCCER AND FOOTBALL UNSPECIFIED
232	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, SOFTBALL AND ROUNDERS
233	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, SWIMMING & DIVING INC WATER POLO
234	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, TENNIS AND BADMINTON
235	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, TRACK AND FIELD EVENTS
236	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, WRESTLING,JUDO,UNARMED COMBAT TRNG
237	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, HORSEMANSHIP
239	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, OTHER ATHLETICS (EXC OBSTACLE CRSE)
250	COMPLICATIONS OF PROPHYLACTIC INOCULATION, POSTVACCINAL ENCEPHALITIS
251	COMPLICATIONS OF PROPHYLACTIC INOCULATION,SMALLPOX VAC REACT (NOT ENCPH)
252	COMPLICATIONS OF PROPHYLACTIC INOCULATION, TYPHOID/PARATYPHOID VACCINE
253	COMPLICATIONS OF PROPHYLACTIC INOCULATION, TETANUS TOXIN-ANTITOXIN
254	COMPLICATIONS OF PROPHYLACTIC INOCULATION, TETANUS TOXOID
255	COMPLICATIONS OF PROPHYLACTIC INOCULATION,DIPHTHERIA ANTITOXIN/TOXOID
256	COMPLICATIONS OF PROPHYLACTIC INOCULATION, BCG
257	COMPLICATIONS OF PROPHYLACTIC INOCULATION, PROPHYL. USE OF ANTIBIOTICS
265	COMPLICATIONS OF PROPHYLACTIC INOCULATION,OTHER SPECIFIED VACCINE
266	COMPLICATION OF PROPHYLACTIC INOCULATION, OTHER SPEC TOXOID/ANTITOXIN
267	COMPLICATIONS OF PROPHYLACTIC INOCULATION,UNSPEC VACCINE,TOXOID,ANTITOXIN
268	COMPLICATIONS OF PROPHYLACTIC INOCULATION,COMB OF TWO/MORE ABOVE
269	COMPLICATIONS OF PROPHYLACTIC INOCULATION,OTHER BIOL SUB INC IMMUNE SERUM
273	COMPLICATIONS, ANESTHESIA WITH DIAGNOSTIC/OTHER NONTHERAPEUTIC PROCEDURES
274	COMPLICATIONS, SURGICAL PROCEDURES (EXCEPT IN THERAPY) INCLUDES COSMETIC
275	COMPLICATIONS, DIAGNOSTIC USE OF X-RAY OR RADIOACTIVE ISOTOPES
276	COMPLICATIONS, DIAGNOSTIC SPINAL TAP
279	COMPLICATIONS, OTHER NONTHERAPEUTIC TEST OR PROCEDURE
280	COMPLICATIONS, TRANSFUSION/INFUSION BLOOD,BLOOD SERUM,PLASMA,PLASMA SUB
281	COMPLICATIONS,THERAPEUTIC ADMINISTRATION OF ANTIBIOTICS
282	COMPLICATIONS, THERAPEUTIC ADMINISTRATION OF OTHER DRUGS OR BIOLOGICALS
283	COMPLICATIONS, ANESTHESIA IN CONNECTION WITH THERAPEUTIC PROCEDURES
284	COMPLICATIONS, SURGICAL TREATMENT
285	COMPLICATIONS, TREATMENT BY X-RAY, RADIUM OR RADIOACTIVE ISOTOPES
286	COMPLICATIONS, THERAPEUTIC SPINAL TAP
287	COMPLICATIONS, OTHER SPECIFIED THERAPY
289	COMPLICATIONS, UNSPECIFIED THERAPY
299	LATE COMPLICTIONS OR LATE EFFECTS OF OLD INJURIES
300	INJURIES, BLAST OF NUCLEAR EXPLOSION, DIRECT EFFECTS
301	INJURIES, HEAT FROM NUCLEAR EXPLOSION (INC FIREBALL), DIRECT EFFECTS
302	INJURIES, EXPOSURE TO PROMPT IONIZING RADIATION
303	INJURIES, SECONDARY MISSILE FROM NUCLEAR EXPLOSION (FALLING WALL, ETC)
304	INURIES, FIRE SECONDRY TO NUCLEAR EXPLOSION
305	INJURIES, OTHER SPECIFIED SECONDRY EFFECT AT TIME OF NUCLEAR EXPLOSION
309	INJURIES, UNSPECIFIED DIRECT EFFECTS OF NUCLEAR EXPLOSION
3[illegible]	SUBSEQUENT INJURIES, EXPOSURE TO RESIDUAL RADIATION
3[illegible]	SUBSEQUENT INJURY, INGESTION/INHALATION OF RADIOACTIVE PRODUCTS NUC EXPL
3[illegible]	AGENTS OF CHEM WARFARE, LUNG IRRITANTS AND IRRITANT[illegible]E
321	AGENTS OF CHEM WARFARE, VESICANTS (INCLUDING MUSTAR[illegible]
322	AGENTS OF CHEM WARFARE, NERVE GASES
3[illegible]	[illegible] WARFARE, LACRIMATORS AND SCREENING SMOKES

CAUSE OF INJURY CODE	DESCRIPTION
359	BIOLOGICAL WARFARE AGENTS
400	AIRCRAFT INJURY, ARTILLERY SHELL
401	AIRCRAFT INJURY, ROCKET
402	AIRCRAFT INJURY, BALLISTIC MISSILE
409	AIRCRAFT INJURY, SHELL FRAGMENT OTHERWISE UNSPECIFIED
410	AIRCRAFT INJURY, BULLET, NONEXPLOSIVE NONINCENDIARY, OR UNSPECIFIED
411	AIRCRAFT INJURY, BULLET, EXPLOSIVE
412	AIRCRAFT INJURY, BULLET, INCENDIARY
418	AIRCRAFT INJURY, OTHER SPECIFIED CONVENTIONAL WEAPON
419	AIRCRAFT INJURY, UNSPECIFIED WEAPON, PRESUMABLY CONVENTIONAL
420	INJURY ON BOARD SHIP BY ARTILLERY SHELL
421	INJURY ON BOARD SHIP BY ROCKET
422	INJURY ON BOARD SHIP BY BALLISTIC MISSILE
423	INJURY ON BOARD SHIP BY BOMB, FREE-FALLING
426	INJURY ON BOARD SHIP BY CONTACT MINE OR TORPEDO
427	INJURY ON BOARD SHIP BY UNDERWATER BLAST
429	INJURY ON BOARD SHIP BY SHELL FRAGMENT, OTHER AND UNSPECIFIED
430	INJURY ON BOARD SHIP, BULLET, NONEXPLOSIVE, NONINCENDIARY OR UNSPECIFIED
431	INJURY ON BOARD SHIP, BULLET, EXPLOSIVE
432	INJURY ON BOARD SHIP, BULLET, INCENDIARY
438	INJURY ON BOARD SHIP, OTHER SPECIFIED CONVENTIONAL WEAPON
439	INJURY ON BOARD SHIP, UNSPECIFIED WEAPON, PRESUMABLY CONVENTIONAL
440	PERSONAL INJURY ON LAND/UNSPEC BY ARTILLERY SHELL
441	PERSONAL INJURY ON LAND/UNSPEC BY ROCKET
442	PERSONAL INJURY ON LAND/UNSPEC BY BALLISTIC MISSLE
443	PERSONAL INJURY ON LAND/UNSPEC BY BOMB, FREE-FALLING
444	PERSONAL INJURY ON LAND/UNSPEC BY MORTAR
445	PERSONAL INJURY ON LAND/UNSPEC BY BAZOOKA
446	PERSONAL INJURY ON LAND/UNSPEC BY ANTIPERSONNEL MINE, BOOBY-TRAP, ETC.
447	PERSONAL INJURY ON LAND/UNSPEC BY MINE, OTHER OR UNSPECIFIED
448	PERSONAL INJURY ON LAND/UNSPEC BY GRENADE
449	PERSONAL INJURY ON LAND/UNSPEC BY SHELL FRAGMENT, OTHER AND UNSPECIFIED
450	PERSONAL INJURY ON LAND/UNSPEC BY BULLET, NON-EXPLOSIVE/INCENDIARY,UNSPEC
451	PERSONAL INJURY ON LAND/UNSPEC BY BULLET, EXPLOSIVE
452	PERSONAL INJURY ON LAND/UNSPEC BY BULLET, INCENDIARY
453	PERSONAL INJURY ON LAND/UNSPEC BY FLAME THROWER
454	PERSONAL INJURY ON LAND/UNSPEC BY OTHER INCENDIARIES
455	PERSONAL INJURY ON LAND/UNSPEC BY BAYONET, ETC.
458	PERSONAL INJURY ON LAND/UNSPEC BY OTHER SPECIFIED CONVENTIONAL WEAPON
459	PERSONAL INJURY ON LAND/UNSPEC BY UNSPEC/PRESUMABLY CONVENTIONAL WEAPON
460	INDIRECT/SECONDARY EFFECTS IN WARTIME, AIRCRAFT CRASH OR DESTRUCTION
461	INDIRECT/SECONDARY EFFECTS IN WARTIME, SINKING OF VESSEL
462	INDIRECT/SECONDARY EFFECTS IN WARTIME, FIRE ON AIRCRAFT
463	INDIRECT/SECONDARY EFFECTS IN WARTIME, FIRE ON SHIP
464	INDIRECT/SECONDARY EFFECTS IN WARTIME, FIRE ON LAND
465	INDIRECT/SECONDARY EFFECTS IN WARTIME, EXPLOSION ON AIRCRAFT
466	INDIRECT/SECONDARY EFFECTS IN WARTIME, EXPLOSION ON SHIP
467	INDIRECT/SECONDARY EFFECTS IN WARTIME, EXPLOSION ON LAND
477	INDIRECT/SECONDARY EFFECTS IN WARTIME, OTHER IN AIRCRAFT
478	INDIRECT/SECONDARY EFFECTS IN WARTIME, OTHER ON SHIP
479	INDIRECT/SECONDARY EFFECTS IN WARTIME, OTHER ON LAND
480	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, OWN NUCLEAR WEAPONS
481	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, OWN CHEMICAL WARFARE AGENTS
	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, BIOLOGICAL WARFARE AGENTS

CAUSE OF INJURY CODE	DESCRIPTION
487	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, LAUNCHING MECHS
488	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, OWN BOMBS, ARTILLERY/ETC
489	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, MECHS OF ARTILLERY/ETC
490	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, MINES, TORPEDOS, ETC.
491	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, OWN SMALL ARM FIRE
492	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, EXPLOSION OF MUNITIONS
493	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, EXPLOSION OF OWN WEAPONS
494	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, EFFECTS OF WEAPON DISCHARGE
495	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, MECHS OF SMALL ARM WEAPONS
496	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, HANDLING WEAPONS/MUNITION
499	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, UNSPEC INJURY IN WARTIME
500	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON IN AIR,SPACE(CRAFT)
501	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON ON SHIP, IN/ON WATER
502	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON ON LAND, AT AIRFIELD
503	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON ON LAND, AT DOCK
504	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON AT INDUSTRIAL PLANT
505	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON ON RANGE, DRILLFIELD
506	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON ON OBSTACLE COURSE
507	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON IN KITCHEN, MESS
508	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON, IN HOME, QTRS,ETC
509	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON, ON LAND OTH/UNSPEC
510	INJURY NOT INSTRUMENTALITY OF WAR BY CHEMICAL WARFARE IN AIR,SPACE(CRAFT)
511	INJURY NOT INSTRUMENTALITY OF WAR BY CHEMICAL WARFARE ON SHIP,IN/ON WATER
512	INJURY NOT INSTRUMENTALITY OF WAR BY CHEMICAL WARFARE, AT AIRFIELD
513	INJURY NOT INSTRUMENTALITY OF WAR BY CHEMICAL WARFARE, AT DOCK
514	INJURY NOT INSTRUMENTALITY OF WAR BY CHEMICAL WARFARE, AT INDUSTRIAL PLT
515	INJURY NOT INSTRUMENTALITY OF WAR BY CHEM WARFARE, ON RANGE, DRILLFIELD
516	INJURY NOT INSTRUMENTALITY OF WAR BY CHEM WARFARE, ON OBSTACLE COURSE
517	INJURY NOT INSTRUMENTALITY OF WAR BY CHEM WARFARE, IN KITCHEN, MESS
518	INJURY NOT INSTRUMENTALITY OF WAR BY CHEM WARFARE, IN HOME, QTRS
519	INJURY NOT INSTRUMENTALITY OF WAR BY CHEM WARFARE, ON LAND OTH/UNSPEC
520	INJURY NOT INSTRUMENTALITY OF WAR BY BIOLOGICAL AGENT IN AIR,SPACE(CRAFT)
521	INJURY NOT INSTRUMENTALITY OF WAR BY BIOLOGICAL AGENT ON SHIP,IN/ON WATER
522	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, AT AIRFIELD
523	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, AT DOCK
524	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, AT INDUSTRIAL PLANT
525	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, RANGE, DRILLFIELD
526	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, ON OBSTACLE COURSE
527	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, IN KITCHEN, MESS
528	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, IN HOME, QTRS
529	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, ON LAND OTHER/UNSPEC
530	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSILE IN AIR/SPACE(CRAFT)
531	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSILE, ON SHIP IN/ON WATER
532	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSILE, AT AIRFIELD
533	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSILE, AT DOCK
534	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSILE, AT INDUSTRIAL PLANT
535	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSILE, ON RANGE, DRILLFIELD
536	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSILE, ON OBSTACLE COURSE
537	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSILE, IN KITCHEN, MESS
538	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSILE, IN HOME, QTRS
539	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSILE, ON LAND OTHER/UNSPEC
540	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES IN AIR,SPACE(CRAFT)
541	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, ON SHIP IN/ON WATER
	INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, AT AIRFIELD

CAUSE OF INJURY CODE	DESCRIPTION
544	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, AT INDUSTRIAL PLT
545	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECT, RANGE, DRILLFIELD
546	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, ON OBSTACLE CRS
547	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, IN KITCHEN, MESS
548	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECT, IN HOME, QTRS
549	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, ON LAND OTH/UNSP
550	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, IN AIR/SPACE(CRAFT)
551	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, SHIP, IN/OUT WATER
552	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, AT AIRFIELD
553	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, AT DOCK
554	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, AT INDUSTRIAL PLANT
555	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, ON RANGE, DRILLFIELD
556	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, ON OBSTACLE COURSE
557	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, KITCHEN, MESS
558	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, IN HOME, QTRS
559	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, ON LAND OTHER/UNSPEC
560	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, IN AIR,SPACE(CRAFT)
561	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, SHIP,IN/ON WATER
562	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, AT AIRFIELD
563	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, AT DOCK
564	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, AT INDUSTRIAL PLANT
565	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, RANGE, DRILLFIELD
566	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, ON OBSTACLE CRS
567	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, IN KITCHEN, MESS
568	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, IN HOME, QTRS
569	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, ON LAND OTH/UNSP
570	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, IN AIR/SPACE(CRAFT)
571	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, SHIP IN/ON WATER
572	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, AT AIRFEILD
573	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, AT DOCK
574	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, AT INDUSTRIAL PLANT
575	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, RANGE, DRILLFIELD
576	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, ON OBSTACLE COURSE
577	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, IN KITCHEN, MESS
578	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, IN HOME, QTRS
579	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, ON LAND/OTHER/UNSPEC
580	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, IN AIR/SPACE(CRAFT)
581	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, SHIP, IN/ON WATER
582	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, AT AIRFIELD
583	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, AT DOCK
584	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, AT INDUSTRIAL PLANT
585	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, ON RANGE, DRILLFLD
586	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, ON OBSTACLE CRS
587	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, IN KITCHEN, MESS
588	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, IN HOME, QTRS
589	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, ON LAND/OTH/UNSP
590	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, IN AIR,SPACE(CRAFT)
591	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, SHIP,IN/ON WATER
592	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, AT AIRFIELD
593	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, AT DOCK
594	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, AT INDUSTRIAL PLANT
595	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, ON RANGE,DRILLFIELD
596	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, ON OBSTACLE COURSE
[illegible]	INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, IN KITCHEN, MESS

CAUSE OF INJURY CODE	DESCRIPTION
599	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, ON LAND/OTH/UNSPEC
600	MACHINERY (INC CRANES OR ELEVATORS) IN AIR,SPACE(CRAFT)
601	MACHINERY (INC CRANES OR ELEVATORS) ON SHIP, IN/ON WATER
602	MACHINERY (INC CRANES OR ELEVATORS) AT AIRFIELD
603	MACHINERY (INC CRANES OR ELEVATORS) AT DOCK
604	MACHINERY (INC CRANES OR ELEVATORS) AT INDUSTRIAL PLANT
605	MACHINERY (INC CRANES OR ELEVATORS) AT RANGE, DRILLFIELD
606	MACHINERY (INC CRANES OR ELEVATORS) ON OBSTACLE COURSE
607	MACHINERY (INC CRANES OR ELEVATORS) IN KITCHEN, MESS
608	MACHINERY (INC CRANES OR ELEVATORS) IN HOME, QTRS
609	MACHINERY (INC CRANES OR ELEVATORS) ON LAND, OTHER/UNSPECIFIED
610	TOOLS, POWER/HAND (EXC KNIVES) IN AIR, SPACE(CRAFT)
611	TOOLS, POWER/HAND (EXC KNIVES) ON SHIP IN/ON WATER
612	TOOLS, POWER/HAND (EXC KNIVES) AT AIRFIELD
613	TOOLS, POWER/HAND (EXC KNIVES) AT DOCK
614	TOOLS, POWER/HAND (EXC KNIVES) AT INDUSTRIAL PLANT
615	TOOLS, POWER/HAND (EXC KNIVES) AT RANGE, DRILLFIELD
616	TOOLS, POWER/HAND (EXC KNIVES) ON OBSTACLE COURSE
617	TOOLS, POWER/HAND (EXC KNIVES) IN KITCHEN, MESS
618	TOOLS, POWER/HAND (EXC KNIVES) IN HOME, QTRS
619	TOOLS, POWER/HAND (EXC KNIVES) ON LAND, OTHER/UNSPECIFIED
620	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) IN AIR, SPACE(CRAFT)
621	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) ON SHIP, IN/OUT WATER
622	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) AT AIRFIELD
623	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) AT DOCK
624	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) AT INDUSTRIAL PLANT
625	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) ON RANGE, DRILLFIELD
626	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) ON OBSTACLE COURSE
627	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) IN KITCHEN, MESS
628	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) IN HOME, QTRS
629	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) ON LAND, OTHER/UNSPECIFIED
630	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) IN AIR,SPACE(CRAFT)
631	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) ON SHIP, IN/ON WATER
632	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) AT AIRFIELD
633	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) AT DOCK
634	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) AT INDUSTRIAL PLANT
635	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) ON RANGE, DRILLFIELD
636	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) ON OBSTACLE COURSE
637	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) IN KITCHEN, MESS
638	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) AT HOME, QTRS
639	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) ON LAND, OTH/UNSPEC
640	CUTTING, PIERCING INSTRUMENTS/OBJECTS IN AIR, SPACE(CRAFT)
641	CUTTING, PIERCING INSTRUMENTS/OBJECTS ON SHIP, IN/ON WATER
642	CUTTING, PIERCING INSTRUMENTS/OBJECTS AT AIRFIELD
643	CUTTING, PIERCING INSTRUMENTS/OBJECTS AT DOCK
644	CUTTING, PIERCING INSTRUMENTS/OBJECTS AT INDUSTRIAL PLANT
645	CUTTING, PIERCING INSTRUMENTS/OBJECTS ON RANGE, DRILLFIELD
646	CUTTING, PIERCING INSTRUMENTS/OBJECTS ON OBSTACLE COURSE
647	CUTTING, PIERCING INSTRUMENTS/OBJECTS IN KITCHEN, MESS
648	CUTTING, PIERCING INSTRUMENTS/OBJECTS IN HOME, QTRS
649	CUTTING, PIERCING INSTRUMENTS/OBJECTS ON LAND, OTHER/UNSPECIFIED
650	EXPLOSION OF PRESSURE VESSEL, NO FIRE IN AIR, SPACE(CRAFT)
651	EXPLOSION OF PRESSURE VESSEL, NO FIRE ON SHIP, IN/ON WATER
652	EXPLOSION OF PRESSURE VESSEL, NO FIRE AT AIRFIELD

CAUSE OF INJURY CODE	DESCRIPTION
654	EXPLOSION OF PRESSURE VESSEL, NO FIRE AT INDUSTRIAL PLANT
655	EXPLOSION OF PRESSURE VESSEL, NO FIRE ON RANGE, DRILLFIELD
656	EXPLOSION OF PRESSURE VESSEL, NO FIRE ON OBSTACLE COURSE
657	EXPLOSION OF PRESSURE VESSEL, NO FIRE IN KITCHEN, MESS
658	EXPLOSION OF PERSSURE VESSEL, NO FIRE IN HOME, QTRS
659	EXPLOSION OF PRESSURE VESSEL, NO FIRE ON LAND, OTHER/UNSPECIFIED
660	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) IN AIR, SPACE(CRAFT)
661	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) ON SHIP, IN/ON WATER
662	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) AT AIRFIELD
663	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) AT DOCK
664	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) AT INDUSTRIAL PLANT
665	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) ON RANGE, DRILLFIELD
666	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) ON OBSTACLE COURSE
667	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) IN KITCHEN, MESS
668	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) IN HOME, QTRS
669	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) ON LAND, OTH/UNSPEC
670	STATIC OBJECTS (INC "BUMPING AGAINST") IN AIR, SPACE(CRAFT)
671	STATIC OBJECTS (INC "BUMPING AGAINST") ON SHIP, IN/ON WATER
672	STATIC OBJECTS (INC "BUMPING AGAINST") AT AIRFIELD
673	STATIC OBJECTS (INC "BUMPING AGAINST") AT DOCK
674	STATIC OBJECTS (INC "BUMPING AGAINST") AT INDUSTRIAL PLANT
675	STATIC OBJECTS (INC "BUMPING AGAINST") ON RANGE, DRILLFIELD
676	STATIC OBJECTS (INC "BUMPING AGAINST") ON OBSTACLE COURSE
677	STATIC OBJECTS (INC "BUMPING AGAINST") IN KITCHEN, MESS
678	STATIC OBJECTS (INC "BUMPING AGAINST") IN HOME, QTRS
679	STATIC OBJECTS (INC "BUMPING AGAINST") ON LAND, OTHER/UNSPECIFIED
680	FOREIGN OBJECT ENTERING BODY (IN EYE, ETC) IN AIR, SPACE(CRAFT)
681	FOREIGN OBJECT ENTERING BODY (IN EYE, ETC) ON SHIP, IN/ON WATER
682	FOREIGN OBJECT ENTERING BODY (IN EYE, ETC) AT AIRFIELD
683	FOREIGN OBJECT ENTERING BODY (IN EYE, ETC) AT DOCK
684	FOREIGN OBJECT ENTERING BODY (IN EYE, ETC) AT INDUSTRIAL PLANT
685	FOREIGN OBJECT ENTERING BODY (IN EYE, ETC) ON RANGE, DRILLFIELD
686	FOREIGN OBJECT ENTERING BODY (IN EYE, ETC) ON OBSTACLE COURSE
687	FOREIGN OBJECT ENTERING BODY (IN EYE, ETC) IN KITCHEN, MESS
688	FOREIGN OBJECT ENTERING BODY (IN EYE, ETC) IN HOME, QTRS
689	FOREIGN OBJECT ENTERING BODY (IN EYE, ETC) ON LAND, OTHER/UNSPECIFIED
690	SHOES, CLOTHING, ETC. IN AIR, SPACE(CRAFT)
691	SHOES, CLOTHING, ETC. ON SHIP IN/ON WATER
692	SHOES, CLOTHING, ETC. AT AIRFIELD
693	SHOES, CLOTHING, ETC. AT DOCK
694	SHOES, CLOTHING, ETC. AT INDUSTRIAL PLANT
695	SHOES, CLOTHING, ETC. ON RANGE, DRILLFIELD
696	SHOES, CLOTHING, ETC. ON OBSTACLE COURSE
697	SHOES, CLOTHING, ETC. IN KITCHEN, MESS
698	SHOES, CLOTHING, ETC. IN HOME, QTRS
699	SHOES, CLOTHING, ETC. ON LAND, OTHER/UNSPECIFIED
700	POISONING BY INGESTION OF TOXIC SUBSTANCE IN AIR, SPACE(CRAFT)
701	POISONING BY INGESTION OF TOXIC SUBSTANCE ON SHIP, IN/ON WATER
702	POISONING BY INGESTION OF TOXIC SUBSTANCE AT AIRFIELD
703	POISONING BY INGESTION OF TOXIC SUBSTANCE AT DOCK
704	POISONING BY INGESTION OF TOXIC SUBSTANCE AT INDUSTRIAL PLANT
705	POISONING BY INGESTION OF TOXIC SUBSTANCE ON RANGE, DRILLFIELD
706	POISONING BY INGESTION OF TOXIC SUBSTANCE ON OBSTACLE COURSE
	POISONING BY INGESTION OF TOXIC SUBSTANCE IN KITCHEN, MESS

CAUSE OF INJURY CODE	DESCRIPTION
709	POISONING BY INGESTION OF TOXIC SUBSTANCE ON LAND, OTHER/UNSPECIFIED
710	POISONING BY INHALATION OF TOXIC SUBSTANCE IN AIR, SPACE(CRAFT)
711	POISONING BY INHALATION OF TOXIC SUBSTANCE ON SHIP, IN/ON WATER
712	POISONING BY INHALATION OF TOXIC SUBSTANCE AT AIRFIELD
713	POISONING BY INHALATION OF TOXIC SUBSTANCE AT DOCK
714	POISONING BY INHALATION OF TOXIC SUBSTANCE AT INDUSTRIAL PLANT
715	POISONING BY INHALATION OF TOXIC SUBSTANCE ON RANGE, DRILLFIELD
716	POISONING BY INHALATION OF TOXIC SUBSTANCE ON OBSTACLE COURSE
717	POISONING BY INHALATION OF TOXIC SUBSTANCE IN KITCHEN, MESS
718	POISONING BY INHALATION OF TOXIC SUBSTANCE IN HOME, QTRS
719	POISONING BY INHALATION OF TOXIC SUBSTANCE ON LAND, OTHER/UNSPECIFIED
720	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE IN AIR, SPACE(CRAFT)
721	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE ON SHIP, IN/ON WATER
722	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE AT AIRFIELD
723	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE AT DOCK
724	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE AT INDUSTRIAL PLANT
725	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE ON RANGE, DRILLFIELD
726	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE ON OBSTACLE COURSE
727	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE IN KITCHEN, MESS
728	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE IN HOME, QTRS
729	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE ON LAND, OTH/UNSPEC
730	STING OR BITE OF VENOMOUS REPTILE IN AIR, SPACE(CRAFT)
731	STING OR BITE OF VENOMOUS REPTILE ON SHIP, IN/ON WATER
732	STING OR BITE OF VENOMOUS REPTILE AT AIRFIELD
733	STING OR BITE OF VENOMOUS REPTILE AT DOCK
734	STING OR BITE OF VENOMOUS REPTILE AT INDUSTRIAL PLANT
735	STING OR BITE OF VENOMOUS REPTILE ON RANGE OR DRILLFIELD
736	STING OR BITE OF VENOMOUS REPTILE ON OBSTACLE COURSE
737	STING OR BITE OF VENOMOUS REPTILE IN KITCHEN, MESS
738	STING OR BITE OF VENOMOUS REPTILE IN HOME, QTRS
739	STING OR BITE OF VENOMOUS REPTILE ON LAND, OTHER/UNSPECIFIED
740	STING OR BITE OF VENOMOUS ARTHROPOD IN AIR, SPACE(CRAFT)
741	STING OR BITE OF VENOMOUS ARTHROPOD ON SHIP, IN/ON WATER
742	STING OR BITE OF VENOMOUS ARTHROPOD AT AIRFIELD
743	STING OR BITE OF VENOMOUS ARTHROPOD AT DOCK
744	STING OR BITE OF VENOMOUS ARTHROPOD AT INDUSTRIAL PLANT
745	STING OR BITE OF VENOMOUS ARTHROPOD ON RANGE, DRILLFIELD
746	STING OR BITE OF VENOMOUS ARTHROPOD ON OBSTACLE COURSE
747	STING OR BITE OF VENOMOUS ARTHROPOD IN KITCHEN, MESS
748	STING OR BITE OF VENOMOUS ARTHROPOD IN HOME, QTRS
749	STING OR BITE OF VENOMOUS ARTHROPOD ON LAND, OTHER/UNSPECIFIED
750	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION IN AIR, SPACE(CRAFT)
751	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION ON SHIP, IN/ON WATER
752	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION AT AIRFIELD
753	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION AT DOCK
754	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION AT INDUSTRIAL PLANT
755	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION ON RANGE, DRILLFIELD
756	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION ON OBSTACLE COURSE
757	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION IN KITCHEN, MESS
758	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION IN HOME, QTRS
759	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION ON LAND, OTHER/UNSPECIFIED
760	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) IN AIR, SPACE(CRAFT)
761	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) ON SHIP, IN/ON WATER
	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) AT AIRFIELD

CAUSE OF INJURY CODE	DESCRIPTION
764	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) AT INDUSTRIAL
765	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) ON RANGE, DRILLFIELD
766	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) ON OBSTACLE COURSE
767	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) IN KITCHEN, MESS
768	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) IN HOME, QTRS
769	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) ON LAND, OTHER/UNSPECIFIED
770	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, IN AIR, SPACE(CRAFT)
771	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, ON SHIP, IN/ON WATER
772	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, AT AIRFIELD
773	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, AT DOCK
774	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, AT INDUSTRIAL PLANT
775	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, ON RANGE, DRILLFIELD
776	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, ON OBSTACLE COURSE
777	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, IN KITCHEN, MESS
778	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, IN HOME, QTRS
779	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, ON LAND, OTHER/UNSPEC
780	HOT SOLIDS, OTHER HOT OBJECTS IN AIR, SPACE(CRAFT)
781	HOT SOLIDS, OTHER HOT OBJECTS ON SHIP, IN/ON WATER
782	HOT SOLIDS, OTHER HOT OBJECTS AT AIRFIELD
783	HOT SOLIDS, OTHER HOT OBJECTS AT DOCK
784	HOT SOLIDS, OTHER HOT OBJECTS AT INDUSTRIAL PLANT
785	HOT SOLIDS, OTHER HOT OBJECTS ON RANGE, DRILLFIELD
786	HOT SOLIDS, OTHER HOT OBJECTS ON OBSTACLE COURSE
787	HOT SOLIDS, OTHER HOT OBJECTS IN KITCHEN, MESS
788	HOT SOLIDS, OTHER HOT OBJECTS IN HOME, QTRS
789	HOT SOLIDS, OTHER HOT OBJECTS ON LAND, OTHER/UNSPECIFIED
800	EXCESSIVE HEAT OR ISOLATION IN AIR, SPACE(CRAFT)
801	EXCESSIVE HEAT OR ISOLATION ON SHIP, IN/ON WATER
802	EXCESSIVE HEAT OR ISOLATION AT AIRFIELD
803	EXCESSIVE HEAT OR ISOLATION AT DOCK
804	EXCESSIVE HEAT OR ISOLATION AT INDUSTRIAL PLANT
805	EXCESSIVE HEAT OR ISOLATION ON RANGE, DRILLFIELD
806	EXCESSIVE HEAT OR ISOLATION ON OBSTACLE COURSE
807	EXCESSIVE HEAT OR ISOLATION IN KITCHEN, MESS
808	EXCESSIVE HEAT OR ISOLATION IN HOME, QTRS
809	EXCESSIVE HEAT OR ISOLATION ON LAND, OTHER/UNSPECIFIED
810	EXCESSIVE COLD IN AIR, SPACE(CRAFT)
811	EXCESSIVE COLD ON SHIP, IN/ON WATER
812	EXCESSIVE COLD AT AIRFIELD
813	EXCESSIVE COLD AT DOCK
814	EXCESSIVE COLD AT INDUSTRIAL PLANT
815	EXCESSIVE COLD ON RANGE, DRILLFIELD
816	EXCESSIVE COLD ON OBSTACLE COURSE
817	EXCESSIVE COLD IN KITCHEN, MESS
818	EXCESSIVE COLD IN HOME, QTRS
819	EXCESSIVE COLD ON LAND, OTHER/UNSPECIFIED
820	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) IN AIR, SPACE(CRAFT)
821	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) ON SHIP, IN/ON WATER
822	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) AT AIRFIELD
823	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) AT DOCK
824	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) AT INDUSTRIAL PLANT
825	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) ON RANGE, DRILLFIELD
826	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) ON OBSTACLE COURSE
[illegible]	[illegible] (ATMOSPHERIC OR ARTIFICIAL) IN KITCHEN, MESS

CAUSE OF INJURY CODE	DESCRIPTION
829	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) ON LAND, OTHER/UNSPECIFIED
830	EXCESSIVE NOISE IN AIR, SPACE(CRAFT)
831	EXCESSIVE NOISE ON SHIP, IN/ON WATER
832	EXCESSIVE NOISE AT AIRFIELD
833	EXCESSIVE NOISE AT DOCK
834	EXCESSIVE NOISE AT INDUSTRIAL PLANT
835	EXCESSIVE NOISE ON RANGE, DRILLFIELD
836	EXCESSIVE NOISE ON OBSTACLE COURSE
837	EXCESSIVE NOISE IN KITCHEN, MESS
838	EXCESSIVE NOISE IN HOME, QTRS
839	EXCESSIVE NOISE ON LAND, OTHER/UNSPECIFIED
840	HUNGER, THIRST, OR EXPOSURE IN AIR, SPACE(CRAFT)
841	HUNGER, THIRST, OR EXPOSURE ON SHIP, IN/ON WATER
842	HUNGER, THIRST, OR EXPOSURE AT AIRFIELD
843	HUNGER, THIRST, OR EXPOSURE AT DOCK
844	HUNGER, THIRST, OR EXPOSURE AT INDUSTRIAL PLANT
845	HUNGER, THIRST, OR EXPOSURE ON RANGE, DRILLFIELD
846	HUNGER, THIRST, OR EXPOSURE ON OBSTACLE COURSE
847	HUNGER, THIRST, OR EXPOSURE IN KITCHEN, MESS
848	HUNGER, THIRST, OR EXPOSURE IN HOME, QTRS
849	HUNGER, THIRST, OR EXPOSURE ON LAND, OTHER/UNSPECIFIED
850	LIGHTNING OR CATACLYSM IN AIR, SPACE(CRAFT)
851	LIGHTNING OR CATACLYSM ON SHIP, IN/ON WATER
852	LIGHTNING OR CATACLYSM AT AIRFIELD
853	LIGHTNING OR CATACLYSM AT DOCK
854	LIGHTNING OR CATACLYSM AT INDUSTRIAL PLANT
855	LIGHTNING OR CATACLYSM ON RANGE, DRILLFIELD
856	LIGHTNING OR CATACLYSM ON OBSTACLE COURSE
857	LIGHTNING OR CATACLYSM IN KITCHEN, MESS
858	LIGHTNING OR CATACLYSM IN HOME, QTRS
859	LIGHTNING OR CATACLYSM ON LAND, OTHER/UNSPECIFIED
860	DROWNING/SUBMERSION N.E.C. IN AIR, SPACE(CRAFT)
861	DROWNING/SUBMERSION N.E.C. ON SHIP, IN/ON WATER
862	DROWNING/SUBMERSION N.E.C. AT AIRFIELD
863	DROWNING/SUBMERSION N.E.C. AT DOCK
864	DROWNING/SUBMERSION N.E.C. AT INDUSTRIAL PLANT
865	DROWNING/SUBMERSION N.E.C. ON RANGE, DRILLFIELD
866	DROWNING/SUBMERSION N.E.C. ON OBSTACLE COURSE
867	DROWNING/SUBMERSION N.E.C. IN KITCHEN, MESS
868	DROWNING/SUBMERSION N.E.C. IN HOME, QTRS
869	DROWNING/SUBMERSION N.E.C. ON LAND, OTHER/UNSPECIFIED
870	MOTION: TRAVEL SICKNESSES IN AIR, SPACE(CRAFT)
871	MOTION: TRAVEL SICKNESSES ON SHIP, IN/ON WATER
872	MOTION: TRAVEL SICKNESSES AT AIRFIELD
873	MOTION: TRAVEL SICKNESSES AT DOCK
874	MOTION: TRAVEL SICKNESSES AT INDUSTRIAL PLANT
875	MOTION: TRAVEL SICKNESSES ON RANGE, DRILLFIELD
876	MOTION: TRAVEL SICKNESSES ON OBSTACLE COURSE
877	MOTION: TRAVEL SICKNESSES IN KITCHEN, MESS
878	MOTION: TRAVEL SICKNESSES IN HOME, QTRS
879	MOTION: TRAVEL SICKNESSES ON LAND, OTHER/UNSPECIFIED
880	ANIMALS, N.E.C. IN AIR, SPACE(CRAFT)
881	ANIMALS, N.E.C. ON SHIP, IN/ON WATER
[illegible]	ANIMALS, N.E.C. AT AIRFIELD

CAUSE OF INJURY CODE	DESCRIPTION
884	ANIMALS, N.E.C. AT INDUSTRIAL PLANT
885	ANIMALS, N.E.C. ON RANGE, DRILLFIELD
886	ANIMALS, N.E.C. ON OBSTACLE COURSE
887	ANIMALS, N.E.C. IN KITCHEN, MESS
888	ANIMALS, N.E.C. IN HOME, QTRS
889	ANIMALS, N.E.C. ON LAND, OTHER/UNSPECIFIED
900	FALL/JUMP FROM STAIRS OR LADDER IN AIR, SPACE(CRAFT)
901	FALL/JUMP FROM STAIRS OR LADDER ON SHIP, IN/ON WATER
902	FALL/JUMP FROM STAIRS OR LADDER AT AIRFIELD
903	FALL/JUMP FROM STAIRS OR LADDER AT DOCK
904	FALL/JUMP FROM STAIRS OR LADDER AT INDUSTRIAL PLANT
905	FALL/JUMP FROM STAIRS OR LADDER ON RANGE, DRILLFIELD
906	FALL/JUMP FROM STAIRS OR LADDER ON OBSTACLE COURSE
907	FALL/JUMP FROM STAIRS OR LADDER IN KITCHEN, MESS
908	FALL/JUMP FROM STAIRS OR LADDER IN HOME, QTRS
909	FALL/JUMP FROM STAIRS OR LADDER ON LAND, OTHER/UNSPECIFIED
910	OTHER FALL/JUMP IN AIR, SPACE(CRAFT)
911	OTHER FALL/JUMP ON SHIP, IN/ON WATER
912	OTHER FALL/JUMP AT AIRFIELD
913	OTHER FALL/JUMP AT DOCK
914	OTHER FALL/JUMP AT INDUSTRIAL PLANT
915	OTHER FALL/JUMP ON RANGE, DRILLFIELD
916	OTHER FALL/JUMP ON OBSTACLE COURSE
917	OTHER FALL/JUMP IN KITCHEN, MESS
918	OTHER FALL/JUMP IN HOME, QTRS
919	OTHER FALL/JUMP ON LAND, OTHER/UNSPECIFIED
920	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) IN AIR, SPACE(CRAFT)
921	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) ON SHIP, IN/ON WATER
922	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) AT AIRFIELD
923	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) AT DOCK
924	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) AT INDUSTRIAL PLANT
925	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) ON RANGE, DRILLFIELD
926	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) ON OBSTACLE COURSE
927	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) IN KITCHEN, MESS
928	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) IN HOME, QTRS
929	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) ON LAND, OTHER/UNSPECIFIED
930	MARCHING OR DRILLING N.E.C. IN AIR, SPACE(CRAFT)
931	MARCHING OR DRILLING N.E.C. ON SHIP, IN/ON WATER
932	MARCHING OR DRILLING N.E.C. AT AIRFIELD
933	MARCHING OR DRILLING N.E.C. AT DOCK
934	MARCHING OR DRILLING N.E.C. AT INDUSTRIAL PLANT
935	MARCHING OR DRILLING N.E.C. ON RANGE, DRILLFIELD
936	MARCHING OR DRILLING N.E.C. ON OBSTACLE COURSE
937	MARCHING OR DRILLING N.E.C. IN KITCHEN, MESS
938	MARCHING OR DRILLING N.E.C. IN HOME, QTRS
939	MARCHING OR DRILLING N.E.C. ON LAND, OTHER/UNSPECIFIED
940	TWISTING, TURNING, SLIPPING, ETC, W/O FALL IN AIR, SPACE(CRAFT)
941	TWISTING, TURNING, SLIPPING, ETC W/O FALL ON SHIP, IN/ON WATER
942	TWISTING, TURNING, SLIPPING, ETC W/O FALL AT AIRFIELD
943	TWISTING, TURNING, SLIPPING, ETC W/O FALL AT DOCK
944	TWISTING, TURNING, SLIPPING, ETC W/O FALL AT INDUSTRIAL PLANT
945	TWISTING, TURNING, SLIPPING, ETC W/O FALL ON RANGE, DRILLFIELD
946	TWISTING, TURNING, SLIPPING, ETC W/O FALL ON OBSTACLE COURSE
	SLIPPING, ETC W/O FALL IN KITCHEN, MESS

CAUSE OF INJURY CODE	DESCRIPTION
949	TWISTING, TURNING, SLIPPING, ETC W/O FALL ON LAND, OTHER/UNSPECIFIED
950	LIFTING, PUSHING, PULLING IN AIR, SPACE(CRAFT)
951	LIFTING, PUSHING, PULLING ON SHIP, IN/ON WATER
952	LIFTING, PUSHING, PULLING AT AIRFIELD
953	LIFTING, PUSHING, PULLING AT DOCK
954	LIFTING, PUSHING, PULLING AT INDUSTRIAL PLANT
955	LIFTING, PUSHING, PULLING ON RANGE, DRILLFIELD
956	LIFTING, PUSHING, PULLING ON OBSTACLE COURSE
957	LIFTING, PUSHING, PULLING IN KITCHEN, MESS
958	LIFTING, PUSHING, PULLING IN HOME, QTRS
959	LIFTING, PUSHING, PULLING ON LAND, OTHER/UNSPECIFIED
960	HANGING, SUFFOCATION, STRANGULATION, ETC IN AIR, SPACE(CRAFT)
961	HANGING, SUFFOCATION, STRANGULATION, ETC ON SHIP, IN/ON WATER
962	HANGING, SUFFOCATION, STRANGULATION, ETC AT AIRFIELD
963	HANGING, SUFFOCATION, STRANGULATION, ETC AT DOCK
964	HANGING, SUFFOCATION, STRANGULATION, ETC AT INDUSTRIAL PLANT
965	HANGING, SUFFOCATION, STRANGULATION, ETC ON RANGE, DRILLFIELD
966	HANGING, SUFFOCATION, STRANGULATION, ETC ON OBSTACLE COURSE
967	HANGING, SUFFOCATION, STRANGULATION, ETC IN KITCHEN, MESS
968	HANGING, SUFFOCATION, STRANGULATION, ETC IN HOME, QTRS
969	HANGING, SUFFOCATION, STRANGULATION, ETC ON LAND, OTHER/UNSPECIFIED
970	FIGHTING N.E.C. IN AIR, SPACE(CRAFT)
971	FIGHTING N.E.C. ON SHIP IN/ON WATER
972	FIGHTING N.E.C. AT AIRFIELD
973	FIGHTING N.E.C. AT DOCK
974	FIGHTING N.E.C. AT INDUSTRIAL PLANT
975	FIGHTING N.E.C. ON RANGE, DRILLFIELD
976	FIGHTING N.E.C. ON OBSTACLE COURSE
977	FIGHTING N.E.C. IN KITCHEN, MESS
978	FIGHTING N.E.C. IN HOME, QTRS
979	FIGHTING N.E.C. ON LAND, OTHER/UNSPECIFIED
980	OTHER SPECIFIED AGENTS N.E.C. IN AIR, SPACE(CRAFT)
981	OTHER SPECIFIED AGENTS N.E.C. ON SHIP, IN/ON WATER
982	OTHER SPECIFIED AGENTS N.E.C. AT AIRFIELD
983	OTHER SPECIFIED AGENTS N.E.C. AT DOCK
984	OTHER SPECIFIED AGENTS N.E.C. AT INDUSTRIAL PLANT
985	OTHER SPECIFIED AGENTS N.E.C. ON RANGE, DRILLFIELD
986	OTHER SPECIFIED AGENTS N.E.C. ON OBSTACLE COURSE
987	OTHER SPECIFIED AGENTS N.E.C. IN KITCHEN, MESS
988	OTHER SPECIFIED AGENTS N.E.C. IN HOME, QTRS
989	OTHER SPECIFIED AGENTS N.E.C. ON LAND, OTHER/UNSPECIFIED
990	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN IN AIR, SPACE(CRAFT)
991	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN ON SHIP, IN/ON WATER
992	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN AT AIRFIELD
993	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN AT DOCK
994	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN AT INDUSTRIAL PLANT
995	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN ON RANGE, DRILLFIELD
996	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN ON OBSTACLE COURSE
997	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN IN KITCHEN, MESS
998	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN IN HOME, QTRS
999	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN ON LAND, OTHER/UNSPECIFIED

MED EVAL BOARD (MEB) STATUS LIST

MEB STATUS CODE	DESCRIPTION	FLAGS
C	CONFIRMED CANDIDATE	1
F	MEB FORWARDED TO HQ	
H	MEB HELD	
P	POTENTIAL CANDIDATE	2
R	MEB RESOLVED	

CASUALITY STATUS LIST

CAS STATUS CODE	DESCRIPTION	FLAGS
EXP	EXPIRED	2
III	INCAPCITATING ILLNESS OR INJ	1
REM	REMOVED AS CASUALTY	2
SC	SPECIAL CATEGORY	1
SI	SERIOUSLY ILL	1
TI	TERMINALLY ILL	1
VSI	VERY SERIOUSLY ILL	1

RELATIONSHIP LIST

RELATIONSHIP	DESCRIPTION
BROTHER	BROTHER OF PATIENT
DAUGHTER	DAUGHTER OF PATIENT
FATHER	FATHER OF PATIENT
FATHER INLAW	FATHER IN-LAW
FRIEND	FRIEND OF PATIENT
GRANDFATHER	GRANDFATHER OF PATIENT
GRANDMOTHER	GRANDMOTHER OF PATIENT
GUARDIAN	GUARDIAN OF PATIENT
HUSBAND	HUSBAND OF PATIENT
MOTHER	MOTHER OF PATIENT
MOTHER INLAW	MOTHER IN-LAW
SELF	PATIENT
SISTER	SISTER OF PATIENT
SON	SON OF PATIENT
STEP FATHER	STEP FATHER OF PATIENT
STEP MOTHER	STEP MOTHER OF PATIENT
WIFE	WIFE OF PATIENT

PROGNOSIS LIST

PROGNOSIS	DESCRIPTION
CI	CONDITION IMPROVED
CU	CONDITION UNCHANGED
CW	CONDITION WORSE
EX	EXPECTED
FA	FAIR
GO	GOOD
GU	GUARDED
MO	MORIBUND
NE	NOT EXPECTED
PO	POOR
QU	QUESTIONABLE
RE	REMOVED FROM ROSTER

ARMY LENGTH OF SERVICE LIST

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LENGTH OF SERVICE	DESCRIPTION	CR CONVERSION
01D	ONE DAY	A1
01M	ONE MONTH	A3
02D	TWO DAYS	A1
02M	TWO MONTHS	A4
03D	THREE DAYS	A1
03M	THREE MONTHS	B1
04D	FOUR DAYS	A1
04M	FOUR MONTHS	B2
05D	FIVE DAYS	A1
05M	FIVE MONTHS	B3
06D	SIX DAYS	A1
06M	SIX MONTHS	C1
07D	SEVEN DAYS	A2
07M	SEVEN MONTHS	C2
08D	EIGHT DAYS	A2
08M	EIGHT MONTHS	C3
09D	NINE DAYS	A2
09M	NINE MONTHS	D1
10D	TEN DAYS	A2
10M	TEN MONTHS	D2
11D	ELEVEN DAYS	A2
11M	ELEVEN MONTHS	D3
12D	TWELVE DAYS	A2
12M	TWELVE MONTHS	E1
13D	THIRTEEN DAYS	A2
13M	THIRTEEN MONTHS	E1
14D	FOURTEEN DAYS	A2
14M	FOURTEEN MONTHS	E1
15D	FIFTEEN DAYS	A2
15M	FIFTEEN MONTHS	F1
16D	SIXTEEN DAYS	A2
16M	SIXTEEN MONTHS	F1
17D	SEVENTEEN DAYS	A2
17M	SEVENTEEN MONTHS	F1
18D	EIGHTEEN DAYS	A2
18M	EIGHTEEN MONTHS	G1
19D	NINETEEN DAYS	A2
19M	NINETEEN MONTHS	G1
20D	TWENTY DAYS	A2
20M	TWENTY MONTHS	G1
21D	TWENTY ONE DAYS	A2
21M	TWENTY ONE MONTHS	H1
22D	TWENTY TWO DAYS	A2
22M	TWENTY TWO MONTHS	H1
23D	TWENTY THREE DAYS	A2
23M	TWENTY THREE MONTHS	H1
24D	TWENTY FOUR DAYS	A2
25D	TWENTY FIVE DAYS	A2
26D	TWENTY SIX DAYS	A2
27D	TWENTY SEVEN DAYS	A2
28D	TWENTY EIGHT DAYS	A2
29D	TWENTY NINE DAYS	A2
30D	THIRTY DAYS	A2
31D	THIRTY ONE DAYS	A2

ARMY FACILITY TYPE LIST

FACILITY CODE	DESCRIPTION
OTH	OTHER, NON-FEDERAL, CIV HOSP
PUB	PUBLIC HEALTH SERVICE HOSP
VET	VETERANS HOSP

CLASS OF TRAUMA LIST

CODE	DESCRIPTION OF TRAUMA CODE
0	DIRECT RESULT OF ACTION BY OR AGAINST ORGANIZED ENEMY
1	OTHER BATTLE CASUALTIES, SO CLASSIFIED BY DEP REGS
2	RESULT OF INTERVENTION OF LEGAL AUTHORITY
3	ASSAULT OR INTENTIONALLY INFLICTED BY ANOTHER PERSON
4	SELF INFLICTED (INTENTIONAL)
5	OCCURING WHILE OF DUTY (INCLUDES LEAVE, PASS AND AWOL)
6	SCHEMES (MANEUVERS) AND EXERCISES
7	ALL OTHER SCHEDULED TRAINING (INCLUDES BASIC,FTC)
8	OCCURING WHILE ON DUTY
9	UNKNOWN WHETHER ON OR OFF DUTY
C	INJURY, NOT CLASSIFIED AS BATTLE CASUALTY

AAD SUBTITLES ARMY LIST

AAD KEY	KEY	SUBTITLE	FLAG
1	1	GAINS (ADMISSIONS)	
2	2	CHANGE OF STATUS IN	
3	3	LOSSES (DISPOSITIONS)	
4	4	CHANGES TO STATUS OUT	
5	5	OTHER TRANSACTIONS	
6	6	CORRECTIONS TO PRIOR AAD REPORTS	
101	101	DIRECT ADMISSIONS TO HOSPITAL	
102	102	DIRECT ADMISSION ABSENT SICK	
103	103	TRANSFER ADMISSION	1
104	104	NEWBORN	
201	201	FROM LEAVE	
202	202	FROM SUBSISTING OUT	
203	203	FROM AWOL (LESS THAN 11 DAYS)	
204	204	FROM ABS-SICK IN NON MIL HTF	
205	205	FROM TDY/SDY	
207	207	FROM SUPPLEMENTAL CARE	
208	208	FROM COOPERATIVE CARE	
210	210	FROM MEDICAL HOLD	
211	211	FROM ABSENT IN CUSTODY OF MILITARY AUTHORITY	
212	212	FROM OTHER AUTHORIZED ABSENCE	
301	301	RETURNED TO DUTY	
302	302	SEPARATD FROM SERVICE	
303	303	RETIRED - LENGTH OF SERVICE	
304	304	RETIRED - PDRL	
305	305	RETIRED - TDRL	
306	306	AWOL OVER 10 DAYS	
307	307	DISCHARGED FROM HOSPITAL	
308	308	DIED	
309	309	TRANSFERRED	2
401	401	TO LEAVE	
402	402	TO SUBSISTING OUT	
403	403	TO AWOL	
404	404	TO ABS SICK IN NONMIL HOSP	
405	405	TO TDY/SDY	
406	406	TO RCS HOME OR VA HOSPITAL	
408	408	TO SUPPLEMENTAL CARE	
409	409	TO COOPERATIVE CARE	
410	410	TO MEDICAL HOLD	
411	411	TO ABSENT IN CUSTODY OF MILITARY AUTHORITY	
412	412	TO OTHER AUTHORIZED ABSENCE	
501	501	INTERWARD TRANSFERS	
502	502	CARDED FOR RECORD ONLY	
503	503	PASSES IN EXCESS OF 24 HOURS	
504	504	FROM NEWBORN TO PAY PATIENT	
601	601	CORRECTIONS TO GAINS	3
602	602	CORRECTIONS FOR CHANGE OF STATUS IN	3
603	603	CORRECTIONS FOR LOSSES	3
604	604	CORRECTIONS FOR CHANGE OF STATUS OUT	3
605	605	CORRECTIONS FOR INTERWARD TRANSFERS	3
606	606	ADMISSIONS CANCELLED FOR PREVIOUS DATE	3
607	607	DISPOSITIONS CANCELLED FOR PREVIOUS DATE	3
609	609	OTHER CORRECTIONS	3
10101	10101	ACTIVE DUTY:	
10102	10102	DEPENDENTS MILITARY PERSONNEL:	
10103	10103	RETIRED MILITARY PERSONNEL:	
[illegible]	10104	OTHERS:	
30[illegible]	30701	DEPENDENTS OF MIL PERSONNEL:	
30702	30702	RETIRED MILITARY PERSONNEL:	

A&D SUBTITLES ARMY LIST

KEY	KEY	SUBTITLE	FLAG
30703	30703	NEWBORN:	
30704	30704	OTHERS:	
30801	30801	NEWBORN:	
30802	30802	OTHERS:	
30901	30901	NEWBORN:	1
30902	30902	OTHERS:	1
50301	50301	TO PASS:	
50302	50302	FROM PASS:	
60201	60201	FROM LEAVE	3
60202	60202	FROM SUBSISTING OUT	3
60203	60203	FROM AWOL (LESS THAN 11 DAYS)	3
60204	60204	FROM ABSENT SICK IN NONMILITARY MTF	3
60205	60205	FROM TDY/SDY	3
60207	60207	FROM SUPPLEMENTAL CARE	3
60208	60208	FROM COOPERATIVE CARE	3
60210	60210	FROM MEDICAL HOLD	3
60211	60211	FROM ABSENT IN CUSTODY OF MILITARY AUTHORITY	3
60212	60212	FROM OTHER AUTHORIZED ABSENCE	3
60213	60213	FROM PASS	3
60401	60401	TO LEAVE	3
60402	60402	TO SUBSISTING OUT	3
60403	60403	TO AWOL	3
60405	60405	TO TDY/SDY	3
60406	60406	TO PCS HOME OR VA HOSPITAL	3
60408	60408	TO SUPPLEMENTAL CARE	3
60409	60409	TO COOPERATIVE CARE	3
60410	60410	TO MEDICAL HOLD	3
60411	60411	TO ABSENT IN CUSTODY OF MILITARY AUTHORITY	3
60412	60412	TO OTHER AUTHORIZED ABSENCE	3
60413	60413	TO PASS	3

A&D INDICATORS ARMY LIST

INDICATOR	SORT KEY	FLAG
4	50100	
1!ABS!!	10200	
1!CBC	50200	
1!CDA	50200	
1!CDD	50200	
1!CDS	50200	
1!CDT	50200	
1!DIR!1	10101	
1!DIR!2	10103	
1!DIR!3	10102	
1!DIR!9	10104	
1!ERD	50200	
1!NB	10400	
1!P/S	50400	
1!TAF	10300	1
1!TAR	10300	1
1!TDP	10300	1
1!TFN	10300	1
1!TNV	10300	1
2!AWOL!1	30600	
2!CRDD	50200	
2!DAAF	30200	
2!DAMA!3	30701	
2!DAMA!9	30704	
2!DFTS	30300	
2!DFT!2	30702	
2!DFT!3	30701	
2!DFT!9	30704	
2!DMPS	30200	
2!DNT	30802	
2!DNFS	30200	
2!DOA	50200	
2!DOTH	30802	
2!DUTY	30100	
2!FDRL	30400	
2!SEF	30200	
2!SWDP	30200	
2!SWFL	30200	
2!TAF	30902	1
2!TDRL	30500	
2!TDUT	30100	
2!TFF	30902	1
2!TNF	30902	1
2!TFDR	30500	
3!!!AB	20300	
3!!!AM	21100	
3!!!AS	20400	
3!!!AW	20300	
3!!!CC	20800	
3!!!CL	20100	
3!!!MH	21000	
3!!!OL	20100	
3!!!OR	20100	
3!!!P	21200	
3!!!S	50302	
3!!!T	20700	
3!!!SE	20200	

A&D INDICATORS ARMY LIST

INDICATOR	SORT KEY	FLAG
3[1]TD	20500	
3[2]AB	40300	
3[2]AM	41100	
3[2]AS	40400	
3[2]AW	40300	
3[2]CC	40900	
3[2]CL	4010[illegible]	
3[2]MH	41000	
3[2]OL	40100	
3[2]OR	40100	
3[2]OT	41200	
3[2]PH	40600	
3[2]PS	50301	
3[2]PV	40600	
3[2]SC	40800	
3[2]SE	40200	
3[2]TD	40500	
511	60100	3
512	60300	3
513[1]AB	60203	3
513[1]AM	60211	3
513[1]AS	60204	3
513[1]AW	60203	3
513[1]CC	60208	3
513[1]CL	60201	3
513[1]MH	60210	3
513[1]OL	60201	3
513[1]OR	60201	3
513[1]OT	60212	3
513[1]PS	60213	3
513[1]SC	60207	3
513[1]SE	60202	3
513[1]TD	60205	3
514[1]AB	60403	3
514[1]AM	60411	3
514[1]AW	60403	3
514[1]CC	60409	3
514[1]CL	60401	3
514[1]MH	60410	3
514[1]OL	60401	3
514[1]OR	60401	3
514[1]OT	60412	3
514[1]PH	60406	3
514[1]PS	60413	3
514[1]PV	60406	3
514[1]SC	60408	3
514[1]SE	60402	3
514[1]TD	60405	3
515	60500	3
516	60600	3
517	60700	3
519	60900	3
61[0]AMA	30703	
61[0]ISN	30703	
61[0]NEW	30801	
61[0]NN	30801	
61[0]OTH	30801	

AND INDICATORS ABBR LIST

INDICATOR	SORT KEY	FLAG
61TAF	30901	1
61TFF	30901	1
61TNF	30901	1

CAUSE OF DEATH/SEPARATION LIST

CODE	DESCRIPTION	SERVICE FAIG
1	1ST DIAGNOSIS	AF
2	2ND DIAGNOSIS	AF
3	3RD DIAGNOSIS	AF
4	4TH DIAGNOSIS	AF
5	5TH DIAGNOSIS	AF
6	6TH DIAGNOSIS	AF
7	7TH DIAGNOSIS	AF
8	8TH DIAGNOSIS	AF
J	1ST DIAGNOSIS(INJURY SEPARATION)	A
K	2ND DIAGNOSIS(INJURY SEPARATION)	A
L	3RD DIAGNOSIS(INJURY SEPARATION)	A
M	4TH DIAGNOSIS(INJURY SEPARATION)	A
N	5TH DIAGNOSIS(INJURY SEPARATION)	A
O	6TH DIAGNOSIS(INJURY SEPARATION)	A
P	7TH DIAGNOSIS(INJURY SEPARATION)	A
R	8TH DIAGNOSIS(INJURY SEPARATION)	A

ICD 6TH DIGIT LIST

CODE	DESCRIPTION	SERVICE FLAG
A	ASTERISK	AFN
D	DAGGER	AFN
J	MULT FRACTURE	F
S	SECONDARY	AN
T	MULTIPLE CODE	A

PRESENTATION OF FETUS (TABLE) LIST MAR 26,1985 10:29 PAGE 1

CODE	TABLES DESCRIPTION
1A	UNDETERMINED, LIVEBIRTH
1B	LEFT/RIGHT OCCIPITOANTERIOR, LIVERITH
1C	LEFT/RIGHT OCCIPITOTRANSVERSE, LIVEBIRTH
1D	LEFT/RIGHT OCCIPITOPOSTERIOR, LIVEBIRTH
1E	DOUBLE FOOTLING, LIVEBIRTH
1F	FOOTLING, LIVEBIRTH
1H	LEFT/RIGHT SACROANTERIOR, LIVEBIRTH
1J	LEFT/RIGHT SACROPOSTERIOR, LIVEBIRTH
1K	FRANK (OR SINGLE), LIVEBIRTH
1L	COMPLETE (OR DOUBLE), LIVEBIRTH
1M	INCOMPLETE, LIVFBIRTH
1N	LEFT/RIGHT FRONTOANTERIOR, LIVEBIRTH
1P	LEFT/RIGHT FRONTOPOSTERIOR, LIVEBIRTH
1Q	LEFT/RIGHT MENTOANTERIOR, LIVEBIRTH
1R	LEFT/RIGHT MENTOPOSTERIOR, LIVEBIRTH
1S	LEFT/RIGHT SCAPULOANTERIOR, LIVEBIRTH
1T	LEFT/RIGHT SCAPULOPOSTERIOR, LIVEBIRTH
1W	COMPOUND (POSITION UNSPECIFIED), LIVEBIRTH
2A	UNDETERMINED, STILLBIRTH
2B	LEFT/RIGHT OCCIPITOANTERIOR, STILLBIRTH
2C	LEFT/RIGHT OCCIPITOTRANSVERSE, STILLBIRTH
2D	LEFT/RIGHT OCCIPITOPOSTERIOR, STILLBIRTH
2E	DOUBLE FOOTLING, STILLBIRTH
2F	FOOTLING, STILLBIRTH
2H	LEFT/RIGHT SACROANTERIOR, STILLBIRTH
2J	LEFT/RIGHT SACROPOSTERIOR, STILLBIRTH
2K	FRANK, (OR SINGLE), STILLBIRTH
2L	COMPLETE, (OR DOUBLE), STILLBIRTH
2M	INCOMPLETE, STILLBIRTH
2N	LEFT/RIGHT FRONTOANTERIOR, STILLBIRTH
2P	LEFT/RIGHT FRONTOPOSTERIOR, STILLBIRTH
2Q	LEFT/RIGHT MENTOANTERIOR, STILLBIRTH
2R	LEFT/RIGHT MENTOPOSTERIOR, STILLBIRTH
2S	LEFT/RIGHT SCAPULOANTERIOR, STILLBIRTH
2T	LEFT/RIGHT SCAPULOPOSTERIOR, STILLBIRTH
2W	COMPOUND (POSITION UNSPECIFIED), STILLBIRTH

ARMY ICD 7TH DIGIT LIST

CODE	DESCRIPTION
0	TREATED AT REPORTING MTF
9	TREATED/CURED PRIOR TO THIS HOSP
2	CRD AND CASES ENTIRELY ABS SICK

AIRFORCE ICD 7TH DIGIT LIST

CODE	DESCRIPTION
0	NO INFECTION OR COMPLICATION
1	POST OP INFECTION, THIS HOSP
2	POST OP INFECTION, OTHER HOSP
3	OTHER HOSP INFECTION, THIS HOSP
4	OTHER HOSP INFECTION, OTHER HOSP
5	POST OP COMPLICATION, THIS HOSP
6	POST OP COMPLICATION, OTHER HOSP
7	OTHER COMPL, THIS HOSP
8	OTHER COMPL, OTHER HOSP
9	9TH INFECT OR COMPLICATION

NAVY ICD 7TH DIGIT LIST

CODE	DESCRIPTION
N	NOT PRE-EXISTING
Y	PRE-EXISTING CONDITION

WHERE PROCEDURE PERFORMED LIST

OPERATION CODE	DESCRIPTION	SERVICE CODE
P	PRINCIPLE OPERATION IN THIS HOSPITAL	FN
		A
D	THIS MTF	FN
	ASSOCIATED OPERATION IN THIS HOSPITAL	A
N	NON-HOSPITAL MTF	AFN
T	OPERATION PERFORMED IN ANOTHER HOSPITAL	A
U	IN SAME DAY SURGERY PGM	
X		

ARMY AGE TABLE LIST

CODE	DESCRIPTION
T1	PRE-TERM
T2	NORMAL TERM
T3	POST-TERM

AIRFORCE AGE CODE LIST MAR 26,1985 10:31 PAGE 1

CODE	DESCRIPTION
A1	PRE-TERM - LARGE FOR GEST AGE - SINGLE BIRTH
A2	PRE-TERM - LARGE FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
A3	PRE-TERM - LARGE FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
A4	PRE-TERM - LARGE FOR GEST AGE,ONE OF MULTIPLE,MATES ALL LIVEBORN
A5	PRE-TERM - LARGE FOR GEST AGE,ONE OF MULTIPLE,MATES NOT ALL LIVEBORN
B1	PRE-TERM - SMALL FOR GEST AGE - SINGLE BIRTH
B2	PRE-TERM - SMALL FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
B3	PRE-TERM - SMALL FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
B4	PRE-TERM - SMALL FOR GEST AGE,ONE OF MULTIPLE,MATES ALL LIVEBORN
B5	PRE-TERM - SMALL FOR GEST AGE,ONE OF MULTIPLE,MATES ALL NOT LIVEBORN
K1	POST-TERM - LARGE FOR GEST AGE, SINGLE BIRTH
K2	POST-TERM - LARGE FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
K3	POST-TERM - LARGE FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
K4	POST-TERM - LARGE FOR GEST AGE, ONE OF MULTIPLE, MATES LIVEBORN
K5	POST-TERM - LARGE FOR GEST AGE, ONE OF MULTIPLE, SOME MATES STILLBORN
M1	POST-TERM - AVERAGE FOR GEST AGE, SINGLE BIRTH
M2	POST-TERM - AVERAGE FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
M3	POST-TERM - AVERAGE FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
M4	POST-TERM - AVERAGE FOR GEST AGE, ONE OF MULTIPLE, MATES ALL LIVEBORN
M5	POST-TERM - AVERAGE FOR GEST AGE, ONE OF MULTIPLE, SOME MATES STILLBORN
P1	PRE-TERM - AVERAGE FOR GEST AGE, SINGLE BIRTH
P2	PRE-TERM - AVERAGE FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
P3	PRE-TERM - AVERAGE FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
P4	PRE-TERM - AVERAGE FOR GEST AGE, ONE OF MULTIPLE, MATES ALL LIVEBORN
P5	PRE-TERM - AVERAGE FOR GEST AGE, ONE OF MULTIPLE, SOME MATES STILLBORN
R1	POST-TERM - SMALL FOR GEST AGE, SINGLE BIRTH
R2	POST-TERM - SMALL FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
R3	POST-TERM - SMALL FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
R4	POST-TERM - SMALL FOR GEST AGE, ONE OF MULTIPLE, MATES ALL LIVEBORN
R5	POST-TERM - SMALL FOR GEST AGE, ONE OF MULTIPLE, SOME MATES STILLBORN
T1	TERM - LARGE FOR GEST AGE, SINGLE BIRTH
T2	TERM - LARGE FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
T3	TERM - LARGE FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
T4	TERM - LARGE FOR GEST AGE, ONE OF MULTIPLE, MATES ALL LIVEBORN
T5	TERM - LARGE FOR GEST AGE, ONE OF MULTIPLE, MATES ALL NOT LIVEBORN
X1	TERM - AVERAGE FOR GEST AGE, SINGLE BIRTH
X2	TERM - AVERAGE FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
X3	TERM - AVERAGE FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
X4	TERM - AVERAGE FOR GEST AGE, ONE OF MULTIPLE, MATES ALL LIVEBORN
X5	TERM - AVERAGE FOR GEST AGE, ONE OF MULTIPLE, SOME MATES STILLBORN
Y1	TERM - SMALL FOR GEST AGE, SINGLE BIRTH
Y2	TERM - SMALL FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
Y3	TERM - SMALL FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
Y4	TERM - SMALL FOR GEST AGE, ONE OF MULTIPLE, MATES ALL LIVEBORN
Y5	TERM - SMALL FOR GEST AGE, ONE OF MULTIPLE, SOME MATES STILLBORN

RECORD TRACKING STATUS LIST

STATUS	DESCRIPTION
C	COMPLETE
I	INCOMPLETE
O	OUT - Record is checked out.
W	WAITING FOR RESULTS

INCIDENT PERSON TYPE LIST

TYPE	DESCRIPTION
A	INPATIENT
B	OUTPATIENT
C	VISITOR
D	STAFF
OTHER	SPECIFY IN SINGLE QUOTES (E.G. 'VIP VISITOR')

INCIDENT TYPE LIST

TYPE OF INCIDENT	DESCRIPTION
A	MEDICATION
B	TREATMENT
C	EQUIPMENT FAILURE
D	PROCEDURE/TEST
E	SUICIDE
F	FALL
G	FIRE
H	ALTERCATION
I	THEFT
J	COMPLAINT
OTHER	SPECIFY IN SINGLE QUOTES (E.G. 'FIST FIGHT')

INCIDENT LOCATION LIST

INCIDENT LOC	DESCRIPTION
A	PATIENT ROOM
B	STAIRWAY
C	ER
D	BATH/WASH ROOM
E	NURSE STATION
F	TREATMENT ROOM
G	HALLWAY
H	OR
I	ICU/CCU
J	FACILITY GROUNDS
OTHER	SPECIFY IN SINGLE QUOTES (E.G. 'WAITING ROOM')

INCIDENT PERSONNEL INV/REP LIST

PERSONNEL TYPE	DESCRIPTION
A	PHYSICAN
B	NURSE
C	MED STUDENT
D	RAD STAFF
E	LAB STAFF
F	RESIDENT
G	INTERN
H	PHARM STAFF
I	DIET STAFF
J	NURSE PRACTITIONER
K	PA
L	CORPSMAN
M	MAINT STAFF
N	HOUSEKEEPING STAFF
OTHER	SPECIFY IN SINGLE QUOTES (E.G. 'WARD CLERK')

ACTION CODE BYTE 1 LIST

FIRST DIGIT	DESCRIPTION
A	CREDENTIALS COMMITTEE
B	BLOOD UTILIZATION COMMITTEE
C	THERAPEUTIC AGENTS BOARD
D	TISSUE COMMITTEE
E	INFECTION CONTROL COMMITTEE
F	RISK MANAGER
G	COMMANDER
H	CHIEF OF SERVICE
I	GRADUATE MEDICAL EDUC
J	EXECUTIVE COMMITTEE
K	QA COMMITTEE
L	QA COORDINATOR

ACTION CODE BYTE 3 LIST

ACTION CODE CHARACTER	DESCRIPTION
A	FAILED CRITERIA BUT WITHIN PRACTICE PARAMETERS
B	CLINICAL PRIVILEGES LIMITED
C	CLINICAL PRIVILEGES SUSPENDED
D	CLINICAL PRIVILEGES REVOKED
E	REMEDIAL TRAINING STIPULATED
F	PROCTOR ASSIGNED

DOD REPORTED SURGICAL PROCEDURES LIST

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PROCEDURE NBR	PROCEDURE DESC	NORMAL PERCENTAGE	PROCEDURE CODE
1	CAESARIAN SECTION, ALL	*	5740
			5741
			5742
			5748
			5749
2	DILATATION AND CURETTAGE	*	5690
3	REPAIR, INGUINAL/FEMORAL HERNIA	*	5530
			5531
			5532
			5533
4	TUBAL LIGATION	*	5664
5	LAPAROTOMY	20	5541
6	APPENDICTOMY	*	5470
			5471
			5479
7	TONSILLECTOMY AND/OR ADENOIDECTOMY	*	5281
			5282
			5283
			5284
			5285
			5286
			5287
			5288
			5289
8	OPEN REDUCTION OF FRACTURE	*	5791
			5792
9	CHOLECYSTECTOMY	3	5511
10	ABDOMINAL HYSTERECTOMY	*	5682
			5683
11	VAGINAL HYSTERECTOMY	*	5684
12	THORACOTOMY	25	5340
13	TRANSURECTH RESECTION, PROSTATE	*	5601
14	SALPINGO-OOPHORECTOMY	*	5653
			5655
15	EXCISION INTERVERTEBRAL DISC	*	5803
16	EXCISION SEMILUNAR CARTILAGE, KNEE	*	5804
17	EXTRACTION, INTRAOCULAR LENS	*	5142
			5143
			5144
			5145
			5146
18	THYROIDECOTOMY, ALL	*	5061
			5062
			5063
			5064
19	MASTECTOMY, ALL	*	5861
			5862
			5863
			5864
			5865
20	COLECTOMY, PARTIAL	15	5455
21	ARTHROPLASTY, KNEE	*	5814
22	REPAIR, HERNIA, ABDOMINAL WALL	*	5535
23	TRANSURETHRAL RESECTION, BLADDER	*	5573
[illegible]	SALPINGECTOMY	3	5381

AQCESS SYSTEM SPECIFICATION: QUALITY ASSURANCE SUBSYSTEM



TRIMIS Program Office
5401 Westbard Avenue
Bethesda, Maryland 20816

CONTRACT NO:
MDA 903-85-C-0107

March 29, 1985



NDC Federal Systems, Inc.
1300 Piccard Drive
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PART I - GENERAL

SECTION 1. GENERAL

1.1 Purpose. This Subsystem Specification (SS) for the Quality Assurance subsystem of the Automated Quality of Care Evaluation Support System (AQCESS) is written to:

a. Provide a detailed definition of the system functions.

b. Communicate details of the ongoing analysis between the user's operational personnel and the appropriate development personnel.

c. Define in detail the interfaces with other systems and subsystems.

1.2 Project References. For a brief history of the TRIMIS Program and the references relevant to this project, see section 1.1 of the System Specification for the *Automated Quality of Care Evaluation Support System* (National Data Corporation/Federal Systems, Inc.; March 14, 1985). This System Specification will be hereafter referred to as the AQCESS System Specification.

1.3 Terms and Abbreviations. For a list of terms and abbreviations relevant to this document, please see the AQCESS System Specification.

SECTION 2. SUMMARY OF REQUIREMENTS

2.1 System Description. A description of the AQCESS as a whole is included in section 2.1 of the AQCESS System Specification.

AQCESS's Quality Assurance (QA) subsystem will provide MTF command, professional, and administrative staff with automated support for the monitoring of quality of care within the MTFs. Information collected during patient registration, admission, disposition, transfer, and Clinical Records activities will be used to facilitate identification, tracking, and documentation of quality assurance (QA) activities within the MTFs. The QA subsystem will also contain specific functions for collecting, maintaining, and reporting QA data.

The following chart lists all the AQCESS subsystems, including the QA subsystem, and the functions that make up each of them.

Access Control Subsystem

- User Entry
- Patient Identification (PTID)

Quality Assurance Subsystem

- Quality Assurance
- Profiling

R/ADT Subsystem

- Registration
- Admission
- Transfer
- Disposition
- Correction Management
- Bed Management
- System Management
- Inpatient History
- Patient Inquiry
- R/ADT Reports

Clinical Records Subsystem

- Clinical Records
- Clinical Records Reports

This section summarizes the capabilities of the Quality Assurance subsystem and its functions, Quality Assurance and Profiling.

2.1.1 Quality Assurance Subsystem.

2.1.1.1 Quality Assurance. The QA function enables the MTF to monitor quality of care indicators, and allows for the identification, documentation, and tracking of quality of care problems occurring at the MTF. Through this function, users are able to:

a. Identify problems by initiating audits of clinical documentation based on multiple criteria developed at the MTF level. The criteria include such factors as length of stay at unit and MTF, diagnosis, specific procedures, treatment, morbidity, and others.

b. Document problems, solutions, recommendations, re-evaluation dates, and follow-up activities. Documentation includes such information as the type of problem, the source of information, type of person involved (patient, visitor, etc.), and other factors.

c. Track problems, solutions, follow-up actions, and other QA Committee activities, and produce reports or displays of requested data.

The system will provide, at a later date, a means of identifying patient care trends according to specified criteria using ad hoc reporting.

Specifically, the QA function:

a. Provides data to assist in the Occurrence Screening program both for inpatients and for Emergency Service patients (through the Occurrence Screening subfunctions).

b. Allows input of significant incidents and recall of these incidents sorted to highlight various areas of high risk (through the Incident Reporting subfunction).

c. Enables identification and tracking of QA problems by activity and status (through the Problem Audit Tracking subfunction).

d. Generates the following reports on quality assurance activities (through the Reports subfunction):

1. Blood Utilization Pull List (BUPL)

2. Delinquent Occurrence Screening List (DOSL)

3. Emergency Service Occurrence Screening Suspense List (ESOSSL)

4. Emergency Service Pull List

5. Facility Emergency Service Occurrence Screening Summary (FESOSS)

6. Facility Occurrence Screening Summary (FOSS)

7. Incident Summary (IS)

8. Occurrence Screening Pull List (OSPL)

9. Occurrence Screening Suspense List (OSSL)

10. Provider Emergency Service Occurrence Screening Audit (PESOSA)

11. Provider Emergency Service Occurrence Screening Summary (PESOSS)

12. Provider Occurrence Screening Audit (POSA)

13. Provider Occurrence Screening Summary (POSS)

14. Quality Assurance Problem Audit (QAPA)

15. Specialty Occurrence Screening Summary (SOSS)

2.1.1.2 Profiling. The Provider Profiling function maintains the administrative data and clinical indicators necessary for inclusion on the Provider Profile and the Provider Procedures/Mortalities Summary. This function is accessible only by personnel designated by the MTF Commander--normally the Credentials Committee Chairman and the Credentials Committee Secretariat.

Authorized users are able to query the system for a Credentials Pull List, which lists providers by specialty and gives the dates of their last credentials reviews. The Credentials Committee uses the Provider Profile and the Provider Procedures/Mortalities Summary when formulating their recommendations to the Commander regarding the privileges to be granted to providers.

This function generates the following reports:

a. Provider Procedure Summary (PPS)

b. Provider Procedures/Mortalities Summary (PP/MS)

c. Credential Pull List (CPL).

2.2 System Functions. For this information, please see section 2.2 of the AQCESS System Specification.

PART II - SCREENS

SECTION 3. QUALITY ASSURANCE SCREENS

3.1 Quality Assurance Function - Overview. The Quality Assurance function enables MTF personnel to monitor quality of treatment provided at the MTF. Through QA, users are able to:

a. Perform occurrence screening for inpatients and for patients of the Emergency Service.

b. Monitor incidents happening at the MTF and report these incidents.

c. Identify and track problems by activity and status.

d. Produce reports on QA activities.

Occurrence screening identifies "potentially important unaccepted or untoward results of medical or surgical treatment and . . . ensure[s] timely staff review and analysis of these cases" (Reference correspondence from the Adjutant General to commanders of all medical treatment facilities within the command, November 16, 1984). Occurrences can fall into the categories of unexpected health impairment, unexpected medical intervention, or unexpected intensity of services (e.g., transfer to a special care unit).

Incidents tracked by the QA function are events that occur within the MTF and its environs that are not necessarily related to treatment, and that may affect anyone who happens to be at the MTF, not just patients. The QA function collects and reports data on incidents, sorted by type of incident and date/time of incident. By reporting on types of incidents, QA helps the MTF to identify problems, which can be considered collections of similar incidents. For example, if many incidents of people falling down a particular staircase are reported, this points to a problem regarding that staircase. The problem tracking subfunction allows users to identify problems and keep a record of their resolution.

The menu screen for the QA function is displayed when an authorized user selects this function from the User Entry Menu Screen. The Quality Assurance Menu Screen lists the subfunctions available through QA. For a list of these subfunctions, see the example of the QA Menu Screen in Figure 3-1.

The QA function contains highly sensitive data. The last line of each QA screen and report displays the message, "A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER."

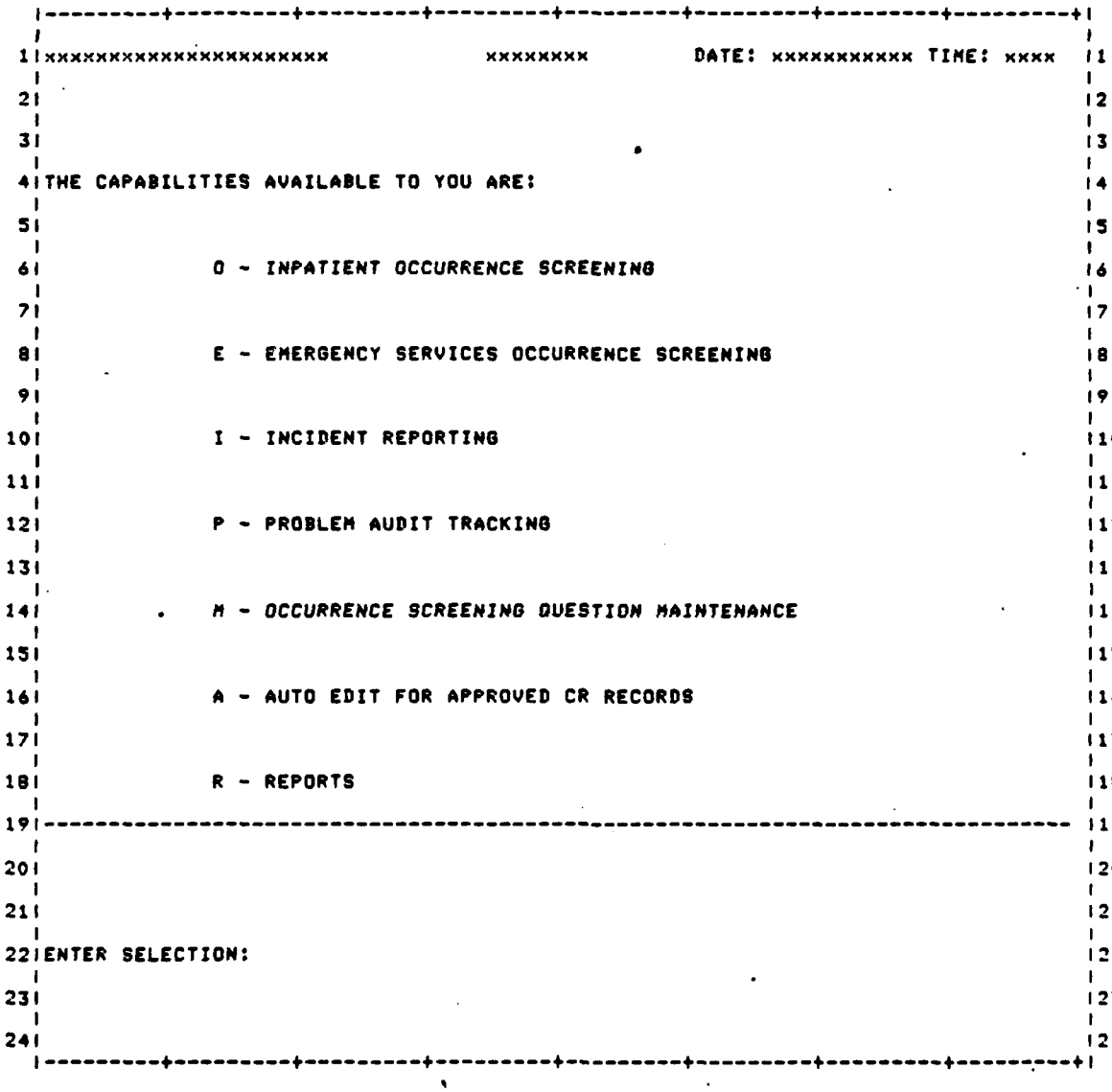


Figure 3-1. QUALITY ASSURANCE MENU SCREEN

3.2 Occurrence Screening. In occurrence screening, the user enters the physician's responses to a list of questions regarding a particular hospital visit. Occurrence.screening is performed by two subfunctions: Inpatient Occurrence Screening, for inpatient episodes, and Emergency Services Occurrence Screening, for outpatient visits to the Emergency Service. The questions asked and the screens used are similar for both subfunctions. In addition to the questions standard for all MTFs using AQCESS, the individual MTF can add up to six questions to the Inpatient checklist, and up to nine for the Emergency Services checklist.

These questions must be answered by yes or no, and an answer to each is required. Some questions should be answered with "yes" except in certain circumstances. These exceptions are specified in Help messages. The user can enter a question mark in the answer field and a Help message will inform the user of the exception. If the exception applies, the question should be answered "no."

3.2.1 Inpatient Occurrence Screening. If the record of this inpatient episode has been approved in Clinical Records when the inpatient checklist is accessed, answers to several of the checklist questions will default to "yes" if indicated by the CR data. The following chart lists the checklist questions that will default and the criteria involved. Except for the last item on the list, these are all ICD diagnosis codes. If any of this data is found in the record, the corresponding Inpatient Checklist question will be defaulted to "yes."

CR Data	Inpatient Checklist Question
E930-E949, 9950, 9952, 9996-9998 (drug/transfusion reactions)	3
4275, 9971, 7991 (cardiac or (respiratory arrest)	6
any death disposition code or 65640, V2710, V2730, V2740, V277	8
9982, 6640-6649, 6650-6659 (laceration, perforation, tear, puncture of organ or body part)	11
6743, 6694, 9980-9989 (post op complication)	14
9984 (operation for removal of foreign body left in operative site)	16
disposition code indicating discharge against medical advice	18

Inpatient Occurrence Screening uses three screens: the Inpatient Occurrence ID Screen, the Inpatient Occurrence Screening Checklist, and the Inpatient Screening Audit. When the user chooses this option from the QA Menu Screen, the Inpatient Occurrence ID Screen is displayed.

a. Inpatient Occurrence ID Screen (Figure 3-2). On this screen the user enters the register number of the inpatient episode for which screening will be performed. When a valid register number has been entered, the Screening Checklist will be displayed.

b. Inpatient Occurrence Screening Checklist (Figure 3-3). This screen appears with data on the patient, the discharge date, and names of the primary and secondary care providers (see Data Chart 3-1). It then lists the questions to be answered. As there are 18 to 24 questions on the checklist, several pages of this screen are used to display them. The options in the screen's sub-menu allow the user to move forward and backward in the series of pages.

Figure 3-3 displays only the first page of the Inpatient Occurrence Screening Checklist. The complete list of standard Inpatient Occurrence Screening questions appears following the screen example, along with the exceptions to each question (i.e., the situations in which the question should be answered "no").

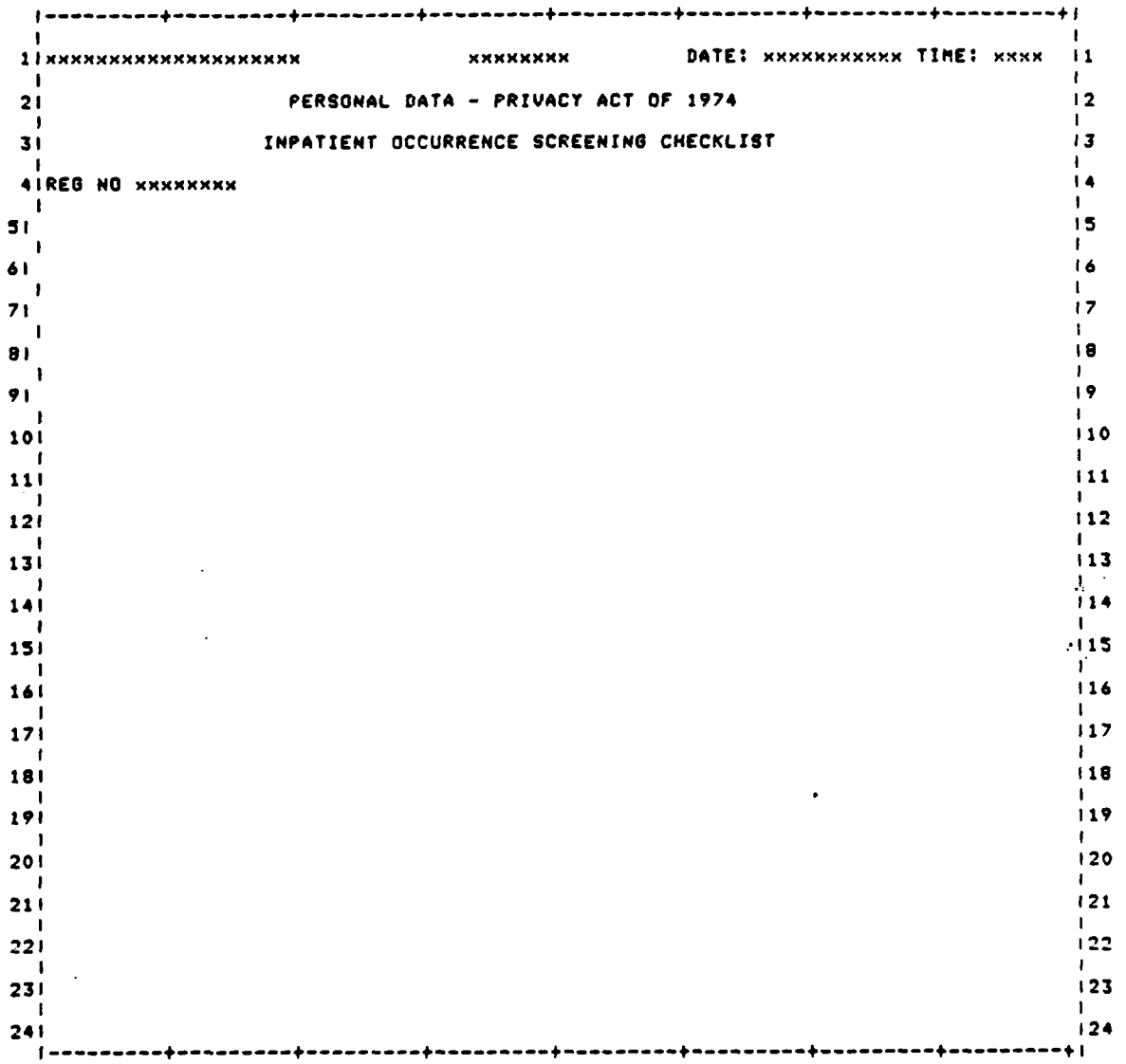


Figure 3-2. QA - INPATIENT OCCURRENCE ID SCREEN

```
1 xxxxxxxxxxxxxxxxxx            xxxxxxxx        DATE: xxxxxxxxxx TIME: xxxx  1
2                  PERSONAL DATA - PRIVACY ACT OF 1974                       2
3                INPATIENT OCCURRENCE SCREENING CHECKLIST                    3
4 REG NO xxxxxxxxx    NAME xxxxxxxxxxxxxxxxxxxxxxxxxx     EMP xx  SSN xxxxxxxxxx 4
5 DISC DATE xxxxxxxxxx  PROVIDER: PRIM xxxxxx SEC xxxxxx   DATE ENTD xxxxxxxxxx 5
6                                                                            6
7 NRR  DESCRIPTION                                                  Y/N      7
8 01   ADMISSION FOR CONDITION WHICH MAY REPRESENT COMPLICATION      x       8
9      OF PREVIOUS OUTPATIENT TREATMENT                                      9
10                                                                           10
11 02  READMISSION WITHIN 6 MONTHS FOR CONDITION WHICH IS POSSIBLY   x       11
12     A COMPLICATION OF PREVIOUS TREATMENT                                  12
13                                                                           13
14 03  DRUG OR TRANSFUSION REACTION                                  x       14
15                                                                           15
16 04  UNEXPECTED TRANSFER FROM GENERAL CARE BED TO SPECIAL CARE BED  x       16
17                                                                           17
18 ------------------------------------------------------------------------ 18
19     1 - NEXT PAGE          2 - PREVIOUS PAGE       3 - PERFORM AUDIT     19
20                                                                           20
21 ENTER SELECTION:                                                          21
22                                                                           22
23 -- A MEDICAL QA DOCUMENT, DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. -- 23
24                                                                           24
```

Figure 3-3. INPATIENT OCCURRENCE SCREENING CHECKLIST

(1) REG NO. Register number of the inpatient episode being screened.

(2) NAME of patient.

(3) FMP of patient.

(4) SSN of patient's sponsor.

(5) DISCHARGE DATE for this inpatient episode.

(6) PROVIDER: PRIM. Patient's primary care provider. From Clinical Records, or from attending physician entered in Admission.

(7) SEC. Patient's secondary care provider. Table 1004.

(8) DATE ENTERED. Date on which QA personnel filled out this checklist.

(9) NBR. Number of the question on the checklist.

(10) DESCRIPTION. Text of the question.

(11) Y/N. Field in which yes or no answer is entered. This is a required field for every question on the screen.

Data Chart 3-1. QA - INPATIENT OCCURRENCE SCREENING CHECKLIST

(1) Admission for condition which may represent complication of previous outpatient treatment.

(2) Readmission within 6 months for condition which is possibly a complication of previous treatment. (Exception: readmission for previously scheduled surgery.)

(3) Drug or transfusion reaction.

(4) Unexpected transfer from general care bed to special care bed. (Exception: transfer from ER directly to special care unit, isolation, or surgery.)

(5) Unanticipated transfer to another acute care facility. (Exception: transfer for administrative reasons.)

(6) Cardiac or respiratory arrest. (Exception: presence of "DO NOT RESUSCITATE" order or equivalent.)

(7) Organ failure (heart, kidney, lung, brain) not present on admission.

(8) Death.

(9) Neurosensory or functional deficit or intractable pain not present on admission.

(10) Apgar score of 4 or less at one minute or 7 or less at five minutes.

(11) Injury of organ/body part during invasive procedure (including obstetrical delivery).

(12) Unexpected return to operating room. (Exception: check op notes or preop counseling note for preplanned and/or multi-stage operative procedure; planned tubal ligation after delivery.)

(13) Unplanned removal or repair of normal body part during surgery (not documented on the informed consent).

(14) Post operation complication. (Exception: temperature elevation abating within 48 hours of surgery; sore throat, hoarseness.)

(15) Acute MI or CVA after surgery.

(16) Operation for removal of foreign body left in operation site.

(17) Repeat of the same invasive procedure during the same admission.

(18) Discharge against medical advice.

Pages following question 18 display occurrence screening questions that have been devised by the particular MTF. The MTF-specific questions are entered into the system via the Occurrence Screening Question Maintenance subfunction, which is accessible from the QA Menu Screen. Up to six questions can be entered.

When the checklist is first displayed, all questions will be defaulted to "no" except where indicated "yes" by the approved CR record. The cursor will be positioned at the first enterable field, and the user must go through each question, updating as necessary. The user fills out the checklist from the hard-copy checklist already completed by the patient's primary care provider. The user can override these defaults by changing "no" answers to "yes," but cannot change "yes" answers to "no." If the QA clerk fills out the checklist before CR processing has been completed, an automatic audit may cause the system to override a "no" entered by the clerk with a "yes" calculated by the edits. If all checklist questions are answered "no," the user will be prompted to confirm that the totally negative checklist is correct.

The first two options on the sub-menu of the Inpatient Occurrence Screening Checklist (1-NEXT PAGE and 2-PREVIOUS PAGE) allow the user to view the checklist's next and previous pages, respectively. The third option, 3-PERFORM

AUDIT, enables the user to initiate an audit of all yes answers to the checklist. When this option is selected, the Inpatient Screening Audit is displayed.

c. Inpatient Screening Audit (Figure 3-4). When this screen appears it displays the number and text of the first question on the checklist that has been answered with "yes." The system will display this screen for each yes question. For each question in the audit the user can enter data on the review of the case and post a variation or death to the profile of the appropriate care provider. Data Chart 3-2 describes this data.

For descriptions of patient and episode data displayed on lines 4 and 5, see Data Charts for Admission and Disposition.

(1) REVIEW LEVEL. Number of the review. Up to 3 are possible.

(2) DATE OUT. Date on which the case was assigned to a reviewer.

(3) DATE DUE. Date on which the review should be completed and returned.

(4) DATE IN. Date on which the completed review was returned.

(5) ACTION CODE. 4 characters are entered for each review level.

- 1st code - indicates the job classification of the person to whom the review was assigned. Table 6054.
- 2nd code - indicates whether the case involved the patient's physician. (1 = physician involved; 2 = not involved).
- 3rd code - indicates the result of the review. Table 6055.
- 4th code - indicates whether this event is to be entered in the physician's profile (Y/N).

(6) VARIATIONS POSTED TO PROVIDERS. When the fourth action code is "Y" the variation will be posted to the profile of the provider whose name is entered here. Names of up to five providers can be entered. If a validated occurrence/death has already been posted, the provider name(s) will be displayed. They may be updated or additional providers may be identified for posting as a result of subsequent reviews. A given provider can only be specified once.

Data Chart 3-2. QA - INPATIENT SCREENING AUDIT

```
 1|xxxxxxxxxxxxxxxxxxxx            xxxxxxxx          DATE: xxxxxxxxxxx TIME: xxxx  | 1
 2|                    PERSONAL DATA - PRIVACY ACT OF 1974                        | 2
 3|                  INPATIENT OCCURRENCE SCREENING CHECKLIST                      | 3
 4|REG NO xxxxxxxx    NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxx     FMP xx  SSN xxxxxxxxxxx | 4
 5|DISC DATE xxxxxxxxxxx  PROVIDER: PRIM xxxxxx SEC xxxxxx   DATE ENTD xxxxxxxxxxx | 5
 6|                                                                               | 6
 7|NBR  DESCRIPTION                                                              | 7
 8|#xx  xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx | 8
 9|     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx | 9
10|     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx | 10
11|                                                                               | 11
12|REVIEW LEVEL    DATE OUT       DATE DUE       DATE IN       ACTION CODE      | 12
13|     #1         xxxxxxxxxxx    xxxxxxxxxxx    xxxxxxxxxxx     x x x x        | 13
14|     #2         xxxxxxxxxxx    xxxxxxxxxxx    xxxxxxxxxxx     x x x x        | 14
15|     #3         xxxxxxxxxxx    xxxxxxxxxxx    xxxxxxxxxxx     x x x x        | 15
16|                                                                               | 16
17|VARIATIONS POSTED TO PROVIDERS:  xxxxxx  xxxxxx  xxxxxx  xxxxxx  xxxxxx      | 17
18|-------------------------------------------------------------------------------| 18
19|                                                                               | 19
20|                                                                               | 20
21|ENTER SELECTION:                                                              | 21
22|                                                                               | 22
23|-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --| 23
24|                                                                               | 24
```

Figure 3-4. QA - INPATIENT SCREENING AUDIT

3.2.2 Emergency Service Occurrence Screening. When the user chooses this option from the QA Menu, the Emergency Service PTID Screen is displayed, on which the user indicates the Emergency Service patient episode to be processed.

a. Emergency Service PTID Screen (Figure 3-5). On this screen the user identifies the Emergency Service episode to be screened. The user can enter a log number to identify the particular episode, or can use this screen to identify the patient.

The user can access the Emergency Service checklist through any of the following routes: (1) If the user enters a log number, the Emergency Services Occurrence Screening Checklist will be displayed. (2) If the user enters PTID data and the patient is located directly, the Emergency Service Episode List Screen will list any episodes for that patient. The Checklist will be displayed when the user selects an episode. (3) If the user initiates searches similar to those used in the PTID function, he or she can identify the patient from a Candidate List Screen. When the user selects a candidate, the Episode List will be displayed. When the user selects an episode, the Emergency Services checklist will appear.

If a record of the Emergency Service episode does not exist on the system, the user enters data identifying the patient on this screen and indicates that this is a new patient. Emergency Service Log Numbers are assigned either automatically or manually, at the MTF's option. The Emergency Service Occurrence Screening Checklist will be displayed next.

b. Emergency Service Candidate List Screen (Figure 3-6). Each page of the Emergency Service Candidate List Screen displays the names of up to 10 candidates, giving the LIST number, NAME OF PATIENT, FMP, and SSN for each. When the user chooses a patient from the candidate list, the Emergency Services Episode List will appear, showing data on the patient's Emergency Room visit or visits.

c. Emergency Service Episode List Screen (Figure 3-7). This screen lists the Emergency Room visits of the patient selected, giving the patient's NAME, SSN, and FMP, and listing the ER LOG NBR, the DATE OF TREATMENT, and the PROVIDER for each visit. Up to 10 visits can be listed for each page of the screen.

If this screen does not display the particular Emergency Room visit that the user wants, the user can assume that the episode has not been entered. Option R on the sub-menu enables the user to create a new Emergency Room episode record.

If the user does locate the record of the desired episode, he or she selects it from this screen, and the Emergency Service Occurrence Screening Checklist will be displayed.

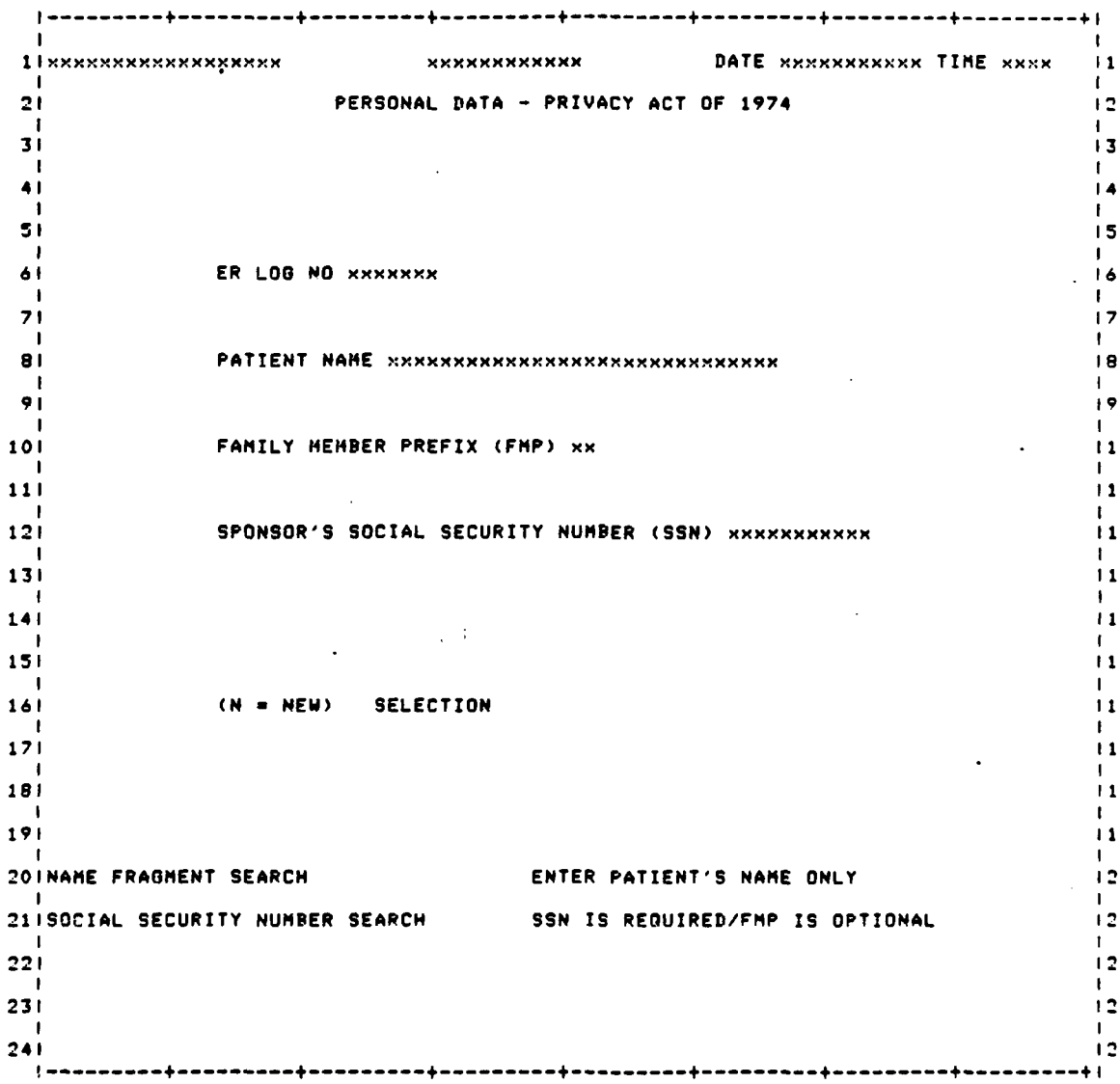


Figure 3-5. QA - EMERGENCY SERVICE PTID SCREEN

```
1 xxxxxxxxxxxxxxx                    xxxxxxxxxxxxx    DATE xxxxxxxxxxx TIME xxxx
2                        PERSONAL DATA - PRIVACY ACT OF 1974
3
4 LIST     NAME OF PATIENT                  FMP            SSN
5
6
7   0      xxxxxxxxxxxxxxxxxxxxxxxxxx       xx          xxxxxxxxx
8   1      xxxxxxxxxxxxxxxxxxxxxxxxxx       xx          xxxxxxxxx
9   2      xxxxxxxxxxxxxxxxxxxxxxxxxx       xx          xxxxxxxxx
10  3      xxxxxxxxxxxxxxxxxxxxxxxxxx       xx          xxxxxxxxx
11  4      xxxxxxxxxxxxxxxxxxxxxxxxxx       xx          xxxxxxxxx
12  5      xxxxxxxxxxxxxxxxxxxxxxxxxx       xx          xxxxxxxxx
13  6      xxxxxxxxxxxxxxxxxxxxxxxxxx       xx          xxxxxxxxx
14  7      xxxxxxxxxxxxxxxxxxxxxxxxxx       xx          xxxxxxxxx
15  8      xxxxxxxxxxxxxxxxxxxxxxxxxx       xx          xxxxxxxxx
16  9      xxxxxxxxxxxxxxxxxxxxxxxxxx       xx          xxxxxxxxx
17
18 ------------------------------------------------------------------------------
19 [ 0 - x ] PATIENT SELECTED          xxxxxxxxxxxxxxx          N - VIEW NEXT PAGE
20
21
22 ENTER SELECTION:
23
24
```

Figure 3-6. QA - EMERGENCY SERVICE CANDIDATE LIST SCREEN

```
1 xxxxxxxxxxxxxxx                    xxxxxxxxxxxxx    DATE xxxxxxxxxx TIME xxxx  1
2                      PERSONAL DATA - PRIVACY ACT OF 1974                       2
3 NAME: xxxxxxxxxxxxxxxxxxxxxxxxxxxx          SSN: xxxxxxxxx    FMP: xx          3
4                                                                                4
5 LIST        ER LOG NBR        DATE OF TREATMENT       PROVIDER                 5
6                                                                                6
7  0            xxxxxxx            xxxxxxxxxxx           xxxxxx                 7
8  1            xxxxxxx            xxxxxxxxxxx           xxxxxx                 8
9  2            xxxxxxx            xxxxxxxxxxx           xxxxxx                 9
10 3            xxxxxxx            xxxxxxxxxxx           xxxxxx                 10
11 4            xxxxxxx            xxxxxxxxxxx           xxxxxx                 11
12 5            xxxxxxx            xxxxxxxxxxx           xxxxxx                 12
13 6            xxxxxxx            xxxxxxxxxxx           xxxxxx                 13
14 7            xxxxxxx            xxxxxxxxxxx           xxxxxx                 14
15 8            xxxxxxx            xxxxxxxxxxx           xxxxxx                 15
16 9            xxxxxxx            xxxxxxxxxxx           xxxxxx                 16
17                                                                               17
18 ------------------------------------------------------------------------------ 18
19 [ 0 - x ] PATIENT SELECTED          xxxxxxxxxxxxxxx          N - VIEW NEXT PAGE  19
20                                                          R - CREATE NEW ER EPISODE 20
21                                                                               21
22 ENTER SELECTION:                                                              22
23                                                                               23
24                                                                               24
```

Figure 3-7. QA - EMERGENCY SERVICE EPISODE LIST SCREEN

d. Emergency Service Occurrence Screening Checklist (Figure 3-8). The ES Occurrence Screening Checklist displays the following data identifying the patient and the ES episode: PATIENT NAME, FMP, SSN, ER LOG NBR, DATE/TIME OF TREATMENT, and PRVDR ID (ID of primary care provider). This screen is used in essentially the same way as the Inpatient Occurrence Screening Checklist (see section 3.2.1). The questions on the ER checklist, and their exceptions, are as follows:

(1) Patient seen in ER who has either been discharged or seen in ER within the past 48 hours. (Will be defaulted to "yes" if a checklist has been entered for an ER episode within the last 7 days, or if the patient was an inpatient within the last 7 days.) (Exception: condition on previous encounter well-documented with instructions to return at a specified interval or for a specified reason.)

(2) Patient discharged or admitted to hospital without being seen by doctor.

(3) Patient arrives DOA.

(4) Patient dies in ER.

(5) Patient leaves without being seen or leaves AMA.

(6) Final X-ray report differs substantially from ER diagnosis and/or X-ray interpretation in the ER (especially fractures, foreign bodies and abnormal air). (Exception: unimportant incidental findings unrelated to aging or normal anatomical variance.)

(7) Unexpected abnormal diagnostic test results returned to ER after patient discharged.

(8) Medication error/reaction.

(9) Treatment/procedure errors (e.g., lab, X-ray wrong patient, wrong treatment).

(10) No written consent or improper consent for procedure or treatment when consent was necessary.

(11) Patient and/or family complains about present or past treatment.

(12) Cardiac arrest. (Exception: patient admitted with cardiac arrest or with diagnosis of myocardial infarction and on monitor.)

(13) Respiratory arrest.

(14) Patient seen previously for head trauma returns with altered state of consciousness or with neurological deficit.

```
 1|xxxxxxxxxxxxxxxxxx          xxxxxxxxxx          DATE xxxxxxxxxx TIME xxxx     1
 2|                    PERSONAL DATA - PRIVACY ACT OF 1974                       2
 3|             EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST                 3
 4|PATIENT NAME xxxxxxxxxxxxxxxxxxxxxxxxxx            FMP xx   SSN xxxxxxxxxxx  4
 5|ER LOG NO xxxxxxx    DATE/TIME OF TREATMENT xxxxxxxxxxxxxxx   PRVDR ID xxxxxx  5
 6|                                                                             6
 7|NBR  DESCRIPTION                                                      Y/N    7
 8|#1   PATIENT SEEN IN ER WHO HAS EITHER BEEN DISCHARGED OR SEEN IN ER    x     8
 9|     WITHIN THE PAST 48 HOURS                                                9
10|                                                                            10
11|#2   PATIENT DISCHARGED OR ADMITTED TO HOSPITAL WITHOUT BEING SEEN BY   x    11
12|     DOCTOR                                                                 12
13|                                                                            13
14|#3   PATIENT ARRIVES DOA                                              x    14
15|                                                                            15
16|#4   PATIENT DIES IN ER                                               x    16
17|                                                                            17
18|----------------------------------------------------------------------------18
19|       1 - NEXT PAGE         2 - PREVIOUS PAGE        3 - PERFORM AUDIT     19
20|                                                                            20
21|ENTER SELECTION:                                                           21
22|                                                                            22
23|-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. -- 23
24|                                                                            24
```

Figure 3-8. QA - EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST

(15) Patient discharged from ER after having received parenteral analgesics without appropriate documentation of instructions and disposition in the record.

The next page of this screen after question 15 displays the MTF-specific ES questions.

e. Emergency Service Screening Audit (Figure 3-9). This screen operates in the same way as the Inpatient Service Screening Audit (see section 3.2.1). Except for the patient and episode data on lines 4 and 5, the fields on this screen are the same as those described in Data Chart 3-2.

```
 1 xxxxxxxxxxxxxxxxxx            xxxxxxxxxx          DATE xxxxxxxxxxx TIME xxxx
 2                    PERSONAL DATA - PRIVACY ACT OF 1974
 3             EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST
 4 PATIENT NAME xxxxxxxxxxxxxxxxxxxxxxxxxx              FMP xx   SSN xxxxxxxxxxx
 5 ER LOG NO xxxxxxx    DATE/TIME OF TREATMENT xxxxxxxxxxxxxxx   PRVDR ID xxxxxx
 6
 7 NBR  DESCRIPTION
 8 #xx  xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
 9      xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
10      xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
11
12 REVIEW LEVEL     DATE OUT       DATE DUE       DATE IN       ACTION CODE
13      #1         xxxxxxxxxxx    xxxxxxxxxxx    xxxxxxxxxxx     x x x x
14      #2         xxxxxxxxxxx    xxxxxxxxxxx    xxxxxxxxxxx     x x x x
15      #3         xxxxxxxxxxx    xxxxxxxxxxx    xxxxxxxxxxx     x x x x
16
17 VARIATIONS POSTED TO PROVIDERS:  xxxxxx  xxxxxx  xxxxxx  xxxxxx  xxxxxx
18 ------------------------------------------------------------------------
19
20
21 ENTER SELECTION:
22
23 -- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --
24
```

Figure 3-9. QA - EMERGENCY SERVICE SCREENING AUDIT

3.3 Incident Reporting. As mentioned in the overview of the QA function, incidents are events that occur within the MTF but are not necessarily related to patients or their treatment. The Incident Reporting subfunction collects data on incidents, and helps the MTF to identify problems, which can be considered collections of similar incidents.

When the user makes this selection from the QA Menu, the Incident ID Screen is displayed.

3.3.1 Incident ID Screen (Figure 3-10). On this screen the user enters the log number that identifies the incident to be processed. Log numbers are assigned automatically by the system when the user enters "NEW" in the LOG NBR field. Log numbers will be ascending but not necessarily consecutive. If the user cancels or if the system crashes before a new entry is completed, that log number will not be used again.

When a valid log number has been entered, the Incident Log Screen appears, displaying data on that incident. Then the Incident Log Screen is displayed, and the user can enter data on the incident.

3.3.2 Incident Log Screen (Figure 3-11). On this screen the user can enter, update, or review data on the incident, including the incident type and location, the type of person involved and that person's name, etc. See Data Chart 3-3 for a description of the data.

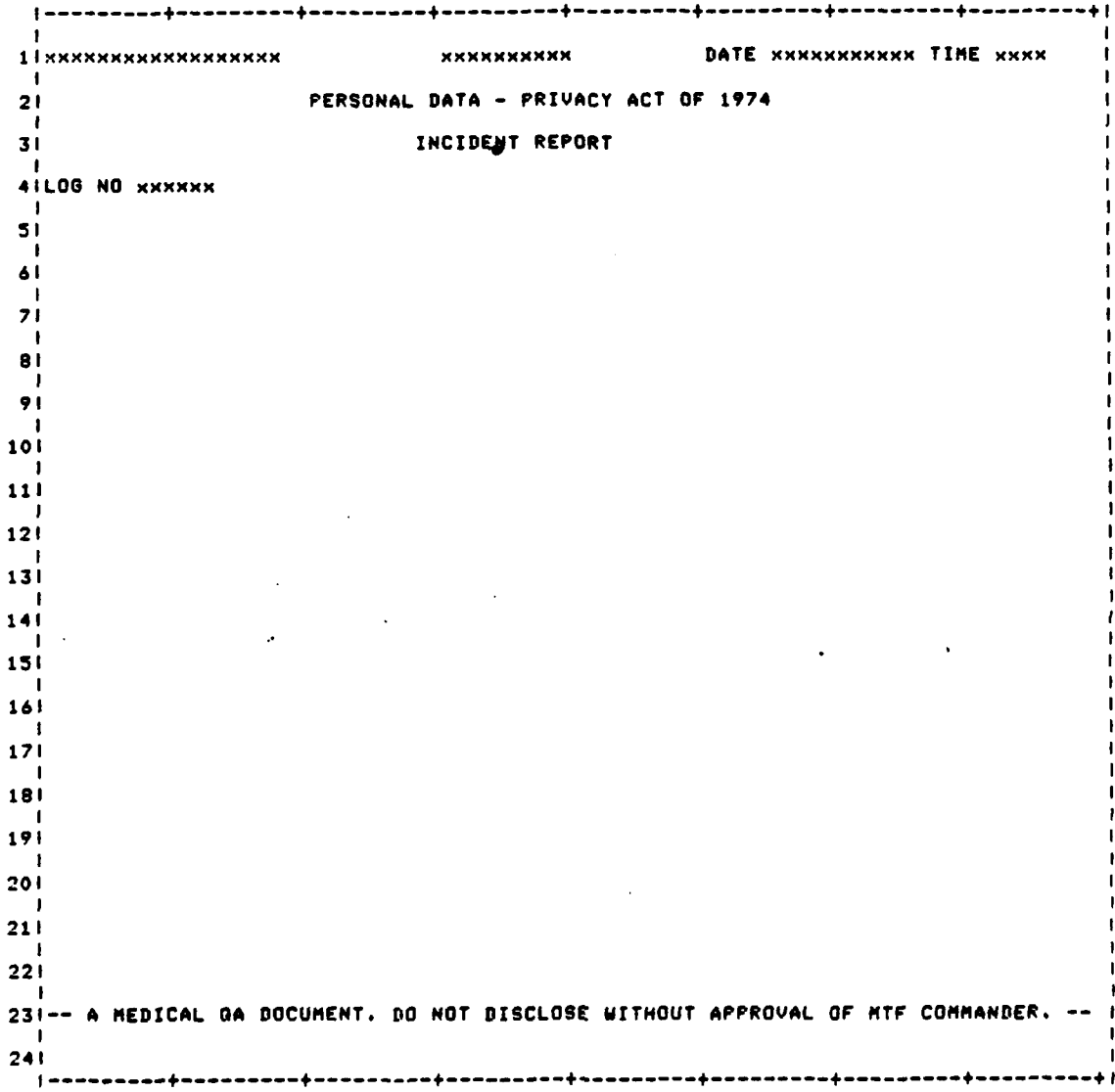


Figure 3-10. QA - INCIDENT ID SCREEN

```
 1 xxxxxxxxxxxxxxxxxx          xxxxxxxxxx          DATE xxxxxxxxxxx TIME xxxx
 2                    PERSONAL DATA - PRIVACY ACT OF 1974
 3                             INCIDENT REPORT
 4 LOG NO xxxxxx
 5 DATE/TIME OF INCIDENT xxxxxxxxxxxxxxx
 6 PERSON INVOLVED: TYPE xxxxxxxxxxxxxxx NAME xxxxxxxxxxxxxxxxxxxxxxxxxx
 7                                    FMP xx  SSN xxxxxxxxxxx  REG NO xxxxxxxx
 8 TYPE OF INCIDENT xxxxxxxxxxxxxxxxxxx
 9 LOCATION OF INCIDENT xxxxxxxxxxxxxxxxxxxxxxxx
10 PERSONNEL INVOLVED   xxxxxxxxxxxxxxx   PERSONNEL REPORTING xxxxxxxxxxxxxxx
11 RESULT OF INCIDENT   x
12
13 DATE REVIEWED BY RISK MANAGER xxxxxxxxxxx
14 JAG REVIEW x                          DATE SENT TO JAG xxxxxxxxxxx
15 DATE OF ACTION xxxxxxxxxxx            ACTION CODE x x x x
16 DATE OF ACTION xxxxxxxxxxx            ACTION CODE x x x x
17 DATE OF ACTION xxxxxxxxxxx            ACTION CODE x x x x
18 ------------------------------------------------------------------------
19
20
21 ENTER SELECTION:
22
23 -- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --
24
```

Figure 3-11. QA - INCIDENT LOG SCREEN

(1) LOG NO. Number that identifies the incident.

(2) DATE/TIME OF INCIDENT.

(3) PERSON INVOLVED: TYPE. Code for the type of person involved in the incident (e.g., patient, visitor, or type of MTF personnel). Table 6050.

(4) NAME of the person involved.

(5) FMP of person involved.

(6) SSN of person involved.

(7) REG NO. of person involved, if a patient.

*(8) TYPE OF INCIDENT. For example, a fall. Can be entered by a 1-character code from the incident table. More than one of these codes can be entered.

*(9) LOCATION OF INCIDENT. Can be indicated by a 1-character code from Table 6052. More than one of these codes can be entered.

*(10) PERSONNEL INVOLVED. Code for the type of MTF personnel (i.e., job classification) involved in the incident. More than one can be entered. Table 6053.

(11) PERSONNEL REPORTING. Code for the type of MTF personnel reporting the incident. More than one can be entered. Table 6053.

(12) RESULT OF INCIDENT. Code for the result. Yes/No.

(13) DATE REVIEWED BY RISK MANAGER.

(14) JAG REVIEW. 1-character code for whether this incident will be reviewed by the Judge Advocate General. (Yes/No.)

(15) DATE SENT TO JAG. Date when record of this incident was sent to the Judge Advocate General's office.

(16) DATE OF ACTION taken regarding this incident.

(17) ACTION CODE. See Data Chart 3-2.

*Free text can be entered in these fields if enclosed in single quotes.

Data Chart 3-3. QA - INCIDENT LOG SCREEN

3.4 Problem Audit Tracking. This subfunction enables the user to track quality of care problems, which can be considered collections of similar incidents, as well as the solutions of these problems. When the user selects Problem Audit Tracking from the QA Menu, the Problem ID Screen is displayed.

3.4.1 Problem ID Screen (Figure 3-12). On this screen the user enters the problem number that identifies the problem to be processed. When a valid number has been entered, the Problem Audit Screen appears, displaying data on that problem. If data on the problem has not yet been entered, the user types "NEW" in the PROBLEM NO field. A problem number will be assigned by the system. Then the Problem Audit Screen is displayed, and the user can enter data.

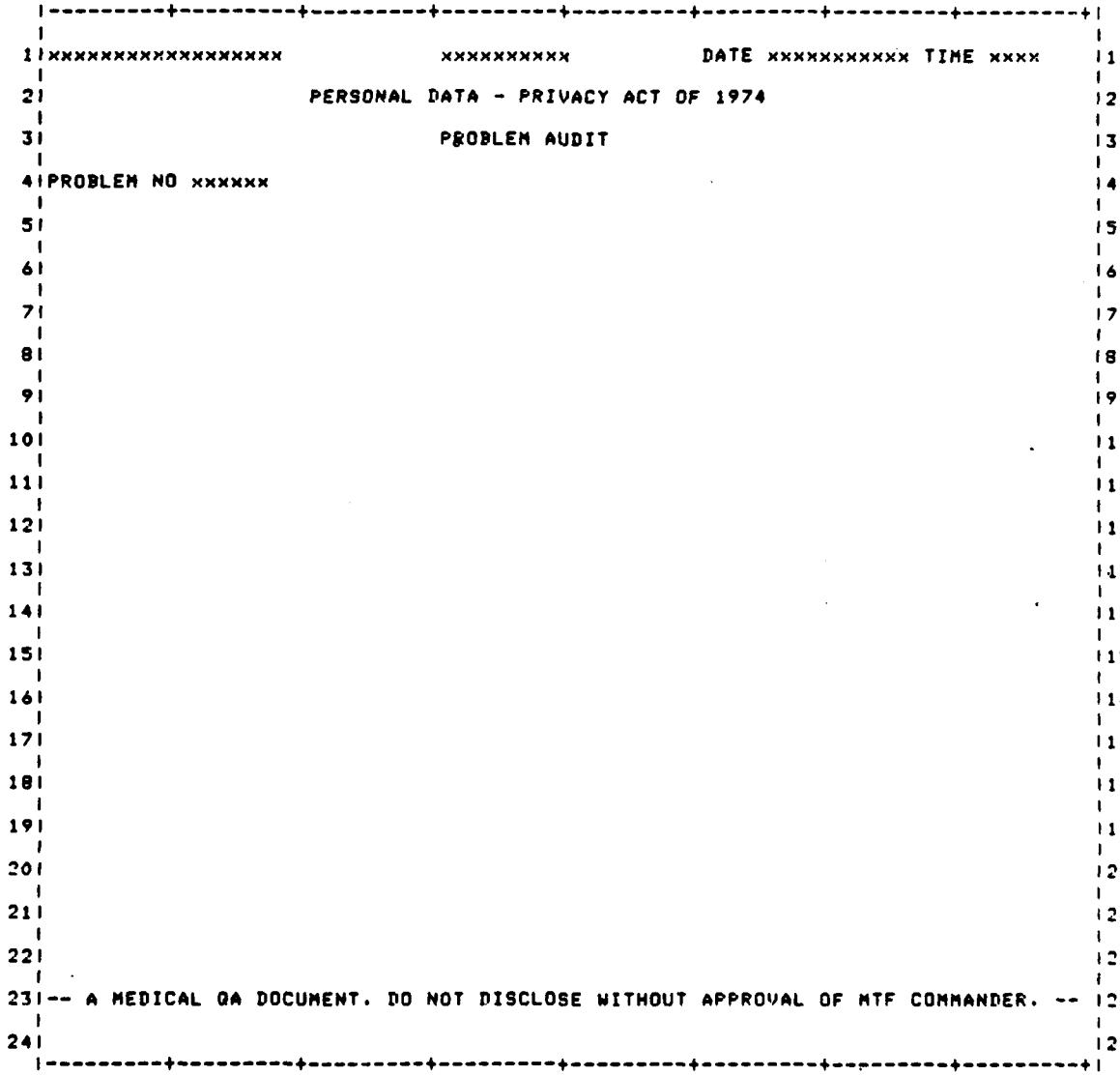


Figure 3-12. QA - PROBLEM ID SCREEN

3.4.2 Problem Audit Screen (Figure 3-13). On this screen the user can enter, update, or review data on the problem, including its impact on patient care, the action taken, and follow-up date. See Data Chart 3-4 for a description of the data.

(1) PROBLEM NO. Number identifying the problem.

(2) DATE PRESENTED. Date on which the problem was presented.

(3) REFERRAL ACTIVITY. Free text describing to whom the problem was referred.

(4) IMPACT ON PATIENT CARE. Free text.

(5) ACTION ACTIVITY. Free text.

(6) STATUS DATE.

(7) ACTION TAKEN. The action taken on the problem. Free text.

(8) FOLLOWUP DATE. Date on which any followup activity occurred.

Data Chart 3-4. QA - PROBLEM AUDIT SCREEN

```
 1|xxxxxxxxxxxxxxxxxx          xxxxxxxxxx          DATE xxxxxxxxxx TIME xxxx    | 1
 2|                    PERSONAL DATA - PRIVACY ACT OF 1974                      | 2
 3|                              PROBLEM AUDIT                                  | 3
 4|PROBLEM NO xxxxxx                                                          | 4
 5|DATE PRESENTED xxxxxxxxxxx          REFERRAL ACTIVITY xxxxxxxxxxxxxx        | 5
 6|                                                                           | 6
 7|IMPACT ON PATIENT CARE                                                     | 7
 8|xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx | 8
 9|xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx | 9
10|                                                                           |10
11|ACTION ACTIVITY xxxxxxxxxxxxxxx      STATUS DATE xxxxxxxxxxx                |11
12|                                                                           |12
13|ACTION TAKEN                                                               |13
14|xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx |14
15|                                                                           |15
16|FOLLOWUP DATE   xxxxxxxxxxx                                                |16
17|                                                                           |17
18|---------------------------------------------------------------------------|18
19|                                                                           |19
20|                                                                           |20
21|ENTER SELECTION:                                                           |21
22|                                                                           |22
23|-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --|23
24|                                                                           |24
```

Figure 3-13. QA - PROBLEM AUDIT SCREEN

3.5 Occurrence Screening Question Maintenance. The MTF can devise as many as six questions for the Inpatient Occurrence Screening Checklist and nine questions for the Emergency Services Checklist. These questions are listed after question 18 on the inpatient checklist, and after question 15 on the Emergency Services checklist. The Occurrence Screening Question Maintenance option on the QA Menu allows the user to edit, replace, or add to the MTF's questions.

When the user selects this function, the QA Question Maintenance ID Screen is displayed.

a. Question Maintenance ID Screen. The user indicates whether the Inpatient or Emergency Services checklist is to be changed. Then the Occurrence Screening Question Maintenance Screen is displayed.

b. Occurrence Screening Question Maintenance Screen (Figure 3-14). The user enters the number of the question to be added or changed. If the user is adding a question to the list, he or she enters the text of the question in the TEXT field.

If the user has entered the number of an existing question, its text is displayed when this screen appears. The user can make changes that do not affect the question's meaning, or can replace the old question with an entirely new one. If the meaning of the existing question is substantially changed, all data currently stored under the old question must be deleted from the system. After the new text has been entered, the screen will display a message asking the user whether data stored on the old version of the question should be deleted. The user should answer "yes" if the meaning of the question has substantially changed. The user will be asked to reconfirm the "yes" in order to delete old data.

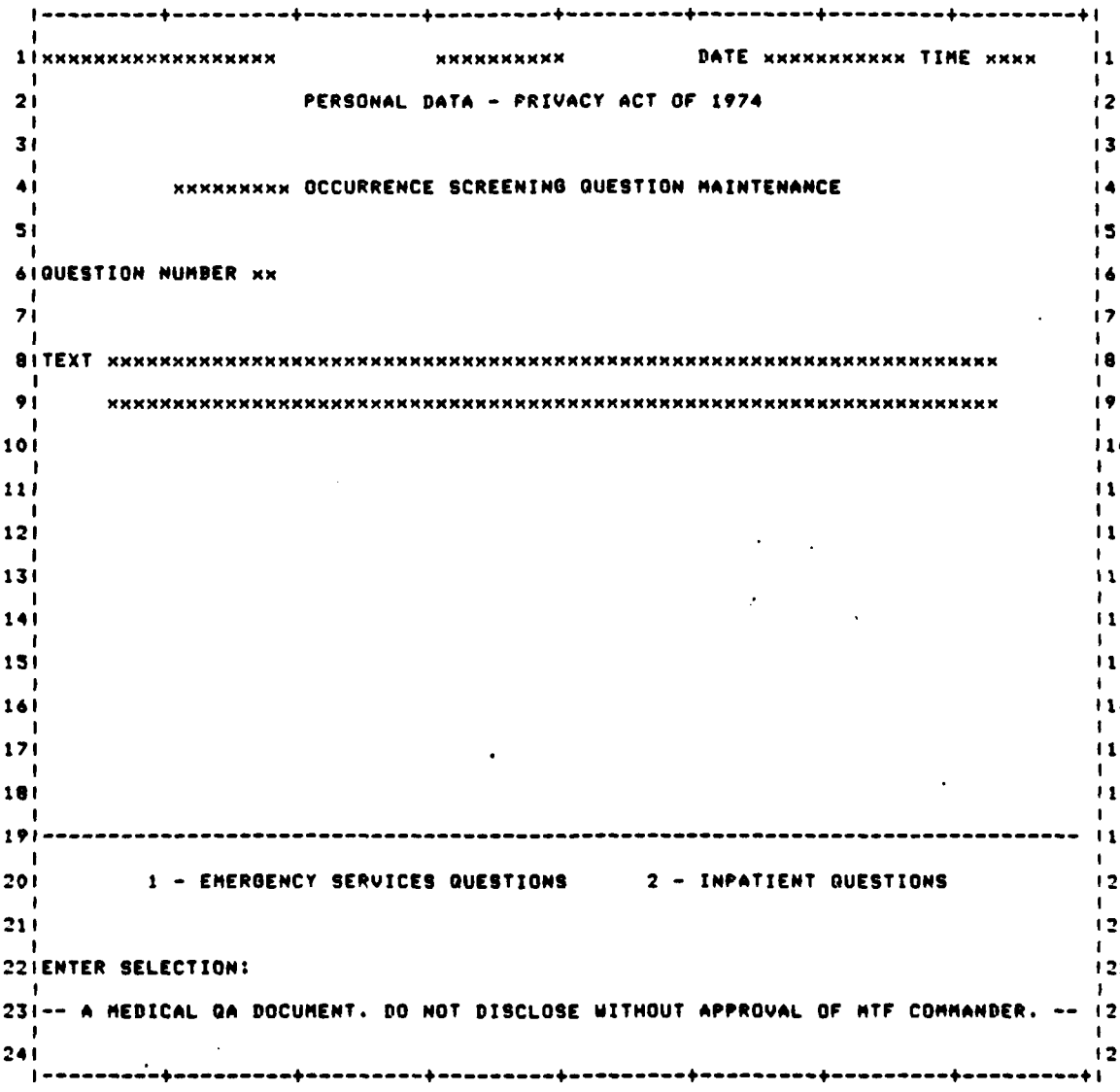
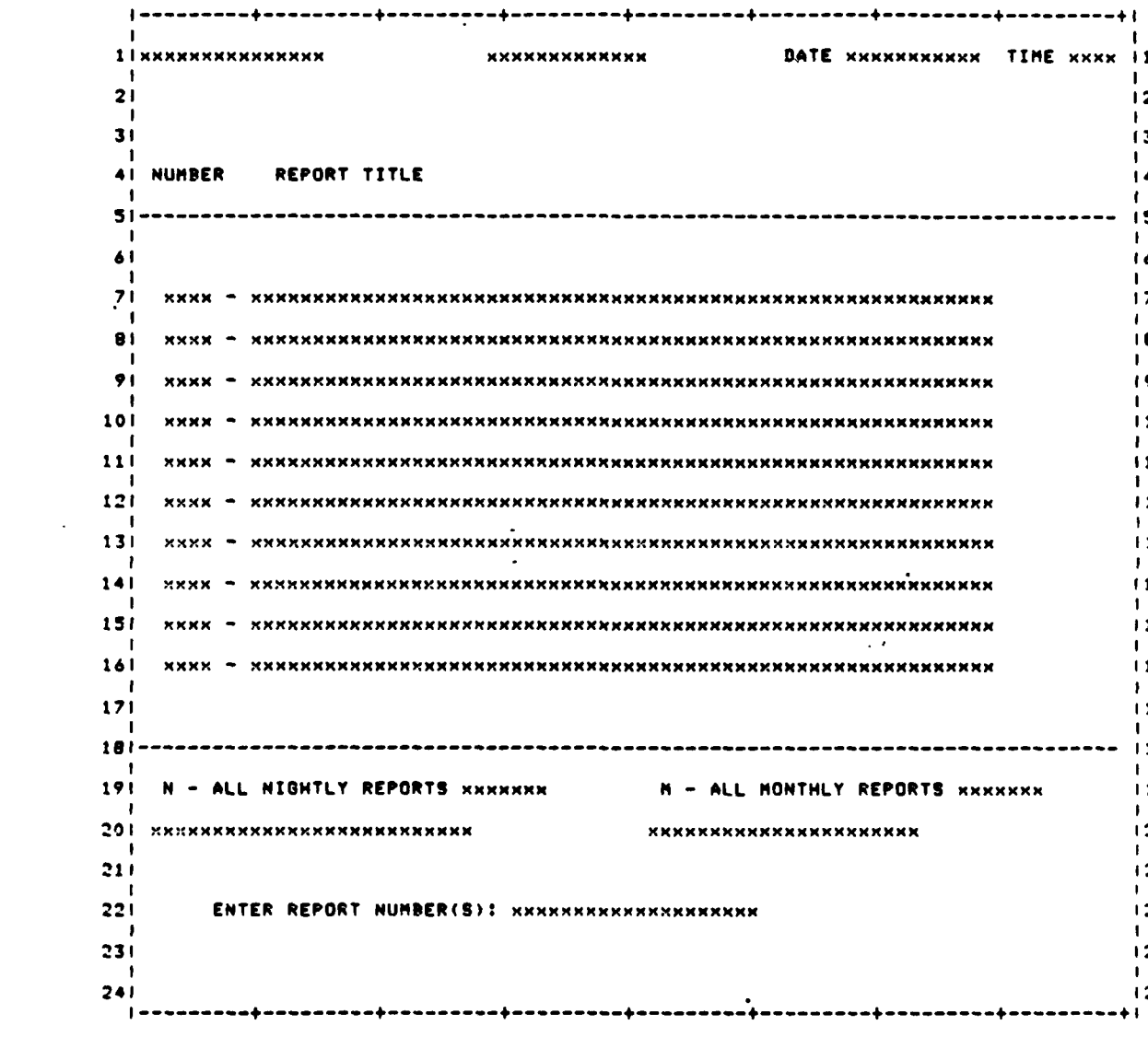


Figure 3-14. QA - OCCURRENCE SCREENING QUESTION MAINTENANCE SCREEN

3.7 Auto Edit for Approved CR Records. This selection initiates an edit of the records that have been processed in Occurrence Screening but that have not been approved in Clinical Records. The edit determines if the record was just approved in CR, and which Occurrence Screening questions can be defaulted by CR data. If any questions answered with "no" on the checklist should be answered affirmatively as indicated by CR data, the "no" answer will be changed to "yes" and the question will be listed on the Pull List. Questions answered by "yes" on the checklist can not be changed to "no" by the CR data. No screen is displayed by this selection.

3.8 Reports. With this selection, the QA Reports Selection Screen is displayed and the user can choose which QA reports to print. See Figure 3-15. The QA reports, which are described in detail in Part III, are:

1. Blood Utilization Pull List (BUPL)
2. Delinquent Occurrence Screening List (DOSL)
3. Emergency Service Occurrence Screening Suspense List (ESOSSL)
4. Emergency Service Pull List
5. Facility Emergency Service Occurrence Screening Summary (FESOSS)
6. Facility Occurrence Screening Summary (FOSS)
7. Incident Summary (IS)
8. Occurrence Screening Pull List (OPL)
9. Occurrence Screening Suspense List (OSSL)
10. Provider Emergency Service Occurrence Screening Audit (PESOSA)
11. Provider Emergency Service Occurrence Screening Summary (PESOSS)
12. Provider Occurrence Screening Audit (POSA)
13. Provider Occurrence Screening Summary (POSS).
14. Quality Assurance Problem Audit (QAPA)
15. Specialty Occurrence Screening Summary (SOSS)


xxxxxxxxxxxxxxx
xxxxxxxxxxxxx
DATE xxxxxxxxxxx TIME xxxx
NUMBER REPORT TITLE
xxxx - xxxxxxxxxxxxxx

SECTION 4. PROFILING SCREENS

4.1 Profiling Function - Overview. The Profiling process maintains physician profile data and assists the Credentials Committee in formulating their recommendations regarding the privileges to be granted to care providers. This process is only available to personnel designated by the MTF Commander--normally the Credentials Committee Chairman and the Credentials Committee Secretariat.

Data entered and updated in this process is included on the following displays and reports, which are requested through this process:

a. Provider Profile

b. Batch Posting to Provider Profile

c. Credentials Pull List

d. Provider Procedure Summary

e. Provider Procedures/Mortalities Summary.

When an authorized user selects this process from the User Entry Main Menu, the Profiling Menu is displayed (see Figure 4-1). Selecting either of the first two options on the menu, *Provider Profile or Batch Posting to Provider* Profile, will cause screens to be displayed. Selecting the remaining options--Provider Procedure Summary, Credentials Pull List, and Provider Procedures/Mortalities Summary--will cause the specified reports to be printed. For details on these reports, see Part III, Outputs.

4.2 Provider Profile. This option allows the user to update all information on file for the physician selected. When this option is selected from the Profiling Menu, the first screen to appear is the Provider ID (Figure 4-2). On this screen, the user enters the code identifying the physician whose profile is to be processed.

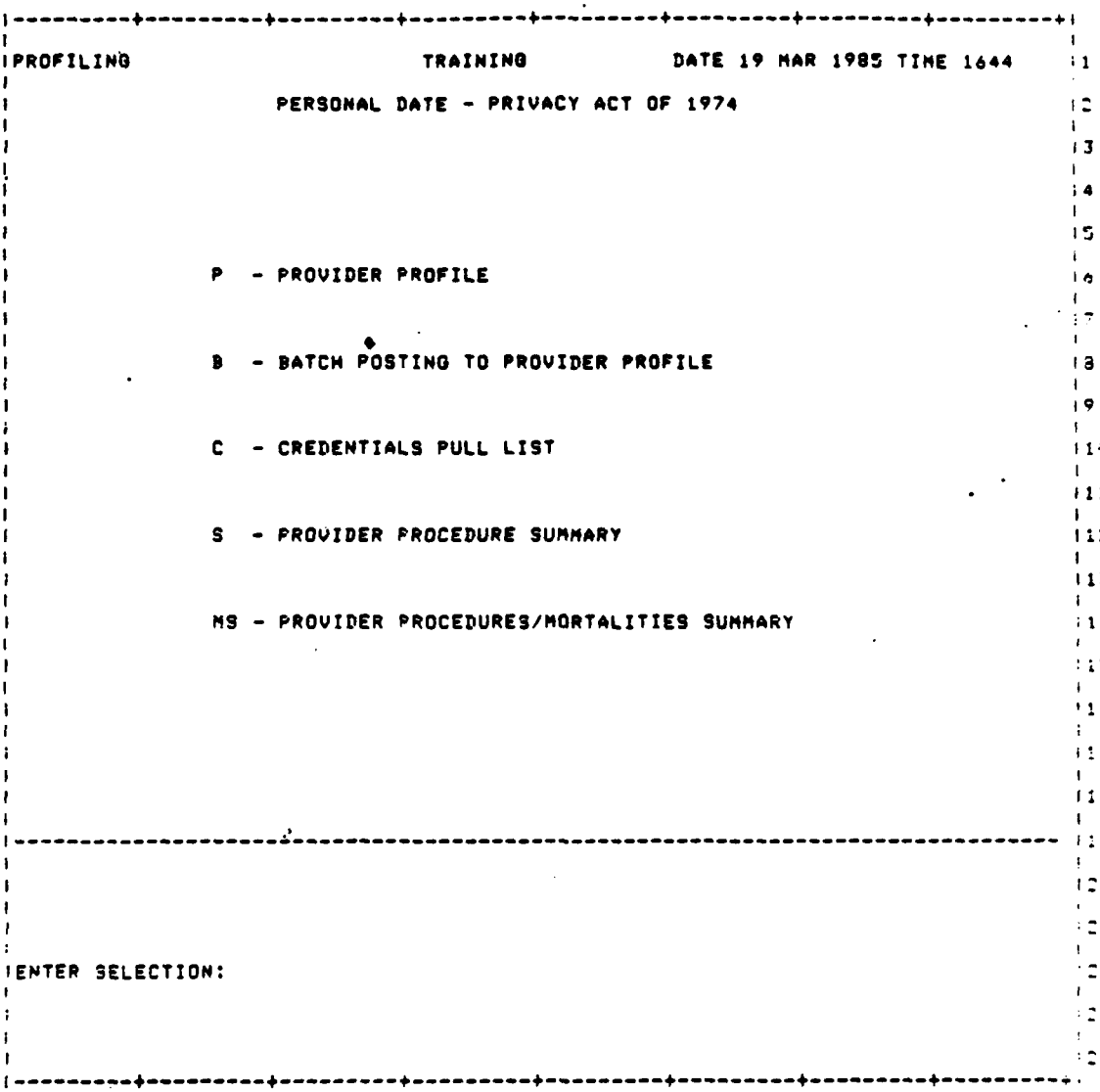


Figure 4-1. PROFILING MENU

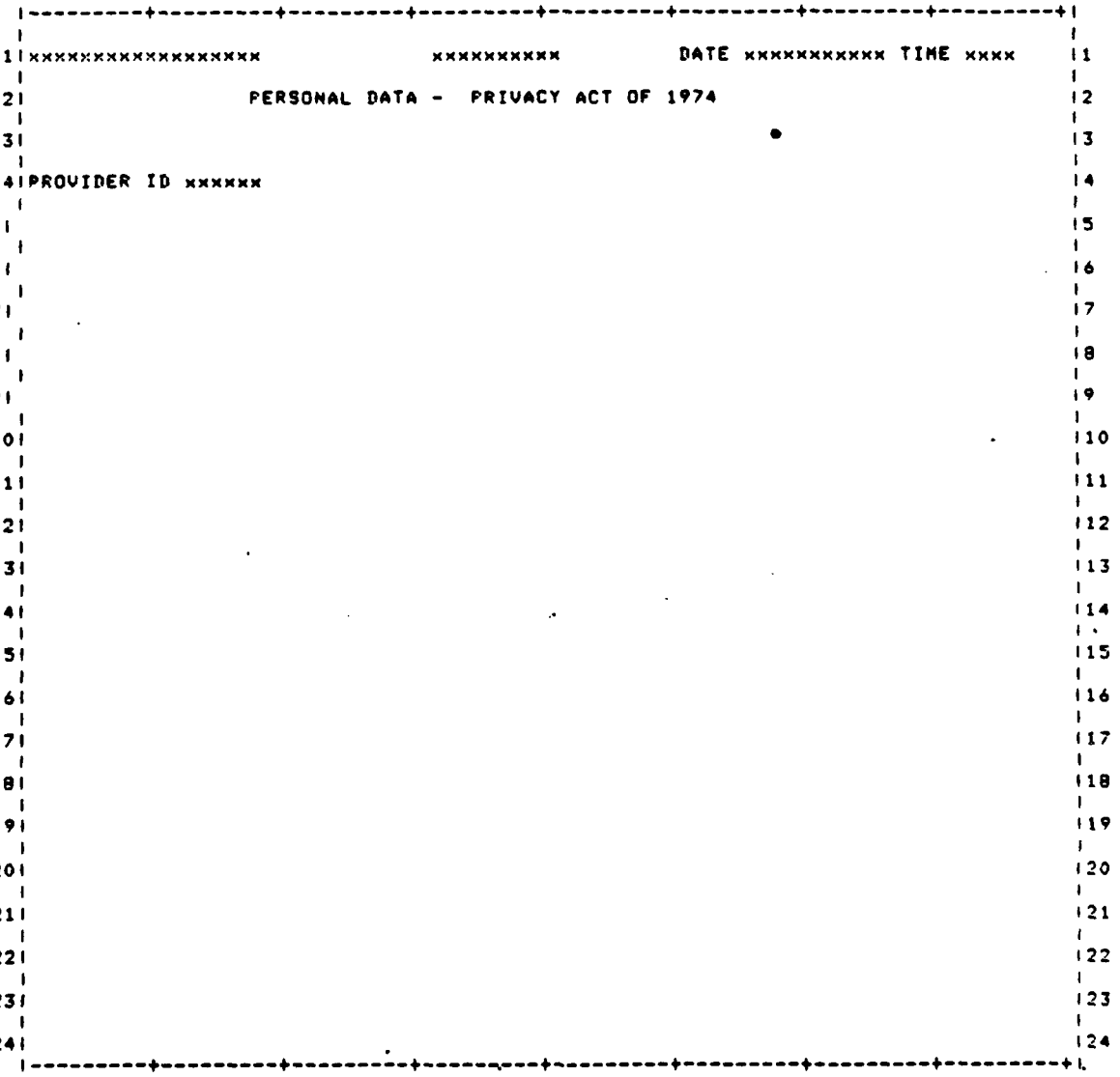


Figure 4-2. PROFILING - PROVIDER ID SCREEN

After a valid physician ID is entered, the Provider Profile Screen is displayed (Figure 4-3). The clinical indicator data on this screen is kept for six six-month periods beginning with the date the physician was assigned to the MTF. When first accessed, the Provider Profile displays the date for the current six-month period. The user can page back to Provider Profiles for previous six-month periods, and can update profile data for any period.

(1) PROVIDER ID. Short version of the doctor's name.

(2) PROVIDER NAME. Last name, first name, middle initial. For display only (i.e., user cannot update).

(3) SPEC. Specialty of the physician. From Table 2005. Display only.

(4) QA ID CODE. Scrambled SSN of provider. Used to identify provider on QA reports. For display only.

(5) CONT ED (YY/HH). Continuing education completed by the provider, followed by the year completed and the number of credit hours.

(6) ASGN DTE. Date on which the physician was assigned to this MTF. This date will be used to calculate the 6-month period for which the clinical indicator totals are kept. Up to 6 6-month sets of counts will be maintained. For display only.

(7) DATE OF: CPR TRAINING. Date on which physician completed CPR training.

(8) ACLS CERT. Date on which physician was certified by ACLS.

(9) ATLS CERT. Date on which physician was certified by ATLS.

(10) CREDENTIALS RENEWAL. Date on which physician's credentials are due to be renewed by Credentials Committee.

(11) LICENSE RENEWAL. Date on which physician's license to practice are to be renewed by state licensing board.

(12) STATE OF LICENSE. 2-character abbreviation from Table 1015.

(13) CLINICAL INDICATOR TOTALS FOR 6 MONTH PERIOD BEGINNING (date). The data on this screen is valid for the six-month period beginning on this date.

Data Chart 4-1. PROFILING - PROVIDER PROFILING SCREEN

(14) PROCEDURES PERFORMED. Number of procedures performed by this physician. Maintained by Clinical Records and posted to this provider profile after the CR record is approved. For display only.

(15) PATIENTS DISCHARGED. Number of patients dispositioned with this physician as the attending/primary provider. Maintained by Clinical Records and posted to this provider profile after the CR record is approved. For display only.

(16) MALPRACTICE CLAIMS FILED. Number of claims filed against this physician.

(17) MED REC DEFICIENCIES. Number of medical records considered deficient due to missing data that this physician must provide (e.g., signature, history notes, etc.).

(18) MED RECORD DELINQUENCIES. Number of medical records considered delinquent by Clinical Records due to missing data that this physician must provide. Defaulted to the number calculated by Clinical Records. For display only.

(19) VALIDATED: ANTIBIOTIC VARIATIONS. The number of occurrences related to antibiotic variations for which the provider has received a "failed" audit result.

(20) COMPLAINTS. Number of validated patient complaints lodged against this physician.

(21) NORMAL SURGICAL TISSUE. The number of occurrences related to surgical normal tissue for which the provider has received a "failed" audit result.

(22) TRANSFUSIONS. The number of occurrences related to transfusions for which the provider has received a "failed" audit result.

(23) SCREENING VARIATIONS. From the Inpatient and Emergency Services Occurrence Screening Audits. Number of validated "yes" answers to occurrence screening questions for which the audit action code indicates that the variation should be posted against this provider's profile. For display only.

(24) TOTAL DEATHS. From Inpatient and Emergency Services Occurrence Screening Audits. Number of patient deaths that reflect a failure on the physician's part. For display only.

Data Chart 4-1 (continued). PROFILING - PROVIDER PROFILING SCREEN

PROVIDER PROFILE

```
1 xxxxxxxxxxxxxxxxxx              xxxxxxxxxx          DATE xxxxxxxxxxx TIME xxxx     1
2                  PERSONAL DATA -  PRIVACY ACT OF 1974                            2
3                                                                                  3
4 PROVIDER ID xxxxxx  NAME xxxxxxxxxxxxxxxxxxxxxxxxxxxx  SPEC xxxxxxxxxxxxxxxxxxx  4
5 QA ID CODE xxxxxxxxxxx  CONT ED (YY/HH) xx/xx xx/xx xx/xx  ASGN DTE xxxxxxxxxxx  5
6                                                                                  6
7 DATE OF: CPR TRAINING xxxxxxxxxxx  ACLS CERT xxxxxxxxxxx  ATLS CERT xxxxxxxxxxx  7
8          CREDENTIALS RENEWAL xxxxxxxxxxx                                         8
9          LICENSE RENEWAL     xxxxxxxxxxx     STATE OF LICENSE xx                 9
10                                                                                 10
11 ----- CLINICAL INDICATOR TOTALS FOR A MONTH PERIOD BEGINNING xxxxxxxxxxx -----  11
12 PROCEDURES PERFORMED xxxxxx           PATIENTS DISCHARGED       xxxxxx          12
13 MALPRACTICE CLAIMS FILED xxxxxx       MED RECORD DEFICIENCIES   xxxxxx          13
14                                       MED RECORD DELINQUENCIES  xxxxxx          14
15 VALIDATED: ANTIBIOTIC VARIATIONS xxxxxx   COMPLAINTS   xxxxxx                  15
16            NORMAL SURGICAL TISSUE xxxxxx  TRANSFUSIONS xxxxxx                  16
17            SCREENING VARIATIONS   xxxxxx  TOTAL DEATHS xxx                     17
18 ------------------------------------------------------------------------------ 18
19                                                                                 19
20      1 - PREVIOUS 6 MONTH PERIOD      2 - NEXT 6 MONTH PERIOD                   20
21                                                                                 21
22 ENTER SELECTION:                                                                22
23 -- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --  23
24                                                                                 24
```

Figure 4-3. PROFILING - PROVIDER PROFILE SCREEN

4.3 Batch Posting to Provider Profile. This option allows the user to enter specific types of profile data for more than one provider at a time. When this option is chosen from the Profiling Menu, the Batch Posting Menu Screen is displayed, which lists the types of profile data that can be entered (see Figure 4-4). Choosing any menu option causes a Posting Screen to appear, on which the user enters the name of the physician and the effective date of the entry. The Posting Screen for the first six options also includes a quantity field, in which the number of malpractice claims, for example, can be entered (Figure 4-5). On the Posting Screen for the other options the user just enters the name of the provider and the date. Entries made on these screens will be posted to the profile for a given six-month period, depending on the effective date entered.

```
PROFILING                    TRAINING              DATE 19 MAR 1985 TIME 1644

                    PERSONAL DATA - PRIVACY ACT OF 1974

                    BATCH POSTING TO PROVIDER PROFILE

                     1 -  MALPRACTICE CLAIMS FILED
                     2 -  VALIDATED PATIENT COMPLAINTS
                     3 -  MED REC DEFICIENCIES
                     4 -  VALIDATED SURGICAL TISSUE
                     5 -  VALIDATED DRUG VARIATIONS
                     6 -  VALIDATED TRANSFUSION REACTIONS
                     7 -  CONTINUING MEDICAL EDUCATION
                     8 -  ACLS DATES
                     9 -  ATLS DATES
                    10 -  CPR DATES
                    11 -  CREDENTIALS RENEWAL

ENTER SELECTION:
```

Figure 4-4. PROFILING - BATCH POSTING MENU SCREEN

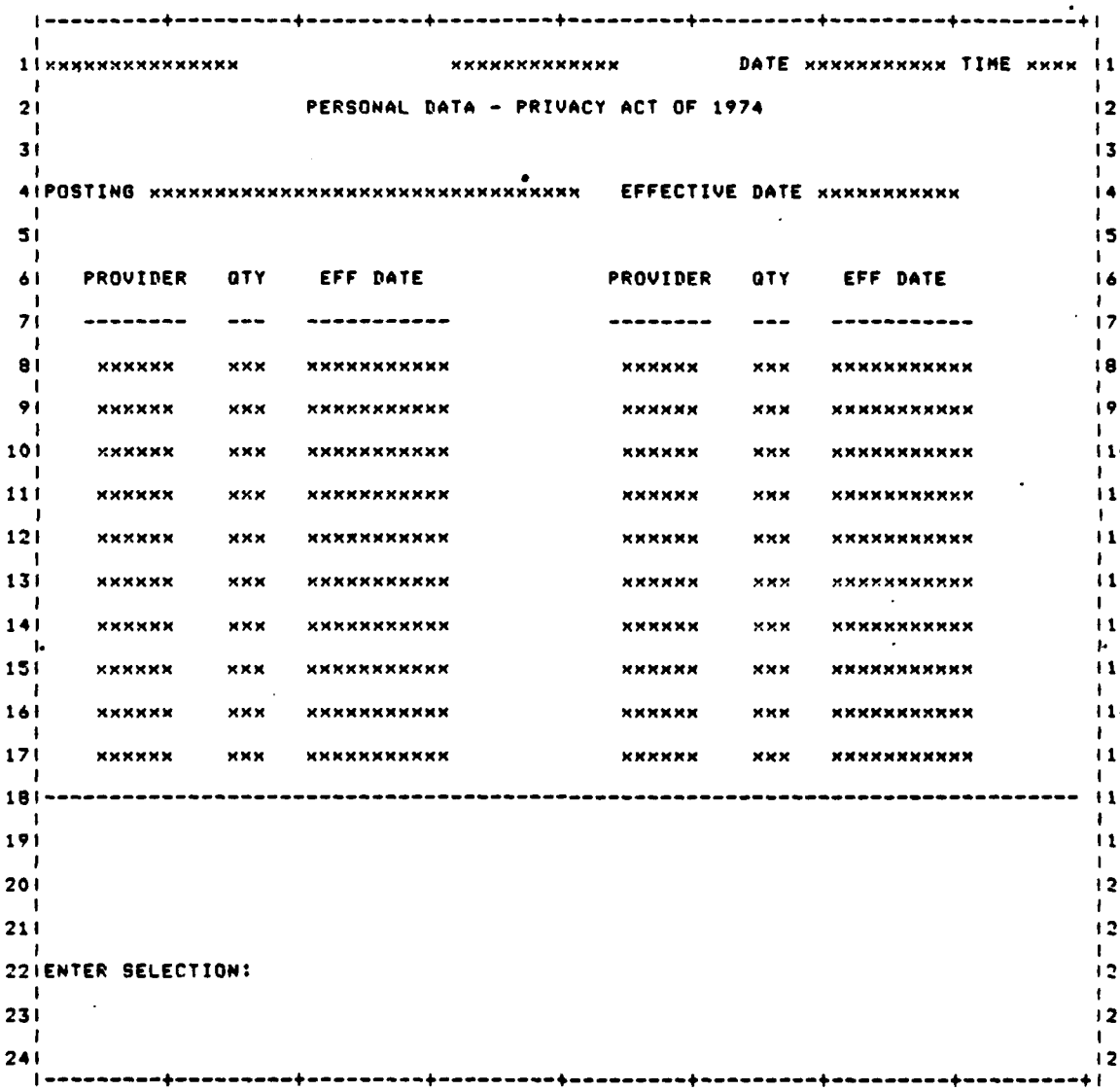


Figure 4-5. PROFILING - POSTING SCREEN

PART III - OUTPUTS

SECTION 5. OUTPUTS

5.1 Overview. The Quality Assurance Reports, described in section 5.2, are as follows:

a. Blood Utilization Pull List

b. Delinquent Occurrence Screening List

c. Incident Summary

d. Occurrence Screening Pull List, Inpatient and Emergency Service versions

e. Occurrence Screening Summary, in the following versions:

(1) Facility Emergency Service Occurrence Screening Summary
(2) Facility Inpatient Occurrence Screening Summary
(3) Provider Emergency Service Occurrence Screening Summary
(4) Provider Inpatient Occurrence Screening Summary
(5) Specialty Occurrence Screening Summary

f. Occurrence Screening Suspense List, Inpatient and Emergency Service versions

g. Provider Occurrence Screening Audit, Inpatient and Emergency Service versions

h. Quality Assurance Problem Audit.

The Profiling Reports, described in section 5.3, are:

a. Credential Pull List
b. Provider Procedure Summary
c. Provider Procedures/Mortality Summary.

5.2 Quality Assurance Reports. The standard header for the Quality Assurance reports shows, on line 1, the TRIMIS version number and the run date. The second line of the header shows the name of the report.

5.2.1 Blood Utilization Pull List. This report summarizes blood product utilization, by care provider, over a specified time period. It lists records that are to be reviewed by the Blood Utilization Review Committee, and is produced on demand.

In addition to the standard heading data, this report also includes the dates of the reporting period on line 3.

The body of the report lists the care provider, then gives the following information for each of that physician's patients who had blood transfusions:

a. REG NO
b. FMP
c. SSN
d. DISCHARGE DATE.

See Figure 5-1 for an example of this report.

```
                    REPORT NUMBER   65  BLOOD UTILIZATION PULL LIST

hfffffffffffffffffff                                    RUN DATE: ffffffffffff

h                          BLOOD UTILIZATION PULL LIST
h                        PERIOD: ffffffffffff TO ffffffffffff

h      PROVIDER     REG NO      FMP       SSN         DISCHARGE DATE
h-------------------------------------------------------------------------------

        xxxxxx      xxxxxxxx    xx    xxxxxxxxxxx    xxxxxxxxxxxxxxxx




t -------------------------------------------------------------------------------
t    A MEDICAL QA DOCUMENT. DO NOT RELEASE WITHOUT APPROVAL OF MTF COMMANDER
```

Figure 5-1. BLOOD UTILIZATION PULL LIST

5.2.2 Delinquent Occurrence Screening List. This report includes names of all patients whose inpatient occurrence screening checklist is not completed within a certain number of days after disposition (the number of days is specified by the MTF on the MTF Profile).

This report contains the standard QA heading data.

The body of this report lists a DISCHARGE DATE, and the REGISTER NUMBER, FMP, and SSN of the patient discharged on that date.

See Figure 5-2 for an example of this report.

```
                    REPORT NUMBER   63  DELINQUENT OS LIST

hfffffffffffffffffff                                    RUN DATE: fffffffffff

h                   DELINQUENT OCCURRENCE SCREENING LIST

hDISCHARGE DATE          REGISTER NUMBER          FMP     SSN
h-------------------------------------------------------------------------

xxxxxxxxxxxxxxxxxx       xxxxxxxxx                xx    xxxxxxxxxxx


t-------------------------------------------------------------------------
t A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-2. DELINQUENT OCCURRENCE SCREENING LIST

5.2.3 Incident Summary. This report provides a summary listing of all or selected incidents, sorted by specified criteria over specified periods of time. It is produced on demand.

See Figure 5-3 for an example.

```
                    REPORT NUMBER   67  INCIDENT SUMMARY BY DATE/TIME

hfffffffffffffffffff                                        DATE RUN: fffffffffff

h                                  INCIDENT SUMMARY

h                  FROM INCIDENT DATE fffffffffff THRU fffffffffff

h INCIDENT DATE/TIME  LOG #  INJURY  ACTION 1    ACTION 2    ACTION 3  JAG REVIEW
hTYPE PERSON  TYPE                LOCATION OF           CATEGORY OF PERSONNEL
hINVOLVED     INCIDENT            INCIDENT              REPORTING   INVOLVED
h-------------------------------------------------------------------------------

   xxxxxxxxxxxxxxxx    xxxx    x       xxxx       xxxx       xxxx          x
xxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxxxxxxxx xxxxxxxxxxx
xxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxxxxxxxx xxxxxxxxxxx
xxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxxxxxxxx xxxxxxxxxxx


t-------------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-3. INCIDENT SUMMARY

5.2.4 Occurrence Screening Pull List. These reports identify the records of patients involved in Occurrence Screening discrepancies, allowing those records to be pulled for further review. They are produced monthly and on demand.

This report comes in two versions: the Inpatient Occurrence Screening Pull List, and the Emergency Service Occurrence Screening Pull List, depending on the checklist involved.

The body of this report gives the FMP/SSN of the patient, and the REG NBR (for inpatients) or LOG NO (Emergency Service patients), and the OCCURRENCE CRITERION, which is the "yes" question that needs review (from the Occurrence Screening Checklist).

See Figure 5-4 for an example of the Emergency Service Pull List, and Figures 5-5 and 5-6 for examples of the Inpatient Pull List.

```
                REPORT NUMBER   57  EMER SVC OCCUR SCREEN PULL LST

hfffffffffffffffffff                                    RUN DATE: fffffffffff

h                EMERGENCY SERVICE OCCURRENCE SCREENING PULL LIST

hLOG NO     FMP/SSN         OCCURRENCE CRITERION
h-------------------------------------------------------------------------------

 xxxxxxx   xx xxxxxxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx




t-------------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-4. EMERGENCY SERVICE PULL LIST

```
                REPORT NUMBER   55  OCCURENCE SCREENING PULL LIST

hfffffffffffffffffff                                    RUN DATE: fffffffffff

h                        OCCURRENCE SCREENING PULL LIST

h  REG NO         FMP/SSN        OCCURRENCE CRITERION
h-------------------------------------------------------------------------------

   xxxxxxxx    xx xxxxxxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx




t-------------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-5. INPATIENT PULL LIST (1)

```
                    REPORT NUMBER   56  OCCURRENCE SCREENING PULL LIST

hfffffffffffffffffff                                        RUN DATE: fffffffffff

h                          OCCURRENCE SCREENING PULL LIST

h    FMP/SSN       REG NO      OCCURRENCE CRITERION
h-------------------------------------------------------------------------------

  xx xxxxxxxxxxx   xxxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx




t-------------------------------------------------------------------------------
t   A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-6. INPATIENT PULL LIST (2)

5.2.5. Occurrence Screening Summary. These reports summarize all exceptions to the occurrence screening criteria for a specified period. The Occurrence Screening Summary comes in the following versions, depending on the information included and the checklist used. These versions are:

a. Facility Occurrence Screening Summary, Inpatient and Emergency Service versions

b. Provider Occurrence Screening Summary, Inpatient and Emergency Service versions

c. Specialty Occurrence Screening Summary.

All of the Occurrence Screening Summaries are produced on demand.

5.2.5.1 Facility Occurrence Screening Summary. These reports summarize exceptions to the occurrence screening criteria for each provider in the facility, for a specified period. The Facility Emergency Service Occurrence Screening Summary gives information about exceptions to the Emergency Service Checklist, and the Facility Inpatient Occurrence Screening Summary, about exceptions to the Inpatient Checklist.

In addition to the standard QA header information, the period of the report is displayed on line 3.

The body of the report shows the code for the physician (PRVDR), the number of records included in the report (RECORDS), and the total number of occurrences listed on the report (TOT OCCS). Then the number of exceptions for each checklist question is given. See Figure 5-7 for an example of the Facility Emergency Service Occurrence Screening Summary, and Figure 5-8 for an example of the Facility Inpatient Occurrence Screening Summary.

5.2.5.2 Provider Occurrence Screening Summary. These reports summarize exceptions to the occurrence screening criteria for individual providers in the facility, for a specified period. The Provider Emergency Service Occurrence Screening Summary gives information about exceptions to the Emergency Service Checklist, and the Provider Inpatient Occurrence Screening Summary, about exceptions to the Inpatient Checklist.

In addition to the standard header information, the period of the report is given on line 3, and line 4 shows the name of the PROVIDER involved, the NUMBER OF RECORDS SCREENED, and the TOTAL OCCURRENCES. The body of the report gives the number of exceptions to each checklist question. See Figure 5-9 for an example of the Provider Emergency Service Occurrence Screening Summary, and Figure 5-10 for an example of the Provider Inpatient Occurrence Screening Summary.

```
                REPORT NUMBER   59  EMER SVC OCCUR SCREEN SUMMARY

hfffffffffffffffffff                                    RUN DATE: ffffffffffff

h          FACILITY EMERGENCY SERVICE OCCURRENCE SCREENING SUMMARY

h                  PERIOD: ffffffffffff THRU ffffffffffff

h       ----------------- OCCURRENCES BY CRITERION NUMBER --------------------
h         1     3     5     7     9    11    13    15    17    19    21    23
h           2     4     6     8    10    12    14    16    18    20    22    24

PRVDR: xxxxxx
   xxx RECORDS
 xxxxx TOT OCCS

        xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx
           xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx


t-------------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-7. FACILITY EMERGENCY SERVICE OCCURRENCE SCREENING SUMMARY

NOT AVAILABLE AT THIS TIME

Figure 5-8. FACILITY INPATIENT OCCURRENCE SCREENING SUMMARY

```
                    REPORT NUMBER   58  EMER SVC OCCUR SCREEN SUMMARY

hfffffffffffffffffff                                        RUN DATE: fffffffffff

h            PROVIDER EMERGENCY SERVICE OCCURRENCE SCREENING SUMMARY

h                      PERIOD: fffffffffff THRU fffffffffff

hPROVIDER: xxxxxxx   NUMBER OF RECORDS SCREENED: xxxx   TOTAL OCCURRENCES: xxxxx

h      ------------------ OCCURRENCES BY CRITERION NUMBER ---------------------
h       1     3     5     7     9     11    13    15    17    19    21    23
h          2     4     6     8     10    12    14    16    18    20    22    24

       xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx
          xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx


t-------------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-9. PROVIDER EMERGENCY SERVICE OCCURRENCE SCREENING SUMMARY

```
                    REPORT NUMBER   60  PROVIDER OCCUR SCREEN SUMMARY

hfffffffffffffffffff                                        RUN DATE: fffffffffff

h                       PROVIDER OCCURRENCE SCREENING SUMMARY

h                       PERIOD: fffffffffff THRU fffffffffff

hPROVIDER: xxxxxxx   NUMBER OF RECORDS SCREENED: xxxx   TOTAL OCCURRENCES: xxxxx

h      ------------------ OCCURRENCES BY CRITERION NUMBER --------------------
h       1     3     5     7     9     11    13    15    17    19    21    23
h          2     4     6     8     10    12    14    16    18    20    22    24

       xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx
          xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx   xxx



t-------------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-10. PROVIDER INPATIENT OCCURRENCE SCREENING SUMMARY

5.2.5.3 Specialty Occurrence Screening Summary. This report summarizes, by medical specialty, exceptions to the inpatient occurrence screening criteria identified for each provider within the specialty, for a specified time period.

In addition to the standard QA header data, line 3 of this report shows the specialty, and line 4 gives the report period. The body of the report shows the PRVDR name, the number of RECORDS, and the total occurrences reported for that provider. Then the number of exceptions is given for each checklist question.

See Figure 5-11 for an example of this report.

REPORT NUMBER 61 FACIL OCCUR SCREEN SUMMARY

fffffffffffffffffff RUN DATE: ffffffffff

SPECIALTY OCCURRENCE SCREENING SUMMARY

SPECIALTY: ffffffffff

PERIOD: ffffffffff THRU ffffffffff

---------- OCCURRENCES BY CRITERION NUMBER ----------

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24

PRVDR: xxxxxx
xxx RECORDS
xxxx TOT OCCS

x.x	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx
	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx

---

f A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

Figure 5-11. SPECIALTY OCCURRENCE SCREENING SUMMARY

5.2.6 .Occurrence Screening Suspense List. These reports list occurrence screening open items which have been assigned for review and have not been returned by the date due. The Inpatient Occurrence Screening Suspense List gives open items for the Inpatient Checklist, and the Emergency Service Occurrence Screening Suspense List gives those for the Emergency Service Checklist. The Suspense Lists are produced daily.

These reports display the standard QA heading data.

The Inpatient Suspense List shows the REGISTER NUMBER of the record, the patient's DISCHARGE DATE, the REVIEW LEVEL, the date that review was assigned (DATE OUT), and the ACTION CODE of the resulting action.

The Emergency Service Suspense List shows the patient's FMP/SSN and DATE OF TREATMENT, then the REVIEW LEVEL, DATE OUT, and ACTION CODE.

See Figure 5-12 for an example of the Emergency Service Suspense List, and Figure 5-13 for an example of the Inpatient Suspense List.

```
                    REPORT NUMBER   53  EMER SVC SCREEN SUSPENSE LIST

hfffffffffffffffffff                                        RUN DATE ffffffffff ffff

h              EMERGENCY SERVICE OCCURRENCE SCREENING SUSPENSE LIST

h                          DATE OF          REVIEW        DATE          ACTION
h    FMP/SSN               TREATMENT        LEVEL         OUT           CODE
h-------------------------------------------------------------------------------

   xxxxxxxxxxx         xxxxxxxxxxx
                                          1        xxxxxxxxxxx       xxxx
                                          2        xxxxxxxxxxx       xxxx
                                          3        xxxxxxxxxxx       xxxx


t-------------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-12. EMERGENCY SERVICE SUSPENSE LIST

```
                    REPORT NUMBER   54  OCCUR SCREEN SUSPENSE LIST

hfffffffffffffffffff                                  RUN DATE: fffffffffff ffff

h                       OCCURRENCE SCREENING SUSPENSE LIST

h  REGISTER      DISCHARGE       REVIEW        DATE         ACTION
h   NUMBER         DATE          LEVEL         OUT          CODE
h-------------------------------------------------------------------------------

    xxxxxxxxx    xxxxxxxxxxx
                                   1        xxxxxxxxxxx     xxxx
                                   2        xxxxxxxxxxx     xxxx
                                   3        xxxxxxxxxxx     xxxx


t-------------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-13. INPATIENT SUSPENSE LIST

5.2.7 Provider Occurrence Screening Audit. These reports record, by provider, all QA actions taken on exceptions to occurrence screening standards. The Provider Inpatient Occurrence Screening Audit lists actions taken on exceptions to the Inpatient occurrence standards, and the Provider Emergency Service Occurrence Screening Audit lists actions taken on exceptions to the Emergency Service standards. These reports are produced monthly and on demand.

In addition to the standard heading data, the PROVIDER ID and the period of the report are shown on line 4.

The inpatient version of this report gives the patient's REG NO and DISCHARGE DATE. The Emergency Service version shows the patient's FMP/SSN and the DATE/TIME OF TREATMENT. The body of both reports gives the number of the checklist question, the text of the question (OCCURRENCE DESCRIPTION), the REVIEW LEVEL, DATE OUT, DATE DUE, DATE IN, and the ACTION CODE.

See Figure 5-14 for an example of the Provider Emergency Service Screening Audit, and Figure 5-15 for an example of the Provider Inpatient Screening Audit.

```
                    REPORT NUMBER   51  EMER SVC OCCUR SCREEN AUDIT

hfffffffffffffffffff                                        RUN DATE: fffffffffff
h                       PERSONAL DATA - PRIVACY ACT 1974

h           PROVIDER EMERGENCY SERVICE OCCURRENCE SCREENING AUDIT

h            PROVIDER ID xxxxxx      PERIOD fffffffffff THRU fffffffffff

h FMP/SSN  xxxxxxxxxxxx
h NBR     OCCURENCE DESCRIPTION
h REVIEW LEVEL     DATE OUT      DATE DUE       DATE IN     ACTION CODE
h-------------------------------------------------------------------------------

  DATE/TIME OF TREATMENT: xxxxxxxxxxxxxxxx
  xxx     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
          xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
          xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
      1             xxxxxxxxxxx   xxxxxxxxxxx   xxxxxxxxxxx      xxxx
      2             xxxxxxxxxxx   xxxxxxxxxxx   xxxxxxxxxxx      xxxx
      3             xxxxxxxxxxx   xxxxxxxxxxx   xxxxxxxxxxx      xxxx


t-------------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-14. PROVIDER EMERGENCY SERVICE SCREENING AUDIT

```
                    REPORT NUMBER   52  INPNT OCCUR SCREEN AUDIT

hfffffffffffffffffff                                        RUN DATE: fffffffffff
h                     PERSONAL DATA - PRIVACY ACT 1974

h                     PROVIDER OCCURRENCE SCREENING AUDIT

h          PROVIDER ID: xxxxxx    PERIOD fffffffffff THRU fffffffffff

h   REG NBR     DISCHARGE DATE
h NBR     OCCURENCE DESCRIPTION
h REVIEW LEVEL     DATE OUT      DATE DUE       DATE IN     ACTION CODE
h-------------------------------------------------------------------------------

     xxxxxxxxx     xxxxxxxxxxx
   xxx     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
           xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
       1             xxxxxxxxxxx   xxxxxxxxxxx   xxxxxxxxxxx      xxxx
       2             xxxxxxxxxxx   xxxxxxxxxxx   xxxxxxxxxxx      xxxx
       3             xxxxxxxxxxx   xxxxxxxxxxx   xxxxxxxxxxx      xxxx


t-------------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-15. PROVIDER INPATIENT SCREENING AUDIT

5.2.8 Quality Assurance Problem Audit. This report provides a list of all or selected QA problems and their statuses. It is produced weekly and on demand.

Figure 5-16 shows an example of this report.

```
                    REPORT NUMBER   50  QA PROBLEM AUDIT

hfffffffffffffffffff                                        RUN DATE: fffffffffff
h                    PERSONAL DATA - PRIVACY ACT 1974

h          * * * * *  QUALITY ASSURANCE PROBLEM AUDIT  * * * * *

hNBR   PRESENTED  REFERRAL ACTIVITY  ACTION ACTIVITY    STATUS     FOLLOW UP
h ACTION TAKEN
h IMPACT ON PATIENT CARE
h-------------------------------------------------------------------------------

 xxx  xxxxxxxxxxx  xxxxxxxxxxxxxxx   xxxxxxxxxxxxxxx  xxxxxxxxxxx xxxxxxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx



t-------------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-16. QUALITY ASSURANCE PROBLEM AUDIT

5.3 Profiling Reports.

5.3.1 Credential Pull List. This report lists providers by specialty to facilitate pulling the provider's credential file and performing credential review. The header gives the date of the reporting period, and the body of the report lists the PROVIDER NAME, SPECIALTY, and dates for CPR and ACLS certifications, CREDENTIAL RENEWAL, and LICENSE RENEWAL. It is produced monthly and on demand.

See Figure 5-17 for an example of this report.

```
                    REPORT NUMBER   64  CREDENTIAL PULL LIST

hfffffffffffffffffff                                    RUN DATE: ffffffffffff

h                              CREDENTIAL PULL LIST
h                        PERIOD: ffffffffffff TO ffffffffffff

h                              CREDENTIAL      LICENSE        CPR
h PROVIDER   SPECIALITY          RENEWAL        RENEWAL      TRAINING        ACLS
h-------------------------------------------------------------------------------

   xxxxxx    xxxxxxxxxx    xxxxxxxxxxx    xxxxxxxxxxx   xxxxxxxxxxx   xxxxxxxxxxx

t-------------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-17. CREDENTIAL PULL LIST

5.3.2 Provider Procedure Summary. This report gives the mortality rate, by procedure, for any or all providers in the MTF. This report includes the following data:

(1) PROCEDURE: CODE
(2) TEXT
(3) PROCS PERFORMED
(4) DEATHS
(5) MORTALITY RATE
(6) ANES RISK CODE CNTS

See Figure 5-18 for an example of this report.

```
                    REPORT NUMBER   71  PROVIDER PROCEDURE SUMMARY

hfffffffffffffffffff                                        RUN DATE: fffffffffff
h                       PERSONAL DATA - PRIVACY ACT 1974

h                          PROVIDER PORCEDURE SUMMARY
h                             PROVIDER ID: xxxxxx

h  PROCEDURE:  CODE     TEXT                              ANES RISK CODE CNTS
h    PROCS PERFORMED    DEATHS    MORTALITY RATE          1  2  3  4  5 UNK
h-------------------------------------------------------------------------------

                 xxxx     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
               xxxx         xxxx          xxx             xx xx xx xx xx xx


t-------------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-18. *PROVIDER PROCEDURE SUMMARY*

5.3.3 Provider Procedures/Mortality Summary. This report summarizes, for a specified period of time, the procedure and mortality statistics for a provider for each of the 26 categories of procedure codes that are reportable to DoD. It includes the following data:

(1) PROCEDURE TEXT
(2) PROCS PERFORMED
(3) DEATHS
(4) MORT RATE
(5) RATE CRITERION
(6) ANES RISK CODE CNTS

The Provider Procedures/Mortality Summary is produced quarterly and on demand. See Figure 5-19 for an example of this report.

```
                REPORT NUMBER   70  PRVDR PROCEDURE/MORTALITY SUMM

hfffffffffffffffffff                                    RUN DATE: fffffffffff
h                       PERSONAL DATA - PRIVACY ACT 1974

h                    PROVIDER PROCEDURE/MORTALITY SUMMARY
h                            PROVIDER ID: xxxxxx

h PROCEDURE TEXT                                                ANES RISK CODE CNTS
h     PROCS PERFORMED    DEATHS    MORT RATE  RATE CRITERION    1  2  3  4  5 UNK
h---------------------------------------------------------------------------------

xxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
            xxxx.          xxxx        xxx            xxx        xx xx xx xx xx xx


t---------------------------------------------------------------------------
t  A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.
```

Figure 5-19. PROVIDER PROCEDURES/MORTALITIES SUMMARY

PART IV - TECHNICAL APPENDIX

SECTION 6. ENVIRONMENT

6.1 Equipment Environment. This information will not be available until award of the hardware contract.

6.2 Support Software. Please see section 18.2 of the AQCESS System Specification.

6.3 Interfaces. Interfaces will be specified at a later date.

6.4 Security and Privacy. The AQCESS meets the privacy requirements set forth in the Privacy Act of 1974, Public Law 93-579, and complies with all applicable provisions of this Act and of subsequent laws and directives which amend and amplify it, as described in section 5.6 of the AQCESS Functional Description (reference 1.2.b of the AQCESS System Specification).

6.5 Controls. No specific controls have been established within the AQCESS.

SECTION 7. DESIGN DETAILS

7.1 System Logical Flow. For a chart showing the system logical flow for the QA subsystem, see Figure 19-1 in the AQCESS System Specification.

7.2 Data Base Description. Please refer to the Data Base Specification for the Automated Quality of Care Evaluation Support System accompanying this document.

7.3 Program Descriptions. The paragraphs to follow describe the programs that make up the Quality Assurance subsystem.

7.3.1 Quality Assurance Process. The QA process is accessed by selection Q from the User Entry Menu. Figure 7-2 shows the hierarchy of QA process programs, and Figure 7-3 shows the selection table for the QA process.

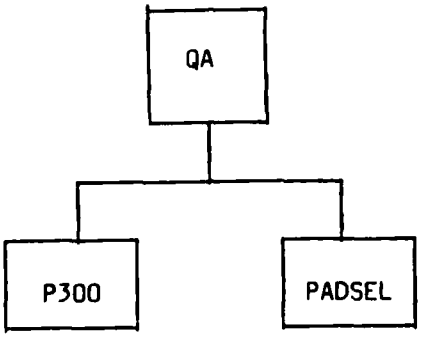


Figure 7-2. HIERARCHY OF QUALITY ASSURANCE PROCESS PROGRAMS

Selection	Program	Function
E	QAE	Emergency Services Occurrence Screening
O	QAO	Inpatient Occurrence Screening
I	QAPI	Incident Tracking
P	QAPI	Problem Audit
M	QAQ	Occurrence Screening Question Maintenance
R	RPR	Reports

Figure 7-3. SELECTION TABLE 300

7.3.1.1 Emergency Services Occurrence Screening Program. Figure 7-4 is the hierarchy chart for this function, and Figure 7-5 shows its selection table.

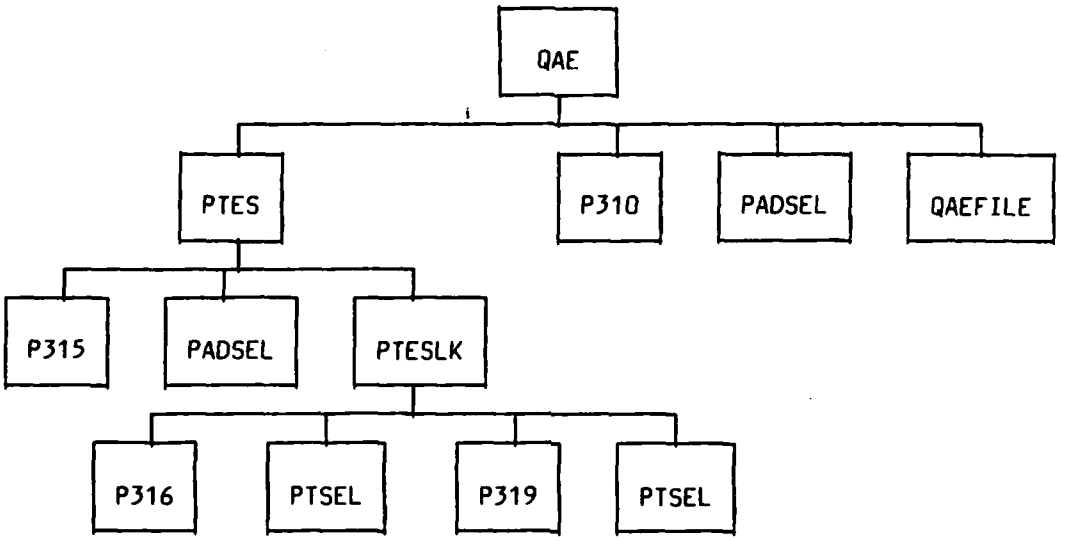


Figure 7-4. HIERARCHY OF EMERGENCY SERVICES OCCURRENCE SCREENING PROGRAMS

a. Purpose. The Emergency Services Occurrence Screening program allows the user to identify the Emergency Episode and enter the emergency checklist responses. For each Y response, an audit may be performed.

Invoked by: PADSEL (selection table 300).

Globals referenced: ^ESLCK
^DIC(6005)
^DIC(6001)
^DIC(6002)

File 6005 is a registration-type file for ER patients. It contains only the name and SSN/FMP. File 6005.01 is a subfile with a record for each emergency room episode. It contains the ER log number and the pull list data.

File 6001 is the occurrence screening data for each ER episode. Node 0, pieces 6 through n are the question answers. Node 1 is the audit subfile; node 2 is the clerk trace subfile.

File 6002 contains the fixed emergency services occurrence screening question text. Exceptions are implemented as 1- or 2-line help messages in DD(6001). File 6002, 16-n contains MTF-specific question text; there are no exceptions to MTF-specific questions.

b. Input Variables: None.

c. Processing Logic.

(1) Perform lookup (^PTES).
On return: SMPT is patient ID
ERN is episode ID.
(2) Lock patient (if already locked, error).
(3) Load existing data into ^SMSCR. If new patient, get name, SSN/FMP from SMZ(1010). If new ER episode, default question 1 from previous ER data or inpatient episodes, set other questions to "N ".
(4) Paint first screen (P310).
(5) If new episode, set PADCHN to chain through each screen of questions.
(6) Call ^PADSEL to process all entry and selections.
(7) If user cancels, go to exit.
(8) If all questions negative, ask for confirmation before filing.
(9) Set recovery node.
(10) File data.
(11) Kill local variables, exit.

d. Output Variables: Globals: ^DIC(6001)
^ DIC(6005)

e. PADSEL.

Screen	Selection	Program	Consistency Programs
310	1	P312	QAEC
	3	QASA P318	
312	1	P313	QAEC
	2	P310	
	3	QASA	
313	1	P314	QAEC
	2	P312	
	3	QASA	
314	1	QAMTF	QAEC
	2	P313	
	3	QASA	
317	1	QAMTF	QAMC
	2	QAMTF	
	3	QASA	
	+	E317	
	#nn	QAME	
318			QASAC

f. Compiled Painter Programs.

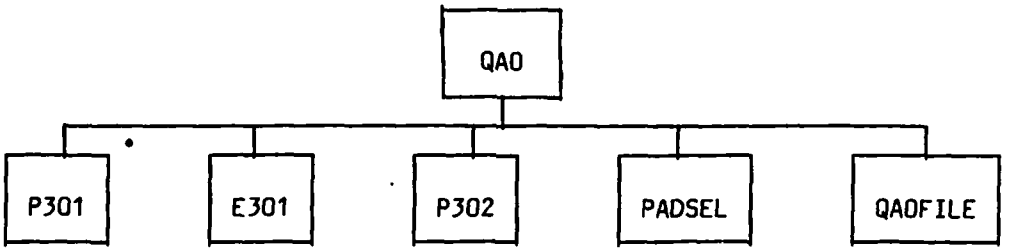
Program	Source
P310	ES Occurrence Screening, pg. 1
P312	ES Occurrence Screening, pg. 2
P313	ES Occurrence Screening, pg. 3
P314	ES Occurrence Screening, pg. 4
P317	ES Occurrence Screening, MTF questions
P318	ES Occurrence Screening Audit

g. Compiled Entry Programs.

E310	E314
E312	E317
E313	E318

h. Consistency Edits. Consistency programs QAEC, QAMC, and QASAC only file data from local to scratch disk. QAEC ensures that a defaulted "yes" to question 1 is not changed to "no."

7.3.1.2 Inpatient Emergency Occurrence Screening Program.



a. Purpose. The Inpatient Occurrence Screening program allows the user to identify the inpatient episode by register number and enter the checklist criteria. For each Y response, an audit may be performed.

Invoked by: PADSEL (selection table 300)

Globals referenced: ^DIC(6000)
^DIC(6003)

File 6000 is the patient occurrence screen data. Node 0, pieces 6 through n, are the question answers. Node 1 is the audit subfile. Node 2 is the clerk trace subfile. Node 3 is a flag set when the CR record is approved (if node 3 is not defined, the nightly QAO occurrence screening audit check will process this record; see section 3.7 of this document). Node 4 is the pull list data. Node 5 is the Y answers from CR that may not be changed to "no."

File 6003 contains the fixed inpatient occurrence screening question text. Exceptions are implemented as 1- or 2-line help messages in ^DD(6000). File 6003, 19-n, contains the MTF-specific question text; there are no exceptions to MTF-specific questions.

b. Input Variables: None.

c. Processing Logic.

(1) Paint reg number ID screen (P301).
(2) Get reg number (E301).
(3) Load Occurrence Screening (OS) data:
(a) If OS data already exists for this reg number: If CR record not approved or CR approved flag is on for this OS data, load old responses. Otherwise, set default answers based on CR record and set CR approved flag on for this OS data.

(b) If CR record exists: Get primary provider and disposition date from CR record and set up default responses. Otherwise, get disposition date from Admission record, SSN and FMP from Reg record.

(4) Paint first question screen.
(5) If new occurrence episode, set PADCHN to chain through all questions.
(6) Call PADSEL to process all input and user selections.
(7) If user cancels, kill variables and loop to 1.
(8) If all questions negative, ask for confirmation before filing.
(9) Set up recovery node.
(10) File data.
(11) Go to 1.

d. Output Variables: Globals: ^DIC(6000)

e. PADSEL.

Screen	Selection	Program	Consistency Programs
302	1	P303	QAEC
	3	QASA	
303	1	P304	QAEC
	2	P302	
	3	QASA	
304	1	P305	QAEC
	2	P303	
	3	QASA	
305	1	QAMTF	QAMC
	2	P304	
	3	QASA	
306	1	QAMTF	
	2	QAMTF	
	3	QASA	
	+	E306	
	#nn	QAME	
307			QASAC

f. Compiled Painter Programs.

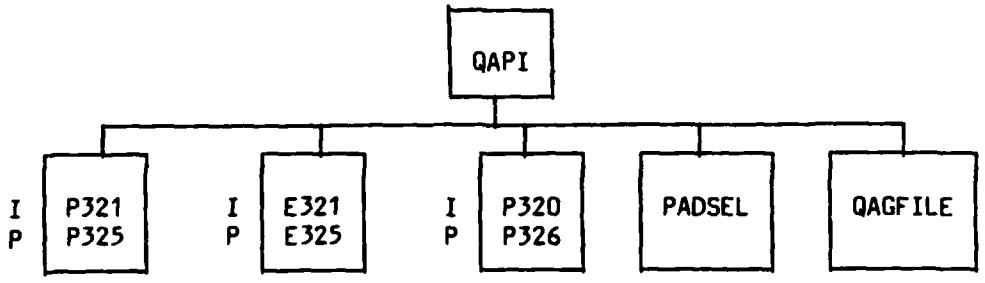
Program	Source
P301	Register Number ID
P302	Inpatient Occurrence Screening, pg. 1
P303	Inpatient Occurrence Screening, pg. 2
P304	Inpatient Occurrence Screening, pg. 3
P305	Inpatient Occurrence Screening, pg. 4
P306	Inpatient Occurrence Screening, MTF questions
P307	Inpatient Occurrence Screening Audit .

g. Compiled Entry Programs.

E301	E305
E302	E306
E303	E307
E304	

h. Consistency Edits. Consistency program QAEC ensures that any "yes" default based on CR data is not changed to "no." All consistency programs file SMZ into ^SMSCR.

7.3.1.3 Problem/Incident Program.



a. Purpose. The Problem/Incident programs maintain the problem audit and the incident file.

Invoked by: PADSEL (selection table 300)

Globals referenced: ^DIC(6010)
^DIC(6020)

b. Input Variables: PADSEL (=P for problems)
(=I for incidents)

c. Processing Logic.

The incident log number and the problem number are assigned by the system. They will be ascending but not necessarily sequential. When a number is assigned, it is tagged as "initiated." If the user leaves his terminal and it times out, or if the system fails, the number will not be re-used. If the user cancels after initiating a problem or incident report, the tag is changed to "cancelled." Again, this number will not be re-used. Thus there may be "holes" in the numbering of reported incidents or problems but internally the numbers are tracked as initiated or cancelled.

(1) Set file numbers and screen numbers based on PADSEL.
(2) Paint ID screen.
(3) Do ID entry program.
(4) If user is done, exit.
(5) If user entered "NEW", get next entry number, set to "INITIATED" and PADCHN to "+" for auto entry.
(6) Display main screen.
(7) Do PADSEL for entry.
(8) If user cancels and this was a new entry, set node to "CANCELLED" and kill local data, go to 2.
(9) Set up recovery node.
(10) Do filer, kill local data, go to 2.

d. Output Variables. Globals: ^DIC(6010)
^DIC(6020)

e. PADSEL. Not applicable.

f. Compiled Painter Programs.

Program	Source
P321	Incident ID
P325	Problem ID
P320	Incident Screen
P326	Problem Audit Screen

g. Compiled Entry Programs.

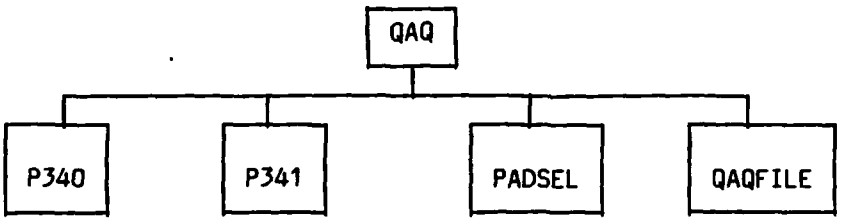
E321	E320
E325	E326

h. Edits. Program E320, entry of incident data, has a special edit, QAIML. It is used on fields with multi-letter input. It will validate that each letter is in the respective table.

Consistency Edits on Incident Data (Program QAPJC):

(1) If person involved in incident, register number must be entered (error 6010).

7.3.1.4 Occurrence Screening Question Text Maintenance Program.



a. Purpose. The QAQ program controls the maintenance of the text for the MTF-specific occurrence screening questions (emergency services and inpatient). If the text of a question changes, the user has the option to delete all existing data for the question. If the change is editorial, this would not be appropriate. If it is a new, different question, old data must be deleted.

Invoked by: PADSEL (selection table 300)

Globals referenced: ^DIC(6002)
^DIC(6003)

File 6002 contains question text for emergency services occurrence screening; 6003 for inpatient occurrence screening. Each file has a clerk trace of all updates at node 2.

b. Input Variables. None.

c. Processing Logic.

(1) Paint option screen (P340 has selection table for validity of selection but returns control; selection 1 = emergency services, 2 = inpatient).
(2) Set header variable based on selection.
(3) Paint question maintenance screen (P341).
(4) Set PADCHN = "+" for update.
(5) Do PADSEL for entry. Program E341 has a special edit, QAQLKP, which, given the question number entered, validates it and loads/displays current text if it exists. (Edit checks that question number is not lower than first MTF question or higher than 1 more than the last MTF question currently defined.)
(6) If user cancels or doesn't enter question, exit.
(7) If question changed, ask if old data is to be deleted. If Y, ask for confirmation again. Then if Y, set variable for filer.
(8) Set recovery node.
(9) File data (QAQFILE).
(10) Kill local variables, quit.

d. Output Variables.

Globals updated: ^DIC(6002)
^DIC(6003)

e. PADSEL. Not applicable.

f. Compiled Painter Programs.

Program	Source
P340	Question Maintenance Selection Screen
P341	Question Maintenance Screen

g. Compiled Entry Programs.

E341 (special edit QAQLKP)

h. Edits. Not applicable.

7.3.2 Profiling Process. Figure 7-4 shows the hierarchy of programs for the Profiling process, and Figure 7-5 shows the selection table.

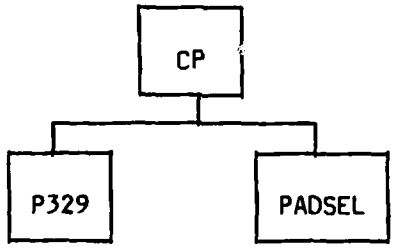
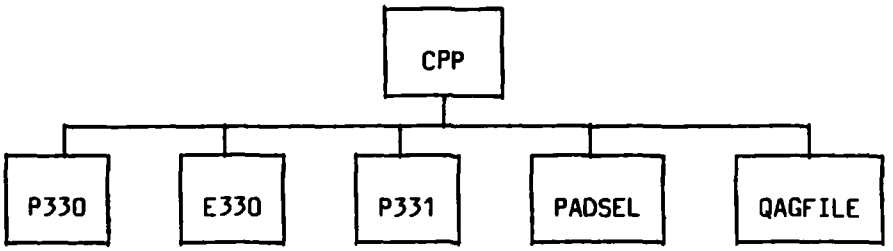


Figure 7-4. HIERARCHY OF PROFILING PROGRAMS

Selection	Program	Function
P	CPP	Provider Profile
B	P350	Batch Posting to Provider Profile
C	Reports	Credentials Pull List
S	Reports	Provider Procedure Summary
MS	Reports	Provider Procedures/Mortalities Summary

Figure 7-5. SELECTION TABLE 329

7.3.2.1 Provider Profile Program.



a. Purpose. The Provider Profile program controls the retrieval/entry of provider profile data. Three profile data items are derived from the Clinical Record: number of dispositions and number of procedures and medical record delinquencies. These fields are not updateable by the Provider Profile option.

Invoked by: PADSEL (selection table 329)

Globals referenced: ^DIC(1004), ^DIC(6030)

b. Input Variables. None.

c. Processing Logic.

(1) Paint provider ID screen.
(2) Perform ID entry program.
(3) If user cancels or does not enter a provider ID, exit.
(4) Get provider name and specialty from provider table.
(5) If there is not an existing provider profile, set PADCHN to "+" for entry from first field.
(6) Do PADSEL for control of entry.
(7) If user cancels, exit.
(8) Set QAF variable to file number to use general QA filer program.
(9) Set up recovery node.
(10) File data (QAGFILE).
(11) Kill local variables and exit.

d. Output Variables. Globals updated: ^DIC(6030)

e. PADSEL. Not applicable.

f. Compiled Painter Programs.

Program	Source
P330	Provider ID Screen
P331	Provider Profile Screen

g. Compiled Entry Programs.

E330 E331

h. Edits. There are no currently defined consistency edits for the Provider Profile data.