PIP Table of Contents

DESCRIPTION: a concise label/text depicting the specific data contained in this field.

DEFINITION: a brief description of the data element.

FIELD NAME: how a particular unit of data within the data base file is identified. The field name aids the user in accessing specific data and is also useful when preparing reports utilizing external programs such as R & R Report Writer. Changes made for the purposes of the data warehouse are indicated by parenthetical references (***)

FORMAT:

LENGTH = A field's length determines how much of a particular type of data may be stored within that field.

TYPE = The field type is the characteristic which governs the type of information that can be stored in a particular field.

- C = Character Code - These fields may contain any alphanumeric character. The letters A-Z, the numbers 0-9 and any keyboard or ASCII characters are acceptable (PIP only accepts upper case letters).
- N = Numeric Code - These fields are used to store numeric data that will be used for calculations. A numeric field will only accept number as data, the + and - signs, and the decimal point.
- D = Date Code - This is a field that will accept only dates. Pip stores dates as mm/dd/yyyy, but reports can be generated using other formats. Based on the format selected, the field can prevent entry of invalid dates such as "13/30/92".
- L = Logical Code - These fields contain information that can be stored as a one character field. The data can be represented by "T" meaning true and "F" meaning false, or optionally "Y" for yes and "N" for no. Typically they are used to store the answer to a question or the result of a condition.
- M = Memo Code - This is a field of variable length that contains data in the form of free flowing text.

POPUP = This line contains the name of the Popup database used to insert information into the field, if appropriate.

ALLOWABLE VALUES: contains definitions of codes that are used in the program or appear in the Popup.

DATA ENTRY PROMPT: the field description/text as displayed on the computer screen.

HELP TEXT: contains the instructions and procedures regarding the entry of data in a particular field.

DATA ENTRY EDITS: are to ensure that only valid codes are entered in this field.

MISSING DATA LOGIC: data is considered missing if this field is left blank.

INDICATORS: data elements are either suggested for inclusion in or required for all patient records.

REASON FOR COLLECTING: Many auxiliary level entities make extensive use of patient data to develop typologies. They are interested in this data to assess equity of patient treatment, accessibility to service and the continuity of the treatment provided to patients. To foster and monitor continuity of care, it is necessary to have a uniform method of identifying clients within a system as well as a method for linking the information on particular clients.

Standardization refers to the general acceptance of concepts, quantities, terms and definitions that serve as reference points against which comparisons can be made. The adoption of these standards permits communication, judgements and comparisons which allows decisionmakers to make alterations in their service programs intended to improve their approaches to the care of the mentally ill.

The Mental Health Statistics Improvement Program (MHSIP) is most often viewed as the recommended minimum data elements needed to collect and report this information. Therefore, PIP utilizes the standards established by MHSIP so that PIP is compatible with and responsive to information requests dependent on these data sets.

DESCRIPTION: AFTERCARE APPOINTMENT TOC Index

DEFINITION: The numeric equivalent of the month, day and year of the date of the client's first scheduled mental health follow-up aftercare appointment.

FIELD NAME: AFT_APP

FORMAT: MMDDYYYY
Length = 8
Type = Date
Popup used = N/A

ALLOWABLE VALUES: MM=Month (01-12)
DD=Day (01-31)
YYYY=Year (e.g., 1991)
A valid date must be entered (e.g., 02/30/1993 is not a valid date).

DATA ENTRY PROMPT: After Care Appointment: / /

HELP TEXT: The numeric equivalent of the month, day and year of the date of the client's first scheduled aftercare appointment.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: Continuity of care

DESCRIPTION:	AGE	TOC Index
DEFINITION:	The code which represents the age of the client at admission.	
FIELD NAME:	AGE	
FORMAT:	Length = 2 Type = Numeric Popup used = N/A	
ALLOWABLE VALUES:	This field will not accept an entry.	
DATA ENTRY PROMPT:	Age:	
HELP TEXT:	The age of the client is automatically calculated and entered when the user inserts the birth date of the client.	
DATA ENTRY EDITS: N/A		
MISSING DATA LOGIC:	N/A	
INDICATORS:	N/A	
REASON FOR COLLECTING:	Demographic	

DESCRIPTION:	BROUGHT BY TOC Index
DEFINITION:	The identity (text) of the person(s) who brought the client to the facility.
FIELD NAME:	BROUGHT_BY (BRGHT_BY)
FORMAT:	Length = 15 Type = Character Popup used = N/A
ALLOWABLE VALUES:	N/A
DATA ENTRY PROMPT:	Brought by:
HELP TEXT:	Enter the name of the person(s) who brought the client to the facility, i.e., police, parents, etc.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Contact information

DESCRIPTION:	CASE COORDINATOR TOC Index
DEFINITION:	The code which represents the identity of the Case Coordinator to whom this client's case is assigned.
FIELD NAME:	CASEMANGR1 (CASEMNG1)
FORMAT:	Length = 4 Type = Character Popup used = STAFF.DBF
ALLOWABLE VALUES:	Refer to popup for values.
DATA ENTRY PROMPT:	Case Manager: Client Coordinator:
HELP TEXT:	Enter the code to identify the Case Coordinator to whom this client's case is assigned. Staff Codes: Hospitals and Acute units will be responsible for maintaining staffing codes in the popup database file. Members of the Admissions Staff, Social Workers, physicians and those staff members who determine the disposition of potential clients will each be assigned a four-digit provider code.
DATA ENTRY EDITS: N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	MHSIP, CQI

DESCRIPTION:	COMMENTS, MISCELLANEOUS	TOC Index
DEFINITION:	Miscellaneous comments (text) about the client.	
FIELD NAME:	COMMENT1, COMMENT2, COMMENT3, COMMENT4	
FORMAT:	Length = 50 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Misc. Comments:	
HELP TEXT:	Enter (up to four lines of 50 characters or less) any miscellaneous comments about the client.	
DATA ENTRY EDITS: N/A		
MISSING DATA LOGIC:	N/A	
INDICATORS:	N/A	
REASON FOR COLLECTING:	Clinical utility	

DESCRIPTION: COMMUNITY LIVING NEEDS TOC Index

DEFINITION: The codes which represent the needs of the client to live outside the hospital environment.

FIELD NAME: READYNEED1, READYNEED2, READYNEED3, READYNEED4
(RDYNEED1 - RDYNEED4)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = NEEDS.DBF

ALLOWABLE VALUES:

?	Unknown
01	Housing - No housing is available to this client upon discharge.
02	Entitlements/Benefits - Successful community living will require this client to receive entitlements/benefits.
03	Employment/Pre-employment - The client will require employment or pre-employment services upon discharge.
04	Education/Special Education - The client will require educational and/or special education referral upon discharge.
05	Money Management - The client will require assistance with money management upon discharge.
06	Social/Recreational - The client will require services through a structured social and recreational program upon discharge.
07	Family Living - The client will require a family living environment upon discharge.
08	Mental Health - The client will require continued mental health services upon discharge.
09	Physical Health - The client will require general medical care services upon discharge.
10	Other Community Living Needs - The client will require other community living needs not listed above.
11	Assessment/Service Plan - The client requires a special assessment and/or service plan for a successful discharge.
12	Court Order - The client has been mandated to received evaluation and/or treatment as evidenced by a current civil or juvenile court order.

DATA ENTRY PROMPT: Community Living Needs: 1. 2. 3. 4.

HELP TEXT: Select the appropriate codes, (up to 4 fields) for the needs of the client to live outside the hospital environment. Community living needs are client needs which must be met in order to achieve successful community placement.

DATA ENTRY EDITS: 1. Only codes not already entered as a Community Living Need will be allowed.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: Continuity of care, Expansion of needs and barriers

DESCRIPTION:	CRIMINAL CHARGES RELATING TO ADMISSION - CODES TOC Index
DEFINITION:	The codes which represent those legal charges against the client which ultimately resulted in the client being committed to this hospital.
FIELD NAME:	CRIMINAL1, CRIMINAL2, CRIMINAL3, CRIMINAL4 (CRIMIN1 - CRIMIN4)
FORMAT:	Length = 12 Type = Character Popup used = LEGALCD.DBF
ALLOWABLE VALUES:	Refer to popup for values.
DATA ENTRY PROMPT:	Criminal Charges relating to admission:
HELP TEXT:	Admit - select the code which best represents those legal charges against the client which ultimately resulted in the client being committed to this hospital. Up to four sets of charges may be included for each client. Codes are available in the popup. Enter the number of counts of each legal charge. Staffing - the codes that were entered on admission will automatically be entered.
DATA ENTRY EDITS: 1.	Criminal Charges must have at least one entry if Legal Status is "03 Transfer from Corrections", "11 Judicial-Lockhart vs. Armistead", "12 Judicial-Not Competent to Proceed", or "13 Judicial-NGBRI".
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Legal tracking

DESCRIPTION:	CRIMINAL CHARGES RELATING TO ADMISSION - COUNTS TOC Index
DEFINITION:	The numeric equivalent of the counts of each legal charge against the client which ultimately resulted in the client being committed to this hospital.
FIELD NAME:	L_CNTS1, L_CNTS2, L_CNTS3, L_CNTS4
FORMAT:	Length = 2 Type = Character Popup used = N/A
ALLOWABLE VALUES:	N/A
DATA ENTRY PROMPT:	Admit A Patient - Criminal Charges: Counts
HELP TEXT:	Enter the number of counts of each legal charge against the client which ultimately resulted in the client being committed to this hospital.
DATA ENTRY EDITS: N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Legal tracking

DESCRIPTION:	CUSTODY OF PATIENT TOC Index
DEFINITION:	The identity (text) of the person(s) having legal custody over the client, i.e., parents, OS worker, etc.
FIELD NAME:	CUSTODY
FORMAT:	Length = 15 Type = Character Popup used = N/A
ALLOWABLE VALUES:	N/A
DATA ENTRY PROMPT:	Custody of:
HELP TEXT:	Enter the name of the person or persons who have legal custody over the client, i.e., parents, OCS worker, etc.
DATA ENTRY EDITS: N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Contact information

DESCRIPTION:	DATE CHART ANALYZED BY MEDICAL RECORDS TOC Index
DEFINITION:	The numeric equivalent of the month, day, and year of the date indicating completion of chart review for deficiencies.
FIELD NAME:	DCANALYSED (DCANALYS)
FORMAT:	MMDDYYYY Length = 8 Type = Date Popup used = N/A
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991) A valid date must be entered (e.g., 02/30/1993 is not a valid date).
DATA ENTRY PROMPT:	Dated Analyzed:
HELP TEXT:	Enter the numeric equivalent of the month, day and year of the date indicating completion of chart review for deficiencies.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Data quality tracking, CQI

DESCRIPTION: DATE CHART ASSEMBLED BY MEDICAL RECORDS TOC Index

DEFINITION: The numeric equivalent of the month, day, and year of the date indicating chart assembly into discharge record by Medical Records.

FIELD NAME: DCASSEMBLE (DCASSEMB)

FORMAT: MMDDYYYY
Length = 8
Type = Date
Popup used = N/A

ALLOWABLE VALUES: MM=Month (01-12)
DD=Day (01-31)
YYYY=Year (e.g., 1991)
A valid date must be entered (e.g., 02/30/1993 is not a valid date).

DATA ENTRY PROMPT: Dated Assembled:

HELP TEXT: Enter the numeric equivalent of the month, day, and year of the date indicating chart assembly into a discharge record by Medical Records.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: Data quality tracking, CQI

DESCRIPTION:	DATE CHART COMPLETE TOC Index
DEFINITION:	The numeric equivalent of the month, day, and year of the date the chart was completed and put into a permanent file by Medical Records.
FIELD NAME:	DCPERMFILE (DCPERMFI)
FORMAT:	MMDDYYYY Length = 8 Type = Date Popup used = N/A
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991) A valid date must be entered (e.g., 02/30/1993 is not a valid date).
DATA ENTRY PROMPT:	Date Chart Complete:
HELP TEXT:	Enter the numeric equivalent of the month, day, and year of the date the chart was completed and put into a permanent file by Medical Records.
DATA ENTRY EDITS: N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Data quality tracking, CQI

DESCRIPTION:	DATE CHART PLACED IN DOCTORS FILES FOR SIGNATURE TOC Index
DEFINITION:	The numeric equivalent of the month, day, and year of the date the chart was placed in the Doctor's files for review, correction, and/or completion.
FIELD NAME:	DCDOCFILES (DCDOCFIL)
FORMAT:	MM/DD/YYYY Length = 8 Type = Date Popup used = N/A
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991) A valid date must be entered (e.g., 02/30/1993 is not a valid date).
DATA ENTRY PROMPT:	Date placed in Doctor Files:
HELP TEXT:	Enter the numeric equivalent of the month, day, and year of the date the chart was placed in the Doctor's files for review/correction/completion.
DATA ENTRY EDITS	N/A
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Data quality tracking, CQI

DESCRIPTION:	DATE CHART RECEIVED BY MEDICAL RECORDS TOC Index
DEFINITION:	The numeric equivalent of the month, day, and year of the date the chart was received from unit by Medical Records.
FIELD NAME:	DCRECVD
FORMAT:	MMDDYYYY Length = 8 Type = Date Popup used = N/A
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991) A valid date must be entered (e.g., 02/30/1993 is not a valid date).
DATA ENTRY PROMPT:	Recvd By M. Records:
HELP TEXT:	Enter the numeric equivalent of the month, day, and year of the date the chart was received from the unit by Medical Records.
DATA ENTRY EDITS: N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Data quality tracking, CQI

DESCRIPTION:	DATE D/C DIAGNOSIS WAS CODED TOC Index
DEFINITION:	The numeric equivalent of the month, day, and year of the date the discharge diagnoses were coded by Medical Records.
FIELD NAME:	DCCODED
FORMAT:	MM/DD/YYYY Length = 8 Type = Date Popup used = N/A
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991) A valid date must be entered (e.g., 02/30/1993 is not a valid date).
DATA ENTRY PROMPT:	Dated Coded:
HELP TEXT:	Enter the numeric equivalent of the month, day and year of the date the discharge diagnoses were coded by Medical Records.
DATA ENTRY EDITS	N/A
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Data quality tracking, CQI

DESCRIPTION:	DATE D/C SUMMARY DICTATED	TOC Index
DEFINITION:	The numeric equivalent of the month, day, and year of the date the discharge summary was dictated.	
FIELD NAME:	DCDICTATED (DCDICTAT)	
FORMAT:	MM/DD/YYYY Length = 8 Type = Date Popup used = N/A	
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991) A valid date must be entered (e.g., 02/30/1993 is not a valid date).	
DATA ENTRY PROMPT:	Dated Dictated:	
HELP TEXT:	Enter the numeric equivalent of the month, day and year of the date the discharge summary was dictated.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Data quality tracking, CQI	

DESCRIPTION:	DATE D/C SUMMARY RECEIVED	TOC Index
DEFINITION:	The numeric equivalent of the month, day, and year of the date the typed discharge summary was placed on the record for signature by Medical Records.	
FIELD NAME:	SUMRECVD	
FORMAT:	MMDDYYYY Length = 8 Type = Date Popup used = N/A	
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991) A valid date must be entered (e.g., 02/30/1993 is not a valid date).	
DATA ENTRY PROMPT:	Dated Received:	
HELP TEXT:	Enter the numeric equivalent of the month, day and year of the date the discharge summary was placed on the record for signature by Medical Records.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Data quality tracking, CQI	

DESCRIPTION:	DATE D/C SUMMARY SIGNED TOC Index
DEFINITION:	The numeric equivalent of the month, day, and year of the date the discharge summary was signed by the doctor.
FIELD NAME:	DC_SIGN
FORMAT:	MM/DD/YYYY Length = 8 Type = Date Popup used = N/A
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991) A valid date must be entered (e.g., 02/30/1993 is not a valid date).
DATA ENTRY PROMPT:	Dated Summary Signed:
HELP TEXT:	Enter the numeric equivalent of the month, day and year of the date the discharge summary was signed by the doctor.
DATA ENTRY EDITS	N/A
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Data quality tracking, CQI

DESCRIPTION:	DATE D/C SUMMARY TYPED	TOC Index
DEFINITION:	The numeric equivalent of the month, day, and year of the date the discharge summary was typed.	
FIELD NAME:	DCTYPED	
FORMAT:	MM/DD/YYYY Length = 8 Type = Date Popup used = N/A	
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991) A valid date must be entered (e.g., 02/30/1993 is not a valid date).	
DATA ENTRY PROMPT:	Dated Typed:	
HELP TEXT:	Enter the numeric equivalent of the month, day and year of the date the discharge summary was typed.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Data quality tracking, CQI	

DESCRIPTION:	DATE LEGAL STATUS EXPIRES TOC Index
DEFINITION:	The numeric equivalent of the month, day and year of expiration of the current legal status of the client.
FIELD NAME:	STATEXP_DT (STATEXP_)
FORMAT:	MM/DD/YYYY Length = 8 Type = Date Popup used = N/A
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991)
DATA ENTRY PROMPT:	N/A
HELP TEXT:	The date of expiration of the client's current legal status is automatically calculated and displayed when the user enters the date and time of the execution of the client's current legal status.
DATA ENTRY EDITS:	N/A
MISSING DATA LOGIC:	N/A
INDICATORS:	N/A
REASON FOR COLLECTING:	Legal tracking

DESCRIPTION: DATE OF ADMISSION TOC Index

DEFINITION: The numeric equivalent of the month, day, and year of the date of the client's formal admission (current episode) to the hospital/acute unit.

FIELD NAME: ADM_DATE

FORMAT: MMDDYYYY
Length = 8
Type = Date
Popup used = N/A

ALLOWABLE VALUES: MM=Month (01-12)
DD=Day (01-31)
YYYY=Year (e.g., 1991)
A valid date must be entered (e.g., 02/30/1993 is not a valid date).

DATA ENTRY PROMPT: Admit Date: / /

HELP TEXT: Enter the numeric equivalent of the month, day, and year of the date the client was admitted to the facility as an inpatient. MANDATORY FIELD: This field may not be left blank at admission.

DATA ENTRY EDITS: 1. The Admission Date cannot be blank.
2. The Admission Date must be the same as or prior to today's date.
3. The Admission Date cannot be earlier than the Date of Pre-Admission Interview.
4. The Admission Date must be within 31 days of the Date of Pre-Admission Interview.
5. The Admission Date cannot be earlier than the discharge date for the previous episode of care.
5. The Admission Date cannot be later than the discharge date for that stay.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is required for all client records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION:	DATE OF BIRTH	TOC Index
DEFINITION:	The numeric equivalent of the month, day, and year of the client's date of birth.	
FIELD NAME:	BIRTHDATE (BIRTHDAT)	
FORMAT:	MMDDYYYY Length = 8 Type = Date Popup used = N/A	
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991) A valid date must be entered (e.g., 02/30/1993 is not at valid date).	
DATA ENTRY PROMPT:	DOB: / /	
HELP TEXT:	Enter the numeric equivalent of the month, day, and year for the date of the client's birth. If the actual date of birth isn't known, code the month and day as "01" and code the year with your estimate. Update when accurate information is obtained.	
DATA ENTRY EDITS 1.	Date cannot be greater than current date.	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	MHSIP	

DESCRIPTION: DATE OF DISCHARGE TOC Index

DEFINITION: The code which represents the numeric equivalent of the month, date and year of the date of discharge.

FIELD NAME: DC_DATE

FORMAT: MMDDYYYY
Length = 8
Type = Date
Popup used = N/A

ALLOWABLE VALUES: This field will not accept an entry.

DATA ENTRY PROMPT: MM=Month (01-12)
DD=Day (01-31)
YYYY=Year (e.g., 1991)

HELP TEXT: No entry is required. This field is automatically updated by PIP. The numeric equivalent of the month, day and year of the date of discharge.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: N/A

INDICATORS: N/A

REASON FOR COLLECTING: MHSIP

DESCRIPTION: DATE OF LAST DISCHARGE FROM FACILITY TOC Index

DEFINITION: The numeric equivalent of the month, day, and year of the date of the client's discharge from their previous episode of care at this facility.

FIELD NAME: LAST_DC

FORMAT: MMDDYYYY
Length = 8
Type = Date
Popup used = N/A

ALLOWABLE VALUES: MM=Month (01-12)
DD=Day (01-31)
YYYY=Year (e.g., 1991)
A valid date must be entered (e.g., 02/30/1993 is not a valid date).

DATA ENTRY PROMPT: Last DC Date: / /

HELP TEXT: Enter the numeric equivalent of the month, day, and year of the date of the client's discharge from their previous episode of care at this facility. It may not be earlier than the Date of Admission for the client's previous stay.

DATA ENTRY EDITS: 1. The Date of Last Discharge may not be earlier than the Date of Admission for the client's previous stay.
2. The Date of Last Discharge may not be later than the Date of Admission for the client's current stay.
3. If Date of Last Discharge is completed, then Prior Inpatient MH Service cannot be "00 None".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: Continuity of care

DESCRIPTION: DATE OF LAST MODIFICATION OF RECORD TOC Index

DEFINITION: The numeric equivalent of the month, day and year of the most recent date the client's record was modified.

FIELD NAME: MOD_DATE

FORMAT: MMDDYYYY
Length = 8
Type = Date
Popup used = N/A

ALLOWABLE VALUES: MM=Month (01-12)
DD=Day (01-31)
YYYY=Year (e.g., 1991)

DATA ENTRY PROMPT: N/A

HELP TEXT: This field is automatically updated when the client's record is modified. This field is not visible to the user.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: N/A

INDICATORS: N/A

REASON FOR COLLECTING: Upload Project

DESCRIPTION:	DATE OF LAST TREATMENT TEAM REVIEW/STAFFING TOC Index
DEFINITION:	The numeric equivalent of the month, day, and year of the date of the client's last treatment team review or staffing.
FIELD NAME:	REV_DATE
FORMAT:	MMDDYYYY Length = 8 Type = Date Popup used = N/A
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991) A valid date must be entered (e.g., 02/30/1993 is not a valid date).
DATA ENTRY PROMPT:	Review Date: / /
HELP TEXT:	Enter the numeric equivalent of the month, day, and year of the date of the client's treatment review or staffing. This field is updated after each treatment team meeting. This item MAY NOT be left blank if there has been a Review Team Meeting.
DATA ENTRY EDITS: 1.	The date of review may not be left blank if there has been a Review Team Meeting.
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	CQI, Clinical Utility

DESCRIPTION: DATE RECORD CREATED TOC Index

DEFINITION: The numeric equivalent of the month, day and year of the most recent date the client's record was entered into PIP.

FIELD NAME: CREATEDATE (CREATDAT)

FORMAT: MMDDYYYY
Length = 8
Type = Date
Popup used = N/A

ALLOWABLE VALUES: MM=Month (01-12)
DD=Day (01-31)
YYYY=Year (e.g., 1991)

DATA ENTRY PROMPT: N/A

HELP TEXT: This field is automatically updated when the client's record is entered into PIP. This field is not visible to the user.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: N/A

INDICATORS: N/A

REASON FOR COLLECTING: Upload Project, Quality Assurance

DESCRIPTION: DATE RELEASE OF INFORMATION SIGNED TOC Index

DEFINITION: The numeric equivalent of the month, day and year of the date the client's release of confidential information was signed.

FIELD NAME: RELSIGN_D (RELSIGN)

FORMAT: MM/DD/YYYY
Length = 8
Type = Date
Popup used = N/A

ALLOWABLE VALUES: MM=Month (01-12)
DD=Day (01-31)
YYYY=Year (e.g., 1991)
A valid date must be entered (e.g., 02/30/1993 is not a valid date).

DATA ENTRY PROMPT:

HELP TEXT: For the Acute Units only, enter the numeric equivalent of the monthe, day and year of the date the client's release of confidential information was signed. This field is seen only by users at these locations.

DATA ENTRY EDITS: 1. If Release of Confidential Information is signed and "Y" is entered, THEN Date Release Signed must be entered.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records. N/A

REASON FOR COLLECTING: Confidentiality

DESCRIPTION: DEVELOPMENTALLY DISABLED TOC Index

DEFINITION: The code which represents whether the client is developmentally disabled.

FIELD NAME: DEV_DABLED (DVDABLED)

FORMAT:
Length = 2
Type = Character
Popup used = N/A

ALLOWABLE VALUES:
Y Yes, client is developmentally disabled.
N No, client is not developmentally disabled.

DATA ENTRY PROMPT: Is client Developmentally Disabled:

HELP TEXT: Enter the choice that reflects whether the client is developmentally disabled. The term "developmental disability" refers to a severe, chronic disability that:

a. is attributable to a mental or physical impairment or combination of mental and physical impairments;
b. is manifested before the person reaches age 22;
c. is likely to continue indefinitely;
d. results in substantial limitations in three or more of the following area of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic sufficiency; and
e. reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

DATA ENTRY EDITS 1. Is client Developmentally Disabled: must be "Y" if Patient Handicaps is "01 Autism" or "04 Mental Retardation".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING:

DESCRIPTION: DIAGNOSIS, AXIS I, A - D TOC Index

DEFINITION: The code which represents the diagnosis according to the DSM-III-R classification (clinical syndromes and V codes) showing the condition that was responsible for causing the client's clinical care.

FIELD NAME:

FD_AXIS1AC Axis I A Diagnosis Code
FD_AXIS1BC Axis I B Diagnosis Code
FD_AXIS1CC Axis I C Diagnosis Code
FD_AXIS1DC Axis I D Diagnosis Code

FD_AXIS1AD Axis I A Diagnosis Label Discriminator
FD_AXIS1BD Axis I B Diagnosis Label Discriminator
FD_AXIS1CD Axis I C Diagnosis Label Discriminator
FD_AXIS1DD Axis I D Diagnosis Label Discriminator

FD_AXIS1AP Axis I A Diagnosis Provisional
FD_AXIS1BP Axis I B Diagnosis Provisional
FD_AXIS1CP Axis I C Diagnosis Provisional
FD_AXIS1DP Axis I D Diagnosis Provisional

FORMAT: Length = 7, 1, 1
Type = Character, Character, Logical
Popup used = DSM3_R.DBF

ALLOWABLE VALUES: Refer to popup for values.

DATA ENTRY PROMPT: I. A.
B.
C.
D.

HELP TEXT: Select the appropriate diagnostic code according to the DSM-III-R classification (clinical syndromes and V codes) showing the condition that was responsible for causing the client's clinical care.

Enter the proper code for each diagnosis. The text for the diagnosis will automatically appear.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION: DIAGNOSIS, AXIS II, A - D TOC Index

DEFINITION: The code which represents the diagnosis according to the DSM-III-R classification (developmental disorders and personality disorders) showing the condition that was responsible for causing the client's clinical care.

FIELD NAME:

FD_AXIS2AC Axis II A Diagnosis Code
FD_AXIS2BC Axis II B Diagnosis Code
FD_AXIS2CC Axis II C Diagnosis Code
FD_AXIS2DC Axis II D Diagnosis Code

FD_AXIS2AD Axis II A Diagnosis Label Discriminator
FD_AXIS2BD Axis II B Diagnosis Label Discriminator
FD_AXIS2CD Axis II C Diagnosis Label Discriminator
FD_AXIS2DD Axis II D Diagnosis Label Discriminator

FD_AXIS2AP Axis II A Diagnosis Provisional
FD_AXIS2BP Axis II B Diagnosis Provisional
FD_AXIS2CP Axis II C Diagnosis Provisional
FD_AXIS2DP Axis II D Diagnosis Provisional

FORMAT:
Length = 7, 1, 1
Type = Character, Character, Logical
Popup used = DSM3_R.DBF

ALLOWABLE VALUES: Refer to popup for values.

DATA ENTRY PROMPT:
II. A.
B.
C.
D.

HELP TEXT: Select the appropriate diagnostic code according to the DSM-III-R classification (developmental disorders and personality disorders) showing the condition that was responsible for causing the client's clinical care.

Enter the proper code for each diagnosis. The text for the diagnosis will automatically appear.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION: DIAGNOSIS, AXIS III, A - D TOC Index

DEFINITION: The code which represents the diagnosis according to the ICD 9 classification (physical disorders and conditions) showing the condition that was responsible for causing the client's clinical care.

FIELD NAME:

FD_AXIS3AC Axis III A Diagnosis Code
FD_AXIS3BC Axis III B Diagnosis Code
FD_AXIS3CC Axis III C Diagnosis Code
FD_AXIS3DC Axis III D Diagnosis Code

FD_AXIS3A Axis III A Diagnosis Text
FD_AXIS3B Axis III B Diagnosis Text
FD_AXIS3C Axis III C Diagnosis Text
FD_AXIS3D Axis III D Diagnosis Text

FD_AXIS3AD Axis III A Diagnosis Label Discriminator
FD_AXIS3BD Axis III B Diagnosis Label Discriminator
FD_AXIS3CD Axis III C Diagnosis Label Discriminator
FD_AXIS3DD Axis III D Diagnosis Label Discriminator

FD_AXIS3AP Axis III A Diagnosis Provisional
FD_AXIS3BP Axis III B Diagnosis Provisional
FD_AXIS3CP Axis III C Diagnosis Provisional
FD_AXIS3DP Axis III D Diagnosis Provisional

FORMAT: Length = 7, 55, 1, 1
Type = Character, Character, Character, Logical
Popup used = N/A

ALLOWABLE VALUES N/A

DATA ENTRY PROMPT: III. A.
B.
C.
D.

HELP TEXT: Select the appropriate diagnostic code according to the ICD 9 classification (physical disorders and conditions) showing the condition that was responsible for causing the client's clinical care.

Manually enter the proper code and text for each diagnosis.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION: DIAGNOSIS, AXIS IV TOC Index

DEFINITION: Not in use at this time. To be used for future storage of Axis IV information.

FIELD NAME: FD_AXIS4CD Axis IV Diagnosis Code
FD_AXIS4D Axis IV Diagnosis Label Discriminator

FORMAT: Length = 7, 1
Type = Character, Logical
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: N/A

HELP TEXT: N/A

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: N/A

INDICATORS: N/A

REASON FOR COLLECTING: N/A

DESCRIPTION: DIAGNOSIS, AXIS V TOC Index

DEFINITION: Not in use at this time. To be used for future storage of Axis V information.

FIELD NAME: FD_AXIS5CD Axis V Diagnosis Code
FD_AXIS5D Axis V Diagnosis Label Discriminator

FORMAT: Length = 7, 1
Type = Character, Logical
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: N/A

HELP TEXT: N/A

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: N/A

INDICATORS: N/A

REASON FOR COLLECTING: N/A

DESCRIPTION:	DIAGNOSIS, PRIMARY, ADMISSION TOC Index
DEFINITION:	The code which represents the diagnostic code according to the DSM-III-R classification showing the condition that was primarily responsible for causing the admission to inpatient care.
FIELD NAME:	CON_DIAG1 (DIAGADMP) Primary Diagnosis Code at Admission CON_DIAG1D Primary Diagnosis Code at Admission, Text Discriminator CON_DIAG1P Primary Diagnosis Code at Admission, Provisional
FORMAT:	Length = 7, 1, 1 Type = Character, Character, Logical Popup used = DSM3_R.DBF
ALLOWABLE VALUES:	Refer to the available diagnosis codes in the popup.
DATA ENTRY PROMPT:	Primary Diagnosis for admission:
HELP TEXT:	Select the appropriate diagnostic code according to the DSM-III-R classification showing the condition that was primarily responsible for causing the admission to inpatient care. The text of the diagnosis will be automatically be entered upon selecting the code. Diagnoses codes are available in the popup.
DATA ENTRY EDITS	N/A
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	MHSIP, Billing

DESCRIPTION: DIAGNOSIS, PRIMARY, DISCHARGE TOC Index

DEFINITION: The code which represents the diagnostic code according to the DSM-III-R classification showing the diagnosis that is the principle diagnosis of the client at the time of discharge.

FIELD NAME: CON_DIAG3 (DIAGDISP) Primary Diagnosis Code at Discharge
CON_DIAG3D Primary Diagnosis Code at Discharge, Text Discriminator
CON_DIAG3P Primary Diagnosis Code at Discharge, Provisional

FORMAT: Length = 7, 1, 1
Type = Character, Character, Logical
Popup used = DSM3_R.DBF

ALLOWABLE VALUES: Refer to the available diagnosis codes in the popup.

DATA ENTRY PROMPT: Primary Diagnosis at Discharge:

HELP TEXT: Select the appropriate diagnostic code according to the DSM-III-R classification showing the diagnosis that is the principle diagnosis of the client at the time of discharge. The text of the diagnosis will automatically be entered when the code is selected. Codes are available in the popup.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Billing

DESCRIPTION:	DIAGNOSIS, PRIMARY, TREATING TOC Index
DEFINITION:	The code which represents the diagnostic code according to the DSM-III-R classification showing the condition that was primarily responsible for causing the continued hospital stay.
FIELD NAME:	CON_DIAG2 Primary Treating Diagnosis Code CON_DIAG2D Primary Treating Diagnosis Code, Text Discriminator CON_DIAG2P Primary Treating Diagnosis Code, Provisional
FORMAT:	Length = 7, 1, 1 Type = Character, Character, Logical Popup used = DSM3_R.DBF
ALLOWABLE VALUES:	Refer to the available diagnosis codes in the popup.
DATA ENTRY PROMPT:	Primary Treating Diagnosis
HELP TEXT:	Select the appropriate diagnostic code according to the DSM-III-R classification showing the condition that was primarily responsible for causing the continued hospital stay. The text of the diagnosis will be automatically be entered upon selecting the code. Diagnoses codes are available in the popup.
DATA ENTRY EDITS	N/A
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	MHSIP, Billing

DESCRIPTION: DIAGNOSIS, PROVISIONAL CODE, LABELS 1 - 2 TOC Index

DEFINITION: The codes which represent the diagnostic codes according to the DSM-III-R classification showing the conditions that were the provisional diagnoses responsible for requiring inpatient care.

FIELD NAME: PROVDG_COD Provisional Diagnosis Code, Label 1
PROVDG_CD2 Provisional Diagnosis Code, Label 2

PRVDIAG1D Provisional Diagnosis Code, Label 1 Text Discriminator
PRVDIAG2D Provisional Diagnosis Code, Label 2 Text Discriminator

FORMAT: Length = 7, 1
Type = Character
Popup used = DSM3_R.DBF

ALLOWABLE VALUES: Refer to the available diagnoses codes in the popup.

DATA ENTRY PROMPT: Provisional Diagnosis: Code:
1.
2.

HELP TEXT: Select the appropriate diagnostic codes according to the DSM-III-R classification showing the conditions that were the provisional diagnoses responsible for requiring inpatient care. The text of the diagnoses will be automatically entered upon selecting the code. Diagnoses codes are available in the popup.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING:

DESCRIPTION: DIAGNOSIS, PROVISIONAL CODE, LABEL 3 TOC Index

DEFINITION: The code which according to the ICD 9 classification shows the current medical conditions that were the provisional diagnoses responsible for requiring inpatient care.

FIELD NAME: PROVDG_CD3 Provisional Diagnosis Code, Label 3
PROV_DIAG3 Provisional Diagnosis Code, Label 3 Text
PRVDIAG3D Provisional Diagnosis Code, Label 3 Text Discriminator

FORMAT: Length = 7, 55, 1
Type = Character
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: Provisional Diagnosis: Code:
3.

HELP TEXT: Select the appropriate diagnostic codes according to the ICD9 classification showing the conditions that were the provisional diagnoses responsible for requiring inpatient care. The text of the diagnosis must be entered manually.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING:

DESCRIPTION: DISCHARGE BARRIERS TOC Index

DEFINITION: The codes which represent the items preventing the discharge of the client.

FIELD NAME: BARRIER1, BARRIER2, BARRIER3, BARRIER4

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = NEEDS.DBF

ALLOWABLE VALUES:

?	Unknown
01	Housing - No housing is available to this client upon discharge.
02	Entitlements/Benefits - Successful community living will require this client to receive entitlements/benefits.
03	Employment/Pre-employment - The client will require employment or pre-employment services upon discharge.
04	Education/Special Education - The client will require educational and/or special education referral upon discharge.
05	Money Management - The client will require assistance with money management upon discharge.
06	Social/Recreational - The client will require services through a structured social and recreational program upon discharge.
07	Family Living - The client will require a family living environment upon discharge.
08	Mental Health - The client will require continued mental health services upon discharge.
09	Physical Health - The client will require general medical care services upon discharge.
10	Other Community Living Needs - The client will require other community living needs not listed above.
11	Assessment/Service Plan - The client requires a special assessment and/or service plan for a successful discharge.
12	Court Order - The client has been mandated to received evaluation and/or treatment as evidenced by a current civil or juvenile court order.

DATA ENTRY PROMPT: Discharge Barriers: 1. 2. 3. 4.

HELP TEXT: Select the appropriate codes, (up to 4 fields) which best describe the items preventing the discharge of the client. For every community living need noted, the case manager should note under Discharge Barriers whether there is an absence of arrangements for those needs which constitutes a barrier to discharge.

DATA ENTRY EDITS: 1. Only codes not already entered as a Discharge Barrier will be allowed.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: Continuity of care, Decision support data/statistical

DESCRIPTION: DISPOSITION TOC Index

DEFINITION: The code which represents the outcome of the initial contact with respect to what subsequent service, if any, are planned for the client.

FIELD NAME: DISPOSITN (DSPOSITN)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = DISPOST.DBF

ALLOWABLE VALUES:

01 Admission - This code cannot be selected during the patient interview.
02 Placed on waiting list - The individual is not formally admitted on the date of the initial interview, but the client's name is placed on a waiting list to be scheduled for timely admission to the hospital.
03 Referred to CMHC - The individual is not formally admitted to the hospital on the date of the initial interview, but rather is referred to a community mental health center/clinic.
04 Referred to OMH acute unit - The individual is not formally admitted to the hospital on the date of the initial interview, but rather is referred to the appropriate Office of Mental Health Acute Treatment Unit.
05 Referred to substance abuse facility - The individual is not formally admitted to the hospital on the date of the initial interview, but is referred to a substance abuse facility, whether public or private.
06 Referred elsewhere - The individual is not formally admitted to the hospital on the date of the initial interview, but the client is referred by the therapeutic staff to another agency or resource for service provision.
07 No referral - The individual is not formally admitted to the hospital on the date of the initial interview and is not referred elsewhere.

DATA ENTRY PROMPT: Disposition:

HELP TEXT: Select the appropriate code that best describes the outcome of the initial contact with respect to what subsequent service, if any, are planned for the client. User cannot select 01 - admission. MANDATORY FIELD: This field may not be left blank at pre-admission.

Upon admission, this field is automatically entered and defaults to 01, signifying an admission.

DATA ENTRY EDITS: 1. "01 Admission" cannot be selected at pre-admission.
2. If Disposition is "03 Referred to CMHC" or "04 Referred to OMH Acute Treatment Unit", THEN Unit Referred To AND Clinical Staff ID must be completed.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is required for all patient records.

REASON FOR COLLECTING: Continuity of care

DESCRIPTION: DRUG TOC Index

DEFINITION: The code which represents the client's reported drug(s) of use.

FIELD NAME: DRUG1, DRUG2, DRUG3

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = DRUGS.DBF

ALLOWABLE VALUES:

? Unknown
00 None
01 Heroin - Heroin (horse, smack).
02 Non-Rx Methadone - Non-prescribed methadone, Dolophine.
03 Other opiates and synthetics - Opiate and synthetic narcotics including codeine, morphine and opium derivatives other than heroin. Demerol, Dilaudid, Hydromorphone, Mepergan, Meperidine HCL, Morphine Sulphate, Numorphan, Percodan, Pectpral Syrup, Paregoric Pantophen (chloride of opium alkaloids), Pentazocine (Talwin), Lomotil, Darvon, Fentanyl. SLANG NAMES: dover powder, cube dreamer, junkie, snow, stuff, junk, chinese red, boy, schoolboy, lords, "T's and Blues", etc.
04 Alcohol - Beer, wine, whiskey, liqueurs, including both ethyl and methyl alcohol. SLANG NAMES: moonshine, shine, stumpjuice, booze, etc.
05 Barbiturates - Amobarbital, Butisol, Phenobarbital, Secobarbital, Tuinal. SLANG NAMES: yellow jackets, nimbles, reds, pinks, red devil, pink lady, blues, blue devil, double trouble, Christmas trees, barbs, downers, block busters, green dragons, goofballs, peanuts, rainbows, Mexican reds. TRADE NAMES: Nembutal, Seconal, Amytal, Luminal, Butisol.
06 Other sedatives and hypnotics - Sedative or hypnotic acting non-barbiturate drugs; gluthemide (Doriden), methaqualone (Quaalude, Sopor, Optimil), chloral hydrate (Noctec, Somuos) and trade names, Noludor, Placidyl, Phenergan, Restaril, Halcion and Mandrox. SLANG NAMES: doors and fours, quads, ludes, soapers, sopes.
07 Amphetamines - Stimulants other than cocaine, biphetamine, dexedrine, methamphetamine, dextroamphetamine, phenmetrazine (Preludin), and methylphenidate (Ritalin). SLANG NAMES: pop pills, bennies, uppers, black mollies, copilots, pocket rockets, truck drivers, speed, black beauties, crank, meth, jelly beans, black cadillacs, browns, greenies, b-bomb, oranges, etc. TRADE NAMES: Desoxin, Dexedrine, Mediatric, Preludin, Delcobese.
08 Cocaine - The stimulant cocaine. SLANG NAMES: coke, flake, snow, speed-ball, gold dust, toot, nose heaven, paradise, lady snow, girl, frisky powder, uptown.
09 Marijuana/hashish - Cannabis and cannabis derivatives, THC.
10 Hallucinogens - Hallucinatory agents other than PCP, including LSD-25, Mescaline and Peyote, certain amphetamine variants (2, 5 DMA, PMA, STP, MDMA, TMA, DOM, and DOB), Bufotenine, Ibogaine, Psilocybin and Psilocin. SLANG NAMES: acid, cubes, royal blue, wedding bells, big d, sugar lump, microdots, windowpane, purple haze, mushrooms, mesc, buttons, cactus, mercel, chocolate chips, etc.
11 Inhalants - Volatile organic solvents such as spray paint, glue, toluene, amylnitrate, lighter fluid, gasoline, liquid paper thinner, freon, polish remover, nitrous oxide, cleaning fluid, sealer, shoe polish.
12 Over-the-counter drugs - Legal over-the-counter preparations exclusive of items listed elsewhere. Include analgesics, diet preparations, relaxants, cold and sleep preparations (Nyquil, Sominex, aspirin, etc.).
13 Tranquilizers - Depressants not otherwise listed as barbiturates, benzodiazepines or sedative-hypnotics. Anti-anxiety drugs, musde relaxants. Includes chlordiazepoxides, reserpine, lithium compounds, phenothiazines. TRADE NAMES: Equanil, Miltown, Mellaril, Serentil, Triavil, Valmid.

14 Methamphetamine - Stimulant closely related to amphetamine and ephedrine. SLANG NAMES: speed, crystal.

15 PCP - Phencyclidine and/or phencyclidine analogs (PCE, PCP, TCP). SLANG NAMES: angel dust, hog, peace hill, cyclone, rocket fuel, killer weed, super grass, bad grass, elephant.

16 Other stimulants - Includes such trade names as Adipex, Bacarate, Cylert, Didrex, Ionamin, Plegine, Pre-Sate, Sanorex, Tenuate, Tepanil, Voranil.

17 Benzodiazepine - Includes tranquilizers such as Ativan, Azene, Clonopin, Dalmane, Diazepam, Librium, Serax, Tranxene, Valium, Verstran.

18 Other - Any other drugs or chemical, singular or in combination not otherwise classified as narcotics, hallucinogens, barbiturates or stimulants, including over-the-counter or "street" drugs not classified herein.

DATA ENTRY PROMPT: Primary, Drug
Secondary, Drug
Tertiary, Drug

HELP TEXT: Select the 2-digit code(s) which most nearly represents the client's reported drug(s) of use. The primary drug is that drug which is causing the client to seek help and for which (s)he is being admitted. If a client uses more than one type on a fairly equal basis, select under "primary", the client's preferred drug of choice.

DATA ENTRY EDITS: 1. Only codes not entered into Primary Drug will be allowed as Secondary Drug.

2. Only codes not entered into Primary and Secondary Drug will be allowed as Tertiary Drug.
3. If Drug Type is completed for secondary drugs, there must also be primary drugs.
4. If Drug Type is completed for tertiary drugs, there must also be primary and secondary drugs.
5. If there is a Primary Drug type, THEN Age at First Use, AND Frequency of Use, AND Method must all be completed for the primary drug.
6. If there is a Secondary Drug type, THEN Age at First Use, AND Frequency of Use, AND Method must all be completed for the secondary drug.
7. If there is a Tertiary Drug type, THEN Age at First Use, AND Frequency of Use, AND Method must all be completed for the tertiary drug.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Substance abuse history

DESCRIPTION: DRUG, AGE AT FIRST USE TOC Index

DEFINITION: The code which represents the age of the client at first use selected drug(s).

FIELD NAME: DRUG_AGE1, DRUG_AGE2, DRUG_AGE3
(DR_AGE1 - DR_AGE3)

FORMAT: Length = 2
Type = Numeric
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: Primary, Age @ 1st Use
Secondary, Age @ 1st Use
Tertiary, Age @ 1st Use

HELP TEXT: Enter the 2-digit number representing the age of the client at first use of the primary drug.

DATA ENTRY EDITS: 1. If Age at First Use is completed for secondary drugs, there must also be primary drugs.
2. If Age at First Use is completed for tertiary drugs, there must also be primary and secondary drugs.
3. If there is a Primary Age At First Use, THEN Drug Type, AND Frequency of Use AND Method must all be completed for the primary drug.
4. If there is a Secondary Age At First Use, THEN Drug Type, AND Frequency of Use AND Method must all be completed for the secondary drug.
5. If there is a Tertiary Age At First Use, THEN Drug Type, AND Frequency of Use AND Method must all be completed for the tertiary drug.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Substance abuse history

DESCRIPTION: DRUG, FREQUENCY TOC Index

DEFINITION: The code which represents the client's frequency of use of the selected drug(s) during the month prior to admission.

FIELD NAME: DRUG_FREQ1, DRUG_FREQ2, DRUG_FREQ3
(DRFREQ1 - DRFREQ3)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = FREQUENT.DBF

ALLOWABLE VALUES:

00 No past month use - Client, or credible collateral, reports client has not used this drug during the 30 days immediately preceding admission to this hospital.

01 1 to 3 time use in past month - Regardless of the amount of intake, client or credible collateral reports usage pattern of one to three episodes of use per week during the 30 days immediately preceding admission.

02 1 to 2 times per week - The client or credible collateral reports one or two episodes of use per week during the 30 days immediately preceding admission.

03 3 to 6 times per week - The client or credible collateral reports three to six episodes per week during the 30 days immediately preceding admission.

04 Daily use - The client or credible collateral reports the client used alcohol/drugs on a daily, or almost daily basis during the month prior to admission.

05 Unknown - Neither the client nor any credible witness can state or estimate the frequency of use during the past 30 days.

DATA ENTRY PROMPT: Primary, Frequency
Secondary, Frequency
Tertiary, Frequency

HELP TEXT: Select the code which indicates the frequency of use of the primary drug during the month prior to admission. NOTE: Use Query Patient Record to update or correct frequency when more reliable data is obtained, but relate this data only to the month prior to admission. Do not update changing patterns during treatment of use/abuse.

DATA ENTRY EDITS 1. If Frequency is completed for secondary drugs, there must also be primary drugs.

2. If Frequency is completed for tertiary drugs, there must also be primary and secondary drugs.
3. If there is a Primary Frequency of Use, THEN Drug Type, AND Method AND Age at First Use must all be completed for the primary drug.
4. If there is a Secondary Frequency of Use, THEN Drug Type, AND Method AND Age at First Use must all be completed for the secondary drug.
5. If there is a Tertiary Frequency of Use, THEN Drug Type, AND Method AND Age at First Use must all be completed for the tertiary drug.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Substance abuse history

DESCRIPTION: DRUG, METHOD TOC Index

DEFINITION: The code which represents the method of administration the client has used for the selected drug(s).

FIELD NAME: DRUG_RTE1, DRUG_RTE2, DRUG_RTE3
(DR_RTE1 - DR_RTE3)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = ROUTE.DBF

ALLOWABLE VALUES:

?	Unknown
01	Oral - Used in or administered through the mouth.
02	Intravenous - Administered with an injection into the vein(s).
03	Smoking - Administered/inhaled in the form of smoke.
04	Inhalation - Administered through the nasal passages.
05	Other - Not covered in above choices.
06	None reported - This code is to be used by prevention programs and collateral contacts only.

DATA ENTRY PROMPT: Primary, Method
Secondary, Method
Tertiary, Method

HELP TEXT: Select the code which indicates the method of administration the client has used for the selected drug(s).

DATA ENTRY EDITS:
1. If Method is completed for secondary drugs, there must also be primary drugs.
2. If Method is completed for tertiary drugs, there must also be primary and secondary drugs.
3. If there is a Primary Method of Administration, THEN Drug Type, AND Frequency of Use AND Age at First Use must all be completed for the primary drug.
4. If there is a Secondary Method of Administration, THEN Drug Type, AND Frequency of Use AND Age at First Use must all be completed for the secondary drug.
5. If there is a Tertiary Method of Administration, THEN Drug Type, AND Frequency of Use AND Age at First Use must all be completed for the tertiary drug.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Substance abuse history

DESCRIPTION: EDUCATION LEVEL TOC Index

DEFINITION: The code which represents the educational attainment of the client.

FIELD NAME: EDUCATION (EDUC)

FORMAT: Length = 3
Type = Numeric
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: Education:

HELP TEXT: Record the educational level of the client by entering the number of school years completed. Record only the highest grade completed.

For example, if the client has completed high school, but has not had any college education, educational attainment would be recorded as "12". If the client has completed school through grade 9, educational attainment would be coded as "09". All levels should be recorded in two digit, whole year numbers that reflect typical levels (e.g., completion of college = "16"; master's degree = "18").

If the individual never attended school, record this as "00". If the client is currently participating in special education or another ungraded classroom situation, or if the highest level achieved was in an ungraded situation, then code this as "99".

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION:	EMERGENCY CONTACT, ADDRESS	TOC Index
DEFINITION:	The street address (text) of the emergency contact person.	
FIELD NAME:	EMR_ADDRES	
FORMAT:	Length = 25 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Emergency Contact Address	
HELP TEXT:	Enter, in 25 characters or less, the emergency contact's street address. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	EMERGENCY CONTACT, CITY	TOC Index
DEFINITION:	The city of residence (text) of the emergency contact person.	
FIELD NAME:	EMR_CITY	
FORMAT:	Length = 20 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Emergency Contact City	
HELP TEXT:	Enter, in 20 characters or less, the emergency contact's city of residence. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	EMERGENCY CONTACT, NAME	TOC Index
DEFINITION:	The name of the person (text) to notify in the event of an emergency.	
FIELD NAME:	EMR_NAME	
FORMAT:	Length = 25 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Emergency Contact Name	
HELP TEXT:	Enter, in 25 characters or less, the full name of the person to notify in the event of an emergency (First Name, MI, Last Name). If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	EMERGENCY CONTACT, PHONE NUMBER	TOC Index
DEFINITION:	The telephone number (text) of the emergency contact person.	
FIELD NAME:	EMR_TELE	
FORMAT:	Length = 12 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Emergency Contact Phone - -	
HELP TEXT:	Enter the emergency contact's area code and telephone number. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	EMERGENCY CONTACT, RELATIONSHIP	TOC Index
DEFINITION:	The relationship (text) of the emergency contact person to the client.	
FIELD NAME:	EMR_RELATE	
FORMAT:	Length = 7 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Emergency Contact Relation	
HELP TEXT:	Enter emergency contact's relationship to the client. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	EMERGENCY CONTACT, STATE	TOC Index
DEFINITION:	The state of residence (text) of the emergency contact person.	
FIELD NAME:	EMR_STATE	
FORMAT:	Length = 2 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Emergency Contact State	
HELP TEXT:	Enter the 2 letter abbreviation for the emergency contact's state of residence. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	EMERGENCY CONTACT, ZIP CODE	TOC Index
DEFINITION:	The zip code (text) of the emergency contact person.	
FIELD NAME:	EMR_ZIP	
FORMAT:	Length = 10 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Emergency Contact Zip -	
HELP TEXT:	Enter the emergency contact's five or nine-digit zip code. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION: ETHNICITY TOC Index

DEFINITION: The code which represents the ethnic heritage of the client.

FIELD NAME: ETHNIC

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = ETHNIC.DBF

ALLOWABLE VALUES:

? Unknown

01 Non-Hispanic - The client is an individual not of Spanish heritage or culture, regardless of race.

02 Puerto Rican - The client is an individual of Puerto Rican heritage or culture, regardless of race.

03 Mexican/Mexican American - The client is an individual of Mexican heritage or culture, regardless of race.

04 Cuban - The client is an individual of Cuban heritage or culture.

05 Other Hispanic - The client is an individual from Central or South America and all other Spanish cultures or origins (including Spain), regardless of race.

DATA ENTRY PROMPT: Ethnicity:

HELP TEXT: Select the code which represents the ethnic heritage of the client.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION:	FACILITY CODE	TOC Index
DEFINITION:	The code which represents the public psychiatric hospital, or community mental health center/clinic to which this client has been referred upon discharge.	
FIELD NAME:	REFER_UNIT (REF_UNIT)	
FORMAT:	Length = 5 Type = Character Popup used = HOSPUNIT.DBF	
ALLOWABLE VALUES:	Refer to popup for values.	
DATA ENTRY PROMPT:	Facility Code:	
HELP TEXT:	Select the appropriate code that represents the public psychiatric hospital or community mental health center/clinic to which this client has been referred upon discharge. The facility codes are available in the popup.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Continuity of care, Decision support data/Statistical	

DESCRIPTION: FACILITY IDENTIFIER TOC Index

DEFINITION: The code which represents the identification number assigned to the user's facility.

FIELD NAME: HOSP_UNIT (FACIL)

FORMAT: Length = 5
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: N/A

HELP TEXT: This field contains the identification number assigned to the user's facility. It is automatically entered when the database is compiled and forwarded to the state office. The user will never see or use this element while entering data.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: N/A

INDICATORS: N/A

REASON FOR COLLECTING: MHSIP

DESCRIPTION: FACILITY IDENTIFIER, EARL K. LONG TOC Index

DEFINITION: The code which represents the billing identification number assigned to clients at the Earl K. Long facility.

FIELD NAME: EKLONG

FORMAT: Length = 6
Type = Character
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: N/A

HELP TEXT: For the Earl K. Long Acute Unit, the selection can be made to use the billing number. This number is seen only by users at this location.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: N/A

INDICATORS: N/A

REASON FOR COLLECTING: Billing

DESCRIPTION: FATHER, ADDRESS TOC Index

DEFINITION: The street address (text) of the client's father.

FIELD NAME: FATHER_ADD

FORMAT: Length = 35
Type = Character
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: Father's Address:

HELP TEXT: Enter, in 35 characters or less, the father's street address. If this information is unknown, leave the item blank.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: Contact information

DESCRIPTION: FATHER, CITY TOC Index

DEFINITION: The city of residence (text) of the client's father.

FIELD NAME: FATHERCITY

FORMAT: Length = 20
Type = Character
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: Father's City

HELP TEXT: Enter, in 20 characters or less, the father's city of residence. If this information is unknown, leave the item blank.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: Contact information

DESCRIPTION:	FATHER, NAME	TOC Index
DEFINITION:	The name of the father (text) of the client.	
FIELD NAME:	FATHER	
FORMAT:	Length = 25 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Father's name:	
HELP TEXT:	Enter, in 25 characters or less, the full name of the client's father (First Name, MI, Last Name). If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	FATHER, OCCUPATION	TOC Index
DEFINITION:	The occupation (text) of the client's father.	
FIELD NAME:	FATHER_OCC	
FORMAT:	Length = 15 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Father's Occupation:	
HELP TEXT:	Enter, in 15 characters or less, the father's occupation. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	FATHER, PHONE NUMBER	TOC Index
DEFINITION:	The telephone number (text) of the client's father.	
FIELD NAME:	FATHR_PHON	
FORMAT:	Length = 12 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Father's Phone - -	
HELP TEXT:	Enter the father's area code and telephone number. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	FATHER, STATE	TOC Index
DEFINITION:	The state of residence (text) of the client's father.	
FIELD NAME:	FATHER_ST	
FORMAT:	Length = 2 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Father's State	
HELP TEXT:	Enter the 2 letter abbreviation for the father's state of residence. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	FATHER, ZIP CODE	TOC Index
DEFINITION:	The zip code (text) of the client's father.	
FIELD NAME:	FATHER_ZIP	
FORMAT:	Length = 10 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Father's Zip -	
HELP TEXT:	Enter the father's five or nine-digit zip code. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION: HANDICAPS TOC Index

DEFINITION: The codes which represent the physical or mental impairments or disabilities observed in the client.

FIELD NAME: HANDI_1, HANDI_2, HANDI_3, HANDI_4, HANDI_5

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = HANDICAP.DBF

ALLOWABLE VALUES:

? Unknown

00 No impairments

01 Autism - Autism is a severe developmental disability that is behaviorally defined. The essential features are typically manifested prior to 30 months of age and include:
- a. Disturbance of developmental rates and sequences
- b. Disturbances of responses to sensory stimuli
- c. Disturbances of speech, language, cognition and nonverbal communication
- d. Disturbance of the capacity to appropriately relate to people, events or objects

02 Hearing impaired - Hearing impaired includes both deaf and hard-of-hearing persons.
- a. Deaf: A hearing impairment that is so severe that the person is impaired in processing linguistic information through hearing, with or without amplification.
- b. Hard-of-Hearing: A hearing loss that may range from mild to severe unaided, but which does not significantly impede the learning of speech and language through normal channels.

03 Attention deficit disorder
- a. With hyperactivity: Displays for disorder his/her mental and chronological age, signs of developmentally inappropriate inattention, impulsivity, and hyperactivity. Onset occurs before the age of seven, with a duration of at least six months. Condition is not due to schizophrenia, affective disorder, or severe or profound mental retardation.
- b. Without hyperactivity: Same as (a) above except that the individual never had signs of hyperactivity.
- c. Residual type: Signs of hyperactivity are no longer present, but other signs of the illness have persisted without periods of remission, as evidenced by signs of both attention deficits and impulsivity which result in some impairment in social or occupational functioning. Not due to schizophrenia, affective disorder, or severe or profound metal retardation.

04 Mental retardation - Characterized by:
- a. Significantly subaverage general intellectual functioning; an IQ of 70 or below on an individually administered IQ test. (Since available intelligence tests do not yield numeric values for infants, this would be a clinical judgement of significant subaverage intellectual functioning.)
- b. Concurrent deficits or impairments in adaptive behavior, the person's age being taken into consideration.
- c. Onset before the age of 18.

05 Orthopedically handicapped - Includes impairments caused by congenital anomaly (e.g., clubfoot, absence of some member, etc.), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis, etc.), and amputations and fractures or burns that cause contracture.

06 Language disorder - Speech impairment resulting from any physical or

psychological condition that seriously interferes with the development, formation, or expression of language.

07 Visually impaired - Includes both blind and partial-sight persons:
   a. Blind: persons who have so little remaining vision that they must use non-sight methods as their medium
   b. Partial-Sight: persons who have experienced significant loss of vision.

08 Epilepsy - A nervous disorder characterized by recurring attacks of motor, sensory, or psychic malfunctions with or without unconsciousness or convulsive movements.

09 Cerebral palsy - Impaired muscle power and coordination from brain damage usually occurring at or before birth.

10 Other health impairment - Examples include limited strength, vitality, or alertness; chronic or acute health problems; or any other physical impairment to a major body system.

DATA ENTRY PROMPT: Patient Handicaps: 1. 2. 3. 4. 5.

HELP TEXT: Select the code(s) that describes up to 5 physical or mental impairments or disabilities observed in the client in order of significance.

DATA ENTRY EDITS: 1. Only codes not already entered into Patient Handicaps will be allowed.
2. If Patient Handicaps is "01 Autism" or "04 Mental Retardation" THEN "Is Patient Developmentally Disabled?" must be "Yes".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical, Expansion of needs and barriers, Clinical utility

DESCRIPTION: HOSPITAL NUMBER TOC Index

DEFINITION: The code which represents the case number assigned by this hospital when admitting the client for all episodes of treatment at this facility.

FIELD NAME: HOSP_NUM (HOSPNUM)

FORMAT: Length = 9
Type = Character
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: Hospital Number:

HELPTEXT: Enter the case number assigned by this hospital when admitting the client for this episode of treatment. A case number should be used only if the client is actually admitted to the hospital. The case number must be at least 6 digits or characters.

Upon completion of an interview, PIP forces a hospital number of '000000000'. When the client is admitted, the user must alter the hospital number to reflect a correct number. The case number becomes the primary client identifier after admission. MANDATORY FIELD: This field may not be left blank at admission.

DATA ENTRY EDITS: 1. This field may not be left blank.
2. Only numbers representing those patients who are not current admissions will be allowed.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is required for all patient records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION: HOSPITAL NUMBER, PREFIX TOC Index

DEFINITION: The code which represents the option to display the (T)ulane or (L)SU prefixes of the hospital numbers for Medical Center of Louisiana.

FIELD NAME: TBA

FORMAT: Length = 1
Type = Character
Popup used = N/A

ALLOWABLE VALUES: T Tulane
L LSU

DATA ENTRY PROMPT: N/A

HELP TEXT: For Medical Center of Louisiana, contains the (T)ulane or (L)SU prefixes of the hospital numbers. This prefix is seen only by users at this location.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: N/A

INDICATORS: N/A

REASON FOR COLLECTING: Decision support data/Statistical

DESCRIPTION: HOUSEHOLD COMPOSITION TOC Index

DEFINITION: The code which represents the current household composition or living arrangements of the client upon admission.

FIELD NAME: HOUSE_COMP (HSE_COMP)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = HOUSEHOL.DBF

ALLOWABLE VALUES:

?	Unknown
01	Adult only - The client is an adult and lives alone.
02	Adult; relatives - The client is an adult and lives with other family members (e.g., spouse, children, etc.).
03	Adult; non-relatives - The client is an adult and does not live with family members (e.g., lives with friends, in an institutional environment, etc.).
04	Child; both parents - The client is a child, lives with both parents.
05	Child; one parent - The client is a child and lives with only one of his/her parents.
06	Child; relatives, not parents - The client is a child and lives with family members other than his/her parents (e.g., lives with an uncle, sister, etc.).
07	Child; foster family - The client is a child, lives in a foster care family.
08	Child; non-relatives - The client is a child and doesn't live with family members (e.g., lives with friends, an institutional setting, etc.).

DATA ENTRY PROMPT: Household Composition:

HELP TEXT: Select the code that best indicates the current household composition or living arrangements of the client upon admission.
NOTE: The following definitions apply to "parents" and "relatives":
Parent: A natural parent or an adult who is occupying a parental role to the client, such as an adoptive parent or an individual married to a natural parent (e.g., step-parent).
Relative: An individual who is related to the client by kinship, marriage, or legal action (e.g., spouse, sibling, etc.).

DATA ENTRY EDITS 1. Household Composition must be "03 Adult; non-relatives" or "08 Child; non-relatives" if Type of Residence is "03 Nursing Home/Care Facility", "04 Residential Hotel", "06 Group Home/Halfway House", "07 Supervised Apartment", "08 Board and Care", "09 Jail/Prison/Training Institute" or "10 Hospital".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical

DESCRIPTION: HOUSING TOC Index

DEFINITION: The code which represents the client's type of residence or living quarters after discharge.

FIELD NAME: DC_RESID

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = RESIDENT.DBF

ALLOWABLE VALUES:

? Unknown

01 Single-family dwelling - The client lives in a dwelling which houses only a single family. May include mobile homes.

02 Apartment - The client lives in a multiple-family dwelling, including duplexes, triplexes, and apartment buildings.

03 Nursing home or intermediate care facility - The client lives in a nursing home, convalescent home, etc.

04 Residential hotel - The client lives in a residential hotel or other type of boarding house arrangement, or rents a single room in someone's house.

05 No permanent residence - The client's residence is primarily transient (for example, a camper trailer or motor home), or the client may live "on the street". This includes clients living in a shelter, mission, or temporary living quarters or in a place that is limited/short-term stay.

06 Group home/halfway house - The client lives in a group home or halfway house as part of a supervised residential program designed to meet special needs.

07 Supervised apartment - The client lives in a supervised apartment as part of a supervised residential program designed to meet special needs.

08 Board and care - The client lives in a licensed, supervised "board and care" 24-hour residence as part of a supervised residential program designed to meet special needs.

09 Jail/prison/training institution - The client is incarcerated in a jail, prison, or training institution.

10 Hospital - The client has been in a medical or psychiatric hospital prior to admission.

11 Other quarters - For use if none of the other categories is appropriate (for example, military barracks, dormitory, fraternity, sorority, etc.).

DATA ENTRY PROMPT: Housing:

HELP TEXT: Select the appropriate code that best describes the client's residence or living quarters after discharge.

DATA ENTRY EDITS 1. If Housing is "03 Nursing Home/Care Facility", "04 Residential Hotel", "06 Group Home/Halfway House", "07 Supervised Apartment", "08 Board and Care", "09 Jail/Prison/Training Institute" or "10 Hospital" THEN Living Arrangement at Discharge must be "03 Adult; non-relatives" or "08 Child; non-relatives".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical

DESCRIPTION: INCOME, PRINCIPAL SOURCE OF TOC Index

DEFINITION: The code which represents the primary source of the client's income.

FIELD NAME: INC_SOURCE (INC_SOUR)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = SOURCE.DBF

ALLOWABLE VALUES:

? Unknown

01 Employment/Wages - The majority of the family's income is derived through employment. The money is earned as:
- a. salary, wages, tips, commissions, and/or bonuses;
- b. farm self-employment (after deductions for operating expenses) or tenant farmer or sharecropper
- c. non-farmer self-employment, partnerships, or professional practices

Also included are retirement incomes/pensions from private or governmental sources (such as Social Security, Railroad Retirement, State Employees' Retirement, Teachers' Retirement, military retirement, etc.) and payments from the military for National Guard or Reserve duty.

02 Public Assistance - The majority of the family's income is derived from some form of public assistance, including Aid to Families with Dependent Children, Supplemental Security Income, and Social Security Disability Insurance.

03 Other - The majority of the family's income is derived from other sources, such as interest, dividends, royalties, net rentals, alimony, child support, or any other source of income regularly received. (Do not include one-time or lump-sum payments such as inheritance or sale of a house.)

DATA ENTRY PROMPT: Principal Source of Income

HELP TEXT: Select the code which indicates the primary source of the client's income.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is required for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical

DESCRIPTION: INCOME, TOTAL FAMILY TOC Index

DEFINITION: The numeric equivalent which represents the amount of total family income as reported before deductions for taxes, bonds, dues or other items.

FIELD NAME: TOTINCOME (TOTINCOM)

FORMAT: Length = 9 2 decimal places
Type = Numeric
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: Total Family Incom:

HELP TEXT: Enter the amount of the total family income as reported before deductions for taxes, bonds, dues or other items.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is required for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical

DESCRIPTION:	JUDGE	TOC Index
DEFINITION:	The name (text) of the Judge issuing the criminal commitment on the client.	
FIELD NAME:	COM_JUDGE (COM_JUDG)	
FORMAT:	Length = 20 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Judge	
HELP TEXT:	Enter, in 20 characters or less, the name of the Judge issuing the criminal commitment on the client.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Legal tracking, Contact Information	

DESCRIPTION:	LAST SCHOOL ATTENDED	TOC Index
DEFINITION:	The name (text) of the last school attended by the client.	
FIELD NAME:	LASTSCHOOL (LASTSCHO)	
FORMAT:	Length = 30 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Last School Attended:	
HELP TEXT:	If the client is a child or youth under the age of 18, in 30 characters or less, enter the name of the last school attended by the client.	

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Contact information

DESCRIPTION:	LEGAL GUARDIAN, ADDRESS	TOC Index
DEFINITION:	The street address (text) of the client's legal guardian.	
FIELD NAME:	GRD_ADDRES	
FORMAT:	Length = 25 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Legal Guardian Address	
HELP TEXT:	Enter, in 25 characters or less, the legal guardian's street address. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	LEGAL GUARDIAN, CITY	TOC Index
DEFINITION:	The city of residence (text) of the client's legal guardian.	
FIELD NAME:	GRD_CITY	
FORMAT:	Length = 20 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Legal Guardian City	
HELP TEXT:	Enter, in 20 characters or less, the legal guardian's city of residence. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	LEGAL GUARDIAN, NAME	TOC Index
DEFINITION:	The name of the person (text) who is the legal guardian of the client.	
FIELD NAME:	GUARDIAN	
FORMAT:	Length = 25 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Legal Guardian Name	
HELP TEXT:	Enter, in 25 characters or less, the full name of the person who is the legal guardian of the client (First Name, MI, Last Name). If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	LEGAL GUARDIAN, PHONE NUMBER TOC Index
DEFINITION:	The telephone number (text) of the client's legal guardian.
FIELD NAME:	GRD_TELE
FORMAT:	Length = 12 Type = Character Popup used = N/A
ALLOWABLE VALUES:	N/A
DATA ENTRY PROMPT:	Legal Guardian Phone - -
HELP TEXT:	Enter the legal guardian's area code and telephone number. If this information is unknown, leave the item blank.
DATA ENTRY EDITS	N/A
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Contact information

DESCRIPTION:	LEGAL GUARDIAN, RELATIONSHIP	TOC Index
DEFINITION:	The relationship (text) of the legal guardian to the client.	
FIELD NAME:	GRD_RELATE	
FORMAT:	Length = 7 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Legal Guardian Relation	
HELP TEXT:	Enter the legal guardian's relationship to the client. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	LEGAL GUARDIAN, STATE	TOC Index
DEFINITION:	The state of residence (text) of the client's legal guardian.	
FIELD NAME:	GRD_STATE	
FORMAT:	Length = 2 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Legal Guardian State	
HELP TEXT:	Enter the 2 letter abbreviation for the legal guardian's state of residence. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact information	

DESCRIPTION:	LEGAL GUARDIAN, ZIP CODE TOC Index
DEFINITION:	The zip code (text) of the client's legal guardian.
FIELD NAME:	GRD_ZIP
FORMAT:	Length = 10 Type = Character Popup used = N/A
ALLOWABLE VALUES:	N/A
DATA ENTRY PROMPT:	Legal Guardian Zip -
HELP TEXT:	Enter the legal guardian's five or nine-digit zip code. If this information is unknown, leave the item blank.
DATA ENTRY EDITS	N/A
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Contact information

DESCRIPTION: LENGTH OF MENTAL DISABILITY TOC Index

DEFINITION: The code which represents, for those clients who are disabled by their psychiatric condition, the length of time for which the disability has existed.

FIELD NAME: LEN_DABLED (LNDABLED)

FORMAT:
Length = 2
Type = Character (Numeric)
Popup used = LENGTH.DBF

ALLOWABLE VALUES:
? Unknown
01 A year or longer - client has been disabled by their psychiatric condition for at least one year.
02 Less than one year - client has been disabled by their psychiatric condition for less than one year.
03 Not Applicable

DATA ENTRY PROMPT: Length Mental Disability:

HELP TEXT: For clients who are disabled by their psychiatric condition, indicate the code for the length of time for which the disability has existed.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION: LENGTH OF STAY, CURRENT TOC Index

DEFINITION: The code which represents the client's current length of stay.

FIELD NAME: N/A

FORMAT: Length = N/A
Type = N/A
Popup used = N/A

ALLOWABLE VALUES: This field will not accept an entry.

DATA ENTRY PROMPT: Patient's Current LOS

HELP TEXT: This field will not accept an entry. It is automatically calculated and displayed.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: N/A

INDICATORS: N/A

REASON FOR COLLECTING: N/A

DESCRIPTION:	LENGTH OF STAY, EXPECTED	TOC Index
DEFINITION:	The numeric equivalent of the amount of days from last client treatment team review date until expected discharge date.	
FIELD NAME:	ELOS	
FORMAT:	Length = 3 Type = Numeric Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Expected LOS from review	
HELP TEXT:	Enter the numeric equivalent of the amount of days from lst client treatment team review date until expected discharge date. This item MAY NOT be left blank after the first treatment team review.	
DATA ENTRY EDITS: 1.	The expected LOS from review cannot be blank after first treatment team review.	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is required for all patient records after first treatment team review.	
REASON FOR COLLECTING:	Decision support data/Statistical, Clinical utility	

DESCRIPTION: LIVING ARRANGEMENT TOC Index

DEFINITION: The code which represents the household composition or living arrangements of the client upon discharge.

FIELD NAME: DC_LIVING (DC_LIVN)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = HOUSEHOL.DBF

ALLOWABLE VALUES:

?	Unknown
01	Adult only - The client is an adult and lives alone.
02	Adult; relatives - The client is an adult and lives with other family members (e.g., spouse, children, etc.).
03	Adult; non-relatives - The client is an adult and does not live with family members (e.g., lives with friends, in an institutional environment, etc.).
04	Child; both parents - The client is a child, lives with both parents.
05	Child; one parent - The client is a child and lives with only one of his/her parents.
06	Child; relatives, not parents - The client is a child and lives with family members other than his/her parents (e.g., lives with an uncle, sister, etc.).
07	Child; foster family - The client is a child, lives in a foster care family.
08	Child; non-relatives - The client is a child and doesn't live with family members (e.g., lives with friends, an institutional setting, etc.).

DATA ENTRY PROMPT: Living Arrangement:

HELP TEXT: Enter the code which best indicates the household composition or living arrangements of the client upon discharge.

DATA ENTRY EDITS 1. Living Arrangement at Discharge must be "03 Adult; non-relatives" or "08 Child; non-relatives" if Housing is "03 Nursing Home/Care Facility", "04 Residential Hotel", "06 Group Home/Halfway House", "07 Supervised Apartment", "08 Board and Care", "09 Jail/Prison/Training Institute" or "10 Hospital".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION: MEDICAID, ELIGIBILITY BEGAN TOC Index

DEFINITION: The numeric equivalent of the month, date and year that the client's Medicaid eligibility began.

FIELD NAME: CAIDBEG

FORMAT: MMDDYYYY
Length = 8
Type = Date
Popup used = N/A

ALLOWABLE VALUES: MM=Month (01-12)
DD=Day (01-31)
YYYY=Year (e.g., 1991)
A valid date must be entered (e.g., 02/30/1993 is not a valid date).

DATA ENTRY PROMPT: Medicaid # Eligibility Began / /

HELP TEXT: Enter the numeric equivalent of the month, date and year of the date that the client's Medicaid eligibility began, if appropriate. If the client has a current card, you may use the Date of Admission. If client is not eligible, or if this information is unknown, leave the item blank.

Because the date of admission may be used, this date is not to be used to determine medicaid availability for billing purposes; each date of service will continue to need to be checked according to federal requirements.

DATA ENTRY EDITS: 1. If there is no eligibility, this data element will be blank.
2. If Date Medicaid Eligibility Began is completed THEN Medicaid Number must be completed.

MISSING DATA LOGIC N/A

INDICATORS: This data element is required for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Billing

DESCRIPTION: MEDICAID, ELIGIBILITY ENDED TOC Index

DEFINITION: The numeric equivalent of the month, date and year that the client's Medicaid eligibility ended.

FIELD NAME: CAIDEND

FORMAT: MMDDYYYY
Length = 8
Type = Date
Popup used = N/A

ALLOWABLE VALUES: MM=Month (01-12)
DD=Day (01-31)
YYYY=Year (e.g., 1991)
A valid date must be entered (e.g., 02/30/1993 is not a valid date).

DATA ENTRY PROMPT: Medicaid # Eligibility Ended / /

HELP TEXT: Enter the numeric equivalent of the month, date and year of the date that the client's Medicaid eligibility ended, if appropriate. If client is not eligible, or if this information is unknown, leave the item blank.

DATA ENTRY EDITS: 1. This date may not be earlier than the Date Medicaid Eligibility Began.
2. If this data element is not needed, it is to be left blank.
3. If Date Medicaid Eligibility Ended is completed, then Medicaid Number and Date Medicaid Eligibility Began must be completed.

MISSING DATA LOGIC: N/A

INDICATORS: This data element is required for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Billing

DESCRIPTION:	MEDICAID, NUMBER	TOC Index
DEFINITION:	The client's Medicaid number, if appropriate (text).	
FIELD NAME:	MEDCAID	
FORMAT:	Length = 14 Type = Character (Numeric) Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Medicaid # Medicaid Number:	
HELP TEXT:	Enter the client's Medicaid number, if appropriate. If client is not eligible, or if this information is unknown, leave the item blank.	
DATA ENTRY EDITS	1. If Source of Payment is "05 Medicaid" THEN Medicaid Number must be entered. 2. If Medicaid Number is completed THEN Date Medicaid Eligibility must be completed.	
MISSING DATA LOGIC	N/A	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	MHSIP, Billing	

DESCRIPTION: MEDICARE, ELIGIBILITY BEGAN TOC Index

DEFINITION: The numeric equivalent of the month, date and year that the client's Medicare eligibility began.

FIELD NAME: CAREBEG

FORMAT: MMDDYYYY
Length = 8
Type = Date
Popup used = N/A

ALLOWABLE VALUES: MM=Month (01-12)
DD=Day (01-31)
YYYY=Year (e.g., 1991)
A valid date must be entered (e.g., 02/30/1993 is not a valid date).

DATA ENTRY PROMPT: Medicare # Eligibility Began / /

HELP TEXT: Enter the numeric equivalent of the month, date and year of the date that the client's Medicare eligibility began, if appropriate. If client has a current care, you may use the Date of Admission. If client is not eligible, or if this information is unknown, leave the item blank.

DATA ENTRY EDITS: 1. If there is no eligibility, this data element will be blank.
2. If Date Medicare Eligibility Began is completed THEN Medicare Number must be completed.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Billing

DESCRIPTION: MEDICARE, ELIGIBILITY ENDED TOC Index

DEFINITION: The numeric equivalent of the month, date and year that the client's Medicare eligibility ended.

FIELD NAME: CAREEND

FORMAT: MMDDYYYY
Length = 8
Type = Date
Popup used = N/A

ALLOWABLE VALUES: MM=Month (01-12)
DD=Day (01-31)
YYYY=Year (e.g., 1991)
A valid date must be entered (e.g., 02/30/1993 is not a valid date).

DATA ENTRY PROMPT: Medicare # Eligibility Ended / /

HELP TEXT: Enter the numeric equivalent of the month, date and year of the date that the client's Medicare eligibility ended, if appropriate. If client is not eligible, or if this information is unknown, leave the item blank.

DATA ENTRY EDITS: 1. This date may not be earlier than the Date Medicare Eligibility Began.
2. If this data element is not needed, it is to be left blank.
3. If Date Medicare Eligibility Ended is completed, then Medicare Number and Date Medicare Eligibility Began must be completed.

MISSING DATA LOGIC: N/A

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Billing

DESCRIPTION:	MEDICARE, NUMBER	TOC Index
DEFINITION:	The client's Medicare number, if appropriate (text).	
FIELD NAME:	MEDICARE	
FORMAT:	Length = 14 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Medicare # Medicare Number:	
HELP TEXT:	Enter the client's Medicare number, if appropriate. If client is not eligible, or if this information is unknown, leave the item blank.	
DATA ENTRY EDITS	1. If Source of Payment is "04 Medicare" THEN Medicare Number must be entered. 2. If Medicare Number is completed THEN Date Medicare Eligibility must be completed.	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	MHSIP, Billing	

DESCRIPTION:	MOTHER, ADDRESS	TOC Index
DEFINITION:	The street address (text) of the client's mother.	
FIELD NAME:	MOTHER_ADD	
FORMAT:	Length = 35 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Mother's Address	
HELP TEXT:	Enter, in 35 characters or less, the mother's street address. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact Information	

DESCRIPTION:	MOTHER, CITY	TOC Index
DEFINITION:	The city of residence (text) of the client's mother.	
FIELD NAME:	MOTHERCITY	
FORMAT:	Length = 20 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Mother's City	
HELP TEXT:	Enter, in 20 characters or less, the mother's city of residence. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact Information	

DESCRIPTION:	MOTHER, NAME	TOC Index
DEFINITION:	The name of the mother (text) of the client.	
FIELD NAME:	MOTHER	
FORMAT:	Length = 25 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Mother's Name	
HELP TEXT:	Enter, in 25 characters or less, the full name of the client's mother (First Name, MI, Last Name). If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact Information	

DESCRIPTION:	MOTHER, OCCUPATION	TOC Index
DEFINITION:	The occupation (text) of the client's mother.	
FIELD NAME:	MOTHER_OCC	
FORMAT:	Length = 15 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Mother's Occupation	
HELP TEXT:	Enter mother's occupation. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact Information	

DESCRIPTION:	MOTHER, PHONE NUMBER	TOC Index
DEFINITION:	The telephone number (text) of the client's mother.	
FIELD NAME:	MOTHR_PHON	
FORMAT:	Length = 12 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Mother's Phone - -	
HELP TEXT:	Enter the mother's area code and telephone number. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact Information	

DESCRIPTION:	MOTHER, STATE	TOC Index
DEFINITION:	The state of residence (text) of the client's mother.	
FIELD NAME:	MOTHER_ST	
FORMAT:	Length = 2 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Mother's State	
HELP TEXT:	Enter the 2 letter abbreviation for the mother's state of residence. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Contact Information	

DESCRIPTION:	MOTHER, ZIP CODE TOC Index
DEFINITION:	The zip code (text) of the client's mother.
FIELD NAME:	MOTHER_ZIP
FORMAT:	Length = 10 Type = Character Popup used = N/A
ALLOWABLE VALUES:	N/A
DATA ENTRY PROMPT:	Mother's Zip -
HELP TEXT:	Enter the mother's five or nine-digit zip code. If this information is unknown, leave the item blank.
DATA ENTRY EDITS	N/A
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	Contact Information

DESCRIPTION:	NUMBER OF DEPENDENTS	TOC Index
DEFINITION:	The numeric equivalent which represents the number of persons in the client's family dependent on the household income as accepted by the Internal Revenue Service (IRS) for federal income tax purposes.	
FIELD NAME:	NOFAMILY	
FORMAT:	Length = 2 Type = Numeric Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Number of Dependents	
HELP TEXT:	Enter the number of persons in the client's family dependent on the household income as accepted by the Internal Revenue Service (IRS) for federal income tax purposes. Because the minimum number that may be entered is 01, a minor client – even though reported on someone else's income tax – is coded as 01.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	MHSIP, Billing	

DESCRIPTION: NUMBER OF DRUG TREATMENT EPISODES TOC Index

DEFINITION: The code which represents the category for the number of prior treatment episodes in any drug or alcohol treatment program.

FIELD NAME: DRUG_EPISO (DR_EPISO)

FORMAT: Length = 1
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:

0 None/zero times - The client or a credible collateral reports no previous treatment services for this substance.

1 One time - The client or a credible collateral reports one previous episode of treatment for substance use/abuse, whether inpatient, outpatient, or residential from some public or private chemical dependency program.

2 Two times - The client or a credible collateral reports two previous episodes of treatment for substance use/abuse, whether inpatient, outpatient, or residential from some public or private chemical dependency program.

3 Three times - The client or a credible collateral reports three previous episodes of treatment for substance use/abuse, whether inpatient, outpatient, or residential from some public or private chemical dependency program.

4 Four times - The client or a credible collateral reports four previous episodes of treatment for substance use/abuse, whether inpatient, outpatient, or residential from some public or private chemical dependency program.

5 Five or more times - The client or a credible collateral reports five or more previous episodes of treatment for substance use/abuse, whether inpatient, outpatient, or residential from some public or private chemical dependency program.

DATA ENTRY PROMPT: Number of drug treatment episodes:

HELP TEXT: Enter the code which represents the category for the number of prior treatment episodes in any drug or alcohol treatment program. If the client has ever been treated in another chemical dependency or substance abuse program, including those in mental hospitals, general hospitals, or VA hospitals, the user should enter the number of times the client has received prior treatment. NOTE: If it is known that the client has been through treatment before, but the exact number of times is not known, give the best estimate.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: Substance abuse history, Clinical utility

DESCRIPTION:	NUMBER OF PREVIOUS ADMISSIONS TO THIS FACILITY TOC Index
DEFINITION:	The code which represents the number of previous admissions by this client to this facility.
FIELD NAME:	PREV_ADM
FORMAT:	Length = 2 Type = Numeric Popup used = N/A
ALLOWABLE VALUES:	N/A
DATA ENTRY PROMPT:	# of Prev. Admits Prev. Admissions
HELP TEXT:	Enter the number of previous admissions of this client to this facility; Or, if user admits client from the Patient Selection Screen containing patients who have been previously admitted and discharged from the facility, this field is automatically updated when a client is readmitted.
DATA ENTRY EDITS: N/A	
MISSING DATA LOGIC:	N/A
INDICATORS:	N/A
REASON FOR COLLECTING:	Decision support data/Statistical

DESCRIPTION: PAPERWORK COMPLETED FOR ADMISSION TOC Index

DEFINITION: The code which represents the whether the client's paperwork regarding admission is complete.

FIELD NAME: READY_ADM (READYADM)

FORMAT: Length = 1
Type = Logical
Popup used = N/A

ALLOWABLE VALUES:
Y YES, all documents are prepared for client's admission to this facility.
N NO, client's paperwork is incomplete pending further information regarding client.

DATA ENTRY PROMPT: Is Patient's Paperwork prepared for admission:

HELP TEXT: Enter the choice that reflects whether client's paperwork regarding admission is complete. This item is used for clients who are placed on waiting lists for admission.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING:

DESCRIPTION:	PARISH OF LEGAL COMMITMENT	TOC Index
DEFINITION:	The code which represents the parish that is the legal domicile of the court which committed the client to this facility.	
FIELD NAME:	COMI_PARISH (COMI_PARI)	
FORMAT:	Length = 2 Type = Character (Numeric) Popup used = CODES.DBF	
ALLOWABLE VALUES:	Refer to popup for values.	
DATA ENTRY PROMPT:	Parish of Commitment:	
HELP TEXT:	Select the appropriate 2-digit code for the parish that is the legal domicile of the court which committed the client to this hospital. The user will be prompted for entry only if the client's LEGAL STATUS identifies him/her as being admitted under circumstances other than voluntary. Codes are available in the popup.	
DATA ENTRY EDITS: 1.	The parish of commitment cannot be blank if the client's legal status is other than voluntary.	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Legal tracking	

DESCRIPTION:	PARISH OF RESIDENCE	TOC Index
DEFINITION:	The code which represents the parish of the client's residence.	
FIELD NAME:	ORGPARISH (PARISH)	
FORMAT:	Length = 2 Type = Character Popup used = CODES.DBF	
ALLOWABLE VALUES:	Refer to popup for values.	
DATA ENTRY PROMPT:	Resident Parish:	
HELP TEXT:	Select the appropriate 2-digit code for the parish of the client's residence. For clients whose residence is out-of-state, list the Parish of Origin/location of referring agency. Note: This will be used to identify region for the bed allocation process. MANDATORY FIELD: This field may not be left blank at admission. Codes are available in the popup.	
DATA ENTRY EDITS: 1.	The resident parish cannot be blank.	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is required for all patient records.	
REASON FOR COLLECTING:	Demographics	

DESCRIPTION:	PATIENT, ADDRESS	TOC Index
DEFINITION:	The street address (text) of the client.	
FIELD NAME:	STADDRESS	
FORMAT:	Length = 25 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Street Address:	
HELP TEXT:	Enter, in 25 characters or less, the client's street address. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Billing, Contact information	

DESCRIPTION:	PATIENT, BIRTHPLACE	TOC Index
DEFINITION:	The city and state (text) of the client's place of birth.	
FIELD NAME:	BIRTHPLACE	
FORMAT:	Length = 15 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Place of Birth:	
HELP TEXT:	Enter, in 15 characters or less, the city and state of the client's place of birth. If the client was born outside of the USA, add the country of birth. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Demographics	

DESCRIPTION:	PATIENT, CITY	TOC Index
DEFINITION:	The city of residence (text) of the client.	
FIELD NAME:	CITY	
FORMAT:	Length = 20 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	City:	
HELP TEXT:	Enter, in 20 characters or less, the client's city of residence. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Billing, Contact information	

DESCRIPTION:	PATIENT, NAME, FIRST	TOC Index
DEFINITION:	The first name (text) of the client.	
FIELD NAME:	FNAME	
FORMAT:	Length = 15 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	First:	
HELP TEXT:	Enter, in 15 characters or less, the client's first name. MANDATORY FIELD: This field may not be left blank at admission.	
DATA ENTRY EDITS: 1.	The first name of patient cannot be blank.	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is required for all patient records.	
REASON FOR COLLECTING:	Billing	

DESCRIPTION:	PATIENT, NAME, LAST	TOC Index
DEFINITION:	The last name (text) of the client.	
FIELD NAME:	LNAME	
FORMAT:	Length = 20 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Last:	
HELP TEXT:	Enter, in 20 characters or less, the client's last name. MANDATORY FIELD: This field may not be left blank at admission.	
DATA ENTRY EDITS: 1.	The last name of patient cannot be blank.	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is required for all patient records.	
REASON FOR COLLECTING:	Billing	

DESCRIPTION:	PATIENT, NAME, MIDDLE INITIAL	TOC Index
DEFINITION:	The initial (text) of the client's middle name.	
FIELD NAME:	MID_INIT	
FORMAT:	Length = 1 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Mid Initial:	
HELP TEXT:	Enter the client's middle initial.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is required for all patient records.	
REASON FOR COLLECTING:	Billing	

DESCRIPTION:	PATIENT, PHONE NUMBER	TOC Index
DEFINITION:	The telephone number (text) of the client.	
FIELD NAME:	TELEPHONE	
FORMAT:	Length = 12 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Telephone: - -	
HELP TEXT:	Enter the client's area code and telephone number. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Billing, Contact information	

DESCRIPTION:	PATIENT, STATE	TOC Index
DEFINITION:	The state of residence (text) of the client.	
FIELD NAME:	STATE	
FORMAT:	Length = 2 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	State:	
HELP TEXT:	Enter the two letter abbreviation for the client's state of residence. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Billing, Demographics, Contact information	

DESCRIPTION:	PATIENT, ZIP CODE	TOC Index
DEFINITION:	The zip code (text) of the client.	
FIELD NAME:	ZIP	
FORMAT:	Length = 10 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Zip: -	
HELP TEXT:	Enter the client's five or nine-digit zip code. If this information is unknown, leave the item blank.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	MHSIP, Billing, Demographics, Contact information	

DESCRIPTION: PAYMENT, SOURCE OF TOC Index

DEFINITION: The code which represents the primary, secondary and tertiary source(s) of payment.

FIELD NAME: FISSTAT, FISSTAT2, FISSTAT3

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = FISCODE.DBF

ALLOWABLE VALUES:
00 None
01 No Fee Payment - Based upon the DHH Liability Limitation Schedule, no fee is to be charged to the client.
02 Private/Personal - The fee (in total or in part) will be paid from the client's personal income or that of the client's household.
03 Private Health Insurance - The fee (in total or in part) will be paid by the client's personal insurance carrier in accordance with the specifications of the policy.
04 Medicare - The fee (in total or in part) will be paid by insurance provided through Social Security or Railroad Retirement.
05 Medicaid - The fee (in total or in part) will be paid by the Title XIX program.
06 VA - The fee (in total or in part) will be paid by the Veteran's Administration.
07 CHAMPUS - The fee (in total or in part) will be paid by insurance provided by the Civilian Health and Military Personnel Uniformed Services.
08 Other Public Sources - The fee (in total or in part) will be paid by another organization, including Workman's Compensation.

DATA ENTRY PROMPT: Primary Source of Payment
Secondary Source of Payment
Tertiary Source of Payment

HELP TEXT: Select the appropriate code(s) from the Popup menu that represents the source(s) of payment for the client's account.

DATA ENTRY EDITS:
1. Only codes not entered into Primary Source of Payment will be allowed as Secondary Source of Payment.
2. Only codes not entered into Primary and Secondary Source of Payment will be allowed as Tertiary Source of Payment.
3. If Source of Payment is "01 No Fee Payment" THEN Amount of Fee must be 0000.
4. If Source of Payment is "01 No Fee Payment" THEN no other payment source may be entered.
5. If Source of Payment is "02 Personal Resources" THEN amount of Fee must be greater than 0000.
6. If Source of Payment is "04 Medicare" THEN Medicare Number AND Date Medicare Eligibility Began must be entered.
7. If Source of Payment is "04 Medicare" THEN an additional payment source may be "02 Personal Resources".
8. If Source of Payment is "05 Medicaid" THEN Medicaid Number AND Date Medicaid Eligibility Began must be entered.
9. If Source of Payment is "05 Medicaid" THEN "01 No Fee Payment" or "02 Personal Resources" cannot be entered as additional payment sources.
10. If Source of Payment is "06 VA" THEN VA Number AND Date Eligibility Began must be completed and Veteran's Eligibility must be "01 Is Qualified" or "03 Is A Qualified Dependent".
11. If Source of Payment is not "06 VA" THEN VA Number AND Date Eligibility Began may not be completed.
12. If Source of Payment is "07 CHAMPUS" THEN "01 No Fee Payment" cannot be entered as an additional payment source.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Billing, Demographics

DESCRIPTION: PERSON HANDLING CHART TOC Index

DEFINITION: The name of the person (text) handling the client's chart.

FIELD NAME: DCHANDLED (DCHANDLE)

FORMAT: Length = 25
Type = Character
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: Person Handling Chart:

HELP TEXT: Enter the name of the person handling the client's chart.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING:

DESCRIPTION:	PHYSICIAN, ADMITTING	TOC Index
DEFINITION:	The code which represents the admitting physician who provided the diagnosis.	
FIELD NAME:	ATTD_PHYS (ATTPHYS1)	
FORMAT:	Length = 4 Type = Character Popup used = STAFF.DBF	
ALLOWABLE VALUES:	Refer to popup for values.	
DATA ENTRY PROMPT:	Admitting Physician:	
HELP TEXT:	Select the code to identify the admitting physician who provided the diagnosis. Refer to the popup for staff codes. Staff Codes: Hospitals and Acute units will be responsible for maintaining staffing codes in the popup database file. Members of the Admissions Staff, Social Workers, physicians and those staff members who determine the disposition of potential clients will each be assigned a four-digit provider code.	
DATA ENTRY EDITS: 1.	Only those codes representing members of the facility's clinical staff may be selected.	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	MHSIP, Billing	

DESCRIPTION:	PHYSICIAN, DISCHARGING	TOC Index
DEFINITION:	The code which represents the physician who provided the discharging diagnosis.	
FIELD NAME:	ATTD_PHYS3 (ATTPHYS3)	
FORMAT:	Length = 4 Type = Character Popup used = STAFF.DBF	
ALLOWABLE VALUES:	Refer to popup for values.	
DATA ENTRY PROMPT:	Discharging Phys: Dx Physician:	
HELP TEXT:	Select the code to identify the physician who provided the discharging diagnosis. Refer to the popup for staff codes. Staff Codes: Hospitals and Acute units will be responsible for maintaining staffing codes in the popup database file. Members of the Admissions Staff, Social Workers, physicians and those staff members who determine the disposition of potential clients will each be assigned a four-digit provider code.	
DATA ENTRY EDITS: 1.	Only those codes representing members of the facility's clinical staff may be selected.	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	MHSIP, Billing	

DESCRIPTION:	PHYSICIAN, TREATING/ATTENDING TOC Index
DEFINITION:	The code which represents the physician who provided the diagnosis under each of the circumstances.
FIELD NAME:	ATTD_PHYS2 (ATTPHYS2)
FORMAT:	Length = 4 Type = Character Popup used = STAFF.DBF
ALLOWABLE VALUES:	Refer to popup for values.
DATA ENTRY PROMPT:	Treating Physician: Tx Physician:
HELP TEXT:	Select the code to identify the physician who provided the diagnosis under each of the circumstances. Refer to the popup for staff codes. Staff Codes: Hospitals and Acute units will be responsible for maintaining staffing codes in the popup database file. Members of the Admissions Staff, Social Workers, physicians and those staff members who determine the disposition of potential clients will each be assigned a four-digit provider code.
DATA ENTRY EDITS: 1.	Only those codes representing members of the facility's clinical staff may be selected.
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	MHSIP, Billing

DESCRIPTION: PREGNANT TOC Index

DEFINITION: The code which represents whether the client believes she is pregnant at the time of admission.

FIELD NAME: PREGNANT

FORMAT: Length = 1
Type = Logical (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
Y YES, client believes she is pregnant at the time of admission.
N NO, client does not believe she is pregnant at the time of admission.

DATA ENTRY PROMPT: Pregnant:

HELP TEXT: Specify, by "Y" or "N" is the client believes she is pregnant at the time of admission. If the client is male, this field is automatically set to "N".

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: N/A

INDICATORS: This data element is required for all female patient records.

REASON FOR COLLECTING: Substance abuse history, Decision support data/Statistical, Clinical utility

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - ABUSE/RAPE VICTIM TOC Index

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: RAPE (PP_rape)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Abuse/Rape Victim

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:
a. Client was physically assaulted, contributing to current psychological difficulties.
b. Client was sexually abused, contributing to current psychological difficulties.

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical, Clinical utility

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - ALCOHOL USE TOC Index

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: ALCOHOL (PP_alcoh)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Alcohol use:

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:

a. Problem in control of use of alcohol as indicated by: need for use of alcohol to escape stress or maintain adequate functioning; occasional consumption of excessive amounts of alcohol (e.g., fifth of spirits or its equivalent in wine or beer); binges (remaining intoxicated throughout the day for at least two days); inability to stop or reduce drinking despite consequences to physical health, or to social or occupational functioning.

b. Tolerance: need for markedly increased amounts of the substance to achieve the desired effect, or markedly diminished effect with regular use of the same amount, and/or

c. Withdrawal: development of withdrawl symptoms (e.g., "shakes", nausea and vomiting, malaise, or weakness) after cessation of reduction in substance use.

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Substance abuse history, Decision support data/Statistical, Clinical utility

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - CRIMINAL INVOLVEMENT Index TOC

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: CRIMINAL (PP_crim)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Criminal Involvement:

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:
a. Legal action is pending involving the client. This is not to include mental health/substance abuse commitment.
b. Illegal and/or anti-social acts by the client involving property (e.g., vandalism, breaking and entering, fire setting).
c. Illegal and or anti-social acts by the client involving other people (e.g., rape, mugging, assault, robbery).

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Legal tracking, Decision support data/Statistical

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - DRUG USE TOC Index

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: DRUGS (PP_drugs)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Drug use:

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:

a. Problem is control of uses of substance as indicated by: need for use of substance to escape stress or maintain adequate functioning; occasional consumption of excessive amounts of substance; binges (remaining intoxicated throughout the day for at least two days); inability to stop or reduce substance use despite consequences to physical health, or to social or occupational functioning.

b. Tolerance: need for markedly increased amounts of the substance to achieve the desired effect, or markedly diminished effect with regular use of the same amount, and/or

Withdrawal: development of withdrawal symptoms (e.g., "shakes", nausea and vomiting, malaise, or weakness) after cessation of or reduction in substance use.

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Substance abuse history, Decision support data/Statistical

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - EATING DISORDER TOC Index

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: EATING (PP_eatin)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Eating Disorder:

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:
a. Client's nutrition (dietary balance, vitamin intake, etc.) or weight (gain or loss) are in need of correction. May include anorexia nervosa or bulimia.

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, , Decision support data/Statistical, Clinical utility

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - GRAVELY DISABLED TOC Index

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: DISABLED (PP_dable)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Gravely Disabled:

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:
a. A condition in which the client cannot survive independently as the result of mental or combined mental and physical problems. Client is likely to require psychiatric hospitalization, detoxification, or other protective environment.

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - MARITAL PROBLEM TOC Index

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: FAMILY (PP_famly)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Marital Problem:

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:
a. Physically assaultive or destructive behavior among family members.
b. Adult: An interpersonal difficulty of the client involving spouse, mate or primary partner (legal or common-law).
Child: An interpersonal difficulty of the child involving the parent(s) or guardian(s).
c. Adult: An interpersonal difficulty of the client involving children, parents, siblings, and/or close family members.
Child: An interpersonal difficulty of the child involving siblings and/or close family members other than parent(s) or guardian(s).

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical, Clinical utility

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - MEDICAL/SOMATIC TOC Index

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: MEDICAL (PP_medic)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Medical/Somatic:

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:
a. Any non-psychiatric illness/injury (e.g., broken bones, flu, mumps) of short duration, current, or during past three (3) weeks.
b. Any non-psychiatric illness/injury (e.g., diabetes, glaucoma) of long or potentially long duration which needs to be controlled or contained.
c. A physical condition (e.g., loss of limb or sensory modality) which produces a permanent loss of normal functioning.
d. Disturbance in frequency, amount, or patterning of sleep (e.g., insomnia, nightmares, sleep-walking).

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical, Clinical utility

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - MOOD DISORDER TOC Index

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: MOOD (PP_mood)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Mood Disorder:

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:
a. Lowered initiative, inaccessible to stimulation; gloomy, bleak outlook.
b. Distress or agitation resulting from concern about something impending or anticipated.
c. Unpleasant sensations associated with anticipation or awareness of danger. A phobia is an exaggerated, usually inexplicable and illogical fear of a particular object or class of objects.
d. Feels of no use or value to self or others; low self esteem.
e. Jumpy, jittery, taut; easily excited or irritated.
f. Wide or dramatic shifts or swings from elated/euphoric to depressed/sad.
g. A deep and pervasive sense of insecurity and dissatisfaction arising from unresolved problems.
h. Intense displeasure; rage, fury; irate, wrathful.
i. A sense of having committed some breach of conduct; recrimination, blaming, fault-finding with self.
j. Feelings of isolation, solitary desolation.
k. A sense of lack of challenge, stimulation or change; unmotivated.
l. Lack of responsiveness, especially in social relations; removal of self from daily experiences and conflicts (e.g., distant, aloof or cold).
m. Actively hostile, quarrelsome, contentious.
n. Excessive movement, animation (e.g., pacing, incessant talking, excessive running, difficulty keeping seated.

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical, Clinical utility

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - PROBLEMS W/ DAILY ACTIVITIES TOC Index

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: DAY_ACT (PP_daily)

FORMAT:
Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Problems w/ daily activities:

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:
a. Frequent/extended/unexplained/unapproved absence from the job, school or training program.
b. Fails to meet expectations for job, school, or training program.
c. Presently unable to/won't perform duties on job, in school, or in training program due to illness, lack of skills, lack of motivation, or for other personal reasons.
d. Suspended/terminated from job or suspended/expelled from school or training program.
e. Disruptive behavior on the job, in school, or in training program.
f. Problem in maintaining hygiene, diet, or clothing according to age appropriate expectations, given the financial support available.
g. Problem in finding satisfying leisure time activities.
h. Problems in performance of general household duties, such as housekeeping or home maintenance, budgeting finances or paying bills, shopping for groceries or supplies, or preparation of meals for self and/or family.
i. Problems in performance of child care and/or child management, such as caring for child's physical, social, and emotional well being, and providing for appropriate discipline of behavior.
j. Unable to obtain sufficient and health-sustaining food, adequate clothing, public or private transportation, or decent shelter in an age appropriate manner and independent of finances.
k. Unable to obtain sufficient money for living expenses.
l. Behavior strikingly out of the ordinary for age, sex, culture (e.g., odd, eccentric).
m. Counteracting, opposing, withstanding the force or effect of something or someone; can be either active or passive (e.g., provocative resistance or opposition to authority, temper tantrums, stubbornness, passive aggressive behavior).

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical, Clinical utility

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - RUNAWAY BEHAVIOR TOC Index

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: RUNAWAY (PP_runaw)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Runaway Behavior:

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:
a. Unauthorized physical departure or elopement, possibly being a status offense (e.g., run away from home, elope from facility).

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Legal tracking, Decision support data/Statistical, Clinical utility

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - SERIOUS IMPAIRMENT TOC Index

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: S_IMPAIR (PP_mpair)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Serious Impairment:

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:
a. Impairment of functioning (compared to others of the same age) in one or more major roles (e.g., school, family, interpersonal relations, self care, etc.). Immediate intervention is necessary to prevent further disabling effects on the individual.

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical, Clinical utility

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - SOCIAL/INTERPERSONAL Index TOC

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: SOCIAL (PP_socia)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Social/Interpersonal:

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:
a. The client does not consider ordinary societal controls as personally applicable (e.g., traffic signs, violation of school rules, truancy, etc.).
b. Deliberate lying, cheating, and/or fraud, even though not always criminal.
c. An interpersonal problem of the client's involving other than close family.
d. Lack of or difficulty mastering dress, presentation, manners, verbal expression, and any factors associated with successful interactions with other people.
e. Has difficulty making friends, developing close relationships or is so unselective in making friends that client is taken advantage of.
f. Difficulty keeping desired friends or relationships.
g. Any problem connected in some way with sex or sexuality.
h. Illegal and/or anti-social acts by the client involving property (e.g., vandalism, breaking and entering, fire-setting).
i. Illegal and/or anti-social acts by the client involving other people (e.g., rape, mugging, assault, robbery).
j. Deliberately plays upon or controls others by deceptive or unfair means, usually to the client's own advantage; manipulative.
k. Behavior strikingly out of the ordinary for age, sex, culture (e.g., odd, eccentric).
l. Counteracting, opposing, withstanding the force or effect of something or someone; can be either active or passive (e.g., provocative resistance or opposition to authority, temper tantrums, stubbornness, passive aggressive behavior).

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical, Clinical utility

DESCRIPTION: PRESENTING PROBLEMS ON ADMISSION - THOUGHT DISORDER Index
TOC

DEFINITION: The code which represents whether or not this is a presenting problem at the time of admission.

FIELD NAME: THOUGHT (PP_thoug)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
1 Yes, this is a presenting problem
2 No, this is not a presenting problem
3 Don't know if this is a presenting problem
4 Not Applicable

DATA ENTRY PROMPT: Thought Disorder:

HELP TEXT: Enter the code that best indicates whether or not this is a presenting problem at the time of admission.

YES, this is a presenting problem including conditions such as the following:
a. Has loss of recent or remote memory, forgetfulness (e.g., amnesia, "blackouts"); difficulty concentrating, focusing, or sustaining attention.
b. Has difficulty in conceptualizing or understanding; limited intellectual capacity.
c. Uses words, phrases, ideas that perseverate; has obsessive thoughts.
d. Is overly wary, lacks confidence in others, questions their motives, doubts their reasons (e.g., guarded, secretive, hypervigilant).
e. Thinks actions or thoughts by others have reference to self in the absence of clear evidence.
f. Has perceptions which appear real to the client but are not supported by objective stimuli or social consensus; basis may be organic or functional.
g. Unshakable, false belief(s) held in the face of evidence normally sufficient to destroy that belief (e.g., delusions of grandiosity or persecution, religious or somatic delusions).
h. Persistent, pervasive, or frequently repeated actions (e.g., compulsive acts, ritualistic behaviors).

DATA ENTRY EDITS 1. Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical, Clinical utility

DESCRIPTION:	PRESENTING PROBLEMS ON ADMISSION - VIOLENT/DANGEROUS TO OTHERS	Index TOC
DEFINITION:	The code which represents whether or not this is a presenting problem at the time of admission.	
FIELD NAME:	VIOLENT (PP_viole)	
FORMAT:	Length = 2 Type = Character (Numeric) Popup used = N/A	
ALLOWABLE VALUES:	1 Yes, this is a presenting problem 2 No, this is not a presenting problem 3 Don't know if this is a presenting problem 4 Not Applicable	
DATA ENTRY PROMPT:	Violent to Others:	
HELP TEXT:	Enter the code that best indicates whether or not this is a presenting problem at the time of admission. YES, this is a presenting problem including conditions such as the following: a. In association with mental health/substance abuse problems, the client shows potential for assaultiveness, homicide, or other acts of violence directed toward other people.	
DATA ENTRY EDITS 1.	Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	MHSIP, Decision support data/Statistical, Clinical utility	

DESCRIPTION:	PRESENTING PROBLEMS ON ADMISSION - VIOLENT/DANGEROUS TO SELF	Index TOC
DEFINITION:	The code which represents whether or not this is a presenting problem at the time of admission.	
FIELD NAME:	SUICIDE (PP_sucid)	
FORMAT:	Length = 2 Type = Character (Numeric) Popup used = N/A	
ALLOWABLE VALUES:	1 Yes, this is a presenting problem 2 No, this is not a presenting problem 3 Don't know if this is a presenting problem 4 Not Applicable	
DATA ENTRY PROMPT:	Violent to Self:	
HELP TEXT:	Enter the code that best indicates whether or not this is a presenting problem at the time of admission. YES, this is a presenting problem including conditions such as the following: a. In association with mental health/substance abuse problems, client shows the potential to display suicidal or self-mutilating behavior.	
DATA ENTRY EDITS 1.	Presenting Problems On Admission must have at least one Presenting Problem (at least one problem must equal "1 Yes").	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	MHSIP, Decision support data/Statistical, Clinical utility	

DESCRIPTION: PRIOR MENTAL HEALTH SERVICE, INPATIENT TOC Index

DEFINITION: The code which represents the client's previous history of inpatient mental health service(s).

FIELD NAME: IN_MH_PAT (IN_MHPAT)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = MHSERV.DBF

ALLOWABLE VALUES:

?	Unknown
00	None - The client has never received inpatient mental health services.
01	Within last day - The client has received some type of inpatient mental health service(s), with the most recent service occurring on this date.
02	Within last 7 days - The client has received some type of inpatient mental health service(s), with the most recent service occurring within the last 7 days.
03	Within last 30 days - The client has received some type of inpatient mental health service(s), with the most recent service occurring within the last 30 days.
04	Within last 6 months - The client has received some type of inpatient mental health service(s), with the most recent service occurring within the last 6 months.
05	Within last year - The client has received some type of inpatient mental health service(s), with the most recent service occurring within the last year.
06	Over one year ago - The client has received some type of inpatient mental health service(s), with the most recent service occurring over a year ago.

DATA ENTRY PROMPT: Inpatient MH Service:

HELP TEXT: Select the code that represents the client's previous history of inpatient mental health service(s). Inpatient service is defined as 24-hour hospitalization, and the provisions of such service (if any) could have been by any mental health agency, organization, or practitioner.

DATA ENTRY EDITS 1. Prior Inpatient MH Service cannot be "00 None" if Date of Last Discharge from this Hospital is completed.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION: PRIOR MENTAL HEALTH SERVICE, NON-INPATIENT TOC Index

DEFINITION: The code which represents the client's previous history of non-inpatient mental health service(s).

FIELD NAME: NI_MH_PAT (NI_MHPAT)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = MHSERV.DBF

ALLOWABLE VALUES:

?	Unknown
00	None - The client never received non-inpatient mental health services.
01	Within last day - The client has received some type of non-inpatient mental health service(s), with the most recent service occurring on this date.
02	Within last 7 days - The client has received some type of non-inpatient mental health service(s), with the most recent service occurring within the last 7 days.
03	Within last 30 days - The client has received some type of non-inpatient mental health service(s), with the most recent service occurring within the last 30 days.
04	Within last 6 months - The client has received some type of non-inpatient mental health service(s), with the most recent service occurring within the last 6 months.
05	Within last year - The client has received some type of non-inpatient mental health service(s), with the most recent service occurring within the last year.
06	Over one year ago - The client has received some type of non-inpatient mental health service(s), with the most recent service occurring over a year ago.

DATA ENTRY PROMPT: Prior Non-Inpatient MH Service:

HELP TEXT: Select the code that represents the client's previous history of Non-inpatient mental health service(s). Non-inpatient services are defined as either outpatient or day treatment/partial hospitalization, and the provision of such services (if any) could have been by any mental health agency, organization, or practitioner.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION: RACE TOC Index

DEFINITION: The code which represents the racial origin of the client.

FIELD NAME: RACE

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = RACE.DBF

ALLOWABLE VALUES:

?	Unknown
01	White - An individual having origins in any of the original peoples of Europe (including Portugal), North Africa, or the Middle East.
02	Black/African American - An individual having origins in any of the original black racial groups of Africa.
03	Asian or Pacific Islander - An individual having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands (e.g., Japan, China, Samoa, India, Korea, the Philippine Islands, Vietnam, Thailand, etc.).
04	American Indian - An individual having origins in any of the original peoples of North America and who maintains cultural identity through tribal affiliation or community recognition.
05	Alaskan (Aleut, Eskimo, Indian) - An individual having origins in any of the original peoples of Alaska and who maintains cultural identity through tribal affiliation or community recognition.
06	Other - A default category for use in instances in which the client is not classified above or whose origin group, because of area custom, is regarded as a racial class distinct from the above categories.

DATA ENTRY PROMPT: Race:

HELP TEXT: Select the appropriate code from the Popup menu that represents the client's race. For individuals with parents of different races or for individuals unsure of their race, the race of the client's mother should be used.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is blank.

INDICATORS: This data element is suggested for inclusion in all client records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical, Demographics

DESCRIPTION: REFERRAL CODE, ADMISSION TOC Index

DEFINITION: The code which represents the main source of referral that resulted in this client being admitted to this hospital.

FIELD NAME: ADMREF_COD (ADMIREF_C)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = REFERRAL.DBF

ALLOWABLE VALUES:

?	Unknown
00	None
01	Self - The client decided on his/her own volition to come to this facility (walk-in).
02	Family/friend - The client decided to come to this facility based on the advice or recommendation of family and/or friends or any other individual that is not listed in any other category.
03	School/educational program - The client was referred to this facility by a school or education agency or program (e.g., school system psychologist, a principal, counselor, teacher, etc.)
04	Private psychiatrist - The client was referred to this facility by a licensed psychiatrist who is in private practice.
05	Other pvt MH practitioner - The client was referred to this facility by a mental health practitioner, such as psychologist or social worker, who is in private practice.
06	Pvt inpatient psych facility - The client was referred to this facility by an inpatient psychiatric facility that is not a public mental health hospital.
07	Pvt MH clinic organization - The client was referred to this facility by a private organization that provides primarily outpatient mental health services.
08	Clergy - The client decided to come to this facility based upon the advice and/or recommendation of a member of the clergy.
09	Other source of referral - A source of referral not covered by the other categories.
10	DWI referral - The client was referred to this facility by the courts subsequent to being charged with Driving While Intoxicated or Driving Under the Influence.
11	Coroner - The client was referred to this facility by a duly appointed Parish Coroner or his Deputy.
12	Other private physician - The client was referred to this facility by a licensed medical doctor (other than a psychiatrist) who is in private practice.
13	Private general hospital - The client was referred to this facility by a private general hospital.
14	Court local corrections - The client was referred to this facility by an agency within the courts or a local correctional system (below the level of the Department of Corrections) including judge, prosecutor, probation officer; referred for deferred prosecution, pretrial release, pre-parole, pre-release, work release, civil commitment, or a parish prison program. Does not include DWI or DUI referrals.
15	Pvt inpatient SA tx facility - The client was referred to this facility by a private inpatient substance abuse rehabilitation organization.
16	Pvt outpatient SA tx facility - The client was referred to this facility by a private outpatient substance abuse rehabilitation organization.
17	Pvt nursing home/ext care - The client was referred to this facility by a private nursing home or an extended care facility.
18	Order for Protective Custody - The client was transported to this facility under an Order for Protective Custody issued by a Parish Coroner or his Deputy.
19	Law enforcement agency - The client was referred to this facility by a law enforcement agency for reasons other than a court order.
20	Employer/EAP - The client was referred to this facility by his/her employer or employee assistance plan, whether formal or informal. Includes supervisor or an

employee counselor.

21 Shelter for homeless abused - The client was referred to this facility by a shelter for the homeless and/or abused.

22 Other OMH facility - The client was referred to this facility by another OMH facility, including a public psychiatric hospital, an OMH Acute Treatment Unit, or a CMHC.

23 Other State agency - The client was referred to this facility by another State agency or facility.

24 Patient deceased - Not applicable upon admission.

DATA ENTRY PROMPT: Admit Referral Code:

HELP TEXT: Select the code that indicates the main source of referral that resulted in this client being admitted to this hospital. If admission was arranged through SPOE, select the person or facility that referred client to SPOE.

DATA ENTRY EDITS 1. If Source of Referral is "22 Other OMH facility" or "23 Other State agency", THEN Referring Unit must be completed.

2. Source of Referral must be "04 Private Psychiatrist", "05 Other Private Mental Health Practitioner", "06 Private Inpatient Psychiatric Facility", "07 Private Mental Health Clinic Organization", "11 Coroner", "12 Other Private Physician", "13 Private General Hospital", "15 Private Inpatient Substance Abuse Treatment Facility", or "16 Private Outpatient Substance Abuse Treatment Facility", OR Source of Referral must be "22 Other OMH Facility" AND Referring Unit must be completed if Legal Status is "05 Physician's Emergency Certificate", "06 Psychologist's Emergency Certificate", or "07 Coroner's Emergency Certificate".

3. Source of Referral must be "10 DWI Referral", "14 Court Local Corrections", or "18 Order for Protective Custody" if Legal Status is "10 Judicial Civil", "11 Judicial-Lockhart vs. Armistead", "12 Judicial-Not Competent to Proceed", "13 Judicial-NGBRI", or "14 Judicial-Juvenile".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Continuity of care, Decision support data/Statistical

DESCRIPTION: REFERRAL CODE, DISCHARGE TOC Index

DEFINITION: The code which represents to what program/service/agency the client is referred upon discharge.

FIELD NAME: DCREFCODE (DCREFCOD)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = REFERRAL.DBF

ALLOWABLE VALUES:

? Unknown
00 None
01 Self - The client was discharged into his/her own custody.
02 Family/friend/individual - The client was referred to his/her family and/or friends or any other individual that is not listed in any other category.
03 School/education program - The client was referred to a school or education agency or program (e.g., school system psychologist, a principal, counselor, teacher, etc.)
04 Private psychiatrist - The client was referred to a licensed psychiatrist who is in private practice.
05 Other private mental health practitioner - The client was referred to a mental health practitioner, such as psychologist or social worker, who is in private practice.
06 Private inpatient psychiatric facility - The client was referred to an inpatient psychiatric facility that is not a public mental health hospital.
07 Private mental health clinic/organization - The client was referred to a private organization that provides primarily outpatient mental health services.
08 Clergy - The client was referred to consult with a member of the clergy.
09 Other source of referral - A source of referral not covered by the other categories.
10 DWI referral - The client was returned to the court for adjucation.
11 Coroner - The client was referred to this facility by a duly appointed Parish Coroner or his Deputy.
12 Other private physician - The client was referred to a licensed medical doctor (other than a psychiatrist) who is in private practice.
13 Private general hospital - The client was referred to a private general hospital.
14 Court or local corrections - The client was referred to an agency within the courts or a local correctional system (below the level of the Department of Corrections) including judge, prosecutor, probation officer; referred for deferred prosecution, pretrial release, pre-parole, pre-release, work release, civil commitment, or a parish prison program.
15 Private inpatient substance abuse treatment facility - The client was referred to a private inpatient substance abuse rehabilitation organization.
16 Private outpatient substance abuse treatment facility - The client was referred to a private outpatient substance abuse rehabilitation organization.
17 Private nursing home/extended care facility - The client was referred to a private nursing home or an extended care facility.
18 Order for Protective Custody - The client was transported to another facility under an Order for Protective Custody issued by a Parish Coroner or his Deputy.
19 Law enforcement agency - The client was referred to a law enforcement agency for reasons other than a court order.
20 Employer/EAP - The client was referred to his/her employer or employee assistance plan, whether formal or informal. Includes supervisor or an employee counselor.
21 Shelter for homeless/abused - The client was referred to a shelter for the homeless and/or abused.
22 Other OMH facility - The client was referred to another OMH facility, including a

public psychiatric hospital, an OMH Acute Treatment Unit, or a CMHC.

23 Other State agency - The client was referred to another State agency or facility.

24 Patient deceased - The client died, no referral.

DATA ENTRY PROMPT: D/C Referral Code:

HELP TEXT: Select the appropriate code to indicate to what program/service/agency the client is referred upon discharge.

DATA ENTRY EDITS 1. D/C Referral Code must be "22 Other OMH facility" or "23 Other State Agency" if Current Status is "32 Discharged - Transfer to Another La. Psych Hospital" AND Type Termination must be "06 Discharge to Other Public Psychiatric Facility", AND Facility Code must be entered.

2. D/C Referral Code must be "22 Other OMH facility" or "23 Other State Agency" if Current Status is "33 Discharged - Referred to CMHC" AND Type Termination must be "02 No Further Treatment Needed/Referred Elsewhere", AND Facility Code must be entered.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Continuity of care, Decision support data/Statistical

DESCRIPTION:	REFERRAL, UPON ADMISSION TOC Index
DEFINITION:	The name of the person/facility (text) by whom the client was referred to this facility.
FIELD NAME:	REFER_ORG (REF_ORG)
FORMAT:	Length = 15 Type = Character Popup used = N/A
ALLOWABLE VALUES:	N/A
DATA ENTRY PROMPT:	Referred by:
HELP TEXT:	Enter the name of the person/facility by whom the client was referred to this facility, i.e., doctor's name, judge's name, private hospital, treatment program, etc. If referral is by SPOE, enter the name of the peron/facility who made the referral to SPOE.
DATA ENTRY EDITS	N/A
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	MHSIP, Continuity of care, Decision support data/Statistical

DESCRIPTION: REFERRAL, UPON DISCHARGE TOC Index

DEFINITION: The name of the person/facility (text) to whom the client was referred upon discharge.

FIELD NAME: DC_REFERAL (DC_REFER)

FORMAT: Length = 25
Type = Character
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: Referred to:

HELP TEXT: Enter the name of the person/facility to whom the client was referred upon discharge, i.e., doctor's name, judge's name, private hospital, treatment program, etc.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING:

DESCRIPTION: REFERRAL, UPON DISCHARGE, OTHER TOC Index

DEFINITION: The code which represents to what other program service agency the client is referred upon discharge.

FIELD NAME: OUNITREFTO (OUINTREF)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = O_REFER.DBF

ALLOWABLE VALUES:

?	Unknown
00	None
01	Drug Treatment Facility/Program - The client has been referred to a drug treatment facility or program upon discharge from this hospital.
02	Alcohol Treatment Facility/Program - The client has been referred to an alcohol treatment facility or program upon discharge from this hospital.
03	Community Residential Program - The client has been referred to a community residential program upon discharge from this hospital.
04	Nursing Home/Extended Care - The client has been referred to a nursing home or extended care facility upon discharge from this facility.
05	Other - The client has been referred to a facility or program not included above upon discharge from this hospital.

DATA ENTRY PROMPT: Other Referral upon Discharge:

HELP TEXT: Select the appropriate code to indicate to what other program service agency the client is referred upon discharge. Codes are available in the popup.

DATA ENTRY EDITS 1. Other Referral upon Discharge must be completed if type of Status Change is "34 Discharged; Referred Elsewhere" AND Type Termination must be "02 No Further Treatment Needed/Referred Elsewhere", "03 No Further Treatment Needed in Facility - Appropriate Referral Not Available", "04 Appropriate Treatment Not Available Within Facility", or "06 Discharged To Other Public Psychiatric Facility".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION:	REFERRING UNIT, ADMISSION	TOC Index
DEFINITION:	The code which represents the public psychiatric hospital, OMH Acute Treatment Unit, or CMHC that referred the client to this hospital.	
FIELD NAME:	REFER_UNIT (REF_UNIT)	
FORMAT:	Length = 5 Type = Character Popup used = HOSPUNIT.DBF	
ALLOWABLE VALUES:	Refer to the popup for codes.	
DATA ENTRY PROMPT:	Ref. Unit:	
HELP TEXT:	Select the appropriate code that represents the public psychiatric hospital, OMH Acute Treatment Unit, or CMHC that referred the client to this hospital. If the referral was not from one of these referral sources, the field will be automatically set to "00". The facility codes are available in the popup.	
DATA ENTRY EDITS 1.	If Referring Unit is completed, THEN Source of Referral must be "22 Other OMH Facility", or "23 Other State Agency".	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Continuity of care, Decision support data/Statistical	

DESCRIPTION: RELEASE OF INFORMATION SIGNED TOC Index

DEFINITION: The code which represents whether or not the client has signed, or refused to sign, a release of confidential information.

FIELD NAME: RELSIGN

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
Y Yes, release has been signed by the client.
N No, release has not been signed by the client.
R Refused, client has refused to sign the release.

DATA ENTRY PROMPT: RELEASE

HELP TEXT: For the Acute Units only, enter the code which represents whether or not the client has signed, or refused to sign, a release of confidential information. This field is seen only by users at these locations.

DATA ENTRY EDITS: 1. If Release of Confidential Information is signed and "Y" is entered, THEN Date Release Signed must be entered.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.N/A

REASON FOR COLLECTING: Confidentiality

DESCRIPTION: RELIGION TOC Index

DEFINITION: The code which represents the current religious preference of the client.

FIELD NAME: RELIGION

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = RELIGION.DBF

ALLOWABLE VALUES:

?	Unknown
01	Catholic - The client is a member of the Roman Catholic faith.
02	Baptist - The client is a member of the Baptist faith.
03	Jewish - The client is a member of the Jewish faith.
04	Episcopalian - The client is a member of the Episcopalian faith.
05	Methodist - The client is a member of the Methodist faith.
06	Other Protestant - The client is a member of another Protestant faith, including Lutheran, Pentecostal, Seventh Day Adventist, Assembly of God, Church of God, Spiritual Church, and the Church of God in Christ.
07	Other Christian - The client is a member of another Christian church, including Jehovah's Witness, Mormon, Unitarian, Quaker, or Mennonite.
08	Christian Non-Denom- The client is a member of a "Non-denominational Christian Church".
09	Other - The client is a member some religion other than those indicated above, including Muslim, Buddhist, or Hindu.
10	None - The client practices no organized religion or is an agnostic or an atheist.

DATA ENTRY PROMPT: Religion:

HELP TEXT: Insert the code that best indicates the current religious preference of the client.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: Demographics

DESCRIPTION: SEX TOC Index

DEFINITION: The code which represents the sex of the client.

FIELD NAME: SEX

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = N/A

ALLOWABLE VALUES:
? Unknown
M Male
F Female

DATA ENTRY PROMPT: Sex:

HELP TEXT: Select the appropriate code for the sex of the client.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical

DESCRIPTION:	SOCIAL SECURITY NUMBER TOC Index
DEFINITION:	The code which represents a valid SSN or pseudo ID for the client.
FIELD NAME:	SSN
FORMAT:	Length = 11 Type = Character Popup used = N/A
ALLOWABLE VALUES:	N/A
DATA ENTRY PROMPT:	SSN: - -
HELP TEXT:	If the client has a valid SSN and he or his parent/guardian signs the official consent form for the use of that SSN, the SSN should be entered in the nine-digit space provided. If the client does not have a valid SSN or the client refuses consent for use of the SSN, a DHH State Identifier is to be assigned to that client for identification purposes in the DHH data system. MANDATORY FIELD: This field may not be left blank at admission.
DATA ENTRY EDITS: 1.	The social security number cannot be left blank.
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is required for all patient records.
REASON FOR COLLECTING:	Billing

DESCRIPTION: SPECIAL POPULATION CODES - ACUTE TOC Index

DEFINITION: The code which represents whether or not the client meets criteria for acute mental disturbance.

FIELD NAME: ADM_ACUTE (ADMACUTE) Acuity at Time of Admission
ACUTE Current Acuity

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = ACUTE.DBF

ALLOWABLE VALUES:

? Unknown
00 Not Applicable
01 Applicable
Select applicable if client is of any age and mental disorder who is acutely disturbed and meets the criteria below:
a. Abrupt and serious disruption in level of functioning in the direction of severe impairment and marked personal distress.
b. Urgent/immediate need for clinical intervention to stabilize condition and prevent further, serious disabling effects.
c. Severity of current impairment tends to be short-term and intermittent rather than persistent and enduring.
1. For coding purposes, the maximum duration of an acute mental state is six months, at which time client is reclassified.

DATA ENTRY PROMPT: Acute:

HELP TEXT: Select the code that indicates whether or not the client meets criteria for acute mental disturbance.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is required for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION: SPECIAL POPULATION CODES - SMI/EBD TOC Index

DEFINITION: The code which represents whether or not the client meets criteria for a seriously mentally ill adult or a child/youth who has an emotional/behavioral disorder.

FIELD NAME: ADM_CHRONI (ADMCHRON) Chronicity at the Time of Admission
CHRONIC Current Chronicity

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = CMISED.DBF

ALLOWABLE VALUES:

? Unknown

00 Not Applicable

01 Seriously Mentally Ill Adult - An individual age 18 or older who meets all the criteria below:

1. Age - 18 years or older
2. Diagnosis - Severe non-organic mental illnesses including, but not limited to, schizophrenia, schizoaffective disorders, mood disorders, and severe personality disorders, that substantially interfere with a person's ability to carry out such primary aspects of daily living as self-care, household management, interpersonal relationships at work or school.
3. Disability - Impaired role functioning, caused by mental illness, as indicated by at least two of the following functional areas:
   a. Unemployed or has markedly limited skills and a poor work history, or if retired, is unable to engage in normal activities to manage income.
   b. Employed in a sheltered setting.
   c. Requires public financial assistance for out-of-hospital maintenance (e.g., SSI) and/or is unable to procure such without help. Does not apply to routine retirement benefits.
   d. Severely lacks social support systems in the natural environment (e.g., no close friends or group affiliations, lives alone, or is highly transient).
   e. Requires assistance in basic life skills (e.g., must be reminded to take medicine, must have transportation arranged for them, needs assistance in household management tasks).
   f. Exhibits social behavior which results in demand for intervention by the mental health and/or judicial/legal system.
4. Duration - Must meet at least one of the following indicators of duration:
   a. Psychiatric hospitalizations of at least six months (cumulative total) in the last five years.
   b. Two or more hospitalizations for mental disorders in the last 12 month period.
   c. A single episode of continuous structural supportive residential care other than hospitalization for a duration of at least six months.
   d. A previous psychiatric evaluation indicating a history of treatment for severe psychiatric disability of at least six months duration.

02 Emotional/Behavioral Disorder -- Child/Youth - A child or youth (age zero through 17) who has behavioral or emotional responses so different from appropriate age, cultural, or ethnic norm that they adversely affect performance. Performance includes academic, social, vocational or personal skills. Such a disability is more than a temporary, expected response to stressful events in the environment; is consistently exhibited in two different settings; and persists despite individualized intervention within general education and other settings. Emotional and behavioral disorders can co-exist with other disabilities.

Criteria (All criteria must be met):

1. Age - Under age 18.
2. Meets one of the following criteria which operationalize the above definition:
   a. Exhibits seriously impaired contact with reality, and severely impaired social, academic, and self-care functioning whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre, and whose emotional reactions are frequently inappropriate to the situation; or,
   b. Manifest long-term patterns of inappropriate behaviors, which may include but are not limited to aggressiveness, anti-social acts, refusal to accept adult requests or rules, suicidal behavior, developmentally inappropriate inattention, hyperactivity, or impulsiveness; or,
   c. Experience serious discomfort from anxiety, depression, or irrational fears and concerns whose symptoms may include but are not limited to serious eating and/or sleeping disturbances, extreme sadness, suicidal ideation, persistent refusal to attend school or excessive avoidance of unfamiliar people, maladaptive dependence on parents, or non-organic failure to thrive; or,
   d. Have a DSM-III-R (or successor) diagnosis indicating a severe mental disorder, such as, but not limited to psychosis, schizophrenia, major affective disorders, reactive attachment disorder of infancy or early childhood (non-organic failure to thrive) or severe conduct disorder. This category does not include children/youth who are socially maladjusted unless it is determines that they also meet the criteria for emotional/behavior disorders; and,
3. Disability: There is evidence of severe, disruptive and/or incapacitating functional imitations of behavior characterized by at least two of the following:
   a. Inability to routinely exhibit appropriate behavior under normal circumstances.
   b. Tendency to develop physical symptoms or fears associated with personal or school problems.
   c. Inability to learn or work that cannot be explained by intellectual, sensory, or health factors.
   d. Inability to build or maintain satisfactory interpersonal relationships with peers and adults.
   e. A general pervasive mood of unhappiness or depression.
   f. Conduct characterized by lack of behavioral control or adherence to social norms which is secondary to an emotional disorder. If all other criteria are met, then "conduct disorders" are eligible.
4. Duration:
   a. The impairment or pattern of inappropriate behavior(s) has persisted for at least one year, or
   b. There is substantial risk that the impairment or pattern of inappropriate behavior(s) will persist for an extended period, or
   c. There is a pattern of inappropriate behaviors that are severe and of short duration.

DATA ENTRY PROMPT: SMI/EBD:

HELP TEXT: Select the appropriate code that indicates whether or not the client meets criteria for a seriously mentally ill adult or a child or youth who has an emotional/behavioral disorder. PIP will only allow you to select the proper code for either SERIOUSLY MENTALLY ILL ADULT (18 years and older), or EMOTIONAL/BEHAVIORAL DISORDER – CHILD OR

YOUTH (Under age 18).

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical, Clinical utility

DESCRIPTION: SPECIAL POPULATION CODES - JUDICIAL TOC Index

DEFINITION: The code which represents whether or not the client meets criteria for a current legal mandate for mental health evaluation and/or treatment including Gary W. Classmembers, Forensic clients, and other court-ordered clients.

FIELD NAME: ADM_COURT (ADMCOURT) Court Intervention at Admission
COURT Any Court Intervention

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = COURT.DBF

ALLOWABLE VALUES:

? Unknown

00 Not Applicable

10 Criteria for GW Classmembers - This individual is a member of the Gary W. class action suit which is verifiable through a DHH Office.

Forensic client - This individual is mandated to receive services by the Settlement Agreement (consent decree) in Forensic class action suits. Client types 20-24 below or emergency certificate (citation in parentheses):

20 NGBRI; Not Guilty/Insane - Those adjudicated Not Guilty by Reason of Insanity (NGBRI) (C.Cr.Pr., Art. 654).

21 Not competent for trial - Pretrial clients adjudged not competent to proceed to trial (C.Cr.Pr., Art. 648, et seq.)

22 Not to regain competency - Pretrial clients adjudged unlikely to regain competency in the foreseeable future and may be civilly committed (C.Cr.Pr., Art 648 or La. R.S. 28:54, et seq.); Commonly known as "Lockharts".

23 Transfer from Dept. Corr. - Transfers from the Department of Public Safety and Corrections (La. R.S. 28:59 and/or 28:54 or by emergency certificate).

24 Transfers from OMH Hosp. - Transfer from other OMH Hospitals who are dangerous to others and cannot be controlled at the civil hospital. (This may be done administratively and does not require court approval.)

30 Other court-ordered client - These clients are mandated to receive evaluation or treatment as evidenced by a current civil or juvenile court order.

DATA ENTRY PROMPT: Judicial:

HELP TEXT: Select the code that indicates whether or not the client meets criteria for a current legal mandate for mental health evaluation and/or treatment including Gary W. Classmembers, Forensic clients, and other court-ordered clients.

DATA ENTRY EDITS 1. Judicial must be completed if Legal Status is "10 Judicial Civil", "11 Judicial-Lockhart vs. Armistead", "12 Judicial-Not Competent to Proceed", "13 Judicial-NGBRI", or "14 Judicial-Juvenile", THEN Source of Referral must be "10 DWI Referral", "14 Court Local Corrections", or "18 Order for Protective Custody" AND Parish of Legal Commitment must be completed AND Criminal Charges must have at least one entry.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is required for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Legal tracking, Decision support data/Statistical

DESCRIPTION: SPECIAL POPULATION CODES - JUVENILE IN STATE CUSTODY TOC Index

DEFINITION: The code which represents whether or not the client meets criteria for a juvenile in state custody.

FIELD NAME: ADM_JUVCUS (ADMJUVCU) Agency Having Custody of Juvenile at Admission
JUV_CUSTDY (JUV_CUST) Juvenile in State Custody

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = JUV_CUST.DBF

ALLOWABLE VALUES:

?	Unknown
00	Not Applicable
01	DSS-Office of Community Service - In the custody of the Department of Social Services - Office of Community Services.
02	DPSC-Office of Juv. Service - In the custody of the Department of Public Safety and Corrections - Office of Juvenile Services
03	DSS-OCS & DPSC-OJS - In the custody of both DSS-OCS and DPSC-OJS.
04	DSS-OCS or DPSC-OJS & OMH - In the custody of DSS-OCS or DPSC-OJS and OMH.

DATA ENTRY PROMPT: Juv. Custody:

HELP TEXT: Select the code that indicates whether or not the client meets the criteria for a juvenile in state custody. If the client is over the age of 18, PIP will not access this field.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Legal tracking, Decision support data/Statistical

DESCRIPTION: STATUS, CURRENT TOC Index

DEFINITION: The code which represents the most recent activity of the client.

FIELD NAME: STATUS

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = STATUS.DBF

ALLOWABLE VALUES:

01 Admission/Active - The formal acceptance by a hospital of a client who is to be provided with room, board, and continuous nursing service in an area of the hospital where clients generally stay at least overnight. An admission may be first time admission to this facility or a readmission to this facility. Admission to other OMH inpatient facilities are not counted by this facility. The decision to admit requires that the client (or legal representative) authorize such services, for the hospital's therapeutic staff to plan for a timely interdisciplinary staffing of the client, and for the development of a documented course of treatment.

03 Status Change - Utilized to allow comments to be added.

10 Inter-Unit Transfer - The client is reassigned from one distinct hospital (service) unit to another distinct hospital (service) unit (for continuation of treatment). Transfers are recorded by time and date. For statistical purposes, the inpatient day on which the transfer occurs is allocated to the new unit only.

11 On Leave/Pass - Trial Discharge - Client goes on trial pass, which will result in discharge if successful. Client may or may not physically return to facility. Bed is held for client until client is formally discharged. Maximum length of a trial discharge is 14 days.

12 On Leave/Pass - Therapeutic Pass/Home Visit - The client has formal, authorized absence for a time-limited period. Client is expected to return to the facility, and a bed is held for the client.

13 On Leave/Pass - Trans. to Hospital for Med. Care - Client is transferred to a general medical hospital for medical treatment with prior knowledge that client will return to the facility (a bed is held for the client the entire time the client is on leave).

14 On Leave/Pass - Court Pass - (For Feliciana Forensic Facility only) Client has been transferred to the custody of law enforcement officials for court action. Bed is held for client the entire time client is on court pass.

15 On Leave/Pass - Failure to Return from Leave/Pass - Client (or legal representative) has notified the facility that there will be a delay in the client's return to the facility. The client is willing to return to the facility. The bed is held for the client.

19 On Elopement - Client is on unauthorized leave from the hospital or other location authorized by the hospital for leave/pass. Clients are placed on elopement the day of the reported elopement, regardless of the time remaining in any other leave/pass situation. The day the elopement is reported is counted as the first elopement day. A bed is held for the client during the time the client is on elopement. Client days are counted after the day the elopement was reported and are then discharged from elopement.

20 Returned from Leave/Pass/Elopement - The return to regular inpatient status from leave/pass or elopement. The return is recorded by date and time, but, for statistical purposes, the 24 hour period ending at midnight during which the client return is counted as a regular inpatient day.

31 Discharged - No Referral -Formal, signed release of a client from this facility completing this episode of care. No referral applies to the following conditions:

1) No further treatment is needed, so client is not referred to another facility or agency.
2) No further treatment is needed at this facility, but there is further treatment needed. However, client is not referred to another facility or agency as the appropriate referral is not available.

32 Discharged - Transfer to Another La. Psych Hospital - Formal, signed release of a client from this facility completing this episode of care. Client is then "transferred" to and admitted by another OMH inpatient facility for additional treatment. This may be done because the appropriate treatment is not available at this facility or for other reasons.

33 Discharged - Referred to CMHC - Formal, signed release of a client from the hospital completing this episode of care. Client is referred to a CMHC for additional treatment. Further treatment may be rejected by client and/or guardian.

34 Discharged - Referred Elsewhere - Formal, signed released of a client from the hospital completing this episode of care. Client is referred elsewhere for additional treatment (such as drug treatment facility/program, alcohol treatment facility/program, community residential program, nursing home/extended care, or other). Admission to appropriate referral may not be available. Further treatment may be rejected by client.

35 Discharged - Against Medical Advice - Formal, signed release of a client from the facility following a request in writing from the client and/or guardian with 72 hours prior notification. The hospital has determined that the client needs further hospitalization at this facility/there has been no consensus that the client is stable for discharge, but the client does not meet the criteria to be legally committed to the hospital.

36 Discharged - From Elopement - Administrative release of a client due to prior unauthorized leave from the hospital. There is no consensus by the treatment team that the client is stable for discharge. A bed is held for the client and the client is included in the daily census - for up to 7 days following the partial day of elopement. This includes clients "lost from contact" as well as those gone for more than 7 days after the elopement is reported.

37 Discharged - While On Leave/Pass - Discharge of a client who is currently on any type of leave/pass. Client does not have to physically return to the facility before discharge.

38 Discharged - Client Died - Discharge of any "active" client who dies, whether or not the client was on leave/pass/elopement at the time of death.

39 Discharged - Disciplinary - Client has been discharged from this facility for disciplinary reasons. Client may or may not need additional treatment, and may or may not be referred elsewhere for additional treatment.

40 Discharged - Conditional - Client has been conditionally discharged from this facility; final/complete discharge is dependent on the client meeting certain legal requirements.

50 Discharged - Other - Client has been discharged for any reason not listed above.

DATA ENTRY PROMPT: Current Status:
Last Status:

HELP TEXT: Select the appropriate status activity code that indicates the most recent activity of the client as supplied by the 24-hour report, performed in each facility.

DATA ENTRY EDITS 1. If Current Status is "31 Discharged - No Referral" THEN Type Termination must be "01 No Further Treatment/No Referral" or "03 No Further Treatment/Appropriate refferal not available".

2. If Current Status is "32 Discharged - Transfer to Another La. Psych Hospital" THEN Type Termination must be "06 Discharge to Other Public Psychiatric Facility", AND D/C Referral Code must be "22 Other OMH facility" or "23 Other State Agency" AND Facility Code must be entered.

3. If Current Status is "33 Discharged - Referred to CMHC" THEN Type Termination must be "02 No Further Treatment Needed/Referred Elsewhere", AND D/C Referral Code must be "22 Other OMH facility" or "23 Other State Agency" AND Facility Code must be entered.

4. If Current Status is "34 Discharged - Referred Elsewhere" THEN Type Termination

must be "02 No Further Treatment Needed/Referred Elsewhere", "03 No Further Treatment Needed in Facility - Appropriate Referral Not Available", "04 Appropriate Treatment Not Available Within Facility", or "06 Discharged To Other Public Psychiatric Facility", AND Other Referral upon Discharge must be completed.

5. If Current Status is "35 Discharged - Against Medical Advice" or "39 Discharged - Disciplinary" THEN Type Termination must be "'05 Further Treatment Needed - Client Refused".
6. If Current Status is "37 Discharged - While On Leave/Pass" THEN Type Termination must be "01 No Further Treatment/No Referral", "02 No Further Treatment Needed/Referred Elsewhere", "03 No Further Treatment Needed in Facility - Appropriate Referral Not Available", "05 Further Treatment Needed - Client Refused", "06 Discharged To Other Public Psychiatric Facility", or "08 Client Lost To Contact".
7. If Current Status is "38 Discharged - Client Died" THEN Type Termination must be "07 Client Died".
8. If Current Status is "50 Discharged - Other" THEN Type Termination must be "08 Client Lost To Contact".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical

DESCRIPTION: STATUS, EMPLOYMENT TOC Index

DEFINITION: The code which represents the current employment status of the client.

FIELD NAME: EMPLOY_STA (EMPL_STA)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = EMPLOY.DBF

ALLOWABLE VALUES:

?	Unknown
01	Employed, full time - The client is regularly employed at least 35 hours per week.
02	Employed, part-time - The client is employed, but for less than 35 hours per week.
03	Unemployed, on layoff - The client is currently laid off, but is awaiting recall by a previous employer.
04	Unemployed; looking for job - The client is currently unemployed, and looking for a job.
05	Unemployed; not looking for job - The client is currently unemployed and is not seeking employment.
06	Homemaker - The client's primary responsibility is maintaining a household.
07	Student/preschool child - The client is a child/youth attending school (college, high school, elementary) or (s)he is not yet of school age.
08	In Armed Forces - The client is a member of the Army, Navy, Marines, etc.
09	Retired worker - The client has retired from active work.
10	Disabled - The client is unable to pursue an occupation because of physical or mental impairment and has been certified as "disabled" by a public agency, retirement program, or a branch of the military services. This code is not to be used if the client is certified as disabled, but holds down another full-time job.
11	Supported Employment - The client is engaged in non-competitive employment (not on the open market) provided in a controlled work environment with long-term support from a community support program. Examples include sheltered workshops, job coaches, "friendship clubs", or mobile work crews.
12	Jail/prison/training institute - The client is out of the workforce because of incarceration in a jail, prison, or training institution.
13	In hospital - The client is out of the workforce because (s)he has been in a hospital prior to admission to this facility.
14	Other - For use if none of the other categories is appropriate.

DATA ENTRY PROMPT: Employment Status:

HELP TEXT: Select the code that best represents the current employment status of the client.

DATA ENTRY EDITS 1. If Employment Status is "12 Jail/Prison/Training Institute" THEN Type of Residence must be "09 Jail/Prison/Training Institute".
2. If Employment Status is "13 In Hospital" THEN Type of Residence must be "10 Hospital".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP

DESCRIPTION: STATUS, LEGAL TOC Index

DEFINITION: The code which represents the legal authorization by which the client is receiving service.

FIELD NAME: ADMLEGSTAT (ADMLEGST) Legal Status Upon Admission
ADM_TYPE Current Legal Status

FORMAT: Length = 2
Type = Character (ADMLEGST) (Numeric)
Popup used = ADM_TYPE.DBF

ALLOWABLE VALUES:

01 Voluntary-Informal - Admission for service by consent of the client or the parent/guardian/curator of the client. Admission may be made upon the client's request without a formal application.

02 Voluntary-Formal - Admission for service by consent of the client or the parent/guardian/curator of the client. Admission may be made upon the client's request with a formal application.

03 Formal Voluntary with Notice - Client on formal voluntary status has made a valid written request for discharge.

04 Noncontested - Admission for service of a client who does not have the ability to make a knowing or voluntary consent, but who does not object to admission.

05 Physician's Emergency Certificate - Admission for service of a client by an emergency certificate executed after an examination by a physician.

06 Psychologist's Emergency Certificate - Admission for service of a client by an emergency certificate executed after an examination by a psychologist.

07 Coroner's Emergency Certificate - Admission for service of a client by an emergency certificate executed after an examination by a coroner or his deputy.

08 PEC/CEC - An emergency certificate for the client has been executed by a physician or psychologist, and by a coroner or his deputy.

09 Judicial Petition - A petition is pending for judicial commitment of a client on a PEC/CEC or Voluntary status with 72 hour notice.

10 Judicial Civil - The client has been ordered into the state mental health system by a civil court.

11 Judicial-Lockhart vs. Armistead - The client has been ordered into the state mental health system by a criminal court after being found incompetent to proceed to trial in the foreseeable future.

12 Judicial-Not Competent to Proceed - The client has been ordered into the state mental health system as incompetent to proceed to trial pursuant to recommendation of a Sanity Commission.

13 Judicial-NGBRI - The client has been ordered into the state mental health system after having been found not guilty by reason of insanity.

14 Judicial-Juvenile - The client is legally a juvenile and has been ordered into the state mental health system.

DATA ENTRY PROMPT: ADMIT - Legal Status Admit Current

STATUS CHANGE - Current Legal Status:
New Legal Status Code:

HELP TEXT: ADMIT - Select the code that indicates the legal authorization by which the client is admitted for service. Only allowed choices will be lit in the popup. A popup will appear to allow entry of date and time of legal status. In the case of PEC/CECs, the date and time of execution of the initial PEC or CEC should be entered. The cursor will skip the current legal status field.

STATUS CHANGE - Select the code that indicates the new legal authorization by which the client is receiving service. Only allowed choices will be lit in the popup.

DATA ENTRY EDITS 1. If Legal Status is "05 Physician's Emergency Certificate", "06 Psychologist's Emergency Certificate", or "07 Coroner's Emergency Certificate", THEN Source of Referral must be "04

Private Psychiatrist", "05 Other Private Mental Health Practitioner", "06 Private Inpatient Psychiatric Facility", "07 Private Mental Health Clinic Organization", "11 Coroner", "12 Other Private Physician", "13 Private General Hospital", "15 Private Inpatient Substance Abuse Treatment Facility", or "16 Private Outpatient Substance Abuse Treatment Facility", OR Source of Referral must be "22 Other OMH Facility" and Referring Unit must be completed.

2. If Legal Status is "10 Judicial Civil", "11 Judicial-Lockhart vs. Armistead', "12 Judicial-Not Competent to Proceed', "13 Judicial-NGBRI", or "14 Judicial-Juvenile", THEN Source of Referral must be "10 DWI Referral", "14 Court Local Corrections", or "18 Order for Protective Custody" AND Parish of Legal Commitment must be completed.
3. If Legal Status is "11 Judicial-Lockhart vs. Armistead', "12 Judicial-Not Competent to Proceed", or "13 Judicial-NGBRI" THEN Criminal Charges must have at least one entry.

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Legal tracking, Decision support data/Statistical

DESCRIPTION: STATUS, MARITAL TOC Index

DEFINITION: The code which represents the current marital status of the client.

FIELD NAME: MARITAL

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = MARITAL.DBF

ALLOWABLE VALUES:

?	Unknown
01	Never married - The client has never married (either legal or "common law") or the client's only marriage(s) ended in annulment.
02	Married - The client has been married only once and is still married to the same spouse (includes "common law" marriages and those living together as a married couple).
03	Remarried - The client has been married more than once and is now currently married (includes "common law" marriages and those living together as a married couple).
04	Separated - The client is married, but is currently living apart from (or has been deserted by) his/her spouse because of marital discord (includes informal as well as legal separations).
05	Divorced - The client is currently legally divorced.
06	Widowed - The client's spouse is deceased and the client has not remarried.

DATA ENTRY PROMPT: Marital:

HELP TEXT: Select the code that best indicates the current marital status of the client.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical, Demographics

DESCRIPTION: SUPPLEMENTAL SECURITY INCOME ELIGIBLE TOC Index

DEFINITION: The code which represents the client's current status with respect to the SSI (Supplemental Security Income) or SSDI (Social Security Disability Insurance) programs of the Social Security Administration.

FIELD NAME: SSI_ELIG

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = SSI_ELIG.DBF

ALLOWABLE VALUES:

?	Unknown
00	Not Applicable
01	Eligible & receiving payments - The client is eligible for, and is currently receiving SSI or SSDI benefits.
02	Eligible, not receiving payments - The client is eligible for, but is not currently receiving SSI or SSDI payments.
03	Potentially eligible/has applied - The client's claim for SSI or SSDI has been submitted or is in the process of determination.
04	Potentially eligible/has not applied - No claim for SSI or SSDI has been filed although the client is believed to be eligible.
05	Determined ineligible - The client's claim for SSI or SSDI has been submitted and reviewed, and a decision of ineligible was returned.

DATA ENTRY PROMPT: SSI ELIGIBLE

HELP TEXT: Select the code which represents the client's current status with respect to the SSI (Supplemental Security Income) or SSDI (Social Security Disability Insurance) programs of the Social Security Administration.

DATA ENTRY EDITS N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Billing

DESCRIPTION: TIME LEGAL STATUS EXPIRES TOC Index

DEFINITION: The numeric equivalent of the four digit time of expiration of the current legal status of the client.

FIELD NAME: STATEXP_TM (STATEX62)

FORMAT: Length = 5
Type = Character
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: N/A

HELP TEXT: The time of expiration of the client's current legal status is automatically calculated and displayed when the user enters the date and time of the execution of the client's current legal status.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: N/A

INDICATORS: N/A

REASON FOR COLLECTING: Legal tracking

DESCRIPTION:	TIME OF ADMISSION	TOC Index
DEFINITION:	The numeric equivalent of the four digit time the client was admitted.	
FIELD NAME:	ADM_TIME	
FORMAT:	Length = 5 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Admit Time:	
HELP TEXT:	Using the 24-hour clock ("military time"), enter the four digit time the client was admitted. For example, 7:30 a.m. would be entered as 0730, while 7:30 p.m. would be entered as 1930.	
DATA ENTRY EDITS:	1. The Admit Time cannot be blank. 2. The Admit Time must use the 24-hour clock/be in "military time". 3. The Admit Time must be the same as or prior to the current time. 4. The Admit Time cannot be earlier than the discharge time for the previous episode of care. 5. The Admit Time cannot be later than the discharge time for that stay.	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is required for inclusion in all patient records.	
REASON FOR COLLECTING:	Billing, Data quality tracking, Clinical utility	

DESCRIPTION:	TIME OF DISCHARGE	TOC Index
DEFINITION:	The numeric equivalent of the four digit time the client was discharged.	
FIELD NAME:	DC_TIME	
FORMAT:	Length = 5 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	Discharge Time: :	
HELP TEXT:	Using the 24-hour clock ("military time"), enter the four digit time the client was discharged. For example, 7:30 a.m. would be entered as 0730, while 7:30 p.m. would be entered as 1930.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Billing, Data quality tracking, CQI	

DESCRIPTION: TIME RECORD CREATED TOC Index

DEFINITION: The code which represents the numeric equivalent of the four digit time this record was entered into PIP.

FIELD NAME: CREATETIME (CREATIME)

FORMAT: Length = 5
Type = Character
Popup used = N/A

ALLOWABLE VALUES: This field will not accept an entry.

DATA ENTRY PROMPT: N/A

HELP TEXT: No entry is required. This field is automatically updated by PIP with the code which represents the numeric equivalent of the four digit time this record was entered into PIP.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: N/A

INDICATORS: N/A

REASON FOR COLLECTING: Quality Assurance

DESCRIPTION: TYPE OF RESIDENCE TOC Index

DEFINITION: The code which represents the client's housing arrangements or living quarters upon admission.

FIELD NAME: TYPE_RES

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = RESIDENT.DBF

ALLOWABLE VALUES:

? Unknown

01 Single-family dwelling - The client lives in a dwelling which houses only a single family. May include mobile homes.

02 Apartment - The client lives in a multiple-family dwelling, including duplexes, triplexes, and apartment buildings.

03 Nursing home/care facility - The client lives in a nursing home, convalescent home, etc.

04 Residential hotel - The client lives in a residential hotel or other type of boarding house arrangement, or rents a single room in someone's house.

05 No permanent residence - The client's residence is primarily transient (for example, a camper trailer or motor home), or the client may live "on the street". This includes clients living in a shelter, mission, or temporary living quarters or in a place that is limited/short-term stay.

06 Group home/halfway house - The client lives in a group home or halfway house as part of a supervised residential program designed to meet special needs.

07 Supervised apartment - The client lives in a supervised apartment as part of a supervised residential program designed to meet special needs.

08 Board and care - The client lives in a licensed, supervised "board and care" 24-hour residence as part of a supervised residential program designed to meet special needs.

09 Jail/prison/training institute - The client is incarcerated in a jail, prison, or training institution.

10 Hospital - The client has been in a medical or psychiatric hospital prior to admission.

11 Other quarters - For use if none of the other categories is appropriate (for example, military barracks, dormitory, fraternity, sorority, etc.).

DATA ENTRY PROMPT: Type Residence:

HELP TEXT: Select the appropriate code that best describes the Client's Current residence or living quarters upon admission.

DATA ENTRY EDITS 1. If Type of Residence is "03 Nursing Home/Care Facility", "04 Residential Hotel", "06 Group Home/Halfway House", "07 Supervised Apartment", "08 Board and Care", "09 Jail/Prison/Training Institute" or "10 Hospital" THEN Household Composition must be "03 Adult; Non-relatives", or "08 Child; Non-relatives".

2. Type of Residence must be "09 Jail/Prison/Training Institute" if Employment Status is "12 Jail/Prison/Training Institute".

3. Type of Residence must be "10 Hospital" if Employment Status is "13 In Hospital".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING:

DESCRIPTION: TYPE OF TERMINATION TOC Index

DEFINITION: The code which represents the circumstances at the time of service termination.

FIELD NAME: TYPE_TERM (TPE_TERM)

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = TERMIN.DBF

ALLOWABLE VALUES:

01 No further treatment/no referral - The client requires no further service(s) and is not referred to any other organization for treatment continuation.

02 No further treatment needed/referred elsewhere - The client requires no further service(s) at this hospital and is referred to another organization for treatment continuation.

03 No further treatment/Appropriate referral not available - The client requires no further service(s) at this hospital, but further treatment is needed elsewhere, however, referral(s) to another organization for appropriate treatment or continuation are not possible/available.

04 Appropriate treatment not available within facility - The client requires service(s) that cannot be provided by this hospital. If possible, the client is referred to an appropriate organization for treatment.

05 Further treatment needed - client refused - The client requires further service(s), but declines to continue with further treatment.

06 Discharged to other public psychiatric facility - The client has been discharged from this hospital and referred to another public psychiatric hospital.

07 Client died - Client died while an active client of this hospital.

08 Client lost to contact - The client is no longer available for treatment.

09 Discharged-court order - The client is discharged pursuant to orders of the court.

10 Discharged-correctional facility - Client is discharged to a Department of Corrections facility.

DATA ENTRY PROMPT: Type Termination:

HELP TEXT: Select the appropriate code to describe the circumstances at the time of service termination. Codes are available in the popup.

DATA ENTRY EDITS 1. If Type of Termination is completed, THEN Current Status may not be "01 Admission", "03 Status Change",

2. Type of Termination must be "01 No Further Treatment/No Referral" or "03 No Further Treatment Needed/Referred Elsewhere" if Current Status is "31 Discharged - No Referral".

3. Type of Termination must be "02 No Further Treatment Needed/Referred Elsewhere" if Current Status is "33 Discharged - Referred to OMHC" AND D/C Referral Code must be "22 Other OMH facility" or "23 Other State Agency" AND Facility Code must be entered.

4. Type of Termination must be "02 No Further Treatment Needed/Referred Elsewhere", "03 No Further Treatment Needed in Facility - Appropriate Referral Not Available", "04 Appropriate Treatment Not Available Within Facility", or "06 Discharged To Other Public Psychiatric Facility" if Current Status is "34 Discharged - Referred Elsewhere" AND Other Referral upon Discharge must be completed.

5. Type of Termination must be "05 Further Treatment Needed - Client Refused" if Current Status is "35 Discharged - Against Medical Advice" or "39 Discharged - Disciplinary".

6. Type of Termination must be "06 Discharge to Other Public Psychiatric Facility" if Current Status is "32 Discharged - Transfer to Another La. Psych Hospital" AND D/C Referral Code must be "22 Other OMH facility" or "23 Other State Agency"

AND Facility Code must be entered.

7. Type of Termination must be "07 Client Died" if Current Status is "38 Discharged - Client Died".
8. Type of Termination must be "08 Client Lost To Contact" if Current Status is "50 Discharged - Other".
9. Type of Termination must be "01 No Further Treatment/No Referral", "02 No Further Treatment Needed/Referred Elsewhere", "03 No Further Treatment Needed in Facility - Appropriate Referral Not Available", "05 Further Treatment Needed - Client Refused", "06 Discharged To Other Public Psychiatric Facility", or "08 Client Lost To Contact" if Current Status is "37 Discharged - While On Leave/Pass".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Continuity of care

DESCRIPTION:	UNIT	TOC Index
DEFINITION:	The code which represents the unit to which the client is admitted.	
FIELD NAME:	UNIT	
FORMAT:	Length = 10 Type = Character Popup used = UNIT.DBF	
ALLOWABLE VALUES:	Refer to popup for values.	
DATA ENTRY PROMPT:	Unit:	
HELP TEXT:	Select the unit to which the client has been admitted. MANDATORY FIELD: This field may not be left blank at admission. Each facility will maintain its own list in its Popup database.	
DATA ENTRY EDITS: 1.	The unit to which the patient has been admitted cannot be blank.	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is required for all patient records.	
REASON FOR COLLECTING:	Decision support data/Statistical	

DESCRIPTION:	UNIT REFERRED TO, INTERVIEW	TOC Index
DEFINITION:	The code which represents the public psychiatric hospital or community mental health center/clinic to which this client has been referred.	
FIELD NAME:	UNITREF_TO (UNREF_TO)	
FORMAT:	Length = 5 Type = Character (Numeric) Popup used = HOSPUNIT.DBF	
ALLOWABLE VALUES:	Refer to popup for values.	
DATA ENTRY PROMPT:	Unit Referred to:	
HELP TEXT:	Select the appropriate code that represents the public psychiatric hospital or community mental health center/clinic to which this client has been referred. If there was no referral, the item will be automatically set to '00'. Codes are available in the popup.	
DATA ENTRY EDITS N/A		
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	Data quality tracking, CQI	

DESCRIPTION: UPLOAD TRANSMIT FLAG TOC Index

DEFINITION: The code which represents the signal to PIP to allow the upload of modified client records to a central data collection system.

FIELD NAME: UP_DATE

FORMAT: Length = 1
Type = Logical
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: N/A

HELP TEXT: This code sets to "True" if client's record has been modified so that current information may be uploaded. This code is not accessible by/visible to users.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: N/A

INDICATORS: N/A

REASON FOR COLLECTING: MHSIP

DESCRIPTION: USER DEFINED CHARACTER FIELD #1, #2, #3 TOC Index

DEFINITION: The code(s) which represent(s) the characters as defined by the user through the maintenance menu.

FIELD NAME: MZC1, MZC2, MZC3

FORMAT: Length = 20
Type = Character
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: N/A

HELP TEXT: These fields are user defined through the maintenance menu. Check with the PIP project team prior to utilizing these fields.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: If field is utilized, this data is considered missing if this field is left blank.

INDICATORS: If field is utilized, this data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: N/A

DESCRIPTION:	USER DEFINED DATE FIELD #1, #2, #3 TOC Index
DEFINITION:	The numeric equivalent of the month, day, and year of the date as defined by the user through the maintenance menu.
FIELD NAME:	MZD1, MZD2, MZD3
FORMAT:	MMDDYYYY Length = 8 Type = Date Popup used = N/A
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991) A valid date must be entered (e.g., 02/30/1993 is not a valid date).
DATA ENTRY PROMPT:	N/A
HELP TEXT:	These fields are user defined through the maintenance menu. Check with the PIP project team prior to utilizing these fields.
DATA ENTRY EDITS: N/A	
MISSING DATA LOGIC:	If field is utilized, this data is considered missing if this field is left blank.
INDICATORS:	If field is utilized, this data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	N/A

DESCRIPTION: USER DEFINED NUMERIC FIELD #1, #2, #3 TOC Index

DEFINITION: The code(s) which represent(s) the characters as defined by the user through the maintenance menu.

FIELD NAME: MZN1, MZN2, MZN3

FORMAT: Length = 10 2 decimal places
Type = Numeric
Popup used = N/A

ALLOWABLE VALUES: N/A

DATA ENTRY PROMPT: N/A

HELP TEXT: These fields are user defined through the maintenance menu. Check with the PIP project team prior to utilizing these fields.

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: If field is utilized, this data is considered missing if this field is left blank.

INDICATORS: If field is utilized, this data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: N/A

DESCRIPTION: VETERAN'S STATUS TOC Index

DEFINITION: The code which represents the client's veteran status.

FIELD NAME: VETERAN

FORMAT: Length = 2
Type = Character (Numeric)
Popup used = VETERAN.DBF

ALLOWABLE VALUES:
? Unknown
01 No - The client is not a veteran.
02 Yes, but no active duty - The client served in the Reserves or the National Guard, but did not serve on active duty for more than 180 consecutive days, or (s)he served in the Merchant Marines.
03 Yes, had active duty - The client has served on active duty for more than 180 consecutive days in the Armed Forces (including the Coast Guard).

DATA ENTRY PROMPT: Veteran's Status

HELP TEXT: Select the code that indicates the client's veteran status.

DATA ENTRY EDITS 1. If Veteran Status is "03 Yes, Had Active Duty" then Veteran's Eligibility is "01 Is Qualified".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Decision support data/Statistical

DESCRIPTION: VETERANS' ADMINISTRATION ELIGIBILITY TOC Index

DEFINITION: The code which represents the client's Veterans' Administration eligibility.

FIELD NAME: VET_ELIG

FORMAT: Length = 3
Type = Character (Numeric)
Popup used = VET_ELIG.DBF

ALLOWABLE VALUES:
? Unknown
01 Is qualified - The client has a VA file number based on his/her active military service.
02 Is not qualified - The client does not have a VA benefits file number based on active military service.
03 Is a qualified dependent - The client is listed as a qualified dependent under someone's VA file number.

DATA ENTRY PROMPT: Vet. Eligibility:

HELP TEXT: Select the code which best represents the client's Veterans' Administration eligibility.

DATA ENTRY EDITS 1. If Veteran's Eligibility is "01 Is Qualified" then Veteran Status must be "03 Yes, Had Active Duty".
2. If Veteran Is Eligibility is "01 Is Qualified" or "03 Is A Qualified Dependent" THEN VA Number AND Date VA Eligibility Began must be completed and Sources of Payment must include "06 VA".

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is suggested for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP, Billing

DESCRIPTION:	VETERANS' ADMINISTRATION, ELIGIBILITY BEGAN TOC Index
DEFINITION:	The numeric equivalent of the month, date and year that the client's VA eligibility began.
FIELD NAME:	VABEG
FORMAT:	MMDDYYYY Length = 8 Type = Date Popup used = N/A
ALLOWABLE VALUES:	MM=Month (01-12) DD=Day (01-31) YYYY=Year (e.g., 1991) A valid date must be entered (e.g., 02/30/1993 is not a valid date).
DATA ENTRY PROMPT:	VA Eligibility Began / /
HELP TEXT:	Enter the numeric equivalent of the month, day and year of the date that VA eligibility began. If the client has a current card, you may use the Date of Admission.
DATA ENTRY EDITS: 1.	If there is no eligibility, this data element is to be left blank. 2. If there is a V.A. Number, there must be a date entered here.
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.
INDICATORS:	This data element is suggested for inclusion in all patient records.
REASON FOR COLLECTING:	MHSIP, Billing

DESCRIPTION:	VETERANS' ADMINISTRATION, NUMBER	TOC Index
DEFINITION:	The code which represents the client's Veterans' Administration number.	
FIELD NAME:	VANUMBER	
FORMAT:	Length = 14 Type = Character Popup used = N/A	
ALLOWABLE VALUES:	N/A	
DATA ENTRY PROMPT:	VA #	
HELP TEXT:	Enter the client's Veteran's Administration number, if appropriate. If the client is not eligible, this item may be left blank.	
DATA ENTRY EDITS	N/A	
MISSING DATA LOGIC:	This data is considered missing if this field is left blank.	
INDICATORS:	This data element is suggested for inclusion in all patient records.	
REASON FOR COLLECTING:	MHSIP, Billing	

DESCRIPTION:

DEFINITION:

FIELD NAME:

FORMAT: Length =
Type =
Popup used =

ALLOWABLE VALUES:

DATA ENTRY PROMPT:

HELP TEXT:

DATA ENTRY EDITS: N/A

MISSING DATA LOGIC: This data is considered missing if this field is left blank.

INDICATORS: This data element is required for inclusion in all patient records.

REASON FOR COLLECTING: MHSIP

PIP - USER REQUEST FOR CORRECTION OR MODIFICATION

Complete one report per correction/modification requested. Please PRINT or TYPE. Use the back of the page, as needed.

Date of Request: _____/_____/____ **PIP Version #: _____**

Facility Name: _____ **User Name: _____**

Phone#: (____)-_____ **Email address:_____**

Level of request: (please check one)

- ☐ **Need**
- ☐ **Want**

Urgency of request: (please check one)

- ☐ **high priority, desperate need**
- ☐ **medium priority**
- ☐ **low priority**

Statement of request for correction/ modification needed/wanted (Be as specific as possible):

Title of PIP screen(s) involved, if applicable (attach screen prints ,if possible):

Title of PIP function involved, if applicable:

Title of PIP report involved, if applicable (Attach copy of report if possible):

Previous solutions attempted/proposed (If relevant):

Facility Coordinator Action Taken Thus Far:

" Approved _____ _____/____/____
" Not-Approved **Signature of MIS Committee Chair or Acute Unit Manager** **Date**
Reasons not approved:

Please forward this form to your facility HIM Director (state hospitals) or Acute Unit Manager (acute units). Please retain a copy for your files.

PIP- USER REQUEST FOR CORRECTION OR MODIFICATION -- INSTRUCTIONS

It is expected that PIP will be continuously improved with feedback from its users. Your comments regarding corrections and enhancements to PIP are welcomed and appreciated to facilitate the further development of PIP.

All requests should be submitted utilizing the ***PIP Request for Correction or Modification Form***. This form can be found and completed electronically on the OMH Decision-Support On-Line Website, or a hard copy is available through your facility HIM Director or Acute Unit Manager.

Instructions for completing the PIP Request for Corrections or Modification Form:

Please submit one form for each individual correction or enhancement.

Complete all entries applicable. Print legibly if using the hard copy form.

Distinguish between "Wants" ("it would be nice if ...") and "Needs" ("in order to do my job function the following changes are needed"), and indicate the urgency of the request (e.g., critical to collection of data, affects operating systems and or provides inaccurate outputs or reports), by checking the appropriate boxes.

Include as much detail as possible to assure understanding and implementation of the request. Use the exact language as it appears on the computer screen, manual or as defined in the PIP Manual Glossary, Appendix D. Information such as: screen text, field name, Pop-up name, page numbers, and screen identifying information are helpful. Provide examples and a detailed description of the problem or comment. Use the DOS Print Screen command (shift\PRT SC) or a screen capture utility to illustrate a specific concern in the program whenever possible. Include copies of source documents that the comments reference.

Routing Process and Steps in the Approval and Implementation Process:

1. The *Request Form* is completed by the user and submitted to the facility HIM Director for state hospitals, or the Acute Unit Manager for acute units.

2. For State Hospital Requests - The facility HIM Director submits the request for review/discussion by the facility MIS Committee and sponsors the request at the Committee meeting. The MIS Committee reviews the request for appropriateness and need and as a point of coordination for the facility. It is also the responsibility of the facility MIS Committee to assure that the request is complete and written in sufficient detail to be understood. If the request is not approved, the process stops here and the MIS Committee notifies the user making the request of the decision and reasons on the form.

Acute Unit Requests - The Acute Unit Manager submits the request for review/discussion at the meeting of the Acute Unit Managers and sponsors the request at the meeting. The group reviews the request for appropriateness and need as a point of coordination for the acute units. It is the responsibility of this group to assure that the request is complete and written in sufficient detail to be understood. If the request is not approved, the process stops here with the Acute Unit Manager notifying the user making the request of the decision and reasons on the form.

3. Approved user requests are forwarded to the Health Information Directors Committee for approval and prioritization, with a copy back to the user making the request. For state hospitals, the facility HIM Director sponsors the request at the meeting. For acute units, the State Office Acute Unit Manager sponsors the request at the meeting.

4. The HIM Directors approve and prioritize the request in consideration of other pending requests and the resources available to process the request.

5. A listing of all approved and active requests is posted on the OMH Decision-Support On-line Website for enterprise-wide viewing, including the priority status and anticipated date of implementation of the correction/enhancement. Corrections/enhancements to the PIP software will be implemented twice a fiscal year. For the schedule, consult the website.