



AUSCR

Australian Stroke Clinical Registry

Data Dictionary

Data Information: How to collect and enter data

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Introduction

The AuSCR Data Dictionary provides variable definitions and codes to assist with data collection within the AuSCR database, including acute hospital and follow-up variable information for both adults and paediatrics.

Standard definitions and codes are of fundamental importance to data quality and integrity. All people involved in the collection, processing and analysis of AuSCR data should use this dictionary.

To maximise the use of data and to ensure comparability and compatibility with other information systems, data must conform to standard definitions, standard codes and standard field lengths. This will also ensure separate databases can be used to exchange information or be linked. To achieve this, AuSCR definitions have been carefully matched to national health data dictionary (available from the metadata online registry: METeOR) standards, the National Stroke Foundation national audit data dictionary, Registry of the Canadian Stroke Network, SNOMED CT, and individual state health department data dictionaries wherever possible. In cases where there was found to be a disagreement between METeOR standards and other available definitions, the METeOR standard has been used.

The AuSCR Management Committee is responsible for the content of this publication. We continue to welcome comments on this and other relevant publications. All queries and comments should be directed in the first instance to:

AuSCR Project Manager

Postal: PO Box M201, Missenden Road, Sydney NSW 2050 Australia

Street: Level 10 King George V Building, Royal Prince Alfred Hospital, Missenden Road, Camperdown NSW 2050

Tel: +61 (0) 2 9993 4592

Fax: +61 (0) 2 9993 4502

Email: admin@auscr.com.au

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Prepared By Dr Natasha Lannin, Dr Dominique Cadilhac, Mrs Joyce Lim, Ms Kate Paice, Mr. François Pelucca.

Corresponding Author Dr Natasha Lannin.

What does the Dictionary cover?

The definitions in this dictionary cover the AuSCR database variables that are found in the database and the paper-based data collection form to ensure users understand the variables and can also interpret data which can be directly exported into a Microsoft Office Excel spreadsheet (version 2003). It is essential that all data entered in AuSCR are consistent to ensure reliability and validity when used for reporting on the quality of stroke care. For some variables, additional codes are only used when data are directly imported into AuSCR from data extracts provided by hospitals. This ensures greater compatibility across a range of hospital Patient Administration Systems.

Using the Dictionary

Page Layout

Each variable in the data dictionary has a consistent layout and will contain some or all of the fields listed below:

Common Name	Lists any alternative common names for the data item i.e. Person Birth Date may be known as Date of Birth
Definition	Gives a brief explanation of the data item
Main Source of Standard	Shows the derivation of the data item' definition i.e. METeOR catalogue
Format	The format of the data item i.e. (DD/MM/YYYY)
Recording Guidance	This section will give data entry advice/ relevant AuSCR system information for individuals who are entering data in AuSCR
Codes and Values	This section shows any codes and values, where applicable
Help Notes	This section provides guidance for clinicians who are entering and interpreting the data item
Further Information	Shows any further information on the data item. May include context, rationale and/or additional references or links to relevant documents.

Dictionary Sections and variable navigation

The Dictionary is divided into four distinct sections: Introduction to the dictionary; Definitions of the database variables, References and Appendices. Note that the paper-based forms designed for AuSCR contain the same on the database.

This Data Dictionary includes hyperlinks to allow users easy navigation between definitions. Each variable is listed in the Table of Contents, which is hyperlinked to its definition in the Data

Dictionary. Definitions listed by A-Z can be easily located by using the *hyperlinks* on the Index pages.

1 Hospital Details

1.1 Healthcare Provider Identifier - Organisation (HPI-O)

<i>This variable is not currently in use. Will be auto-populated within the AuSCR database.</i>	
Common Name	Identity of the facility or location which is responsible for the healthcare services, and where information is created or received – a ‘healthcare organisation’ identifier (HPI-O).
Data Dictionary Definition	Healthcare Provider Identifier – Organisation (HPI-O) is the unique identifier that is assigned to a Healthcare Provider Organisation. The unique identifier is a number.
Main Source of Standard	National e-Health Transition Authority (NEHTA) www.nehta.gov.au
Format	Numerical and is a required field
Recording Guidance	Not currently in use, refer to Help Notes below. When creating a new hospital in the AuSCR online system the Superuser and Project Administration user levels will choose a hospital name from a drop down list. Once the number is created in AuSCR, each time a user enters data from a hospital this field will be auto-populated in the AuSCR database.
Codes and Values	Numerical AuSCR administration creates a sequential, numerical code to represent each hospital (organisation).
Help Notes	This is a provisional variable to accommodate NEHTA standards for clinical disease registries that is currently under development by NEHTA so that all health care organisations will have a unique identifier to permit future data linkage.
Further Information	This variable is not deleted when a person or episode is opted out of the AuSCR database, allowing records of the number of admissions to be retained. However, all nominated details of the person which may include their stroke episode of care will have been removed.

1.2 Hospital Name

<i>This variable is auto-populated within the AuSCR database</i>	
Common Name	Name of the hospital
Data Dictionary Definition	The title (<i>appellation</i>) by which a hospital (<i>establishment, agency or organisation</i>) is known or called.
Main Source of Standard	METeOR National Health Data Dictionary <i>METeOR Identifier 288917</i> <i>Registration: Health, Standard 04/05/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/288917
Format	Free text and is a required field
Recording Guidance	This variable is auto-populated in the AuSCR database at the Hospital User level, based on the log-in details of the user. Superuser and Project Administration user levels are able to assign hospitals to users, choosing from a drop down list.
Codes and Values	Free text AuSCR administration creates a sequential, numerical code to represent each hospital (organisation).
Help Notes	Generally, the complete organisation name should be used to avoid any ambiguity in identification. This should usually be the same as company registration name. However, in certain circumstances a locally used name (e.g. where a medical practice is known by a name that is different to the company registration name) can be used. Further, a business unit within an organisation may have its own separate identity; this should be captured.
Further Information	The hospital name is automatically assigned to a patient when a new patient is created in AuSCR by a Hospital User. This variable is not deleted when a person or episode is opted-out of the AuSCR database, allowing records of the number of admissions to be retained in the core opt out table within the database. However, all nominated details of the person, which may include their stroke episode of care, will have been removed.

2 Patient Record – Personal Information

Australian Clinical Quality Registries should collect individually identifiable patient or subject information to permit data linkage. Data linkage is the activity of finding connections between different pieces of information that are thought to belong to the same person, or between events that occurred at the same place or happened at or about the same time. Probabilistic linkage is the method used to find links and relies on the availability of similar demographic information (e.g. name, sex, date of birth, address).

2.1 First Name

<i>This variable is mandatory</i>	
Common Name	Person's given name
Data Dictionary Definition	The patient's identifying name within the family group or by which the person is socially identified, as represented by text.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 287035</i> <i>Registration: Health, Standard 04/05/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/287035
Format	Free text and is a required field <i>Maximum character length: 20</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	Free text
Help Notes	<ul style="list-style-type: none">• The format it is written should be the same as that indicated by the person (e.g. written on a form) or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.• In instances where the person has a number of different names and there is uncertainty about which name to record for a person, please record the person's name as it appears on their Medicare card.• Some people do not have a family name and a given name, they have only one name by which they are known. If the person has only one name, record it in the 'Last Name' field and place a hyphen in the 'First Name' field to indicate that it should read as blank.

2.2 Last Name

<i>This variable is mandatory</i>	
Common Name	Person's surname or family name
Definition	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her first or given names, as represented by text.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 286953</i> <i>Registration: Health, Standard 04/05/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/286953
Format	Free text and is a required field <i>Maximum character length: 20</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	Free text
Help Notes	<ul style="list-style-type: none"> • The full family name should be recorded. • The format it is written should be the same as that indicated by the person (e.g. written on a form) or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data. • In instances where the person has a number of different names and there is uncertainty about which name to record for a person, please record the person's name as it appears on their Medicare card.


2.3 Date of Birth

<i>This variable is mandatory</i>	
Common Name	Date of birth
Definition	Record of the day, month and year when the patient was born.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 287007</i> <i>Registration: Health, Standard 04/05/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/287007
Format	Recorded as DD/MM/YYYY format and is a required field. The forward slashes do not need to be typed in. <i>Maximum character length: 10</i>
Recording Guidance	Individual patient medical records – Admission form.
Codes and Values	Date recorded as DD/MM/YYYY format. String
Help Notes	<ul style="list-style-type: none"> Although collection of date of birth allows more precise calculation of age, this may not be feasible in some cases. When exact date of birth is unknown, the alternative questions to ask are: <i>What month is..... birthday? and What was age last birthday? or What is age in complete years?</i> This will allow clinicians to estimate month and year of birth. If the day of birth is unknown, use 01 for the day (01/MM/YYYY) and select the 'date estimated' box. If the month of birth is unknown, use 01 for the month (DD/01/YYYY) and select the 'date estimated' box. If the year of birth is unknown, estimate the client's age in years and subtract this from the current year. Write in the estimated year of birth and select the 'date estimated' box.

2.4 Individual Healthcare Identifier (IHI)

<u>This variable is not currently in use</u>	
Definition	The Individual Healthcare Identifier is the unique healthcare identifier for individuals within the healthcare system. The unique identifier is a number
Main Source of Standard	National e-Health Transition Authority (NEHTA): The IHI Record will be based on the Australia Standard [AS5017] for Healthcare Individual Identification and will conform to the International Standard ISO/PDTS 22220 [ISOTC215/SCN].
Format	Numerical <i>The IHI will be a 16 digit number</i>
Recording Guidance	Not currently in use, refer to Help Notes below.
Codes and Values	Numerical
Help Notes	<ul style="list-style-type: none"> • This is a provisional variable to accommodate NEHTA standards for clinical disease registries that is currently under development by NEHTA so that all individuals using health care services will have a unique identifier to permit future data linkage • The IHI associated with a Healthcare Individual will remain with them for life.

2.5 Medicare Number

Common Name	Number on the person's Medicare Card, used as an Australian Commonwealth Government identifier.
Definition	Person identifier, allocated by the Health Insurance Commission to eligible persons under the Medicare scheme that appears on a Medicare card.
Main Source of Standard	National Health Data Dictionary <i>METeOR identifier 270101</i> <i>Registration: Health, Standard 01/03/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/270101
Format	Numerical Representational layout: NNNNNNNNNNN <i>Character length: 10</i>
Recording Guidance	Individual patient medical records – Admission sheet. Full Medicare number including the individual reference number should be recorded.
Codes and Values	Numerical
Help Notes	<p>The full Medicare number for an individual should be recorded. This includes the family number plus person (individual reference) number.</p> <p>For example, John Smith's full Medicare number is 1234 56789 0 1</p>  <p>If only the Veterans Affairs (VA) code is known enter this number into the Medicare field. VA code format for a Veteran: up to 4 alphabetical + 4 digits. VA code for Veteran Spouse: same as for Veteran with an "A" appended to the end.</p>

2.6 Age

<i>This variable is auto-calculated from Date of Birth in the AuSCR database.</i>	
Common Name	The person's age on the date of admission
Definition	The age in (completed) years, months and days on the day of admission, calculated from date of birth.
Main Source of Standard	National Health Data Dictionary <i>METeOR identifier 303794</i> <i>Registration: Health, Standard 08/02/2006</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/303794
Format	Calculated automatically from date of birth and date of admission in years, months and days.
Recording Guidance	No entry required; Calculated from date of birth and date of admission by the AuSCR database.
Codes and Values	Calculated in years, months and days (YYYY, MM, DD)
Help Notes	This variable is not found on the paper-based form as it will be auto-calculated when the data are entered in AU SCR on-line.
Further Information	Age provides important epidemiological information. Age associated with severity of stroke is an important predictive factor for outcomes both in terms of mortality and resulting dependency.

2.7 Title

Common Name	Person's name title.
Data Dictionary Definition	An honorific form of address, commencing a name, used when addressing a person by name, whether by mail, by phone, or in person
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 287166.</i> <i>Registration: Health, Standard 04/05/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/287166
Format	Drop down list: Mr. Mrs. Ms. Miss. Dr. Master.
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	Variable codes: Mr. Mrs. Ms. Miss. Dr. Master
Help Notes	This field indicates the person's personal preference not their marital status.

2.8 Hospital Medical Record Number (MRN)

<i>This variable is mandatory</i>	
Common Name	Medical Record Number, also known as Unit Number and Patient Record Number.
Definition	Person identifier unique within establishment or agency assigned by the establishment or agency.
Main Sources of Standard	<p>Definition: National Health Data Dictionary <i>METeOR Identifier: 290046</i> <i>Registration: Health, Standard 04/05/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/290046</p> <p>Format: Victorian Hospital in the Home (HITH) Minimum Data Set</p>
Format	<p>Free text: Alpha numeric code and is a required field <i>Maximum character length: 10</i></p>
Recording Guidance	Individual patient medical records – the numbering system including the content and format of the medical record number is usually specific to the individual health care service.
Codes and Values	Free text
Further Information	MRN is collected to assist in individual patient identification and to identify potential duplicates in the database. It is the current method of patient identification being used for purposes including delivery of care, record keeping and communication.

2.9 Gender

Common Name	Sex
Definition	The biological distinction between male and female.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 287316 [Sex]</i> <i>Registration: Health, Standard 04/05/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/287316
Format	Drop down list: Male Female <i>Maximum character length: 1</i>
Recording Guidance	Individual patient medical record – Admission form
Codes and Values	1 Male 2 Female 9 <i>Not stated/inadequately described (AuSCR Office Use Only: this option is not available on the AuSCR screen, however code is accepted in the database if this information is 'missing' for data Import compatibility).</i>
Help Notes	Operationally, gender will be captured as it is written in the medical record. If there is a conflict, document with the self-identified gender, i.e. <i>gender as reported by the person</i> .
Further Information	Required to stratify data on the basis of gender.

2.10 Is the patient of Aboriginal/Torres Strait Islander origin?

Common Name	Whether a person identifies as being of Australian indigenous origin.
Definition	<p>Whether a person identifies as being of Aboriginal or Torres Strait Islander origin, as represented by a code.</p> <p>This is in accord with the first two of three components of the Commonwealth definition, commonly known as 'The Commonwealth Definition': 'An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives'.</p> <p>There are three components to the Commonwealth definition:</p> <ul style="list-style-type: none"> • descent; • self-identification; and • community acceptance. <p>In practice, it is not feasible to collect information on the community acceptance and, therefore, the AuSCR definition relates to descent and self-identification only or as noted on the medical admission sheet.</p>
Main Source of Standard	<p>National Health Data Dictionary <i>METeOR Identifier: 291036</i> <i>Registration: Health, Standard 04/05/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/291036</p>
Format	<p>Drop down list:</p> <p>Aboriginal but not Torres Strait Islander origin Torres Strait Islander but not Aboriginal origin Both Aboriginal and Torres Strait Islander origin Neither Aboriginal nor Torres Strait Islander origin</p> <p><i>Maximum character length: 1</i></p>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	<p>1 Aboriginal but not Torres Strait Islander origin 2 Torres Strait Islander but not Aboriginal origin 3 Both Aboriginal and Torres Strait Islander origin 4 Neither Aboriginal nor Torres Strait Islander origin</p> <p><i>8 Indigenous not otherwise described (AuSCR Office Use Only: this option is not available on the AuSCR screen, however code is accepted in the database if this information is not further defined for data Import compatibility).</i></p> <p><i>9 Not stated/missing (AuSCR Office Use Only: this option is not available on the AuSCR screen, however code is accepted in the database if this information is 'missing' for data Import compatibility).</i></p>

Help Notes	<ul style="list-style-type: none"> • Variable codes of 8 and 9 are permissible when data from other systems are imported into AuSCR. These values cannot be entered directly when using the AuSCR database. • Operationally, Australian indigenous status will be captured as it is written in the medical record. If there is a conflict, document with the self-identified origin i.e. <i>origin as reported by the person</i>.
Further Information	<p>Rationale: Indigenous Australians suffer poorer health outcomes than their counterparts. Stroke subtypes also vary by different ethnic statuses, as well as risk factor prevalence.</p>

2.11 Country of birth

Common Name	The country in which the person was born.
Definition	The country in which the person was born, as represented by a code.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 370943</i> <i>Registration: Health, Standard 01/10/2008</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/370943
Format	Select from drop down list of countries consistent with the Standard Australian Classification of Countries 1998 (SACC). SACC is a four-digit, three-level hierarchical structure specifying major group, minor group and country.
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	Four digit numerical code (NNNN) Country names are coded in accordance with the SACC 1998. http://www.abs.gov.au/ausstats/ABS@.nsf/Latestproducts/1837ADE79569F330CA2572680017FE07?opendocument
Help Notes	When entering these data in the database: <ul style="list-style-type: none"> • The 10 most common countries of birth according to the ABS data list appear at the top of the drop down list with all others listed below in alphabetical order. • Typing in the first letter will move you to the next country in the drop down list starting with that letter. • Each time a new letter is typed the cursor will be moved to the next country starting with that letter.
Further Information	ABS cat. no. 1269.0. Standard Australian Classification of Countries (SACC), 2008. Canberra: Australian Bureau of Statistics. A full list of country names and codes available in AuSCR is presented in Appendix 1.

ABS: Australian Bureau of Statistics

2.12 Language spoken

Common Name	Preferred language; language spoken at home.
Definition	The language (including sign language) most preferred by the person for communication in his/her home (or most recent private residential setting occupied by the person) with other residents of the home or setting and regular visitors. This may be a language other than English, even where the person can speak fluent English.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 304128</i> <i>Registration: Health, Standard 08/02/2006</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/304128
Format	Drop down list of languages taken from the Australian Standard Classification of Languages 2005.
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	4-digit numerical code (NNNN) consistent with the Australian Standard Classification of Languages 2005.
Help Notes	<ul style="list-style-type: none"> • This may be a language other than English even where the person can speak fluent English. Response to this variable will not determine the necessity of an interpreter. • The 10 most common languages spoken in Australian (according to the ABS) appear at the top of the drop down list with all other languages listed immediately following in alphabetical order. • Typing in the first letter will move you to the next language in the drop down list starting with that letter. Each time a new letter is typed you will be moved to the next language starting with that letter.
Further Information	<p>ABS cat. no. 1267.0. Australian Standard Classification of Languages (ASCL), 2005-06. Canberra: Australian Bureau of Statistics.</p> <p>A full list of languages available in AuSCR is presented in Appendix 2.</p>

2.13 *Interpreter needed*

Common Name	Need for interpreter service
Definition	An indicator of whether an approved interpreter service is required by or for the person.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 304294</i> <i>Registration: Health, Standard 08/02/2006</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/304294
Format	Drop down list: Yes No <i>Maximum character length: 1</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	1 Yes 2 No
Help Notes	<ul style="list-style-type: none"> Context: Required to assist in planning for the provision of approved interpreter and multilingual services. Includes whether approved interpreter services are required for a verbal language, sign language and languages other than English. Persons requiring the use of approved interpreter services for any form of sign language should be coded to 'Yes' – 'Interpreter required' Please note: information about aphasia or cognitive impairments that may inhibit a person's ability to communicate will be collected at the 3-month follow-up and do not need to be recorded on the acute form.

3 Contact Details

Contact details are required to permit clinical follow-up of patients between 3 to 6 months after a stroke admission. To attain the greatest follow up rate possible to ensure reliable data about the stroke population in Australia, more than one complete set of contact details are preferred. Reporting of survival rates, quality of life after hospital discharge and other valuable statistical analyses are heavily dependent on accurate and complete follow up information.

3.1 Type of address

At least one address must be recorded.	
Common Name	The address type, residential/business/other
Definition	A code set representing a type of address, as represented by a code.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 286728</i> <i>Registration status: Health, Standard 04/05/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/286728
Format	Drop down list: Home Business Other <i>Maximum character length: 1</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	1 Business 3 Home [Residential] 9 Other
Help Notes	Overseas address: Record the overseas address as the home address and record a temporary accommodation address as their contact address in Australia as 'Other' . This is important for follow-up if the patient will be in Australia six months after leaving hospital.

3.2 Street address

Common Name	Address line
Definition	A composite of standard address components that describe a low level of geographical/physical description of a location, as represented by text. Used in conjunction with the other high-level address components i.e. Suburb/town/locality, Postcode— Australian, Australian state/territory, and Country, forms a complete geographical/physical address of a person.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 286620</i> <i>Registration: Health, Standard 01/03/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/286620
Format	Standard address data elements that may be included in the 'Street Address' line: Building/complex sub-unit type Building/complex sub-unit number Building/property name Floor/level number Floor/level type House/property number Lot/section number Street name Street type code Street suffix code <i>Maximum character length: 180</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	Text string
Help Notes	<ul style="list-style-type: none"> • Enter 'Unknown' when the locality name or geographic area for a person is not known. • Enter 'No fixed address' when a person has no fixed address or is homeless.

3.3 Suburb

Common Name	Name of suburb, town or locality.
Definition	The full name of the locality contained within the specific address of a person, as represented by text.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 287326</i> <i>Registration: Health, Standard 04/05/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/287326
Format	Free text <i>Maximum character length: 50</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	Text string.
Help Notes	The suburb/town/locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community.

3.4 State

Common Name	Australian State or Territory (code)
Definition	The Australian state or territory where a person can be located, as represented by a code.
Main Source of Standard	National Health Data Dictionary Based on the METeOR Identifier: 286919 Registration: Health, Standard 04/05/2005 http://meteor.aihw.gov.au/content/index.phtml/itemId/286919
Format	Drop down list: New South Wales Victoria Queensland South Australia Western Australia Tasmania Northern Territory Australian Capital Territory Overseas Other <i>Maximum character length:8</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	NSW New South Wales VIC Victoria QLD Queensland SA South Australia WA Western Australia TAS Tasmania NT Northern Territory ACT Australian Capital Territory Other Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory) Overseas Overseas
Help Notes	For non- Australian addresses 'Overseas' should be selected for acceptance of a non-Australian postcode.
Further Information	Australian Bureau of Statistics 2005. Australian Standard Geographical Classification (ASGC) . Cat No. 1216.0. Canberra: ABS.

3.5 Postcode

Common Name	Australian postcode
Definition	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a person.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 287224</i> <i>Registration: Health, Standard 04/05/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/287224
Format	Numerical <i>Maximum character length: 4</i> Or if Overseas postcode then <i>Maximum character length: 10</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	Numerical Secure first digit for the Australian States Overseas: available only if “Overseas” is recorded in the State variable.
Help Notes	Leave blank for: Unknown address, No fixed address.
Further Information	In-built quality check: State and Postcode must be compatible. i.e. NSW postcodes must start with a ‘2’, unless it is a PO Box specific postcode

3.6 Phone number

Common Name	Contact telephone number
Definition	The person's contact telephone number.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 270266</i> <i>Registration: Health, Standard 01/03/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/270266
Format	Free text telephone number including area code/prefix <i>Maximum character length: 10</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	Numerical using prefix plus telephone number.
Help Notes	<ul style="list-style-type: none">• Record the area code prefix plus telephone number. For example, 08 8226 6000• Record the full phone number (including any prefixes) with no punctuation (hyphens or brackets). These are automated in the database.• More than one telephone number may be recorded as required. Additional numbers should be recorded under an assigned emergency or alternate contact person.• Unknown contact details- leave the field blank.

3.7 **Mobile number**

Common Name	Contact mobile telephone number.
Definition	The person's contact mobile telephone number.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 270266</i> <i>Registration: Health, Standard 01/03/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/270266
Format	Numerical, with no punctuation (hyphens or brackets). These are automated in the database. <i>Maximum character length: 10</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	Numerical
Help Notes	<ul style="list-style-type: none"> Record the area code prefix plus telephone number. For example, 0412345678 More than one telephone number may be recorded as required. Additional numbers should be recorded under an assigned emergency or alternate contact person. Unknown contact details- leave the field blank.

3.8 *Emergency contact*

Common Name	A person who is given as the next of kin or proxy contact.
Definition	Name and contact details of a representative that can be contacted in case of an emergency involving the patient. The contact shall have familiarity with the person's geographical location, and authority to make decisions regarding the person.
Main Source of Standard	<i>Refer to Sections 3.1 to 3.7</i>
Format	<i>Refer to Sections 3.1 to 3.7</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	<i>Refer to Sections 3.1 to 3.7</i>

3.9 *Alternate contact*

Common Name	A person who is given as a proxy contact for the patient.
Definition	Name and contact details of secondary representative that can be contacted in the event that the primary emergency contact is not available for the purpose of contacting the patient in the event that the patient's details are missing or incorrect.
Main Source of Standard	<i>Refer to Sections 3.1 to 3.7</i>
Format	<i>Refer to Sections 3.1 to 3.7</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	<i>Refer to Sections 3.1 to 3.7</i>

3.10 Relationship

Definition	The relationship of the next of kin to the person, as represented by a code.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 270012</i> <i>Registration: Health, Recorded 13/05/2008</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/270012
Format	Drop down list: Spouse/Partner Friend/Associate Other Relative Parent Professional Carer Sibling Son/Daughter Other: If "Other relative" is selected or none of the above matches the relationship, details should be completed in the free text box provided.
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	1 Spouse/Partner 2 Parent 3 Son/Daughter 5 Other Relative 6 Friend/Associate 7 Professional Carer 8 Sibling 9 Not stated/inadequately described (for use during Data Import Only)
Help Notes	<ul style="list-style-type: none"> Other Relative – one who is related to the patient but not represented by the available selections. This could include a grandparent, step-parent or foster-parent. Professional Carer – one who has been paid to perform the duties of caring for the patient. Someone who is performing the duties of caring for the patient but is unpaid is not a professional carer.

3.11 General Practitioner (GP) contact

Common Name	Name and contact details of person's <i>usual</i> general medical practitioner (local medical officer).
Definition	Name and contact details (address, telephone number, email and/or facsimile number) of the patient's <i>usual</i> General Practitioner who can be contacted in the event that the patient's other contacts are not available for the purpose of contacting the patient in the event that the patient's details are missing or incorrect.
Main Source of Standard	<i>The contact details requested in this section are defined in their respective variables.</i> Note: for the GP contact, please record the Fax (facsimile) number in preference to the mobile telephone number. <i>The database has not yet been altered to accommodate this change, however in the interim, users are asked to record the fax number in the mobile telephone number field.</i>
Format	<i>Refer to Sections 3.1 to 3.7</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	<i>Refer to Sections 3.1 to 3.7</i>
Help Notes	<ul style="list-style-type: none"> • Please provide as much detail as there is available in the patient medical record for General Practitioner (GP). This field will accept a name only, or the business name only (i.e. it is not necessary to know all details of the GP before entering data in this field). • Please record the Fax (facsimile) number, in addition to the office telephone number for the GP if available in the medical record.
Further Information	This is composite information for a range of variables related to contact details for a patient's usual GP as recorded on the hospital admission form.

4 Episode Details

4.1 Stroke episode

Common Name	Episode of acute inpatient care for a person who has had a stroke.
Definition	The period of admitted patient care for a patient who had a stroke between a formal or statistical admission and a formal or statistical separation.
Main Source of Standard	Queensland Health Data Dictionary <i>Data Element ID: 040019</i> http://www.health.qld.gov.au/performance/docs/QHDDReport.pdf
Recording Guidance	Individual patient medical records – Admission form Individual patient medical records – Discharge summary
Help Notes	<ul style="list-style-type: none">• Acute care episode for admitted patient care. An episode is a phase of treatment.• For each stroke episode a new episode of care must be completed in the AuSCR database.<ul style="list-style-type: none">– A subsequent stroke event (second to the indexed stroke event) which occur ≥ 24 hours after the indexed stroke event should be recorded as an in-patient stroke, and a second episode of care should be commenced.• An episode of care ends when the patient is formally separated from the facility. Separation may be the result of death, discharge, change of episode type, or transfer to another facility.

4.2 *Is there documented evidence of a previous stroke?*

<i>This variable is mandatory</i>	
Common Name	Has the person had a previous/past stroke?
Definition	Previous stroke event/s that occurred prior to the current admission (does not include TIA).
Main Source of Standard	Registry of the Canadian Stroke Network <i>Operations Manual 2003</i>
Format	Drop down list: Yes No Unknown This is a required field. <i>Maximum character length: 1</i>
Recording Guidance	Individual patient medical records – Admission form, Medical Notes
Codes and Values	1 Yes 2 No 9 Unknown
Help Notes	Select “Yes” if there is a history of stroke, probable stroke, history consistent with stroke (Not TIA). The list includes documented evidence of: <ul style="list-style-type: none"> • Brain infarct • Cerebellar infarct • Cerebral artery occlusion • Cerebral bleeding/hemorrhage • Cerebral infarct • Cerebral occlusion or thrombosis • Cerebrovascular accident (CVA) • Cortical Infarction • Hemorrhagic cerebrovascular accident • Hemorrhagic infarct of the brain • Intracerebral bleeding or hemorrhage • Intracranial bleeding or hemorrhage • Lacunar infarct • Multi-infarct dementia • Partially reversible ischemic neurologic deficit • Reversible ischemic neurologic deficit lasting >24 hours (RIND) • Ruptured intracranial aneurysm • Stroke

5 Admission Information

5.1 Date of arrival at Emergency Department

<i>This variable is mandatory</i>	
Common Name	Date of arrival to the Emergency Department (otherwise known as Accident & Emergency (A&E) Department or Casualty Department).
Definition	The date of patient presentation at the Emergency Department is the earliest occasion of being registered clerically or triaged.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier:270393 Registration: Health, Standard 01/03/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/270393
Format	Date recorded as DD/MM/YYYY format and is a required field. The forward slashes do not need to be typed in. <i>Maximum character length: 10</i>
Recording Guidance	Individual patient medical records – Admission form
Codes and Values	Date recorded as DD/MM/YYYY format. String
Help Notes	<ul style="list-style-type: none"> • If the accurate (exact) date is unknown and not obtainable, “Estimate” radio button should be selected below the entered date. • When month and year are known the date should be recorded as 01/MM/YYYY and the “Estimate” radio button should be selected. When only the year is known the date should be recorded as 01/01/YYYY and the “Estimate” radio button should be selected below the entered date. • If not applicable (not applicable because patient did not present to ED.) enter 01/01/1900 into the date field and select the “Estimate” radio button below the date field.

5.2 Time of arrival at Emergency Department

<i>This variable is mandatory</i>											
Common Name	Arrival time to the Emergency Department (ED) (otherwise known as accident & emergency (A&E) department or casualty department).										
Definition	The time of patient presentation at the emergency department is the earliest occasion of being registered clerically or triaged.										
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier:270080 Registration: Health, Standard 01/03/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/270080										
Format	Time is recorded using the 24 hour clock format hh:mm and is a required field.										
Recording Guidance	Individual patient medical records – Emergency Department Records; Admission form										
Codes and Values	24 hour clock format, hh:mm String										
Help Notes	<table border="1" data-bbox="613 1045 1284 1354"> <thead> <tr> <th>Hints for Recording Time</th> <th>Record Time as</th> </tr> </thead> <tbody> <tr> <td>Midnight (12:00 am)</td> <td>23:59</td> </tr> <tr> <td>Noon (12:00 pm)</td> <td>12:00</td> </tr> <tr> <td>12:15 am</td> <td>00:15</td> </tr> <tr> <td>6:00 am</td> <td>06:00</td> </tr> </tbody> </table> <ul style="list-style-type: none"> • Time of arrival at ED is <i>not</i> the admission time. • When reviewing ED records, do NOT include documentation from external sources (i.e. Ambulance records) obtained prior to arrival. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital. • If the patient is in an outpatient or an inpatient setting of the hospital at the time of stroke, the time of '99:99' should be entered to indicate that the patient did not attend the Emergency Department. Then select the Estimate radio button below the time field. • If an exact time cannot be recorded (i.e. not in the chart or proxy/ family does not know), a best estimate should be entered. Descriptions of time such as <i>2 hours before arrival, about 1 hour ago or approximately 2 and a half hours ago</i> are specific enough to perform a calculation or express a time as "Accurate". 	Hints for Recording Time	Record Time as	Midnight (12:00 am)	23:59	Noon (12:00 pm)	12:00	12:15 am	00:15	6:00 am	06:00
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Noon (12:00 pm)	12:00										
12:15 am	00:15										
6:00 am	06:00										

Help Notes

- If a time cannot be clearly determined, use the table below for estimating times in conjunction with the time the note was recorded (or the time of arrival if not noted). *Only use the following as a last resort:*

Description of Time	Record Time as
Middle of the night	03:00
Breakfast	08:00
Early morning	08:00
Morning	09:00
Late morning	10:00
Lunch	12:00
Midday or 12 Noon	12:00
Early afternoon	14:00
Afternoon or mid-afternoon	15:00
Late afternoon	16:00
Dinner/Supper	18:00
Early evening	19:00
Evening	21:00
Late evening	22:00

5.3 Onset of stroke date

<i>This variable is mandatory</i>	
Common Name	Date of the current stroke, this is also known as the date of symptom discovery (i.e., when the patient was found with the symptoms of stroke or TIA).
Definition	The date of the most recent stroke or TIA experienced by a person.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 338263</i> <i>Registration: Health, Standard 01/10/2008</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/338263
Format	Date recorded as DD/MM/YYYY format and is a required field. The forward slashes do not need to be typed in. <i>Maximum character length: 10</i>
Recording Guidance	Individual patient medical record – Admission form, Discharge summary, ED Nurses notes, History and Medical /nursing notes. Ambulance report. If there are conflicting dates, please use the following hierarchy: 1. stroke team/neurologist 2. admitting physician 3. emergency department physician 4. ED nursing notes 5. Emergency medical staff/Ambulance reports
Codes and Values	Date recorded as DD/MM/YYYY format. String

Help Notes	<ul style="list-style-type: none"> • The date that the patient’s symptoms were first recognized. • If the patient describes progressive symptoms, record the date of the very first symptom. • If the patient woke with symptoms of stroke that were not present when they went to sleep then record the date they woke with symptoms. • If the accurate (exact) date is unknown and not obtainable, “Estimate” radio button should be selected below the entered date. • When month and year are known the date should be recorded as 01/MM/YYYY and the “Estimate” radio button should be selected below the entered date. • When only the year is known the date should be recorded as 01/01/YYYY and the “Estimate” radio button should be selected below the entered date.
Further Information	<p>Compliant with:</p> <ul style="list-style-type: none"> • Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009, • Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), • Registry of the Canadian Stroke Network Operations Manual 2003

5.4 Onset of stroke time

<i>This variable is mandatory</i>	
Common Name	Time of onset of the current stroke, this is also known as the time of symptom discovery (i.e., when the patient was found with the symptoms of stroke or TIA).
Definition	The time of the most recent stroke or TIA experienced by a person.
Main Source of Standard	<p>Definition Attributes: Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009</p> <p>Representational Standard: National Health Data Dictionary</p> <p><i>Based on METeOR Identifier: 270080</i></p> <p><i>Registration: Health, Standard 01/03/2005</i></p> <p>http://meteor.aihw.gov.au/content/index.phtml/itemId/270080</p>
Format	Time is recorded using the 24 hour clock format hh:mm and is a required field.
Recording Guidance	<p>Individual patient medical record – Admission form, Discharge summary, ED Nurses notes, History and Medical /nursing notes. Ambulance report.</p> <p>If there are conflicting dates, please use the following hierarchy:</p> <ol style="list-style-type: none"> 1. stroke team/neurologist 2. admitting physician 3. emergency department physician 4. ED nursing notes 5. Emergency medical staff/Ambulance reports
Codes and Values	<p>24 hour clock format, hh:mm</p> <p>String</p>
Help Notes	<ul style="list-style-type: none"> • Time is recorded to the nearest minute, however time to within 15 minutes of exact time of stroke onset is acceptable to be coded as “Accurate”. • The time that the patient’s symptoms were first recognized. • If the patient describes progressive symptoms, record the time of the very first symptom. • If the patient woke with symptoms of stroke that were not present when they went to sleep then record the time they woke with symptoms. Then select the Estimate radio button below the time field.

Help Notes	<ul style="list-style-type: none"> Hints for recording time: <table border="1" data-bbox="695 205 1299 390"> <thead> <tr> <th>Time</th> <th>Record Time as:</th> </tr> </thead> <tbody> <tr> <td>Midnight (12:00 am)</td> <td>23:59</td> </tr> <tr> <td>Noon (12:00 pm)</td> <td>12:00</td> </tr> <tr> <td>12:15 am</td> <td>00:15</td> </tr> <tr> <td>6:00 am</td> <td>06:00</td> </tr> </tbody> </table> If an exact time cannot be recorded (i.e. not in the chart or proxy/ family does not know), the best estimate should be given. If the accurate (exact) time is unknown and not obtainable, “Estimate” radio button should be selected below the entered time. Time is considered “Accurate” to within 15 minutes of exact time. Descriptions of time such as <i>two hours prior to arrival</i>, <i>about 1 hour ago</i> or <i>approximately 2 and a half hours ago</i> are specific enough to perform a calculation or express a time as Exact. If a time cannot be clearly determined, use the table below for estimating times in conjunction with the time the note was recorded (or the time of arrival if not noted). These should only be used as a last resort, and the time should be recorded as an “Estimate”: <table border="1" data-bbox="695 926 1279 1518"> <thead> <tr> <th>Description of Time</th> <th>Record Time as:</th> </tr> </thead> <tbody> <tr> <td>Middle of the night</td> <td>03:00</td> </tr> <tr> <td>Breakfast</td> <td>08:00</td> </tr> <tr> <td>Early morning</td> <td>08:00</td> </tr> <tr> <td>Morning</td> <td>09:00</td> </tr> <tr> <td>Late morning</td> <td>10:00</td> </tr> <tr> <td>Lunch</td> <td>12:00</td> </tr> <tr> <td>Midday or 12 Noon</td> <td>12:00</td> </tr> <tr> <td>Early afternoon</td> <td>14:00</td> </tr> <tr> <td>Afternoon or mid-afternoon</td> <td>15:00</td> </tr> <tr> <td>Late afternoon</td> <td>16:00</td> </tr> <tr> <td>Dinner/Supper</td> <td>18:00</td> </tr> <tr> <td>Early evening</td> <td>19:00</td> </tr> <tr> <td>Evening</td> <td>21:00</td> </tr> <tr> <td>Late evening</td> <td>22:00</td> </tr> </tbody> </table> <ul style="list-style-type: none"> If a time is unknown, enter ‘99:99’. Then select Estimate radio button below the time field. 	Time	Record Time as:	Midnight (12:00 am)	23:59	Noon (12:00 pm)	12:00	12:15 am	00:15	6:00 am	06:00	Description of Time	Record Time as:	Middle of the night	03:00	Breakfast	08:00	Early morning	08:00	Morning	09:00	Late morning	10:00	Lunch	12:00	Midday or 12 Noon	12:00	Early afternoon	14:00	Afternoon or mid-afternoon	15:00	Late afternoon	16:00	Dinner/Supper	18:00	Early evening	19:00	Evening	21:00	Late evening	22:00
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Further Information	<p>Consistent with:</p> <ul style="list-style-type: none"> Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009, Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), Registry of the Canadian Stroke Network Operations Manual 2003 																																								

5.5 Date of admission to hospital

<i>This variable is mandatory</i>	
Common Name	Date that the patient was actually admitted to acute care or inpatient unit of the hospital. This is <i>not</i> the date of arrival to ED.
Definition	Date on which an admitted patient commences an episode of care.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 269967</i> <i>Registration: Health, Standard 01/03/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/269967
Format	Date recorded as DD/MM/YYYY format and is a required field. The forward slashes do not need to be typed in. <i>Maximum character length: 10</i>
Recording Guidance	Hospital admission date and the date the patient first arrived at the hospital are frequently different for ED admissions. If the patient arrived through the ED, please ensure you use the actual date of admission to acute care and not the arrival date to the ED.
Codes and Values	Date recorded as DD/MM/YYYY format. String
Help Notes	<ul style="list-style-type: none"> • Date of admission is a required field, and must be completed. • If the accurate (exact) date is unknown and not obtainable, the closest date should be estimated and the “Estimate” radio button should be selected below the entered date. • When month and year are known the date should be recorded as 01/MM/YYYY and the “Estimate” radio button should be selected below the entered date. • When only the year is known the date should be recorded as 01/01/YYYY and the “Estimate” radio button should be selected below the entered date. • Length of stay in AuSCR reports is calculated with reference to the date of admission and date of discharge (See 7.1). In calculations of length of stay, date of admission is counted if the patient in hospital at midnight and date of discharge is not counted, even if the patient was discharged at the end of the day. A same-day patient is allocated a length of stay of one day.

Further Information	<p>Compliant with:</p> <ul style="list-style-type: none">• Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009,• Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), and• Registry of the Canadian Stroke Network Operations Manual 2003• Length of stay definition consistent with in the National Health Data Dictionary <i>Episode of admitted patient care- length of stay (including leave days)</i> METeOR Identifier: 269983 <p>http://meteor.aihw.gov.au/content/index.phtml/itemId/269983</p>
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5.6 Was the patient transferred from another hospital?

<i>This variable is mandatory</i>	
Common Name	Was the patient admitted straight from another hospital (did not present at ED and did not have their stroke while an inpatient at the current hospital)?
Definition	Transfer includes from other hospitals intrastate, interstate and international.
Main Source of Standard	National Stroke Foundation Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009
Format	Drop down list: Yes No Unknown This is a required field <i>Maximum character length: 1</i>
Recording Guidance	Ambulance report. Individual patient medical record – Admission form, Discharge summary, ED Nurses notes, History and Medical /nursing notes.
Codes and Values	1 Yes, transferred from another hospital 2 No, not transferred from another hospital 9 Unknown
Help Notes	Transfer includes from other hospitals intrastate, interstate and international.
Further Information	Consistent with: <ul style="list-style-type: none"> • Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009, • Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), and • Registry of the Canadian Stroke Network Operations Manual 2003

5.7 *Did the stroke occur while the patient was in hospital?*

<i>This variable is mandatory</i>	
Common Name	Also known as 'In-hospital stroke'
Definition	Stroke or Transient Ischaemic Attack (TIA) with onset during an episode of admitted patient care for another condition.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 354816</i> <i>Registration Status: Health, Standard 05/02/2008</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/354816
Format	Drop down list: Yes No Unknown This is a required field. <i>Maximum character length: 1</i>
Recording Guidance	Individual patient medical record – Admission form, Discharge summary, ED Nurses notes, History and Medical /nursing notes. Select "No" if this is not an in-hospital stroke. Select "Yes" if the stroke occurred while the patient was an in-patient
Codes and Values	1 Yes- Condition (stroke) with onset during the episode of admitted patient care 2 No- Condition (stroke) not noted as arising during the episode of admitted patient care 9 Unknown
Help Notes	The occurrence of stroke or TIA during an episode of admitted patient care for a different condition (e.g. admitted for another reason or procedure). If the patient suffered another stroke event while still in hospital for their index stroke this will be captured at the 3 month follow-up.
Further Information	Consistent with: <ul style="list-style-type: none"> • Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009, • Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), and • Registry of the Canadian Stroke Network Operations Manual 2003

5.8 Was the patient able to walk independently on admission?

<i>This variable is mandatory</i>	
Definition	An indicator of a person's need for assistance with mobility
Main Source of Standard	Clinical audit method and help notes – Data Dictionary – National Stroke Foundation 2009. Validated prognostic variable originally from Counsell C, Dennis M, McDowall M, Warlow C. Predicting outcome after acute and subacute stroke: development and validation of new prognostic models. <i>Stroke</i> 2002;33(4):1041-7.
Format	Drop down list: Yes No Unknown This is a required field. <i>Maximum character length: 1</i>
Recording Guidance	Individual patient medical record – Admission form, Discharge summary, ED Nurses notes, History and Medical /nursing notes.
Codes and Values	1 Yes- Patient able to walk on admission 2 No 9 Unknown
Help Notes	<ul style="list-style-type: none"> • The ability of the patient to mobilise without the assistance of another person recorded on admission to hospital (i.e. may include walking aid, but without assistance of another person). • Able to walk: <ul style="list-style-type: none"> – Patient walked independently (no equipment, no help from another person) – Patient walked with assistance from an assistive device (e.g. walking stick, walking frame) – Patient walked to and from bathroom – Patient received supervision • Not able to walk: <ul style="list-style-type: none"> – Patient needed assistance from another person/s to walk – Patient used a wheelchair or bed trolley – Patient is only getting out of bed to the bedside commode (or up in chair) • A modified Rankin Score of 4 or 5 would mandate a selection of “No” • A FIM™ Score of 4 or less would mandate a selection of “No”

Further Information	<p>The variable is used as a measure of stroke severity at time of hospital admission (e.g. first few hours of presentation). The variable can be used in statistical models to make corrections for differences in patient case mix to ensure comparisons of quality of care and/or health outcomes between patient sub-groups are valid. This variable is not used as a functional outcome measure.</p> <p>Compliant with:</p> <ul style="list-style-type: none">• Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009.
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6 Clinical Information

6.1 Was the patient treated in a Stroke Unit at any time during their stay?

<i>This variable is mandatory</i>	
Definition	<p>Was the patient treated in a Stroke Unit at any time during their stay?</p> <p>'Stroke Unit ' is defined as care provided in a hospital ward with the following elements:</p> <ul style="list-style-type: none"> – Co-located beds within a geographically defined unit. – Dedicated, multidisciplinary team with members who have a special interest in stroke or rehabilitation. – Multidisciplinary team meet at least once per week to discuss patient care – Coordinated care. This may occur via one particular person (stroke coordinator / case manager) or established mechanisms. – Team has access to regular professional development and education relating to stroke. – Routine involvement of carers in the rehabilitation/therapy process. – Early (from day 1) active rehabilitation. – Routine use of guidelines, care plans and protocols.
Main Source of Standard	Clinical audit method and help notes – Data Dictionary – National Stroke Foundation 2009.
Format	<p>Drop down list:</p> <p>Yes No Unknown</p> <p>This is a required field.</p> <p><i>Maximum character length: 1</i></p>
Recording Guidance	Individual patient medical records – Admission form, Ward admission list
Codes and Values	<p>1 Yes</p> <p>2 No</p> <p>9 Unknown</p>

<p>Help Notes</p>	<p>There are 2 types of stroke units that treat acute stroke patients. Each has a service provided in a discrete ward or dedicated beds within a larger ward, with a specialised multidisciplinary team with allocated FTE for the care of patients with stroke.</p> <ol style="list-style-type: none"> 1. Acute Stroke Unit if it accepts patients acutely but discharges early (usually within 7 days). 2. Comprehensive Stroke unit which accepts patients acutely but also provides rehabilitation for at least several weeks. <ul style="list-style-type: none"> • When answering this question you should answer yes if the patient was admitted to any type of stroke unit outlined above. • For the purposes of this question a rehabilitation stroke unit does not count as we are looking at the acute phase of treatment. • If care type changes but patient is not physically discharged, then the date of discharge for acute care is the transfer of care date (e.g. rehabilitation unit coordinates care instead of acute stroke unit team)
<p>Further Information</p>	<p>Compliant with:</p> <ul style="list-style-type: none"> • National Stroke Foundation Stroke Audit 2009, • Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), and • Registry of the Canadian Stroke Network Operations Manual 2003

6.2 Type of stroke

<i>This variable is mandatory</i>	
Definition	The clinical diagnosis of stroke type ascertained on discharge.
Main Source of Standard	Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009.
Format	Drop down list: Ischaemic Haemorrhagic TIA Undetermined This is a required field.
Recording Guidance	MRI or CT Scan Report, Radiologist's report, History and physical examination, ED Admission history, Discharge history, Progress notes, Consultant's notes. <ul style="list-style-type: none"> • Select "Ischaemic" if the CT/MRI report is consistent with cortical, sub-cortical, brainstem or cerebellar infarction. • Select "Haemorrhage" if the CT/MRI report is consistent with intraventricular, intracerebral haemorrhage or other non-traumatic intracerebral haemorrhage. • Select "Undetermined" if the CT/MRI report is inconclusive or if no brain imaging has been undertaken and stroke type cannot be confirmed through other diagnostic assessments.
Codes and Values	Ischaemic Haemorrhagic TIA Undetermined
Help Notes	If a patient has an ICH transformation the main type of stroke on admission is listed e.g. ischaemic stroke.
Further Information	Compliant with: <ul style="list-style-type: none"> • Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009, • Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), and • Registry of the Canadian Stroke Network Operations Manual 2003

6.3 ***If an Ischaemic stroke, did the patient receive Intravenous Thrombolysis (tPA)?***

<i>This variable is mandatory</i>	
Common Name	Was thrombolytic therapy given?
Definition	For those patients who suffered an ischaemic stroke, there should be documented evidence that intravenous thrombolysis (tissue plasminogen activator [tPA] e.g. alteplase) is prescribed and recorded as administered on the patient's medication chart.
Main Source of Standard	Clinical audit method and help notes – Data Dictionary – National Stroke Foundation 2009
Format	Drop down list: Yes No Unknown This is a required field. <i>Maximum character length: 1</i>
Recording Guidance	ED record/notes, ED physician's medication orders, History and Physical examination, Emergency Nurses notes, Physicians Progress notes. Select "No" if there is no documentation that the patient received thrombolytic therapy. Select "Yes" if there is documentation of thrombolytic therapy being given to the patient. If there is not documentation of thrombolytic therapy in the physician or nurses notes, check the ED medication order documentation, medication ordering system in the computer (if available at your hospital), Acute stroke Pathway documentation or admission notes.
Codes and Values	1 Yes 2 No 9 Unknown
Help Notes	As tPA is only for Ischaemic strokes, a link to type of stroke field selection of Ischaemic stroke is created in the database so this variable will only be visible if Stroke Type = Ischaemic stroke. Do not include thrombolytic therapy for indications other than ischaemic stroke. That is, do not include intra-cerebral venous infusion for cerebral venous thrombosis, intraventricular infusion for intraventricular hemorrhage, intraparenchymal infusion for percutaneous aspiration of intracerebral hematoma, myocardial infarction, pulmonary embolism, or peripheral clot.

Further Information	<p>Compliant with:</p> <ul style="list-style-type: none">• Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009,• Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), and• Registry of the Canadian Stroke Network Operations Manual 2003
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6.4 Cause of stroke

<i>This variable is mandatory</i>	
Definition	Whether or not the underlying cause of the stroke was known or unknown. For example, large artery vessel disease, cardiac embolic source, etc.
Main Source of Standard	Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009
Format	Drop down list: Known Unknown This is a required field.
Recording Guidance	ED record/notes, History and Physical examination, Emergency Nurses notes, Physicians Progress notes, CT/MRI scan results.
Codes and Values	Known Unknown
Help Notes	Select “ Known ” if there is documented evidence of a structural, haematological, genetic or drug-related cause of stroke. Specifically, these causes include large-artery atherosclerosis, cardioembolism, small-vessel occlusion, or stroke of other determined etiology, such as illicit drug use, a diagnosed metabolic disorder, or intervention/post-operative. Select “ Unknown ” if cause cannot be identified, or if two potential causes are present but it is unknown which is likely.
Further Information	Cryptogenic stroke is common and understanding the cause of stroke is important for making treatment decisions including secondary prevention management. This information is necessary for defining and monitoring control targets, understanding resource utilisation implications and identifying relevant cases for future research. It is also may be used as a quality of care indicator of adverse patient outcomes.

6.5 ICD10 Code - Principal Diagnosis

Common Name	ICD10 Principal Diagnosis																						
Definition	The Principal Diagnosis established after hospital admission as the main reason for an episode of admitted patient care, as represented by an ICD10 code.																						
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 361034</i> <i>Registration Status: Health, Standard 05/02/2008</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/361034																						
Format	Drop down list (or free text if not in the list) <table border="1" data-bbox="581 709 906 1150"> <tr><td>I61.0</td><td>I63.1</td></tr> <tr><td>I61.1</td><td>I63.2</td></tr> <tr><td>I61.2</td><td>I63.3</td></tr> <tr><td>I61.3</td><td>I63.4</td></tr> <tr><td>I61.4</td><td>I63.5</td></tr> <tr><td>I61.5</td><td>I63.6</td></tr> <tr><td>I61.6</td><td>I63.8</td></tr> <tr><td>I61.8</td><td>I63.9</td></tr> <tr><td>I61.9</td><td>I64</td></tr> <tr><td>I62.9</td><td>G45.9</td></tr> <tr><td>I63.0</td><td></td></tr> </table> <p><i>Maximum character length: 8</i> <i>ANN{.N[N]}</i></p>	I61.0	I63.1	I61.1	I63.2	I61.2	I63.3	I61.3	I63.4	I61.4	I63.5	I61.5	I63.6	I61.6	I63.8	I61.8	I63.9	I61.9	I64	I62.9	G45.9	I63.0	
I61.0	I63.1																						
I61.1	I63.2																						
I61.2	I63.3																						
I61.3	I63.4																						
I61.4	I63.5																						
I61.5	I63.6																						
I61.6	I63.8																						
I61.8	I63.9																						
I61.9	I64																						
I62.9	G45.9																						
I63.0																							
Recording Guidance	The ICD-10-AM 6th edition codes reported by the Medical Records/Coding department for the individual patient.																						
Codes and Values	I61 Intra cerebral Haemorrhage (I61.0-I61.9) I62 Other non-traumatic intra cerebral haemorrhage (I62.9) I63 Cerebral Infarction (I63.0, I63.1, I63.2, I63.3, I63.4, I63.5, I63.6, I63.8, I63.9) I64 Stroke, not specified as haemorrhage or infarction G45.9 Transient Ischaemic Attack Other (<u>See Help Notes below</u>)																						

<p>Help Notes</p>	<ul style="list-style-type: none"> • The delay to coding within your hospital will influence when the ICD10 codes can be entered • ICD10 may be entered at a later date; when medical record has been coded with episode details. • The AuSCR Office staff will contact you to ask you to complete the ICD10 code if codes are missing during regular data cleaning processes. • When Principal Diagnosis is not one of the codes listed in the drop down list, just directly type the code provided in the Medical Record into the Principal Diagnosis input box. That is, you can manually enter any code correctly formatted or select from the list.
<p>Further Information</p>	<ul style="list-style-type: none"> • The principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and health care planning purposes. Therefore, these codes are important for international, national or state-based comparative analyses of stroke separations. <p>Compliant with:</p> <ul style="list-style-type: none"> • Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009, • Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), and • Registry of the Canadian Stroke Network Operations Manual 2003

6.6 ICD10 Code - Medical Condition

Common Name	ICD10 Medical Condition
Definition	All related sundry diagnosis and/or medical conditions during the episode of admitted patient care represented by an ICD10 code.
Main Source of Standard	Based on National Health Data Dictionary <i>METeOR Identifier: 391328</i> <i>Registration Status: Health, Standard</i> <i>05/02/2008</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/391328
Format	Free text <i>Maximum character length: 10</i>
Recording Guidance	The ICD-10-AM 6th edition codes reported by the Medical Records/Coding department for the individual patient admission episode.
Codes and Values	Any valid ICD10 code or Casemix code.
Help Notes	<ul style="list-style-type: none"> • The delay to coding within your hospital will influence when the ICD10 codes can be entered • ICD10 codes may be entered at a later date; when the medical record has been coded with episode details. • The AuSCR Office staff will contact you to ask you to complete the ICD10 code if codes are missing during regular data cleaning processes. • Enter all Secondary Diagnosis codes provided in Medical Records for the relevant episode of care. • Enter each code individually then click the Add button after entering each code.
Further Information	Compliant with: <ul style="list-style-type: none"> • Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009, • Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), and • Registry of the Canadian Stroke Network Operations Manual 2003

6.7 ICD10 Code - Medical Complication

Common Name	ICD10 Medical Complication
Definition	All related complications that occurred during the episode of admitted patient care represented by an ICD10 code
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 405823</i> <i>Registration Status: Health, Standard 05/02/2008</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/405823
Format	Free Text <i>Maximum character length: 10</i>
Recording Guidance	The ICD-10-AM 6th edition codes reported by the Medical Records/Coding department for the individual patient admission episode.
Codes and Values	Any valid ICD10 code or Casemix procedure code.
Help Notes	<ul style="list-style-type: none"> • The delay to coding within your hospital will influence when the ICD10 codes can be entered • ICD10 codes may be entered at a later date; when the medical record has been coded with episode details. • The AuSCR Office staff will contact you to ask you to complete the ICD10 code if codes are missing during regular data cleaning processes. • Enter all Complication codes provided in Medical Records for the relevant episode of care. • Enter each code individually then click the Add button after entering each code.
Further Information	Compliant with: <ul style="list-style-type: none"> • Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009, • Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), and • Registry of the Canadian Stroke Network Operations Manual 2003

6.8 ICD10 Code – Medical Procedure

Common Name	ICD10 Medical Procedure
Definition	The codes established after hospital admission as represented by an ICD10 code on the patient discharge summary, Casemix summary or Medical Record.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 391347</i> <i>Registration Status: Health, Standard 05/02/2008</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/391347
Format	Free Text <i>Maximum character length: 20</i>
Recording Guidance	The ICD-10-AM 6th edition codes reported by the Medical Records/Coding department for the individual patient admission episode.
Codes and Values	Any valid ICD10 code or Procedures code used by the Hospital Medical Records department.
Help Notes	<ul style="list-style-type: none"> • The delay to coding within your hospital will influence when the ICD10 codes can be entered • ICD10 may be entered at a later date; when medical record has been coded with episode details. • The AuSCR Office staff will contact you to ask you to complete the ICD10 code if codes are missing during regular data cleaning processes. • Enter all Procedure codes provided in Medical Records or those used by the hospital for the relevant episode of care. • Enter each code individually then click the Add button after entering each code.
Further Information	Compliant with: <ul style="list-style-type: none"> • Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009, • Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), and • Registry of the Canadian Stroke Network Operations Manual 2003

7 Discharge Information

7.1 Date of discharge, if known

<i>This variable is mandatory</i>	
Definition	Date on which an admitted patient completes an episode of care.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 270160</i> <i>Registration Status: Health, Standard</i> 01/03/2005 http://meteor.aihw.gov.au/content/index.phtml/itemId/270160
Format	Date recorded as DD/MM/YYYY format and is a required field. The forward slashes do not need to be typed in. <i>Maximum character length: 10</i>
Recording Guidance	Physician's and Nursing Progress notes, Discharge Summary, Care plan.
Codes and Values	Date recorded as DD/MM/YYYY format. String
Help Notes	<ul style="list-style-type: none"> • Date of discharge is a required field, and must be completed. • If the patient dies while in hospital please enter discharge date as the date of death. • In the rare event that the accurate (exact) date is unknown and not obtainable, the closest date should be estimated and "Estimate" radio button should be selected below the entered date. • When month and year are known the date should be recorded as 01/MM/YYYY and the "Estimate" radio button should be selected below the entered date. • When only the year is known the date should be recorded as 01/01/YYYY and the "Estimate" radio button should be selected below the entered date.
Further Information	Compliant with: <ul style="list-style-type: none"> • Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009, • Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), and • Registry of the Canadian Stroke Network Operations Manual 2003

7.2 Discharge destination/mode

<i>This variable is mandatory</i>	
Common Name	Discharge destination
Definition	Status at separation of person (discharge/transfer/death) and place to which person is released as represented by a code.
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 270094</i> <i>Registration Status: Health, Standard 01/03/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/270094 Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009
Format	Drop down list: Hospital Rehabilitation (inpatient) Low level Residential care High level Residential care Home with supports Home without supports Transitional care service Died in Hospital Other This is a required field.
Recording Guidance	Physician's and Nursing Progress notes, Discharge Summary, Care plan
Codes and Values	<ol style="list-style-type: none"> 1. Hospital 2. Rehabilitation (inpatient) 3. Low level Residential care 4. High level Residential care 5. Home with supports 6. Home without supports 7. Transitional care services 8. Died in Hospital 9. Other
Help Notes	<i>Hospital:</i> Includes admission or transfer to another acute hospital, including transfer to a psychiatric unit or to a palliative care hospital.

Help Notes	<p>Rehabilitation- inpatient: Includes any rehabilitation ward or part of a ward where the patient is undergoing rehabilitation <i>as an inpatient</i>, prior to discharge. Beds in a rehabilitation ward may be allocated to the specialty of rehabilitation medicine or to any other specialty. Note: geriatric assessment units, such as Geriatric Evaluation and Management (GEM) Units are excluded. GEM Units should be coded as transfers to a Transitional Care Service.</p> <p>Low level Residential care: Includes residents of residential aged care services (formerly nursing homes: low level care, special accommodation and aged care hostels) and multipurpose services or multipurpose centres, who are receiving low level care. This category includes Indigenous Flexible Pilots.</p> <p>High level Residential care: Includes residents of residential aged care services (formerly nursing homes) and multipurpose services or multipurpose centres, who are receiving high level care. This category includes Indigenous Flexible Pilots and private nursing home for the purpose of Palliative Care.</p> <p>Home with supports: Includes private residences (such as such as houses, flats, units, units in a retirement village, caravans, mobile homes, boats, marinas) in which patients are provided with support in some way by staff or volunteers (including family members or spouse). This category includes domestic-scale living facilities (such as group homes for people with disabilities, cluster apartments where a support worker lives on site, community residential apartments, congregate care arrangements, etc.) which may or may not have 24-hour supervision and care.</p> <p>Support may be provided by a family member/friend who may or may not be living in the same residence, and is identified as providing regular care and assistance. Support may also be provided on a paid basis and may include community care, meals on wheels or other support organisations.</p> <p>Home without supports: Includes private residences (such as such as houses, flats, units, units in a retirement village, caravans, mobile homes, boats, marinas) in which patients are will not be provided with any support (note that support from a spouse should be recorded as Home with Supports).</p> <p>Transitional care service: Transition care can take place either at home or in a live-in setting. When it's offered in a live-in setting, it includes hospital-in-the-home, and home-based rehabilitation services. Hospital staff may create an internal transfer/separation to the Geriatric Evaluation and Management (GEM) Unit, this should also be recorded as discharge to a Transition care service. Even in self-discharge the destination should be recorded.</p> <p>If the patient dies in hospital it is also mandatory to tick the "Patient Deceased" tick box in the Death Information section and complete the date of death. See "Date of Discharge" and "Date of Death" Help notes.</p>
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7.3 Discharged on antihypertensive agents

<i>This variable is mandatory</i>	
Common Name	Was antihypertensive medication provided at discharge?
Definition	Antihypertensive agents commonly include angiotensin converting enzyme inhibitors (e.g. Perindopril, Ramipril) with or without diuretic and angiotensin II receptor antagonists (e.g. Telmisartan, Losartin) with or without diuretic. Other agents include alpha blockers (e.g. Prazosin), beta blockers (e.g. Atenolol, Metoprolol), calcium channel blockers (e.g. Amlodipine, Diltiazem hydrochloride) and thiazide diuretics (refer to MIMS for full list).
Main Source of Standard	Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009
Format	Drop down list: Yes No Unknown This is a required field. <i>Maximum character length: 1</i>
Recording Guidance	Physician's medication orders, Physician's and Nursing Progress notes, stroke pathway documentation, Discharge Summary, Care plan.
Codes and Values	1 Yes 2 No 9 Unknown
Further Information	Compliant with: <ul style="list-style-type: none"> • Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009, • Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008), and • Registry of the Canadian Stroke Network Operations Manual 2003

7.4 Is there evidence that a care plan outlining post discharge care in the community was developed with the team and the patient and/or family?

<i>This variable is mandatory</i>	
Definition	<p>Documented evidence that the patient received a plan that outlines care in the community after discharge, developed with input from both the multi-disciplinary team and the patient.</p> <p>The specific care plan should address one or more of the following:</p> <ul style="list-style-type: none"> i) Monitoring and managing symptoms and signs of illness including risk management if symptoms develop or become worse. ii) Managing the impacts of illness on their lifestyle, emotions and interpersonal relationships. iii) Adherence to treatment regimes.
Main Source of Standard	Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009
Format	<p>Drop down list:</p> <p>Yes No Unknown</p> <p>This is a required field.</p> <p><i>Maximum character length: 1</i></p>
Recording Guidance	Physician's and Nursing Progress notes, Discharge Summary, Care plan.
Codes and Values	<p>1 Yes</p> <p>2 No</p> <p>3 Not Applicable</p> <p>9 Unknown</p>
Help Notes	<ul style="list-style-type: none"> • Compliance with this indicator requires; <ul style="list-style-type: none"> – Documentary evidence of a care plan having been provided to any patient who is going home or to a non medical private setting. – Evidence of engagement of other health care providers such as pharmacists, GP's and community based services. • Patients transferred to inpatient rehabilitation are excluded and "Not Applicable" should be selected. • There is considerable variation in the approaches to a consumer self management care plan. As a self management plan is individually tailored, and what constitutes a comprehensive plan is open to interpretation and it may have to be taken in good faith that professional obligation will follow the spirit of it.

	<p>Documentation will be a major obstacle as a lot of self management information is verbal and currently happens in an ad hoc manner by different health professionals (and may not always be consistent).</p>
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<p>Help Notes</p>	<ul style="list-style-type: none"> • With this indicator we are looking for a deliberate and more formal process. A verbal discharge discussion is not a care plan formulated with a patient.
<p>Further Information</p>	<ul style="list-style-type: none"> • Good discharge planning reduces LOS & readmissions with enhanced community reintegration. Complex process that relies on good communication between carers, patient and family, and treating staff. <p>Compliant with:</p> <ul style="list-style-type: none"> • Clinical audit method and help notes – Data Dictionary - National Stroke Audit 2009, <p>Consistent with:</p> <ul style="list-style-type: none"> • Core data elements 12.12 of the Paul Coverdell National Acute Stroke Registry (January 16, 2008)

8 Death Information

8.1 Patient deceased

Common Name	Whether or not the patient has died.
Definition	Cessation of the patient's life.
Main Source of Standard	National Health Data Dictionary Related Data Reference: is used in conjunction with Discharge Destination/Mode <i>METeOR Identifier: 270094</i> <i>Registration Status: Health, Standard 01/03/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/270094
Format	Tick box
Recording Guidance	Physician's and Nursing Progress notes, Discharge Summary. Death certificate in medical record.
Codes and Values	Yes
Help Notes	This variable should be used in conjunction with variable "Discharge Destination/Mode" which codes in-hospital death. When the tick box is ticked a date picker box will appear with Accurate and Estimate radio buttons. Where the date of death can be specified. Patient who has died in hospital, the discharge information of the current episode should be completed and locked.
Further Information	If a patient is known to have died after discharge from hospital this information can be entered here. This will avoid the AuSCR Office attempting to make contact at 3 months with someone who is deceased. If the episode has been locked you can ask the AuSCR Office to unlock this episode so that the information can be recorded.

8.2 Date of death

<i>This variable is mandatory if “Patient Deceased” is coded 1 (Yes)</i>	
Definition	Date of death of the person
Main Source of Standard	National Health Data Dictionary <i>METeOR Identifier: 287305</i> <i>Registration Status: Health, Standard 04/05/2005</i> http://meteor.aihw.gov.au/content/index.phtml/itemId/287305
Format	Date recorded as DD/MM/YYYY format and is a required field if the patient is deceased. The forward slashes do not need to be typed in. <i>Maximum character length: 10</i>
Recording Guidance	Individual patient medical records – Medical notes, death certificate in medical record. Telephone contact with family member/s Telephone or postal follow-up contact with family member/s
Codes and Values	Date recorded as DD/MM/YYYY format. String
Help Notes	<ul style="list-style-type: none"> • If the accurate (exact) date is unknown and not obtainable, “Estimate” radio button should be selected below the entered date. • When month and year are known the date should be recorded as 01/MM/YYYY and the “Estimate” radio button should be selected below the date field. • When only the year is known the date should be recorded as 01/01/YYYY and the “Estimate” radio button should be selected below the date field.

9 Opt-out

Exclusion of cases in a disease registry can compromise the usefulness and generalisability of data to assess the quality of care provided in hospitals. Information about patients is included in the AuSCR database unless they actively request to have some or all of their data removed.

This process is a recommended national standard for disease registries and all hospitals providing data to the AuSCR database have ethics approvals to enter data using this 'Opt-out' method of consent.

Patients may inform hospital staff about their desire to have some or all of their information removed from AuSCR. In addition, patients may decide that they do not want to be contacted for follow-up after they leave hospital. Hospital staff can inform AuSCR Office about the information the patient would not like to be retained in AU SCR or if they want to refuse a three month follow-up using the Opt-out screen. The Opt-out screen is located under the Administration side menu bar. For further details refer to page X of the Hospital User Manual.

Note, a patient who does not want to be contacted at 3 or more months after stroke is not an 'opt-out' case, but is considered a refusal for follow-up. All patients contacted by AuSCR Office staff when they leave hospital for follow-up are again given the option to refuse participating in a follow-up assessment.

9.1 Opt-out Type

Definition	Variable list of the parts of the registry that the patient does not wish to have recorded in the AuSCR database.
Main Source of Standard	Nil.
Format	Tick box of each variable required to be excluded/removed from the registry database. Additional choices include the ability to nominate "do not contact for follow-up". <i>Maximum characters 255</i>
Recording Guidance	Consistent with the signed paper-based opt-out form. Please file form in the patient's Medical record.

Comments:

Select All Do not contact for follow-up

<input type="checkbox"/> First Name	<input type="checkbox"/> Last Name	<input type="checkbox"/> Date of Birth	<input type="checkbox"/> Medicare No	<input type="checkbox"/> Title
<input type="checkbox"/> Gender	<input type="checkbox"/> Phone Number	<input type="checkbox"/> Mobile Number	<input type="checkbox"/> Aboriginal/Torres St. Islander	<input type="checkbox"/> Country of Birth
<input type="checkbox"/> Language Spoken	<input type="checkbox"/> Interpreter Needed			
<input type="checkbox"/> Address/Mailing Address	<input type="checkbox"/> Address/Address Type	<input type="checkbox"/> Address/Street Address	<input type="checkbox"/> Address/Suburb	<input type="checkbox"/> Address/State
<input type="checkbox"/> Address/Postcode	<input type="checkbox"/> Address/Country			
<input type="checkbox"/> Contacts/First Name	<input type="checkbox"/> Contacts/Last Name	<input type="checkbox"/> Contacts/Phone Number	<input type="checkbox"/> Contacts/Mobile Number	<input type="checkbox"/> Contacts/Relationship
<input type="checkbox"/> Contacts/Address Type	<input type="checkbox"/> Contacts/Address	<input type="checkbox"/> Contacts/Suburb	<input type="checkbox"/> Contacts/State	<input type="checkbox"/> Contacts/Postcode
<input type="checkbox"/> Contacts/Country				
<input type="checkbox"/> Date of arrival to emergency department	<input type="checkbox"/> Time of arrival to emergency department	<input type="checkbox"/> Onset of stroke date	<input type="checkbox"/> Onset of stroke time	<input type="checkbox"/> Date of admission to hospital
<input type="checkbox"/> Was the patient transferred from another hospital?	<input type="checkbox"/> Did this stroke occur while the patient was in hospital?	<input type="checkbox"/> Was the patient able to walk independently on admission?	<input type="checkbox"/> Is there documented evidence of a previous stroke?	<input type="checkbox"/> Was the patient treated in a Stroke Unit at any time during their stay?
<input type="checkbox"/> Type of stroke	<input type="checkbox"/> Did the patient receive Intravenous Thrombolysis?	<input type="checkbox"/> Cause of stroke		
<input type="checkbox"/> ICD10 code - Diagnosis	<input type="checkbox"/> ICD10 code - Medical Condition	<input type="checkbox"/> ICD10 code - Complications	<input type="checkbox"/> ICD10 code - Procedures	
<input type="checkbox"/> Date of discharge known	<input type="checkbox"/> Date of discharge	<input type="checkbox"/> Discharge destination/mode	<input type="checkbox"/> Discharge on Antihypertensive agent	<input type="checkbox"/> Is there evidence that a care plan outlining post discharge care
<input type="checkbox"/> Deceased	<input type="checkbox"/> Date of death			

Save Cancel

Figure: Patient Specified Opt-Out Details Page

References

1. EuroQoL Group EQ-5D User Guide Version 1 (2008)
2. Cadilhac D, Pearce DC, Levi CR, Donnan G. (2008). Improvements in the quality of care and health outcomes with new stroke care units following implementation of a clinician-led, health system redesign programme in New South Wales, Australia. *Quality and Safety in Health Care*, 17:329-333
3. Counsell C, Dennis M, McDowall M, Warlow C. Predicting outcome after acute and subacute stroke: development and validation of new prognostic models. *Stroke* 2002;33(4):1041-7.
4. MeTEOR , National Health Data Dictionary
<http://meteor.aihw.gov.au/content/index.phtml/itemId/181162> (2008)
5. National Stroke Foundation, Clinical Audit Method and Help Notes- Data dictionary National Stroke Audit (2009)
6. Paul Coverdell National Acute Stroke Registry Data Elements (January 16, 2008).
7. Registry of the Canadian Stroke Network Operations Manual Phase 3 (ICES and CSN, 2003)
8. Riks-Stroke, Acute Phase. Version 8.0 (1 January, 2007).

Appendix 1: Available Countries of Birth and Codes

Australian Bureau of Statistics 2008. [Standard Australian Classification of Countries 2008 \(SACC\)](#). Cat No. 1269.0. Canberra: ABS

Alphabetical Order:

4101	Algeria
8402	Antigua and Barbuda
7202	Armenia
1101	Australia
2301	Austria
7203	Azerbaijan
8404	Bahamas
4201	Bahrain
7101	Bangladesh
8405	Barbados
3301	Belarus
2302	Belgium
8301	Belize
9202	Botswana
5201	Brunei Darussalam
3202	Bulgaria
5101	Burma (Myanmar)
5102	Cambodia
9103	Cameroon
8102	Canada
8204	Chile
6101	China (excludes SARs and Taiwan)
9204	Comoros
1501	Cook Islands
3205	Cyprus
3302	Czech Republic
2401	Denmark
9205	Djibouti
8408	Dominica
4102	Egypt
3303	Estonia
911	Europe, nfd
1502	Fiji
2403	Finland
914	Former Czechoslovakia, nfd
912	Former USSR, nfd

913	Former Yugoslavia, nfd
2303	France
9114	Gambia
4202	Gaza Strip and West Bank
7204	Georgia
2304	Germany
9115	Ghana
3207	Greece
8412	Grenada
8211	Guyana
6102	Hong Kong (SAR of China)
3304	Hungary
2405	Iceland
7103	India
5202	Indonesia
4203	Iran
4204	Iraq
2201	Ireland
3104	Italy
8415	Jamaica
6201	Japan
4206	Jordan
7205	Kazakhstan
9208	Kenya
1402	Kiribati
6203	Korea, Republic of (South)
4207	Kuwait
7206	Kyrgyzstan
5103	Laos
3305	Latvia
4208	Lebanon
9211	Lesotho
4103	Libya
2305	Liechtenstein
3306	Lithuania
2306	Luxembourg
9213	Malawi

5203	Malaysia
7104	Maldives
3105	Malta
1403	Marshall Islands
9122	Mauritania
9214	Mauritius
8306	Mexico
1404	Micronesia, Federated States of
3208	Moldova
4104	Morocco
9216	Mozambique
9217	Namibia
1405	Nauru
2308	Netherlands
1201	New Zealand
9124	Nigeria
1504	Niue
2406	Norway
4211	Oman
7106	Pakistan
1407	Palau
1302	Papua New Guinea
8213	Peru
5204	Philippines
3307	Poland
3106	Portugal
4212	Qatar
3211	Romania
3308	Russian Federation
1505	Samoa
4213	Saudi Arabia
9223	Seychelles
9127	Sierra Leone
5205	Singapore
3311	Slovakia
3212	Slovenia

1303	Solomon Islands
9224	Somalia
9225	South Africa
3108	Spain
7107	Sri Lanka
8422	St Kitts and Nevis
8423	St Lucia
8424	St Vincent and the Grenadines
4105	Sudan
9226	Swaziland
2407	Sweden
2311	Switzerland
4214	Syria
6105	Taiwan
7207	Tajikistan
9227	Tanzania
5104	Thailand
1508	Tonga
8425	Trinidad and Tobago
4106	Tunisia
4215	Turkey
7208	Turkmenistan
1511	Tuvalu
9228	Uganda
3312	Ukraine
4216	United Arab Emirates
2100	United Kingdom
8104	United States of America
7211	Uzbekistan
1304	Vanuatu
8216	Venezuela
5105	Vietnam
4217	Yemen
9231	Zambia

Numerical Order:

911	Europe, nfd
912	Former USSR, nfd
913	Former Yugoslavia, nfd
914	Former Czechoslovakia, nfd
1101	Australia
1201	New Zealand
1302	Papua New Guinea
1303	Solomon Islands
1304	Vanuatu
1402	Kiribati
1403	Marshall Islands
1404	Micronesia, Federated States of
1405	Nauru
1407	Palau
1501	Cook Islands
1502	Fiji
1504	Niue
1505	Samoa
1508	Tonga
1511	Tuvalu
2100	United Kingdom
2201	Ireland
2301	Austria
2302	Belgium
2303	France
2304	Germany
2305	Liechtenstein
2306	Luxembourg
2308	Netherlands
2311	Switzerland
2401	Denmark
2403	Finland
2405	Iceland
2406	Norway
2407	Sweden
3104	Italy
3105	Malta
3106	Portugal
3108	Spain
3202	Bulgaria
3205	Cyprus
3207	Greece

3208	Moldova
3211	Romania
3212	Slovenia
3301	Belarus
3302	Czech Republic
3303	Estonia
3304	Hungary
3305	Latvia
3306	Lithuania
3307	Poland
3308	Russian Federation
3311	Slovakia
3312	Ukraine
4101	Algeria
4102	Egypt
4103	Libya
4104	Morocco
4105	Sudan
4106	Tunisia
4201	Bahrain
4202	Gaza Strip and West Bank
4203	Iran
4204	Iraq
4206	Jordan
4207	Kuwait
4208	Lebanon
4211	Oman
4212	Qatar
4213	Saudi Arabia
4214	Syria
4215	Turkey
4216	United Arab Emirates
4217	Yemen
5101	Burma (Myanmar)
5102	Cambodia
5103	Laos
5104	Thailand
5105	Vietnam
5201	Brunei Darussalam
5202	Indonesia
5203	Malaysia
5204	Philippines
5205	Singapore

6101	China (excludes SARs and Taiwan)
6102	Hong Kong (SAR of China)
6105	Taiwan
6201	Japan
6203	Korea, Republic of (South)
7101	Bangladesh
7103	India
7104	Maldives
7106	Pakistan
7107	Sri Lanka
7202	Armenia
7203	Azerbaijan
7204	Georgia
7205	Kazakhstan
7206	Kyrgyzstan
7207	Tajikistan
7208	Turkmenistan
7211	Uzbekistan
8102	Canada
8104	United States of America
8204	Chile
8211	Guyana
8213	Peru
8216	Venezuela
8301	Belize
8306	Mexico
8402	Antigua and Barbuda
8404	Bahamas
8405	Barbados

8408	Dominica
8412	Grenada
8415	Jamaica
8422	St Kitts and Nevis
8423	St Lucia
8424	St Vincent and the Grenadines
8425	Trinidad and Tobago
9103	Cameroon
9114	Gambia
9115	Ghana
9122	Mauritania
9124	Nigeria
9127	Sierra Leone
9202	Botswana
9204	Comoros
9205	Djibouti
9208	Kenya
9211	Lesotho
9213	Malawi
9214	Mauritius
9216	Mozambique
9217	Namibia
9223	Seychelles
9224	Somalia
9225	South Africa
9226	Swaziland
9227	Tanzania
9228	Uganda
9231	Zambia

Appendix 2: Languages

ABS cat. no. 1267.0. Australian Standard Classification of Languages (ASCL), 2005-06.
Canberra: Australian Bureau of Statistics.

8000	Aboriginal
8998	Aboriginal Australian
8000	Aboriginal dialect
8000	Aboriginal east
8998	Aboriginal English, so described
8924	Aboriginal kreol
8000	Aboriginal language
8000	Aboriginal lingo
8000	Aboriginal north
8000	Aboriginal west coast
8000	Aborigine
8000	Abriginal
8000	Abrignal
2101	Acadian
6513	Acehnese
4203	Acerian
6513	Achenese
6513	Achinese
9201	Acholi
8901	Adnamatana
8901	Adnamathana
8901	Adnyamathana
8901	Adnyamathanha
8901	Adnymathana
8901	Adnymathanha
8901	Adnymathna
8901	Adynamathana
8901	Adynyamathanha
2201	Aegean
4000	Afghan
4000	Afghans
4000	Afghany
9200	African
9299	African Languages, nec
9200	African Languages, nfd
1403	Africanse
1403	Afrikaans
1403	Afrikaner
1403	Afrikanss
7999	Ainu
8515	Airman

9203	Akan
9203	Akani
6599	Aklanon
9201	Akoli
8121	Alawa
8603	Alaywarra
3901	Albaian
3901	Albania
3901	Albanian
3901	Albanien
4202	Algerian
8603	Aljawara
0000	All
8707	Aluridja
8603	Alyawara
8603	Alyawarr
8603	Alyawarr (Alyawarra)
8603	Alyawarra
8603	Alyawarre
8603	Alyawarri
8200	Alyere
8603	Alyuwara
8603	Alywarr
8604	Amajara
8604	Amanantjere
9214	Amarike
8604	Amatjira
8604	Amatyere
9214	Ameherik
1201	American
9101	American Indian
9101	American Languages
9799	American sign language
9799	Ameslan
9214	Amharic
9214	Amhariec
9214	Amhrice
8604	Ami
8718	Anangu
8899	Andajin
8101	Andiljaukwa

8101	Andilyakwa
8101	Andilyaugwa
9599	Angal
8101	Aninailyakwa
8101	Anindilakwa
8101	Anindiljaugwa
8101	Anindilyaga
8101	Anindilyagwa
8101	Anindilyakna
8101	Anindilyakua
8101	Anindilyakwa
8101	Anindilyakwa - Kriol
8101	Anindilyaugwa
8101	Aninilyakwa
8604	Anmatjere Walpiri
8604	Anmatjerra
8604	Anmatjerre
8604	Anmatjirra
8604	Anmatyarra
8604	Anmatyer
8604	Anmatyere
8604	Anmatyerr
8604	Anmatyerr (Anmatyirra)
6302	Annamese
8703	Antikarinya
8703	Antikirinya
9299	Anuak Arabic
0001	Aphasic
8902	Arabana
4202	Arabic
4202	Arabic (including Lebanese)
8902	Arabuna
8902	Arabunna
6199	Arakanese
4203	Aramaic
4203	Aramic
8605	Aranda
8605	Aranda (eastern)
8605	Aranda (western)
8699	Arandic, nec
8600	Arandic, nfd
8605	Aranta
8605	Ararnda
8899	Arawarri
8605	Arente
2303	Argentina
6199	Arkannese

4901	Armenian
8199	Arnhem Land and Daly River Region Languages, nec
8100	Arnhem Land and Daly River Region Languages, nfd
9599	Aroma
3903	Aromunian
3903	Aromunian (Macedo-Romanian)
8605	Arranda
8605	Arranta
8605	Arrarente
8605	Arrent
8605	Arrent western
8605	Arrenta
8605	Arrente
8605	Arrente eastern
8605	Arrente
8605	Arrente (Aranda)
8605	Arrinda
8605	Arrunta
8605	Arunda
8605	Arunta
9203	Asante
4203	Aseriam
9203	Ashanti
9203	Ashanti Twi
0000	Asian
9701	Asl
5213	Assamese
4203	Assyrian
4203	Assyrian Kildian
4203	Assyrian (including Aramaic)
9299	Ateso
9701	Aulan
9701	Auslan
9701	Auslan sign language
1201	Aussie
9401	Aussie Pidgeon
9401	Aussie Pidgin
9701	Aussie sign language
1201	Aust
9701	Aust sign
9701	Aust sign language
1201	Aust slang
9701	Austlan
8924	Australia Kriol

1201	Australian
8000	Australian Aboriginal
8000	Australian Aboriginal language not given
8000	Australian Creoles
9701	Australian deaf sign
8000	Australian Indigenous
8000	Australian Indigenous Languages, nfd
9701	Australian sign
9701	Australian sign language
1201	Australian slang
1301	Austrian
9300	Austronesian Oceanic
0001	Autistic
8999	Awabakal
8399	Ayan
4302	Azerbaijan
4302	Azerbaijani
4302	Azerbaijanian
4302	Azeri
8936	Baagandji
0001	Babble
0001	Baby
0001	Baby language
0001	Baby talk
8801	Bad
1201	Bad English
8801	Badi
8401	Badu
8303	Bagadji
6500	Bahasa
6504	Bahasa Indonesia
6504	Bahasa Indonesian
6505	Bahasa Malay
6505	Bahasa Malaysia
6505	Bahasa malaysian
9599	Bai
6514	Balinese
8250	Balmawi
8250	Balmbi
4104	Balochi
5999	Balti
3100	Baltic
3100	Baltic, nfd
4104	Baluchi
9299	Bambara

8903	Bandjalang
8904	Bandjima
5201	Bangalie
5201	Bangla
5201	Bangladeshi
5201	Banglali
5201	Bangoli
5201	Bangoloy
8903	Banjalang
9200	Bantu
8904	Banyjima
8102	Bara
8102	Barada
8102	Barara
8102	Bararra
8801	Bard
8801	Barda
8801	Bardi
8102	Barea
6599	Basian
2901	Basque
6599	Batak
8905	Batjala
9599	Bau
1301	Bavaria
8102	Bawera
9402	Beach la Mar
4202	Bedouin
3401	Belarusian
0000	Belgian
3401	Belorus
3401	Belorussian
9215	Bemba
5201	Bengalee
5201	Bengali
5201	Bengoli
8308	Berang
9299	Berber
6501	Besayan
9299	Bete
7901	Bhotia
5999	Bhutanese Dzonkha
9402	Bichelamar
6515	Bicol Tagalog
6515	Bicolano
6505	Bidayuh Malay
8906	Bidjara

5299	Bihari
6515	Bikol
8516	Bililuna dialect
8504	Bilinarra
8716	Bindinini
9299	Bini
8102	Birarra
6501	Bisaya
6501	Bisayan
9402	Bislama
9299	Bobangi
8308	Bohran
1503	Bokmal
2303	Bolivia
9299	Bongli
8802	Booneba
3501	Bosanski
3501	Boshiah
3501	Bosnia
3501	Bosnian
3501	Bosnijen
9236	Botswanian
8102	Brada
8102	Brarrda
8102	Brarrua
2302	Brasilian
2302	Brazilian
1199	Breton
8403	Broken
8403	Broken Eng
8403	Broken English
6505	Bruneian
6599	Buginese
8401	Bulgai
3502	Bulgarian
8802	Bunaba
8903	Bundjalung
8903	Bungalong
8904	Bunjima
8802	Bunuba
8802	Bunuba (Bunaba)
8102	Burada
8102	Burara
8102	Burarra
6101	Burma
6101	Burman
6101	Burmese

6199	Burmese and Related Languages, nec
6100	Burmese and Related Languages, nfd
8102	Burrarda
8605	Burringah
8905	Butchulla
3401	Byelorussian
2401	Calabrian
4203	Caldian
0000	Caledonian
6301	Cambodia
6301	Cambodian
0001	Can't speak
1201	Canadian
2101	Canadian French
7101	Canton
7101	Cantonese
1403	Cape Dutch
8300	Cape York Aboriginal
8300	Cape York Peninsula Aboriginal
8399	Cape York Peninsula Languages, nec
8300	Cape York Peninsula Languages, nfd
2303	Castellano
2303	Castilian
2301	Catala
2301	Catalan
2301	Catalonian
2401	Catanese
6502	Cebuan
6502	Cebuano
3601	Ceck
1100	Celtic
1199	Celtic, nec
1100	Celtic, nfd
4900	Central Asian
5211	Ceylonese
6999	Chabacano
0000	Chadonese
4203	Chaldean
4203	Chaldian
6599	Cham
5999	Chamba
7100	Chang Chow
7100	Chang Chow Fu
7105	Chao Zhou

7105	Chaochon
8131	Chauan
7105	Chauv Cou
6999	Chavacano
4999	Chechen
3601	Chek
4203	Cheldean
8924	Cherole
9232	Chewa
7105	Chewchow
3601	Chez
9232	Chichewa
0000	Child
2303	Chili
2303	Chilian
9599	Chimbu
7100	Chin
7100	China
7100	Chinchchou
7100	Chinese
7100	Chinese dialect
7102	Chinese Hakka
7102	Chinese Hucka
7105	Chinese Tio Chiu
7199	Chinese, nec
7100	Chinese, nfd
7105	Chiu Chou
7105	Cho Chau
9299	Chokwe
7105	Chow Chiw
7105	Chue Chow
7105	Chui Chow
7105	Chuo Chao
0000	Cibian
3503	Coation
1201	Cockney
6505	Cocos
6505	Cocos Island
6505	Cocos Malay
6301	Combodia
9303	Cook Island
9303	Cook Island Maori
8505	Coorinji
8921	Coorn
1199	Cornish
8924	Creol Wan Jida
0005	Creole

8000	Creole Aust
8924	Creole Australian
0006	Creole French
8403	Creole Iland
9205	Creole Mauritian
0008	Creole Portuguese
9238	Creole Sechyelles
0007	Creole Spanish
8403	Creole Torres Strait
0005	<i>Creole, nfd</i>
8403	Criole tsi
3503	Croashian
3503	Croat
3507	Croat Serbian
3503	Croataen
3503	Croaten
3503	Croatian
3507	Croatian Serbian
3503	Croatian
3507	Croato Serbian
3503	Crouation
1103	Cymraeg
1103	Cymric
0004	Cyprian
0004	Cypriot
0004	<i>Cypriot, so decribed</i>
0004	Cyprus
3601	Czech
3600	Czechoslovakian
3601	Czeck
8233	Daatiwuy
9299	Dabani
9299	Dagbani
8220	Daii
8311	Daiyuri
8122	Dalabon
8221	Dalawangu
3503	Dalmation
8100	Daly River language
8999	Dandi
8399	Dangedl
1501	Danish
1501	Dansk
4105	Daree
4105	Darei
4105	Darey Afghani
4105	Dari

4105	Dariy
4105	Darre
4105	Darri
8999	Darug
4105	Dary
8233	Datiwuy
0001	Deaf
9700	Deaf language
9700	Deaf sign
8925	Deemin
5299	Degarlo
4105	Deria
1301	Deutsch
8210	Dhaangu
8220	Dhai
8221	Dhalwangu
8231	Dhambarrpuynu
8907	Dhanggatti
8210	Dhangu
8219	Dhangu, nec
8210	Dhangu,nfd
8999	Dharug
8999	Dharuk
8220	Dhay'yi
8229	Dhay'yi, nec
8220	Dhay'yi, nfd
5214	Dhivehi
8230	Dhuwal
8240	Dhuwala
8249	Dhuwala, nec
8240	Dhuwala, nfd
8239	Dhuwal, nec
8230	Dhuwal, nfd
8241	Dhuwaya
0000	Dialect
8908	Dieri
9216	Dinka
5214	Divehi
8908	Diyari
8299	Djaba
8231	Djabarrpsynga
8305	Djabugay
8231	Djambapuingu
8231	Djambarapuyngu
8231	Djambarrbuygu
8231	Djambarrbuyngu
8231	Djambarrbynu

8231	Djambarrpugyu
8231	Djambarrpunu
8231	Djambarrpuy
8231	Djambarrpuyagu
8231	Djambarrpuynau
8231	Djambarrpuynga
8231	Djambarrpuyngu
8231	Djambarrpuynju
8231	Djambarrpuynu
8231	Djambarrpuyu
8231	Djambarruuyngu
8232	Djapu
8222	Djarwark
8507	Djaru
8148	Djeebbana
8250	Djinang
8259	Djinang, nec
8250	Djinang, nfd
8260	Djinba
8269	Djinba, nec
8260	Djinba, nfd
9599	Dobu
0001	Does not speak yet
0001	Doesnt talk
8999	Doonin
1101	Doric
0000	Double Dutch
5100	Dravidian
5199	Dravidian, nec
5100	Dravidian, nfd
1201	Drunken English
9299	Duala
8907	Dungutti
4105	Duri
8231	Durili
1401	Dutch
1400	Dutch and Related Languages, nfd
8507	Dyaru
8306	Dyirbal
9299	Dyula
5999	Dzonglha
5999	Dzonkha
8399	Eacham
8000	East Aboriginal
3400	East Slavic
3400	East Slavic, nfd
8605	Eastern Arrada

8605	Eastern Arrante
8605	Eastern Arrente
7000	Eastern Asian
7000	Eastern Asian Languages, nfd
0005	Eastern Creole
3000	Eastern European
3000	Eastern Eropean Languages, nfd
9101	Ebonics
9299	Edo
9299	Edo Ishan
9299	Efik
4202	Egyptian
4202	Egytion
2303	El Salvadorian
8199	Emmi
1201	England
1201	English
8231	English Djambarrpuyngou
8243	English Gupapuyngu
9401	English Pidgeon
9401	English Pidgin
9401	English Pigin
9799	English signed
9200	Eritrean
1102	Erse
9101	Eskimo
2303	Espagnol
2303	Espanish
2303	Espanol
9601	Esperanto
1601	Estonian
9200	Ethiopa
9200	Ethiopian
0000	European
2000	European south
9217	Ewe
1599	Faeroese
9299	Fang
9203	Fante
1599	Faroese
4106	Farsi
4106	Farsi Persian
9301	Fiji
9301	Fijian
5203	Fijian Indian
6512	Filipino
6511	Filipino Tagalog

1602	Fin
1602	Finland
1602	Finn
1600	Finnic
1602	Finnis
1602	Finnish
1699	Finnish and Related Languages, nec
1600	Finnish and Related Languages, nfd
1401	Flemish
1401	Flemish French
7103	Foo Chow
7103	Foochow
7103	Fookien
6599	Formosan
2101	Francais
2101	France
1301	Franco German
2101	French
2101	French Canadian
0006	French Creole
0006	<i>French Creole, nfd</i>
2101	French Swiss
1402	Friesian
1402	Frisian
2999	Friulian
7103	Fu Jian
7103	Fu Zhou dialect
7103	Fuchian
7103	Fuchien
7103	Fuchow
7103	Fukien
7103	Fukienese
9299	Fulani
3504	Fyr Macedonia
3504	Fyr of Macedonia
3504	Fyro Macedonia
9218	Ga
1102	Gaeilge
1101	Gaelic
1102	Gaelic Irish
1101	Gaelic Scotland
1101	Gaelic Scottish
1101	Gaelic (Scotland)
1101	Gaidhlig
8899	Gajirrawoong

1101	Galic
2399	Galician
9299	Galla
8211	Galpu
8133	Gambalang
8911	Gamilaraay
8261	Ganalbingu
9226	Ganda
8243	Gapapuyngu
8912	Garawa
8912	Garrawa
8912	Garrwa
8913	Garuwali
8199	Geimbio
4902	Georgian
1301	German
1300	German and Related Languages, nfd
1301	Germany
9200	Ghana
9200	Ghanaian
9200	Ghanian
0000	Gibberish
8914	Gidabal
8923	Gidj
8923	Gidja
9302	Gilbertese
8199	Gimba
8307	Giramai
8307	Girramay
8307	Girramy
8307	Girrimay
8914	Githabul
8706	Gogodja
8212	Golumala
8803	Goonian
8803	Goonien
8803	Goonihandi
8803	Gooniyandi
8803	Goonyah
8913	Goore
8126	Gorogone
8912	Grawa
3402	Great Russian
2201	Greek
2201	Greek Cypriot
9101	Greenlandic

8101	Groote Eylandt
9101	Guarani
2303	Guatamalan
8243	Gubabuyngu
8243	Gubapunuy
8123	Gudanji
8706	Gugaja
5202	Gugrati
8300	Gugu
8303	Gugu Jao
8399	Gugu Muminh
8301	Gugu Yalandji
8301	Gugu Yalanj
8301	Gugu Yalanji
8303	Gugu Yau
8302	Gugu Yimidir
8302	Gugu Yimidjir
8302	Guguyimithin
9299	Guinean
5202	Gujarati
5202	Gujrati
8242	Gumadji
8242	Gumatj
8242	Gumats
8915	Gumbaynggir
8125	Gun-nartpa
8803	Gunan
8148	Gunavidji
8148	Gunaviji
8108	Gunawingu
8124	Gundjajeimi
8124	Gundjehmi
8134	Gunei
8126	Gungurugoni
8803	Gunian
8108	Gunwinggu
8108	Gunwingo
8108	Gunwingu
8108	Gunwinku
8243	Gupanuyngu
8243	Gupapungu
8243	Gupapuyngu
8243	Gupapuynju
8243	Gupapuynu
8243	Gupapuyungu
8243	Gupapuyuu
9299	Gurage

8999	Gurama
5202	Gurati
8505	Gurindji
8506	Gurindji Kriol
8505	Guringi
8505	Gurinji
5206	Gurkhali
9299	Gurma
8916	Gurnai
8126	Gurr-goni
8303	Guugu yau
8302	Guugu Yimidhirr
8302	Guugu Yimithirr
8244	Guyamirrilili
9101	Guyanese
8148	Gwornabidji
3905	Gypsy
7102	Hacca
7102	Hacka
7103	Hainam
7103	Hainanese
9101	Haitian
6102	Haka
7102	Hakah
7102	Hakha
7102	Hakka
7102	Hakka Chinese
7102	Hakkah
7102	Hakkar
9399	Halia
3301	Hangery
9221	Harari
9221	Hararian
7102	Harka
7102	Harrka
9222	Hausa
9399	Hawaiian
9403	Hawaiian English
4204	Hebrew
4204	Herrew
6517	Hiligaynon
5203	Hindhi
5203	Hindi
5200	Hindi Punjabi
5203	Hindie
5203	Hindou
5203	Hinds

5203	Hindu
5203	Hindustani
5212	Hindustani Urdu
5203	Hindy
2300	Hispanic
6201	Hmong
6299	Hmong-Mien, nec
6200	Hmong-mien, nfd
6201	Hmong Mien
7103	Hockian
7103	Hokien
7102	Hokka
7103	Hokkien
1401	Hollands
7101	Hong Kong
8199	Hongalla Hongalla
3503	Hrvatska
3503	Hrvatski
7102	Hukka
9599	Huli
7199	Hunan
7199	Hunanese
3301	Hungari
3301	Hungarian
3301	Hungary
6516	Iban
2300	Iberian romance
2399	Iberian Romance, nec
2300	Iberian romance, nfd
9223	Ibo
1502	Icelandic
8313	Idinji
1303	Idisch
9223	Igbo
9299	Ijaw
9302	Ikiribati
8403	Iland Creole
6503	Ilicano
8603	Illaura
6517	Illonggo
8603	Illura
6503	Ilocano
6503	Ilokano
6517	Ilongo
6517	Ilongo (Hiligaynon)
0000	<i>Inadequately Described</i>
8944	Inawonga

8000	Indegenous Australian
5000	Indian
9101	Indian American
5205	Indian Marathi
8943	Indibandi
5000	Indie
8000	Indigenous
8000	Indigenous language
8943	Indjibandi
8943	Indjibandje
6504	Indo
5299	Indo-Aryan, nec
5200	Indo-Aryan, nfd
5200	Indo Aryan
6504	Indonesia
6504	Indonesia Bahasa
6504	Indonesian
6504	Indonesian bahasa
0001	Infant
8999	Ingada
8943	Ingibundy
8101	Ingura
4999	Ingush
8943	Injabadi
8943	Injabundi
8943	Injibandi
8943	Injibardi
8943	Injibarndi
8943	Injibund
8943	Injibundie
8943	Injie bundie
8943	Injinbarndi
8944	Innawonga
9601	Interlingua
9601	Invented Languages
4106	Iran
4106	Iranian
4100	Iranic
4199	Iranic, nec
4100	Iranic, nfd
4202	Iraqi
1102	Irish
1102	Irish gaelic
0000	Islamik
4204	Israeli
2999	Istrian
2401	Italian

2401	Italiano
2401	Italy
8127	Iwadjja
8127	Iwaidja
8148	Jabanna
8199	Jabaru
9101	Jamaican
8128	Jaminjung
8718	Jankundjara
8303	Jao
7201	Jap
7201	Japan
7201	Japanese
6599	Jarai
8507	Jarrou
8507	Jarroo
8507	Jarru
8507	Jaru
8507	Jaru (Djaru)
8131	Jarwin
8131	Jarwon
6518	Javanese
8999	Jawara
8131	Jawoyn
0000	Jedi
8301	Jelanji
1201	Jersey channel island
1303	Jewish
0000	Jibberish
8943	Jindjaparndi
8132	Jingalu Mudbura
8132	Jingili
8132	Jingilli
8132	Jingulu
8306	Jirrabal
1303	Judaeo German
2399	Judaeo Spanish
3507	Jugoslav
3507	Jugoslavian
3507	Jugoslavina
8199	Jugul
8231	Jumbabuingo
8516	Juwaliny
8399	Kaanju
8507	Kabiri
6199	Kachin
6599	Kadazan

8606	Kadich
8922	Kaiadilt
8199	Kaiali
8606	Kaidich
8606	Kaidilt Bentinck
8606	Kaitish
8606	Kaititj
8606	Kaititja
9299	Kakwa
8401	Kala Kawa Ya
8401	Kala Kawaw Ya
8401	Kala Lagau Ya
8401	Kala Lagaw
8401	Kala Lagaw Kriol
8401	Kala Lagaw Ya
8401	Kalakuwiya
8401	Kalalaguya
9599	Kalami
8401	Kalaw Kawa Ya
8401	Kalaw Kawaw Ya
8401	Kalaw Kawaw Ya/Kalaw Lagaw Ya
8401	Kalaw Lagaw Ya
8401	Kalaw Lagaw Ya (Kalaw Kawa Ya)
8401	Kalawga
6599	Kalinga
8211	Kalpu
9599	Kamba
9211	Kamba Swahilli
6301	Kamer
8911	Kamilaroi
6301	Kampuchean
8916	Kanai
8811	Kanar
5101	Kanarese
8399	Kanju
6599	Kankanaey
5101	Kannada
9299	Kanuri
8303	Kao
6521	Kapampangan
8917	Karajarri
8917	Karatjarri
8912	Karawa
1699	Karelian
6103	Karen
6103	Karen Thai
8918	Kariarra

8912	Kariwa
8918	Kariyarra
8917	Karrajarrri
8912	Karrawar
8912	Karwa
8704	Kartujarra
8912	Karwa
5215	Kashmiri
9599	Kate
8606	Katiji
8606	Katitja
8606	Katschi
8704	Katutjara
8921	Kaurna
8922	Kayardild
8606	Kaydish
8606	Kaytej
8606	Kaytetye
4399	Kazakh
4399	Kazakstani
8924	Kearol
4203	Keldan
9200	Kenyan
6301	Khamer
6399	Khasi
6301	Khemer
6301	Khmar
6301	Khmer
6399	Khmu
9200	Khoisan
8923	Kidja
8923	Kija
9299	Kikamba
9299	Kikongo
9224	Kikuyu
4203	Kildian Assyrian
8899	Kimberley Area Languages, nec
8800	Kimberley Area Languages, nfd
9299	Kinyarwanda
9299	Kinyrwanda
4399	Kirgiz
9302	Kiribatese
9302	Kiribati
9299	Kisii
9211	Kiswahili
8923	Kitja
9502	Kiwai

1201	Kiwi
8401	Kky
0000	Klingon
6301	Kmer
6301	Kmhere
5199	Koda
5199	Kodava
6399	Koho
8705	Kokatha
5204	Kokni
8300	Koko
8308	Koko-Bera
8308	Koko Bera
8199	Kokori
5199	Kolami
8308	Konanin
8803	Konean
9299	Kongo
5204	Konkani
8705	Kookatha
8000	Koori
8505	Koorignie
7301	Korean
8505	Korindji
8505	Koringi
8912	Korraawa
8924	Kreol
9205	Kreole
9225	Krio
8924	Kriol
8924	Kriole
8924	Kroil
9299	Kru
8301	Ku ku Yalangi
9599	Kuanua
8399	Kugu Muminh
8706	Kukadja
8706	Kukaja
8706	Kukata
8705	Kukatha
8706	Kukatja
8706	Kukatja (Gugaja)
9299	Kuku
8303	Kuku Ya'o
8303	Kuku Ya O
8301	Kuku Yalandji
8301	Kuku Yalangi

8301	Kuku Yalanji
8706	Kukutja
8301	Kukyaoanji
8242	Kumatj
5299	Kumauni
8199	Kumertuo
8803	Kunan
8108	Kunawinjku
8108	Kunawinku
8133	Kunbarlang
8134	Kune
8803	Kunian
8135	Kuninjku
8399	Kunjen
8108	Kunkingku
8108	Kunwing
8108	Kunwinggu
8108	Kunwinjku
4101	Kurdish
8505	Kurindi
8260	Kurka
5199	Kurukh
5200	Kutchi
8199	Kutji
8311	Kuuk Thayorre
8303	Kuuku-Ya'u
8303	Kuuku Yau
8108	Kuwinku
9399	Kwarae
8505	Kwaranjee
8899	Kwini
8301	Kyahara
6401	Lad
6401	Ladation
2999	Ladin
2399	Ladino
9101	Lakota
8312	Lama Lama
8312	Lamalama
5207	Landa
9299	Lango
6401	Lao
6401	Laos
6401	Laostian
6401	Laotian
6401	Laotien
6401	Laotienne

6401	Laotion
1699	Lapp
8136	Laragia
8136	Larakia
8925	Lardil
8136	Larrakia
8136	Larrakiya
2902	Latin
3101	Lativan
3101	Latvian
9399	Lau
4202	Lebanese
4202	Lebenese
4202	Lebo
3101	Lettish
1302	Letzeburgesch
1302	Letzeburgish
6499	Li
9200	Liberian
8508	Light Warlpiri
9299	Lingala
0000	Lingo
6199	Lisu
3102	Lithuanian
8235	Liyagalawumirr
8707	Loritja
9299	Luba
1699	Ludic
9226	Luganda
9226	Lugandian
9299	Luhya
8923	Lunga
8923	Lungga
9299	Lunyankole
9227	Luo
8707	Luraja
8707	Luridji
8707	Lurita
8707	Luritcha
8707	Luritga
8707	Luritja
8707	Luritja Arrente
8707	Luritua
8707	Lurritja
3999	Lusatian
1302	Luxembourgish
9227	Lwo

8401	Mabuiag
3504	Macadian
3504	Macadonian
3504	Macedon
3504	Macedonan
3504	Macedonia
3504	Macedonian
3504	Macedonijan
0000	Maco
3504	Macodian
8245	Madarrpa
9299	Madi
6599	Madurese
8711	Maduwonga
8402	Maer
3301	Magyar
5205	Maharastrian
8145	Maiali
9702	Makaton
9702	Makaton sighning
9702	Makaton sign
3504	Makedoneki
3504	Makedonia
3504	Makedonian
3504	Makedonski
9299	Malagasay
9299	Malagasy
8137	Malak
8137	Malak Malak
9299	Malawian
6505	Malay
5102	Malayalam
6505	Malaysian
6505	Malaysian Bahasa
5103	Malaysian tamil
6505	Malayu
5214	Maldivian
8712	Maliar
8511	Malngin
2501	Malta
2501	Maltease
2501	Maltese
2501	Malthese
2501	Malti
5199	Malto
8926	Managala
8234	Manarrngu

7999	Manchu
7104	Mandarin
7104	Mandarine
4203	Mandi
8708	Mandildjara
8708	Mandjildjarra
7104	Mandren
7104	Mandrin
8708	Mandyildyarra
8926	Mangala
8246	Mangalili
8138	Mangarayi
8708	Mangarla
8138	Mangarrayi
8246	Manggalili
8708	Mangu
8926	Mangula
5999	Manipuri
8708	Manjiljara
8708	Manjiljarra
8708	Mantjiltjarra
1199	Manx
0000	Many
8708	Manyjilyjarra
9304	Maori
9303	Maori Is.
9303	Maori (Cook Island)
9304	Maori (New Zealand)
8142	Mara
5205	Marathi
5205	Marathi Indian
5205	Marati
8927	Marawari
8711	Mardo
8711	Mardu
8143	Mari Dhiyel
8141	Mari Ngarr
8199	Maridan
8199	Marimanindji
8141	Marin-ngarr
8141	Maringar
8141	Maringarr
9205	Maritian
8804	Mariyung
9304	Maroi
9399	Marova
8142	Marra

8239	Marrakulu
8199	Marramaninyshi
8234	Marrangu
8141	Marri
8199	Marridan
8143	Marrithiyel
9399	Marshallese
8711	Martu
8711	Martu Wangka
8999	Martuthunira
8711	Martuwanga
8711	Martuwangka
9299	Masai
9207	Mashona
3504	Massadona
8144	Matngala
8111	Mau
8111	Maung
9304	Maurie
9205	Mauritian
9205	Mauritian creole
9205	Mauritius
8111	Mawng
8145	Mayali
8145	Mayeli
8507	Meening
8141	Meil
9300	Melanesian
6505	Melayu
9299	Mende
0000	Mendi
6201	Meo
8402	Meram
8402	Meriam
8402	Meriam Meir
8402	Meriam Mir
8402	Meryam
5299	Mewari
2303	Mexican
8145	Miali
8145	Mialli
6201	Miao
9300	Micronesian
4200	Middle Eastern
4299	Middle Eastern Semitic Languages, nec
4200	Middle Eastern Semitic Languages,

	nfd
8250	Milingimbi
8402	Miriam
8402	Miriam Kriole
8402	Miriam Mer
8804	Miriwong
8804	Miriwoong
8804	Miriwung
8804	Mirong
8804	Mirrawong
8804	Mirriwong
8804	Mirriwoong
8199	Miwa
5999	Mizo
6399	Mnong
9304	Moari
3904	Moldavian
3904	Moldovan
8141	Moli
2501	Moltease
6303	Mon
6303	Mon-Khmer
6399	Mon-Khmer, nec
6300	Mon-Khmer, nfd
6201	Mong
7902	Mongol
7902	Mongolian
3505	Montenegrin
1699	Mordovian
9299	More
4202	Moroccan
9299	Mossi
9305	Motu
8141	Moyl
8512	Mudbera
8512	Mudbura
8512	Mudburra
8512	Mudburra Djingli
8512	Mudburra Garrawa
8146	Muinpatta
8146	Muinpotta
8146	Muintatta
8714	Mulatara
0000	Multilingual
8137	Muluk muluk
5999	Munda
5999	Mundari

8138	Munga
8138	Mungari
8304	Mungkan
8304	Muncan
8304	Munkan
8304	Munkanm
8146	Murinbada
8146	Murinpatha
8146	Murinykata
8146	Murinykata
8000	Murri
8146	Murrinh Patha
8146	Murrinhpatha
8927	Muruwari
0001	Mute
8512	Mutpurra (Mudburra)
6101	Myanmar
8147	Na-kara
5999	Naganese
8932	Nagrrindjeri
8147	Nakara
8147	Nakkara
8712	Nalada
8299	Nangga
8113	Nangikurrungurr
8113	Nangkykurungurr
8934	Nangumarda
8934	Nangumarta
8113	Nangykurungurr
8928	Naranga
8928	Narangga
8515	Nariman
8515	Narinman
8147	Narkarrar
8399	Narnar
8932	Narrinyari
8928	Narrunga
8928	Narungga
9303	Native Cook Island
9306	Nauruan
9228	Ndebele
8148	Ndjebbana
8148	Ndjebbana (Gunavidji)
8148	Ndjebbana
1401	Nederlands
9401	Neo Melanesian
5206	Nepalese

5206	Nepali
1401	Netherlandic
1401	Netherlands
9499	New Caledonian French
1201	New Zealand
9304	New Zealand Maori
5999	Newari
0001	Newborn
0001	Newborn baby
8712	Ngaadjadjar
8113	Ngaagi Kurunggurr
8712	Ngaagi Kurunggurr
8712	Ngaanyatjara
8712	Ngaanyatjarra
8712	Ngaatjatjara
8999	Ngadyan
8515	Ngaiman
8515	Ngainman
8515	Ngainmun
8151	Ngalakgan
8000	Ngali
8152	Ngaliwurru
9599	Ngalum
8113	Ngan'gikurunggurr
8113	Ngan'giwumirri
8712	Nganandjara
8113	Ngancikurunggurr
8999	Ngandangara
8513	Ngandi
8113	Ngangikurunggurr
8113	Ngangikurungurr
8113	Ngangikurrungurr
8113	Ngangikurungurr
8113	Ngangiwiwirr
8113	Ngangkikurungurr
8113	Nganikurungurr
8712	Ngannyatjarra
8199	Ngara
8514	Ngardi
8000	Ngari
8515	Ngaringman
8515	Ngarinman
8805	Ngarinyin
8515	Ngarinyman
8999	Ngarla
8931	Ngarluma
8932	Ngarranjeri

8932	Ngarrindejeri
8932	Ngarrindjeri
8113	Ngenkikurunggurr
8999	Ngiyampaa
8934	Ngolibardu
8935	Ngoongar
8515	Ngrainmun
8113	Ngukkurra
9399	Ngunese
9299	Nguni
8281	Nhangu
0000	Nia
8806	Nigena
9200	Nigerian
0001	Nil
9200	Nilotic
8507	Nining
7201	Nippon
9307	Niue
9307	Niuean
8934	Njangamarda
0001	No
0001	No language
0001	No speech
0001	Non speaking
0001	Non verbal
0001	<i>Non Verbal, so described</i>
0001	None
0001	Nonverbal communication
8935	Noogarr
8935	Noongah
8935	Noongar
8935	Noongyar
9404	Norfolk English
9404	Norfolk Isl
9404	Norfolk Isl lang
9404	Norfolk Island
9404	Norfolkese
1503	Norsk
8000	Northern Aboriginal
8599	Northern Desert Fringe Area Languages, nec
8500	Northern Desert Fringe Area Languages, nfd
1000	Northern European
1000	Northern European Languages, nfd
1503	Norwegian

1503	Norwegan
1503	Norwegian
1503	Norwegian
0001	Not able to speak
0001	Nothing
0001	Nothing yet
0002	<i>Not Stated</i>
1201	Nth Ireland
9299	Nubian
9231	Nuer
8114	Nuggaboju
8114	Nugubuyu
8999	Nukunu
8000	Nunga
8114	Nungabuju
8114	Nungabuyu
8153	Nungali
8114	Nunggubuyu
8114	Nungubuyu
5999	Nuristani
8933	Nyamal
8933	Nyamil
9232	Nyang
8934	Nyangamada
8934	Nyangumarda
8934	Nyangumarta
8934	Nyangumata
9232	Nyanja (Chichewa)
9299	Nyasan
8935	Nygoonah
8806	Nyigina
8806	Nyikina
8507	Nyinin
8933	Nymal
8935	Nyoogar
8935	Nyoonga
8935	Nyoongar
8935	Nyungah
8935	Nyungar
8935	Nyungar (Noongar)
1201	NZ
8100	N/E Arnham Land Aboriginal dialect
2101	Occitan
9400	Oceanian Creole
9400	Oceanian Pidgin
9499	Oceanian Pidgins and Creoles, nec

9400	Oceanian Pidgins and Creoles, nfd
9400	Oceanic Creole
9400	Oceanic Pidgin
8399	Olgol
5216	Oriya
9599	Orokaiva
9206	Oromifa
9206	Oromo
4199	Ossetic
8999	Other Australian Indigenous Languages, nec
8900	Other Australian Indigenous Languages, nfd
7999	Other Eastern Asian Languages, nec
7900	Other Eastern Asian Languages, nfd
3999	Other Eastern European Languages, nec
3900	Other Eastern European Languages, nfd
9000	Other Languages, nfd
6999	Other Southeast Asian Languages
5999	Other Southern Asian Languages
2999	Other Southern European Languages, nec
2900	Other Southern European Languages, nfd
4999	Other Southwest and Central Asian Languages, nec
4900	Other Southwest and Central Asian Languages, nfd
8299	Other Yolngu Matha
1201	Ozzi
9000	P n g
8936	Paakantji
8936	Paakantyi
9000	Pacific
9399	Pacific Austronesian Languages, nec
9300	Pacific Austronesian Languages, nfd
7999	Paiwan
5200	Pakistani
9399	Palauan
6399	Palaung
4202	Palestinian
8937	Palyku/Nyiyaparli
6521	Pampangan

6521	Pampango
6599	Pangasinan
6521	Pangpango
5207	Panjabi
8904	Panjima
9101	Papiamento
9599	Papua New Guinea Papuan Languages, nec
9500	Papua New Guinea Papuan Languages, nfd
9000	Papua New Guinean
9500	Papuan
4106	Parisan
4106	Parsi
4106	Parsian
4105	Parsian Daree
4102	Pashto
4102	Pashtu
9299	Pedi
6303	Peguan
9399	Penryn
4106	Perion
4105	Persian Dari
4106	Persian Farsi
4106	Persian (excluding Dari)
2303	Peruvian
4106	Pharsi
8000	Phil
6512	Phili
6512	Philipens
6512	Philippines
6512	Philippino
6512	Phillipines
6512	Phillopino
0009	Pidgeon
9401	Pidgeon English
9405	Pidgeon Solomon Island
0009	Pidgin
0009	<i>Pidgin, nfd</i>
9401	Pidgin English
9499	Pidgin French
9400	Pidgin Oceanian
9405	Pidgin Solomon Island
0000	Pig Latin
0009	Pigeon
9401	Pigeon English
0009	Pigin

9405	Pigin Solomon Island
8714	Pijantjatjara
9499	Pijin
1201	Pikey
6512	Pilipina
6512	Pilipino
6512	Pilipo
8716	Pindini
8713	Pindu
8714	Pintjatjarra
8713	Pintubi
8713	Pintupi
8605	Pirdima
9599	Pisa
8000	Pit
8714	Pit jan jat jarra
8714	Pitanjatjara
9404	Pitcairnese
8714	Pitdjandjara
8714	Pitimjara
8714	Pitindjatjara
8714	Pitjandara
8714	Pitjandjadjara
8714	Pitjanjajarra
8714	Pitjanjara
8714	Pitjanjarra
8714	Pitjant
8714	Pitjantjajara
8714	Pitjantjara
8714	Pitjantjarra
8714	Pitjantjartjara
8714	Pitjantjatjara
8714	Pitjantjatjaraa
8714	Pitjantjtajara
8714	Pitjantjtjara
8714	Pitjanttatjara
8605	Pitjapitja
8714	Pitjara
8714	Pitjatjara
8714	Pitjatjatjara
8714	Pitjijinarra
8714	Pitjindjatjara
8714	Pitjinjara
8714	Pitjinjiara
9000	Png
9401	Png Pidgin
3602	Poland

9601	Polari
3602	Polish
3602	Polski
9300	Polynesian
2302	Portages
2302	Portugal
2302	Portugese
2302	Portugues
2302	Portuguese
0008	Portuguese Creole
0008	<i>Portuguese Creole, nfd</i>
9399	Puka Pukan
5207	Punjabi
5207	Punjbi
8713	Puntubu
4102	Pushto
8799	Putijarra
7104	Putonghua
6499	Puyi
9101	Quechua
9499	Queensland Canefield English
6599	Rade
5299	Rajasthani
8115	Rambaranga
8115	Rambarrnga
8115	Ramberranga
9303	Rarotongan
3402	Rashan
9312	Ratuman
6199	Rawang
8115	Rembaranga
8115	Rembarrnga
6399	Rengao
2999	Rhaetian
8219	Rirratjingu
8271	Ritharngu
8271	Ritharrngu
2401	Roman
3905	Romanes
3904	Romanian
2999	Romansch
2999	Romansh
2999	Romantsch
3905	Romany
9599	Roro
9312	Rotuman
3904	Roumanian

9399	Roviania
3904	Rumanian
9299	Rundi
3402	Rusian
3402	Russe
3402	Russia
3402	Russian
3401	Russian White
3403	Ruthenian
9299	Rwandan
1699	Saami
2303	Salvadorian
9208	Samalian
9308	Samoa
9308	Samoan
9299	Sango
5299	Sanskrit
7999	Santa
2401	Sardinian
1500	Scandinavian
1599	Scandinavian, nec
1500	Scandinavian, nfd
1301	Schweizerdeutsh
2401	Scilian
1201	Scotish
1201	Scotland
1201	Scottish
1101	Scottish Gaelic
6000	Se Asian
6399	Sedang
9299	Senegalese
3505	Serb
3507	Serb Croat
3507	Serb Croatian
3505	Serbia
3505	Serbian
3507	Serbian Croat
3507	Serbian croatian
3505	Serbien
3505	Serbo
3507	Serbo-Croatian/Yugoslavian, so described
3507	Serbo Croat
3507	Serbo Croatian
3507	Serbo Croato
3505	Serbs
9299	Serer

9299	Sesothoian
9236	Setswana
0000	Several
9238	Seychelles Creole
6499	Shan
7106	Shanghai
7106	Shanghaiese
7106	Shanghainese
9233	Shilluk
9207	Shona
6402	Siamese
2401	Sicilian
9299	Sierra Leone
9700	Sign
9700	Sign for the deaf
9700	Sign language
9799	Sign language American
9701	Sign language Aust
9701	Sign language Australian
9799	Sign languages, nec
9700	Sign languages, nfd
9700	Signe hearing
9700	Signed English
9700	Signing
9399	Sikaiana
5200	Sikh
5999	Sikkamese
5211	Sinanese
5208	Sindhi
5211	Singaleese
5211	Singalese
0000	Singaporean
5211	Singhala
5211	Singhale
5211	Singhalese
5211	Singhelis
5211	Sinhaelies
5211	Sinhala
5211	Sinhala Tamil
5211	Sinhalais
5211	Sinhale
5211	Sinhalease
5211	Sinhalese
5211	Sinhalis
5211	Sinhaliss
5211	Sinhelees
5211	Sinhlise

7100	Sinitic
9299	Siswati
0000	Slang
3000	Slav
3000	Slavic
3500	Slavic south
3000	Slavonic
3000	Slov
3603	Slovak
3603	Slovakian
3506	Slovanian
3506	Slovene
3506	Slovenian
3506	Slovenijen
3506	Slovensky
9405	Solomon Islands Pijin
9405	Solomon Island Pidgeon
9405	Solomon Island Pidgin
9405	Solomon Island Pigeon
9405	Solomon Island Pigin
9405	Solomon Islands Pidgeon
9405	Solomon Islands Pidgin
9208	Somali
9208	Somalia
9208	Somalian
9299	Songhai
3999	Sorbian
9299	Sotho
0000	South African
2300	South American
5000	South Asian
7301	South Korean
3500	South Slavic
3500	South Slavic, nfd
6000	Southeast Asian
6599	Southeast Asian Austronesian Languages, nec
6500	Southeast Asian Austronesian Languages, nfd
6000	Southeast Asian Languages, nfd
5000	Southern Asian Languages, nfd
2000	Southern European
2000	Southern European Languages, nfd
4000	Southwest and Central Asian Languages, nfd
4000	Southwest Asian
2303	Spain

2303	Spanish
0007	Spanish Creole
0007	<i>Spanish Creole, nfd</i>
0001	Speech impediment
3505	Srbian
3505	Srbijan
5000	Sri Lanka
5000	Sri Lankan
3505	Srpski
5000	Sth Asian
6000	Sttheast Asian
1201	Strine
9200	Sudanese
2101	Suisse
5999	Sumi
1602	Suomi
1504	Svensk
9211	Swahili
7101	Swatow
9299	Swazi
1504	Swedish
0003	Swiss
2101	Swiss French
1301	Swiss German
0003	Swiss, so described
4203	Syriac
4202	Syrian
7105	T-chow
4199	Tadjik
6511	Tagalo
6511	Tagalog
6511	Tagalog Filipino
6511	Tagalog Visayan
6511	Tagalog (Filipino)
6511	Tagarlog
9399	Tahitian
6402	Tai
8220	Taii
8311	Taiol
7103	Taiwanese
6499	Tai, nec
6400	Tai, nfd
6511	Talago
5103	Tamail
5103	Tamil
5103	Tamil Malay
5103	Tamil Malayalam

5103	Tamils
9299	Tani ewe
9299	Tanzanian
7105	Tao chow
4303	Tartar
6511	Tatalog
4303	Tatar
9304	Te Reo Maori
7105	Teachieu
7105	Techao
7105	Tei Chow
5104	Telgu
5104	Telugu
9299	Temne
7105	Teo Chauv
7105	Teo Chew
7105	Teo Chiew
7105	Teochew
7105	Teochiu
7105	Teow Chew
6507	Tetum
6507	Tetun
6507	Tetun Portuguese
6507	Tetuna Indonesia
8311	Thaaryore
8311	Thaayore
6402	Thai
6402	Thailand
8999	Thalanyji
8221	Thalwungu
8311	Thayorre
8400	Thursday Is
8400	Thursday island
8400	Ti language
7901	Tibetan
7105	Tie Chiu
7105	Tie Chiw
7105	Tieu Chau
7105	Tieu Chow
9235	Tigray
9234	Tigre
9235	Tigrina
9235	Tigringa
9235	Tigrinya
9235	Tigrnga
6508	Timorese
6507	Titun Haka

9299	Tiv
8117	Tiwi
8117	Tiwi island
8305	Tjapukai
8507	Tjaru
8714	Tjitiadjara
7105	To Chu
9599	Toaripi
7105	Tochew
9399	Togar
9401	Tok Pisin
9313	Tokelau
9313	Tokelauan
9599	Tolai
9311	Tonga
9311	Tongan
0000	Tongues
0001	Too small
0001	Too young
0001	Too young to speak
8924	Top End Kriol
8400	Torres Strait
8403	Torres Strait Creole
8403	Torres Strait Creole (broken)
8400	Torres Strait Island
8400	Torres Strait Island Languages, nfd
8400	Torres Strait Islander
8403	Torres Strait Pigeon
8000	Tribal
8000	Tribal language
2401	Triestine
7105	Trieu Chau
5999	Tripriui
8403	Tsi Criole
9299	Tsonga
9236	Tswana
5105	Tulu
7999	Tungus
9101	Tupi
4301	Turk
4301	Turkce
4301	Turkey
4399	Turkic, nec
4300	Turkic, nfd
4301	Turkihs
4301	Turkish
4300	Turkistani

4304	Turkmen
9314	Tuvaluan
9203	Twi
9203	Twi akan
8311	Tyorre
9299	Ugandan
4305	Uighur
3403	Ukrahian
3403	Ukraine
3403	Ukrainian
3403	Ukranian
3403	Ukranian Rusian
8199	Umbia
8399	Umpila
0000	Unknown tongue
8000	Urben koori
5212	Urdu
5212	Urdu
5212	Urdu Hindi
5212	Urdu Hindustani
5212	Urdu Punjabi
4305	Urhur
9299	Uroba
2303	Uruguayan
4305	Uyгур
4306	Uzbek
6302	Viet Nam
6302	Vietnam
6302	Vietnamese
6501	Visaya
6501	Visayan
6501	Visayan tagalog
1401	Vlaams
3903	Vlach
8999	Waanyi
8155	Wadaman
8938	Wadgaree
8938	Wadjari
8938	Wadjeri
8199	Wageman
8199	Wagiman
8938	Waian
8521	Wailbri
8938	Wajari
8938	Wajarri
8999	Wakaya
8521	Walberri

8521	Walbiri
8521	Walbrai
8521	Walbri
8521	Waljpiri
2101	Walloon
8518	Walma
8516	Walmadjari
8516	Walmadyeri
8516	Walmajari
8516	Walmajarri
8516	Walmajarri (walmadjari)
8516	Walmajeri
8516	Walmatjari
8516	Walmatjiri
8521	Walpari
8521	Walparri
8521	Walpire
8521	Walpiri
8521	Walpiri Anmatjere
8521	Walpiri Warramunga
8521	Walpri
8521	Walprie
8521	Walpuri
8999	Wamba Wamba
8154	Wambaya
8715	Wangajunka
8715	Wangatjunga
8715	Wangkajunga
8716	Wangkatha
8716	Wangkatja
8715	Wangkatjunga
8000	Wangu
8213	Wanguri
8213	Wangurri
8101	Wanindilyaugwa
8716	Wankaija
8716	Wankatja
8516	Wanmadjari
8000	Wanybarran
8517	Wanyjirra
8000	War
8522	Waramunga
8522	Waramungu
6599	Waray
8155	Wardaman
8521	Warlbiri
8518	Warlmanpa

8521	Warlpiri
8521	Warlpiri Aranda
8717	Warnman
8522	Warnmun
8921	Warra
8522	Warra munga
8521	Warrabri
8522	Warramanga
8522	Warramangu
8522	Warramunga
8199	Warrangari
8522	Warranmunga
8522	Warrumugu
8522	Warrumungu
8899	Warwa
8522	Warumungu
8938	Watjari
1103	Welsh
3999	Wendish
9200	West African
3600	West Slavic
3600	West Slavic, nfd
9308	Westera Samoa
8605	Western Aranda
8605	Western Arrante
8605	Western arrernte
8799	Western Desert Language, nec
8700	Western Desert Language, nfd
8707	Western Loritja
9308	Western Samoan
3401	White Russian
8304	Wik Hungkan
8304	Wik Monkan
8304	Wik Munggan
8304	Wik Mungkan
8304	Wik Mungken
8314	Wik Ngathan
8314	Wik Ngathana
8304	Wika Munkan
8304	Wikmungkan
8304	Wikmunkan
8941	Wiradjuri
8941	Wiradyuri
8199	Witchi
8938	Wodjeri
9299	Wolof
8716	Wongaii

8716	Wongatha
8716	Wonggai
8716	Wonggail
8716	Wongi
8605	Wongkatjeri
8716	Wongutha
8304	Woran am
8808	Worara
8807	Worla
8808	Worora
8808	Wororra
8808	Worrora
8808	Worrorra
7106	Wu
8247	Wubulkarra
8251	Wulagi
8251	Wulaki
8516	Wulmatjerie
8811	Wunambal
8251	Wurlaki
8522	Wurrumungu
9237	Xhosa
9237	Xhosa Afrikaans
8270	Yakuy
8270	Yakuy, nfd
8279	Yakuy, nec
8301	Yalandji
8938	Yamaji
8938	Yamatji
8938	Yamigi
8943	Yanari
8718	Yangkuntjatjara
8718	Yankunjara
8718	Yankuntjara
8718	Yankuntjatjara
8718	Yankutjara
8942	Yanula
8942	Yanuwa
8942	Yanyula
8942	Yanyuwa
8942	Yanyuwa (Anula)

9315	Yapese
8812	Yawuru
0001	Yet to speak
3507	Ygoslave
1303	Yiddisch
1303	Yiddish
8313	Yidiny
8899	Yijji
8711	Yindi
8943	Yindjibarndi
8943	Yingiebandie
8944	Yinhawangka
8399	Yir Yoront
8200	Yolgu
8200	Yolgu Matha
8200	Yolngu
8200	Yolngu Matha
8200	Yolngu Matha, nfd
8200	Yolnu Mata
8945	Yorta Yorta
8945	Yortayorta
9212	Yoruba
3507	Yougslavia
7101	Yue
3507	Yug
8999	Yugambeh
3507	Yugo
3507	Yugoslav
3507	Yugoslavian
8721	Yulaparitya
8721	Yulbarija
8721	Yulparija
8721	Yulparitja
8301	Yung kurara
8301	Yungurara
8718	Yunkuntjatjara
8301	Yunkurara
9299	Zambian
9299	Zande
9299	Zimbabwean
9213	Zulu

Appendix 3: International Classification of Diseases (ICD)

International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Version for 2007, Diseases of the circulatory system, Cerebrovascular diseases.

I61 Intracerebral haemorrhage

Excludes: sequelae of intracerebral haemorrhage ([I69.1](#))

I61.0 Intracerebral haemorrhage in hemisphere, subcortical

Deep intracerebral haemorrhage

I61.1 Intracerebral haemorrhage in hemisphere, cortical

Cerebral lobe haemorrhage
Superficial intracerebral haemorrhage

I61.2 Intracerebral haemorrhage in hemisphere, unspecified

I61.3 Intracerebral haemorrhage in brain stem

I61.4 Intracerebral haemorrhage in cerebellum

I61.5 Intracerebral haemorrhage, intraventricular

I61.6 Intracerebral haemorrhage, multiple localized

I61.8 Other intracerebral haemorrhage

I61.9 Intracerebral haemorrhage, unspecified

I62 Other nontraumatic intracranial haemorrhage

Excludes: sequelae of intracranial haemorrhage ([I69.2](#))

I62.0 Subdural haemorrhage (acute)(nontraumatic)

I62.1 Nontraumatic extradural haemorrhage

Nontraumatic epidural haemorrhage

I62.9 Intracranial haemorrhage (nontraumatic), unspecified

I63 Cerebral infarction

Includes: occlusion and stenosis of cerebral and precerebral arteries, resulting in cerebral infarction

Excludes: sequelae of cerebral infarction ([I69.3](#))

I63.0 Cerebral infarction due to thrombosis of precerebral arteries

I63.1 Cerebral infarction due to embolism of precerebral arteries

- I63.2 Cerebral infarction due to unspecified occlusion or stenosis of precerebral arteries
- I63.3 Cerebral infarction due to thrombosis of cerebral arteries
- I63.4 Cerebral infarction due to embolism of cerebral arteries
- I63.5 Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries
- I63.6 Cerebral infarction due to cerebral venous thrombosis, nonpyogenic
- I63.8 Other cerebral infarction
- I63.9 Cerebral infarction, unspecified
- I64** **Stroke, not specified as haemorrhage or infarction**
Cerebrovascular accident NOS
Excludes: sequelae of stroke ([I69.4](#))
- G45** **Transient cerebral ischaemic attacks and related syndromes**
Excludes: neonatal cerebral ischaemia ([P91.0](#))
- G45.9** **Transient cerebral ischaemic attack, unspecified**
Spasm of cerebral artery
Transient cerebral ischaemia NOS